

# Exhibit 588

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF NORTH CAROLINA

IN RE: )  
)  
CAMP LEJEUNE WATER LITIGATION ) Case No.:  
\_\_\_\_\_ ) 7:23-cv-00897  
)  
This Document Relates to: )  
)  
ALL CASES )

- - -

VIDEOTAPED DEPOSITION OF MATTHEW COOPER, MD  
THURSDAY, JULY 10, 2025

- - -

Videotaped deposition of MATTHEW COOPER, MD,  
held at Center for Advance Care Building, 8900 West  
Doyme Avenue, Wauwatosa, Wisconsin, commencing at  
a.m., on the above date, before Juliana F. Zajicek,  
Registered Professional Reporter, Certified Shorthand  
Reporter, Certified Realtime Reporter.

- - -

Job No. 7450002

1 A P P E A R A N C E S :

2 ON BEHALF OF THE PLAINTIFFS:

3 MANDELL, BOISCLAIR & MANDELL, LTD.

One Park Row

4 Providence, Rhode Island 02903

401-273-8330

5 BY: MARK MANDELL, ESQ.

mmandell@mbmjustice.com;

6

7 ON BEHALF OF THE DEFENDANT:

8 U.S. DEPARTMENT OF JUSTICE

Trial Attorney, Civil Division

9 P.O. Box 340

Washington, DC 20044

10 202-616-8461

BY: CARSON M. GARAND, ESQ.

11 carson.m.garand@usdoj.gov;

ERICK MARQUINA, ESQ.

12 erick.marquina@usdoj.gov;

JOSHUA CARPENITO, ESQ. (Via Zoom)

13 joshua.g.carpenito@usdoj.gov

14

15 ALSO PRESENT:

16 LEXI DOROTINSKY, (Via Zoom)

Mandell, Boisclair & Mandell, Ltd.

17

18 THE VIDEOGRAPHER:

19 STEPHAN HOOG,

Golkow Technologies, a Veritext Division.

20

21

22

23

24

I N D E X

WITNESS:

PAGE:

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E X H I B I T S

DR. COOPER EXHIBIT

MARKED FOR ID

No. 1 Plaintiffs' Designation and 15  
Disclosure of Phase III Expert  
Witnesses with Respect to Kidney  
Cancer; Materials Considered List  
for Matthew Cooper's Report on  
Plaintiff Frank W. Mousser

No. 2 Plaintiffs' Designation and 16  
Disclosure of Phase III Expert  
Witnesses with Respect to Kidney  
Cancer; Materials Considered List  
for Matthew Cooper's Report on  
Plaintiff Jacqueline J. Tukes

No. 3 Supplemental Materials Considered 16  
List, February 2, 2025

No. 4 Third Supplemental Materials 17  
Considered List, February 2, 2025

No. 5 Invoice dated 12/15/2024 22

No. 6 Fee Schedule dated 8/29/2024 34

No. 7 Specific Causation Expert Report: 37  
Frank Mousser, 2/2/2025

No. 8 Specific Causation Expert Report: 37  
Jacqueline Tukes, 2/2/2025

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No. 9 Laboratory results; 00667_MOUSSER_0000005598 - 5812	94
No. 10 Dep transcript of Daniel Kevin Flood, M.D., 8/7/2024	107
No. 11 Progress Note dated 4/18/2022; 00667_MOUSSER_VHA_0000000375	113
No. 12 Mr. Mousser's lab results from March 20, 2023; 0667_MOUSSER_VBA_0000005164 - 5165	118
No. 13 Progress note dated 5/6/2024; 0667_MOUSSER_VHA_0000001499 - 1504	122
No. 14 Progress notes dated 11/12/2024; 0667_MOUSSER_VHA_0000001624 - 1626	123
No. 15 Lab results dated 3/22/2016; 0667_MOUSSER_VHA_0000001567 - 1568	124
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No. 20 Progress notes dated 11/8/2024; 0667_MOUSSER_VHA_0000001631 - 1638	153
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DR. COOPER EXHIBIT	MARKED FOR ID
No. 22 Medical records from South Texas Cardiovascular Consultants, dated 3/16/2021; 0667_MOUSSER_STCC_0000000054 - 57	160
No. 23 Medical records from South Texas Cardiovascular Consultants, dated 10/24/2021; 0667_MOUSSER_STCC_0000000044 - 47	162
No. 24 Supplemental Specific Causation Expert Report for Frank Mousser by Armine K. Smith, MD	169
No. 25 Medical records; 00667_MOUSSER_0000007336 - 7366	200
No. 26 Peterson Health medical records; 00667_MOUSSER_0000008702 through 8732	205

1 THE VIDEOGRAPHER: We are now on the record. My  
2 name is Stephan Hoog. I am the videographer for  
3 Golkow, a Veritext Division.

4 Today's date is July 10th, 2025. The time  
5 is 8:50 a.m., as indicated on the video screen.

6 This video deposition is being held at  
7 8900 West Doyne Avenue, Wauwatosa, Wisconsin, In the  
8 Matter of In Re: Camp Lejeune Water Litigation.

9 The deponent today is Dr. Matthew Cooper.  
10 Counsel will be noted on the stenographic  
11 record.

12 The court reporter is Juliana Zajicek.  
13 Can you please swear in the doctor.

14 (WHEREUPON, the witness was duly  
15 sworn.)

16 THE VIDEOGRAPHER: Please proceed.

17 MATTHEW COOPER, MD,  
18 called as a witness herein, having been first duly  
19 sworn, was examined and testified as follows:

20 EXAMINATION

21 BY MR. GARAND:

22 Q. Dr. Cooper, my name is Carson Garand. I'm  
23 here with my colleague Erick Marquina. We are  
24 attorneys with the Department of Justice, and we

1 represent the United States in this matter.

2 Do you understand that?

3 A. I do.

4 Q. Can you please state your full name for  
5 the record, please?

6 A. Matthew Cooper.

7 Q. And can you please state your current  
8 business address?

9 A. 8900 West Wisconsin Avenue, Milwaukee,  
10 Wisconsin 53005.

11 Q. Okay. Doctor, you've been deposed before?

12 A. I have.

13 Q. Okay. I'm going to go over some ground  
14 rules just to make sure everything goes smoothly  
15 today. It's probably, you know, things you've heard  
16 before, but just to make sure we're all on the same  
17 page.

18 Do you understand that you took an oath to  
19 tell the truth today?

20 A. I do.

21 Q. Do you understand that this is the same  
22 oath that you would take in court subject to the same  
23 penalties of perjury?

24 A. I do.



1           Q.     During the deposition the court reporter  
2     is going to record and transcribe everything we say  
3     while we're on the record. So to make sure everything  
4     gets transcribed properly, I'll ask that you give me  
5     verbal responses to my questions. Is that okay?

6           A.     I understand.

7           Q.     If you didn't hear or understand a  
8     question, please let me know. I'm going to be asking  
9     you a lot today, so some of them might not be worded  
10    perfectly. So if you don't understand, certainly let  
11    me know and I'd be happy to rephrase. Okay?

12          A.     Thank you.

13          Q.     But if you do answer my question, I'm  
14    going to under -- assume that you understood it.  
15    Okay?

16          A.     Okay.

17          Q.     Please be sure to let me finish asking my  
18    question before you begin to answer, and I'll do my  
19    best to allow you to fully answer before I ask my next  
20    question. Okay?

21          A.     Okay.

22          Q.     While we're here, you can correct your  
23    testimony at any time. So if we talk about something  
24    and you want to modify it or add or change an answer

1 that we discussed earlier, please feel free to do  
2 that. Okay?

3 A. I understand.

4 Q. We're going to try to take a break about  
5 every hour or so, but if you need to take a break for  
6 any reason or no reason at all, you just want to --  
7 want to take a five-minute break, please let me know.  
8 I'm -- I'm happy to stop at any point. The only  
9 caveat there is if I've asked a question, I'll ask  
10 that you answer the question before we take the break.  
11 Okay?

12 A. Understood.

13 Q. During the deposition, you may hear  
14 Mr. Mandell object to certain questions. Unless he  
15 instructs you not to answer, I'm going to ask that you  
16 answer the question, but, of course, if he instructs  
17 you not to, then you're -- you're of course able to  
18 take his advice there.

19 Is there any reason why you would be  
20 unable to give your most truthful and accurate  
21 testimony today?

22 A. No.

23 Q. Doctor, what did you do to prepare for  
24 your deposition today?

1           A.       So I reviewed a number of the voluminous  
2 materials as part of this case. Most importantly, I  
3 reviewed my expert opinion and had conversations with  
4 Mr. Mandell and his office in preparation for today's  
5 planned testimony.

6           Q.       How did you decide which materials to  
7 review in preparation for the deposition?

8           MR. MANDELL: The only thing I would instruct  
9 you is that if it's any information or part of a  
10 conversation with me as your attorney here, or anyone  
11 else in my office, I'm instructing you not to answer  
12 that. If you can otherwise answer the question as to  
13 how you chose what you reviewed, fine, but nothing  
14 that we discussed. Okay?

15          THE WITNESS: Understood.

16          MR. MANDELL: Thank you.

17 BY THE WITNESS:

18          A.       So I reviewed what I believed were the  
19 pertinent documents to not only specifically the case  
20 but, you know, to my expertise, things that, again, I  
21 thought were going to be most relevant to our  
22 conversation today, but the specifics of which I can't  
23 recall.

24 BY MR. GARAND:

1 Q. Okay. So you don't recall what -- what  
2 records exactly that you reviewed?

3 A. In general I can give you some of the --  
4 the big pieces but not all of them. Certainly I  
5 reviewed, again, the substantive medical histories of  
6 both of the -- the parties in this case, focused  
7 certainly on the operative reports and the pathology  
8 reports, reviewed some of the data following  
9 nephrectomy for both of the -- the plaintiffs in this  
10 case, looked at some of the depositions that I believe  
11 were most important and pertinent to my testimony,  
12 reviewed the deposition of Dr. Johnstone as I thought  
13 that would be important, as well as some of the data  
14 that was in his deposition. And I believe that's the  
15 substance that I can recall.

16 Q. Okay. And you also said that you met with  
17 your attorneys, and as Mr. Man- -- Mandell said, I'm  
18 not asking for the substance of any of those  
19 conversations, but can you tell me which lawyers you  
20 consulted with in preparing for your deposition today?

21 A. Mr. Mandell and one of -- and one of his  
22 associates. Sorry, I don't remember her last name.

23 Q. Okay. Do you remember how many times you  
24 met to prepare for your deposition today?

1           A.     Yes.   About three or four times over a  
2     couple of days, a couple of hours each time.

3           Q.     And those three or four times, are those  
4     within the last week or so?

5           A.     The last couple of weeks.

6           Q.     And you said each was about -- each of the  
7     three or four times was about a couple of hours each  
8     time?

9           A.     That's correct.

10          Q.     Were these persons -- or were these  
11     meetings in person, over the phone?

12          A.     Video conference, Zoom.

13          Q.     Have you had any communications with  
14     anyone other than an attorney to prepare for your  
15     deposition today?

16          A.     No.

17          Q.     Have you had any communications with any  
18     of the plaintiffs in the Camp Lejeune Water Litigation  
19     about your deposition?

20          A.     No.

21          Q.     Have you had any communications with any  
22     of Mr. Mousser's or Ms. Tukes' treating physicians to  
23     prepare for your deposition?

24          A.     No.

1           Q.     How did you first become aware of the Camp  
2     Lejeune Water Litigation?

3           A.     I was contacted by Mr. Mandell.

4           Q.     So Mr. Mandell was the -- the person who  
5     first contacted you about working in this litigation?

6           A.     Yes, that's correct.

7           Q.     Do you recall when you were first  
8     contacted by Mr. Mandell?

9           A.     Boy, I just don't remember the specifics.  
10    It was last year, summertime perhaps.

11          Q.     Okay. So summer of 2024?

12          A.     That sounds about right.

13          Q.     Were you provided with any information  
14    during this initial contact?

15          A.     No, just conversation.

16          Q.     So you had been hired as an expert witness  
17    in this matter, right?

18          A.     Yes, that's correct.

19          Q.     You did not execute a retainer agreement  
20    with the plaintiffs' leadership group or any of the  
21    plaintiffs regarding this liti- -- litigation, though,  
22    right?

23          A.     That's correct.

24          Q.     Is that typical practice for you when

1       you're providing expert services?

2           A.       Yes, sir.

3           Q.       Do you recall when you were formally  
4 retained then?

5           A.       I'm sorry, I don't.

6           Q.       Presumably after that summer of 2024  
7 conversation?

8           A.       Correct, sometime after that conversation.

9           Q.       Do you recall if it was, you know, pretty  
10 quick after, if it was a couple of months later?

11          A.       I believe it was pretty quickly after.

12          Q.       And is it Mr. Mandell's firm that retained  
13 you?

14          A.       Yes.

15          Q.       Did you perform any work in connection  
16 with the Camp Lejeune Water Litigation prior to being  
17 formally retained?

18          A.       No.

19          Q.       What did you -- what was your assignment  
20 in this matter?

21           MR. MANDELL:  Objection.  Again, anything that  
22 comes from me or anybody in my firm to you is  
23 privileged.  You're not to answer that.  If you can  
24 otherwise explain it, perhaps in terms of what you

1 generally did, that's -- that would be appropriate, or  
2 more appropriate, okay.

3 BY THE WITNESS:

4 A. Yeah, I was -- well, I was provided  
5 documentation that included the medical records of the  
6 plaintiffs in this case as well as some information  
7 surrounding the instances at Camp Lejeune that I was  
8 asked to review and to provide my expert opinion.

9 BY MR. GARAND:

10 Q. Do you have any support staff that's  
11 helping you with this matter?

12 A. No.

13 Q. Okay. Dr. Cooper, we're going to mark a  
14 few exhibits here which are your Materials Considered  
15 List. So bear with me here while we do this. And  
16 we'll go first with the Materials Considered List for  
17 Mr. Mousser, the initial list, and we'll mark this as  
18 Cooper Exhibit 1.

19 (WHEREUPON, a certain document was  
20 marked Dr. Cooper Deposition Exhibit  
21 No. 1, for identification, as of  
22 07/10/2025.)

23 THE WITNESS: Thank you.

24 MR. MANDELL: Thank you.



1 MR. GARAND: Madam Court Reporter, would you  
2 like me to hand you the -- the record?

3 THE COURT REPORTER: Sure.

4 BY MR. GARAND:

5 Q. Yeah, if you don't mind reviewing that  
6 quickly.

7 So I'll mark -- I'll mark as Cooper No. 2  
8 your Materials Considered List for plaintiff  
9 Jacqueline J. Tukes.

10 (WHEREUPON, a certain document was  
11 marked Dr. Cooper Deposition Exhibit  
12 No. 2, for identification, as of  
13 07/10/2025.)

14 MR. GARAND: I'll mark as Cooper Exhibit 3, the  
15 document entitled Dr. Matthew Cooper, Supplemental  
16 Materials Considered List.

17 (WHEREUPON, a certain document was  
18 marked Dr. Cooper Deposition Exhibit  
19 No. 3, for identification, as of  
20 07/10/2025.)

21 MR. GARAND: And as Cooper Exhibit 4, I'll mark  
22 the document titled Dr. Matthew Cooper, Third  
23 Supplemental Materials Considered List.

24 (WHEREUPON, a certain document was

1 marked Dr. Cooper Deposition Exhibit  
2 No. 4, for identification, as of  
3 07/10/2025.)

4 MR. GARAND: And just for the record, I believe  
5 we received a second Third Supplemental Materials  
6 Considered List from Ms. Giles of your office. It  
7 contained the same information that's in this document  
8 there, so I'm just providing this one.

9 MR. MANDELL: Okay. Thank you.

10 BY MR. GARAND:

11 Q. And just to make sure I'm not missing  
12 anything, there's no second supplemental Materials  
13 Considered List, right, that you are aware of?

14 A. Not that I'm aware of.

15 Q. Okay. Doctor, do you recognize each of  
16 these four documents?

17 A. I do, having seen them in the past.

18 Q. Okay. Doctor, did you prepare these  
19 documents, or did counsel prepare them?

20 A. Counsel prepared these.

21 Q. Okay. In looking between these four  
22 exhibits, again, Cooper Exhibits 1 through 4, are they  
23 a complete and accurate copy of your lists of  
24 materials considered?

1           A.     Well, there's a lot on here.

2           Q.     There is.

3           A.     I believe they are.  They -- they look  
4 complete to the best of my knowledge, but, again, I'm  
5 uncertain of the totality of all of the documents that  
6 were provided to me and currently in the DropBox that  
7 I think we have available.

8           Q.     And we'll go through some of those, but if  
9 there are any documents we've discussed that are  
10 either not on those or you don't recall reviewing,  
11 certainly let me know.

12          A.     Okay.

13          Q.     Are there any documents that you reviewed  
14 but decided not to rely on?

15          A.     I am -- oh, boy.  I'm sorry, I don't  
16 remember that.  I'd say I reviewed a lot in here.  I  
17 can't remember exactly which pieces from sort of what  
18 part of this, you know, were used in creating my  
19 expert testimony.

20          Q.     So, Doctor, according to -- to your  
21 Materials Considered List, you reviewed over 35,000  
22 documents for Mr. Mousser's case.

23                   Does that sound about right to you?

24          MR. MANDELL:  Objection.  Go ahead.

1 BY THE WITNESS:

2 A. Boy, I don't remember the totality of what  
3 I reviewed over the course of these many months, but,  
4 again, that -- this is the substance of what was put  
5 before me.

6 BY MR. GARAND:

7 Q. Could you --

8 MR. MANDELL: Sorry, can I just ask for  
9 clarification. When you say "this is the substance,"  
10 what is "this," just for the record? I'm sure  
11 Mr. Garand wants that.

12 MR. GARAND: Thank you, Mr. Mandell.

13 BY THE WITNESS:

14 A. What's actually listed in these documents.

15 MR. MANDELL: Do you mean Exhibits 1 through 4?

16 BY THE WITNESS:

17 A. Exhibits 1 through 4, yes, thank you very  
18 much.

19 MR. GARAND: Thank you, Mr. Mandell, for that.

20 MR. MANDELL: Yeah, and --

21 THE WITNESS: Point taken.

22 MR. MANDELL: -- I -- I don't mean to impose  
23 myself. I just wanted -- I thought you'd want it  
24 clear too.

1 MR. GARAND: Thank you.

2 MR. MANDELL: Okay.

3 BY MR. GARAND:

4 Q. So according to your Materials Considered  
5 Lists, you reviewed over 15,000 documents for Ms. --  
6 Ms. Tukes' case.

7 Does that sound about right to you?

8 MR. MANDELL: Objection.

9 BY THE WITNESS:

10 A. Same answer to the last question. I -- I  
11 believe what's in Exhibits 1 through 4, yeah, was  
12 inclusive of what was put before me.

13 BY MR. GARAND:

14 Q. And I'll represent to you my math is not  
15 great. Addition is about the extent of it, but -- but  
16 that is, you know, if you total up the amount of  
17 records in there, that's about what that looks like,  
18 about 35,000 dollars -- 35,000 documents for  
19 Mr. Mousser and 15,000 pages of records for Ms. Tukes,  
20 okay?

21 MR. MANDELL: Objection.

22 BY MR. GARAND:

23 Q. Doctor, did you actually review all of  
24 those records?

1           A.       I can't remember the specifics of what  
2       contained through Exhibits 1 through 4 I reviewed, but  
3       I reviewed what I believed was the important  
4       substantive material in order for me to provide what  
5       you see in my expert opinion and what we'll talk about  
6       today.

7           Q.       So, Doctor, let me ask then, given the  
8       voluminous records in this case, how did you decide  
9       what to review and what to rely on?

10          MR. MANDELL:   Okay.   I'm going to give you the  
11       same instruction that I gave you before, that if it's  
12       anything to do with conversations between you and me  
13       or any other person in my office, you're not to answer  
14       that question, but if you can otherwise answer it, go  
15       ahead.

16       BY THE WITNESS:

17          A.       So I primarily focused on the patient  
18       records, the clinical record of the patient as well as  
19       materials that I thought were necessary to support  
20       information that I had gathered in the patient's  
21       records.   That's the substance of what, again, I  
22       remember in the review of all of these materials.

23       BY MR. GARAND:

24          Q.       Thank you, Doctor.   I'm going to show you

1     what I'll mark as Cooper Exhibit 5, I believe we're  
2     on.

3                     (WHEREUPON, a certain document was  
4                     marked Dr. Cooper Deposition Exhibit  
5                     No. 5, for identification, as of  
6                     07/10/2025.)

7     BY MR. GARAND:

8             Q.     Doctor, please review this record and  
9     please let me know if this is something you've seen  
10    before.

11            A.     Yes, it is.

12            Q.     And, Doctor, what is it?

13            A.     This is the bill that I submitted, excuse  
14    me, to Mr. Mandell's office for some initial work in  
15    preparation for this case.

16            Q.     Was this the first invoice you submitted  
17    to Mr. Mandell?

18            A.     I believe, yes, yes, it is.

19            Q.     Do you recall if this is the only invoice  
20    you've sent to Mr. Mandell?

21            A.     It is the only invoice that I've  
22    submitted.

23            Q.     Okay. So, Doctor, this was -- and just  
24    for the record, again, this is a December 15th, 2024,

1 invoice that Dr. Cooper sent to Mr. Mandell and his  
2 law firm for services rendered in this case.

3 So this document is dated eight months  
4 ago, is that right, approximately?

5 A. Approximately, yes.

6 Q. So you've only sent Mr. Mandell one  
7 invoice in the past eight months, is that right?

8 A. That's correct, yes.

9 Q. Have you done additional work after this  
10 date, after December 15th of 2024?

11 A. I have, yes.

12 Q. Is it your typical practice -- or what is  
13 your typical billing practice for your expert  
14 services?

15 A. Well, I do my best to try and stay current  
16 with billing. This is not my full-time job. And so,  
17 you know, my responsibilities with my current  
18 profession oftentimes prevent me from, as much as I  
19 want to, to stay current. So I just haven't submitted  
20 a supplementary bill, you know, since this in  
21 December.

22 Q. Can you give me an estimate of how many  
23 hours you've spent in the last eight months working on  
24 this case and just -- and, Doctor, for the record,



1 just for -- by "this case" --

2 A. Yeah.

3 Q. -- I mean Mr. Mousser's case and  
4 Ms. Tukes' case?

5 A. I'd say approximately 20 additional hours.

6 Q. Okay. And what have you been doing in  
7 those 20 additional hours?

8 A. So I was provided additional patient  
9 records. I was provided some additional deposition  
10 testimony. I was provided particularly information,  
11 the testimony of Dr. Johnstone, which I reviewed  
12 including some articles that were cited there. And  
13 that's I think the extent of what I've done since  
14 then; and preparations that we talked about for today.

15 Q. Well, Doctor, I know there's -- well, let  
16 me ask. Will -- will you be submitting an additional  
17 invoice to Mr. Mandell's firm at -- at some point in  
18 the future?

19 A. Yes, I plan to.

20 MR. GARAND: Okay. When that happens,  
21 Mr. Mandell, we're going to request that that invoice  
22 be produced to us.

23 BY MR. GARAND:

24 Q. So just ballpark again, over the last

1 eight months, about 20 -- approximately 20 additional  
2 hours. Can you, you know, again, give an approximate  
3 number as to how many hours you've spent doing which  
4 activities that you just discussed?

5 A. Boy, I think we talked earlier about, you  
6 know, five or so hours in preparation for this and  
7 then the remaining was in the review of those  
8 additional materials and depositions.

9 Q. So about 15 hours reviewing the additional  
10 materials. Do you know -- and presumably part of that  
11 is drafting your expert reports, right?

12 A. (Nodding head).

13 Q. Do you recall how long it took for you to  
14 draft your expert reports?

15 A. Three or four hours.

16 Q. Is that three or four hours total or per  
17 expert report?

18 A. I've been -- probably between the two of  
19 them, it's probably more like five or six hours.

20 Q. Okay. So that leaves about nine or ten  
21 hours reviewing the additional depositions and  
22 records, is that right?

23 MR. MANDELL: Objection.

24 BY THE WITNESS:

1           A.       That sounds about right. And I'm not a  
2 math major either, but that sounds about right.

3 BY MR. GARAND:

4           Q.       And I know I'm asking you for, you know,  
5 approximations here and guesses, but we don't have  
6 another invoice here to go off of, so I'm just trying  
7 to understand what you've done over the last eight  
8 months.

9                   And so -- so out of that, again,  
10 approximate nine or ten hours remaining, how would you  
11 divide that between deposition review and record  
12 review?

13           A.       The majority of it is -- is record review.  
14 And I said the additional -- sorry, the deposition of  
15 Dr. Johnstone. So it's probably three hours with that  
16 deposition and the remainder was record review.

17           Q.       So three hours with Dr. Johnstone's  
18 deposition?

19           A.       Yeah.

20           Q.       And the remainder is record review?

21           A.       Yes.

22           Q.       Okay. And so in looking at this invoice  
23 here, again, Cooper Exhibit 5, it says, "Re:  
24 Mousser v. United States of America."

1 Do you see that bolded and underlined  
2 there?

3 A. I do.

4 Q. This invoice is also for work done in  
5 Ms. Tukes' case, is that right?

6 A. That's correct.

7 Q. And the invoice is for \$21,200, right?

8 A. That's correct.

9 Q. Okay. Okay. So it looks like this first  
10 entry here is record and literature review for  
11 4.5 hours.

12 Do you recall what percentage of that  
13 4.5 hours was for record review and what percentage  
14 was for literature review?

15 A. I'm sorry, I don't.

16 Q. Okay. So assuming -- well, so -- well,  
17 okay.

18 And so this -- so the 4.5 hours of record  
19 review here and then the approximately seven hours  
20 that we've discussed for record review in the last  
21 eight months, that's for both cases, right?

22 A. That's correct, yes.

23 Q. So at most, 7 plus 4.5, 11-1/2 hours for  
24 the approximate 50,000 pages of records in this case,

1 is that right?

2 MR. MANDELL: Objection.

3 BY THE WITNESS:

4 A. Well, again, I -- I didn't admit the  
5 50,000 --

6 BY MR. GARAND:

7 Q. Oh.

8 A. -- but that's the amount of time that I  
9 spent in the record review of both cases, is what I  
10 believe you have.

