SUPPLEMENTAL REPORTER'S RECORD

VOLUME 4 OF 15

COURT OF APPEALS CAUSE NO. 05-12-01394-CV

TRIAL COURT CAUSE NO. 08-8056-E

MARCELA and JOSE BUSTAMANTE, as Next Friends of DANIELLA BUSTAMANTE, Plaintiffs, VS. JORGE FABIO LLAMAS-SOFORO, M.D.; JORGE FABIO LLAMAS-SOFORO, M.D., P.A. d/b/a EL PASO EYE CARE CENTER; ENRIQUE N. PONTE, JR., M.D.; PEDIATRIX MEDICAL SERVICES, INC. and PEDIATRIX MEDICAL GROUP,INC. Defendants.	) IN THE DISTRICT COURT))))))))))) DALLAS COUNTY, TEXAS)))))) 101ST DISTRICT COURT

OPENING STATEMENTS OF COUNSEL,

TESTIMONY OF DR. DARIUS MOSHFEGHI

and TESTIMONY OF DR. ENRIQUE PONTE

which were heard on

Wednesday, October 26, 2011

On the 26th day of October 2011, the following proceedings came on to be heard in the above-entitled and numbered cause before the Honorable Martin Lowy, Judge Presiding, held in Dallas, Dallas County, Texas.

Proceedings reported by machine shorthand utilizing computer-assisted realtime transcription.

for these rulings. These are purely matters of law.

Lastly, no statement, ruling, or remark that I make during the entire time this case is on trial is intended in any way to indicate my opinion about the facts. The Court has no right to indicate an opinion as to the facts. You will decide the facts in the case, and in this determination you alone will determine the believability of the evidence and its weight and value.

At this time, ladies and gentlemen, we are going to begin to hear the opening statements of the attorneys. Mr. Girards will go first on behalf of the plaintiffs.

MR. GIRARDS: Thank you, sir. May it please the Court. Good morning, ladies and gentlemen.

A doctor is never allowed to expose his patient to a needless risk of danger, a needless risk of harm. If a doctor exposes his patient to a needless risk of harm, then he is responsible for the harm that results.

In this case a baby is born at 23 weeks and one day. A normal pregnancy takes 40 completed weeks. And this is a grid with 40 seven-day weeks. Daniella was born 23 completed weeks and one day. She weighed less than 750 grams. That's less than two

pounds.

Whenever a baby is born at 23 weeks and less than 750 grams, that baby has a 90 percent -- that baby has a 90 percent chance of developing retinopathy of prematurity. When a doctor is caring for a -- is taking care of a baby born at 23 weeks, he must always make sure the baby's eyes get checked by seven weeks of age, and the baby's eyes are rechecked every other week until the risk of retinopathy of prematurity goes away or retinopathy of prematurity is diagnosed and treated.

If he does not check the baby's eyes by seven weeks of age and again every other week until the risk of retinopathy of prematurity goes away, then the baby may go needlessly blind. Retinopathy of prematurity is diagnosable, and it is treatable.

Let me show you what retinopathy of prematurity is so you can see how that works.

(The videotape was played for the jury.)

MR. GIRARDS: This is a baby's eyes, and the blood vessels in the eye start growing from the back of the eye here. (Indicating) This is the optic nerve, and the blood vessels grow out and until this whole area is vascularized, until the whole area has the arteries.

This normally happens between 14 weeks

and after during the pregnant -- during the 40-week pregnancy. When a baby is born early, then this takes place while the baby is outside the womb in the neonatal intensive care unit.

The reason these blood vessels grow is because this tissue out here that doesn't have blood vessels makes a chemical that says, we need blood vessels. Grow out to us. Grow, grow, grow, grow, grow.

And in some patients, sometimes in some babies -- well, 90 percent or nine out of ten of the 23-weekers, the chemicals make these blood vessels grow too fast, too aggressively, and it starts to form scar tissue--which I'm going to show you in just a moment. And the scar tissue contracts, and it pulls the retina away from the back of the eyeball, causing the baby to be blind.

And so that's what you are going to see here, the blood vessels growing.

Now the blood vessels are getting jumbled up, and scar tissue is forming, and a ridge is created here. (Indicating)

Okay. Now, what has happened here is that the scar tissue started with a little line that we saw, and then it grew further into a ridge. Then

the scar tissue forms, and you see the retina being pulled off of the back of the eyeball, here. (Indicating) And this is when the baby goes blind.

The treatment to stop this, to preserve the vision of the baby, to maximize the vision of the baby, is to take a laser and zap all of this tissue here, every bit of it. (Indicating) Not just little spots where you poke and destroy some of it. But you take the laser, and you destroy all of this tissue right here so that it stops making that chemical that says, grow, grow, grow, blood vessels. Blood vessels, we need blood vessels and arteries and veins coming out here. (Indicating)

And if that happens at the correct time, then this laser therapy is effective and stops the progression of ROP in most babies. This is a condition that's diagnosable, and it is treatable. Most babies that have it, get diagnosed and treated on time. Most babies that get treated have functional good vision.

It was known by PMG -- let me back up a second. I want to show you something. (Writing on the easel sheet)

This is the hospital. Inside the hospital is the PMS neonatal intensive care unit. Inside the intensive care unit is Dr. Ponte's office.

Dr. Llamas's office is ten miles away.

PMS had complete responsibility for the professional services in the unit, everything that had to do with diagnosis and treatment of babies.

Dr. Ponte was the medical director, and he was also Daniella's attending physician. PMS and Ponte knew--90 percent--knew that Daniella was going to -- most likely was going to need laser therapy sometime down here.

Now let's go back to our safety rule. The baby's eyes must be checked by seven weeks of age, and then every other week thereafter until the risk of retinopathy goes away.

Dr. Ponte -- Daniella, after she was born, was moved into the neonatal intensive care unit because she had all of the problems that you would expect in a baby that young: respiratory, heart, infections, and all of those were treated by protocol.

And Dr. Ponte asked Dr. Llamas to be the one to do the eyes, the eye checks. Dr. Llamas came in when the baby was seven weeks of age and checked her eyes, and he wrote, "Fetal fundi, follow up in four weeks." And he wrote that in the medical record. And she did not have retinopathy of prematurity on the first exam.

Dr. Llamas returned four weeks later, and he wrote in the medical record that Daniella now had severe end stage ROP that was so severe that she needed laser treatment as soon as possible, even if it required her to be transferred to another hospital.

(Pointing to the calendar chart) Daniella did not receive laser treatment on this day, and she was not transferred to another hospital on this day.

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She received laser therapy on this day. (Highlighting a day on the calendar chart)

The laser therapy -- Daniella went on to go completely blind in her right eye. The scar tissue pulled the retina off the back of her eyeball in her right eye. Her eye is now shriveled. It is going to have to be removed.

Her left eye, she is legally blind, and she can only see things when they are about this far in front of her face. (Indicating)

We have on Daniella's behalf sued PMS, the corporation that runs the neonatal intensive care unit, and the medical director and the attending physician, Dr. Ponte. And we have sued Dr. Llamas because the three of them together were required to follow the safety rule of examining the baby's eyes during the seventh week of life, and then every other week until the risk of retinopathy of prematurity had gone away.

Had they followed the safety rule, Daniella's retinopathy of prematurity would have been diagnosed more likely than not at a mild stage when it could be treated, and she would have functional vision. An exam that would take place no later than here (pointing to a date on the calendar chart). And then when the retinopathy of prematurity is diagnosed, then more frequent follow-ups happen every few days until it is at the treatable stage and her vision is preserved. We have sued them for violating this clear safety rule.

We are also suing Dr. Ponte and PMS because the reason why Daniella didn't get laser therapy on this day and she didn't get it on this day, is because back here, when Daniella was born and they all knew she had a 90 percent chance of developing

retinopathy of prematurity, that there was a high degree that she was going to need laser therapy, PMS and Ponte never checked to make sure that the laser was going to be available down here when it would have been needed.

And so the reason Daniella didn't get laser therapy on this day is because nobody knew where the laser was. And Dr. Ponte didn't transfer her to another hospital for that emergency laser therapy. We have sued them because if they had made a phone call to make sure that the laser was available, then it would have more likely than not been found back here, and it would have been available when it was needed here. (Pointing to dates on the calendar chart)

We are going to show you something -- I want to show you this diagram. This is the eyes. Can you think of like sunglasses. When you look in the eyes, this is a medical diagram that the doctors use for a classification, just the special words used to describe retinopathy of prematurity. And I want to show you this because --

Remember when I said back at the first exam, Dr. Llamas wrote in the medical records, "Fetal fundi, follow up in four weeks." There were two really big problems with that. Two clear safety rules were

violated. You have already heard about the "follow up in four weeks." Dr. Ponte and PMS should have seen that. That was a red flag, and an alarm should have gone off.

But when he wrote "fetal fundi," this is in the year 2005. Back in 1984, all the doctors who assess and check these babies' eyes agreed to use a special international classification. Because back at that time doctors would look at a baby's eyes, and then they would write down in the medical record, Bad ROP. Very bad ROP. Oh, my god, unbelievably bad ROP. And nobody knew exactly what it was. They were all looking at the same eye.

So they decided to come up with a classification system so that everybody--not only the doctors but also the nurses, the technicians, the hospital administrators, the PMS folks--would be able to look at the record and know what the baby's eyes looked like, and know when the baby's eyes were supposed to be checked again. And that's what this is here.

The first thing Dr. Llamas was supposed to write in the medical record--and Dr. Ponte was supposed to insist that he write down in the medical record--number one, the zone. This is zone I. This

is zone II. And this is zone III.

So remember when we looked at the diagram with the blood vessels growing in the back of the eye? The zone means how far those blood vessels have gotten. If the blood vessels have only gotten here -- if any of the blood vessels haven't crossed this line, then it is a zone I eye. If the blood vessels have crossed that line -- have crossed this line and are here, that's a zone II eye. And if the blood vessels have crossed this line and gotten out here, that's a zone III eye.

The blood vessels never go backwards. So if you have a zone II eye on any given date, you are not going to have a zone I eye later. That's going to be important to you because we are going to show you some photographs of this baby's retinas that were taken the day after this second exam, that show that on this date--the second exam, four weeks later--she had zone I eyes. Her blood vessels were still in zone I.

Which means -- which means that the safety rule for this particular baby required Dr. Llamas to check her eyes at least every week instead of every other week. So at the end of the day, we have sued Dr. Llamas and Dr. Ponte because they didn't make sure Daniella's eyes were checked every single week until the risk of ROP goes away.

Now, the risk of ROP going away happens down here after -- after week 34. That's when it starts to go down.

The safety rules that I'm telling you about are going to be explained to you by a couple of experts that I have asked to come and talk to you. One is a fellow named William Good, who is one of the country's premier pediatric ophthalmologists. He is the Smith-Kettlewell Chair of Ophthalmology at a big medical school. He is the chair of the committee that wrote the "Early Treatment of ROP Protocol," and he is going to explain to you the safety rules.

I have also asked a neonatologist to come and visit with you during the trial. Her name is Dale Phelps. She is also one of the premier neonatologists in the area of retinopathy of prematurity. She is the one who authored -- co-authored many of the leading studies and papers on retinopathy of prematurity, and she will tell you these safety rules.

I'm also going to ask that the expert ophthalmologist that Dr. Llamas and PMS hired -- His name is Graham Quinn. And the words that I have explained to you are the very words from Dr. Graham Quinn. And they are the very words from the vice president of this corporation.

Everybody is going to agree at the end of the day that these are the safety rules. When a 23-week baby is born at less than 750 grams, 90 percent chance probability of ROP, you should check the baby by seven weeks of age and then at least every other week until the risk of ROP is gone.

The only difference is, Dr. Quinn is going to come into the courtroom and try to tell you something different than what he was telling the doctors and the hospitals. And the evidence is going to show you, there is nothing more dangerous than a doctor coming into a courtroom and saying something different than he said to his buddies in the hospital. But we will get to that later.

The other thing -- I have gotten ahead of myself, which I'm bad about doing, and I'm going to try not to do it too much. We talked about the zone, which is what Dr. Llamas was supposed to write in the records, where the zone was. He was also supposed to write in the medical record the stage.

Remember the video about the stages? This disease goes through stages that takes a while. It doesn't happen overnight. And when the ridge forms at stage 1, when the ridge widens at stage 2, and when the blood vessels start shooting out these scar tissue

little fibers/stage 3, eventually to stage 3 where the retina is pulled off the back of the eyeball.

So since around 1984, the pediatric ophthalmologists are supposed to write not only the zone but the stage that you are looking at. And then the doctor is supposed to write in the medical record whether those arteries are big and fat and twisted, or whether they are not--because that makes a difference.

