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

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

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Job No. 7450002

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

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ALSO PRESENT:

LEXI DOROTINSKY, (Via Zoom)
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THE VIDEOGRAPHER:

STEPHAN HOOG,
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I N D E X

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E X H I B I T S

E X H I B I T S

DR. COOPER EXHIBIT		MARKED FOR ID
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
No. 16	Progress note dated 7/19/2022; 0667_MOUSSER_VHA_0000000327 - 333	131
No. 17	Progress note dated 12/11/2023; 0667_MOUSSER_VHA_0000000111 - 112	134
No. 18	Progress note dated 12/15/2023; 0667_MOUSSER_VHA_0000000097 - 103	138
No. 19	Pages 1, 101 - 103 and 118 of Andrew P. Rockwood, MD, deposition transcript from 7/24/24	144
No. 20	Progress notes dated 11/8/2024; 0667_MOUSSER_VHA_0000001631 - 1638	153
No. 21	Medical records from South Texas Cardiovascular Consultants, dated 4/6/2016; 0667_MOUSSER_STCC_0000000078 - 80	157

E X H I B I T S

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

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

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

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

The deponent today is Dr. Matthew Cooper.

Counsel will be noted on the stenographic record.

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

(WHEREUPON, the witness was duly sworn.)

THE VIDEOGRAPHER: Please proceed.

MATTHEW COOPER, MD,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. GARAND:

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

represent the United States in this matter.

Do you understand that?

A. I do.

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

A. Matthew Cooper.

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

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

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

A. I have.

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

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

A. I do.

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

A. I do.

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

A. I understand.

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

A. Thank you.

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

A. Okay.

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

A. Okay.

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

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

A. I understand.

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

A. Understood.

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

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

A. No.

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

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

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

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

THE WITNESS: Understood.

MR. MANDELL: Thank you.

BY THE WITNESS:

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

BY MR. GARAND:

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

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

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

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

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

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

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

A. The last couple of weeks.

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

A. That's correct.

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

A. Video conference, Zoom.

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

A. No.

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

A. No.

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

A. No.

Q. How did you first become aware of the Camp Lejeune Water Litigation?
A. I was contacted by Mr. Mandell.
Q. So Mr. Mandell was the -- the person who first contacted you about working in this litigation?
A. Yes, that's correct.
Q. Do you recall when you were first contacted by Mr. Mandell?
A. Boy, I just don't remember the specifics. It was last year, summertime perhaps.
Q. Okay. So summer of 2024?
A. That sounds about right.
Q. Were you provided with any information during this initial contact?
A. No, just conversation.
Q. So you had been hired as an expert witness in this matter, right?
A. Yes, that's correct.
Q. You did not execute a retainer agreement with the plaintiffs' leadership group or any of the plaintiffs regarding this liti- -- litigation, though, right?
A. That's correct.
Q. Is that typical practice for you when

you're providing expert services?
A. Yes, sir.
Q. Do you recall when you were formally retained then?
A. I'm sorry, I don't.
Q. Presumably after that summer of 2024 conversation?
A. Correct, sometime after that conversation.
Q. Do you recall if it was, you know, pretty quick after, if it was a couple of months later?
A. I believe it was pretty quickly after.
Q. And is it Mr. Mandell's firm that retained you?
A. Yes.
Q. Did you perform any work in connection with the Camp Lejeune Water Litigation prior to being formally retained?
A. No.
Q. What did you -- what was your assignment in this matter?
MR. MANDELL: Objection. Again, anything that comes from me or anybody in my firm to you is privileged. You're not to answer that. If you can otherwise explain it, perhaps in terms of what you

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

BY THE WITNESS:

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

BY MR. GARAND:

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

A. No.

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

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

THE WITNESS: Thank you.

MR. MANDELL: Thank you.

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

THE COURT REPORTER: Sure.

BY MR. GARAND:

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

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

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

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

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

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

(WHEREUPON, a certain document was

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

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

MR. MANDELL: Okay. Thank you.

BY MR. GARAND:

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

A. Not that I'm aware of.

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

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

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

A. Counsel prepared these.

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

A. Well, there's a lot on here.
Q. There is.
A. I believe they are. They -- they look complete to the best of my knowledge, but, again, I'm uncertain of the totality of all of the documents that were provided to me and currently in the DropBox that I think we have available.
Q. And we'll go through some of those, but if there are any documents we've discussed that are either not on those or you don't recall reviewing, certainly let me know.
A. Okay.
Q. Are there any documents that you reviewed but decided not to rely on?
A. I am -- oh, boy. I'm sorry, I don't remember that. I'd say I reviewed a lot in here. I can't remember exactly which pieces from sort of what part of this, you know, were used in creating my expert testimony.
Q. So, Doctor, according to -- to your Materials Considered List, you reviewed over 35,000 documents for Mr. Mousser's case.
Does that sound about right to you?
MR. MANDELL: Objection. Go ahead.

BY THE WITNESS:

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

BY MR. GARAND:

Q. Could you --

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

MR. GARAND: Thank you, Mr. Mandell.

BY THE WITNESS:

A. What's actually listed in these documents.

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

BY THE WITNESS:

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

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

MR. MANDELL: Yeah, and --

THE WITNESS: Point taken.

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

MR. GARAND: Thank you.
MR. MANDELL: Okay.
BY MR. GARAND:
Q. So according to your Materials Considered Lists, you reviewed over 15,000 documents for Ms. -- Ms. Tukes' case.
Does that sound about right to you?
MR. MANDELL: Objection.
BY THE WITNESS:
A. Same answer to the last question. I -- I believe what's in Exhibits 1 through 4, yeah, was inclusive of what was put before me.
BY MR. GARAND:
Q. And I'll represent to you my math is not great. Addition is about the extent of it, but -- but that is, you know, if you total up the amount of records in there, that's about what that looks like, about 35,000 dollars -- 35,000 documents for Mr. Mousser and 15,000 pages of records for Ms. Tukes, okay?
MR. MANDELL: Objection.
BY MR. GARAND:
Q. Doctor, did you actually review all of those records?

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

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

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

BY THE WITNESS:

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

BY MR. GARAND:

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

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

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

BY MR. GARAND:

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

A. Yes, it is.

Q. And, Doctor, what is it?

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

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

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

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

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

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

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

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

A. Approximately, yes.

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

A. That's correct, yes.

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

A. I have, yes.

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

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

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

just for -- by "this case" --

A. Yeah.

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

A. I'd say approximately 20 additional hours.

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

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

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

A. Yes, I plan to.

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

BY MR. GARAND:

Q. So just ballpark again, over the last

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

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

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

A. (Nodding head).

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

A. Three or four hours.

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

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

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

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

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

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

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

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

A. Yeah.

Q. And the remainder is record review?

A. Yes.

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

Do you see that bolded and underlined there?

A. I do.

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

A. That's correct.

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

A. That's correct.

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

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

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

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

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

A. That's correct, yes.

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

is that right?

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

Q. Oh.

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

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

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

A. Correct.

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

Is that right?

A. That's what it says, yes.

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

A. Correct.

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

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

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

A. I don't recall.

Q. Do you know who Mr. Mercer is?

A. I don't, no.

Q. Do you know who Dr. Rockwood is?

A. No.

Q. Do you know who Dr. Flood is?

A. I don't recall.

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

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

A. Thank you.

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

A. No.

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

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

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

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

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

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

BY MR. GARAND:

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

A. I do.

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

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

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

MR. MANDELL: Objection.

BY MR. GARAND:

Q. Go ahead.

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

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

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

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

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

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

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

A. Correct.

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

A. Correct.

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

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

I don't remember the specifics.

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

MR. MANDELL: Objection; go ahead.

BY THE WITNESS:

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

BY MR. GARAND:

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

What does this refer to?

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

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

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

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

compensation have you received to date in this case?

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

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

A. That's correct.

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

A. No, it does not.

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

A. Less than 1 percent.

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

A. Yes, sir, most recently.

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

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

MR. GARAND: Thank you.

THE WITNESS: Thank you.

MR. GARAND: Thank you.

BY MR. GARAND:

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

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

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

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

Q. Thank you, Doctor.

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

A. It does.

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

A. That's correct.

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

A. Yes.

Q. Do you recall approximately how many cases

that's been?

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

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

A. No.

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

A. Not to my knowledge.

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

A. Not to my knowledge.

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

A. Not to my knowledge.

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

A. Not to my knowledge.

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

A. Not to my knowledge.

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

A. National.

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

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

MR. GARAND: Thank you, Erick.

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

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

BY MR. GARAND:

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

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

A. It is two-sided?

Q. Yes.

A. Yes.

MR. MANDELL: Off the record.

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

BY MR. GARAND:

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

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

Q. Thank you, Doctor.

Do you recognize this document as your CV?

A. I do, yes.

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

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

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

A. Yes.

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

A. It is.

Q. Does this document contain all of your publications?

A. It does.

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

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

BY MR. GARAND:

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

MR. MANDELL: Thank you.

BY THE WITNESS:

A. No.

BY MR. GARAND:

Q. Okay. Doctor, if we look at Page 1 of your CV, you are a transplant surgeon, is that right?
A. Yes, sir.
Q. And your residency was in general surgery?
A. It was.
Q. And your fellowship was in transplant surgery, right?
A. Yes, sir.
Q. You are a board certified -- or sorry, you are board certified in surgery only, is that right?
A. Board certified general surgery, yes, sir.
Q. What is your current role?
A. So I am the division chief for the division of transplantation here at the Froedtert Memorial Lutheran Hospital. I am also the director for the service line for Froedtert and for Children's Hospital overseeing all of the adult and the pediatric transplant programs.
Q. Doctor, you mentioned overseeing. Do you still see patients directly?
A. I do.
Q. Do you still perform surgeries?
A. I do.
Q. So can you tell me just generally what

does a transplant surgeon do?

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

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

A. Pre- and post-transplant, correct.

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

A. I do.

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

A. Can you ask that again, please?

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

you be treating that type of patient?

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

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

A. It is.

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

A. Yes, I would.

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

A. Yes, sir.

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

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

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

A. Currently kidney and pancreas transplantation.

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

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

Q. Do you see any other kind of patients?

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

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

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

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

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

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

A. Can you be more specific? Any diagnosis?

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

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

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

MR. MANDELL: Objection.

Go ahead.

BY THE WITNESS:

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

BY MR. GARAND:

Q. My apologies.

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

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

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

A. Okay.

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

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

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

MR. MANDELL: Objection.

Go ahead.

BY THE WITNESS:

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

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

BY MR. GARAND:

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

A. Typically, yes.

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

A. Not often, no.

Q. And why is that?

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

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

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

A. No.

Q. You are not an epidemiologist, right?

A. No, sir.

Q. And you are not a geneticist, right?

A. No, sir.

Q. You're not a toxicologist, right?

A. No, sir.

Q. You're not an oncologist, right?

A. No, sir.

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

A. No, sir.

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

A. No, sir.

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

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

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

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

A. No, sir.

Q. You have no degrees in pharmacology, correct?

A. No, sir.

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

A. No, sir.

Q. You have no degrees in occupational medicine?

A. No, sir.

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

A. No, sir.

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

A. I have not.

Q. Have you ever met them or spoken with

them?

A. I have not.

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

A. No, sir.

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

A. No, sir.

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

A. Guarantees, no, no.

Q. And why is that?

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

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

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

Q. And why is that?

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

Q. Would the treatment and -- or diagnosis,

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

A. Can you say that again, please?

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

MR. MANDELL: Objection; form.

BY THE WITNESS:

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

BY MR. GARAND:

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

MR. MANDELL: Objection.

Go ahead.

BY THE WITNESS:

A. We do.

BY MR. GARAND:

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

MR. MANDELL: Objection; go ahead.

BY THE WITNESS:

A. Not often.

BY MR. GARAND:

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

A. Prognosis. Yes, we do.

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

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

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

right?

A. That's part of it, yes.

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

A. That's correct.

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

A. In general, yes.

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

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

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

A. No. It's actually not accurate.

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

A. Because it's easy to obtain.

Q. And why is it not accurate?

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

pretty easily with many different interventions.

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

A. No.

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

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

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

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

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

A. We do.

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

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

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

A. Comparatively, it does.

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

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

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

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

A. Not that I saw, no.

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

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

A. That's correct.

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

A. That's correct.

Q. And this represents normal kidney function, correct?

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

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

A. That's correct.

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

A. That's correct.

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

A. Correct.

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

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

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

A. That's correct.

Q. And this represents moderate to severe reduction in kidney function, right?
A. It does.
Q. And CKD Stage 3b is when you stated you typically will begin seeing patients who may need surgery, a transplant surgery, in the future, right?
A. We'd hope to, yes.
Q. CKD Stage 4 is a GFR between 15 to 29, right?
A. That's correct.
Q. And this represents severe reduction in kidney function, correct?
A. It does, yes.
Q. And then finally, CKD Stage 5 is a GFR of less than 15, is that right?
A. That's correct.
Q. And this represents kidney failure, correct?
A. Endstage renal disease.
Q. And so whenever somebody gets to Stage 5, that's typically when they would require either dialysis or a kidney transplant, right?
A. At some point with endstage. Some people can be in Stage 5 for a period and not need either of

those.