11 Q. Okay. Let's look at Cooper Exhibit 1,  
12 which is your Materials Considered List for  
13 Mr. Mousser, your initial Materials Considered List.

14 If you look at Page 2 of this record, at  
15 the very top, the third line from the top, it says,  
16 "Plaintiffs specifically identify the following facts,  
17 data, and publications considered by Dr. Cooper in  
18 forming his opinions for Frank W. Mousser," right?

19 A. Correct.

20 Q. And then No. 2 says, "Transcripts of the  
21 depositions of Plaintiff Frank W. Mousser, Heather  
22 Mousser, Richard Eugene Mercer, Andrew P. Rockwood,  
23 MD, Daniel Kevin Flood, MD, Janet Mueller, PsyD, and  
24 all documents marked as exhibits therein."

1 Is that right?

2 A. That's what it says, yes.

3 Q. So, and, again, if we look at Exhibit 5,  
4 again, which is your December 2024 invoice, it states,  
5 lines 3 through 4 -- or sorry, 2 through 4 of this  
6 invoice date, you reviewed the deposition of Heather  
7 Mousser, Frank Mousser, and Dr. Mueller, is that  
8 right?

9 A. Correct.

10 Q. Did you review the deposition transcripts  
11 of Mr. Richard Eugene Mercer, Dr. Rockwood, and  
12 Dr. Flood?

13 A. I don't recall. Those came later.

14 Q. But you don't recall that you've reviewed  
15 the -- whether you've reviewed those deposition  
16 transcripts?

17 A. I don't recall.

18 Q. Do you know who Mr. Mercer is?

19 A. I don't, no.

20 Q. Do you know who Dr. Rockwood is?

21 A. No.

22 Q. Do you know who Dr. Flood is?

23 A. I don't recall.

24 Q. So Dr. Rockwood is Mr. Mousser's VA

1 urologist, do you understand -- or do you know that?

2 A. Thank you.

3 Q. So you did not know that before I told  
4 you?

5 A. No.

6 Q. So you did not know that Dr. Rockwood is  
7 the urologist that initially found Mr. Mousser's  
8 cancer, correct?

9 A. I don't know the name associated with the  
10 individual.

11 Q. Okay. But you're -- you're unaware that  
12 he was deposed in this case, is that right?

13 MR. MANDELL: Objection.

14 BY THE WITNESS:

15 A. I'm not unaware. I just didn't -- don't  
16 remember specifically the name and the individual who  
17 was Mr. Mousser's urologist.

18 BY MR. GARAND:

19 Q. And I'm assuming the same is true for  
20 Dr. Daniel Flood, you don't know that he was deposed  
21 in this matter either?

22 MR. MANDELL: Objection, he didn't testify to  
23 that, but go ahead.

24 BY MR. GARAND:

1 Q. Are you aware that Dr. Flood was deposed  
2 in this matter?

3 A. I do.

4 Q. And -- but you don't recall whether or not  
5 you reviewed Dr. Flood's deposition transcript, right?

6 A. Again, I don't remember the specifics of  
7 that.

8 Q. And Dr. Flood is Mr. Mousser's VA  
9 nephrologist. Do you understand that, or did you know  
10 that?

11 MR. MANDELL: Objection.

12 BY MR. GARAND:

13 Q. Go ahead.

14 A. I understand he has a nephrologist, but I  
15 didn't have a name associated with that.

16 Q. Would the deposition transcripts of  
17 Mr. Mousser's VA neurologist and VA nephrologist be  
18 relevant to your opinions today?

19 A. I believe that the portions of what  
20 they -- they say in their deposition may be important,  
21 but I relied mostly on the medical direct -- on the  
22 medical records following treatment of Mr. Mousser's  
23 cancer.

24 Q. Okay. Let's go to Cooper Exhibit 2, which



1 is the initial Materials Considered List for  
2 Mrs. Tukes. And we'll again look at Page 2, and I'll  
3 be asking you a lot of the same questions here.

4 So if we look at Numbers 4 and 5, it  
5 states you reviewed the "Transcripts of the  
6 depositions of Plaintiff Jacqueline J. Tukes,  
7 April 11th, 2024, and January 15 of 2025, Nagesh H.  
8 Jayaram, MD, Roc McCarthy, DO, Heather Jones, MD, Mary  
9 Katherine Garbarini, MS, CGC, and all documents marked  
10 as exhibits therein." And Number 5 says, "Transcripts  
11 of the depositions of Willie Tukes, Jr. and K.V.  
12 George Thomas, MD."

13 And if we go back to Cooper Exhibit 5,  
14 which is your December 15, 2024, invoice, it states  
15 that you reviewed the depositions of Jayaram, Thomas,  
16 McCarthy, and Ms. Tukes, is that right?

17 A. Correct.

18 Q. And I'm assuming "Tukes" there is  
19 Ms. Jacqueline Tukes, not her husband Mr. Tukes?

20 A. Correct.

21 Q. So you have -- did you review the  
22 deposition transcripts of Heather Jones, Mary  
23 Katherine Garbarini, and Mr. Willie Tukes?

24 A. Again, I've looked at them in passing, but

1 I don't remember the specifics.

2 Q. Would you agree that the deposition  
3 transcript of Heather Jones, which is Mrs. Tukes'  
4 post-transplant nephrologist, would be relevant to  
5 your opinions?

6 MR. MANDELL: Objection; go ahead.

7 BY THE WITNESS:

8 A. Not necessarily. Like I said, I relied on  
9 the medical records to make my determination.

10 BY MR. GARAND:

11 Q. Okay. The last entry here on Cooper  
12 Exhibit No. 5 is, "Complete Damage Questions -  
13 3.0 hours."

14 What does this refer to?

15 A. These were conversations that I had had  
16 with Mark and his office about questions, you know,  
17 surrounding post nephrectomy, what the outlook would  
18 be for Ms. Tukes and Mr. Mousser, of which, you know,  
19 I in addition put in my expert report.

20 Q. So the contents of that is in your expert  
21 report, is that right?

22 A. The substance is in the expert report,  
23 yes, sir.

24 Q. Doctor, have you received -- or how much

1 compensation have you received to date in this case?

2 A. Solely what you see on this invoice of  
3 December 15th.

4 Q. And is it fair to assume the approximately  
5 20 hours that you've done since this invoice would  
6 also be billed at this 80 -- or \$800 an hour rate?

7 A. That's correct.

8 Q. Does your payment depend on the outcome of  
9 this case at all?

10 A. No, it does not.

11 Q. What percentage of your annual income is  
12 earned from serving as an expert witness?

13 A. Less than 1 percent.

14 Q. Is your fee schedule in this case the same  
15 as fee schedules you've used in other cases?

16 A. Yes, sir, most recently.

17 Q. Okay. I'm going to show you your fee  
18 schedule here, and I will mark this as Cooper  
19 Exhibit 6.

20 (WHEREUPON, a certain document was  
21 marked Dr. Cooper Deposition Exhibit  
22 No. 6, for identification, as of  
23 07/10/2025.)

24 MR. GARAND: Thank you.

1 THE WITNESS: Thank you.

2 MR. GARAND: Thank you.

3 BY MR. GARAND:

4 Q. Is this an accurate depiction of your  
5 current fee schedule?

6 A. Yes, it is. Well, no. This is a little  
7 bit old. The chart review is -- is 800 based upon,  
8 like we said here.

9 Q. So when did the rate change from \$750 an  
10 hour to \$800 an hour?

11 A. I'm sorry, I don't know the specifics of  
12 that. Sometime following -- following August and  
13 December.

14 Q. Thank you, Doctor.

15 And for chart review, does that include  
16 deposition transcript review as well?

17 A. It does.

18 Q. And presumably that includes medical  
19 record review as well?

20 A. That's correct.

21 Q. Have you ever served as an expert witness  
22 for a defendant?

23 A. Yes.

24 Q. Do you recall approximately how many cases

1       that's been?

2           A.       Over the course of the last four years, I  
3       have been deposed approximately eight times, and for  
4       the question about defense, about those eight times,  
5       about five for the plaintiff and three for defense.

6           Q.       Prior to this case, have you ever worked  
7       as an expert witness for the Bell Legal Group?

8           A.       No.

9           Q.       Prior to this case, have you ever worked  
10       as an expert witness for Keller Postman, LLC?

11          A.       Not to my knowledge.

12          Q.       Prior to this case, have you ever worked  
13       as an expert witness for Lief Cabraser Heimann &  
14       Bernstein LLP?

15          A.       Not to my knowledge.

16          Q.       Prior to this case, have you ever worked  
17       as an expert witness for the Dowling firm, PLLC?

18          A.       Not to my knowledge.

19          Q.       Prior to this case, have you ever worked  
20       as an expert witness for Weitz & Luxenberg, PC?

21          A.       Not to my knowledge.

22          Q.       Prior to this case, have you ever worked  
23       as an expert witness for Wallace & Graham, P.A.?

24          A.       Not to my knowledge.

1 Q. And we'll talk about this a little bit  
2 later, but is your expert -- are your expert services  
3 typically in the Milwaukee or Wisconsin area or is it  
4 national?

5 A. National.

6 Q. Okay. Dr. Cooper, I'm going to mark your  
7 reports as exhibits now, and we'll start first with  
8 the specific causation expert report for Frank  
9 Mousser, dated February 2nd, 2025, and we'll mark this  
10 as Cooper Exhibit 7.

11 (WHEREUPON, a certain document was  
12 marked Dr. Cooper Deposition Exhibit  
13 No. 7, for identification, as of  
14 07/10/2025.)

15 MR. GARAND: Thank you, Erick.

16 And then we'll also mark as Cooper  
17 Exhibit 8 your specific causation expert report for  
18 Jacqueline Tukes, dated February 2nd of 2025.

19 (WHEREUPON, a certain document was  
20 marked Dr. Cooper Deposition Exhibit  
21 No. 8, for identification, as of  
22 07/10/2025.)

23 BY MR. GARAND:

24 Q. And, Doctor, I'll ask that you briefly

1 review the reports in this case. I know that this  
2 exhibit also contains your CV, but I just want to make  
3 sure this report is the report that you drafted -- or  
4 these reports are the reports that you drafted.

5 A. It is two-sided?

6 Q. Yes.

7 A. Yes.

8 MR. MANDELL: Off the record.

9 (WHEREUPON, discussion was had off the  
10 stenographic record.)

11 BY MR. GARAND:

12 Q. Okay. Doctor, if we could look at Cooper  
13 Exhibit 7, which is your Mousser report, and we are  
14 going to turn to the CV here, which is directly after  
15 the record. And, Doctor, I know your CV is about 100  
16 pages here, so I'll ask you to -- to briefly review  
17 it, but it's -- it's been printed off of what you  
18 submitted to us, so it should be fully accurate.

19 A. Okay. Yes, it looks complete, yes.

20 Q. Thank you, Doctor.

21 Do you recognize this document as your CV?

22 A. I do, yes.

23 Q. Is this the most current version of your  
24 CV?

1           A.     I believe I may have updated it with a  
2     couple of lectures within the last couple of months.

3           Q.     Okay.  Would the lectures be the only  
4     additions within the last few months?

5           A.     Yes.

6           Q.     Is this document a complete representation  
7     of your educational and employment background?

8           A.     It is.

9           Q.     Does this document contain all of your  
10    publications?

11          A.     It does.

12          Q.     Is there any information you did not  
13    include in your CV?

14          MR. MANDELL:  Objection.  Could you rephrase  
15    that?  I mean, it's obvious there's information about  
16    his life that he doesn't have in there.

17    BY MR. GARAND:

18          Q.     Is there any professional information  
19    other than the lectures we've just discussed that are  
20    included in your CV?

21          MR. MANDELL:  Thank you.

22    BY THE WITNESS:

23          A.     No.

24    BY MR. GARAND:



1 Q. Okay. Doctor, if we look at Page 1 of  
2 your CV, you are a transplant surgeon, is that right?

3 A. Yes, sir.

4 Q. And your residency was in general surgery?

5 A. It was.

6 Q. And your fellowship was in transplant  
7 surgery, right?

8 A. Yes, sir.

9 Q. You are a board certified -- or sorry, you  
10 are board certified in surgery only, is that right?

11 A. Board certified general surgery, yes, sir.

12 Q. What is your current role?

13 A. So I am the division chief for the  
14 division of transplantation here at the Froedtert  
15 Memorial Lutheran Hospital. I am also the director  
16 for the service line for Froedtert and for Children's  
17 Hospital overseeing all of the adult and the pediatric  
18 transplant programs.

19 Q. Doctor, you mentioned overseeing. Do you  
20 still see patients directly?

21 A. I do.

22 Q. Do you still perform surgeries?

23 A. I do.

24 Q. So can you tell me just generally what

1 does a transplant surgeon do?

2 A. So we are -- we're fortunate to be the  
3 interface between referring doctors with patients who  
4 have end organ failure and the decision as to whether  
5 or not they meet candidacy for solid organ transplant.  
6 Once they are approved for surgery, we are then  
7 responsible, particularly from the surgeon's side, for  
8 performing the operations and then manage them  
9 post-transplant throughout the -- really the entirety  
10 of their post-transplant care.

11 Q. So you are involved with not just the  
12 surgery but also the post-transplant care, is that  
13 right?

14 A. Pre- and post-transplant, correct.

15 Q. Do you typically see patients who are  
16 considering or going to be having a transplant  
17 surgery?

18 A. I do.

19 Q. Do you typically see patients with, you  
20 know, kidney or other organ issues that are less  
21 severe?

22 A. Can you ask that again, please?

23 Q. Sure. So, for example, a patient with  
24 chronic kidney disease in the earlier stages, would

1       you be treating that type of patient?

2           A.       We do. We ask patients to come to us  
3       prior to end organ failure to discuss transplant.

4           Q.       And, Doctor, you said "we do." Is that  
5       something that you do as well?

6           A.       It is.

7           Q.       Presurgery and postsurgery, would you be  
8       somebody's primary treater regarding their organ  
9       issues?

10          A.       Yes, I would.

11          Q.       You're also a professor of surgery, is  
12       that right?

13          A.       Yes, sir.

14          Q.       What percentage of your time is spent  
15       practicing as a surgeon versus teaching surgery?

16          A.       Teaching, very little. Our teaching is  
17       limited to residents and students that rotate on our  
18       service. So it's probably around 5 percent of time.

19          Q.       And what kind of transplant surgeries do  
20       you perform?

21          A.       Currently kidney and pancreas  
22       transplantation.

23          Q.       Can you give me a ballpark of how many  
24       transplant surgeries you do per year?

1           A.     I do approximately 100 kidneys and about  
2     20 pancreatic per year.

3           Q.     Do you see any other kind of patients?

4           A.     Well, I also see patients pre- and  
5     post-transplant that are in need of some general  
6     surgical procedures as well that we also care for.

7           Q.     What are those general surgical  
8     procedures? What does that look like?

9           A.     Patients that may have a hernia,  
10    particularly incisional hernias after their  
11    transplants. We put in dialysis access catheters and  
12    peritoneal dialysis catheters, and we can do small  
13    surgeries, we call them lumps and bumps, lipomas, and  
14    sometimes things like gallbladders if we feel  
15    comfortable doing that too, and those are the cases  
16    that I do.

17          Q.     What are -- what percentage of your  
18    surgical practice is attributed to this general --  
19    these general surgical procedures?

20          A.     Very small, 2 to -- 2 percent.

21          Q.     How long do you have to meet with a  
22    patient before you can render a diagnosis for that  
23    patient?

24          A.     Can you be more specific? Any diagnosis?

1           Q.     So if you are -- so if you're going to  
2     determine whether or not a patient needs a kidney  
3     transplant, how long would you need to meet or how  
4     many times would you need to meet with that patient  
5     before you could determine whether they needed a  
6     kidney transplant?

7           A.     That's very different based upon the  
8     individual. Some are more complex than others. I'd  
9     say on average, you know, we meet with patients  
10    pre-transplant to determine their candidacy about  
11    between an hour and an hour-and-a-half, and then it  
12    includes some record review thereafter to help make  
13    that determination.

14          Q.     And so after an hour or an  
15    hour-and-a-half, you're able to determine whether or  
16    not a patient needs a kidney transplant?

17          MR. MANDELL: Objection.

18                 Go ahead.

19    BY THE WITNESS:

20          A.     No, that's not what I said.

21    BY MR. GARAND:

22          Q.     My apologies.

23          A.     We meet with them initially for an hour  
24    and a half, and then we have record review and data

1 collection that all has to be put together. And the  
2 decision is made by a multidisciplinary team and not  
3 by myself alone.

4 Q. Thank you, Doctor. And -- and as we go  
5 today, I'm not trying to put any words into your  
6 mouth, so if I misstate your testimony, please let me  
7 know.

8 A. Okay.

9 Q. So you do treat patients with chronic  
10 kidney disease who are not nearing renal failure, is  
11 that right?

12 A. I deal with patients who have chronic  
13 kidney disease whose expectation is that they will  
14 eventually potentially develop chronic renal failure.

15 Q. When you say their expectation is that  
16 they'll get to endstage renal disease or chronic  
17 kid -- or kidney failure, what does that type of  
18 patient look like in terms of, like, their lab results  
19 and symptoms and things of that nature?

20 MR. MANDELL: Objection.

21 Go ahead.

22 BY THE WITNESS:

23 A. So we ask to see patients before they need  
24 to make a decision such as transplant, and so we see

1 patients in CKD, late Stage 3, and certainly CKD  
2 Stage 4 to be able to talk about what we would like to  
3 perform, is a preemptive kidney transplant. And so we  
4 have conversations with they and family about options  
5 available before they develop endstage renal disease  
6 and -- and potentially need dialysis.

7 BY MR. GARAND:

8 Q. And so when you say -- when you say late  
9 Stage 3, you mean CKD Stage 3b?

10 A. Typically, yes.

11 Q. Do you typically see patients in CKD  
12 Stage 2 or 3a?

13 A. Not often, no.

14 Q. And why is that?

15 A. My services aren't often necessary,  
16 although there are some occasional patients that have  
17 problems with a kidney that has maybe a somewhat  
18 normal GFR that still could benefit from a -- we call  
19 it a nephrectomy, an autotransplant, but that's few.

20 Q. Okay. Doctor, I'm going to ask you a  
21 handful of questions here just to -- to try to  
22 understand what exactly the specialty is that you  
23 possess and the specialty in which you're -- you're  
24 testifying and providing opinions in this matter.

1 Doctor, you're not an attorney, is that  
2 right?

3 A. No.

4 Q. You are not an epidemiologist, right?

5 A. No, sir.

6 Q. And you are not a geneticist, right?

7 A. No, sir.

8 Q. You're not a toxicologist, right?

9 A. No, sir.

10 Q. You're not an oncologist, right?

11 A. No, sir.

12 Q. You're not a nephrologist, is that right?

13 A. No, sir.

14 Q. And you're not a transplant nephrologist,  
15 right?

16 A. No, sir.

17 Q. Can you explain the difference between a  
18 transplant surgeon like yourself who handles kidney  
19 transplants and a nephrologist or a transplant  
20 nephrologist?

21 A. The difference primarily is medical versus  
22 surgical specialty. A transplant nephrologist and  
23 transplant surgeons, really all transplant physicians  
24 and surgeons work collaboratively in the diagnosis and



1 care of patients. What primarily distinguishes the  
2 surgeon from the nephrologist is we have the ability  
3 to perform the surgical procedure, but, again, most of  
4 what we do is, you know, collaborative work between  
5 the two specialties.

6 Q. And, Doctor, you are not a urologist, is  
7 that right?

8 A. No, sir.

9 Q. You have no degrees in pharmacology,  
10 correct?

11 A. No, sir.

12 Q. You have no degrees in environmental  
13 health, is that right?

14 A. No, sir.

15 Q. You have no degrees in occupational  
16 medicine?

17 A. No, sir.

18 Q. And you have no degrees in statistics,  
19 right?

20 A. No, sir.

21 Q. Have you ever physically examined Frank  
22 Mousser or Jacqueline Tukes?

23 A. I have not.

24 Q. Have you ever met them or spoken with

1       them?

2             A.       I have not.

3             Q.       Doctor, have you ever been subject to any  
4       disciplinary action or censure by any licensing body?

5             A.       No, sir.

6             Q.       Have you ever been subject to any  
7       disciplinary action by any court or tribunal?

8             A.       No, sir.

9             Q.       Doctor, in your practice, do you offer any  
10      guarantees to your patients?

11            A.       Guarantees, no, no.

12            Q.       And why is that?

13            A.       Really, everything is -- I can't guarantee  
14      what happens biologically in the field that I  
15      practice, so we don't use the word "guarantee."

16            Q.       Would you agree that medicine is not an  
17      exact science?

18            A.       No, I wouldn't agree to that.

19            Q.       And why is that?

20            A.       Because I think there's many parts in  
21      medicine that we have very good data to be able to  
22      provide information to patients that I think is  
23      critical for them to make important decisions.

24            Q.       Would the treatment and -- or diagnosis,

1 treatment, and prognosis of chronic kidney disease  
2 fall into that category?

3 A. Can you say that again, please?

4 Q. So would the diagnosis, treatment, and --  
5 and prognosis, determining the prognosis of chronic  
6 kidney disease fall into the subset of science -- or  
7 of medicine that is an exact science?

8 MR. MANDELL: Objection; form.

9 BY THE WITNESS:

10 A. I think -- I think it's different for  
11 every patient. I think we have, fortunately in  
12 transplant, decades and decades of data that allow us  
13 to be able to look at a patient in front of us and be  
14 able to give them information about what their path is  
15 expected to be based upon those -- that data that we  
16 have a requirement to collect.

17 BY MR. GARAND:

18 Q. Do we also have significant, you know,  
19 decades and decades of data regarding progression of  
20 CKD?

21 MR. MANDELL: Objection.

22 Go ahead.

23 BY THE WITNESS:

24 A. We do.

1 BY MR. GARAND:

2 Q. So, Doctor, like we discussed, typically  
3 patients with CKD Stage 2 and 3a -- stable CKD Stage 2  
4 and 3a, don't come to see you, right?

5 MR. MANDELL: Objection; go ahead.

6 BY THE WITNESS:

7 A. Not often.

8 BY MR. GARAND:

9 Q. Do you typically provide a prognosis in  
10 your practice?

11 A. Prognosis. Yes, we do.

12 Q. Okay. And is that -- what -- at what  
13 point in the transplant surgery process do you  
14 typically provide a prognosis?

15 A. Really, when we have that initial  
16 interview with patients and we put the story together  
17 with their past medical history, again, the fortunate  
18 fact that we have, as I said, decades of data, and  
19 with my education, experience, and consistent review  
20 of the literature, I've been able to provide that  
21 prognosis for patients at the time that I'm seeing  
22 them.

23 Q. Doctor, CKD staging is measured by looking  
24 at the glomerular filtration rate, or GFR, is that

1 right?

2 A. That's part of it, yes.

3 Q. Is the other part the level of protein in  
4 somebody's urine?

5 A. That's correct.

6 Q. So the GFR is a measure of how well the  
7 kidneys are filtering blood, right?

8 A. In general, yes.

9 Q. Is it true that often clinicians will use  
10 the estimated GFR or eGFR to measure kidney function?

11 A. They do. That's the convenient way of  
12 measuring a -- not even measuring -- of providing a  
13 GFR.

14 Q. When you say "convenient," is it typically  
15 accurate as well?

16 A. No. It's actually not accurate.

17 Q. Okay. Is it -- so then why is it relied  
18 on by doctors?

19 A. Because it's easy to obtain.

20 Q. And why is it not accurate?

21 A. Because your creatinine ends -- the  
22 changes in creatinine are really not reflective of  
23 what, in fact, is that kidney's ability to do its  
24 filtering mechanism. It can change pretty rapidly and

1 pretty easily with many different interventions.

2 Q. Would you agree that a measure of  
3 somebody's creatinine is an accurate assessment of  
4 kidney function?

5 A. No.

6 Q. So how does anybody -- how does any  
7 nephrologist measure accurately kidney function?

8 A. Most don't, so they utilize creatinine as  
9 an estimate for the GFR, and in following patients,  
10 seeing changes in their creatinine, they can get an  
11 idea as to whether or not GFR needs to be measured  
12 more accurately.

13 Q. And what are the ways to measure GFR more  
14 accurately?

15 A. So we can use radiotracer excretion to be  
16 able to measure someone's GFR. We can use something  
17 called inulin, which is actually cleared by the kidney  
18 as well and that gives, again, a measure of the  
19 kidney's function to do that actual clearance part  
20 that we just mentioned.

21 Q. Those two procedures or -- or tools that  
22 you just referenced, is that something you typically  
23 use in your practice?

24 A. We do.

1           Q.     So typically a higher eGFR indicates  
2     better kidney function, is that right?

3           A.     I'm sorry, can you repeat that?

4           Q.     Typically a higher eGFR indicates better  
5     kidney function, right?

6           A.     Comparatively, it does.

7           Q.     Well, doctor, let me ask, I know in your  
8     report -- and we'll get through this and we'll talk  
9     about your report in detail. I know you mentioned as  
10    part of your bases for why you believe Mr. Mousser  
11    will require renal replacement therapy is a creatinine  
12    of 1.5 to 1.6 and declining GFR.

13                   If those are not reliable measures, why  
14    did you use them in your report?

15           A.     Because that's the information that I had  
16    available based upon his -- review of his medical  
17    records.

18           Q.     The two more reliable methods we just  
19    discussed, and I apologize, I don't remember the exact  
20    names, were those available in the medical records  
21    that you saw for Mr. Mousser?

22           A.     Not that I saw, no.

23           Q.     Okay. So let's discuss the -- the  
24    different stages of CKD. The stages of CKD are based

1 primarily on kidney function and secondarily on the  
2 amount of albumin in urine, is that right?

3 A. That's correct.

4 Q. And CKD Stage 1 is when someone has a GFR  
5 of 90 or higher, right?

6 A. That's correct.

7 Q. And this represents normal kidney  
8 function, correct?

9 A. That's how it's characterized, yes.

10 Q. And CKD Stage 2 is a GFR between 60 and  
11 89, right?

12 A. That's correct.

13 Q. And this represents mild reduction in  
14 kidney function, correct?

15 A. That's correct.

16 Q. CKD Stage 3a is a GFR between 45 and 59,  
17 right?

18 A. Correct.

19 Q. And this represents moderate reduction in  
20 kidney function, correct?

21 A. Again, that's how it's characterized.

22 Q. CKD Stage 3b is a GFR between 30 and 44,  
23 right?

24 A. That's correct.



1 Q. And this represents moderate to severe  
2 reduction in kidney function, right?

3 A. It does.

4 Q. And CKD Stage 3b is when you stated you  
5 typically will begin seeing patients who may need  
6 surgery, a transplant surgery, in the future, right?