And then, finally, the doctor is supposed to write the extent of the disease. And you will see the clock hours here: 3:00, 6:00, 9:00, 12:00. And he should write in the record the disease is present between 12:00 and 3:00 or 12:00 and 6:00 or 3:00 and 7:00, so that anybody who looks at the record will know exactly what that eye looks like, and so that everybody will know when that baby's eyes are supposed to be rechecked and what the risk profile is. Not just the doctors but technicians, nurses, everybody.

We have sued Dr. Llamas because he didn't switch in 1984, or at any time after that, to the new classification. And PMS and Dr. Ponte didn't make him do it. And so that when he writes "Fetal fundi, follow up in four weeks," nobody really knows what's in Dr. Llamas's head.

And the reason -- and because of that,

nobody at PMS--not the ROP person, not the nurse, not the technicians--nobody was able to look at the record and say, hey, wait a second, where is Dr. Llamas? He is supposed to check this kiddo's eyes, and he is not here. It's been a week; it's been two weeks; it's been three weeks.

That is another reason why Daniella fell through the cracks, is because Dr. Ponte and PMS were supposed to make sure -- it was their job to make sure she did not fall through the cracks.

We also sued Dr. Ponte and PMS because they knew or should have known something about Dr. Llamas. In 2005, Dr. Llamas had not had any formal training to treat babies with a laser in their eyes. You will hear that he went to a one-day seminar, and a professor showed him how to do it, and he practiced on a little plastic eye.

And then he went back home, and sometime over the next couple of years he started shooting lasers in babies' eyes with retinopathy of prematurity. And he didn't have any preceptor or proctor, like normally physicians do to get trained. He didn't have anybody who actually knew how to do the laser following him around for a period of time to check that he was doing it right, to watch him do it, to look in the

baby's eyes after he did it to make sure it was done correctly.

The reason why that is very important is because -- the reason that is critically important is because if you don't zap all of this tissue, the tissue that's still alive is still making that chemical, and it is still saying, we need blood vessels over here.

So if you have skip areas, if you have shot it so it looks like a bunch of polka dots like a leopard or if you leave large sections untreated, the ROP is still going to progress because that chemical is still being produced.

So when Dr. Llamas did the laser therapy, it was too late. He did it incorrectly. And we are going to show you photographs of the retina, and you are going to see polka dot/leopard spots all through here and large areas that didn't get zapped with the laser at all. When it is done correctly, all of this turns white off the photographs. All of it.

But Dr. Llamas left the polka dot/ leopard pattern, and that's one of the reasons why Daniella's ROP didn't stop when she got laser therapy, and that's another reason why she is permanently blind, legally blind in her left eye and completely blind in her right eye.

Now, Dr. Ponte and PMS should have known about Dr. Llamas's training because they had the responsibility to ask. They are supposed to know. And it really wasn't any secret, and Dr. Llamas would have told him if he would have asked him.

There is another reason that we have sued Dr. Ponte and PMS, and that is this clear safety rule violation: the one where a baby is born with a 90 percent probability of ROP and has to be examined by seven weeks of age, and then at least every other week and sometimes every week.

Dr. Llamas had violated that safety rule before, a lot, and he would -- when a baby is born down here, he had the same pattern: take a look and write "Fetal fundi and follow up in four weeks."

It was no secret to PMS and to Dr. Ponte that Dr. Llamas was violating a clear-cut safety rule that was in lots of medical literature. And so those events happened before Daniella came along. And by the time Daniella came along, PMS and Dr. Ponte should have been watching Dr. Llamas real closely.

And they should have said, Look, Llamas, you've got to use the international classification so we will know what you are doing. You've got a 23-weeker, and you have written down that you are not

coming back for four weeks.

It was their job to say, No, no, no, no, no. You've either got to do it right, or we are getting somebody else. And there were others in town who were available to do that correctly.

Now, what is so dangerous about violating these safety rules? I want you to imagine from the evidence that you are going to hear what it means for doctors to fail to diagnose disease as soon as it is diagnosable, and fail to treat it as soon as it is treatable because they are not paying attention. They have complete control of the patient 24 hours a day, seven days a week.

Imagine what it means for people who go into the hospital with chest pains, getting dizzy and passing out. The doctor says, Oh, I will have a look at you, and I will come back in four weeks. Would any of us be able to survive that kind of practice?

All right. So what do they have to say about this? Well, they are going to say that -- they are going to deny they did anything wrong, and they are going to pull out some general guidelines that they are going to tell you apply to Daniella. But they are going to ignore the specific guidelines that say that a 23-weeker at less than 750 grams has to have an exam at

seven weeks and every other week, and sometimes every week through this entire period.

They are going to make a lot of excuses. Dr. Ponte is going to say that all he had to do in order to do his job was to make sure Llamas came in to look at the baby the first time, and then everything else is up to Dr. Llamas.

But we are going to show you that that ignores the clear safety rule that the neonatologist, Dr. Ponte, and the eye specialist, Dr. Llamas, have to work together, and they are both responsible for the schedule of screening. Even though Dr. Llamas is the one who actually looks in the eyes, they are both responsible to make sure the screening and the diagnostic examinations happen when they are supposed to. Because Dr. Ponte is the one who is ultimately in charge of all the medical care the patient -- his patient gets as the attending physician during that admission to the hospital.

And PMS, they are going to tell you that all we do is send out bills. All we do is, we have a staff of 250 bill collectors. That's all we do. They are going to say, it doesn't matter what happens in the NIC-U. We have no responsibility whatsoever.

But we are going to show you that this

corporation has an exclusive contract with this neonatal intensive care unit where they are responsible for all of the professional services in that unit, and they are responsible to make sure the medical care meets or exceeds the standards of care, the safety rules.

And we are going to see that they control NIC-Us in 33 states and Puerto Rico, and they control over 2,000 neonatologists. And they have done absolutely nothing all these years to make sure that everybody knows the treatment schedule, the eye exam schedule on these very premature babies--even though they see them all the time.

Dr. Quinn, Dr. Llamas, and PMS's eye specialist and the vice president of this medical corporation, are going to tell you -- at least they tell their buddies in writing that if you follow -- that they proved -- they proved that following this exam schedule--checking the eyes at seven weeks and then every one to two weeks thereafter until the risk of ROP has gone away--that if the safety rule is followed, they proved that they could prevent 300 babies per year from going blind.

And they will tell you -- at least they tell their buddies -- that if you follow the schedule,

not only will the babies not go blind, but they will save up to $65 million a year in medical expenses. They knew that.

And even today, PMS doesn't have the protocol in place for any of the NIC-Us, including this one. Had they had that treatment protocol in place, and had they enforced it, Daniella would not be blind. She would have functional function more likely than not.

PMS is so uninterested in this lawsuit that they don't even have a representative here in the courtroom. And when you hear the evidence, I think you will understand when I ask you to get their attention. If this little blind baby is not even important enough for them to be here, then we've got to do something so they can prevent these blind babies from happening, from diagnosable and treatable ROP.

Now, we mentioned -- we mentioned the fact that Daniella, when she was born, she had all of the issues that a 23-weeker is expected to have. Now, one of those things is, when you are born that early, the blood vessels in your brain are very fragile. Frequently the babies get bleeds in their brain, and it causes some degree of brain damage ranging from mild to severe, to even death sometimes.

And Daniella had some bleeding in her brain, and she's got some mild cerebral palsy.

Now, lots of kids do well with mild cerebral palsy and go on to have functional lives. They need some help, and they need some guidance, and they need some housing sometimes, and it depends upon the range. Some of them live independently, completely independently.

And the evidence is going to show you that Daniella has mild CP and that she is going to need -- but that her blindness has made it many times worse, her functioning many times worse. Because as a child, you learn so much by watching others and repeating the behaviors, mimicking, practicing. And she can't do that.

And it is even more important for a child with mild CP to be able to see because it is more important for someone who is having a diminished ability to work with language, to learn tasks, that she would otherwise learn fairly easily with therapy.

And because she is blind, she needs someone with her 24 hours a day because she can't master the skills. It's much, much more difficult for her to master life's skills. And that's going to be the case for her whole entire life, and the main

reason -- one of the main reasons is because of her blindness.

And so she -- we are going to be looking 20 years, 30 years, 50 years, 60 years down the road because this is the only time that she can be compensated, the only time we can meet her needs -- her future needs with money.

Now, there are also future therapies that we know are going to be available. They are here now. They are just not ready to be used on people.

You remember, you see people now walking around with the cochlear implant. They put a little computer in your brain and a little thing on the outside so they can hear.

Those devices are in development now for retinas, artificial eyes, and they are going to be extremely expensive. But those are the things that are here now. They are just not ready for Daniella yet, but they will be 10, 15, 20 years, 30 years, 50 years down the road.

But Daniella won't be able to come back here 50 years down the road and say, hey, they've got this artificial eye, and I would like to see. It is not my fault. I would like to see. I would like to see now. So we have to decide those things now.

Today is Daniella's some day, and we are going to talk about -- those are the things that we are going to want you to look at and really give some thought to, about what she is going to need for those future medical needs and therapies.

And she is going to need somebody to be with her 24 hours a day for the rest of her life. Her parents do it now, and they love to. But they are not going to be able to do that her whole life, and there is nobody that cares for her like they do, or will care for her like they do. So we need to look at when she is an adult, when she is 20, 30, 40, 50, and who is going to be doing that and how that is going to be paid for.

This lawsuit ultimately is about the harms and losses and the fixes and the helps for her. We are going to show you these violations of the safety rules and how she -- how they caused her to be blind. But we are here to fix the things that can be fixed, to help the things that can be helped, and to compensate her for the things that cannot be fixed and cannot be helped.

And the evidence is going to show you that she will be blind until such a time as they have some of these super devices that are way, way down the

road. She is going to need the help that we have been talking about so far and more, and there is lots of -- You remember the $65 million medical bill that I talked about earlier. That includes lots and lots of therapies for lots and lots of kids who have this blindness and need these helps and these fixes.

And then we will talk about the things that can't be fixed or helped that we want -- that the law requires that she be compensated for, and justice requires that she be compensated for.

All right. I appreciate your being so patient with me, and I'm going to turn this over to the Court and opposing counsel.

THE COURT: Very well. Ms. Fraley, does Dr. Llamas wish to make an opening statement at this time?

MS. FRALEY: He does, Your Honor, through me.

THE COURT: Please proceed.

MS. FRALEY: Thank you.

My goodness. That sounded awful, didn't it? It sounded like there were doctors out there blinding babies and ignoring safety rules and knowing that they were doing that. It felt very uncomfortable, didn't it?

I want to go back to the life care plan. I've got the designation at page 11.

THE COURT: Please approach.

(There was a discussion off the record.)

THE COURT: The objection is sustained.

Q. (BY MR. GIRARDS) Are there -- I want to visit with you briefly about some of the technologies that are being worked on today that are not quite ready for being put in patients. Can you tell us about what some of the technologies are that are promising and will be on the -- that are on the horizon?

A. I would be happy to. The horizon is not nearby, but there are a number of technologies that are really coming along that are hopefully going to be remarkable advances for visually impaired, children and adults.

One is a gene therapy. There is already a gene therapy that is available for retinopathy -- not retinopathy of prematurity but a certain retinal disease that occurs at birth. The gene therapy works remarkably effectively in dogs. I know that sounds like a -- it is a lot, but it also is now being tried in phase 1 trials in humans, and it seems to have an effect for human beings as well.

And while gene therapy has had its ups

and downs in terms of safety factors, it seems to be safe. So I think there will be a molecular management for Daniella that may come along sometime in the next hopefully 10 or 20 years or so.

Secondly, there are microchips that can be placed in the eye that are photoresponsive. Initially, these were actually placed on the foreheads of patients, and that somehow allowed the patient to experience at least some sort of visual sensation. But now they can be placed in the eye, and they are being made with greater and greater sophistication.

And for reasons that are not clear, these microchips do hook up to the optic nerve and allow patients, who have them implanted, to have better vision than they would have had without it. They still don't have very good vision, but they can see the direction of movement of things. They can see lights off and on. I believe they can see some color also.

So, you know, with the technology going the way that it is, we can be hopeful that at some point on the horizon, there will be things like that that will be available for Daniella.

Q. I forgot to ask you. What do you think more likely than not would be -- would Daniella's visual

acuity be had she been treated appropriately by these defendants?

A. I would say more likely than not, she would have had visual acuity better than 20/200.

Q. Okay. What does that mean for us? What does that look like?

A. Well, again, this is a linear scale, so 20/200 means a person like Daniella -- if her vision, let's say, was 20/100, she could see something at 20 feet that anyone with normal vision could see at 100 feet. Now, that doesn't sound too good, but that puts her in the domain of having the ability to have a sighted life.

