Exhibit A

(Transcript Excerpts)

State of South Carolina)
)
County of York)

Court of Common Pleas

2009-CP-46-05195

Angela Patton)
vs.) Transcript of Record
)
Dr. Gregory A. Miller, et al)
)
Defendant)

January 4-14, 2022
York, South Carolina

B E F O R E:

Honorable William McKinnon, Judge

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

Edward L. Graham, Esq.
David Bradley Jordan, Esq
Attorneys for the Plaintiff

Ashby Davis, Esq.
Drew Traylor, Esq.
Attorneys for the Defendants

Proceedings Recorded by DCRP
Transcribed by Joy Holston

one, we believe there are 12 jurors.

THE COURT: Twelve jurors that were themselves patients or are you counting men whose wives were treated when they were pregnant?

MR. GRAHAM: Eight that are female patients or that are presumably husband's married to female patients.

THE COURT: Okay.

MR. GRAHAM: But, certainly we would like to explore it for peremptory strikes.

THE COURT: Absolutely. You can ask questions during your 30 minutes, and normally we don't get to that because I typically exclude them. But in this case I just don't think I can do a blanket rule with that many prospective jurors at issue.

MR. GRAHAM: Not even with respect to the eight that are actual patients.

THE COURT: I mean, I am not telling you I am going to deny a for cause motion in every case. I mean, I will hear what they say, how long it was, all that kind of thing. I am just saying, I am not going to issue a blanket ruling at the start that anybody who has been a patient cannot serve.

MR. GRAHAM: I understand. Thank you, Your Honor.

THE COURT: Yes, sir. Mr. Jordan, the first one, I think I have got an issue with. There is one that says,

starts out some people believe a medical doctor should not be held responsible for treating a patient in an emergency. I think that is one of those, can you follow the law as the Judge explains it.

MR. JORDAN: Well, Your Honor, it ask about, I believe, about training. It is different from the statute. We have got a legal issue that we plan to raise about, what general emergency is as compared to emergents.

THE COURT: Right. My only point is, for voir dire purposes. I mean this is getting into what the law is in South Carolina which is not something I typically allow. I understand, you can make your argument. I am not saying, for voir dire I don't typically allow attorneys to get into the points, you can do it in opening as long as you are correct. And the same with the question after that, do you feel a medical doctor should only be responsible if there was intentional harm. So, Mr. Jordan, I am going to say no on those two.

MR. JORDAN: I want to mark through those. I want to make sure I have those right, I want to remove those from the power point, Your Honor.

THE COURT: Thank you. Mr. Jordan, I am near the end. There is one that says, members of the health care community including your treating physician, show up for trial and sit behind the Defendant, is that something that

never denied that. But he may tell you that injury alone, evidence of injury alone is not, cannot be the basis of your determination, that there was negligence in this case. That is not the law in South Carolina and the Judge may tell you that. Let me talk to you about an emergency, an obstetrical emergency. And the questions I want you to ask as you go through this case and you listen to the experts and you listen to Dr. Miller, the only eyewitness who is going to testify about what happened in that operating room when Alexia was delivered. The only eyewitness that is going to tell you is Dr. Miller. Was this an obstetrical emergency. Was Alexia in immediate danger of serious bodily harm or death as a result of this shoulder dystocia. Was it forceable, was it foreseeable, was it predicable. And, yes, you will be asked to weigh the testimony because it is not all going to be the same. You are going to have some people saying this, some people saying that, that happens in every case. When I was a Deputy Solicitor in Greenville County many years ago, I had the burden of proof, beyond a reasonable doubt. That is a doubt for which you can give a reason, is what we used to say in our criminal cases. It is not that way anymore in a civil case, that is not the burden of proof that we are talking about. But every case I have been a prosecuting attorney on in a criminal case or in a civil

A Yes. If the doctor went through every maneuver, nothing was working, went through every maneuver again and nothing was working and the time getting toward that is five to six minutes then you get the baby out by whatever means you have to. And in that case, yes, I would defend that type of a situation, I would defend that doctor.
Q After 45 seconds or two minutes, whatever it was, between delivery of the head and delivery of the body, what would you have the doctor do to comply with the rules given all of these things he says he had already done?
A Well, again, you avoid excessive traction in any event if you are talking about between 45 second and two minutes. You go through maneuvers once again. You, perhaps try a reverse wood corkscrew, go the other direction if the first one hasn't been successful. Now you can try perhaps to deliver the posterior arm which is formerly the left arm and now is the right arm. That is another maneuver that you could, you try, you have another three minutes to work with before you start to worry about; asphyxia, minimally. So you go through all of those maneuvers and you perform them in the way you were trained to do and until it works. And after that and the five minutes are up and then you go to more desperation types of maneuvers if need be.
Q I am guessing if I or a taxi driver or anybody else

who is not an obstetrician was in a position where you had to deliver a baby, would you consider that a genuine emergency?

