IN THE COURT OF COMMON PLEAS
FOR THE COUNTY OF CHESTER, PENNSYLVANIA
- - -

ROBERT KIMBLE, ADMINISTRATOR AND, :
PERSONAL REPRESENTATIVE OF THE ESTATE:
OF SHARON KIMBLE, DECEASED AND :
ROBERT KIMBLE IN HIS OWN RIGHT :
Plaintiff, :
: NO. 16-00569
:
-VS- :
:
LASER SPINE INSTITUTE - , :
PHILADELPHIA, ET AL. :
Defendants. :
- - -

Courtroom 4
Chester County Justice Center
West Chester, Pennsylvania
March 27, 2018

BEFORE:

THE HONORABLE WILLIAM P. MAHON, JUDGE

APPEARANCES:

LANE R. JUBB, ESQUIRE
on behalf of the Plaintiff;

KEVIN H. WRIGHT, ESQUIRE
on behalf of the Defendant.

Cara M. Fitzpatrick, Gale Fitzpatrick, Kim Kercher
Official Court Reporters

I-N-D-E-X

DEFENDANT'S WITNESS PAGE

JAMES NOONE

Voir Dire Direct Examination by Mr. Wright..........3
Voir Dire Cross-Examination by Mr. Jubb.............8
Direct Examination by Mr. Wright....................9
Cross-Examination by Mr. Jubb.......................46
Redirect by Mr. Wright..............................73
Recross-Examination by Mr. Jubb.....................80

GLEN RUBENSTEIN

Direct Examination by Mr. Wright....................90
Cross-Examination by Mr. Jubb.......................119
Redirect Examination by Mr. Wright..................135
Recross Examination by Mr. Jubb.....................139

ANDREW HARHUT

Direct Examination by Mr. Wright....................142
Cross-Examination by Mr. Jubb.......................147

1 THE COURT: Okay. Do we have any points for
2 charge?
3 MS. MANNINGS: May I approach, your Honor?
4 THE COURT: Yes. How was it last night,
5 Chloe?
6 MS. MANNINGS: It was okay.
7 MR. WRIGHT: Should I step outside?
8 THE COURT: Not if you're willing to change
9 the name of the firm.
10 Okay, bring them in, Frank, please.
11 (Whereupon, the jury enters the courtroom.)
12 THE COURT: All right. Please be seated,
13 ladies and gentlemen.
14 All right, Mr. Wright, call your next
15 witness, please.
16 MR. WRIGHT: Dr. James Noone.
17 - - -
18 JAMES NOONE, after having been first duly sworn,
19 was examined and testified as follows:
20 - - - VOIR DIRE DIRECT EXAMINATION - - -
21 BY MR. WRIGHT:
22 Q. Morning, sir.
23 A. Good morning.
24 Q. Are you licensed to practice medicine in this
25 Commonwealth, sir?

1 A. I am.
2 Q. And do you limit your practice to a certain
3 specialty or subspecialty?
4 A. Yes. I did my residency in anesthesia and I'm the
5 Chair of an Anesthesia Department that does 13, 14,000
6 anesthetics a year.
7 Q. And do you also perform pain management?
8 A. Yeah. I'm Board Certified in Anesthesia and Pain
9 Medicine.
10 Q. Excuse me. Okay, let's go back. Tell us where
11 you went to school, where you trained.
12 A. Well, I went to Cardinal Dougherty High School.
13 LaSalle College. St. Louis University, med school.
14 George Washington University for internship. And
15 Georgetown University for residency. I left there and
16 started practicing at Redeemer Health System and I have
17 been there for 41 years. I left Georgetown on a Friday
18 and started Redeemer on a Monday and never left. And I
19 have been Chair of the Department there for 29 years.
20 Q. Okay. You mentioned that you do a number of
21 surgeries at Holy Redeemer?
22 A. Yeah. Our Department does about 13 to 14,000
23 anesthetics a year.
24 Q. For what type of procedure, sir?
25 A. Everything except heart. And we are not a Trauma

1 I Center.
2 Q. Okay.
3 A. But we don't do hearts.
4 Q. Orthopedic surgery?
5 A. A lot of orthopedics and a lot of spine.
6 Q. Okay. Spine surgery?
7 A. Yes.
8 Q. And do you also -- the pain management portion of
9 your practice, what exactly is that?
10 A. Well, I'm Board Certified in Pain Medicine. It's
11 a relatively new specialty that came out in '94. I got
12 Board Certified in '94, '04, and '14. Every 10 years
13 you need recertification. And it's the practice of
14 acute and chronic pain medicine. We see consults around
15 the hospital for pain problems and also see patients in
16 the office for chronic pain.
17 Q. Okay. Let's start with that. The folks you see
18 with chronic pain, are they treated with pain
19 medications, opioids, for example?
20 A. Commonly. But less now than before, but yes.
21 Q. Okay. So are you familiar with I guess the
22 effects that opioids have upon a patient?
23 A. Sure.
24 Q. Are you familiar with their half-life, how long
25 they remain in the patient's system?

1 A. Yes.
2 Q. And do any of those patients receive different
3 types of medications?
4 A. Sure.
5 Q. Are you familiar with this concept of synergistic
6 effects of pain medications?
7 A. Synergism in drugs is a result of an outcome from
8 the drugs which is greater than the sum of the parts.
9 So if you give a sedative and a narcotic, you'll see an
10 outcome that can be greater than the sum of either drug
11 by themselves.
12 Q. Now, at Holy Redeemer I assume some of the
13 surgeries are for patients who remain hospitalized?
14 A. Yes.
15 Q. Do they also do outpatient surgery at Holy
16 Redeemer?
17 A. Most of our procedures are outpatient. Probably
18 of the 13 or 14,000, probably eight or 9,000 a year are
19 outpatient procedures.
20 Q. So I guess are you familiar with the proper
21 parameters for discharging a patient who's undergone a
22 outpatient procedure from an anesthetic point of view?
23 A. Yes.
24 Q. Are you familiar with the proper instructions that
25 are given to those patients?

1 A. Well, everybody who leaves a hospital is given
2 written and verbal instructions. So if there's a
3 written instruction form that is given to the caregiver
4 on follow-up care and they also are reviewed with the
5 nurse before they leave. So they don't just sign a
6 form. They go through the form with the nurse before
7 discharge.
8 Q. Well, I guess my question was, are you familiar
9 with what parameters should be followed when a decision
10 is made by an anesthesiologist to discharge a patient
11 after they have undergone an outpatient procedure?
12 A. Parameters should be followed?
13 Q. Yeah. Are you familiar with what they are, sir?
14 A. Yes.
15 Q. Okay. And, again, I think you already told us
16 this, but you're familiar with the impact of pain
17 medications that a patient receives either during the
18 surgery or after the surgery in a recovery unit and the
19 half-life of those medications; is that a fair
20 statement?
21 A. Very much.
22 Q. Okay. And just to touch on that other point,
23 there's going to be some testimony about a
24 post-anesthetic state. Are you familiar with, I assume,
25 the medications that are used during anesthesia itself,

1 how long they last, how long they have an effect upon a
2 patient after surgery?
3 A. Yes.
4 Q. Okay. Thank you.
5 MR. WRIGHT: Your Honor, we offer Dr. Noone
6 as an expert in the area of Anesthesiology and Pain
7 Management.
8 THE COURT: Cross-examine.
9 - - -VOIR DIRE CROSS-EXAMINATION - - -
10 BY MR. JUBB:
11 Q. Dr. Noone, good morning. My name is Lane Jubb.
12 We have never met before. I represent the plaintiff in
13 this case.
14 A. Good morning.
15 Q. Thank you. On your curriculum vitae, am I correct
16 you have no publications?
17 A. No. We have been in a purely clinical practice
18 for 40 years.
19 Q. Am I also correct that of the five to six teaching
20 hospitals in the Philadelphia area, you do not have any
21 teaching responsibilities?
22 A. No. As I said, we have been in a -- this is a
23 purely clinical practice I have been in for 40 years.
24 We don't have medical students or residents rotating
25 through the hospital.

1 Q. And am I also correct that as a medical legal
2 consultant, you perform services for the defense 95
3 percent of the time?
4 MR. WRIGHT: Objection, your Honor.
5 Qualifications?
6 THE COURT: Overruled. Go ahead.
7 THE WITNESS: Yeah, I have reviewed probably,
8 through 20 years I've been doing this probably, I have
9 reviewed probably 100 hundred to 110 cases. Probably
10 ninety percent of those -- I have reviewed probably
11 eight to 10 for the plaintiff. And not because I don't
12 do it, it's just that I'm not asked very commonly. I
13 don't advertise or put my name any place and I don't get
14 asked commonly by plaintiff's counsel.
15 MR. JUBB: Thank you, your Honor.
16 THE COURT: All right. Accepted.
17 MR. WRIGHT: Thank you.
18 - - - DIRECT EXAMINATION - - -
19 BY MR. WRIGHT:
20 Q. Doctor, at my request did you review certain
21 materials concerning the care that was provided to
22 Ms. Kimble in January of 2014 by the folks at Laser
23 Spine?
24 A. Yes, I did.
25 Q. Can you tell us -- and you prepared a report dated

1 January 24, this year?
2 A. Yes.
3 Q. Can you tell us -- can you go through the list and
4 tell us what materials you did review, sir?
5 A. Um, I reviewed all the past medical records, the
6 pain medicine records, which were extensive, for
7 Ms. Kimble. Reviewed the records from the Laser Spine
8 Center. Reviewed the police documents when they came to
9 the Marriott. Reviewed the discharge instructions.
10 Reviewed the deposition testimony of Doctors Rubenstein
11 and Finkelstein. The deposition testimony of
12 Mr. Kimble, as well as the police officer who came to
13 the Marriott. And I read the plaintiff's expert
14 reports; Dr. Dinner, Dr. Brent, and Dr. Hood.
15 Q. Okay. And have you had a chance to review some or
16 all of the testimony that has been given in this
17 courtroom so far?
18 A. I have reviewed all the trial testimony except
19 what was given yesterday.
20 Q. Okay. And then did you mention that you also
21 reviewed the records concerning the autopsy in this
22 case?
23 A. Yes, I did.
24 Q. Having completed that review, sir, did you reach
25 an opinion as to whether or not the care that was

1 provided to Ms. Kimble by Dr. Rubenstein, the
2 Anesthesiologist, was appropriate?
3 A. Yes. As I told you when I first saw the case, I
4 thought it was consistent with accepted standards of
5 care and I didn't think the medications that were
6 provided at the Laser Spine Center, or the medications
7 that she was on, really caused the death.
8 Q. Okay. Let's break that down a little bit. In
9 your report you talk a little bit about this concept of
10 tolerance. Can you tell us what that is, sir?
11 A. Tolerance occurs with certain classes of drugs
12 where the physiological effect of the drug diminishes
13 with time. So the longer you're on the drug, the less
14 effect that you'll get from the same dose of drug.
15 Benzodiazepine, the Valium-types of drugs, have
16 tolerance associated with them and the narcotics are
17 notorious.
18 So if you are on a narcotic this year for a
19 certain level of pain, next year, for the same level of
20 pain, you're going to need more drug to give you the same
21 analgesic. That is not true with like NSAIDs, the
22 non-steroidals. So if you take Aleve or Advil or
23 something, that drug will do the same for you next year as
24 it's doing this year. Not so with the narcotics.
25 Q. Why is that, sir?

1 A. Um, well, tolerance. The exact mechanism of
2 tolerance has to do with the mu receptors or where the
3 narcotics bind and the reaction of the mu receptors to
4 the narcotics. And so it's pharmacodynamics and the
5 narcotics are notorious for this.
6 Q. In your experience, folks who have developed a
7 tolerance to opioids, let's say, what impact does that
8 have upon your treatment of -- in pain management?
9 A. Well, when a tolerance develops, all of the
10 aspects of what the drug causes also becomes tolerant
11 and you become tolerant of. So you get less analgesia,
12 you get less sedation, you get less respiratory
13 depression. So all of the effects, even side effects of
14 drugs, are less effective as tolerance develops.
15 Q. Now, in this case it's been suggested to the jury
16 that because this patient received I guess 12 milligrams
17 of Dilaudid, along with other medications and some
18 Flexeril, in the recovery unit and then was told to take
19 other medications after she left the PACU, that as a
20 result of that, that she developed an opioid toxicity
21 which caused respiratory arrest and lead to her death.
22 Assuming the jury has heard that, would you agree with
23 that?
24 A. I do not.
25 Q. Why not?

1 A. Well, it will be a long answer.
2 Q. Okay.
3 A. If I --
4 Q. I'll interrupt if I have to.
5 A. All right. If you go back through her pain
6 history starting in 2007, she was on multiple drugs that
7 caused depression, that work in a synergistic manner;
8 Oxycodone, Baclofen, Xanax, Valium. That goes back to
9 '07 and in '08. There was more drugs. She started
10 seeing a pain medicine doctor, Dr. Demangone --
11 Q. Demangone.
12 A. Demangone in 2008 and he started to increase the
13 amount of pain medication she was taking, so that in
14 2010 she was taking 150 Morphine equivalent. So when we
15 look at different drugs, we can standardize the drugs if
16 you convert them to Morphine equivalents. So Oxycodone,
17 okay, is equivalent, each milligram is equivalent to
18 about one and a half milligrams of Morphine. So it's
19 stronger than Morphine, the Oxycodone.
20 So in 2011 she was up to about 150 equivalents of
21 Morphine every day, plus the other medication, the muscle
22 relaxants and the sedatives and the sleep medication at
23 night. So she had been on these drugs.
24 In 2012 she stated that the pain was so bad that
25 Dr. Demangone increased her to 200 milligrams a day of

1 Morphine. This is an enormous dose. And she stated in
2 one of his records that she needed this amount of
3 medication for her to function. And, notably, at this
4 level of narcotic she continued to drive. And she even
5 stated in the medical record that she needed more of the
6 Oxycodone to allow her to drive. So she was on, in 2011
7 and 2012, she was on doses of Morphine equivalents up at
8 150 milligrams to 200 milligrams, plus she would take
9 additional Oxycodone and she was still driving.
10 So narcotics will produce sedation. They will
11 produce somnolence. They will give analgesia. She was
12 resistent enough through all those years that she
13 continued to drive with this amount of a narcotic on
14 board, plus the other sedatives. She was taking Xanax at
15 the time. She was taking a muscle relaxant at the time.
16 And she had a sleep medication, Elavil.
17 So she was taking all these medications during
18 that time and functioning well. And you can see that she
19 functioned well because she drove, all right. So we get,
20 you know, you'll get a DWI at .08 percent alcohol. She
21 continued to drive on 200 of Morphine, plus additional
22 Oxycodone.
23 So when it came to the hospital, she had more pain
24 than would be expected in the recovery room. And this is
25 typical when we see chronic pain in the recovery room.

1 Somebody who's had a long history of chronic pain, when
2 they get acute pain on top of it, it is very difficult to
3 control the acute pain. They have a level of chronic pain
4 that they have been taking a certain level of drug for and
5 then when they get to the recovery room, it is very
6 difficult to control the pain.
7 They take more pain medication than you would
8 expect. She got more pain medication than you would
9 expect, okay. The average postop may take two to four of
10 Dilaudid, and she got six doses of two milligrams. They
11 didn't give her 12 milligrams of Dilaudid. They gave her
12 two milligrams, two milligrams, two milligrams each time
13 because her pain wasn't controlled. So this wasn't 12
14 milligrams of Dilaudid. It was two times six. And if you
15 look at the -- if you look at the recovery room records,
16 okay, after eight milligrams of Dilaudid at 9:48 in the
17 morning, her pain was ten over ten. And shortly following
18 that she was crying.
19 (Whereupon, proceedings continued to the next page without
20 loss of context.)
21
22
23
24
25

1 Q Let me interrupt you for a second. Let me
2 put that up for the jury. You're talking about the
3 pain flow sheet from Laser Spine, Sir?
4 A Yes.
5 MR. WRIGHT: Michael, that's D-1 Page
6 2, I believe.
7 BY MR. WRIGHT:
8 Q This kind of goes backwards. It starts at
9 the bottom and goes up. Is that what you're talking
10 about, Sir?
11 A Yes, that's correct.
12 Q It looks like at 9:48 the patient was
13 given medication, but -- she was given medication
14 just before that, and then here at 9:48 it's noted
15 that she had pain of 10?
16 A That's correct. So this was a larger than
17 you would expect dose of Dilaudid. As I said, the
18 average being 2 to 4 milligrams. So she was taking
19 a lot of Dilaudid trying to control the pain. But
20 the point is, they didn't give 12, they kept giving
21 medication, medication, medication, medication. And
22 you can see pain scores, okay? They were not
23 controlling her pain in the PACU, despite larger
24 doses than you would expect of Dilaudid.
25 Q Now, at 10:40 it's noted that her pain

1 level is now at five?
2 A Yeah. Five is generally the threshold.
3 We won't discharge them with a pain score above
4 five, so that's -- she finally hit the threshold
5 there for discharge.
6 Q Now, throughout this time period, it's
7 noted she's awake and alert. Is that significant,
8 sir?
9 A Sure. And this is what I was talking
10 about with tolerance. Tolerance means that you
11 don't get the normal analgesic effect from the drug,
12 but you also don't get the side effects from the
13 drugs. This amount of narcotic, okay, can produce
14 somnolence and can produce decrease in respirations
15 and decrease in oxygen in the blood. The first sign
16 of respiratory depression with a narcotic is
17 somnolence and a decrease in the respiratory rate.
18 And if you look at the respiratory rate there --
19 MR. WRIGHT: You're getting ahead of
20 me here.
21 Let's go to Page 1, if you could,
22 Michael. D-1.
23 BY MR. WRIGHT:
24 Q You're talking about this section here?
25 (Indicating.)

1 A Well, this has it also.
2 Q Okay. There's references here to the
3 patient being on room air, there's notations
4 concerning respiration, pulse and blood pressure.
5 A That's correct.
6 Q Okay. To what significance, if any, did
7 you attribute these numbers, sir?
8 A All right. So that means that they were
9 not giving her oxygen in the recovery room. So if
10 you look at the oxygen saturations, they're 97 to
11 98 percent. That's without supplemental oxygen,
12 which is commonly given in the recovery room. So
13 her oxygen had changed. Her respirations were not
14 depressed, and she had normal oxygen, despite
15 getting the Dilaudid, larger doses than you would
16 expect.
17 The next vital sign you see here is
18 respirations, okay? And the first sign of narcotic
19 induced respiratory depression is a decrease in the
20 respiratory rate; you breathe slower. And you don't
21 go from 18 or 16 to zero; you go from 16 to 14 to 12
22 to 10 and you become somnolent. And your cO2 will
23 start to accumulate, okay? And that's why you
24 become somnolent, you get cO2 narcosis. So here you
25 can see despite getting repeated doses of Dilaudid,

1 the respiratory rate never changed, the oxygen
2 saturation never changed. So she was tolerant. If
3 you look at this, she was tolerant by definition.
4 She got a larger than expected dose of Dilaudid. It
5 did not control her pain and it did not affect her
6 breathing at all and she wasn't somnolent. She was
7 wide awake, talking. So this is the classic example
8 of tolerance for analgesia and no side effects from
9 a larger than expected dose of narcotic.
10 Q I know this is all second nature to you,
11 but how do they measure oxygen levels in a recovery
12 unit?
13 A They have a censor that goes on the finger
14 or the ear, generally the finger. It's called a
15 Pulse Oximeter. And that will measure the oxygen
16 saturation in pulsatile blood flow. So there has to
17 be a pulse going through the finger for this to be
18 measured. So this is quantitative. This is a
19 figure that the PACU nurse was recording off the
20 oximeter.
21 Q The blood pressures are included in here,
22 Sir. Are they of any significance?
23 A Yeah, they're also stable. It would vary
24 by five points, basically. So the blood pressure,
25 the ventilatory figures and all this point to a

1 person who is having marked tolerance to narcotics.
2 MR. WRIGHT: Can we go back to Page
3 2, please. Actually, why don't we go to Page
4 3, D-1 Page 3.
5 There are additional notes here
6 what's called the nurses' progress notes.
7 BY MR. WRIGHT:
8 Q According to this, the patient arrived in
9 the -- what's that, P-A-C-U stands for
10 Post-Anesthesia Recovery Unit?
11 A Post-Anesthesia Care Unit.
12 Q Care Unit, I'm sorry. The patient arrived
13 there at about 8:43 in the morning?
14 A Yes.
15 Q All right. If you take us through this,
16 how was the patient doing throughout this time
17 period up until 10:40?
18 A She was fully awake when she came in. She
19 didn't need any supplemental oxygen. She was
20 completely stable the whole time she was there
21 except for very poor pain control, despite larger
22 than normal doses of Dilaudid.
23 Q The fact that the patient was able to
24 tolerate food and drink, is that of any
25 significance, Sir?

