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DISTRICT COURT

CLARK COUNTY, NEVADA

ELISA SALES, Plaintiff(s), vs. SUMMERLIN HOSPITAL AND MEDICAL CENTER, LLC, Defendant(s).	CASE NO. A-17-758060-C DEPT. NO. XXIX

BEFORE THE HONORABLE DAVID M. JONES, DISTRICT COURT JUDGE

WEDNESDAY, OCTOBER 2, 2019

RECORDER'S TRANSCRIPT OF HEARING: JURY TRIAL - DAY 3 PM

APPEARANCES:

For the Plaintiffs: SEAN K. CLAGGETT
JENNIFER MORALES
CAROL F. HAY
GEORDAN LOGAN

For the Defendants: MIKE PRANGLE
MAJORIE E. KRATSAS

RECORDED BY: MELISSA MURPHY-DELGADO, COURT RECORDER
TRANSCRIBED BY: ALLISON SWANSON, CSR No. 13377

[OUTSIDE THE PRESENCE OF THE JURY.]

[DISCUSSION OFF THE RECORD.]

THE COURT: Counsel, anything that needs to come before the bench before we get our jury in here?

MR. PRANGLE: No, sir.

MS. KRATSAS: Oh, Your Honor, we have some stipulations for you.

THE COURT: That's nice. Like those. What stipulations do we have?

MR. CLAGGETT: This was on a couple of the experts from other parties that aren't testifying.

MS. KRATSAS: EDCR 2.47 conference.

THE COURT: Okay. [Indiscernible] regarding motions in limine.

I'm gonna change the date from "August" to "October." Okay.

Anything else?

MR. CLAGGETT: Dr. Reynolds, the outstanding motion.

THE COURT: Right here. Got it right here.

MR. CLAGGETT: Okay.

THE COURT: All right.

MR. CLAGGETT: You want me to put this down so you can --

THE COURT: As long as you guys stand where I can

see you.

MR. CLAGGETT: I'll just stand right here. It's fine.

THE COURT: In regards to Dr. Reynolds's testimony in the motion for clarification, Dr. Reynolds will be allowed to testify as to his first report and any additional materials that were not available before -- excuse me -- and any additional materials that were not available as of that date; okay? So if we have additional documents.

So any opinions that he has that were based on materials he reviewed after April 16th that were available to him or available to the Defendants before that date, he's not going to testify to. So the materials that he received -- okay -- if those were materials that were in the possession of the parties and he did not review them before he did his report and they were available, he cannot comment on 'em.

If they were not, they were done late, like depositions that were done later, he can comment upon those that were done later. But anything material that he had or could have had or should have had, depending on how you look at it, as of that April 16th deadline, he doesn't get to testify to.

MR. CLAGGETT: Thank you, Judge.

MR. PRANGLE: And, Judge, would the same rule apply to Dr. Burroughs?

THE COURT: I didn't get a motion on Dr. Burroughs. So if I got something on Dr. Burroughs, I need to know about it.

MR. PRANGLE: Okay.

THE COURT: I didn't -- all I received was the one on Reynolds.

MS. KRATSAS: Well, Your Honor, see, things are getting a little bit muddy as it relates to Dr. Reynolds. For instance, one of Ms. Sales's treating providers is her primary provider. She keeps presenting and presenting and presenting for follow-up care. It's her PCP. So --

THE COURT: But that's stuff that wasn't available at the time, Counsel.

MS. KRATSAS: Okay. Yeah.

THE COURT: And so if it was available April 16th; okay? So if it's -- for example, if it's an EKG strip that's available April 12th or if it was a medical report available January --

MS. KRATSAS: Okay.

THE COURT: -- and it was in the possession of the parties and she should have had it and could have had and could have turned it over to that expert. They didn't. They don't get to use it because of the fact that it was available at that time period.

If it came available after that time period and he's utilized that as part of his basis for his report or the way I read some of his report, he's using it in defense of his position. For example, he hasn't changed his position. His position is the same, exactly.

MS. KRATSAS: Yes.

THE COURT: So if he comes in and says, "My position was reinforced about this item," and that item was something that could have been in his possession at the time his initial report was -- or his rebuttal report was due, he doesn't get to comment on it. We don't get to refresh or add more stuff to someone's report if it should have been given to them prior; okay? It's that simple.

MS. KRATSAS: Yes, Your Honor.

MR. CLAGGETT: Okay, Judge.

THE COURT: Anything else that needs to come before the bench?

MR. CLAGGETT: That is all I have, Your Honor.

THE COURT: Are we ready to proceed?

MR. CLAGGETT: Are we -- Geordan, are we ready?

MR. LOGAN: Yes, Judge.

THE COURT: Okay.

MR. LOGAN: Let's turn it all on.

MR. CLAGGETT: Okay. Let us just turn everything

on, Judge, and we'll be ready to go.

THE COURT: Ladies and gentlemen in the gallery, please turn off your cell phones. Don't put 'em on vibrate. Don't put 'em on airplane mode. I want them completely turned off. We've got enough AV equipment in here, I don't need any interference. Okay?

If you're gonna leave during the presentations of this and it's not at a break, please do so quietly.

Counsel for the Defense, here's your other stipulation. Counsel, here's your other stipulation.

MS. KRATSAS: Oh, thank you, Your Honor.

THE COURT: Thank you.

MS. KRATSAS: I could approach? We'll get that filed, Your Honor.

THE COURT: Thank you.

[DISCUSSION OFF THE RECORD.]

MR. CLAGGETT: Judge, just to [indiscernible], opposing counsel has no objection to our slides.

THE COURT: Okay.

MR. CLAGGETT: Do I want animation to be shown, he's fine with that, too.

THE COURT: And that's -- what's going to be on here is going to be on that lower projection so I can see it?

MR. CLAGGETT: Yeah, so it'll be on here. It will

be showing [indiscernible] our next slide.

THE COURT: When we use these, just make sure that my view to the jurors is not blocked, please.

MR. CLAGGETT: Okay.

THE COURT: I should be able to see all of 'em right now. But just make sure it stays where it's at.

MR. CLAGGETT: Okay.

THE COURT: 'Cause I have to be able to view my jurors at all times.

MR. CLAGGETT: Okay. If we have to, we can scoot it a little bit.

THE COURT: I think we're fine right now because they're gonna start it at [indiscernible].

MR. CLAGGETT: Okay.

THE COURT: All adjust if I need to.

MR. CLAGGETT: Okay. Thanks, Judge.

THE MARSHAL: All rise for the jury.

[IN THE PRESENCE OF THE JURY.]

THE MARSHAL: All jurors accounted for. Please be seated.

THE COURT: Counsel, stipulate to the presence of the jury.

MR. CLAGGETT: Yes, Your Honor.

MR. PRANGLE: Yes, Judge.

THE COURT: Counsel for the Plaintiff, we ready to proceed?

MR. CLAGGETT: Yes, Your Honor.

THE COURT: Proceed.

MR. CLAGGETT: Thank you, Your Honor.

Can you guys hear me on this? Okay.

OPENING STATEMENT BY THE PLAINTIFF

MR. CLAGGETT: Good afternoon.

This is a simple case. This case involves a simple trip to Summerlin Hospital that was an outpatient procedure. Supposed to take 45 minutes. And Elisa Sales, my client, was supposed to go home with her husband.

She goes to Summerlin Hospital to have her pacemaker replaced because the battery was at the end of the life. It's a very simple procedure that's done all the time. Forty-five minutes. And instead of going home, she's wheeled out on life support to the ICU, after suffering a severe hypoxic brain injury, which means lack of oxygen to her brain.

Before talking about the events that happened in this case, it's important to know who Elisa Sales was before. Elisa Sales was a grandmother, a mother, and a wife. Elisa Sales, three weeks before this event took place was in Alaska with her husband, friend, and sister. And they were enjoying a vacation. She was active. She was having

meaningful relationships with her husband, family, friends. She was a Deaconess at her church. She had meaningful relationship with her granddaughter and her daughters.

She had a long period of time that she traveled as a -- her husband, Edgar, and her traveled in their older years a lot together. And they were companions and best friends.

This injury has left Elisa with the mental capacity of a five-year-old and the bowel and bladder of a two-year-old. So that she has accidents and she poops and pees herself and her husband has to clean her up and she wears a diaper. That's where she is today.

That's also why they're not going to be here. We talked about that during jury selection. And they're not going to be here because the evidence will show that Elisa Sales, if she was sitting here, she may not realize she has to go to the bathroom and she may have an accident. And she's also, the evidence is going to show, severely cognitively disabled now. And she can't assist us in the trial. So she can't help us prepare because she can't communicate with us meaningfully.

And so we're not gonna have her here at trial. And I -- we wanted to tell you that during jury selection, but we couldn't. But now, you know. And that's why they're not gonna be here. Edgar takes care of his wife.

Now, this process of being a jury we hope is enjoyable

for you and that your role as a juror is that of an investigator. And you've got to investigate different elements of what happened in this case. It's kind of like CSI Las Vegas. And throughout the course of this trial, you're going to hear witnesses testify; you're going to see documents. And, ultimately, you'll decide it.

Now, it's not a criminal case, as we -- I think you all understand, it's a civil case. So the burden is more likely than not for us to prove. But the evidence in this case will be overwhelming.

The first thing that you investigate's gonna have you look at is the motive. Why this happened. The next thing the evidence is gonna lead you to is who had the means, how did it happen, and who had the capability of preventing it. Then the evidence is going to show the injuries, which are the harms and damages that were done to Elisa Sales because of this.

And not just Elisa Sales, Edgar sales, her husband. Edgar has a claim for what we call for loss of consortium. And that's just a word that basically means the loss of the companionship and affection and solace of your spouse. And you'll hear how Elisa, now, it's more babysitting than relationship. And that while there's still the love and they absolutely have the love, the relationship of two loving spouses is not there like it used to be because Elisa doesn't

have the capability to have the relationships that she used to.

Ultimately, the final thing you'll look at is the alibis. What excuses does Summerlin Hospital have for why this happened? And we'll go through that in great detail in this opening and the evidence will spend a lot of time going through those.

Ultimately, as the investigators on this jury, your job is to ascertain the truth of what really happened and why it really happened. And it's important because, at the end of the day, the truth in this case will be clear.

The first thing we're going to talk about is the motive. What motivated this to happen? Now, some of you may be thinking, "Well, geesh, the lady goes in for a procedure and something bad happens and she ends up with a brain injury. How can there be a motive there?"

Well, let me tell you, first of all, you got to know what the motive is. And it's good old fashioned money, folks. And what we're gonna hear -- we're gonna hear a lot about policies and procedures in this case. And the one thing that there's no dispute about, Summerlin Hospital has fine -- their policies and procedures, as written, are fine.

The evidence will also show that those policies and procedures are not known, are no followed, and are not

enforced. So you ask yourselves, why? That's the motive. Well, one thing that we know is that the policies and procedures create a perception of safety. That's what they do. And you're gonna hear people talk about that.

You're also gonna hear that these policies and procedures are part of a hospital getting accreditation. They need to have these written policies and procedures so when -- it's called the Joint Commission. The Joint Commission comes in -- and you're gonna hear about this in this case. The Joint Commission comes in and they accredit the hospital. Every three years they do this. And just a week before this event takes place, the Joint Commission accredited Summerlin Hospital again, re-upped 'em. Said, everything looks okay here.