A In a situation where a cab driver is delivery a baby --

Q Shoulder dystocia, cab driver, shoulder dystocia?

A Sure. That would be an emergency because you have an untrained person in that type of situation trying to deliver the baby.

Q Do you make a distinction between a genuine emergency of someone who does not receive obstetric training to manage a shoulder dystocia and an obstetrician who is trained to manage a shoulder dystocia?

A Again, I think I do make that distinction recognition. Shoulder dystocia is considered an emergency but it becomes certainly much more obstetrically emergent after five minutes go by. It is very much a complication of labor and delivery and it certainly has occurred to all of us who have been out there long enough and delivered enough babies. But it is different than the general emergency. For someone in good hands, you know, it is going to be someone who is well trained, it could be successful in tracting the problem if you have been trained to do so. And trained to do so without trauma to the baby and that is what we are trained to do.

isn't that true?
A No. It is not an issue of training. This is strictly an issue for safety for that baby. The minute you diagnose shoulder dystocia every single literature source will say that is an emergent from that point forward. It is an emergency whether you are a cop on a beat; it is an emergency whether you are a taxi car driver; it doesn't matter. You have got a baby's life on your hand. And bad things happen really quickly. Okay. You and this is where Dr. Duboe and I disagree. I disagree completely with six to eight minutes. That is a farce in my world. You have got four to five minutes. This is a baby's life, whose life is on the line. So you try to do things really, you try to have a routine protocol. You are not going to wait five or six minutes before you get serious about a shoulder dystocia. That is one of the true classic obstetrical emergencies in our literature.
Q And something that you are trained for?
A Yes.
Q And, Doctor, you mentioned safety and you always want to do the safest thing for the patient, for Angela and Alexia, right?
A Yes.
Q Using excessive traction would never be the safest

force you used, you, (inaudible).
A I don't quite understand.
Q You were there and you had hands on Alexia's head, your testimony here is you used gentle traction, correct?
A Yes.
Q And whatever amount of force you used, you used that force to help deliver Alexia, correct?
A That gentle downward traction, yes.
Q And you, (inaudible).
A That was my force that I used, yes.
Q And, again Doctor, knowing what we know about this case you would do nothing different.
MR. DAVIS: Your Honor, again, that has been asked and answered, I believe.
THE COURT: I am going to allow it with an adverse witness.
MR. DAVIS: Thank you.
Q And, Doctor, the shoulder dystocia, and your testimony it was an emergency. If you did your normal routine protocol for shoulder dystocia?
A Yes, involving the right shoulder.
Q You didn't do anything differently with this case than you would have done on other cases of shoulder dystocia?
A Well, each case is a little different and you have to

THE COURT: Just so the jury understands. So Mr. Graham is going to read the questions that the attorneys asked at the deposition. And then Ms. Jordan is going to read the Doctor's answers.

MR. GRAHAM: First Dr. Gurewitsch was sworn and then the questions start.

(Whereupon, the Deposition of Dr. Edith Gurewitsch is read into the record. Mr. Graham is reading the questions by Mr. Davis. Ms. Grace Jordan is reading the answers by Dr. Gurewitsch. This reading of the deposition starts at 10:07 a.m.)

THE COURT: A good time for a lunch break. Ladies and gentlemen, let's a lunch break to 2:15. Have a great lunch and see you back at 2:15.

(Whereupon, the jury is excused for a lunch break.)

THE COURT: After lunch what do we have.

MR. GRAHAM: We have the mother and just to make sure all of our exhibits are in.