1 A Again, narcotics, I.V. narcotics, can
2 cause nausea. They're one of the most common causes
3 is postoperative nausea, and when you get more than
4 you expect it's not uncommon to have nausea with
5 narcotics, and she did not. This is, again,
6 consistent with somebody who had been on narcotics
7 for a long time and was tolerant.
8 Q Based on your review of the records, Sir,
9 was the patient demonstrating any signs of being
10 overly medicated at this point in time up until the
11 time she's discharged at 10:40?
12 A There was nothing in this entire record
13 that showed that she had any adverse reaction to the
14 narcotics that she received.
15 Q Okay. Now, there was testimony from
16 Dr. Hoffman, who is a pathologist, who we had review
17 the case. And his best estimate was at the time
18 this patient stopped breathing it was about
19 4:00 p.m. Assuming that that's accurate, sir, would
20 any of the medications that the patient received in
21 the PACU or even the Oxycodone that she took after
22 she left the PACU, would they have caused a
23 respiratory arrest at 4:00 p.m.?
24 A So the peak analgesic and respiratory
25 depressant effects of Dilaudid are anywhere between

1 10, 20, 30 minutes after it's given of I.V.
2 Dilaudid. So when you saw that over the time that
3 she was in the recovery room, she had no effects
4 from the I.V. narcotic at all, okay? It would be
5 very uncommon, okay? You would not expect it to
6 have caused respiratory depression at 4 o'clock in
7 the afternoon.
8 We know the breakdown times of
9 different drugs, and the half life of Dilaudid is
10 2.3 hours. So 2.3 hours half life means that 2.3
11 hours after it is given into the vein, the plasma
12 concentration, the amount of drug that you have in
13 your plasma, in your blood, is half. At 4.6 hours,
14 the amount of Dilaudid is half of half, so that's
15 25 percent, okay? At 6.9 hours, it's half of half
16 of half, which is 12-and-a-half percent.
17 So as of 3:50 in the afternoon, the
18 Dilaudid that she got in the recovery room, in the
19 Marriott would have been at 12.5 percent of what it
20 was in the PACU. And she showed know respiratory
21 depressant effects of this drug, no somnolence, no
22 physiologic changes at all in the recovery room to
23 claim that the Dilaudid caused this at 4 o'clock is
24 not reasonable. We know the breakdown times of this
25 drug. And she would have been at 12.5 percent at

1 4 o'clock, compared to what she had in the recovery
2 room.
3 Q What about this theory of a synergisitic
4 effect of drugs, Sir? Could that account for her
5 respiratory depression or arrest?
6 A Sure. So then you look at the other drugs
7 that she was instructed -- the normal way that we
8 would give pain medication following surgery is that
9 you continue on your chronic pain meds. We know
10 what she was on for chronic pain. And then you give
11 an additional drug, five or 10 of Oxycodone for
12 what's called breakthrough pain. This is the acute
13 pain that she's going to experience following the
14 procedure. This is what they did, okay? Continue
15 on your pain medication, and they gave her a
16 prescription for Oxycodone to take for the
17 breakthrough pain. So she was back on the normal
18 medication. The breakthrough pain, which she would
19 take PRN, just if she needed it, was the way the
20 prescription was written. So she would take the
21 Oxycodone, 10 milligrams Q6, every six hours on a
22 PRN basis, if she needed it.
23 So we then can look at the blood
24 levels of the drugs in the autopsy report. And none
25 of these medications were even at therapeutic

1 levels, let alone toxic levels.
2 Q What does that mean, sir?
3 A It means that she was barely getting
4 analgesia probably because of the liver enzyme
5 induction that she had. When you're on medications
6 for a long time, the enzymes in the liver increase
7 and you break the drug down more. So if you look at
8 the tox report in the autopsy, okay, the Dilaudid
9 was less than therapeutic. The Oxycodone was less
10 than therapeutic. The Phenobarb, which was from the
11 Donnatal for bowel spasms, okay, was less than
12 therapeutic. So you would never have a synergisitic
13 effect causing a death in somebody who was narcotic
14 tolerant and had subtherapeutic levels of every
15 drug. Every drug that she had by prescription was
16 subtherapeutic. So you would not expect this to
17 occur.
18 Q In your report you make reference to the
19 12 bottles of medication that were in the bag. Do
20 we know what was in there?
21 A No. As I mentioned in the report, we
22 don't know what was in the 12 bottles of meds that
23 Mr. Kimble gave to the EMTs to go to the hospital.
24 And this was never investigated, all right, what
25 other medications were in there.

1 It was interesting that in the
2 toxicology report there was Ephedrin and caffeine.
3 She may have had a cup of coffee when she came back
4 to the room because she did have a smoke, she went
5 outside and had a smoke, had a cup of coffee. But
6 Ephedrin, Ephedra, okay, which is metabolized to
7 Ephedrin, can be cardiotoxic, can be very
8 cardiotoxic.
9 And these diet pills --
10 MR. JUBB: Objection, your Honor.
11 This is way outside the scope.
12 You don't mention the word Ephedrin
13 in here, Doctor.
14 BY MR. WRIGHT:
15 Q Let's take a step back.
16 THE COURT: Can you point me to it?
17 MR. WRIGHT: Sure. Well, we're going
18 to go through the anesthesia record,
19 patient-guided anesthesia.
20 THE COURT: Sustained. Because he
21 was mentioning diet pills.
22 MR. JUBB: Thank you.
23 BY MR. WRIGHT:
24 Q Doctor, stay with that issue for a second.
25 In your report, you make reference to the

1 conversation that Mr. Lindberg said he had with
2 Mr. Kimble, correct? That's on Page 5 of your
3 report.
4 A Yes.
5 Q Okay. Your understanding of the
6 conversation is what? Do you have your report up
7 there, Sir?
8 A I do. What Mr. Lindberg testified to was
9 that Mr. Kimble told him that he knew his wife
10 shouldn't have taken the other pills. Mr. Lindberg
11 stated in his deposition that Mr. Kimble had said
12 that he knew his wife shouldn't have taken those
13 other pills, and that she had other pills in a bag.
14 Q Do we know what exactly -- what pills were
15 in that bag, sir, or how many pills were left in the
16 vial?
17 A No. That's what I'm saying. From the
18 investigation that went on, you would have expected
19 that these pills would have been counted and the
20 drugs would have been screened and the autopsy
21 report -- we have no idea what these 12 bottles of
22 pills, which is what the estimate was -- what were
23 in those bottles. And she clearly took something
24 from there, because Mr. Kimble mentioned to
25 Mr. Lindberg that he knew that she shouldn't have

1 taken that.

2 Q All right. Now, I kind of got ahead of

3 myself here. There was some discussion that the

4 patient was in a post-anesthetic state when she was

5 in the recovery unit and that somehow contributed to

6 her demise here. Do you remember that testimony --

7 or that in the report, sir?

8 A I think that that was referenced in

9 Dr. Hood's expert opinion, or Dr. Brent, I can't

10 remember which one, stating that she was in a

11 post-anesthetic state, and that's not so.

12 Q Let me put up the anesthesia record for a

13 moment.

14 MR. WRIGHT: Michael, this is D-1,

15 Pages 77 and 78.

16 BY MR. WRIGHT:

17 Q Do you have a pointer up there, Sir?

18 Here, take mine.

19 If you would, explain to us what

20 we're looking at here.

21 A I can't see it.

22 Q Why don't we do it one page at a time, all

23 right? Left side first. What exactly is this

24 document?

25 A This is the anesthesia record.

1 Q Okay. So what is that reporting?
2 A This is the medication that she gave
3 during the -- that she received during the
4 procedure. And she received 2 milligrams of Versed,
5 which is a fast-acting Valium-type drug that will
6 improve anxiety from when you come into the OR. So
7 the vast majority of patients when they come into
8 the OR will immediately get 2 milligrams of Versed
9 just to allay the anxiety. And that's what they
10 gave her here. Then this was not general
11 anesthesia. This was local anesthesia and sedation.
12 MR. WRIGHT: Can you blow that up?
13 BY MR. WRIGHT:
14 Q There was some reference I think yesterday
15 to the passing of gas. Was the patient given gas or
16 general anesthesia during this...
17 A No. There was no gas, there was no
18 breathing tube, there was no muscle paralysis. All
19 the stuff that you see with general anesthesia she
20 did not get. This is all sedation. Oxygen is all
21 she got. Versed, 2 milligrams, Sufentanil and
22 Remifentanil are two ultra short-acting narcotics
23 that work within a minute or two and are basically
24 gone in 30 minutes. They have basically no residual
25 effect. Propofol, this was on a pump, okay? See

1 that line going through there? And the Remifentanil
2 was probably on a pump. When you see a line going
3 through, generally that means there's a pump,
4 there's a consistent infusion of that drug.
5 Propofol is Michael Jackson's use,
6 the white solution you see with anesthesia, and it
7 is extremely short acting. That's why it's on a
8 pump with the Remifentanil. You can't just give
9 that drug because they'll wake up in five minutes,
10 all right? So you give it as a continuous infusion.
11 This is presumably 15 micrograms per kilogram per
12 minute.
13 So this is a sedative dose of this
14 drug that ran throughout the procedure and stopped
15 at the end of the procedure. So Mrs. Kimble was
16 sedated. She didn't receive gas, she didn't receive
17 a breathing tube, she didn't receive a muscle
18 relaxer. This was just sedation. And the surgeon
19 used local -- the surgeon used marking to inject the
20 skin and fascia and muscle.
21 Q Is this the Ephedrin we heard about
22 earlier, Sir?
23 A Yeah. So Ephedrin is a stimulant. It's a
24 respiratory stimulant, it's a cardiovascular
25 stimulant, it's a cerebral stimulant, all right? So

1 this is a commonly used drug to correct blood
2 pressure. And this was very small doses of
3 Ephedrin, 5 milligram. And if you look, it
4 correlates where the blood pressure dropped, okay?
5 So as they were giving the sedation, the blood
6 pressure, which started out at 110 had dipped down
7 to 80 -- down to 70 here, okay? They then gave the
8 Ephedrin, which then brings the blood pressure back
9 up. Then it dips down here again, they give more
10 Ephedrin and it comes back up. This is routine
11 management. These drugs will tend to drop blood
12 pressure. And the Ephedrin, which is a stimulant,
13 will then increase cardiac output and you'll see the
14 blood pressure come back up.
15 - - -
16 (Whereupon, proceedings continue on
17 the following page without loss of context.)
18 - - -
19
20
21
22
23
24
25

1 Q. Well, just for the stake of completeness, what are
2 these other notations here, sir? LR is what?
3 A. Lactated ringers which is a crystaloid clear fluid
4 that's running in during the case. Zofran here is for
5 nausea. I can't read the other one. This line.
6 Q. Can we go to the other side of the same page,
7 Michael. There is, I guess, there is some reference
8 here to Decadron?
9 A. That would have been ten milligrams either four or
10 ten. It wouldn't have been 30. Decadron is an
11 antiinflammatory medication. So they are trying to
12 decrease the inflammatory response to the procedure and
13 it also is a potent antinausea drug.
14 Q. Okay. And if you go to the next page, Michael,
15 page 78, right-hand side you want to go to. There is a
16 reference here that patient's in the PACU at 8:43?
17 A. Yes. So the surgery ended at 8:37 and by 8:43 she
18 was in the PACU which is about the time it would take to
19 transport the patient.
20 Q. Okay. So my question is based on what the patient
21 received during this procedure. Would she have been in
22 a post-anesthetic state while in the PACU up to and
23 including the time that she was discharged at 10:40?
24 A. Well, she initially -- all right, this is phase
25 one of the PACU where somebody comes out of the

1 anesthesia. These drugs would have had some some
2 residual effect when she got to the recovery room or
3 PACU. Propofol and Fentanyl dissipates and are
4 metabolized extremely quickly in the liver.
5 So certainly within 30 minutes there would have
6 been basically no effect of these drugs left. And if you
7 look at the PACU scoring, when she got there even though
8 the Propofol and Remifentanil was stopped just at the end
9 of the case, when she was there her initial score was that
10 she was fully awake and very responsive. So she had no
11 effect of the drugs even at the time when she got to the
12 PACU.
13 Certainly by four o'clock in the afternoon, there
14 would be no effects, zero.
15 Q. Sir, if somebody told this jury that this patient
16 was in a post-anesthetic state which contributed to her
17 respiratory depression and/or arrest after she arrived
18 at the Marriott, would you agree with that statement,
19 sir?
20 A. No, that's not true at all, okay. And we saw that
21 on the toxicology at the autopsy. None of these
22 anesthetic drugs showed up, zero. You would not expect
23 them to have any pharmacologic activity at four o'clock.
24 You wouldn't expect them to have any effect left when
25 she was discharged, that she would have had some effect

1 when she first got to the PACU, but she was fully awake
2 when she first got there. So even by that time she had
3 minimal effect.
4 Q. Now, your report also makes reference to, I guess,
5 to the discharge instructions?
6 A. Yes.
7 Q. And they're contained on D-1 at pages 12 and 13.
8 Can you tell us from memory or do you need to take a
9 look at exactly what those instructions were, sir?
10 A. Well, the key instruction which I thought was that
11 Mr. Kimble was specifically instructed -- these were
12 singed instructions and they are discussed with the
13 patient and the caregiver that --
14 Q. Enlarge this.
15 A. -- that he should remain with and monitor his wife
16 for 24 hours, and as I told you when I first got the
17 case, I think that you can summarize this case that if
18 Mr. Kimble had complied with those instructions,
19 Mrs. Kimble wouldn't have died and we wouldn't have been
20 here.
21 MR. JUBB: Objection, outside the scope.
22 Move to strike.
23 THE COURT: Point that out to me, Mr. Wright.
24 MR. WRIGHT: Sure. Do you want me to read
25 directly from the report, sir?

1 THE COURT: Tell me the page.
2 MR. WRIGHT: Page six, paragraph starts
3 Mr. Kimble's statements.
4 MR. JUBB: Big difference with that and but
5 for, your Honor.
6 MR. WRIGHT: The egregious conduct.
7 THE COURT: Overruled.
8 MR. WRIGHT: Thank you.
9 BY MR. WRIGHT:
10 Q. Go ahead, sir, would you finish your statement.
11 A. As I said, I think that if Mr. Kimble had complied
12 with and not come back in the room and had left his wife
13 no matter what went on, he would have been present with
14 her to monitor her as he signed the discharge summery
15 that was discussed with him, that he would be monitoring
16 and with his wife and would not have come back in the
17 room when she was dead. He would have been there with
18 her and could have provided some intervention, no matter
19 what went on in the room at that time. So if he had
20 followed these instructions, we wouldn't be here today.
21 Q. Sir, if the patient was not suffering from a drug
22 overdose when she -- at say at around four o'clock in
23 the Marriott, how could Mr. Kimble have prevented her
24 death?
25 A. Well, no matter what went on whether it was

1 something that she took from the pills, no matter what
2 was going on from the other pills, no matter what was
3 going on at the time, he would have been there to
4 provide intervention. She was laying face down on the
5 bed with her face directly into the mattress and spread.
6 You know, you would have thought, you know, he could
7 have turned her over, he could have down something and
8 most importantly, he could have called 911 and they
9 would have gotten there within a couple of minutes.
10 So you don't have respiratory arrest. The theory
11 of this case is that it was a respiratory arrest. Okay.
12 You don't have a respiratory arrest, you are not breathing
13 18 times a minute and then from residual narcotics stop
14 breathing. What happens is you become increasingly
15 somnolent, you become less responsive and your respiratory
16 rate will start to diminish gradually. It doesn't go from
17 normal to zero. It goes down gradually, and Mr. Kimble
18 would have been there to intervene on his wife's behalf
19 and certainly could have called 911. And that's why they
20 give these instructions.
21 Q. Now, let's go to page two of these instructions,
22 and that's on D-1 page 13. Here I think it is, Michael.
23 All right. Okay.
24 According to these instructions -- well, what
25 position was the patient supposed to be in while

1 recovering from the surgery, sir?
2 A. Well, she was supposed to apply icepacks 20 on, 20
3 off, and she was supposed to be lying supine which is on
4 your back with the icepack under her back down in the
5 lumbar region where she had the surgery. She was not
6 supposed to be lying face down with the ice on her back
7 while she's lying on her belly.
8 Q. Now, you on page 8 of your report you make
9 reference to the pulmonary edema. I think it's been
10 suggested to the jury, the fact that the patient
11 developed pulmonary edema is evidence of the fact that
12 she suffered from an opioid overdose. Assuming the jury
13 heard that testimony, would you agree with that, sir?
14 A. So I looked this up extensively when this was
15 being claimed in this case. There is -- there are no
16 reports in the medical literature that I could find --
17 MR. JUBB: Objection. Not talking about
18 medical literature and what he's looked up. That's not
19 even identified in his report, and I wasn't allowed to
20 do it.
21 MR. WRIGHT: Well, putting aside --
22 THE COURT: Ladies and gentlemen, can I have
23 a moment, please.
24
25 - - -

1 (Whereupon the jury exits the courtroom at
2 10:34 AM.)
3 - - -
4 THE COURT: Explain to me, I wasn't allowed
5 to do it rule of evidence that your -- that creates the
6 basis for your objection?
7 MR. JUBB: Your Honor, the basis of my
8 objection was --
9 THE COURT: No, answer my question.
10 MR. JUBB: Well, your Honor, I would --
11 THE COURT: Because you just suggested to the
12 jury that you have been prevented from doing this, and
13 as a result of that I should prevent him from doing
14 this.
15 MR. JUBB: Your Honor, I specifically recall
16 going over the FDA insert with my experts and I was not
17 allowed to do that.
18 THE COURT: And why do you point that out to
19 the jury, comment on my prior rulings?
20 MR. JUBB: Your Honor, off first --
21 THE COURT: Because I'm getting tired of you,
22 Mr. Jubb. You sit back there like you own this
23 courtroom. You walk around this courtroom like it's
24 your own.
25 MR. JUBB: Your Honor, my objection was from

1 Aldridge versus Edmunds, and the point that I made about
2 not being able to do it in my case was simply to enhance
3 my argument that it would not be appropriate --
4 THE COURT: You are insolent. You sit there
5 and roll your eyes. I have been watching you for the
6 entire trial. You sit there and then when objections
7 are being made, you roll your eyes and you smirk.
8 MR. JUBB: Your Honor, my smirking if -- I
9 apologize, if you thought I was smirking in any way
10 related to the Court's ruling.
11 THE COURT: I have put up with this for like
12 five days now.
13 MR. JUBB: Your Honor, I'm simply making an
14 objection to what I believe, this witness is far outside
15 of the scope of his report and talking about literature
16 --
17 THE COURT: And that's the objection that you
18 make.
19 MR. JUBB: And I specifically made an
20 objection to Aldridge versus Edmunds.
21 THE COURT: From now on stand when you
22 address me.
23 MR. JUBB: I am happy to do that. And your
24 Honor, I apologize, I would point out that I had
25 attempted to have all of my objections heard at sidebar

