STATE OF MICHIGAN
IN THE 67TH DISTRICT COURT, GENESEE COUNTY

PEOPLE OF THE STATE OF MICHIGAN,

Plaintiff, Case No. 17T-01355-FY

v

Hon. David J. Goggins

NICOLAS LEONARD LYON,

Defendant.
_____/

John J. Bursch (P57679)
BURSCH LAW PLLC
9339 Cherry Valley Avenue, S.E., Unit 78
Caledonia, Michigan 49316-0004
(616) 450-4235
jbursch@burschlaw.com

Todd F. Flood (P58555)
Special Assistant Attorney General

Larry C. Willey (P28870)
Charles E. Chamberlain, Jr. (P33536)
Britt M. Cobb (P69556)
WILLEY & CHAMBERLAIN LLP
300 Ottawa Avenue, N.W., Suite 810
Grand Rapids, Michigan 49503-2304
(616) 458-2212

Attorneys for Defendant

DEFENDANT LYON'S POST-HEARING MEMORANDUM

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INTRODUCTION

The outbreak of Legionnaires' disease in Flint is undeniably tragic. But that does not mean Director Nick Lyon is responsible for the outbreak or any deaths. To the contrary, despite more than nine months of testimony, the prosecutor has insufficient evidence for a bind over regarding multiple elements of every charge. Certain failures of proof are particularly glaring.

Regarding the two manslaughter charges, the prosecutor must prove that Director Lyon's alleged failure to warn about Legionnaires *caused* Mr. Robert Skidmore and Mr. John Snyder to die. But the evidence shows that the hospitals and medical providers in the community—including the entire McLaren Hospital provider network—had been pointedly warned about Legionnaires at MDHHS' direction. There is no evidence that, had Director Lyon issued his own warning, Messrs. Skidmore and Snyder or their treating physicians would have acted any differently. And McLaren Hospital's own failure to warn was a superseding cause the prosecutor completely ignores. In an act of desperation, the prosecutor now suggests, for the very first time, that Director Lyon should have ordered the water supply switched back to DWSD. There is no evidence that the Director even had that power, much less that doing so would have been prudent.

As for the charge of misconduct in office, there is no evidence supporting the allegation that Director Lyon "delegated" the investigation of the Legionnaires outbreak to the Flint Area Community Health and Environmental Partnership (FACHEP), nor that he impeded FACHEP in its investigation. To the contrary, MDHHS secured funding from the Legislature for FACHEP's proposed work promptly and as a priority. And there simply is no other alleged misconduct.

Absent specific evidence supporting each element of every charge, it would be a grave mistake to bind over Director Lyon for trial. Doing so will inflict irreparable harm on his professional career and family, and it will dangerously chill all Michigan public servants, especially executive officers. The charges should be dismissed immediately.

BACKGROUND

Overview of MDHHS and Director Nick Lyon

As explained in the pre-hearing briefs, MDHHS is massive, with more than 14,000 employees (30% of the entire state workforce) and a $29.2 billion budget (45% of total Michigan spending). MDHHS has more than 220 programs through some 6,600 contracts, and just one person to administer it—Director Nick Lyon. (I Becker 77-78; XXI Hanley 9.)

Director Lyon began working for what was then the Michigan Department of Community Health (DCH) in 2003 and became its Chief Deputy in August 2011. He is not a scientist or epidemiologist (I Becker 78-79); he is a public administrator, and there are numerous other key MDHHS staff with medical and infectious-disease expertise. As one would expect from the head of a 14,000-person organization, Director Lyon necessarily relies on these key staff members to tell him when he needs to be more involved or to take official action.

Director Lyon became Director of DCH on September 29, 2014. In February 2015, just weeks after he was notified about a Legionnaires wave in Flint, DCH merged with the Department of Human Services and became MDHHS. (Ex 4.) Director Lyon is the new agency's first director, and his 2015 consisted of merging Michigan's two largest agencies, obtaining funding for his 220 programs, proposing legislation (e.g., regarding opioids), meetings in Washington, D.C., for Medicare and Medicaid, supervising many MDHHS litigation matters including a federal-court consent decree governing the State's entire child-welfare system, and numerous special projects, including Ebola preparation, the Kalamazoo Psychiatric Hospital, and projects in Detroit.

Key Events and Non-Events

At the July 11th hearing, Director Lyon presented a comprehensive timeline of events reflected in the record, beginning with the Flint municipal water switch in April 2014 and ending with a detailed discussion about what Director Lyon's interactions with FACHEP in the summer

and fall of 2016. For the Court's convenience, a replica of that timeline with all Transcript and Exhibit citations is attached as Addendum A: Timeline of Key Events. A second timeline tracks the number of Legionnaires cases by month, compared to McLaren intervention measures, and is attached as Addendum B.

The prosecutor also made a great number of statements at the July 11th hearing, often without testimony or exhibit citations and in a scattershot order. Many of these statements have no support in or are flatly contradicted by the record. Others are simply irrelevant to Director Lyon and the prosecutor's charges. For the Court's convenience, a summary of those statements—and what the record actually reflects—are attached as Addendum C: Facts, Not Words (Prosecutor's Argument). A second summary details similar discrepancies in the prosecutor's post-hearing brief and is attached as Addendum D: Facts, Not Words (Prosecutor's Brief).

In sum, Director Lyon first learned about Legionnaires on January 28, 2015. The issue was serious, but it was obvious that MDHHS staff would be pursuing an investigation. (III Miller 61-62.) There was a lot of speculation about the cause due to a lack of information (Ex 3), and there was insufficient information to go public (III Miller 47-48). Chief Deputy Becker was satisfied that the appropriate MDHHS experts were involved and working on the issue. (I Becker 83-84.) And Director Lyon specifically asked Dr. Miller, the state's top epidemiologist, to be kept informed. (II Miller 95.) It is undisputed that Dr. Miller did not recommend to Director Lyon that a public notice be issued. (III Miller 121.) And only two days later, MDHHS suggested to GCHD that a *Legionella* notice go out to the entire Flint-area medical community, providing GCHD a MIHAN example to use for that purpose. (Exs 24, DA.)

At that point, Director Lyon realized there was a potential problem, and he did what a reasonable person in his shoes would have done (i.e., a public administrator, not a scientist or epidemiologist, about to merge the State's two largest agencies, totaling 14,000 staff): ensure that

the Department's top staff and experts were fully engaged. That is precisely what happened. The entire premise of the prosecution's argument is that Director Lyon should have known the Flint River water was the cause of the outbreak on January 28, 2015, and should have acted accordingly. But the evidence is that at that time, the source of the outbreak "was all speculation because we don't have the case information that we need yet." (Ex 3).

Indeed, no one brought the issue of Legionnaires to Director Lyon's attention again until there was communication with Dennis Muchmore on July 22, 2015, well *after* Messrs. Skidmore (May 13-19, 2015) and Snyder (June 16-23, 2015) had already contracted Legionnaires. And it's not like MDHHS was doing nothing in the meantime. There were dozens of meetings and communications among MDHHS, GCHD, and the CDC (Addendum A); at MDHHS's behest, detailed notices and instructions about Legionnaires were distributed to the entire McLaren healthcare network plus two other Flint-area hospitals on February 13, 2015 (Exs D, DC, DB, DD(2); VI Kilgore 99), and June 1, 2015 (Exs LL, I; XXII Warden 83); and the CDC cautioned about taking a "measured response" to the outbreak. (Exs 76, 84, QQQQ.)

The record details massive and understandable confusion among all concerned about the source of Legionnaires. (Addendum A.) The full report that MDHHS staff issued to Director Lyon and others on January 11, 2016—an entire *year* after the prosecutor says Director Lyon should have given public notice—shows that nearly a quarter of the Legionnaires cases in the first wave had *no* exposure to a Flint hospital in the two weeks before the onset and did *not* live on Flint water. (Ex 9.) It's easy to second-guess the MDHHS staff's work on Legionnaires with the benefit of 20/20 hindsight. It was not easy to unravel the complex and confounding situation as it happened (XX Edwards 93), and MDHHS was treating Legionnaires Disease as "an urgent problem." (XIX Band 121.) Nor was it Director Lyon's personal responsibility to decide when to give "public notice"; this is often done by staff without his input or approval. (II Zervos 42-43.)

As for FACHEP, it presented its $12 million proposal and budget for Phase II to MDHHS (but not Director Lyon) on April 29, 2016. (Ex TT.) Six days later, on May 5, 2016, FACHEP was listed as an MDHHS top-3 funding request in an internal report. (Ex SSSS.) Director Lyon had his first meeting with FACHEP on May 16, 2016. There, Dr. Kilgore became profane and was banging on the table, yelling at Director Lyon about the project's urgency. (IX McElmurry 57-58; XXI Hanley 51-52.) Drs. Zervos and McElmurry gave inconsistent testimony as to whether Director Lyon gave a flippant response to this inappropriate outburst; Hanley did not hear such a response and would "absolutely" remember if it was made. (VIII McElmurry 55; I Zervos 142; XXI Hanley 50-54, 82.) Regardless, two days later, on May 18, 2016, MDHHS forwarded FACHEP's final request for $9 million to the State Budget Office. (XXI Hanley 54; Ex 48.) Ten days later, on May 28, 2016, MDHHS followed up with the Budget Office to inquire about the funding; the email said FACHEP is ready to start research and "we are running out of time." The Department is "just trying to be sure we can flip the switch on this as soon as possible," said Hanley. (Ex RRRR.)

The final understanding was a $4.1 million FACHEP contract, with $3.1 million allocated the first year, $1 million for the second. (IX McElmurry 79.) In nearly record time, the Legislature approved the first-year $3.1 million (Ex HH at 1), and by June 23, 2016, the contract was entered in MDHHS' eGrAMS system (XXI Hanley 28; Ex NNNN), only one month and a day after Director Lyon's first meeting with FACHEP. But FACHEP took until July 23rd, an entire month later, to finalize its obligations in the eGrAMS system. (XXI Hanley 29.) And FACHEP did not take any water samples until September 2016, two months later (XII McElmurry 108), even though the contract had an effective date of June 1, 2016, and Dr. McElmurry testified that collecting water samples is an easy undertaking that could be done in a day and costs maybe $1000 to $2000. (XII McElmurry 12-13; XII McElmurry 112.) Dr. McElmurry could not point to even one specific thing Director Lyon did or did not do to cause delay. (XII McElmurry 107, 109-131; VI Kilgore 90-92.)

The Prosecutor's "Facts"

As discussed in more detail below—in connection with the elements and in Addenda C & D—the prosecutor continues making allegations unrelated to the charges or the record. The prosecutor begins his brief with the switch from DWSD water to City of Flint water "despite warnings that Flint's water treatment system was not prepared to handle the switch." (Pros Br 1-2.) Director Lyon had nothing to do with the switch; he was not even in a position *to* do something had he known about it. The prosecutor then continues with the serious concerns about Flint's drinking water, including discoloration, bad odor, skin rashes, fecal coliform, Trihalomethanes, and the like. (*Id.* at 2.) Again, none of this has anything to do with Director Lyon, who knew nothing about it contemporaneously. The prosecutor then jumps ahead to October 2015, when the State ordered Flint to switch the water back because of "elevated blood levels." (*Id.*) But Director Lyon is not being charged with any misconduct or nonfeasance with respect to lead.

The prosecutor next points to the increase of Legionnaires beginning in June 2014 and continuing into December 2014. (*Id.* at 2-3.) This, of course was all *before* Director Lyon had been given any notice of the Legionnaires issue and could not be something Director Lyon influenced in any way.

The prosecutor then jumps *backward* in time to events at McLaren Hospital in September and October 2014 and early concerns that Legionnaires might be connected to the water switch. (*Id.* at 3.) This still this nothing to do with Director Lyon, who first learned of the issue on January 28, 20*15*. The prosecutor then jumps forward again to May 2015, when, after four months of almost no Legionnaires cases, MDHHS staff believed the outbreak to be over, when—known to GCHD—a second outbreak was brewing. (*Id.* at 4.) There is no evidence suggesting Director Lyon knew any of this, nor is there evidence Director Lyon's top staff were asleep at the switch. Indeed, the evidence shows the exact opposite. (Addendum A.)

When the prosecutor turns to the purportedly "relevant facts," he appropriately starts with the January 28, 2015 meeting. (Pros Br 4-5.) But the prosecutor's next key date is the Muchmore meeting on July 22, 2015 (*id.* at 5)—well *after* Messrs. Skidmore and Snyder had already contracted Legionnaires. There is no evidence that Director Lyon's expert epidemiologists and infectious-disease specialists elevated Legionnaires to the Director's attention in the interim. The prosecutor then jumps to September 2015, when Dr. Miller truthfully indicated that 73% of the 2015 Legionnaire cases "involved individuals that did *not* live on Flint water," (*id.* at 5), contrary to the prosecutor's theory that the switch to Flint water caused all the Legionnaires. The prosecutor then criticizes Director Lyon for immediately relaying this information to the Governor's cabinet, as though informing the Governor's office was somehow a bad thing. (*Id.* at 5.)

The prosecutor next skips ahead once again, to January 11, 2016, when Director Lyon finally received the comprehensive—though still inconclusive—report about the 2015 Legionnaires outbreak and says that Director Lyon did not suggest notifying the public, even though the Director did exactly that, *only two days after receiving the report*. (*Id.* at 5-6.) "By that time," intones the prosecutor, "the outbreak had claimed at least nine lives" (though he means outbreak-associated deaths, needing further investigation). (*Id.* at 6.) Yet the prosecutor fails to connect the dots and show how a single death is related in any way to Director Lyon's actions.

So the substance of the prosecutor's case is this: Director Lyon first received notice of the Legionnaires issue on January 28, 2015; Director Lyon's most experienced staff members handled the problem while he managed and merged the 14,000-person DCH and DHS, but staff struggled to identify the issue's cause; the staff brought Director Lyon back to the issue in the latter half of 2015; and as soon as Director Lyon saw a full report, he gave it to the Governor and the public. Therefore, says the prosecutor, Director Lyon caused the deaths of Messrs. Skidmore and Snyder, who contracted Legionnaires in May and June 2015, respectively. This makes no sense.

STANDARD OF REVIEW

A district court may bind over a defendant for a felony charge only if the prosecutor can produce evidence that satisfies the "probable cause" standard, i.e., "by a reasonable ground of suspicion, (it is) supported by circumstances sufficiently strong to warrant a cautious person in the belief that the accused is guilty of the offense charged." *People v Hudson*, 241 Mich App 268, 278-79; 615 NW2d 784 (2000) (quotation omitted) (reversing district court's bind over decision). As the prosecutor concedes (Pros Br 6), a district court is obligated to "find that there is 'evidence regarding *each* element of the crime charged or evidence from which the elements may be inferred.'" *Id.* at 278 (quoting *People v Selwa*, 214 Mich App 451, 457; 543 NW2d 321 (1995)). Accord, e.g., *People v Mason*, 247 Mich App 64, 71; 634 NW2d 382 (2001) (reiterating "each element" standard and affirming circuit court's decision to quash district court order binding over defendant charged with larceny by conversion); *People v Anderson*, 501 Mich 175, 181; 912 NW2d 503 (2018) (affirming "each element" standard and affirming district court's dismissal of complaint following preliminary examination).

For example, in *Hudson*, a nurse who worked at a long-term care facility was charged with second-degree vulnerable adult abuse arising from her release of an elderly resident who later fell and fractured her hip. Although the district court bound the nurse over for trial and the circuit court declined to quash, the Court of Appeals reversed because there was insufficient evidence that the nurse's release of the resident was reckless or that the release was the "but for" cause of the resident's fall. *Id.* at 280-87.

Of course, the Court may make inferences from the evidence when determining probable cause, and those inferences may be drawn from both direct and circumstantial evidence. *People v Hardiman*, 466 Mich 417, 428; 646 NW2d 158 (2002). But those inferences must be reasonable. *Id.* And the Court must "consider all the evidence presented, including the credibility of witnesses'

testimony." *Anderson*, 501 Mich at 178. So while the prosecutor does not have to prove "water is wet," he does have to produce credible evidence for each element of the offenses and is not entitled to all inferences, only reasonable ones.

Because the prosecutor appears to be trying to hold Director Lyon responsible for the misconduct of the entire MDHHS Department, it is important to emphasize that there is no criminal vicarious liability under Michigan common law. *People v Jackson*, 176 Mich App 620, 626; 440 NW2d 39 (1989); *People v Wilcox*, 83 Mich App 654, 659; 269 NW2d 256 (1978) ("[c]riminal liability does not arise vicariously unless the Legislature so provides"). None of the statutes charged here provide for vicarious criminal liability. So, Director Lyon cannot be held criminally responsible for work that was or was not done by his staff. Period.

ARGUMENT

I. The prosecutor cannot establish each elements of a homicide charge (Counts I & II).

The elements of involuntary manslaughter are found in M Crim JI 16.13 Involuntary Manslaughter—Failure to Perform Legal Duty. They are:

(1) Legal duty.

