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**COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON**

**AMANDA PITTS and PAUL PITTS, individually; and AMANDA
PITTS as Personal Representative of the ESTATE OF TAYLOR
PITTS, et al., *Appellant*,**

v.

INLAND IMAGING, et al., *Respondent*.

APPELLANTS' AMENDED REPLY BRIEF

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I. INTRODUCTION

Microanalysis does not lead to macro-understanding. In this instance, Respondent Inland Imaging's (hereinafter "Inland") focus on individual items of purported court discretion without recognition of the trial court's systematic and, arguably, intentional evisceration of the Pitts' right to a fair trial by jury. The trial court's various rulings restricting evidence, testimony, and witnesses from the trial, and commandeering of the Pitts' counsel's right to determine trial tactics, resulted in undeniable inequity and bias favoring Inland. Contrary to Inland's arguments that the trial court acted within the acceptable bounds of judicial discretion, the actions of the trial court in various individual rulings, and the cumulative thereof, abused its discretion, and disregarded the basic tenets of affording the Pitts the opportunity to have a fair trial by jury. The trial court began its cascade of erroneous rulings when, in reliance only upon Inland's counsel's representations, it mischaracterized the factually relevant medical diagnosis of "Stuck Twin" as a "new theory of recovery." Stuck Twin was a viable differential diagnosis apparent from the time of the emergency c-section delivery of Samantha Pitts, and her stillborn twin Taylor Pitts, whose body literally had a membrane stuck to it and shrink wrapped about it. The trial court further abused its discretion when it allowed Inland to co-opt the Pitts radiology expert, Dr. Patten, by extensive cross-examination of him on Inland's primary

defense, that of the Twin Peak sign, when no testimony concerning the Twin Peak methodology was had on direct examination. The trial court's abuse of discretion continued by further **undue and restrictive rulings and actions which effectively limited the Pitts to a single expert's testimony (Dr. Patten's compromised case in chief testimony), and no rebuttal testimony to address the testimony of Inland's three Twin Peaks expert witnesses.**

Inland's reply brief can be distilled into treatment of issues of the trial court's abuse of discretion which fall under the general headings of: 1) Dr. Patten's Twin Peak Testimony; 2) Stuck Twin Testimony; 3) Rebuttal Testimony; 4) Time and Nature of Rebuttal; 5) Application of *Burnett v. Spokane Ambulance*; and 6) Loss of Chance.

II. LAW AND ARGUMENT IN REPLY

A. Dr. Patten's Twin Peak Testimony.

ER 611 states, in part:

“(b) Scope of Cross Examination. Cross examination should be limited to the subject matter of the direct examination and matters affecting the credibility of the witness. The court may, in the exercise of discretion, permit **inquiry** into additional matters as if on direct examination.”

ER 611(b) (emphasis added)

Contrary to Inland's argument the trial court exceeded it's discretion in allowing Dr. Patten to be examined on the Twin Peak methodology. (Note:

the following page references are to RF filed 11/13/14, Hearing 2/10/15). At trial, initial direct examination of Dr. Patten is contained in 101 pages of transcript, and is void of reference to the Twin Peak methodology (pp. 195-296). Dr. Patten found various breaches of the standard of care by Inland including failure to: measure membrane thicknesses; identify a single placenta; and measure amniotic fluid properly. (pp. 256-60). Initial cross-examination lasted for 94 pages of transcript (pp. 296-390), of which Inland's counsel spent 24 pages (pp. 364-388) on leading Dr. Patten to set forth Inland's Twin Peak theory of defense.

This was much more than "inquiry," and was allowed over objection. Since the Pitts' breach of the standard of care testimony did not rely on Twin Peak methodology, had the Pitts attempted to substantially address the Twin Peak defense during their case in chief, Inland could have objected. **Grounds for objection would have been opposing counsel improperly presented evidence out of order**, thereby disallowing Inland to present its defense in its case in chief. *See* "**Motion to Bar Premature Rebuttal to Affirmative Defenses**," 30 Wash. Prac., Wash. Motions in Limine § 9:15 (2015 ed.). Conversely, **it was a prejudicial abuse of discretion for the court to require Dr. Patten, not a Twin Peak expert, to be drafted by Inland to proffer their defense theory, out of order during the Pitts' case in chief**. Also, found in ER 611.16 "Rebuttal and surrebuttal (rejoinder)," is

the requirement that plaintiffs present evidence that supports their burden of proof to be presented in the case in chief, and not on rebuttal. There is no corresponding requirement to address a defendant's theory of defense in a plaintiffs' case in chief.

This instance of the trial court's abuse of discretion may have been sufferable, if it had stopped there. However it didn't. The court's error was exponentially expanded when it ruled that Dr. Finberg, the nation's leading expert on Twin Peak methodology, could not rebut any of Inland's testimony on Twin Peak. Finberg's testimony, according to the court, would be cumulative to Dr. Patten's forced Twin Peak testimony. (RP Filed 11/14/14, hearing, 1/30/15, 81-2) (see also "**E. Application of *Burnett v. Spokane Ambulance***," below).

B. Stuck Twin Testimony.

Inland now claims that testimony concerning, Intrauterine Growth Restriction (IUGR), Twin to Twin Transfusion Syndrome (TTTS), and Stuck Twin, etc. (collectively hereinafter "Stuck Twin") was improper rebuttal as it is not claimed as a cause of death. Apparently Inland now abandons its argument at trial which was accepted by the trial court, that Stuck Twin was a new and late theory of recovery and/or late issue in the litigation. The "Stuck Twin" controversy came about solely on Inland's counsel's misrepresentation

to the court that, essentially, nothing in the record prior to Dr. D'Alton's deposition on December 16, 2014 (after the discovery cut off) indicated it was a an issue or theory of recovery in this litigation. (RP filed 11/3/14, hearing 1/30/15, 76-77). Further, that there was no trial testimony to that effect. (RP filed 11/14/14, hearing 2/12/15, 568). However, according to Dr. Hardy, the delivering OB/Gyn, Taylor Pitts was stillborn with no amniotic fluid about her, and a membrane wrapped (stuck) about her body. (Trial Exhibit D-104). The pregnancy was monochorionic diamniotic, and at risk for TTTS and resulting apparent Stuck Twin occurrence, which is what Dr. Hardy observed during the delivery of the demised Taylor Pitts and testified to at trial (membrane stuck about demised Taylor Pitts pressing her against the wall, with no fluid about her). (RP filed 11/3/14, hearing 2/11/15, 443)(Trial Exhibit D-104). Facing this, respondent now argues Stuck Twin was not proper rebuttal. The issue of whether testimony about Stuck Twin was proper rebuttal is addressed in the following section. (See **C. Rebuttal Testimony**).

Inland also argues the Pitts counsel did not attempt to voir dire Dr. D'Alton as to qualifications. Inland is interpreting the term "voir dire" too restrictively. Judicial Notice is requested on the various law and common dictionary definitions of voir dire which reference the term's base meaning as "to examine." Here, it was as an offer of proof re: Stuck Twin, to elicit from

Dr. D'Alton that there was no surprise at including Stuck Twin in this case's differential diagnosis, from time of delivery.

“MR. RICCELLI: Your Honor, I request brief voir dire of Ms. D'Alton before she is in front of the jury.

THE COURT: The reason for that?

MR. RICCELLI: To clarify some issues in her testimony and to clarify what I will be able to ask her on cross-examination.

THE COURT: Any objection?

MR. HART: Yes, your Honor. We'd like to get started and he took her deposition for three hours.

MR. RICCELLI: An expert in the court to hear what she has to say, your Honor.

THE COURT: Counsel, this is a matter you should have brought to my attention. You are now on the defendant's time so you have to do that during your cross-examination.

(RP filed 11/3/14, Hearing 2/18/14, 581)

...

Q. So what would go into the differential diagnosis? What types of occurrences might have occurred other than the one that you referenced earlier?

MR. HART: **Objection, your Honor;** I think I know where this is going.

THE COURT: **Prior order. Sustained.**

BY MR. RICCELLI:

Q. When I spoke to you of an alternative during your deposition, was that a surprise to you that there might be an alternative?

MR. HART: These would be questions he brought up, your Honor.

THE COURT: Sustained, counsel. You need to move to another area of inquiry.

MR. RICCELLI: **I'm not allowed to voir dire any more?**

THE COURT: **Counsel, you are not allowed.** You need to move to another area of inquiry, your cross-examination.”

(RP Filed 11/14/14, Hearing 2/18/14, 486-87)(emphasis added)

Inland's counsel and the trial court were well aware of this from the

context, as there was only one prior order restricting testimony, that regarding Stuck Twin, etc. (RP filed 11/4/14, Hearing 2/12/14, pp. 568-70).

ER 103 states, in relevant part:

“(a) Effect of Erroneous Ruling. Error may not be predicated upon a ruling which admits or excludes evidence unless a substantial right of the party is affected, and

...

(2) Offer of Proof. In case the ruling is one excluding evidence, the substance of the evidence was made known to the court by offer or was apparent from the context within which questions were asked.

...

(c) Hearing of Jury. In jury cases, proceedings shall be conducted, to the extent practicable, so as to prevent inadmissible evidence from being suggested to the jury by any means, such as making statements or offers of proof or asking questions in the hearing of the jury.”