1 from the beginning. That's what I prefer to do.
2 THE COURT: And that's asinine. If you don't
3 have a valid basis for your objection, why make it? Do
4 you have to hide it?
5 MR. JUBB: Your Honor, my objection of
6 Aldridge versus Edmunds in allowing an expert to talk
7 about literature that he reviewed not cited in his
8 expert report is valid, and whether that's at sidebar or
9 in front of the jury, it's valid, and I simply pointed
10 out that I was not permitted to do so in my case in
11 chief. That's the only reason why I pointed it out.
12 THE COURT: Do we understand each other now?
13 MR. JUBB: I understand, your Honor.
14 MR. WRIGHT: I'll have him disregard -- in
15 front of the jury, I'll say, Doctor, don't tell us what
16 the medical literature says, simply tell us what your
17 experience has been in this area?
18 THE COURT: Is there a basis -- is there a
19 reference in the report to his consulting literature?
20 MR. WRIGHT: I don't believe so. Is there,
21 Doctor?
22 THE WITNESS: No, nothing.
23 THE COURT: Then he shouldn't be referring to
24 unspecified literature that he was referring to.
25 MR. WRIGHT: I agree. I don't know he was

1 going to say that. I'm sorry. I was trying to keep him
2 to his report.
3 THE COURT: Anything else?
4 MR. WRIGHT: No, sir.
5 THE COURT: All right. Frank, bring them
6 back in, please.
7 - - -
8 (Whereupon the jury enters the courtroom at
9 10:38 AM.)
10 THE COURT: All right. Thank you, ladies and
11 gentlemen. You may be seated. Objection sustained.
12 Ask another question of the Doctor.
13 MR. WRIGHT: Yes, sir.
14 BY MR. WRIGHT:
15 Q. Doctor, without referring to medical literature --
16 first off, do you have any personal experience in
17 diagnosing patients who have pulmonary edema?
18 A. Yes.
19 Q. Can you tell us what that experience has been?
20 A. Yeah. So this is not an uncommon occurrence after
21 anesthesia. It can develop an air way obstruction
22 either lingual spasm or your tongue falls back after a
23 general anesthetic or even with this type of sedation.
24 If you obstruct the upper airway sucking in and trying
25 to get a breath will produce noncardiac edema. It's

1 post obstructive pulmonary edema. HOPE. We call it
2 post-obstructive.
3 So especially in a younger person, older folks
4 don't have the muscle strength, but when you inhale
5 against an occluded airway you can develop flash edema.
6 So we see it in the recovery room where there is frothy
7 secretions in the lungs that are coming up. It occurs
8 when airway obstructions occur after you remove an
9 endotracheal tube. Most commonly loringo spasm, your
10 vocal cords will go into spasm and then they are still
11 trying to breath, and if you breathe in against an airway
12 obstruction, you'll get flash edema which this patient had
13 edema, but that's one of the causes.
14 Q. If somebody suggest to this jury that the fact
15 that the patient developed pulmonary edema which was
16 found at autopsy clearly indicates or is evidence of an
17 opioid overdose, would you agree with that, sir?
18 A. No. We see that this was not on opioid overdose.
19 Not only were there no toxic levels of narcotics in the
20 report, they weren't even at therapeutic levels. So
21 this is not the type of narcotic overdose that you see
22 edema with. You need very large doses. All of these
23 drugs were subtherapeutic.
24 Q. Okay. We've been through this. I don't want
25 to -- I just want you to clarify exactly what we are

1 talking about here, sir.
2 Now, we are going to D-6, page -- my page again is
3 not numbered. It starts out the detailed findings,
4 Michael. And this is part of the autopsy. Is this what
5 we are talking about here, sir?
6 A. Yes, it is.
7 Q. Okay. For example, the Hydromorphone which is the
8 Dilaudid?
9 A. Yes, that's correct.
10 Q. That level was what?
11 A. It's ten nanograms per milliliter. The
12 therapeutic level for Hydromorphone is generally
13 considered to be about 15 nanograms per milliliter. The
14 toxic level for Hydromorphone was about 100, ten times
15 this, 100 nanograms per milliliter and the lethal dose,
16 average leading dose for lethal levels of Hydromorphone
17 are 200 nanograms per millimeter. So the toxic dose is
18 ten times what you see there and the medium dose for
19 fatal overdoses is 20 times that dose.
20 Q. What about the Oxycodone levels, sir?
21 A. So the Oxycodone is also subtherapeutic. She was
22 on Oxycodone. She was on Oxycontin, 20 milligrams twice
23 a day. So Oxycontin is the extended release form of
24 Oxycodone. So Oxycontin will provide somebody with
25 chronic pain a consistent blood level because it's being

1 released at a certain time. So this was managing her
2 chronic pain with the Oxycontin, and then the Oxycodone
3 that they prescribed, she should have taken one pill
4 because it was written for every six hours.
5 So that would reflect both the Oxycontin that she
6 had been on for chronic pain and the Oxycodone that they
7 prescribed for breakthrough pain and even at that with the
8 two prescriptions that is a subtherapeutic level of
9 Oxycodone.
10 - - -
11 (Whereupon proceedings continued onto the next
12 page without loss of context.)
13 - - -
14
15
16
17
18
19
20
21
22
23
24
25

1 Q. The Flexeril or Cyclobenzaprine --
2 A. Cyclobenzaprine.
3 Q. That's listed here is 6.6, sir?
4 A. Yeah. Again, this is substantially subtherapeutic
5 and not anywhere close to toxic levels. She had been on
6 this class of drug for probably six or seven years. She
7 had been on Baclofen with the narcotics that she had
8 been receiving, which is a stronger drug than Flexeril.
9 This is Flexeril: When somebody strains their back, the
10 orthopod will prescribe Flexeril 10, three times a day.
11 And that's a muscle relaxant commonly given and it can
12 act synergistically with a narcotic. But these are,
13 again, very low levels and these are commonly prescribed
14 with narcotics for acute back spasms. So they were
15 treating her back pain by giving her some Flexeril in
16 the recovery room trying to diminish any back muscle
17 spasm that was causing pain.
18 MR. WRIGHT: Go to the next page, Michael.
19 BY MR. WRIGHT:
20 Q. There's a heading of Cyclo --
21 A. Benzaprine.
22 Q. Benzaprine, parenthesis, Flexeril. What does this
23 last sentence refer to, sir?
24 A. So it says plasma concentration of 20 to 30
25 nanograms per milliliter are required for skeletal

1 muscle relaxant effects. So this wasn't toxic. It
2 wasn't even close to being therapeutic.
3 Q. When you say therapeutic --
4 A. It means that she wouldn't have gotten any
5 skeletal muscle relaxant effects at 5:00 when this was
6 drawn.
7 Q. Well, it was actually drawn -- well, it was
8 actually drawn the next day.
9 A. That's right. But when she had died, she stopped
10 metabolizing the drug.
11 Q. That was my next question.
12 A. Yeah.
13 Q. Okay. Referring back to the bags of drugs, sir.
14 If, in fact, she took some other medications in that bag
15 of drugs, wouldn't that show up here on this report
16 here?
17 A. I don't know that. I don't think that has been
18 answered. Usually a toxicology report that you see are
19 a number of pages long. Here it's six, seven drugs.
20 This is not what you generally see, what I see, when
21 there is tox reports coming in. There's two or three --
22 there's probably 30 or 40 drugs that they screen for.
23 Q. Taking all of that into consideration, sir, do you
24 have an opinion as to whether or not the medications
25 that the patient received in the recovery unit at Laser

1 Spine and was instructed to take after she left Laser
2 Spine caused or contributed to her death in this matter?
3 A. No, I don't. I feel strongly that they didn't.
4 And we have quantitative proof that she was not -- she
5 did not have toxic levels of these drugs in her system
6 when she stopped metabolizing the drugs, when there was
7 a cardiac arrest. She did not have therapeutic levels.
8 She certainly didn't have toxic levels. She didn't even
9 have therapeutic levels. And if you theorize about the
10 synergistic effect of these drugs, she had been on these
11 classes of drugs for years and drove around without ever
12 stopping driving.
13 Q. Thank you, sir.
14 MR. WRIGHT: Those are all the questions I
15 have, your Honor.
16 THE COURT: All right. Cross-examine,
17 please.
18 MR. JUBB: Thank you, your Honor.
19 - - - CROSS-EXAMINATION - - -
20 BY MR. JUBB:
21 Q. Dr. Noone, hello again. Is it important for
22 experts who come into the courtroom to offer opinions to
23 be truthful?
24 A. Yes.
25 Q. Is it important for them to be accurate?

1 A. Yes.
2 Q. Is it important for them to be objective?
3 A. Yes.
4 Q. Dr. Noone, am I correct that in Luzerne County
5 there was an anesthesiologist who was stealing Fentanyl
6 from the pregnant women and replacing it with water and
7 you wrote 27 different reports in support of that
8 physician?
9 A. That's not correct at all. That's -- may I,
10 please? That is a complete misstatement. I was
11 retained by counsel for Hazleton General Hospital.
12 There was a class action suit after this became apparent
13 filed by 27 plaintiffs. I was representing Hazleton
14 General Hospital to see whether these patients all were
15 part of a legitimate class, some of them were, where
16 they had breakthrough pain with epidurals in labor. In
17 fact, some of these were filed for postoperative pain in
18 the recovery room. Some of these were filed because of
19 pain during a procedure where they never got an
20 epidural.
21 So what I was asked to do -- I didn't defend the
22 physician at all. It was not defensible. I was defending
23 Hazleton General Hospital to determine to the extent that
24 all of these were consistent with a class action.
25 Q. Doctor, in that case you wrote reports saying that

1 the pregnant women, saying that they were in excessive
2 pain, were not telling the truth, correct?
3 A. No.
4 Q. Doctor, when you wrote those reports you actually
5 said that the epidural was administered properly,
6 correct?
7 A. The epidural was administered properly. And the
8 concentration that he used would be expected to provide
9 analgesia. He was not pulling in the .2 micrograms per
10 milliliter of the Fentanyl which would provide
11 additional analgesia. Not all places even do that.
12 So what I was asked to do was, okay, was that a
13 consistent class, okay, to represent a class action, which
14 is what the litigation was.
15 Q. And, Doctor, you wrote all these reports saying
16 that the women were not in excessive pain, some of them
17 were not in excessive pain after Dr. Peterson had
18 already pled guilty, correct?
19 A. No. What I did in the reports was to try to
20 correlate the nursing notes, all right, with the claims
21 in the complaint. So they said they had pain all during
22 labor. If you read nursing notes and they say their
23 pain is zero, their pain is zero, their pain is two,
24 then that is inconsistent with what was stated in the
25 complaint. If they say their pain is eight and 10, then

1 it is consistent, all right. And I tried to honestly
2 reflect a legitimate class in that litigation. I did
3 not defend the physician. And you know I did not defend
4 the physician. And what you stated wasn't true.
5 Q. Doctor, you testified about this particular
6 instance before, correct?
7 A. Testified about what?
8 Q. Dr. Peterson, you've testified about your actions
9 in that case before, correct?
10 A. Yes.
11 Q. Doctor, in that report did you write that the
12 epidurals administered by Dr. Peterson after he stole
13 the Fentanyl was appropriate?
14 A. If the pain complaint in the complaint -- if the
15 patient's statements in the complaint did not correlate
16 with what was in the medical record written by the
17 nurses, right, when you have a -- when you're in labor,
18 the nurses, every 10 or 15 minutes, will document the
19 pain. That's why we top off the epidurals. And if the
20 pain was zero, was zero, and one, and if you read the
21 complaint saying that she had very bad pain during
22 labor, then that is not consistent. Some of those
23 complaints were even in the recovery room where they
24 were claiming they had excessive pain. That had nothing
25 to do with Fentanyl added to an epidural.

1 Q. Do you remember my question?
2 A. What was it?
3 Q. It was in those reports that you wrote you say you
4 didn't defend the physician. Am I correct that in those
5 reports you stated that the administration of the
6 epidural was appropriate?
7 A. In some of the cases, if you looked at the pain
8 levels during labor, the epidural worked fine without
9 the Fentanyl. In other cases, it did not. In other
10 cases they with OR cases. In other cases they were
11 recovery room cases. So don't misstate what I did. I
12 was not defending Dr. Peterson. I was defending
13 Hazleton General Hospital to look at the complaints in
14 the medical records and if they were consistent with the
15 statements in the complaints by the plaintiff's
16 attorney.
17 Q. And, Dr. Noone, did you apply the same level of
18 truthfulness, objectivity, and accuracy to Ms. Kimble's
19 case as you did for the 27 in support of the hospital?
20 A. I did.
21 Q. Doctor, over the last couple of days we keep
22 talking about this post-anesthetic state. Before she
23 goes into anesthesia, that's called the preanesthesia
24 state, correct?
25 A. It would be the normal state. It wouldn't be a

1 preanesthesia state, but yes.
2 Q. I see. The records say preanesthesia record,
3 correct?
4 A. Preanesthesia assessment.
5 Q. Okay. So there is such a thing as a preanesthetic
6 time period, correct?
7 A. Sure.
8 Q. Then there is that chart you showed us, which is
9 the anesthetic time period, correct?
10 A. Yes.
11 Q. And you understand that there are no claims in
12 this case that any of the medication that was given
13 during the anesthesia was improper, right?
14 A. Not that were improper, but your experts in their
15 reports stated that she was in a post-anesthetic state
16 when this occurred and that is not true.
17 Q. Doctor, when she gets out of anesthesia, that's
18 called the post-anesthetic state, correct?
19 A. That's not what they were referencing. Yes, you
20 are correct, but that's not what their report was
21 referencing.
22 Q. Did you hear them testify that what they were
23 talking about was the general time period after
24 anesthesia?
25 A. No.

1 Q. There were no criticisms of anesthesia that was
2 given during the procedure.
3 A. No, I'm speaking from their report.
4 Q. And did you also understand that the claims are
5 not that she went into respiratory depression in Laser
6 Spine. You understand that, correct?
7 A. Yes.
8 Q. Okay. The claims were that it was after she got
9 back to the hotel and she took those medications that
10 she was told to take, that's when she went into
11 respiratory depression, correct?
12 A. That's what the claim is.
13 Q. Understood. You also heard, I image, if you read
14 all of the transcripts from yesterday, Dr. Hoffman, the
15 Pathologist, said that her CO2 receptors were depressed
16 such that mild pressure could have caused suffocation.
17 Did you read that?
18 A. I did not get the testimony from yesterday.
19 Q. Should --
20 A. I can.
21 Q. Should any of us in this courtroom be worried
22 tonight and move all of our pillows off of our bed for
23 fear of that happening?
24 A. I can tell you that her CO2 receptors were not
25 depressed in the recovery room, because her respiratory

1 rate was 14 to 18 breaths per minute. And the first
2 effect of narcotic is on the C02 receptors in the brain
3 stem and the respiratory rate will decrease. And my
4 position is if she didn't show respiratory depression in
5 the recovery room when the Dilaudid was at peak blood
6 levels, you would not expect her to have that after 4:00
7 when she was discharged at 10:40.
8 Q. Doctor, our experts have never said that
9 Ms. Kimble passed away at 4:00. They have said when she
10 got back to the hotel room that it was that combination
11 when she took the drugs, which could have been anywhere
12 from the 12:00 to 1:00 range.
13 MR. WRIGHT: Objection. I think that is
14 misstating the testimony. I lost the end of that
15 question. Could you restate it?
16 MR. JUBB: Sure.
17 THE COURT: Sure.
18 BY MR. JUBB:
19 Q. Doctor, you understood that the testimony in this
20 case from our physicians is that she went into this
21 depression after she took the Oxycodone in her post --
22 her preoperative medications that she was instructed to
23 take postoperatively, correct?
24 A. That's correct.
25 Q. Okay. So then according to our experts, that's

1 when it occurred.
2 MR. WRIGHT: No. I object to that. That is
3 misstating the testimony.
4 THE COURT: Overruled. The jury will
5 remember what the testimony is and what the facts are in
6 the case.
7 MR. WRIGHT: Thank you, your Honor.
8 BY MR. JUBB:
9 Q. You understood that, Doctor, correct?
10 A. Yes. Mr. Kimble didn't call the desk until
11 4:49 that afternoon. So when the -- it would be
12 reasonable to presume -- he said in one of his
13 statements, a number of statements, one of them was that
14 he took a nap for 45 minutes. So if you extrapolate
15 back, that would be somewhere around 4:00. So it would
16 be between 4:00 and 4:49 when he was there supposedly
17 and found his wife at 4:49 and called the desk.
18 Q. Doctor, is it also possible that Mr. Kimble, after
19 giving his wife the Oxycodone and the antibiotics, and
20 she took her post-anesthetic pain medication when they
21 got back to the hotel, actually passed away and
22 Mr. Kimble, in his shock, thinking it was 45 minutes,
23 woke up finding his wife passed away, it was actually a
24 couple of hours? Is that possible?
25 A. She passed away when?

1 Q. If she passed away as soon as she took the
2 medication and went into respiratory depression then,
3 can we agree that perhaps Mr. Kimble fell asleep and it
4 wasn't 45 minutes?
5 A. Well, you certainly wouldn't pass away when you
6 take the medication. This was oral medication. So it
7 wouldn't peak for one to two hours after taking it
8 orally. And if she didn't take the medication until
9 1:00, okay, the minimum time it could be is 2:00 or 3:00
10 when you're getting a peak blood level of oral
11 medication. This is not like the IV drugs, all right.
12 She took these orally. So you wouldn't take the
13 medication and then die.
14 Q. Doctor, can we agree that these are Oxycodone
15 fast-acting, correct, immediate release?
16 A. Well, she had Oxycontin.
17 Q. In her system?
18 A. And then she took 10 milligrams of Oxycodone,
19 okay. She had, in the year or two before, been taking
20 up to 90 a day of that drug.
21 Q. We're going to talk about that in a minute --
22 A. Okay.
23 Q. Your opinions on that in a little bit. But,
24 Doctor, can we agree that when she gets back to the
25 hotel, that's when the peak effect of the oral Flexeril

1 is kicking in?
2 A. The oral Flexeril would be high at that time, but
3 we know what the peak level was. And it was
4 subtherapeutic. So you can theorize that this may have
5 been the peak effect, but we know, all right, that, in
6 fact, the Flexeril was substantially subtherapeutic.
7 Not toxic, but subtherapeutic.
8 Q. Doctor, is it your testimony to these folks that
9 the drugs would have to be considered in the therapeutic
10 range on a postmortem blood test in order for there to
11 be a synergistic effect to cause respiratory depression?
12 A. At these levels with this patient, I think that's
13 safe to say.
14 Q. Let's talk a little bit about that tolerance you
15 guys are referring to. Can we agree that the tolerance
16 for opioids comes as quickly as it goes away?
17 A. Tolerance will come and go. Tolerance for opioids
18 in this case is specifically defined. You have
19 tolerance for opioids when you are on a threshold of 30
20 milligrams a day of Oxycodone. That defines somebody
21 who is going to be tolerant. We know physiologically
22 that she was tolerant. So you can't minimize the
23 tolerance in this case.
24 She received six doses of two milligrams of
25 Dilaudid in the recovery room with high blood levels at

1 that time and showed no evidence of respiratory
2 depression, no evidence of somnolence and, in fact, no
3 pain relief. So we know physiologically she was tolerant.
4 Q. Doctor, Oxycodone fast release comes in five, 10,
5 15, 20, 30, 40, 60, 80, 160 milligrams, correct?
6 A. If you say so.
7 Q. Because you don't know?
8 A. I don't prescribe all of those, no.
9 Q. And, Doctor, can we agree that for Ms. Kimble
10 being so tolerant, they gave her the 10's, correct?
11 A. Yes.
12 Q. It's on the low end of the spectrum, is it not?
13 A. Not considering that she has a consistent blood
14 level of Oxycontin. So you wouldn't give more, okay.
15 You would give less with somebody who has a constant
16 blood level. That is the whole point of the Oxycontin.
17 Q. The MS-Contin you were referring to, and I believe
18 you told these folks she was taking 200 milligrams of
19 MS-Contin and driving her car. That's what you told
20 them, correct?
21 A. Yes.
22 Q. Okay. The 100 milligrams of Oxycontin -- excuse
23 me, of MS-Contin that she was on, she was told to take
24 that twice a day. So in 24 hours she got the 200
25 milligrams over the course of 24 hours, correct?

