

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

JENNIFER MILLS and JASON LUKAS,
individually and as guardians for M.L.,
minor child; JOHN P. ALBRECHT and
CELMA BARRETO, individually and as
guardians for V.A., minor child; JARED
KAPLAN and BRIANNE KAPLAN,
individually and as guardians for W.K.,
minor child; STEPHANIE MARZOLF,
individually and as guardian for J-A.M.,
minor child;

Plaintiffs,

v.

SEATTLE CHILDREN’S HOSPITAL, a
non-profit Washington Corporation,

Defendant.

NO. 19-2-31648-9 SEA

PLAINTIFFS’ TRIAL BRIEF

I. OVERVIEW

This bellwether trial involves four child patients and their patients. The underlying class action lawsuit includes 77 child patients of Seattle Children’s Hospital who were exposed to Aspergillus fungus in cardiac and neurosurgery operating rooms in 2019. This exposure put each child at risk of invasive and deadly Aspergillus infection. Defendant therefore recommended and prescribed prophylactic (preventative) treatment and diagnostic testing to mitigate the likelihood that more children would die. Liability has been established. This trial is one of damages only.

1 **II. PARTIES & COUNSEL**

2 Plaintiffs are represented by trial counsel Karen Koehler and Andrew Ackley. With
3 supportive briefing from Shannon Kilpatrick and Debbie Silberman.

4 Seattle Children’s Hospital is represented by trial counsel Jake Winfrey and Caitlin
5 Spencer.

6 **III. DEFENDANT’S ADMITTED NEGLIGENCE**

7 In September, it was established that Defendant failed to use reasonable care in the
8 maintenance of buildings and grounds for the protection of patients:

9 Seattle Children’s Hospital does not contest and therefore stipulates that (1) it was
10 negligent in exposing the Prophylaxis Class and all its members to the risk of
11 Aspergillus surgical site infection in 2019, (2) because of this risk, Seattle
12 Children’s Hospital recommended prophylactic treatment to Class members, and
13 (3) the risk was sufficient such that each Class member need not prove the extent
14 of each child’s exposure to Aspergillus.

15 This stipulation establishes that the negligent exposure was sufficient to cause injury to
16 Plaintiffs. It allows the child plaintiffs and their parents to present damages claims for all harms
17 flowing from the exposure.

18 **IV. ASPERGILLUS RISKS, TESTING, AND TREATMENT**

19 **A. Risks Presented by Aspergillus Fungus Infection.**

20 Defendant’s standards call for zero Aspergillus surgical site infections because it can cause
21 serious injury and death.

22 **B. Aspergillus Infection Testing.**

23 Testing for Aspergillus infection is typically done in two ways. First, hospitals use tissue
24 and blood tests (Galactomannan test). Drawing blood from young children and infants is a
significant medical procedure. Children with severe or chronic medical conditions, or those who
have recently undergone major surgery, often have veins that have collapsed down. The blood

1 then makes its way through deeper veins buried inside muscles, which are harder to reach. This
2 requires doctors and nurses to hunt for useable veins with multiple insertions. It can require others
3 to hold the child down and put them in an awkward position to access a vein to draw blood.

4 Imaging is often used to test for Aspergillus infection. This typically includes repeated X-
5 rays and CT scans, which carry with them serious radiation risk, especially in a pediatric
6 population. The imaging needs to include the chest and sometime involves the head, which means
7 that radiosensitive organs like the thyroid and the eyes are often irradiated repeatedly, and this can
8 lead to cancer in those tissues.

9 Aspergillus infections are particularly difficult to diagnose. First, the incubation period is
10 lengthy and imprecise. Defendant’s letter to patients and families indicates “Most Aspergillus
11 surgical site infections show up within 4 months after the surgery.” Second, testing is not always
12 reliable or definitive. A positive Galactomannan does not always mean an infection, and a negative
13 Galactomannan one time does not preclude one. Patients and parents therefore face prolonged
14 uncertainty on the child’s risk and outcome.

15 **C. Aspergillus Fungus Treatment and Prophylaxis.**

16 Whether an infection is confirmed or potential, Aspergillus is most commonly treated with
17 anti-fungal medications, such as Voriconazole and Posaconazole. These medications carry a
18 serious side-effect profile especially when given to children who are taking other medications with
19 serious toxicities and with serious underlying health conditions. The below list is from
20 Defendant’s publication for its Aspergillus prophylaxis plan:

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1 If your patient is taking
2 prophylactic antifungal
3 medication
4 voriconazole or
5 posaconazole:

They will receive galactomannan testing 7-10 days after they begin taking the medication.

They will receive an ALT test 2 weeks after starting the medication.

Possible side effects:

Common or concerning Voriconazole side effects

- Visual disturbances
- Fever
- Nausea
- Vomiting
- Rash
- Headache
- Liver function test increased
- Hallucinations
- Tachycardia
- Arrhythmias and QT prolongation
- Hypersensitivity
- Hepatic toxicity
- Photosensitivity

Common or concerning Posaconazole side effects

- Headache
- Nausea/vomiting
- Rash
- Fever
- Chills
- Liver function test increased
- Tachycardia
- Arrhythmias and QT prolongation
- Bone/muscle aches

Management of

19 These medications can also impact a patient's underlying treatment. They can alter the
20 metabolism of other medications requiring that those other medication dosages get altered,
21 verified, or that they get swapped out entirely. Some (like Voriconazole) require measuring levels
22 to ensure that the drug is within the therapeutic zone, and if they are not therapeutic it could mean
23 that a child is subjected to all of the risk with minimal benefit. When Aspergillus testing and
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1 treatment impacts the child’s underlying care, that can in turn lead to worse clinical outcomes.

2 **D. Modification of Treatment Plans Due to Negligent Exposure.**

3 While Plaintiff-parents have their own damages claims, they also serve an important role
4 as medical decision-makers for their plaintiff-children. Many of them made treatment decisions
5 after their children’s negligent exposure as to prophylaxis, diagnostics, and underlying treatment:

- 6 • Some discontinued prophylaxis.
- 7 • Some transferred all future care to other hospitals—a significant undertaking in this area
8 given Defendant’s status as a regional children’s hospital.
- 9 • Some delayed other necessary medical care and returned to Defendant’s hospital with
10 extreme anxiety after the child’s prior exposure.

11 Some parents made treatment decisions after the exposure based in part on what happened
12 before exposure. For example, V.A.’s surgery was postponed twice due to “air issues” in the ORs.
13 The family began transferring her care to Stanford, when Defendant called to advise they had an
14 open OR. Only then after surgery, Defendant prescribed prophylaxis for Aspergillus exposure
15 anyway. This impacted V.A.’s ability to trust Defendant with the care of their child.