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

A. That's correct.

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

A. Stage 3, no.

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

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

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

A. In my practice, yes.

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

A. Yes.

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

A. I do.

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

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

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

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

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

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

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

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

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

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

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

A. We do.

Q. And this is called ACR, right?

A. Albumin creatinine ratio, yes.

Q. Thank you.

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

A. That's right.

Q. And that's classified as A1?
A. Correct.
Q. An ACR of 30 to 300 milligrams of albumin per gram creatine is classified as A2, right?
A. Yes, sir.
Q. And an ACR of more than 300 milligrams of albumin per gram creatinine is A3, right?
A. Yes.
Q. Proteinuria refers to elevated levels of protein in the urine, right?
A. Yes, sir.
Q. And albu- -- albuminuria refers to elevated levels of albumin in the urine, right?
A. That's correct.
Q. And albumin is just an example of a specific protein, right?
A. That's correct.
Q. Is albumin the most -- the protein most likely to appear in the urine?
A. It is.
Q. Is it sometimes -- or is proteinuria and albuminuria, are sometimes those named interchanged?
A. Mistakenly, but yes.
Q. Thank you, Doctor.

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

A. That's correct.

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

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

Q. What are some of those other variables?

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

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

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

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

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

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

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

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

Q. Thank you, Doctor.

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

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

Q. And CKD stage is also important because

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

A. One of many.

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

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

Q. And why do you do that, Doctor?

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

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

function?

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

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

A. Yes.

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

A. I am.

Q. Do you ever use it in your practice?

A. I don't.

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

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

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

MR. MANDELL: Objection.

Go ahead.

BY THE WITNESS:

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

BY MR. GARAND:

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

A. We don't find that valuable.

Q. And why not?

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

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

A. Two most common, correct.

Q. Thank you.

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

A. Yes, sir.

Q. A person will not require dialysis simply

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

A. Can you ask that again, please?

Q. So, yes.

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

A. That's correct.

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

A. That's correct.

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

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

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

MR. MANDELL: Perfect.

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

(WHEREUPON, a recess was had

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

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

BY MR. GARAND:

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

A. Transplant patient?

Q. Yes.

A. Yes, sir. Yes.

Q. Thank you.

How many doctors are typically on that team?

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

Q. Correct, a single patient?

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

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

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

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

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

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

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

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

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

A. That's correct.
Q. Is it accurate that you won't be testifying on -- as to the cause of Ms. Tukes or Mr. Mousser's cancers?
A. That's correct.
Q. Is it accurate that you won't be testifying or providing an opinion on the toxins present in the water at Camp Lejeune?
A. That's correct.
Q. Is it also accurate that you won't be testifying or providing an opinion on the levels of exposure to these toxins in terms of what causal role the toxins played in the development of their cancers?
A. That's correct.
Q. Okay. Doctor, I want to go through your report real quick, and we'll start on Page 6, and I'd -- I'd like to ask if any of these sections or specific opinions listed in your report are still in play.
So we're on Page 6 of Mr. Mousser's -- or Dr. Cooper's report for Mr. Mousser. It is Cooper Exhibit 7. I'm looking at heading VI, "Risk Factors for UTUC Kidney Cancer" that goes to Page 7.
Is -- is anything in there still in play?

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

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

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

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

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

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

BY MR. GARAND:

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

I'm not asking about that.

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

A. Not -- not specifically, no.

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

Are these opinions and analyses still in play?

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

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

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

A. It does, yes, sir.

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

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

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

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

A. Let me take a quick peek, please.

Q. Sure.

A. Yes, sir, that's correct.

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

A. Okay.

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

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

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

A. No, sir.

Q. Thank you, Doctor.

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

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

A. Okay.

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

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

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

BY THE WITNESS:

A. Yes, that's correct.

BY MR. GARAND:

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

A. That's correct, yes, sir.

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

A. No. No, I will not.

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

Camp Lejeune. It goes from Pages 7 to 10.

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

A. No, sir.

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

A. No, sir.

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

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

MR. GARAND: Yes, of course.

MR. MANDELL: Okay.

BY THE WITNESS:

A. I will not be testifying to that either.

BY MR. GARAND:

Q. Okay. Thank you, Doctor.

Okay. Let's look again at Cooper

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

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

A. I'm here.

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

A. Yes, sir.

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

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

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

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

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

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

Q. Of course.

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

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

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

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

A. Yes, sir, it is.

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

Jacqueline Tukes?

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

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

A. Yes, sir, that's correct.

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

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

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

A. That's correct.

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

A. Yes, they are.

Q. Did you review the Camp Lejeune Justice

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

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

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

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

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

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

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

A. Yes, sir.

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

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

A. It is, sir, yes.

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

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

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

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

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

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

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

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

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

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

A. Not -- no.

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

A. No.

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

A. Yes.

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

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

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

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

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

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

Is that right?

A. Yes, sir.

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

A. It says that, yes, sir.

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

MR. MANDELL: Objection.

Go ahead.

BY MR. GARAND:

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

A. Yes.
Q. A decline in GFR, is that right?
A. Correct.
Q. Significant proteinuria, is that right?
A. Correct.
Q. Elevated protein creatinine ratio, is that right?
A. Correct.
Q. Are there any other reasons that you think Mr. -- or you believe Mr. Mousser will require renal replacement therapy in three to five years?
MR. MANDELL: Could -- could I just ask before you said, Carson, please, I'm sorry?
MR. GARAND: Yes. So serum creatinine of 1.5 to 1.6, decline in GFR, significant proteinuria, and elevated protein creatinine ratio. And, again, those are in the -- the last two paragraphs on Page 3.
MR. MANDELL: So -- okay. So you are leaving out purposefully other things in those two sentences?
MR. GARAND: No, I'm not. So if he has -- if there are other --
MR. MANDELL: Okay. All right.
BY THE WITNESS:
A. Yeah, importantly, the most important one

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

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

BY MR. GARAND:

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

A. That alone, correct.

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

Is that in your report anywhere?

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

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

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

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

your opinions?

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

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

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

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

BY THE WITNESS:

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

BY MR. GARAND:

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

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

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

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

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

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

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

A. No.

Q. And why is that?

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

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

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

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

But go ahead.

BY MR. GARAND:

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

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

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

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

A. That's fair.

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

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

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

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

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

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

A. I do.

Q. And what is that?

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

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

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

Q. Would you expect any non-nephrologist or

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

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

Q. On what basis?

MR. MANDELL: Objection.

BY THE WITNESS:

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

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

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

you the same answer.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I am not.

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

Mr. Mousser's prognosis?

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

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

A. (Inaudible response.)

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

A. Yes.

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

A. Okay.

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

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

A. The binder, okay.

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

A. Okay. Thank you.

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

BY MR. GARAND:

Q. Dr. Cooper, have you reviewed Mr. -- and just for the record, again this is Cooper Exhibit 9. These are Mr. Mousser's VA lab results from June of 2020 through November of 2023, and then I have some -- some more recent ones after that, but this binder, for the record, the records are Bates-stamped 00667_MOUSSER_05598 through 05812.

Doctor --

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

of foundation, but go ahead.

BY MR. GARAND:

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

A. Yes, sir, I do.

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

A. That's correct.

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

A. That's correct.

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

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

A. I do.

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

A. Correct, yes.

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

creatinine is 1.2?

A. I do.

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

A. 5781. Okay.

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

A. Yes, sir, that's correct.

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

A. Four.

Q. Stage 4?

A. Um-hum.

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

Do you remember that?

A. I do.

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

A. His creatinine of 62.4.

Q. Where did you see that?

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

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

you meant the eGFR.
BY THE WITNESS:
A. eGFR. Yeah, the eGFR.
BY MR. GARAND:
Q. Is 6 -- so an eGFR of -- of 62 is CKD Stage 4?
A. 60 to 90, yes.
Q. I think we might be getting our numbers mixed up. Is that not CKD Stage 2?
A. I apologize.
Q. Okay. I was -- I was -- I was worried we were going to have to go back a little bit.
A. Yep, I apologize.
Q. No, no problem.
A. Stage 2. I apologize.
Q. Okay. So at the outset, assuming stable GFR and creatinine results of 1.2 and 62, would you be -- would you be worried that a patient with these results would need dialysis or a kidney transplant in three to five years, assuming stability?
A. Pardon me, I missed the beginning. Could you ask me one more time?
Q. Assuming stable creatinine levels of 1.2 and GFR of 62, would it be your opinion that somebody

would require renal replacement therapy in three to five years?

MR. MANDELL: Objection; lack of foundation.

Go ahead.

BY THE WITNESS:

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

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

BY MR. GARAND:

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

MR. MANDELL: Objection. Go ahead.

BY THE WITNESS:

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

BY MR. GARAND:

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

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

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

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

Q. Thank you, Doctor.

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

A. 057 -- I'm sorry, one more time? 56?
Q. 5762.
A. 5762, okay.
Q. I know we'll be jumping around a little bit --
A. Okay.
Q. -- so I ask that you bear with me here.
A. I'm here.
Q. So at the very bottom of this page, do you see that the date is September 7th of 2020?
A. I do.
Q. Flip to the next page, which is Bates ending in 05763, the third line down, Mr. Mousser's creatinine is 1.0.
Do you see that?
A. I do.
Q. And if you flip to Bates ending in 05766, his eGFR is 77.
Do you see that?
A. I see that.
Q. Okay. Now, let's look at Bates ending in 05710.
A. 5710.
Q. And please let me know when you're there.

A. I'm here, sir.
Q. And, Doctor, I apologize if I asked this, but I want to make sure that I have, have you seen these records before?
A. I have.
Q. At the bottom of Page 2, do you see that the date collected there is October 22nd, 2020, right?
A. I do.
Q. And this was just two days after his October 20, 2020, nephroureterectomy, right?
A. I believe that's the dates, the -- the PO date, yes.
Q. So if you flip to the next page, Bates ending in 05711, his creatinine is 1.2, right?
A. I do see that here, yes.
Q. And then if you flip to Bates ending in 05713, at the top of the page, again, his eGFR is 62.4, right?
A. Yes.
Q. Okay. Please turn to Bates ending in 05704.
A. Okay.
Q. Do you see that the date there at the bottom is 28 April 2021?

A. I do, yes.
Q. If you flip to the next page, it's Bates -- Bates ending in 05705. Do you see at the top there that Mr. Mousser's creatinine is 1.5?
A. I do.
Q. And if you flip to page ending in 05707, his eGFR is 48.2 at the very top.
Do you see that?
A. I do, yes.
Q. Okay. If you can flip to Bates ending in 05682.
A. 05682. Okay.
Q. And these are January 19, 2022, results.
Do you see that?
A. I do, sir.
Q. And his creatinine is 1.5, a few lines down on this page?
A. I see that.
Q. And if you flip to Bates ending in 05684, at the very bottom, his eGFR is 48.1, right?
A. Correct.
Q. All right. Let's look at 05671.
A. 05671. Okay.
Q. So do you see the date there at the bottom

of the page is March 9th of 2022?

A. I do.

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

A. That sounds right, yes, sir.

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

A. That's correct.

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

A. Correct.

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

MR. MANDELL: Objection. Based on these records?

MR. GARAND: Correct, based on these records.

BY THE WITNESS:

A. Yes.

BY MR. GARAND:

Q. Okay. Please turn to Bates ending in

05665.

A. 5665. Okay.

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

Do you see that?

A. I do, sir.

Q. And the creatinine is 1.4, right?

A. Yes.

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

Do you see that?

A. I see that.

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

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

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

BY THE WITNESS:

A. That's correct, yes.

BY MR. GARAND:

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

A. Yes, according to these records.
Q. Is it typical for somebody's kidney function to increase significantly like that in just one month after it was declining?
A. Is it typical. Are you talking about for a -- anybody or for --
Q. Anybody with chronic kidney disease, and what I'm getting at is it was at 1.9 and then it goes back down to 1.4. It was at 36.6 and then, you know, a couple of weeks later it's at 58.
Do you have any explanation as to why that may be?
A. Yes.
Q. And what is that?
A. So it can happen in -- in patients who have, again, chronic kidney disease, particularly those that have significant damage to the organ itself that make it very susceptible to things like volume status and to medications and to, just, general physiology.
So, again, we -- we see that there can be significant fluctuations which, again, are -- are very concerning, especially when you see at this level changes in creatinine and the significant change it

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

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

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

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

A. Not that I saw in the medical record.

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

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

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

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

MR. GARAND: Thank you.

BY THE WITNESS:

A. Okay.

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

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

BY MR. GARAND:

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

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

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

A. Thank you.

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

A. Yes. Thank you.

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

A. Yes, they can.

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

A. They can, yes.

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

A. Page 87:15.

Q. Okay. So the question:

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

"Do you see that?"

Answer: "I do."

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

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

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

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

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

Did I read that correctly?

A. Yes, sir.

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

Do you see that?