1 A. Yes.
2 Q. Can we agree that that amount of MS-Contin in 24
3 hours is less than what she got of Dilaudid comparison
4 in 90 minutes? If you need a pen and paper --
5 A. No, you can't -- no, you don't. You basically, in
6 a chronic pain patient, you really can't -- we can
7 convert IV drugs to IV drugs. It's very difficult to
8 convert Morphine -- very difficult to convert oral drugs
9 to IV drugs because of the liver enzyme induction. So
10 when you take an oral drug, it's absorbed through your
11 stomach and goes through your liver before you get a
12 blood level. And with the IV drugs, it goes right into
13 the blood stream. So you -- it's very difficult in a
14 chronic pain patient to convert the oral drug level to
15 an IV drug level.
16 Q. Well, you had no problem telling these folks that
17 she was on more of it then and that was more than
18 what -- that it was less than what she got at Laser
19 Spine.
20 A. No, that's not what I said. I said it was much
21 less than she had in her system, okay, when she had
22 whatever event she had. She was subtherapeutic.
23 Q. Doctor, I want to take you back to your
24 Chemistry-101 class that I'm sure you took at some
25 point. You can convert oral Morphine equivalents to an

1 IV equivalent of Morphine, correct?
2 A. Yeah. It's generally considered three to four --
3 three to one is the -- but that data is from the 50's
4 and 60's and did not take into effect the hepatic, the
5 liver enzyme induction that narcotics cause. That's why
6 they need more and more drug. So in somebody who's not
7 used to taking narcotics, the three to one ratio is
8 reasonable. When somebody is on those medications for a
9 long time, it is less reasonable.
10 Q. Just focus on my question. We can then take the
11 equivalent of IV Morphine and equate that to what the
12 Dilaudid equivalent would be, correct?
13 A. You can convert Morphine to Dilaudid.
14 Q. Okay. And that's two either multiplication or
15 division problems that we could actually convert
16 MS-Contin over a span of 24 hours to what it would be in
17 Dilaudid IV, and she got less of MS-Contin back in 2012
18 in 24 hours than she did the pain medication in 90
19 minutes, correct?
20 A. Yeah. And that's not uncommon if you want to just
21 look at the 90 minutes. You needed to -- you needed to
22 treat her pain. And they didn't give 12 milligrams.
23 They gave two milligrams at a time times six. And after
24 eight milligrams her pain was still ten over ten, so you
25 need to give the pain medication. So you're correct in

1 that 90-minute period that she had more narcotic. She
2 did not have more narcotic at 4:00 in the afternoon.
3 Q. Doctor, if the patient is in pain, can we agree
4 there could be something else going on that you should
5 check before just simply administering pain medication?
6 A. I'm sorry?
7 Q. If somebody is in pain after surgery -- first of
8 all, surgery is painful, isn't it?
9 A. The interpretation of pain varies tremendously.
10 Q. Okay. And especially spinal surgery, that's a
11 painful experience, correct?
12 A. It is painful.
13 Q. Okay. But when somebody is in pain, it wouldn't
14 just be appropriate to keep dousing them with pain
15 medication, because there could be something else going
16 on that's causing the pain, correct?
17 A. No. I think if somebody just had back surgery and
18 tells you that they have ten over ten pain in their
19 back, it would be reasonable to presume it's coming from
20 the back surgery.
21 (Whereupon, proceedings continued to the next page without
22 loss of context.)
23
24
25

1 Q Understood. Could there be something else
2 causing the pain that would maybe cause someone to
3 actually check before simply giving the pain
4 medication?
5 A Well, they're in conversation with the
6 patient, and I'm sure the patient is saying that, in
7 fact, the pain is coming from her back. So it would
8 be certainly reasonable to presume it was coming
9 from the back surgery. And there's no evidence that
10 she had pathology anyplace else, so I think it
11 was -- it is and was reasonable to presume that the
12 pain was coming from the back surgery.
13 Q No one checked, though, can we agree, so
14 we can't say that this was because we knew there was
15 no other problem, correct?
16 A You would have to depose the PACU nurse.
17 I don't think he was ever deposed.
18 Q I wrote down a very specific question that
19 Mr. Wright asked you, and you said that the care by
20 Dr. Rubenstein was appropriate, correct?
21 A Based on her symptoms, yes.
22 Q Doctor, would it be appropriate for the
23 pre-anesthesia team to not communicate with the
24 post-anesthesia team of what her medications were
25 that she was being instructed to take after?

1 A We communicate by what's in the medical
2 record. We don't talk to each nurse or each doctor,
3 that's why we write what's in the medical record.
4 So they will give a history. So the nurse
5 anesthetist that did the case will give a hand off
6 to the PACU nurse. And part of that is to review
7 the medications that she was on and the medications
8 that she got during the procedure.
9 Q Doctor, can we agree, then, that if it's
10 in the record, you would expect the nurses to read
11 it, correct?
12 A Well, again, when they would have time to
13 go through the record. It's communicated during the
14 hand off, but if you want to go back through
15 history, you go back through the medical record.
16 That's the way we communicate, is through the
17 medical record.
18 Q Can we agree that that didn't occur in
19 this case? Did you read Mr. Perez's testimony?
20 A I did not see Mr. Perez's testimony. He
21 was not deposed, so I couldn't tell you that.
22 Q I thought you -- oh, did you not learn
23 that -- what he testified to yesterday?
24 A I'm not aware of what went on yesterday.
25 Q Okay. I'll represent to you that

1 Mr. Perez was not aware of what Ms. Kimble's
2 preoperative medication was when she was instructed
3 to continue that. I would like for you to assume
4 for me that that's the testimony that these folks
5 have heard. That's not appropriate, correct?
6 A No, no, I disagree. He was a PACU nurse,
7 he was not giving the medical instructions upon
8 discharge. The medical instructions were coming
9 from the physician, so he wouldn't necessarily have
10 to know every medication that the lady was on, if,
11 in fact, the physician said to continue your prior
12 medications. He wouldn't want to know -- he would
13 want to know what she had been on that morning, what
14 she was taking, okay, when she got to the recovery
15 room. That's part of the hand off, okay, so the
16 meds she got during the procedure and the
17 medications that she was on, and any other medical
18 problems we had. So they are the three things that
19 go on during the hand off from anesthesia to a PACU
20 nurse.
21 Q Doctor, can we agree that while you were
22 telling these folks about the respiratory rate,
23 they're not measuring the depth of the breath,
24 correct?
25 A They would not measure the depth

1 without -- there would be no way to measure the
2 depth.
3 Q Have you ever heard of end title cO2,
4 Doctor?
5 A Not in somebody who doesn't have a
6 breathing tube. I'm well aware of end title carbon
7 dioxide, and I use it 25 times a day. I have never
8 used it in the recovery room. It is not a standard
9 of care in the recovery room, and there's no way to
10 measure end title carbon dioxide in somebody who
11 does not have a breathing tube in place.
12 Q Doctor, it's your testimony that
13 Ms. Kimble was, I believe you said, in the July 2012
14 time frame, so tolerant on these opioids, correct?
15 A Well, July of 2012 is when Dr. Demangone
16 discharged her from the pain practice for falsifying
17 the narcotic prescriptions. That's what happened in
18 July of 2012.
19 MR. JUBB: Your Honor, move to strike
20 this.
21 MR. WRIGHT: The records have already
22 been shown to the jury.
23 THE COURT: Basis, Mr. Jubb?
24 MR. JUBB: It has no relevance to
25 what occurred in January of 2014. The issue is

1 the deviation of standard of care of Laser,
2 Spine whether it increased the risk of harm to
3 Ms. Kimble. And that was a shot they just took
4 at Ms. Kimble. It has nothing to do with Ms.
5 Kimble's prior --
6 MR. WRIGHT: I disagree.
7 THE COURT: Overruled. The jury will
8 remember what the evidence is. They will draw
9 their own conclusions.
10 And you can continue questioning the
11 doctor about that comment. Overruled. Go
12 ahead.
13 BY MR. JUBB:
14 Q Doctor, can you point me to a single
15 document in the records that suggest that Ms. Kimble
16 was on more opioids in that 2012 time frame than she
17 was on in January 2015?
18 A From an oral perspective, the 200 of
19 Morphine that she was on was greater than the 20 of
20 Oxycontin -- 20 of Oxycontin will convert to 30 of
21 Morphine. So she was on the equivalent of
22 30 milligrams of Morphine twice a day in January of
23 '14. So that is less than the 200 of Morphine that
24 she was on in June of 2012.
25 Q In July of 2012, Doctor, Ms. Kimble

1 underwent an excision of an abdominal wall suture
2 granuloma, correct?
3 A Yeah, I can't remember that.
4 Q What is that excision of abdominal wall
5 suture granuloma? Tell us what that is.
6 A Just a reaction around a suture.
7 Q There's a surgery for that, correct?
8 A Very minor. It's like this.
9 (Indicating.)
10 Q They scrape away the skin?
11 A The cut the skin and excise the granuloma.
12 It's a skin reaction to a stitch. So it's a very
13 limited procedure.
14 Q Very limited procedure; is that right?
15 A Yes.
16 MR. JUBB: Would you pull up for me
17 P-60.37 and 38?
18 BY MR. JUBB:
19 Q Doctor, you reviewed the Lake Health West
20 records, correct?
21 A Yes.
22 Q And you just told this jury she was so
23 tolerant to pain medications.
24 MR. JUBB: I want you to zoom in on
25 how they administered Dilaudid in 2012 at that

1 time when she apparently was so tolerant. I
2 want you to highlight for me the time and what
3 was given.
4 THE WITNESS: I can't read this.
5 MR. JUBB: He's going to blow it up
6 for you.
7 Just the top.
8 BY MR. JUBB:
9 Q .3 milligrams at 9 o'clock. Do you see
10 that, Doctor?
11 A Yes.
12 MR. JUBB: Go down to the next one,
13 Brandon. All the Dilaudid.
14 BY MR. JUBB:
15 Q .3 milligrams. Do you see that, Doctor?
16 A Yes.
17 Q Another .3 milligrams. Do you see that,
18 Doctor?
19 A Yes.
20 Q The total amount Miss Kimble received was
21 3 milligrams in an hour and 20 minutes, correct?
22 A Yes. But may I comment? Let's not
23 confuse things. This was a suture granuloma that
24 was probably that much of an incision, (indicating),
25 and probably that deep, versus a spine procedure

1 where they cut away bone and took out a disc and
2 also burned the nerves that go to the facet joints.
3 So you should not compare this procedure with what
4 went on at the Spine Center, as far as the
5 postoperative pain requirements.
6 Q Doctor, this small procedure, do you know
7 how long she was in the PACU for?
8 A I'd like to see how long the procedure was
9 and what they did, not how long she was in the PACU.
10 Q Doctor, you've already told us this is a
11 minor procedure, correct?
12 A Yes.
13 Q Compared to a spinal surgery?
14 A Yes.
15 Q Would it surprise you if she actually
16 spent longer at Lake Health for this procedure than
17 she did at Laser Spine when they did all that
18 cutting of her spine?
19 A Would it surprise me?
20 Q Yes.
21 A No. Because they were continuing to give
22 pain medication. She took -- this is more pain
23 medication, okay? She got three of Dilaudid, okay?
24 This is the equivalent of 21 of Morphine in the
25 recovery room for a granuloma around a stitch. So I

1 would say to you rather than this being a small
2 dose, that it was actually a large dose relative to
3 the procedure that was done.
4 Q What about the repair of a hernia, Doctor?
5 What's that mean?
6 A I don't know. What kind of hernia?
7 Q Abdominal hernia.
8 A Again, you have to -- there's all kinds of
9 hernias and all sizes of hernias.
10 Q Have you ever heard of a repair of an
11 abdominal hernia, removal?
12 A Some of them are like this. (Indicating.)
13 Q Okay. In November of 2010, Ms. Kimble had
14 that done, correct?
15 A She had a hernia repair.
16 Q And after her hernia repair, which she was
17 reporting pain scores of 10, nine, nine, eight, do
18 you know how much Dilaudid she got?
19 A I don't recall.
20 Q She didn't get any.
21 MR. WRIGHT: Your Honor, can he show
22 the witness the record --
23 THE COURT: Sure.
24 MR. WRIGHT: -- rather than testify?
25 THE COURT: Sustained.

1 MR. JUBB: 16.264 through 16.265.
2 THE WITNESS: What did they give her
3 for pain medication?
4 BY MR. JUBB:
5 Q Yes, sir.
6 THE COURT: It's in front of you,
7 Doctor.
8 MR. JUBB: Zoom in so everyone can
9 see.
10 BY MR. JUBB:
11 Q What's it state for the total amount of
12 Percocet she got?
13 A Percocet?
14 Q Yep.
15 A I don't see where she got Percocet.
16 Q Total for Percocet in all phases it says
17 five, correct?
18 A Yes.
19 Q Okay. Percocet on that spectrum of
20 opioids, it's at the back end?
21 A Yeah, but if you look -- is this the
22 recovery room record here?
23 Q It is. And it's actually for all phases
24 as well.
25 A So if you look, that's not what she got

1 for pain medication, right? She got Sublimaze,
2 Sublimaze, Sublimaze, Sublimaze. So she got 200
3 micrograms of Sublimaze, which would -- which
4 would -- the equivalent to 20 of Morphine I.V.
5 Q Which is a lot less than 12 milligrams of
6 Dilaudid, correct, Doctor?
7 A Yeah, but you do this by pain scale. They
8 weren't treating her pain. You can't say that she
9 shouldn't have gotten the pain medication at Laser
10 Spine when she has a score of 10, pain of 10, crying
11 with pain, all right, after they have given her
12 8 milligrams of Dilaudid.
13 MR. JUBB: This is for the record
14 16.263.
15 BY MR. JUBB:
16 Q These are her pain scores, Doctor: 10,
17 nine, nine, eight. They didn't douse her with
18 2 milligrams of Dilaudid each time.
19 MR. WRIGHT: Objection, your Honor;
20 form of the question.
21 THE COURT: Sustained.
22 BY MR. JUBB:
23 Q Doctor, they didn't administer
24 2 milligrams of Dilaudid right away, correct?
25 A They gave her Fentanyl, which is a very

1 potent short-acting narcotic. So this type of pain
2 you would not expect to have the same level of pain
3 postop from something like this than you would from
4 bone work. So you would expect them to give a
5 longer-acting drug in the recovery room at the
6 Laser Spine than you would following this.
7 Q Doctor, you commented that Mr. Kimble
8 should have followed those instructions and perhaps
9 Miss Kimble would be alive, correct?
10 A That's what I believe.
11 Q Can we agree, Doctor, that Mr. Kimble
12 spent more time with his wife after surgery than
13 Dr. Rubenstein did?
14 A Dr. Rubenstein complied with the standard
15 of care for PACU management. I do not believe that
16 Mr. Kimble complied with what he signed that he was
17 responsible for.
18 MR. JUBB: No further questions.
19 THE COURT: Redirect?
20 MR. WRIGHT: Yes, sir. I'll try to
21 be quick here.
22 ---REDIRECT EXAMINATION---
23 BY MR. WRIGHT:
24 Q Doctor, let's go back to the
25 post-anesthetic state, okay?

1 The first time that's mentioned in
2 the records I believe is in the autopsy report of
3 Dr. Hood.
4 MR. WRIGHT: Can we put up D-6? I
5 think it's the first page. Right here.
6 (Indicating.)
7 BY MR. WRIGHT:
8 Q This is where Dr. Hood is talking about
9 how he arrived at his conclusion that the cause of
10 death was this adverse interaction of drugs. He
11 indicated that the patient may have been in a
12 post-anesthetic state at the time of her death.
13 A Yes.
14 Q Is that accurate, sir?
15 A It is not accurate at all. There were no
16 physiologic effects at that time from the anesthetic
17 drugs that were administered in the morning.
18 Q Okay. Then after he prepared that report
19 he was retained as an expert by plaintiff's counsel;
20 is that right?
21 A Yes.
22 Q And if you look at that report on Page
23 2 --
24 MR. WRIGHT: It's D-27, Michael.
25 BY MR. WRIGHT:

1 Q This is now prepared in December of '17.
2 He again indicates that the patient may have been in
3 a post-anesthetic state?
4 A That's correct.
5 Q Was she in a post-anesthetic state, Sir?
6 A No. I mean Dr. Hood admits that he made
7 these statements without looking at the anesthetic
8 record. And to have stated that with Remifentanil
9 and Sufentanil, which are ultra short-acting
10 narcotics, propofol, which is gone in 10 or 15
11 minutes, and to say she was in a post-anesthetic
12 state at 4:00 or 5 o'clock in the afternoon is not
13 correct.
14 Q Then Dr. Brent, who is plaintiff's
15 toxicology expert, in his report quotes from
16 Dr. Hood's autopsy.
17 MR. WRIGHT: That's on Page 4,
18 Michael. That is D-29. Right here.
19
20 BY MR. WRIGHT:
21 Q We talked about a tolerant individual who
22 may have been in a post-anesthetic state. Was this
23 patient in a post-anesthetic state, Sir?
24 A No, sir.
25

1
2 Q. And you were asked questions about what evaluation
3 the patient underwent at Laser Spine prior to her
4 discharge; is that correct, sir?
5 A. Yes.
6 Q. Okay. According to the record was the patient
7 visited by the spine surgeon while in the recovery room?
8 A. She was visited by the spine surgeon and also the
9 anesthesia physician, Dr. Rubenstein.
10 Q. Dr. Rubenstein saw the patient also at the very
11 end before she was discharged?
12 A. The surgeon and anesthesia saw the patient.
13 Q. Okay. Let me go to the records of Dr. Demangone
14 that you mentioned. That's D-9, Michael.
15 Let's go right to the note for June 13, 2012.
16 D-9, page 54.
17 MR. JUBB: Again, your Honor, objection to
18 this.
19 THE COURT: Basis?
20 MR. JUBB: Hearsay and relevance.
21 THE COURT: Did the Doctor review this?
22 MR. WRIGHT: Yes, it was in his report and it
23 was in his testimony a moment ago.
24 THE COURT: Overruled.
25 MR. WRIGHT: Thank you.

1 BY MR. WRIGHT:
2 Q. The reference here, sir, is that because the drug
3 agreement was broken the patient essentially was
4 discharged from Dr. Demangone's care; is that what you
5 were referring to earlier?
6 A. You provided false information regarding the use
7 of a prescription medication, yes.
8 Q. So that was the reason for the discharge from his
9 --
10 A. He discharged her from his practice. If you look
11 at the preoperative assessment, she stated in the
12 preoperative assessment that she had fired him and that
13 wasn't the case. This is in the medical records that he
14 discharged her from his practice.
15 Q. The preoperative assessment at Laser Spine?
16 A. That's right.
17 Q. -- is what you are referring to?
18 A. She had stated she fired her pain management
19 physician which is not the case.
20 Q. If you just go back a couple of pages 50, 51, 52,
21 53. Starting on page 50, what was the patient on at
22 that point in time, can you tell from that, sir?
23 A. Where is this down?
24 Q. Up here. I think there is a reference to both the
25 MS Contin and Percocet.