ER 103

Further:

AUTHOR'S COMMENTS

§103:5 Offers of proof

“**Purpose.** When your evidence has been excluded, you should make an offer of proof, thus creating a record for subsequent motions and a possible appeal. An offer of proof assists the trial court in evaluating its ruling and assists the appellate court by assuring that it has an adequate record to review the merits of the evidentiary issue. **An offer of proof may be made as a matter of right.** Gray v. Lucas, 677 F.2d 1086, 10 Fed. R. Evid. Serv. 1314 (5th Cir. 1982).”

5D Wash. Prac., Handbook Wash. Evid. ER 103 (2016-17 ed.) (emphasis added)

Consider, also:

“A trial lawyer has the right to make the record for appeal. Barci v. Intalco Alum. Corp., 11 Wn. App. 342, 346 n.1, 522 P.2d 1159 (1974). Where evidence is excluded, the court must permit counsel to

make an offer of proof so that the propriety of the proposed but excluded evidence may be examined as to admissibility. *Barci*, 11 Wn. App. at 346 n.1. “The exclusion by the court of a proffer of testimony by interrogating the witness or by counsel reciting the evidence that would be presented precludes review and is erroneous.” *Barci*, *supra*, 11 Wn. App. at 346 n.1.”

Consistent with the foregoing, it was abuse of discretion not to allow the Pitts’ counsel to voir dire Dr. D’Alton, outside the presence of the jury, as an offer of proof that Stuck Twin did not constitute a new theory of recovery, or late disclosed issue.

C. Rebuttal Testimony.

Inland argues the proposed testimony of Dr. Finberg and Professor Coffin were not proper rebuttal, presumably leaving it as direct testimony, if at all. In the Pitts’ opening brief, a number of references were made about the trial court’s continuing references to the purported “late disclosure” of Dr. Finberg, Prof. Coffin, and Stuck Twin, but with no comment about Inland for their gamesmanship in delaying discovery on their experts. The trial court was long known to value form over substance, and keeping strictly to a pre-set trial schedule, regardless of the interests of justice.

Most notable of the court’s restriction on rebuttal testimony is that of Twin Peak testimony. Recall that Twin Peak was not raised in the Pitts’ case in chief, but that Dr. Patten, not a Twin Peak expert, was required, over objection, to engage in a lengthy cross-examination on Twin Peak.

Inland presented three “Twin Peak” experts:

“Q. All right. And do you think you're an expert in what's been termed the Twin Peak sign?

A. Yes.

Q. Why do you believe Dr. Hoefler met the standard of care in his determination that this pregnancy of Ms. Pitts was consistent with a dichorionic diamniotic twin pregnancy?

A. Because he was able to obtain images documenting a Twin Peak sign, which is virtually diagnostic for a dichorionic placentation and is the way we would make that diagnosis. And he also -- the report that he generated left no doubt that he had decided, based on his review of the images, that it was a dichorionic diamniotic pregnancy.”

...

Q. Have you personally -- well, I should say has your department personally tried **to ascertain in your department's hands the reliability of the Twin peak sign?**

A. Yes.”

(RP Filed 11/14/15, hearing 2/13/18, 314-15)(Dr. D’Alton)
(emphasis added)

Inland’s Radiology expert Dr. Callen also testified extensively on Twin Peak. (RP Filed 11/14/15, hearing 2/13/18, 385-415). **Further, Inland’s third, Radiology expert, Dr. Filly, also testified extensively on Twin peak.** (RP Filed 11/14/15, hearing 2/13/19, 471-91).

A review of the Appendices will reveal appropriate, proposed rebuttal testimony for Dr. Finberg on the following trial testimony for Inland:

“Q. Were you able to, looking at the images, determine whether there was evidence of a membrane on December 12th -- excuse me, December 21st, 2007, the study interpreted by Dr. Balmforth at a time point that I think is 3:43:12 where there's a profile of the baby?

A. Yes.

Q. And do you think -- did you determine whether that was an umbilical cord like Dr. Patten did or evidence of an inter twin membrane?

A. **To me it's evidence of an inter twin membrane.**"

(RP Filed 11/4/15, hearing 2/13/18, 332)(Dr. D'Alton)(emphasis added)

Dr. Finberg was to dispute this testimony, as the membrane had fully collapsed on Taylor Pitts long before December 21, 2007. See Appendix 1, CP 1371-72). Testimony from inland was consistent with what its counsel, Mr. Hart, represented in opening:

"I'm holding a picture that he actually asked Dr. Callen to prepare for him, that you'll have in the jury room but I can't show you right now, **where Dr. Callen wrote arrows showing him, here's the inner twin membrane on the radiology at Inland Imaging December 21st, 2007.**

(RP filed 11/14/14, Hearing 2/6/15, 113-14) (Hart Opening Statement) (emphasis added)

...

I'm telling you, **there are pictures of membranes on virtually every single study. And if there was a membrane visible on December 21st, it was probably there, wasn't it, on October 4th** regardless of Mr. Riccelli's belief about that."

(RP Filed 11/14/14, Hearing 2/6/15, 134) (Hart Opening Statement) (emphasis added)

Also, Dr. D'Alton was asked to make, and did make a broad standard of care statement:

"Q. And do you have an opinion about whether the various ultra

sonographers and radiologists who interpreted the studies after the first two, Dr. Backman, Dr. Bhat, Dr. Lewis, etc., met the standard of care in the way that they handled the interpretation and reporting of Ms. Pitts' various ultrasound studies?

A. Yes, I do.

Q. And what is that opinion, Dr. D'Alton?

A. My opinion is that **the subsequent ultrasounds that were done on all occasions in this case were completely within the standard of care, both in terms of the images that were generated and in terms of the reporting.**"

(RP filed 11/14/14, Hearing 2/6/14, 303-04) (Dr. D'Alton Direct)
(emphasis added)

This expansive standard of care testimony went well beyond Dr. Patten's limited standard of care testimony dealing with, primarily, Inland's breach of the standard of care in interpreting Ms. Pitts' first two ultrasounds. This expansive standard of care testimony was to be rebutted by Dr. Finberg. For various hearings on Dr. Finberg's proposed testimony, excerpts from his discovery deposition (CP 1180-83); an offer of proof for the testimony of Dr. Finberg (CP 1370-73) and Prof. Coffin (CP 1368-70); and Dr. Finberg's attached PowerPoint presentation (CP 1375-1411) were provided the trial court. (See, also Appendices 1 and 2). Review of the appendices substantiates that the proffered testimony of Dr. Finberg on Stuck Twin, IUGR, TTTS, etc., does not constitute a new, late theory of recovery, or new, late issue in this litigation. Even if it was new, it would be properly received as rebuttal to Inland's claim that the inter-twin dividing membrane was present through the December 21, 2007 ultrasound. Dr. Finberg describes

an obvious, known condition, apparent to and commented upon by Dr. Hardy in his operative report on the delivery of the Pitts twins. (Trial Exhibit D-104).

Simply stated, Stuck Twin was the mechanism that caused the collapse of the inter-twin membrane as of October 4, 2007. It was no new theory of recovery or new issue in the litigation. It was the medical condition at the top of a differential diagnosis as to the demise of Taylor Pitts. The collapse of the membrane exposed the Pitts twins' umbilical cords to each other, and movement of Samantha Pitts in the then monoamniotic womb allowed the cords to become entangled and Taylor's cord to be restricted, as the efficient cause of death. (Trial Ex. D-104) (RP filed 11/3/14, Hearing 2/10/15 pp. 265-74).

The offer of Proof of Dr. Finberg's proposed rebuttal testimony, and attached demonstrative PowerPoint he prepared, was designed to properly rebut Inland's experts trial testimony that, among other things: a dividing membrane was to be seen after October 4, 2007; amniotic fluid indices (which required visualization of the membrane) were done properly; and, all ultrasound procedures and reporting thereon were according to the standard of care. (Note that, per the court's order restricting Stuck Twin testimony, Dr. Finberg's proposed testimony and PowerPoint, excluded reference to "Stuck Twin," but functionally describes it). (CP 104-05, 1368-1411). Regardless, this attempt garnered persistent opposition at hearing. (See

Appendix 1, CP 1368-1411) (RP Filed 11/4/14, hearings 2/13/15, 578-79, 2/19/15, 637-43)

Dr. Finberg was also to address other testimony of Inland's experts:

“Q. The Doppler flows and the discordance, the jurors have heard about that but I would ask you to tell the jurors whether from the monitoring during the – during this period in question, October 4th to December 21st, **my clients met the standard of care in the way that they monitored -- evaluated the pregnancy to determine that their discordance was appropriate by virtue of evaluations of size along with the Doppler's?**

A. **Yes. My opinion is that Inland Imaging totally met the standard of care in the assessment of the biometry or assessment of the size of each of the babies and assessment of the blood flow through the umbilical cord or the Doppler's assessment.** I was able to say this by review of the images and review of the measurements that they took on each scan.”

(RP Filed 11/14/14, Hearing February 6, 2015, p. 328)(Dr. D'Alton) (emphasis added)

Dr. Finberg was to testify that the umbilical cord Doppler was misread, after the membrane had fully collapsed on Taylor Pitts. (one umbilical cord read in two locations, not two cords read). (See Appendices and see CP 1373, 1411).