(2) Defendant knew of the facts that gave rise to the duty.

(3) Defendant willfully neglected or refused to perform that duty, and that failure to perform was grossly negligent to human life.

(4) Death was "directly caused" by Defendant's failure.

The prosecutor fails to satisfy any of these four elements. But as noted in the Introduction, the lack of causation (element four), is particularly glaring. Accordingly, the defense will begin there.

A. The prosecutor cannot prove causation.

As explained in Director Lyon's pre-hearing brief, an involuntary manslaughter charge requires both factual and proximate causation. *People v Tims*, 449 Mich 83, 94; 534 NW2d 675 (1995). The prosecutor concedes this is his burden (Pros Br 19), but he can prove neither.

1. Factual causation

"Actual cause" or "cause in fact," requires a defendant's actions to be more than a mere condition to an outcome, but to "*positively* contribute to" that outcome. *People v Zak*, 184 Mich App 1, 11; 457 NW2d 59 (1990). For example, selling a murder weapon to a murder's perpetrator is a "necessary condition" to the murder, the sale is not "*the cause*" of the victim's death. *Id.* (emphasis added). Rather it is the perpetrator "shooting the victim" which causes his death. *Id.*

Here, there is no evidence that Director Lyon was "the cause" of Mr. Skidmore's or Mr. Snyder's death. If either man even died of Legionnaires, Director Lyon's alleged inactions hardly constituted "necessary conditions" or positively contributed to their deaths.

As to the issue of whether either Mr. Snyder or Mr. Skidmore actually died of Legionnaires, as opposed to other causes, Director Lyon's position is detailed in the motion to strike Dr. Joel Kahn's testimony. Both Mr. Skidmore's (Ex 62) and Mr. Snyder's (Ex 75) Death Certificates said nothing about Legionnaires as the cause of death, creating a legal presumption that it was not such a cause. MCL 333.2886, 333.2871. And there is insufficient evidence to rebut the presumption that Mr. Skidmore and Mr. Snyder did not die from Legionnaires. Both suffered from many other ailments

But this Court need not even rule on the cause of death to dismiss the charges because there is insufficient evidence of factual causation for two additional reasons: (1) there *was* substantial notification of Legionnaires; and, (2) there is zero evidence Messrs. Skidmore or Snyder or their doctors would have done anything different had Director Lyon made a public announcement.

a. There was ample notice.

First, there was ample disclosure about the outbreak to the community, including the medical community—which was the most important community to be advised under the circumstances. (XXIII Reilly 71, 73; XIX Band 41-44.)

- MDHHS posted "weekly disease reports" on its website in real time that included county-by-county disease reports—including Legionnaires. (I Becker 113.)
- GCHD posted a fact sheet on its website and used it in a broadcast email, likely in 2014 or 2015, and also posted communicable disease reports in real time. (XVII Henry 54-58; Ex CCCC, BBBB.)
- The Governor's office was aware of the situation; MDEQ's Wurfel reported to Murray, in the Governor's Office, on January 30, 2015 that there had been "42 case of LD in Genesee County since last May." (Ex N.) And on March 13, 2015, MDEQ twice gave a full report to many Governor's office staff about a "significant uptick" in confirmed *Legionella* illnesses. (Exs 28, F; V Hollins 137-138.)
- City of Flint officials were made also aware of the outbreak by GCHD, at least by March 10, 2015. (Ex 28.)
- GCHD—at MDHHS' behest—sent Legionnaires health alerts and clinical guidance on February 13, 2015, and June 1, 2015, to the *entire* McLaren, Hurley, and Genesys hospital systems (Ex D, DC, DB, DD(2)), forwarded to at least 700 providers.
- Hamilton Community Health Network received the same notices and forwarded them to all HCHN providers and nurses too. (XXII Warden 22, 76, 78-79, 82-84.) There was a third notice sent by GCHD on June 29, 2015.
- The EPA was aware of the increase in cases by March 2015. (Ex R.)
- The CDC was aware of the outbreak early on, and there are numerous CDC employees embedded in MDHHS. The Timeline in Addendum A shows the CDC's consistent involvement throughout the spring of 2015.
- The report of the June 2014-March 2015 outbreak was sent to the CDC, the GCHD, and to the hospitals on June 4, 2015. (Exs 69, FFFF, PP.)

Given this widespread notice, it is not clear how Director Lyon's failure to notify in early 2015 "caused" anything with respect to Messrs. Skidmore and Snyder. The prosecutor offers no explanation. The Prosecutor faults Director Lyon for: (1) not issuing a warning until January 13, 2016 (Pros Br 20); (2) not eliminating the source of the disease (*id.*); and (3) not switching Flint's water back to the DWSD (*id.*). The prosecutor fails to explain (1) how an earlier warning would have made a difference in light of the other notices, catalogued above, (2) how an unknown source could be eliminated, or (3) how Director Lyon could order a switch when he had no power to do so, even had he been so advised (and he was not). Then the prosecutor simply declares victory: "But for Defendant's negligent omissions, neither Mr. Snyder nor Mr. Skidmore would have contracted Legionnaires' Disease or died as a result." (*Id.*) Such *ipse dixit* hardly proves causation.

b. Notice from Director Lyon would not have changed things.

Both Mr. Skidmore and Mr. Snyder contracted Legionnaires at McLaren, and McLaren's Borowski testified that all medical providers in McLaren's network were notified about the Legionnaires outbreak. (XI Borowski 85-87.) As a result, there is no evidence that any announcement from Director Lyon would have changed anything with respect to Messrs. Skidmore and Snyder's medical doctors and assistants.

For example, Mr. Skidmore's past practice was to *always* use McLaren hospital, and his doctor was affiliated with that hospital. (XIV Skidmore 7.) Mr. Skidmore's medical records show that he regularly went to McLaren (Exs 66, AAA, BBB), and he continued to go to McLaren *after* contracting Legionnaires there. (XIV Skidmore 20.)

Mr. Snyder also used McLaren Hospital regularly. (X Tribble 20; Exs 73, CCC.) Mr. Snyder's oncologist even sent him by ambulance to see a specific orthopedic doctor at McLaren on June 16, 2015, the visit where he is said to have contracted Legionnaires. (X Tribble 22-23, 25.) The oncologist is part of the McLaren system and would have been notified about the outbreak on February 13, 2015, and June 1, 2015. In sum, there is no evidence that Director Lyon caused Messrs. Skidmore or Snyder to contract Legionnaires' Disease by something he did or did not do.

As the Timeline in Addendum A demonstrates, information about Legionnaires was sketchy in the early part of 2015, but what was known was disseminated widely to the parties who needed to know it: medical providers, including the entire McLaren Hospital network. Had there been a public announcement about a Legionnaires outbreak, there would have been *no* recommendations, because the cause of the outbreak was undetermined as of May and June 2015.

An announcement certainly could have described the symptoms, so people would know to go to the hospital. But as Dr. Miller said that at the time, she believed a non-traditional health advisory to the public would not have been a good idea. (II Miller 96; III Miller 47-48, 19-121.)

More important, both Messrs. Skidmore and Snyder *did* go to the hospital—promptly—when they were sick, necessarily breaking any causal connection. Mr. Snyder was not even experiencing any of the classic symptoms of Legionnaires—no fever, no chills, no cough, no elevated white blood count, "no symptoms" (X Tribble 27-28)—that an announcement would have addressed.

For their part, Drs. Reilly and Band testified that it would have been reckless to *make* announcements about the association with the hospitals at that point given what little was known, because it would deter patients from going to the hospital when needed and would result in unnecessary and dangerous hospital transfers. (XXIII Reilly 65-68; XIX Band 36-37.) Both doctors opined that a generalized announcement about the outbreak, without recommendations, could cause panic and worry in an already stressed community and would tax the healthcare system, taking away resources from those truly ill. (XXIII Reilly 65-68; XIX Band 143-144.)

The prosecutor's brief asserts that after receiving boil water advisories, "citizens of Flint took effective steps to minimize exposure to Flint river water." (Pros Br 22.) But the prosecutor does not explain how a notice to the public by Director Lyon would have positively improved on that behavior.

The prosecutor also says Director Lyon should have "promptly mandated a switch back to safe drinking water." (Pros Br 21.) Again, the prosecutor misses the point. Any switch was a City of Flint/Emergency Manager/MDEQ experts decision, not an MDHHS decision, and certainly not Director Lyon's decision. (Ex. P.) The prosecutor says that had Director Lyon "issued public notice about the Legionnaires' Disease a year earlier, citizens in Genesee County, including Messrs. Snyder and Skidmore, could have taken precautions and protected themselves from harm." (*Id.*) How? No one knew where the Legionnaires was coming from, and Messrs. Skidmore and Snyder's own doctors appropriately treated them at McLaren. And Mr. Skidmore was already drinking bottled water exclusively as of June 4, 2015. (Ex BBB at 159.)

The prosecutor claims that had Director Lyon issued an outbreak notice in 2014, "hospital operations going forward would have been different." (*Id.*) Again, how? McLaren already knew about the outbreak and was still formally notified on February 13, 2015. (Ex B). So the concerning surge of Legionnaires cases in late 2014, and the notice to the entire McLaren medical community in February 2015, was inadequate to effect hospital operations? No evidence supports that supposition. Next, the prosecutor says that "Legionella can be eradicated with a simple dose of antibiotics." (*Id.*) But that is equally true whether the antibiotics result from public notice by Director Lyon, or from notice to the entire McLaren medical system to be on the lookout for Legionnaires, the very medical system where Messrs. Skidmore and Snyder were actually being treated.

The prosecutor takes one last shot. He notes that after the boil-water advisories went into effect, the residents of Flint took precautions to protect themselves, presumably by boiling water. (*Id.* at 22.) But what more would a Director Lyon announcement have done that the all-hands-on-deck medical-personnel notices did not when Flint citizens had already changed their behavior? No one knew where the Legionnaires was coming from, no one knew how to stop it, and Messrs. Skidmore and Snyder contracted Legionnaires at McLaren *despite* all McLaren medical personnel having been warned. To say Director Lyon should have switched the Flint water supply back to DWSD ignores what the Director actually knew as well as the scope of his authority. And to suggest that Director Lyon should be bound over on manslaughter charges because he relied on his expert staff to investigate the problem before making a public announcement is pure sophistry.

At the end of the day, there is zero proof that there was anything Director Lyon did or did not do that actually caused either Mr. Skidmore or Mr. Snyder to get sick from *Legionella*. The prosecutor's theory is akin to blaming Director Lyon the next time someone dies after a Michigan hospital-acquired infection; when the entire medical community knows about that risk, Director Lyon's failure to give public notice is not a cause in fact. Charges I and II must be dismissed.

2. Proximate causation

"Proximate causation is a legal construct designed to prevent criminal liability from attaching when the result of the defendant's conduct is viewed as too remote or unnatural." *People v Feezel*, 486 Mich 184, 195; 783 NW2d 67 (2010). If an intervening cause supersedes a defendant's conduct "such that the causal link between the defendant's conduct and the victim's injury was broke," there is no proximate cause or criminal liability. *Id.* (quotation omitted). As M Crim JI 16.15 puts it, death must be "the natural or necessary result of the defendant's act." Here, it is clear that McLaren Hospital, at least, was an intervening cause of Skidmore and Snyder contracting Legionnaires.

The only evidence regarding Messrs. Snyder and Skidmore's contraction of the disease is that both were at McLaren during their incubation period. In fact, McLaren is the only known connection of either gentleman to Flint water. And unlike Director Lyon, McLaren actually owed a common law duty to Messrs. Skidmore and Snyder, that of a premises owner to invitees. E.g., *Stitt v Holland Abundant Life Fellowship*, 462 Mich 591, 596; 614 NW2d 88 (2000), as amended (Sept. 19, 2000).

Several months *before* Director Lyon had any knowledge of the outbreak, McLaren knew that its water had unacceptable levels of *Legionella*, and that its patients were contracting Legionnaires in unprecedent numbers. McLaren typically had only one or two cases of *Legionella* per year but in June 2014, three out of the six Genesee County cases were associated with McLaren; two of the five cases in July 2014 were associated with McLaren; four out of 10 in August, seven out of eight in September, two out of five in October, two out of three in November and two out of five in December 2014. (Ex 59.) Julie Borowski had never seen numbers like these in any medical facility with which she had ever been associated. (XI Borowski 8, 10-13, 27, 30.)

By October 2014, McLaren had sampled locations throughout its facility for *Legionella*. Some samples came back at counts of 23 and 24, and anything over 10 is a concern. (Ex GGGG.) Water sampling by Environmental Testing & Consulting, Inc. (ETC) in December 2014 revealed that the McLaren incoming water supply had no *Legionella*. ETC reasonably concluded that the *Legionella* was an internal McLaren issue, *not* an issue with the City water supply. (Ex NN.) Ms. Borowski started meeting with MDEQ experts and MDHHS to discuss "future testing and communications" and "clinical guidance" on January 28, 2015. (XI Borowski 74-75.)

McLaren received the outbreak information and clinical guidance that the GCHD sent on February 13, 2015, and on June 1 and June 29, 2015. (XI Borowski 57-60, 87; Ex D, LL, MM.) McLaren disseminated these notices to over 700 providers in its network. In May 2015, two of the three new Genesee County cases were associated with McLaren, and the number of cases—including the number of McLaren-associated cases, continued to increase in the summer of 2015. (XI Borowski 35.) All this even though the December 2014 and August 2015 testing showed that McLaren's incoming water-supply lines had no *Legionella* (Exs NN, OO), breaking any causal link between Flint water and the Legionnaires outbreak at McLaren.

After consulting with a *Legionella* expert, Dr. Janet Stout, McLaren added new disinfection systems beginning in late August 2015, and the Legionnaires cases associated with McLaren stopped. (Ex 59; XI Borowski 33-35.) McLaren notified its employees of the outbreak in a news-letter dated August 14, 2015. (Ex V.) Certainly, McLaren's failure to notify its patients as they were admitted was an intervening cause to any alleged failure of Director Lyon to notify the public.

So Director Lyon was neither the cause in fact of Messrs. Snyder and Skidmore contracting Legionnaires nor was he the proximate cause—that was McLaren. And though the defense explained this reality in great detail at the July 11th hearing, the prosecutor does not even address it in his brief, implicitly conceding that Counts I and II must be dismissed on this basis, too.

B. The prosecutor cannot prove a legal duty.

The prosecutor's brief alleges that the Director's duty flows from MCL 333.2221. As noted at the July 11th hearing, this statutory provision—which the prosecutor quotes in full on page 9 of his brief—provides directives solely to the "department," not the "Director." Citing a civil case regarding the meaning of the word "shall," the prosecutor characterizes MCL 333.2221's commands as though Director Lyon was personally responsible for each. So Director Lyon apparently has to personally collect and use vital and health statistics, investigate the cause of epidemics, prevent sources of illness, etc. This Court would be the first in Michigan's history to take such a statute and make it the source of manslaughter liability for a public official. No government employee could possibly satisfy it. If one Michigan citizen contracted an illness and a second citizen later caught the same illness, Director Lyon would be criminally responsible under the prosecutor's theory. That is why—contrary to the prosecutor's representation—MCL 333.2205(1) vests the Department's duties in the director "*or* an employee or agent" of the Department that the Director designates. Director Lyon has designated many employees to fulfill these duties.

Unsurprisingly, no legal authority supports the prosecutor's theory. The prosecutor has cited MCL 333.2231, but § 2231 does not contain an enforceable duty; it merely requires officials of the state to "furnish the *department* with information relating to public health *which may be requested by the department*," and it requires the *department* to "report periodically to the governor and Legislature as to the activities carried on under this code." MCL 333.2231(1), (2) (emphasis added). The first requirement does not apply here, and the second is not specific enough to be enforceable. Director Lyon does report periodically to the Governor and Legislature as to the activities carried on by MDHHS. There is no duty to make a specific report about a specific subject at a specific time. Incidentally, no case has ever held that MCL 333.2231 can be used as a predicate for the legal duty required in an involuntary manslaughter prosecution, either.

The prosecutor has also made passing reference to the Critical Health Problems Reporting Act. But that Act creates reports for the Director to use, not reports he must give. For diseases, conditions, or procedures that the director determines constitute a critical health problem, see MCL 325.73, a report must be made by "(a)n attending physician or other person representing or employed by a facility." MCL 325.74. Such reports are supposed to be maintained by the department, MCL 325.76, not promulgated, though they can be made available for essential health-related research. *Id.*, MCL 325.75(3).

The prosecutor similarly ignores the discretion inherent in all of these activities. As the *amicus curiae* brief for the Association of State & Territorial Health Officials explains, there is no legal duty to issue a public notice about an outbreak at a particular time or in a particular way. The testimony has consistently established that such decisions are a matter of professional discretion, and the only literature anyone pointed to on the topic was by Dr. Reilly, who talked about CDC guidelines about risk communication. (XIX Band 34-35, 41, 45, 62; XXIII Reilly 22, 23, 35-38, 70-71, 75-76, 170.) Those guidelines simply stress various issues public health professionals might consider when making a judgment call about issuing a public notice, issues that are particularly important to consider in a case like this, where the healthcare community was on high alert and there was no notice that could have been given to the public to protect people them from contracting the disease. (XIII Reilly 23, 25-26, 70-71.)