A. I do.

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

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

"Yeah, that's correct."

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

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

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

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

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

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

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

Answer: "No, it's reassuring."

Did I read that correctly?

A. Yes, sir.

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

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

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

Did I read that correctly?

A. Yes.

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

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

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

MR. MANDELL: Objection.

BY THE WITNESS:

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

BY MR. GARAND:

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

A. I do.

Q. Okay. And what's that?

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

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

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

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

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

BY THE WITNESS:

A. Are we coming back to this?

BY MR. GARAND:

Q. We will come back --

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

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

A. Okay.

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

A. Thank you.

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

A. Yeah, thank you.

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

A. Okay. Okay. Thank you.

Q. Again, this is Cooper Exhibit 11.

Okay. So this is a -- again, an April 18th, 2022, VA treatment note. This is Bates 00667_MOUSSER_VHA_0375.

Doctor, at the top do you see that the

author is Dr. Andrew Rockwood?

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

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

A. Yes, sir, I do.

Q. The middle of the page, do you see that Dr. Rockwood stated that, "His updated serum creatinine was 1.4 and a 24-hour urine for CrC1 calculates out to a 102 cc per minutes..."

Do you see that?

A. Yes.

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

A. Correct.

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

A. Correct.

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

MR. MANDELL: Objection.

Go ahead.

BY THE WITNESS:

A. I do.

BY MR. GARAND:

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

A. I do.

Q. And you understand that they're --

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

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

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

Q. Thank you, Doctor.

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

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

MR. MANDELL: Objection. Objection to the

preface too.

Go ahead.

BY THE WITNESS:

A. Amongst other things.

BY MR. GARAND:

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

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

A. Okay.

Q. I know, there is...

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

Q. Thank you, Doctor.

A. Okay.

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

A. Okay, sir.

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

A. Yes, sir.

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

A. Correct.

Q. And if you flip to Bates ending in 05659, his eGFR is 58, is that right?
A. Correct.
Q. Let's look at Bates ending in 05645.
A. Okay.
Q. These are September 19, 2022, results. Do you see that at the bottom of the page?
A. I do, sir, yes.
Q. The next page is 05646 and the creatinine is 1.3.
Do you see that?
A. I do, sir.
Q. If you flip to page Bates ending in 05648, the eGFR is 63, is that right?
A. Correct.
Q. Okay. We'll look at -- put these to the side, but we're going to come right back to them.
A. Okay.
Q. Thank you. It would be convenient if all of these were right in the same spot, but unfortunately they're not.
MR. GARAND: I'll mark this as, let's see, we are on 12. I'll mark this as Cooper Exhibit 12.
(WHEREUPON, a certain document was

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

BY MR. GARAND:

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

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

A. I do, yes.

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

A. I do, yes, sir.

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

A. I do, sir.

Q. And the eGFR is 66, correct?

A. I see that also, yes.

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

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

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

BY THE WITNESS:

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

BY MR. GARAND:

Q. From April of 2022 --

A. Yeah.

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

A. Yes.

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

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

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

A. Not that I can recall.

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

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

Q. Thank you, Doctor.

All right. Back to the binder we go.

A. Okay.

Q. And if you could turn to Bates ending in 05623.
A. I'm getting closer to the front.
Q. We're almost done with these.
A. Okay.
Q. At the bottom of this page, do you see that the date is July 17th of 2023?
A. Yes, sir, I do.
Q. And if you look at the next page, which is Bates ending in 05624, at the very top Mr. Mousser's creatinine is 1.4, correct?
A. Correct.
Q. If you look to the bottom of Bates ending in 05625, his eGFR is 58. Is that accurate?
A. It is.
Q. Okay. Flip to Bates ending in 05618.
A. Okay.
Q. And these are July 27, 2023, results. Do you see that at the very bottom of the page?
A. I do.
Q. And this is just ten days after the prior lab results that I just showed you, which is July 17th of 2023, right?
A. It sounds right, yes, sir.

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

A. Yes, sir.

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

Do you see that?

A. I see that, yes.

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

A. Awesome.

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

Do you see that?

A. I do, sir, yes.

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

A. That's correct.

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

Do you see that?

A. I see that, yes.

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

A. Okay.
Q. I'll show you what I'll mark as Cooper Exhibit 13.
(WHEREUPON, a certain document was marked Dr. Cooper Deposition Exhibit No. 13, for identification, as of 07/10/2025.)
BY THE WITNESS:
A. Thank you.
BY MR. GARAND:
Q. Doctor, have you seen this record before?
A. I can't remember specifically, sir, I'm sorry.
Q. That's okay. For the record, this is a May 6th, 2024, VA treatment note, and it is Bates-stamped 00667_MOUSSER_VHA_01499 through 01504. Turn to Bates ending in 01501, please.
A. 01, sir?
Q. Yes, correct.
A. Okay. Thank you.
Q. And at the -- towards the bottom of the page, you'll see that Jan- -- there's a January 12, 2024, creatinine results and it's 1.5.
Do you see that?

A. I do, sir, yes.

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

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

BY THE WITNESS:

A. Thank you.

BY MR. GARAND:

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

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

Q. That's okay.

For the record, this is a November 12th, 2024, VA treatment note for Mr. Mousser. It's Bates-stamped 00667_MOUSSER_VHA_01624 through 01626.

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

Do you see that?

A. I do, yes.

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

Do you see that?

A. I do, yes.

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

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

BY THE WITNESS:

A. Thank you.

BY MR. GARAND:

Q. Doctor, have you seen this record before?

A. I don't recall, sir.

Q. That's okay.

So for the record, this document is Bates-numbered 00667_MOUSSER_VHA_01567 through 01568.

And these are, if you see, the "Chem I Profile Routine" heading.

Do you see that there, in the middle of the page?

A. I do.

Q. If you look directly below that, it says January 6th of 2025, correct?
A. It does.
Q. Three lines down the creatinine is 1.3, correct?
A. That's correct.
Q. And the -- if you flip to the next page, which is Bates ending in 01568, in the middle of the page there, the eGFR is 63. Is that accurate?
A. That's correct.
Q. And as we've discussed, an eGFR of 63 is CKD Stage 2, right?
A. That's right.
Q. Do you have any evidence or information demonstrating that Mr. Mousser's CKD has changed since January of 2025?
A. One more time, please, do I?
Q. Are you aware of any medical records or anything indicating that his CKD staging has changed since January of 2025?
A. I don't, not based upon lab data, no.
Q. Okay. So from April of 2023 -- sorry -- April of 2022 through January of 2025, and I'll represent to you in, you know, my review of the

records, these are all of the -- what I've shown you is all of the lab results I've seen for Mr. Mousser for that time period.

A. Okay.

Q. He has had one instance of a -- of a creatinine at 1.7, one instance of a creatinine at 1.5, and more than -- or he's at 11 instances of a creatinine at 1.4 or lower.

Is that -- I know we just went through a lot of them, but I'll represent to you that that's the case. So Mr. Mousser's creatinine has been consistently been below 1.5 to 1.6, is that accurate --

MR. MANDELL: Objection --

MR. GARAND: -- since April of 2022?

MR. MANDELL: Objection; form and foundation.

Go ahead.

BY THE WITNESS:

A. Based upon the creatinine values that we've looked at, yes --

BY MR. GARAND:

Q. So --

A. -- those numbers.

Q. And I apologize for jumping in there.

So can you explain why you listed 1.5 to 1.6 as the creatinine values in your expert report?

A. Yeah, because at the time that I wrote the report, the data that I had in front of me was -- included, again, a lot of these numbers, but as we talked about before, I was most interested in the demonstration that his kidney, you know, has the inability to compensate, you know, when we have sort of changes in volume and potential interventions, such as blood pressure medications.

That is, again, the rationale for why I made that conclusion about his longevity of his remaining kidney. So that's why it's in my report as -- because that's what I focused on as being significant and based upon, again, my experience, that contributes to my conclusion.

Q. So the -- so a creatinine value of 1.5 to 1.6 that's over three years old is what's most significant to you in his lab results?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I didn't say that. I said that's a -- I said that's a part of what I considered to be significant in my determination of his chronicity of

disease and the future of his kidney.
BY MR. GARAND:
Q. So lower, more recent creatinine results is not significant?
MR. MANDELL: Objection.
BY THE WITNESS:
A. No, I didn't say that either. It is a piece -- it's a part of the decision, but it alone is not in my mind the most important determination of, you know, what his future kidney health is going to look like.
BY MR. GARAND:
Q. Yeah, and, Doctor, I'm sure you understand, all I'm trying to do is figure out why 1.5 to 1.6 was listed as the creatinine values in your report, as opposed to lower creatinine values that are more consistent -- or more recent?
MR. MANDELL: Objection; asked and answered.
Go ahead.
BY THE WITNESS:
A. Again, it's because I was at that time putting together all of the information, included all of the things that we talked about, his unilateral nephrectomy, his hyperfiltration of that remaining

kidney, his comorbidities, and the fact that soon after surgery and even sometime following surgery that he had significant rises in creatinine.

So I think it's important, and you've actually laid it out very nicely, minimal changes in creatinine result in significant drops in creatinine clearance.

BY MR. GARAND:

Q. And, Doctor, you didn't explain any of this in your report, is that -- any of the explanation you just gave as to why you picked certain creatinine results, none of that is in your expert report, is that right?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I didn't feel the need to.

BY MR. GARAND:

Q. And why is that?

A. Because, again, the -- the information that I placed there in addition to the other parts of the expert opinion, and -- and including, you know, my experience, is what allows me to make that conclusion.

MR. MANDELL: Objection.

MR. GARAND: Okay. I think we've been going for

about an hour, and I'm at a good stopping point, if that's all right with you, Doctor.

THE WITNESS: Sure.

MR. MANDELL: Five minutes.

MR. GARAND: Sure.

THE VIDEOGRAPHER: Going off the record at 11:04 a.m.

(WHEREUPON, a recess was had from 11:04 to 11:16 a.m.)

THE VIDEOGRAPHER: We are back on the record at 11:16 a.m.

BY MR. GARAND:

Q. Doctor, I just showed you a whole lot of GFR -- or lab results with GFR results and -- and creatinine levels.

Did you have all of those records when you wrote your initial report?

A. I believe I had if -- everything but maybe the last one, sometime in -- with the one in 2024, but I know I had all of the others.

Q. Okay. Did you consider -- or was there any consideration in drafting a supplemental report with the most updated creatinine and GFR results?

A. No. I didn't believe that was necessary.

It didn't change my opinion that I provided in the initial report.

Q. Okay. Doctor, you also -- as part of your bases, you also found that Mr. Mousser was likely to require renal replacement therapy in three to five years be- -- because he had significant proteinuria and an elevated protein creatinine ratio, is that right?

A. Correct, that's what I have in here.

Q. And let me just ask generally, what's the difference between significant proteinuria and an elevated protein creatinine ratio?

A. Pretty much the same, yeah.

Q. Okay. Okay. So let's talk about those two pieces. And Erick per usual is ahead of the game. We're going to mark this as Cooper Exhibit 16.

(WHEREUPON, a certain document was marked Dr. Cooper Deposition Exhibit No. 16, for identification, as of 07/10/2025.)

BY MR. GARAND:

Q. Doctor, have you seen this exhibit before?

A. I don't recall specifically whether I had these records.

Q. Okay. Just for the record, this is a July 19, 2022, treatment note from Mr. Mousser, and it's Bates-stamped 0667_MOUSSER_VHA_0327 through 0333.

If you flip to the very last page, which is Bates ending in 0333, you'll see that it's signed by a -- yeah, sorry about that.

A. Okay.

Q. It's signed by a nephrology fellow and a staff nephrologist.

Do you see that?

A. Yes.

Q. In the middle of the page?

A. I do, yes.

Q. And if you flip to just one page earlier, Bates ending in 0332, do you see that the provider assesses CKD Stage G3a A1. Is that right?

A. I see that, yes.

Q. The last sentence of that first paragraph -- so I guess two -- two or three lines up from the bottom there to the right, it says, "Found to uptrend to 1.6 few months after and has remains stable 1.5 to 1.6 since then and currently at 1.4," is that right?

A. Yes, that's correct.

Q. Okay. In the middle of the next paragraph, the second line from the top, is -- if you see UA in a medical record, is that urinalysis?

A. Yes, sir, most often.

Q. So it says, "UAs showing now resolved hematuria with negative proteinuria on dipstick," is that right?

A. Give me one second. The second sentence. Yes, yes, it says that.

Q. So at this point in July of 2022, there was no proteinuria, correct?

A. According -- according to this record, correct.

Q. Yes. And, Doctor, of course, yeah, if we are referencing a record, I'll assume that you mean according to this record and, you know, not that there is some other record out there that would contradict it.

So if we flip to the very last page, which is Bates ending in 0333, do you see the "Plan" heading at the top of the page, towards the top?

A. I do.

Q. The second -- the second --

A. The last page.

MR. MANDELL: No, it's just -- go ahead, I've got it.