So one of the things we did before coming is we talked to the witness hired by the Defense, his name's Dr. Pietrafesa. And we asked him, we said, "Well, what's the purpose of the Joint Commission accreditation?"

And he told us, "Well, it's simple. It's all about taking Medicare, Medicaid eligible patients." It's not about patient safety. That's what it's about.

Well, when you can take more of those type of patients, you create increased revenue for the hospital. And if we weren't completely sure what the evidence was gonna show about

the motive, we spoke to Dr. Koide. Dr. Koide is the director of the EP lab.

And so let me explain how the labs are set up. So you have the Cardiology Department. And underneath the Cardiology Department, there is the, what they call cath lab. And the cath lab, in Summerlin Hospital, is three suites. And one of those suites is the EP lab. And Dr. Koide is the individual who is the director of that.

And so we deposed Dr. Koide. And you're gonna hear him testify in this case. We've subpoenaed him to show up.

He explained to us -- we said, "Well, is your job as the director have to do with patient safety?"

"No."

"Okay. Well, if there's, like, an adverse outcome that happens, are you made aware of it as the director?"

"No."

"Okay. Well, if there's a medical error that results in permanent injury to a patient, you would be made aware of that; right?"

He's like, "No."

So we go, "What are your responsibilities? It's not about patient safety."

He goes, "Well, look, my primary job is to get more doctors to bring more patients to Summerlin Hospital to do

more procedures. That's my job."

And that's what he's gonna tell you. His job was to put more heads in the beds. More doctors at Summerlin Hospital equals more money. And that's the motive.

So let's talk about the means. How did this happen? How did we get here today? Well, the evidence is going to show that Edgar and Elisa were told, "Hey, this is an outpatient procedure. We'll be right back. Come back in an hour. She'll be fine. Go home. Be all good to go."

Well, Edgar goes and grabs that bite to eat. Unfortunately, when Edgar comes back, Elisa is being wheeled away on life support to the ICU and she's fighting for her life.

Now, Summerlin Hospital, when you think about the means, who had control of the situation, Summerlin Hospital controlled the environment in which this took place. And the evidence is going to show that these individuals were there and part of the process that took place.

You have Dr. Nemiroff. Dr. Nemiroff is an anesthesiologist; okay? He was there at the procedure back on July 8, 2016. Dr. Anh was a cardiologist. He's the one that's doing the procedure to actually replace the pacemaker. Then you have Boz Knezevic, and he's a nurse. And he's assisting Dr. Nemiroff.

You have Jay Sayoc, who's another nurse who was in the room assisting Dr. Nemiroff. And then you have Dimitri Antonopoulos. And he is what they call a tech. But he's a scrub tech. And Dimitri was assisting Dr. Anh. So he -- Dimitri was the one giving Dr. Anh the tools that Dr. Anh needed during the procedure.

And then we have Jesse Hanna. And Jesse was another tech, but he's called a monitor tech. And if you look, right here you see this demonstrative exhibit of what a monitor looks like. Jesse Hanna's sitting back in this monitor room and there's glass. So imagine you all are in the monitor room and -- where Jesse is and it's glass and over here is the procedure room. Jesse's looking in. And his primary job responsibility is to take notes of what's actually happening real-time during this procedure.

He also has a job of making sure that the vital signs are taken. Now, the system that they use automatically takes vitals every five minutes and then Jesse can make it more frequent by hitting a button and then the vitals are all put on and recorded. And you'll hear that Jesse Hanna was doing that during this procedure.

Now, one thing I have to correct, because it was said during multiple times during your selection, is the hospital suggested that the only people they represent are the nurses

and the techs. And that's simply not the case. You're gonna hear lots of evidence that they represent the entire hospital. And that's what goes on in the hospital, such as the chairs of the departments, the directors, all those things.

And you're also gonna hear about Dr. Nemiroff is an anesthesiologist. And the hospital, when a patient comes in, they have no relationship with him at all. He just -- and he'll -- Dr. Nemiroff will explain that he just kind of comes along with the procedure from the hospital. And so, ultimately, during this case, you're going to have to determine whether or not Dr. Nemiroff -- whether my clients believe that Dr. Nemiroff was an employee of the hospital or an agent of the hospital or not.

And the evidence in this case will make it clear that my clients never saw him, spoke to him, knew him. Dr. Nemiroff will say that he never saw the patient, never met the patient. The first time that Dr. Nemiroff meets our patient is when Elisa Sales is lying in the surgery suite and right before he starts doing the anesthesiology on her. And that's somewhat common.

And Dr. Nemiroff will explain that he doesn't think that she would have had any idea that he was anything but an employee of the hospital. Okay?

So that's the group of individuals that were in the room

at the time. There was also one other individual, who I don't think will testify, and he was the manufacturer rep, the medical rep for the device that was put in the patient. I don't think he will testify. But he might. And he was there. He didn't perform or have any responsibility with what happened, though.

All right. So then Summerlin Hospital also had control of the alarms. Now, the evidence is going to show -- and we asked Summerlin Hospital, "Hey, give us a list of all the equipment in this room that had audible alarms." That's what we wanted to know.

And they said, "Well, the GE Mac-Lab, the LifePak defibrillators, the GE Aespire anesthesia machine, and the maximum pulse oximeter."

Now, what are those? Well, those are all the devices that get hooked up to this patient for the procedure. And these alarms act as a back up to what the physicians and nurses are doing. So if something starts going wrong -- you know, I'm sure you've all seen it on TV. It's that noise that gets made from these alarms to alert, "Hey, something's not going right."

And there's actually a policy at Summerlin Hospital about the alarms. And so we wanted to find out -- 'cause in this case, it's undisputed, the alarms were not on. There was no

audible alarms on during this procedure. Okay? So there was no safety net there if the people in that room didn't do their job.

And so we wanted to know, how could it be that all these people could be in this room and not know about these alarms? So we went to the chair of cardiology of Summerlin Hospital, Dr. Khan. And we asked him because he's the leadership of the hospital. He's the guy. And we said, "Hey, this alarm policy, what do you know about it?"

"Nothing. I don't know anything about the alarms policy."

"Well, what do you mean you don't know anything about the alarm policy? You're the chair of cardiology. Of course you know something. Well, are you aware, Doctor, that the policy says that alarms are to be clearly audible to caregivers and maintained in their 'on' position in order to give caregivers the opportunity to respond to the alarm?"

"I'm not aware of any of those policies."

That's the chair of the cardiology department, folks, at Summerlin Hospital. So you wonder how everybody below him -- the others will know, that's exactly why. Because if he doesn't know, how is anybody below him going to know?

We also talked to the chair of anesthesiology, Dr. Davidson. And we asked both Dr. Khan and Dr. Davidson,

"Hey, as the chairs, are you aware of what your responsibilities are pursuant to the Summerlin Hospital bylaws? You aware of this?"

Dr. Khan's like, "No. I don't know. I don't know what they say."

Dr. Davidson testified and will testify in this case, "Yeah, I'm aware of 'em. But you know what? It doesn't matter because I get to interpret them. It's how I interpret them." In fact, she'll tell ya, what's written down on paper isn't the way it works in real-life.

So one of the things that they had to do and one of the issues that we have in this case is, we said, "Hey, you didn't even make sure that Dr. Anh or Dr. Nemiroff were safe to be in that room to begin with." Because one of the things you're supposed to do as a chair of a department is to supervisor and observe, they call it survey, surveillance on the providers, make sure they're doing a good job. Watch them in action. Not on paper.

Dr. Davidson, Dr. Khan, they don't do that. They don't do that at Summerlin Hospital. So you start to see, as we're going through this, they don't know these basic things. And these basic things that they don't know, ultimately, the evidence will prove, caused the injury to Elisa Sales.

Now, there's also the CPR policy. And this is from the

code blue resuscitation. A code blue is when somebody codes. It's when they start doing compressions. And this policy says that the purpose is to provide guidelines for early recognition and management of patients who are experiencing respiratory and/or cardiac arrest.

Specifically, the code or the policy says, "Immediate implementation of BLS/CPR is crucial to patient survival." It's black and white. It's dirt simple. And the evidence will prove in this case they didn't follow this policy.

So we know the evidence will show that the policies and procedures exist, but we know the staff wasn't instructed, the policies are not adhered to and the policies are not enforced. And you're gonna hear excuses about this later. But just understand that the policies say what the policies say.

And so it begins. Let's talk about what happened in that cath lab. We know that at 12:19:48 they note that the case starts. And that's when Dr. Anh goes in and you can see that he gives one percent lidocaine administered and he's doing an area right here on the chest. And this is where they're going to open up a pocket. They call it a pocket. So they can go down in and pull that pacemaker out.

Now, if you look, the blood pressure is 130 over 79. And this one right here, SP O2, that's the oxygen saturation in the blood; okay? And that's gonna tell you, everything's good

right there. It's 100 percent. And once it gets under 95 percent, you start having real problems. So you don't want to see that. And the RR is the respiration rate. So how many times is she breathing per minute? Twelve. Everything's looking okay at 12:20.

Now, at 12:25, everything's still good. We got 127 over 82. Pulse ox still at 100 and she's got 18 breaths a minute. We're looking okay here at 12:25.

We have the pocket revision performed at 12:27. Now all this stuff on the right-hand side, Jesse Hanna, that guy in that room is typing in; okay? The stuff on the left, if you notice, it's every five minutes at this point. That's automatic.

The computer -- she's hooked up to a pulse oximeter. And that's the little device they put on your finger. She's got a blood pressure cuff on her arm. And so had she -- and she's also got EKG strips. The EKG, you won't see on here. But we'll talk about that in a little bit. She's got EKGs, the four leads, on her body. And -- but what we know here is at 12:27 Dr. Anh removes the old device. 12:30, 128 over 78. Pulse ox at 100 percent. Twenty-six breaths per minute. Everything's still okay.

Now, Dr. Anh, you can see he's -- "the generator attached by MD," that's Dr. Anh. He's getting the new one ready to go

in her. 12:35, the oxygen's still 100 percent. Blood pressure 132 over 78. Breathing 20 breaths per minute. Looking good.

"The pacer pocket irrigated with antibiotic solution." They're getting it ready to put in. And then at 12:37 they get the new generator placed in the pocket. And then you see at 12:40, everything's still good. 141 over 89. Oxygen level, 100 percent; 14 breaths per minute.

Now, we get to the point -- so when they put the new device in, one of the things they have to do is they have to test it. Got to make sure it works because this is a pacemaker and defibrillator. So if for some reason the device detects that the heart needs to be shocked to get it going, again, they have a defibrillator in there. So they got to test it.

It's really painful to do that to someone. So they put 'em -- they sedate 'em. They give 'em anesthesia. And so we know that around 12:44:55 -- and appreciate that when Jesse Hanna is typing things in, he has to observe it, see it, and then type it. So there may be a 10 or 15 second delay on what Jesse's seeing and what he -- by the time it gets entered. Just because of the fact that you can't type at the same exact speed that things happen. So it's going to be a slight delay before he hits "enter."

And Jesse Hanna then knows that they sedate the patient. And Dr. Nemiroff uses a total of 50 milligrams of propofol.

Now, you will hear from an expert anesthesiologist that we hired, Dr. Mazzei. And he's going to explain that 50 milligrams of propofol is appropriate for 110 kilogram woman, not a 110-pound woman.

And so one of the effects of propofol is that it will cause your blood pressure to drop; okay? And it's a known risk of that drug. And the more you give of the drug, the more it's likely to happen.