7 A. We'd hope to, yes.

8 Q. CKD Stage 4 is a GFR between 15 to 29,  
9 right?

10 A. That's correct.

11 Q. And this represents severe reduction in  
12 kidney function, correct?

13 A. It does, yes.

14 Q. And then finally, CKD Stage 5 is a GFR of  
15 less than 15, is that right?

16 A. That's correct.

17 Q. And this represents kidney failure,  
18 correct?

19 A. Endstage renal disease.

20 Q. And so whenever somebody gets to Stage 5,  
21 that's typically when they would require either  
22 dialysis or a kidney transplant, right?

23 A. At some point with endstage. Some people  
24 can be in Stage 5 for a period and not need either of

1 those.

2 Q. Would you say that the vast majority of  
3 the patients you see have either CKD Stage 4 or CKD  
4 Stage 5?

5 A. That's correct.

6 Q. You wouldn't typically put someone on  
7 dialysis or suggest that they need a kidney transplant  
8 if they have stable CKD Stage 3, is that right?

9 A. Stage 3, no.

10 Q. Can we agree that a single value of  
11 creatinine is insufficient to estimate GFR in  
12 someone's kidney function?

13 A. No. We can see significant abnormalities  
14 in someone's creatinine which is a harbinger of  
15 believe -- what I believe to be some significant  
16 kidney dysfunction which needs to be further  
17 evaluated.

18 Q. So a single elevated creatinine level or  
19 low GFR would be indicative of further tests that need  
20 to be done or -- or further monitoring?

21 A. In my practice, yes.

22 Q. If somebody's creatinine or GFR returns to  
23 normal limits after those abnormal results, would you  
24 still think that those people need to be monitored?

1           A.     Yes.

2           Q.     Would you agree that a single value of  
3 creatinine or single GFR result is insufficient to  
4 stage CKD?

5           A.     I do.

6           Q.     Would you agree that the diagnosis of a  
7 CKD stage requires a person to have a persistently  
8 elevated creatinine or excessive albumin in the urine  
9 or both for at least three months?

10          A.     No, I don't think that's necessary.

11          Q.     Okay. What is necessary to diagnose a CKD  
12 stage?

13          A.     So, again, based upon creatinine as  
14 inaccurate as it is, and if we're talking about the  
15 patients that are Stage 3b and later, very small  
16 changes in creatinine warrants additional testing,  
17 i.e., an effort to measure someone's GFR.

18                 And so I believe even single measurements  
19 for a couple of measurements within a three-month  
20 period still to me indicate that someone could have  
21 significant decline in their GFR outside of the  
22 numbers that we just talked about.

23          Q.     When diagnosing or determining a patient's  
24 CKD stage, would you typically look at, you know, the

1 last five or six lab results, or would you focus on a  
2 single lab result to determine the CKD stage?

3 A. We would often use a -- a number of  
4 measurements in order to make that determination.

5 Q. And, Doctor, simply I'm asking, would you  
6 look at kind of the totality of the circumstances in  
7 attempting to stage CKD and determining prognosis?

8 A. If you mean the totality, I would look at,  
9 again, the patient's entire medical history, including  
10 conditions which we know have significant untoward  
11 effects to the kidney as well as estimated and  
12 measured GFRs to be able to fully characterize  
13 someone's position on that chart that we talked about  
14 earlier.

15 Q. Doctor, clinicians also measure the ratio  
16 of albumin to creatinine in urine, is that right?

17 A. We do.

18 Q. And this is called ACR, right?

19 A. Albumin creatinine ratio, yes.

20 Q. Thank you.

21 A normal ratio is less than 30 milligrams  
22 of albumin per gram of creatinine in the urine, is  
23 that right?

24 A. That's right.

1 Q. And that's classified as A1?

2 A. Correct.

3 Q. An ACR of 30 to 300 milligrams of albumin  
4 per gram creatine is classified as A2, right?

5 A. Yes, sir.

6 Q. And an ACR of more than 300 milligrams of  
7 albumin per gram creatinine is A3, right?

8 A. Yes.

9 Q. Proteinuria refers to elevated levels of  
10 protein in the urine, right?

11 A. Yes, sir.

12 Q. And albu- -- albuminuria refers to  
13 elevated levels of albumin in the urine, right?

14 A. That's correct.

15 Q. And albumin is just an example of a  
16 specific protein, right?

17 A. That's correct.

18 Q. Is albumin the most -- the protein most  
19 likely to appear in the urine?

20 A. It is.

21 Q. Is it sometimes -- or is proteinuria and  
22 albuminuria, are sometimes those named interchanged?

23 A. Mistakenly, but yes.

24 Q. Thank you, Doctor.

1           And so, again, the only difference between  
2     proteinuria and albuminuria is that proteinuria is  
3     refer -- is referencing proteins generally and  
4     albuminuria is referencing albumin in the urine  
5     specifically, right?

6           A.     That's correct.

7           Q.     Would you agree that CKD stage is  
8     important because it predicts the likelihood a patient  
9     with CKD will progress to endstage kidney disease?

10          A.     I believe it is one of many variables  
11     that's important in predicting someone's progression  
12     to endstage renal disease.

13          Q.     What are some of those other variables?

14          A.     Again, patient's past medical history,  
15     including their comorbidities that we know have  
16     untoward effects on the kidney and additional lab data  
17     potentially reflective of those comorbidities that  
18     give us indication of the -- the -- the progression of  
19     someone's chronic kidney disease that potentially  
20     could lead to endstage renal disease.

21          Q.     If those comorbidities are controlled or  
22     treated with medication, would that impact your  
23     prognosis?

24          A.     It would, but, again, the definition of

1 "treated" or "controlled" I think is an important one.

2 Q. Okay. How would you define "treated" or  
3 "controlled"?

4 A. Well, "treated" is, you know, patients are  
5 on medications. Whether or not the results of that  
6 treatment have developed -- have resulted in that  
7 condition being controlled is very different.

8 Q. So if a patient is treated and controlled  
9 for a co- -- comorbidity that could impact kidney  
10 function and kidney progression to endstage renal  
11 disease, that would impact your -- your prognosis,  
12 right?

13 A. It would be part of the conversation.  
14 But, again, even the ability to have someone treated  
15 and have independent -- sorry, measures of controlled  
16 during whatever time it's being measured, can't  
17 confirm that it's been controlled 24/7, 365.

18 Q. Thank you, Doctor.

19 CKD stage is important because it predicts  
20 the likelihood a patient with CKD will have a major  
21 adverse cardiac event, is that right?

22 A. Again, one -- one of the -- the things  
23 that can predict that.

24 Q. And CKD stage is also important because

1 it's one of the things that predicts a likelihood that  
2 a patient with CKD will die from any cause, is that  
3 right?

4 A. One of many.

5 Q. We talked a little bit about this, but  
6 when you're looking to diagnose someone's CKD,  
7 temporally what lab results are you looking at? Are  
8 you looking at the most recent? Are you looking at  
9 the last couple of years? What are you looking at?

10 A. I personally look at the last couple of  
11 years.

12 Q. And why do you do that, Doctor?

13 A. Because, again, I'm utilizing not only the  
14 creatinine measurements, as we talked about being  
15 accurate, I also want to be able to look at the  
16 progression or change of those numbers, but then  
17 factor into the care and the treatment of those  
18 comorbidities that I believe also can affect the  
19 kidney but aren't reflective in creatinine as we just  
20 talked about.

21 Q. If creatinine results or GFR results are  
22 more stable -- are stable throughout those couple of  
23 years, would you agree that that makes it a more  
24 accurate -- or accurate reflections on kidney



1 function?

2 A. I believe it makes me more comfortable  
3 that they have potentially more stable renal function  
4 than those that do not.

5 Q. Is it fair to assume that when you are  
6 giving a prognosis for someone's chronic kidney  
7 disease, you would also look at lab results from the  
8 last, you know, two or three years?

9 A. Yes.

10 Q. Are you aware of the Kidney Failure Risk  
11 Equation?

12 A. I am.

13 Q. Do you ever use it in your practice?

14 A. I don't.

15 Q. Are you aware that this equation can  
16 estimate the absolute risk that a patient with CKD  
17 will progress to endstage kidney disease based on  
18 stable measurements of creatinine and urine ACR?

19 A. Again, I -- I know that it is utilized for  
20 that purpose, but it, again, is utilizing estimated  
21 values.

22 Q. Are you aware of whether or not this  
23 equation is becoming a standard of care for  
24 nephrologists and transplant nephrologists?

1 MR. MANDELL: Objection.

2 Go ahead.

3 BY THE WITNESS:

4 A. I am not aware. We don't use it in our  
5 practice.

6 BY MR. GARAND:

7 Q. Is there a -- or why don't you use it in  
8 your practice?

9 A. We don't find that valuable.

10 Q. And why not?

11 A. We just don't believe that that is the --  
12 the appropriate use of data and patient history to be  
13 able to have an appropriate sort of counseling session  
14 to be able to speak about, as you asked before, a  
15 prognosis of someone's progression of kidney disease.

16 Q. Two of the most common causes of CKD are  
17 diabetes and hypertension, right?

18 A. Two most common, correct.

19 Q. Thank you.

20 You mentioned renal replacement therapy in  
21 your reports. Does this refer to dialysis and  
22 transplants?

23 A. Yes, sir.

24 Q. A person will not require dialysis simply

1 because they have one kidney, assuming that kidney is  
2 functioning well, is that right?

3 A. Can you ask that again, please?

4 Q. So, yes.

5 Assuming somebody's kidney is  
6 functioning -- lone kidney is functioning well, they  
7 won't require dialysis just because they have one  
8 kidney, right?

9 A. That's correct.

10 Q. And same question for transplantation.  
11 Assuming they have a lone well-functioning kidney,  
12 they won't require a kidney transplant just because  
13 they have one kidney, right?

14 A. That's correct.

15 MR. GARAND: Doctor, I believe we've been going  
16 for about an hour. So we'll take a little break here  
17 if that's okay.

18 MR. MANDELL: Before we get off, how long  
19 because -- five minutes?

20 MR. GARAND: Yeah, I'm fine with five minutes.

21 MR. MANDELL: Perfect.

22 THE VIDEOGRAPHER: Going off the record at  
23 9:53 a.m.

24 (WHEREUPON, a recess was had

1 from 9:53 to 10:02 a.m.)

2 THE VIDEOGRAPHER: We are back on the record at  
3 10:02 a.m.

4 BY MR. GARAND:

5 Q. Doctor, you mentioned previously that  
6 there's often a transplant team or a team of -- of  
7 doctors who are, you know, evaluating and treating a  
8 patient, is that right?

9 A. Transplant patient?

10 Q. Yes.

11 A. Yes, sir. Yes.

12 Q. Thank you.

13 How many doctors are typically on that  
14 team?

15 A. Can I just clarify, for a particular --  
16 for a single patient, are we talking about?

17 Q. Correct, a single patient?

18 A. So often we have a surgeon, a  
19 nephrologist. If we're just talking physicians,  
20 that's really the extent of the physicians. We have a  
21 whole group of support staff also.

22 Q. And so what's -- why is there both a  
23 surgeon and a nephrologist on these teams?

24 A. Well, we -- we compliment each other, we

1 coordinate care between each other, and we both bring  
2 training and expertise and experience to the table  
3 that all benefits the care of the individual patient.

4 Q. Are there certain areas that you would  
5 defer to the nephrologist on, and are there certain  
6 areas where the nephrologist would defer to you?

7 A. Well, certainly the nephrologist would  
8 defer to us on surgical issues pre- and  
9 post-transplant. For us, we would defer to the  
10 nephrologist on pre-transplant care of primary  
11 glomerular disease that may result in endstage renal  
12 disease. That's where their expertise is.

13 And then post-transplant, we -- we both  
14 collaborate in the immediate post-transplant care, but  
15 then the -- the longer post-transplant care, typically  
16 six to -- months to a year, primarily then nephrology  
17 takes over.

18 Q. Doctor, let's look at your Mousser and  
19 Tukes reports, and these are -- we'll look at  
20 Mr. Mousser's report first. It is Cooper Exhibit 7.

21 So, Doctor, after discussing the scope of  
22 your testimony with Mr. Mandell, it's my understanding  
23 that there are a number of topics you won't be  
24 testifying on, is that correct?

1           A.     That's correct.

2           Q.     Is it accurate that you won't be  
3     testifying on -- as to the cause of Ms. Tukes or  
4     Mr. Mousser's cancers?

5           A.     That's correct.

6           Q.     Is it accurate that you won't be  
7     testifying or providing an opinion on the toxins  
8     present in the water at Camp Lejeune?

9           A.     That's correct.

10          Q.     Is it also accurate that you won't be  
11     testifying or providing an opinion on the levels of  
12     exposure to these toxins in terms of what causal role  
13     the toxins played in the development of their cancers?

14          A.     That's correct.

15          Q.     Okay. Doctor, I want to go through your  
16     report real quick, and we'll start on Page 6, and  
17     I'd -- I'd like to ask if any of these sections or  
18     specific opinions listed in your report are still in  
19     play.

20                     So we're on Page 6 of Mr. Mousser's -- or  
21     Dr. Cooper's report for Mr. Mousser. It is Cooper  
22     Exhibit 7. I'm looking at heading VI, "Risk Factors  
23     for UTUC Kidney Cancer" that goes to Page 7.

24                     Is -- is anything in there still in play?

1           A.       I certainly am aware of these risk  
2 factors, and if there's questions that you'd like to  
3 ask, I would, you know, very much like to answer those  
4 for you.

5           Q.       Will you be providing any opinions on  
6 these -- on this topic, risk factors for UTUC kidney  
7 cancer at trial?

8           A.       Again, only -- only if you have questions  
9 specifically about me for these -- to these.

10          Q.       I do not, unless you are going to be  
11 offering opinions on these risk factors?

12          MR. MANDELL: To the extent -- just for the  
13 record, to the extent that they may impact  
14 Dr. Cooper's opinions about Mr. Mousser, Ms. Tukes'  
15 condition and/or need for future medical care, then he  
16 may well be giving opinions on that, but not as to the  
17 cause of the cancer in the first place.

18          MR. GARAND: Thank you, Mr. Mandell. I  
19 understand.

20 BY MR. GARAND:

21          Q.       And so -- and so just to make sure, you  
22 know, we're on the same page, to the extent -- and I'm  
23 just picking an example here. Smoking impacts chronic  
24 kidney disease and transplant and things like that.

1 I'm not asking about that.

2 I'm asking, will you be providing any  
3 opinions as to the risk factors for kidney cancer, for  
4 UTUC kidney cancer?

5 A. Not -- not specifically, no.

6 Q. Okay. So if we look at heading VII, which  
7 is on Page 7 and it goes through Page 10, and it's  
8 the -- it's titled, "Mr. Mousser's Exposure at  
9 Camp Lejeune."

10 Are these opinions and analyses still in  
11 play?

12 A. Not something I'll be providing testimony  
13 on.

14 Q. Okay. If we look at Page 10, heading  
15 VIII, it says, "Levels of the Toxins Known to Cause  
16 Kidney Cancer."

17 That would fall within the topics we just  
18 discussed, correct?

19 A. It does, yes, sir.

20 Q. And so those opinions are no longer in  
21 play, correct?

22 A. It is not something that I will be  
23 testifying to.

24 Q. Thank you, Doctor. And so on Page 13,



1 heading IX is "Differential Diagnosis." And my  
2 understanding is that's a differential diagnosis as to  
3 the cause of Mr. Mousser's kidney cancer. Is that  
4 accurate?

5 A. Let me take a quick peek, please.

6 Q. Sure.

7 A. Yes, sir, that's correct.

8 Q. And -- and again, Doctor, we'll be going  
9 through a bunch of records today. If I ever move too  
10 quickly for you, let me know and I'm happy to slow  
11 down.

12 A. Okay.

13 Q. So from Page 13 to 14, heading IX is no  
14 longer in place, is that right?

15 A. I will not be testifying to that, no.

16 Q. Okay. And then finally, heading X, on  
17 Page 14 to 15, entitled -- or titled "Responses to the  
18 Government's Interrogatories," are any of those  
19 opinions -- will you be providing testimony as to any  
20 of those opinions?

21 A. No, sir.

22 Q. Thank you, Doctor.

23 Let's look at Ms. Tukes' report which is  
24 Cooper Exhibit 8. And we'll start on page -- Page 5

1 here. And I appreciate you bearing with me here,  
2 Doctor.

3 A. Okay.

4 Q. So Page 5, there's a heading -- heading  
5 VI, "Risk Factors for Renal Cell Cancer." That  
6 opinion is no longer in play, is that right?

7 MR. MANDELL: Objection as -- with the same  
8 explanation I gave before as to each of these  
9 sections, okay.

10 MR. GARAND: Thank you, doc- -- thank you,  
11 Mr. Mandell.

12 BY THE WITNESS:

13 A. Yes, that's correct.

14 BY MR. GARAND:

15 Q. And then Page 6 to Page 7, there's a  
16 heading VII, "Dr. Irving Allen Report," Dr. Irving  
17 Allen is a geneticist, is that right?

18 A. That's correct, yes, sir.

19 Q. And so does the -- the opinions in heading  
20 VII, will you be testifying or providing opinions  
21 regarding the content in heading VII?

22 A. No. No, I will not.

23 Q. Headings VIII and IX are discussing  
24 Ms. Tukes' exposures at different places at

1 Camp Lejeune. It goes from Pages 7 to 10.

2 Will you be providing testimony or  
3 opinions regarding that -- that content or that  
4 heading?

5 A. No, sir.

6 Q. Heading -- or Page 10, heading X is  
7 "Levels of the Toxins Known to Cause Kidney Cancer,"  
8 and it goes from Page 10 to 13, will you be providing  
9 testimony on these opinions?

10 A. No, sir.

11 Q. And then finally, Page 13 to 15, heading  
12 XI, "Differential Diagnosis," it's my understanding  
13 that that is a differential diagnosis as to the cause  
14 of Ms. Tukes' kidney cancer, is that right?

15 MR. MANDELL: Again, with the same explanation,  
16 that it may relate to the need for future treatment or  
17 condition, okay?

18 MR. GARAND: Yes, of course.

19 MR. MANDELL: Okay.

20 BY THE WITNESS:

21 A. I will not be testifying to that either.

22 BY MR. GARAND:

23 Q. Okay. Thank you, Doctor.

24 Okay. Let's look again at Cooper

1 Exhibit 7, which is Mr. Mousser's report, and we're  
2 going to be going through this here.

3 If we look at Page 16 of the report,  
4 please let me know when you're there.

5 A. I'm here.

6 Q. And that's your signature there, right?

7 A. Yes, sir.

8 Q. Does this report contain all of the  
9 opinions you've formed to date in this case regarding  
10 Mr. Mousser?

11 A. So I -- it contains certainly the -- the  
12 four corners of what we're going to talk about today,  
13 but if there's questions that come up that result from  
14 conversation in this, there may be additional pieces  
15 that need to be added.

16 Q. Are there any pieces you envision adding  
17 at this point?

18 A. Not that specifically comes to mind, but  
19 certainly it may as we talk more about this.

20 Q. At this point in time, you know, through  
21 the conversation we've had right now, and through your  
22 medical review of -- review of medical records and  
23 review of deposition transcripts, do you have any  
24 other opinions to add at this point?

1           A.       Not that I can think of. But, again,  
2       reserving the fact that during our conversation, we  
3       may need further explanations based upon what's in  
4       this document.

5           Q.       Of course.

6                    Doctor, does this report, again, at this  
7       point in time, contain all of your explanations and  
8       analyses to support the opinions contained in your  
9       Mousser report?

10          MR. MANDELL: Objection.

11       BY THE WITNESS:

12          A.       I believe it contains, again, the  
13       substance of what is my opinion. There may be  
14       additional details that may need to be brought out as  
15       we have more conversation.

16       BY MR. GARAND:

17          Q.       Okay. We'll look at Ms. Tukes' report  
18       real quick. I'll just ask the same questions.

19                    If you look at Page 16, which is the last  
20       page of the report, that's your signature there, is  
21       that correct?

22          A.       Yes, sir, it is.

23          Q.       And does this report contain all of the  
24       opinions you formed to date in this case regarding

1 Jacqueline Tukes?

2 A. Again, it's the same answer with  
3 Mr. Mousser. It contains the substance of what is my  
4 opinion, but if there's conversation that requires  
5 additional data or additional thoughts around it, I  
6 would love to be able to share those as well.

7 Q. And I'm assuming your answer is the same  
8 regarding the explanations and analyses in these  
9 opinions?

10 A. Yes, sir, that's correct.

11 Q. Do you -- are you planning on forming any  
12 additional opinions regarding Ms. Tukes at this point  
13 in time?

14 A. Only if it -- only if additional  
15 information comes before me.

16 Q. In these two reports, you used the more  
17 likely as not standard when rendering all of your  
18 opinions regarding Mr. Mousser and Mrs. Tukes, is that  
19 right?

20 A. That's correct.

21 Q. And your opinions were to a reasonable  
22 degree of medical certainty?

23 A. Yes, they are.

24 Q. Did you review the Camp Lejeune Justice

1 Act in prepara- -- or to -- before pro- -- before  
2 drafting your reports?

3 A. I -- I don't recall if that's specific.  
4 Like I said when we talked earlier, there's many  
5 documents that were put before me. I'm unsure what  
6 that specific one was.

7 Q. Do you know whether or not you've reviewed  
8 the Camp Lejeune Justice Act?

9 A. I believe that I have. Again, it's a long  
10 time ago, but I don't know specifically if that was  
11 one of the documents.

12 Q. Did anything in the Camp Lejeune Justice  
13 Act, any of that language, play any role in you  
14 formulating your opinions in this case?

15 A. No. My opinions were based upon review of  
16 the medical records, my review of the data that was  
17 put in front of me, and making conclusions based upon  
18 my training, education, experience.

19 Q. Okay. Doctor, let's look at Mr. Mousser's  
20 report, again, which is Cooper Exhibit 7. If we look  
21 at Page 2 of this report under heading IV.

22 A. Yes, sir.

23 Q. On the second line there's a sentence that  
24 reads, "His past medical history includes

1 hypertension, CAD, status post 4v CABG,  
2 hyperlipidemia, chronic back pain status post  
3 discectomy, anxiety, and depression," is that right?

4 A. It is, sir, yes.

5 Q. When you say "past medical history," what  
6 point in time are you referring to as "past"?

7 A. Any time prior to which the records that I  
8 was given contain that diagnosis.

9 Q. Okay. So -- so essentially you're stating  
10 that the records that you've reviewed have those  
11 diagnoses in them?

12 A. And -- and not only the diagnoses, but the  
13 supporting documentation to confirm those diagnoses.

14 Q. How did you decide which medical  
15 conditions to include here?

16 A. Hmm, I believe I included all of the ones  
17 that I felt were both pertinent to this case and were  
18 a significant risk going forward for, you know,  
19 Mr. Mousser specifically here.

20 Q. Is there any reason why you didn't  
21 include, like, his kidney cancer and  
22 nephroureterectomy?

23 A. No. This -- this sentence as put in this  
24 document was prior to that event. So this was sort



1 of, as you can see, a timeline of events and was not  
2 included in that sentence.

3 Q. Would severe obstructive sleep apnea be  
4 relevant to your opinions in this case at all?

5 A. Not -- no.

6 Q. Would overactive bladder or nocturia be  
7 relevant to your opinions in this case?

8 A. No.

9 Q. Would diabetes be relevant to your  
10 opinions in this case?

11 A. Yes.

12 Q. Okay. Why is diabetes or prediabetes not  
13 listed here?

14 A. I forgot to put that in there, but it's  
15 mentioned somewhere later in the report. I'm sure  
16 we'll get to that.

17 Q. Let's look at the last paragraph -- okay.  
18 So on Page 3, the last paragraph before heading V?

19 A. Page 3, okay. Page 3, yes.

20 Q. And then we're going to look at the first  
21 part of this -- this paragraph under heading V. So  
22 right above heading V, you write, "Following  
23 nephrectomy, however, Mr. Mousser has had a rise in  
24 serum creatinine (1.5 to 1.6 mg/dl) with significant

1 proteinuria, elevated protein/creatinine ratio (287  
2 milligrams/milligrams) and remains under the care of  
3 nephrology and psychology."

4 Is that right?

5 A. Yes, sir.

6 Q. And then this next paragraph, it reads,  
7 "Based upon Mr. Mousser's decline in GFR following  
8 unilateral nephrectomy with episodic elevations in  
9 creatinine as well as the expected hyperfiltration of  
10 his remaining kidney, Mr. Mousser will to a reasonable  
11 degree of medical certainty require renal replacement  
12 therapy in three to five years while in his early  
13 60s," is that right?

14 A. It says that, yes, sir.

15 Q. Okay. So looking at these two sentences,  
16 there are four bases that I see for you to determine  
17 that he will require renal replacement therapy in  
18 three to five years.

19 MR. MANDELL: Objection.

20 Go ahead.

21 BY MR. GARAND:

22 Q. And I'm looking at one, serum creatinine  
23 of 1.5 to 1.6 after his nephroureterectomy, is that  
24 right?

1 A. Yes.

2 Q. A decline in GFR, is that right?

3 A. Correct.

4 Q. Significant proteinuria, is that right?

5 A. Correct.

6 Q. Elevated protein creatinine ratio, is that  
7 right?

8 A. Correct.

9 Q. Are there any other reasons that you think  
10 Mr. -- or you believe Mr. Mousser will require renal  
11 replacement therapy in three to five years?

12 MR. MANDELL: Could -- could I just ask before  
13 you said, Carson, please, I'm sorry?

14 MR. GARAND: Yes. So serum creatinine of 1.5 to  
15 1.6, decline in GFR, significant proteinuria, and  
16 elevated protein creatinine ratio. And, again, those  
17 are in the -- the last two paragraphs on Page 3.