It is a lot different for a child who grows up with 20/100 visual acuity and then, as an adult, acquires that kind of loss of visual acuity. It is much more difficult for an adult to cope with that.

Q. How is that? What does that mean for us? Help us to understand that part, where you have the difference between going blind later or starting out as a kiddo like Daniella.

A. Children are just tougher. You know, they are more malleable. They are more flexible. They learn to cope with various impairments. They learn to adapt.

They do get a lot of assistance from the environment.

In most states they have various forms of rehabilitation and services that give them the chance to have extra time to learn to read and so on. And growing up, it is a lot different than say if you are 80, developing bilateral macular degeneration, and going from being able to read to not being able to see clearly at all.

Q. All right. And then what about -- what is your experience with the kids? How does the loss of vision impact the way they learn and develop? You mentioned that a little bit earlier.

A. Total loss of vision?

Q. Like Daniella's loss of vision.

A. Again, the question is, how does it impact their --

Q. Yes. You said it made it more difficult or took longer or something like that.

A. Yes, it will take her much longer. Let's say she is driven to learn to try to read or something like that. It is going to take her a whole lot longer to be able to read across the page -- or across a line to even find her place in a book if she is trying to read a book or to read a page.

It is going to take her longer to find

the sorts of things that she needs to do her school-work, longer to find crayons, pencils. Everything is going to get slowed down.

Q. Okay. Now, do you deal with CP kids who have functional vision, who have a sighted life as well?

A. Yes.

Q. And do those kids, are they -- do they require attendant care and things on a level like Daniella does?

A. No.

Q. What's the difference?

A. Well, the difference is that a child who has cerebral palsy who is sighted can see what's going on in his or her environment. And most of the children I see with cerebral palsy have -- are either in a wheelchair, or they can ambulate with a lot of assistance. And so they can get around without having to have someone with them, helping direct them to where they are going.

As they get older, they can do activities of daily living on their own in many cases without assistance, again depending upon what limbs are affected by the cerebral palsy.

But they can -- they can see what time it is. They can straighten out -- straighten up a house, do all kinds of things that just go into your daily

life that you don't think about, but that are major obstacles to children who are significantly visually impaired.

Q. What about safety issues?

A. There are safety issues for children who are profoundly visually impaired, yes.

Q. Compared to someone who is mildly sighted?

A. Yes, sure.

Q. What are some of those? What does that look like?

A. Well, very -- very much trouble ambulating or getting around.

At our institute, we are trying to make things like talking signs and things that give feedback to visually impaired people so that they know that when they are crossing the street, there might be a car coming. That would be, I guess, maybe one easy example.

They have to be very careful when they are moving around crossing streets and so on. Safety issues related to using the stove, to everything you can think of.

Q. Okay.

MR. GIRARDS: Your Honor, subject to our bill, I pass the witness.

At this time, ladies and gentlemen, you will hear the closing arguments of the attorneys. Mr. Girards will go first on behalf of the plaintiff.

MR. GIRARDS: May it please the Court, Counsel.

Ladies and gentlemen, good morning. The first thing I want to do is say thank you. You guys really paid a lot of attention, and you really wrote a lot of notes; and, you know, most of the time y'all were just -- everybody was referred to by name except for you guys, the jury, and you had the hardest part. So I wanted to thank you all, first of all, for doing such a great job.

Mrs. Vasquez, you really paid close attention.

Mr. Patel, I think you wrote down every question.

Mrs. Strickland, you did a great job.

Mrs. Elswick, I saw you leaning forward from the very first witness.

Mrs. Macedon, thank you for paying close attention.

Mrs. Glenn, you wrote a lot of notes.

Ms. Snipes, you really paid attention. I saw you looking around and looking at the witnesses.

And, Ms. Fryer, I think you probably wrote almost everything down.

Mrs. Hill, thank you for paying such close attention.

And Ms. Gonzalez and Mr. Kersey and Mr. Lafayette, you did a really great job during the trial.

And I know that it is hard for two weeks to write so much down and to pay such close attention. Because we've had a couple of years to digest all the information, and you all had it just firing at you as quickly as we could to try to be efficient and yet, you know, get you the information you need for the verdict. So I want to thank each and every one of you.

And Mr. Lewis and Mr. Carter, thank you so much. I feel kind of bad for you guys because I'm assuming y'all will be dismissed shortly, and y'all will have paid such close attention and not get to participate in the verdict. So thank you for paying such close attention to you two folks as well.

Well, I want to -- since this whole case really is going to come down to what happens with this charge -- what you folks do with the charge, I want to address my attention to the charge mostly; and I don't want to insult you by going over two weeks of -- two weeks of testimony and what witnesses were here and

what they told you, although I do want to reference some of the testimony that I thought was particularly important.

The first thing that you are going to do, when you go back to the jury room -- and you probably have figured out by now that the most important room in this whole courthouse is not this courtroom at all. It is that room, the jury room. That's the most important room. That's the room where y'all have complete control, and it is the most secure, private room. During this trial we are not allowed to go in there, only you folks, and we won't be in there for deliberations. Only you folks are allowed in there for deliberations, and the door is protected by a bailiff.

That's the most important room in the courthouse because that's where you folks directly decide what your government is going to do about this case--the only time where you have a direct say in government. And it is so important because this is where justice occurs, and it is the best way to do justice that has been devised in recorded history. And so it is very, very important.

So y'all will go back to the jury room, and the first thing you are going to do is, you are

going to elect a foreperson. And that is an election. That is something that you are allowed to run for, if you think about it. If you want to be the foreperson, you are allowed to say so.

And I would like -- Daniella would like somebody who, if you feel real strongly in the justice of her case, I want you to volunteer for that. I want you to volunteer for that and be the foreperson. So consider doing that during this time before y'all go back there.

And then after -- after the foreperson is elected, then you will read the whole charge. And once again, we have spent years with these kinds of documents, and y'all have had this fired at you. If you are like me, it takes a little while for it to start to sink in before you start to understand what some of the meaning -- the real meaning of some of this language is.

So I want to address with you some of these things that are going to be real important. Let me see if I can pull this up.

Okay. This is page 2 of the charge, or it's supposed to be. There it is. Okay. And if you look at the very top -- there we go.

All right. What you are going to see

here is something which we have been talking about from the very beginning, that is this burden of proof. You will decide if a fact is more likely true than not true, and so that's what we have been talking about. And that's where we had testimony, and I asked, you know, some of the witnesses, is that more likely true than not true what you are telling us, because that's the -- that's the legal standards. Once you have decided or you can agree that something is more likely true than not true, then we have met that burden of proof.

And if you go down to -- if you go down to this paragraph right here, this paragraph is one of the most important paragraphs for you. Okay. If a juror breaks any of these rules, then it is your job--every single one of you--it is your job to tell that person to stop. And if he or she doesn't stop, then it is your job to get the bailiff and have the bailiff notify the judge.

Now, what does that mean, though? Why would you want to do that? Well, for example, if you are deliberating and someone says, you know what, he probably messed up but I'm not going to find him negligent, more likely than not he probably did mess up but I'm not convinced, I think a doctor has to intend

to cause harm and there has been no evidence that he intended to cause harm, that's where this comes into play.

You say, wait a second, that's not -- That's violating the Court's instructions. This is more likely true than not. And if that person doesn't stop, then you get the bailiff and say, we need to talk to the judge. And Judge Lowy will be glad to visit with you about that.

Now, the next paragraph is a good one and an important one. It says, a fact may be established by circumstantial evidence that may be reasonably and fairly inferred from other facts in the case. What that means is, the witnesses say what they have to say. They establish facts that you have heard, and the documents in this notebook establish things that happened.

But you folks are allowed to connect the dots because, you know, this is something that's been going on for years with this child, and there are -- Imagine just how many stacks of medical records there are and things that happened. And so what you are allowed to do is to listen to the testimony, listen to the evidence, and make reasonable inferences from those -- from that testimony.

For example, just one example, you remember when Dr. Ponte was on the stand, he said in 2005 and up until 2010 he thought this baby had zone I eyes. He thought fetal fundi meant zone I eyes. And then he told you that somewhere between 2010 and today, he had changed his mind, and he now understands that's zone 2 eyes.

And we talked about that and what happened that made him change his mind and what the inferences are of that. And we will get into that maybe in a little bit more detail in a little while.

But that's one example. You are allowed to infer what's gone on. You are allowed to look behind what the witnesses have told you and, using common sense and reason, and really figure out what's going on there. So that's what this instruction is about.

Now, the next one is also one that we have talked about a lot, and that's the standard right here. The standard for negligence is what would an ophthalmologist, for Dr. Llamas--a neonatologist for Dr. Ponte--what would a doctor of ordinary prudence do in the same circumstances? What would a careful doctor do? What would a prudent doctor do? That's the question that you will be asking yourself every time we

get to a negligence question and the topic is were they negligent or not.

And so when -- if someone in the jury room wants to talk about some higher level, intent or other types of issues, then it is your job to say, wait a second. The instructions are, what would a prudent doctor do. That's the question. And if these doctors didn't do what a prudent doctor would do, then they are negligent, and you answer those questions "yes."

But I'm getting ahead of myself. But that's what this means.

And when we go on to proximate cause, proximate cause simply means that it is a cause that produces an event, and the event would not have occurred but without that cause. And this is a really important part right here. (Indicating)

Well, I don't have that on this one. Let me see here.

All right. This part right here, there may be more than one proximate cause of an event. That means that lots of different factors can come together to produce an event. But if the negligence of the doctors was one of those causes, one of those proximate causes, then proximate cause exists, and you move on to

the damages questions -- the apportionment question and then the damages questions.

So there may be more than one proximate cause. It is kind of like I envision, you know, if we were out at Lake Ray Hubbard and, you know, there is a power plant out there. If there were two or three other power plants out there and they were all dumping poisonous stuff into the lake, and at the south end of the lake somebody got sick from the poison, it would be impossible to tell which power plant the actual poison came from. But they were all producing it, and all of them were causes -- were proximate causes of the sickness. That would be just one example of how that works.

Now, when we are talking about what a prudent doctor would do, we are talking about using the level of care that is appropriate for the level of danger. And the danger here is, we've got a baby who needed to be closely monitored, her eyes, or she would -- could go blind forever. And that's a big danger. And so we look at the danger and compare the level of care that was exercised. And then -- we will get into some more details about that in a minute.

Once you are satisfied that they violated -- they didn't use the level of care that a prudent

doctor would use, then the focus will be on what are the harms and losses to Daniella that resulted from their not using the appropriate level of care.

Now, that's important because when we get to the damages questions over here -- let me flip over to those. When we get to these questions here, these are the harms and losses questions. And in answering the harms and losses questions, the only thing -- the only thing you are allowed to consider is, what are the harms and losses.

Now, we go back to the part that we talked about earlier where you have to follow the Court's instructions, and each of you have an obligation to alert the Court--Judge Lowy--if somebody doesn't. This is one of those areas where it is really important that you focus on those two different instructions, because the harms and losses are the only things that you are allowed to consider for these questions.

And if someone says, well, we need to change the damages number because of X, Y, Z, because of something that's not in evidence, because of concerns about, you know, the effects of your verdict or anything other than just the harms or losses, that's where each of you have an obligation to say, Oh, hold

on a second. We are just supposed to focus on harms and losses. That's our instructions from the Court, and we need to not talk about these other things. And if you don't stop, we are going to have to talk to the bailiff and get the judge to visit with us. And I know Judge Lowy will be pleased to visit with you and explain that. Harms and losses only for these questions.

Well, all right. So we started at the beginning of this process talking about the safety rules that apply to this case. A doctor is never allowed to expose his patient to needless risk of harm. Never allowed to expose his patient to a needless risk of blindness. ROP must be diagnosed as soon as it is diagnosable and treated as soon as it is treatable. Those are the safety rules that everybody agreed to. Even their witnesses agreed to it. There is no question that those are the safety rules.

And the safety rules were violated in this case, and we will talk about some of the reasons why in just a minute. But let's talk about why the safety rules are important.

How important are they? What does it mean for us to have these safety rules in place? So imagine what would happen if all doctors just abandoned

the safety rules. Didn't stop diagnosing disease as soon as it was diagnosable or treating it as soon as it was treatable.

Most diseases are progressive diseases. Most diseases require timely follow-up. And so what if doctors just stopped doing that and just followed up whenever they felt like it? Diagnosed disease as soon as they felt like it, not as soon as it was diagnosable? What would that mean for our brothers and sisters, our grandchildren?

Would anybody be safe if doctors just violated the safety rules like that? If it just became too inconvenient for them because maybe they are too busy, there are too many people in the waiting room or whatever, and they just stopped following those safety rules, stopped doing what was safest for the patient, stopped making decisions based upon what was the safest thing for the patient.