The only other source of a duty that the prosecutor has mentioned (though his brief does not) is MCL 333.2221(1), which requires only that the department "endeavor" to achieve certain general goals through "organized programs." There is no evidence the Director abandoned that duty. Director Lyon relied on staff in the Population Health division of MDHHS—an "organized program" established by regulations—to conduct the public health investigation, apprise him of developments, and advise him about any recommended courses of action.

In fact, the most relevant legal authority in these circumstances places the legal duty on the local county health department, *not* the director. MCL 333.2235(2) states that the director "shall" consider the local health department "primary" in circumstances like these. That is why MDHHS staff worked so closely with the GCHD. Dr. Miller underscored the local nature of the outbreak by pointing out to Director Lyon that there had not been a similar increase in cases in surrounding counties (II Miller 92), and GCHD appropriately assumed the lead (e.g., Exs 24, DA, L, E, 25, 28, 44, F, 80, AAAA, etc.). No one advised the Director that MDHHS should "take over" GCHD,

A separate problem for the prosecutor is that common-law manslaughter in Michigan has only ever been based on common-law duties, such as parents and children or adults standing *in loco parentis* with a child, like babysitters or teachers. See, e.g., *People v Giddings*, 169 Mich App 631; 426 NW2d 732 (1988) (parent/child); *People v Thomas*, 85 Mich App 618; 272 NW2d 157 (1978) (teacher/student). There appears to be no Michigan case where a duty was wholly imported from a statute for purposes of a common-law manslaughter conviction.

This case should not, and cannot, be the first because doing so would be bad public policy and would violate Director Lyon's Due Process rights under ex post facto principles. *People v Doyle*, 451 Mich 93, 100; 545 NW2d 627 (1996); *United States v Lanier*, 520 US 259, 266 (1997); *Bouie v City of Columbia*, 378 US 347, 354 (1964). Had Director Lyon known he could be charged with manslaughter for a Flint water switch made by the City and its Emergency Manager in consultation with MDEQ experts—officials over whom Director Lyon has no responsibility or control—he never would have taken the Director position in the first place. And had he known he could be so charged when any Michigan citizen dies and there is an after-the-fact allegation that one of MDHHS' 14,000 employees could have done a better job, he would have been foolish to even consider it. Any sensible person considering future public service in Michigan will certainly take the prosecutor's allegations into account.

The prosecution cites to *People v Sails*, No. 330192 (Mich Ct App, Apr 20, 2017), a failure-to-perform-a legal-duty involuntary manslaughter case. *Sails* involved a substitute teacher who taught a swim class without having a lifeguard certification and without properly supervising the students in his care while they were in the pool. A student drowned. *Sails* is a hybrid duty case, deriving some duties from the common-law teacher-student duty of care, and some duties from regulations regarding the duty of care owed by a swim instructor to the students. The administrative rules relied upon to create the statutory duties at issue in *Sails* were highly specific as to what the individual teacher must do relative to each student in his care—the duty to have a lifeguard certification, to be watching all students at all times, be able to provide immediate attention to any student in distress—and not at all like the broad, general and aspirational statements of the mission of the MDHHS found in MCL 333.2221 or other statutes.

What actually controls this case is the seminal (and widely cited) decision in *People v Beardsley*, 150 Mich 206; 113 N2d 1128 (1908). As the Michigan Supreme Court held, the type of relationship that will support the imposition of a legal duty sufficient to form the basis of a manslaughter charge is a close, personal one, in which the defendant is directly responsible for the care of a specific individual. *Id.* at 209-10 (requiring the legal relation of "protector, as husband to wife, parent to child, master to seaman, etc.," one who has "the custody and care of a human being, helpless either from imprisonment, infancy, sickness, age imbecility, or other incapacity of mind or body"). So a defendant may be held criminally liable only (1) based on a certain status relationship to another, (2) based on the assumption of a contractual duty, (3) based on the voluntary assumption of the care of another, and (4) where a statute imposes a duty to care for another. *Id.* This is consistent with the prosecutor's very best case on the subject, *People v Albers*, 258 Mich App 578, 582; 672 NW2d 336 (2003), which found a legal duty based on an assumed contractual obligation, the defendant's lease agreement. *Id.* at 585.

Here, of course, Director Lyon had no "status relationship" (parent-child, teacher-student, etc.) with Mr. Skidmore or Mr. Snyder, he owed no contractual duty to either man, and he did not voluntarily assume the care of either to the exclusion of others. Nor did the Director have an employer-employee relationship with the gentlemen, as in the case on which the prosecutor relies heavily, *People v General Dynamics Land Systems, Inc*, 175 Mich App 701, 703; 438 NW2d 359 (1989). As noted above, MCL 333.2221 does not create such a status relationship, and the prosecutor has not cited a single case or other authority in support, because the law under *Beardsley* runs the exact opposite way, even in the civil context. E.g., *Hobrla v Glass*, 143 Mich App 616, 636; 372 NW2d 630 (1985) (although governmental official violated a statute requiring suspension of a driver's license following a felonious-driving conviction, the official could not be liable for someone hurt by that failure because "the statutory duty is one owed to the general public not to any individual citizen").

Lacking a showing of any personal legal duty that Director Lyon owed to Mr. Skidmore or Mr. Snyder, the prosecutor's manslaughter charges in Counts I and II necessarily fail.

C. The prosecutor cannot prove that Director Lyon knew of facts giving rise to any hypothetical duty.

It is undisputed that Director Lyon was first made aware of the Legionnaires outbreak in January 2015. But there is no evidence that anyone put the Director on notice—at any time before the end of June 2015—that a second outbreak was possible or that he should make a public announcement about the potential for a second outbreak. The record shows the exact opposite.

Here is the Legionnaire case count in Genesee County in early 2015: January (2), February (0), March (1), April (0). There were three cases in May 2015—one of them was Skidmore—and notice was promptly sent a second time to all Genesee County hospitals on June 1, 2015. Even if these facts had been conveyed to Director Lyon contemporaneously (and they were not, until long after Messrs. Skidmore and Snyder had gotten ill from their McLaren hospital stays), it would have

negated any hypothetical duty to warn of an ongoing Legionnaires outbreak. This is a third, independent reason to dismiss Counts I and II.

D. The prosecutor cannot prove that Director Lyon willfully neglected or refused to perform a duty in a manner that was grossly negligent to human life.

As M Crim JI 16.18 explains, gross negligence means more than carelessness. It means willfully disregarding the results to others that might follow from an act or failure to act. Accordingly, M Crim JI 16.18 requires proof that the defendant: (1) knew there was a danger *to another* that required him to act; (2) could have avoided injuring another by using ordinary care; and, (3) failed to use ordinary care when, to a reasonable person, it must have been apparent that the result was likely to be serious injury. This is a foreseeability test, and it differs from the instruction for ordinary negligence, M Crim JI 16.17, which leaves out all references to knowledge of "another" person.

Here, the evidence shows that as of mid-May 2015, when Mr. Skidmore contracted Legionnaires, and mid-June 2015, when Mr. Snyder is said to have contracted the disease, hundreds of individuals from McLaren Hospital, staff at Hurley and Genesys hospitals, GCHD, MDEQ, MDHHS, the Governor's office, City of Flint officials, the EPA and the CDC were aware of a Legionnaires outbreak. While Director Lyon was alerted on January 28, 2015, to the Legionnaires problem that had arisen at the end of 2014, he appropriately relied on his staff to handle the problem and received no information about it until well after Messrs. Skidmore's and Snyder's diagnoses. Nothing was communicated to Director Lyon about Legionnaires after January 2015 before the end of June 2015, the time by which both Snyder and Skidmore had become ill. The chain of command at MDHHS would be that the Population Health staff would elevate the issue and make recommendations for action if more needed to be done, and that did not happen here. (I Becker 78.) And it was hardly gross negligence for Director Lyon to rely on his expert staff.

Moreover, the experts cannot agree whether, in early 2015, a second wave of Legionnaires was foreseeable. (See, e.g., VI Kilgore 56; XIX Band 109.) It would be exceedingly odd to hold a non-expert like Director Lyon—who necessarily relied heavily on the medical and epidemiological experts in his department—to a foreseeability standard that even the experts do not satisfy.

The prosecutor does not take these deficiencies head on but dodges. He again deems it "incredible" that Director Lyon "did not call for a switch back to DWSD" (Pros Br 12), ignoring that Director Lyon had no knowledge a switch was necessary and lacked the power to direct one. The prosecutor finds it equally "incredible" that Director Lyon did not at least order that the water be immediately tested for *Legionella*. (*Id.*) But Legionella appears in almost all water (XIX Band 38, 86-87; VI Kilgore 128-129) and does not implicate impending illness (VIII McElmurry 129-130, 132, 138-139; XX Edwards 39). Simply testing water willy-nilly would have been pointless and unhelpful. (XIX Band 97-98.) This theory also ignores that no one on MDHHS's staff (or otherwise) ever suggested to Director Lyon that he *should* undertake testing (or suggested that the staff was not already working with the GCHD to do just that), and that MDHHS staff had a plan and was prepared to help GCHD with water testing when requested. (Ex I; III Miller 111.)

Lacking any proof of gross negligence, the prosecutor attempts to smear Director Lyon's character with disputed evidence about statements the Director made regarding lead, about Dr. Reynolds' personal opinion of Director Lyon's attitude, and purportedly false statements during the January 13, 2016 public announcement. (Pros Br 13-14.) The first two allegations are hotly disputed; the last allegation is simply false. (Addendum D.) No matter. None of them shows that Director Lyon willfully neglected or refused to undertake any particular duty that he owed. This is simple mudslinging and, quite frankly, a desperate attempt to throw anything possible against the wall to see if it sticks as an "inference." The Court should not be taken in. The lack of any evidence showing willful neglect is a fourth reason to dismiss Charges I and II.

II. The prosecutor cannot establish each element of misconduct in office (Count III).

A. The prosecutor has brought the wrong charge.

MCL 750.505 provision makes it a felony for an individual to "commit any indictable offense at the common law," but only "for the punishment of which no provision is expressly made by any statute of this state." In *People v Waterstone*, 296 Mich App 121, 144; 818 NW2d 432 (2012), the Michigan Court of Appeals held that MCL 750.505 cannot be invoked with respect to misconduct "that entails willful neglect to perform a legal duty (nonfeasance)," because that misconduct is expressly covered by another statute, MCL 750.478 ("every willful neglect to perform (a public) duty . . . constitutes a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than $1,000.00"). In other words, misconduct in office allegations involving nonfeasance are found under MCL 750.478, not as a felony under 750.505. As a result, any charges seeking punishment for misconduct in office and alleging willful neglect to perform a legal duty must be brought under MCL 750.478, *not* MCL 750.505. *Id.* at 144. As in *Waterstone*, nonfeasance includes alleged concealment of communications that should have been disclosed. *Id.* at 133 n3.

To the extent the prosecutor is still arguing that Director Lyon intentionally misled and withheld information about the Legionnaires outbreak from the Governor, the Legislature and/or the public—a theory he properly abandons in his brief based on all of the evidence—then this is the exact same type of nonfeasance charged in *Waterstone*. That part of the allegation in Count III should be dismissed under *Waterstone*.

The one theory the prosecutor does raise in his brief—that Director Lyon affirmatively directed the FACHEP group to not engage in an analysis that would aid in determining the source of the outbreak—is appropriately charged under MCL 750.505 but fails for lack of proof, as outlined below.

B. The prosecutor cannot establish each element of a misconduct-in-office charge (Count III).

The elements of the common-law offense of misconduct in office are: (1) a public officer; (2) engaged in conduct in the exercise of the duties of the office or done under the color of the office; (3) whose acts constitutes malfeasance or misfeasance; and, (4) which amount to corrupt behavior. *People v Carlin*, 239 Mich App 49, 64; 607 NW2d 733 (1999) (citing Perkins & Boyce, Criminal Law (3d ed), pp 540–545). In addition, "the existence of a duty owned to the public is essential to be liable for misconduct in office, for otherwise the offending behavior becomes merely the private misconduct of one who happens to be an official." *Id.* at 65–66 (quoting 63C Am Jur 2d, Public Officers and Employees, § 371, pp 811–812 (1997)). Count III requires proof of: (1) a duty; (2) malfeasance/misfeasance in performance of the duty; and, (3) corrupt behavior.

1. The prosecutor again cannot prove a duty.

The only basis for a legal duty that the prosecutor cites with respect to Count III is again MCL 333.2221. (Pros Br 24.) Under the statute, says the prosecutor, "the DHHS is duty bound to investigate the cause of diseases and epidemics and the cause, prevention, and control of environmental health hazards, nuisances, and sources of illnesses." (*Id.*) The prosecutor suggests that Director Lyon delegated this duty to FACHEP. (*Id.*) But the Timeline (Addendum A) shows that the Director actually relied on his staff to do the public health investigation, not FACHEP; FACHEP itself was simply contracted to do research through a grant. (VII McElmurry 66-69; XII McElmurry 16-18). And as explained above, the statute does not impose a particular duty on Director Lyon to do anything. There certainly is no legal duty to contract with an outside research group like FACHEP, or to behave in a certain way. No statute, no case, no nothing. Lacking a legal duty, the prosecution cannot "establish an essential element of the offense—that defendant ha(s) committed criminal malfeasance or misfeasance." *Carlin*, 239 Mich App at 68–69. Count III therefore fails as a matter of law.

2. The prosecutor cannot prove malfeasance/misfeasance.

The prosecutor's *only* remaining theory of malfeasance/misfeasance is Director Lyon's purported thwarting of FACHEP's investigation. (Pros Br 24-29.) The prosecutor has abandoned the theory that Director Lyon failed to timely notify the Governor's office, and with good reason, because the Governor's office knew early and often about the Legionnaires outbreak:

- MDEQ's Brad Wurfel references "42 cases of Legionnaires disease in Genesee County since last May" in a January 30, 2015 email to David Murray in the Governor's office. (Ex N.)
- Harvey Hollins, the Governor's Director of Urban Initiatives, learned about the Legionella outbreak on March 13, 2015 from MDEQ's Wurfel. (Ex 28.)
- Sarah Wurfel and Jarrod Agen, both on the Governor's staff, received blind copies of the same email. (V Hollins 137-138.)
- This email was also sent to the Governor's David Murray. (Ex F.)
- No later than March 13, 2015, the following Governor's office staff knew about the outbreak: Hollins, Wurfel, Agen, and Murray.

In addition, Director Lyon himself discussed the increase in *Legionella* cases with the Governor's staff during a September 18, 2015 conference call. (Ex 23; V Hollins 113-118; XXII Brown 18.)

Regarding the prosecutor's FACHEP theory—that Director Lyon thwarted an investigation—there is zero supporting evidence. Although the evidence was summarized above and in the Timeline in Addendum A, here is a more detailed treatment of the alleged "delay":

- Shawn McElmurry was handpicked by Hollins to lead FACHEP in late January 2016. There was not a standard bidding process. (VIII McElmurry 21-22; IX McElmurry 57.)
- MDHHS awarded FACHEP $250,000 for Phase I. (II Zervos 26-27; XXI Hanley 16.)
- April 29, 2016 – FACHEP presented a Phase II plan for about $12 million to MDHHS staff. (XII McElmurry 23; Ex TT.) Hanley was surprised at the $12 million figure and called it an "outlier." (XXI Hanley 40.) It was far greater than any other group had asked for relative to Flint and was two to three times more money than was being allocated by MDHHS to bottled water and filters for Flint. (XXI Hanley 40.) Hanley told FACHEP that it was highly unlikely the Legislature would authorize that level of funding and it may want to consider trimming the budget. (XXI Hanley 41-42.)

- Shortly after the April 29, 2016 meeting, Drs. McElmurry and Kilgore had dinner with Rich Baird of the Governor's office. Dr. McElmurry said that Baird—not Director Lyon—told them to get the budget down to $4.1 million. (IX McElmurry 82-83; XII McElmurry 23-24; VI Kilgore 141.) The Legislature—not Director Lyon—controlled the funding. (II Zervos 27.)

- May 5, 2016 – MDHHS was anticipating needing $5 million per year for two years for FACHEP, $10 million total, and funding for FACHEP was highlighted as a department top-three funding priority. (Ex SSSS at 10; Ex RRRR; XXI Hanley 21, 32.)

- May 16, 2016 – at a meeting with members of FACHEP, Director Lyon, and Hanley, Dr. Kilgore became profane and was banging on the table, yelling at Lyon about the urgency of getting their project underway. (IX McElmurry 57-58; XXI Hanley 50-51.) Dr. Kilgore denied being profane. (VI Kilgore 123-124.) This was Director Lyon's first meeting with FACHEP.