So Dr. Anh -- after the patient's sedated, Dr. Anh successfully tests the device. Everything's fine. And then automatically, at 12:45:26, we got problems. The oxygen level's at 99 percent. The blood pressure's now 67 over 48. And one thing in this case, every witness will agree at that point that's an emergency. That is a non-sustainable life blood pressure. When you have blood pressure that low and you maintain it, you're not gonna sustain life there. And everybody agrees with that.

So what happened next? Oops. So here we have -- this is the 12:45:46. First indication we got problems. Oh, and I forgot to tell you, after Dr. Nemiroff gave the propofol, he walks from the patient's bedside -- he walks away. And he walks into the monitor room with Jesse Hanna.

Well, when you get that -- when that first nonreassuring vital sign comes up, Boz comes out and says, "Hey, Dr. Nemiroff, the vitals, it's not good."

Dr. Nemiroff comes back out. And Dr. Nemiroff will tell you, "Well, he didn't have to get me. I saw this in the monitor room. I would have come out anyways."

Well, when he comes back, he says out loud, "I guess she didn't like the propofol." And that got Dr. Anh's attention. Dr. Anh looks up and he sees the monitor. And he looks and he sees the anesthesiologist, Dr. Nemiroff, and the two nurses. Okay. You guys got it. I'm gonna keep focusing on getting this patient sewed up so we can complete the procedure. You guys, your jobs are to handle this issue. And that's what Dr. Nemiroff's job and the two nurses' jobs were.

Dimitri and Dr. Anh were there doing the procedure. Nemiroff -- Dr. Nemiroff, Boz Knezevic, and Jan Sayoc were there to make sure the airway was okay.

So we know that doctor -- Dr. Nemiroff will tell us that he then comes in and gives two different doses of ephedrine. And ephedrine is a booster. They want to boost your heart so it starts beating; okay? That's what a booster is. And -- so at 12:46:44, now it's been about a minute. And we see that the oxygen level's dropped. Blood pressure now even lower, 57 over 44. The resting heart -- the respiration rate's down to

ten per minute.

Now, we see at 12:47:44 -- now, so what happens is -- this is important. Somebody tells Jesse Hanna, "Hey, we can't keep doing it every five minutes. We need you to be in that room and hit the button every minute so we can get the vital signs every minute."

So Jesse Hanna, every minute -- and he'll tell us this -- he was in that room hitting a button. So every time you see these vital signs here, he's hitting a button in that monitor room. Okay?

And so then we see at 12:47 the ephedrine's not working because the blood pressure remains low. The oxygen level's dropping further. The breaths are even worse. Then at 12:49:14, oxygen level drops to 95 percent. Blood pressure down to 58 over 46. And now she's not breathing.

It's a code situation. And nobody's reacting. They give more ephedrine. It's not doing any good. At 12:49:14, or 12:49:46, the oxygen level's down to 94. Now it's at a dangerous level. This is bad. And you'll hear a lot of witnesses talk about how this is bad. And then the blood pressure stays low at 59 over 46. And her breathing is three per minute. That's barely breathing. Like, you're dying. And you'll hear people talk about that these are her dying breaths.

Then at 12:50:58, she's coded. There's no blood pressure. Her oxygen level's at 85 percent. And, again, she's having her dying breaths. At that point in time, Jesse Hanna notes that somebody tested her finger and squeezed it. And it's called poor -- when you see "poor peripheral cap refill," right here, that means they squeezed the finger and the circulation was so bad, the color didn't come back.

Now, what happens is there is some testimony in this case from a couple of the nurses that suggest that they were messing around with the devices. And, in fact, in Dr. Nemiroff's record, they say, "Hey, the pulse ox machine is broken." And so there's testimony that they were switching -- they start switching the fingers. Like, maybe it's that finger. Try a different finger. Try a different finger. All the mean while, her vital signs are -- she's dying. And they're worried about the devices.

Now, here's the thing, everybody will agree that the very last second of time that anybody could ever do CPR with even being close to the standard of care would be 12:50:58. Okay? And their records, which they control, which they created -- they didn't start CPR at 12:51:42. Another minute goes by. She's coding. No CPR. Another minute goes by, 12:52:49. No compressions. She's coded. She's dying. What are you doing? 12:53:42, she's coded. What are you doing?

And Dr. Anh hears this movement and Dr. Anh, the cardiologist who's worried about doing the procedure and he's got his whole team of people there supposed to be worried about this, he looks up at the monitor and he goes, "Has anybody checked for a pulse?" Silence.

Dr. Anh jumps into action and he starts compressions at 12:54:04, as is noted. We know that the actual CPR started slightly before. But Dr. Anh was the last person in that room that should have been starting CPR. He had a team of Summerlin Hospital people there that should have been doing this. His job was to do the procedure, not to worry about the airway.

So in this case, we were -- there was a suggestion that maybe Jesse Hanna, this monitor tech, got it wrong. Maybe what he saw was wrong. And he might even come in here and testify -- I'm not sure what he'll say. We have his deposition. But we know that we wanted to confirm that Jesse Hanna was right.

So what we did is we looked at the EKG strips. And what's interesting about the EKG strips -- and mat -- so understand that EKG, there's four leads. Okay. In this case, they couldn't put a lead here because he was working on this area. So it's behind the left shoulder. And then placed on different parts of the body.

But what you're gonna hear from Dr. Anh, the cardiologist who was in the room, the one who started CPR, Dr. Anh is going to tell you that when he looked at the EKG strips, he could see when CPR started. We also have doctor -- and we'll talk about this in a minute, but Dr. Ott and Dr. Mazzei, couple of our experts, say the same thing, as does our nurse expert, Nurse Navarro.

And what they tell you is that when you see this consistency -- and they're called rhythmic artifacts. Now, what happens is it's pretty much common sense. They're sitting there doing compressions, 90 to 120 a minute. And what you see is those leads moving up and down, up and down, up and down, up and down, up and down. And they're called rhythmic artifacts. And you see them throughout the EKG.

So we can tell specifically when CPR was happening and when it was not, based upon the EKG. Now, the evidence in this case will show you that their medical records say that CPR wasn't done for almost -- for way too long.

And I even want to go back to something. Here is -- after CPR was started, something else happens there. The compressions stop. And they stop for minutes. And you can see that when CPR got resumed by Dr. Anh at 12:57, there was about a two-minute gap of CPR.

And going back to Dr. Khan, the chair of cardiology for

Summerlin Hospital, we asked him about, "Hey, what's the policy for CPR at Summerlin Hospital? Like, for how long can you stop once you start?"

And Dr. Khan tells us, "Well, five minutes." This is the chair of cardiology of Summerlin Hospital, folks. He says that once you start compressions, if the person's not breathing, you can stop for five minutes.

The problem with that answer is that Summerlin Hospital adopted the American Heart Association guidelines for CPR, as has almost every hospital in American do the same. And the right answer's ten seconds. Not five minutes.

So when people are in this room and they're stopping CPR for minutes on end, well, it's consistent with what the chair -- the chair of cardiology knows. He didn't see a problem with it.

So who had control of the investigation? This is very interesting. Laura Fiaccato is a nurse. And she's the director of the cardiology -- of the cath lab. Laura Fiaccato. You'll hear from Laura Fiaccato. And when we talked to her, we learned something. We learned that when there's something like this that happens in a cath lab, she's the one who starts the investigation. And if she determines that nothing's wrong, it stops with her.

She's a nurse. Doesn't go to a doctor, doesn't go to a

panel. It starts and stops with her.

Okay. So we then go and look, say, "Hey, what happened? What did you do to investigate what happened that day? What did you do?"

Well, we asked Dr. Anh, "Did anybody come talk to you about what happened?"

He's like, "No."

"Well, Dr. Nemiroff, did anybody talk to you?"

"No."

We're like, "Well what normally happens when something like this happens?"

He goes, "Well, I mean, if they're doing an investigation, they'll have you write a statement or they'll interview you. One of the two."

I go, "Well, did that happen?"

He's like, "No."

Well, Jan Sayoc, the nurse, "Anybody talk to you?"

He's like, "No."

Jesse Hanna, "Anybody talk to you?"

"No."

Dimitri, "Did anybody talk to you?"

He goes, "You know what? Maybe I might have. I'm not sure."

And Boz Knezevic, "Anybody talk to you?"

"Well, yeah. I talked to Laura Fiaccato because when there's a code, we have to fill out this, like, two-page form called a Patient Safety Event Report. And I filled it out and on it I basically said, hey, look at the cath lab records." Which those documents we just went through, that timeline of events, that's the cath lab record. That's part of it. But that's the timing that they would review. Those are the exact pages out of that; okay? So he says, "Hey, take a look at that."

So she did. And she said, "I reviewed that and everything appears okay to me."

A patient coded for over three minutes with no CPR when your policy says start immediately. And that's okay to you? Three minutes of letting somebody just code in front of you? She says, "Yeah." And then she says, "Actually, it meets or exceeds our standards for patient care at Summerlin Hospital."

That's the patient safety care at Summerlin Hospital? Not doing CPR for over three minutes when somebody's coded? That's what she says. And what we found, that's where the investigation ended. Nobody else even looked at this.

So we did an external investigation. We hired Dr. Peter Ott, who's a cardiologist. In fact, he's an associate professor of clinical medicine at University of Arizona. He's triple board certified in cardiology disease,

internal medicine, and electrophysiology. And he's going to come in here and explain the EKG strips very clearly. You will all -- the evidence will be very clear to you what those EKG strips say and what they mean.

And more importantly, he's going to say that the failure to start CPR falls way below the standard of care. And that by doing what they did, they directly put Elisa Sales's life in jeopardy and they're directly responsible for the severe hypoxic brain injury that she suffers from today.

He also hired Dr. William Mazzei, who's an anesthesiologist. He's a clinical professor of anesthesiology at the University of San Diego Hospitals. Now, Dr. Mazzei also says that it's incontrovertible what the -- when chest compressions started based upon what the EKG strips show. And he's going to explain how giving 50 milligrams of propofol by Dr. Nemiroff fell below the standard of care.

And it was interesting because he was asked in this case, "Hey, how many times in this setting, where you're testifying in a legal case, have you ever given an opinion that compressions started at a certain time based upon looking at the EKG?"

And he goes, "You know, never. Never had to do that."

And then he was asked, "Well, how many times have you looked at EKG strips to determine when CPR started?"

He goes, "Well, hundreds. I sit on the code blue review committee at UC -- at the University of San Diego Hospitals. So every time there's a code blue, we look at the EKG strips, if they're available, to determine when and how effective the CPR was."

"Well, have you ever had a dispute as to when CPR started in your 30-year career based upon looking at EKGs?"

And he goes, "You know, nope. This is the first time. This case." This isn't something that gets disputed, folks. But in this case, it has. And it's gonna be you to investigate and determine the truth of why it's being disputed in this case. And how are they really disputing it?

Dr. Burroughs is another one of our experts. And he's a hospital administration expert. And he has optimized the service operations of over 1500 healthcare organizations in this country and around the world. He will explain that what happened in this case was a systemic cultural failure on Summerlin Hospital's part.

He will explain that the culture created at Summerlin Hospital by Summerlin Hospital was a direct cause of what occurred in that cath lab. That Summerlin Hospital, itself, independent of any nurse or doctor, created the situation for everybody in that room to fail, and the victim to be Elisa Sales. And it's systemic.

