

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

HERBERT FRUH, VIRGINIA FRUH,)	
Individually, and as Parent and Next)	
Friend of TRACEY FRUH, and)	
KEVIN FRUH,)	UNITED STATES DISTRICT
Plaintiffs)	COURT FOR THE DISTRICT
vs.)	OF MASSACHUSETTS
WELLBRIDGE CLUB MANAGEMENT,)	
INC., (F/K/A CLUB SPORTS)	
INTERNATIONAL, INC.) D/B/A THE)	
WELLBRIDGE COMPANY AND/OR)	
WELLBRIDGE HEALTH and)	
FITNESS CENTER and MONSANTO)	
COMPANY,)	
Defendants)	CASE NUMBER: 02-10689 PBS

**PLAINTIFFS' RESPONSES TO DEFENDANTS' STATEMENT OF UNDISPUTED
FACTS FOR THEIR MOTION FOR SUMMARY JUDGMENT AND PLAINTIFFS'
FURTHER STATEMENT OF MATERIAL FACTS**

Plaintiffs, Herbert Fruh, Virginia Fruh, Individually, and as Parent and Next Friend of Tracey Fruh, and Kevin Fruh, for their Responses to the Statement of Undisputed Facts of the Defendants, Wellbridge Club Management, Inc., (f/k/a Club Sports International, Inc.) d/b/a The Wellbridge Company and/or Wellbridge Health and Fitness Center and Monsanto Company, and for their Further Statement of Material Facts, state as follows:

General Objections: Any admissions made by Plaintiffs in these Responses are made solely for purposes of this Motion for Summary Judgment by the Defendants. Furthermore, to the effect that statements of facts in paragraphs 16 through 47 are related to the incident and are directed to causation, *i.e.* whether or not more prompt defibrillation from an AED on the premises would have successfully resuscitated Mr. Fruh, Plaintiffs object to them. Causation is nowhere raised as an issue, even as a collateral one, by the Defendants in their papers in support of Summary Judgment. (See, Motion, ¶¶ 4-7.) Where necessary to give a more complete picture of the

incident, Plaintiffs have made reference to additional factual material, either in direct response to the Defendants' Statements, or in their Further Statement of Material Facts.

**PLAINTIFFS' RESPONSES TO DEFENDANTS' STATEMENT OF UNDISPUTED
FACTS FOR THEIR MOTION FOR SUMMARY JUDGMENT**

A. RELATIONSHIP BETWEEN WELLBRIDGE AND MONSANTO

1. In 1989, Defendant Monsanto founded a company called the Wellbridge Company (the "Former Wellbridge Company"). (Complaint ¶ 9; Answer ¶ 9.)

Response: Plaintiffs admit this statement.

2. In 1989, Club Sports International ("Club Sports") managed athletic clubs for several different developers mostly in the western half of the United States. (Ex. B, Curtis dep. at 5:22 - 6:4.)

Response: Plaintiffs admit this statement.

3. The Former Wellbridge Company owned and operated a health and fitness facility located at 695 Atlantic Avenue in Boston, Massachusetts (the "Atlantic Center"). (Complaint ¶ 14; Answer ¶ 14.)

Response: Plaintiffs admit this statement.

4. In or around March 1999, Monsanto sold certain assets and trademarks of the Former Wellbridge Company, including the Atlantic Center, to Club Sports. (Ex. B, Curtis dep. at 26:2- 5; Answer ¶ 16.)

Response: Plaintiffs deny this statement. The closing documents produced by the Defendants show that the Asset Purchase Agreement was dated and signed as of December 31, 1998. (Excerpts from Asset Purchase Agreement, Pltf. Ex. J).

5. In 2001, Club Sports changed its name to Wellbridge Club Management, Inc. ("Wellbridge"). (Ex. U, Mass. Secretary of State filing.) For convenience, all current and former Club Sports and Wellbridge entities will be referred to as "Wellbridge."

Response: Plaintiffs admit this statement regarding the name change, but suggest that the use of the term “Wellbridge” for all entities, pre- and post-purchase, will be confusing.

B. PLAINTIFF HERBERT FRUH'S MEMBERSHIP AT THE ATLANTIC CENTER

6. Plaintiff Herbert Fruh was a member of the Atlantic Center in April 1999. (Complaint ¶ 20; Answer ¶ 20.)

Response: Plaintiffs admit this statement.

7. Mr. Fruh had executed a Membership Agreement (the "Agreement") that indicates his membership at the Atlantic Center began October 30, 1995. (Ex. F, V. Fruh. dep. at 23:10-19; Ex. V, Membership Ag.)

Response: Plaintiffs admit this statement.

8. The reasons that Mr. Fruh chose to join the Atlantic Center were because he wanted to exercise and the Atlantic Center was close to where he worked. (Ex. S, H. Fruh Int. Resp. No. 29.)

Response: Plaintiffs admit that these reasons are to the best of Virginia Fruh’s recollection, and that Herb Fruh does not now recall the circumstances of his joining the Atlantic Center due to his severe anoxic brain injury, which includes memory loss. See, Response to Statement No. 9. According to the Medical History and Health Evaluation filled out by Mr. Fruh on October 27, 1995, his four most important reasons for joining the Wellbridge Center were to (1) improve sense of well-being, (2) become more physically fit, (3) improve cholesterol, and (4) lose weight. See, Pltf. Exhibit E at p. 5, Bate no. 10.

9. Mr. Fruh does not now remember joining the Atlantic Center. (Ex. E, H. Fruh dep. at 38:4-6.)

Response: Plaintiffs admit this statement.

10. The Agreement includes the following provisions:

6. Member Responsibilities.

6.1 Member acknowledges that:

- The physical fitness programs offered by the Center and any health risk appraisal provided by the Center are not a substitute for regular medical checkups and proper diet or other activities related to good health maintenance; and
- Participation in physical fitness activities, including those available at the Center, may be physically stressful and may result in illness or physical injury. Member acknowledges that his or her physical capability to engage in the specific activities offered by the Center must be reviewed and approved by Member's personal physician...

MEMBER FURTHER AGREES TO: Consult a physician if any new or existing medical or physical injury or other problem or condition arises which may affect or limit Member's ability to participate in the physical fitness activities offered by the Center, or in the event of any new illness, injury, discomfort or other health problem.

(Ex. V, Membership Ag. § 6.)

Response: Plaintiffs object to this statement on the grounds that the member responsibilities are not relevant to the grounds for Summary Judgment raised by the Defendants. Defendants have not pressed a waiver or assumption of the risk defense. Without waiving this objection, Plaintiffs admit that this is an accurate excerpt of the Agreement, but may be misleading in the context of all representations made by the Defendants and/or all documents signed by Mr. Fruh in connection with joining Wellbridge.