18 MR. MANDELL: So -- okay. So you are leaving  
19 out purposefully other things in those two sentences?

20 MR. GARAND: No, I'm not. So if he has -- if  
21 there are other --

22 MR. MANDELL: Okay. All right.

23 BY THE WITNESS:

24 A. Yeah, importantly, the most important one

1 is the unilateral nephrectomy. So the fact that he  
2 has had a kidney removed is incredibly important, and  
3 with that remaining kidney, the response is going to  
4 be the need for that remaining kidney to  
5 hyper-filtrate, to work harder than two kidneys  
6 normally would work in concert. If we talk about  
7 the -- the stress that that puts on that remaining  
8 kidney, which eventually can cause injury to the  
9 podocytes and glomerular sclerosis in that remaining  
10 kidney, in addition to what we know is in the  
11 pathology specimen of his nephrectomized kidney that  
12 shows evidence of nephrosclerosis as well, we add on  
13 top the fact of those comorbidities that we sort of  
14 chatted about a few minutes ago.

15 And so the nephrectomy, the  
16 hyperfiltration, the -- the pathology report that  
17 shows nephrosclerosis in the kidney that was removed  
18 that we know is a bilateral disease and his  
19 comorbidities that include, and thank you, the  
20 diabetes, hypertension, coronary artery disease,  
21 peripheral vascular disease, all of those in  
22 combination with the erratic serum creatinine  
23 estimated GFR, and that evidence of proteinuria  
24 following his nephrectomy in 2020.

1 BY MR. GARAND:

2 Q. Okay. Doctor, and so you testified  
3 previously that simply having a well-functioning  
4 single kidney does not necessarily mean somebody will  
5 require renal replacement therapy, correct?

6 A. That alone, correct.

7 Q. I don't see in your report, and please  
8 correct me if I'm wrong, that you discuss a path --  
9 the pathology report with nephrosclerosis.

10 Is that in your report anywhere?

11 A. No, it's not in my report, but it is  
12 something that I considered in forming this opinion.

13 Q. So if that's one of the bases for your  
14 opinion that he'll need renal replacement therapy in  
15 three to five years, why was it not included in your  
16 report?

17 A. Again, I -- the information that I used to  
18 put this together was as complete as I thought was  
19 necessary. The fact that I used that in my  
20 discussions or my decisions around his prognosis at  
21 three to five years is not because it wasn't  
22 considered. It just didn't make it into this report.

23 Q. Okay. Is it important, you know,  
24 generally to fully explain the -- the rationales for

1 your opinions?

2 MR. MANDELL: Objection.

3 BY THE WITNESS:

4 A. It is, and that's what I think part of  
5 today is about.

6 BY MR. GARAND:

7 Q. Okay. So other than -- okay. So we  
8 listed the four I listed and then the unilateral  
9 nephrectomy, hyperfiltration, pathology report with  
10 nephrosclerosis, and his comorbidities.

11 Is there anything else that you're relying  
12 on to determine that he will require renal replacement  
13 therapy in three to five years?

14 MR. MANDELL: Objection; asked and answered, but  
15 go ahead.

16 BY THE WITNESS:

17 A. Well, also his age which is, you know,  
18 part of the -- of the equation and, you know, I --  
19 utilizing, you know, some of that data allows us to  
20 look at expected kidney survival with all of those  
21 comorbidities and in addition my, again, experience  
22 and my practice of 25 years that takes care of  
23 patients exactly like this.

24 BY MR. GARAND:

1 Q. Is it fair to assume that the rationales  
2 that are listed in your report are weighted more  
3 heavily in -- in determining his prognosis?

4 MR. MANDELL: Objection.

5 BY THE WITNESS:

6 A. No. Again, all of the things that we  
7 talked about are a component that makes up this  
8 opinion.

9 BY MR. GARAND:

10 Q. Are any of these factors weighted more  
11 heavily than the others?

12 A. They are. The fact that he has one kidney  
13 that was removed because of his cancer.

14 Q. Is that the only one? Is that the only  
15 factor that's weighted more heavily than the others?

16 A. His comorbidities would equally be  
17 important, but the number one reason is the fact that  
18 he had to have a kidney removed because of cancer.

19 Q. And his current kidney function is not  
20 something that's weighted more heavily than others?

21 A. No.

22 Q. And why is that?

23 A. Because, again, when -- in my practice and  
24 my experience of evaluating patients, recognizing all

1 of the information and the pieces of data that bring  
2 us to currency is more important than kind of where we  
3 find ourselves now, because, again, we can normalize  
4 someone's kidney function many different ways, but  
5 it's really what's underlying that inaccurate  
6 measurement of creatinine that I believe has a much  
7 higher weight in determining his future kidney care  
8 and future kidney needs.

9 Q. So if his comorbidities are weighted more  
10 heavily, you know, in addition to the unilateral  
11 nephrectomy, why is that not discussed in your report  
12 really at all as an explanation for why he will  
13 require renal replacement therapy?

14 MR. MANDELL: Objection. I don't think that  
15 accurately re- -- reflects the report.

16 But go ahead.

17 BY MR. GARAND:

18 Q. And, Doctor, if it's in the report, please  
19 show me where it is.

20 A. Can you just ask that question again,  
21 please?

22 Q. Sure. So you mentioned that Mr. Mousser's  
23 comorbidities is a factor that's weighted more heavily  
24 in your -- in determining that he will require renal



1 replacement therapy in three to five years, is that  
2 right?

3 A. That's fair.

4 Q. Can you please show me where in your  
5 report you explain why that is, what those comor- --  
6 comorbidities include, anything of that nature?

7 A. So later we do talk about his -- his  
8 hypertension, and we certainly do talk about the fact  
9 that he has had a unilateral nephrectomy in that sense  
10 that we talked about. His age is, you know,  
11 throughout this document, and the fact that he had  
12 these comorbidities is how we started this medical  
13 history.

14 In my practice, and the way that I put  
15 together these -- these expert reports, while it might  
16 not have it in the sentence, it's contained here in  
17 this entirety of this expert opinion and is utilized  
18 in my decision-making around the specifics of this  
19 timeframe of three to five years.

20 Q. So if -- again, so can you please show me  
21 in your report, is there any analysis as to why, for  
22 example, Mr. Mousser's hypertension will -- increases  
23 his risk of requiring renal replacement therapy in  
24 three to five years?

1           A.       It's a well-known fact, and it's something  
2       that, again, we understand in the field of transplants  
3       and appreciate that that is a significant risk factor  
4       as we talked about for developing chronic kidney  
5       disease.

6           Q.       Doctor, do you understand generally what  
7       your role as an expert is?

8           A.       I do.

9           Q.       And what is that?

10          A.       It's to review the medical records and the  
11       data in front of me and determine what I believe is  
12       the potential course of the records that I review, as  
13       well as to provide, as the name implies, expert  
14       opinion of, again, the data in front of me based upon  
15       my experience as someone who works in this field on a  
16       regular basis.

17          Q.       And who is your reader of the expert  
18       report?

19          MR. MANDELL:   Objection.

20       BY THE WITNESS:

21          A.       I believe it's anyone that is involved in,  
22       you know, this litigation.

23       BY MR. GARAND:

24          Q.       Would you expect any non-nephrologist or

1 transplant surgeon to understand or know that  
2 hypertension is a major risk factor for somebody  
3 progressing to endstage renal disease?

4 MR. MANDELL: Objection.

5 BY THE WITNESS:

6 A. I would expect a lot of people would know  
7 that.

8 BY MR. GARAND:

9 Q. On what basis?

10 MR. MANDELL: Objection.

11 BY THE WITNESS:

12 A. It is a -- it's something that, again, is  
13 taught to really every primary care physician about  
14 managing hypertension and diabetes as being the number  
15 one and two causes of chronic kidney disease, and  
16 individuals, again, who have any experience in kidney  
17 disease, which infects one in seven people in the  
18 United States, it's, again, a very common conversation  
19 around controlling hypertension and the risks thereof  
20 resulting in chronic kidney disease.

21 Q. Yeah, so, I mean, one in seven is -- I  
22 can't do the math. It's certainly less than  
23 20 percent of the people, is that right?

24 A. It's a lot of people. That's -- I'll give

1       you the same answer.

2           Q.       So let me ask you, Doctor. Whenever you  
3       have -- well, I'll strike that.

4                   Whether or not somebody's hypertension is  
5       controlled or -- yeah, controlled, does that impact  
6       your decision -- or impact your determination as to  
7       somebody's prognosis?

8           A.       Yeah, we talked about this before.  
9       Having -- on medications and whether or not it's  
10      controlled at certain time points when it's measured  
11      is very different what happens, again, 24/7, 365. So  
12      if they're on medications versus not, that's, you  
13      know, I think part of the -- the calculus that we  
14      utilize in counseling patients, sure.

15          Q.       Doctor -- okay. So, for example, when you  
16      discuss the serum creatinine of 1.5 to 1.6 and a  
17      decline in GFR, what records are you relying on to  
18      make those determinations?

19          A.       The -- again, the medical records of  
20      Mr. Mousser that were supplied to me.

21          Q.       Is it your opinion that Mr. Mousser's  
22      current creatinine levels are at that -- are at 1.5 to  
23      1.6?

24          A.       I don't know what they are currently.

1           Q.     So his current creatinine levels are not  
2 relevant to your -- or -- and let me not -- let me  
3 back up.

4                     Is it your opinion that his current  
5 creatinine levels are relevant to your -- to his  
6 prognosis -- prognosis for chronic kidney disease?

7           A.     Yes, they are, again, part of the  
8 conversation. And while -- while I didn't have them  
9 in front of me, I also had the ability to read  
10 Dr. Johnstone's report which actually had information  
11 about his current creatinine.

12          Q.     And, Doctor, when you discussed a decline  
13 in GFR, again, do you recall what records you're --  
14 you're referencing?

15          A.     Referencing his -- Mr. Mousser's medical  
16 records following the nephrectomy in 2020 and the  
17 follow-up that he has had at multiple VAs -- or at the  
18 VA by multiple physicians, some of which we named  
19 earlier.

20          Q.     Are you aware of his current GFR test  
21 results?

22          A.     I am not.

23          Q.     And, again, is that something that would  
24 be relevant to your determination regarding

1 Mr. Mousser's prognosis?

2 A. Again, I think they're a part of the --  
3 the decision-making for Mr. Mousser and his team going  
4 forward, but, again, the information that was put in  
5 this expert opinion based upon the data that I had up  
6 until February -- or sorry, this was February, up to  
7 February, is in conjunction with all of these other  
8 things that I talked about was how I formed this  
9 opinion specifically around the need for renal  
10 replacement in three to five years.

11 Q. And you've mentioned -- sorry, I didn't  
12 mean to cut you -- did I cut you off there?

13 A. (Inaudible response.)

14 Q. And, Doctor, so you mentioned serum  
15 creatinine levels and GFR are a part of a bigger  
16 picture. They're certainly important enough to  
17 mention in your report, right?

18 A. Yes.

19 Q. Okay. Doctor, we are going to look at  
20 Mr. Mousser's serum creatinine levels and GFR from  
21 around the time of his surgery through the present  
22 day, okay.

23 A. Okay.

24 Q. If we can have -- and this is a -- we have

1 a binder of records here, and we'll be going through  
2 some others. I'm going to mark this as -- are we on  
3 9, Erick -- Cooper Exhibit 9. And I will just  
4 typically refer to this as "the binder."

5 A. The binder, okay.

6 Q. This is the only one that has a binder.

7 A. Okay. Thank you.

8 (WHEREUPON, a certain document was  
9 marked Dr. Cooper Deposition Exhibit  
10 No. 9, for identification, as of  
11 07/10/2025.)

12 BY MR. GARAND:

13 Q. Dr. Cooper, have you reviewed Mr. -- and  
14 just for the record, again this is Cooper Exhibit 9.  
15 These are Mr. Mousser's VA lab results from June  
16 of 2020 through November of 2023, and then I have  
17 some -- some more recent ones after that, but this  
18 binder, for the record, the records are Bates-stamped  
19 00667\_MOUSSER\_05598 through 05812.

20 Doctor --

21 MR. MANDELL: Can I just object on -- on the  
22 record to the lack of foundation. Even though there  
23 was no question, it was a prefatory -- it was a  
24 preface to questions. So that -- my objection is lack

1 of foundation, but go ahead.

2 BY MR. GARAND:

3 Q. And, Doctor, if we look at the very first  
4 page here, which is Bates ending in 05598 -- and just  
5 I'll ask, do you understand what Bates numbers are?

6 A. Yes, sir, I do.

7 Q. Okay. Mr. Mousser's name is here at  
8 the -- the top left corner, is that right?

9 A. That's correct.

10 Q. And it says "VA Laboratory Results" at the  
11 top, right?

12 A. That's correct.

13 Q. Okay. Let's turn to -- we're going to be  
14 starting towards the end. Let's look at Bates ending  
15 in 05778, and we're going to be working our way back  
16 up.

17 Doctor, do you see the date there is  
18 August 31st of 2020, in the middle of the page?

19 A. I do.

20 Q. And this is right around the time when  
21 Mr. Mousser was first diagnosed with cancer, is that  
22 right?

23 A. Correct, yes.

24 Q. At the bottom of the page, do you see his



1 creatinine is 1.2?

2 A. I do.

3 Q. And if you turn to Bates ending in 05781?

4 A. 5781. Okay.

5 Q. The very bottom of the page, his eGFR is  
6 62.4, is that right?

7 A. Yes, sir, that's correct.

8 Q. What stage of CKD would someone be  
9 diagnosed with with a GFR of 62 and a creatinine of  
10 1.2?

11 A. Four.

12 Q. Stage 4?

13 A. Um-hum.

14 Q. Doctor, we just looked previously, we went  
15 over the different stages of CKD.

16 Do you remember that?

17 A. I do.

18 Q. And we determined -- or let me ask, why --  
19 why is that CKD Stage 4?

20 A. His creatinine of 62.4.

21 Q. Where did you see that?

22 A. Between 60 and 90. eGFR. Am I looking at  
23 the wrong page?

24 MR. MANDELL: No. You said creatinine. I think

1       you meant the eGFR.

2       BY THE WITNESS:

3             A.       eGFR.   Yeah, the eGFR.

4       BY MR. GARAND:

5             Q.       Is 6 -- so an eGFR of -- of 62 is CKD  
6       Stage 4?

7             A.       60 to 90, yes.

8             Q.       I think we might be getting our numbers  
9       mixed up.   Is that not CKD Stage 2?

10            A.       I apologize.

11            Q.       Okay.   I was -- I was -- I was worried we  
12       were going to have to go back a little bit.

13            A.       Yep, I apologize.

14            Q.       No, no problem.

15            A.       Stage 2.   I apologize.

16            Q.       Okay.   So at the outset, assuming stable  
17       GFR and creatinine results of 1.2 and 62, would you  
18       be -- would you be worried that a patient with these  
19       results would need dialysis or a kidney transplant in  
20       three to five years, assuming stability?

21            A.       Pardon me, I missed the beginning.   Could  
22       you ask me one more time?

23            Q.       Assuming stable creatinine levels of 1.2  
24       and GFR of 62, would it be your opinion that somebody

1 would require renal replacement therapy in three to  
2 five years?

3 MR. MANDELL: Objection; lack of foundation.

4 Go ahead.

5 BY THE WITNESS:

6 A. I would be significantly worried with  
7 someone who has an eGFR of 62.4 without, you know, any  
8 expectation of what was to follow, that's an abnormal  
9 eGFR. As we mentioned, you know, 90 and above is  
10 normal.

11 So the fact that he has an eGFR of 62  
12 concerns me, but the answer specifically to your  
13 question, I wouldn't specifically think that he would  
14 have a risk for developing chronic -- sorry, endstage  
15 renal disease in three to five years, but based upon  
16 this number and the totality of his medical history, I  
17 would be very worried about his future with two  
18 kidneys as we're talking about right now.

19 BY MR. GARAND:

20 Q. Is it abnormal for somebody -- and please  
21 let me know if you don't know the answer to this. Is  
22 it abnormal for somebody in their late 50s to have CKD  
23 Stage 2?

24 MR. MANDELL: Objection. Go ahead.

1 BY THE WITNESS:

2 A. One more time. Is it ab- --

3 BY MR. GARAND:

4 Q. Is it abnormal for somebody in their late  
5 50s, a patient in their late 50s, to have a CKD  
6 Stage 2?

7 MR. MANDELL: Objection.

8 BY THE WITNESS:

9 A. It's -- people in -- as we talked about,  
10 can have -- well, chronic kidney disease, even  
11 Stage 2, for various reasons, but age is one of the  
12 risk factors for developing progressive kidney  
13 disease. So I wouldn't say it's abnormal, but it's  
14 also not normal.

15 BY MR. GARAND:

16 Q. My understanding is that as somebody ages,  
17 their kidney function decreases. Is that -- is that  
18 accurate?

19 A. That's correct, but, again, if we're going  
20 to talk specifics about where it decreases to, that's  
21 a different question.

22 Q. Thank you, Doctor.

23 Okay. Let's now look at Bates ending in  
24 05762.

1 A. 057 -- I'm sorry, one more time? 56?

2 Q. 5762.

3 A. 5762, okay.

4 Q. I know we'll be jumping around a little  
5 bit --

6 A. Okay.

7 Q. -- so I ask that you bear with me here.

8 A. I'm here.

9 Q. So at the very bottom of this page, do you  
10 see that the date is September 7th of 2020?

11 A. I do.

12 Q. Flip to the next page, which is Bates  
13 ending in 05763, the third line down, Mr. Mousser's  
14 creatinine is 1.0.

15 Do you see that?

16 A. I do.

17 Q. And if you flip to Bates ending in 05766,  
18 his eGFR is 77.

19 Do you see that?

20 A. I see that.

21 Q. Okay. Now, let's look at Bates ending in  
22 05710.

23 A. 5710.

24 Q. And please let me know when you're there.

1           A.     I'm here, sir.

2           Q.     And, Doctor, I apologize if I asked this,  
3 but I want to make sure that I have, have you seen  
4 these records before?

5           A.     I have.

6           Q.     At the bottom of Page 2, do you see that  
7 the date collected there is October 22nd, 2020, right?

8           A.     I do.

9           Q.     And this was just two days after his  
10 October 20, 2020, nephroureterectomy, right?

11          A.     I believe that's the dates, the -- the PO  
12 date, yes.

13          Q.     So if you flip to the next page, Bates  
14 ending in 05711, his creatinine is 1.2, right?

15          A.     I do see that here, yes.

16          Q.     And then if you flip to Bates ending in  
17 05713, at the top of the page, again, his eGFR is  
18 62.4, right?

19          A.     Yes.

20          Q.     Okay. Please turn to Bates ending in  
21 05704.

22          A.     Okay.

23          Q.     Do you see that the date there at the  
24 bottom is 28 April 2021?

1           A.     I do, yes.

2           Q.     If you flip to the next page, it's  
3     Bates -- Bates ending in 05705. Do you see at the top  
4     there that Mr. Mousser's creatinine is 1.5?

5           A.     I do.

6           Q.     And if you flip to page ending in 05707,  
7     his eGFR is 48.2 at the very top.

8                     Do you see that?

9           A.     I do, yes.

10          Q.     Okay. If you can flip to Bates ending in  
11     05682.

12          A.     05682. Okay.

13          Q.     And these are January 19, 2022, results.  
14                     Do you see that?

15          A.     I do, sir.

16          Q.     And his creatinine is 1.5, a few lines  
17     down on this page?

18          A.     I see that.

19          Q.     And if you flip to Bates ending in 05684,  
20     at the very bottom, his eGFR is 48.1, right?

21          A.     Correct.

22          Q.     All right. Let's look at 05671.

23          A.     05671. Okay.

24          Q.     So do you see the date there at the bottom

1 of the page is March 9th of 2022?

2 A. I do.

3 Q. And we're about 17 months, a year and a  
4 half, after his nephroureterectomy at this point,  
5 right?

6 A. That sounds right, yes, sir.

7 Q. So if we look at the next page, Bates  
8 ending in 05672, in the middle of the page his  
9 creatinine is 1.9, is that right?

10 A. That's correct.

11 Q. If we flip to Bates ending in 05675, his  
12 eGFR is 36.6, right?

13 A. Correct.

14 Q. So from October of 2020 where he had a GFR  
15 of 62 and a creatinine of 1.2, to March of 2022, he  
16 had a GFR of 36 and a creatinine of 1.9, is that  
17 right?

18 MR. MANDELL: Objection. Based on these  
19 records?

20 MR. GARAND: Correct, based on these records.

21 BY THE WITNESS:

22 A. Yes.

23 BY MR. GARAND:

24 Q. Okay. Please turn to Bates ending in



1 05665.

2 A. 5665. Okay.

3 Q. At the very top, the date is April 7th of  
4 2022.

5 Do you see that?

6 A. I do, sir.

7 Q. And the creatinine is 1.4, right?

8 A. Yes.

9 Q. And if you flip to Bates ending in 05668,  
10 his eGFR is up to 58.

11 Do you see that?

12 A. I see that.

13 Q. So from March of 2022 to April of 2022,  
14 his GFR went from 36 to 58, right?

15 MR. MANDELL: Again, based on these records?  
16 Objection.

17 MR. GARAND: Yes, correct, based on these  
18 records.

19 BY THE WITNESS:

20 A. That's correct, yes.

21 BY MR. GARAND:

22 Q. And based off of these records from March  
23 of 2022 to April of 2022, his creatinine went from 1.9  
24 back down to 1.4, is that right?

1           A.     Yes, according to these records.

2           Q.     Is it typical for somebody's kidney  
3     function to increase significantly like that in just  
4     one month after it was declining?

5           A.     Is it typical. Are you talking about for  
6     a -- anybody or for --

7           Q.     Anybody with chronic kidney disease, and  
8     what I'm getting at is it was at 1.9 and then it goes  
9     back down to 1.4. It was at 36.6 and then, you know,  
10    a couple of weeks later it's at 58.

11                   Do you have any explanation as to why that  
12    may be?

13           A.     Yes.

14           Q.     And what is that?

15           A.     So it can happen in -- in patients who  
16    have, again, chronic kidney disease, particularly  
17    those that have significant damage to the organ itself  
18    that make it very susceptible to things like volume  
19    status and to medications and to, just, general  
20    physiology.

21                   So, again, we -- we see that there can be  
22    significant fluctuations which, again, are -- are very  
23    concerning, especially when you see at this level  
24    changes in creatinine and the significant change it

1 has in just your eGFR. And so that's why to our  
2 conversation earlier, the creatinine alone I don't  
3 believe is a good measure of someone's true kidney  
4 function.

5 Q. And, again, we -- we mentioned -- you  
6 mentioned earlier there were a couple of other  
7 measures that would more accurately measure kidney  
8 function, is that right?

9 A. Well, they truly measure kidney function,  
10 yes.

11 Q. And we don't have access to any of those  
12 in this -- this case for Mr. Mousser as far as you're  
13 aware, right?

14 A. Not that I saw in the medical record.

15 Q. Doctor, let's -- okay. Put that to the  
16 side just for a minute.

17 MR. MANDELL: Is -- is that the binder?

18 MR. GARAND: Yes, the binder. Thank you. And  
19 we'll come back to it, but --

20 MR. MANDELL: That's fine. No, no, I just  
21 wanted to influence the binder.

22 MR. GARAND: Thank you.

23 BY THE WITNESS:

24 A. Okay.

1 MR. GARAND: Erick, can we have Tab 12 here.  
2 Let's see. We are on Cooper Exhibit 10.

3 (WHEREUPON, a certain document was  
4 marked Dr. Cooper Deposition Exhibit  
5 No. 10, for identification, as of  
6 07/10/2025.)

7 BY MR. GARAND:

8 Q. And, Doctor, we discussed earlier you  
9 don't recall whether or not you reviewed the  
10 deposition transcript of Dr. Flood, correct?

11 A. I'm sorry, I don't recall that.

12 Q. That's okay. We'll go through it. And  
13 you understand that Dr. Flood --

14 A. Thank you.

15 Q. -- is Mr. Mousser's VA nephrologist,  
16 correct?

17 A. Yes. Thank you.

18 Q. Does a nephrologist -- is a nephrologist  
19 typically able to evaluate someone's chronic kidney  
20 disease?

21 A. Yes, they can.

22 Q. Are they -- are they able to provide a  
23 prognosis for someone's chronic kidney disease?

24 A. They can, yes.

1           Q.     Okay.  Let's look at Page 87 of this  
2 transcript.  And we'll look at Line 15 and we'll go to  
3 Page 88:17.

4           A.     Page 87:15.

5           Q.     Okay.  So the question:

6                   "And so if we look at the top of Page 3,  
7 which is Bates ending in 05146, these are the lab  
8 results, and it notes that his creatinine is up to 1.9  
9 in March of 2022.

10                   "Do you see that?"

11                   Answer:  "I do."

12                   Question:  "Do you have an opinion on what  
13 caused the increase from 1.5 in January to 1.9 in  
14 March?"

15                   Answer:  "So I opined in this that I  
16 thought that it was probably due to hemodynamic  
17 changes with the low blood pressure and the use of the  
18 lisinopril, which is what an ACE inhibitor is,  
19 angiotensin-converting-enzyme inhibitor.

20                   "So that's -- that was my suspicion,  
21 because his urine was otherwise normal from it, so  
22 when -- things being normal the creatinine can go up  
23 not because of intrinsic kidney problems, which is  
24 decreased flow to the kidney with diminished blood

1 pressure, so if he was on too much of his blood  
2 pressure medicine, it would affect that.

3 "And so that's what I was hoping for, so I  
4 recommended making changes to it, and then I think I  
5 ordered a follow-up study in April, which confirmed my  
6 preclinical -- or excuse me -- my -- my suspicion of  
7 the cause because his creatinine improved."

8 Did I read that correctly?

9 A. Yes, sir.

10 Q. Okay. Let's go to Page 91. If you look  
11 at the bottom of Page 91, you'll see Mr. Garand, and  
12 we're -- we're discussing an April 28, 2022, treatment  
13 note.

14 Do you see that?

15 A. I do.

16 Q. Okay. If we look at Page 92, Line 3, and  
17 we'll go through Line 24.

18 "And if you look at the bottom of Page 1  
19 of this document under the 'Labs' heading, it says  
20 creatinine is down to 1.4 in April of 2022, is that  
21 right?"

22 "Yeah, that's correct."