He also will explain that what happened to Elisa Sales that day is what they call a sentinel event, which means it was an unanticipated bad result to a patient. And there should have been a full and complete investigation, which the evidence shows there was none.

The internal investigation, on the other hand, said, nothing to see here. Everything's just fine.

So what's the resulting injury? Hypoxia of the brain. And let me explain what this is and how it happens. So your brain, like any other cell of your body, requires a steady supply of oxygen in order to function properly. And so as long as the brain's getting the steady supply of oxygen, you're going to be okay. But when you start to have less oxygen, it's called cerebral hypoxia.

So when the supply of oxygen to the brain is significantly decreased, the brain and the cells in the brain start to become damaged. And you remember, we had five minutes of severely reduced blood pressure, which means there was severely reduced oxygen to the brain for those five minutes. And then we have nine minutes after that, where there was no oxygen getting to the brain of Elisa Sales, based upon the vital signs.

So when the blood flow's diminished, the neurons cannot function properly because the oxygen isn't getting to 'em.

And in prolonged hypoxia, which we have here, which is greater than five minutes, brain cells begin to die. And in minutes, massive, massive cell death can occur. And when that happens, there could be severe and permanent, debilitating brain damage to the patient. And that's what happened here, in this case.

Elisa Sales, when she went in, was normal. And when she came out, she was like a five-year-old with her cognitive ability and a two-year-old with her bowel and bladder control. You'll see that there's records in the hospital where, after this, she's in the hospital and she's pooping and peeing her bed. She's confused. And we'll show you a few of those records. So the hypoxic brain injury occurred because of the lack of oxygen.

We had to consider what the hospital was saying, though. What are they saying? They're saying, "You know what? Before this lady came in, she had diabetes. She had a bad heart. You know, she also had breast cancer back in the day. That's why she's the way she is today. It's not because she had no oxygen to her brain for nine minutes that everybody knows kills massive amounts of brain cells. No. It's because she had diabetes."

And the evidence is going to show that if diabetes was the cause, it would sure be strange that, three weeks before, she's functioning completely perfect and on a big trip to

Alaska with friends and family. That's gonna be part of your investigation. How much credibility do you give that type of argument?

And, yeah, you can understand how the evidence in this case and your job as an investigator matters. 'Cause you've got to decide whether or not that type of argument is believable based upon the evidence.

They're also gonna say -- Summerlin Hospital will also say, "You know what? Back in June of 2011, Elisa Sales went to a doctor and said, 'You know, my memory doesn't seem as sharp as it used to be.'" And that's true. There's a record that says that. You're gonna hear all about it.

And Elisa's doctor will come in, Dr. Villa -- Averilla will come in and tell you that, "Yeah, that was mentioned in that one record. But after that time, when I treated her, never brought it up again."

And on that day, her physical examination, the doctor's, did not support a need for Elisa to be concerned about memory loss. More importantly, the doctor will tell us that, "Hey, had I seen any reason to be concerned, I would have referred her to a neurologist, which I didn't do because it wasn't a big deal."

That's argument that they may raise, that five years before this event she had one record that says that. It's

just for you to determine if it has any credibility whatsoever or if it's just what we call a red herring to take your eye off the real issue of what happened here.

And, again, three weeks earlier, does this look like -- and the evidence will prove it's not a person that has a severe hypoxic brain injury and her diabetes wasn't slowing her down much at all. She's all over the place in Alaska.

They shut the switch off to her brain, folks. When they chose not to do CPR timely, when they chose to violate their policy and procedure, the evidence will show they shut her brain off and they left Edgar, her husband, with a wife that is so damaged that it's more like taking care of a child.

And you're going to hear about little things that Elisa used to do. She used to cook for big groups from her church and her friends. They'd come over and karaoke. After this, Elisa tried to cook a chicken and forgot to take the plastic off and caused a big smokey issue in the house. She tried to cook corn and forgot to put water in the pot.

She's just -- and it doesn't get better, folks. The evidence will -- you'll hear lots of testimony from Dr. Tucker, who's a neurologist, and Carol Anderson, who's a neuropsychologist. And Carol Anderson will tell you, this is one of the worst cases she's every seen of a hypoxic brain injury in her entire career. And Dr. Tucker will explain how

you don't get better after this. It's permit, irreversible damage.

Now, the Defense, they hired a guy named Dr. Amos. Now, I hope that Dr. Amos comes here and testifies. 'Cause I think that it would be really good for you all to hear what Dr. Amos has to say. But one thing that you will learn when Dr. Amos comes here is that he did an evaluation of our client, Elisa Sales.

And when he did it, we had it recorded, audio recorded so we could know exactly what he was doing. And that recording will show some really interesting things. A, it's gonna show that Elisa Sales doesn't know the day of the week, the month. She doesn't know the name of her kids. She doesn't know the name of her siblings. One of the issues that's the biggest concern that Edgar has is that she's gonna get lost one day.

And Dr. Amos, during this interview, does an exam. It's called the Folstein exam. It's call a mini-mental exam. And we will show how he manipulated that exam and gave it wrong, scored it wrong in an effort to show that she wasn't severely cognitively disabled, she was only moderately cognitively disabled. And that will be for you all to decide, why would somebody like Dr. Amos do something like that?

And it's black and white, folks. The evidence will be crystal clear on this issue. You will know exactly what he

did and how it was wrong and how it didn't comply with the test protocols. That's why I hope he shows up. So we can show you exactly what he did and how he did it.

Then we have the life care plan. We hired Susan Wright to come in and determine, hey, based upon the damage that Summerlin Hospital did to Elisa Sales, how much is it going to cost to give her the proper care that not only her, but Edgar deserve for the rest of her life? And Susan Wright determined that it's gonna cost $7,805,000 -- $7,805,707.13.

The Defense hired Aubrey Corwin. Aubrey Corwin says, "Well, Dr. Amos says that all these problem are because of diabetes, the fact that she has a bad heart." So I -- doctor -- Aubrey Corwin reviewed all of the medical records, all of the -- our expert reports, everything, and she just says, "Well, because Dr. Amos says so, 5900 bucks."

So the hospital's gonna come in -- I don't know if Aubrey's gonna show up. But during discovery, we figured this out. And that's her opinion. $5,900. $5,900. Folks, the evidence is gonna show that that is wrong. And in your investigation to seek the truth will show you that Susan Wright's number is the right number and that Aubrey Corwin's number is based upon bad, bad medicine. And that what Dr. Amos did was wrong to get to that conclusion. And, thus, Aubrey Corwin's opinion has no value to you.

So what's their life like today, Edgar and Elisa? Well, Edgar's loss is significant, just as Elisa's is. He's lost the love, companionship, affection, society, and solace of his wife. It doesn't mean that his -- you'll hear a lot of people tell you that Elisa is a loving person. And she'll smile at you and she'll be polite, but she's not there. The lights are there but nobody's home.

And so she's just this very polite person. And she'll just sit there. And you'll hear that when asked, she'll tell you, I -- "Do you dress yourself?"

"My husband helps me to -- I don't know how to" -- she can't do buttons anymore or zippers because the brain injury's damaged her functioning that way. And so the basic -- basics of life have been taken from them. And Edgar's loss is as equal or greater than his wife's because he's left there taking care of his wife.

But, if anything ever happens to Edgar, this trial's a -- a big part of this trial's about whether or not the evidence and your investigation support taking care of this family the right way.

So let's talk about the hospital's alibis. Their first alibi, she doesn't have a brain injury. Really? What will the records of the hospital say about this? Well, we went and looked, folks, because suggesting this lady didn't have a

brain injury is somewhat amazing.

So the day after -- the morning after this event took place, Dr. Chaudhry -- and I guess you should know this -- Dr. Chaudhry was Elisa's normal cardiologist. Dr. Chaudhry was the one that was gonna do the procedure, but something came up and Dr. Anh, Dr. Chaudhry's associate, came in and stepped into Dr. Chaudhry's place.

Dr. Chaudhry goes to the hospital and said -- does a -- tries to do a neurologic exam. And the neuro exam wasn't performed because the patient was like in a comatose state. Was not -- was out. Done. But they note that the patient has some decerebrate posturing.

Well, what's decerebrate posturing? It's an abnormal body posture that involves the arms and the legs being held straight out, the toes being pointed downward, and the head and neck arched backward. The muscles are tight in the head and they're held rigidly. And this type of posturing usually means that there's been severe damage to the brain.

This is an involuntary position your body goes into when you've had a severe hypoxic brain injury. And she's not conscious at this point. And this is an observation that's made of what her condition is. And they may want to come in here and suggest there's no brain injury. This stuff can't be made up, folks. And it's black and white. It's simple.

What else do the records say? Well, they assess a possible hypoxic ischemic encephalopathy status post-cardiopulmonary arrest. That's a big terminology there. But basically what it means is that the brain didn't receive enough oxygen after she coded. And that's in the records.

What else do the records say? Anoxic brain injury. [Indiscernible] following the patient for suspected anoxic brain injury. An anoxic brain injury's a type of brain injury that isn't usually caused by a blow to the head. Instead, it's caused when the brain is deprived of oxygen.

These are in their records. Black and white. Simple.

What else do the records say? Well, this is on the day she's getting released, folks. And it says that the patient is confused. Patient is noted to have an unsteady gait, which means that her coordination now is off because of the brain injury. And the patient noted she's not calling for help to get out of bed.

And, oh, by the way, she's now incontinent of bowel and bladder and we had to give her a bath and change her linens because she pooped and peed her bed. This is the day she gets out of the hospital, folks. No brain injury? You don't just start pooping and peeing yourself if something isn't really wrong.

What else do the records say? Well, they note that the

patient would often get confused throughout conversation and would resort to smiling rather than answering questions. That's where they left her. And you know what you're going to hear, folks? That's never changed. That's how she is today. It's the same thing. No brain injury? The records will tell you differently.

What else do the records say? Hypophonic and dysarthric speech. Now, what is that? Well, first let's look at the first four. Her mood and affect, mildly, pleasantly confused. She's polite but she doesn't know what's going on. Attention and concentration is decreased. Fund of knowledge, decreased.

And her speech, what does that mean? Hypophonia is soft speech, especially with -- especially resulting from a lack of coordination in the vocal muscular. And that's caused by a brain injury.

Dysarthria often is characterized by slurred or slow speech that can be difficult to understand. Common causes include brain damage.

That's no different than today. When she does talk, you can hear that it's soft. At times it's slurred. These are all stemming from what happened in the hospital. Again, these are their records.

Yeah, and for what it's worth, when they billed her -- because they did bill her for all the time she had to spend in

the hospital, by the way, after this. What does it say? Diagnosis, acute respiratory failure with hypoxia. So the evidence will show when they billed her, they charged her for it. But now they want to come in and say she doesn't have it. You'll have to investigate that and figure out why they would do such a thing.

So just Elisa Sales doesn't have a brain injury, the evidence is going to show that alibi just doesn't fly.

What's their second alibi? Their next alibi's gonna be that their own records are wrong. And that the EKG strip that confirms that the records are accurate aren't reliable for determining when compressions started.

You're gonna hear evidence that Jan Sayoc and Boz Knezevic signed off on these records from the cath lab that we went over with that timing. And they signed off on them as being accurate and complete. They both signed off on those records at the time. And now they want to come into trial and tell you, well, you know what? Maybe they're not right. And they're gonna suggest that the EKG strips aren't accurate.