- There is conflicting testimony about a sarcastic response that Director Lyon may or may not have made at the meeting – he "can't save everyone," "everyone will die of something." (VI Kilgore 54; VII McElmurry 89; II Zervos 142.) He may have said neither of those things. (XXI Hanley 51-54, 81-82.)

- May 18, 2016 – FACHEP's final proposal for Phase II was submitted to MDHHS. Hanley promptly forwarded FACHEP's request for about $9 million to the State Budget Office. (XXI Hanley, 54; Exhibit 48.)

- May 28, 2016 – Ten days later, Hanley followed up with an e-mail to the State Budget Office, asking about the funding because FACHEP was anxious to get going on its work and Director Lyon wanted them to get going on it as soon as possible. (Ex RRRR.)

- FACHEP was allocated $4.1 million by the Legislature. $3.1 million was to be paid out on the contract between June 1, 2016 and Ex 31, 2017, and $1 million was to be paid out in 2018. (IX McElmurry 82-83; Exhibit HH.)

- June 23, 2016 – FACHEP's approved grant proposal was entered into the MDHHS eGrAMS system. (XXI Hanley 28; Ex NNNN.) This was a mere month and a week from the May 16th meeting, lightspeed for state contracting.

- July 23, 2016 – FACHEP waited an entire month to finalize *its* obligations under the eGrAM process. (XXI Hanley 29.)

- Phase II of the project was heavily focused on testing water in homes for *Legionella*; the home testing study had five components. MDHHS questioned FACHEP about one of those five components – the shower filter study. Dr. Edwards wondered why FACHEP was testing where the "*Legionella* were not," as his group had studied Flint homes in August 2015 and found no pathogenic *Legionella*, consistent with FACHEP findings from January 2016 and subsequent findings from Dr. Edwards' group throughout 2016. (Exs 48, KKKK, Y; XX Edwards 71, 52-54.)

- August 5 and 12, 2016 – Dr. Wells, Director Lyon, and others asked FACHEP team members about the value of the filter study; according to Dr. McElmurry, they seemed skeptical about that portion of the study and said so during hallway discussion following a FWICC meeting but ultimately, the filter study was fully funded as requested by FACHEP. (VIII 47-48, 51, 77, 80-83; Ex 52.) MDHHS concerns were legitimate, scientific questions. (VII McElmurry 28-29.) Director Lyon's "skepticism" about the filter study was that he asked Dr. McElmurry to explain the proposal to Director Keith Creagh of MDEQ, and said that he had to balance the importance of the study with upsetting the public. (VII McElmurry 94; Ex 52.)

- August 16, 2016 – FACHEP Phase II contract was executed effective June 1, 2016.

- September 2016 – FACHEP did not begin taking any water samples until September 2016 (XII McElmurry 108), even though the contract had an effective date of June 1, 2016, and Dr. McElmurry testified that it is collecting water samples is an easy undertaking that could be done in a day and costs maybe $1000 to $2000 (XIII McElmurry 12-13; XII McElmurry 112).

- McLaren Hospital refused to participate in FACHEP's study. (VIII McElmurry 139.)

So the prosecutor has taken some disputed testimony about Director's Lyon (1) possibly making a flippant remark and (2) questioning the methodology of the filter study and FACHEP's gargantuan proposed budget, and turned it into a felony, even though Dr. Edwards had very similar criticisms of FACHEP's focus on the home study, at a time when the scientific data showed that *Legionella* was not a problem in Flint homes, just the hospitals. (XX Edwards 71.)

More important, there is no evidence Director Lyon actually slowed down the contracting. Pressed over many pages of cross-exam, Dr. McElmurry was unable to point to *anything* Director Lyon said or did to delay the execution of the contract, and he acknowledged there were several standard administrative issues that had to be worked through (a data use agreement, an IRB), as well as a protective order obtained by the prosecutor and a legislative appropriation process, before the contract could be executed. (VI Kilgore 90-92; VII McElmurry 63-65, 67-68, 74-75.)

On the other hand, there *is* evidence of the Legislature's lightning-fast approval of the appropriation. There is also evidence that a holdup was caused by: (1) FACHEP's one-month delay in entering its contract information into the eGrAMS system; (2) FACHEP's refusal to take any

water sample until months after the appropriation had been made, none of which is attributable to Director Lyon; and, (3) the improvident protective orders that the prosecutor obtained from the Genesee County Circuit Court regarding McLaren on June 27, August 17, and August 24, 2016, orders which the Court of Appeals rejected as based on "catchy phrases or naked assertions devoid of factual support." *DHHS v Genesee Circuit Judge*, 318 Mich App 395, 410; 899 NW2d 57 (2016). The lack of evidence dooms Count III.

3. The prosecutor cannot prove that Director Lyon acted corruptly.

Corruption means acts reflecting "depravity, perversion or taint." *People v Milton*, 257 Mich App 467, 471; 668 NW2d 387 (2003) (quotation omitted). Corrupt intent can be shown where there "is intentional or purposeful misbehavior or wrongful conduct pertaining to the requirements and duties of office by an officer." *Id.* It requires "a tainted or perverse use of the powers and privileges" of office, "or a perversion of the trust placed in" an officer. *Id*.

There is no evidence that Director Lyon intentionally or purposefully misled the public or anyone else about the *Legionella* outbreak. Given his long history of exemplary public service as well as his substantial responsibilities overseeing a mammoth state agency, it is wrong to suggest that Director Lyon engaged in a tainted or perverse use of his office's powers and privileges.

At the July 11th hearing, the prosecutor said that Director Lyon lied, misled and tried to cover up the Legionnaires outbreaks. But the evidence is to the contrary: Director Lyon directed that the epidemiological investigation be done as a priority. (Ex 28.) As a result, MDHHS staff caused the entire Genesee County medical community to be specifically notified of the outbreaks on multiple occasions (once in February 2015, twice in June 2015), notified the CDC, and posted weekly information about cases on its website. Director Lyon himself told the Governor's office staff about the outbreak in September 2015 and shared the stage with the Governor at the January 2016 press conference. This is the opposite of a cover up.

The prosecutor also sees coverup in an email from Colonel Kriste Etue to Baird on November 25, 2015, where Baird says the Governor wants MDEQ's Dan Wyant and Director Lyon to work through the lead situation without having to declare an emergency. That declaration was about lead, not Legionnaires, and Etue said it is common for the state to work with a local community in a local crisis *without* declaring an emergency. (III Etue 155.) This Baird-Etue exchange has nothing to do with Legionnaires, the actual charge, and the lead emergency declaration issued within a month of the email. Most significant, the email states nothing about Director Lyon's perspective on an emergency declaration, only purportedly the Governor's.

Likewise, the so-called "strong statement" email that the prosecutor continually uses as purported misleading behavior by Director Lyon involves lead, not Legionnaires. (Ex 7.) And both Dr. Edwards *and* Chief Deputy Becker testified that this email—where Director Lyon is asking for a strong statement with a demonstration of proof in support of the MDHHS's lead data—is obviously just a request by Director Lyon to have his staff confirm whether the Department's lead data, previously provided to Director Lyon, "was accurate because it seemed we had a conflict between ours and Dr. Hanna-Attisha's." (I Becker 30; XX Edwards 134-136, 147.)

The prosecutor suggests that Director Lyon had a feigned response to the comprehensive outbreak report he received on January 11, 2016 (Ex 9), suggestive of a cover up. Not so. Director Lyon has repeatedly stated that he first learned of the outbreak in January 2015, as did Becker and the rest of MDHHS upper-level management. Becker said that he did not know the "numbers" and likewise thought Director Lyon was seeing the "numbers" for the first time. Exhibit 9 is a comprehensive 20-page outbreak report, not a 1-page Epi Graph, and the Court will see that it contains a massive amount of data. The actual evidence is that January 11, 2016, was indeed when Director Lyon saw this comprehensive report, which informed him for the very first time about the number of outbreak-associated deaths, not just the number of cases, as well as other detailed

information about potential sources of exposure and the "outlier" cases. Director Lyon's response to seeing these details, according to Becker, was that the Governor and the public needed to know right away, a wholly appropriate response acted upon immediately. (I Becker 52.)

The prosecutor has also suggested that Director Lyon lied under oath about when he learned of Legionnaires. The testimony could not be clearer that the discussion to which the prosecutor refers was about lead. Director Lyon testified under oath, and *immediately following his testimony* told a reporter that he learned of Legionnaires in January 2015. (Ex 11, p 95.) There is no proof of corruption or intentional or purposeful misbehavior by Director Lyon. Period.

III. The prosecutor cannot establish each element of willful neglect of duty (Count IV)

For the reasons set forth in Director Lyon's motion to dismiss Count IV, there is no legal or factual basis for the charge, which must be dismissed.

CONCLUSION

This is not a close case. The prosecutor's legal theories underlying each of Counts I, II, and III are contradicted by well-settled Michigan law and bereft of any evidentiary support. It is not enough for the prosecutor to wave his hands in the air and cry that bad things happened to the people of Flint, so someone must be held responsible. Notwithstanding the tragic events that transpired, this is still a legal proceeding that requires proof of probable cause: it is the prosecutor's burden to show the specific legal duties that Director Lyon owed, how he breached those duties, and how that misconduct actually caused the complained-of harm. Because the prosecution has failed to show probable cause sufficient to support each element of Counts I, II and III, those charges must be dismissed. And because Count IV must be separately dismissed pursuant to Director Lyon's motion, there is nothing left for trial. If Due Process means anything in Michigan, it means that a public official cannot be bound over for criminal charges based on the wholly inadequate record and legal theories the prosecutor advances here.

Respectfully Submitted,

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BURSCH LAW PLLC
Attorneys for Defendant Lyon

John J. Bursch (P57679)

9339 Cherry Valley Avenue, S.E., Unit 78
Caledonia, Michigan 49316-0004
(616) 450-4235

WILLEY & CHAMBERLAIN LLP
Attorneys for Defendant Lyon

Larry C. Willey (P28870)
Charles E. Chamberlain, Jr. (P33536)
Britt M. Cobb (P69556)

300 Ottawa Avenue, N.W., Suite 810
Grand Rapids, Michigan 49503-2314
(616) 458-2212

STATE OF MICHIGAN
IN THE 67TH DISTRICT COURT, GENESEE COUNTY

PEOPLE OF THE STATE OF MICHIGAN,

Plaintiff, Case No. 17T-01355-FY

v

Hon. David J. Goggins

NICOLAS LEONARD LYON,

Defendant.
_____/

John J. Bursch (P57679)
BURSCH LAW PLLC
9339 Cherry Valley Avenue, S.E., Unit 78
Caledonia, Michigan 49316-0004
(616) 450-4235
jbursch@burschlaw.com

Todd F. Flood (P58555)
Special Assistant Attorney General

Larry C. Willey (P28870)
Charles E. Chamberlain, Jr. (P33536)
Britt M. Cobb (P69556)
WILLEY & CHAMBERLAIN LLP
300 Ottawa Avenue, N.W., Suite 810
Grand Rapids, Michigan 49503-2314
(616) 458-2212

Attorneys for Defendant

DEFENDANT LYON'S POST-HEARING MEMORANDUM ADDENDA

Addendum A: Timeline of Key Events

Addendum B: Timeline of Legionnaires Cases by Month

Addendum C: Facts, Not Words – July 11th Oral Argument

Addendum D: Facts, Not Words – Prosecution's Brief

Addendum A

Timeline of Key Events

Addendum A: Timeline of Key Events[1]

- **April 2014** – Flint municipal water switched from DWSD to Flint River. It is undisputed that neither Director Lyon nor anyone else in public health was consulted about the decision to switch. (VIII McElmurry 106.)

- **June 2014** – Onset of 1st Legionnaires wave.

- **January 28, 2015** – Lyon first learns of *Legionella* in meeting with Miller and Moran.
  - Corinne Miller, the state epidemiologist and head of the Bureau of Epidemiology, shows Lyon the epi curves. (Ex 8; II Miller 90.) Sue Moran, Deputy Director of the Population Health and Community Services Administration, also attended the meeting. Moran and Miller led the epidemiology group at MDHHS. (Ex A.)
  - Miller showed Lyon the Epi Graph showing the rise in cases. (Ex 8).
  - Miller showed (and possibly gave) Lyon a 1/27/15 email written by MDHHS' Shannon Johnson (the Department's subject-matter expert in *Legionella*, Infectious Disease Epidemiologist) that was sent to Genesee County Health Department (GCHD) staff with a detailed list of nine MDHHS requests for information and seven things MDHHS could do to help GCHD in the *Legionella* investigation. (Ex B; III Miller 51.)
  - "We look forward to continued communication and collaboration with you," Johnson wrote to GCHD. (Ex B.)
  - In her meeting with Lyon, Miller said it was obvious that MDHHS staff would be pursuing the *Legionella* investigation. (III Miller 61-62.)
  - Director Lyon asked to be kept informed. (II Miller 95.)
  - Miller did not know if there had been any deaths. (II Miller 111.)
  - Miller did not suggest that any type of public notification, traditional or otherwise, was necessary. (III Miller 121.) And Miller did not explain to Lyon that the cases could come back in the summertime but did point out the temporal relationship between the switch in the water and rise in cases. (II Miller 99.)
  - Most important, there was *not* enough information to go public yet. (III Miller 47-48.)

- **January 28, 2015** – Lyon was copied on Miller's email regarding her call with two Flint hospitals and Michigan Department of Environmental Quality (MDEQ) staff. (Ex 3.)
  - Miller noted that "we are working with the local health department to collect additional case information."
  - The call was frustrating because the source of the *Legionella* infections "was all speculation because we don't have the case information that we need yet."
  - Moran to Miller: "Has the (Genesee County) Health Department agreed to let us help?"
  - Two days later, Lyon forwarded the 1/28/15 email to himself as a reminder.
  - Lyon emailed Moran "soon after" the 1/28/15 meeting to see if things had been worked out with GCHD. (II Miller 103.) There was no request back asking Lyon to do anything.

[1]In all four Addenda, preliminary examination transcript citations are noted by Volume, Witness, Page number. Exhibits are noted by number or letter.

- Chief Deputy Director Tim Becker also learned about the rise in cases that day and was satisfied that the appropriate MDHHS staff have been engaged and were working on the *Legionella* issue. There was no indication that things needed to be handled any differently. (I Becker 81-82, 83-84.)
- As a result of this (Ex 3) and other communications on 1/28/15, Becker, Moran, Miller and the Chief Medical Executive Matt Davis (Ex 1, 2, 3) as well as numerous other relevant MDHHS staff members (Johnson and Jim Collins, to name two) all knew of the outbreak by January 28, 2015.
- It is undisputed that no one recommended to Lyon that a public notice be issued, either in January 2015 or at any time in 2015. (III Miller 121.) Moran, Miller, Davis and the other medical and scientific staff were the ones tasked with reporting public health concerns to upper management. (I Becker 7.)

- **January 30, 2015** – MDHHS' Jim Collins (Director of Communicable Disease). forwarded Johnson's 1/28/15 email to GCHD again and suggested GCHD issue a *Legionella* notice to the medical community, enclosing a MIHAN example. (Ex 24, DA.) Collins said that GCHD was in the best position to distribute the notice but said MDHHS could assist if GCHD requested it.
  - GCHD responded: "We do not want to jump to conclusions based upon very limited and inconclusive evidence."
  - MDHHS staff express some "frustration" to GCHD email in a way that did not represent the professional culture Lyon was building at MDHHS. (III Miller 93-94.)

- **January 30, 2015** – GCHD's Suzanne Cupal emails MDHHS' Collins. She says GCHD is taking the lead. "We do not want to jump to conclusions based upon very limited and inconclusive evidence." (Ex L.)

- **January 30, 2015** – Governor's staff also knew what Director Lyon knew. (Ex N.)

- **February 4, 2015** – Johnson wrote a follow-up email to GCHD offering *more* MDHHS help, including help with messaging to the public and media. Regarding messaging, GCHD wanted to control that and responded: "Should we need MDCH PIO (Public Information Officer) assistance, we will request it." (Ex E.)
  - Johnson asked for an estimated date that a HAN with the legionellosis guidance would go out. (Ex E.)

- **February 13, 2015** – At the suggestion of MDHHS, GCHD notified infection control staff at all three area hospitals of the outbreak and provided clinical guidance for clinicians. (Ex D, DC, DB, DD(2); VI Kilgore 99.)
  - Hamilton Community Health Network also received the notice and forwarded it to all HCHN providers and nurses too. (XXII Warden 76-79.)
  - Julie Borowski at McLaren Hospital forwarded it to over 700 medical providers in its system. (11 Borowski 87.)
  - The notice warns that Genesee County has reported over 45 cases of *legionellosis* since June 2014, the highest number of cases in the past five years.
  - Cases are continuing to be identified.
  - Investigations are ongoing to determine the cause.

- Asks the clinical community for assistance.
- Attaches clinical guidance, testing protocol, etc.
- Dr. Kilgore said notice to the medical community is the most efficient method of getting the word out (VI Kilgore 106), and the expert witnesses, Drs. Band and Reilly, testified that these notices were the most effective thing that could have been done under the circumstances. (XXIII Reilly 71, 73; XIX Band 41-44.)