BY MR. GARAND:

Q. The second line there says, "UACR undetected at this time with UPCR 0.07 changing his grade to A1 kidney disease. Continue with ACEi," which is ACE inhibitor, right?

A. Yes, sir.

Q. And as we discussed earlier, UACR means urine albumin-to-creatinine ratio, right?

A. It does.

Q. So undetected UACR and 0.07 UPCR is not evidence of elevated protein creatinine ratio, right?

A. That's correct.

Q. Okay. Let's look at another exhibit here, which I'll mark as Cooper Exhibit 17.

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

BY THE WITNESS:

A. Thank you.

BY MR. GARAND:

Q. And, Doctor, I'll ask if you've seen this

record before?

A. Again, I had these records. I don't remember this specifically.

Q. Okay. Just for the record, this is a December 11th, 2023, VA treatment note for Mr. Mousser. It is Bates-stamped 00667_MOUSSER_VHA_0111 through 0112.

Do you see that this is a nephrology consult at the very top of the page?

A. Yes, sir, I do.

Q. And do you see that the author is Jay Bucci?

A. I do, yes.

Q. I hope I'm pronouncing that correctly. But if you flip to the second page at the very top, the signature line shows that Jay Bucci is a staff nephrologist with the VA, right?

A. Yes, sir.

Q. Okay. Do you see the findings on Page 1 of this record, which is Bates ending in 0111, Dr. Bucci found that "Mr. Mousser is a 60-year-old male with hypertension, CAD status post CABG, urothelial cell carcinoma mall status post nephroureterectomy in October of 2020 and CKD G3a A1

(creatinine 1.4 to 1.5) attributed to reduced renal mass from the nephrectomy. He previously had proteinuria prior to his nephrectomy, but it has resolved. He has managed with lisinopril and empagliflozin. He has no complications of CKD."

Did I read that correctly?

A. You did.

Q. So just like in July of 2022, in December of 2023, Mr. Mousser again was found not to have proteinuria, is that right?

A. Correct.

Q. And, in fact, this -- this examiner -- or provider found that the proteinuria had resolved, right?

A. Correct.

Q. Okay. If we look at the "Impression" heading on the same page, Dr. Bucci again found that Mr. Mousser had stable CKD -- and sorry, we're looking at 0111. Sorry about that.

A. I was flipping the page. I apologize.

Q. That's okay.

A. Okay.

Q. So the "Impression" tab -- or heading, Dr. Bucci found that Mr. Mousser had "stable CKD G3a

A1 from reduced renal mass status post nephrectomy three years ago," right?

A. Yes.

Q. He also notes right beneath that that "Patients with stable CKD attributed to a nephrectomy without albuminuria and without complications of CKD generally do not require long-term nephrology follow-up unless there is evidence of disease in the remaining kidney," is that right?

A. That's right, that's what it says.

Q. And then under the "Recommendations" heading, the fourth entry there, Dr. Bucci stated that Mr. Mousser "is discharged from the nephrology clinic," is that correct?

A. Yes, sir, that's what it says.

Q. And as discussed, that's because he had CKD Stage G3 A1 and Dr. Bucci found that it was stable, is that right?

MR. MANDELL: Objection.

BY THE WITNESS:

A. That's what he states here in his note.

BY MR. GARAND:

Q. And he also found that the proteinuria had resolved, right?

A. That's what's in his note, yes.
Q. Okay. I'll show you what I'll mark as Mousser -- or Cooper Exhibit 18.
(WHEREUPON, a certain document was marked Dr. Cooper Deposition Exhibit No. 18, for identification, as of 07/10/2025.)
BY THE WITNESS:
A. Thank you.
BY MR. GARAND:
Q. Thank you.
Doctor, again, I'll ask if you've seen this record before?
A. Again, not specifically, but I did have these in my possession.
Q. So, and, again, this is a December 15th, 2023, VA treatment note. It's Bates-stamped 00667_MOUSSER_VHA_097 through 0103. And so this is just a few days after the December 11th, 2023, treatment that we just looked at, is that right?
A. That's right.
Q. And this is a different VA provider, right, Katherine Adams-Krick?
A. Correct.

Q. Okay. Please turn to Page 6 of this document, which is Bates ending in 0102. If you see the "Assessment/Plan" heading there in the middle of the page, if you look at Number 1, she again diagnoses chronic kidney disease Stage G3 A1, is that right?

A. That's correct, yes.

Q. The second bullet under Number 1 is "Serum creatinine stable at baseline at 1.4," is that right?

A. That's right.

Q. And the Number 2 under the Assessment/Plan heading is that, "Proteinuria: Controlled," is that right?

A. Yes, sir.

Q. Do you understand that to mean that she found that his proteinuria was controlled?

A. Based upon her note, yes.

Q. Okay. Doctor, we're going to look back at Exhibit 14, which I hope is one of the ones that I told you to keep.

A. Yes, I have it.

Q. Okay. If we look at Page 2 of this document, which is Bates ending in 01625, right after the -- that double dotted line in the middle of the page, this provider states, "Your kidney function

remains stable as reflected by the serum creatinine at your baseline of 1.4," is that right?

A. I see that.

Q. And if you skip to the next paragraph, she states that, "Additional evidence for stable kidney function is the microalbumin in your urine or protein in your urine remains undetectable at less than 7.0 mg/L," is that right?

A. Yes, sir, that's what it says.

Q. So, again, as of November -- or in November of 2024, this provider found that Mr. Mousser's microalbumin in the urine was undetectable, correct?

A. That's correct. Excuse me.

Q. Okay. So let's look at Dr. Flood's deposition transcript, which is Exhibit 10.

A. Ten, okay.

Q. We'll look at Page 41. And take your time getting there, Doctor. I know there's a lot of documents flying around.

A. I'm trying to get these close. I'm sorry, page...?

Q. 41.

A. God bless you.

Q. We'll look at lines 2 to 6. And Dr. Flood stated:

"So he had kidney disease by virtue of single kidney, longstanding proteinuria/albuminuria, which interestingly is resolved on the current medication, which is wonderful for him."

Did I read that correctly?

A. You did.

Q. We'll look at Page 43. We'll look at again Lines 1 through 8. Dr. Flood testified that:

"His albumin level in 2022 and his urine was under 30, so that was okay by 2022. So he had some proteinuria on one test in 2020, so, yeah, I've got to restate what -- what I wrote as -- at least based on that, unless I was able to find older data, he had proteinuria on one episode, and actually's been doing just fine since that time," correct?

A. That's correct.

Q. Is there any reason why you did not include these more recent medical records in your report that indicate that there is no pro- -- that the proteinuria has resolved and that the pro- -- protein creatinine ratio was undetectable?

A. Yes, because at -- at the time that I -- I

wrote this report, again, I was, you know, evaluating the, as I said before, the totality of Mr. Mousser and additional data that, again, none of those talked about, that he has had the ability to look at his other kidney.

It's just surprising to me that the nephrologist say that he has no evidence of intrinsic disease when they could look at his pathology and know that he does. And the fact that he had proteinuria and elevated urine creatinine ratio after his nephrectomy at any time to me is incredibly significant.

You said it yourself. He's on medications now to control his proteinuria. So his providers themselves know that he has proteinuria and they're controlling it with the medications, which, again, is an indication that this kidney has injury associated with it and they're treating.

And so your question earlier about does control matter? Sure, it matters, but there still is the demonstration that that single kidney secondary to having a nephrectomy that's hyper-filtrating with all of his co- -- multiple comorbidities is damaged and is going to have problems in the future.

Q. And I appreciate that, Doctor. My question was, why didn't you discuss specifically those more recent results that contradict your finding of elevated proteinuria or significant -- significant proteinuria and an elevated protein creatinine ratio?

A. They don't con- --

MR. MANDELL: Objection; asked and answered.

Go ahead.

BY THE WITNESS:

A. They don't contradict what I said. I said that the fact that he has had that following his nephrectomy is part of my equation in calculating those three to five years.

BY MR. GARAND:

Q. Doctor, are you aware of what medications Mr. Mousser is on that protect his kidney function?

A. Currently?

Q. Currently.

A. I -- I don't remember specifically. He has been on several medications including like the ACE inhibitors and the ARBs, but what he's on currently right now, I am unfamiliar.

Q. Do you know whether the medications that protect his kidney, whether he's on those medications

specifically to protect his kidney or he's on those medications for other purposes?

A. No, he's on those medications to protect his kidney.

Q. Okay. Okay. And, again, you don't remember what medication -- or you don't know specifically what medications those are?

A. No. Again, I -- they're under the class that are renal protective agents.

Q. And he was prescribed those medications to protect his kidneys?

A. Correct.

Q. Okay. Doctor, again, I think I asked you about this earlier, but you don't recall reviewing Dr. Andrew Rockwood's deposition transcript in this matter, do you?

A. I don't specifically recall, I'm sorry.

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

BY MR. GARAND:

Q. This is a portion of Dr. Rockwood's deposition transcript.

A. Excuse me.

Q. And, Doctor, if you flip to Page 101 for me, please.

And, again, you understand that Dr. Rockwood is Mr. Mousser's VA urologist?

A. I do.

Q. Okay. Let's look at Page 101, Lines 4 to 15.

Question: "Does Mr. Mousser being diagnosed with chronic kidney disease change your opinion of his life expectancy?"

Answer: "No."

Question: "Why doesn't that change your opinion?"

"It's a very minimal risk factor, the fact that his -- or at least based on the last renal function assessment, his creatinine was 1.4, but that would have a very minimal impact on his life expectancy."

Did I read that correctly?

A. You did.

Q. And if you will turn to Page 103 for me. We'll look at Lines 5 through 8. And Dr. Rockwood testifies that "...if his kidney function remains

where it is, it should have essentially zero impact on his ability to function normal daily activities..."

And then at Lines 11 through 12, "... but in terms of his working inside in an office-type setting, it should have zero impact," is that right?

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

Q. So Dr. Rockwood's opinion is that Mr. Mousser's CKD would not impact Mr. Mousser's life expectancy, correct?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I believe that's his opinion, yes.

BY MR. GARAND:

Q. Okay. Let's look back at Dr. Flood's transcript, which is --

A. Ten.

Q. -- Cooper Exhibit 10. Thank you.

We'll look at Page 70 of his transcript, please. Specifically we'll look at Lines 18 to 20.

A. Okay.

Q. And you'll see that Dr. Flood stated that, "But as of 2024, I can see he's," meaning Mr. Mousser, "doing really, really well, which is great."

Do you see that?

A. I do.
Q. Look at Page 92 for me, please.
A. Yes, sir.
Q. And I'll -- we'll just look at Lines 17 to -- through 19 which again we discussed. You say that, "And that creatinine of 1.4 is entirely consistent with somebody that has one kidney that's doing quite well," is that right?
A. Yes, sir, that's what it says.
Q. Look at Page 23 for me.
A. 20 -- 20 --
Q. 23?
A. We are back to 23?
Q. Yes. Sorry about that.
A. Yep. One second.
Q. Sure, yeah, no problem.
A. Okay.
Q. We're looking at Lines 5 through 18. Dr. Flood testified that:

"And I just looked at his recent labs, and actually for somebody that only has one kidney, the creatinine is fairly well preserved, and he no longer has albuminuria, meaning that the filter units are no longer damaged.

"When I saw him in 2022, he was having some albumin or protein, which is a reflection of damage to either the kidney with the albumin or tubules with the protein.

"But that all seems to have resolved, and his urine -- urine looks good. So he's actually doing quite well from my perspective, looking at his current numbers."

Is that what -- did I read that correctly?

A. You did.

Q. Let's go to line -- page 114.

A. One more. Okay.

Q. And we agreed earlier that a nephrologist is in an acceptable position to opine on somebody's prognosis, is that correct, with chronic kidney disease?

A. Yes.

Q. Take a look at 114, Line 3. Are you there, Doctor?

A. I am, yes, sir.

Q. He says -- Dr. Flood testifies, "He's got one kidney, but he is doing very, very well."

Question: "So -- and just in line with this, Doctor, what would you say Mr. Mousser's

prognosis is related to his chronic kidney disease at this time?"

He answers: "I think it's -- I think it's excellent. He's got one kidney which needs to be protected all the more because he only has one kidney, but with good blood pressure control and avoiding nephrotoxins, things that might hurt the kidney, like Motrin, Advil, that type of thing, and then taking medicines that help protect the kidney, so the lisinopril and the empagliflozin, he has an outstanding lifelong -- barring some unforeseen serious injury or, you know, ill -- critical illness or something that causes acute kidney injury within the kidney itself, I mean, it's an excellent prognosis."

Did I read that correctly?

A. You did.

Q. And so, you know, we've just looked at four or five different passages from Dr. Flood who is, again, Mr. Mousser's -- one of Mr. Mousser's VA treating nephrologists, correct?

A. Correct.

Q. And, you know, his essential sentiment is Mr. Mousser's prognosis is excellent, correct?

A. With a lot of "ifs" in there, yes.

Q. And, Doctor, you're aware that doctor -- well, maybe you aren't. Do you know that Dr. Flood utilized the Kidney Failure Risk Equation here with Mr. Mousser?