All right. So we began with -- if you will remember when I first visited with you, I said, they are going to spend all of their time focusing on a general guideline, and they are going to ignore the specific rule that applied to Daniella. And so I don't think we were disappointed. They spent all their time talking about the 2001 guidelines--which are here.

Now, due to a -- I don't know how you might characterize it, but a funny thing, I will say. A funny thing is, you are not going to be able to have this in the jury room to deliberate with. So if there is something off of this thing that you wanted to have to help Daniella, you need to write it down so you can have it back there with you.

So I want to spend a few minutes visiting with you about the specific information and write it down -- all right. Here we are. Well, we are supposed to be here, but where are we? All right. There we go.

The 2001 guidelines. Now, if you will look, one thing that we didn't really hear much about, but if you look in the very lower corner here, it says -- I don't know if you can see this very well. It says, "This is not to be used as a standard of care."

Let me see if I can make that a little bit bigger. No, I can't do that, but we can look at it down here if that's too blurry for you.

You see it says, all right, "The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care."

Now, why is that important? Right down

here, see? Why is that important? Because the defense has been saying, hey, look, this is the standard of care and, by god, we met the standard of care; because we have the 2001 guideline, and it is in writing, and we can show the jury; they will believe it, and we will be okay.

But what guidelines are is a starting place. That's common sense. You take the guidelines where you start, and then you take the additional information that comes out between 2001 and 2005, and you apply that. And then you look at your patient, and then you decide what the appropriate, safest course of action is.

And, in fact, they violated the 2001 guidelines, and they didn't tailor it to the specific patient. And, see, you see all of this highlighting here, but what the defense hasn't highlighted is here. The timing of the initial screening examination may be adjusted appropriately on the basis of other reliable data, such as local incidence--how many babies in your community get ROP--and risk factors. Risk factors like how sick is the baby. The sicker the baby, the more likely the baby gets ROP.

So every time you hear the defense stand up in front of you and say, oh, my goodness, that baby

was sick, sick, sick; you say, yeah, the baby was going to get ROP. Oh, that baby was early, small. Absolutely, that baby was going to get ROP, wasn't it? That's what this means. So you tailor the examination, the initial examination to the risk profile of that particular baby.

All right. And then the initial examination -- or the follow-up examinations are also set out here; and they violated that, too, because it tells you what we are supposed to do with follow-up. For example, if the retinal vasculature is immature and it extends into zone 2 with no ROP, the follow-up examination should be planned at approximately two- to three-week intervals.

Follow-up exam in two to three weeks for zone 2. And Dr. Llamas and Dr. Ponte said that this was a zone 2 baby after the first examination. And if that's true, the follow-up would be two to three weeks. Okay. And so in a minute, I want to visit with you about whether they followed up in two to three weeks.

But we want to talk about zone I eyes because Dr. Ponte thought, in 2005, that fetal fundi meant zone I eyes, and because of the photographs which I will visit with you about in a minute.

So down here we've got another repeat of

zone 2, no ROP, follow-up visit in two to three weeks. And then over here it says, "Those without ROP" -- right here -- "Those without ROP but with incomplete vascularization in zone I should be seen at one- to two-week intervals."

So we have a one- to two-week follow-up or a two- to three-week follow-up. So we are going to ask ourselves in a few minutes, was there a repeat examination in one to two weeks or in two to three weeks. And, if not, what was the result.

Now, before I put the guideline down, there are two other things I wanted to visit with you about. I'm sort of getting ahead of myself, but it looks like somebody underlined this, and they want to talk to you about the treatment -- the laser treatment within 72 hours. But, remember, common sense tells us when the baby's eye is dying, you want to get the laser done as soon as you can. And that's what Dr. Good told you, and that's what Dr. Phelps told you.

And then you remember the video guy from Thursday. You remember, Mrs. Vasquez, he said -- and I saw a change in a lot of you. He said, yeah, I wrote that you have to do the laser within a day or two, because you don't want to sit on your hands for 72 hours. Anyway, we will revisit that in just a minute.

Now, over here, "The responsibility for the examination and follow-up of infants at risk for ROP must be carefully defined -- carefully defined by each NIC-U." And it says, "Unit specific criteria for examination of ROP should be established for each NIC-U by consultation," communication between neonatology--Dr. Ponte, and ophthalmology--Dr. Llamas--and others in the department.

The criteria should be recorded. You remember the written criteria we talked about, written protocol, and it says, "should trigger" -- here we go. "Should automatically trigger scheduled ophthalmology examinations." Automatically trigger.

It is not supposed to have to be anybody sitting around going, gee, I wonder what you do about fetal fundi. It is supposed to be a protocol that is written that triggers automatic follow-up examinations. And we will visit with you some more about that in just a few minutes.

So here we go. In order to figure out if they did the screening examinations, I have prepared a chart. And the defense didn't like the chart, but it is a chart of 40 weeks of pregnancy. This is not the baby's age over here. This is just the week of the pregnancy.

So, for example, a baby born in week -- in the 23rd week is not 23 weeks old until day seven of week 23. This was just to refer to what week we are talking about in the pregnancy. So when a baby is 23 weeks and one day, the baby is in the first day of the 24th week.

Now, Dr. Ponte actually agrees with that. I mean, it is just common sense. Simple math. But if you look at Dr. Ponte's calendar here, I was originally going to do it this way, but I thought this was easier to follow. But if you look here, date of birth was May 19th, 29 weeks and one day.

So when we look at the guideline -- of course, the one thing I didn't talk to you about is right here. Now, if you want to help Daniella, you can write this down in quotation marks. The first examination should be within the 31st to 33rd week. Within 31 to 33.

So if we look at the weeks of the pregnancy, the green zone is week 31 and 32 and 33. Now, were there any examinations at all within week 31, 32, or 33?

Exam one was here, 30 days -- I mean, 29 weeks and five days. Exam 2 was 33 weeks plus five days. So was there any examination in the green zone?

If there was not an examination in the green zone, then they violated the rule.

Now, did they modify the rule -- okay. You will probably remember, we didn't really quibble too much about this first examination, the one during the 29th week plus five days. I'm sorry, in the 30th week, week 29 plus five days. The reason why is because that was a good exam. When you have a 23-weeker that's got 100 percent chance of getting ROP, you want to evaluate that kid early and often.

And if you look at the red book, which is Dr. Quinn's chapter--the defense expert--he says you evaluate the kid by week seven, and then every other week thereafter until the risk of ROP is gone.

And this first examination was during week seven. See how that works? One, two, three, four, five, six, seven. During the seventh week there was an exam. So the question is, was there an exam every week or every other week afterwards? Well, no. Dr. Llamas didn't come back for four weeks.

Now, Dr. Ponte told Dr. Llamas, I want you to screen the kid on July 11th. You remember, originally, it was come and see the kiddo on July 11. Well, July 11th is this square right here. That would be five days into this 31st week. That would have been

right in the green zone. But Dr. Llamas didn't do that; he came in early. But we are not going to really quibble about that, because what was supposed to save Daniella were the follow-up examinations.

And if they did -- if she had a zone I eye, then she would have been seen within two to three weeks right here. And we will talk about what they would have seen more likely than not in just a minute. And if it was a zone I eye, then there would an exam every single week to diagnose as soon as diagnosable and to treat as soon as treatable.

So rather than take our word for whether she really did have a zone I eye or not, you remember Dr. Moshfeghi, the first witness. He had his laptop, and he taught you how to figure out if the baby had a zone I eye. And he took the images, and he put them together.

You remember, he said there is 120 degrees across from edge to edge. Half of that is going to be 60 degrees. And so if you put that over the optic nerve, you have 30 degrees all the way around. And you can see the vasculature stops before that 30-degree border. That is the definition of a zone I eye.

So a zone I eye needed to have an exam,

a follow-up exam every single week. And so remember I had Dr. Good and Dr. Phelps tell me where to put these yellow squares because these are the examinations that should, at a minimum, have occurred.

Now, once ROP is diagnosed, depending upon how bad it is, you are going to reexamine the kid. If it is not treatable, you reexamine the kid every two to four days or up to a week, just depending upon how bad it is.

And Dr. Good said there would be in reasonable medical probability a diagnosis and laser treatment by the middle of week 33, which it would have been right in the middle of the green zone, right in the middle of when you expect to see ROP in most babies.

And remember this square right here represents a notation that was in the record, every single day starting on June the 3rd, I believe. Somebody decided that this kiddo needed an ROP eye exam on July 26th, which is that square right there, which would have been right toward the tail end of week 33.

And even if -- even if the eye exam had occurred then, there would have been a diagnosis and there would have been treatment back here, and we wouldn't have had to worry about whether her -- whether

she needed that shunt. We wouldn't have to worry about where was the laser, because we would have got a little bit more of a head start.

But the laser would have been ready if Dr. Ponte had done his job. And I want to talk about that for a few minutes, because we never really did talk about what the Xes are. The Xes are the days that nobody called for the laser but they knew they might need it. When she was born this week, they had a handful. They had a handful getting the baby stabilized.

But by the end of that week and the start of the second week, Dr. Ponte should have been thinking, I know this child is going to get ROP, a hundred percent certainty she is going to get ROP. Babies who have ROP have a one-in-five chance of requiring laser to save their vision. So let's make sure that down here, when it is most likely she is going to need treatment, we have a laser available.

You remember Dr. Quinn said his department has got two lasers. They have a backup. The options are, let's be prepared.

So if somebody in your deliberations -- If somebody says, hey, you know, they didn't have the laser, they got the laser as soon as they could, they

did it within 72 hours, three days later; you say, wait a second. Dr. Ponte was the attending physician, the director of the service. He is supposed to plan ahead.

Henry Ford said, The key to success is always being ready ahead of time. JFK said, You put the roof on the house -- you repair the roof on the house while the sunshine is out.

You get ready because you know that you might need something really important, or this baby is going to be blind forever. So you plan ahead. It would have just taken a phone call, and the backup plan would have been to go to Providence, like they had sent the other kids over to Providence. And the worst case scenario would be, they call Dr. Radenovich and say, "Can we borrow your laser." But nobody made a call on the days with the X, so nobody was prepared.

How would you feel, for example, if you got on a plane to fly to--I don't know--New York or Miami or Chicago or somewhere, and you got halfway there and the pilot said, Boy, you know what, it is really storming in Chicago today and, well, we knew there was a 20 percent chance of rain, but we didn't bring the chart. So we are going to have to turn around and go back or take a poll and see where you guys want to go today.

You wouldn't think much of that, would you, because the pilot is supposed to check to make sure he has the charts before he leaves the ground. And if you don't need them, you haven't lost anything.

And what about this 20 percent chance of requiring a laser? How would you feel about somebody who runs a red light but only hits a kid one time out of every five? You wouldn't think much of that.

So this child was -- had a large chance of needing the laser, and nobody made any preparation to take care of that. Now --

THE COURT: Mr. Girards --

MR. GIRARDS: Yes, sir.

THE COURT: -- you are coming up on 35 minutes.

MR. GIRARDS: Thank you, sir. I am going to speed up. All right.

So -- all right. So Dr. Llamas comes in here and writes "Fetal fundi, follow up in four weeks."

Now, Dr. Ponte knows that Dr. Llamas is 20 years behind on describing the baby's eyes in an ROP examination. You remember the international classification which came out in 1985. We are 20 years down the road, and Dr. Llamas is still not using the international classification.

So why is that important? The international classification is what gives you an additional safety net. Dr. Ponte, the attending physician, responsible for all of the medical care of the baby, responsible for coordinating the care, responsible for getting the eye specialist to come in, the heart specialist to come in, he is the safety net number one.

Dr. Llamas is safety net number two because he is going to focus specifically and only on the eyes. But because Dr. Llamas didn't use the international classification and Dr. Ponte didn't say, Hey, wait a second. Hey, Llamas, what are you doing here? We need to know what zone. We need to know the international classification, and we need you to write it down in the record. Because Dr. Ponte didn't do that, this safety net was absent.

This is Dr. Ponte as medical director of their service, but it is also the scheduling nurse, the unit clerk who looks at the record and says, aha, zone I eye, follow up in one week, let's check the calendar. And because they did that, there were only two levels of safety net. That's why it is important that they use the correct terminology.

And when you have a high-risk baby, a

23-weeker less than 750 grams that's going to get ROP, you can't take a look in week seven and not come back for four weeks. Because, you remember, the disease process takes two- to four-ish weeks to start into the mild and the moderate and then the severe and then plus disease and bleeding and vitreous hemorrhaging and all the bad things that happen. It takes two to four weeks for that child for the process to go through.

Well, if you go in and take a look at that baby in week seven and then you don't go back for four weeks, it is not a question of if the baby is going to go blind. The only question is whose baby is going to go blind.

When Dr. Llamas writes, "I take a look at the baby, fetal fundi, follow up in four weeks," somebody is going to go blind. We just don't know whose baby it is until you have situation that becomes a disaster like Daniella.