- **February 20, 2015** – MDHHS and GCHD enhanced patient questionnaire is finalized for use in epidemiologic investigation. (Ex C.) MDHHS initiated this.
  - MDHHS coordinated with GCHD and the plan was that MDHHS staff would re-interview all prior cases using the enhanced questionnaire and GCHD would interview any new cases. (Exs C, CA, E.)

- **March 9, 2015** – End of 1st Legionnaires wave. (Ex YA.)

- **March 10, 2015** – GCHD's Henry requested info from MDEQ and City of Flint officials (but *not* from MDHHS). (Exs 25, 28, 44, F.)
  - Says McLaren "identified *and mitigated Legionella* in their water system."

- **March 19, 2015** – After MDEQ responded, Henry wrote a reply noting that GCHD is working with MDHHS and consulting with the CDC. (Ex XXX.)
  - *No conclusions regarding source of Legionella* and GCHD still gathering information

- **April 7, 2015** – All but seven of the 2014-15 patients have been contacted and re-interviewed by MDHHS staff using the enhanced questionnaire. (Ex 80.)

- **April 15, 2015** – GCHD's Cupal responds to MDHHS email. (Ex 80.)
  - McLaren tested, found *Legionella* in its water, hyperchlorinated, tested again and found nothing; McLaren continues to monitor monthly and will create a remediation plan; GCHD has identified Janet Stout, a *Legionella* remediation expert for building water systems, Joan Rose, a *Legionella* expert at Michigan State University, and an EPA water systems' expert to consult on building and water system issues.

- **April 22, 2015** – GCHD is in contact with the CDC. The CDC recommends that GCHD have a "measured response" to outbreak. (Exs 76, 84, QQQQ.)

- **April 23, 2015** – GCHD acknowledges it does not have sufficient data for further action at this time. (Exs 76, 84, QQQQ.) MDHHS provides GCHD help obtaining water data from MDEQ. (Ex AAAA.)

- **April 27, 2015 to April 29, 2015** – Numerous emails among MDHHS, GCHD, and CDC where entities exchange and review information regarding epi curves, water-quality tests, and the investigation. The CDC gives detailed instructions on how to collect environmental samples (water samples). (Exs AAAA, 76, 84, QQQQ, ZZZZ.) MDHHS is clearly engaged.

- **April 30, 2015** -A conference call between CDC, GCHD and MDHHS occurs. (Ex QQQQ, ZZZ, 84.)

- **May 1, 2015** – Susan Bohm at MDHHS recommends to GCHD that another notification to "all Genesee providers" be issued with clinical guidance.
  - Bohm offers the assistance of the CDC-EIS officer embedded at MDHHS to assist GCHD with water sampling. (Ex I.)
  - Email exchange notes that Tim Bolen, Regional Epidemiologist for MDHHS, will be attending meeting with hospitals in Flint on 5/7/15. (Ex I.)

- **May 4 or 8, 2015** – First Legionnaires case since March 2015. (Ex YA, 21, 69.)

- **May 13, 2015** – Mr. Skidmore is admitted to McLaren. (Ex BBB at 83.)

- **May 15, 2015** – Email between MDHHS and CDC; nothing remarkable stands out from the patient interviews except the initial cluster of cases at McLaren. (Ex EEEE; XVII Henry 74.)

- **May 19, 2015** – Mr. Skidmore is released from McLaren. (Ex BBB at 85.)

- **June 1, 2015** –Mr. Skidmore is admitted to McLaren and diagnosed with Legionnaires.

  GCHD again notifies the medical community as suggested by MDHHS on May 1, 2015 (Ex I) about Legionnaires and attaches updated clinical guidance, testing protocol, and requisition form. (Ex LL.)
  - Notice again reaches over 700 providers in the McLaren system as well as Hurley and Genesys hospitals (XI Borowski 87); Hamilton Community Health Network again received the notice and forwarded it to all HCHN providers and nurses, too. (XXII Warden 83.)

- **June 4, 2015** – MDHHS email attaching executive summary of outbreak and investigation report is sent to GCHD, CDC and hospitals; MDHHS mistakenly believes that the Legionnaires "outbreak is over" because the last reported case occurred in March 2015, but the Department urges "vigilant" awareness and surveillance. (Exs 69, FFFF, PP.) The data is confounding, to say the least:
  - 21 of 45 cases (47%) occurred in people whose residence received Flint water.
  - 10 cases had no exposure to a Flint hospital in the 2 weeks prior to illness nor were their homes on the Flint water system.
  - "The lack of clinical *Legionella* isolates precludes our ability to link cases to an environmental source."
  - "(E)pidemiologic data did not indicate a common community source."

- **June 5, 2015** – GCHD's Henry responds to Collins email, copying CDC, that there have been three more confirmed *Legionella* cases since the beginning of May 2015. (Ex 69.)

- **June 8, 2015** – MDHHS' Collins emails GCHD and CDC and continues to offer resource and informational support; Collins notes that GCHD communications should be directed to MDHHS staff rather than directly to the CDC and that the CDC agrees with this approach; an epi aid is not warranted at this time. (Ex 77.)

- **June 16, 2015** – Mr. Snyder is admitted to McLaren; an oncologist sends him to McLaren by ambulance after initial visit. (Ex CCC at 64; X Tribble 22-23, 25.)

- **June 23, 2015** – Mr. Snyder is discharged from McLaren. (Ex CCC at 64; X Tribble 10.)

- **June 26, 2015** – Internal GCHD emails (Ex XXXX):
  - Describes conference call with MDHHS.
  - Six *Legionella* cases in June, four had "a direct association" with McLaren.
  - McLaren needs to be more aggressive. McLaren should hire a better consultant (MDHHS is tracking down the contact info) and share positive *Legionella* environmental samples with MDHHS so that MDHHS can compare with clinical samples.

- **June 29, 2015** – GCHD again notifies the medical community about the outbreak with guidance; again, more than 700 medical providers at McLaren and HCHN, as well as other hospitals, receive this information a *third* time about Legionnaires. (Ex MM; XI Borowski 87; XXII Warden 83.)
  - Attaches clinical testing protocol, updated clinical guidance, and test requisition form.
  - Outbreak identifier.
  - Asks to take the sputum sample *before* administration of antibiotics.

- **June 30, 2015** – Mr. Snyder is admitted to McLaren and then dies; the death certificate lists cause of death as "Health-Care Associated Pneumonia." (Ex 75.)

- **July 2, 2015** – MDHHS lab informs GCHD of a successful test of a clinical sample (Mr. Skidmore); GCHD requests that McLaren take a more aggressive approach. (Exs YYYY, J.)

- **July 8, 2015** – Internal GCHD emails note one *Legionella* case in May, seven in June, three in July; 10 of the 11 cases are associated with McLaren; GCHD's Henry to request water samples from McLaren be provided to MDHHS to compare with clinical isolates. (Ex YYYY.)

- **July 22, 2015** – Lyon and Muchmore meet; Lyon is asked to "personally take a look at this" relative to the lead problems; Lyon makes notes about a wide range of Flint water problems and "legionnaires (hospital)." (Exs O, M, ZZ, 67, 68.)
  - The prosecutor suggests that cracked iPhone screen means Lyon tried to break the device to hide his notes. It is also true that when you drop a phone, the screen sometimes cracks. It is undisputed that *no* data was actually compromised. If Lyon was trying to deliberately conceal something, he did a terribly bad job of it.

- **July 24, 2015-September 2015** – Much investigatory activity by MDEQ, MDHHS, GCHD, and McLaren continues. (E.g., Exs H, OO, V, PPPP, IIII.) Testing at McLaren by Special Pathogens Laboratory reveals pathogenic *Legionella* across the interior of the hospital but none in the "incoming CW." (Ex OO.)
- **September 16, 2015** – Lyon, through his assistant, asks Moran for an update on Flint water; Moran in turn asks Miller who provides an update via email. (Ex 23.)
  - 31 new cases of *Legionella* from June to August 2015.
  - 73% did *not* live on Flint water.
  - Met with hospitals and GCHD to review steps; another meeting scheduled.

- **September 18, 2015** – Lyon shares with Governor's office the information from Miller's email from two days earlier (Ex 23) about the increase in Legionnaires' Disease and notes that 73% of patients do not live on Flint water. (Exs GC, GB; V Hollins 113-118; XXII Brown 18.)

- **September 28, 2015** – MDEQ/Lyon exchange emails regarding *lead*. (Ex 7.) By September, lead had become an overwhelming issue according to Miller. (III Miller 62.)

- **October 16, 2015** – Flint water source switched back to DWSD (Detroit Water).

- **October 16, 2015** – Email exchange between Michigan Public Radio's Carmody, Dr. Marc Edwards at Virginia Tech, and GCHD. (Ex JJJJ.)
  - Carmody asks about "opportunistic pathogens" in Flint water; Edwards responds, "Our initial sampling did not find a worse problem in Flint than in other cities."
  - Edwards found high levels of *Legionella pneumophila* in two large buildings (hospitals) "just *before* the switch." Further testing "will take awhile." Testing by Edwards in August 2015 of homes and small buildings throughout Flint revealed *no pathogenic Legionella*. (Exs NN, P; XX Edwards 37-38, 52-54, 69-70, 145.)

- **October 29, 2015** – End of second Legionnaires wave. (Ex 21.)

- **November 10, 2015** – MDHHS's Eden Wells connects EPA and GCHD. (Ex HA.)

- **November 27, 2015** – GCBOH's Kay Doerr emails GCHD; concerned that information reaches the public on the *Legionella* outbreak; "GCHD is best equipped" to make that announcement. (Ex OA.)

- **December 1, 2015** – GCHD emails the CDC. (Ex KA.)
  - Since May 2015, 41 cases of Legionnaires, 18 of those cases were previously hospitalized at McLaren.
  - Still seeing increase in cases in Genesee County, but have not seen any previously-hospitalized cases since August 2015, when McLaren did its remediation. (Ex KA.)

- **December 13, 2015** – Mr. Skidmore dies; his death certificate lists the cause of death as "end stage congestive heart failure." (Ex 62.)

- **January 11, 2016** – MDHHS Lasher email to Lyon and others attaches "full report" of June 2014-March 2015 outbreak. (Ex 9.) Conclusions:
  - Legionnaires data is a hodgepodge.
  - Only 27/45 cases in the first wave had healthcare-facility exposure in the two weeks before onset of the disease.
  - Only 21/45 cases occurred in people whose residence received Flint water.
  - Out of 18 cases with no healthcare exposure, only 8/18 (44%) were exposed to Flint water at home.
  - 10 of 45 cases (22%) had no exposure to a Flint hospital in the two weeks before onset *and* did not live on Flint water!

- **January 13, 2016** – Lyon press conference. (Ex 82.)
  - Right before Lyon starts speaking, the Governor introduces the topic of the press conference by noting that the medical community knew but not the public because the investigation was ongoing. "(T)his is a preventive measure to communicate information (so that) the citizens of Flint can . . . know that actions are being taken to address the issue." (18 Henry 30-31.)
  - MDHHS cannot conclude that Legionnaires increase is related to the water switch.
  - Continuing investigation plus increased diligence with monitoring with the hospital systems.

- **April 15, 2016** – GCHD's Henry emails about an upcoming Genesee County Board presentation where he says that GCHD may get questions about why a public notice was not issued sooner, a question that he says is not reasonable. (Ex Q.)
  - The Legionnaires cases were sporadic.
  - Worked closely with hospitals and helped mitigate McLaren's situation.
  - All area hospital physicians were informed; increased surveillance and testing.
  - 113 cases of Legionnaires in Wayne County in 2013; many diseases are cyclical.
  - "*There was no evidence that would have supported a public statement about a source of exposure. If we had made a statement, then we'd probably be facing litigation, also*." (Ex Q).

- **April 25, 2016** – Lyon testifies before the joint select committee of the Legislature; Lyon learned about *Legionella* in January 2015 but the problem did not rise to his level again from staff until September 2015. (Ex 11 at 95). Lyon believed (correctly) that the epidemiological staff was trying to solve the problem, i.e. determining the source and having a solution for it, before elevating the *Legionella* issue to him again. (Ex 11 at 53-54.) Lyon also says he was not aware of the serious health-related issues about lead until Muchmore's 7/22/15 email. (Ex 11 at 34-35.)

- **April 29, 2016** – FACHEP presents its Phase II proposal and budget to MDHHS totaling $12 million. (Ex TT.)

- **May 5, 2016** – FACHEP is listed as an MDHHS top-3 funding request. (Ex SSSS.)

- **May 16, 2016** – Director Lyon has his first meeting with FACHEP.

- Dr. Kilgore became profane and was banging on the table, yelling at Director Lyon about the urgency of getting their project underway. (IX McElmurry 57-58; XXI Hanley 51-52.)
- There is disputed evidence as to whether Director Lyon gave a flippant response to this inappropriate outburst. (VIII McElmurry 55; II Zervos 135; XXI Hanley 82).

- **May 18, 2016** – Regardless, MDHHS immediately forwarded FACHEP's final request for $9 million to the State Budget Office. (XXI Hanley 54; Ex 48.)

- **May 28, 2016** – MDHHS follows up with the Budget Office only 10 days later to inquire about funding; the email says FACHEP is ready to start research and "we are running out of time." The Department is "just trying to be sure we can flip the switch on this as soon as possible." (Ex RRRR.)

- **June 23, 2016** – The final understanding was a $4.1 million FACHEP contract, with $3.1 million allocated the first year, $1 million for the second. (IX McElmurry 79.) In nearly record time, the Legislature approved the $3.1 million for the first year (Ex HH at 1), and by June 23, 2016, the contract was entered in MDHHS' eGrAMS system. (XXI Hanley 28; Ex NNNN.)

- **July 23, 2016** – FACHEP took until July 23rd, an entire month, to finalize its obligations in the eGrAMS system. (XXI Hanley 29.)

- **September 2016** – FACHEP did not take any water samples until September 2016 (XII McElmurry 108), even though the contract had an effective date of June 1, 2016, the appropriation for FACHEP had been made by June 23, 2016 and Dr. McElmurry testified that collecting water samples is an easy undertaking that could be done in a day and costs maybe $1000 to $2000. (XII McElmurry 12-13; XII McElmurry 112.)
  - When pressed, Dr. McElmurry was not able to point to anything Director Lyon said or did to cause any delay in FACHEP's research. (XII McElmurry 107, 109-131; VI Kilgore 90-92.)
  - And one of the entities which refused to participate in FACHEP's study was McLaren Hospital. (VIII McElmurry 139.)

Postscript

- As Edwards testified, the *Legionella* outbreak in Flint was a complex and confounding situation. (XX Edwards 93.)
- Cupal and Henry agree with that assessment. (Ex 76; XVII Henry 64.)
- Dr. Band testified that "both the GCHD and the MDHHS were treating Legionnaires' Disease as an urgent problem. . . . They were giving it, they were doing a comprehensive investigation." (XIX Band 121.)

Addendum B

Timeline of Legionnaires Cases by Month

Addendum B: Number of Genesee County Legionnaires Cases by Month
(with McLaren Remedial Measures)

Year	***Month***	***Event***
2014	April	Flint municipal water switched from DWSD to Flint River
	June	5 cases
	July	6 cases
	August	4 cases
	September	14 cases
	October	5 cases
	November	2 cases
	December	4 cases • Two of those cases were from McLaren even though water testing at McLaren showed no Legionella coming in to the hospital from the municipal water supply (Exs 59, NN; VIII McElmurry 28) • "[S]upply water coming from the City of Flint is not contributing to the legionella issues at McLaren and that any issues are likely internal to the hospital." Ex NN
2015	January	2 cases
	February	0 cases
	March	1 case
	April	0 cases
	May	3 cases
	June	7 cases
	July	13 cases
	August	13 cases • McLaren engages Janet Stout • hyperchlorinates system on August 14, 2015 (Ex V) • later in the month, installs first monochloramine unit. (Ex 59.)
	September	9 cases McLaren installs second and third monochloramine units. (Ex 59.)
	October	1 case • October 16, 2015 Flint municipal water supply switched back to DWSD
	November	0 cases • McLaren installs fourth and fifth monochloramine units. (Ex 59.)