1 A. So she was taking MS Contin which was the long
2 acting Morphine, 30 milligrams three times a day. So
3 that's 90 milligrams. It wears off. So it doesn't last
4 her the full amount of time and she uses Percocet when
5 she has to drive somewhere. This is what I was
6 referencing. So she was on large doses of Morphine on a
7 daily basis and then would take the Oxycodone prior to
8 driving.
9 Q. So the next page is now March of 2012. What was
10 she taking at this time, sir, references the MS Contin
11 and Oxycodone?
12 A. So she was taking ten Oxycodone, ten milligrams
13 Q6, and she was taking MS Contin 30 milligrams, two
14 times, three times a day with Oxycontin, 30 milligrams
15 three times a day. So she was taking long acting
16 narcotics. MS Contin, 30 milligrams three times a day
17 and Oxycontin which is 30 milligrams three times a day
18 which if you transfer that into Morphine equivalences,
19 she was taking an additional 45 of Morphine, three times
20 a day at that time. And then she stated that her
21 daughter stole the drugs.
22 Q. There is also a reference here to Elavil, sir --
23 MR. JUBB: Objection, your Honor.
24 THE COURT: Sustained.
25

1 BY MR. WRIGHT:
2 Q. Let's go here, Doctor, to the Elavil. Was she
3 taking the Elavil as well?
4 A. So that's the amitriptyline that you saw that she
5 was still taking. That's a tricyclic antidepressant
6 which was used for sleep which she was taking that
7 medication for sleep and can also be used in chronic
8 pain patients. So she was on that at that time and she
9 was on that when she would -- when she had the spine
10 procedure done.
11 Q. April 18, 2012. Next page, Michael. Page 52.
12 What was she taking at that time?
13 A. Well, the Avinza which is a long acting morphine.
14 So she was taking that 120 milligrams of the long acting
15 Morphine, plus an additional long acting Morphine of 60
16 milligrams twice a day. So there she was on 240
17 milligrams of long acting Morphine on a daily basis.
18 Q. Then if you go to the next note 5-16-12, what was
19 she taking at that point?
20 A. She again is taking MS Contin, increase MS Contin
21 from -- 60 MS Contin is long acting Morphine -- from 60
22 milligrams twice a day. Now he jumps her up from
23 60 milligrams twice a day to 100 milligrams twice a day.
24 So he increased the dose by two-thirds. So this was a
25 large increase in drug in one week's time. She went

1 from 120 milligrams of long acting Morphine a day to 200
2 milligrams. So she went up 66 percent of the dose in
3 one week's time.
4 Q. Is that significant to you, sir?
5 A. Well, again I think it shows that she was very
6 tolerant. That's not what you would do. Normally you
7 wouldn't increase somebody's long acting Morphine by
8 66 percent with one prescription. You would gradually
9 start to increase them. But he felt confident that she
10 was tolerant enough that he could go from 120 milligrams
11 to 200 milligrams without an affect and, in fact, that
12 is what happened.
13 Q. Okay. And one other thing, sir, regarding the
14 time when the patient stopped breathing. Did you read
15 the testimony that Dr. Ian Hood gave in this courtroom
16 on March 23, 2018?
17 A. Yes, I did.
18 Q. I think it was suggested that Dr. Hood said that
19 the patient stopped breathing around one o'clock. I
20 want you to assume I was questioning him and this is
21 what he said. So sitting here today, can you tell us by
22 whatever means when it was that she sopped breathing?
23 His answer was, no, I can't.
24 Do you recall him ever testifying that he believed
25 that the patient stopped breathing at one o'clock or

1 thereabouts, sir?
2 A. No.
3 MR. WRIGHT: Thank you, sir, those are all of
4 the questions that I have.
5 THE COURT: Cross.
6 - - -
7 RECROSS-EXAMINATION
8 - - -
9 BY MR. JUBB:
10 Q. Doctor, you're not a pathologist, correct?
11 A. That's correct.
12 Q. You're not a toxicologist?
13 A. That's correct.
14 Q. And can we also agree that whatever she was on in
15 2012, that's less than she was on in 2014; is that
16 correct?
17 A. No, that's not correct.
18 Q. I see. And, Doctor, Oxycodones, they actually
19 come in 60, 80 and 160 and those are for Opioid tolerant
20 patients, correct?
21 A. Oxycontin not Oxycodone. Oxycontin does.
22 Q. She wasn't on anywhere close to that?
23 A. When?
24 Q. January of 2014?
25 A. No. She was on 20 twice a day at that point.

1 Q. Yeah. And according to the FDA only 60, 80 and
2 160 are reserved for opioid tolerant patients, correct?
3 A. That's not clinically the way it's practiced. If
4 somebody has chronic pain you give Oxycontin in the
5 lowest effective dose, LED, lowest effective dose where
6 they will get reasonable pain relief with that level
7 giving them constant blood level.
8 So, okay, even if somebody is on Oxycontin,
9 Oxycodone and they're opioid tolerant, you wouldn't jump
10 to 60 milligrams because that's what the FAA says. You
11 would try 20 milligrams of Oxycontin twice a day. If it
12 doesn't work, you bump it up to 30 milligrams, twice a
13 day. So you wouldn't start with 60 just because they were
14 tolerant.
15 Q. Doctor, anything in 2012 that Ms. Kimble was on
16 have anything to do with the fact that she got
17 12 milligrams of Dilaudid in this case? She didn't have
18 that in 2012, did she?
19 A. She didn't get Dilaudid, but it shows that -- it
20 shows that she was very opioid tolerant and dependent.
21 MR. JUBB: No further questions, your Honor.
22 MR. WRIGHT: I have nothing further, your
23 Honor.
24 THE COURT: Okay. Thank you. You are
25 excused.

1 - - -

2 (Witness excused.)

3 - - -

4 THE WITNESS: Thank you. Your Honor.

5 THE COURT: All right. Mr. Wright, what who
6 would be your next witness?

7 MR. WRIGHT: Dr. Rubenstein, your Honor. We
8 have a short video, do you want me to show that?

9 THE COURT: I'm trying to think when we will
10 take lunch. I want to take a break now. Everybody has
11 been sitting for awhile. Maybe we can do the video
12 then.

13 MR. WRIGHT: Fine whatever you want, Judge.

14 THE COURT: Let's take a break, ladies and
15 gentlemen. Keep your mind open. No independent
16 investigation. We'll come back in 15 minutes and then
17 we'll do a video and take lunch.

18 - - -

19 (Whereupon a ten minute recess was taken.)

20 - - -

21 (Whereupon proceedings continued onto the next
22 page without loss of context.)

23 - - -

24

25

1 THE COURT: Everyone please be seated.
2 Any issues?
3 MR. WRIGHT: Yeah, your Honor. I'm reluctant
4 to get into the PFA order again, but I believe
5 Mr. Kimble did testify on cross-examination that there
6 was an order in effect at the time of these events. And
7 what I -- Dr. Rubenstein is the next witness. I intend
8 to ask him had he known about that, would he still have
9 permitted Mr. Kimble to be the patient's caregiver once
10 she left Laser Spine. And I don't want to do that if
11 it's going to draw an objection that the Court would
12 then sustain.
13 THE COURT: Mr. Jubb?
14 MR. JUBB: Your Honor, the issue with Dr.
15 Rubenstein is whether or not he deviated from the
16 standard of care. The opinions in this case are related
17 to the post-anesthetic pain management, as well as
18 discharging Ms. Kimble with that much medication. It
19 is, I think, this attempt at this part of the game --
20 this stage of the game to try and bring up this
21 Protection from Abuse Act again is just an attempt to
22 get it in front of the jury.
23 It's improper. Whether or not he knew about
24 it or not, that's not the facts in this case. He didn't
25 know about it. And it's certainly intended to unfairly

1 prejudice the plaintiffs. It has no relevance in his
2 medical decision making. It has no relevance on why he
3 did what he did. And at this stage it is particularly
4 intended as trial surprise. And I have -- to try and
5 bring this up with Dr. Rubenstein, what he would have
6 done if he had known something, is -- I'm sorry, that's
7 exactly what it is. It's trial surprise.
8 They got remarried after the Protection from
9 Abuse Act. So then what I'm going to have to do is
10 Mr. Kimble will have to explain, I didn't -- and he did
11 not say there was that. For him, it was we got married
12 afterwards. We're not the type of people who are going
13 to go back and take this off the record, I think that's
14 silly.
15 THE COURT: Well, what relevance is it?
16 MR. WRIGHT: Well, because I think during the
17 cross-examination of Dr. Khanna it was suggested that we
18 didn't do a proper evaluation of Mr. Kimble to determine
19 whether or not he was an appropriate party to oversee
20 his wife's care for the 24 hours after she was
21 discharged.
22 THE COURT: Yeah, but that skill set to do
23 whatever it is that they thought that he should do, as
24 opposed to whether or not he should be the person in the
25 first place, how would they make a determination on

1 whether or not it was still valid? I mean, if they
2 thought it was relevant, why didn't they ask?
3 MR. WRIGHT: Well, that's not their standard
4 of care to ask every --
5 THE COURT: That's the bottom line. It has
6 nothing to do with the standard of care.
7 MR. WRIGHT: Secondly, Judge, my last witness
8 is Officer Harhut. Officer Harhut was the first police
9 officer on the scene. And after Ms. Kimble was removed
10 to the hospital, according to his record, his report, he
11 then ran their -- both Mr. and Mrs. Kimbles' names
12 through the NCIC and discovered there was an active PFA
13 by Sharon against Robert.
14 THE COURT: Which Mr. Kimble has already
15 said.
16 MR. WRIGHT: Okay. Well, but when I tried to
17 ask about this police report, there was an objection.
18 The Court sustained it. It's hearsay. We now have the
19 gentleman who created this form. I would like to be
20 able to ask him about that.
21 THE COURT: And ask him what? What more do
22 you need to ask him other than what Mr. Kimble's already
23 admitted in front of the jury?
24 MR. WRIGHT: Well, that he was the one who
25 contacted Ohio and learned that there was a Protection

1 from Abuse order in effect. Still in effect.
2 MR. JUBB: Your Honor, if I may? It looked
3 like you were thinking. I didn't mean to interrupt you.
4 My thought was what does that have anything to do with
5 this case, what the officer did to investigate it? And
6 most respectfully, at the conclusion of this case, there
7 is nothing that happened. I mean, what is it? He just
8 wants to bring it in front of the jury so they hear
9 about it again.
10 THE COURT: Well, no. It does have -- it has
11 bearing, Mr. Jubb, on the calculation of damages on the
12 wrongful death claim.
13 MR. WRIGHT: Correct.
14 THE COURT: But it's already in front of the
15 jury, admitted by Mr. Kimble, that there was a
16 Protection from Abuse order in place. And Officer
17 Harhut is simply going to reconfirm that.
18 MR. WRIGHT: Yes, sir.
19 THE COURT: So isn't it cumulative then?
20 MR. WRIGHT: Well, I think it's more
21 effective coming from a police officer than it is from
22 the plaintiff, who doesn't really recall whether or not
23 it was in effect, or what led up to it, or whether or
24 not it's related to the divorce, which is what his
25 answers were to the questions along those lines.

1 THE COURT: But neither does Mr. -- neither
2 does Officer Harhut. He doesn't know that. All he
3 knows is that it's in existence and that's been
4 established by Mr. Kimble. I didn't hear him equivocate
5 on it. I didn't hear him equivocate.
6 MR. WRIGHT: Just for the record then, your
7 Honor, I would like the opportunity to have -- and then,
8 as a result of that, the records from Ohio were
9 obtained, made part of this official police record.
10 THE COURT: But that's all hearsay. We went
11 over this, Mr. Wright.
12 MR. WRIGHT: We did.
13 THE COURT: If there was a particular way of
14 bringing in official court documents. And we went over
15 that. You were stuck with Mr. Kimble's answer. And
16 Mr. Kimble admitted that he -- that it was in existence.
17 MR. WRIGHT: Your Honor, I believe it's an
18 exception to the Hearsay Rule, your Honor. I understand
19 the Court's ruling.
20 THE COURT: What's the exception?
21 MR. WRIGHT: It's an official document.
22 THE COURT: Well, that means it's authentic.
23 It doesn't mean it's not full of hearsay. There is a
24 complete distinction between authenticity and hearsay.
25 MR. WRIGHT: Well, my understanding of the

1 Rules of Evidence are if it's an official document
2 prepared in the course of his performance, of his
3 duties, that is an exception to the Hearsay Rule.
4 THE COURT: Yeah, it's an exception for
5 authenticity and admissibility, as long as it's not
6 otherwise hearsay. I mean, how does -- what does the
7 attachment of a record from Ohio, how does the fact that
8 the police officer attaches that to his record make that
9 any more or less hearsay?
10 MR. WRIGHT: Well, because it is hearsay, but
11 it's an exception to the Hearsay Rule, because it was
12 obtained in preparation of his investigation -- or his
13 performance of his investigation in this case, and
14 became part of the Tredyffrin Township Police Department
15 record.
16 THE COURT: Well, that would be like saying
17 that if in the investigation of this case, or the
18 investigation of anything -- say there was a burglar
19 alarm that went off at your house and Officer Harhut
20 shows up and attaches your latest EKG to his report for
21 some reason or other and then seeks to have that
22 admitted during the burglary trial. That it is now an
23 exception to the Hearsay Rule.
24 MR. WRIGHT: Well, Judge, I have nothing in
25 my house worth stealing and I don't have an alarm.

1 THE COURT: All right. But you see the
2 point.
3 MR. WRIGHT: I see the point. I understand,
4 Judge. I just want to make a record. I disagree. I
5 think it's admissible and it's definitely relevant.
6 THE COURT: And I understand the EKG was just
7 fine. It was just fine.
8 MR. WRIGHT: I have not had one of those in
9 years, so I couldn't attest to that either. I'm just
10 saying -- I want, for the record, to say I believe I'm
11 permitted to get into this, at least the fact that he
12 made the call or went on the computer and found this
13 information. I understand the Court's ruling. I just,
14 for the purposes of the record, I disagree.
15 THE COURT: Okay. And with respect to Dr.
16 Rubenstein testifying about what-ifs, if I knew, I don't
17 think that -- that's complete speculation. It's not in
18 their questions and it's all after the fact. And the
19 fact that it may even be in existence doesn't mean that
20 he's not qualified under whatever the standards are that
21 he's supposed to live up to as caregiver. I mean, it's
22 all spelled out there, but not in any great detail. It
23 just says you are to pay attention for 24 hours. I'm
24 not sure what that means.
25 MR. WRIGHT: In terms of the relevance,

1 Judge, of the Protection from Abuse, I think the Court's
2 already mentioned that, but that goes to the damages.
3 THE COURT: Goes to the damages, but it's
4 already in.
5 MR. WRIGHT: All right. I understand, your
6 Honor.
7 THE COURT: It's already in.
8 MR. WRIGHT: Give me one minute.
9 THE COURT: Sure.
10 (A discussion was held off the record.)
11 MR. WRIGHT: Thank you, your Honor. We are
12 ready.
13 THE COURT: Okay.
14 (Whereupon, the jury enters the courtroom.)
15 THE COURT: Okay. Please be seated, ladies
16 and gentlemen.
17 Mr. Wright, call your next witness, please.
18 MR. WRIGHT: Dr. Rubenstein.
19 - - -
20 GLEN RUBENSTEIN, after having been first duly
21 sworn, was examined and testified as follows:
22 - - - DIRECT EXAMINATION - - -
23 BY MR. WRIGHT:
24 Q. Dr. Rubenstein, first of all, as I understand it,
25 you currently practice in Florida?

1 A. Yes, I do.
2 Q. Do you still have a valid Pennsylvania license?
3 A. Yes, I do.
4 Q. Okay. And do you limit your practice in Florida
5 to a certain specialty or subspecialty?
6 A. I am an M.D. Anesthesiologist.
7 Q. Okay.
8 A. And that's what I practice.
9 Q. All right. And what exactly are you doing today?
10 What type of anesthesia, I guess is the question?
11 A. I'm doing anesthesia at two outpatient centers in
12 Palm Beach County, where we do a lot of orthopedic
13 surgery and GI procedures, like colonoscopies and
14 endoscopies.
15 Q. Now, I want you to take us back a little bit.
16 Where did you grow up? Where did you go to school?
17 Where did you train?
18 A. I grew up in New York City. I went to college at
19 the State University of New York in Binghamton. And I
20 went to medical school at the State University of New
21 York Upstate Medical School at Syracuse, New York.
22 Q. And what year is that, sir?
23 A. I graduated medical school in 1987.
24 Q. Okay. And following that, what did you do next?
25 A. Following that, I did a one-year internship in

1 Internal Medicine at New Rochelle Medical Center. And
2 then I did my Anesthesia Residency at Yale University,
3 New Haven Hospital in New Haven, Connecticut.
4 Q. So from when until when were you at Yale?
5 A. I graduated from that program in 1991.
6 Q. Okay. And then following the completion of your
7 residency at Yale, what did you do next, sir?
8 A. Following that, I took a position here in
9 Pennsylvania with a group that was practicing primarily
10 in Delaware County. I was with that group for 21 years.
11 And during that time we expanded to cover a number of
12 different hospitals and surgery centers in Delaware
13 County, Chester County, and Philadelphia.
14 I spent two years as the Chief of Anesthesia at
15 Misericordia Hospital in Philadelphia. And following
16 that, I was the Chief of Anesthesia at Pottstown Memorial
17 Medical Center.
18 Q. From when until when?
19 A. Roughly from the year 2000 to 2010.
20 Q. Okay. And then when you left that position in
21 Pottstown -- as Chief in Pottstown, what did you do
22 next, sir?
23 A. I was still with the same anesthesia group for two
24 years after that. Our group was no longer practicing at
25 Pottstown any more, but I still worked for the group at

1 various other facilities. And then in 2012 I took a
2 position with Laser Spine Institute in Wayne.
3 Q. Okay. And what exactly was your position at Laser
4 Spine?
5 A. I was an M.D. Anesthesiologist at Laser Spine and
6 the Director of Anesthesia there.
7 Q. Okay. Can you tell us specifically what does the
8 practice of anesthesia entail, sir?
9 A. The practice of anesthesia entails the
10 preoperative preparation and the perioperative
11 management of patients undergoing surgery or diagnostic
12 procedures that require anesthesia.
13 Q. And what were your duties as -- what was your
14 position at Laser Spine? Director?
15 A. I was the Director of Anesthesiology there.
16 Q. Other than actually treating patients, did you
17 have other responsibilities as the Director?
18 A. We had -- we took care of seeing patients in the
19 clinic in the preoperative setting. We also sometimes,
20 depending on the patient, reviewed material on patients'
21 medical history before they got to Laser Spine
22 Institute.
23 Q. I guess we heard a little bit about the process at
24 Laser Spine. Can you take us through that again, sir,
25 what exactly -- a patient contacts Laser Spine and

1 believes they can benefit from treatment there, what
2 happens? How does it work from there? What happens
3 next?
4 A. Well, typically what happens is they are in
5 contact with a manager in Tampa, which was our main, and
6 still is, the main headquarters of Laser Spine. So
7 they're speaking to somebody in Tampa. They oftentimes
8 have MRIs that they have gotten on their own that they
9 send into them. They speak to the people in Tampa about
10 their medical history, where a decision is made as to
11 whether they need to send records to us to review prior
12 to them coming to our center. And they also make
13 decisions about whether they may or may not be
14 candidates, which is not definitive necessarily, because
15 we don't really decide that until we see them at our
16 centers. But they do make a preliminary decision as to
17 whether they are possibly a candidate for the type of
18 surgery that Laser Spine does.
19 And they also decide which center they're going to
20 send the patients to, because Laser Spine has seven
21 centers. Although, back in 2014 they had less than that.
22 There were three or four.
23 Q. Did they have the one in Ohio then?
24 A. They did not have one. It was not open yet in
25 Ohio back then.