16 **V. DEFENDANT’S ASPERGILLUS PROPHYLAXIS PLAN**

17 Defendant acknowledges that notifying patients of an exposure to a potentially deadly
18 infection that can spread inside a child’s body is itself a harm to patients and/or parents. Hospitals
19 analyze the risks for and against notification and deploy strategies to minimize—and avoid
20 compounding—harm in patient communications. All of the parent and child experience,
21 information-seeking, and decision-making starts with Defendant’s Aspergillus Prophylaxis Plan.

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1 Here, this played out in three steps. First, Defendant's Infection Prevention Department
2 developed methodology as to which patients should be recommended prophylactic treatment
3 through risk stratification like the below:

4 **Risk stratification for Aspergillus surgical site infections for Cardiac Surgery Patients**

5 Most post-operative Aspergillus infections occur within 4 months of exposure. Based on the
6 epidemiology of Aspergillus surgical site infections, ORs where we have seen cases or concerning
7 environmental levels (12 and 14, 15) and our local prior experience, we are considering the following
management steps. Be aware that we cannot rule out environmental risk in other ORs, but they have
not had concerning levels of fungus identified. See below for instructions on how to find what room a
patient had their surgery.

8 **For procedures (1/20/19-5/18/19) that were complex, prolonged, involved implants, or occurred in
9 immunocompromised patients (this will include most cardiac surgery patients):**

- 10 • If patient is asymptomatic,
 - 11 ○ Antifungal prophylaxis is recommended.
 - 12 ▪ See separate guidance for drug selection and dosing.
 - 13 ▪ Duration of prophylaxis would be 1 month for most; up to 3 months for patients
with significant immune compromise
 - 14 ○ Obtain serum galactomannan
 - 15 ▪ If positive, contact ID for treatment recommendations
 - 16 ▪ If negative, repeat weekly until 4 months after last surgery date between
1/20/19-5/18/19
- 17 • If patient is symptomatic (has evidence of a surgical site infection):
 - 18 ○ Test for Aspergillus (see below)
 - 19 ○ Initiate empiric therapy (discuss with ID) if not already receiving.

20 Second, Defendant devised a procedure of how and what to inform patients and parents
21 about the danger of infection and prophylaxis options, in addition to what individual treatment
22 teams communicated. Third, the Infection Prevention team worked in tandem with Patient and
23 Family Relations and Risk Management to mitigate harm caused by patient notifications and avoid
24 compounding it. All three steps play a role in how what parents are told and how they are treated
as caregivers and medical decision-makers.

Defendant used the below PowerPoint to describe family reactions:

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Principles on answering the calls

- Families will have a range of emotions
 - Anger
 - Fear
 - Mistrust – “here we go again”
 - Disappointment
 - Confusion (why are you contacting people if it is not a big risk?)
 - Appreciation

Because notifications are harmful, Defendant analyzed the risks² for and against notification and deployed strategies to minimize—and avoid compounding—harm in patient communications. Defendant’s internal policies on adverse events (pre-existing this event),³ directives regarding the Aspergillus outbreak specifically,⁴ documents produced in discovery on ethics in disclosure,⁵ and defense testimony call for patient/family communications that are immediate, transparent, and ongoing.

Defendant instructed staff how to deescalate distress caused by adverse event notification, including sharing information:

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¹ See Plaintiffs’ Ex. 20.

² See Plaintiffs’ Ex. 4.

³ See Plaintiffs’ Ex. 1.

⁴ See Plaintiffs’ Ex. 8 & 10.

⁵ See Plaintiffs’ Ex. 19, Dr. Thomas H. Gallagher, Professor at UW Department of Medicine.

Helping Someone who is Escalated

- An essential step in helping anyone deescalate is ensuring they feel heard
- Listen with full attention and without interrupting
- Empathize genuinely
- Naming emotions has a calming effect
 - I suspect you may be feeling ... <frightened, worried, disappointed>
- Convey sincere regret and apologize.
 - “I’m really sorry this has happened”
- Talk about next steps
- Share information clearly and completely



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The failure to follow these procedures compounds harm:

Consequences of Failed Response to Adverse Events



- Compounds suffering of patients and family

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Plaintiff will call three of Defendant’s witnesses to explain the components of Defendant’s communications with patients:

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⁶ See Plaintiffs’ Ex. 20.

⁷ *Id.*

- Dr. Danielle Zerr, Head of Infection Prevention and CR 30(b)(6) designee on hospital policies and procedures;
- Amanda Mogg, the Interim Director of Patient and Family Relations in 2019;
- Caitlin Morray of Risk Management, and CR 30(b)(6) designee on patient communications.

VI. PLAINTIFFS AND PLAINTIFFS' CLAIMS

1. V.A.



John Albrecht is an Alaskan married to Celma Baretta, a Brazilian woman. On October 27, 2007, V.A. was born in Brazil and quickly evaluated for a heart murmur. She was later diagnosed with a complex form of pulmonary atresia, a congenital heart defect that occurs when the pulmonary valve, connecting the heart's right ventricle to the pulmonary artery does not form properly.

The Brazilian doctors recommended that the family return to the United States to find a surgical specialist for V.A.'s heart defect. With the help of John's brother who lives in

1 Philadelphia, they found a cardiothoracic surgeon at Children’s Hospital of Philadelphia.

2 Further tests refined V.A.’s diagnosis to Tetralogy of Fallot, a cardiac anomaly that refers
3 to a combination of four related heart defects. The first surgery occurred on June 19, 2008, and
4 successfully connected some blood vessels from V.A.’s aorta to her lungs and closed a hole in her
5 heart. Surgeons also crafted a tube connecting her right lower heart chamber to her lung vessels
6 and created a small opening between the upper heart chambers.

7 Over the next few years, V.A. had several additional cardiac procedures. In 2009, doctors
8 at Miami Children's Hospital placed an adult sized stent, or small tube, in V.A.’s left
9 pulmonary artery to increase the size of her artery and provide for better blood flow. Three years
10 later, doctors at Nemours Children’s Hospital in Orlando, Florida performed a left pulmonary
11 artery stent dilation for the stent placed by Miami Children’s Hospital. This increased the size of
12 the tube to provide better blood flow.

13 By 2014, when V.A. was 7 years old, the family predominately resided in Brazil, returning
14 to visit Alaska during the summer. There, V.A. was seen for routine heart evaluations and follow-
15 up care at SCH Pediatric Cardiology of Alaska. Over the next five years, V.A. continued cardiac
16 monitoring both at SCH in Alaska and in Seattle.

17 On August 5, 2019, V.A. went to SCH in Seattle to undergo cardiac catheterization.
18 Several blood vessels had narrowed. Attempts to dilate the vessels were not completely successful.
19 A pre-existing artificial blood vessel channel needed replacement. V.A. was scheduled for heart
20 surgery at SCH.

21 The family had spent V.A.’s lifetime managing her health and going through cardiac
22 procedures. Each procedure involved increased stress and fear, not only for V.A., but also for her
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1 parents. John and Celma knew their child’s health and survival relied upon having her procedures
2 completed in a timely manner at the best medical institutions they could find.