23 "And then on Page 2, about halfway down  
24 the page, you wrote that you 'Reviewed above lab tests

1 with marked improvement in creatinine from 1.9 to  
2 1.4,' in parentheses, '(baseline) on 20 milligrams  
3 lisinopril with well controlled BP.'

4 "So Mr. Mousser's creatinine had improved  
5 significantly since the March 2022 labs, is that  
6 right?"

7 Answer: "Yes. And that creatinine of 1.4  
8 is entirely consistent with somebody that has one  
9 kidney that's doing quite well."

10 Question: "It's not a cause --"

11 Answer: "So that -- I'm sorry?"

12 Question: "It's not a -- it's not a cause  
13 for concern then?"

14 Answer: "No, it's reassuring."

15 Did I read that correctly?

16 A. Yes, sir.

17 Q. Lastly, let's go to Page 100 and we'll go  
18 from Lines 1 through 9.

19 "So I think I mentioned it just a moment  
20 ago -- and I can go back and look -- but if he was --  
21 he's -- he's no longer receiving IV fluids, if he's on  
22 the lisinopril, that can affect the flow to the  
23 kidneys, and so that can make the creatinine appear  
24 higher and suggest kidney -- worsening kidney

1 function, when, in fact, it's a reflection of just  
2 flow rather than intrinsic disease."

3 Did I read that correctly?

4 A. Yes.

5 Q. So it was Dr. Flood's opinion that  
6 Mr. Mousser's spike in creatinine was not caused by  
7 intrinsic issues with the kidney but reduced blood  
8 flow to the kidney, is that correct?

9 MR. MANDELL: Objection.

10 BY THE WITNESS:

11 A. Based upon what you've read here, I  
12 believe that's what his opinion is, yes.

13 BY MR. GARAND:

14 Q. And he found that a creatinine of 1.4 is  
15 entirely consistent with somebody that has one kidney  
16 that's doing quite well, is that correct?

17 MR. MANDELL: Objection.

18 BY THE WITNESS:

19 A. That's what he stated here in this  
20 deposition.

21 BY MR. GARAND:

22 Q. Do you have any reason to dispute his  
23 findings there?

24 A. I do.



1 Q. Okay. And what's that?

2 A. Again, I -- I believe that the lisinopril,  
3 speaking specifically about these comments here, can  
4 contribute potentially to the changes in creatinine  
5 that we've gone through in the binder, but I think  
6 it's, again, not taking into account all of the things  
7 that we've talked about before.

8 To look at sort of simply a change in the  
9 medication as the only reason why someone who has had  
10 a unilateral nephrectomy, secondary to cancer, has  
11 that remaining kidney with we know some  
12 nephrosclerotic damage to it that we've seen or the  
13 biopsy record, with all of the additional  
14 comorbidities, to simply say that changing the  
15 medication and fixing someone's number is confidence  
16 that he has no evidence of intrinsic kidney disease  
17 when we know there is intrinsic kidney disease, we  
18 know there's nephrosclerosis, is not a complete  
19 thought.

20 Q. Okay. Doctor, let's look at an  
21 April 18th, 2022, treatment note. And we'll mark this  
22 as Cooper Exhibit 11.

23 (WHEREUPON, a certain document was  
24 marked Dr. Cooper Deposition Exhibit

1                               No. 11, for identification, as of  
2                               07/10/2025.)

3       BY THE WITNESS:

4               A.       Are we coming back to this?

5       BY MR. GARAND:

6               Q.       We will come back --

7               A.       I've just got so many papers in front of  
8       me.

9               Q.       We'll come back to it, but not right now.

10              A.       Okay.

11              Q.       So, yeah, you can close it and we'll put  
12       it to the side.

13              A.       Thank you.

14              Q.       I know there's a -- there's a lot of  
15       moving pieces here.

16              A.       Yeah, thank you.

17              Q.       I'll try to tell you if we are going to be  
18       coming back to an exhibit or not.

19              A.       Okay. Okay. Thank you.

20              Q.       Again, this is Cooper Exhibit 11.

21                      Okay. So this is a -- again, an  
22       April 18th, 2022, VA treatment note. This is Bates  
23       00667\_MOUSSER\_VHA\_0375.

24                      Doctor, at the top do you see that the

1 author is Dr. Andrew Rockwood?

2 A. I -- I do see that, yes.

3 Q. And, again, you understand that that's  
4 Mr. Mousser's VA urologist, correct?

5 A. Yes, sir, I do.

6 Q. The middle of the page, do you see that  
7 Dr. Rockwood stated that, "His updated serum  
8 creatinine was 1.4 and a 24-hour urine for CrCl  
9 calculates out to a 102 cc per minutes..."

10 Do you see that?

11 A. Yes.

12 Q. And Dr. Rockwood found that "which is  
13 obviously very good for solitary kidney," correct?

14 A. Correct.

15 Q. And then if you look at the assessment,  
16 the little paragraph beneath that, Dr. Rockwood found  
17 that the "current renal function studies showing  
18 excellent and preserved renal function," is that  
19 right?

20 A. Correct.

21 Q. And so it's your opinion -- it's your  
22 testimony that you disagree with Mr. Mousser's VA  
23 nephrologist and now his VA urologist; is that  
24 accurate?

1 MR. MANDELL: Objection.

2 Go ahead.

3 BY THE WITNESS:

4 A. I do.

5 BY MR. GARAND:

6 Q. And you understand that these are  
7 Mr. Mousser's VA treaters in this case?

8 A. I do.

9 Q. And you understand that they're --

10 A. Post -- post-nephrectomy, yes, sir.

11 Q. You understand that Dr. Rockwood was the  
12 provider who first discovered the mass?

13 A. I do. I'm just talking about what we're  
14 speaking about right now.

15 Q. Thank you, Doctor.

16 Okay. So we just finished discussing  
17 Mr. Mousser's GFR and creatinine results from the time  
18 of his surgery in October of '20 through April  
19 of 2022. We are going to keep looking at these  
20 results.

21 And, again, I'll just ask, you know, we --  
22 we discussed previously that you relied on a dip in  
23 GFR and a creatinine of 1.5 to 1.6, correct?

24 MR. MANDELL: Objection. Objection to the

1       preface too.

2                       Go ahead.

3       BY THE WITNESS:

4               A.       Amongst other things.

5       BY MR. GARAND:

6               Q.       Of course. So I'll ask just that as we  
7       review a bunch of numbers here, you keep those in  
8       mind.

9                       All right. So we'll go back to the binder  
10       here.

11              A.       Okay.

12              Q.       I know, there is...

13              A.       I'm just trying to keep my mounds  
14       appropriate here.

15              Q.       Thank you, Doctor.

16              A.       Okay.

17              Q.       So let's look at Bates ending in 05657.

18              A.       Okay, sir.

19              Q.       So at the very top of the page, do you see  
20       that these are July 15 of 2022 results, correct?

21              A.       Yes, sir.

22              Q.       And if you look a few lines down, his  
23       creatinine is 1.4, right?

24              A.       Correct.

1 Q. And if you flip to Bates ending in 05659,  
2 his eGFR is 58, is that right?

3 A. Correct.

4 Q. Let's look at Bates ending in 05645.

5 A. Okay.

6 Q. These are September 19, 2022, results. Do  
7 you see that at the bottom of the page?

8 A. I do, sir, yes.

9 Q. The next page is 05646 and the creatinine  
10 is 1.3.

11 Do you see that?

12 A. I do, sir.

13 Q. If you flip to page Bates ending in 05648,  
14 the eGFR is 63, is that right?

15 A. Correct.

16 Q. Okay. We'll look at -- put these to the  
17 side, but we're going to come right back to them.

18 A. Okay.

19 Q. Thank you. It would be convenient if all  
20 of these were right in the same spot, but  
21 unfortunately they're not.

22 MR. GARAND: I'll mark this as, let's see, we  
23 are on 12. I'll mark this as Cooper Exhibit 12.

24 (WHEREUPON, a certain document was

1 marked Dr. Cooper Deposition Exhibit  
2 No. 12, for identification, as of  
3 07/10/2025.)

4 BY MR. GARAND:

5 Q. And for the record, this is a --  
6 Mr. Mousser's lab results from March of 20 -- March 20  
7 of 2023.

8 Do you see, Doctor, Mr. Mousser's name in  
9 the top left corner there?

10 A. I do, yes.

11 Q. And do you see that the date collected is  
12 3/20/2023?

13 A. I do, yes, sir.

14 Q. Do you see that the third entry is  
15 creatinine, and it's 1.25 in the lab results?

16 A. I do, sir.

17 Q. And the eGFR is 66, correct?

18 A. I see that also, yes.

19 Q. So at this point from April of 2022 to  
20 March of 2023, we have not seen a -- seen a creatinine  
21 level of 1.5 to 1.6, right?

22 MR. MANDELL: Objection. In the records you've  
23 shown so far?

24 MR. GARAND: Correct, in the records I've shown.

1 BY THE WITNESS:

2 A. The dates again, I'm -- can you do it one  
3 more time just so I'm --

4 BY MR. GARAND:

5 Q. From April of 2022 --

6 A. Yeah.

7 Q. -- to March of 2023. And the records I've  
8 shown --

9 A. Yes.

10 Q. -- we have not seen a decline -- or a  
11 creatinine at 1.5 to 1.6, is that right?

12 A. With what we've shown, yes, sir.

13 Q. Are you aware of any other lab results  
14 during this timeframe that indicate a creatinine level  
15 of 1.5 to 1.6?

16 A. Not that I can recall.

17 Q. Are you aware of any lab results from this  
18 same April of 2022 to March of 2023 time -- time  
19 period that shows a decline in GFR?

20 A. No, not -- these -- the labs that you've  
21 shown me are the ones that I recall.

22 Q. Thank you, Doctor.

23 All right. Back to the binder we go.

24 A. Okay.



1 Q. And if you could turn to Bates ending in  
2 05623.

3 A. I'm getting closer to the front.

4 Q. We're almost done with these.

5 A. Okay.

6 Q. At the bottom of this page, do you see  
7 that the date is July 17th of 2023?

8 A. Yes, sir, I do.

9 Q. And if you look at the next page, which is  
10 Bates ending in 05624, at the very top Mr. Mousser's  
11 creatinine is 1.4, correct?

12 A. Correct.

13 Q. If you look to the bottom of Bates ending  
14 in 05625, his eGFR is 58. Is that accurate?

15 A. It is.

16 Q. Okay. Flip to Bates ending in 05618.

17 A. Okay.

18 Q. And these are July 27, 2023, results. Do  
19 you see that at the very bottom of the page?

20 A. I do.

21 Q. And this is just ten days after the prior  
22 lab results that I just showed you, which is July 17th  
23 of 2023, right?

24 A. It sounds right, yes, sir.

1 Q. If you flip to page Bates ending in 05619,  
2 the third entry there is creatinine of 1.7, correct?

3 A. Yes, sir.

4 Q. And then if you flip to Bates ending in  
5 05621, his eGFR is 46.

6 Do you see that?

7 A. I see that, yes.

8 Q. Okay. Please turn to the very first page.  
9 We're almost done with the binder.

10 A. Awesome.

11 Q. Bates ending in 05598, you'll see that  
12 these are November 17, 2023, results.

13 Do you see that?

14 A. I do, sir, yes.

15 Q. At the very top of the next page, which is  
16 Bates ending in 05599, the creatinine is 1.4, is that  
17 right?

18 A. That's correct.

19 Q. And if you flip to Bates ending in 05602,  
20 his eGFR is 58.

21 Do you see that?

22 A. I see that, yes.

23 Q. Okay. Okay. We're done with this binder,  
24 thankfully.

1           A.     Okay.

2           Q.     I'll show you what I'll mark as Cooper  
3     Exhibit 13.

4                     (WHEREUPON, a certain document was  
5                     marked Dr. Cooper Deposition Exhibit  
6                     No. 13, for identification, as of  
7                     07/10/2025.)

8     BY THE WITNESS:

9           A.     Thank you.

10    BY MR. GARAND:

11           Q.     Doctor, have you seen this record before?

12           A.     I can't remember specifically, sir, I'm  
13     sorry.

14           Q.     That's okay. For the record, this is a  
15     May 6th, 2024, VA treatment note, and it is  
16     Bates-stamped 00667\_MOUSSER\_VHA\_01499 through 01504.  
17     Turn to Bates ending in 01501, please.

18           A.     01, sir?

19           Q.     Yes, correct.

20           A.     Okay. Thank you.

21           Q.     And at the -- towards the bottom of the  
22     page, you'll see that Jan- -- there's a January 12,  
23     2024, creatinine results and it's 1.5.

24                     Do you see that?

1           A.     I do, sir, yes.

2           Q.     All right. I'm going to show you what  
3 I'll mark as Cooper Exhibit 14.

4                   (WHEREUPON, a certain document was  
5 marked Dr. Cooper Deposition Exhibit  
6 No. 14, for identification, as of  
7 07/10/2025.)

8 BY THE WITNESS:

9           A.     Thank you.

10 BY MR. GARAND:

11           Q.     And, Doctor, I'll ask if you've seen this  
12 record before?

13           A.     Again, I'm sorry, I don't -- I don't know  
14 specifically.

15           Q.     That's okay.

16                   For the record, this is a November 12th,  
17 2024, VA treatment note for Mr. Mousser. It's  
18 Bates-stamped 00667\_MOUSSER\_VHA\_01624 through 01626.

19                   If you look at this very first page,  
20 you'll see about two-thirds of the way down the page,  
21 you'll see a November 8th, 2024, date and a May 15th,  
22 2024, date.

23                   Do you see that?

24           A.     I do, yes.

1           Q.     And if you go over three or four lines,  
2     you'll see the creatinine results for those days are  
3     1.4 for -- for each.

4                     Do you see that?

5           A.     I do, yes.

6           Q.     Okay. I'll show you what I'll mark as  
7     Cooper Exhibit 15.

8                     (WHEREUPON, a certain document was  
9                     marked Dr. Cooper Deposition Exhibit  
10                    No. 15, for identification, as of  
11                    07/10/2025.)

12    BY THE WITNESS:

13           A.     Thank you.

14    BY MR. GARAND:

15           Q.     Doctor, have you seen this record before?

16           A.     I don't recall, sir.

17           Q.     That's okay.

18                     So for the record, this document is  
19     Bates-numbered 00667\_MOUSSER\_VHA\_01567 through 01568.

20                     And these are, if you see, the "Chem I  
21     Profile Routine" heading.

22                     Do you see that there, in the middle of  
23     the page?

24           A.     I do.

1           Q.     If you look directly below that, it says  
2     January 6th of 2025, correct?

3           A.     It does.

4           Q.     Three lines down the creatinine is 1.3,  
5     correct?

6           A.     That's correct.

7           Q.     And the -- if you flip to the next page,  
8     which is Bates ending in 01568, in the middle of the  
9     page there, the eGFR is 63. Is that accurate?

10          A.     That's correct.

11          Q.     And as we've discussed, an eGFR of 63 is  
12     CKD Stage 2, right?

13          A.     That's right.

14          Q.     Do you have any evidence or information  
15     demonstrating that Mr. Mousser's CKD has changed since  
16     January of 2025?

17          A.     One more time, please, do I?

18          Q.     Are you aware of any medical records or  
19     anything indicating that his CKD staging has changed  
20     since January of 2025?

21          A.     I don't, not based upon lab data, no.

22          Q.     Okay. So from April of 2023 -- sorry --  
23     April of 2022 through January of 2025, and I'll  
24     represent to you in, you know, my review of the

1 records, these are all of the -- what I've shown you  
2 is all of the lab results I've seen for Mr. Mousser  
3 for that time period.

4 A. Okay.

5 Q. He has had one instance of a -- of a  
6 creatinine at 1.7, one instance of a creatinine at  
7 1.5, and more than -- or he's at 11 instances of a  
8 creatinine at 1.4 or lower.

9 Is that -- I know we just went through a  
10 lot of them, but I'll represent to you that that's the  
11 case. So Mr. Mousser's creatinine has been  
12 consistently been below 1.5 to 1.6, is that  
13 accurate --

14 MR. MANDELL: Objection --

15 MR. GARAND: -- since April of 2022?

16 MR. MANDELL: Objection; form and foundation.

17 Go ahead.

18 BY THE WITNESS:

19 A. Based upon the creatinine values that  
20 we've looked at, yes --

21 BY MR. GARAND:

22 Q. So --

23 A. -- those numbers.

24 Q. And I apologize for jumping in there.

1           So can you explain why you listed 1.5 to  
2           1.6 as the creatinine values in your expert report?

3           A.     Yeah, because at the time that I wrote the  
4           report, the data that I had in front of me was --  
5           included, again, a lot of these numbers, but as we  
6           talked about before, I was most interested in the  
7           demonstration that his kidney, you know, has the  
8           inability to compensate, you know, when we have sort  
9           of changes in volume and potential interventions, such  
10          as blood pressure medications.

11                That is, again, the rationale for why I  
12          made that conclusion about his longevity of his  
13          remaining kidney. So that's why it's in my report  
14          as -- because that's what I focused on as being  
15          significant and based upon, again, my experience, that  
16          contributes to my conclusion.

17          Q.     So the -- so a creatinine value of 1.5 to  
18          1.6 that's over three years old is what's most  
19          significant to you in his lab results?

20                MR. MANDELL: Objection.

21                BY THE WITNESS:

22           A.     I didn't say that. I said that's a -- I  
23           said that's a part of what I considered to be  
24           significant in my determination of his chronicity of



1 disease and the future of his kidney.

2 BY MR. GARAND:

3 Q. So lower, more recent creatinine results  
4 is not significant?

5 MR. MANDELL: Objection.

6 BY THE WITNESS:

7 A. No, I didn't say that either. It is a  
8 piece -- it's a part of the decision, but it alone is  
9 not in my mind the most important determination of,  
10 you know, what his future kidney health is going to  
11 look like.

12 BY MR. GARAND:

13 Q. Yeah, and, Doctor, I'm sure you  
14 understand, all I'm trying to do is figure out why 1.5  
15 to 1.6 was listed as the creatinine values in your  
16 report, as opposed to lower creatinine values that are  
17 more consistent -- or more recent?

18 MR. MANDELL: Objection; asked and answered.

19 Go ahead.

20 BY THE WITNESS:

21 A. Again, it's because I was at that time  
22 putting together all of the information, included all  
23 of the things that we talked about, his unilateral  
24 nephrectomy, his hyperfiltration of that remaining

1 kidney, his comorbidities, and the fact that soon  
2 after surgery and even sometime following surgery that  
3 he had significant rises in creatinine.

4 So I think it's important, and you've  
5 actually laid it out very nicely, minimal changes in  
6 creatinine result in significant drops in creatinine  
7 clearance.

8 BY MR. GARAND:

9 Q. And, Doctor, you didn't explain any of  
10 this in your report, is that -- any of the explanation  
11 you just gave as to why you picked certain creatinine  
12 results, none of that is in your expert report, is  
13 that right?

14 MR. MANDELL: Objection.

15 BY THE WITNESS:

16 A. I didn't feel the need to.

17 BY MR. GARAND:

18 Q. And why is that?

19 A. Because, again, the -- the information  
20 that I placed there in addition to the other parts of  
21 the expert opinion, and -- and including, you know, my  
22 experience, is what allows me to make that conclusion.

23 MR. MANDELL: Objection.

24 MR. GARAND: Okay. I think we've been going for

1     about an hour, and I'm at a good stopping point, if  
2     that's all right with you, Doctor.

3             THE WITNESS:    Sure.

4             MR. MANDELL:   Five minutes.

5             MR. GARAND:    Sure.

6             THE VIDEOGRAPHER:  Going off the record at  
7     11:04 a.m.

8                             (WHEREUPON, a recess was had  
9                             from 11:04 to 11:16 a.m.)

10            THE VIDEOGRAPHER:  We are back on the record at  
11     11:16 a.m.

12     BY MR. GARAND:

13            Q.     Doctor, I just showed you a whole lot of  
14     GFR -- or lab results with GFR results and -- and  
15     creatinine levels.

16                    Did you have all of those records when you  
17     wrote your initial report?

18            A.     I believe I had if -- everything but maybe  
19     the last one, sometime in -- with the one in 2024, but  
20     I know I had all of the others.

21            Q.     Okay. Did you consider -- or was there  
22     any consideration in drafting a supplemental report  
23     with the most updated creatinine and GFR results?

24            A.     No. I didn't believe that was necessary.

1 It didn't change my opinion that I provided in the  
2 initial report.

3 Q. Okay. Doctor, you also -- as part of your  
4 bases, you also found that Mr. Mousser was likely to  
5 require renal replacement therapy in three to  
6 five years be- -- because he had significant  
7 proteinuria and an elevated protein creatinine ratio,  
8 is that right?

9 A. Correct, that's what I have in here.

10 Q. And let me just ask generally, what's the  
11 difference between significant proteinuria and an  
12 elevated protein creatinine ratio?

13 A. Pretty much the same, yeah.

14 Q. Okay. Okay. So let's talk about those  
15 two pieces. And Erick per usual is ahead of the game.  
16 We're going to mark this as Cooper Exhibit 16.

17 (WHEREUPON, a certain document was  
18 marked Dr. Cooper Deposition Exhibit  
19 No. 16, for identification, as of  
20 07/10/2025.)

21 BY MR. GARAND:

22 Q. Doctor, have you seen this exhibit before?

23 A. I don't recall specifically whether I had  
24 these records.

1 Q. Okay. Just for the record, this is a  
2 July 19, 2022, treatment note from Mr. Mousser, and  
3 it's Bates-stamped 0667\_MOUSSER\_VHA\_0327 through 0333.

4 If you flip to the very last page, which  
5 is Bates ending in 0333, you'll see that it's signed  
6 by a -- yeah, sorry about that.

7 A. Okay.

8 Q. It's signed by a nephrology fellow and a  
9 staff nephrologist.

10 Do you see that?

11 A. Yes.

12 Q. In the middle of the page?

13 A. I do, yes.

14 Q. And if you flip to just one page earlier,  
15 Bates ending in 0332, do you see that the provider  
16 assesses CKD Stage G3a A1. Is that right?

17 A. I see that, yes.

18 Q. The last sentence of that first  
19 paragraph -- so I guess two -- two or three lines up  
20 from the bottom there to the right, it says, "Found to  
21 uptrend to 1.6 few months after and has remains stable  
22 1.5 to 1.6 since then and currently at 1.4," is that  
23 right?

24 A. Yes, that's correct.

1           Q.     Okay. In the middle of the next  
2 paragraph, the second line from the top, is -- if you  
3 see UA in a medical record, is that urinalysis?

4           A.     Yes, sir, most often.

5           Q.     So it says, "UAs showing now resolved  
6 hematuria with negative proteinuria on dipstick," is  
7 that right?

8           A.     Give me one second. The second sentence.  
9 Yes, yes, it says that.

10          Q.     So at this point in July of 2022, there  
11 was no proteinuria, correct?

12          A.     According -- according to this record,  
13 correct.

14          Q.     Yes. And, Doctor, of course, yeah, if we  
15 are referencing a record, I'll assume that you mean  
16 according to this record and, you know, not that there  
17 is some other record out there that would contradict  
18 it.

19                   So if we flip to the very last page, which  
20 is Bates ending in 0333, do you see the "Plan" heading  
21 at the top of the page, towards the top?

22          A.     I do.

23          Q.     The second -- the second --

24          A.     The last page.

1 MR. MANDELL: No, it's just -- go ahead, I've  
2 got it.

3 BY MR. GARAND:

4 Q. The second line there says, "UACR  
5 undetected at this time with UPCR 0.07 changing his  
6 grade to A1 kidney disease. Continue with ACEi,"  
7 which is ACE inhibitor, right?

8 A. Yes, sir.

9 Q. And as we discussed earlier, UACR means  
10 urine albumin-to-creatinine ratio, right?

11 A. It does.

12 Q. So undetected UACR and 0.07 UPCR is not  
13 evidence of elevated protein creatinine ratio, right?

14 A. That's correct.

15 Q. Okay. Let's look at another exhibit here,  
16 which I'll mark as Cooper Exhibit 17.

17 (WHEREUPON, a certain document was  
18 marked Dr. Cooper Deposition Exhibit  
19 No. 17, for identification, as of  
20 07/10/2025.)

21 BY THE WITNESS:

22 A. Thank you.

23 BY MR. GARAND:

24 Q. And, Doctor, I'll ask if you've seen this

1 record before?

2 A. Again, I had these records. I don't  
3 remember this specifically.

4 Q. Okay. Just for the record, this is a  
5 December 11th, 2023, VA treatment note for  
6 Mr. Mousser. It is Bates-stamped  
7 00667\_MOUSSER\_VHA\_0111 through 0112.

8 Do you see that this is a nephrology  
9 consult at the very top of the page?

10 A. Yes, sir, I do.

11 Q. And do you see that the author is Jay  
12 Bucci?

13 A. I do, yes.

14 Q. I hope I'm pronouncing that correctly.  
15 But if you flip to the second page at the very top,  
16 the signature line shows that Jay Bucci is a staff  
17 nephrologist with the VA, right?

18 A. Yes, sir.

19 Q. Okay. Do you see the findings on Page 1  
20 of this record, which is Bates ending in 0111,  
21 Dr. Bucci found that "Mr. Mousser is a 60-year-old  
22 male with hypertension, CAD status post CABG,  
23 urothelial cell carcinoma mall status post  
24 nephroureterectomy in October of 2020 and CKD G3a A1



1 (creatinine 1.4 to 1.5) attributed to reduced renal  
2 mass from the nephrectomy. He previously had  
3 proteinuria prior to his nephrectomy, but it has  
4 resolved. He has managed with lisinopril and  
5 empagliflozin. He has no complications of CKD."

6 Did I read that correctly?

7 A. You did.

8 Q. So just like in July of 2022, in December  
9 of 2023, Mr. Mousser again was found not to have  
10 proteinuria, is that right?

11 A. Correct.

12 Q. And, in fact, this -- this examiner -- or  
13 provider found that the proteinuria had resolved,  
14 right?

15 A. Correct.

16 Q. Okay. If we look at the "Impression"  
17 heading on the same page, Dr. Bucci again found that  
18 Mr. Mousser had stable CKD -- and sorry, we're looking  
19 at 0111. Sorry about that.