Addendum C

Facts, Not Words – July 11th Oral Argument

Addendum C: Facts, Not Words – July 11th Oral Argument

What the prosecutor said:	*What the record actually reflects:*
Lyon's February 14, 2017 letter to McLaren says, in his own words, that "he has the ability to do something. He has the ability to shut the place down." (Argument, p. 3.)[1]	• The letter was an Order Requiring McLaren Flint Hospital to Correct Conditions. (Ex 71.) • It says nothing about "shutting down" McLaren. • It lists seven things McLaren must do, including implementing all CDC recommendations from October and November 2106, amend its Water Management Plan to reflect the CDC recommendations, preserve *Legionella* isolates from water samples, cooperate with MDHHS requests for information and essentially allow oversight and water testing by MDHHS and CDC. • There had been hospital-acquired *Legionella* cases at McLaren in 2016, and the CDC along with GCHD came to McLaren to investigate in August 2016. (Ex RR.) CDC made recommendations to McLaren about water treatment, etc. (Ex RR.) • On January 10, 2017, Director Lyon and Wells sent a letter to the GCHD and McLaren stating that MDHHS wanted to know if McLaren was following the CDC recommendations and additional information. It stated that MDHHS was prepared to issue an imminent danger order if McLaren did not address the issues. (Ex RR.) • McLaren did not address the issues, so the letter was sent. (Ex 71.) • Ultimately a cooperative agreement was reached in May 2017. (Ex SS.) • The situation is not remotely comparable to the confusing circumstances that existed on January 28, 2015.
The "hypothesis" that the water could be contributing to the *Legionella* problem was known since October 2014. (Argument, p. 6.)	• Director Lyon did not know of the "temporal relationship between the. . .switch in the source of the water and the rise in the cases" until Miller told him on January 28, 2015. (II Miller 99.) • As of that time, the water switch was just one hypothesis and the source of the outbreak was all "speculation" because the case data was incomplete (Ex 3.) • A hypothesis is not a conclusion.

[1]To assist with the post-hearing briefing process, the defense had a court reporter create a rough, unofficial transcript of the prosecutor's remarks at the July 11, 2018 hearing. Page numbers reference that transcript, which is accurate to the best of the court reporter's ability but not certified.

What the prosecutor said:	*What the record actually reflects:*
	• Miller said that in January 2015, the MDHHS staff had one "hypothesis" that the *Legionella* increase might be related to the switch to the Flint River, "but no one wanted to ignore that there might be other things going on." (II Miller 94.) • Miller said there also "was a hospital (McLaren) of concern" and that was another "hypothesis" in January 2015. (II Miller 122; III Miller 120.) • Hypotheses are meant to be confirmed and are tested from the epidemiology and then can be further tested by microbiology before a conclusion can be reached. (XIX Band 30-33.)
Chlorine levels from PX 54 and BLL from PX 55 were clear and Becker said it would have been easy to "call downstairs" and get the material (Argument, pp. 7-8.)	• BLL data from (Ex 55) is from a paper Hanna-Attisha wrote *after* the crisis was over. Contrary to the prosecutor's implication, Director Lyon had no access to these exhibits in early 2015. • Chlorine levels from Ex 54 were created by McElmurry as part of his retrospective analysis. (VII McElmurry 82-84, 87-88.) • Becker said he could have "called" down to find out how many people died of *Legionella* when he learned of it in January 2015, but he did not. (I Becker 17-18.)

Corinne Miller testified about the foreseeability of what might happen; "As the state epidemiologist did you have an understanding of the consequences of if nothing was done as it relates to the summer months of 2015? If you are talking about something was done with regard to the water source, if that hypothesis were true, if you will, then you would expect to see more cases." (Argument, p. 8.)	• The very next question to Miller was whether this concept was explained to Director Lyon and the answer was: "The *only* thing I pointed out to the Director was the temporal relationship between the, the switch in the source of the water and the rise in the cases." (II Miller 99.)
	• In fact, Miller did *not* recall telling Director Lyon that it was possible an outbreak could occur again:
	  • "And, did you agree at that time you'd indicated about the possibilities, it's possible it could happen again?
	  • It's possible but I don't recall saying that.
	  • Well what is the purpose of showing him –
	  • I may not to Director Lyon, I don't recall saying that." (II Miller 98.)

"Judge, what happens when they switch back on October 2nd of 2015, back to the water of Detroit? What happens? The outbreak is over." (Argument, p. 8.)	• The water source for Flint switched back to Detroit water on October 16, 2015. (Ex P, p 24.) • Cases started declining *before* then, after McLaren installed monochloramine units in August 2015; there was only one case in October 2015.

What the prosecutor said:	*What the record actually reflects:*

	• *August 2015* – 13 cases
	  • McLaren engages Janet Stout; hyperchlorinates system on August 14, 2015 (Ex V] and then later in the month, installs first monochloramine unit. (Ex 59.)
	• *September 2015* – 9 cases
	  • McLaren installs second and third monochloramine units. (Ex 59.)
	• *October 2015* – 1 case
	• *October 16, 2015* – Flint municipal water supply switched back to DWSD.
	• *November 2015* – 0 cases
	  • McLaren installs fourth, fifth monochloramine units. (Ex 59.)

"Why is it that it's political. And she (Miller) tells you because it deals with the Flint Water Treatment Plant and change of water. An emergency manager was in place. That's what she tells you. That's why it was political. And now politics are coming into play about health. And we will get to the money aspect of it, Judge, as it came here in this courtroom to you." (Argument, p. 9.)	• There was no evidence that politics played a role in Director Lyon's reaction to learning of the outbreak on January 28, 2015. • Miller said there was always sensitivity about communicating with the public in Flint. There had been highly publicized difficulties with water quality problems that had "political overtones." (III Miller 9, 16-17.) She said communication was a complicated and sensitive matter that also triggered the concern that any communication would cause undue fear. (III Miller 126-127.) • Sometime close to the meeting with Director Lyon on January 28, Miller talked with Linda Dykema about the "politics" of the *Legionella* issue. Miller said she "observed" to Dykema that it may be a difficult situation for the Governor's office, given the involvement of an Emergency Manager, if the switch to the Flint River could actually be related to *Legionella* outbreak. Miller characterized these statements as her opinion and part of "normal conversation." (II Miller 101.) • Miller did *not* garner this opinion/observation from Director Lyon. (II Miller 101.) • Although she works in a state agency and "political concerns always filter through those agencies," she does not let politics intrude on policy. (III Miller 115-116.)

What the prosecutor said:	***What the record actually reflects:***
"[W]hen the health crisis comes to his table, when it comes to him in January, we have six people that have died at least." (Argument, p. 9.)	• At the time of the meeting on January 28, 2015, even Miller did not know if there had been any deaths. (II Miller 111.) • The first evidence of Director Lyon being told the number of deaths is Ex 9, on January 11, *2016*.

Regarding Tim Becker, he was asked "Why is it you had to tell the Governor once you-all discovered it? Why didn't you tell the public? And we heard crickets"
(Argument, p. 10.)
	• The actual testimony from Becker was:
	  • Yeah, as I said that was kind of the AHA moment if you will that we've got something here that needs to be raised. Needs to go up the flight.
	  • What does that mean?
	  • This information needs to go to the Governor's office.
	  • What about the public?
	  • Yeah, the conversation on the public I'm sure was going on throughout this period." (I Becker 52.)
	• Two days after the "aha" moment on January 11, 2016, there was a press conference about *Legionella*. (I Becker 117-118; Ex 82.)

Becker "starts sending up the chain what do we know about this and rumors of Legionnaires disease in Flint" via emails on January 28, 2015 (Argument, p. 10.)	• Ex 1 and 2 were sent *down* to Population Health staff, not "up the chain" to Director Lyon. (Exs 1, 2.)
Four people in the room during the January 28, 2015 meeting, Director Lyon, Moran, Miller and Mark Miller. (Argument, p. 11.)	• Corinne Miller said she "can't picture him (Mark Miller) in my mind's eye" being at the meeting. (II Miller 91.)
Director Lyon has "the information the number two (Becker) doesn't." (Argument, p. 11.)	• Director Lyon saw the Epi Graphs (Ex 8) and Becker did not. • But, Becker knows on January 28, 2015 there are "rumors of legionnaires disease in Flint," there are "elevated levels of *Legionella* infection that seems, anecdotally to coincide with the changeover in Flint water," that "*Legionella* can be transmitted through inhalation of aerosolized contaminated water" and that staff was working with GCHD and MDEQ from Exhibits 1 and 2. He also knows everything Director Lyon knows from Exhibit 3.

What the prosecutor said:	*What the record actually reflects:*
"Their expert says I would have checked all of these sites for water contamination of *Legionella* where there was boil water alerts." (Argument, p. 14.)	• Boil water alerts, which were issued due to high levels of ecoli and coliform (bacteria) only occurred twice, in August and September 2014. (Ex 51.) • There were no boil water alerts after Director Lyon became aware of the *Legionella* outbreak on January 28, 2015. (VIII McElmurry 125.)
Director Lyon's iPhone was "destroyed" when law enforcement seized it to copy it. (Argument, p. 15).	• Agent Seipenko said the screen was shattered and the iPhone was broken. (XIV Seipenko 27.) • The phone was retrieved from the MDHHS building in Lansing. (XIV Seipenko 27.) • There is no evidence anywhere in this record that this damage was intentional, as opposed to an accidental dropping of an iPhone. • The agent took it to a forensic cellphone analyst at the Oakland County Sheriff's department and the contents of the phone were downloaded to a flash drive. (XIV Seipenko 27.) • Exhibit bears production date, "06-06-2016 SOM0072179," [Ex 68], more than a year before the agent event retrieved the phone. • If Director Lyon were intentionally trying to destroy data, he did a terrible bad job at doing so.
Reynolds described Lyon as "glib and dismissive," which prosecutor characterized as "covering up, and lying." (Argument, p. 17.)	• This meeting was in December 2015 or January 2016 and could not have contributed to Messrs. Snyder or Skidmore getting sick. (IV Reynolds 31.) • Reynolds never identified a single thing Director Lyon said that was established to be untrue • When Director Lyon said the outbreak was over, it had been over for a few months.
Part of *Legionella* "coverup" was that "they are trying to make this go away without a declaration of emergency" in January 2016, per an email between Etue and Baird on Thanksgiving 2015. (Argument, p. 19.)	• The emergency declaration was about lead, *not Legionella*. (Ex 36.) • The emergency declaration was issued by the Governor on January 5, 2016, within weeks of the Thanksgiving email. (Ex 36.) • Etue said not every local emergency becomes a state emergency, it depends on whether resources are needed from the State. (III Etue 143.) Etue said that it is common for the state to work through a local problem without declaring an emergency, yet

What the prosecutor said:	*What the record actually reflects:*
	still be providing assistance to the locals. (III Etue 155.) • The email was from Baird saying that the Governor wanted "us to work through this without a disaster declaration of possible;" this was not Director Lyon's directive. (III Etue 143.)
Hanley asked for appropriation for *Legionella* study in November 2015; Why ask "for money [in late 2015] if no one knows about the *Legionella* outbreak?" (Argument, p. 20.)	• This was at least five months after Messrs. Skidmore and Snyder got sick and cannot be the cause of either man contracting the disease. • Becker asked her to start "pulling together" funding requests for a variety of things related to Flint water, including research on *Legionella*; this was in *December "around Christmas,"* 2015 (XXI Hanley 58-60.) • Hanley did not talk to Director Lyon about this. (XXI Hanley 59.) • Director Lyon had already reported about *Legionella* to the Governor's staff, others on September 18, 2015. (XXII Brown 5, 18; Exs 23, G, GB, GC.) No one is suggesting they "don't know" about *Legionella*.
Becker said Director Lyon acted surprised in January 2016 as though he "learned about these numbers for the very first time"; it was "a lie or a feigned response." It "surprised" Becker to hear that Lyon learned about *Legionella* in January 2015 and he did not know how to "align that up with the timing." (Argument, pp. 21-22.)	• Becker actually said, "we all kind of had a light bulb moment." (I Becker 39.) • Becker was aware of the elevated levels of *Legionella* infection no later than January 28, 2015, just like Director Lyon. (Exs 1, 2, 3.) • Becker and Lyon were both copied on Ex 3 on January 28, 2015, so Becker should have been aware at that time that Lyon knew about *Legionella*. • The data Becker and Director Lyon saw on January 11, 2016 was far more comprehensive than what they saw and/or learned about on January 28, 2015: it was a 12-page report with a massive amount of data from what was then the completed investigation of the June 2014-March 2015 outbreak. (Ex 9.)
Becker issued a notice "to the world" about contamination at Wurtsmith AFB. (Argument, p. 24.)	• Becker notified 24 residences (not "the world") of a decades-old water contamination problem; he made the notification based on staff recommendations and lessons learned from Flint. (I Becker 70, 55-58, 112-113.)

What the prosecutor said:	*What the record actually reflects:*
	• The notice was not a statewide or county-wide notification, much less a notice "to the world," as it went to just 24 homes whose wells had tested high for PFCs. (I Becker 74.)
Mr. Skidmore's son said his father "had no life left in him" after contracting *Legionella*; "he didn't move." (Argument, p. 26.)	• After Mr. Skidmore's discharge, his wife of 62 years died from pancreatic cancer. (XIV Skidmore 14, 15.) • After her death, he lived alone at their marital home in Mt. Morris until his death on December 13, 2015. (XIV Skidmore 24.) • His sons checked in on him twice a day, once in the morning and once in the evening. (XIV Skidmore 24.) • His son testified that Mr. Skidmore just never seemed to get better after the hospital stay with Legionnaires' Disease; he would have some good days but would always revert back to not feeling good. (XIV Skidmore 24.)
Marc Edwards is the only one who did not think the so-called "strong statement" email [Ex 7] was backwards. (Argument, pp. 27-28.)	• Becker said the email was a request by Director Lyon to have his staff tell him whether the department's lead "data was accurate because it seemed we had a conflict between ours and Dr. Hanna-Attisha's." (I Becker 31.) • Edwards said this email was appropriate and is nothing more than a sound request by Lyon to his staff to reevaluate its data before issuing a message to the public about human health. (XX Edwards 147.) • Miller said that this email was not worded in the way an epidemiologist would phrase it. (III Miller 103.) It is backwards because it seemingly called for a conclusion before collecting the information but her reaction to it was that "knowing the Director I thought that doesn't make sense." (III Miller 103.)
Director Lyon testified falsely before the joint legislative committee that he first learned of *Legionella* in July 2015; statement to reporter following the hearing was inconsistent with that testimony. This was a theme throughout argument but stated that	• Director Lyon testified truthfully on April 25, 2016 that he learned about *Legionella* in <u>January 2015</u> but the problem did not rise to his level again until September 2015. (Exs 11 p. 95, 3, 23.) • Director Lyon testified that he believed the epidemiological staff was trying to solve the problem, i.e. determining the source and having a

What the prosecutor said:	***What the record actually reflects:***
Director Lyon "lies to the legislature (Rebuttal, p. 3.)	solution for it, before elevating the *Legionella* issue to him again. (Ex 11 p. 53-54.) • The discussion where Director Lyon says he was not aware of the serious health related issues until Muchmore's 7/22/15 email was about *lead* not *Legionella*. (Ex 11 p. 34-35.) • Director Lyon likewise told a reporter after his testimony that he learned of the outbreak in January 2015. (Ex 13.)
"[H]e (Lyon) is the Doppler center. Corinne Miller. He is the Doppler center. He gives notice to those people in advance that may be harmed." (Argument, p. 30).	• There was no evidence or testimony that Director Lyon is a "Doppler center" or that "he gives notice to those people in advance that may be harmed." • It is undisputed that no one recommended to Director Lyon that a public notice be issued, either in January 2015 or at any time in 2015. (III Miller 121.)
"When the. . .Henry emails start going back and forth the CDC is somehow mysteriously off the emails." (Rebuttal, p. 2.)	• CDC (Yoder, Langley, Fialkowski, Weinberg, Tyndall-Snow) all were, in fact, on the email from Henry dated June 5, 2015, advising of the three new cases and stating that there may not be consensus that the outbreak is over. (Ex 69.)
Henry "begging for water samples" via his FOIA to the city. (Rebuttal, p. 2.)	• Henry FOIA'd a map of water system and water testing data about various bacteria in water as monitored throughout system. (Ex 28.) The FOIA was *not* about water samples and was directed to MDEQ and the City of Flint *not* MDHHS and certainly not to Director Lyon.
When McLaren did incoming water supply testing in December 2014, "it's cold" and *Legionella* "grows more in the warm months." (Rebuttal, p. 4.)	• Testing of water coming in to McLaren from the city supply over a 15-day period in December 2014 revealed no *Legionella*; "Supply water coming from the City of Flint is not contributing to the *Legionella* issues at McLaren and that any issues are likely internal to the hospital." (Ex NN.) • What's important is that McLaren had two Legionnaires' cases in December 2014 even though water testing at McLaren showed no *Legionella* coming in to the hospital from the municipal water supply. (Exs 59, NN; IX McElmurry 28.)

What the prosecutor said:	***What the record actually reflects:***
"Higher amounts of iron were found within the water samples of McLaren Hospital…from the water system based on the higher amounts." (Rebuttal, p. 4.)	• There was no evidence that high iron counts within McLaren were from the municipal water system.
MDHHS never told McLaren that the outbreak was "back on" and never came to McLaren to help them (Rebuttal, p. 5.)	• McLaren knew first hand that new cases were happening, including that two out of the three cases in May 2015 were associated with McLaren and that they had many new cases throughout the summer of 2015. (Ex 59.) • McLaren was still seeing cases and they continued to follow clinical guidance after the "outbreak is over" email. (XI Borowski 67-69.) • Tim Bolen, Regional Epidemiologist for MDHHS, attending a meeting with hospitals in Flint on May 7, 2015. (Ex I.)