3 Just before the procedure was to occur, John was called by SCH and told that V.A.’s
4 surgery would need to be rescheduled because of “air quality issues” in the operating rooms. This
5 was unsettling, but John was reassured that SCH was taking precautions. Even though surgeons
6 said the surgery was critical, the family waited – trusting in SCH.

7 Then, just before the rescheduled date for V.A.’s surgery, SCH called again and told them
8 that V.A.’s surgery would have to be rescheduled a second time due to “air quality issues” in the
9 operating rooms. The family was shocked and upset.

10 John and Celma took the initial steps to transfer V.A.’s care to Stanford in California.
11 Stanford was in the process of obtaining V.A.’s medical records from SCH when two days later,
12 SCH called to report that an OR was now available.



1 The Albrechts decided to trust in SCH's apparent diligence. On October 3, 2019, in OR 11,
2 a left pulmonary arterioplasty was successfully performed to address V.A.'s left pulmonary artery.

3 The family was relieved and grateful that the protracted surgery had gone so well. V.A.
4 awoke and they were looking forward to taking her home. It was then that a physician came into
5 the room and advised them that the air quality in the OR had not been safe after all. V.A. had been
6 exposed to the risk of an Aspergillus infection during her surgery.

7 The pediatric cardiology and infectious disease teams subsequently met with V.A.'s
8 parents and recommended that V.A. undergo prophylaxis care which included a baseline antigen
9 test, repeated blood tests, and Voriconazole antifungal medication.

10 For unclear reasons, it was not until early November about a month following discharge,
11 that SCH administration notified the family of a possible Aspergillus exposure in the OR and asked
12 that V.A. be monitored for symptoms of infection as recommended by the pediatric cardiology
13 and infectious disease teams.

14 In November, SCH sent the prophylaxis medication Voriconazole to the family back in
15 Alaska. The medication interfered with V.A.'s recovery from surgery, causing her to experience
16 sickness, nausea, and periods of vomiting which were extremely painful to her fractured sternum
17 and surgical incision. John and Celma stopped giving V.A. the medication after a week but
18 continued the blood draws (which V.A. dreaded as she had a fear of needles) and antigen tests in
19 December and January which were negative.

20 V.A., now 16 years old, is a High School sophomore. She loves English, science, and being
21 with her friends.

22 John and Celma are no longer able to have trust and faith in SCH or the other doctors who
23 care for their child.

1 **2. W.K.**

2 Jared, who had been an EMT/Paramedic for 15 years, and Brianne Kaplan, an L.A.
3 undercover narcotics officer, had two sons, Hunter, and Hudson. Their dream of having a daughter
4 came true when W.K. Faith Kaplan was born on November 16, 2018, in Missoula, Montana.

5 W.K., nicknamed “faithers,” or “wild west” by her parents was prenatally diagnosed with
6 duodenal atresia abnormality of the small intestine, Trisomy 21, also known as Down syndrome,
7 and congenital heart disease.

8 W.K. immediately underwent surgical repair of the duodenal atresia at the Billings Clinic
9 Heart and Vascular Community Medical Center. She spent the next three weeks in the neonatal
10 intensive unit. Knowing W.K. would soon need heart surgery, Jared and Brianne began researching
11 both hospitals and surgeons to find the best care for their daughter.

12 At three and half months, the family transferred W.K.’s care to SCH. The medical team
13 discussed anticipated surgical repair of her heart between four and six months of age and



23 recommended that unnecessary travel be avoided with W.K. to avoid infectious exposures.

1 The family lived in a farmhouse. Jared and Brianne took every precaution to avoid
2 infection. They bleached their shoes after leaving the house; hosed down the older boys to avoid
3 bringing in viruses; and wiped clean everything being brought into the house. They educated
4 themselves as best they could about how to care for W.K. post-surgery. They paid close attention
5 to details on her mobility, pain management, medication, follow-up appointments, and surgical
6 site and other infection prevention for W.K. following her surgery. They would do everything to
7 keep their baby safe.

8 Heart surgery was scheduled for May 3, 2019, at SCH in OR 12. In a presurgical
9 appointment, physicians explained that the heart condition was more severe than they previously
10 understood and could only provide more information once the surgery started. It was initially
11 anticipated to be a 2.5-hour surgery.

12 For Brianne, handing W.K.'s tiny, swaddled body over to the anesthesiologists was nearly
13 "impossible." Surgery revealed a ventricular septal defect (hole in the wall) with abnormal
14 connecting tissues. Four hours into surgery, Jared and Brianne were informed that more extensive
15 surgery was needed. The surgery ended up taking nine hours. Surgeons closed the hole using a
16 special patch, adjusted the abnormal tissue, and repaired the valves. W.K.'s heart was temporarily
17 stopped and cooled down for the repairs, then restarted and warmed up multiple times.

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Dr. Muhammad A. Nuri, the attending cardiac surgeon advised Jared and Brianne that the surgery was completed and that while W.K. pulled through, she had a long road of recovery ahead of her. This had been the most complicated and severe heart repair he had completed. (Surgical notes indicated he had only seen a few such cases reported in autopsy findings).

Jared and Brianne spent the next several days by W.K.'s bedside. They began to make plans. Jared would take several months off from work. They would continue their strict house hygiene and implement a quarantine process. Five days later W.K. was discharged, and they returned to Montana.

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11 Jared called the pharmacy in Seattle to transfer W.K.'s heart medications to Bozeman.
12 While the pharmacist was listing the medications, Jared stopped him mid-sentence. Jared said there
13 was a mistake--no anti-fungal medication was prescribed.

14 The pharmacist informed Jared that the medication was written because W.K. had been
15 exposed to Aspergillus during open-heart surgery. Jared and Brianne were dumbfounded and in
16 complete shock. They became consumed with questions, including why they were learning about
17 this from a pharmacist.

18 Over the next several days and weeks, Jared and Brianne spoke with representatives from
19 SCH and the head of infectious disease. They were told that if W.K. did not take the prophylaxis,
20 and if she was infected with Aspergillus, she would not survive. These conversations were
21 followed by a form letter from SCH advising them of the air quality issues found in its operating
22 rooms.

23 Doctors recommended to Jared and Brianne that W.K. start the prophylaxis medication
24 Posaconazole and obtain weekly antigen tests for a four-month period.

1 Now that W.K. needed weekly blood draws, Jared and Brianne had to drive her to a hospital
2 an hour away with sick patients and expose her to several people every week. They endured
3 sleepless nights, unbearable stress, anxiety and worry about the health and welfare of their baby.

4 At W.K.'s second blood draw, no one could get a vein, not even a pediatric nurse. W.K.
5 was crying and screaming so hard it was feared that she could tear through her heart repairs. Jared
6 finally volunteered to do the blood draw himself and did so each time thereafter.