Now, if somebody in the deliberations says, listen, Dr. Ponte only said he was responsible for the first scheduling of the first exam, and then after that it is all Dr. Llamas, I want you to remind them of what the defendants' own expert wrote. And the book that got -- you remember the book that got mailed for Christmas presents to all the Pediatrix

neonatologists, it says that the neonatologist and the ophthalmologist have to work together as a team to take an active role to prevent -- to stop this disease as soon as possible.

And we see that that's also true because the guidelines require the cooperation of neonatology and ophthalmology just to get the guidelines into place. It is a job for both of them.

All right. Now, if someone in deliberations says, you know, you remember the early treatment of ROP study that we talked about, ETROP, if somebody says, look, early treatment doesn't really matter, then remind them. Early treatment of ROP was shown to stop the progression of ROP in most babies.

And Dr. Quinn, their own expert, agreed that if you treated timely with eyes -- type 1 eyes just like Daniella had, you get a 91 percent success rate. And then there were a couple of other studies we talked about--85.4 percent success rate, 83.3 percent success rate. Either way, if there is early treatment, the diagnosis is timely, and the laser treatment is instituted correctly.

All right. So what about the laser? It is the hospital's fault. If somebody back in deliberations says, yeah, you know, it is the

hospital's fault, the laser wasn't there, it should have been there and wasn't, just remind them about the Xes. Nobody made a plan. The person whose job it was to make the plan, Dr. Ponte, didn't do it. He didn't plan in advance, and of course they were caught flat-footed.

All right. One other thing that I wanted to talk about is -- let me talk about the harms and losses. I need to jump ahead to that. The harms and losses questions are on the charge, and let's get to them because I want to talk with you about them. There are a number of different harms and losses questions.

You know, before I do that, let me show you this. This is the apportionment question. We are asking you to put a finding of negligence against Dr. Llamas and Dr. Ponte, and you can think the hospital was negligent because they were flat-footed and put a "yes" on their blame as well.

But on this apportionment question right here, you have to decide who is responsible on what level. And I'm going to suggest to you that if you find the hospital negligent, it is not really worth fighting about. Maybe they were. Maybe they are responsible for 1, 2 percent, maybe 5 percent. It is not really worth arguing about, so put something

like that in there if you are convinced of that.

But on Dr. Ponte and Dr. Llamas, Dr. Llamas was one safety net layer. Dr. Ponte was the attending physician. He had that hat on. He was supposed to coordinate the care. He was supposed to -- He had the authority to get rid of Llamas and say, you are not doing it right, let me get somebody else. But he didn't do that either. He was another safety net.

Ponte was also a third safety net. He was the director of services at Del Sol Hospital for Pediatrix Medical Services. He was the third safety net. Because he had much more responsibility to Daniella, then I'm going to suggest to you that you put something in the neighborhood of 55 percent for Dr. Ponte and something in the neighborhood of 45 percent to Dr. Llamas; because Ponte was two layers of safety net, two to Llamas's one.

Now, I don't want you to think that I'm letting Llamas off the hook because he is responsible for what he did and what he failed to do.

And when we get to the damages questions, the harms and losses questions, there are a number of these that --

THE COURT: That's 42 minutes, Mr.

Girards.

MR. GIRARDS: All right. Thank you, sir.

There are a number of these that I'm not going to spend much time with you because I think it is something that y'all will use your common sense and decide what the appropriate damages figures are: physical pain and mental anguish, disfigurement, physical impairment, on those.

I want to spend a couple of minutes talking with you, though, about the most important ones in my view and I think based upon the evidence, and that is the medical care expenses and the attendant care expenses.

I saw a lot of you writing down what Helen Woodard said. You remember on the first day, she is the rehabilitation specialist. Now, we didn't total up her numbers. I don't suppose any of y'all did that based upon her testimony.

But I totaled up these numbers, and what these -- what I did here was on the low end. I took the minimum amounts that she had testified about, and I used an 80.1 life year -- 80.1 years of life expectancy for a female. You remember, Dr. Tomasovic admitted she had a normal life expectancy. And I subtracted 18 years because we are talking about age 18 and beyond.

And then on the high end, I took the larger numbers that Helen Woodard talked about, and I extended Daniella's life span to 90 years of age because -- and I hope I'm not blocking anybody -- because when you have an 80.1-year life expectancy statistically as a female, that means that at 80.1 years from 2005, half of those females are dead, and the other half are still alive. So I just picked 90 years life expectancy on the high end just because that made some sense to me.

And y'all are free to use your own judgment about how that works. So I took the numbers, and I put this chart together. And what you will see here is, assistance care right there, we are going to talk about that separately.

On the low end, that leaves about $50,000 of medical expenses on the low end -- here -- and about $150,000 in medical expenses on the high end over here. And we will separate out $2.6 million for assistance care on the low end and $3.8 million for assistance care on the high end.

Now, this is up to y'all to figure out what you want to do to satisfy yourself that Daniella has all the medical care that she might need and the assistant care that she might need because of the

blindness. But these are the numbers that I'm asking you to consider.

And then the last thing is, what I think is really, really important for you to consider are the future medical expenses. Because with about 80 years to go, we heard testimony about her medical expenses in the future. We heard testimony about the technology that is being worked on now, being tested on animals. It is going to be used on human beings as soon as it is ready, and it will be available for human beings within Daniella's lifetime.

THE COURT: You have used 45 minutes, Mr. Girards.

MR. GIRARDS: Thank you, sir.

Artificial retinas, artificial eyes, they are all in existence now, and they are being tested. They will be perfected sometime in the next 20, 30, 40, 80 years.

And Daniella ought to be able to take advantage of those things. Those things are going to be expensive. They are going to require surgery. They are going to be painful. But if she chooses to take advantage of those things, I want her to be able to do that because she won't be able to come back and say, hey, wow, look what we've got now that's available, and

I can't pay for it because nothing was put in there for me to pay for it.

So I'm asking you to do that. And I am going to suggest to you that a figure somewhere in the neighborhood of $1,000,000 will be enough to pay for all of her medical needs for the next 90 years.

And so I want you to think about that because we are not talking about a blind little girl who is six years old now. We are talking about a blind young lady who is in her 20s, and a blind woman who is in her 30s, in her 40s, in her 50s, and in her 60s. She will be someone who you will choose whether she is isolated and immobile and trapped in a living situation, either her own apartment or group living where she doesn't have what she needs to go outside and be safe from strangers, be safe from stepping in traps, to be able to do the things that she ought to be able to do but for her vision.

Or you will set her on a path and make sure she has an assistant to be with her that she can be mobile, she can get out and she can go to all of the events that she is capable of doing but for her blindness. So that is the -- those are the decisions that you have to make, what her life is going to be about, and so those are -- that's why I suggested those

numbers for you.

Now I'm out of time, and I have used up some of my additional time. But when I visit with you in just a couple of minutes, I will address what the other lawyers have said and give you a final word.

Okay. Thank you.

Thank you, Your Honor.

MS. FRALEY: Your Honor --

THE COURT: All right.

MS. FRALEY: -- I don't believe he fully opened on the issue of gross negligence.

MR. GIRARDS: Oh, I can do that, if you will give me two minutes, Your Honor.

THE COURT: You can have two minutes.

MR. GIRARDS: Okay. Gross negligence. I got a little flustered running out of time. Let me address this because this is going to be important.

Why were they grossly negligent? They were grossly negligent because of what they actually knew.

I think we are all satisfied that what they should have known was that you have to carefully monitor this baby or she might go blind forever. There is a diagnosis; there is available treatment. And if she doesn't get it timely, she will go blind forever.

But the testimony shows they actually knew that. They actually knew for a fact that she was going to get ROP, that she had a one-in-five chance of needing the laser; that if she didn't get it, she would go blind. That if you don't -- if you don't screen the babies with follow-up timely, then babies will go blind.

They also knew, right here in the red book -- we talked about this, and I will show it to you. Starting with the cryo-ROP study, right there. The cryo-ROP study showed that if they screen the babies properly, they could save 300 babies from a lifetime of blindness every single year. And they could save up to $64 million in needless health care expenses if they did it correctly.

They actually knew it. They actually knew that if they didn't do it right, they could cause this kind of tragedy in these lives. That's why they were grossly negligent, and that's why I'm asking you to write "Yes" in each of the blanks on that page.

Thank you, Your Honor.

THE COURT: All right. Ms. Fraley, are you ready to proceed?

MS. FRALEY: I am, Your Honor.

Good morning. There is a phrase Mr.

Girards has used over and over again in this trial. Needlessly blinding babies. Needlessly blinding babies. You have heard it again and again. The safety nets so we don't needlessly blind babies.

What has happened, though, is that he has, by refusing to meet his burden of proof, tried to needlessly blind you to the truth. Because his experts agree that what these doctors did met what the published guidelines were at the time, met what the collective wisdom of the Academy of Ophthalmology, the American Academy of Pediatrics, the American Academy of Pediatrics and Strabismus. They did what should have happened.

The safety net that he drew actually worked, because this is not some sort of, let's have a checklist and check off when we should screen or what we should do. There is a bigger issue here. And the issue is, can we identify children, that small number who might need treatment, and can we get to them before their retinas detach.

Dr. Phelps told you that. She told you, look, the bigger picture here is that up to the time the retinas detach, treatment provides the benefit we can give. It's all over the published guidelines. The guidelines don't say, this is a meaningless checklist.

The guidelines specifically say that the point of this is to treat before retinal detachment. That is the why.

This is not a cookbook. And while it makes for a nice sound bite to say that these are safety rules, the truth is, we are not treating a cookbook. We are not mixing eggs and flour and hoping to get cake. We are treating people. We are treating babies.

Look to your left. Look to your right. Do you truly think that the care that would be perfect for you would be the same care for you, for you, or for you? Or do you look at people and treat the people, the babies who are in the NIC-U?

That's why the guidelines give us an end point. That's why they give us vision and insight into the truth. Because what we know is that if you can treat before there is retinal detachment, that's where the benefit can be had. If the retinas detach before you treat, that's when you have lost your window of opportunity.

And so for all of this statement about treat as soon as it is treatable, diagnose as soon as it is diagnosable, that's not in any of the medical literature. That's not in anything that's published.

The only end point that is published is, the timeliness is before the retinas detach. And to say anything else is to be needlessly blinded to the truth and to the science.

And so when we look at the plaintiffs' burden of proof, have they convinced you that the things they are complaining about actually made a difference? That they fell below the standard of care? And that they could have changed Daniella's outcome?

You heard testimony from a number of different experts about this window of screening. And it is clear that one of the things that comes out is, we know there is a time period when it is too early. We know there is a time period where the view to the back of the eye is going to be so hazy that we can't see where the vessels are. It is like looking through a haze. You get back to the back of the eye, and you simply can't see the vessels. They are so immature, you can't see them.

And while Mr. Girards tells you that Dr. Llamas was 20 years behind and didn't know the ICROP designation, the gentleman who created ICROP--or ICROP, that's probably the right way to say it--Dr. Quinn said, no, that's exactly the terminology we use.

We call it fetal fundi. We call it incomplete vascularization.

And to say, well, you should have said zone I or zone II, it's a trick question. The point is, they are immature. They are incomplete, and you can't see zone I or zone II.

The author of ICROP said, that's the right designation.

He also told you something else that's important about that. He said, we really try to discourage the neonatologists from looking that early because we know there is not going to be anything to see. But if they want us to come, we will. And then what do we do? We try to get the baby back on the right schedule, which is 31 to 33 weeks.

Now, how do you know that Dr. Quinn was telling you the right thing about this getting them back on the right screening schedule? Well, you know that from the plaintiffs' expert, Dr. Phelps. Do you remember what she said? We had the calendar up. You remember the calendar we were using to talk to Dr. Phelps? And she said, the first exam was a little early. This is before the 31 to 33 weeks.

And then she said something very telling. If Dr. Llamas had simply come in on August 1st, that

would have met the standard of care. If he had done the minimum, if he had only come in, this was in the 31st to 33rd week, and this would have been acceptable.

So then what is the standard that you hear from that message? Don't do anymore than the bare minimum, Doctor, because it is a trap. If you had just come in here according to Dr. Phelps, she would have no complaint whatsoever. That would have been fine.

He came in, he screened, he did the appropriate thing. And Dr. Phelps said, that is perfectly appropriate. It is only if you do more than the minimum that she says he is negligent. When he came in here, it became a trap to the unwary.

But what Dr. Quinn told you is, sure, we will come in early if a neonatologist asks us to, because we are working together. If a colleague says, Will you come look, the answer is, Sure, I would be happy to. Then we try to get them back on schedule.