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

Q. Let's flip to Page 113, which we're very close.

A. Okay.

Q. Okay. So 113, Line 14, Dr. Flood testified, "Okay. So for -- for a 61-year-old man who has a GFR of 57, with an albumin-to-creatinine that's very low because it's undetectable right now, so less than 5, his risk of going on dialysis in five years is 0.12 percent."

He continues, "And that's from the kidney" -- sorry. "And that's -- that's from the Kidney Failure Risk Equation. It's -- it is well-accepted in the literature; in fact, it's becoming a standard of care for reference in management for it."

Did I read that correctly?

A. You did.

Q. And based off our prior discussion, you disagree with Dr. Flood's analysis there, correct?
A. I do.
Q. Doctor, let me -- okay.
Doctor, let's look at one more. If we look at Page 124 here.
A. 124?
Q. Yes, 124.
A. Okay.
Q. We're looking at Line 12 through 19.
A. Okay.
Q. Dr. Flood again testified, "I mean, this is pretty incred- -- you know, 1.4, no albumin in his urine would be pretty normal and expected for somebody that even donated a kidney. That would be very normal.
"So a healthy individual that donated a kidney, these are the kind of numbers we would see."
Is that correct?
A. That's what he says, yes.
Q. Doctor, would you agree that achieving good blood pressure control can reduced the five-year risk of requiring renal replacement therapy?
A. Compared to not controlling it, yes.

Q. So if Mr. Mousser's hypertension is well controlled, it will reduce his risk of progressing to endstage renal disease, is that correct?

MR. MANDELL: Objection.

Go ahead.

BY THE WITNESS:

A. He has a better chance than if it's uncontrolled.

BY MR. GARAND:

Q. Are you aware whether or not Mr. Mousser's hypertension is well controlled at this point?

A. So he has intermittent fluctuations of some elevation in his blood pressure, but it's better with the medication that he's on than if he was not.

Q. Are you aware whether or not it's controlled at this time?

MR. MANDELL: Objection.

Go ahead.

BY THE WITNESS:

A. I believe I answered that. Like I said, I believe he's on medication, but he still has elevations at times of that blood pressure above what would be considered normal. So it's better than if it wasn't -- he wasn't on medication, but the definition

of controlled is, again, extremely variable.
BY MR. GARAND:
Q. Okay. Doctor, let's look at --
MR. GARAND: Tab 23.
BY MR. GARAND:
Q. And I'll mark this as Cooper Exhibit 20.
(WHEREUPON, a certain document was marked Dr. Cooper Deposition Exhibit No. 20, for identification, as of 07/10/2025.)
MR. GARAND: Thank you, Erick.
THE WITNESS: Thank you very much.
MR. GARAND: Of course.
BY MR. GARAND:
Q. And, Doctor, I'll ask if you've seen this record before?
A. Again, I'm sorry, I don't remember the specifics of this one, but I know it was in my possession.
Q. Okay. Doctor, just for the record, this is a November 8th, 2024, nephrology note for Mr. Mousser. It's Bates stamped 0 -- sorry, 00667_MOUSSER_VHA_01631 through 01638.
If you'll flip to Bates ending in 01637.

A. Okay.

Q. If you'll look at No. 3 under the "Assessment/Plan" heading, you'll see that it says, "Hypertension-CKD: Controlled."

Do you see that?

A. I do.

Q. Okay. Doctor, would you also agree that an ACE inhibitor or ARB can reduce the five-year risk of needing renal replacement therapy?

A. It can, yes. That's why folks are put on it, particularly those with a demonstrable CKD.

Q. Are you -- you're aware that Mr. Mousser is on lisino- -- is taking lisinopril, correct?

A. Yes sir.

Q. And lisinopril is an ACE inhibitor, right?

A. That's correct.

Q. Do you know whether Mr. Mousser was placed on lisinopril for his cardiovascular issues or his kidney issues?

A. He was put on it for both.

Q. For both.

Okay. Doctor, would you also agree that an SGLT2 inhibitor can reduce the five-year risk of requiring renal replacement therapy?

A. The newer data, that's not my area of expertise, but it's certainly proffered as one.

Q. Are you aware that Mr. Mousser is taking empagliflozin?

A. I am, yes.

Q. And that's an SGLT2 inhibitor, correct?

A. That's correct.

Q. Okay. Let's go back to your expert report for Mr. Mousser. I know we went through a whole bunch of records and now we're circling back.

A. Okay. Okay.

Q. If you look at Page 3 for me.

A. The Mousser report, Page 3. Yes, sir.

Q. You write that, "In addition to the risk of CKD/ESRD" -- and, sorry, this is at the very bottom of the page.

A. Yes.

Q. "In addition to the risk of CKD/ESRD, Mr. Mousser has an increased risk of hypertension with decreased glomerular mass."

When you say -- what do you mean by an increased risk of hypertension?

A. So one of the roles of our kidneys is to help regulate volume, and when patients have either a

loss of glomerular mass or a loss of a kidney, in both these respects, they have more challenges with regulating blood pressure.

So the fact that he has lost a kidney means that he has increased challenges with regulating his blood pressure compared to what he had before his nephrectomy for cancer.

Q. And you're aware that Mr. Mousser had stents placed in 2012, correct?

A. Cardiac stents.

Q. Correct.

A. I am, yes.

Q. Are you aware that he had a quadruple bypass surgery in 2016?

A. I'm aware, yes.

Q. Are you aware that he was -- he has been diagnosed with hypertension at least since 2016?

A. I don't know when it started, but I know he has been diagnosed for some time.

Q. Okay. So it's not your opinion that the chronic kidney disease could cause the hypertension that preexisted before his kidney cancer, right?

A. I'm sorry, one more time.

Q. So his hypertension predates his kidney

cancer, correct, and I'll show you a record?

A. It does. Yes, it does.

Q. So your opinion is not that his chronic kidney disease can cause hypertension. It already exist -- he's already being treated for it, correct?

A. Correct. It can worsen his hypertension.

Q. Okay, yeah. That's what I wanted to make sure I understood.

A. Okay.

Q. Okay. I'm going to show you --

MR. GARAND: We'll go Tab 24.

BY MR. GARAND:

Q. -- what I'll mark as Cooper Exhibit 21.

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

BY MR. GARAND:

Q. And, Doctor, I'm assuming you have not seen these records before. This is records from South Texas Cardiovascular Consultants. We just obtained them. We produced them on Monday. It took us forever to actually get them. So you haven't seen them, so if you need to take a minute to, you know, review it,

please do so, and just let me know when you're ready.

A. Okay. Thank you.

Q. And I'll just state for the record that this is an April 6th, 2016, treatment note for Mr. Mousser from South Texas Cardiovascular Consultants, and it's Bates-stamped 00667_MOUSSER_STCC_078 through 080.

A. Okay. I think I'm good.

Q. Doctor, first I want to ask you, again, so this is a -- you see the top right, it's Mousser, Frank?

A. Yes.

Q. And then to the left, there's an April 6th, 2016, date there, correct?

A. Yes, sir.

Q. Are you aware of any kidney problems or issues Mr. Mousser was having in April of 2016?

A. Am I aware of any kidney -- no.

Q. Okay. Do you see under the current medications, one, two, three, the fourth one down is lisinopril, correct?

A. I see that, yes, sir.

Q. Is it -- so Mr. Mousser was prescribed lisinopril prior -- over four years before he was

diagnosed with kidney cancer, correct?

A. That sounds about right. I don't know when exactly it started, but yes.

Q. Okay. So if you'll look at, again, Page 1, this is Bates ending in 078, the "Previous Cardiology Testing" heading, do you see that?

A. Yes, sir.

Q. The second paragraph under there, the last sentence states, "He has developed labile hypertension which is controlled on his beta blockade and ACE-I, which we were initially -- which were initially started after his initial presentation."

Is that right?

A. Yes, sir.

Q. And if you flip to Page 2, which is Bates ending in 079, do you see the "Assessments" tab at the top of the page there?

A. I do, sir, yes.

Q. And Number 3 under there is "Essential hypertension," correct?

A. Correct.

Q. And then under the "Treatment" heading, Number 3 is again "Essential hypertension," right?

A. It does.

Q. And the provider here states, "Blood pressures are borderline controlled on today's examination. No change in his medical routine is recommended at this time," right?

A. Yes, sir.

Q. Okay. I'm going to show you what --

MR. GARAND: Tab 25.

BY MR. GARAND:

Q. -- what I'll mark as exhibit -- Cooper Exhibit 22. And, again, this is another South Texas Cardiovascular Consultants record, so if you need to take a minute to review it, please do so.

A. Thank you.

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

BY MR. GARAND:

Q. And just let me know when you're ready, Doctor.

A. Okay.

Q. And I'll just note for the record, this is a March 16, 2021, treatment note for Mr. Mousser from South Texas Cardiovascular Consultants, and it's

Bates-numbered 00667_MOUSSER_STCC_054 through 057.

A. Okay. I think I'm good.

Q. Okay. Doctor, under the previous cardiology history -- let me make sure I'm looking at the right one here. Yes, okay.

So the "Previous Cardiology History" heading there in the very middle of the page, the last sentence of that paragraph states that, "He has developed labile hypertension after his CABG," is that correct?

A. Yes, sir.

Q. And CABG refers to the 2016 quadruple bypass surgery, correct?

A. It does, sir, yes.

Q. If you'll flip to the second page, which is Bates ending in 055, under the "Assessments" heading, Number 6, he is again diagnosed with "essential hypertension," right?

A. Yes, sir.

Q. And Number 3 under the "Treatment" tab is again "essential hypertension," right?

A. Right.

Q. And on that second line, it says, "Well controlled and he will continue to monitor at least

weekly with the goal of pressures 130/80 or below," correct?

A. It says that, yes, sir.

Q. Okay. I'll show you what I'll mark as Cooper Exhibit 23.

A. Exhibit 23.

Q. And, again, this is another South Texas Cardiovascular Consultants record, so please feel free to review and let me know when you're ready.

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

BY THE WITNESS:

A. Can you just tell me what the date is on that?

MR. MANDELL: Yes, what is the date?

BY MR. GARAND:

Q. Yeah, sorry. It's -- so the date -- if you look at the top right, it says date of service is 10/24/2024.

A. Okay.

Q. That's easier to read.

A. Thank you.

Okay.

Q. Okay. Doctor, so we'll look at Page 1 of this record, which is Bates ending in 044, under the "History of Present Illness" paragraph, the third line down states that, "Blood pressure as far as he knows his," I think it meant "is," "well-controlled, 130/80 or below," is that right?

A. Yes, yes.

Q. And I also just want to point out again if you look at the medications he is taking to the left there in the left column, he is -- four and five down, I believe, so he's still taking the lisinopril, correct?

A. Yes.

Q. And he is taking Jardiance?

A. Jardiance.

Q. And do you understand that that's em- -- empagliflozin?

A. Um-hum.

Q. What is -- what's the -- what -- what are some of the reasons why someone would be prescribed Jardiance or empagliflozin?

A. Diabetes most commonly.

Q. Okay. Doctor, let me make sure there's

nothing on here that I wanted to discuss.

Okay. Doctor, let's go back to your report --

A. Okay.

Q. -- for Mr. Mousser, which is Cooper Exhibit 7, I believe, and we're looking at Page 4.

A. Okay.

Q. So in that big paragraph in the middle of the page, six lines down, there's a -- to the right of the -- of the page, there's a sentence that starts "The ability."

Do you see that?

A. I am there, yes, sir.

Q. It reads, "The ability to main -- maintain full-time employment for dialysis patients is difficult despite the interest," is that right?

A. That's correct.

Q. And it's your opinion that Mr. Mousser -- Mr. Mousser will need renal replacement therapy in three to five years, correct?

A. It is.

Q. Do you know what age Mr. Mousser testified he would retire at?

A. Oh, I don't know that.

Q. Mr. Mousser I'll -- Mr. Mousser testified and then admitted in a -- in a separate pleading that he would retire at age 65. If he required renal replacement in -- therapy in three years, he'd be 65, is that correct?

MR. MANDELL: Objection. Foundation and form.

BY THE WITNESS:

A. It seems like the right math, yeah.

BY MR. GARAND:

Q. I know, that's -- that's again about the extent of my math skills there.

So if he began renal replacement therapy at 65, it would have little impact on his ability to maintain employment because he'd be retired, correct?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I don't know how we're connecting those two. If he goes on dialysis, my -- my point still sticks here that most folks have difficulty even if he changes his mind that he wants to work, that he'd be able to gain meaningful employment, but I don't know how I can put those two together.

BY MR. GARAND:

Q. Sure. Doctor, let's look at Page 5 of

your report.

A. Okay.

Q. And we're looking at the middle paragraph that begins "The reality."

Do you see that?

A. I do.

Q. The third line down all of the way to the right side, there is a para -- a sentence that says, "If Mr. Mousser suffers a recurrence now more than four years following surgery for the original cancer, his prognosis would be extremely poor as it would more likely than not be a metastatic site not appreciated in early follow-up - bones, lungs, liver and brain."