7 While the blood draws for the antigen tests were painful and upsetting for the whole family,
8 the Posaconazole made W.K. really sick. She had a blank gaze and grey cloudy eyes. W. K. was
9 lethargic, throwing up, spitting up, bloated, uncomfortable, not sleeping, and lacked engagement.
10 Jared and Bri repeatedly expressed their concern with W.K.'s health care professionals, and they
11 all advised them to continue the medicine and monitor her recovery.

12 To make matters even worse, late on the evening of July 2, 2019, a pharmacist at SCH
13 called to advise that W.K. was dosed incorrectly, putting her at risk for liver and kidney failure.
14 The Posaconazole needed to be cut nearly in half. Jared and Brianne were so traumatized believing
15 their child was in danger that they stopped giving W.K. the medication altogether.

16 To date, the Kaplans cannot bring their children to a medical appointment without
17 reservation or anxiety. Their trust in medical institutions is just gone. Reflecting on this experience
18 both Jared and Brianne will testify that the damage will "be with us forever."

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1 **3. M.L.**

2 M.L. was born at SCH on November 19, 2018, the third child born to Dr. Jason Lukas and
3 Dr. Jen Mills. Both Jason and Jen trained at the University of Washington in Internal Medicine.
4 Dr. Lukas is employed with UW Medicine as a general hematologist and oncologist. He also works
5 for Seagen, a biotechnology company that develops cancer treatments. Dr. Mills is a partner at a
6 direct medical care practice.



16 During prenatal screening, M.L. was diagnosed with Trisomy 21, also known as Down
17 syndrome and a commonly associated heart problem: complete atrioventricular canal defect
18 (“CAVC”). This involved a large hole in the center of the heart affecting all four chambers. A
19 CAVC allows blood to mix and the chambers and valves to not properly route the blood to each
20 station of circulation.

21 Given M.L.’s diagnoses and upcoming heart surgery, the family took serious safety precautions so
22 as not to infect M.L. with even a common cold. They counted every calorie consumed and weighed
23 her daily. When M.L. was a month old, she started to exhibit signs of heart failure. The next three
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1 months were a daily battle to keep M.L. healthy enough for her necessary heart surgery.



10 M.L. went into surgery at SCH on March 19, 2019, in OR 6. Jason and Jen were terrified
11 as they knew exactly how high the risks were, including bleeding, infection, stroke, heart block,
12 and organ damage. Surgeons made an incision in M.L.'s heart and used two patches to close the
13 hole between the chambers. Next, they made an incision in M.L.'s atrial wall and used sutures to
14 close the opening between the left and right atria.

15 When they received the news that the operation went well, Jason and Jen were
16 overwhelmed with relief and gratitude.

17 Those feelings vanished two months after M.L. returned home. SCH notified the family
18 that M.L. may have been exposed to Aspergillus in the OR. Jen and Jason were shocked and
19 horrified. Jen conjured, "memories of a young patient [she] took care of during residency who died
20 of an invasive Aspergillus infection. It was memorable in the most horrible way." Neither Jen nor
21 Jason had ever heard of Aspergillus infections secondary to an OR exposure and while they are
22 not surgeons by training or temperament, they both work with surgeons on a regular basis and
23 understand the field.

1 Jason and Jen spoke with Dr. Margaret Vernon, M.L.'s cardiologist, and the head of the
2 infectious disease department, who recommended that M.L. obtain a baseline antigen test to
3 determine whether she was infected followed by repeat blood draws for weeks to come.
4 Additionally, it was recommended that M.L. start taking Posaconazole (dosing based on weight)
5 three times daily.

6 When Jen picked up the medication from the SCH pharmacy, she noted that the dose was
7 incorrect and told the pharmacy to correct the script.

8 On June 5, 2019, M.L.'s blood was drawn. Dr. Vernon called Jen and advised that M.L.'s
9 galactomannan index was .868—a positive result for Aspergillus. Jen was instructed to
10 immediately bring M.L. into SCH for repeat blood tests, an echocardiogram, and a CT scan.
11 Consumed with terror and panic, Jen and Jason drove M.L. back to the hospital.

12 Although the subsequent tests and repeated blood draws were negative for Aspergillus, the
13 process was agonizing. Phlebotomists had a difficult time finding a vein and M.L. had to be poked
14 and prodded repeatedly. Jason or Jen needed to physically hold their baby down as she screamed
15 and cried. M.L. hated the medicine and had to be forced to swallow it three times a day.

16 M.L. has needed three additional surgeries since her heart surgery. Jen and Jason
17 experience indescribable panic from the Aspergillus exposure. They have an ongoing need to
18 advocate on M.L.'s behalf and manage her healthcare. Jen engaged a counselor shortly after this
19 experience and was diagnosed with PTSD from these events.

20 Jason and Jen had strong reactions involving breach of trust in the spring of 2019 when
21 SCH came forward in the media with the disclosure regarding Aspergillus in the ORs. Then only
22 a few months later in the fall, SCH announced reclosure of the ORs due to Aspergillus. Jen and
23 Jason will testify that their own experiences and SCH's repeated problems with Aspergillus
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1 fundamentally altered M.L.'s other medical care and their ability to trust the only regional
2 children's hospital.

3 **4. J-A. M.**

4 J-A. M. was born to Stephanie Marzolf on May 14, 2019, at the University of Washington
5 Medical Center, with a prenatal diagnosis of a hypoplastic left heart syndrome and a restrictive
6 atrial septum. She was transported urgently to SCH where she remained ill with critical aortic
7 stenosis requiring vasoactive infusions for acute chronic cardiac failure. J-A. M. was sent for close
8 monitoring in the SCH cardiac ICU.

9 Stephanie was discharged later in the day. But as she also had a 21-month-old child, it was
10 not possible for him to stay with Stephanie in J-A. M.'s room. Caring for her older child, who had
11 special needs, and being at her daughter's side was a source of stress and conflict for Stephanie.
12 Their home was in Puyallup. Typically, she was at J-A. M.'s bedside during daytime hours
13 Monday through Friday. She was unable to come to the hospital on weekends and asked that a
14 doctor call her every day. The father was not in J-A. M.'s life and did not participate in her care.

15 On May 15, 2019, physicians performed the first of what would be many heart
16 catheterizations for angiogram, balloon dilation and other monitoring and procedures. From the
17 cardiac ICU J-A. M. was brought to the catheterization laboratory. Cardiorespiratory monitors
18 were placed, she was sedated, and her airway was secured by endotracheal intubation. Under
19 ultrasound guidance, attempts were made to access one of the femoral veins. This basic process,
20 with variations such as stenting and decompression, would be repeated on May 19 and 24, 2019.
21 Then three more times in June and July before she was ultimately discharged on July 25, 2019.