D. Time and Nature of Rebuttal

Here, the trial court would not take Dr. Finberg's live testimony out of order, but had set aside only 20 minutes for videoconference testimony on Thursday, February 20, 2014, to be followed by closing. (RP filed 11/3/14, Hearing 2/19/15, 640). The Finberg's reside in Phoenix, AZ. Due to a previously scheduled outpatient surgery for Dr. Finberg's spouse, February 20th was the only day Dr. Finberg could

not attend trial in person. When the Pitts counsel could not persuade the court to reconsider the schedule, a motion for video conference testimony was made, and Inland objected.

“THE COURT: So we'll go forward, then, on the case. Now, the other one is this motion for video testimony. I'm still not even sure that there will be any testimony but I think we need to talk about it because **the defense is objecting to the format of the testimony because apparently Dr. Finberg cannot be here and there is only one time for rebuttal and that is Thursday afternoon at 1:30 and then we are going into closings.** Mr. Riccelli, I got a motion from you and I got an objection from the defense to the format.

MR. RICCELLI: I just find it curious that a month and a half or so ago they thought they were gonna have video testimony from Dr. Nyberg and they moved forward and I had no objection and they seemed to think it was reasonable. Dr. Finberg, given the restriction of the rebuttal to the time, his wife is having some outpatient surgery in the morning and he can leave her to some other's care for the afternoon testimony, but he can't leave Phoenix. That's the sum of it.”

(RP Filed 11/4/14, hearing,2/18/15, 436-37)(emphasis added)

Inland's treatment of the videoconferencing non-event is not based in fact. Inland claims videoconferencing was not fully operational in the time frame allowed by the court. As was discussed in the Pitts's opening brief, the court required readiness by 1:30 p.m., Thursday, February 20, 2014. The equipment was fully operational by 12:00 Noon, at which time the video conference provider's staff was instructing the Pitts' counsel on how to make manual screen adjustments. The court's judicial assistant countermanded the prior 1:30 PM deadline at 1:00 PM, with no inquiry as to readiness.

Regardless, the court imposed 20 minute total time limit for any and all direct and cross examinations of Dr. Finberg, which effectively made rebuttal testimony in this three week trial meaningless, had it occurred. (RP filed 11/14/14, hearing 2/19/14, p. 632-636, 645).

Consider, also, a three week trial in which one party is allowed to utilize PowerPoint presentations, and the other not allowed:

“So we get to say things as lawyers. Here's what I'm going to tell you, then **I'm gonna get into my Power Point that I had prepared.**”

(RP Filed 11/14/14, hearing 2/6/15, 114) (Defense counsel Hart Opening Statement)(emphasis added)

“Q. **Dr. Filly, have you created a PowerPoint** that sort of scientifically gives the basis of your pinion going from the embryology right through to the cines from Ms. Pitts' prenatal ultrasounds?

A. **Yes, I have.**”

(RP Filed 11/14/14, hearing 2/19/15, 473-74) (Dr. Filly direct examination)(emphasis added)

When considering the possible scope of Dr. Finberg's rebuttal testimony, Inland objected to a PowerPoint presentation, and the court agreed:

“MR. HART: The PowerPoint is 40 pages long.

THE COURT: **He is not doing a PowerPoint.** There is no PowerPoint here. I have no PowerPoint. He can talk about his -- there will be no PowerPoint. He can talk about his background and he can do the work with the images **no PowerPoint.**

MR. HART: Thank you for indulging me.”

(RP Filed 11/4/14, hearing 2/19/15, 648)(emphasis added).

Note: The trial court did have a copy of the PowerPoint. (CP 1375). See Appendix 1.

E. Application of *Burnett v. Spokane Ambulance*

Inland argues the inapplicability of *Burnett v. Spokane Ambulance*, 131 Wn.2d 484, 493-494, 933 P.2d 1036, 1040-1041 (1997), as no witness was excluded from testimony due to late disclosure. However, *Burnett* applies to exclusion of evidence due to late disclosure. Total exclusion of a witness merely constitutes exclusion of all relevant testimony the witness may have had to offer.

“When "a party fails to obey an order entered under rule 26(f), the court in which the action is pending may make such orders in regard to the failure as are just[.]" CR 37(b)(2). Among the sanctions available for violations of this rule is "an order refusing to allow the disobedient party to support . . . designated claims . . . or prohibiting him from introducing designated matters in evidence." CR 37(b)(2)(B).

This rule is consistent with the general proposition that a trial court has broad discretion as to the choice of sanctions for violation of a discovery order. *Phillips v. Richmond*, 59 Wn.2d 571, 369 P.2d 299 (1962). Such a "discretionary determination should not be disturbed on appeal except on a clear showing of abuse of discretion, that is, discretion manifestly unreasonable, or exercised on untenable grounds, or for untenable reasons." *Associated Mortgage Investors v. G.P. Kent Constr. Co.*, 15 Wn. App. 223, 229, 548 P.2d 558, review denied, 87 Wn.2d 1006 (1976). Those reasons should, typically, be clearly stated on the record so that meaningful review can be had on appeal. **When the trial court "chooses one of the harsher remedies allowable under CR 37(b), . . . it must be apparent from the**

record that the trial court explicitly considered whether a lesser sanction would probably have sufficed," and whether it found that the disobedient party's refusal to obey a discovery order was willful or deliberate and substantially prejudiced the opponent's ability to prepare for trial. Snedigar v. Hodderson, 53 Wn. App. 476, 487, 768 P.2d 1 (1989) (citing to due process considerations outlined in Associated Mortgage), rev'd in part, 114 Wn.2d 153, 786 P.2d 781 (1990). We have also said that "it is an abuse of discretion to exclude testimony as a sanction (for noncompliance with a discovery order) absent any showing of intentional nondisclosure, willful violation of a court order, or other unconscionable conduct." Fred Hutchinson Cancer Research Ctr. v. Holman, 107 Wn.2d 693, 706, 732 P.2d 974 (1987) (quoting Smith v. Sturm, Ruger & Co., 39 Wn. App. 740, 750, 695 P.2d 600, 59 A.L.R.4th 89, review denied, 103 Wn.2d 1041 (1985))."

Burnett v. Spokane Ambulance, 131 Wn.2d 484, 493-494, 933 P.2d 1036, 1040-1041 (1997) (emphasis added)

Unfortunately, the trial court misinterprets *Burnett* as has Inland. Both apparently believe *Burnett* only applies to total witness exclusion rather than evidence exclusion, due to lateness in violation of a discovery order:

“THE COURT: Thank you, counsel. I am not going to exclude Dr. Finberg at this point. I only said he may be called on rebuttal. Here is what he is not going to testify to. One, **he is not going to cumulatively testify to anything that Dr. Patten testified to.** If it is simply cumulative evidence, it will not be allowed on rebuttal. Two, **the fact that counsel asked Dr. D'Alton about some Stuck Twin without any -- having proffered any opinion independently that that was a cause, is not a basis to call Dr. Finberg for rebuttal.** You will not be allowed to essentially enter a new theory by a negative answer that Dr. D'Alton did. **You have had plenty of time to develop all the theories you needed to develop. It is not fair, this is not fair to the defense. Although I am not excluding them, the Burnett analogy is still a good analogy.** You have had plenty -- this event occurred what, in '08? MR. HART: '07 and '08. THE COURT: '07 and '08. This case has been on file since 2011. **You have had plenty of time to develop any appropriate theories. And**

the fact that a witness said no, which I think is what she said – MR. HART: Yes, ma'am.

THE COURT: -- does not create a rebuttable issue. This is a theory that you would have had to put in your case-in-chief. He cannot testify to that, he would be excluded. You are right, I do not know what else may come about that it may be proper rebuttal but those two things are not; simply cumulative testimony with regard to Dr. Patten and introducing a completely new theory into the case when the plaintiff did not develop that theory through their witnesses in case-in-chief, and the defense did not develop that theory as a response to the plaintiff's case-in-chief. However that leaves him, it leaves him, I do not know.”

(RP Filed 11/14/14, hearing,1/30/15, 81-2) (emphasis added)

Clearly, the trial court was of the opinion Dr. Finberg's testimony, as the nation's leading Twin Peak expert, should provide any Twin Peak testimony in the Pitts' case in chief (and not on rebuttal), something the court never would allow. This is, evidently, why the court required Dr. Patten to be cross examined by Inland on Twin Peak methodology, during the Pitts' case in chief. Regardless, the court never made any *Burnett* findings excluding Dr. Finberg's testimony, on direct or on rebuttal. The court's specific, and apparently contrived, action on Twin Peak testimony was to deny Dr. Finberg on rebuttal, as being cumulative to Dr. Patterson's Twin Peak Testimony. (RP filed 11/14/14, Hearing 1/30/15, 81). In another hearing addressing Dr. Finberg's proposed testimony, the court stated:

“THE COURT: Well, I haven't seen it. You have not offered it, at this point, in your case in chief, which is where it rightly belongs. But you cannot do that because you disclosed Finberg way too late for any kind of case in chief. So you have to abide by how I

want to deal with it, counsel, period.”

(RP Filed 11/4/15, hearing 2/13/15, 579)(emphasis added)

Also:

“I never did understand why Dr. Finberg apparently is the guru of the Twin Peak test and apparently he is widely known in the medical community. Everybody who has testified so far seems to know his name, but he was disclosed so late that I found it was prejudicial for him to be testifying in the case in chief.”