Did I read that correctly?

A. That's correct.

Q. Doctor, again, we've discussed this. You're not an oncologist, correct?

A. No, sir.

Q. You don't treat people for their kidney cancer, correct?

A. I do not.

Q. What is the basis of this statement?

A. Really knowing the -- the pathophysiology of cancerous lesions if they recur in a metastatic

fashion, these are the most common, renal cell cancer is something that we see all of the time in our practice as causative for nephrectomy and potentially transplant, and this is some of the workup that we do in order to assure that somebody meets candidacy for kidney transplantation.

Q. Are you aware that Mr. Mousser had a second cancer?

A. I am.

Q. Do you know when that second cancer occurred?

A. Sometime I think it was after -- soon after this report. It was like in March -- February, March. I think it's around that time.

Q. Doctor, why did you -- is there any reason why you decided not to draft a supplemental report?

MR. MANDELL: Objection.

Don't -- listen, in terms of anything that comes from conversations we've had or anybody at my -- at my office has had with you, do not answer that question. If you can answer it otherwise, fine. But the question is why didn't you do a redraft. So that's my objection.

BY THE WITNESS:

A. The answer is as it was before, it didn't -- it didn't change this opinion at all.
BY MR. GARAND:
Q. So in your expert opinion, Mr. Mousser's second cancer did not impact his chronic kidney disease prognosis?
MR. MANDELL: Objection.
BY THE WITNESS:
A. That -- that's correct.
BY MR. GARAND:
Q. Are you aware that Mr. Mousser was diagnosed with low-grade papillary urothelial carcinoma?
MR. MANDELL: Objection.
BY THE WITNESS:
A. Yes, sir.
MR. MANDELL: Go ahead.
BY THE WITNESS:
A. Yes, sir.
BY MR. GARAND:
Q. And, again, you don't treat patients with this specific type of cancer, correct?
A. I do not.
MR. MANDELL: When you say "treat," you mean for

that cancer?

MR. GARAND: Correct, for that cancer.

MR. MANDELL: That's what I thought you meant.

MR. GARAND: Thank you.

BY MR. GARAND:

Q. Doctor, did you review the expert report of Dr. Armine Smith in this matter?

A. I -- I don't recall that specifically, Armine Smith.

Q. Do you know -- do you have any familiarity with what her expert opinion would be on?

A. Again, connecting names and professions at this point, there's just so many names here. I'm sorry, I don't.

Q. I'll make it easier for us, Doctor. I'll show you what I'll mark as Cooper Exhibit 24.

(WHEREUPON, a certain document was marked Dr. Cooper Deposition Exhibit No. 24, for identification, as of 07/10/2025.)

BY MR. GARAND:

Q. And, Doctor, I'll represent to you that she is a specific causation expert on behalf of Mr. Mousser.

A. Okay.

Q. She issued an initial opinion and then a supplemental opinion after Mr. Mousser's second cancer.

A. Okay.

Q. And so I'm going to show you her supplemental specific causation expert report.

MR. GARAND: Thank you.

BY THE WITNESS:

A. Thank you.

BY MR. GARAND:

Q. And, Doctor, if you have not had a chance to review this, please feel free to do so. It's -- it's not long, so just let me know when you're ready.

A. Okay.

Q. So, Doctor, if we'll look at the second main paragraph, the very last sentence states that, "In Mr. Mousser's case, this new bladder tumor is best understood as part of the continuum of his existing urothelial disease process, not as a new or unrelated malignancy."

Did I read that correctly?

A. Yes.

Q. If we look at her -- if you see then the

next line is, "Based on my review of the updated clinical documentation, I conclude the following," and she lists three reports -- or three opinions there, right?

A. She does.

Q. All right. Number 3 states that, "The development of low-grade bladder cancer does not independently impact or worsen Mr. Mousser's overall prognosis, which remains governed by his prior high-grade UTUC and the associated nephroureterectomy," is that correct?

A. That's correct, sir.

Q. So if we go back to your expert report for Mr. Mousser. Again, we're looking at Page 4.

So Mr. Mousser did, in fact, have a recurrence more than four years after his surgery, is that correct?

A. That's correct.

Q. Would you agree -- so his -- as stated by Dr. Smith, which, again, is Mr. Mousser's specific causation expert, she found that his prognosis is still governed by the original UTUC, correct?

A. That's correct.

Q. And his cancer was not a metastatic site

that appeared in the bones, lungs, liver, or brain, correct?

A. That's correct.

Q. Okay. Let's look at the last paragraph -- or at the bottom of Page 5 of your Mousser report, the third line down, Mr. -- you write in your report that, "Mr. Mousser also calls himself a 'slave' to his employment schedule making the opportunity for gainful employment impossible," is that correct?

A. That's correct, sir.

Q. Is the "making the opportunity for gainful employment impossible" part of that sentence, is that Mr. Mousser's statement or your opinion?

A. I apologize, one more time.

Q. So you -- is the "making the opportunity for gainful employment impossible" part of that sentence Mr. Mousser's statement or your opinion?

A. So you're talking about previously what was said, not that statement?

Q. No. So I'm asking, what you wrote in here is that, "He calls himself a 'slave' to his appointment schedule" --

A. Yeah, I know that, but we -- the gainful employment we talked about elsewhere.

Q. But I'm -- I'm asking, is that your opinion or did Mr. Mousser say his -- did you see in some record that his appointment schedule makes it impossible for him to maintain employment?

A. Yeah, I just want to make sure I have my statements correct.

Q. Of course.

A. So just -- just to be clear, my statement says, the ability to maintain full-time employment is difficult, not impossible, despite his interest. And then we go over here, we talk about "slave to his appointment schedule, the opportunity for gainful employment impossible." That's what I interpreted his statement to be based upon his deposition that I read.

Q. Okay. So that's not your opinion, that's your recitation of his statement?

A. Correct. My -- my opinion is several paragraphs earlier that we talked about.

Q. Okay. Okay. If you look at this, again, Page 5 in the bottom, the sentence immediately following what we were just discussing, you write, "His psychological concerns have resulted in significant insomnia which contributes to his ongoing feelings of fatigue," is that correct?

A. That's correct.
Q. Again, is this your opinion, or was it based off Mr. Mousser's deposition testimony or medical records or anything like that?
A. Both. I mean, based -- based upon his medical records from the VA, including the -- the psychologist who is caring for him, as well as Mr. Mousser's deposition.
Q. Are you aware that Mr. Mousser has severe obstructed sleep apnea that impacts his ability to sleep?
A. I am, yes.
Q. Are you aware that Mr. Mousser's musculoskeletal pain significantly impacts his sleep?
A. I don't know that part specifically.
Q. Are you aware that Mr. Mousser's nocturia causes him to wake up five to six times a night to use the bathroom?
A. I recall that being as part of his history, yes.
Q. Are you aware that Mr. Mousser has stated that his tinnitus interferes with his ability to sleep?
A. I don't recall that specifically, no.

Q. Okay. So there are many possible reasons or bases for him feeling fatigued, correct?

MR. MANDELL: Objection.

BY THE WITNESS:

A. According to Mr. Mousser, he believes that the -- you know, the most concerning reason for why he has an inability to work is his constant concern about recurrence of his cancer and, you know, the fact that he has so many now appointments. So he doesn't specifically call out to those other things.

BY MR. GARAND:

Q. Okay. And, again, I was just asking about his fatigue, not -- not his overall ability to work?

A. Same.

Q. So are you aware that there's, yeah, many different reasons for Mr. Mousser's fatigue?

MR. MANDELL: Objection.

BY THE WITNESS:

A. So there are reasons. Those aren't the ones that Mr. Mousser calls as to why he is so fatigued.

BY MR. GARAND:

Q. Okay. Again, looking at his deposition transcript, correct?

A. And in the records when he's speaking with a psychologist.

Q. Okay. All right. And then that last sentence in this last full paragraph on Page 5 of your Mousser report, you write, "Based on review of Mr. Mousser's postsurgical records, he has significant stress and illness anxiety disorder and will require lifetime psychological counseling and support," is that correct?

A. That's correct.

Q. Doctor, you're not a psychologist, correct?

A. I'm not.

Q. And you're not a psychiatrist?

A. I am not.

Q. You're not a mental health professional of any kind, correct?

A. No, sir.

Q. You don't treat patients for mental health conditions?

A. Not primarily, no.

Q. Is this a diagnosis of significant stress and illness anxiety disorder?

A. Say what again?

Q. Is that a -- is that a specific diagnosis you're making?

A. It is, it is. That's found in the medical record.

Q. So there is a medical record that diagnoses him with stress and illness anxiety disorder?

A. There is, his psychologist.

Q. Okay. And so that's not your diagnosis; you're just quoting what someone else has diagnosed him with?

A. That's correct.

Q. Do you have an opinion on the cause of his mental health issues?

A. Again, based upon the medical records and treating similar patients, I can certainly understand why he feels the way that he does.

Q. Do you have a complete -- or -- or a full understanding of Mr. Mousser's personal and professional background that could contribute to mental health conditions?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I believe I've read a lot of records and

notes about Mr. Mousser and following the nephrectomy for cancer and everything that followed, I, again, see a lot of these patients and I can certainly understand why he describes the way that he does.

BY MR. GARAND:

Q. Doctor, do you have any knowledge regarding Mr. Mousser's relationship with his parents?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I don't know.

BY MR. GARAND:

Q. Do you have any knowledge of any traumatic events that Mr. Mousser or his family members experienced when he was a kid?

MR. MANDELL: Objection.

BY THE WITNESS:

A. No, I don't.

BY MR. GARAND:

Q. Do you have any knowledge regarding whether Mr. Mousser was abused as a child?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I don't.

BY MR. GARAND:

Q. Do you have any knowledge regarding his marital history?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I don't.

BY MR. GARAND:

Q. Do you have any knowledge regarding his relationship with his own children?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I don't.

BY MR. GARAND:

Q. Do you have any knowledge regarding Mr. Mousser's work dynamic before he stopped working?

MR. MANDELL: Objection.

BY THE WITNESS:

A. Could you just -- could you be more -- his work dynamic?

BY MR. GARAND:

Q. Sure. He -- do you know who he last worked for before he retired in October of 2023?

A. I know he worked at a car agency.

Q. Okay. Do you understand or do you have any knowledge about the professional dynamic at this

car auto dealership?

A. No, not specifically, no.

Q. Do you have any knowledge regarding Mr. Mousser's use of opioids?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I don't, no.

BY MR. GARAND:

Q. Do you have any knowledge regarding Mr. Mousser's severe obstructive sleep apnea, which we've discussed a little bit today?

MR. MANDELL: Objection.

BY THE WITNESS:

A. Just that he had the diagnosis.

BY MR. GARAND:

Q. Did you know that he had the diagnosis before this deposition today?

A. Yes.

Q. Doctor, can you also explain how you're able to determine that Mr. Mousser will require lifetime psychological counseling and -- and support?

A. That's, again, in his notes from his psychologist. He's on disability and his psychologist says that that's what he's -- going to be necessary.

Q. And by "his psychologist," do you mean Dr. Mueller?

A. Those are the -- I believe that's the name.

Q. Have you -- did you look at Dr. Roger Moore's expert opinion in this case?

A. Again, I don't remember specifically his name.

Q. Do you recall reviewing an expert psychologist report on behalf of Mr. Mousser?

A. I don't remember that specifically, no.

Q. Okay. Doctor, let's look at Jacqueline Tukes' report, which is Exhibit 8. I'm happy to say we're done with Mr. Mousser, or at least for a few minutes.

MR. MANDELL: Well, that was quick.

MR. GARAND: Yeah, you know.

BY MR. GARAND:

Q. Okay. Doctor, Ms. Tukes received a deceased donor kidney transplant, correct?

A. Yes, sir, she did.

Q. And the transplant occurred on April 23rd of 2024, is that right?

A. I believe that's the right date, April 24,

yes.

Q. And she was 59 years old at the time?

A. She was.

Q. Okay. Let's look at Page 3 of your Tukes report. The first paragraph under heading V?

A. Yes.

Q. The first line all of the way to the right, you write, "The half-life (mean survival) for DD transplants is 13 years."

Did I read that correctly?

A. That's correct.

Q. So you'd agree by definition if 13 years is the median graft survival, that's just an average, not a maximum, correct?

A. Correct, but it's the mean, not median.

Q. Okay. Okay. Thank you, Doctor.

So it's true that some deceased donor kidney transplants last well beyond 13 years, is that right?

A. They do.

Q. So it's a possibility that Ms. Tukes' transplant can last longer than 13 years, is that right?

A. I believe it's unlikely based upon the

deceased donor that -- that she received and, again, the facts of -- or the number that we're talking about here is based upon the quality of all grafts. So I believe based upon the information that we know about her graft that it's more likely than not that she'll have 13 or less years for her kidney transplant.

Q. Delayed graft function is the need for hemodialysis in the first week after transplant surgery, right?

A. That's the standard definition, yes, sir.

Q. Delayed graft function is a major risk factor for early transplant graft loss, is that right?

A. It -- not necessarily. It is a -- a potential complication that occurs after transplant that if folks develop delayed graft function that can then go on to become primary non-function, yes.