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12 On May 22, 2019, after news reports had come out, Stephanie asked about the reported
13 hospital OR air quality issues. The doctor made note of this request and their response:

14 *I told her about the presence of Aspergillus in some operating rooms, but not in*
15 *cath labs where she had her procedure. And I reiterated that the risk of infection*
16 *is solely in open procedures, and that patient did not have an open procedure. I*
17 *did not discuss the impending hybrid procedure.*

18 *After this discussion an update has been made to the current situation. Going*
19 *forward all cases in the Cath Lab from 5/20/2019 will be prophylactically*
20 *treated with Posaconazole for Aspergillus for at least a month weekly*
21 *galactomannan tests will be sent. We have spoken with the parents giving them*
22 *this update.*

23 Stephanie was fragile as she struggled to come to terms with her daughter's critical illness
24 and the possibility that she would either not survive or would have a poor outcome to the medical
procedures. She put her trust in the physicians. When they said not to worry about Aspergillus,
she did not. Until they corrected their position and admitted the risk of exposure.

1 By June 18, 2019, Posaconazole prophylaxis had been administered for 10 days before
2 being discontinued as J-A. M. needed to undergo another lifesaving procedure in the Cath lab. The
3 Galactomannan screening was to continue every Monday for one more month.

4 Since those early months of life, J-A. M. has suffered further complications to the heart
5 defect including cerebral palsy, developmental delay, vision impairment, epilepsy, and seizure
6 disorder.

7 VII. PLAINTIFFS' EXPERTS

8 **Dr. Rishi Desai – Patient Medical Conditions and Patient/Family Outcomes**

9 Dr. Rishi Desai is double-board certified in pediatrics and pediatric infectious diseases and
10 has a master's degree in Public Health – Epidemiology. He completed his pediatric residency at
11 Boston Children's Hospital and his fellowship in pediatric infectious disease at Children's Hospital
12 Los Angeles. He has worked at the CDC as an epidemiologic intelligence service officer on
13 international and national matters involving infectious diseases. From 2012 to 2019, Dr. Desai
14 worked as a pediatric infectious disease clinical instructor at Stanford University Medical Center
15 where he managed immunocompromised and immunocompetent pediatric patients with infectious
16 diseases in the outpatient clinic setting and trained rotating fellows, residents, and medical
17 students.

18 Dr. Desai will testify about each child's underlying health conditions and treatment,
19 prophylaxis treatment, and diagnostics. He will offer opinions about the effects of prophylaxis
20 medication, its impact on underlying treatment, and any long-term risks caused by exposure. He
21 will also testify about how adverse events like Defendant's negligence impact parent-caregivers
22 and their relationship with the medical institution they rely upon.

23 ///

1 estimating the amount of the loss. This rule has been consistently applied by the Washington
2 courts, in both personal injury and commercial litigation.

3 The rule in Washington on the question of the sufficiency of the evidence
4 to prove damages is: “[T]he fact of loss must be established with sufficient
5 certainty to provide a reasonable basis for estimating that loss.”
6 Mathematical exactness is not required.

7 *Haner v. Quincy Farm Chems., Inc.*, 97 Wn.2d 753, 757, 649 P.2d 828 (1982) (internal citations
8 omitted).

9 In the same case below, the court of appeals stated:

10 Once the fact of damage is established, the precise amount need not be
11 shown with mathematical certainty. Evidence of damage is sufficient if it
12 affords a reasonable basis for estimating the loss and does not subject the
13 trier of fact to mere speculation or conjecture.

14 *Haner v. Quincy Farm Chemicals, Inc.*, 29 Wn. App. 93, 97, 627 P.2d 571 (1981).

15 This is particularly true with regard to general damages, as the law has not furnished us
16 with any fixed standards by which to measure noneconomic damages. *See* WPI 30.01.01.

17 **2. Plaintiffs’ General Damages Include All Harms Caused by Defendant’s Negligent
18 Exposure.**

19 Once injury has been established, the jury must consider a wide range of general damages
20 flowing from Defendant’s admitted negligence in “exposing the Prophylaxis Class and all its
21 members to the risk of Aspergillus surgical site infection in 2019.” This includes the entire patient
22 and family experience after the exposure, and relevant pre-exposure treatment.

23 For children, the jury will consider:

- 24 • The nature and extent of each child-plaintiff’s injuries.
- The disability, disfigurement, loss of enjoyment of life experienced and with
reasonable probability to be experienced by the child in the future.

- 1 • The pain and suffering, both mental and physical, inconvenience, and mental
2 anguish experienced and with reasonable probability to be experienced by the child
3 in the future.

4 For parents' claims brought under RCW 4.24.010, the jury will consider:

- 5 • The loss of love and injury to the parent-child relationship between each child and
6 their parent(s), including their grief, mental anguish, and suffering of the parent(s)
7 as a result of the child's injury.
- 8 • The loss of emotional support of the child to their parent(s).
- 9 • The loss of companionship, including mutual society and protection, of the child to
10 their parent(s).

11
12 WPI 30.01.01, 30.04, 30.05, 30.06, 30.07.01, 30.07.02, 30.08.02, 30.09.01, 30.09.02; WPI
13 32.06.01; RCW 4.24.010; RCW 4.56.250.

14 Defendant's negligence caused each family one or more of these categories of harms:

- 15 • Effects of anti-fungal medication Voriconazole or Posaconazole. These include, but are not
16 limited to:
- 17 ○ Nausea
 - 18 ○ Vomiting
 - 19 ○ Diarrhea
 - 20 ○ Loss of appetite and refusal to eat
 - 21 ○ Extreme fatigue and catatonic state
 - 22 ○ Risk and harm to kidneys

- 1 • Diagnostics concurrent with and part of prophylactic treatment. These include, but are not
2 limited to:
 - 3 ○ Regular blood testing, which is both difficult and traumatic for infants and young
4 children;
 - 5 ○ Other diagnostic testing.
- 6 • Impact on underlying treatment. This includes but is not limited to:
 - 7 ○ Delays in treating the child’s underlying condition;
 - 8 ○ Modifications to treatment plans; and
 - 9 ○ Parents having to find other, trusted treatment providers.
- 10 • Mental pain, suffering and anguish of both the child and parents. This includes but is not
11 limited to:
 - 12 ○ Mental anguish of parents and older children caused by the high or extreme risk of
13 death to the child, if infected;
 - 14 ○ Mental anguish of parents and older children by having to return to Defendant
15 hospital for treatment after the hospital negligently endangered the life of the child;
 - 16 ○ Mental anguish of parents in having to weigh the risk of the child’s death from
17 Aspergillus exposure with the risks and side effects of harsh anti-fungal
18 medications;
 - 19 ○ Mental anguish, pain and suffering caused by drawing blood from infants;
 - 20 ○ Loss of bonding experience with the child.

21 The patient and parent experience prior to the exposure is also relevant to measure
22 damages. For example, evidence of the children’s medical condition, treatment, and what parents
23 were told or not told would explain treatment decisions and effects for both prophylaxis and
24

1 underlying conditions. It also provides necessary context as to Plaintiffs’ shock, distress and
2 mistrust described in Defendant’s own documents, that led to parent decisions to relocate or delay
3 treatment and impacted the parent-child bonding experience.