MR. DAVIS: I have got a witness under subpoena, should be very short. Hope we can get her up today and I will call Dr. Miller and that will be a very long direct. I would appreciate the Court's consideration with where we are today, just let me start tomorrow with Dr. Miller. There is nothing else I can bring tomorrow other than his testimony. I think in all fairness, would be more fair

there would be two people at the bedside, on either side of the sterile field. One would be the operating surgeon and the other would be, the surgeon's tech, the OR tech who is the technician who passes instruments, provides the, what the surgeon needs, suctions, you know, is the main assistance to the surgeon.

Q Is that main assistant sterile?

A Yes.

Q And the surgeon is as well?

A Correct.

Q And that is for patient's safety?

A Of course, yes, sterility, yes.

Q Looking at your records again, both preanesthesia checklist and your anesthesia record which I want to ask you about in some detail, it is not very long. I think everybody knows why. When you were reading earlier you said something about an emergency. Did I hear that correctly, explain that?

A Yes. That is right. The ASA Classification was a 2E, and a 2 means a patient who is in general and in quite good health but not a perfect specimen of health like a healthy 20-year-old. And we consider a pregnancy a Class 2 for purposes of grading. And then E means emergency.

Q Who makes that determination?

A I would have done that.

2012, which would be a little bit after eight o'clock, she was dilated to ten centimeters. The station of the baby is still pretty high at zero station, but she was dilated ten centimeters. And we know that the heart rate precipitously dropped, something we call bradycardia, into the 60s. The baby had been running a baseline of closer to 140 and it dropped down in the 60s to 90s at that point.

Q What concern, if any, did that give you for this baby?

A It gives us a lot of concern. That's a life-threatening situation.

Q Why is that a life-threatening situation?

A Because when you see bradycardia, that means the baby is no longer being oxygenated well and the babies have limited time before they'll suffer some damage or even die. And that was our concern in this case.

Q What, if anything, did you do in response to your observing the extended bradycardia at about -- did you say 8:00 p.m., is that when it happened?

A A little after 8:00 p.m., yes.

Q After 8:00, okay. What, if anything, did you do?

A So the cervix is now completely dilated, so the patient is in a situation where they can push the baby out. Prior to that when the cervix is not fully dilated,

the baby is not going to fit, so you can't even -- the only option would be a C-section if the cervix is not completely dilated. I knew that Angela had a nine pound, 11 ounce baby before in a labor that took two hours, which is very short, so I thought we had a very real chance of being able to successfully deliver this baby vaginally. You know, I tried to encourage her to push harder and push harder. The baby wasn't descending. It was stuck at that zero station. It wasn't descending down and that gave me even greater concern that we were going to have to do something more emergent. I tried to put a vacuum on. A vacuum is a device that helps us provide some extra effort in the labor process. But, unfortunately, it wouldn't attach. And in this case, putting a vacuum on at zero station, typically, you don't do that and that would probably not be the standard of care unless you have a life-threatening situation. And knowing Angela's history, I believed that she was going to be able to push this baby out. I thought her history was in our favor. We just had to get the coordinated pushing effort to occur. So I was hoping to put the vacuum on, maybe bring the baby down just one or two centimeters. A lot of times when the baby is that high and they are not pushing, you know, it does not appear they're pushing well, the problem is that the baby is just not low enough. Anyone that's ever had a

baby, you will reach a certain stage where the urge is almost overwhelming to push a baby out. That pressure down there is truly, you know, amazing in the sense that it motivates everybody to push. And Angela hadn't reached that. So I was hoping that we'd get the baby down just a little bit, she would be able to effectively push. The vacuum wouldn't apply. We were still not making any descent at all, so at that time, the decision was made to take her to the operating room for possible C-section.

Q Describe to the jury as you recall how you communication to Ms. Patton about urging her or encouraging her to push.

A At this point, this is an emergency and the baby's life is on the line. So you're somewhat succinct in the way you describe it. We need to take you to the back --

Q Excuse me, how did you encourage her to push? What kind of words would you have used?

A The main thing is you just say you've got to push harder. You've got to push harder. Can you feel where the pressure is? Push where that pressure is. Push harder. Push harder. And as you've heard in earlier testimony, it's not just me encouraging her. It's family. It's the nurses. We're all -- this is a team effort and we're all trying to get this baby out, you know, as quickly and as safely as possible.