Q. Ms. Tukes did not experience delayed graft function, correct?

A. Not according to the records, no.

Q. And at worst, it's at least not a bad thing that that happened, correct? It doesn't negatively impact her prognosis, right?

A. That's correct.

Q. Are you aware that as of January 2025

Ms. Tukes had not shown any signs of rejection of the transplant?

A. I'm aware that she didn't show any signs of acute rejection based upon the fact that she hasn't had a biopsy.

Q. Are there any -- and I appreciate the distinction between acute and chronic. Thanks for that clarification, Doctor.

Are there any signs that you're aware of of acute rejection?

A. Not that I saw in the medical record.

Q. Are you aware that as of January 2025, Ms. Tukes had not shown any signs of cancer recurrence?

A. Yes, sir, I do not.

Q. As of January 2025, none of Ms. Tukes' healthcare providers had expressed concerns about her kidney function since the transplant, is that right?

A. That's correct.

Q. As of January 2025, Ms. Tukes had not had any issues with infections, is that right?

A. She had CMV uremia, so she had some viral particles in her blood and urine that required a changing of her immunosuppression.

Q. Okay. Were there any other infections other than that instance?
A. Not that I saw.
Q. Are you aware of any more recent records indicating signs of rejection, cancer recurrence, or infections?
A. Not that I am aware of, no.
Q. Would you agree that risk of acute rejection is highest in the first year?
A. Highest comparatively to years thereafter, yes.
Q. Would you agree that early transplant stability is generally associated with better long-term outcomes?
A. As one of the factors that can help determine long-term outcomes, yes, I do.
Q. Acute rejection negatively affects long-term survival of the graft, is that right?
A. Any acute rejection, yes.
Q. Are you aware of an instance of -- of acute rejection since Ms. Tukes' kidney transplant in April of 2004?
A. No.
Q. And we're over a year removed from that

transplant, correct?

A. That's correct.

Q. After a kidney transplant, what would you consider a positive creatinine level?

A. One more time? A positive creatinine, you mean --

Q. Yeah, so in terms of, like, what -- that is demonstrating that the kidney func- -- you know, the graft and the kidney function is operating well.

A. All based upon the kidney -- the quality of the kidney that the patient received. I'd certainly like to see creatinines, you know, somewhere below 1.5 milligrams per deciliter.

Q. Okay. And so for the quality of kidney transplant that Ms. Tukes received, would that same creatinine level still hold true?

A. It would. Again, as we've talked about before, we're utilizing a poor man's measure of kidney function in creatinines. We use those only as a marker for how well we need to -- or closely need to follow these patients and what to look out for.

Q. And, Doctor, I know we've -- we've -- yeah, we've talked about the creatinine and the GFR. That is the standard -- or what nephrologists rely on

and look at to, again, determine endstage kid -- chronic kidney disease, correct?

MR. MANDELL: Objection.

BY THE WITNESS:

A. Post-transplant, yes, but it's a little different in a post-transplant patient. So very small changes in creatinine are something we respond to very aggressively.

BY MR. GARAND:

Q. Doctor, are you aware of Ms. Tukes' post-transplant creatinine levels?

A. I -- again, what I had in the records that I reviewed, yes.

Q. Are you aware that her creatinine level was 14 -- was over 14 on the date of her transplant?

A. I don't remember that number specifically. That's probably right.

Q. Do you recall that it was high on the --

A. It was high.

Q. Are you aware that it was below 1 in March of 2025?

A. That sounds about right.

Q. Would you agree that creatinine in the low 1s is generally viewed as a favorable sign for a

transplant recipient at her stage?

A. At this stage that she's in, yes, I believe that's a good creatinine.

Q. Would you agree that generally patients with kidney transplants live longer than patients on dialysis?

A. The data supports that, yes.

Q. Would you agree that generally patients with kidney transplants have a better functional status compared to those patients on dialysis?

A. On average, yes.

Q. You're aware that Ms. Tukes' post-transplant nephrologist Heather Jones stated that Ms. Tukes has a good prognosis in terms of her kidney function, correct?

A. I don't remember that comment specifically, but I'm -- I'm sure that that's what their team has said.

Q. Doctor, there's no standard age limit for kidney transplantation, correct?

A. It depends on where you are. Different programs do have absolute age limits for transplant.

Q. What would an absolute age limit for a transplant look like?

A. Some are above 65, some are above 70.
Q. Are you aware of an age limitation in North Carolina where Ms. Tukes resides?
A. I don't -- I'm not sure what their -- if they have one.
Q. Is it true that chronological age is less important that physiologic age?
A. As one -- as one of the factors -- and I assume we're talking with candidacy for transplant?
Q. Correct.
A. Sure. I mean, if we were to look at one versus the other, we'd try and take in more than just a number at our program.
Q. Ms. Tukes does not have diabetes, correct?
A. She does. So she has what's often referred to as prediabetes or early diabetes and -- and is currently on medication for it.
Q. But not diabetes, not diabetes 1 or 2, correct?
A. Well, that would be diabetes.
Q. Prediabetes?
A. Yes.
Q. Okay. Does she have a known cardiovascular disease?

A. I don't know if she has a diagnosis of cardiovascular disease, no.

Q. Okay. Doctor, I think we've been going for about an hour. If we can take another quick break, and then I should be able to wrap up.

A. Okay.

Q. There are just a couple of other topics that I would like to discuss.

A. Okay.

THE VIDEOGRAPHER: Going off the record at 12:20 p.m.

(WHEREUPON, a recess was had from 12:20 to 12:27 p.m.)

THE VIDEOGRAPHER: We are back on the record at 12:27 p.m.

BY MR. GARAND:

Q. Doctor, in each of your reports, and we can look at -- which one do you have in front of you?

A. I have Tukes still open.

Q. Okay. Let's look at Page 16 of Tukes, just for ease of reference.

Okay. So Number 2, you write, "The treatment and care Ms. Tukes has received and is now receiving is reasonable and medically necessary."

And you write the same thing essentially for Mr. Mousser; is that right? And I can --

A. I do, yes, sir.

Q. Yeah, it's Page 15 --

A. Just make sure they're in the same order -- yeah.

Q. What medical treatment are you referring to for Ms. Tukes when you make that statement?

A. The entirety of her medical -- I mean, the entirety of her medical. So her -- the fact that -- and we've discussed some of this. Her treatment for her kidney cancers, the -- I guess the ongoing care of her while then on dialysis was appropriate, the transition to peritoneal dialysis I think is a better thing, the kidney transplant certainly is a better thing than dialysis and, you know, the care that she has received from her transplant team is, again, I think reasonable and medically necessary.

Q. And, Doctor, when you make that statement for Mr. Mousser, what medical treatment are you referring to for him?

A. Again, the diagnosis of his cancer, the treatment of his ongoing comorbidities, the post-nephrectomy management by his team at the VA.

I -- you know, I would hesitate in only that discharging him from a nephrology clinic, I think is a mistake because, as we've talked about, I still think he has risks.

But, again, I think the fact that he's receiving care for his comorbidities that we know and have talked about, potentially reduced the impact of his injured kidney following a nephrectomy for cancer that's hyper-filtrating, I -- I think that's appropriate.

Q. Are you aware whether or not Mr. Mousser has seen a nephrologist since he was discharged by Dr. Bucci, I believe?

A. I -- no, I'm sorry, I don't know that.

Q. Doctor, why did you opine on Mr. Mousser's and Mrs. Tukes' past and future medical treatment?

MR. MANDELL: Objection.

To the extent that it results from any conversations that we've had or anybody else from my office had with you, that I'm instructing you not to answer. But if you can otherwise answer independently, please do.

BY THE WITNESS:

A. So, again, my role as an expert was to

look at the totality of the information that I had, which included the medical records and, as talked about, some of these depositions, and to determine whether or not where Ms. Tukes and Mr. Mousser currently were following their nephrectomy was, you know, appropriate. And as one has been transplanted, my area of expertise, and as one as approaching the need for transplant, was, again, what I believe my role was in reviewing these records.

BY MR. GARAND:

Q. Is -- do you typically opine on the reasonable -- reasonableness and necessity of medical treatment?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I do, yes.

BY MR. GARAND:

Q. Okay. Also in each report, again, Mousser's report Page 15 and Tukes's on Page 16, you state that the harms and injuries and damages suffered by Mr. Mousser or Ms. Tukes that are described in this report are permanent. Is that right?

A. Correct.

Q. So in regards to Mr. Mousser, when you

mention harms, injuries, or damages are permanent, what harms, injuries, or damages are you referring to?

A. He'll never get that kidney back because of his cancer.

Q. Is that the only permanent harm, injury, or damage?

A. And the fact that he has now only one kidney and all of the things that we continue to talk about, the hyper-filtration of that kidney that has to work, and an individual who has multiple comorbidities that we know cause and worsen chronic kidney disease, to my opinion, stated earlier, it is expected that kidney is going to be long lost in three to five years.

Q. And Mr. Mousser's VA nephrologists have described his chronic kidney disease as stable CKD Stage G3a A1, correct?

MR. MANDELL: Objection.

BY THE WITNESS:

A. That's -- that's their statement.

BY MR. GARAND:

Q. And his hypertension according to his VA -- his VA -- I guess, yeah, his VA team as well as his cardiology team at South Texas -- South Texas

Cardiovascular Consultants have found that his hypertension is well controlled as well, correct?

MR. MANDELL: Objection.

BY THE WITNESS:

A. Currently, yes, but at times borderline.

BY MR. GARAND:

Q. And what are the permanent harms, injuries, or damages suffered by Ms. Tukes?

A. So Ms. Tukes is now absent two kidneys, you know, secondary to the -- the cancer and the bilateral nephrectomies, completion nephrectomies that were necessary for the identification and treatment. She then has the risk associated with long-term immunosuppression that increases both infections and malignancies. And we know despite the fact that her lifespan is better than dialysis, it still is reduced because of the need to receive renal replacement therapy.

Q. Doctor, on Page 16 of both reports, you also found that the care costs Mr. Mousser or Ms. Tukes incurred for past treatment and care are fair, reasonable, and medically necessary, is that right?

A. That's correct.

Q. What -- for Mr. Mousser, what is the -- what's the past treatment that you're referring to?

A. Again, as we talked about before, his, you know, identification of his cancer, the workup of that, the nephrectomy, the post-transplant care, you know, all of that that leads us up to today.

Q. And what's the past treatment that you're referring to for Ms. Tukes?

A. And, again, the identification of the multiple renal cancers that led to her bilateral nephrectomies, the interventions and the postsurgical care that was necessary for that, her institution of dialysis, both in center and then home peritoneal dialysis, and the successful transplant in 2024 and the management of that allograft thereafter.

Q. What methodology did you use to determine that their medical bill -- bills were fair, reasonable, and medically necessary?

MR. MANDELL: Objection.

BY THE WITNESS:

A. I received a copy of their medical bills and just briefly reviewed all of those. And, again, based upon what we just talked about and, you know, again, a cursory comparison of those activities that I

believe were appropriate and what those billings were, I came to that conclusion.

BY MR. GARAND:

Q. In your practice as a transplant surgeon, do you typically review medical bills?

MR. MANDELL: Objection.

BY THE WITNESS:

A. As a transplant surgeon. Can you ask that one more time?

BY MR. GARAND:

Q. Sure. In your practice --

A. Yeah.

Q. -- as a transplant surgeon, are you ordinarily responsible for evaluating and reviewing medical bills?

MR. MANDELL: Objection.

BY THE WITNESS:

A. Not routinely, but if asked to. So I -- I -- as the chief of this division, I'm routinely asked to look at finances, and those include sometimes patients who are sort of dissatisfied with the cost of their care.

BY MR. GARAND:

Q. And how often do you review the -- you

know, the bills for the patients that are dissatisfied with their care?

A. Maybe one or two a year.

Q. Does your hospital have a separate department that manages medical billing to patients?

A. We do.

Q. Do you oversee that office at all?

A. I do not.

Q. In prior cases where you served as an expert witness, have you opined on whether a party's medical bills were reasonable and medical -- medically necessary?

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

Q. So you don't know one way or the other whether you have?

A. I don't recall. I don't know.

Q. It's not a part of your typical practice as an expert?

MR. MANDELL: Objection.

BY THE WITNESS:

A. Different asks are -- you know, have different requests. So I -- I've been asked in the past, but I don't know the frequency.

BY MR. GARAND:

Q. Okay. If we look at your initial -- and we don't -- we don't have to, but your initial MCL for Mr. Mousser, which is Cooper Exhibit 1.

A. MCL?

Q. Yes.

A. Oh, gosh, I've got to find one.

Q. I know, we're going -- going back there.

MR. MANDELL: I've got it right here for you.

THE WITNESS: God bless you. Thank you, thank you.

BY MR. GARAND:

Q. And if we look at Page 3.

A. Yes, sir.

Q. And we look at Number 10, it states that, "Frank W. Mousser's medical expenses," and then you -- sorry. And so this is what you've reviewed and what you considered. And it says, "Frank W. Mousser's medical expenses," and you list some Bates numbers there, right?