1 Q. Okay.
2 MR. WRIGHT: Now, Michael, can we go to D-1,
3 page 121? There's a patient registration form here that
4 it looks like it's dated 12/22/13.
5 BY MR. WRIGHT:
6 Q. See that, sir? And this is actually I guess
7 several pages in length?
8 A. Uh-huh.
9 Q. And then there is also a partial history form.
10 Are these, first of all, all from the same packet of
11 information?
12 A. That's a packet that they fill out before they
13 ever come to our center.
14 Q. Okay. And then once they, I guess, go through the
15 initial screening process and it's determined that they
16 may benefit from treatment, then what happens?
17 A. Well, if it is determined they are a potential
18 candidate for something that we do at Laser Spine, then
19 they would be directed to come to our center and they
20 would be given preliminary information about the types
21 of things about medications to stop, medications to
22 continue. It's not somethings that I, as an
23 Anesthesiologist, really had anything to do with. But
24 it was something that they spoke to people in Tampa
25 about.

1 Q. But in the case -- in I guess most cases, or
2 definitely in this case, you would see the patient
3 before the day of surgery; is that right?
4 A. Correct. But not until they came to our center,
5 usually the day before the surgery.
6 Q. Okay. Let's go to page 75. And this is dated
7 January 28, '14?
8 A. Correct.
9 Q. Now, is this the first day that the patient is
10 seen at Laser Spine? Is that ordinarily how it would
11 work?
12 A. Ordinarily they would see us on the second day.
13 But I will say that did vary, but typically they saw us
14 on day two.
15 (Whereupon, proceedings continued to the next page without
16 loss of context.)
17
18
19
20
21
22
23
24
25

1 Q There has been testimony already that the
2 patient was sent for an MRI at the University of
3 Pennsylvania's Valley Forge office, and then came
4 back with the actual study and reviewed it with a
5 physician there. Who was that, Sir?
6 A The physician that would have reviewed the
7 MRI would be Dr. Finkelstein.
8 Q What is Dr. Finkelstein's specialty?
9 A He was a physiatrist. His involvement was
10 in trying to help diagnose and localize where a
11 patient's pain was coming from, determining if they
12 needed any additional diagnostic tests. And
13 eventually if he determined that LSI could help the
14 patient, then he would write a surgical order, which
15 would then -- and all this information would then be
16 given to the surgeon.
17 Q Okay. I guess there's been some
18 discussion about the patient not taking the
19 medication just prior to visiting Laser Spine. You
20 were here for that testimony, Sir?
21 A Yes, I was.
22 MR. WRIGHT: That's on Page 51, I
23 believe. If you can highlight that, Michael?
24 BY MR. WRIGHT:
25 Q Well, first of all, the patient apparently

1 gave a history to the management of care and pain
2 management physician for a year but recently fired
3 him. She's been taking Oxycontin 20 milligrams
4 twice a day, took last dose 1/25. She also shares
5 that she slipped and fell on her buttocks two weeks
6 ago, reinjuring her back.
7 Referring to the fact that she
8 stopped her dosage of Oxycontin, do you know why
9 that was, sir?
10 A Typically -- and, again, it wasn't
11 something that I was involved with, but typically
12 patients would stop their pain medication, they'd be
13 asked to stop their pain medication because they --
14 we wanted -- not me, but the diagnostic team wanted
15 to make sure that they actually had the pain that
16 they were typically dealing with when they came to
17 see them. So, A, they could talk in the present
18 tense about what type of pain they were
19 experiencing. And, B, so that if Dr. Finkelstein
20 decided that diagnostic studies needed to be done,
21 which were called SNRBS, or Selective Nerve Root
22 Blocks, they needed to have pain before those were
23 done to see if the pain would disappear when
24 Dr. Finkelstein would make an injection to the area
25 where he determined the pain may be coming from.

1 That would help him localize where the surgery
2 needed to be done.
3 Q In this particular case the patient has
4 undergone an MRI, met with Dr. Finkelstein. Now
5 you're seeing the patient on January 28.
6 MR. WRIGHT: Go back to Page 75,
7 Michael.
8 BY MR. WRIGHT:
9 Q Does your handwriting appear anywhere on
10 this document, Sir?
11 A Yes, it does.
12 Q Would you tell us where and what this
13 document says?
14 A My handwriting is in blue. And this is
15 our preoperative order form. And there's basically
16 two sections to this. There's the preoperative
17 section, which is at the top where I am ordering any
18 medications that I want our staff to give the
19 patient preoperatively, before we take them back to
20 the surgery. And I have checked off that I want
21 this patient to get Pepcid, Decadron and
22 Acetaminophen, all intravenously.
23 Q Just generally, what are you giving those
24 medications for?
25 A Well, Pepcid is a gastric acid reducer, so

1 she had a history of gastric reflux, so we want to
2 decrease her gastric acid. Decadron has two roles;
3 it works as an antinausea meds and it also works as
4 an anti-inflammatory, which would hopefully help
5 decrease any pain postoperatively. She's given
6 Acetaminophen, more commonly known as Tylenol. That
7 is also to decrease pain postoperatively. But it's
8 given preoperatively to kind of preempt the pain.
9 Q There's also orders concerning what should
10 occur in the recovery unit?
11 A Correct.
12 Q Before we get there. This is your
13 handwriting over here, as well?
14 A Yes.
15 Q What does that say?
16 A I have the date of January 28, 2014, and I
17 have listed her allergies, which is very important
18 for anybody to know who is going to be giving the
19 patient any medications. So she's allergic to
20 sulfa, an antibiotic; Compazine, typically used to
21 treat nausea; and Seroquel, which is an
22 antidepressant.
23 Q Is that your signature?
24 A Yes, it is.
25 Q Whose signature is this up here?

1 A That is Sharon Cassidy's. She was the
2 preoperative nurse. She was taking care of the
3 patient before we brought her back to the operating
4 room. She admitted her to Laser Spine Institute on
5 the morning of the surgery and probably started her
6 I.V. and would have been the person to have given
7 her her preoperative medications.
8 Q On the 29th?
9 A Yes, on the 29th.
10 Q Okay. Now, let's drop down a little bit.
11 The PACU section here, sir, does your handwriting
12 appear anywhere there?
13 A Yes, in the blue.
14 Q Okay.
15 A Number one is her intravenous fluids,
16 which in the PACU should be continued at 100 cc's,
17 per hour.
18 Q Why is that, Sir?
19 A You always want to give patients I.V.
20 fluids so that they're not dehydrated. It helps
21 keep their blood pressure up, it's a root for giving
22 any medications that we're going to be giving, and
23 it helps us so they'll be able to urinate
24 postoperatively; if they're dehydrated they won't
25 necessarily do that.

1 Q Down here, the pain control medications,
2 did you check those off, Sir?
3 A Yes, I did.
4 Q Specifically with the Dilaudid --
5 A Mm-hmm.
6 Q -- it indicates .5 milligrams IVP every 5
7 minutes to maximum 2 milligrams?
8 A Correct.
9 Q And then there's also -- this is your
10 signature down here?
11 A Yes, it is.
12 Q This, I believe, Sean Perez testified was
13 his signature?
14 A You have my signature highlighted right
15 now.
16 Q Okay. How about up here?
17 A Up next to the order in black is Sean
18 Perez's signature.
19 Q All right. There was some discussion I
20 think about the typed preop orders for the Dilaudid.
21 You were here for that, Sir? That's on Page 37.
22 A Yes, I was.
23 Q I just want to ask you if there's some
24 discrepancy between the two, the typed orders on
25 page 37?

1 A Yes.
2 Q Top of the page.
3 A Mm-hmm. There is an absolute discrepancy.
4 Q Okay. Tell me what the discrepancy is.
5 A The discrepancy is, it says 2 milligrams
6 I.V. PRN, which is as needed, times two. And my
7 written orders clearly say 0.5 milligrams I.V. Q5
8 minutes up to 2 milligrams.
9 Q That indicates you approved this on the
10 29th at 6:50?
11 A And that is not true. I believe that was
12 something that was put in after the fact. There
13 would be absolutely no reason for me to order
14 additional pain medication at 6:50 in the morning,
15 which was prior to her going to the operating room.
16 Q Going back to your handwritten note or the
17 note that you checked off on Page 75, Sir.
18 A Mm-hmm.
19 Q Exactly what was your plan in terms of the
20 patient getting pain medication in the recovery
21 unit?
22 A My plan preoperatively?
23 Q Preoperatively. And then did it change is
24 my next question. So let's start with
25 preoperatively.

1 A Well preoperatively my plan was to give
2 her the things I had checked off there, which were
3 Fentanyl, 25 milligrams I.V. push times one, if she
4 had pain. And that could be repeated times four.
5 And Dilaudid, 0.5 milligrams I.V. push every five
6 minutes to a maximum of 2 milligrams. And she was
7 also allowed to have Flexeril and Percocet if
8 needed.
9 Q Then based on, I guess the complaints of
10 pain in the recovery unit, those orders were added?
11 MR. JUBB: Objection.
12 BY MR. WRIGHT:
13 Q What occurred in the recovery unit in
14 terms of the pain medication, Sir?
15 A Well, the initial dose of 0.5 milligrams
16 up to 2 milligrams total was insufficient. She was
17 still having a great deal of pain.
18 Q Okay. We'll get to that.
19 When do you next see the patient
20 after you write these orders the day before the
21 surgery?
22 A I don't see her until the morning of
23 surgery, probably at about quarter of 7:00 in the
24 morning.
25 Q Okay. Let's go to Page 77. 77 to 78 are

1 the two pages of the anesthesia record; is that
2 right?
3 A Yes.
4 Q Okay.
5 A Those are the same.
6 Q Just two copies of the same page?
7 A Two copies of the same.
8 Q Okay, good. Let's stay with the one page,
9 all right? Let's stay with 77. There's a note
10 about preop vital signs. This is the morning of the
11 surgery?
12 A Correct.
13 Q Okay. Does your handwriting appear
14 anywhere on this document, Sir?
15 A It does.
16 Q Okay. Tell us either from memory or from
17 looking at this what exactly happened on the morning
18 of the surgery, January 29, 2014.
19 A It was nothing out of the ordinary with
20 her induction of anesthesia. She received
21 2 milligrams of Versed, which is a Benzodiazepine.
22 Prior to going into the operating room, which was
23 given by my nurse anesthetist, Adriana Debella.
24 Once she got in the operating room and is hooked up
25 to the monitors, and there is a number of monitors

1 that we place on the patient; blood pressure, EKG
2 pulse oximetry, and the patient at this point is on
3 the operating room table laying prone, on their
4 stomach, for the surgery, which is on their back.
5 So at that point when she's hooked up
6 to the monitors and she's receiving oxygen by mask,
7 then we start giving her other medications.
8 MR. WRIGHT: Can we drop that down a
9 bit, Michael?
10 BY MR. WRIGHT:
11 Q It appears again there's some blue writing
12 on this document. Do you see that, Sir?
13 A Okay. Now the whole box is in blue.
14 Q For example, up here there's no notations
15 in blue?
16 A Those are things that I had circled prior
17 to her going back to the operating room, standard
18 monitors that she was going to be getting.
19 Q And why were you circling those?
20 A Because they are standard monitors that we
21 use in the operating room, and we were hooking them
22 up. So she has end title cO2, which tells us how
23 much cO2 is coming out of her lungs when she's
24 breathing. FiO2, which is the amount of oxygen she
25 is receiving. EKG I have she's being monitored on

1 lead 2. NIBP is not invasive blood pressure
2 monitoring, which is basically a blood pressure cuff
3 hooked up to an automatic machine and pulse oximetry
4 to measure her oxygen saturation.
5 Q There's a notation here in blue. Is that
6 your handwriting, Sir?
7 A Yes.
8 Q What does that represent?
9 A Well, at that time we did not have
10 Fentanyl; it was on back order, and we weren't able
11 to obtain Fentanyl, so we used another medication
12 similar to Fentanyl called Sufentanil. They are
13 both synthetic opioids, they work the same way. And
14 that's the medication that we used that's part of
15 the anesthetic.
16 Q How long lasting are the effects of the
17 medications that were used during surgery?
18 A Sufentanil is -- Sufentanil in particular?
19 Q Yes. Sufentanil or the other agent,
20 Versed.
21 A Sufentanil lasts between an hour,
22 hour-and-a-half. And it's really very short-acting.
23 Remifentanil is an ultra short-acting narcotic. Its
24 half life is three to 10 minutes. So Remifentanil
25 is a narcotic, an opioid that we give by infusion,

1 and she was getting 0.0125 micrograms per kilogram
2 per minute, which is a standard dose to start a
3 sedation anesthetic with. So that was being given
4 through a pump by infusion as well as Propofol, all
5 very short-acting medications. So once you stop
6 giving them, they really wear off within 10 minutes.
7 Q There's a note here about Ketamine.
8 A Just that she didn't receive any.
9 Q Okay. And below that, Sir, again, this is
10 your handwriting?
11 A No, that's not my handwriting.
12 Q Okay.
13 A That's Nurse Debella's handwriting. She
14 gave her Zofran and Phenergan both to prevent nausea
15 and vomiting. She also gave her Ketorolac or
16 Toradol, 30 milligrams, which is an
17 anti-inflammatory, also to help with pain and
18 inflammation.
19 Q LR is reference to the?
20 A Lactated Ringers, which is the
21 crystal-like fluid that we're using through the I.V.
22 And she got a full liter, and then a second liter
23 was started later on where it says Number 2.
24 Q And then this note here, Sir, what is
25 that?

1 A Which one are you referring to?
2 Q I think it says Ephedrin here.
3 A Ephedrin. She got two doses of
4 5 milligrams because her blood pressure had dropped
5 down some. And then probably about 20 minutes later
6 she got an additional 5 milligram dose, which is
7 very standard medication to use in the operating
8 room to help control blood pressure. She really got
9 a very small dose of that, having a total of
10 15 milligrams.
11 MR. WRIGHT: Can we go over to the
12 right side here, Michael?
13 BY MR. WRIGHT:
14 Q There's a reference here to Decadron. Why
15 is that given, Sir?
16 A Again, Decadron is used for two things.
17 One of them is an anti-inflammatory, and it is also
18 used to decrease nausea. In this case, we had given
19 her some Decadron preoperatively primarily for
20 prevention of nausea, but the surgeon had ordered
21 6 milligrams additional to decrease inflammation.
22 Q Okay. And then there's some times over
23 here, there are OR times, anesthesia, in room, in
24 PACU, and then in the procedure itself, all those
25 times. Who makes those notations, Sir?

1 A The nurse anesthetist in conjunction with
2 the operating room nurse.
3 Q So according to this, the patient is in
4 the PACU at about 8:43 a.m. is that your
5 recollection, Sir?
6 A Correct.
7 Q All right. So walk us through what
8 happens next once the patient leaves the operating
9 room and goes to the PACU.
10 A Once they leave the operating room and go
11 to the PACU, they are hooked up again to monitors in
12 the PACU; blood pressure, EKG, pulse oximetry. And
13 the transfer is made from the nurse anesthetist and
14 the operating room nurse to the PACU nurse telling
15 them any history the patient had, what was done in
16 the operating room, what medications they received
17 and if there were any problems at all, that would be
18 told to the PACU nurse at that time.
19 - - -
20 (Whereupon, proceedings continue on
21 the following page without loss of context.)
22 - - -
23
24
25

1 Q. Okay. Can we go to page three of D-1 3, Michael.
2 And I think at 8:43 it's right here. There is a note
3 here that the patient is transmitted to PACU and the
4 report was given to Sean VS upon arrival. What is that
5 referring to, sir?
6 A. Vital signs stable.
7 Q. Okay. And at this point, I guess, whose in charge
8 of the patient's care?
9 A. Well, this is at the time of transfer. So it says
10 Amedeo Zelli, who is the operating room nurse. It
11 should -- I don't where it would say that Adriana
12 DeBello, the nurse anesthetist, but the two of them are
13 basically transferring the patient to Nurse Perez.
14 Q. Okay. And at this point the patient is log rolled
15 onto a stretcher?
16 A. No. That occurs in the operating room.
17 Q. Oh, I'm sorry.
18 A. They move her from the operating room table onto
19 the stretcher in preparation for bringing her to the
20 PACU which is the post anesthesia care unit, recovery
21 room.
22 Q. About ten minutes later there is a note that the
23 patient is able to tolerate food and fluids?
24 A. Yes.
25 Q. Okay. Is that important, sir?

1 A. I think so. It speaks to the fact that she was
2 awake and alert and not having any depressive effects
3 from the anesthetic that she had gotten.
4 Q. Okay. The next note at 9:13 says the surgeon is
5 at bedside with the patient and caregiver for operative
6 review discussion?
7 A. Correct.
8 Q. Okay. That refers to who, Dr. Luke?
9 A. Correct.
10 Q. And I think Sean Perez told us that that
11 discussion involved showing the photographs taken during
12 the surgery?
13 A. Typically it does.
14 Q. All right.
15 A. I was not there for that discussion.
16 Q. Okay. We're going to get to you. At some point
17 you do come to the recovery unit, is that right, sir?
18 A. Yes. Well, understand that the whole recovery
19 room and the preoperative area are smaller than this
20 courtroom. So I am in and out many times during this
21 time because in addition to checking on the patients who
22 are there post operatively, I'm also seeing other
23 patients coming in preoperatively.
24 There are typically four bays, four places where
25 patients can be and two of them are for post-opt and two

1 of them are for pre-opt and they, you just run down a line
2 with curtains between them. So all the patient pre and
3 post-opt are in the same room.
4 So I'm in and out of that room very often during
5 the course of an operative day. I'm also in the operating
6 room of which we have two. So there are two surgeries
7 generally going on simultaneously in the operating room
8 and those are the sites that I'm typically at.
9 Q. Okay. In this particular case, the next note is
10 9:48. It said that the patient was able to ambulate or
11 walk to the bathroom with the assistance of the nurse
12 and then is assisted in getting dressed?
13 A. Correct.
14 Q. All right. And then apparently you were at about
15 10:05 you were called; is that right, sir?
16 A. Correct.
17 Q. All right. Tell us about this note?
18 A. Well, I can read it. It says patient able to void
19 without difficulty. Escorted by RN which would be the
20 nurse. Patient ambulated to a wheelchair with a steady
21 gait. So they were walking well. A back brace was
22 applied with instruction. Patient is crying from pain.
23 Dr. Rubenstein called and orders received. Dr.
24 Rubenstein orders pain meds and a muscle relaxer.
25 Q. The muscle relaxer was the Flexeril?

1 A. Correct.
2 Q. All right. and the pain meds was more Dilaudid?
3 A. More Dilaudid.
4 Q. Okay.
5 A. That was at the point where her pain level was a
6 ten. She was awake. She was alert. Her vitals signs
7 were stable, meaning her blood pressure, her heart rate,
8 her respiratory rate were all normal, but she was crying
9 in pain. That was not normal, and despite any pain meds
10 we had given her already, wasn't touching her pain yet
11 and she needed more pain medication.
12 Q. Let's go to page two, Michael. Pain flowchart.
13 The ten here is around the time that you received the
14 phone call?
15 A. Correct.
16 Q. When her pain was reported to be at a level of
17 ten?
18 A. Right which was after she changed into clothing.
19 Q. Okay. And at that point she was given additional
20 Dilaudid?
21 A. Correct.
22 Q. All right. And I think Sean Perez told us that he
23 would give it over a period of two to three minutes, the
24 Dilaudid, .5 milligrams every two or three minutes or
25 words to that effect?