Folks, you're gonna hear from four or five different witnesses that will be able to easily explain this to you and tell you they're absolutely accurate. Folks, that alibi doesn't work either.

So the next alibi is that they want to come in and suggest that, hey, don't look at our records or the EKG strips, trust our testimony as to what happened years ago. That's more accurate than the records. Part of an investigator's to determine do you believe that or do you think that's just silly?

So we went and asked ourselves because we wanted to see, what do 33 people have to say? We asked Jesse Hanna, the monitor tech, "Hey, do you remember Elisa Sales?"

"Vaguely. Vaguely I -- you know, a little bit."

"Well, do you remember the details of what happened that day?"

He's like, "Nah, I don't remember the details. That's too long ago. I don't remember." But he did know that he understood the importance of accurate real-time documentation of cath lab records, especially when emergency situation's happening. He understood that clearly. And he knew that then and he knew it when we disposed him.

And he documented CPR starting at 12:54:04. And he tells us that he -- he'd have to rely upon the records. And what you may see happen in this case, because it happened in the deposition, is that he starts saying, "Well, I know what I wrote down. But that doesn't mean that it's absolutely accurate."

And there's a suggestion that maybe Jesse Hanna had to run in to the cath lab to help herb during the situation when she was coding. Well, just think about what that would actually mean. It would mean that Jesse Hanna was in the monitor room hitting the button, then running out, helping for a couple seconds, then running all the way back to the monitor room, hitting the button, again, running back out, hitting -- helping a little bit and then back and forth, back and forth, back and forth for nine minutes. It lacks common sense.

And, oh, by the way, he doesn't have a memory of doing that. But they want to suggest that's what was happening.

His alibi's -- the evidence will show, it doesn't make any sense. He had to rely on the records and the records speak for themselves.

Jan Sayoc, we asked him. "You have any memory of Elisa Sales?"

He goes, "Nope. I don't remember her at all."

"Any memory of the incident?"

"No. I'd have to rely on the records."

Well, we know what the records say. Records say they didn't meet standard of care. In fact, it showed a complete conscious disregard for the safety of their patient. And he signed off on the cath lab record as being complete and accurate. That alibi's not gonna fly that his testimony's

better than the records.

And then there's Dimitri. He vaguely remembers Elisa. He doesn't remember the details of the incident. And he'd have to rely on the records. Well, the records speak for themselves. So Dimitri, he's not gonna help anybody here know the details.

And there's Boz. Boz vaguely remembers Elisa. He doesn't remember the details of the incident. And Boz is a little bit different. He thought he remembered. And you may hear this. He thought he knew what happened. And then when we showed him additional documents, like, "You know what? My memory's actually not crystal clear. The records will probably be more accurate." And he signed off on the records.

And unlike Jan Sayoc, Boz qualified it. He goes, "Whoa, whoa, whoa. I only signed off on the records as to what I did as being complete and accurate. Not that the records themselves are complete and accurate."

I'm like, "Okay. So anything that you did that's listed there is complete and accurate; right?"

"Yeah."

"Great. You didn't do CPR. You didn't start compressions. Nothing in here says you did anything timely."

His alibi doesn't work, folks.

And then we have Dr. Nemiroff. The anesthesiologist.

Who was the captain of this ship for dealing with the blood pressure and the airways here. He vaguely remembers Elisa Sales. He doesn't remember the details of the incident and his records only narrow it down to a 15-minute window.

His records, which they're not real clear here, but what you'll see when we get into the case is that there's blocks. And each block -- you'll see a little block here, right there. That's 15 minutes worth of time. And so he can't -- like, all the stuff in this case, we all agree essentially happened between 12:45 and 1:00 o'clock. And he can't narrow it down based upon his records.

Okay. When we pressed Dr. Nemiroff on the details, he goes, "Look, man, I have to look at the records. I can't remember the specific details." Well, the records speak for themselves. And Dr. Nemiroff's alibi doesn't work.

And that leaves Dr. Anh, the cardiologist. He will tell you that, yeah, he clearly remembers Elisa Sales. He clearly remembers this incident. He's gonna tell you, he'll never forget this incident. Dr. Anh -- when Dr. Nemiroff came in, you'll hear Dr. Anh tell us that he heard Dr. Nemiroff say, "I guess she didn't like the propofol." And he looked up and saw the monitor and the vital signs were not good.

But Dr. Nemiroff and the two nurses were right there. And he assumed they had it under control. He was finishing

the procedure and then, ultimately, when he's getting close to the end -- he didn't even get all the way done because when he looked up, he wasn't -- the patient wasn't fully sewn up in the pocket. And when he looked up he's, "Has anybody checked for a pulse?"

And he'll tell you, he was shocked that nobody had checked for a pulse. And he stepped in and he did what he could to start CPR at 12:54. And Dr. Anh's also going to tell you that the reason why he'll never forget this is because he went to go check on Elisa Sales after this happened and he knew there was something wrong. He knows.

Folks, the evidence in this case is going to show that Summerlin Hospital had the motive, they had the means, they caused these injuries and none of their alibis make any sense. Summerlin Hospital, itself, was negligent and we're gonna prove that.

And at the end of the case, when we come back and you got to deliver a verdict, the evidence will show that the verdict should be against Summerlin Hospital directly. And that's where the blame should fall.

You'll also understand that, in this case, when it's gonna cost $7.8 million to care for somebody, that doesn't do anything except pay for the bills that they caused. The real damage in this case is the loss of the ability of Elisa to

follow her passions with her husband. And Edgar and Elisa to be able to enjoy life together.

And you'll understand why, at the end of this case, we're going to be asking you to return a verdict for pain and suffering that is in the tens of millions of dollars.

Thank you.

Thank you, Judge.

THE COURT: Counsel, approach.

[BENCH CONFERENCE]

THE COURT: Counsel for the Defense, are you prepared to go forward with your opening?

MR. PRANGLE: I am, Judge.

THE COURT: Begin.

OPENING STATEMENT BY THE DEFENSE

MR. PRANGLE: May it please the Court, Counsel, Corrin, Majorie, and ladies and gentlemen of the jury, before I begin my opening statement, I just want to take a minute on behalf of Summerlin Hospital and the nursing staff to thank you for the time you're committing to this case. It's already been somewhat of an arduous process. But since the date of this lawsuit has been filed, Summerlin Hospital made the decision to defend the conduct of its staff. And they did so with the assumption that some day in the future, today, we would be able to put a jury in the box that would listen to

this case, wait until they hear both side of the story, before rendering a verdict.

We understand and appreciate the imposition we're making on you. So on behalf of Summerlin, on behalf of the nurses, I'd like to thank you.

So as you heard in Mr. Claggett's opening -- and actually why don't you just turn this off for a moment, Majorie. Just -- I don't -- I think that's a Monet.

What you heard Mr. Claggett say is that for nine minutes, for nine minutes we had six medically trained people who did nothing for this patient. Knowing she had no pulse, knowing she had no blood going to her brain, we had six medically trained people, two board certified physicians who were both -- that were ACLS certified, two nurses who were ACLS certified and two techs that were BLS certified. He wants you to believe that they knowingly let a patient who had no pulse, did nothing. And that's really what he's saying.

And actually what he's saying is a little bit worse than that. Because what he's saying is that when we finally got around to doing chest compressions, we did them for about 35 seconds and then stopped. That's what he wants you to believe. That's his side of the story.

My side of the story is a little bit different. And it's somewhat similar to what Mr. Claggett's telling you, but it's

different in key respects. As Mr. Claggett told you, Mrs. Sales is in to have the battery replaced. When Dr. Anh completes that process, he needs to test the device.

And the way they test the device is to shock your heart into a dysrhythmia. It's called V-fib, which is -- you will die if you stay in V-fib. But the whole purpose of the AICD, this pacemaker, is to deliver a shock to bring her back to a normal sinus rhythm. So that's what they're doing.

So with that, you heard that Dr. Nemiroff sedated Mrs. Sales with propofol. But then they delivered a shock to her heart. And then after they delivered that shock to her heart, Mrs. Sales had a predictable complication from that. She developed hypotension.

So hypotension is low blood pressure. That happened at approximately 12:45. It was immediately recognized. And as soon as it was recognized, several things began to happen. Number one, the nurses started taking vital signs faster. They started taking vital signs every minute as opposed to every five minutes.

Dr. Nemiroff, who had gone to the control room so that he could monitor the patient on the screens they had there, immediately came back and he started pushing fluids. If you have low blood pressure, that could be due to volume where you don't have enough volume in your circulation. So he gave

saline to help increase the blood pressure. And then he gave a dose of ephedrine.

Ephedrine is a presser that Mr. Claggett told you kind of boosts the heart. The whole point of doing that is to reverse this low blood pressure. The key point there is that it demonstrates a recognition that something was going on. This change in condition was immediately recognized. Unfortunately, that initial dose of ephedrine was not successful in correcting the problem.

So as the minutes go by, we see the blood pressure staying low. One of the other vitals you hear a lot about is oxygen saturation. It's the, basically, the percent of oxygen contained within the red blood cells in the circulation. Mr. Claggett told you that 95 is normal. That's not right. 90 is normal. Anything above 90 is considered normal.

And what you'll see in this window of 12:45 to 12:50, even though her blood pressure was low, her oxygen saturations were normal. And what that means -- and trust me, I'm not suggesting that a blood pressure as low as it was is a good thing. It's not. Dr. Nemiroff is trying to respond to the situation. He's trying to reverse is.

Dr. Anh was aware this was going on. Everybody knew what was going on with Mrs. Sales. They were responding to it. They were trying to fix it.

So what Dr. Nemiroff then does is, "Well, I need to give a bigger dose of ephedrine." So he gives a bigger dose of ephedrine. Unfortunately, that too does not work. So then what happens at about 12:50 -- and Mr. Claggett put up that cath lab record, and we're gonna dissect that thing to the second during this trail. So you'll have it memorized by the end of the trial.

And at 12:50, the blood pressure cuff that's on her arm and it's now cycling every minute now doesn't register a number. We still see the third number, which is called the mean arterial pressure. But the systolic and diastolic numbers, those are the first two numbers -- so like 140 or 110 or 140 over 90, that's the diastolic and systolic numbers on a blood pressure. The third number's called the mean. It's the average of the two.

So at 12:50 it was immediately recognized that, hey, we now have a change. We're now -- we don't even have that number. Now, what Dr. Nemiroff's going to tell you is he immediately felt for a carotid pulse. And he felt a carotid pulse.

So he then tells the nurses, "Check the machines. Check the blood pressure cuff. Check the pulse ox." And now at this point, the pulse ox had dropped to 85. So it was below normal. It's mildly depressed, but it's going the wrong way.

So Dr. Nemiroff tells the nurses, check the equipment.

Dr. Anh hears that. He hears Dr. Nemiroff tell the nurses at 12:50, check the equipment. Dr. Anh looks up. And Mr. Claggett's correct, Dr. Anh's gonna say he said the word, "Has anybody checked a pulse?" You will have heard that Dr. Nemiroff did check for a pulse and felt it.

Dr. Anh immediately checked the pulse himself. And I think he'll tell you he did it on her groin. And he did not feel a pulse. So Dr. Anh did the right thing. He started chest compressions. Dr. Anh -- not Dr. Nemiroff, Dr. Anh, if you want to use a nautical analogy, is the captain of this ship. When we get to the code situation, it's Dr. Anh, not Dr. Nemiroff, that's directing it.