11. Mr. Fruh submitted a form titled "Wellbridge ParQ++" to Wellbridge dated October 25, 1995. (Ex. W, Wellbridge ParQ++.) On the ParQ++, Mr. Fruh's responded "no" to questions about, among other things, whether a doctor has ever told him that he has heart trouble, whether he has had pains in his heart or chest, whether he has at times felt faint or had spells of severe dizziness, and whether a doctor has ever said that his blood pressure was too high. (*id.*, Nos. 1, 4, 5, 11.)

Response: Plaintiffs admit this statement. Responding further, Plaintiffs state that Mr. Fruh also disclosed a moderately high cholesterol level, that he was a male 40 or older, and that he led

a sedentary lifestyle, in responding to questions in a Wellbridge form at or around the time he joined Wellbridge as a member. All of these are coronary risk factors recognized by Wellbridge.

(Medical History and Health Evaluation, Pltf. Ex. E, Bates nos. 4, 6-7, 9).

12. Mr. Fruh also submitted a form titled "Wellbridge Membership Patient Referral Form" to Wellbridge dated October 26, 1995. (Ex. X, Patient Ref. Form.) The form states that it is in reference to Herbert Fruh, is signed by a physician, Dr. Michael Guidi, and has a box marked indicating that "[p]atient [is] cleared to exercise without restriction." (*Id.*) Dr. Guidi was Mr. Fruh's primary care physician. (Ex. F, V. Fruh dep. at 41:20-22.)

Response: Plaintiffs object to this statement on the grounds the physician's clearance is not relevant to the grounds for Summary Judgment raised by the Defendants. Without waiving this objection, Plaintiffs admit this statement.

13. At no time prior to April 1999 did Mr. Fruh have any heart-related problems, high or elevated blood pressure, or any condition requiring medication (other than an impotence problem). (Ex. F, V. Fruh dep. at 56:12-23.)

Response: Plaintiffs object to the phrase "heart-related problems" as being vague and subject to varying interpretations. Furthermore, at the time of his cardiac arrest, when he was in the hospital, physicians diagnosed a blockage in a coronary artery which likely existed prior to April, 1999. (Link report, Pltf. Ex. N, at 2) Plaintiffs deny this statement and respond further that, according to Wellbridge records, Herbert Fruh disclosed that he had moderately high cholesterol, a condition diagnosed in 1992, three years before he sought to join Wellbridge as a member. (Medical History and Health Evaluation, Pltf. Ex. E, Bates no. 7).

14. The types of activities that Mr. Fruh typically engaged in while using the Atlantic Center included running on the treadmill and swimming in the pool. (Ex. F, V. Fruh dep. at 53:17-23.) Mr. Fruh used the Atlantic Center every weekday unless he was traveling, which was approximately four or five times per week. (*Id.* at 54:1-10.)

Response: Plaintiffs admit the first sentence of this statement. As to the second sentence, Plaintiffs object on the grounds that it is confusing, as to whether Mr. Fruh traveled four or five times a week, or exercised four or five times a week. Further responding, Plaintiffs state that, according to Wellbridge records, Mr. Fruh exercised between three and five times per week after he joined and before April 15, 1999.

C. THE EVENTS OF APRIL 15, 1999

15. Mr. Fruh was present at the Atlantic Center on the morning of April 15, 1999. (Ex. P, Tomaz dep. 11:17-23; Answer ¶ 22.)

Response: Plaintiffs admit this statement.

16. There are differing reports regarding the activities that Mr. Fruh may have engaged in at the Atlantic Center on April 15, 1999. (*See, e.g.*, Ex. F, V. Fruh dep. at 59:8-14, 60:12-15 (no knowledge of what he was doing); Ex. G, K. Fruh dep. at 10:19-11:7 ("on a treadmill"); Ex. J, Lathrop dep. at 26:5-16 ("came out of the steam room"); Ex. P, Tomaz dep. at 15:8-18 (swimming or finishing a shower); Ex. Y, EMS - Ambulance Incident Rep. ("stationary bicycle").

Response: Plaintiffs note their general and continuing objection to occurrence-related facts in Statement Nos. 16-47; subject to that objection, Plaintiffs admit this statement.

17. Shortly before 7 a.m. on April 15, 1999 (Ex. Z, Boston Fire Dept. Form 13-C; Ex. Y, EMS Ambulance Incident Rep.), Mr. Fruh collapsed in the men's locker room of the Atlantic Center, falling forward off of a bench and onto the tile floor (the "Incident"). (Ex. P, Tomaz dep. 11:17 - 12:12.)

Response: Plaintiffs admit this statement insofar as the statement indicates that the collapse occurred before 6:52 a.m. (See, Link Report, Pltf. Ex. N, at 1).

18. Another member of the Atlantic Center, Femand Tomaz, saw Mr. Fruh collapse and alerted an Atlantic Center employee that there was a "man down" in the locker room. (Ex. P, Tomaz dep. 12:6-21.)

Response: Plaintiffs admit this statement.

19. The employee to whom Mr. Tomaz made his announcement was Tim Plantikow, who worked at the front desk of the Atlantic Center. (Ex. J, Lathrop dep. 21:1-7; Ex. K, Marini dep. 29:23 - 30:4.)

Response: Plaintiffs admit this statement.

20. The Boston Fire Department records indicate that a 911 call was received from the Atlantic Center at 6:52 a.m. (Ex. AA, Boston Fire Dept. Incident History Rep.)

Response: Plaintiffs admit this statement.

21. Another Atlantic Center employee, Brooke Lathrop, was coming out of the ladies' locker room and heard Mr. Tomaz's announcement about Mr. Fruh. (Ex. J, Lathrop dep. 23:4-24:4.)

Response: Plaintiffs admit this statement.

22. Ms. Lathrop then ran to the men's locker room and found Mr. Fruh lying on his back in the shower area. (Ex. J, Lathrop dep. 24:5-9.)

Response: Plaintiffs admit this statement.

23. After assessing the situation and determining that Mr. Fruh was breathless and pulseless, which took less than 10 seconds, Ms. Lathrop began administering breaths to and chest compressions on Mr. Fruh, a process commonly known as cardiopulmonary resuscitation ("CRP") (sic). (Ex. J, Lathrop dep. at 25:2-23, 26:17-20, 27:14-20, 28:9-33:11.)

Response: Plaintiffs admit that Ms. Lathrop testified that the process described took less than ten seconds, but deny that all necessary steps could be effectively accomplished in less than ten seconds.