A. Yes, sir.

Q. If we look at this, the first range, you have Bates ending in 07362 to 7336. That doesn't seem to make sense to me in terms of just -- is -- do you -- do you recall or know what those Bates should

have been?

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

Q. Okay. And I'll show --

A. That's obviously a misprint.

Q. -- you these records. Sure.

Do these two Bates ranges that you list here include all of the invoices that you are aware of for Mr. Mousser's past medical expenses?

A. I don't know that for sure.

Q. Okay. As you're sitting here right now, though, you are not aware of any or -- and I'm going to show you these medical records, but you're not aware of any other outstanding invoices that you're providing this opinion on?

A. Not that I'm aware of, no.

Q. Okay. Let's see. We'll mark this as Cooper Exhibit 25.

(WHEREUPON, a certain document was marked Dr. Cooper Deposition Exhibit No. 25, for identification, as of 07/10/2025.)

BY THE WITNESS:

A. Thank you.

BY MR. GARAND:

Q. And, Doctor, I'll allow you to review that briefly and let me know if you've seen these records before.

And just for the record, this is that first subset of records that you listed, which is 00667_MOUSSER_07336 through 07362. I wasn't 100 percent sure what records, so I just included all of them.

A. I don't remember these specifically, sir, but, again, I had all of the information that was in materials reviewed in my possession.

Q. Okay. So let's start at the very beginning, and I apologize that some of these numbers are cut off, but we should be able to work through them here.

I'll ask that you flip through 07336 through 07356, so about those first 20 pages here, and then I'll ask you a few questions whenever you are ready.

A. Okay.

Q. Okay. So anything that you just saw from 7336 to 7356, are any of those invoices?

A. No.

Q. And these are treatment records from the

Franklin Clinic, is that correct?

A. They are.

Q. Are you aware of Mr. Mousser being treated for his kidney cancer at the Franklin Clinic?

A. I don't believe so, no.

Q. And I'll note, if you look at the dates, they are from 2012 to 2015. Did Mr. Mousser have kidney cancer during those dates, during those years?

A. I don't -- it certainly wasn't diagnosed at that time.

Q. You're aware that he had gross hematuria in 2017, correct?

A. I do recall that, yes.

Q. And he had a workup at that time, right?

A. He did.

Q. And there was no -- he did not have cancer at that time, correct?

A. There was no diagnosis made of cancer, no, not at that time.

Q. Okay. So if we look at 7357 through 7361. Take a minute to review those and let me know when you're ready.

A. Okay.

Q. So these are invoices from May of 2021,

and if you just look through -- sorry, from May 17 -- of 2017 through May of 2021, is that right? Do you see any dates outside of that?

A. Tell me those dates again, I'm sorry, what you said.

Q. May of '17 through May of 2021.

A. Yes, I see that.

Q. Mr. Mousser wasn't diagnosed with kidney cancer until late August and September of 2020, is that right?

A. Correct.

Q. And he had no treatment for the kidney cancer until October 2020 when he had his nephroureterectomy, is that right?

A. That's correct.

Q. And that was done at VA, a VA facility?

A. It was, yes, sir.

Q. And his postsurgery treatment for the medical conditions, you know, his kidney cancer, chronic kidney disease, that's all been done at VA as well, right?

A. It has, yes.

Q. Do you have any knowledge that he was treated at the Franklin Clinic for his kidney cancer?

A. No.
Q. So you would agree that these medical records are unrelated to Mr. Mousser's UTUC treatment?
A. That's correct.
Q. They're also unrelated to his second bladder cancer diagnosis in 2025, correct?
A. That's correct.
Q. Why did you include invoices from the Franklin Clinic in your Materials Considered List as evidence of Mr. Mousser's medical expenses?
A. They were the wrong numbers.
Q. Okay. So these -- these are all incorrect then?
MR. MANDELL: Objection.
BY THE WITNESS:
A. These -- these are the incorrect records.
BY MR. GARAND:
Q. Okay.
MR. MANDELL: And just so it's clear for the record, you're talking about Exhibit No. 25?
THE WITNESS: Correct, Exhibit 25.
MR. GARAND: Thank you, Mr. Mandell.
BY MR. GARAND:
Q. Okay. I'm going to show you what I hope

is our last exhibit here.

A. Erick is cheering over there.

Q. He -- he's excited.

And we are going to mark it as Cooper Exhibit 26.

(WHEREUPON, a certain document was marked Dr. Cooper Deposition Exhibit No. 26, for identification, as of 07/10/2025.)

BY THE WITNESS:

A. Thank you.

BY MR. GARAND:

Q. Thank you.

Doctor, I'll represent to you that this is the second set of Bates ranges that's listed in your initial Materials Considered List for Mr. Mousser and it's Bates-stamped 00667_MOUSSER_08702 through 8732.

A. Okay.

Q. And, again, Mr. Mousser was not diagnosed with kidney cancer until August or September of 2020, correct?

A. Yes, sir.

Q. And his nephroureterectomy was in October of 2020, right?

A. Yes, sir.
Q. Okay. And if you flip through these records, they're all from the -- from Peterson Health, is that right?
A. Yes, that appears correct.
Q. And as we discussed, all of Mr. Mousser's care for his kidney cancer and related disabilities was done at VA, correct?
A. That's correct.
Q. Okay. So let's look at Pages 8 -- Bates ending in 08702 through 14, 8 -- 087114. And specifically, Doctor, I'll ask you to look at the dates of those invoices, and so please take your time reviewing.
A. Okay.
Q. These invoices are all from 2012 to 2019, correct?
A. That's correct.
Q. And he was not diagnosed -- Mr. Mousser was not diagnosed with kidney cancer until 2020, right?
A. Yes, sir.
Q. So can we agree that all of those records, meaning Bates ending in 08702 through 08714 predate

his kidney cancer diagnosis, right?

A. Yes, sir, that's correct.

Q. Can you tell me why you included these invoices, please?

A. I believe these are the wrong Bates numbers also.

Q. Okay. So let's look at Bates ending in 08715 -- well, actually, Doctor, so can you look through those records and tell me what the correct -- if any of them are the correct invoices that you meant to cite?

A. No, these I believe are the wrong Bates numbers.

MR. MANDELL: Up to 14, you're talking about?

THE WITNESS: Yeah, I looked --

MR. GARAND: Well, so I'm asking for the entire --

THE WITNESS: I looked through the rest of them.

MR. MANDELL: Okay. Fine.

BY THE WITNESS:

A. Yeah, I did. These are, I think, are the -- the wrong Bates numbers and the wrong records.

BY MR. GARAND:

Q. Can you describe to me what the right

records were? Again, most of Mr. Mousser's treatment for his cancer, I think all of his treatment for his cancer and other disabilities or other conditions have been at VA at no cost to Mr. Mousser. So I'm curious what the records you meant to -- to cite were.

A. So, yeah, it has been a while since I looked at those. So I had records that were shared with me that I'm -- I don't remember exactly where they were from, but, they, again -- they -- they were costs associated with care. I don't believe they were all from the VA. I think they were from other locations.

Q. Do you --

A. But I'm sorry, I don't remember specifically what those were.

Q. Okay. Doctor, you've testified at deposition or trial before, right?

A. I have, sir, yes.

Q. Okay. Let's look at -- let's look at Cooper Exhibit 7, which is Mr. Mousser's report, and I'm looking at the very -- let's see -- last page.

THE VIDEOGRAPHER: Mr. Mandell, your microphone.

BY THE WITNESS:

A. Mr. Mousser's, sir, the last?

BY MR. GARAND:

Q. Yes, the very last page which is a list of your testimony history, is that right?

A. Yes, sir.

Q. Have you ever served as an expert in a case on behalf of the United States?

A. I have not.

Q. Have you ever served as an expert in a case against the United States?

A. No, sir.

Q. Is this an accurate list of the cases in which you provided a deposition or trial testimony?

A. I'm looking at the wrong thing. Oh, at the end of my CV.

Q. Sorry about that.

A. Yes, I apologize. It is, yes. I apologize.

Q. So is the first time you served -- was August 2018 the first time you served as an expert, or is that just the first listed?

A. That -- it's the first listed. I believe -- I believe I began expert review soon after the completion of my fellowship, so in the mid 2000s.

Q. Doctor, I'll just ask generally, are

these -- are they predominantly one kind of case, like medical malpractice or anything like that?

A. Predominantly, yes.

Q. Medical malpractice?

A. Correct.

Q. Can you identify which cases are not medical malpractice?

A. On -- on this list?

Q. Yes, to the extent you remember.

A. I believe these are all medical malpractice cases.

Q. Okay. Have you provided testimony either at deposition or at trial in a toxic or environmental tort case other than this one?

A. No, sir, I have not.

Q. In any of these cases did you provide an opinion as to someone's chronic kidney disease, prognosis or whether they'll require a transplant or dialysis?

A. Yes.

Q. Okay. Do you recall which ones those are?

A. I'm sorry, any of these cases?

Q. Any of these cases.

A. I'll have to look at these. But I've

certainly reviewed cases that have asked that question. I don't know whether they actually went to deposition or to trial.

I'm sorry, sir, this is so long ago I don't remember these specifically as to whether or not that was the issue in question.

Q. Do you recall generally what your opinions were in those cases?

A. I don't recall that either. It has been a long time.

Q. Doctor, have you ever been involved in litigation in your personal capacity?

A. No.

Q. Okay. Doctor, if we could just take a two-minute break, I should be able to wrap up and then I'll hand it over to Mr. Mandell.

A. Thank you.

MR. MANDELL: We're just going to stay.

MR. GARAND: We'll step out real quick. I'm just going to chat and then we'll be good.

THE VIDEOGRAPHER: Going off the record at 12:50 p.m.

(WHEREUPON, a recess was had from 12:50 to 12:53 p.m.)

THE VIDEOGRAPHER: We are back on the record at 12:53 p.m.

MR. GARAND: All right. Doctor, I have no further questions. I appreciate your time this afternoon -- or this morning.

THE WITNESS: Thank you. Thank you very much.

MR. MANDELL: I just have one question -- actually maybe two.

EXAMINATION

BY MR. MANDELL:

Q. Dr. Cooper, you were asked questions about creatinine levels after Mr. Mousser's nephrectomy in terms of whether they were normal and/or reassuring.

Do you have an opinion to a reasonable degree of medical certainty as to whether or not the creatinine levels that were identified for Mr. Mousser after his nephrectomy were normal and/or reassuring?

So the first question is, do you have an opinion to a reasonable degree of medical certainty about that subject, yes or no?

A. I do.

Q. All right. What is that opinion to a reasonable degree of medical certainty?

A. So, again, my opinion is, and the

definition of normal, if we want to use what's considered the standard reference values for normal creatinine, above 1.3 we can consider that to be abnormal. And the majority of Mr. Mousser's creatinines were almost all above that.

And I'm -- I guess I'm shocked when we talked about the -- the various individuals that provided care for Mr. Mousser after that, with all of the things that really everybody knows about the inaccuracies of creatinine plus all of the additional information that is readily available to utilize that abnormal number and get a true assessment of that remaining kidney, i.e., the -- the fact that that kidney is having to work much harder than a single kidney -- or sorry, than two kidneys would have to, the fact that we have a pathology report that shows that there's some underlying damage based upon his comorbidities, I mean, all of that information to me is demonstrable of an abnormal kidney.

I take care of a lot of people who have a kidney removed. We asked earlier about can people live a normal life with a single kidney. We're -- we're blessed that we have living donors that want to come forward and they want to donate a kidney, and we

do all of those tests. We measure their GFR, we check for protein in the urine, and we clear them to donate an organ.

And then they donate a kidney and their kidney, yes, it does hyper-filtrate for a short period of time and corrects and they go back to have a normal creatinines. They have creatinines of .9, 1.0. They have no evidence of albuminuria. But we have -- if there's ever any question, we even biopsy people that want to donate a kidney because that's the -- the -- the gold standard of what the kidney looks like regardless of a normal creatinine.

And I've also been blessed, you know, we have a number of people who are deceased donors, and the majority of them have normal creatinines, but when you go in and remove their kidney and look at it under the microscope, because we often take a biopsy, you see that they have significant injury and we can't use those kidneys.

So even in the face of a normal creatinine, we're saying those kidneys are not better than people being on dialysis.

Q. Okay.

A. Because we know that they aren't going to

do well.

MR. MANDELL: I have no further questions. Thank you.

MR. GARAND: Yeah, no further questions.

MR. MANDELL: Great.

THE VIDEOGRAPHER: Going off the record at 12:56 p.m. That concludes today's testimony of Dr. Cooper.

Thereupon, at 12:56 p.m., on Thursday, July 10, 2025, the deposition was concluded.

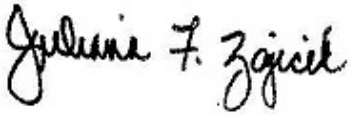
REPORTER'S CERTIFICATE

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

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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.

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