Because what are we trying to figure out? Have we identified a type 1 eye, an eye that is going to need treatment, and have we treated before retinal detachment?

Dr. Phelps and Dr. Good, both the plaintiffs' experts agreed, had he come back two weeks later and screened again, there was going to be nothing

to see and nothing to treat.

And so then you have the question of, had he just come in on the 1st, would that have been sufficient? And their experts say it would have been.

Then we go to the "what if." What if he had come in one more time? Because it feels very good to think, well, what if? Could we have done a little bit more? Could we have looked a little bit earlier? Would there have been something to find?

Dr. Good is the only expert who said he believes there might have been treatable disease here on the 25th. But he never told you why. He never told you how is it, what's the science, what's the factual basis that leads him to believe that there was something there to treat.

Well, the answer is because he knew there wasn't.

Do you remember Dr. Quinn testified -- Dr. Quinn and Dr. Good wrote an article together. It was called "Progression of Type 2 ROP to Type 1," and it followed out of the ETROP data that Dr. Good is so proud of. And what it said is, we have found that when you have a baby who shows up with type 1, it means a week earlier they were type 2. They wrote that paper together. They published that paper together. And

Dr. Good could hardly go back on what he had published. Because everyone knows the rule of ETROP is: you observe type 2, and you treat type 1.

Dr. Good cannot pick and choose from his own literature. He has to be consistent. And as the only doctor who told you that one week before would have made a difference, he owes you facts and he owes you evidence. And the reason he never told you why is because his own writings prove it not to be true. Type 2 goes to type 1 in about one week. Not in a day, not in an hour, in a week.

Why is this important? Because there are a lot of different parts to Question Number 1. It says, first of all, did the negligence, if any, of Dr. Llamas proximately cause the injury? And so first you have to decide, what was the standard that was applicable to Dr. Llamas at the time, and did the plaintiff prove to you that there was one single standard?

I got a little confused hearing him talk about the guidelines. Is it a rule? Is it a guideline? Is it not a standard of care? Which is it? We have heard all three. It is a constantly moving target of whether it is a guideline or a rule. With the burden of proof, which one is it?

Is it reasonable if the three main national organizations, dedicated to preserving the sight of children, agree on it? Is it one reasonable approach to follow it?

The second part of Question Number 1 on your charge is, did the negligence, if you think it occurred, proximately cause an injury?

Well, on the screening issue, the only way for negligence to have caused an injury is if there was treatable disease a week earlier. And no one explained to you the science of how there was treatable disease earlier. The only expert who gave you a basis for his opinion was Dr. Quinn, and he said, Dr. Good and I wrote the article together. There would not have been anything there.

Did you notice that you didn't hear anything about whether Dr. Llamas had adequately performed laser? Do you remember what a big part of the case that was initially? Dr. Llamas is no good with the laser; he didn't do laser adequately. It is because he didn't do enough laser or the right laser that Daniella doesn't have vision.

Through 48 minutes of Mr. Girards' closing argument, did you hear that get mentioned even once? Not even once. And do you know why? First of

all, because they didn't have the facts.

Dr. Moshfeghi did a photoshopping of some images. He couldn't tell you what he did. He couldn't tell you what he put in, what he left out. But one thing everybody told you is, he only used the images from August 4th, which is too early to see the treatment. Even Dr. Good told you, yeah, we really don't expect to see the full effect of the treatment. That takes days or even weeks before you see that.

So what we showed you were the images from the 26th, when you could actually see the treatment. And you can see. You don't have to be an eye doctor. You can see the difference and the tiny white spots to the big areas.

But more important is what you don't see. You don't see a ridge anymore. You don't see those thick, dilated, tortious blood vessels. And you don't see ROP. Because that's the goal of treatment, is to eradicate enough of the retina that the ROP is gone.

That might have been a montage worth seeing had Dr. Moshfeghi decided to put it together, but he didn't.

That makes an even more interesting question. Why then did the left eye do well and the right eye do badly? We know it's not an adequacy of

lasering issue. I think they have even dropped that. And part of that is that Dr. Radenovich's records show that. Do you remember her note where she looked at Daniella's eyes under anesthesia? She said there is a significant amount of laser, and then she actually draws 360 degrees around all of the laser that's there.

So why did it work in the left eye and not in the right eye? Well, I think there are a couple of reasons for that. We know it's not inadequate laser. The right eye actually got 350 more spots of laser than did the left. Can you imagine in that little 12-millimeter eyeball the patience and the painstaking technique to put 2000 laser spots in one eye? The time and the effort to painstakingly treat.

The best answer we have for why the right eye did badly came from Dr. Good. Somehow this didn't survive our flipping the flip chart -- pardon me -- so I put it up here.

What we know is that some eyes, despite the best treatment, don't do well. We know that babies who have zone I disease -- which is what they say Daniella had -- never do as well. We know that babies who bleed, whether it is in their brains where it causes brain damage or in their eyes where it causes retinal damage, don't do well.

We know babies who have bled into their brains do poorly with their eyes. And while the connection is not clear, bleed in the brain, brain damage. Bleed in the eye, eye damage, is one of the working theories.

We know that plus disease gives you a worse outcome. Now, this was really interesting. You remember Mr. Girards got up here and crossed this out and said, well, they shouldn't have let it get to the point where she has plus disease.

Folks, if you don't have plus disease, you don't get treatment. Remember, that's the driver of treatment. You have to have plus disease. That's part of what makes it a type 1 eye. You can't take this out of the mix. There is no science to let you take this out of the mix.

Small babies who rapidly progress and have low gestational age are all at risk, and these are variables that no one can control. How do we know that? Because in the ETROP study, despite the best, most advanced rigorous of a clinical trial, out of 401 babies, 89 are retinas detached. That's not a 91 percent success rate. 89 retinas detached.

Now, understand, we are not even including in that unfavorable structural outcomes,

unfavorable visual outcomes, babies who were still legally blind. We are simply talking about in Dr. Good's ETROP study, the number of babies where they could not keep the retinas on, was nearly a quarter.

They didn't talk quite so much about the other bad outcomes. But to say that laser treatment is some kind of guarantee ignores the science and ignores the truth. It is hands down the best that we have, and it is absolutely something that Daniella needed and got. But it is not a guarantee. It just isn't, because there are factors that are out of everybody's control.

The other issue we have then is this idea of the 72 hours. Now, Dr. Good is the only doctor you heard from who thinks that 72 hours is somehow a standard of care. Dr. Phelps said that was never a standard. That was never supposed to be applied to clinical practice. It was just part of the trial. It was a study design.

How do we know that 72 hours was never shortened? Because in 2006 the AAO, the AAP, the American Academy of Pediatric Ophthalmology and Strabismus had had three years to consider ETROP; and it said, no, it's still 72 hours.

And Dr. Quinn told you why. Again, why

is there science? He said, yeah, we studied this. We actually looked at 24 hours versus 48 hours versus 72 hours, and we found out it didn't make any difference. Well, okay. Then there is the science.

Did Dr. Llamas say, I would like to treat her as soon as possible? You bet, and he did. But to somehow say that it was negligent when the hospital didn't have the laser, when the neurosurgeon had to come in and look, when all the things that took place, that's why there is 72 hours. Because you don't want to needlessly expose a baby to danger like doing eye surgery when maybe you needed brain surgery instead, when there is not a reason.

You know, it sounds really good, oh, we wanted to treat as soon as treatable. But you know that's not true. We have talked about cancer here. I think Mr. Girards even talked about it. You find a mass, you maybe even get your mammogram results saying, oh, this is very worrisome for cancer. You are not rushed into surgery that day.

There are diseases that, while treatment is important, it's not an emergency. It's not a next five minutes got to get you in there.

There are times when the prudent thing to do is to stop, look at the whole situation, and then

move forward with treatment. That's how treatment of ROP is designed. It's how all the science supports it. And it's what happened here.

And so the three criticisms that they have made--did he screen on time, 72 hours, did he adequately treat with laser--the answer is he did do the right things. And how do we know that? Because Daniella's retinas had not detached. Did not detach. She made it through the surgery, and she lived.

Not only does she live, but she lives a sighted life. Did anyone keep track of how many times you have heard Daniella called blind? And yet her parents say she runs and plays hide and seek with her cousins. Her parents say she matches her own clothes.

You saw her on the video running on her driveway and going down steps.

Dr. Good told you the definition of functional vision, and that is a child who leads a sighted life, one who gets around without a cane or some other ambulatory assistance, and one who can see symbols.

What did Daniella's school records show you? She can see symbols that are a half an inch. She does better when they are bigger, but she can see them.

If you look at her day-in-the-life video,

the books are down here. (Holding hands down) They are not here. (Holding hands in front of her face) They are here. (Holding hands down) She colors here. She performed the Peabody picture vocabulary test, eight-and-a-half-by-eleven sheet of paper with four images on it.

Her parents tell you, her school records tell you that she lives a sighted life. And that is very clear from the pictures as well.

This is in evidence. And here is Daniella walking along: no parent, no assistance, nothing.

And, more importantly, look at her face. Where are her glasses? You remember, she has glasses to correct her vision. The testing at school says she wears them for that.

These are wonderful parents. And if she needed to correct her vision to be safe outside like this, she would have her glasses on.

Look at all the pictures that are in the notebook. Out of the five or six, she is wearing them in one. And that, ladies and gentlemen, is excellent evidence of a sighted life. She sees the Christmas trees. She sees her baby brother. She sees the words in books. She sees the family that loves her. She

sees.

What then is the issue with Daniella? It's wiring. It's comprehension. It is the ability for her brain to take the image that her eye clearly sees and process it.

If you have a chances, look at the day-in-the-life video, that little few-minute clip. Daniella is singing the ABCs, and she is tapping her crayons and letters. But she doesn't match the letters of the song to the corresponding letter.

When my three kids were little, we would read books over and over again. I don't know if y'all have had that experience. But we had favorites, and you would read them 10 or 20 or 50 times. And when they were two or three, they would get to the point that they had them memorized, we had read them so much. And they would say, Mommy, let me read this book to you.

And they could open a page, and they could say the words, and sometimes they could even turn the pages with the right corresponding pictures, and they would say they were reading.

They weren't reading yet. They had memorized, but that is not the same brain processing as reading.

Daniella does very well. She can memorize. She can keep a lot of things straight. And she has been given tremendous, tremendous parents. But at the end of the day, the damages that the plaintiffs are asking you to compensate for are not related to her vision. The attendant care, if we want to talk about a safety rule, this is not a child where it would be safe for her to be alone, and that is independent of her vision.

You know, with the plaintiff having the burden of proof, you would have thought that if Dr. Tomasovic or the school records or the testing or any of that was not accurate, didn't fairly tell you about Daniella, they would have had an expert up here. I mean, it is their burden of proof. There was no one, and that's because the testing wasn't reliant on Daniella. It wasn't skewed. It wasn't something where they weren't aware or didn't take into account the problems she has. It's from her mother. It's from her teacher. And it is from Daniella herself.

When you think about where she was 6.67 standards below the mean, she could improve two or three or four full standard deviations and not cognitively be in the first percentile. That is where Daniella will need attendant care.

And when you look at the other issues of damages, when you look at what her eyes need, the only thing an expert told you that she would need more likely than not is the conformer and the porcelain shell for cosmetic reasons.

While we love to think about all of this idea of she needs a retina transfer or she needs a false eye, no doctor told you that that was probable or feasible or that Daniella would be a candidate. And so consider the facts, not the hope or the speculation.

When you go through the charge, the very first question, Question Number 1 will ask you about Dr. Llamas. And we think that the only evidence shows that, no, there wasn't any act or omission by him, negligence that caused injury to this child. And at that point, that is the last question from our perspective you would need to answer.

But I want to turn your attention to that last question, the gross negligence question, where plaintiffs have taken the position that by following the published guidelines, by keeping up with year after year all of the education, all of the conferences, all of the academy meetings, Dr. Llamas was just indifferent to Daniella. He was consciously indifferent to Daniella.

And let me tell you, first of all, if he is, then every ophthalmologist, pediatrician, and member of the American Academy for Pediatric Ophthalmology and Strabismus is consciously indifferent to children, too, because they keep publishing these guidelines. And what he is saying is, they are needlessly trying to blind children. These are meant to educate. These are meant to keep doctors current. And they are meant to help them know what to do in a complex situation.

And so, first of all, you have to believe that all three organizations are just indifferent to babies. They don't care.

But then I want you to think more specifically about Dr. Llamas because, folks, he is not indifferent. He's invested. He could have gone to UCLA. He could have been a teacher. He could have been many things, I'm sure, at a big university like that. But he was invested in his community. He came back to El Paso.

He could have been indifferent when Dr. Ponte asked him to come in on July 4th, which is what the testimony was. He called and said, hey, will you come in even earlier than the 11th, come in on the 4th.