Addendum D

Facts, Not Words – Prosecution's Brief

Addendum D: Facts, Not Words – Prosecution's Brief

What the Prosecutor's Brief says:	*What the record actually reflects:*
"In an effort to save the City of Flint millions of dollars, State-appointed emergency managers, with the approval of numerous state officials," switch the interim source of Flint water from the DWSD to the Flint River. (Pros Br, pp 1-2).	• There is no evidence that Director Lyon was involved in this decision in any way. • Neither Director Lyon nor anyone else in public health was consulted about the decision to switch. (VIII McElmurry 106.) • This decision to use the Flint River as an interim water source was made by Flint officials after engaging consultants and getting the approval of the Michigan Department of Environmental Quality (MDEQ). (VIII McElmurry 106.)
Water problems in Flint begin to develop in 2014, including discoloration, bad odors, fecal coliform bacteria, and TTHMs, resulting in boil water alerts. (Pros Br, pp 2, 12).	• Director Lyon first became aware of *Legionella* on January 28, 2015, and the other serious health concerns about Flint water on July 22, 2015. (Ex 11, pp 34-35, 95; Exs 3, 23.) • Information in the prosecutor's brief about non-*Legionella* water problems in Flint in 2014 are irrelevant to this proceeding. • Boil water alerts, which were issued due to high levels of *E. coli* and coliform (bacteria) only occurred twice, in August and September 2014. (Ex 51.) • There were no boil water alerts or coliform/*E. coli* problems after Lyon became aware of the *Legionella* outbreak on January 28, 2015. (VIII McElmurry 125.) • Until June 24, 2015, MDEQ was holding out the water as being treated properly. (Exs 39, 28.) It was not until the DelToral EPA memo of June 24, 2015 that it became publicly known that MDEQ was *not* treating the water for corrosion and was *not* in compliance with the federal Lead and Copper Rule. (VIII McElmurry 119, XX Edwards 23-25, Ex R.) • The DelToral memorandum that exposed the MDEQ for not requiring corrosion control treatment in Flint had a "major impact" on the unfolding of Flint water issues more widely. (VIII McElmurry 121-123.) But it had nothing to do with Director Lyon

What the Prosecutor's Brief says:	***What the record actually reflects:***
"In September 2015, Michigan Department of Health and Human (DHHS) officials begin criticizing research conducted by Dr. Mona Hanna-Attisha" regarding blood lead levels. (Pros Br, p 2).	• There is no evidence that Director Lyon was critical of Hanna-Attisha's data; Lyon sent an email (Ex 7) to his staff wanting to know whether MDHHS lead "data was accurate because it seemed we had a conflict between ours and Dr. Hanna-Attisha's." (I Becker 31.) • This email is all about lead, *not* Legionella. • The MDHHS changed its position on the blood lead level data within a few days and was able to acknowledge that a different view of the data was warranted. (XX Edwards 148.) This was a good example of how a government agency should work. (XX Edwards 92.)
The number of cases of Legionnaires in 2014 are recited, as well as McLaren's efforts to mitigate. (Pros Br, pp 2-3).	• Director Lyon did not become aware of the number of cases of Legionnaires until January 28, 2015, and it was speculation that the hospital and the water were potential sources because the data was not yet collected. (Ex 3; II Miller 99.) • Evidence of McLaren's knowledge that it had a problem in 2014 are not relevant to Lyon in that time period, who did not know until January 28, 2015.
Discussion of Shannon Johnson's October 13, 2014 email. (Ex 18.) (Pros Br, p 3).	• This email was written *before* Director Lyon was even aware of the outbreak, and there is no evidence this email reached Director Lyon or any staff at MDHHS above the level of Jim Collins. (Ex 18.)
"[O]n May 29, 2015, Bohm mailed a letter to Sue Forrest of McLaren Hospital Declaring the outbreak of Legionnaires Disease over." Staff at McLaren found this strange. (Pros Br, p 4).	• This is an email, not a letter, sent by Bohm to the infection control staffs at all three hospitals on June 4, 2015. (Ex PP.) • The Bohm email attached the executive summary of the June 2014-March 2015 outbreak and investigation report dated May 29, 2015; it stated the "outbreak is over" because last reported case occurred in March 2015 but urges "vigilant" awareness and surveillance. (Ex PP.) • On June 5, 2015, GCHD's Henry notified Collins that there have been three more confirmed *Legionella* cases since beginning of May 2015. (Ex 69.) • McLaren knew first hand that new cases were happening including that two out of the three cases in May 2015 were associated with McLaren and

What the Prosecutor's Brief says:	*What the record actually reflects:*
	that they had many new cases throughout the summer of 2015. (Ex 59.) • McLaren was still seeing cases and they continued to follow clinical guidance after the "outbreak is over" email. (XI Borowski 67-69.) • There is no evidence that any of this had to do with Director Lyon.
Nick Lyon was Director of MDHHS during the series of events comprising what is now known as the "Flint Water Crisis." (Pros Br, p 4).	• Nick Lyon became Director of DCH on September 29, 2014. In February 2015, just weeks after he was notified about a Legionnaires wave in Flint, DCH merged with the Department of Human Services and became MDHHS. (Ex 4.) As the "Flint Water Crisis" was unfolding, Director Lyon was merging 14,000 employees in Michigan's two largest agencies.
The "third" time Lyon was notified of the outbreak. (Pros Br, p 5).	• Director Lyon was notified of the outbreak by Miller and Ex 3 on January 28, 2015. • On July 22, 2015, he made a note during a meeting with Muchmore to get an "update on legionnaires (hospital)" along with notes about many other Flint water problems. (Ex O, M, ZZ, 67, 68.) There is no evidence he received any update or notification about any cases, new or old, on this date, or any additional information. • On September 16, 2015, Lyon asks Moran, via his assistant, for an update on Flint water and among other things, is told that there is a continued sustained increase in Legionnaires cases, with specific data (Ex 23); he gives the information to the Governor's office only two days later.
During the meeting on January 11, 2016, "Becker believed that he and Defendant were learning of the Legionnaires outbreak for the first time." (Pros Br, pp 5-6).	• Becker also learned of the outbreak on January 28, 2015. (Ex 1, 2, 3.) • Becker and Lyon learned of the outbreak on the same day, January 28, 2015 and Becker knew this on January 28, 2015 because he and Lyon were copied on the same email. (Ex 3.)

"Becker does not remember Defendant, at any point during this conversation, suggesting that the public be notified."
(Pros Br, p 6).
	• The testimony from Becker was:
	  • Yeah, as I said that was kind of the AHA moment if you will that we've got something here that needs to be raised. Needs to go up the flight.
	  • What does that mean?

What the Prosecutor's Brief says:	*What the record actually reflects:*
	• This information needs to go to the Governor's office. • What about the public? • Yeah, the conversation on the public I'm sure was going on throughout this period." (I Becker 52). • Two days after the "aha" moment on January 11, 2016, there was a press conference about *Legionella* (I Becker 117-118; Ex 82.) Director Lyon had a major role.
The Epi Graphs Lyon was shown on January 28, 2015 indicated a "point source." (Pros Br, p 10).	• The "point source" as of January 28, 2015 was pure speculation – water source or McLaren Hospital or something else – because they did not have the case data they needed. (Ex 3.)
Director Lyon "knew that representatives from the MDEQ and area hospitals were expressing 'concerns,' and knew that the outbreak was likely connected to the water switch." (Pros Br, p 11).	• As of January 28, 2015, the water switch was just one of several hypotheses, and the source of the outbreak was all "speculation" because the case data was incomplete. (Ex 3.) • Miller said that in January 2015, the MDHHS staff had one "hypothesis" that the *Legionella* increase might be related to the switch to the Flint River, "but no one wanted to ignore that there might be other things going on." (II Miller 94.) • Miller said there also "was a hospital (McLaren) of concern" and that was another "hypothesis" in January 2015. (II Miller 122; III Miller 120.) • Miller pointed out to Lyon the "temporal relationship" between the water switch and the rise in cases. (II Miller 99.)
The July 22, 2015 note on Lyon's phone shows that Legionella was "an ongoing concern." (Pros Br, p 11).	• There is no evidence that between January 2015 and July 22, 2015, *Legionella* was even mentioned to Director Lyon by anyone. • Director Lyon learned of the increase in cases in the Miller meeting and the follow-up email on January 28, 2015 and shortly thereafter, emailed Sue Moran to see if things had been worked out with the GCHD. (II Miller 103.) • By the time this note is written, Mr. Skidmore and Mr. Snyder have both contracted the disease.

What the Prosecutor's Brief says:	***What the record actually reflects:***
Director Lyon should have called for a switch back to Detroit water or should have immediately tested the water for Legionella when he learned of the rise in cases. (Pros Br, p 12).	• Director Lyon had no responsibility whatsoever for determining the source of Flint water. Moreover, the switch in water source was only one hypothesis, unconfirmed as of the time Lyon learned of the increase in cases in January 2015. • None of his staff recommended any particular action be taken in January 2015, or at any time in 2015.
The "strong statement" email is between Lyon, Muchmore and Hollins and evidences Lyon's "intent to minimize the public's awareness of water problems and his disregard for properly gathered scientific data. (Pros Br, p 13).	• Neither Muchmore nor Hollins are included on Lyon's "strong statement" email, only MDHHS staff. (Ex 7.) • Becker explained that the email was a request by Director Lyon to have his staff tell him whether MDHHS lead "data was accurate because it seemed we had a conflict between ours and Dr. Hanna-Attisha's." (I Becker 31.) • Dr. Edwards said this email was appropriate and is nothing more than a sound request by Director Lyon to his staff to reevaluate its data before issuing a message to the public about human health. (XX Edwards 147.) • This email is about lead, not *Legionella* and was sent months after Mr. Snyder and Mr. Skidmore became ill.
The email exchange between Etue and Baird on November 26, 2015 about the Governor wanting to work through the lead emergency without a disaster declaration shows Lyon's "intent to cover up his involvement in the botched management of the water crisis…." (Pros Br, p 13).	• The emergency declaration was about lead, *not Legionella*. (Ex 36.) • The email was from Baird saying that the Governor wanted "us to work through this without a disaster declaration of possible;" this was not Director Lyon's directive. (III Etue 143.) • The emergency declaration was issued by the Governor on January 5, 2016, within weeks of the Thanksgiving email. (Ex 36.) • Etue said not every local emergency becomes a state emergency, it depends on whether resources are needed from the State. (III Etue 143.) Etue said that it is common for the state to work through a local problem without declaring an emergency, yet still be providing assistance to the locals. (III Etue 155.)

What the Prosecutor's Brief says:	***What the record actually reflects:***
The "strong statement" email and the Etue/Baird email support the inference that Lyon's intent regarding the *Legionella* outbreak was to "minimize public knowledge and prioritize the reputation of his own office over the public health." (Pros Br, p 13).	• The Etue/Baird email and the "strong statement" email are about lead, not *Legionella*. • There is *no* evidence that Lyon was concerned about the reputation of his own office above public health, or above anything.
Reynolds says Lyon was "glib and dismissive" of task force questions about the outbreak and this evidences Lyon's intent to act in his own interests rather than the interests of public health. (Pros Br, pp 13-14).	• This meeting was in December 2015 or January 2016 and could not have contributed to Mr. Snyder or Mr. Skidmore getting sick. (IV Reynolds 31.) • Reynolds never identified a single thing that Director Lyon did or said that was established to be untrue. • Director Lyon told Reynolds that the outbreak was over, and indeed, it had been over for a few months; the last case was in October 2015. • Director Lyon referred Reynolds to his professional staff for more specific answers.
Director Lyon made a demonstrably false statement on January 13, 2016 when he said during the press conference that alerting the public was "part of our effort to be transparent and share information as quickly as possible as we can with the public." (Pros Br, p 14).	• Director Lyon received the comprehensive June 2014-March 2015 outbreak report for the first time on January 11, 2016. (Ex 9.) • Two days later, the press conference was held detailing the data contained in the comprehensive June 2014-March 2015 outbreak report. (Ex 82.) • This was part of an effort to be transparent. The fact that MDHHS did not conduct a press conference before the comprehensive outbreak report was finished shows reasonable caution, not disregard or recklessness.
Director Lyon knew within months of the water switch that the water in Flint was bad, caused rashes and contained contaminants. (Pros Br, p 16).	• The water switch was in April 2014. The evidence is that the Lyon learned about *Legionella* on January 28, 2015. • There is no evidence that Director Lyon knew of other Flint water problems before then, and the prosecutor has not charged Director Lyon for anything in connection with "bad" Flint water, rashes, or alleged contaminants, only Legionnaires.

What the Prosecutor's Brief says:	***What the record actually reflects:***
Director Lyon knew on January 28, 2015 that the outbreak was "likely catalyzed by the water switch and posed a risk of harm to the uninformed public." (Pros Br, p 16).	• As of January 28, 2015, the water switch was just one hypothesis and the source of the outbreak was all "speculation" because the case data was incomplete. (Ex 3.) • Miller said that in January 2015, the MDHHS staff had one "hypothesis" that the *Legionella* increase might be related to the switch to the Flint River, "but no one wanted to ignore that there might be other things going on." (II Miller 94.) • Miller said there also "was a hospital (McLaren) of concern" and that was another "hypothesis" in January 2015. (II Miller 122; III Miller 120.) • Miller pointed out to Lyon the "temporal relationship" between the water switch and the rise in cases. (II Miller 99.) • Lyon was not told that more cases could occur. (II Miller 99.) • Lyon was not advised to issue a public notice; Miller did not suggest any type of public notification, traditional or otherwise. (III Miller 121.)
It was a "full year" after learning of the outbreak that Lyon "made any effort to eliminate contact with the source or alert the public to known health risks." (Pros Br, p 16).	• *See above* • Even the January 2016 public notification could not, and did not, advise the public of any way to eliminate contact with the source, because the source was unknown, nor did it advise the public of symptoms or any other protective action that should be taken. No one had the answers. (Ex 22.)
Becker said there was no reason not to issue a warning at an earlier date. (Pros Br, p 16).	• Becker did not say this. He did not say this at the pages cited in the prosecution's brief or at any time during his testimony. Becker said he "could have" issued the "same warning that you did in 2016 for the groundwater PFC issue" if he had "known those numbers (from the Epi Chart) for, in January of 2015" and there is no threshold or standard that would "prevent you from warning the public if you knew those numbers." (I Becker 57.)
Messrs. Snyder and Skidmore died as a result of their exposure to *Legionella* bacteria that was "due to the switch in water source from DWSD to the Flint River, had	• Messrs. Snyder and Skidmore contracted Legionnaires, if at all, from McLaren. Neither had any known exposure to Flint water during the incubation period other than at McLaren. (X Tribble 14, 30; XIV Skidmore 20.)

What the Prosecutor's Brief says:	***What the record actually reflects:***
flourished in Flint's municipal water system." (Pros Br, p 17). "The People have presented ample evidence that the water in Flint's municipal system after the switch from the DWSD was the source of *Legionella* contributing to the unprecedented disease outbreak in 2014 and 2015." (Pros Br, p 20).	• Water testing in December 2014 and August 2015 that was done showed that the incoming water supply lines to McLaren had no *Legionella*. (Ex NN, OO.) • The water testing done by Edwards' group in August 2015 showed no pathogenic *Legionella* in any of the Flint homes and small buildings tested. (Ex NN, Y; XX Edwards 37-38, 52-54, 69-70, 145.) • Water testing done by Edwards group and also by FACEHP throughout 2016 showed that *Legionella* was not a problem in Flint homes and small buildings. (Ex 48, KKKK, Y; XX Edwards 71, 52-54.) • The *Legionella* problem was confined to the hospitals. (Ex Y.) • The decrease in cases in fall of 2015 coincided with McLaren's installation of monochloramine units, well *before* switch back to DSWD. (Ex 59.) • McLaren had another case of Legionnaires associated with it in November 2016; the sputum sample from that patient was a genetic "match" to a *Legionella* isolate taken from a water sample in McLaren by the CDC in August 2016; in other words, McLaren continued to have a *Legionella* problem even after the switch back to DWSD water. (Ex RR.)

Mr. Snyder was "in relatively good health" before admission to McLaren (Pros Br, p 17).	• Mr. Snyder's daughter said this, *but* Mr. Snyder had a history of
	  • chronic lymphocytic leukemia
	  • coronary artery disease with bypass surgery
	  • congestive heart failure
	  • rheumatoid arthritis
	  • cervical fracture
	• Mr. Snyder was also found to have:
	  • *M Kansasii*
	  • osteomyelitis
	  • *P acnes*
	  • decubitus ulcer (XV Kahn 12, 34, 51, 112, 113, 115, 116.)