24. A third Atlantic Center employee, Robert Marini, eventually joined Ms. Lathrop in the men's locker room and assisted her. (Ex. J, Lathrop dep. 33:12-13; Ex. K, Marini dep. at 34:21-35:8.)

Response: Plaintiffs admit this statement.

25. Of the emergency responders, the first to arrive was a member of the Boston Police Department. (Ex. D, Flynn dep. at 9:15-10:7, 14:9-15.)

Response: Plaintiffs admit that the first emergency responder who was not an employee of Wellbridge was a member of the Boston Police Department.

26. Following right behind the police were members of the Boston Fire Department from Engine Company 10, who arrived on the scene at 6:58 a.m. (Ex. D, Flynn dep. at 9:15-10:7; Ex. O, Pettaway dep. 10:2-19, 27:20-28:5; Ex. AA, Boston Fire Dept. Incident History Rep.)

Response: Plaintiffs admit this statement. Further answering, Plaintiffs say that the members of the Boston Fire Department arrived at the curb outside the building at 6:58:37, five minutes and forty-six seconds after the 911 call was received, and approximately six minutes and forty-six seconds after the witnessed collapse of Mr. Fruh. (Link Report, Pltf. Ex. N, at p. 1; Pettaway dep., Pltf. Ex. WW, at 27-28). The firefighters took at least another three minutes to deploy their gear from the engine, enter the premises, make their way to the victim, and administer the first shock. (Pettaway dep., Pltf. Ex. WW, at 21, 22, 66; Link report, Pltf. Ex. N, at 8).

27. Engine Company 10's location is less than a mile away from the Atlantic Center. (Ex. O, Pettaway dep. at 15:20-22.)

Response: Plaintiffs admit this statement.

28. Upon arrival, three firefighters went into the Atlantic Center, moving as quickly as they could to get to Mr. Fruh. (Ex. O, Pettaway dep. 20:3-20, 22:16-17.) They reported that Mr. Fruh had no pulse, was not breathing, and had no blood pressure. (*Id.* at 24:3-22; Ex. Z, Boston Fire Dept. Form 13-C.)

Response: Plaintiffs admit this statement.

29. Engine Company 10 carried an automatic external defibrillator ("AED") on its fire truck, and each firefighter was trained in how to use it. (Ex. O, Pettaway dep. at 10:2-19; 16:22-18:4; 19:19-20:2; Ex. M, Murphy dep. at 9:18- 10:11.)

Response: Plaintiffs admit this statement.

30. After the AED pads are connected to the patient (*i.e.*, Mr. Fruh), some time will pass to allow the AED to analyze the patient's condition before a shock can be administered, during which time CPR cannot be performed. (Ex. O, Pettaway dep. at 65:8-66:5; 66:16-67:5.)

Response: Plaintiffs admit this statement, but deny the length of time is significant and further object that the characterization “some time” is so vague as to be objectionable.

31. The Fire Department's AED determined that Mr. Fruh was in ventricular fibrillation, and they shocked him [using] the AED. (Ex. O, Pettaway dep. at 17:16 - 18:4, 50:15-17, 52:7-15; Ex. Z, Boston Fire Dept. Form 13-C.)

Response: Plaintiffs admit that the Fire Department's AED determined that Mr. Fruh was in an arrhythmia known as ventricular fibrillation and recommended that a shock be administered. Further answering, Plaintiffs state that this means it is likely that Mr. Fruh was in a shockable rhythm from the moment he arrested. (Myerburg dep., Ex. XX, at 28).

32. A unit from Boston Emergency Medical Services ("EMS"), which provided basic life support, arrived shortly after the firefighters applied the first shock. (Ex. O, Pettaway dep. at 18:5-7, 50:15-17; Ex. R, Williams dep. at 13:7-14:5, 28:11-13; Ex. Y, EMS - Ambulance Incident Rep.; Ex. BB, Boston Emergency Incident History Rep.)

Response: Plaintiffs admit this statement. Further answering, Plaintiffs state that the EMS arrived outside the building at 7:01 a.m., nine minutes after the witnessed cardiac arrest. (Def. Ex. BB; Link Report Pltf. Ex. N, at 1).

33. After EMS arrived on the scene, they took over defibrillator operations. (Ex. O, Pettaway dep. at 17:20 - 18:10.)

Response: Plaintiffs admit this statement.

34. EMS applied their AED to Mr. Fruh and shocked him two more times. (Ex. R, Williams dep. at 13:7 - 14:5; Ex. C, Doyle dep. at 30:23 - 31:3; Ex. Y, EMS - Ambulance Incident Rep.)

Response: Plaintiffs admit that EMS shocked Mr. Fruh two more times but deny that they applied their own AED. Instead, they used the AED brought by the Boston Fire Department. (Def. Ex. Y, at 3). Further answering, Plaintiffs state that the fact that the defibrillator called for two more shocks indicates that Mr. Fruh was still in ventricular fibrillation. The longer a heart

muscle remains in fibrillation without having that arrhythmia reversed, the more difficult it is to defibrillate. (See, Myerburg dep., Pltf. Ex. XX, at 28-32).

35. Paramedics arrived on scene at 7:02 a.m., after the fire department and EMS has applied three shocks to Mr. Fruh, and made contact with Mr. Fruh at 7:06 a.m. (Ex. O, Pettaway dep. at 18:8-10; Ex. R, Williams dep. at 12:8-13; Ex. Y, EMS - Ambulance Incident Rep.)

Response: Plaintiffs admit that the paramedic report indicates that they arrived at the side of Mr. Fruh four minutes after their arrival on scene. Further answering, Plaintiffs state that, according to these records, paramedics did not arrive at Mr. Fruh's side until at least fourteen minutes after his witnessed collapse.

36. Despite the efforts of the fire department and EMS, when the paramedics arrived, Mr. Fruh still had no pulse, no blood pressure and was not breathing on his own. (Ex. C, Doyle dep. at 37:9-23.)

Response: Plaintiffs admit this statement.

37. The paramedics continued CPR and applied their own defibrillator to monitor Mr. Fruh's condition. (Ex. R, Williams dep. at 14:6 - 16:13.) The paramedics' defibrillator is different than the EMS AED because the shock that is delivered by the paramedics' defibrillator can be changed whereas the EMS AED shock level remains constant. (Ex. C, Doyle dep. at 34:7-17.)