4 **3. The Entire Patient and Parent Experience Is Relevant to Damages and Is Not**
5 **Precluded by Defendant’s Concession of Negligence.**

6 Evidence potentially related to liability is properly admitted when it relates to damages. In
7 *Snyder v. General Elect. Co.*, 47 Wn.2d 60, 68, 287 P.2d 108 (1955), the plaintiff sought to recover
8 for injuries sustained as passenger on bus, when struck from behind by a following bus. Defendant
9 admitted liability. Reviewing the trial court decision for an abuse of discretion, the Supreme Court
10 held it appropriate to admit evidence about how the collision occurred insofar as it was relevant to
11 damages (in this case the force and direction of impact) even if it was self-evident to the jury
12 anyway. *See also Murray v. Mossman*, 52 Wn.2d 885, 887-88, 329 P.2d 1089 (1958).

13 Here, evidence related to Defendant’s lengthy prior knowledge about Aspergillus and
14 years-long failure to maintain the air handling units servicing the operating rooms is likely related
15 solely to liability. In contrast, evidence about the plaintiff-children’s medical care, and what
16 parents were told about that care before and after the exposure, directly relates to damages: changes
17 in symptoms, treatment plans, underlying conditions, and treatment decisions, as well as distress
18 of the children and parents and damage to the parent-child bonding experiences. It barely touches
19 on how the exposure (negligence) occurred.

20 **4. If Defendant Minimizes the Risk of Infection, Plaintiffs Are Entitled to Respond,**
21 **and Trial Will Be Considerably Longer.**

22 Plaintiffs’ Motions in Limine address the ways Defendant is expected to minimize the risk
23 of infection and the risk of severe outcome to each child if infected. For example, defense expert
24 Dr. Marr disclosed for the first time on December 20, 2023 (the earliest the defense made her

1 available for deposition) that in her opinion it was highly unlikely that any child would become
2 infected. She based her opinion solely on statistics and biological processes of Aspergillus
3 infection, and has not reviewed anything specific to Defendant's hospital, including air and surface
4 testing, as well as the extraordinarily high rate of Aspergillus surgical site infection compared to
5 peer hospitals, which report none.

6 Defendant may also attempt to present evidence about anti-fungal medication being
7 common and often harmless. Such broad statements have no bearing on Plaintiffs' actual
8 experiences. Defendant stipulated that it recommended the prophylaxis due to its own negligence,
9 so there is no debate over whether the treatment was appropriate. This testimony would only be
10 used to minimize the seriousness of Defendant's negligence, which is not at issue, and would
11 contradict Defendant's own documents.

12 Plaintiffs conducted discovery and planned this trial based on a stipulation and further
13 express statements that the degree of risk of infection and the need for prophylaxis would not be
14 issues at trial. If Defendant is permitted to and does present any such evidence, Plaintiffs are
15 entitled to respond. Trial will take considerably longer than previously anticipated.

16 X. VOIR DIRE

17 1. Zoom.

18 The advent of zoom *voir dire* has changed the dynamics of the struck method. Zoom does
19 not function well in terms of spontaneous group discussion. People must take turns with many
20 artificial pauses. However, the advantages of zoom *voir dire*, including high response rate and the
21 minimizing of juror inconvenience, are well known.

22 Certain problems can arise during zoom *voir dire* that do not occur during in person jury
23 selection. To the extent their participation becomes disruptive, the Court is requested to excuse
24

1 such jurors including, for example, those who participate via cell phone, cannot navigate the
2 technology, and/or are not in a private location.

3 **2. Bias.**

4 The right of trial by jury means a trial by an unbiased and unprejudiced jury, free of
5 disqualifying jury misconduct. *See Smith v. Kent*, 11 Wn. App. 439, 523 P.2d 446 (1974).

6 RCW 4.44.120 provides in relevant part:

7 *A voir dire* examination of the panel shall be conducted for the purpose of
8 discovering any basis for challenge for cause and to permit the intelligent
exercise of peremptory challenges.

9 The purpose of *voir dire* is to enable each party to learn the state of mind of the prospective
10 jurors, so that they can know whether or not any of them may be subject to challenge for cause
11 and determine the advisability of interposing a peremptory challenge. *State v. Tharp*, 42 Wn.2d
12 494, 256 P.2d 482 (1953); *see also Robinson v. Safeway Stores, Inc.*, 113 Wn.2d 154, 159, 776
13 P.2d 676 (1989) (*voir dire* examination enables a litigant to determine whether or not to exercise
14 his statutory right to challenge a juror for cause or to exercise a peremptory challenge).

15 It is not “a function of the *voir dire* examination... to educate the jury panel to the particular
16 facts of the case, to compel the jurors to commit themselves to vote a particular way, to prejudice
17 the jury for or against a particular party, to argue the case, to indoctrinate the jury, or to instruct
18 the jury in matters of law.” *State v. Frederickson*, 40 Wn. App. 749, 752, 700 P.3d 369 (1985). The
19 trial court has considerable latitude in guiding the *voir dire* examination of prospective jurors. The
20 scope of the questions is within its discretion, and the trial court can only be reversed if it can be
21 said that there has been an abuse of discretion. *Murray v. Mossman*, 52 Wn.2d 885, 887, 329 P.2d
22 1089 (1958).

23 If *voir dire* reveals unfitness of a panel member, then the judge must excuse that person:
24

1 It shall be the duty of a judge to excuse from further jury service any juror,
2 who in the opinion of the judge, has manifested unfitness as a juror by
3 reason of bias, prejudice, indifference, inattention or any physical or
4 mental defect or by reason of conduct or practices incompatible with
5 proper and efficient jury service.

6 RCW 2.36.110. A juror should be excused for cause if a particular belief will “prevent or
7 substantially impair the performance of his duties as a juror in accordance with his instructions
8 and his oath.” *Wainwright v. Witt*, 469 U.S. 412, 424, 105 S. Ct. 844, 852, 83 L. Ed. 2d 841 (1985).

7 **3. Rehabilitation.**

8 A frustrating circumstance results when a juror admits to having a fatal bias, but the court
9 then intervenes to rehabilitate the juror. Such jurors may then end up sitting on the impaneled jury
10 by simply stating to the court that, despite having expressed prejudicial attitudes or having had
11 experiences likely to give rise to such attitudes, they can be fair and impartial.