Regarding Mr. Skidmore, Kahn said *Legionella* "seriously impacted his internal organs, including his heart";	• Kahn testimony (XV Kahn 99):
	  • "[Y]ou are confining the organ damage to the lungs, right?"
	  • "Right."

What the Prosecutor's Brief says:	***What the record actually reflects:***
death caused by "severe impact on his organs." (Pros Br, p 18).	• Moreover, lungs are an area outside of Kahn's expertise. • Kahn is not trained to interpret CT scans, either. (XIV Kahn 101.)
Zervos testified that causes of death for Messrs. Skidmore and Snyder "are wholly consistent with *Legionella* infection." (Pros Br, p 19).	• There is no evidence that Zervos reviewed *any* medical records. • Hypothetical assumed that person "never fully recovers." (I Kilgore 167.)
Mr. Skidmore's health dramatically declined after Legionnaires, and he became unable to fully take care of himself. (Pros Br, p 18).	• Simultaneous to Mr. Skidmore's discharge after recovering from Legionnaires' disease, his wife of 62 years died from pancreatic cancer. (XIV Skidmore 14, 15.) • The loss of a spouse can have a tremendous impact on someone's will to live. (XV Kahn 104.) • After her death, Mr. Snyder lived alone at their marital home in Mt. Morris until his death on December 13, 2015. (XIV Skidmore 24.) • His sons checked in on him twice a day, once in the morning and once in the evening. (XIV Skidmore 24.) • His son testified that he just never seemed to get better after the hospital stay with Legionnaires' disease; he would have some good days but would always revert back to not feeling good. (XIV Skidmore 24.)
"'Healthcare associated pneumonia' is a term that can be used simultaneously with Legionnaires' disease. (Pros Br, p 18-19).	• Kahn says this, because he wrongly believes that Legionnaires' disease is the majority of hospital-acquired pneumonias. (XVI Kahn 34.) • In fact, Legionnaires' disease represents no more than 5% of healthcare associated pneumonias. (XIX Band 51.)
Director Lyon was duty bound to notify the public about the outbreak, make efforts to eliminate the source and ensure safe water. (Pros Br, p 20).	• Director Lyon has no duty to notify the public about an outbreak. • In Michigan, the MDEQ regulates the water treatment processes statewide, including the FWTP in Flint, and is responsible for ensuring safe water under federal standards. (VIII McElmurry 107.) • MDHHS has no role in the water treatment process. (VIII McElmurry 108.)

What the Prosecutor's Brief says:	*What the record actually reflects:*
	• Again, MDEQ was holding out the water as being treated properly and that it was working through the numerous problems resulting from the switch, which it described as natural problems with the change, not a manmade problem due to the lack of corrosion control treatment. (Ex 39, 28.) It was not until the DelToral EPA memo of June 24, 2015 that it became publicly known that MDEQ was *not* treating the water for corrosion and was *not* in compliance with the federal Lead and Copper Rule. (VIII McElmurry 119; XX Edwards 23-25; Ex R.)
The experts need not agree that the water was the source, but it can be an inference. (Pros Br, p 20).	• If the experts, with the benefit of hindsight, 20/20 vision, and reams of additional data cannot agree that the water was the source, it is not reasonable to say that Director Lyon should have known that fact in May and June of 2015.
"[M]ultiple witnesses attributed the *Legionella* outbreak to the water switch." (Pros Br, p 20).	• No witness attributed the outbreak solely to the switch. • McElmurry said on the record and in a paper that he wrote that "water chemistry in the Flint River lead to conditions that *could have been* conducive to biological growth and propagation of Legionella in the distribution system." (emphasis added) (VIII McElmurry 101-102; Ex P, p 25.) • Edwards said the switch in the water source was one of the "key triggers" for the outbreak but not the cause. (XX Edwards 118.) He said that buildings following proper *Legionella* control strategies would not have a problem defending against *Legionella* growth even with really "screwed up" water. (XX Edwards 149.) Only in certain buildings that had inadequate infection control strategies was there a problem. (XX Edwards 149.) And, there was no evidence that there was *Legionella* in the Flint homes, contrary to his own hypothesis. (XX Edwards 150.) • Edwards found it absurd that there was a "plume" of *Legionella* moving through the municipal water system: *Legionella* does not work that way, there has never been a case where that has happened and there was plenty of evidence that was *not* happening in Flint due to the lack of *Legionella*

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	anywhere other than the hospitals. (XX Edwards 43.)

The *Legionella* outbreak "ended contemporaneously with the switch back. . . ."
(Pros Br, p 20).
	• The outbreak actually ended contemporaneously with McLaren's installation of monochloramine units beginning in August 2015, well before the switchback on October 16, 2015.
	• Water source for Flint switched back to Detroit water on October 16, 2015. (Ex P, p 24.)
	• Cases started declining before then and after McLaren installed monochloramine units in August 2015; there was only one case in October 2015 even though Flint water was used for more than half of the month.
	• *August 2015* – 13 cases
	  • McLaren engages Janet Stout; hyperchlorinates system on August 14, 2015 (Ex V) and then later in the month, installs first monochloramine unit. (Ex 59.)
	• *September 2015* – 9 cases
	  • McLaren installs second and third monochloramine units. (Ex 59.)
	• *October 2015* – 1 case
	• *October 16, 2015* – Flint municipal water supply switched back to DWSD.
	• *November 2015* – 0 cases
	  • McLaren installs fourth, fifth monochloramine units. (Ex 59.)
	• Moreover, McLaren had another case in November 2016; over a year *after* the switchback. (Ex RR.)

Zervos said that notice to the "public and providers" would have made it more likely for physicians to recognize cases. (Pros Br, p 21).	• Zervos refers *only* to physician notice, not to public notice. (II Zervos 9.) • As has been discussed repeatedly, notice and clinical guidance was given to the medical community by GCHD at the suggestion of MDHHS staff on February 13, 2015, June 1, 2015 and June 29, 2015. (Ex B, LL, MM.)
Miller acknowledged it would have been "reasonable perhaps to release information earlier rather than later. . .." (Pros Br, p 21).	• Miller stated that using hindsight or "in retrospect" or exercising "Monday Morning Quarterbacking," a "non-traditional advisory," one based on an incomplete investigation and not mentioning any source, was possible or reasonable. (II Miller 96; III Miller 48, 119-121.)

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	• Miller believed at the time that the necessary information had not been collected and there was not enough information about source/exposure. Miller never recommended a non-traditional advisory and believed it was not a good idea, using traditional thinking. The staff agreed. (III Miller 47-48.)
"Had the Defendant promptly mandated a switch back to safe drinking water, the source of *Legionella* infections would have been eliminated before Mr. Skidmore and Mr. Snyder contracted this deadly disease." (Pros Br, p 21).	• There is no evidence of this. • As noted above, neither Mr. Skidmore nor Mr. Snyder had any exposure to Flint water during the incubation period other than at McLaren. • There is no evidence that changing the water source would have eliminated McLaren's *Legionella* problem. • The only evidence is that McLaren's *Legionella* problem subsided with the installation of monochloramine units (Ex 59.) • A patient contracted Legionnaires at McLaren in November 2016, more than a year after the switchback. (Ex RR.)
"Similarly, had Defendant issued a public notice about Legionnaires' Disease a year earlier, citizens in Genesee County, including Mr. Snyder and Mr. Skidmore, could have taken precautions and protected themselves from harm." (Pros Br, p 21).	• There is no evidence of this. • The evidence is exactly the opposite from Band, Reilly and Miller: without knowing a source, there was nothing the public could have been told in 2015 that would have advised them how they could protect themselves. (XXIII Reilly 65-68; XIX Band 143-144; II Miller 96; III Miller 48, 119-121.)
"Borowski testified that had Defendant issued a notice to the public in 2014, hospital operations going forward would have been different." (Pros Br, p 21).	• Director Lyon did not know of any increase in cases until January 2015, making it impossible for him to issue a notice in 2014. • Borowski did not give a single example of how the hospital would have operated differently with a 2014 notice. (XI Borowski 102.) • When MDHHS issued a public notice in 2017 about McLaren's continued *Legionella* problem and lack of compliance with the CDC, Borowski felt intimidated. (XI Borowski 92); so, when MDHHS did specifically notify the public of a problem at McLaren, McLaren did not like hearing it.

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"The People have presented evidence to support the inference that had people of Flint been given adequate warning, they would have responded in a way that minimized their risk of exposure to unsafe conditions" and cite a paper written by McElmurry and others that says following the boil water advisories in August/ September 2014, bottle water usage went up in Flint and blood lead levels went down. (Pros Br, p 22).	• As noted above, the only evidence is that there was nothing the public could have been told in 2015 that would have advised them how they could protect themselves and minimize their risk of *Legionella* exposure, other than not to go to McLaren hospital which would have been reckless to do under the circumstances and based on what was known. (XXIII Reilly 65-68; XIX Band 143-144.) • Abstaining from lead contaminated water would be an effective way to reduce blood lead levels. (VII McElmurry 65-68.) • Using bottled water would <u>not</u> be an effective way to keep someone from getting Legionnaires. (IX McElmurry 8-9, 12-13.)
"Here, Defendant had direct knowledge of the Legionnaires' Disease outbreak and the harm that would result from his failure to alert the public. He simply chose to do nothing." (Pros Br, p 23).	• As noted repeatedly, Director Lyon was never told that another outbreak could occur. • There is no evidence alerting the public could have, or would have, had any effect on preventing harm because there was nothing the public could have been told to do to take protective action. (XXIII Reilly 65-68; XIX Band 143-144.) • Director Lyon <u>did</u> act. His choice of action was to order the investigation be done as a priority. (Ex 28.) He made sure that MDHHS staff and GCHD had worked through their difference shortly after he learned of the rise in cases. (II Miller 103.) The investigation was comprehensive, and the medical community was on high alert about the outbreak, as was the CDC, EPA, GCHD, MDEQ, Governor's office, all three hospitals and City of Flint officials. (XIX Band 121; Ex B, LL, MM, 69, FFFF, PP, R.)
Director Lyon delegated the duty to investigate the Legionnaires outbreak to FACHEP "before undertaking to undermine the group's efforts and delay the initiation of FACHEP's important health-related research." (Pros Br, p 24).	• Lyon delegated the duty to investigate the outbreak to his staff and the GCHD in 2015. (Ex 28; III Miller 61-62.) • The Governor asked that FACHEP be formed and it was *not* a public health investigation under statute. (VI Kilgore 93; II Zervos 19-20.) • There is no evidence that Lyon slowed down the contracting process in any way. McElmurry was unable to point to anything Lyon said or did to delay the execution of the contract and noted there were several standard administrative issues that

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	had to be worked through (a data use agreement, an IRB), as well as a protective order obtained by the prosecutor and a legislative appropriation process, before the contract could be executed. (VI Kilgore 90-92; VII McElmurry 63-65, 67-68, 74-75.) • There *is* evidence that delay was caused by: (1) FACHEP's one-month delay in entering its contract information into the eGrAMS system, and (2) FACHEP's refusal to take any water sample until months after the appropriation had been made, none of which is attributable to Director Lyon. (XXI Hanley 29; (XII McElmurry 108.) • There is no evidence Director Lyon undermined FACHEP's investigation; only that he and others expressed scientific "skepticism" about the value of the filter study, that ended up being fully funded and fulfilled by FACHEP in any event. (VIII McElmurry 47-48, 51, 77, 80-83; VII McElmurry 94; Exhibit 52.)
"McElmurry opined that it would cost about a million dollars and Hollins replied that money was not an issue." (Pros Br, p 25).	MDHHS awarded FACHEP $250,000 for Phase I. (II Zervos 26-27; XXI Hanley 16.) On April 29, 2016, FACHEP presented a Phase II plan for about $12 million to MDHHS staff. (XII McElmurry 23; Ex TT.)
"FACHEP researchers wished to start sampling for Legionella during the summer of 2016, when the presence of Legionella would typically increase." (Pros Br, p 25).	• FACHEP did not begin taking any water samples until September 2016 (XII McElmurry 108), even though the contract had an effective date of June 1, 2016 (having been appropriated by June 23, 2016), was executed August 16, 2016 and McElmurry testified that collecting water samples is an easy undertaking that could be done in a day and costs maybe $1000 to $2000. (XIII McElmurry 12-13; XII McElmurry 112.)
FACHEP's plan was to sample 284 homes in Flint and compare to home samples in the surrounding area. (Pros Br, p 25).	• Dr. Edwards said that given his own testing of the homes in 2015 and 2016 which showed no Legionella, and FACHEP's testing in January 2016 showing no Legionella in the homes, he did not understand why they were sampling so extensively "where the Legionella were not." (XX Edwards 71.)

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	• Edwards said FACHEP should have been focusing on large buildings. which was perfectly clear from his, and FACHEP's, data. (XX Edwards 71-72.)
"Contract negotiations were unduly delayed and protracted for the apparent purpose of preventing FACHEP's research." (Pros Br, p 26).	• There is no evidence of this. • Funding for FACHEP was a top priority of Lyon and MDHHS (Ex SSSS, p 10; Ex RRRR; XXI Hanley 21, 32.) • There is no evidence that Lyon – or anyone at MDHHS – intentionally or inadvertently slowed down the contracting process in any way. As noted above, standard administrative issues, a Legislative appropriation, a protective order and FACHEP's own delays with the eGrAMS system resulted in the contract taking time to be executed.
Director Lyon said he "can't save everyone" in the May 16, 2016 meeting with FACHEP. (Pros Br, pp 26-27).	• Hanley said that Director Lyon did <u>not</u> say anything like this. (XXI Hanley 82.) • Kilgore was profane and pounding on the table but denied doing so. (IX McElmurry 57-58; XXI Hanley 50-51; VI Kilgore 123.) • Regardless, as noted above, there is no evidence that Director Lyon did a single thing (or failed to do a single thing) that slowed the FACHEP appropriation and contracting process in any way.
"Defendant had different objections to parts of the home sampling study at different times." (Pros Br, p 27).	• Regarding the home water testing study, Director Lyon was, at times, not in favor of doing the filter portion of the study. (VII McElmurry 90.) • The filter study is the only portion of FACHEP's work about which Director Lyon expressed any concern. The filter study was the only real "sticking point" with MDHHS. (XII McElmurry 27.) • Nevertheless, the filter study was fully funded and fulfilled.
Director Lyon and others expressed "strong resistance" to McElmurry's research at an August 5, 2016 meeting. (Pros Br, p 27).	• There had been a meeting on August 5, 2016 with McElmurry, Wells, Lyon, Baird and Scott Hiipakka (Governor's office) about the scope of Phase II, where McElmurry said "they were quite resistant" to the household sampling, particularly the shower filters. (VIII McElmurry 72-74.) • MDHHS concerns were legitimate, scientific questions. (VII McElmurry 28-29.)

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	• As noted repeatedly, FACHEP was still fully funded for the filter study within 11 days of this meeting. • Edwards also questioned the scientific value of the filter study (XX Edwards 71-72) and like Lyon, believed that FACHEP messaging to the public about the possibility of bacteria in the filters – which had been very helpful to improving water for Flint citizens – could be, and was, harmful to Flint residents. (XX Edwards 89-90.) • There is no evidence that the EPA was not, in fact, against this type of sampling by FACHEP.
"Dr. McElmurry testified that during this discussion (FWICC August 12, 2016), Defendant's 'tone and demeanor suggested he was very skeptical'" of the filter study. (Pros Br, p 28).	• True. Director Lyon's "skepticism" about the filter study was that he asked McElmurry to explain the proposal to Director Keith Creagh of MDEQ and said that he had to balance the importance of the study with upsetting the public. (VII McElmurry 94; Exhibit 52.)
"By delaying the execution of the contract, Defendant forced FACHEP to collect subpar data in an effort to prevent FACHEP from connecting the switch in Flint's drinking water source to the Legionnaires Disease outbreak." (Pros Br, p 29). "Defendant's act of preventing further research was committed with the intent to prevent the public from learning about the DHHS's abdication of duty with respect to Legionnaires. . .." (Pros Br, p 30).	• As discussed above, Lyon did nothing to delay the execution of the contract; he sought funding as a priority. • There is no evidence that anything Lyon did relative to FACHEP was an effort to prevent FACHEP from discovering information about the outbreak. • There is no evidence Lyon prevented research by FACHEP. • It was FCAHEP's decision not to conduct water sampling until September 2016 (XII McElmurry 108), even though the contract had an effective date of June 1, 2016 (having been appropriated by June 23, 2016), and McElmurry testified that collecting water samples is an easy undertaking that could be done in a day and costs maybe $1,000 to $2,000. (XIII McElmurry 12-13;XII McElmurry 112.) • There is no evidence that FACHEP's data was subpar; in fact, the results of FACHEP's data were completely consistent with what Edwards' group had found in its August and October 2015 samplings and throughout 2016: *Legionella* in about 12 percent of the homes sampled, both *Legionella pneumophila* and other non-pathogenic

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	strains, and that this is on the low-end of national averages. (VIII McElmurry 165-166; XII McElmurry 59; XX Edwards 50-52.)