Response: Plaintiffs admit that the paramedics continued CPR and applied their own defibrillator. Plaintiffs deny that the "EMS AED" does not permit changing shock levels. It is not known which AED the Boston Fire Department was using at the time. (Pettaway dep., Pltf. Ex. WW, at 31; Murphy dep., Pltf. Ex. L, at 88-89). Plaintiffs further deny that any difference in shock levels, as it is implied, renders the AED deficient for purposes of reversing ventricular fibrillation. Plaintiffs further deny that the EMS used their AED. They used the Boston Fire Department AED. (See, Response to Statement No. 34).

38. Two minutes passed between the time that the paramedics turned on the power to the AED and time it registered the first notation. (Ex. R,

Williams dep. at 38:17-21.) They discovered an electrical rhythm in Mr. Fruh's heart that was not treatable by shocking him. (*Id.* at 19:7-8, 42:3-17.)

Response: Plaintiffs deny that two minutes elapsed between the time the paramedics turned on the power to the defibrillator and the time it registered the first notation. (See, Link Report Pltf. Ex. N, at 1; Def. Ex. Y, at 5). Plaintiffs further deny this Statement to the extent that it is implied that an AED would not have resuscitated Mr. Fruh without brain damage if it had been applied earlier. (See, Link Report, Pltf. Ex. N, at 8).

39. The paramedics intubated, or inserted endotracheal tube into his lungs, Mr. Fruh to help him breathe, a component of advanced life support that only paramedics could do. (Ex. R, Williams dep. at 16:14 - 18:10; Ex. C, Doyle dep. at 32:17 - 33:3.)

Response: Plaintiffs deny this Statement, to the extent that it is implied that an AED would not have resuscitated Mr. Fruh without brain damage had it been applied earlier or that Advanced Life Support would have been necessary to resuscitate him earlier. (See, Link Report, Pltf. Ex. N, at 8). Otherwise, Plaintiffs admit this statement.

40. The paramedics also gave Mr. Fruh a series of medication to assist his heart in beating automatically again. (Ex. R, Williams dep. at 18:11-19:12.)

Response: Plaintiffs deny this Statement, to the extent that it is implied that an AED would not have resuscitated Mr. Fruh without brain damage had it been applied earlier or that Advanced Life Support would have been necessary to resuscitate him earlier. (See, Link Report, Pltf. Ex. N, at 8). Otherwise, Plaintiffs admit this statement.

41. The paramedics checked Mr. Fruh's heart rhythm again and found him to be in ventricular fibrillation, which is treatable with a shock from the AED. (Ex. R, Williams dep. at 19:13-20:20, 42:18-23.)

Response: Plaintiffs deny this Statement, to the extent that it is implied that an AED would not have resuscitated Mr. Fruh without brain damage had it been applied earlier or that Advanced

Life Support would have been necessary to resuscitate him earlier. (See, Link Report, Pltf. Ex. N, at 8). Otherwise, Plaintiffs admit this statement.

42. The paramedics shocked Mr. Fruh once at 300 joules at 7:13 a.m. (Ex. R, Williams dep. at 20:15-20, 43:2-14.)

Response: Plaintiffs admit this statement.

43. The AED then indicated that Mr. Fruh's heart rhythm had changed to asystole, which indicates no electrical activity at all in the heart. (Ex. R, Williams dep. at 20:21-21:9.)

Response: Plaintiffs deny this Statement, to the extent that it is implied that an AED would not have resuscitated Mr. Fruh without brain damage had it been applied earlier or that Advanced Life Support would have been necessary to resuscitate him earlier. (See, Link Report, Pltf. Ex. N, at 8). Otherwise, Plaintiffs admit this statement.

44. The paramedics gave Mr. Fruh additional medication and continued CPR until the AED indicated that Mr. Fruh was in ventricular fibrillation. (Ex. R, Williams dep. at 21:10- 22:9.)

Response: Plaintiffs deny this Statement, to the extent that it is implied that an AED would not have resuscitated Mr. Fruh without brain damage had it been applied earlier or that Advanced Life Support would have been necessary to resuscitate him earlier. (See, Link Report, Pltf. Ex. N, at 8). Otherwise, Plaintiffs admit this statement.

45. The paramedics shocked Mr. Fruh twice more at 360 joules, first at 7:18 a.m. and again at 7:20 a.m., at which time his heart rhythm returned to a somewhat normal rhythm and he had a detectible pulse. (Ex. R, Williams dep. at 21:10-23:21, 44:23-45:8, 48:21-50:1; Ex. O, Pettaway dep. at 25:12-18.)

Response: Plaintiffs deny this Statement, to the extent that it is implied that an AED would not have resuscitated Mr. Fruh without brain damage had it been applied earlier or that Advanced Life Support would have been necessary to resuscitate him earlier. (See, Link Report, Pltf. Ex. N, at 8). Otherwise, Plaintiffs admit this statement.

46. The battery in the paramedics' AED had to be replaced between shocks two and three, which took approximately two minutes. (Ex. R, Williams dep. at 45:9-48:20.)

Response: Plaintiffs admit that Mr. Williams testified to this estimate of the amount of time needed to replace a battery, but deny that this amount of time was actually necessary under the circumstances.

47. Mr. Fruh was taken by ambulance to Boston Medical Center at 7:25 a.m. (Ex. O, Pettaway dep. at 30:3-11; Ex. R, Williams dep. at 12:8-13; Ex. AA, Boston Fire Dept. Incident History Rep.; Ex. Y, EMS - Ambulance Incident Rep.) The ambulance arrived at Boston Medical Center at 7:30 a.m. (Ex. R, Williams dep. at 12:14-19; Ex. Y, EMS-Ambulance Incident Rep.)

Response: Plaintiffs admit this statement.

48. Mr. Fruh was later diagnosed as having suffered cardiac arrest while at the Atlantic Center, but none of the physicians who treated Mr. Fruh provided the Fruh family with a definitive conclusion about what caused his cardiac arrest (Ex. F, V. Fruh dep. at 58:7-12; Ex. G, K. Fruh dep. at 46:17-19.)

Response: Plaintiffs admit that Kevin and Mrs. Fruh so testified, but deny that the physicians did not provide a definitive diagnosis. The records indicate that Mr. Fruh had a “myocardial ischemia brought on by exercise in the setting of a coronary stenosis of 90% in the left anterior descending coronary artery.” (See, Link Report, Pltf. Ex. N, at 2; Myerburg dep., Pltf. Ex. XX, at 41-42).

49. At some point during or after his cardiac arrest, Mr. Fruh developed an anoxic brain injury that has persisted. (See Ex. F, V. Fruh dep. at 140:9-21.)