12 In *Irvin v. Dowd*, the US Supreme Court cautioned against this practice:

13 Voir dire gives the parties an opportunity to develop information that might
14 disclose a potential juror’s specific bias in a suit of the type at trial. In
15 conducting the voir dire examination, the trial court must evaluate whether
16 a juror can lay aside preconceived impressions or opinions and render a
17 verdict based solely upon the evidence presented in court, the instructions
18 given by the judge, and the requirements of the juror’s oath. This frequently
19 involves asking follow-up questions designed to probe jurors’ initial
20 responses in order to clarify or interpret those responses. In making such an
21 evaluation, however, a trial court cannot accept without question a simple
22 promise by the juror to be fair and impartial if it follows several previous
23 statements of obvious bias by the juror because... notwithstanding that the
24 juror may be sincere in expressing a desire to be fair and impartial, the
psychological impact of requiring such a declaration before the juror’s peers
and a judge could render the promise unreliable.

Irvin v. Dowd, 366 U.S. 717, 81 S. Ct. 1639, 6 L. Ed. 2d 751 (1961).

21 This conundrum is magnified by the circumstances under which *voir dire* occurs. Given
22 that people are often unaware of cognitive facts affecting their biases, it is logical that jurors would
23 be unqualified to render an opinion as to their own ability to be fair. After all, they are placed in a
24

1 position where they are asked to perform a task with which they are generally inexperienced, by
2 following rules that they have not yet been given, while applying those rules to a set of facts yet
3 unknown to them. The unique nature of jury service argues that prospective jurors may not be
4 accurate judges of their own ability to set aside experiences and attitudes in order to judge the facts
5 of a case fairly and impartially. Because seating a biased juror may have a destructive impact on
6 justice, Plaintiff urges the Court to avoid juror “rehabilitation.”

7 **XI. MISCELLANEOUS ISSUES**

8 **1. Opening Statements.**

9 A deposition of a party may be used for any purpose and that includes during opening
10 statements. CR 32. It is well settled that any party may, in opening statement, refer to admissible
11 evidence *expected* to be presented at trial. *State v. Whelchel*, 115 Wn.2d 708, 727, 801 P.2d 948
12 (1990). The only requirement is that counsel have a good faith belief that the evidence will be
13 produced at trial. *City of Puyallup v. Spenser*, 192 Wn. App. 728, 731, 366 P.3d 954 (2016).

14 Plaintiffs may anticipate the defense in opening statement:

15 Anticipating that defense counsel would introduce the film in evidence,
16 plaintiff’s counsel referred to it in his opening statement and on several
occasions thereafter. It is not error for a plaintiff to anticipate a defense.

17 *Snyder v. Gen. Elec. Co.*, 47 Wn.2d 60, 69, 287 P.2d 108 (1955); *see also Snowhill v. Lieurance*,
18 72 Wn.2d 781, 782, 435 P.2d 624 (1967).

19 **2. Use of PowerPoint.**

20 Plaintiffs’ counsel will use PowerPoint or other similar presentation methods during
21 opening statement, closing argument, and examination of witnesses. Most if not all of the
22 documents and images will come from the parties’ ER 904 exchanges. Either defense counsel will
23 have been shown these documents and images prior to the commencement of trial, or the offer to
24

1 view the images will have been made. The precise configuration of photographs and visuals will
2 not have been disclosed, neither will labels or language. Such exchanges should not be needed
3 during closing which is argument.

4 PowerPoint is an aid and acts an outline. An attorney who does not use PowerPoint would
5 be under no obligation to show opposing counsel speaker notes, the outline to be followed, or, for
6 that matter, the order of documents or images used or drawings/graphs to be made upon a
7 whiteboard. To do so would essentially force counsel to put on a “dress rehearsal” of their
8 presentations and would impermissibly disclose counsel’s protected work product.

9 The attorney work product doctrine insulates counsel from premature disclosure of thought
10 processes under both scenarios. *See Limstrom v. Ladenburg*, 136 Wn.2d 595, 606, 963 P.2d 869
11 (1998) (noting that “CR 26(b)(4) ... includes within the definition of work product factual
12 information, which is collected or gathered by an attorney, as well as the attorney’s legal research,
13 theories, opinions and conclusions”); *Hickman v. Taylor*, 329 U.S. 495, 67 S. Ct. 385, 91 L. Ed.
14 451 (1947). Forcing counsel to turn over PowerPoint or other presentation material should
15 therefore not be required here.

16 **3. Photographs.**

17 The photographs taken of the Plaintiff-patients before and after the incident are numerous
18 because we live in the age of cell phone wielding parents. Plaintiffs’ counsel is experienced in trial
19 and knows that the last thing a jury wants to see is a million duplicative photographs. At this stage
20 the photographs have been winnowed, and as trial goes on they will be winnowed further. The
21 Plaintiffs will not use duplicative photos and videos.

22 That said, this evidence is critical in demonstrating the preinjury and post injury status of
23 the Plaintiffs. The photos assist in illustrating damages but also help the jury understand how and
24

1 why they were in the hospital to begin with, for example.

2 Although photographs of injuries may be hard to look at because the Plaintiffs are children,
3 they are relevant and admissible. *Washburn v. Beatt Equipment Co.*, 120 Wn.2d 246, 840 P.2d 860
4 (1992), is directly on point. The case involved a worker who was burned over fifty percent of his
5 body following an explosion. Defendant objected to the introduction of 78 photographs. The Court
6 stated:

7 The fact that the photographic depiction may be gruesome or unpleasant does not
8 render the evidence inadmissible. Photographs of injuries may be gruesome
precisely because they accurately depict what has happened to plaintiff.

9 The photographs are clearly relevant. The condition of plaintiff's body immediately
10 after the explosion is related to plaintiff's damages. The condition of an injured
person's body obviously changes, and photographs can preserve a record of the
11 original condition. In burn cases, grafting of skin and eventual healing (to the extent
it occurs) will improve the appearance of burned areas; photographs taken shortly
12 after the injuries are incurred will record and preserve the pregrafting, prehealing
condition of plaintiff. A number of the photographs here were taken 5 days after
13 the explosion and others within the first month. They showed the condition of
plaintiff's body at that time.

14 The photographs are also relevant to illustrate the testimony of the treating
physicians and help the jury understand the extent and nature of the injuries and the
15 course of treatment. Even where a witness has described an injury, photographs
have evidentiary value in making the description more intelligible. "Much that
16 sounds cold coming from a witness may be better conveyed by a photograph." The
photographs here illustrated the treating physicians' testimony about plaintiff's
17 injuries and the course of treatment.

18 The photographs are in large part sequential photographs of the course of treatment.
Courts have upheld admissibility of photographs of injuries taken during a course
19 of treatment which are accurately reflective of the injuries and the treatment which
plaintiff had to undergo.

20 The photographs are also relevant to Plaintiff's emotional problems arising from
21 the injuries and his pain and suffering.

22 Because the photographs are highly relevant to material issues in the case, and
objectively and accurately portrayed the condition of plaintiff's body and the
23 treatment he underwent, their probative value is great.