Q Did you yell at her, Doctor?
A No, no.
Q Were you mean to her in tone?
A No, sir.
Q Or words? Did you threaten her in any way, sir?
A No, no way.
Q What led you as things were unfolding before you with this low heart rate -- and how long a period of time did that low heart rate go on the fetal monitor strips as you reviewed them?
A It's somewhere between eight and ten minutes.
Q At what point did you decide it would be safest to do a cesarean section?
A When the heart rate stayed down and we weren't making progress and it didn't look like we were going to deliver the baby as quickly as the baby needed to be delivered.
Q Dr. Miller, does the standard of care require that the reasonably prudent OBGYN in a situation that you were in, does the standard of care require that OBGYN to explain the risks and benefits and alternatives to a cesarean section in order to try to obtain informed consent? Are you required to do that?
A Yes, sir.
Q Did you do that, sir?
A Yes, sir.

Q Tell the jury as best you can how you described and informed your recommendation for a C-section to Ms. Patton.
A The first thing is you just have to tell them why. I think at that point any mother knows that it's an emergency and that something is happening, something very dangerous is happening. But you just tell them, say, listen, the baby's heart rate is down, it's not coming up. We need to get this baby out. I'm going to make an incision in your lower abdomen and do a C-section. You know, the risks of C-section include pain, infection, bleeding, damage to internal organs and even death. Do you have any questions? And it has to be that quick because you don't want to spend ten minutes trying to explain something. I wish you could, but you don't have that time because you have to start moving her back.
Q Did you ever say I'm going to cut you?
A No.
Q Sir?
A No, sir.
Q Did she sign the consent to the cesarean section?
A Yes, sir.
Q Was there anything that she expressed to you about any hesitation or reservation about proceeding with the C-section?

A No, sir.
Q Did you explain to her, Dr. Miller, the reasons why you were recommending a C-section relating to the low heart rate of her baby?
A Yes, sir.
Q Dr. Miller, were you in sort of a hurry at that point in your interaction with Angela or any time during the delivery from that point on?
A You are in a little bit of a hurry.
Q Why?
A Because you know you just can't blink and the baby is going to pop out. We're in one room in a part of the hospital and we need to transport her to another room. And not only do we need to transport her in that bed, she has to be transferred from one bed to another. Not only does she have to be one bed to another, the whole operative team has to be ready to go. The neonatal team has to be ready to go. Anesthesia has to be ready to go. Those things, unfortunately, take time. So you know that there's going to be a window where you really don't know. When you start moving her, she's not attached to a monitor, you don't know. So when you get back to the OR, depending on how long it takes and that can take sometimes as little as five to six minutes, but usually somewhere around eight to ten minutes it takes to get a mother from

one room to another on the table and you can check that heartbeat.

Q Are you able to monitor the heart rate of the baby in that transition period?

A No, sir.

Q Doctor, were you tired at eight o'clock that night?

A No.

Q How did she go from the labor and delivery room to the operating room?

A In this situation, when it's an emergency, what happens is we have to -- the first thing we do is we make sure, you know, her arms and legs are inside the railing and we put the railing up on the bed --

Q Is this a bed she's been in for hours?

A Yes, sir.

Q Okay.

A And then what happens is, she has an IV pole in the room, we have to extend the -- there is an IV pole attached to the bed, but the IV pole in the room is separate. You move her IV fluid over to that. That IV fluid is also the medication and the medication pump. Once you have those things onto the bed, then you start moving. In Angela's case, this was an emergency, so I'm moving her. I'm at the front of the bed and the nurse is at the back of the bed.

occiput posterior. So if you turn the baby about 90 degrees, Alexia was down in this -- pointing in that direction so that the nose was pointing up here to what we call ROA.

Q Thank you. You can sit down. We'll get you back up in a minute. Thank you. Dr. Miller, do you have an opinion whether or not a shoulder dystocia is an obstetrical emergency?

MR. GRAHAM: Your Honor, may we approach again?

(WHEREUPON, a bench conference was held in the presence of the jury, but outside the hearing of the jury.)

BY MR. DAVIS:

Q Let me ask the question again, Dr. Miller. As a board certified obstetrician gynecologist delivered over 9,000 babies, do you have an opinion within a reasonable degree of medical certainty whether or not a shoulder dystocia constitutes an immediate obstetrical emergency?

A Yes, I do.

MR. GRAHAM: Objection.

Q Why? Or what's the basis of your --

THE COURT: Hold on one second. For the reasons you just stated at the bench?

MR. GRAHAM: Yes, sir.