Response: Plaintiffs object to this statement to the extent that Mrs. Fruh is put forth as a medical expert. Plaintiffs admit the anoxic brain injury occurred during the period Mr. Fruh was in cardiac arrest and that it has persisted, but further state that it developed only after at least

five minutes of cardiac arrest, untreated by defibrillation, had passed. (See, Link Report, Pltf. Ex. N, at 8).

D. THE FRUH FAMILY

50. Plaintiff Virginia Fruh is Herbert Fruh's wife. (Ex. F, V. Fruh dep. at 4:23-5:3.)

Response: Plaintiffs admit this statement.

51. The only reason Mrs. Fruh knows for Mr. Fruh's decision to join the Atlantic Center is that "he wanted to work out and stay health (sic)." (Ex. F, V. Fruh dep. at 33:11-15; 40:20-41:12.)

Response: Plaintiffs admit this statement.

52. Mr. and Mrs. Fruh left the Atlantic Center and joined another health club, Fitness Factory, after the Incident. (Ex. F, V. Fruh dep. at 25:6-26:1.)

Response: Plaintiffs object to this statement on the grounds that whether or not Mr. and Mrs. Fruh ever joined another health club after the incident is not relevant to any issue in this case or any issue raised in the Defendants' Motion for Summary Judgment. Subject to this objection, Plaintiffs admit that Virginia Fruh joined the Fitness Factory, but deny that she was ever a member of the Atlantic Avenue center. Plaintiffs further deny that Mr. Fruh ever joined the Fitness Factory after the incident. Instead, he was brought as a member guest for a short period of time in the short-lived hope that regular physical activity would assist in his recovery. (V. Fruh dep. Pltf. Ex. YY at 25, 36-38, 128-131).

53. Virginia Fruh did not ask whether the Fitness Factory had a first aid program or an AED on its premises before joining. (Ex. F, V. Fruh dep. at 28:7-13.)

Response: Plaintiffs object to this statement on the grounds that whether Virginia Fruh asked about a first aid program or an on-premises AED at the Fitness Factory is not relevant to any

issue in this case, or any issue raised in the Defendants' Motion for Summary Judgment. Subject to this objection, Plaintiffs admit this statement.

54. Plaintiff Kevin Fruh is the second of Mr. and Mrs. Fruh's three children. (Ex. F, V. Fruh dep. at 5:6-10.) Kevin is now 24 years old, which means he was 20 at the time of the Incident. (*Id.* at 5:9; Ex. G, K. Fruh dep. at 4:22-23.)

Response: Plaintiffs admit this statement.

55. Mr. Fruh did not discuss with Kevin his decision to join the Atlantic Center or his activities there after joining. (Ex. G, K. Fruh dep. at 12:5-13.)

Response: Plaintiffs admit this statement.

56. Kevin attended the University of Massachusetts at Amhearst [sic] from 1996 until he graduated in 2000. (Ex. G, K. Fruh dep. at 5:13- 6:4.)

Response: Plaintiffs admit this statement.

57. While he attended college, Kevin lived away from home and visited home only for vacations and weekends. (Ex. G, K. Fruh dep. at 5:4-12.)

Response: Plaintiffs deny this statement. Kevin Fruh testified that, in addition to visiting home during the college terms, he lived at home during the summers. (K. Fruh dep., Pltf. Ex. 22, at 4-8).

58. Kevin moved back into the Fruh family home after graduating from college in 2000. (Ex. G, K. Fruh dep. at 5:13-17.)

Response: Plaintiffs deny this statement to the extent that it suggests that Kevin Fruh's residence was anywhere other than the Fruh home prior to graduating from college in 2000.

59. Kevin moved out of the family home in February 2003. (Ex. G, K. Fruh dep. at 5:1-3.)

Response: Plaintiffs admit this statement. Further responding, Plaintiffs state that Kevin continues to live very close to the Fruh family home, in the same town, to help take care of Herbert Fruh. (K. Fruh dep., Pltf. Ex. 22, at 4-8).

60. Kevin's first employer after graduating from the University of Massachusetts at Amherst (sic) was the Middlesex School in Concord, Massachusetts where he worked from April 2001 until June 2002. (Ex. G, K. Fruh dep. at 6:18- 7:8.)

Response: Plaintiffs object to this statement on the grounds that Kevin's employer at any time is not relevant to any issue in the case, or any issue raised by the Defendants in their Motion for Summary Judgment. Subject to this objection, Plaintiffs admit this statement.

61. Kevin's second employer after graduating from college was Riverfront Landscape & Design where he worked from July 2002 until January 2003. (Ex. G, K. Fruh dep. at 6:8-17.)

Response: Plaintiffs object to this statement on the grounds that Kevin's employer at any time is not relevant to any issue in the case, or any issue raised by the Defendants in their Motion for Summary Judgment. Subject to this objection, Plaintiffs admit this statement.

62. Plaintiff Tracey Fruh is the youngest of Mr. and Mrs. Fruh's three children. (Ex. F, V. Fruh dep. at 5:6-10.) Tracey is 16 years old. (Id. at 5:9; Ex. H, T. Fruh dep. at 5:6-7.) She was 12 years old at the time of the Incident. (Ex. H, T. Fruh dep. at 7:3-8.)

Response: Plaintiffs admit this statement.

63. Tracey goes to school and lives at home with her parents. (Ex. H, T. Fruh dep. at 5:8 - 6:3.)

Response: Plaintiffs admit this statement.

64. Mr. Fruh did not discuss with Tracey his decision to join the Atlantic Center or his activities there after joining. (Ex. H, T. Fruh at 14:11-13.)

Response: Plaintiffs admit this statement.

E. THE DECISION TO DEPLOY AUTOMATIC EXTERNAL DEFIBRILLATORS AT WELLBRIDGE'S FACILITIES

65. The Atlantic Center did not have an AED on site on April 15, 1999. (Answer ¶ 46.)

Response: Plaintiffs admit this statement.

66. An AED is considered a prescriptive device by the Food and Drug Administration and requires a medical prescription to obtain one. (Ex. M, Murphy dep. at 79:19-80:9.)

Response: Plaintiffs admit this statement. Further responding, Plaintiffs state that the requirement of a prescription for purchase of an AED is and was not onerous. Most AED suppliers offered programs that matched clubs with physicians in their state who were willing to act as the “medical authority” for a designated period of time in order to facilitate purchase and oversight of the AED use. (See, IHSA Briefing Paper, Pltf. Ex. S, at 4; Clay Affidavit, Pltf. Ex. CC ¶ 3; Pltf. Exs. DD and EE; SF ¶¶ 48-50).