1 A. I believe that's what he said.
2 Q. Okay. While we are on this page can you drop down
3 a second, Michael. I think there has been some
4 reference to this, but there is a -- it's called GCS
5 here.
6 A. That's the Glasgow Coma Score.
7 Q. What exactly is that, sir?
8 A. That's a method of determining if patients meet
9 criteria for discharge.
10 Q. Okay. And it's a number system of some sort?
11 A. Correct.
12 Q. Is a 15 a good score?
13 A. It is the best score you can get.
14 Q. Okay. And how is that determined? I mean what
15 parameters are looked at?
16 A. The parameters are vital signs, plus some of the
17 things you see listed on this paper. Eyes opening
18 spontaneously, clear oriented response, obeying
19 commands, muscle strengths, all of these things go into
20 that.
21 Q. Okay. Now, going back up to the column above,
22 Michael. After the pain medication was given, it looks
23 like at 9:48 there was another score, a pain score of
24 ten or six. I am sorry.
25 Why did it go down to six, I guess, is the

1 question?
2 A. Well, she had been given medication. So it had --
3 it had improved after her pain medication finally.
4 Q. And then the next note at 10:40 was that her pain
5 was at five?
6 A. It seems as though that was at the same time.
7 They were both 10:40.
8 Q. Well, is five a good score for pain, sir?
9 A. It's an acceptable score for pain for discharge.
10 Q. All right. Can we go to page one. Page one. All
11 right right here. Page one contains the vital signs
12 which includes, I guess, the blood pressure, the pulse,
13 the respirations. Do you see that, sir?
14 A. I do.
15 Q. Okay. These were being recorded by Nurse Perez?
16 A. Correct.
17 Q. All along. Okay. Let's go back to page three.
18 And there is a note at 10:40 that anesthesia was at
19 bedside?
20 A. Yes, I was -- I was there before she left.
21 Q. Okay. It said anesthesia at bedside to assess for
22 discharge. Patient cleared for discharge. Reports pain
23 within tolerable limits. Denies nausea and able to
24 tolerate food and drinks. She is routinely discharged
25 to a hotel via private vehicle in care of her caregiver.

1 All right. Not, at what point in time are you
2 actually seeing the patient?
3 A. Right then before she left.
4 Q. Okay. And what -- do you make an assessment of
5 your own as to whether or not it's safe for her to leave
6 the Laser Spine Center?
7 A. Yes. I see her. She is awake. She is alert. I
8 have been in touch with Sean Perez who has told me what
9 her vital signs are and that her pain has improved to an
10 acceptable level and, yeah, I see her. I know that she
11 is able to walk. She is able to get dressed, and she's
12 able to eat and tolerate foods and drink.
13 Q. Was there any indication to you, sir, at that
14 point that she was overmedicated?
15 A. None at all.
16 Q. Or stuporous or unsteady on her feet?
17 A. None whatsoever.
18 Q. Do you remember this patient?
19 A. Yes.
20 Q. There has been testimony that she hugged Sean
21 Perez. Did you witness that event?
22 A. Yes, I did.
23 Q. Did she hug you?
24 A. I was -- as she was leaving, I was seeing another
25 patient already.

1 Q. Okay. Based on your observation at that time, was
2 there any reason not to discharge her from Laser Spine?
3 A. There was no reason not to discharge her at that
4 time?
5 Q. Even though she had received 12 milligrams of
6 Dilaudid?
7 A. Correct.
8 Q. Okay. It's been suggested to the jury,sir, that
9 you were negligent in allowing her to leave at that time
10 and that the medication that she received, that is the
11 Dilaudid and the Flexeril and the Oxycodone that she
12 took later caused or contributed to her respiratory
13 arrest and death.
14 Do you agree with that statement, sir?
15 A. I do not agree with that statement.
16 Q. And why is that?
17 A. Because she met all discharge criteria. Patients
18 sometimes need more pain medication than what you think
19 they might need, but we titraited it over time, little
20 bit at a time, and she in the end we got her to a level
21 where she was comfortable and she showed absolutely no
22 signs of any respiratory depression or any depression of
23 any kind, cognitive or otherwise.
24 Q. It's also been suggested, sir, that in that
25 post-operative period either while still in recovery or

1 after she left, she was in a post-anesthetic state and
2 that somehow contributed to her death? Do you agree
3 with that statement, sir?
4 A. No, I do not.
5 Q. And why is that?
6 A. Because all of the medications from her actual
7 anesthetic had worn off by then. Any residual leftover
8 from her anesthesia was miniscule at best.
9 MR. JUBB: Thank you, sir. Those are all of
10 the questions I have, your Honor.
11 THE COURT: Cross examine.
12 MR. JUBB: Thank you, your Honor.
13 - - -
14 CROSS-EXAMINATION
15 - - -
16 BY MR. JUBB:
17 Q. Dr. Rubenstein, good afternoon.
18 A. Good afternoon.
19 Q. The testimony you just gave to these folks is it
20 your testimony that it was your intention to give Ms.
21 Kimble 12 milligrams of Dilaudid?
22 A. At what time?
23 Q. Within 90 minutes?
24 A. My intention was to treat her pain. There was no
25 dose given that was initially going to be my intention.

1 We treat pain because it's important that we do so, and
2 we treat it as needed. So if you ask me, did I intend
3 before the surgery to give her 12 milligrams of
4 Dilaudid, I would say, of course not. But we were
5 not -- we did not know what her pain level would be and
6 how tolerant she would be to the pain meds that we were
7 giving her until we actually gave them to her.
8 Q. Doctor, my question was a tiny bit different. Is
9 it your testimony to those folks that even in that 90
10 minutes you intended to give her two milligrams, six
11 different times. Did you intend for that to happen?
12 A. I intended to give her a half milligram of Q5
13 minutes up to two milligrams each time, and if you ask
14 me was it my intention to do that six times, my answer
15 would be, yes, as we went along.
16 Q. And, Doctor, when you gave a deposition in this
17 case, do you recall giving a different answer than what
18 you just gave to me in that question?
19 A. I don't believe it was different. My answer then,
20 as it is now is that we were going to give her 0.5
21 milligrams IV Dilaudid every five minutes to a total of
22 two milligrams.
23 Q. And yet at some point she got two milligrams right
24 away, correct?
25 A. Not -- that is not my understanding.

1 Q. Did you see the administration records where two
2 milligrams was given right away as opposed to .5, did
3 you see those?
4 A. Which records are you referring to?
5 Q. The Laser Spine records where they are electronic
6 and it says administered, two milligrams IV right away
7 before any .5 or .2 or .3. Did you see those?
8 A. I saw all the records, but I would like you to
9 show me what records you are referring to.
10 Q. Sure. Let's talk about P-1.55, and I want to
11 focus so that the Doctor can see what record I am
12 focused on. Doctor, have you seen this record before?
13 A. I've seen those records. Can you point to where
14 you're referring to?
15 Q. Sure. The order was for Ms. Kimble to receive .5
16 milligrams of Dilaudid every five minutes to a maximum
17 of two milligrams, correct?
18 A. That is correct.
19 Q. And according to this document here, phase one,
20 she received two milligrams IV at 8:48, correct?
21 A. That is what Nurse Perez wrote.
22 Q. And that is not consistent with your initial
23 order, correct?
24 A. I believe he was using a shorthand for giving two
25 milligrams over a period of time. It was not my

1 intention to give two milligrams in one push. But, yes,
2 up to two milligrams was ordered.
3 Q. You were in the courtroom, I know we missed a
4 couple of days, but when you got here Ms. Perez --
5 Mr. Perez, you heard his testimony, correct?
6 A. I did.
7 Q. Did he mention anything about that was shorthand
8 for .5 milligrams up to a maximum of two?
9 A. No. But he did say that he gave it in his words,
10 slowly.
11 Q. Well, Doctor, you had also administered .5
12 milligrams slowly, correct?
13 A. I think you can give .5 milligrams in a single
14 push.
15 Q. Can we please pull up Dr. Rubenstein's deposition
16 which is P-66.31, and I'll draw your attention to line
17 19 on the bottom.
18 It says, we're talking about the preprinted ones.
19 Am I correct that the -- did you approve this medication
20 order at 6:50 in the morning?
21 No. I did not change the dosage from .5
22 milligrams every five minutes to a maximum of two
23 milligrams.
24 Do see where you said that in your deposition,
25 Doctor?

1 A. Yes.
2 Q. And can you agree with me that at least when you
3 first spoke under oath, you did not change the dosage
4 past a maximum of two milligrams?
5 A. That is correct.
6 Q. And you understood that oath then was the same
7 oath you took today, correct?
8 A. Correct. I still agree with what I said then. So
9 if you think I'm saying something differently than that
10 then you're mistaken. My orders were for 0.5 milligrams
11 IV up to Q5 minutes, up to two milligrams and I did not
12 change that.
13 Q. Doctor, it says a maximum of two milligrams?
14 A. Correct.
15 Q. You did not change the dose from a maximum of two
16 milligrams, correct?
17 A. Not initially, no.
18 Q. Doctor, I heard you say our center Laser Spine.
19 You were employed by Laser Spine in 2014, correct?
20 A. Yes, I was.
21 Q. Did you also hear Mr. Perez say that he was
22 unaware of what the -- of what Ms. Kimble was supposed
23 to be taking when she left the PACU with respect to her
24 preoperative medication, did you hear him say that?
25 A. I did hear him say that.

1 Q. And you also heard Mr. Lindberg talk about the
2 importance of continuity of care and communication, did
3 you hear that?
4 A. Yes.
5 Q. Do you believe that there was good communication
6 between the post-operative nurse and preoperative nurse
7 with respect to what Ms. Kimble was supposed to take?
8 A. I cannot tell you if the postoperative nurse and
9 preoperative nurse discussed that, but the medications
10 were listed on the record for Mr. Perez to see.
11 Q. And can we agree, Doctor, that all of the forms
12 that Mr. Wright just showed you about the timeline of
13 Ms. Kimble, you did not see her until 10:40, correct?
14 A. No, I do not agree with that. I saw her a number
15 of times in the PACU. I believe there is documentation
16 to that effect.
17 Q. Well, let's pull up that documentation that
18 Mr. Wright showed you. Would you please pull up for me
19 P-1.54. And just from the top, please.
20 Dr. Rubenstein, can we agree that with respect to
21 after the surgery, the only time it's documented that you
22 were at the bedside was at 10:40?
23 A. There -- no, we cannot agree on that.
24
25

1 Q. Can you tell me where here it says that you were
2 at the bedside?
3 A. In Sean Perez's written orders, there are notes to
4 the fact that I was present.
5 Q. I see. Let's pull up the handwritten orders.
6 A. In addition, like I have said, I was in and out of
7 the recovery room preoperative area multiple times
8 during the time that she was there. So there were many
9 undocumented times when I was eyeballing her, checking
10 her vital signs, looking to see how she was doing.
11 Q. I see. So in this time frame, you're walking
12 around and you're seeing two postop patients, correct?
13 A. Correct.
14 Q. You've got two preop patients you're trying to
15 care for, correct, and make sure their medication
16 reconciliation is good?
17 A. Correct.
18 Q. And then you're also the anesthesiologist in the
19 surgeries that are going on at the same time?
20 A. Correct.
21 Q. We're going -- you're handling one, two, three,
22 four, and how many surgeries at one time are you
23 capable --
24 A. Two.
25 Q. Two. Six different patients are under your

1 purview and it's your testimony that walking by
2 Ms. Kimble is considered bedside treatment; is that
3 right?
4 A. It's not considered bedside treatment. But it is
5 evaluating how she's doing. Even if it's just for a
6 moment, eyeballing her, seeing her conversing with the
7 people in the room, seeing her eating, looking up at her
8 vital signs on the monitor. It doesn't take a long time
9 to make a quick assessment, while also, remember, I'm in
10 communication with the nurse that is taking care of her.
11 MR. JUBB: Let's pull up those handwritten
12 notes that you mention.
13 BY MR. JUBB:
14 Q. Dr. Rubenstein, I want to be clear, TVO means
15 telephone verbal order, correct?
16 A. Um, we actually didn't have telephones. We had
17 walkie-talkies. Does TVO for Sean Perez mean telephone
18 verbal order? Possibly.
19 Q. Okay. And so you picked up your walkie-talkie
20 possibly?
21 A. What Sean Perez means by TVO, you would have to
22 ask Sean. But we are carrying a walkie-talkie at all
23 times, so I'm always available to talk to him even when
24 I'm in the operating room. And when I'm in the PACU,
25 he's talking to me.

1 MR. JUBB: 66.8.
2 BY MR. JUBB:
3 Q. Doctor, at the top you were asked what TVO stood
4 for.
5 MR. WRIGHT: What page are you on?
6 MR. JUBB: We are on page eight of his
7 deposition, line three.
8 BY MR. JUBB:
9 Q. Do you see where it says TVO and you said it means
10 telephone verbal order?
11 A. I said I can only assume that he means telephone
12 verbal order, but I don't know that as an acronym that I
13 have used. I said that then and I will say that now.
14 MR. JUBB: If we can go back to P-1.49 to
15 1.50, please.
16 BY MR. JUBB:
17 Q. Doctor, can we agree that these handwritten notes
18 that the TVO that you're assuming means telephone verbal
19 order, or that Mr. Perez says was the telephone verbal
20 order, is Sean Perez at the bedside and he's getting a
21 telephone verbal order from you, correct?
22 A. Um, refer to which one you're talking about.
23 Q. We can go line-by-line. TVO Dr. Rubenstein to
24 Sean Perez. Assuming that's that walkie-talkie you are
25 talking about while you're paying attention to six other

1 people, can we agree, Doctor, that means that Sean Perez
2 is at the bedside and you are not?
3 A. I would agree with that.
4 Q. Let's go to the next one, 903, it says the exact
5 same thing. Can we agree that Sean Perez is at the
6 bedside and you are not?
7 A. I would agree with that.
8 Q. To next one, TVO Dr. Rubenstein to Sean Perez at
9 bedside. Can we agree that that's saying that Sean
10 Perez is at bedside?
11 A. I would agree that I am at the bedside for that.
12 Q. And you are using your walkie-talkie to
13 communicate with Sean across the --
14 A. I am not, again, I am not familiar with using TVO.
15 But what I would say is I gave a verbal order at the
16 bedside for that order. He makes a distinction between
17 the first two orders and those two orders of saying at
18 bedside. If you look at his last order on that page, it
19 says Dr. Rubenstein at bedside. And I believe he was
20 saying Dr. Rubenstein at bedside there.
21 Q. You have no recollection of that?
22 A. Well, to each specific order, I can't tell you I
23 have a recollection of each specific order. But I do
24 know that I was there assessing Sharon Kimble and I do
25 know that I spoke in person to Sean at the bedside on at

1 least five or six occasions during this time in the
2 PACU.
3 Q. I see.
4 A. And I gave orders to him at bedside.
5 Q. And I guess Sean just didn't mark that in the
6 progress notes that you were at the bedside except for
7 at 10:40; is that right?
8 A. I can't tell you why he would do some of his
9 notations on the order sheet and some of them in the
10 electronic record. I can just tell you that these TVOs,
11 which I think he means as just verbal orders and he
12 writes at bedside.
13 Q. Doctor, can we agree that Laser Spine has certain
14 policies and procedures in place dealing with the
15 administration of pain medication, correct?
16 A. Yes.
17 Q. And can we agree that you are unfamiliar with what
18 those procedures were, correct?
19 A. No. That is not correct.
20 MR. JUBB: Please pull up for me --
21 BY MR. JUBB:
22 Q. Doctor, which part of my question is not correct?
23 Because when we spoke before, it's my understanding
24 that -- and when I say we, I'm referring to when you
25 gave your deposition in this case -- it's my

1 understanding that you were unfamiliar with any pain
2 medication procedures. Am I wrong?
3 A. I don't know what procedures you are referring to,
4 so.
5 Q. I see. Well, potentially that's the answer to my
6 question. Does Laser Spine have any policies and
7 procedures related to the administration of pain
8 medication?
9 A. They have policies and procedures now that didn't
10 exist in 2014, if that's what you're asking.
11 Q. You mean after Sharon Kimble passed away?
12 A. I don't know if Sharon Kimble's passing away had
13 anything to do with orders that -- with policies and
14 procedures that went into place after that.
15 Q. Doctor, would you agree with me that the tolerance
16 to opioids goes away as quickly as it develops?
17 A. No. I would not agree to that.
18 Q. Would you agree with me that as of January of
19 2014, you did not know what Ms. Kimble's pain regiment
20 was in 2013 for medication, correct?
21 A. That is correct.
22 Q. As well as '12 and '11, correct?
23 A. That is correct.
24 Q. That played no role in how you administered this
25 medication to Ms. Kimble, correct?

1 A. Knowledge of the pain medications that she was
2 taking earlier did not play a role. However, she showed
3 every sign of extreme tolerance to the medications that
4 we were giving her. That's what played a role in what
5 we gave her.
6 Q. Dr. Rubenstein, were you here when Nurse Perez was
7 unware of the difference between Dilaudid and Dilaudid
8 HP?
9 A. Yes, I was.
10 Q. Dilaudid HP is ten times stronger than Dilaudid,
11 am I correct?
12 A. Yes.
13 Q. Am I correct that the records that I showed
14 Mr. Perez are that Dilaudid HP was ordered and then they
15 were not signed or approved by you?
16 A. I saw the testimony. Can I answer further?
17 Q. Yes.
18 A. We did not have Dilaudid HP in our pharmacy. That
19 was not a medication that we ever used. So anything
20 that was written about Dilaudid HP was in error. Not --
21 I don't know who put that down. You know, the
22 electronic medical record, there's a lot of boxes that
23 people check off and somebody obviously checked off that
24 medication in error, because we didn't have that. In
25 fact, I have never had that. Have never used it before.

1 And it didn't exist at our facility.
2 Q. Would that be the second or third error that you
3 note is in the medical records?
4 A. You would have to be the one keeping count, but.
5 Q. They might be.
6 A. They might. But that is in error.
7 Q. And am I correct that it was not an error,
8 however, on your part apparently that Ms. Kimble was
9 instructed to take her preoperative medication in
10 addition to the medication that was prescribed to her
11 following her surgery?
12 A. That is standard. Because patients -- once you
13 get patients' pain under control, they are eventually
14 going to need more medication. And this is the
15 medication that she had been on preoperatively, and she
16 was going to be allowed to take that postoperatively as
17 she needed it.
18 Q. Doctor, since you had said that Ms. Kimble was so
19 tolerant that she needed this 12 milligrams of Dilaudid
20 in 90 minutes, can we agree that the 10 milligram dosage
21 of Oxycodone, that would be on the very, very low end of
22 that spectrum for the prescription of that medication?
23 A. Yes. But that was for breakthrough pain only.
24 She was still going to be allowed to take her Oxycontin.
25 And, in addition, if that was not controlling her pain

1 once she got home, she would have the ability to call
2 Laser Spine to potentially have the dose increased if
3 needed.
4 Q. Doctor, at any point in time did anyone from Laser
5 Spine Institute tell you that they reviewed the
6 toxicology results personally of Ms. Kimble?
7 A. No. Not until much later.
8 Q. Did anyone from Laser Spine ever indicated to you
9 they had determined that Ms. Kimble died from medication
10 error?
11 A. Only when I read the autopsy report and read what
12 the pathologist -- what the pathologist had written did
13 I have any idea about that.
14 Q. Did you see Doctor -- excuse me, I keep saying
15 doctor. Did you see Mr. Lindberg's testimony that at
16 least Dr. Seeker, there was some discussion that
17 Ms. Kimble had died from the interaction, that was their
18 conclusion from the toxicology report?
19 A. From what I understand from yesterday's testimony
20 by Mark Lindberg, he spoke with Jeff Seeker. And Jeff
21 Seeker, who, by the way, is a chiropractor, not a
22 medical doctor, he's a chiropractor and he is a nurse.
23 He was just saying to Mark, from my understanding, that,
24 well, we'll wait and see what's in the toxicology
25 report. But we didn't have the toxicology report at

1 that time.
2 Q. Doctor, you heard your expert, Dr. Noone, come up
3 here and say that Mr. Kimble should have done something
4 different and acted quicker. You heard him say that,
5 right?
6 A. Yes, I did.
7 Q. Am I correct, Doctor, that when you were asked
8 what would you do if a patient goes into respiratory
9 depression, you had no answer?
10 A. I don't know what you're referring to.
11 MR. JUBB: 66.16, please.
12 BY MR. JUBB:
13 Q. I'm referring to the top question here and the
14 question reads --
15 MR. JUBB: I want you to pull that up for me.
16 BY MR. JUBB:
17 Q. In the context of a patient who received multiple
18 postoperative doses of Dilaudid and muscle relaxants and
19 discharged to the Marriott, what is a layperson supposed
20 to do if these drugs have an additive effect that
21 depressed the central nervous system to such that the
22 patient stops breathing?
23 Answer: I can't answer that question for you.
24 Doctor, in light of your testimony, do you think
25 that it's fair to say that Mr. Kimble should have acted

1 differently when you, yourself, wouldn't know how?
2 A. I did not say that I wouldn't know what to do.
3 You were asking me, or whomever spoke to me that day,
4 asked me what a layperson is supposed to do. And this
5 is not asking me what I would do. I am not a layperson.
6 Q. Doctor, did you think it was fair, if you don't
7 know what a layperson is supposed to do, to not even
8 tell him what he is supposed to do, because you didn't
9 see him at discharge, correct?
10 A. I did not speak to Mr. Kimble at discharge.
11 Q. And --
12 MR. JUBB: No further questions, Judge.
13 MR. WRIGHT: Michael, do we have the
14 deposition transcript? Can we put up the question and
15 the complete answer, please? Page 16, I think the
16 question starts on line two.
17 - - - REDIRECT EXAMINATION - - - -
18 BY MR. WRIGHT:
19 Q. Okay. The question that was asked, sir, by
20 Mr. Beasley: In the context of a patient who received
21 multiple postoperative doses of Dilaudid and muscle
22 relaxants -- first of all, did she have multiple doses
23 of muscle relaxants?
24 A. Excuse me, ask the question again.
25 Q. Sure. Did she get multiple doses of muscle

1 relaxants?
2 A. No. She only got one dose of muscle relaxant.
3 Q. Okay. And discharged to the Marriott, what is a
4 layperson supposed to do if these drugs have an additive
5 effect that depressed the central nervous system to such
6 that the patient stops breathing?
7 First of all, did that occur in this case, sir?
8 Did the --
9 A. No. I don't believe that that's what happened.
10 If that's what you're asking me.
11 Q. That is what I'm asking. In any event, your
12 answer to that question at the time was what?
13 A. I said: I can't answer that question for you.
14 What I can tell you is that at the time of discharge, I
15 would have expected to have seen that respiratory
16 depression from the medication that she had gotten and
17 she met every discharge criteria; was awake, alert,
18 breathing appropriately, had an excellent oxygen
19 saturation, wasn't confused, was happy and actually
20 hugging everybody and asking to leave. By all discharge
21 criteria, she met them all. I don't know what happened
22 after she left.
23 Q. Is there anything -- you are familiar with the
24 discharge instructions that are given to patients at
25 Laser Spine?