THE COURT: Okay. Your objection is preserved for

the record. Go ahead.
BY MR. DAVIS:
Q Explain in your opinion why that's considered by you to be an immediate and genuine obstetrical emergency?
A It's considered to be immediate and genuine obstetrical emergency by everyone.
Q Why?
A Because a baby's life's on the line.
Q Why?
A You have just a few minutes to resolve this issue. I know we've heard a six-to-eight-minute interval in previous testimony, but it's four to five minutes. And it's four to five minutes before -- we're trained and taught that it's four to five minutes before that baby can quite possibly experience -- it's a fancy term for hypoxic ischemic encephalopathy, but it means brain damage. Plain and simple, it's brain damage. If that doesn't meet the standard of an emergency, I don't know what does. There are reports of babies even dying in less than five minutes. So I think that once you determine that there's a shoulder dystocia, you have to call it what it is. And it is truly one of the main or major emergencies that we deal with and part of that is because it is so unpredictable. Part of that is because it is unpreventable. And, unfortunately, sometimes, injuries to

it is an affirmative defense. So given that, the first -- we had other witnesses that said it was an emergency, any kind of shoulder dystocia. But the first witness that actually went through the statute and said, you know, that it was a genuine emergency, the patient was not medically stable and there was immediate threat of death or great bodily injury, the first person that said that was Dr. Miller. It was objected to. So that means to me the issue is now a Rule 15 issue. I mean, the issue is should I permit an amendment to the pleadings at trial based on that? And it seems to me the Plaintiff is prejudiced. It's the issue -- it is an amendment that would allow an affirmative defense that our case law says is weighing by not being presented when the original answer was made. So that's what I'm thinking right now. I'm open to being convinced otherwise, but that's what my thinking is right now. To me, it's a Rule 15 issue now because I think it's clearly an affirmative defense. It was not made and it was objected to by the Plaintiff.

MR. DAVIS: Your Honor, the history is -- the case has been going on a long time. There was, at least, one significant conversation with Judge Dan Hall while he was sort of on this case, if I might refer to that, in chambers years ago where Mr. Graham -- it was getting ready to be set for trial and we were discussing pretrial

brings us to the end of the testimony for today. So, again, please remember the instructions I've given you. Please don't do any outside research or discuss the case with anyone else or otherwise. I'll see you back at 9:30 tomorrow morning.

(WHEREUPON, the jury exits the courtroom at approximately 4:55 p.m.)

THE COURT: Counsel, let's go ahead and knock out the argument on the amendment issue. But before we get to that, is there anything else we need to take up, Mr. Graham?

MR. GRAHAM: No, Your Honor.

THE COURT: Mr. Davis, anything else we need to take up?

MR. DAVIS: Not that I can think of at the moment, Your Honor.

THE COURT: Mr. Davis, if you want to start. It's your motion to amend your answer.

MR. DAVIS: Thank you, Your Honor. Your Honor, I make a motion to amend my pleadings and answer pursuant to Rule 15, subparagraph B, amendments to conform to the evidence when issues not raised by the pleadings are tried by expressed or implied consent of the parties, they shall be treated in all respects as if they had been raised in the pleadings. Such amendment of the pleadings as may be

necessary to cause them to conform to the evidence and to raise these issues may be made upon motion of any party at any time even after judgment. But failure to so amend does not affect the result of the trial of those issues. If evidence is objected to at the trial on the ground that it is not within the issues made by the pleadings, the Court may allow the pleadings to be amended and shall do so freely when the presentation of the merits of the action will be subserved thereby and the objecting party fails to satisfy the Court that the admission of such evidence would prejudice him in maintaining his action or defense on the merits. Your Honor, the issue of the emergency statute has been discussed with Judge Hall in chambers at length years ago with Mr. Graham and myself. There's no possible prejudice to Mr. Graham or the prosecution of his case or the evidence that has been established so far that this was an obstetrical emergency. That the child was in immediate harm of serious bodily injury or death and was unstable because of the shoulder dystocia is not a secret to Mr. Graham. It does not prejudice him if the Court omits that amendment. And I think it should be liberally granted within the spirit of Rule 15. Again, there is no prejudice whatsoever and no surprise. That's the only thing I can argue at this point, Your Honor. Thank you.

THE COURT: Thank you. Mr. Graham.