67. In 1999, Wellbridge required all employees to be trained in CPR. (Ex. I, Idell dep. at 25:3-6, 27:1-4; Ex. Q, Turgiss dep. at 72:20-73:9, 169:20-170:8.) Each employee was responsible for ensuring the currency of his or her CPR certification as a condition of employment. (Ex. I, Dell dep. at 25:21-26:8, 43:6-14.)

Response: Plaintiffs admit this statement. Further answering, Plaintiffs state that the requirement that all employees be trained in CPR triggered an American Heart Association published standard that all such employees whose duties require them to perform CPR should also be trained in the use of an AED. This included health club personnel. (Murphy dep., Pltf. Ex. L, at 70-72).

68. The American Heart Association provided regular training for directly (sic) for Wellbridge employees. (Ex. Q, Turgiss dep. at 140:8-14.)

Response: Plaintiffs admit this statement. Further answering, Plaintiffs state that all American Heart Association training materials from at least 1994 on stressed the need for rapid defibrillation in responding to cardiac arrest, and the ease of use of AEDs by lay responders. The materials also identified a broad range of personnel who could be trained, including health club employees. (Abbott report, Pltf. Ex. M, at 8-9; Link report, Pltf. Ex. N, at 7-8).

69. Both of the Wellbridge employees who aided Mr. Fruh had been trained in and were current in their certifications for CPR. (Ex. J, Lathrop dep. at 7:19-8:23, 59:8-22; Ex. K, Marini dep. at 11:13-12:16, 16:18-20, 18:20-23.)

Response: Plaintiffs admit that both of the Wellbridge employees had at some point been certified and were current in their AHA certifications for CPR. Plaintiffs deny that they were trained since they were not required to, and did not, participate in any cardiac emergency drills while employed at Wellbridge, contrary to Wellbridge's written policy. (Marini dep., Pltf. Ex. AAA, at 19-20; Lathrop dep., Pltf. Ex. BBB, at 15-16; Idell dep., Pltf. Ex. KK, at 38-39. Pltf. Ex. CCC at 5. See, Abbott report, Pltf. Ex. M, at 9-10).

70. In 1999, all of Wellbridge's staff were provided with a written emergency plan and participated in unannounced drills on a wide range of emergency topics that occurred quarterly. (Ex. I, Idell dep. at 25:15-26:23, 27: 1-4; Ex. Q, Turgiss dep. at 74:22-76:20.)

Response: Plaintiffs admit that the staff was provided with a written emergency plan and deny that they participated in any unannounced cardiac emergency drills. (See, Response to Statement No. 69).

71. Before 1999, Wellbridge had questions about whether laypersons like health club employees responding to an emergency that might warrant use of the AED would easily be able to do so. (Ex. B, Curtis dep. at 65:19-67:13.)

Response: Plaintiffs deny this Statement.¹ Plaintiffs state that, although Mr. Curtis so testified at deposition, he also testified that he had reviewed American Heart Association material during

¹ For purposes of clarification, Club Sports International acquired the Wellbridge assets from Monsanto as of December 31, 1998. This statement relies on the testimony of Mr. Curtis, who was the Club Sports International Executive Vice President. Before 1999, Wellbridge and Club Sports International (Curtis' company) were not affiliated in any way. It would be more accurate to say that Curtis later testified that, as CSI's vice president, he had questions about whether lay persons responding to an emergency might warrant the use of AED would easily be able to do so. The Defendants are properly conceding that, for purposes of an occurrence on April 15, 1999, in light of the Asset Purchase Agreement and assumption of liability, and merger of the two companies, Curtis' knowledge before 1999 is also Wellbridge's knowledge before 1999. This is the case despite the fact that the employees and executives at Wellbridge before 1999, primarily Mr. Patjane and Ms. Turgiss, had a less sophisticated understanding of cardiac arrest and AEDs than did Mr. Curtis.

the period of 1992 to 1999, which proclaimed the ease of use of AEDs by minimally-trained lay persons and suggested health club personnel as targeted responders. (Curtis dep., Pltf. Ex. I at 11-13, 21, 48-49, 52-53,62-64, 68, 73-76; Murphy dep., Pltf. Ex. L, at 70-72). Furthermore, executives and supervisory employees of Wellbridge prior to its purchase by Club Sports testified that they were aware that AEDs could and had been used by lay persons successfully in saving lives in airports, airplanes, and casinos. (See, Turgiss dep., Pltf. Ex. B, at 35-36; Patjane dep., Pltf. Ex. F, at 52-54).

72. Wellbridge's other concerns about the installation and use of AEDs in its health clubs before 1999 included

- a. the technology involved in production of AEDs for public use and support systems for using them were in their infancy (Ex. B, Curtis dep. at 20:7 -21:13, 58:11-14);
- b. the possibility that an AED could provide the recipient with an inappropriate shock, which could then create an irregular heart rhythm (Ex. B, Curtis dep. at 82:25 - 83:3; Ex.Q, Turgiss dep. at 80:5-22);
- c. the possibility that an AED could shock an employee who was using the device (Ex.Q, Turgiss dep. at 81:5-82:19);
- d. the mixed status of Good Samaritan laws regarding non-medical persons who operated AEDs in the states where Wellbridge operated (Ex. B, Curtis dep. at 21:14-19, 79:10-80:11; Ex.Q, Turgiss dep. at 127:9-128:20, 129:12-131:8);
- e. the possibility of a battery explosion (Ex.Q, Turgiss dep. at 83:1-23);
- f. the procedures that health club staff would rely on in responding to an emergency situation (i.e., would they favor the AED over standard emergency procedures) and the fortune of any member who may have a heart-related or other illness that cannot be solved with an AED (Ex. B, Curtis dep. at 80:17 - 81:23, 83:8-16);

g. the lack of guidance or standards from a respected leader in the health and fitness industry, the American College of Sports Medicine, on the installation and use of AEDs (Ex. B, Curtis dep. at 63:23 - 64:13).