Dr. Nemiroff can do certain things. He's following the lead of Dr. Anh. The nurses are following the lead of the doctors. Dr. Nemiroff was managing the airway. Dr. Anh's immediately started chest compressions.

You'll hear all about the ACLS protocol. Every single witness in this courtroom that was in that room at that time will tell you that CPR was started immediately when they knew they lost a pulse. That's the ACLS protocol. You don't do chest compressions for a blood pressure. You do chest compressions when there's no pulse. Every witness in this case, all six people who were in that cath lab --

Mr. Claggett's right, only four of 'em remember this. Jesse and Jan don't. So the four that remember it will tell you, "As soon as we lost a pulse, we started CPR."

They will also tell you that they carried out the code per ACLS protocol, which is basically to do chest compressions at 100 to 120 beats. And every two minutes they would stop for ten seconds to see, do we get a pulse back? Because the -- one of the difficulties here is that because Mrs. Sales had her pacemaker, if you looked at the EKG, it looks like she had a heart beat. Because the pacemaker's firing. And so her heart is actually in a relatively normal sinus rhythm.

But it's called a PEA, a pulseless electrical activity. Means her heart's bumping, but it's not pushing any blood. So you have to stop and you feel for a pulse for ten seconds. If you don't feel a pulse, you then start chest compressions again. And then you switch off. Because, you know, it's actually kind of tiring to do that.

So you'll hear that for the period -- it's about ten minutes -- CPR was doing done until right around 1:00 o'clock, when Dr. Anh felt a pulse and so CPR stopped. The idea that the six medically trained people literally just sat there for nine minutes is simply not true.

All right. So let me back up a second. Now, as you

heard from the beginning of Mr. Claggett's opening, when he talked about motive, as if we did this on purpose. I mean, that's ridiculous. So motive. So one of the claims is that we at Summerlin Hospital did not properly train the staff.

Now what does that mean when -- what does that mean for this case? He wants you to believe that we had six people in that cath lab who didn't know how to do CPR. That we did nothing to determine whether or not they knew how to do CPR.

And then you're gonna hear way too much about alarms. They -- he wants you to believe that the alarms were turned off. They weren't. The alarms were on. And I'll talk more about the alarms as we go forward.

But as to this administrative claim, the evidence is gonna overwhelmingly show that all of these individuals in the cath lab were either BLS or ACLS certified. Many of them had been recertified at Summerlin Hospital. So Summerlin Hospital was doing a training. And while they're doing the training, they demonstrate the ability to do it. We can call it a drill. Call it whatever you want. But we confirmed their ability to do CPR.

So who are the parties here? Obviously I represent Summerlin Hospital. The four individuals that -- who's care is at issue is Jan, Dimitri, Boz, and Jesse. The two nurses and two techs in the room. They are employees of

Summerlin Hospital. Summerlin Hospital is responsible for their negligent conduct if you believe they were negligent.

The other two people in the room are Dr. Anh and Dr. Nemiroff. The physicians at Summerlin Hospital are not employees of the hospital of which is typical throughout the country. The doctors are not employed by the hospital. And the evidence is gonna show that Summerlin Hospital is not responsible for their care.

Now, I say that, but don't think that I'm gonna suggest for a second that Dr. Anh and Dr. Nemiroff did anything wrong. The evidence is gonna show that they fully complied with the standard of care in treating Mrs. Sales. I simply state it as a legal point, it's called agency. We're responsible for the conduct of our agents. The four -- the two nurses and the two techs are our agents. We're responsible for them. The two doctors are not.

We had -- we, Summerlin, had nothing to do with selecting Dr. Anh as this patient's cardiologist and we, Summerlin Hospital, had nothing to do with selecting Dr. Nemiroff as the anesthesiologist. That was between Dr. Anh and Dr. Nemiroff.

So the claim is we did not train -- properly train these people to do CPR. I believe all six of the people in the room, beginning with Dr. Anh, will tell you that he was fully

qualified to do CPR. He himself had had experience with codes in the past.

Dr. Anh is on staff, as is Dr. Nemiroff, pretty much every hospital in this valley. Not just Summerlin Hospital. The doctors go to other hospitals and they go through the same credentialing process at all these other hospitals. So the idea that these board certified ACLS certified physicians didn't know how to do CPR is a joke.

Dimitri, the scrub tech will tell you that he's BLS certified. He has had a lot of experience in doing codes. Jan is one of the circulating nurses in the room. He is ACLS certified. He has been recertified at Summerlin Hospital. He knew how to do CPR. Boz, another one of the circulating nurses. ACLS certified, recertified at Summerlin Hospital, knew perfectly well how to do CPR. And Jesse. Jesse was the junior person on the team. He's the recorder. He's the one in the control room. He was the newest to the team. He had just finished what's called their preceptorship, where he was just now kind of practicing on his own in that role.

So on this idea of training, Mr. Claggett would just have you believe that we have a bunch of directors, they're only interested in making money and we don't do anything to train.

All right. Well let's talk a little bit about that. How does Summerlin Hospital ensure that the people that are at the

hospital providing care to people know what they're doing? Well, let's talk about how they did it with the staff. With the staff, if I'm a nurse, I graduate nursing school. I go and apply to Summerlin Hospital. Summerlin Hospital makes me fill out an application -- and oh, by the way, I'm not a nurse. I'm just a lawyer. But I submit my application and then they ask me a bunch of questions. Are you licensed? Are you BLS or ACLS certified? I have to demonstrate those credentials. They confirm those credentials. And if I meet these criteria, they will hire me.

But then what to they do? They make me go through a preceptorship. So for three months, I'm following another nurse. And this is true whether I'm a new graduate from nursing school or whether I have 20 years experience but I'm new to the hospital or new to the department. Whenever there's a move, whether it's to the hospital or from one department to another, they have to take three months to make sure they know how to do their job.

And so they have certain competencies that they have to demonstrate during this process. And that was done for all four of our staff members. Then, on an annual basis, we require the staff to do education. We require them to demonstrate competencies. We do on the units what are called in-services. Where when there are new things and changes, the

leaders on the floor or the leaders on the unit will have meetings to explain to the people how do we -- how we want you to do things, to keep patients safe. The suggestion that we had a motive to not keep patients safe I think is offensive.

Also, there are just regular meetings that are held within a department to talk about various issues. Then, on a retrospective basis, there's a concept called quality assurance. And so what does that mean? It means that the hospital keeps track of certain statistics. If something unusual or novel happens, it's drawn to the attention of the administration and one degree of investigation or another is done.

Another way -- another component of that is through what's called incident reporting or PSE or might hear it called as a MIDAS report. It's an incident report where the nursing staff is encouraged that if something unusual happens, I want you to tell us about it. Why? It's because we want to make sure we're delivering high quality care. We want to make sure that we're learning from our mistakes if we make mistakes. We want to get better. And that's the system that was set up.

And you'll hear a lot about that through Laura Fiaccato, who was the director of the cath lab. She will tell you how she does that. So in addition to these things, Laura is also

on the unit every day. She's in and out of the cath labs every day. She's going in -- she's not there the whole time, but she's going in.

There are three cath labs there. She's going in, making sure things are running smoothly. And if they're not, she fixes 'em.

The last thing -- or no, actually, it's two more things. Mr. Claggett alluded to this that in the setting of a code blue, which this was, there's a code blue committee. And then the third thing -- and the code blue committee looks at all the codes, again, to look, was this done the right way? And how can we improve on it?

The last thing is called peer review. And it's another level of scrutiny. And it's a bit of an interesting thing. Because it's something -- it's a behavior or activity that is actually governed by federal law. And under federal law, the peer review, when it's done --

MR. CLAGGETT: Your Honor, I'm going to object.

THE COURT: Counsel, approach.

[BENCH CONFERENCE]

THE COURT: Objection sustained.

MR. CLAGGETT: Thank you, Judge.

MR. PRANGLE: So what you will hear in this case is that Laura Fiaccato did an investigation. You will also hear

that this was peer-reviewed. But we can't talk about it because of the federal statute.

Point being is this idea that we just do one of these and said, "Everything's good here," I think is how Mr. Claggett said, it's not true at all. The truth is -- and you'll hear this, most importantly, from the six people that were in that room, is that as soon as Mrs. Sales lost her pulse, CPR was immediately begun and done until her heart rate returned.

Okay. So that's for the -- this process that I just described is for the staff. For the physicians, it's largely the same but a little bit different. It's not as rigorous. These are, you know, board certified physicians. The amount of observation and supervision that we give to the doctors is less. But the way that we make sure that the doctors are appropriately credentialed at the hospital is similarly through this credentialing process and then the recredentialing process that is done by the medical staff.

So basically when a doctor comes in, if I'm an anesthesiologist, if I'm a cardiologist, I apply for privileges. And the same sort of thing. I've got to demonstrate my credentials. They confirm my credentials and then they may grant me staff privileges.

But, again, even as a doctor, there's a period of preceptorship, where they're watched to make sure they know

how to do their job, even though they're physicians. When they recredential, it's the same thing. And there's a big statistical analysis that goes on. They check for, you know, how many patients come back to the hospital. There's all sorts of metrics that are considered when doctors get re-credentialed.

The main point being, with regard to the six individuals that we're talking about, there's no smoking gun anywhere. There's nothing in their past. There's nothing from that day to today, that you're gonna hear about to say this was a problem person. They were a bad nurse. They were a bad tech. They were a bad doctor. You will not hear a single thing about that.

This whole training and supervision issue is a red herring. This sole case is about whether these six individuals, for nine minutes, sat there and did nothing, as Mr. Claggett would suggest to you.

Dr. Anh, who I believe is going to be the first witness you're going to hear from on Monday, he will tell you that he -- and he was the one that started with chest compressions, that he did it per ACLS protocol. You hear the same thing through Dr. Nemiroff, although Dr. Nemiroff didn't do chest compressions. But he was part of that team. He was managing the airway. That not only did -- was this code run per ACLS

protocol, but the nurses did everything that he wanted them to do. Dimitri, Jan, Boz, Jesse, they will all tell you the same thing.

Let's spend a minute to talk about alarms. That's one of the safety policies. And we all agree -- or I believe Mr. Claggett and I agree that the two safety policies that we're gonna hear about in this case, the first one relates to alarms. The second one relates to CPR.

As to the alarms, the policy -- Mr. Claggett correctly stated what it says -- is that if there's an alarm, it needs to be on. You will hear that the alarms that were available were on.

So let's talk about the alarms. And maybe now's a good time to put up the picture of the cath lab.

But when all that's coming up. So the two monitoring devices that were being used for Mrs. Sales during this procedure and in terms of the equipment that's used to monitor, that's physician choice.

MR. CLAGGETT: Before you put that up, I want to see.

MS. KRATSAS: Oh, Exhibit 81. Page 4.

MR. PRANGLE: All right. So, you know, it's up on this screen, Majorie.

MS. KRATSAS: It is up on Plaintiff's counsel's

screen. It's not on that one yet? There it goes. It just took a minute to cycle.

MR. PRANGLE: Oh, well, I see a painting.

MS. KRATSAS: Oh, goodness. Give me one second.

MR. PRANGLE: All right. So -- we can look over here. The thing in the foreground, that's called the LifePak. That's an EKG machine. It's also a defibrillator. You may also hear it referred to as a ZOLL. And what that is, is that's a backup device that's put on the patient that monitors the EKG.