MR. GRAHAM: Yes, sir. Your Honor, under Rule 15 and under various case law, I believe the Byrd case is pretty much right on point. I don't know how you could get more closely on point. But it's an affirmative defense and it wasn't pled. And under Rule 15 and the rules cited therein, it's been waived. We've been prejudiced in terms of -- we started this case a long time ago, before any one of my cases had ever raised this affirmative defense. As we started this case -- if I had known that this defense would have been raised, all of the party depositions, the nurse depositions, virtually, all of the depositions before, say, 2013 or '14, I would not have even known the defense bar was going to raise those as a defense in any case, so we would have handled the case differently. You know, we started off with the hospital as Defendants. We made a tactical decision there. We had made some other decisions about which experts to hire, what we would have them address. There would just be so many different avenues that we would have pursued earlier if we had known that this would be raised.

THE COURT: Mr. Davis.

MR. DAVIS: He knew it was going to be raised, at least, three or four years ago.

THE COURT: So one of the factors in the Rule 15 is

surprise, but the other one is prejudice. The definition of prejudice, I'm looking at the Patton V. Miller case, which is a 2017 case from the Supreme Court, and that case says, a prejudice puts the nonmoving party at a disadvantage which they would not have faced if the -- I'm sorry, I totally lost my train of thought. Rule 15 prejudice is a result flowing from the amendment that puts the nonmoving party at a disadvantage, which they would not have faced had the amended claim been included in the original pleading. In the Court's opinion, that is the case here. I mean, this is a maximally prejudicial amendment because it's changing what the Plaintiffs have to prove. It's shifting from ordinary negligence to gross negligence, which would mean the Plaintiffs would have to redo their -- the experts would have to opine all of them on the issue of gross negligence. The Plaintiffs -- I mean, the Plaintiffs might have even made a different decision about the resources they put into the case. They would have to redo their entire case. So for that reason, I find that allowing an amendment at this point would be severely prejudicial to the Plaintiff and I'm going to deny the request.

MR. DAVIS: Thank you, Your Honor.

THE COURT: Anything else we need to take up before we break for the day?

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) Court of General Sessions
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vs.) Transcript of Record
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Dr. Gregory A. Miller, et al)
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Defendant)

February 16, 2022
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B E F O R E:

Honorable William McKinnon, Judge

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

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it was plain to see in the written discovery proceeding. And so these facts that have the pro-defense, dicta, are really just very unique fact situations that are totally unlike what we have in this case. Now, there is one thing that I believe I need to address. Mr. Davis was talking an awful lot about a motion that I made in October of 2018 and a subsequent status conference with Judge Hall which led to him entering a stay. I went into some detail, in the briefs that I just handed up. But here is, I filed the complaint in '09, the answer was in January of '10. It didn't raise the issue. Then when we amended our complaint to add Piedmont, we hadn't been able to find any response from Mr. Davis. We are not sure that they actually even filed an answer to the amended complaint. But at any rate, we went from the first answer that they had in January of 2010 all the way through, just after we settled with Piedmont. We settled with Piedmont, well the order of approving the settlement with Piedmont was, I think April 5th of 2018. It was in the first few days of April and then from my review of the records and my memory, sometimes shortly before the deposition of Dr. Ernest on May 24th of 2018 something happened to tune me in that Ashby was either about to amend, I mean file a motion for, to add the statute. Or maybe one of his associates said something that I interpreted as that. At

any rate, that is what motivated me to ask questions at deposition of Dr. Ernest and Chauhan that did use some of the statute terminology. And then, a few weeks or months later I know that Ashby confirmed his intent to, well my memory is he confirmed his intent to file a motion for leave to amend, to add the genuine emergency statute. In Ashby's recent filing, in one place he talks about, stating to Judge Hall, that he intended to seek a charge of the genuine emergency statute. But then, so I am not, it seems to me that either scenario works in my favor. If he had stated that he intended to file a motion for leave to amend, then, you know, a reasonable interpretation of that is, it must be coming in the next few weeks, months, year. But we never heard, after the status conference with the Judge, we never heard anything else about amending a complaint until I got a call from one of Ashby's associate's asking me if I would consent to a motion for leave to amend. And I said, to do what. And he said, I will have to get back to you on that. When he got back to me the answer was, we want to add some punitive damages defense. Not a peep about the genuine emergency statute. And so that led me to believe they have, likely abandoned their intent to go forward with an effort to get the statute brought into the case. And then, you know, there was no indication, attempting to