(RP Filed 11/14/14, Hearing, 2/18/358)(statement of the trial court)
(emphasis added)

Please note that it is clear from this record that **the trial court’s primary motivation in all limitations on testimony was the court’s perception of late disclosure or development.** It is also clear that **the trial court failed to enter any significant and sufficient negative *Burnett* findings to support any restriction on any witness or evidence.** Note, also, the appearance of a contrived, boot-strap logic when: 1) no Twin Peak testimony was required or provided by Dr. Patten in the Pitts’ case in chief, in fulfilling the burden of proof on breach of the standard of care; 2) the trial court required Dr. Patten, not a Twin Peak expert, to testify extensively on Twin Peak methodology, on cross examination; and 3) the trial court then functionally precluded the nation’s premiere Twin Peak expert, Dr. Finberg, from any Twin Peak testimony to rebut the defense’s three Twin Peak expert’s testimony, on the basis that Dr. Finberg’s testimony would be

cumulative to Dr. Patten's Twin Peak testimony.

F. Loss Of Chance

Inland relies on Division III's decision in *Estate of Dormaier v. Columbia Basin Anesthesia, PLLC*, 177 Wn. App. 828, 313 P.3d 431, (2013), to deny that a loss of chance claim is viable in this action, due to a stated loss of chance greater than 50%. This result is inconsistent if loss of chance is to be a separate tort action from a traditional ultimate harm tort action. *Dormaier* is the only Washington case to clearly state that: a) percentage of loss of chance, or a range thereof, is required expert testimony to maintain a loss of chance claim, and b) a greater than 50% loss of chance case results in an ordinary tort action for the ultimate harm or result purportedly caused by negligence. Dicta in *Herskovits v. Group Health Cooperative*, 99 Wn.2d 609; 664 P.2d 474 (1983), and *Mohr v. Grantham*, 172 Wn.2d 844; 262 P.3d 490 (2011), may suggest this, but the *Mohr* Court also adopts the reasoning of Justice Pearson's plurality decision, not the lead decision in *Herskovits*. *Mohr* concludes that the loss of chance itself, not the resulting ultimate harm, is the compensable loss, as a separate tort from the ultimate harm. If this is truly the case, linking a percentage of loss of chance to the ultimate harm for calculation of damages is inconsistent, as the loss of chance claim then becomes a direct, subsidiary claim to the ultimate harm claim. Consider, also, that in *Mohr*, there was "at least a 50 to 60 percent chance" of a better

outcome. *Mohr, Id.* At 860.

As in most civil personal injury claims, a loss of chance jury will necessarily sort through testimony from opposing experts, providers of healthcare, family, friends, and neighbors, and the like, to formulate an assessment of damages. The *Mohr* court contemplated this:

“The significant remaining concern about considering the loss of chance as the compensable injury, applying established tort causation, is whether the harm is too speculative. We do not find this concern to be dissuasive because the nature of tort law involves complex considerations of many experiences that are difficult to calculate or reduce to specific sums; yet juries and courts manage to do so.”

Mohr, Id., a 858.

When there is testimony of a 60 percent loss of chance, the testimony is neutral as to responsibility of the alleged tortfeasor health care provider for causation of actual harm. It is a statement that a health care provider, more probably than not, caused a loss of chance which may have resulted in more harm or injury than would otherwise have occurred. It does not clarify whether the injured party in any particular claim falls within the statistical 60% who actually lost a chance, or the 40% who didn't.

Loss of chance and ultimate harm testimony are unrelated, conceptually. It is a comparison between apples and oranges. Even when disregarding the neutrality of loss of chance testimony to direct assignment of causation of harm, the better outcome may be on, part of, or a complete

continuum from slight improvement to great improvement, or perhaps even full recovery. Where a 60% loss of chance demonstrably results in a possible but slight (say 5%) better outcome in a severely injured person, it is not arguable that the claimant suffered the majority of their injury (ultimate harm), more probably than not, from loss of chance. The result is merely a 3 percent (.6 x .05) likely increase in harm. At a 51% loss of chance, the range of a better outcome must be in a small increment near full (100%) recovery to be arguably equivalent to more probable than not causation of the ultimate harm. A 51% loss of chance which may have resulted in a 25% better recovery cannot arguably equate to causation of the ultimate harm. Unlike loss of chance testimony, testimony that a health care provider caused the ultimate harm, on a more probable than not basis, is a direct unequivocal statement on causation of the ultimate harm.

Any attempt to link percentage loss of chance testimony in a linear relationship to the ultimate harm, for calculation of relative damages, is non-sequitur logic. This whole issue was argued before the Washington Supreme Court on November 17, 2015, the day of the windstorm in Washington. The decision is pending.

III. CONCLUSION

The record on appeal evidences: 1) multiple instances of abuse of discretion by the trial Court; and 2) a cumulative record on which it has been

clearly demonstrated that Appellants Pitts, by the court's actions, did not receive a fair trial, and that substantial justice has not been done. The multiple instances of abuse of discretion, both individually and cumulatively, and the concurrent and resulting lack of justice, require return of this action to the trial court for retrial.

RESPECTFULLY SUBMITTED this 22nd day of November, 2016.

MICHAEL J RICCELLI PS

By: 
Michael J. Riccelli, WSBA #7492
Attorney for Appellant

CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of November, 2016, I caused a true and correct copy of the Amended Reply Brief of Appellant to be served on the following in the manner indicated below:

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Michael J. Riccelli

APPENDIX

1. Clerk's Papers No. 95
2. Clerk's Papers No. 88, Ex B

2	<p>1 APPEARANCES</p> <p>2</p> <p>3 Appearing on behalf of the Plaintiffs,</p> <p>4 AMANDA PITTS., et al.:</p> <p>5 MICHAEL J. RICCELLI, ESQUIRE</p> <p>6 Michael J. Riccelli, PS</p> <p>7 400 South Jefferson Street, Suite 112</p> <p>8 Spokane, WA 99204-3144</p> <p>9 (509) 323-1120</p> <p>10 (509) 323-1122 Fax</p> <p>11 mjrps@mjrps.net</p> <p>12</p> <p>13 Appearing on behalf of the Defendants,</p> <p>14 INLAND IMAGING, L.L.C., et al.:</p> <p>15 JOHN E. HART, ESQUIRE</p> <p>16 HART & WAGNER, LLP</p> <p>17 1000 SW Broadway, Suite 2000</p> <p>18 Portland, OR 97205</p> <p>19 (503) 222-4499</p> <p>20 (503) 222-2301 Fax</p> <p>21 jeh@hartwagner.com</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	4
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1 believe there is evidence for it. I do not believe
 2 there was in my notes anything on the November 5th.
 3 There is one single image on maybe December that has
 4 something questionable but does not show a membrane
 5 or after. So it's -- Did I answer your question?
 6 BY MR. HART:
 7 Q. I think so. I think you told me you saw a
 8 dividing membrane on October 4 and what, there is a
 9 suggestion of a dividing membrane on the December
 10 21st, '07 ultrasound?
 11 A. I don't remember which one it is but it's
 12 one of the late ones has a single image with a
 13 little line in it.
 14 Q. Okay. And then looking at your Exhibit 1
 15 again, sir, would you agree that another of your
 16 opinions expressed on lines 10, 11 and 12 is that
 17 their assessment of amniotic fluid volume should
 18 have referenced the individual volume for each twin?
 19 A. That is correct.
 20 Q. Not the gross volume for both of them?
 21 A. That is correct.
 22 Q. All right. And they should have -- is
 23 another of your opinions that they should have -- I
 24 think I already asked you this but I'm looking at
 25 line 8 and 9. They should have suggested further

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1 investigation because there was no identification of
 2 an inner twin dividing membrane or individual
 3 assessments of amniotic fluid indexes for each twin?
 4 A. That is my opinion, yes.
 5 Q. And then if you would just indulge me for
 6 what I think is one of my last questions, Dr.
 7 Finberg, would you read to yourself between line 6
 8 and line 22 of Exhibit 1, just -- I know you have
 9 looked at it before and I belabored it. But would
 10 you read that carefully to yourself, 6 to 22? And I
 11 will have one question for you about that.
 12 A. Okay. Okay. I have read it. And again,
 13 your question?
 14 Q. Yes, sir. My question is this. While you
 15 may have other opinions in this case after reviewing
 16 the depositions and, you know, doing the 12 to 14 or
 17 so hours of work on this case, would you agree, sir,
 18 that looking between line 6 and line 22 of Exhibit
 19 1, you have told me what your opinions are that have
 20 been outlined on that document and in those lines?
 21 A. That I have told you my opinions about the
 22 standard of care?
 23 Q. Yes.
 24 A. Yes.
 25 Q. You and I have -- I mean maybe stated