20 A. I was flipping the page. I apologize.

21 Q. That's okay.

22 A. Okay.

23 Q. So the "Impression" tab -- or heading,  
24 Dr. Bucci found that Mr. Mousser had "stable CKD G3a

1 A1 from reduced renal mass status post nephrectomy  
2 three years ago," right?

3 A. Yes.

4 Q. He also notes right beneath that that  
5 "Patients with stable CKD attributed to a nephrectomy  
6 without albuminuria and without complications of CKD  
7 generally do not require long-term nephrology  
8 follow-up unless there is evidence of disease in the  
9 remaining kidney," is that right?

10 A. That's right, that's what it says.

11 Q. And then under the "Recommendations"  
12 heading, the fourth entry there, Dr. Bucci stated that  
13 Mr. Mousser "is discharged from the nephrology  
14 clinic," is that correct?

15 A. Yes, sir, that's what it says.

16 Q. And as discussed, that's because he had  
17 CKD Stage G3 A1 and Dr. Bucci found that it was  
18 stable, is that right?

19 MR. MANDELL: Objection.

20 BY THE WITNESS:

21 A. That's what he states here in his note.

22 BY MR. GARAND:

23 Q. And he also found that the proteinuria had  
24 resolved, right?

1           A.     That's what's in his note, yes.

2           Q.     Okay. I'll show you what I'll mark as  
3     Mousser -- or Cooper Exhibit 18.

4                     (WHEREUPON, a certain document was  
5                     marked Dr. Cooper Deposition Exhibit  
6                     No. 18, for identification, as of  
7                     07/10/2025.)

8     BY THE WITNESS:

9           A.     Thank you.

10    BY MR. GARAND:

11           Q.     Thank you.

12                     Doctor, again, I'll ask if you've seen  
13     this record before?

14           A.     Again, not specifically, but I did have  
15     these in my possession.

16           Q.     So, and, again, this is a December 15th,  
17     2023, VA treatment note. It's Bates-stamped  
18     00667\_MOUSSER\_VHA\_097 through 0103. And so this is  
19     just a few days after the December 11th, 2023,  
20     treatment that we just looked at, is that right?

21           A.     That's right.

22           Q.     And this is a different VA provider,  
23     right, Katherine Adams-Krick?

24           A.     Correct.

1           Q.     Okay. Please turn to Page 6 of this  
2 document, which is Bates ending in 0102. If you see  
3 the "Assessment/Plan" heading there in the middle of  
4 the page, if you look at Number 1, she again diagnoses  
5 chronic kidney disease Stage G3 A1, is that right?

6           A.     That's correct, yes.

7           Q.     The second bullet under Number 1 is "Serum  
8 creatinine stable at baseline at 1.4," is that right?

9           A.     That's right.

10          Q.     And the Number 2 under the Assessment/Plan  
11 heading is that, "Proteinuria: Controlled," is that  
12 right?

13          A.     Yes, sir.

14          Q.     Do you understand that to mean that she  
15 found that his proteinuria was controlled?

16          A.     Based upon her note, yes.

17          Q.     Okay. Doctor, we're going to look back at  
18 Exhibit 14, which I hope is one of the ones that I  
19 told you to keep.

20          A.     Yes, I have it.

21          Q.     Okay. If we look at Page 2 of this  
22 document, which is Bates ending in 01625, right after  
23 the -- that double dotted line in the middle of the  
24 page, this provider states, "Your kidney function

1 remains stable as reflected by the serum creatinine at  
2 your baseline of 1.4," is that right?

3 A. I see that.

4 Q. And if you skip to the next paragraph, she  
5 states that, "Additional evidence for stable kidney  
6 function is the microalbumin in your urine or protein  
7 in your urine remains undetectable at less than 7.0  
8 mg/L," is that right?

9 A. Yes, sir, that's what it says.

10 Q. So, again, as of November -- or in  
11 November of 2024, this provider found that  
12 Mr. Mousser's microalbumin in the urine was  
13 undetectable, correct?

14 A. That's correct. Excuse me.

15 Q. Okay. So let's look at Dr. Flood's  
16 deposition transcript, which is Exhibit 10.

17 A. Ten, okay.

18 Q. We'll look at Page 41. And take your time  
19 getting there, Doctor. I know there's a lot of  
20 documents flying around.

21 A. I'm trying to get these close. I'm sorry,  
22 page...?

23 Q. 41.

24 A. God bless you.

1           Q.       We'll look at lines 2 to 6. And Dr. Flood  
2       stated:

3                    "So he had kidney disease by virtue of  
4       single kidney, longstanding proteinuria/albuminuria,  
5       which interestingly is resolved on the current  
6       medication, which is wonderful for him."

7                   Did I read that correctly?

8           A.       You did.

9           Q.       We'll look at Page 43. We'll look at  
10       again Lines 1 through 8. Dr. Flood testified that:

11                   "His albumin level in 2022 and his urine  
12       was under 30, so that was okay by 2022. So he had  
13       some proteinuria on one test in 2020, so, yeah, I've  
14       got to restate what -- what I wrote as -- at least  
15       based on that, unless I was able to find older data,  
16       he had proteinuria on one episode, and actually's been  
17       doing just fine since that time," correct?

18          A.       That's correct.

19          Q.       Is there any reason why you did not  
20       include these more recent medical records in your  
21       report that indicate that there is no pro- -- that the  
22       proteinuria has resolved and that the pro- -- protein  
23       creatinine ratio was undetectable?

24          A.       Yes, because at -- at the time that I -- I

1 wrote this report, again, I was, you know, evaluating  
2 the, as I said before, the totality of Mr. Mousser and  
3 additional data that, again, none of those talked  
4 about, that he has had the ability to look at his  
5 other kidney.

6 It's just surprising to me that the  
7 nephrologist say that he has no evidence of intrinsic  
8 disease when they could look at his pathology and know  
9 that he does. And the fact that he had proteinuria  
10 and elevated urine creatinine ratio after his  
11 nephrectomy at any time to me is incredibly  
12 significant.

13 You said it yourself. He's on medications  
14 now to control his proteinuria. So his providers  
15 themselves know that he has proteinuria and they're  
16 controlling it with the medications, which, again, is  
17 an indication that this kidney has injury associated  
18 with it and they're treating.

19 And so your question earlier about does  
20 control matter? Sure, it matters, but there still is  
21 the demonstration that that single kidney secondary to  
22 having a nephrectomy that's hyper-filtrating with all  
23 of his co- -- multiple comorbidities is damaged and is  
24 going to have problems in the future.

1 Q. And I appreciate that, Doctor. My  
2 question was, why didn't you discuss specifically  
3 those more recent results that contradict your finding  
4 of elevated proteinuria or significant -- significant  
5 proteinuria and an elevated protein creatinine ratio?

6 A. They don't con- --

7 MR. MANDELL: Objection; asked and answered.  
8 Go ahead.

9 BY THE WITNESS:

10 A. They don't contradict what I said. I said  
11 that the fact that he has had that following his  
12 nephrectomy is part of my equation in calculating  
13 those three to five years.

14 BY MR. GARAND:

15 Q. Doctor, are you aware of what medications  
16 Mr. Mousser is on that protect his kidney function?

17 A. Currently?

18 Q. Currently.

19 A. I -- I don't remember specifically. He  
20 has been on several medications including like the ACE  
21 inhibitors and the ARBs, but what he's on currently  
22 right now, I am unfamiliar.

23 Q. Do you know whether the medications that  
24 protect his kidney, whether he's on those medications



1 specifically to protect his kidney or he's on those  
2 medications for other purposes?

3 A. No, he's on those medications to protect  
4 his kidney.

5 Q. Okay. Okay. And, again, you don't  
6 remember what medication -- or you don't know  
7 specifically what medications those are?

8 A. No. Again, I -- they're under the class  
9 that are renal protective agents.

10 Q. And he was prescribed those medications to  
11 protect his kidneys?

12 A. Correct.

13 Q. Okay. Doctor, again, I think I asked you  
14 about this earlier, but you don't recall reviewing  
15 Dr. Andrew Rockwood's deposition transcript in this  
16 matter, do you?

17 A. I don't specifically recall, I'm sorry.

18 (WHEREUPON, a certain document was  
19 marked Dr. Cooper Deposition Exhibit  
20 No. 19, for identification, as of  
21 07/10/2025.)

22 BY MR. GARAND:

23 Q. This is a portion of Dr. Rockwood's  
24 deposition transcript.

1           A.       Excuse me.

2           Q.       And, Doctor, if you flip to Page 101 for  
3 me, please.

4                   And, again, you understand that  
5 Dr. Rockwood is Mr. Mousser's VA urologist?

6           A.       I do.

7           Q.       Okay. Let's look at Page 101, Lines 4 to  
8 15.

9                   Question: "Does Mr. Mousser being  
10 diagnosed with chronic kidney disease change your  
11 opinion of his life expectancy?"

12                  Answer: "No."

13                  Question: "Why doesn't that change your  
14 opinion?"

15                   "It's a very minimal risk factor, the fact  
16 that his -- or at least based on the last renal  
17 function assessment, his creatinine was 1.4, but that  
18 would have a very minimal impact on his life  
19 expectancy."

20                  Did I read that correctly?

21           A.       You did.

22           Q.       And if you will turn to Page 103 for me.  
23 We'll look at Lines 5 through 8. And Dr. Rockwood  
24 testifies that "...if his kidney function remains

1 where it is, it should have essentially zero impact on  
2 his ability to function normal daily activities..."

3 And then at Lines 11 through 12, "... but  
4 in terms of his working inside in an office-type  
5 setting, it should have zero impact," is that right?

6 A. That's what it says, yes, sir.

7 Q. So Dr. Rockwood's opinion is that  
8 Mr. Mousser's CKD would not impact Mr. Mousser's life  
9 expectancy, correct?

10 MR. MANDELL: Objection.

11 BY THE WITNESS:

12 A. I believe that's his opinion, yes.

13 BY MR. GARAND:

14 Q. Okay. Let's look back at Dr. Flood's  
15 transcript, which is --

16 A. Ten.

17 Q. -- Cooper Exhibit 10. Thank you.

18 We'll look at Page 70 of his transcript,  
19 please. Specifically we'll look at Lines 18 to 20.

20 A. Okay.

21 Q. And you'll see that Dr. Flood stated that,  
22 "But as of 2024, I can see he's," meaning Mr. Mousser,  
23 "doing really, really well, which is great."

24 Do you see that?

1 A. I do.

2 Q. Look at Page 92 for me, please.

3 A. Yes, sir.

4 Q. And I'll -- we'll just look at Lines 17  
5 to -- through 19 which again we discussed. You say  
6 that, "And that creatinine of 1.4 is entirely  
7 consistent with somebody that has one kidney that's  
8 doing quite well," is that right?

9 A. Yes, sir, that's what it says.

10 Q. Look at Page 23 for me.

11 A. 20 -- 20 --

12 Q. 23?

13 A. We are back to 23?

14 Q. Yes. Sorry about that.

15 A. Yep. One second.

16 Q. Sure, yeah, no problem.

17 A. Okay.

18 Q. We're looking at Lines 5 through 18.

19 Dr. Flood testified that:

20 "And I just looked at his recent labs, and  
21 actually for somebody that only has one kidney, the  
22 creatinine is fairly well preserved, and he no longer  
23 has albuminuria, meaning that the filter units are no  
24 longer damaged.

1                   "When I saw him in 2022, he was having  
2                   some albumin or protein, which is a reflection of  
3                   damage to either the kidney with the albumin or  
4                   tubules with the protein.

5                   "But that all seems to have resolved, and  
6                   his urine -- urine looks good. So he's actually doing  
7                   quite well from my perspective, looking at his current  
8                   numbers."

9                   Is that what -- did I read that correctly?

10                  A.       You did.

11                  Q.       Let's go to line -- page 114.

12                  A.       One more. Okay.

13                  Q.       And we agreed earlier that a nephrologist  
14                   is in an acceptable position to opine on somebody's  
15                   prognosis, is that correct, with chronic kidney  
16                   disease?

17                  A.       Yes.

18                  Q.       Take a look at 114, Line 3. Are you  
19                   there, Doctor?

20                  A.       I am, yes, sir.

21                  Q.       He says -- Dr. Flood testifies, "He's got  
22                   one kidney, but he is doing very, very well."

23                   Question: "So -- and just in line with  
24                   this, Doctor, what would you say Mr. Mousser's

1 prognosis is related to his chronic kidney disease at  
2 this time?"

3 He answers: "I think it's -- I think it's  
4 excellent. He's got one kidney which needs to be  
5 protected all the more because he only has one kidney,  
6 but with good blood pressure control and avoiding  
7 nephrotoxins, things that might hurt the kidney, like  
8 Motrin, Advil, that type of thing, and then taking  
9 medicines that help protect the kidney, so the  
10 lisinopril and the empagliflozin, he has an  
11 outstanding lifelong -- barring some unforeseen  
12 serious injury or, you know, ill -- critical illness  
13 or something that causes acute kidney injury within  
14 the kidney itself, I mean, it's an excellent  
15 prognosis."

16 Did I read that correctly?

17 A. You did.

18 Q. And so, you know, we've just looked at  
19 four or five different passages from Dr. Flood who is,  
20 again, Mr. Mousser's -- one of Mr. Mousser's VA  
21 treating nephrologists, correct?

22 A. Correct.

23 Q. And, you know, his essential sentiment is  
24 Mr. Mousser's prognosis is excellent, correct?

1           A.       With a lot of "ifs" in there, yes.

2           Q.       And, Doctor, you're aware that doctor --  
3 well, maybe you aren't. Do you know that Dr. Flood  
4 utilized the Kidney Failure Risk Equation here with  
5 Mr. Mousser?

6           A.       I don't recall that specifically, I'm  
7 sorry.

8           Q.       Let's flip to Page 113, which we're very  
9 close.

10          A.       Okay.

11          Q.       Okay. So 113, Line 14, Dr. Flood  
12 testified, "Okay. So for -- for a 61-year-old man who  
13 has a GFR of 57, with an albumin-to-creatinine that's  
14 very low because it's undetectable right now, so less  
15 than 5, his risk of going on dialysis in five years is  
16 0.12 percent."

17                   He continues, "And that's from the  
18 kidney" -- sorry. "And that's -- that's from the  
19 Kidney Failure Risk Equation. It's -- it is  
20 well-accepted in the literature; in fact, it's  
21 becoming a standard of care for reference in  
22 management for it."

23                   Did I read that correctly?

24          A.       You did.

1 Q. And based off our prior discussion, you  
2 disagree with Dr. Flood's analysis there, correct?

3 A. I do.

4 Q. Doctor, let me -- okay.

5 Doctor, let's look at one more. If we  
6 look at Page 124 here.

7 A. 124?

8 Q. Yes, 124.

9 A. Okay.

10 Q. We're looking at Line 12 through 19.

11 A. Okay.

12 Q. Dr. Flood again testified, "I mean, this  
13 is pretty incred- -- you know, 1.4, no albumin in his  
14 urine would be pretty normal and expected for somebody  
15 that even donated a kidney. That would be very  
16 normal.

17 "So a healthy individual that donated a  
18 kidney, these are the kind of numbers we would see."

19 Is that correct?

20 A. That's what he says, yes.

21 Q. Doctor, would you agree that achieving  
22 good blood pressure control can reduced the five-year  
23 risk of requiring renal replacement therapy?

24 A. Compared to not controlling it, yes.



1 Q. So if Mr. Mousser's hypertension is well  
2 controlled, it will reduce his risk of progressing to  
3 endstage renal disease, is that correct?

4 MR. MANDELL: Objection.

5 Go ahead.

6 BY THE WITNESS:

7 A. He has a better chance than if it's  
8 uncontrolled.

9 BY MR. GARAND:

10 Q. Are you aware whether or not Mr. Mousser's  
11 hypertension is well controlled at this point?

12 A. So he has intermittent fluctuations of  
13 some elevation in his blood pressure, but it's better  
14 with the medication that he's on than if he was not.

15 Q. Are you aware whether or not it's  
16 controlled at this time?

17 MR. MANDELL: Objection.

18 Go ahead.

19 BY THE WITNESS:

20 A. I believe I answered that. Like I said, I  
21 believe he's on medication, but he still has  
22 elevations at times of that blood pressure above what  
23 would be considered normal. So it's better than if it  
24 wasn't -- he wasn't on medication, but the definition

1 of controlled is, again, extremely variable.

2 BY MR. GARAND:

3 Q. Okay. Doctor, let's look at --

4 MR. GARAND: Tab 23.

5 BY MR. GARAND:

6 Q. And I'll mark this as Cooper Exhibit 20.

7 (WHEREUPON, a certain document was  
8 marked Dr. Cooper Deposition Exhibit  
9 No. 20, for identification, as of  
10 07/10/2025.)

11 MR. GARAND: Thank you, Erick.

12 THE WITNESS: Thank you very much.

13 MR. GARAND: Of course.

14 BY MR. GARAND:

15 Q. And, Doctor, I'll ask if you've seen this  
16 record before?

17 A. Again, I'm sorry, I don't remember the  
18 specifics of this one, but I know it was in my  
19 possession.

20 Q. Okay. Doctor, just for the record, this  
21 is a November 8th, 2024, nephrology note for  
22 Mr. Mousser. It's Bates stamped 0 -- sorry,  
23 00667\_MOUSSER\_VHA\_01631 through 01638.

24 If you'll flip to Bates ending in 01637.

1           A.     Okay.

2           Q.     If you'll look at No. 3 under the  
3     "Assessment/Plan" heading, you'll see that it says,  
4     "Hypertension-CKD: Controlled."

5                     Do you see that?

6           A.     I do.

7           Q.     Okay. Doctor, would you also agree that  
8     an ACE inhibitor or ARB can reduce the five-year risk  
9     of needing renal replacement therapy?

10          A.     It can, yes. That's why folks are put on  
11     it, particularly those with a demonstrable CKD.

12          Q.     Are you -- you're aware that Mr. Mousser  
13     is on lisino- -- is taking lisinopril, correct?

14          A.     Yes sir.

15          Q.     And lisinopril is an ACE inhibitor, right?

16          A.     That's correct.

17          Q.     Do you know whether Mr. Mousser was placed  
18     on lisinopril for his cardiovascular issues or his  
19     kidney issues?

20          A.     He was put on it for both.

21          Q.     For both.

22                     Okay. Doctor, would you also agree that  
23     an SGLT2 inhibitor can reduce the five-year risk of  
24     requiring renal replacement therapy?

1           A.     The newer data, that's not my area of  
2     expertise, but it's certainly proffered as one.

3           Q.     Are you aware that Mr. Mousser is taking  
4     empagliflozin?

5           A.     I am, yes.

6           Q.     And that's an SGLT2 inhibitor, correct?

7           A.     That's correct.

8           Q.     Okay. Let's go back to your expert report  
9     for Mr. Mousser. I know we went through a whole bunch  
10    of records and now we're circling back.

11          A.     Okay. Okay.

12          Q.     If you look at Page 3 for me.

13          A.     The Mousser report, Page 3. Yes, sir.

14          Q.     You write that, "In addition to the risk  
15    of CKD/ESRD" -- and, sorry, this is at the very bottom  
16    of the page.

17          A.     Yes.

18          Q.     "In addition to the risk of CKD/ESRD,  
19    Mr. Mousser has an increased risk of hypertension with  
20    decreased glomerular mass."

21                 When you say -- what do you mean by an  
22    increased risk of hypertension?

23          A.     So one of the roles of our kidneys is to  
24    help regulate volume, and when patients have either a

1 loss of glomerular mass or a loss of a kidney, in both  
2 these respects, they have more challenges with  
3 regulating blood pressure.

4 So the fact that he has lost a kidney  
5 means that he has increased challenges with regulating  
6 his blood pressure compared to what he had before his  
7 nephrectomy for cancer.

8 Q. And you're aware that Mr. Mousser had  
9 stents placed in 2012, correct?

10 A. Cardiac stents.

11 Q. Correct.

12 A. I am, yes.

13 Q. Are you aware that he had a quadruple  
14 bypass surgery in 2016?

15 A. I'm aware, yes.

16 Q. Are you aware that he was -- he has been  
17 diagnosed with hypertension at least since 2016?

18 A. I don't know when it started, but I know  
19 he has been diagnosed for some time.

20 Q. Okay. So it's not your opinion that the  
21 chronic kidney disease could cause the hypertension  
22 that preexisted before his kidney cancer, right?

23 A. I'm sorry, one more time.

24 Q. So his hypertension predates his kidney

1 cancer, correct, and I'll show you a record?

2 A. It does. Yes, it does.

3 Q. So your opinion is not that his chronic  
4 kidney disease can cause hypertension. It already  
5 exist -- he's already being treated for it, correct?

6 A. Correct. It can worsen his hypertension.

7 Q. Okay, yeah. That's what I wanted to make  
8 sure I understood.

9 A. Okay.

10 Q. Okay. I'm going to show you --

11 MR. GARAND: We'll go Tab 24.

12 BY MR. GARAND:

13 Q. -- what I'll mark as Cooper Exhibit 21.

14 (WHEREUPON, a certain document was  
15 marked Dr. Cooper Deposition Exhibit  
16 No. 21, for identification, as of  
17 07/10/2025.)

18 BY MR. GARAND:

19 Q. And, Doctor, I'm assuming you have not  
20 seen these records before. This is records from South  
21 Texas Cardiovascular Consultants. We just obtained  
22 them. We produced them on Monday. It took us forever  
23 to actually get them. So you haven't seen them, so if  
24 you need to take a minute to, you know, review it,

1 please do so, and just let me know when you're ready.

2 A. Okay. Thank you.

3 Q. And I'll just state for the record that  
4 this is an April 6th, 2016, treatment note for  
5 Mr. Mousser from South Texas Cardiovascular  
6 Consultants, and it's Bates-stamped  
7 00667\_MOUSSER\_STCC\_078 through 080.

8 A. Okay. I think I'm good.

9 Q. Doctor, first I want to ask you, again, so  
10 this is a -- you see the top right, it's Mousser,  
11 Frank?

12 A. Yes.

13 Q. And then to the left, there's an  
14 April 6th, 2016, date there, correct?

15 A. Yes, sir.

16 Q. Are you aware of any kidney problems or  
17 issues Mr. Mousser was having in April of 2016?

18 A. Am I aware of any kidney -- no.

19 Q. Okay. Do you see under the current  
20 medications, one, two, three, the fourth one down is  
21 lisinopril, correct?

22 A. I see that, yes, sir.

23 Q. Is it -- so Mr. Mousser was prescribed  
24 lisinopril prior -- over four years before he was

1 diagnosed with kidney cancer, correct?

2 A. That sounds about right. I don't know  
3 when exactly it started, but yes.

4 Q. Okay. So if you'll look at, again,  
5 Page 1, this is Bates ending in 078, the "Previous  
6 Cardiology Testing" heading, do you see that?

7 A. Yes, sir.

8 Q. The second paragraph under there, the last  
9 sentence states, "He has developed labile hypertension  
10 which is controlled on his beta blockade and ACE-I,  
11 which we were initially -- which were initially  
12 started after his initial presentation."

13 Is that right?

14 A. Yes, sir.

15 Q. And if you flip to Page 2, which is Bates  
16 ending in 079, do you see the "Assessments" tab at the  
17 top of the page there?

18 A. I do, sir, yes.

19 Q. And Number 3 under there is "Essential  
20 hypertension," correct?

21 A. Correct.

22 Q. And then under the "Treatment" heading,  
23 Number 3 is again "Essential hypertension," right?

24 A. It does.



1           Q.     And the provider here states, "Blood  
2 pressures are borderline controlled on today's  
3 examination. No change in his medical routine is  
4 recommended at this time," right?

5           A.     Yes, sir.

6           Q.     Okay. I'm going to show you what --

7           MR. GARAND: Tab 25.

8           BY MR. GARAND:

9           Q.     -- what I'll mark as exhibit -- Cooper  
10 Exhibit 22. And, again, this is another South Texas  
11 Cardiovascular Consultants record, so if you need to  
12 take a minute to review it, please do so.

13          A.     Thank you.

14                         (WHEREUPON, a certain document was  
15                         marked Dr. Cooper Deposition Exhibit  
16                         No. 22, for identification, as of  
17                         07/10/2025.)

18          BY MR. GARAND:

19          Q.     And just let me know when you're ready,  
20 Doctor.

21          A.     Okay.

22          Q.     And I'll just note for the record, this is  
23 a March 16, 2021, treatment note for Mr. Mousser from  
24 South Texas Cardiovascular Consultants, and it's

1 Bates-numbered 00667\_MOUSSER\_STCC\_054 through 057.

2 A. Okay. I think I'm good.

3 Q. Okay. Doctor, under the previous  
4 cardiology history -- let me make sure I'm looking at  
5 the right one here. Yes, okay.

6 So the "Previous Cardiology History"  
7 heading there in the very middle of the page, the last  
8 sentence of that paragraph states that, "He has  
9 developed labile hypertension after his CABG," is that  
10 correct?

11 A. Yes, sir.

12 Q. And CABG refers to the 2016 quadruple  
13 bypass surgery, correct?

14 A. It does, sir, yes.

15 Q. If you'll flip to the second page, which  
16 is Bates ending in 055, under the "Assessments"  
17 heading, Number 6, he is again diagnosed with  
18 "essential hypertension," right?

19 A. Yes, sir.

20 Q. And Number 3 under the "Treatment" tab is  
21 again "essential hypertension," right?

22 A. Right.

23 Q. And on that second line, it says, "Well  
24 controlled and he will continue to monitor at least

1 weekly with the goal of pressures 130/80 or below,"  
2 correct?

3 A. It says that, yes, sir.

4 Q. Okay. I'll show you what I'll mark as  
5 Cooper Exhibit 23.

6 A. Exhibit 23.

7 Q. And, again, this is another South Texas  
8 Cardiovascular Consultants record, so please feel free  
9 to review and let me know when you're ready.

10 (WHEREUPON, a certain document was  
11 marked Dr. Cooper Deposition Exhibit  
12 No. 23, for identification, as of  
13 07/10/2025.)