1 A. Yes, I am.
2 Q. Is there anything confusing about those
3 instructions, sir?
4 A. No, there was not. They specifically tell a
5 caregiver that if there is any kind of a problem, to
6 call 911.
7 Q. Is there any instruction about leaving the patient
8 alone?
9 A. Oh, absolutely. They are not supposed to leave a
10 patient alone for 24 hours. Clearly this was something
11 that was not followed by Mr. Kimble. I think that his
12 attention that he gave to his wife was inappropriate and
13 irresponsible, quite frankly, for somebody who had just
14 had surgery done.
15 MR. WRIGHT: Let's go back to those verbal
16 orders very quickly. And this is -- I'm sorry, this is
17 D-1, pages 47 and 48, Michael.
18 BY MR. WRIGHT:
19 Q. As I understand what you're saying, sir, is that
20 even though the notes begin as TVO, any time Sean would
21 make an entry at bedside, for example --
22 MR. WRIGHT: The third order down on the
23 left, Michael.
24 BY MR. WRIGHT:
25 Q. You believe he's indicating that you were at the

1 patient's bedside?
2 A. Correct. I do believe.
3 Q. Same thing about the next note?
4 A. Correct.
5 Q. And the next note?
6 A. Correct.
7 Q. Okay. And then we go to the next page. At 10:05
8 your understanding is he's referring to you being at the
9 bedside?
10 A. Correct.
11 Q. And, again, at 10:20?
12 A. Correct.
13 Q. And then you did -- you were there -- it was noted
14 in the other notes that you were there when the patient
15 was discharged or shortly before that?
16 A. That's true.
17 Q. Okay. One other thing, sir, this issue of
18 tolerance was brought up. I think the question that was
19 asked was do you agree that you lose your -- I'm sorry,
20 your intolerance, I guess, to pain meds as quickly as
21 you gain it. Am I saying that correctly?
22 A. I understand what you're saying.
23 Q. Whether it's correct or not, okay. Do you agree
24 with that statement, sir?
25 A. That you lose your tolerance?

1 Q. Yes.
2 A. No. I don't believe that you lose your tolerance
3 that quickly.
4 Q. Why do you say that?
5 A. Because, I mean, just the fact that she required
6 as much pain medication for us as she did and was having
7 as much pain as she was having is a testament to the
8 fact that she was tolerant. Because even with all the
9 medication that we were giving her, she was not
10 displaying any adverse effects from the medications.
11 Q. And apparently still needed pain medication?
12 A. And apparently did.
13 Q. Okay. Thank you, sir.
14 MR. WRIGHT: Those are all the questions I
15 have.
16 MR. JUBB: Thank you, your Honor.
17 - - - RECROSS-EXAMINATION - - -
18 BY MR. JUBB:
19 Q. Dr. Rubenstein, about this issue of tolerance, am
20 I correct that it's Laser Spine who actually advertises
21 itself to people who have chronic back issues, correct?
22 A. Correct.
23 Q. And the idea is that they have lived with these
24 chronic back issues for however many years and we're
25 here to help, right, Doctor?

1 A. Correct.
2 Q. Yet the standard pain management is .5 milligrams
3 to a maximum of two, correct?
4 A. Correct.
5 MR. JUBB: No further questions.
6 THE WITNESS: But, I don't want to get hung
7 up on that, because I think that the total dose that she
8 needed was still what it was. And the fact that she
9 didn't display any negative, no adverse effects of
10 getting that medication, plus she was still in pain up
11 until we got her down to a pain number of five, shows
12 that, A, she needed the medications to control her pain,
13 and, B, she was tolerant to them.
14 MR. JUBB: There was no question pending,
15 your Honor.
16 MR. WRIGHT: I'm sorry?
17 THE COURT: He said there was no question
18 pending.
19 MR. WRIGHT: I thought that was the answer to
20 the last question. All right, I have no further
21 questions, your Honor. Thank you. Was that the last
22 question?
23 THE COURT: Yes.
24 MR. WRIGHT: Okay. I have no further
25 questions.

1 THE COURT: You are excused, Doctor. Thank
2 you.
3 (Witness excused.)
4 THE COURT: All right. Let's take our
5 afternoon break, ladies and gentlemen. Keep your minds
6 open. Don't discuss it. Don't do any investigation.
7 We'll start up in 15.
8 (Whereupon, the jury exits the courtroom.)
9 (Recess taken.)
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 THE COURT: Please be seated.
2 Are we ready?
3 MR. WRIGHT: Yes, your Honor.
4 MR. JUBB: Yes, your Honor.
5 THE COURT: All right. Frank,
6 please.
7 - - -
8 (Whereupon, the Jury returned to the
9 courtroom at 3:22 p.m.)
10 - - -
11 THE COURT: Please be seated,
12 everyone.
13 Mr. Wright, call your next witness.
14 MR. WRIGHT: Your Honor, our final
15 witness is Officer Andrew Harhut.
16 - - -
17 ANDREW HARHUT,
18 having been first duly sworn, was
19 examined and testified as follows:
20 - - -
21 DIRECT EXAMINATION
22 - - -
23 BY MR. WRIGHT:
24 Q Good afternoon, Sir. Thanks for coming.
25 I'll try not to keep you much longer. Would you

1 tell the jury who you are?
2 A Officer Andrew Harhut, Tredyffrin Township
3 Police Department.
4 Q How long have you held that position?
5 A Since January 2002.
6 Q 2002?
7 A Yes.
8 Q You were working in that capacity in
9 January of 2014?
10 A Yes, I was.
11 Q And did you have occasion, I guess, to go
12 to the Marriott in Wayne, Pennsylvania in response
13 to a phone call of some sort?
14 A Yes.
15 Q Tell me exactly how you wind up at the
16 scene, if you would?
17 A We were dispatched to an unresponsive
18 person, possible cardiac arrest, and I arrived on
19 location. I made contact with Marriott employees
20 who directed me to a specific room where I performed
21 CPR on a person.
22 Q Okay. Do you later learn who the person
23 was?
24 A Yes.
25 Q How did you learn that and when did you

1 learn that?

2 A Through investigative means of talking to

3 the staff at the hotel and the husband, Mr. Kimble,

4 we determined it was Sharon Kimble was our victim or

5 patient in this case.

6 Q You prepared an incident data sheet as a

7 result of that?

8 A Yes.

9 Q Do you have that with you, sir?

10 A Yes.

11 Q I'm just going to ask a couple questions

12 about what's contained on there.

13 A Sure.

14 Q This is -- I guess the report is several

15 pages long. Your portion of it is on Page 3; is

16 that right?

17 A Yes.

18 Q Okay. On the next page there's a

19 reference to 12 medications that were placed in a

20 bag of some sort. Who created that portion of the

21 report, Sir? It appears to be supplemental

22 information provided by Sergeant Barrar,

23 B-A-R-R-A-R.

24 A Yes.

25 Q You typed this yourself, you dictated, how

1 this is created?
2 A I typed the beginning part. The
3 supplemental information by Sergeant Barrar was
4 typed by him.
5 Q Okay. The part you typed, I just want to
6 ask you about a couple entries here. First of all,
7 did you at some point learn that the gentleman in
8 the room was Mr. Kimble?
9 A Yes.
10 Q All right. And did you have a
11 conversation at all with Mr. Kimble about the events
12 leading up to the phone call?
13 A Upon arrival, my normal protocol would be
14 to ask somebody what happened, and I believe I did
15 ask that of Mr. Kimble.
16 Q Did he respond in some fashion?
17 A He responded that his wife recently had
18 surgery, and she was now not breathing.
19 Q Okay. According to your notes, did he
20 tell you, I guess, how long -- when he first knew or
21 realized she wasn't breathing?
22 A Mr. Kimble informed us at the time, at
23 least according to my interaction with him was that
24 he had left the room to go get ice. And upon
25 arrival back to the room, determined that his wife

1 was not breathing.

2 Q Did you ask him how long he had been out

3 of the room?

4 A I don't remember if I asked him or if that

5 information was provided to me or not.

6 Q Okay. In any event, it's not recorded

7 here anywhere?

8 A I don't believe so.

9 Q All right. And just so --

10 MR. WRIGHT: Since we're referring to

11 this, Judge, I'm going to mark this as D-4.

12 It's actually premarked, the whole police

13 report.

14 THE COURT: Okay.

15 MR. WRIGHT: Just for purposes of the

16 record.

17 BY MR. WRIGHT:

18 Q There's also -- there's an indication here

19 as to how Mr. Kimble got to the hospital that day.

20 Is that recorded here in your note?

21 A According to my report, Mr. Kimble rode in

22 the ambulance with his wife, Mrs. Kimble, and the

23 members of the Berwyn Fire Company and Ambulance.

24 Q Now, if you had been -- were you ever

25 contacted by Ian Hood or anybody from the Coroner's

1 office to ask about what you observed when you
2 arrived at the scene or not?
3 A I was not.
4 Q Thank you, Sir. Those are all the
5 questions I have.
6 - - -
7 CROSS-EXAMINATION
8 - - -
9 BY MR. JUBB:
10 Q Good afternoon, Officer. Thank you for
11 being here. I know we meet previously at your
12 deposition. My name is Lane Jubb and I represent
13 Mr. Kimble.
14 When you walked into the room, am I
15 correct that Mrs. Kimble was on her back?
16 A I can't recall if she was on her back or
17 on her stomach face down, I don't remember.
18 Q If that was something that was contained
19 in that report that's in front of you on
20 January 29th, do you want to look at that and see
21 if that refreshes your recollection?
22 I'm referring to the third paragraph
23 that starts, I then observed, and then I believe it
24 says, lying on her back on the bed closest to the
25 hallway. Do you see that?

1 A Yes.
2 Q Does that refresh your recollection as to
3 perhaps how Miss Kimble was when you walked into the
4 room?
5 A A little bit.
6 Q If there was a suggestion to this jury
7 that Miss Kimble was naked, is that consistent with
8 your recollection?
9 A I don't recall if the victim was naked or
10 not.
11 Q Does that refresh your recollection,
12 whether or not the victim was naked or not?
13 A No, it really doesn't, to be honest with
14 you.
15 Q Okay. Thank you.
16 MR. WRIGHT: I have nothing further,
17 your Honor.
18 THE COURT: Okay. Thank you. You're
19 excused.
20 - - -
21 (Witness excused.)
22 - - -
23 MR. WRIGHT: Your Honor, at this
24 point I'd move in our exhibits and we would
25 rest.

1 THE COURT: Okay.

2 MR. WRIGHT: You want to hear them?

3 THE COURT: Yeah, let me -- Mr. Jubb,
4 do you anticipate rebuttal testimony?

5 MR. JUBB: I don't believe so, your
6 Honor. But I do have some objections to
7 whatever he...

8 THE COURT: Well, I understand that.
9 I'm just trying to figure out what I'm going to
10 do with the jury right now.

11 All right. Ladies and gentlemen, we
12 have some matters to address, but it's not
13 necessary for you to be here for that. And
14 what I anticipate now, is that the evidentiary
15 presentation of the trial is completed, at
16 least what you will have to consider. And what
17 is left is the last two stages of the trial;
18 that is, closing arguments and then the final
19 charge that I'll give you regarding the law
20 that you must apply to the facts as you find
21 them.

22 So with that in mind, those matters
23 would take a couple hours, so we're not going
24 to finish that today. So what I think we'll do
25 is we'll spend the time after I discharge you

1 resolving the matters that we need to. And
2 then tomorrow morning you will then hear
3 closing arguments and then my instructions to
4 you regarding the law, and then you will be
5 free to begin deliberations.
6 With that in mind, please keep in
7 mind, keep your minds open. You have not heard
8 closing arguments nor the law that you must
9 apply. You're not in a position to begin
10 deliberating within your own minds or with
11 anyone else until I send you to the jury room
12 to begin deliberations. Please keep your minds
13 open. Don't talk with anyone, don't let anyone
14 talk to you about the case and no independent
15 investigation. And we'll start up with closing
16 arguments tomorrow morning at 9:30. Keep your
17 pads and pens on the seat.
18 - - -
19 (Whereupon, the jury was excused for
20 the evening at 3:32 p.m.)
21 - - -
22 THE COURT: Okay.
23 MR. WRIGHT: Your Honor, I want to
24 place something on the record. During the end
25 of the last witness' testimony, plaintiff's

1 counsel pulled some garment out of the bag that
2 had not been previously identified, no one
3 testified what it was, and showed it to this
4 witness who said he doesn't recognize it. I
5 really object to that. It's totally
6 inappropriate.
7 THE COURT: I'll let you address. I
8 know there was testimony from Mr. Kimble that
9 there was a nightgown that was cut off of her.
10 I don't know if that was it or not.
11 MR. WRIGHT: That's the point. Why
12 didn't he at that point identify it and say
13 this is what was cut off of her, rather than
14 pull it out like a magic trick in front of the
15 jury?
16 MR. JUBB: Your Honor, if I may, for
17 the record, I actually have a shipment here
18 from Lisa Allen. This is Jerry Allen.
19 (indicating.) Lisa Allen is actually the
20 daughter of Mr. Kimble, who, after hearing from
21 his opening statement that Miss Kimble was
22 naked, Mr. Kimble actually saved the nightgown.
23 It was shipped here after Mr. Kimble's
24 testimony.
25 I'm allowed to refresh the

1 recollection of a witness with anything --
2 quite frankly, in terms of showing witnesses, I
3 had no idea that that was going to be his
4 testimony, that this wouldn't refresh his
5 recollection as to whether or not she was
6 naked. I don't have any obligation to disclose
7 cross-examination materials as well.
8 I appreciate, your Honor, for the
9 record, I do want to state that it was shipped
10 from the UPS Store, 9401 Venture Avenue, to the
11 Quality Inn Suites, attention Corey Kimble,
12 Mr. Kimble's son, UPS next day air for Saturday
13 delivery.
14 MR. WRIGHT: That's not the point.
15 First of all, they knew Officer Harhut was
16 deposed in December, last December. And if he
17 intended to question about a nighty, he could
18 have questioned him then, or if he intended to
19 question him when he came to testify, he should
20 have notified us of that intention. And,
21 again, just because somebody put it in a bag in
22 Ohio, that doesn't mean that's what she was
23 wearing that night.
24 MR. JUBB: If you'd like, your Honor,
25 I'm happy to call -- you told the jury that

1 we're not going to hear any more evidence. I
2 could call Mr. Kimble to verify this. It's not
3 necessary under the rules.
4 THE COURT: I don't think that it is,
5 but if you want to preserve your record, you
6 can call him and have him identify that was the
7 nightgown that was cut off her.
8 MR. JUBB: Can you hear okay?
9 He doesn't have his hearing aids,
10 today, your Honor.
11 THE COURT: Well it won't be today.
12 The jury is gone.
13 MR. JUBB: Okay. Fair enough.
14 THE COURT: You can do that tomorrow,
15 if you wish.
16 MR. JUBB: I don't need to.
17 MR. WRIGHT: The plaintiff has
18 rested. He said he has no rebuttal.
19 MR. JUBB: I didn't think you were
20 going to make such a stink.
21 MR. WRIGHT: And now he's asking to
22 reopen his case to put in the garment.
23 THE COURT: Well, I think that he can
24 refresh somebody's recollection with a
25 hamburger if he wants to. So he did it with

1 that -- he tried to do it, anyhow with that cut
2 off -- that piece of clothing. If your
3 objection is that it somehow, I don't know,
4 prejudices you, I don't know how it prejudices
5 you, we can resolve that.
6 MR. WRIGHT: It's not the prejudice,
7 sir, it's the way it was handled. It was
8 inappropriate. If he had it since Saturday,
9 why didn't I see it?
10 MR. JUBB: Well, I didn't know when
11 he was going to call witnesses. In fact, I
12 didn't know who he was going to call until 8:45
13 this morning.
14 MR. WRIGHT: That's not true.
15 MR. JUBB: So if you want to talk
16 about unfair surprise, Kevin.
17 THE COURT: This is much ado about
18 nothing. But if you wish to call Mr. Kimble to
19 identify that as being the nighty he cut off of
20 her, feel free tomorrow.
21 MR. JUBB: Thank you, your Honor.
22 THE COURT: Okay. All right. Let's
23 move towards moving exhibits for the record.
24 MR. WRIGHT: D-1 is Laser Spine
25 Institute medical record. We're going one by

1 one to see if he objects or go through them
2 all?
3 THE COURT: Well, how many do you
4 have?
5 MR. WRIGHT: 10, 15.
6 THE COURT: Why don't you take 10
7 minutes, and I'll revisit you and you can tell
8 me which ones.
9 - - -
10 (Whereupon, a brief recess taken at
11 4:38 p.m.)
12 - - -
13 (End of requested excerpt.)
14 - - -
15
16
17
18
19
20
21
22
23
24
25

C E R T I F I C A T E

We hereby certify that the proceedings, evidence and rulings are contained fully and accurately in the notes taken by us in the trial of the above cause, and that this copy is a correct transcript of the same.

____

CARA M. FITZPATRICK
Official Court Reporter

____

GALE FITZPATRICK
Official Court Reporter

____

KIM L. KERCHER
Official Court Reporter

The foregoing record of the proceedings upon the trial of the above cause is hereby directed to be filed.

____
Judge