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1 otherwise, you and I have clarified what your
 2 opinions are as outlined on Exhibit 1?
 3 A. Yes.
 4 MR. HART: All right. Dr. Finberg, that's
 5 all that I have. Thank you, sir. Send me a
 6 statement.
 7 THE WITNESS: Okay.
 8 EXAMINATION
 9 BY MR. RICCELLI:
 10 Q. Well, in providing your testimony, have
 11 you relied on the imaging of this pregnancy in
 12 total? Did you review --
 13 MR. HART: Excuse me. I just want to
 14 object and I want to note for the record and with no
 15 disrespect to Dr. Finberg, it's five minutes to
 16 1:00. I have concluded my deposition of a rebuttal
 17 witness. And if you want to go on for even five
 18 minutes or five hours, Michael, you're going to have
 19 to pay for it because I am done with my examination.
 20 And Dr. Finberg, you should be fully compensated for
 21 my time. But I am not going to just sit here for
 22 five hours while you try to do something that you
 23 didn't notify us about, Mr. Riccelli, period.
 24 MR. RICCELLI: Well, I don't think you
 25 understand Washington law when it comes to

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1 depositions. You pay for a reasonable response for
 2 clarification of the record. And unless --
 3 MR. HART: Well, I have learned something
 4 every day from you, Michael. Keep it up.
 5 BY MR. RICCELLI:
 6 Q. So in forming your opinions in this
 7 matter, have you reviewed the entire body of the
 8 ultrasounds taken on Ms. Pitts?
 9 A. Yes, I have.
 10 Q. And do you have various opinions that
 11 extend beyond what counsel asked?
 12 A. Yes, I do.
 13 Q. And what are those opinions?
 14 MR. HART: I object. They are way outside
 15 the notification of what this witness was going to
 16 tell us. I can't cross-examine him about something
 17 that I didn't anticipate. You've got to give us
 18 some word in advance. And I also incorporate Judge
 19 O'Connor's rulings in this case about the potential
 20 scope of Dr. Finberg's testimony.
 21 MR. RICCELLI: Well, he is a rebuttal
 22 witness. And are you stating that you don't want to
 23 hear his opinions that might be used in a proper
 24 rebuttal?
 25 MR. HART: I mean, I've got to stay here

34	<p>1 for a while but I just want to make it very clear 2 that this is unacceptable. This is not permitted by 3 the rules of Washington that you keep telling me 4 about. So I will sit here for a while but I don't 5 think this is going anywhere between you and me, 6 Michael. And I'm sorry for being a contentious 7 individual in front of you, Dr. Finberg. 8 BY MR. RICCELLI: 9 Q. Okay. So whether or not you are allowed 10 to testify at trial, do you have opinions about this 11 matter that have not yet been expressed? 12 A. I do. 13 Q. And what are those opinions? 14 A. My opinion is that baby B was a stuck twin 15 with severe oligohydramnios. And the combination of 16 oligohydramnios and a baby smaller than the co-twin 17 indicated strong probability in this case that that 18 fetus was significantly growth restricted and 19 therefore at risk, that should have been recognized, 20 and had it been recognized, would have led to more 21 intensive scrutiny and management of the pregnancy. 22 Q. Okay. And you have prepared a Power Point 23 presentation to illustrate your opinions, haven't 24 you? 25 A. I have.</p>	36	<p>1 A. No, but I can do it. I need to get to 2 down here. 3 Q. Just click to your left. It should get 4 you there. 5 A. Okay. How can I get this to go forward 6 and back? 7 Q. I think if you -- 8 A. Sorry. Why don't I have you -- 9 Q. I have a regular mouse here you can use. 10 Why don't I have you work the buttons. 11 A. Okay. Can you see the screen there. 12 MR. HART: I can't quite see the bottom of 13 the display, Dr. Finberg. I can see the line with 14 IUGR. 15 THE WITNESS: That's the last line. 16 MR. HART: Okay. 17 THE WITNESS: So again, I believe this is 18 a monochorionic diamniotic pregnancy. Twin A always 19 had normal amniotic fluid. Twin B had severe 20 oligohydramnios. There is something which I have 21 written a paper about called amniotic wrinkle around 22 twin B which confirms that twin has very low 23 amniotic fluid. There was a structure called a twin 24 peak sign which is not. It is a synechia. Several 25 of the other expert witnesses agreed it was a</p>
35	<p>1 Q. Can you just briefly go through the Power 2 Point and -- 3 MR. RICCELLI: Do you want to see the 4 Power Point, Counsel, or do you want him to just 5 describe it? 6 MR. HART: I don't know. I can't see it 7 from here if -- 8 THE WITNESS: I can show it to you if you 9 want to see it. 10 MR. RICCELLI: If you want to see it, we 11 will make it visible here. 12 MR. HART: Here's the main part. I'll 13 just restate my prior objection and incorporate it 14 by reference. Can you buzz in on that, despite my 15 limited interest? 16 THE WITNESS: I understand. Let's see. We 17 are going to -- I can do it. Very sensitive. I 18 think that's as big as it gets. 19 BY MR. RICCELLI: 20 Q. Let's move this up a little bit. 21 A. Okay. Let's make this -- Do you have a 22 mouse? 23 Q. Yes, right here. 24 A. I have to enlarge this again. 25 Q. You haven't used this before?</p>	37	<p>1 synechia. And as a result, my opinions are that 2 twin B was growth restricted, not a victim of twin, 3 twin transfusion. 4 This is from the August 10 scan, 12-week 5 scan. It shows a very thin inter-twin membrane, 6 typical of a monochorionic diamniotic pregnancy 7 outlined by the arrows. This is another image from 8 that. This is one of the still images that shows 9 the same thin injured twin membrane. Several other 10 pictures from that study show the same. 11 This is a picture from the August 27 scan. 12 It again shows the thin injured twin membrane, 13 single placenta behind with a little shadow from the 14 limb of the fetus. 15 Back to the August 10 scan, there is a 16 little pointy area over here and several additional. 17 This is from the video sequence. This is what was 18 called initially the twin peak sign but it probably 19 is from the synechia. And one of the findings of 20 it, it's thick and triangular here, thinning out 21 here, but then there is one image right here where 22 it stops. And this should never occur with an 23 actual twin peak sign. This is good evidence that 24 this was an incidental synechia or adhesion, which 25 I think ends up being non-germane to the case, seen</p>

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1 over there again.

2 This is where some of the important

3 information comes. This is from the October 4 scan.

4 The dots over here are a fetal hand, a thumb and

5 fingertips, and there is a membrane extending from

6 them over here. That's part of an amnion which is

7 wrapped around this fetus, become redundant and

8 created a wrinkle, which is indication that there is

9 very little fluid around this twin, what's often

10 referred to as a stuck twin.

11 There are additional images from this

12 October 4 scan that show additional findings for

13 that with parts of that redundant membrane creating

14 wrinkles around portions of the limbs of this

15 restricted fetus. And there are several that I will

16 just go through briefly over here. This shows the

17 same phenomenon.

18 Now, over here from that hand you can see

19 the dots which are the thumb and the fingers again.

20 This is that thing that I called an amniotic

21 wrinkle, which is just a redundant fold of the

22 amnion. But in a very close-up view, it looks like

23 it comes to a point and then comes back. And there

24 is one other one of the still images from the same

25 study that shows that more clearly. It's over here.

39

1 And it's misspelled as membrane over here.

2 But in a close-up view of this, you can

3 see that there is a membrane here that divides into

4 an anterior and posterior thing. And this is

5 wrapping around this fetus so that all the fluid

6 that fetus B has is this little tiny bit. All the

7 rest of the fluid is of twin A.

8 Now, over here, the additional finding,

9 this is going back -- This is the October 4 scan

10 too. We have the lower portion of the body and

11 proximal thighs of fetus B. And there is an area of

12 multiple echos between the knee of this fetus and

13 the wall of the uterus. And almost without

14 question, that is the umbilical cord for this fetus

15 which is clumped together in a very small amount

16 within the same restricted amniotic space. And that

17 was seen both in the videotape and in the still

18 image. So all of the cord of this fetus is

19 restricted, not where the amniotic fluid is over

20 here.

21 Then on a later scan -- This is the

22 October 21st scan -- there were Dopplers done

23 presumably because one of the fetuses was small and

24 they were read to be baby B and baby A. They all

25 have a similar pattern and actually have similar

40

1 numbers. But all of these loops are within the

2 amniotic fluid freely. There is no way of telling

3 from the images themselves which fetus they came

4 from. But because I believe the fluid on the other

5 twin was restricted, I believe all of the signals

6 were on twin A and that no Dopplers were ever

7 obtained on twin B.

8 Finally, there is one image from the

9 December 21st one. That's the one that I said had

10 the single bit of a membrane. I see it. It is not

11 something that can be characterized. I can't tell

12 what it is or whether it represents rupture of the

13 membranes or of amniotic wrinkle like. I just can't

14 make any sense of it. So it's not relevant.

15 I also have other things here that are

16 just descriptive things that I provided showing what

17 a twin peak sign looks like, what uterine synechia

18 looks like and what an amniotic wrinkle looks like.

19 That's all I'm going to say unless you have

20 additional things you want me to say.

21 BY MR. RICCELLI:

22 Q. No. Is that the extent of your opinions

23 and conclusions in this matter regardless of what

24 testimony is allowed at trial?

25 A. Yes, it is.

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1 MR. HART: Same objection just for the

2 record. Sorry, Dr. Finberg.

3 THE WITNESS: Okay.

4 MR. RICCELLI: Okay. So can you download

5 this as an exhibit? Can I give you a flash drive

6 that you can download onto your computer?