14 BY THE WITNESS:

15 A. Can you just tell me what the date is on  
16 that?

17 MR. MANDELL: Yes, what is the date?

18 BY MR. GARAND:

19 Q. Yeah, sorry. It's -- so the date -- if  
20 you look at the top right, it says date of service is  
21 10/24/2024.

22 A. Okay.

23 Q. That's easier to read.

24 A. Thank you.

1                   Okay.

2           Q.     Okay. Doctor, so we'll look at Page 1 of  
3     this record, which is Bates ending in 044, under the  
4     "History of Present Illness" paragraph, the third line  
5     down states that, "Blood pressure as far as he knows  
6     his," I think it meant "is," "well-controlled, 130/80  
7     or below," is that right?

8           A.     Yes, yes.

9           Q.     And I also just want to point out again if  
10    you look at the medications he is taking to the left  
11    there in the left column, he is -- four and five down,  
12    I believe, so he's still taking the lisinopril,  
13    correct?

14          A.     Yes.

15          Q.     And he is taking Jardiance?

16          A.     Jardiance.

17          Q.     And do you understand that that's em- --  
18    empagliflozin?

19          A.     Um-hum.

20          Q.     What is -- what's the -- what -- what are  
21    some of the reasons why someone would be prescribed  
22    Jardiance or empagliflozin?

23          A.     Diabetes most commonly.

24          Q.     Okay. Doctor, let me make sure there's

1 nothing on here that I wanted to discuss.

2 Okay. Doctor, let's go back to your  
3 report --

4 A. Okay.

5 Q. -- for Mr. Mousser, which is Cooper  
6 Exhibit 7, I believe, and we're looking at Page 4.

7 A. Okay.

8 Q. So in that big paragraph in the middle of  
9 the page, six lines down, there's a -- to the right of  
10 the -- of the page, there's a sentence that starts  
11 "The ability."

12 Do you see that?

13 A. I am there, yes, sir.

14 Q. It reads, "The ability to main -- maintain  
15 full-time employment for dialysis patients is  
16 difficult despite the interest," is that right?

17 A. That's correct.

18 Q. And it's your opinion that Mr. Mousser --  
19 Mr. Mousser will need renal replacement therapy in  
20 three to five years, correct?

21 A. It is.

22 Q. Do you know what age Mr. Mousser testified  
23 he would retire at?

24 A. Oh, I don't know that.

1           Q.       Mr. Mousser I'll -- Mr. Mousser testified  
2       and then admitted in a -- in a separate pleading that  
3       he would retire at age 65. If he required renal  
4       replacement in -- therapy in three years, he'd be 65,  
5       is that correct?

6           MR. MANDELL:   Objection.   Foundation and form.  
7       BY THE WITNESS:

8           A.       It seems like the right math, yeah.

9       BY MR. GARAND:

10          Q.       I know, that's -- that's again about the  
11       extent of my math skills there.

12                 So if he began renal replacement therapy  
13       at 65, it would have little impact on his ability to  
14       maintain employment because he'd be retired, correct?

15          MR. MANDELL:   Objection.

16       BY THE WITNESS:

17          A.       I don't know how we're connecting those  
18       two. If he goes on dialysis, my -- my point still  
19       sticks here that most folks have difficulty even if he  
20       changes his mind that he wants to work, that he'd be  
21       able to gain meaningful employment, but I don't know  
22       how I can put those two together.

23       BY MR. GARAND:

24          Q.       Sure. Doctor, let's look at Page 5 of

1 your report.

2 A. Okay.

3 Q. And we're looking at the middle paragraph  
4 that begins "The reality."

5 Do you see that?

6 A. I do.

7 Q. The third line down all of the way to the  
8 right side, there is a para -- a sentence that says,  
9 "If Mr. Mousser suffers a recurrence now more than  
10 four years following surgery for the original cancer,  
11 his prognosis would be extremely poor as it would more  
12 likely than not be a metastatic site not appreciated  
13 in early follow-up - bones, lungs, liver and brain."

14 Did I read that correctly?

15 A. That's correct.

16 Q. Doctor, again, we've discussed this.  
17 You're not an oncologist, correct?

18 A. No, sir.

19 Q. You don't treat people for their kidney  
20 cancer, correct?

21 A. I do not.

22 Q. What is the basis of this statement?

23 A. Really knowing the -- the pathophysiology  
24 of cancerous lesions if they recur in a metastatic

1 fashion, these are the most common, renal cell cancer  
2 is something that we see all of the time in our  
3 practice as causative for nephrectomy and potentially  
4 transplant, and this is some of the workup that we do  
5 in order to assure that somebody meets candidacy for  
6 kidney transplantation.

7 Q. Are you aware that Mr. Mousser had a  
8 second cancer?

9 A. I am.

10 Q. Do you know when that second cancer  
11 occurred?

12 A. Sometime I think it was after -- soon  
13 after this report. It was like in March -- February,  
14 March. I think it's around that time.

15 Q. Doctor, why did you -- is there any reason  
16 why you decided not to draft a supplemental report?

17 MR. MANDELL: Objection.

18 Don't -- listen, in terms of anything that  
19 comes from conversations we've had or anybody at my --  
20 at my office has had with you, do not answer that  
21 question. If you can answer it otherwise, fine. But  
22 the question is why didn't you do a redraft. So  
23 that's my objection.

24 BY THE WITNESS:



1           A.       The answer is as it was before, it  
2       didn't -- it didn't change this opinion at all.

3       BY MR. GARAND:

4           Q.       So in your expert opinion, Mr. Mousser's  
5       second cancer did not impact his chronic kidney  
6       disease prognosis?

7           MR. MANDELL:   Objection.

8       BY THE WITNESS:

9           A.       That -- that's correct.

10       BY MR. GARAND:

11           Q.       Are you aware that Mr. Mousser was  
12       diagnosed with low-grade papillary urothelial  
13       carcinoma?

14           MR. MANDELL:   Objection.

15       BY THE WITNESS:

16           A.       Yes, sir.

17           MR. MANDELL:   Go ahead.

18       BY THE WITNESS:

19           A.       Yes, sir.

20       BY MR. GARAND:

21           Q.       And, again, you don't treat patients with  
22       this specific type of cancer, correct?

23           A.       I do not.

24           MR. MANDELL:   When you say "treat," you mean for

1       that cancer?

2               MR. GARAND:   Correct, for that cancer.

3               MR. MANDELL:   That's what I thought you meant.

4               MR. GARAND:   Thank you.

5       BY MR. GARAND:

6               Q.       Doctor, did you review the expert report  
7       of Dr. Armine Smith in this matter?

8               A.       I -- I don't recall that specifically,  
9       Armine Smith.

10              Q.       Do you know -- do you have any familiarity  
11       with what her expert opinion would be on?

12              A.       Again, connecting names and professions at  
13       this point, there's just so many names here.  I'm  
14       sorry, I don't.

15              Q.       I'll make it easier for us, Doctor.  I'll  
16       show you what I'll mark as Cooper Exhibit 24.

17                               (WHEREUPON, a certain document was  
18                               marked Dr. Cooper Deposition Exhibit  
19                               No. 24, for identification, as of  
20                               07/10/2025.)

21       BY MR. GARAND:

22              Q.       And, Doctor, I'll represent to you that  
23       she is a specific causation expert on behalf of  
24       Mr. Mousser.

1 A. Okay.

2 Q. She issued an initial opinion and then a  
3 supplemental opinion after Mr. Mousser's second  
4 cancer.

5 A. Okay.

6 Q. And so I'm going to show you her  
7 supplemental specific causation expert report.

8 MR. GARAND: Thank you.

9 BY THE WITNESS:

10 A. Thank you.

11 BY MR. GARAND:

12 Q. And, Doctor, if you have not had a chance  
13 to review this, please feel free to do so. It's --  
14 it's not long, so just let me know when you're ready.

15 A. Okay.

16 Q. So, Doctor, if we'll look at the second  
17 main paragraph, the very last sentence states that,  
18 "In Mr. Mousser's case, this new bladder tumor is best  
19 understood as part of the continuum of his existing  
20 urothelial disease process, not as a new or unrelated  
21 malignancy."

22 Did I read that correctly?

23 A. Yes.

24 Q. If we look at her -- if you see then the

1 next line is, "Based on my review of the updated  
2 clinical documentation, I conclude the following," and  
3 she lists three reports -- or three opinions there,  
4 right?

5 A. She does.

6 Q. All right. Number 3 states that, "The  
7 development of low-grade bladder cancer does not  
8 independently impact or worsen Mr. Mousser's overall  
9 prognosis, which remains governed by his prior  
10 high-grade UTUC and the associated  
11 nephroureterectomy," is that correct?

12 A. That's correct, sir.

13 Q. So if we go back to your expert report for  
14 Mr. Mousser. Again, we're looking at Page 4.

15 So Mr. Mousser did, in fact, have a  
16 recurrence more than four years after his surgery, is  
17 that correct?

18 A. That's correct.

19 Q. Would you agree -- so his -- as stated by  
20 Dr. Smith, which, again, is Mr. Mousser's specific  
21 causation expert, she found that his prognosis is  
22 still governed by the original UTUC, correct?

23 A. That's correct.

24 Q. And his cancer was not a metastatic site

1 that appeared in the bones, lungs, liver, or brain,  
2 correct?

3 A. That's correct.

4 Q. Okay. Let's look at the last paragraph --  
5 or at the bottom of Page 5 of your Mousser report, the  
6 third line down, Mr. -- you write in your report that,  
7 "Mr. Mousser also calls himself a 'slave' to his  
8 employment schedule making the opportunity for gainful  
9 employment impossible," is that correct?

10 A. That's correct, sir.

11 Q. Is the "making the opportunity for gainful  
12 employment impossible" part of that sentence, is that  
13 Mr. Mousser's statement or your opinion?

14 A. I apologize, one more time.

15 Q. So you -- is the "making the opportunity  
16 for gainful employment impossible" part of that  
17 sentence Mr. Mousser's statement or your opinion?

18 A. So you're talking about previously what  
19 was said, not that statement?

20 Q. No. So I'm asking, what you wrote in here  
21 is that, "He calls himself a 'slave' to his  
22 appointment schedule" --

23 A. Yeah, I know that, but we -- the gainful  
24 employment we talked about elsewhere.

1           Q.     But I'm -- I'm asking, is that your  
2     opinion or did Mr. Mousser say his -- did you see in  
3     some record that his appointment schedule makes it  
4     impossible for him to maintain employment?

5           A.     Yeah, I just want to make sure I have my  
6     statements correct.

7           Q.     Of course.

8           A.     So just -- just to be clear, my statement  
9     says, the ability to maintain full-time employment is  
10    difficult, not impossible, despite his interest. And  
11    then we go over here, we talk about "slave to his  
12    appointment schedule, the opportunity for gainful  
13    employment impossible." That's what I interpreted his  
14    statement to be based upon his deposition that I read.

15          Q.     Okay. So that's not your opinion, that's  
16    your recitation of his statement?

17          A.     Correct. My -- my opinion is several  
18    paragraphs earlier that we talked about.

19          Q.     Okay. Okay. If you look at this, again,  
20    Page 5 in the bottom, the sentence immediately  
21    following what we were just discussing, you write,  
22    "His psychological concerns have resulted in  
23    significant insomnia which contributes to his ongoing  
24    feelings of fatigue," is that correct?

1           A.     That's correct.

2           Q.     Again, is this your opinion, or was it  
3 based off Mr. Mousser's deposition testimony or  
4 medical records or anything like that?

5           A.     Both. I mean, based -- based upon his  
6 medical records from the VA, including the -- the  
7 psychologist who is caring for him, as well as  
8 Mr. Mousser's deposition.

9           Q.     Are you aware that Mr. Mousser has severe  
10 obstructed sleep apnea that impacts his ability to  
11 sleep?

12          A.     I am, yes.

13          Q.     Are you aware that Mr. Mousser's  
14 musculoskeletal pain significantly impacts his sleep?

15          A.     I don't know that part specifically.

16          Q.     Are you aware that Mr. Mousser's nocturia  
17 causes him to wake up five to six times a night to use  
18 the bathroom?

19          A.     I recall that being as part of his  
20 history, yes.

21          Q.     Are you aware that Mr. Mousser has stated  
22 that his tinnitus interferes with his ability to  
23 sleep?

24          A.     I don't recall that specifically, no.

1 Q. Okay. So there are many possible reasons  
2 or bases for him feeling fatigued, correct?

3 MR. MANDELL: Objection.

4 BY THE WITNESS:

5 A. According to Mr. Mousser, he believes that  
6 the -- you know, the most concerning reason for why he  
7 has an inability to work is his constant concern about  
8 recurrence of his cancer and, you know, the fact that  
9 he has so many now appointments. So he doesn't  
10 specifically call out to those other things.

11 BY MR. GARAND:

12 Q. Okay. And, again, I was just asking about  
13 his fatigue, not -- not his overall ability to work?

14 A. Same.

15 Q. So are you aware that there's, yeah, many  
16 different reasons for Mr. Mousser's fatigue?

17 MR. MANDELL: Objection.

18 BY THE WITNESS:

19 A. So there are reasons. Those aren't the  
20 ones that Mr. Mousser calls as to why he is so  
21 fatigued.

22 BY MR. GARAND:

23 Q. Okay. Again, looking at his deposition  
24 transcript, correct?



1           A.     And in the records when he's speaking with  
2     a psychologist.

3           Q.     Okay. All right. And then that last  
4     sentence in this last full paragraph on Page 5 of your  
5     Mousser report, you write, "Based on review of  
6     Mr. Mousser's postsurgical records, he has significant  
7     stress and illness anxiety disorder and will require  
8     lifetime psychological counseling and support," is  
9     that correct?

10          A.     That's correct.

11          Q.     Doctor, you're not a psychologist,  
12     correct?

13          A.     I'm not.

14          Q.     And you're not a psychiatrist?

15          A.     I am not.

16          Q.     You're not a mental health professional of  
17     any kind, correct?

18          A.     No, sir.

19          Q.     You don't treat patients for mental health  
20     conditions?

21          A.     Not primarily, no.

22          Q.     Is this a diagnosis of significant stress  
23     and illness anxiety disorder?

24          A.     Say what again?

1           Q.     Is that a -- is that a specific diagnosis  
2     you're making?

3           A.     It is, it is. That's found in the medical  
4     record.

5           Q.     So there is a medical record that  
6     diagnoses him with stress and illness anxiety  
7     disorder?

8           A.     There is, his psychologist.

9           Q.     Okay. And so that's not your diagnosis;  
10    you're just quoting what someone else has diagnosed  
11    him with?

12          A.     That's correct.

13          Q.     Do you have an opinion on the cause of his  
14    mental health issues?

15          A.     Again, based upon the medical records and  
16    treating similar patients, I can certainly understand  
17    why he feels the way that he does.

18          Q.     Do you have a complete -- or -- or a full  
19    understanding of Mr. Mousser's personal and  
20    professional background that could contribute to  
21    mental health conditions?

22          MR. MANDELL: Objection.

23          BY THE WITNESS:

24          A.     I believe I've read a lot of records and

1 notes about Mr. Mousser and following the nephrectomy  
2 for cancer and everything that followed, I, again, see  
3 a lot of these patients and I can certainly understand  
4 why he describes the way that he does.

5 BY MR. GARAND:

6 Q. Doctor, do you have any knowledge  
7 regarding Mr. Mousser's relationship with his parents?

8 MR. MANDELL: Objection.

9 BY THE WITNESS:

10 A. I don't know.

11 BY MR. GARAND:

12 Q. Do you have any knowledge of any traumatic  
13 events that Mr. Mousser or his family members  
14 experienced when he was a kid?

15 MR. MANDELL: Objection.

16 BY THE WITNESS:

17 A. No, I don't.

18 BY MR. GARAND:

19 Q. Do you have any knowledge regarding  
20 whether Mr. Mousser was abused as a child?

21 MR. MANDELL: Objection.

22 BY THE WITNESS:

23 A. I don't.

24 BY MR. GARAND:

1           Q.     Do you have any knowledge regarding his  
2 marital history?

3           MR. MANDELL:  Objection.

4 BY THE WITNESS:

5           A.     I don't.

6 BY MR. GARAND:

7           Q.     Do you have any knowledge regarding his  
8 relationship with his own children?

9           MR. MANDELL:  Objection.

10 BY THE WITNESS:

11          A.     I don't.

12 BY MR. GARAND:

13          Q.     Do you have any knowledge regarding  
14 Mr. Mousser's work dynamic before he stopped working?

15          MR. MANDELL:  Objection.

16 BY THE WITNESS:

17          A.     Could you just -- could you be more -- his  
18 work dynamic?

19 BY MR. GARAND:

20          Q.     Sure.  He -- do you know who he last  
21 worked for before he retired in October of 2023?

22          A.     I know he worked at a car agency.

23          Q.     Okay.  Do you understand or do you have  
24 any knowledge about the professional dynamic at this

1 car auto dealership?

2 A. No, not specifically, no.

3 Q. Do you have any knowledge regarding  
4 Mr. Mousser's use of opioids?

5 MR. MANDELL: Objection.

6 BY THE WITNESS:

7 A. I don't, no.

8 BY MR. GARAND:

9 Q. Do you have any knowledge regarding  
10 Mr. Mousser's severe obstructive sleep apnea, which  
11 we've discussed a little bit today?

12 MR. MANDELL: Objection.

13 BY THE WITNESS:

14 A. Just that he had the diagnosis.

15 BY MR. GARAND:

16 Q. Did you know that he had the diagnosis  
17 before this deposition today?

18 A. Yes.

19 Q. Doctor, can you also explain how you're  
20 able to determine that Mr. Mousser will require  
21 lifetime psychological counseling and -- and support?

22 A. That's, again, in his notes from his  
23 psychologist. He's on disability and his psychologist  
24 says that that's what he's -- going to be necessary.

1 Q. And by "his psychologist," do you mean  
2 Dr. Mueller?

3 A. Those are the -- I believe that's the  
4 name.

5 Q. Have you -- did you look at Dr. Roger  
6 Moore's expert opinion in this case?

7 A. Again, I don't remember specifically his  
8 name.

9 Q. Do you recall reviewing an expert  
10 psychologist report on behalf of Mr. Mousser?

11 A. I don't remember that specifically, no.

12 Q. Okay. Doctor, let's look at Jacqueline  
13 Tukes' report, which is Exhibit 8. I'm happy to say  
14 we're done with Mr. Mousser, or at least for a few  
15 minutes.

16 MR. MANDELL: Well, that was quick.

17 MR. GARAND: Yeah, you know.

18 BY MR. GARAND:

19 Q. Okay. Doctor, Ms. Tukes received a  
20 deceased donor kidney transplant, correct?

21 A. Yes, sir, she did.

22 Q. And the transplant occurred on April 23rd  
23 of 2024, is that right?

24 A. I believe that's the right date, April 24,

1       yes.

2           Q.       And she was 59 years old at the time?

3           A.       She was.

4           Q.       Okay. Let's look at Page 3 of your Tukes  
5 report. The first paragraph under heading V?

6           A.       Yes.

7           Q.       The first line all of the way to the  
8 right, you write, "The half-life (mean survival) for  
9 DD transplants is 13 years."

10                  Did I read that correctly?

11           A.       That's correct.

12           Q.       So you'd agree by definition if 13 years  
13 is the median graft survival, that's just an average,  
14 not a maximum, correct?

15           A.       Correct, but it's the mean, not median.

16           Q.       Okay. Okay. Thank you, Doctor.

17                  So it's true that some deceased donor  
18 kidney transplants last well beyond 13 years, is that  
19 right?

20           A.       They do.

21           Q.       So it's a possibility that Ms. Tukes'  
22 transplant can last longer than 13 years, is that  
23 right?

24           A.       I believe it's unlikely based upon the

1       deceased donor that -- that she received and, again,  
2       the facts of -- or the number that we're talking about  
3       here is based upon the quality of all grafts. So I  
4       believe based upon the information that we know about  
5       her graft that it's more likely than not that she'll  
6       have 13 or less years for her kidney transplant.

7           Q.       Delayed graft function is the need for  
8       hemodialysis in the first week after transplant  
9       surgery, right?

10          A.       That's the standard definition, yes, sir.

11          Q.       Delayed graft function is a major risk  
12       factor for early transplant graft loss, is that right?

13          A.       It -- not necessarily. It is a -- a  
14       potential complication that occurs after transplant  
15       that if folks develop delayed graft function that can  
16       then go on to become primary non-function, yes.

17          Q.       Ms. Tukes did not experience delayed graft  
18       function, correct?

19          A.       Not according to the records, no.

20          Q.       And at worst, it's at least not a bad  
21       thing that that happened, correct? It doesn't  
22       negatively impact her prognosis, right?

23          A.       That's correct.

24          Q.       Are you aware that as of January 2025



1 Ms. Tukes had not shown any signs of rejection of the  
2 transplant?

3 A. I'm aware that she didn't show any signs  
4 of acute rejection based upon the fact that she hasn't  
5 had a biopsy.

6 Q. Are there any -- and I appreciate the  
7 distinction between acute and chronic. Thanks for  
8 that clarification, Doctor.

9 Are there any signs that you're aware of  
10 of acute rejection?

11 A. Not that I saw in the medical record.

12 Q. Are you aware that as of January 2025,  
13 Ms. Tukes had not shown any signs of cancer  
14 recurrence?

15 A. Yes, sir, I do not.

16 Q. As of January 2025, none of Ms. Tukes'  
17 healthcare providers had expressed concerns about her  
18 kidney function since the transplant, is that right?

19 A. That's correct.

20 Q. As of January 2025, Ms. Tukes had not had  
21 any issues with infections, is that right?

22 A. She had CMV uremia, so she had some viral  
23 particles in her blood and urine that required a  
24 changing of her immunosuppression.

1 Q. Okay. Were there any other infections  
2 other than that instance?

3 A. Not that I saw.

4 Q. Are you aware of any more recent records  
5 indicating signs of rejection, cancer recurrence, or  
6 infections?

7 A. Not that I am aware of, no.

8 Q. Would you agree that risk of acute  
9 rejection is highest in the first year?

10 A. Highest comparatively to years thereafter,  
11 yes.

12 Q. Would you agree that early transplant  
13 stability is generally associated with better  
14 long-term outcomes?

15 A. As one of the factors that can help  
16 determine long-term outcomes, yes, I do.

17 Q. Acute rejection negatively affects  
18 long-term survival of the graft, is that right?

19 A. Any acute rejection, yes.

20 Q. Are you aware of an instance of -- of  
21 acute rejection since Ms. Tukes' kidney transplant in  
22 April of 2004?

23 A. No.

24 Q. And we're over a year removed from that

1 transplant, correct?

2 A. That's correct.

3 Q. After a kidney transplant, what would you  
4 consider a positive creatinine level?

5 A. One more time? A positive creatinine, you  
6 mean --

7 Q. Yeah, so in terms of, like, what -- that  
8 is demonstrating that the kidney func- -- you know,  
9 the graft and the kidney function is operating well.

10 A. All based upon the kidney -- the quality  
11 of the kidney that the patient received. I'd  
12 certainly like to see creatinines, you know, somewhere  
13 below 1.5 milligrams per deciliter.

14 Q. Okay. And so for the quality of kidney  
15 transplant that Ms. Tukes received, would that same  
16 creatinine level still hold true?

17 A. It would. Again, as we've talked about  
18 before, we're utilizing a poor man's measure of kidney  
19 function in creatinines. We use those only as a  
20 marker for how well we need to -- or closely need to  
21 follow these patients and what to look out for.

22 Q. And, Doctor, I know we've -- we've --  
23 yeah, we've talked about the creatinine and the GFR.  
24 That is the standard -- or what nephrologists rely on

1 and look at to, again, determine endstage kid --  
2 chronic kidney disease, correct?

3 MR. MANDELL: Objection.

4 BY THE WITNESS:

5 A. Post-transplant, yes, but it's a little  
6 different in a post-transplant patient. So very small  
7 changes in creatinine are something we respond to very  
8 aggressively.

9 BY MR. GARAND:

10 Q. Doctor, are you aware of Ms. Tukes'  
11 post-transplant creatinine levels?

12 A. I -- again, what I had in the records that  
13 I reviewed, yes.

14 Q. Are you aware that her creatinine level  
15 was 14 -- was over 14 on the date of her transplant?

16 A. I don't remember that number specifically.  
17 That's probably right.

18 Q. Do you recall that it was high on the --

19 A. It was high.

20 Q. Are you aware that it was below 1 in March  
21 of 2025?

22 A. That sounds about right.

23 Q. Would you agree that creatinine in the  
24 low 1s is generally viewed as a favorable sign for a

1 transplant recipient at her stage?

2 A. At this stage that she's in, yes, I  
3 believe that's a good creatinine.

4 Q. Would you agree that generally patients  
5 with kidney transplants live longer than patients on  
6 dialysis?

7 A. The data supports that, yes.

8 Q. Would you agree that generally patients  
9 with kidney transplants have a better functional  
10 status compared to those patients on dialysis?

11 A. On average, yes.

12 Q. You're aware that Ms. Tukes'  
13 post-transplant nephrologist Heather Jones stated that  
14 Ms. Tukes has a good prognosis in terms of her kidney  
15 function, correct?

16 A. I don't remember that comment  
17 specifically, but I'm -- I'm sure that that's what  
18 their team has said.

19 Q. Doctor, there's no standard age limit for  
20 kidney transplantation, correct?

21 A. It depends on where you are. Different  
22 programs do have absolute age limits for transplant.

23 Q. What would an absolute age limit for a  
24 transplant look like?

1           A.       Some are above 65, some are above 70.

2           Q.       Are you aware of an age limitation in  
3 North Carolina where Ms. Tukes resides?

4           A.       I don't -- I'm not sure what their -- if  
5 they have one.

6           Q.       Is it true that chronological age is less  
7 important than physiologic age?

8           A.       As one -- as one of the factors -- and I  
9 assume we're talking with candidacy for transplant?

10          Q.       Correct.

11          A.       Sure. I mean, if we were to look at one  
12 versus the other, we'd try and take in more than just  
13 a number at our program.

14          Q.       Ms. Tukes does not have diabetes, correct?

15          A.       She does. So she has what's often  
16 referred to as prediabetes or early diabetes and --  
17 and is currently on medication for it.

18          Q.       But not diabetes, not diabetes 1 or 2,  
19 correct?

20          A.       Well, that would be diabetes.

21          Q.       Prediabetes?

22          A.       Yes.

23          Q.       Okay. Does she have a known  
24 cardiovascular disease?

1           A.       I don't know if she has a diagnosis of  
2       cardiovascular disease, no.

3           Q.       Okay. Doctor, I think we've been going  
4       for about an hour. If we can take another quick  
5       break, and then I should be able to wrap up.