1 The mere number of photographs is not determinative. Plaintiff was burned over
2 half his body, and most of the remainder of his body was affected because skin was
3 harvested for grafting. Treatment has taken considerable time—the photographs are
4 a sequence of several series showing results of surgical procedures and other
5 treatment over 13 ½ months. They accurately depict what Plaintiff went through.
6 We do not think the number impermissibly excessive. Nor do we find the
7 photographs impermissibly repetitious. They are in large part photographs of
8 plaintiff's condition shortly after the fire, and the many parts of his body affected,
9 and then sequential sets showing the course of treatment and healing.

10 *Id.* at 284-286 (citations omitted); *see also Carson v. Fine*, 123 Wn.2d 206, 224, 867 P.2d 610
11 (1994) (“We note, for example, that accurate but graphic photographs are admissible even when
12 repulsive or gruesome if their probative value outweighs their prejudicial effect.”).

13 **4. Other Demonstrative Aids.**

14 The use of demonstrative or illustrative evidence is to be favored and the trial court is given
15 wide latitude in determining whether or not to admit demonstrative evidence. Illustrative evidence
16 is appropriate to aid the trier of fact in understanding other evidence, where the trier of fact is
17 aware of the limits on the accuracy of the evidence. *State v. Lord*, 117 Wn.2d 829, 822 P.2d 177
18 (1991), *cert. denied*, 506 U.S. 856, 113 S. Ct. 164, 121 L. Ed.2d 112 (1992) (internal citations
19 omitted).

20 In addition to being allowed for the purpose of illustrating testimony of a witness,
21 demonstrative exhibits are also allowed during opening statement:

22 It is well settled that, within the discretion of the trial judge,
23 diagrams, charts and graphs can be properly used in opening
24 statement. The rule extends both (1) to exhibits that counsel intends
later to introduce and (2) to those that will not be used subsequently
in the trial but are either extemporized (as a blackboard) or prepared
in advance of trial to summarize a claim. G. Joseph, MODERN
VISUAL EVIDENCE, § 9.02[3][a] at 9-13 to 9-14 (1991)
(footnotes omitted)

James v. Heintz, 478 N.W.2d 31, 35 (Wis. App. 1991).

Demonstrative evidence has long been encouraged if it accurately illustrates facts sought

1 to be proved. *State v. Tatum*, 58 Wn.2d 73, 75, 360 P.2d 754 (1961) (“It should be noted that this
2 Court has for many years encouraged the admission and use of demonstrative evidence, including
3 photographs.”); *Knight v. Borgan*, 52 Wn.2d 219, 324 P.2d 797 (1958); *Schroeder v. Hotel*
4 *Commercial Co.*, 84 Wash. 685, 689, 147 P. 417 (1915) (piano used to illustrate testimony; “Courts
5 are permitted a wide discretion in the use of illustrative aids, such as pictures, models, and
6 machines.”). The trial court is given wide latitude in determining whether or not to admit
7 demonstrative evidence.” *State v. Lord*, 117 Wn.2d 829, 855, 822 P.2d 177 (1991).

8 In *Norris v. State*, 46 Wn. App. 822, 733 P.2d 231 (1987), the Court of Appeals approved
9 of a series of drawings prepared by a professional artist depicting the scene of an accident where
10 no photographs were available. Each drawing was identified and authenticated at trial by witnesses
11 who gave the artist the information. The Court approved of the use of the demonstrative evidence:

12 Demonstrative evidence is encouraged if accurate and relevant;
13 admission is within the trial court’s wide discretion. *Jenkins v.*
14 *Snohomish Cy. Publ. Util. Dist. No. 1*, 105 Wn.2d 99, 713 P.2d 79
15 (1986); *State v. Chapman*, 84 Wn.2d 373, 378, 526 P.2d 64 (1974);
16 *see also* 5 K. Tegland, Wash. Prac., *Evidence*, § 95(4) (2d ed. 1982).
17 Illustrative evidence is appropriate to aid the trier of fact in
18 understanding other evidence, where the trier of fact is aware of the
19 limits on accuracy of the evidence. *King Cy. v. Farr*, 7 Wn. App.
20 600, 612, 501 P.2d 612, *review denied*, 81 Wn.2d 1009 (1972). The
21 State was afforded the full opportunity to test the accuracy of the
22 drawings and to establish their limits. Its objection went to weight,
23 not admissibility. The State’s objection seems largely motivated by
24 the novelty of the evidence. Novelty in an exhibit, however, does
not make it inadmissible.

Norris, 46 Wn. App. at 827.

Demonstrative evidence that has been held admissible includes illustrations, models, and
computer-generated animations. Where models are not intended to replicate an original but are
used only to illustrate a witness’s testimony, any dissimilarities to actual conditions can be pointed
out to the jury and do not prevent the use of a model for illustrative purposes. *Brown v. Quick Mix*
Co., 75 Wn.2d 833, 841, 454 P.2d 205 (1969). A sufficient foundation is laid for the use of

1 demonstrative evidence if a witness testifies that it is a reasonable representation of the subject
2 matter. *See, e.g., Kelley v. Great Northern Railway Co.*, 59 Wn.2d 894, 899, 371 P.2d 528 (1962).

3
4 **DATED** this 9th day of January, 2024.

5
6 **STRITMATTER KESSLER
KOEHLER MOORE**

7
8 /s/ Karen K. Koehler

9 Karen K. Koehler, WSBA #15325
10 Andrew Ackley, WSBA #41752
11 Debora Silberman, WSBA #59302
12 Shannon Kilpatrick, WSBA #41495
13 Co-Counsel for Plaintiffs and Class

14
15 **LAYMAN LAW FIRM**

16
17 /s/ John R. Layman

18 John R. Layman, WSBA #13823
19 Taylor J. Burkett, WSBA #56698
20 Co-Counsel for Plaintiffs and Class

CERTIFICATE OF SERVICE

I certify that I served a copy of the foregoing document as follows:

Jake Winfrey
Caitlyn Spencer
Fain Anderson VanDerhoef Rosendahl O’Halloran
Spillane, PLLC
3131 Elliott Avenue, Suite 300
Seattle, WA 98121
(206)749-0094
jake@favros.com
caitlyn@favros.com
danielle@favros.com
lilly@favros.com

- U.S. Mail
- Fax
- Legal Messenger
- Electronic Delivery

Stephen M. Rummage
Brad Fisher
Rachel Herd
Arthur Simpson
Davis Wright Tremaine LLP
920 Fifth Avenue, Suite 3300
Seattle, WA 98104-1610
(206)622-3150
steverummage@dwt.com
bradfisher@dwt.com
rachelherd@dwt.com
ArthurSimpson@dwt.com
DanielaNajera@dwt.com
erickamitterndorfer@dwt.com
LeighaHenson@dwt.com
LisaMerritt@dwt.com

- U.S. Mail
- Fax
- Legal Messenger
- Electronic Delivery

DATED this 9th day of January, 2024.

/s/ Cheryl Baldwin
Cheryl Baldwin
Paralegal