7 MR. HART: Maybe I have a solution.

8 MR. RICCELLI: Go ahead.

9 MR. HART: I'm just going to say without

10 waiving my objection, I could maybe offer a

11 suggestion, especially given the short time before

12 trial starts. You could conceivably take that Power

13 Point and send it to jeh@hartwagner.com and then I

14 would have it before all of the work that needs to

15 go into -- then you can just put the -- you could

16 call that whatever exhibit it is and just put the

17 first page on it and I would accept that again

18 without waiving my earlier objection.

19 MR. RICCELLI: I was intending to email

20 you a copy too but just for the record, I want to

21 get one into the record also. Okay. We will do

22 that. Jeh@hartwagner.com?

23 MR. HART: Yeah. It's one word. I think

24 you have it anyway but --

25 (Exhibit 9 marked.)

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SUPERIOR COURT OF WASHINGTON FOR SPOKANE COUNTY

AMANDA PITTS (nee/aka AMANDA
COMPTON, nee/aka AMANDA
CRUTCHFIELD) and PAUL PITTS,
individually; and AMANDA PITTS as Personal
Representative of the ESTATE OF TAYLOR
PITTS, and on behalf of all statutory claimants
and beneficiaries,

Plaintiffs,

v.

INLAND IMAGING, L.L.C., a Washington
business entity and healthcare provider; INLAND
IMAGING ASSOCIATES, P.S., a Washington
business entity,

Defendants.

No. 11-202449-5

PLAINTIFFS' OFFER OF PROOF

Plaintiffs Amanda Pitts and Paul Pitts and the Estate of Taylor Pitts, by and through their undersigned attorney Michael J. Riccelli of Michael J. Riccelli, P.S., respectfully offer the following testimony.

A. PROFESSOR CAROLYN T. COFFIN

Prof. Carolyn Coffin will be called in rebuttal to address testimony from sonographers Crowley and Rees regarding what they may or may not have learned when they attended Bellevue Community College School of Sonography and what they may or may not have learned regarding application and use of the AIUM/ACR Guidelines. She will also rebut testimony about what is presumed to be the knowledge or understanding of sonographers regarding the use

PLAINTIFFS' OFFER OF PROOF - 1

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001368

1 and application of the guidelines and in conjunction with measurement of amniotic fluid volumes
2 in twin pregnancies, and the "education" of sonographers by Inland's Dr. Cubberly. Her
3 anticipated testimony follows.

4 Q. Name and business address.

5 A. Carolyn T. Coffin, Seattle University, Department of Diagnostic
6 Ultrasound, 901 Twelfth Ave., Seattle, WA 98122

7 Q. Current employment and nature of employment.

8 A. Professor with the Department of Diagnostic Ultrasound at Seattle
9 University and appropriate response.

10 Q. Education, training, background, experience.

11 A. Response consistent with her CV, including Masters in Public Health,
12 University of Denver, and teaching and administrative positions at the
13 University of Colorado in Denver and the Seattle University in their
14 schools of sonography.

15 Q. At times pertinent to this litigation, beginning in approximately the late
16 1980s through 2007, and beyond, what was taught to sonographers about
17 the use and application of the twin peak sign in twin pregnancies?

18 A. The twin peak sign may have been mentioned, but it was not utilized in
19 sonography programs I have been involved with or have familiarity with.
20 Conversely, sonography students were taught throughout that time period,
21 and up to today, to consider multiple factors such as sex, single or dual
22 placenta, etc. Membrane thickness is taught and twin peak sign is not.

23 Q. Are you familiar with AIUM/ACR guidelines?

24 A. Yes.

Q. There has been testimony that in a twin pregnancy, a four-quadrant
assessment without necessity of visualizing the inter twin membrane. Is
this consistent with what sonographers have been taught and are currently
taught?

A. No. Sonographers have been and continue to be taught that the guidelines
require identification of the inter twin membrane to make a proper
assessment of amniotic fluid volumes on each side of the membrane and
that they are expected to report if the inter twin membrane cannot be
identified in the course of assessing amniotic fluid volumes. Further, there
is no instruction on any method of assessing amniotic fluid volumes

1 without reference to the inter twin membrane. There is also no instruction
2 on giving a total amniotic fluid volume for the pregnancy without
quantifying the fluid in each sack or amnion.

3 Q. Are there times at which assessment of the twin membrane is difficult or
4 impossible?

5 A. There can be external factors and/or factors such as the size of the twins,
6 the size of the mother and the gestational age of the twin pregnancy that
make it more difficult, but it is rare that a sonographer could not carefully
follow the placenta and locate an edge of the inter twin membrane.

7 Q. Thank you Ms. Coffin, no further questions.

8 **B. HARRIS FINBERG, M.D.**

9 Harris Finberg, M.D. will be called to rebut testimony regarding the purported twin peak
10 sign and its accuracy and importance in this litigation. As the primary developer/reporter of the
11 twin peak sign, he will also be called to rebut testimony regarding the identification of inter twin
12 membrane in various ultrasound reports and imaging, and the conclusion that on December 21,
13 2007, there was evidence of an inter twin membrane which was sufficient to conclude that one
14 existed; and further, that if one existed on December 21, 2007, it must have existed throughout
15 the prior ultrasounds regardless of whether the inter twin membrane was visualized or not.
16 Dr. Finberg will identify the location of the membrane, collapsed about one of the twins.
17 Dr. Finberg will also testify in rebuttal to Dr. D'Alton's testimony of a spontaneous breach of the
18 inter twin membrane after the December 21, 2007 ultrasound. Dr. Finberg will identify that the
19 membrane was not breached spontaneously as he will locate the membrane in various images
20 beginning October 4, 2007, as collapsing about and/or being collapsed around one of the fetuses.

21 Q. Name and business address.

22 A. Harris Jay Finberg, M.D., Phoenix Perinatal Associates, 3877 North 7th
23 Street, #400, Phoenix, Arizona 85014

24 Q. Education, training, background and experience

A. Response consistent with CV, including Director of Diagnostic Ultrasound

1 at Phoenix Perinatal Associates and Assistant Professor of Radiology at
2 Mayo Medical School.

3 Q. What is your association with the twin peak sign as a diagnostic tool in
4 determining chorionicity and amnionicity in twin pregnancies?

5 A. My research and concurrent research by another in Europe led to a
6 decision sequence incorporating the use of the twin peak sign for assisting
7 in determining the chorionicity and amnionicity of a twin pregnancy.

8 Q. Can you describe that decision sequence?

9 A. Yes. (Dr. Finberg will briefly describe the process or decision sequence.)

10 Q. In the Pitts pregnancy, did the August 10 and August 27, 2007 ultrasounds
11 evidence a reliable twin peak sign upon which a radiologist could
12 reasonably have concluded a dichorionic twin pregnancy?

13 A. Not if the radiologist reviewed all the imaging available. This would
14 include the VHS tape of that ultrasound session. It is vital that all of a
15 patient's ultrasound records be maintained for review, including all
16 imaging done. In this instance, the imaging captured by the sonographer
17 and provided to the radiologist for review might have been reasonably
18 concluded to be a dichorionic pregnancy based upon a twin peak sign.
19 However, review of the VHS recording of the ultrasound provided to the
20 Pitts's to take home reveals a sequence where it becomes evident that
21 there is no continuous membrane to what may have looked to be a twin
22 peak sign. Rather, it clearly demonstrates that there is no continuous
23 membrane and, therefore, no twin peak sign. A twin peak sign refers not
24 only to the delta or triangle area filled with chorionic tissue, but that a
thicker membrane continues uninterrupted through the womb. The images
captured by the sonographers in the August 10 and August 27 ultrasounds
show a very thin inter twin membrane typical of a monochorionic
diamniotic pregnancy and not typical of a dichorionic pregnancy.

Q. There has been testimony that there is evidence of inter twin membranes
being captured on imaging on October 4, 2007 and as late as
December 21, 2007, in which it can be determined that there is a
membrane with ample amniotic fluid on either side of it. Do you agree
with that?

A. No. There is evidence of a collapsed or collapsing membrane on
October 4, 2007, but no substantial evidence thereafter. The one still
image on December 21, 2007 is not sufficient to conclude that the
membrane existed and is most likely an artifact not chorionic or amniotic
tissue. Beginning with the October 4, 2007 ultrasound, there are images
which, on careful review, show that the amniotic membrane began to
collapse if not was fully collapsed over one of the twins. There are images

1 of amniotic wrinkles, not normal membrane, which show this draped
2 between the limbs and feet of the twins. Thereafter, there are no images of
a competent inter twin membrane.

3 Q. There has been testimony from Drs. D'Alton and Callen that an amniotic
4 fluid assessment or index can be performed without visualizing the inter
twin membrane, consistent with the AIUM and ACR guidelines. Do you
5 agree with this?

6 A. No. The AIUM and ACR guidelines clearly require that the inter twin
7 membrane be visualized in order to assess the volume of amniotic fluid
8 available to each twin, on either side of the membrane. It is a breach of
9 the standard of care to process the imaging and report on it without
visualizing the inter twin membrane. It is a further breach of the standard
of care to provide a total amniotic fluid index and report on it as being
normal, but in a situation where no inter twin membrane was visualized
and that fact was not reported to the ordering OB-GYN.

10 Q. The defendants experts and radiologists have made much about the single
11 frame image in which a purported membrane is seen on December 21,
2007. Do you have any other comment about that.