And then so when they test the device, if the AICD doesn't work, such that she gets shocks back into a normal rhythm, they will go to the LifePak, and they will use that to defibrillate the patient. And so it's a backup. That device has an audible alarm. That device is not relevant in this case because Mrs. Sales's AICD was successful.

We'll get this figured out by Monday, hopefully.

MS. KRATSAS: Yeah.

MR. PRANGLE: So but the AICD was successful in shocking Mrs. Sales back. So we had or what appeared to be a normal sinus rhythm. So no audible alarm. The big TV screen you see in the back, that's called the Mac-Lab. That is an 80-inch screen that is basically at the feet of the patient.

You can imagine that Dr. Anh and Dimitri were on either

side of the table with the patient. Dr. Nemiroff, while he's in the room, is at the head of the patient. The two circulating nurses are walking around the room getting stuff.

So this is an 80-inch screen. So what are the vital signs that we're concerned about here? It's the blood pressure and it's the O2 sat. Those are the two vitals. The Mac-Lab does not have an audible alarm for blood pressure or O2 sat. It has a visual alarm. So what it does is it blinks yellow when they become abnormal. And that's exactly what happened in this case.

At 12:45 when that blood pressure became low, and it's registered on the screen, it's blinking yellow. Everybody saw it right away. Even Dr. Anh. When Dr. Nemiroff comes back in the room, saw it immediately. There was no issue with regard to alarms that there somehow was a delay in anything because we weren't paying attention to it. It's a false issue.

At 12:50, so -- and this is even before we lose the blood pressure, there's a comment regarding the pulse ox 'cause in addition to seeing the numbers the on piece of paper, along with the EKG, there's actually a waive form for the pulse ox. And means nothing to me. But somebody who's trained can look at it and say is this okay or not okay?

And at 12:50 there was recognition that there was now beginning to be a problem with the waive form. It was

immediately recognized and responded to.

So all this talk about alarms, we can agree that this is a safety protocol at the hospital. But it was followed. You will not hear from anybody in this case that the nurses turned an alarm off. They didn't.

Okay. Another issue, when was CPR started? You saw in the cath lab at 12:54, Jesse Hanna typed in "CPR started by MD." All right. So let's talk about that. And actually, you're going to see three documents that discuss when CPR was started. You're gonna see that time at 12:54, you're gonna see Dr. Nemiroff's anesthesia record that Mr. Claggett showed you, and you're gonna see the incident report. All the time's are slightly different.

Dr. Nemiroff will tell you that when he wrote what he wrote, what he meant by that -- and it doesn't say to the time or to the second -- but what he with say and what he will explain, he'll be on the stand -- I think, pretty sure he's gonna tell you, that when he wrote that what he meant was exactly what I've been telling you, is that he immediately recognized there was low blood pressure.

When they lost the blood pressure at 12:50, he felt for a pulse and then as soon as it was recognized she didn't have a pulse, CPR was started.

The third piece was Boz's incident report. And so that

is the way that we notify administration that something unusual has happened. Boz filled that out. It wasn't like we didn't care. Boz filled it out. And he put a time on that document. And the time that he put on the document was 12:50. And so he will tell you what that means is that's when the code happened.

So how do we explain Jesse's documentation? It's not wrong, but you have to understand the context. And I asked you questions during jury selection whether patient care is more important than documentation. And that's what this means. So what happened? You will hear Jesse say -- and he doesn't remember this. But he will tell you what his custom and practice is in this situation. And he will say that when a code happens, he comes out of the control room to help.

So he gets up out from his chair, he leaves his keyboard, and he goes into the room. So what we see on there is what he's typing on the keyboard. And the time that he see is when he hit "enter." It's an automatic time stamp for when he hits "enter."

So under the facts of this case, what you're gonna -- I believe what you're gonna conclude is that at approximately 12:50, we see that issue with the blood pressure. There's immediate recognition, this is now a big deal. It's already been a big deal with the low blood pressure, but now it's gone

to a whole another level. It's now a code situation.

Jesse comes out of the control room. And it's when he's able to go back into the control room and do his charting and he types "CPR started by MD" and hits "enter," that's the time we see. There's a bit in delay. It doesn't mean it's wrong. It's not fraudulent. We're not trying to run from it. It is what it is, but it's this recognition that patient care comes first.

You know, Mr. Claggett wants it -- we have a motive. Our motive was good patient care and that's what Jesse Hanna was doing. All right.

All right. Another issue. Mr. Claggett talked about this. Can you tell when chest compressions are being done when looking at a an EKG? Well, if you listen to their experts, the answer to that is yes. They will tell you that I can tell definitively her heart beat when chest compressions were being done. But the only people you will hear that from in this case are Plaintiff's experts.

You will hear from our EKG -- the nurses who know how to read an EKG that you can't always see it. You will hear from our retained experts, including Dr. Goodman, who's a cardiologist that we'll call, is that there is no science behind this idea that you have to be able to see compression artifact. Especially in a situation like this, where the

leads are on the back. They're not on the front of the chest.

But Dr. Anh -- Dr. Anh's gonna be here Monday. Dr. Anh's gonna tell you that from this case, when he learned about this case and he saw that he was being accused of not being -- doing timely CPR, the first thing he did was go look at the EKG strip to see if he could see compression artifact. He looked at it and he couldn't see it.

Doesn't mean that he didn't do 'em. It's just that sometimes you can see it; sometimes you can't. And I'm pretty confident that when Dr. Anh is on the stand on Monday and there's a suggestion that he did CPR for 35 seconds and then stopped for many minutes, I suspect Dr. Anh is going to disagree strongly with that.

I fully expect that Dr. Anh is gonna come in and say that he fully complied with the standard of care and that he did this CPR pursuant to ACLS protocol. So that, to me, I believe on Mr. Claggett's opening -- and what I've been talking about, the single biggest issue is, did we do nothing for nine minutes or did we do CPR per ACLS protocol? That's your job to tell us.

So I'm gonna suggest to you three things to consider as you listen to the evidence. The first is your common sense. Again, the scenario that we have is that with a known cardiac arrest. He's not suggesting that we somehow had our head in

the sand and didn't realize what was going on. Mr. Claggett is saying we did this knowingly. We knew this. So ask yourself, does it make any sense at all for six -- not just one, six medically trained people to sit in a room for 39 minutes and a patient without a pulse and do nothing? I hope you agree the answer to that is absolutely not.

You will be able to assess the credibility of the witnesses when they come in and tell you they did CPR and you can judge that credibility.

So the second way -- and I kind of got ahead of myself. The second way is by listening to the witnesses. Each of those six people will tell you the four who remember it and the two who don't will tell you that CPR was done right. The two who don't remember will tell you that if I had a situation where the doctors weren't running a code for nine minutes, I'd remember that.

It's like, where were you, you know, two Octobers ago during the shooting here? You'd remember it. Because it's such a stark thing. It'd be like watching a plain crash. This is something that would be burned in your mind if it happened. They don't remember, but they would have if what happened is what Mr. Claggett says.

But the third way, and the best evidence of this, is Mrs. Sales. And this gets to that point that Mr. Claggett

finished with. And it goes to the question of did Mrs. Sales suffer a hypoxic brain injury? I will tell you, she didn't.

And I'm going to explain now why I can say that, notwithstanding those pages in the record that Mr. Claggett told you about.

Mrs. Sales was a medically fragile person. She had a longstanding cardiac condition. She had longstanding diabetes that was not well controlled that caused all sorts of problems with her. It had been going on for a decade. If this lady truly was without oxygen for nine minutes, she would have died. She would have died on that table.

So what is the evidence that we have? We know, after the code was run, Mrs. Sales was put in a medically induced coma. She was given sedatives. The sedatives were discontinued the next day and Mrs. Sales woke up. She was alert. She recognized her family.

But absolutely, there was a lot of confusion. She had just gone through a code situation. She just had an extended period of time where she had low blood pressure. She had an encephalopathy, we'll call it, where she had a lot of confusion.

I believe Dr. Anh is going to tell you that when Mrs. Sales left that operating room to go to the ICU, he had every confidence that she was gonna make a full recovery. And

she did.

So what happened at Summerlin Hospital? Without question, there was concern. We were worried, did she suffer this kind of injury? So we brought in a neurologist. We brought in a neurologist to see what was going on. Or I got -- way got ahead of me, myself. So why -- why do I say that Mrs. Sales was this medically fragile person? Well, the story for this begins back in 2010. And that's when Mrs. Sales begins to see Dr. Averilla, who is -- was her primary care physician at that time.

Mrs. Sales, a couple years before that had had a heart attack. She had a bypass procedure. The defibrillator was put in. Mrs. Sales begins being treated by Dr. Averilla because she wants to go on disability. She's tired all the time. She can't -- she has no energy. So she's going to Dr. Averilla so Dr. Averilla will sign a piece of paper saying she's disabled.

So why is she disabled? She's disabled because her heart function is really bad. In addition to needing this pacemaker, she has a low ejection fraction. And that's a key point that you're gonna hear time and time begin throughout this case.

So as you may or may not know, your heart contains four chambers. The left ventricle, which is the biggest chamber in

the heart is the one that when it squeezes, pushes the blood around the body. When it squeezes, we have the ability to measure the percentage of blood that gets squeezed out. That's called the ejection fraction. How much -- what percentage of blood that's in the left ventricle gets squeezed out. Normal is 50 to 75 percent. In 2010, Mrs. Sales's was 20 to 25 to 30, depending on which echocardiogram report you look at.

So how does that affect you? It affects you because your heart is not pumping enough blood. And when your heart doesn't pump enough blood, you're not getting enough oxygen to your whole body. It's not like she's having a brain injury or anything like that. But she has less oxygen than she needs. So she's fatigued. She's tired. She says, "Dr. Averilla, I get winded if I walk 200 feet. So please, sign the disability form for me."

The other thing that happens is that Dr. Averilla does an examination and he determines that she has something called a peripheral neuropathy. And this is from her diabetes. As you may know, when you have diabetes, it affects your circulation on your periphery. Mostly your feet. But it can be anywhere. And what happens, especially if your sugars are not well controlled, is that you start having problems. You have problems with your feet. You have problems with your kidneys.

You have problems with your eyes. You have problems with your brain. And that's exactly what was going on with Mrs. Sales.

She had kidney disease. She had stage two kidney disease in 2010. She had diabetic retinopathy in 2010. And it's not real clear from the records, but from time to time, Mrs. Sales needed oxygen 24 hours a day. She would have good times; she would have bad times, but she needed oxygen. She was a sick, fragile lady.

By 2013, her condition had worsened. You will see from the records -- I think it's from Spring Valley Hospital, when Mrs. Sales went there, that she told the nursing staff, "My husband has to help me get dressed in the morning. My husband has to help me bathe because I can't." You'll see documentation on the nursing record that the patient, Mrs. Sales, forgets her limitations. It's part of a fall risk assessment that was done. So there was -- there were cognitive affects that we're already seeing back in 2013.

By 2014, Mrs. Sales did get her disability placard. It's one of those handicap placards that can hung from a rearview mirror of a car.

Also, Dr. Averilla diagnosed Mrs. Sales with congestive heart failure. And what that -- that's, again, a function when the heart isn't able to pump. This is more affecting the light side of the heart. 'Cause the way the heart works is

the right side of the heart pushes the blood through the lungs. It comes back to the left side of the heart. Now that it's picked up the oxygen from the lungs and then goes to the body. If that right side of the heart isn't pumping well enough, the fluid backs up and it causes congestion. And that's what we call congestive heart failure. Mrs. Sales had that too.