6           A.       Okay.

7           Q.       There are just a couple of other topics  
8       that I would like to discuss.

9           A.       Okay.

10          THE VIDEOGRAPHER: Going off the record at  
11       12:20 p.m.

12                       (WHEREUPON, a recess was had  
13                       from 12:20 to 12:27 p.m.)

14          THE VIDEOGRAPHER: We are back on the record at  
15       12:27 p.m.

16       BY MR. GARAND:

17           Q.       Doctor, in each of your reports, and we  
18       can look at -- which one do you have in front of you?

19           A.       I have Tukes still open.

20           Q.       Okay. Let's look at Page 16 of Tukes,  
21       just for ease of reference.

22                       Okay. So Number 2, you write, "The  
23       treatment and care Ms. Tukes has received and is now  
24       receiving is reasonable and medically necessary."

1                   And you write the same thing essentially  
2                   for Mr. Mousser; is that right? And I can --

3                   A.       I do, yes, sir.

4                   Q.       Yeah, it's Page 15 --

5                   A.       Just make sure they're in the same  
6                   order -- yeah.

7                   Q.       What medical treatment are you referring  
8                   to for Ms. Tukes when you make that statement?

9                   A.       The entirety of her medical -- I mean, the  
10                  entirety of her medical. So her -- the fact that --  
11                  and we've discussed some of this. Her treatment for  
12                  her kidney cancers, the -- I guess the ongoing care of  
13                  her while then on dialysis was appropriate, the  
14                  transition to peritoneal dialysis I think is a better  
15                  thing, the kidney transplant certainly is a better  
16                  thing than dialysis and, you know, the care that she  
17                  has received from her transplant team is, again, I  
18                  think reasonable and medically necessary.

19                  Q.       And, Doctor, when you make that statement  
20                  for Mr. Mousser, what medical treatment are you  
21                  referring to for him?

22                  A.       Again, the diagnosis of his cancer, the  
23                  treatment of his ongoing comorbidities, the  
24                  post-nephrectomy management by his team at the VA.



1 I -- you know, I would hesitate in only that  
2 discharging him from a nephrology clinic, I think is a  
3 mistake because, as we've talked about, I still think  
4 he has risks.

5 But, again, I think the fact that he's  
6 receiving care for his comorbidities that we know and  
7 have talked about, potentially reduced the impact of  
8 his injured kidney following a nephrectomy for cancer  
9 that's hyper-filtrating, I -- I think that's  
10 appropriate.

11 Q. Are you aware whether or not Mr. Mousser  
12 has seen a nephrologist since he was discharged by  
13 Dr. Bucci, I believe?

14 A. I -- no, I'm sorry, I don't know that.

15 Q. Doctor, why did you opine on Mr. Mousser's  
16 and Mrs. Tukes' past and future medical treatment?

17 MR. MANDELL: Objection.

18 To the extent that it results from any  
19 conversations that we've had or anybody else from my  
20 office had with you, that I'm instructing you not to  
21 answer. But if you can otherwise answer  
22 independently, please do.

23 BY THE WITNESS:

24 A. So, again, my role as an expert was to

1 look at the totality of the information that I had,  
2 which included the medical records and, as talked  
3 about, some of these depositions, and to determine  
4 whether or not where Ms. Tukes and Mr. Mousser  
5 currently were following their nephrectomy was, you  
6 know, appropriate. And as one has been transplanted,  
7 my area of expertise, and as one as approaching the  
8 need for transplant, was, again, what I believe my  
9 role was in reviewing these records.

10 BY MR. GARAND:

11 Q. Is -- do you typically opine on the  
12 reasonable -- reasonableness and necessity of medical  
13 treatment?

14 MR. MANDELL: Objection.

15 BY THE WITNESS:

16 A. I do, yes.

17 BY MR. GARAND:

18 Q. Okay. Also in each report, again,  
19 Mousser's report Page 15 and Tukes's on Page 16, you  
20 state that the harms and injuries and damages suffered  
21 by Mr. Mousser or Ms. Tukes that are described in this  
22 report are permanent. Is that right?

23 A. Correct.

24 Q. So in regards to Mr. Mousser, when you

1 mention harms, injuries, or damages are permanent,  
2 what harms, injuries, or damages are you referring to?

3 A. He'll never get that kidney back because  
4 of his cancer.

5 Q. Is that the only permanent harm, injury,  
6 or damage?

7 A. And the fact that he has now only one  
8 kidney and all of the things that we continue to talk  
9 about, the hyper-filtration of that kidney that has to  
10 work, and an individual who has multiple comorbidities  
11 that we know cause and worsen chronic kidney disease,  
12 to my opinion, stated earlier, it is expected that  
13 kidney is going to be long lost in three to five  
14 years.

15 Q. And Mr. Mousser's VA nephrologists have  
16 described his chronic kidney disease as stable CKD  
17 Stage G3a A1, correct?

18 MR. MANDELL: Objection.

19 BY THE WITNESS:

20 A. That's -- that's their statement.

21 BY MR. GARAND:

22 Q. And his hypertension according to his  
23 VA -- his VA -- I guess, yeah, his VA team as well as  
24 his cardiology team at South Texas -- South Texas

1 Cardiovascular Consultants have found that his  
2 hypertension is well controlled as well, correct?

3 MR. MANDELL: Objection.

4 BY THE WITNESS:

5 A. Currently, yes, but at times borderline.

6 BY MR. GARAND:

7 Q. And what are the permanent harms,  
8 injuries, or damages suffered by Ms. Tukes?

9 A. So Ms. Tukes is now absent two kidneys,  
10 you know, secondary to the -- the cancer and the  
11 bilateral nephrectomies, completion nephrectomies that  
12 were necessary for the identification and treatment.  
13 She then has the risk associated with long-term  
14 immunosuppression that increases both infections and  
15 malignancies. And we know despite the fact that her  
16 lifespan is better than dialysis, it still is reduced  
17 because of the need to receive renal replacement  
18 therapy.

19 Q. Doctor, on Page 16 of both reports, you  
20 also found that the care costs Mr. Mousser or  
21 Ms. Tukes incurred for past treatment and care are  
22 fair, reasonable, and medically necessary, is that  
23 right?

24 A. That's correct.

1           Q.       What -- for Mr. Mousser, what is the --  
2       what's the past treatment that you're referring to?

3           A.       Again, as we talked about before, his, you  
4       know, identification of his cancer, the workup of  
5       that, the nephrectomy, the post-transplant care, you  
6       know, all of that that leads us up to today.

7           Q.       And what's the past treatment that you're  
8       referring to for Ms. Tukes?

9           A.       And, again, the identification of the  
10      multiple renal cancers that led to her bilateral  
11      nephrectomies, the interventions and the postsurgical  
12      care that was necessary for that, her institution of  
13      dialysis, both in center and then home peritoneal  
14      dialysis, and the successful transplant in 2024 and  
15      the management of that allograft thereafter.

16          Q.       What methodology did you use to determine  
17      that their medical bill -- bills were fair,  
18      reasonable, and medically necessary?

19          MR. MANDELL:  Objection.

20      BY THE WITNESS:

21          A.       I received a copy of their medical bills  
22      and just briefly reviewed all of those.  And, again,  
23      based upon what we just talked about and, you know,  
24      again, a cursory comparison of those activities that I

1 believe were appropriate and what those billings were,  
2 I came to that conclusion.

3 BY MR. GARAND:

4 Q. In your practice as a transplant surgeon,  
5 do you typically review medical bills?

6 MR. MANDELL: Objection.

7 BY THE WITNESS:

8 A. As a transplant surgeon. Can you ask that  
9 one more time?

10 BY MR. GARAND:

11 Q. Sure. In your practice --

12 A. Yeah.

13 Q. -- as a transplant surgeon, are you  
14 ordinarily responsible for evaluating and reviewing  
15 medical bills?

16 MR. MANDELL: Objection.

17 BY THE WITNESS:

18 A. Not routinely, but if asked to. So I --  
19 I -- as the chief of this division, I'm routinely  
20 asked to look at finances, and those include sometimes  
21 patients who are sort of dissatisfied with the cost of  
22 their care.

23 BY MR. GARAND:

24 Q. And how often do you review the -- you

1 know, the bills for the patients that are dissatisfied  
2 with their care?

3 A. Maybe one or two a year.

4 Q. Does your hospital have a separate  
5 department that manages medical billing to patients?

6 A. We do.

7 Q. Do you oversee that office at all?

8 A. I do not.

9 Q. In prior cases where you served as an  
10 expert witness, have you opined on whether a party's  
11 medical bills were reasonable and medical -- medically  
12 necessary?

13 A. I don't recall. I'm sorry, I don't.

14 Q. So you don't know one way or the other  
15 whether you have?

16 A. I don't recall. I don't know.

17 Q. It's not a part of your typical practice  
18 as an expert?

19 MR. MANDELL: Objection.

20 BY THE WITNESS:

21 A. Different asks are -- you know, have  
22 different requests. So I -- I've been asked in the  
23 past, but I don't know the frequency.

24 BY MR. GARAND:

1 Q. Okay. If we look at your initial -- and  
2 we don't -- we don't have to, but your initial MCL for  
3 Mr. Mousser, which is Cooper Exhibit 1.

4 A. MCL?

5 Q. Yes.

6 A. Oh, gosh, I've got to find one.

7 Q. I know, we're going -- going back there.

8 MR. MANDELL: I've got it right here for you.

9 THE WITNESS: God bless you. Thank you, thank  
10 you.

11 BY MR. GARAND:

12 Q. And if we look at Page 3.

13 A. Yes, sir.

14 Q. And we look at Number 10, it states that,  
15 "Frank W. Mousser's medical expenses," and then you --  
16 sorry. And so this is what you've reviewed and what  
17 you considered. And it says, "Frank W. Mousser's  
18 medical expenses," and you list some Bates numbers  
19 there, right?

20 A. Yes, sir.

21 Q. If we look at this, the first range, you  
22 have Bates ending in 07362 to 7336. That doesn't seem  
23 to make sense to me in terms of just -- is -- do  
24 you -- do you recall or know what those Bates should



1 have been?

2 A. I don't, sir, I'm sorry.

3 Q. Okay. And I'll show --

4 A. That's obviously a misprint.

5 Q. -- you these records. Sure.

6 Do these two Bates ranges that you list  
7 here include all of the invoices that you are aware of  
8 for Mr. Mousser's past medical expenses?

9 A. I don't know that for sure.

10 Q. Okay. As you're sitting here right now,  
11 though, you are not aware of any or -- and I'm going  
12 to show you these medical records, but you're not  
13 aware of any other outstanding invoices that you're  
14 providing this opinion on?

15 A. Not that I'm aware of, no.

16 Q. Okay. Let's see. We'll mark this as  
17 Cooper Exhibit 25.

18 (WHEREUPON, a certain document was  
19 marked Dr. Cooper Deposition Exhibit  
20 No. 25, for identification, as of  
21 07/10/2025.)

22 BY THE WITNESS:

23 A. Thank you.

24 BY MR. GARAND:

1           Q.     And, Doctor, I'll allow you to review that  
2     briefly and let me know if you've seen these records  
3     before.

4                     And just for the record, this is that  
5     first subset of records that you listed, which is  
6     00667\_MOUSSER\_07336 through 07362. I wasn't  
7     100 percent sure what records, so I just included all  
8     of them.

9           A.     I don't remember these specifically, sir,  
10    but, again, I had all of the information that was in  
11    materials reviewed in my possession.

12          Q.     Okay. So let's start at the very  
13    beginning, and I apologize that some of these numbers  
14    are cut off, but we should be able to work through  
15    them here.

16                    I'll ask that you flip through 07336  
17    through 07356, so about those first 20 pages here, and  
18    then I'll ask you a few questions whenever you are  
19    ready.

20          A.     Okay.

21          Q.     Okay. So anything that you just saw from  
22    7336 to 7356, are any of those invoices?

23          A.     No.

24          Q.     And these are treatment records from the

1 Franklin Clinic, is that correct?

2 A. They are.

3 Q. Are you aware of Mr. Mousser being treated  
4 for his kidney cancer at the Franklin Clinic?

5 A. I don't believe so, no.

6 Q. And I'll note, if you look at the dates,  
7 they are from 2012 to 2015. Did Mr. Mousser have  
8 kidney cancer during those dates, during those years?

9 A. I don't -- it certainly wasn't diagnosed  
10 at that time.

11 Q. You're aware that he had gross hematuria  
12 in 2017, correct?

13 A. I do recall that, yes.

14 Q. And he had a workup at that time, right?

15 A. He did.

16 Q. And there was no -- he did not have cancer  
17 at that time, correct?

18 A. There was no diagnosis made of cancer, no,  
19 not at that time.

20 Q. Okay. So if we look at 7357 through 7361.  
21 Take a minute to review those and let me know when  
22 you're ready.

23 A. Okay.

24 Q. So these are invoices from May of 2021,

1 and if you just look through -- sorry, from May 17 --  
2 of 2017 through May of 2021, is that right? Do you  
3 see any dates outside of that?

4 A. Tell me those dates again, I'm sorry, what  
5 you said.

6 Q. May of '17 through May of 2021.

7 A. Yes, I see that.

8 Q. Mr. Mousser wasn't diagnosed with kidney  
9 cancer until late August and September of 2020, is  
10 that right?

11 A. Correct.

12 Q. And he had no treatment for the kidney  
13 cancer until October 2020 when he had his  
14 nephroureterectomy, is that right?

15 A. That's correct.

16 Q. And that was done at VA, a VA facility?

17 A. It was, yes, sir.

18 Q. And his postsurgery treatment for the  
19 medical conditions, you know, his kidney cancer,  
20 chronic kidney disease, that's all been done at VA as  
21 well, right?

22 A. It has, yes.

23 Q. Do you have any knowledge that he was  
24 treated at the Franklin Clinic for his kidney cancer?

1 A. No.

2 Q. So you would agree that these medical  
3 records are unrelated to Mr. Mousser's UTUC treatment?

4 A. That's correct.

5 Q. They're also unrelated to his second  
6 bladder cancer diagnosis in 2025, correct?

7 A. That's correct.

8 Q. Why did you include invoices from the  
9 Franklin Clinic in your Materials Considered List as  
10 evidence of Mr. Mousser's medical expenses?

11 A. They were the wrong numbers.

12 Q. Okay. So these -- these are all incorrect  
13 then?

14 MR. MANDELL: Objection.

15 BY THE WITNESS:

16 A. These -- these are the incorrect records.

17 BY MR. GARAND:

18 Q. Okay.

19 MR. MANDELL: And just so it's clear for the  
20 record, you're talking about Exhibit No. 25?

21 THE WITNESS: Correct, Exhibit 25.

22 MR. GARAND: Thank you, Mr. Mandell.

23 BY MR. GARAND:

24 Q. Okay. I'm going to show you what I hope

1 is our last exhibit here.

2 A. Erick is cheering over there.

3 Q. He -- he's excited.

4 And we are going to mark it as Cooper  
5 Exhibit 26.

6 (WHEREUPON, a certain document was  
7 marked Dr. Cooper Deposition Exhibit  
8 No. 26, for identification, as of  
9 07/10/2025.)

10 BY THE WITNESS:

11 A. Thank you.

12 BY MR. GARAND:

13 Q. Thank you.

14 Doctor, I'll represent to you that this is  
15 the second set of Bates ranges that's listed in your  
16 initial Materials Considered List for Mr. Mousser and  
17 it's Bates-stamped 00667\_MOUSSER\_08702 through 8732.

18 A. Okay.

19 Q. And, again, Mr. Mousser was not diagnosed  
20 with kidney cancer until August or September of 2020,  
21 correct?

22 A. Yes, sir.

23 Q. And his nephroureterectomy was in  
24 October of 2020, right?

1 A. Yes, sir.

2 Q. Okay. And if you flip through these  
3 records, they're all from the -- from Peterson Health,  
4 is that right?

5 A. Yes, that appears correct.

6 Q. And as we discussed, all of Mr. Mousser's  
7 care for his kidney cancer and related disabilities  
8 was done at VA, correct?

9 A. That's correct.

10 Q. Okay. So let's look at Pages 8 -- Bates  
11 ending in 08702 through 14, 8 -- 087114. And  
12 specifically, Doctor, I'll ask you to look at the  
13 dates of those invoices, and so please take your time  
14 reviewing.

15 A. Okay.

16 Q. These invoices are all from 2012 to 2019,  
17 correct?

18 A. That's correct.

19 Q. And he was not diagnosed -- Mr. Mousser  
20 was not diagnosed with kidney cancer until 2020,  
21 right?

22 A. Yes, sir.

23 Q. So can we agree that all of those records,  
24 meaning Bates ending in 08702 through 08714 predate

1 his kidney cancer diagnosis, right?

2 A. Yes, sir, that's correct.

3 Q. Can you tell me why you included these  
4 invoices, please?

5 A. I believe these are the wrong Bates  
6 numbers also.

7 Q. Okay. So let's look at Bates ending in  
8 08715 -- well, actually, Doctor, so can you look  
9 through those records and tell me what the correct --  
10 if any of them are the correct invoices that you meant  
11 to cite?

12 A. No, these I believe are the wrong Bates  
13 numbers.

14 MR. MANDELL: Up to 14, you're talking about?

15 THE WITNESS: Yeah, I looked --

16 MR. GARAND: Well, so I'm asking for the  
17 entire --

18 THE WITNESS: I looked through the rest of them.

19 MR. MANDELL: Okay. Fine.

20 BY THE WITNESS:

21 A. Yeah, I did. These are, I think, are  
22 the -- the wrong Bates numbers and the wrong records.

23 BY MR. GARAND:

24 Q. Can you describe to me what the right



1 records were? Again, most of Mr. Mousser's treatment  
2 for his cancer, I think all of his treatment for his  
3 cancer and other disabilities or other conditions have  
4 been at VA at no cost to Mr. Mousser. So I'm curious  
5 what the records you meant to -- to cite were.

6 A. So, yeah, it has been a while since I  
7 looked at those. So I had records that were shared  
8 with me that I'm -- I don't remember exactly where  
9 they were from, but, they, again -- they -- they were  
10 costs associated with care. I don't believe they were  
11 all from the VA. I think they were from other  
12 locations.

13 Q. Do you --

14 A. But I'm sorry, I don't remember  
15 specifically what those were.

16 Q. Okay. Doctor, you've testified at  
17 deposition or trial before, right?

18 A. I have, sir, yes.

19 Q. Okay. Let's look at -- let's look at  
20 Cooper Exhibit 7, which is Mr. Mousser's report, and  
21 I'm looking at the very -- let's see -- last page.

22 THE VIDEOGRAPHER: Mr. Mandell, your microphone.

23 BY THE WITNESS:

24 A. Mr. Mousser's, sir, the last?

1 BY MR. GARAND:

2 Q. Yes, the very last page which is a list of  
3 your testimony history, is that right?

4 A. Yes, sir.

5 Q. Have you ever served as an expert in a  
6 case on behalf of the United States?

7 A. I have not.

8 Q. Have you ever served as an expert in a  
9 case against the United States?

10 A. No, sir.

11 Q. Is this an accurate list of the cases in  
12 which you provided a deposition or trial testimony?

13 A. I'm looking at the wrong thing. Oh, at  
14 the end of my CV.

15 Q. Sorry about that.

16 A. Yes, I apologize. It is, yes. I  
17 apologize.

18 Q. So is the first time you served -- was  
19 August 2018 the first time you served as an expert, or  
20 is that just the first listed?

21 A. That -- it's the first listed. I  
22 believe -- I believe I began expert review soon after  
23 the completion of my fellowship, so in the mid 2000s.

24 Q. Doctor, I'll just ask generally, are

1       these -- are they predominantly one kind of case, like  
2       medical malpractice or anything like that?

3           A.       Predominantly, yes.

4           Q.       Medical malpractice?

5           A.       Correct.

6           Q.       Can you identify which cases are not  
7       medical malpractice?

8           A.       On -- on this list?

9           Q.       Yes, to the extent you remember.

10          A.       I believe these are all medical  
11       malpractice cases.

12          Q.       Okay. Have you provided testimony either  
13       at deposition or at trial in a toxic or environmental  
14       tort case other than this one?

15          A.       No, sir, I have not.

16          Q.       In any of these cases did you provide an  
17       opinion as to someone's chronic kidney disease,  
18       prognosis or whether they'll require a transplant or  
19       dialysis?

20          A.       Yes.

21          Q.       Okay. Do you recall which ones those are?

22          A.       I'm sorry, any of these cases?

23          Q.       Any of these cases.

24          A.       I'll have to look at these. But I've

1 certainly reviewed cases that have asked that  
2 question. I don't know whether they actually went to  
3 deposition or to trial.

4 I'm sorry, sir, this is so long ago I  
5 don't remember these specifically as to whether or not  
6 that was the issue in question.

7 Q. Do you recall generally what your opinions  
8 were in those cases?

9 A. I don't recall that either. It has been a  
10 long time.

11 Q. Doctor, have you ever been involved in  
12 litigation in your personal capacity?

13 A. No.

14 Q. Okay. Doctor, if we could just take a  
15 two-minute break, I should be able to wrap up and then  
16 I'll hand it over to Mr. Mandell.

17 A. Thank you.

18 MR. MANDELL: We're just going to stay.

19 MR. GARAND: We'll step out real quick. I'm  
20 just going to chat and then we'll be good.

21 THE VIDEOGRAPHER: Going off the record at  
22 12:50 p.m.

23 (WHEREUPON, a recess was had  
24 from 12:50 to 12:53 p.m.)

1 THE VIDEOGRAPHER: We are back on the record at  
2 12:53 p.m.

3 MR. GARAND: All right. Doctor, I have no  
4 further questions. I appreciate your time this  
5 afternoon -- or this morning.

6 THE WITNESS: Thank you. Thank you very much.

7 MR. MANDELL: I just have one question --  
8 actually maybe two.

9 EXAMINATION

10 BY MR. MANDELL:

11 Q. Dr. Cooper, you were asked questions about  
12 creatinine levels after Mr. Mousser's nephrectomy in  
13 terms of whether they were normal and/or reassuring.

14 Do you have an opinion to a reasonable  
15 degree of medical certainty as to whether or not the  
16 creatinine levels that were identified for Mr. Mousser  
17 after his nephrectomy were normal and/or reassuring?

18 So the first question is, do you have an  
19 opinion to a reasonable degree of medical certainty  
20 about that subject, yes or no?

21 A. I do.

22 Q. All right. What is that opinion to a  
23 reasonable degree of medical certainty?

24 A. So, again, my opinion is, and the

1 definition of normal, if we want to use what's  
2 considered the standard reference values for normal  
3 creatinine, above 1.3 we can consider that to be  
4 abnormal. And the majority of Mr. Mousser's  
5 creatinines were almost all above that.

6 And I'm -- I guess I'm shocked when we  
7 talked about the -- the various individuals that  
8 provided care for Mr. Mousser after that, with all of  
9 the things that really everybody knows about the  
10 inaccuracies of creatinine plus all of the additional  
11 information that is readily available to utilize that  
12 abnormal number and get a true assessment of that  
13 remaining kidney, i.e., the -- the fact that that  
14 kidney is having to work much harder than a single  
15 kidney -- or sorry, than two kidneys would have to,  
16 the fact that we have a pathology report that shows  
17 that there's some underlying damage based upon his  
18 comorbidities, I mean, all of that information to me  
19 is demonstrable of an abnormal kidney.

20 I take care of a lot of people who have a  
21 kidney removed. We asked earlier about can people  
22 live a normal life with a single kidney. We're --  
23 we're blessed that we have living donors that want to  
24 come forward and they want to donate a kidney, and we

1 do all of those tests. We measure their GFR, we check  
2 for protein in the urine, and we clear them to donate  
3 an organ.

4 And then they donate a kidney and their  
5 kidney, yes, it does hyper-filtrate for a short period  
6 of time and corrects and they go back to have a normal  
7 creatinines. They have creatinines of .9, 1.0. They  
8 have no evidence of albuminuria. But we have -- if  
9 there's ever any question, we even biopsy people that  
10 want to donate a kidney because that's the -- the --  
11 the gold standard of what the kidney looks like  
12 regardless of a normal creatinine.

13 And I've also been blessed, you know, we  
14 have a number of people who are deceased donors, and  
15 the majority of them have normal creatinines, but when  
16 you go in and remove their kidney and look at it under  
17 the microscope, because we often take a biopsy, you  
18 see that they have significant injury and we can't use  
19 those kidneys.

20 So even in the face of a normal  
21 creatinine, we're saying those kidneys are not better  
22 than people being on dialysis.

23 Q. Okay.

24 A. Because we know that they aren't going to

1 do well.

2 MR. MANDELL: I have no further questions.  
3 Thank you.

4 MR. GARAND: Yeah, no further questions.

5 MR. MANDELL: Great.

6 THE VIDEOGRAPHER: Going off the record at  
7 12:56 p.m. That concludes today's testimony of  
8 Dr. Cooper.

9 ---

10 Thereupon, at 12:56 p.m., on Thursday,  
11 July 10, 2025, the deposition was concluded.

12 ---

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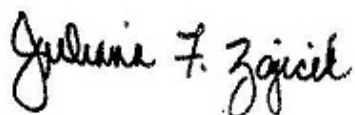
REPORTER'S CERTIFICATE

I, JULIANA F. ZAJICEK, a Registered Professional Reporter and Certified Shorthand Reporter, do hereby certify that prior to the commencement of the examination of the witness herein, the witness was duly sworn by me to testify to the truth, the whole truth and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a verbatim transcript of the testimony as taken stenographically by me at the time, place and on the date hereinbefore set forth, to the best of my availability.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not interested directly or indirectly in the outcome of this action.

IN WITNESS WHEREOF, I do hereunto set my hand on this 22nd day of July, 2025.



JULIANA F. ZAJICEK, Certified Reporter

DEPOSITION ERRATA SHEET

Assignment No. 7450002

Case Caption: In Re: Camp Lejeune Water Litigation

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me, and the same is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

MATTHEW COOPER, MD

SUBSCRIBED AND SWORN TO

before me this                      day  
of                                      , A.D. 20\_\_.

Notary Public

DEPOSITION ERRATA SHEET

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MATTHEW COOPER, MD

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MATTHEW COOPER, MD

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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