12 A. Yes. There is something that can be seen, but it cannot be characterized.
13 It is insufficient to characterize it as a membrane, a rupture in a
membrane, an amniotic wrinkle, or an artifact.

14 Q. You testified earlier about the membrane being collapsed around one of
15 the twins. Can you describe what the nature of the membrane was based
upon information contained in the Pitts medical file.

16 A. Pathology reported that this was a monochorionic diamniotic pregnancy
17 based upon histology of the placenta. It was a single placenta and,
therefore, the pregnancy was monochorionic. Dr. Hardy's operative report
describes a membrane being wrapped about the demised fetus. Given this
18 information it is more probable than not with reasonable medical certainty
that it was the demised fetus's amniotic membrane wrapped around it,
19 which was first evidenced on the imaging of October 4, 2007. Whether it
also was the other twin's amniotic membrane, or when and where the
20 membranes were breached to allow communication, it is clear that this
occurred, which allowed for cord entanglement, resulting from a
21 functional amniotic monochorionic pregnancy.

22 Q. Defense experts have stated that this breach or communication occurred
23 after December 21, 2007. What are your opinions?

24 A. The collapse of the membrane around the demised twin began to occur
prior to October 4, 2007, and likely continued to occur.

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Q. Dopler images of the twins umbilical cords were taken. These purportedly demonstrated healthy twins. Any comment?

A. A reasonable and likely conclusion is that, given the extremely similar doplar readings, that the sonographer took doplar readings on the same fetuses umbilical cord twice, in different locations that the twin's membrane was floating about.

Q. Regardless, Inland and its radiologists are relying heavily upon the twin peak sign in determining the chorionicity in this matter. Do you have any opinions or observations about this reliance?

A. Yes. The twin peak sign which I described in the early '90's is a highly accurate diagnostic tool when utilized appropriately by following a specific decision sequence. Regardless of its reliability and whether it was properly interpreted and applied appropriately in this case, the appearance of a purported twin peak sign cannot minimize or relieve a radiologist from following the pregnancy closely and appropriately by requiring sonographers to capture and provide all imaging that provides unique, non-duplicative views of the pregnancy, and that the radiologists thoroughly review the imaging available. Further, radiologists cannot rely on amniotic fluid volume calculations when not based upon clear visualization of the inter twin membrane. It is a violation of the standard of care to do so and it is a violation of the standard of care to do so and not report that lack of visualization to the ordering OB-GYN for his or her consideration. This is particularly remarkable with respect to the December 21, 2007 note from sonographer Crowley to radiologist Balmforth. In particular, he attempted to but could not ascertain the inter twin membrane and radiologist Balmforth's subsequently reliance on a single frame of a non-descript image which cannot be concluded to be evidence of a membrane was violation of the standard of care.

DATED this 19th day of FEBRUARY, 2014

MICHAEL J RICCELLI PS

By: *Michael J Riccelli*
MICHAEL J RICCELLI, WSBA #7492
Attorney for Plaintiffs

*FINISH DEMONSTRATIVE
EXHIBITS (POWERPOINT)
ATTACHED*

Michael J Riccelli

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DECLARATION OF SERVICE

I caused to be served a true and correct copy of the foregoing by the method indicated below, and addressed to the following:

Jennifer L. Moore
Bennett, Bigelow & Leedom
Two Union Square
601 Union Street, Suite 1500
Seattle, WA 98101-1387

____ Overnight Mail
____ U.S. Mail
 Hand-Delivered
____ E-Mail
____ Facsimile

John E. Hart
Hart & Wagner
1000 SW Broadway, #2000
Portland, OR 97205

____ Overnight Mail
____ U.S. Mail
 Hand-Delivered
____ E-Mail
____ Facsimile

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Dated this 14th day of FEBRUARY, 2014.

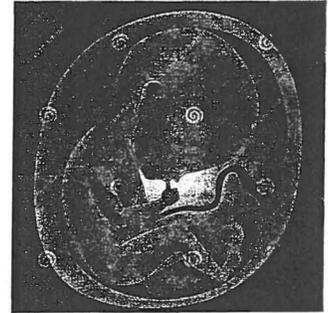


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Two Facts to discuss

- Twin B was smaller than twin A
- Based on an observation thought to be a twin peak, sonograms were interpreted as being dichorionic (2 placentas), but at delivery, the pathologist found that the pregnancy was monochorionic (1 shared placenta - thin 2 layer membrane)

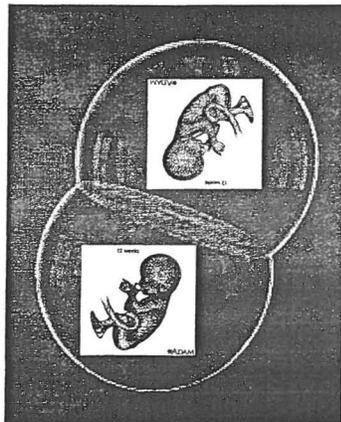
**Baby (Fetus)
Umbilical Cord
Placenta
Amniotic fluid in
membrane-lined
amniotic sac**



001375

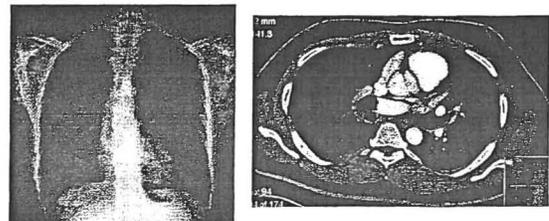
001376

**With twins,
membranes
lining the two
sacs abut,
creating the
inter-twin
membrane**



001377

A Few Imaging Basics



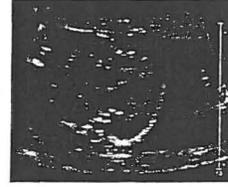
- Xrays, CAT and MRI scans images show all the anatomic information of the body region.

001378



- **Ultrasound is selective**
 - The images are taken by a sonographer.
 - Only what the sonographer thought was important is recorded

001379



**You take images of what you see,
you see what you look for,
and you look for what you know.**

**Important data may be missing
for the radiologist – or for review**

001380

To review an ultrasound study, it is important to look at all the recorded imaging data including all available still images and video.

There may be findings included that the sonographer was not aware of and/or the radiologist did not recognize as important.

001381

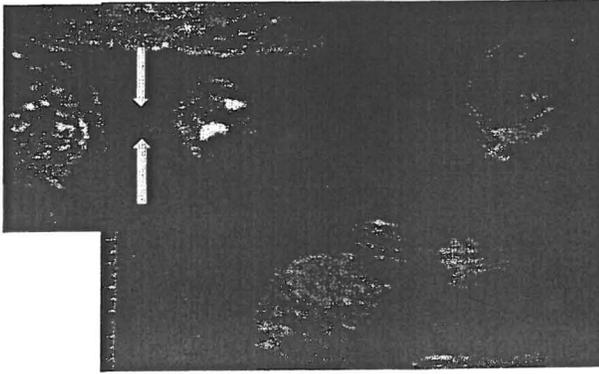
AIUM Guidelines 2003

Multiple gestations require the documentation of additional information:

- chorionicity, amnionicity
 - comparison of fetal sizes
 - estimation of amniotic fluid volume (increased, decreased, or normal)
- on each side of the membrane**