Response: With respect to the alleged concerns (a-g) that “Wellbridge” had before 1999 concerning the installation and use of AEDs, Plaintiffs deny that any such concerns existed on the part of key Wellbridge employees and state that these are, instead, after-the-fact justifications often contradicted by other testimony from the same employees. AED technology was not in its infancy. (SF ¶ 23). There was no real danger of inappropriate shock. (*id.*). There was no danger that an employee could be shocked or that batteries would explode. Mr. Curtis has testified that he reviewed American Heart Association Materials. (Curtis dep., Pltf. Ex. I at 71-77). If he had read them, his concerns, if they actually existed during the period prior to 1999, would have been quickly allayed. (See, SF¶¶ 15, 16, 20, 21, 24). Furthermore, the devices that Wellbridge reviewed and ultimately purchased in the fall of 1999 were all designed and manufactured by the mid-90s, at least two years prior to purchase by Wellbridge. (SF¶¶ 131-134). The issue of the “mixed Good Samaritan Laws” was not even considered by Wellbridge until it decided to deploy after April, 1999. (Curtis dep, Pltf. Ex. I at 79-80). Moreover, the employees of Wellbridge who were called upon to respond to cardiac emergencies by using their CPR training were not, in the first place, “Good Samaritans,” because they had a common law duty of reasonable care to club members to so respond. Nothing in Massachusetts prior to April, 1999 made it illegal for an employee of a health club who was trained in the use of a legally-purchased AED to use one in the course of a medical emergency. (SF¶ 15; Clay Affidavit, Pltf. Ex. CC, ¶ 3; Murphy dep., Pltf. Ex. L, at 84-85; IHRSB Briefing Paper, Ex. S, at 3-8). Defendants have produced no documents authored by any Wellbridge employee showing that

any of these concerns were ever raised or considered prior to April, 1999. As to the ease in deploying AEDs, see SF ¶ 136 below.

73. Wellbridge believed that it would be more difficult to train health club staff to use AEDs than first-responder emergency personnel such as firefighters or police officers. (Ex. B, Curtis dep. at 59:2-5, 60:2-6.) Mr. Curtis believed that the high rate of turnover of health club employees would require constant training and retraining of employees, whereas fire and police departments have a fairly stable labor pool. (*Id.* at 60:7-13, 69:8-16.)

Response: Plaintiffs admit that Curtis testified to this but he also testified they would be no more difficult to train than first responders. (Curtis, dep. Pltf. Ex. I at 90-92). Plaintiffs, therefore, deny the first sentence and further deny that it was an actual or legitimate concern of his prior to 1999. (See, SF ¶¶ 103, 136, Pltf. Ex. DD and EE). Furthermore, it has been well-established that AEDs are so easy to use that “naive” sixth graders can be trained to use them with no effort to the point that they are almost as efficient as trained responders. (See, Pltf. Ex. DDD). Furthermore, O’Hare Airport began, in 1999, leaving defibrillators mounted throughout the airport in the hope that even untrained responders would utilize them to respond to a cardiac emergency. (See, Pltf. Ex. EEE).

74. With so many questions about the use of AEDs before 1999, it was not in Wellbridge's best interest to introduce AED technology at that time. (Ex. B, Curtis dep. at 67:8-13, 75:21-76:3, 76:8-16).

Response: Plaintiffs object that the interests of the club, as opposed to members such as Herb Fruh, are irrelevant. Plaintiffs further object to the argumentative and self-serving nature of the Statement. Subject to these objections, Plaintiffs deny this statement. Further Responding, Plaintiffs state that Wellbridge was unreasonable in not having AEDs on its clubs’ premises before April 15, 1999. (See, SF ¶¶ 17, 18, 20).

75. By mid-1999, Wellbridge believed that some of its concerns about AEDs had been mitigated or alleviated: the state of the technology used

in AEDs had reached a level where it made sense for non-medical personnel to be trained to use them, Wellbridge's own training program had reached a level where training on AEDs seemed feasible, the laws were changing to support non-medical use of AEDs, and Wellbridge's market trends indicated that deploying AEDs made sense. (Ex. B, Curtis dep. 127:2-128:7.)

Response: Plaintiffs deny this statement. Mr. Curtis says he never considered deployment of AEDs until he received a letter from the widow of a member who had died at one of the Wellbridge clubs. (Pltf. Ex. I at 72-78). On the other hand, he testified to his extensive knowledge in the mid-90s of cardiac arrest, AHA principles and training and use of AEDs by some clubs. Wellbridge was unreasonable in not having AEDS on its premises on April 15, 1999. (See, Curtis' letter to Mrs. Rush dated 4/27/99, Pltf. Ex. Q; Curtis, dep., Pltf. Ex. I at 72-76; SF¶¶ 124-125, 127-128).

76. The culmination of these various changes over the years indicated that AEDs may have become a more viable option for lay users like health club personnel than at any time previous. (Ex. B, Curtis dep. at 128:4-7; Ex. Q, Turgiss dep. at 78:10-20.)

Response: Plaintiffs deny this statement. Further Responding, Plaintiffs state that Wellbridge was unreasonable in not having AEDs on its clubs' premises before April 15, 1999. SF¶¶ 17-18, 20).

77. Art Curtis was the chief operating officer of Wellbridge in April 1999. (Ex. B, Curtis dep. at 20:4-6.)

Response: Plaintiffs admit this statement, but deny any implication that Mr. Curtis had any position with Wellbridge before 1999; see, Footnote 1 above.

78. Mr. Curtis oversaw the deployment of AEDs at Wellbridge. (Ex. B, Curtis dep. at 17:10-12.)

Response: Plaintiffs deny this statement. Further responding, the Plaintiffs state that Mr. Curtis delegated responsibility for the investigation and deployment of AEDs to Wellbridge employee Jennifer Turgiss. (Answer to Interrogatory 2, Pltf. Ex. G; Turgiss dep., Pltf. Ex. B at 59-60).

79. The first time that Mr. Curtis became aware of the suggestion for deploying AEDs in public places like a health club was after he read a December 1998 article on the same topic. (Ex. B, Curtis dep. at 49:8 - 51:16.) He read that article a few months after it was published. (*Id.* at 49:13-15.)

Response: Plaintiffs admit that Mr. Curtis so testified but deny that this would have been the first time that he was aware of a suggestion for deploying AEDs in public places like a health club. Since Mr. Curtis testified that he periodically reviewed American Heart Association positions, he must have seen the previously reference American Heart Association materials recommending AED use in places such as health clubs or any facility where employees were called upon as part of their job duties to perform CPR. (Curtis dep. Pltf. Ex. I at 71 - 77; SF¶¶ 15, 16-18, 20, 23-24; Murphy dep., Pltf. Ex. L at 69-72).

80. The first inquiry that Wellbridge received from or made to any manufacturer of AEDs about the technology was in early 1999. (Ex. B, Curtis dep. at 24:9 - 25:15, 67:14-21; Ex. Q, Turgiss dep. at 59:3-20.)

Response: Plaintiffs admit that this was the testimony of Mr. Curtis and Ms. Turgiss but deny that no solicitations had been received prior to early January or February, 1999. Defendants have not produced any such documents, but AED manufacturers had been targeting and soliciting health clubs since the mid-90s. (See, Pltf. Ex FFF).