And he didn't say, hey, it is a national

holiday, and there is nothing to see anyway. He said, "Of course I will come" because he is invested in these babies.

He could have been indifferent to the 72 hours, but he was invested. Even Dr. Good said that his plan was careful and thoughtful and just what we should have seen from the eye doctor. We need to do this as soon as possible.

THE COURT: That's your 30 minutes, Ms. Fraley.

MS. FRALEY: Thank you, Your Honor.

Did they get the laser they have been telling us they were going to get? If so, let's do the laser surgery. If not, can we transfer to Providence? He was invested. Even though Dr. Good and everyone has said that it was not his job to get the laser, he is still invested in the process.

And, folks, he has been invested every day here. He has been here. He has sat and listened while people said things that were not true.

Oh, Dr. Llamas thought this baby was 26 weeks. No. No one said that.

Oh, Dr. Llamas didn't do adequate laser treatment. Let me show you this montage that I made up.

No. That isn't true.

Because at the end of the day, as invested as Dr. Llamas is in the babies and in his community, he, like you, is invested in the truth. And that's why Mr. Girards was not able to cross-examine him at all about his care for Daniella.

Think about the hours that Mr. Girards spent cross-examining him. It wasn't about what he did for Daniella. It wasn't about how did you put those laser spots in, how did you get the angle, did you really get 2,000 in. It wasn't about that at all. Let's talk about a PowerPoint that came out in 2011.

If he were not a truth teller, if he were not invested in the truth, if he had not cared appropriately for Daniella with the burden of proof, the party with the burden of proof should have been able to question him about that, and they didn't.

And so at the end of the day, your search for credible evidence, for believable evidence goes back to, did he use ordinary care? Are the damages they are really complaining about, things he could have done anything differently about? Are they holding him to a standard that they couldn't even achieve in the clinical studies? And is he consciously indifferent, or is he invested?

Mr. Girards and I will agree on at least

one thing in this trial, and that is how much we appreciate you. You have been prompt and thoughtful and diligent.

Don't stop that now. Be rigorous in your search for the truth. Be invested in your search for the truth. And hold the party with the burden of proof to actually proving to you the facts and not inuendo, not gossip, not things that were not proven in court. When you hold them to their burden, we believe you will answer "No" to Question Number 1, and your work will be done.

Thank you.

THE COURT: Thank you, Ms. Fraley.

Ladies and gentlemen, we are going to take a ten-minute recess before we hear the remaining arguments, which will be about 45 minutes. We will reconvene at two minutes after 11:00.

You are still under my instructions not to discuss anything about the case among yourselves or with anyone else. Please don't try to form or express any opinions or conclusions just yet.

We will see you in a few minutes.

(The jury was recessed, after which time the following proceedings were had out of the presence of the jury.)

THE COURT: All right. Ms. Cooley, you've got roughly 28 minutes.

MS. COOLEY: Thank you.

THE COURT: Mr. Girards, you've got roughly 12 minutes remaining.

MS. COOLEY: How much time does he have left?

THE COURT: He has 12 minutes remaining.

(There was a discussion off the record.)

(There was a recess at 10:52 a.m.)

THE COURT: Thank you. Please be seated for a moment.

Are we ready to proceed? Please rise.

(The jury returned into court.)

THE COURT: Please be seated.

Ms. Cooley, you may proceed with your closing argument.

MS. COOLEY: May it please the Court.

Ladies and gentlemen, we are all familiar with that old adage that there are two sides to every story. Obviously, that's true in this case as well. You have now heard both sides of the story. On behalf of Dr. Ponte, I want to thank you for being so patient

and attentive in listening to both sides.

I told you all at the beginning of jury selection that I was proud and honored to be here representing Dr. Ponte. And I just want to reiterate that I am still proud and honored, and actually maybe even prouder now.

Dr. Ponte has had to sit here for a number of days, the days that he could be here, when he could get somebody to take care of the babies in El Paso; and he had to listen to plaintiffs' counsel mischaracterize, misrepresent, miscount. He had to hear from plaintiffs' expert who came in here and said that he was not only negligent, one of them in fact said he was grossly negligent. Now, interestingly, it was the ophthalmology expert who said that, not the neonatologist expert.

But through all of that, Dr. Ponte was very stoic, in control of his emotions. There was only one time in the last two weeks that Dr. Ponte became emotional, and that was the day that the DVD of Daniella was played. And I don't know if any of y'all even knew that, but Dr. Ponte watched a little bit of it and then got up and left the courtroom, composed himself, and then came back in.

Why do you think he did that? Well,

perhaps he did it because he was remembering Daniella when she was barely big enough to hold in his hand, weighed a little bit more than one pound, when he was having to tell her parents that she only had a 5 percent likelihood of surviving.

Perhaps he was remembering when she couldn't breathe on her own for two months. She developed seizures. She was so anemic that he had to order blood transfusions for her. She was bleeding into her brain, and then developed fluid on the brain as a result of that and had to be treated.

Perhaps he was remembering when he had to give anesthesia to her for -- in order for her to have heart surgery. Perhaps those were the things that he was thinking of.

The last time that Dr. Ponte saw Daniella, he didn't know whether she would ever be able to walk, let alone run. He didn't know whether she would be able to even use her hands and arms, let alone color or feed herself or try to brush her teeth. He didn't know whether she would be able to talk, let alone sing songs with her daddy.

So when Dr. Ponte saw that she could do that, he was very gratified. He was very emotional because that's what Dr. Ponte does. Dr. Ponte takes

care of these little babies that are born before they are supposed to be. He takes care of these little babies that aren't supposed to live outside their mother's wombs. That's what he does. That's what he did with Daniella, and I'm proud to represent somebody who is as devoted to these children as Dr. Ponte is.

What do we know about Dr. Ponte other than what I have just told you? We know that Dr. Ponte is double Board certified in pediatrics and in perinatal and neonatal medicine. We know that he has been practicing for more than 25 years and has taken care of hundreds, if not thousands, of these little babies.

We know that Dr. Ponte was an assistant professor of pediatrics at LSU until he went to El Paso in 1989 and started working at Providence Hospital. He worked at Providence Hospital until about 1994 when he went over to Del Sol to establish their neonatal intensive care unit. He grew it from a level 1 to a level 2 to a level 3, and it grew from a neonatal unit that had only one neonatologist to one that currently has four neonatologists and four neonatal nurse practitioners, and they are providing care 24 hours a day, seven days a week.

There is no dispute about Dr. Ponte being

a qualified, competent physician. In fact, Dr. Phelps, the plaintiffs' neonatologist expert, indicated that herself when she came here to testify.

There is also no dispute about any of the other care that Daniella received while she was in the NIC-U. In fact, Dr. Ponte -- or Dr. Phelps said that she believed it was a direct quote when I said, "Did you previously say that Daniella's survival is a testament to the exceptional care that she received in the neonatal intensive care unit?"

And she said, "Yes, I agree. That sounds like a direct quote from me." And it was.

Now, what is in dispute in this case with regard to Dr. Ponte? Well, the plaintiff is claiming that there was no written policy and procedure regarding the screening of these babies in the NIC-U.

Well, what did Dr. Ponte tell us about that? Dr. Ponte told us that they did in fact have a policy in place, that they have a discharge planning nurse. The discharge planning nurse works for the hospital, and she is the nurse who, at the very onset of these babies coming into the NIC-U, is already thinking long term about what things need to be accomplished over the time this baby is in the NIC-U to ensure that it can go home, to ensure that it can

leave in the best shape possible.

And so this nurse has a notebook. And in the notebook, she has a copy of the guidelines--the guidelines that y'all have been seeing for the last two weeks. This was in 2005, and so it was those 2001 guidelines. And so based upon the guidelines, the nurse knows that these babies need to be screened between 31 and 33 weeks, makes an appointment -- doesn't make an appointment, makes an entry into the medical record of that date. And we know that happened in this case because we've got the medical records from June 4th--daily note, June 4, 2005--that indicates "Obtain eye exam at 33 to 34 weeks of age (7-26)."

We have already talked about the 33 to 34 weeks that is not what should have been in there. But we know that's what they were relying on, the 31 to 33 weeks, because we have our calendar that's in evidence that will show us that July 26th, which is the date that initially was in the records for when this child should be screened, would have been at 32 weeks 6 days, which falls in between the 31 and 33 weeks for the babies to be screened.

So we know in fact that there was a policy in place. Otherwise, that entry wouldn't be in the medical record. So there is no question that

there was a policy in place.

In fact, I believe Dr. Phelps even testified that she had a similar policy in that the discharge planning nurse in her NIC-U was the one that arranged these appointments and scheduled for the babies to be screened.

Now, what is the next criticism plaintiffs have of Dr. Ponte? Well, they say that Dr. Ponte should have made sure that Dr. Llamas came in sooner than four weeks to evaluate Daniella.

Well, ladies and gentlemen, we heard from both Dr. Ponte and Dr. Llamas that over the years that they had worked together, they talked. They talked about the babies, and they talked about the screening, and they talked about the follow-up. Dr. Ponte was comfortable with Dr. Llamas's recommendation.

Dr. Ponte, despite what the plaintiffs' counsel is continuing to say, Dr. Ponte understood what fetal fundi means. He understood what Dr. Llamas meant by fetal fundi. That meant no ROP. He knew that that's what he meant by that.

And so in a situation where there is no ROP, it was perfectly reasonable to follow the guidelines, go back to the guidelines to screen this baby between 31 and 33 weeks.

Do you really think that if Dr. Ponte had any concern about that, that he wouldn't have said something to Dr. Llamas? We already know that Dr. Ponte went outside the guidelines and asked Dr. Llamas to see this baby early. Well, if he was willing to do that, he certainly, if he would have had grounds for concern, would have asked him to come and see the baby early again.

There was no reason for Dr. Ponte to believe that this child needed to be screened any time other than the 31 to 33 weeks after the initial exam was performed, and he understood that this baby had no ROP.

Now, a final issue of criticism with Dr. Ponte was this issue of having the laser available. Well, ladies and gentlemen, I think that it's been pretty well established that the hospital is responsible for the laser.

Plaintiffs' counsel said, well, he didn't plan. The reason that Dr. Ponte should be 55 percent liable here is because he had the ability to plan for this. We knew this baby was going to have ROP, and why wasn't he making sure that that laser was available and getting it in place.

Well, we know from Michael Lason who

testified, he said that in fact the hospital had ordered the laser some time before, but it hadn't come in yet. No one knew where it was.

Dr. Good said that Dr. Ponte should have had everybody out looking for the laser. Well, Dr. Ponte did have everybody out looking for the laser.

We heard again from Michael Lason, I'm really not sure why I'm the one who was looking for the laser, but Dr. Ponte asked me to, so I was. He even said it typically would have been the hospital's head nurse, the NIC-U's head nurse; but it was him because Dr. Ponte was doing exactly what Dr. Good said he should be doing.

Well, it is kind of interesting, and maybe we should have explored it further. You remember Dr. Radenovich that you heard abandoned these babies, Dr. Radenovich who would not come in and --

MR. GIRARDS: Your Honor, I will object. There is no evidence that Dr. Radenovich abandoned any babies. That was one of those tricky questions that Ms. Fraley asked like "When did you stop beating your wife."

THE COURT: I will sustain the objection. You may continue, Ms. Cooley.

MS. COOLEY: All right. Dr. Ponte was

doing everything within his control to try to get the laser there for treatment. And, in fact, the laser was brought in in time for Daniella to be treated within the 72 hours that the guidelines recommend.

Let's talk a second about this issue of maybe transferring the baby to Providence. You have all seen the records. There was no question that between July 30th and August 4th, there were serious concerns about Daniella's increasing pressure in her brain. Dr. Ponte didn't know whether this little girl was going to need a shunt or whether it was going to reduce on its own. That's why he ordered a neuro-surgery consult. And you have all seen that note as well.

Now, the neurosurgeon opted to wait on the shunt. Perhaps Dr. Ponte should have said, no, no, no, no, no, no. Wait, you don't know what you're doing. I need to tell you, you need to put this shunt in this baby's head.

Well, ultimately, Daniella never even needed a shunt. That was the neurosurgeon's decision. Dr. Ponte realizes that you need specialists to make special decisions. He doesn't interfere in that, just like he wouldn't have interfered with the decisions that Dr. Llamas would have made with regard to the

treatment of this baby.

But the fact of the matter is that he ordered a neurosurgery consult because he was concerned about increasing pressure in Daniella's brain. You have the ultrasounds. They are in evidence. You can look at them.

We saw a graph that the plaintiff showed you where they were measuring this baby's head circumference, the outside of the brain. But what Dr. Ponte was looking at was the inside of Daniella's brain when he was looking at the ultrasounds. He was able to see exactly what was going on in the ventricles, the size, when they were increasing and decreasing.