001382

Why a 4 quadrant amniotic fluid index does not provide reassurance in twins



001383



001384



001385



001386

Amniotic Wrinkle



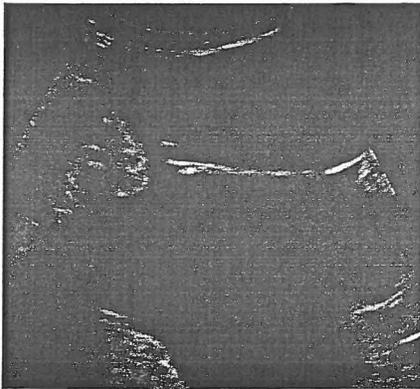
001387

Amniotic Wrinkle



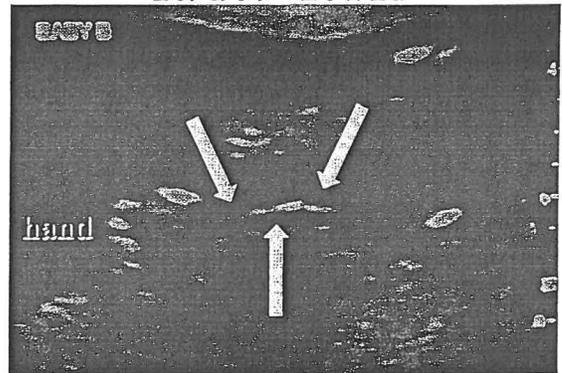
001388

Amniotic membrane between limbs



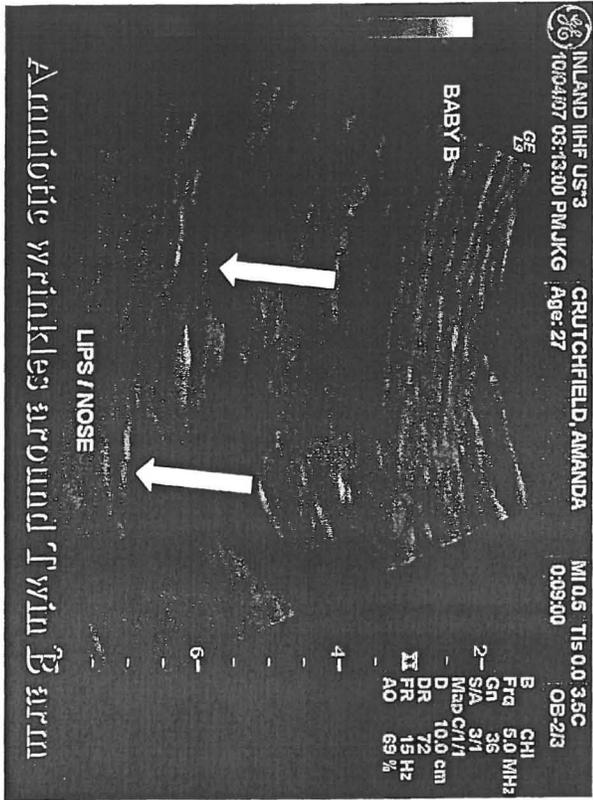
001389

10/4/07 20w1d

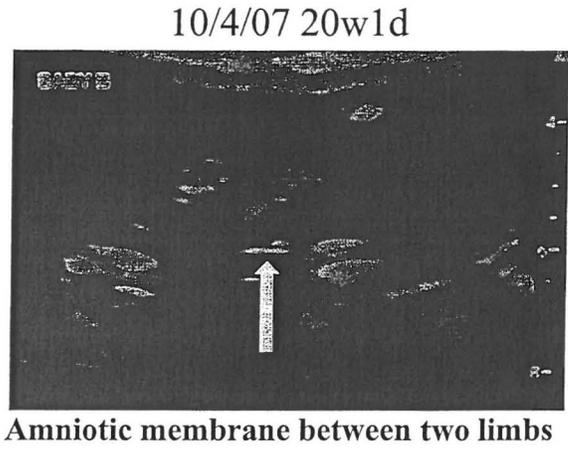


Amniotic wrinkle around Twin B hand

001390



001391



001392

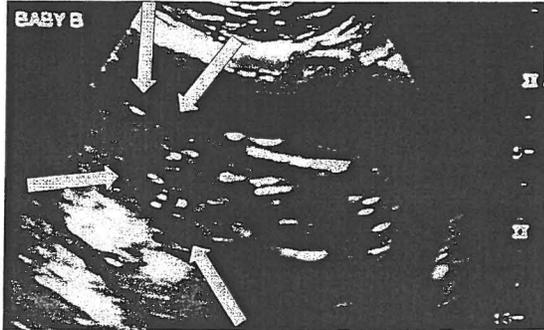


001393



001394

10/4/07 20w1d



Twin B cord between it and membrane

00139

Puzzling Inconsistency in Report Fetal Weight Percentiles

	Gest Age by Previous Scan	Est. Wt. percent by me	Gest Age by Current Scan of EACH FETUS	Est. Wt. percent Reported (and by me)
Twin A	31w2d 1732 g	37%	31w4d	30% (28%)
Twin B	31w2d 1327 g	2%	30w0d	10% (13%)

Fetal Biometry Calculator II

00140

Serious Methodological Error!

- The US program takes the measurements of a fetus and calculates that the fetus is average in size for a fetus of a particular age.
- It calls a smaller fetus younger, and the calculated weight is thus closer to normal for the younger age.

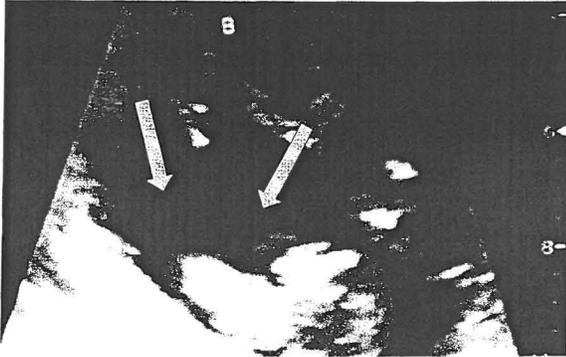
001401

Was it reasonable for the radiologists to mistake the synechia for a twin peak indicative of a dichorionic pregnancy?

Arguable as to images selected by sonographer but not if VHS tape images considered.

001402

8/10/07 12w 2d

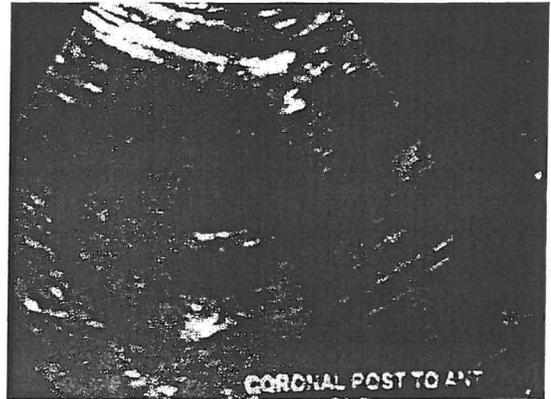


Thin membrane: Monochor.-Diamnio.

001403

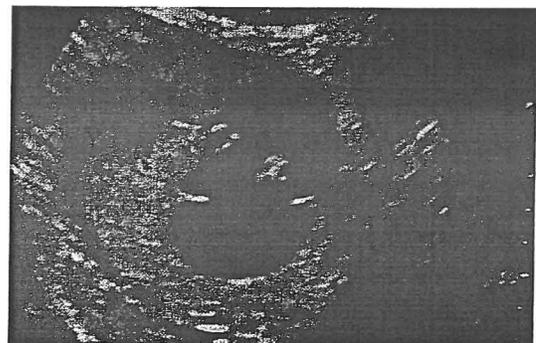
K09100

8/10/07 12w 2d



8/10/07 12w 2d

8/10/07 12w 2d



Membrane discontinuous: Not Twin Peak

001406

001405

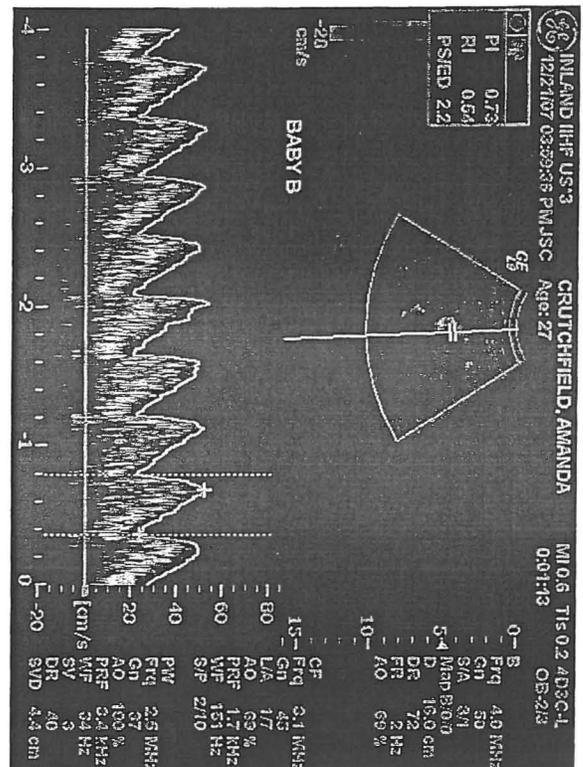
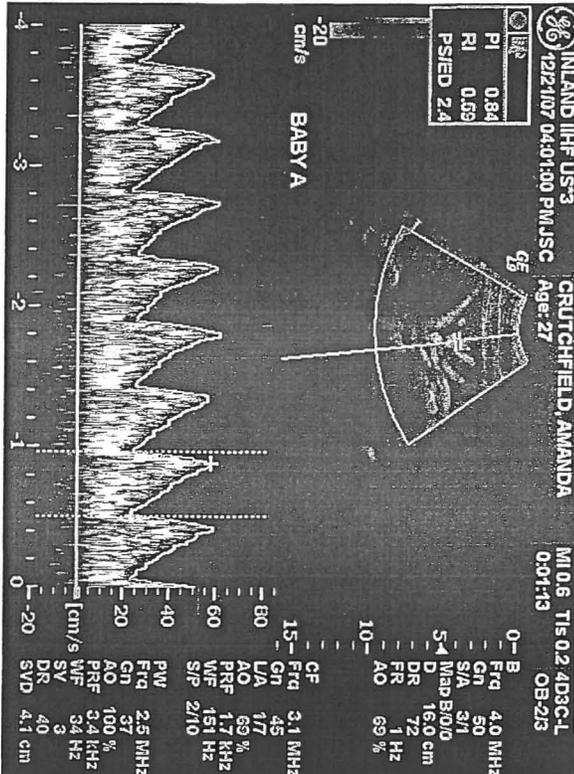
8/10/07



Synechia (adhesion) is most likely

Did their belief that the pregnancy was dichorionic excuse them from evaluating the amniotic fluid separately for each twin on subsequent sonograms?

Definitely NO!



001427

001428

001409

001410

Umbilical artery Doppler

- Images for umbilical cord labeled **Twin A** and **Twin B** show similar positions of cord anteriorly in fluid with similar normal waveforms
- Both Dopplers almost certainly of Twin A only