And I don't know how many records we'll show you, but the record is replete with references that Mrs. Sales, from 2010 to today suffers from fatigue. She has no energy. And we'll talk about today in a minute.

So that was Mrs. Sales' condition when she came to us in July of 2016. She was this fragile patient. And, again, the key point being is that if she truly went for nine minutes without oxygen, she would have died on that table. So the mere fact she survived supports the idea that effective, timely CPR was done.

So now talking about the Summerlin admission in July of 2016, there absolutely was concern. There was question, has this patient suffered an hypoxic brain injury? So we asked a neurologist to take a look at her.

That neurologist was a Dr. Tran. And Dr. Tran followed the patient for the time that she was at Summerlin Hospital and she did a bunch of tests to determine whether Mrs. Sales

actually suffered a brain injury. She did three CT scans of her head. All three were -- showed no acute injury. And when we hear the word "acute," that means new, as opposed to "chronic," which means old.

So the CT scans are not normal, but they show no evidence of an acute injury. There's nothing on those CT scans that suggest in any way a hypoxic brain injury. But what do they show? They show white matter disease. And that's consistent with what I told you earlier about her diabetes. This is a peripheral neuropathy that is causing white matter disease in her brain. Every CT scan that we've seen since then demonstrates it.

So what does that mean? That means that Mrs. Sales had this brain damage. There's not a single expert in this case, whether it be our experts or their experts, are gonna say that that white matter disease is related in any way to what happened in July at Summerlin. It's not. That's an old, chronic injury from this microvascular disease.

The other test that doctor -- the doctor did was called an electroencephalogram, an EEG. It's a test where they put these electrodes on your head and it allows you to measure the brain activity in your head. That was done on Mrs. Sales. It was completely normal.

Mrs. Sales was not diagnosed with a hypoxic brain injury

at Summerlin Hospital. In fact, by the time she's discharged, the neurologic exam by Dr. Tran was perfectly normal. She still had some confusion. And because of that, Mrs. Sales was transferred to a rehabilitation facility, where she stayed for a week. By the time she left the rehabilitation facility, she was independent of all her activities of daily living. She was talking. She was walking. She was able to take care of herself.

So, then, what happens next? There's no diagnosis of a hypoxic brain injury at the rehab facility. So back in 2015, Mrs. Sales changed primary care physicians. She switched from Dr. Averilla to Dr. Adolfo. And getting back to 2015, Dr. Adolfo, when she gets involved, identifies these same problems as they chronic problems as fatigue, her inability to breath well as well as.

But now, on August 9th, 2016, is the first time that Dr. Adolfo sees Mrs. Sales after our event. Doctor -- and you'll see a lot of that note I suspect. And that note, a diagnosis of hypoxic brain injury is not there.

Dr. Adolfo was well aware of what happened at Summerlin Hospital. Dr. Adolfo did a physical examination of Mrs. Sales at that time. And here are some of the findings that she made: She found that Mrs. Sales was completely independent, independent on her ability to take her own

medications, to feed herself, to bathe herself, to dress herself, to walk, to do transfers. She was continent of bowel and bladder.

Mr. Claggett is correct that while she was at Summerlin, there were periods of time when she would wet the bed and she would stool herself. By the time she goes to see Dr. Adolfo on August 9th, that was no longer a problem.

Mrs. Sales was verbal. She was alert. She was cooperative. She had no weakness. She had no tremors. She had no seizures. There were no changes in mentation. And she had no ataxia. Ataxia is kind of a shuffling gait, how you walk. I don't know if you remember, when you saw Mrs. Sales, how she left this courtroom the other day. She had that shuffling gait. That's ataxia.

In August of 2016, Mrs. Sales had none of that. Dr. Adolfo did not diagnose Mrs. Sales with a brain injury. She didn't. In short all of the deficits that Mrs. Sales has today were not present in August of 2016. If Mrs. Sales suffered a hypoxic brain injury, as is claimed in this case, she would have had those same deficits, then. Hypoxic brain injury's not one of those things where you have it and then it takes a period of time for it to show itself. It shows itself right away.

So now about a week later, on August 18th, 2016,

Mrs. Sales has an episode where she's be getting forgetful. And she's also getting dizzy. So she's taken to the emergency department at Mountain View Hospital. The doctors at Mountain View Hospital learn or are aware of what had happened at Summerlin Hospital.

So they too are trying to investigate, well, what's causing this? So they too ask a neurologist to take a look at Mrs. Sales. That neurologist, and it's Dr. Azma. Dr. Azma does a CT scan. Shows no evidence of a hypoxic brain injury. It still shows this white matter disease, this chronic white matter disease, but there's no evidence of a hypoxic brain injury.

Dr. Azma does an assessment. His -- the neurologic examination is normal. What was the diagnosis or what was the conclusion? Is that this change in mentation that she had wasn't due to a hypoxic brain injury but was due to ortho static hypotension. And this is -- I don't know if you've ever had that experience when you're sitting down and you stand up and you feel a little bit lightheaded.

That happened, but it was much worse for Mrs. Sales. And the reason being, begin, is her heart is just not pumping enough. So her head doesn't get enough oxygen. The doctors at Mountain View Hospital diagnoses that that was the cause of that problem. This memory that she had, this dizziness that

she had was due to that.

So then Mrs. Sales -- oh, and actually when Dr. Azma did the CT scan, they also did an angiogram, which is a test involving dye where they can actually see the blood vessels going into your head. And another thing they found, in addition to this white matter disease, was that several of the carotid arteries that feed blood to the brain, one was completely blocked. I think it was the one on the right. And two or three of the others were significantly blocked.

So in addition to Mrs. Sales having a heart that just doesn't pump well, she had a blood vessels that aren't open. So she's getting even less blood to her brain. That's what causing her condition. It's not hypoxic brain injury from Summerlin Hospital.

So then we go forward to August 25, 2016, is the next time that Mrs. Sales is in to see Dr. Adolfo. Dr. Adolfo was aware of the admission to Mountain View Hospital. Dr. Adolfo, again, does a full neurologic examination. And just like she found on August 9th, she finds that Mrs. Sales is completely independent of taking her medications, of eating bathing, dressing, walking, transferring. She was continent of bowel and bladder. And she also had chronic respiratory failure and that she needed oxygen 24 hours a day.

On the neurologic exam, there was no weakness, there were

no tremors, no seizures, importantly, no changes in mentation. And she had no ataxia. Again, this problem walking. In short, she's perfectly normal from a neurologic perspective.

Dr. Adolfo does not diagnose hypoxic brain injury, doesn't refer Mrs. Sales to a neurologist, doesn't do anything. In fact, to today -- to today, in 2019, Mrs. Sales has never been under the care of a neurologist for a brain injury. She hasn't because she doesn't have one.

In fact, we don't see evidence of these -- the changes in mentation until eight months later, until April of 2017, when now we're beginning to see these things that Mrs. Sales has today. That's when the mentation change. That's when, according to the doctors, the medical records we have -- you're going to hear a very different story from the family.

They're gonna talk about how healthy she was, how much she was hiking up mountains, how she was a perfectly healthy person until our event and she's been irrevocably changed since then. That's what they're gonna tell you.

The medical records tell a completely different story. And I would suggest to you that as you weigh the credibility of the evidence, the information contained within the medical records is far more credible than what the family members, who are trying to get many millions of dollars for the patient is.

So why is Mrs. Sales in the condition she is today? I'm

not suggesting at all that she's faking it, that she isn't as injured as much as they say. But what's causing it is her diabetes. By early -- I'm sorry. By mid 2016, her kidney disease had now progressed to stage three. Her ejection fractions is now ten. So it's gone down from 25 to 10. Her condition is getting worse and worse and worse.

And how does that affect you? Well, if you're not getting enough blood through your body, you're not getting enough oxygen through your body, you feel like crap. You feel weak. That's exactly what Mrs. Sales had. Her diabetes, which has never been well controlled -- the last time her blood sugars were measured, they showed 300. A hundred is high, normal. Three hundred is crazy high.

Her blood sugars are not well controlled. You're gonna hear a lot about a test called A1C that has been taken over the years. It's a measurement of how in a three-month window, how compliant a patient has been with their diabetes. Mr. Sales's A1Cs have always been terribly high. It means that her blood sugars are not well controlled.

So how does that affect her body? It causes this peripheral neuropathy with her feet, with her kidneys, with her eyes, with her brain. So you will hear from our experts who will explain that this deteriorations in Mrs. Sales's head is not as a result of this hypoxic brain injury that she

didn't have, but rather the progression of these chronic, persistent, uncontrolled problems. That's why she has it.

And you may ask yourself, if Mrs. Sales has this horrific brain injury that they're saying from hypoxic, why isn't she being treated by a neurologist? Dr. Adolfo referred her to a neurologist in 2017. Mrs. Sales has never gone. Why not? 'Cause she doesn't have a hypoxic brain injury is why not.

In any event -- so those are the three I was that I believe you should assess their credibility of the evidence. And I believe you will convinced by the evidence, even though I don't bear the burden of proof, that the six people in that room did the right thing, did the safe thing, and immediately did chest compressions pursuant to ACLS protocol.

I believe you'll be more than convinced that all of the staff in that room were qualified. They knew how to do CPR. They knew how to set up the rooms with the alarms. And lastly, that the damages that Plaintiff is claiming are not in any way related to what happened on that July day at Summerlin Hospital.

So at the end of the case, when you have the opportunity to address you, again, as I think I alluded to in jury selection, I'm going to ask you to return a verdict in favor of Summerlin Hospital and send this nice lady home with no money.

So, again, just in closing, I would like to thank you for your time that you're devoting to this case and look forward to the presentation of the evidence with you.

Thank you.

THE COURT: Thank you, Counsels.

Ladies and gentlemen, as I talked to you previously, we are going to be dark tomorrow and Friday. And then we will begin the live testimony on Monday morning at 9:00 a.m. Ms. Parks will be giving you your formal badges and I believe all the parking information.

During this recess, you are admonished not to talk or converse among yourselves or with anyone else on any subject connected to this trial or read, watch, or listen to any report of or commentary on the trial or any -- any person connected to this trial by any medium of information, including without limitation newspaper, television, radio, or the Internet or form or express any opinion on any subject connected to this trial until the case is finally submitted to you.

We will see you back here Monday morning at 9:00 a.m.

THE MARSHAL: All rise for the jury.

THE COURT: Just leave your note backs there and your pencils. Take all your personal belongs, please.

Please watch out for the cords that are on the floor.

[OUTSIDE THE PRESENCE OF THE JURY.]

THE COURT: Counsel, anything that needs to come before the bench before we break?

MR. CLAGGETT: No, Your Honor.

MR. PRANGLE: Not from us.

THE COURT: Thank you. Let's make sure we get all this mess cleaned up, please.

MR. CLAGGETT: And 9:00 o'clock Monday?

THE COURT: 9:00 a.m. Please be here quarter till.

[Hearing concluding at 4:03 p.m.]

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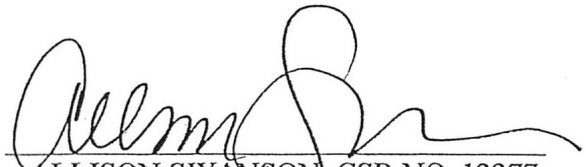
ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.



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