And those ultrasounds are also in evidence so that you can look at those. But looking inside the brain is much more reflective of what was going on with Daniella than looking outside by measuring the circumference.

I want to remind you that the jury charge, in paragraph number 1, says, "Do not let bias, prejudice, or sympathy play any part in your decision." These are, again--we have said it many times, and no one has disputed it--these are very, very nice folks. They are very good parents. They have taken very good

care of this little girl, which is one of the reasons that she is doing as well as she is doing.

But just because you may feel sorry for them, you cannot award them money based upon that. As nice as they are, that is not a valid reason for awarding money.

Now, with regard to the negligence questions, the question regarding Dr. Ponte, Question Number 2, I believe it is going to be very evident when you get back and look at the evidence and think about the testimony that the answer to Question Number 2 is very clearly "No." If you answer "No" to Question Number 2, you won't even get to Question Number 6, which is the question about whether Dr. Ponte acted consciously indifferent.

But I would like to remind you, if there is anybody in the courtroom that made it very clear that Dr. Ponte did not act consciously indifferent when he was caring for Daniella, it was Daniella's mother. And Daniella's mother said on the stand that Dr. Ponte told her that as long as Daniella would fight, he would fight for Daniella.

Do you remember that testimony? Does that sound like conscious indifference to you? I think clearly the answer to that is "No."

Thank you.

THE COURT: All right. Rebuttal, Mr. Girards?

MR. GIRARDS: Yes, sir.

Well, Ms. Cooley never explained why it was that Dr. Ponte sat and watched Dr. Llamas ignore this child for four weeks when he knew that she was going to get ROP and that it might blind her before he came back.

Dr. Ponte knew that because it was in the medical record. He saw that Dr. Llamas wasn't coming back for four weeks. That's more than enough time for a baby to go from perfect, pristine, God-given eyes to blind.

Now, Ms. Fraley, what she told you seems to me to reflect a big problem in credibility that we have seen throughout the trial. First of all, she said that Daniella was out wandering in the street. But, I mean, who do you think took the photograph? Right, Jose.

You know, on the one hand Daniella is so damaged by her brain that she can't function. But look at her, and then a minute later Ms. Fraley is talking about how great she is doing. So which is it?

Now, Dr. Llamas writes down in the

record, look at number 6 over there, rapid rate of progression. That's what he wrote in the medical record on August 1. But how would he know if it was rapidly progressing, because he didn't look but four weeks earlier when there was nothing. Is that one of those notes that the doctors just write to do that, to protect themselves?

And then here is something that might have slipped by, that I think gives us a clue as to what the defense was trying to do. You remember, we saw that the August 1 examination occurred in the middle of week 34. At 33 weeks plus five days. And yet when they got on the stand, they actually wrote on here that the August exam happened before week 34 even began.

What are they trying to do, do you think, with you guys?

All right. I would like you to -- I would like to address the laser issue because you can tell -- you can tell whether Dr. Llamas did it right because Dr. Moshfeghi taught you, and because of something that happened when Dr. Llamas was on the stand.

And when Dr. -- do you remember Dr. Quinn on the video, he said, yes, there are skip areas. Skip

areas mean you didn't do it right. Skip areas means you didn't stop the progression of ROP.

So look at Defendants' -- this is the defendants' notebook binder. Look at Defendants' Exhibit 8A. See, that's the one that they brought you, and you can see the laser burns. When you see the dark areas in between, those are skip areas, especially when the dark area is one and a half times the size of the burn area that's adjacent to it.

The burns are supposed to be right next to each other. Ideally, you want it all -- ideally, this is all supposed to be whited out over here, not looking like a leopard, and not with the brown spots. Look how big these brown spots are. Look, there is a whole area of untreated retina. You remember, these are the cells that are still producing that chemical that say, blood vessels, keep growing, keep growing, which is the big problem with ROP.

So look at Exhibit 8A, and you can measure it for yourself. Just use a piece of paper, and you can measure it for yourself. And then look at that. Look how big an untreated area is left there.

You can figure all of this out for yourself, and that's what I want you to do. That's why I wanted Dr. Moshfeghi to teach you the principles, is

so you can do it yourself and you won't have to take anybody's word for it.

Dr. Good explained why -- he did explain why this kiddo would more likely than not have had ROP diagnosed back here and more than likely not be treated with laser right here. This is a disease that takes approximately two weeks to develop. So if you look a week earlier, you know you are going to see it because she was so severe here.

Their only job -- remember, they had complete control of this baby 24 hours a day, seven days a week. Their only job -- Dr. Llamas's only job was to diagnose ROP as soon as it developed and treat it when it was treatable. That was his only job. That's all he had to do. That was his only focus.

Dr. Ponte had more focus, but Dr. Ponte had red flags that were going up like July the 4th fireworks. I'm not coming back for four weeks, or likely that we may need the laser but where is it. There is a note for 7-26. When 7-26 came and went, Llamas didn't show up. Nobody called him. Ponte didn't call him. These are -- these are the things that shouldn't have happened.

Now, what we did was -- and did Dr. Llamas know better? In the plaintiffs' binder here,

number 38, Exhibit Number 38. These are the excerpts from the annual meetings of the American Academy of Ophthalmology for 2003 and 2004. We pulled out the pages that related to ROP, the classes that were going on. And at the end of this document, you will see the registration records where Dr. Llamas was actually at these meetings. He knew. He knew the ETROP guidelines. He was there. He was taught.

Now, this binder right here, this gray one, these are the Plaintiffs' Exhibits. And what I mean by that is, these are the exhibits that we offered. And what we did was, we put them in a notebook for you to take back into the jury room. And at the beginning of the trial, I tried to arrange them in an order that was more important in the front and lesser important as we went along.

But along the way we found the need for addition records. So in the back of the binder, you will see some of the documents that turned out we needed to stick in the binder during the trial. So I guess my goal wasn't perfect, but if you take this notebook, you will see the records that we put into evidence. And then the black one is the defendants' exhibits.

All right. You know, the thing -- I

mentioned something to you earlier. You know, this is about safety, saving the babies. And there are folks who say that the jury system is here to protect babies, to protect the babies. And I mentioned earlier at the beginning of the trial, there is nothing more dangerous than a doctor who comes into a courtroom and says something different than he tells this doctor or where he writes in the medical literature something that he writes.

You remember Dr. Quinn, I was begging them to bring him live because we wanted to talk to him about the book. You remember in the video that was choppy on Thursday, he never specifically addressed this baby's screening schedule. He only said is this a good guideline, and did it apply.

Well, we already knew that. He didn't have to ask the question. Yeah, we already knew that good guidelines apply.

But Dr. Quinn completely avoided saying anything about the chapter he wrote, Chapter 51 of the neonatology book that says you have to look at the kid's eyes by seven weeks and every other week thereafter until ROP is gone -- the risk of ROP has gone away.

THE COURT: Five minutes, Mr. Girards.

MR. GIRARDS: He never said that. He completely avoided it. And he gave you the impression that he thought the screening schedule that Dr. Llamas did was okay. But it wasn't, and he knows it.

And then remember when he had amnesia about the publication he did that said, you have to laser within a day or two? You don't sit on your hands for 72 hours. That is a doctor who is dangerous to babies because he comes in here and misleads you.

The rules are the same on both sides of the table. Right there in the red book, you look at the babies' eyes by seven weeks and every other week until the diagnosis of ROP or the risk is gone. That's how the babies are saved. And he knew it because he put it in the book. Three hundred babies are saved from blindness each year if you do the screening like he says you do it.

All right. What's the nature of -- What's the nature of the safety rule violations? How much harm was caused? How much harm could have been caused? Those are the questions that I want you to think about when you are thinking about answering these questions. Think about their negligence and what damages they caused this little girl and what the meaning of your verdict is. Your verdict is going

to -- there are people watching your verdict.

You remember, we haven't seen anybody from Pediatrix either. The only person from Pediatrix who showed up was a guy who I had to subpoena and drag down here, Dr. Michael Stanley. Those people are paying attention, and you will give them permission by your verdict to keep a loosey-goosey, no rules screening of babies with ROP, and more babies will go blind.

Or with the strength of your verdict, you are going to say, tighten this up. Use the known guidelines to save the babies. You already proved that babies are saved if you use the screening protocol, so use the screening protocol.

This was totally needless. This was totally unnecessary. Daniella Bustamante should live a functional, sighted life, but she is not because they didn't do the screening that was simple as coming back every other week until the ROP risk went away, or she -- or it was treated. And we know for a fact the laser stops the progression of ROP in its tracks. They just didn't do it.

And so when you go back to the jury room, we will be out here thinking about you, praying about you. We will look forward to visiting with you. And

when you get through with your verdict, if you do the kind of verdict that is going to make sure that you know that Daniella will have the means she needs because of her blindness, then we are going to feel good about it. You are going to feel good about it.

And when your family and friends ask you, you know, why did you give such a strong verdict for this little girl, you can tell them. I saw the evidence. They didn't do the every-other-week screening, and they knew they were supposed to or she would go blind. And they didn't do it, and she went blind. It is important that we give a strong verdict. And if you would have heard the evidence like I did, you would have concluded the same thing.

So I look forward to visiting with you after your verdict today.

Thank you, Your Honor.

THE COURT: All right. Ladies and gentlemen, you have now heard all the evidence in this case, the Court's charge, and the closing arguments of the attorneys. And in a moment the case will be submitted to you for your deliberations and your verdict.

Mr. Carter and Mr. Lewis, I'm sure you have figured out quite some time ago that you were

alternate jurors in this case. I'm glad that we didn't need you, and I'm sorry that we have taken so much of your time without your being able to deliberate on the case. But if you will wait a minute after the jury goes back to the jury room, I will discharge you and give you your final instructions.

Ladies and gentlemen, those of you who will be deliberating the case, at this point in the trial you pretty much take control of your own schedule, within certain limits.

For example, if you decide you want to go to lunch and then begin deliberating, you can do that. If you decide you want to begin your deliberations and go to lunch later, you can do that. You can take breaks when you feel like you need them for reasonable amounts of time.

I never try to guess how long it is going to take a jury to reach a verdict. In this case, should it get to be somewhere close to 5:00, if you think you might be able to reach a verdict by continuing sometime between 5:00 and 6:00, let the bailiff know that. We can stay with you until 6:00. If we go much past that, the bailiff and the court reporter both have a hard time getting home for the night, and so that's kind of our outside limit.

If you don't reach a verdict today, then I will ask you to return tomorrow morning and continue until you do.

At this time, ladies and gentlemen, the bailiff is going to show you into the jury room. He is going to give you the original of my Charge, and we will also send in the exhibits that have been admitted. It will take us a few minutes to make sure those are all in proper order, but we will get them in to you shortly, and we will await your verdict.

Thank you very much.

(The jury was recessed to the jury room to begin its deliberations at 11:30 a.m.)

THE COURT: All right. Gentlemen, please be seated.

You have completed your service in this case, and in a moment I'm going to discharge you. Once you are discharged, you will be released from your secrecy concerning the case.

However, in that the jury will be continuing its deliberations, I'm going to ask you to observe my instructions until the end of the day tomorrow unless you hear from me or one of the court staff.

If you want to hear what the verdict is,

let me or let David know, and he will tell the bailiff, and we will give you a call so you can find out what the jury does.

But I would say by the end of the day tomorrow, probably we will have a verdict. And at that point, if you want to talk to anybody about the case, you are free to do so. If you choose not to talk to anybody about the case, that's also your privilege.

At some point the attorneys or others may contact you to ask you whether you observed anything that would constitute jury misconduct in this trial. You are free to answer such questions. If you tell them about anything that they believe might be jury misconduct, they may ask you to give an affidavit, and you are free to do that. You are also free not to answer those questions, and you are also free not to give an affidavit if that's your preference.

I want to thank you very much for your time. I know it is very difficult to sit through a two-week trial and then not to participate in the deliberations.

I will just tell you, particularly if the trial had gone to three weeks, we were expecting it would not be at all uncommon to lose a juror to an illness or some kind of an emergency, and so that's why

we do seat alternates. We were fortunate in this case that we didn't lose anybody, and so you folks are done. Thank you very much.

JUROR CARTER: Do we go out this way or that way?

THE COURT: You can go out that way. The bailiff probably will have your final paperwork.

JUROR CARTER: Thank you.

THE COURT: David will let you back into the jury room. Okay. Thank you very much.

(There was a discussion off the record.)

THE COURT: Counsel, does anybody have anything for the record at this time?

MR. GIRARDS: No, sir.

MS. FRALEY: No, Your Honor.

MS. COOLEY: No, Your Honor.

THE COURT: Very well then. We will be in recess and await the verdict of the jury.

Thank you.

(There was a recess at 12:33 p.m.)