81. Wellbridge first investigated deployment of AEDs in its facilities shortly after Club Sports acquired the Former Wellbridge Company from Monsanto, which occurred in March 1999. (Ex. Q, Turgiss dep. at 59:3-10, 59:15-20.)

Response: Plaintiffs deny that Club Sports acquired Wellbridge from Monsanto in March, 1999. See, Response to Statement No. 4 above. Furthermore, Plaintiffs deny the balance of this

statement because Mr. Curtis himself testified, as set forth above, that in each and every year from 1996 to 1999 he considered deployment of AEDs at the Club Sports facilities but made the decision not to do so, allegedly based on the reasons set forth in Statement No. 72 above. (Curtis dep., Pltf. Ex. I, at 70-76). Plaintiffs admit that Wellbridge first decided to deploy AEDs shortly after April 15, 1999.

82. One of the events that prompted Wellbridge to investigate deployment of AEDs in its health clubs was an April 27, 1999 letter from the wife of a deceased member of Wellbridge's Northwest Athletic Club. (Ex. B, Curtis dep. at 71:24- 74:6; Ex. Q, Turgiss dep. at 60:1-12.)

Response: Plaintiffs admit that the event referred to prompted Wellbridge to finally decide to deploy. (See, Response to Statement No. 79 and 81 above.)

83. As part of a complete overhaul of Wellbridge's emergency procedures, in late April or May 1999 Art Curtis directed Jennifer Turgiss, then Wellbridge's national fitness manager, to investigate deployment of AEDs in all Wellbridge facilities. (Ex. B, Curtis dep. at 109:12 - 111:2, 117:24 - 118:7, 118:8-18.) Ms. Turgiss engaged the assistance of William Patjane, then Wellbridge's regional health and fitness manager for the clubs in the northeastern United States, in the investigation. (Ex. Q, Turgiss dep. at 79:6-8; Ex. N, Patjane dep. at 15:11-14.)

Response: Plaintiffs deny that there was a “complete overhaul of Wellbridge’s emergency procedures” in April or May 1999. (See, Idell dep., Pltf. Ex. KK, at 46). Plaintiffs further state that the “investigation” of AED deployment does not appear to have begun in earnest until August of 1999, despite a promise to the widow mentioned in Statement No. 82 that it would begin immediately. (Pltf. Ex. Q). Ms. Turgiss testified that the issue occupied about 20% of her time investigating the issue by telephone between April and August, 1999, and she was not concerned that people might die during the interim. (Turgiss dep., Pltf. Ex. B, at 145-146).

84. When Wellbridge began investigating the deployment of AEDs in its facilities in 1999, it discovered that every state in which Wellbridge

operated required physician approval to purchase an AED. (Ex. B, Curtis dep. at 113:1- 114:9.)

Response: The Plaintiffs object to the phrase “physician approval” as vague and confusing. Plaintiffs admit that the purchase of AEDs required a prescription signed by a physician, as set forth in response to Statement No. 66, above. Plaintiffs further deny that Wellbridge first discovered this fact in 1999, since it is stated in most, if not all, of the American Heart Association publications on the subject of public access defibrillation published in the early- and mid-1990s, publications the Defendants’ executives claimed to be familiar with. (Curtis dep., Pltf. Ex. I, at 76-77; Turgiss dep., Pltf. Ex. B, at 35-36; Patjane dep., Pltf. Ex. F, at 25-27, 37-39; see, Pltf. Ex. S at 4-5).

85. By the fall of 1999, Wellbridge had located a vendor and had initiated its program for installing and training employees in the use of AEDs. (Ex. B, Curtis dep. 17:20-22,115:14-16.)

Response: Plaintiffs admit this statement.

86. Wellbridge located an AED vendor it believed could help it navigate through the laws of each state in which Wellbridge operated health club facilities. (Ex. B, Curtis dep. at 111:3-112:23, 115:17-116:4; Ex. Q, Turgiss dep. at 127:9-128:20, 129:12-131:8.)

Response: Plaintiffs object to the argumentative and self-serving characterizations and implications of this Statement, including “navigate through”, and deny any implication that the laws of the states in which Wellbridge did business presented any significant obstacle to the purchase, installation and use of AEDs at the Defendants’ health clubs. (See, Curtis emails in Nov. 2000 and Feb. 2001 Pltf. Exs. DD and EE; see SF¶¶ 48-50, 103, 136 below).

87. Cost was not a factor for Wellbridge after it decided to roll out an AED program. (Ex. B, Curtis dep. at 116:18-117:10; Ex. Q, Turgiss dep. at 62:8-16, 165:9-17.)

Response: Plaintiffs deny that cost was not a factor for Wellbridge in its delay in deciding to roll out an AED program. (See, IHRSA Briefing Paper, Pltf. Ex. S at 7-8; Pltf. Ex. II at 4-5).

88. Wellbridge did not delay the deployment of its AEDs, and in fact moved efficiently and speedily to roll out the program once it decided that doing so was a viable option. (Ex. Q, Turgiss dep. at 174:15-175:19.)

Response: Plaintiffs deny this statement. The essence of this case is, of course, that Wellbridge delayed deployment prior to April 15, 1999. Mr. Curtis promised the widow whose letter allegedly persuaded him to finally deploy AEDs that he would begin deployment in May of 1999, having already identified a manufacturer/vendor. (Pltf. Ex. Q). In fact, the final identification of a vendor did not take place until the Fall of 1999. SF¶ 134). Even after purchase of the AEDs in that time period, deployment and training did not begin until March of 2000. When it finally began, it was mostly accomplished in a one month period. (See and compare, Pltf. Ex. K; Murphy dep., Pltf. Ex. L, at 28-32, 80-81). There is no reason why the same steps could not have been taken in a thirty day period as early as 1997. (Murphy dep., Pltf. Ex. L at 84-85).

89. Wellbridge completed its installation of and training of certain employees in the use of AEDs in all of its health clubs, including the facilities in Boston, by the end of March 2000. (Ex. B, Curtis dep. 120:11-121:21.)

Response: Plaintiffs admit this statement. Responding further, Plaintiffs state that the installation and training was accomplished, in its entirety, in approximately one month, namely March, 2000, after the AEDs had been purchased. (See, Response to Statement No. 88, above).

F. THE COMMUNITY'S POSITION ON AUTOMATIC EXTERNAL DEFIBRILLATORS

90. Even when an AED is used to treat a victim, there is no guaranty that the AED will save the victim's life. (Ex. C, Doyle dep. at 21:2-5; 47:20-23.)

Response: Plaintiffs admit there is no guarantee that an AED will always save a victim's life, but studies show survival rates as high as 90% when the AED is used in a timely fashion. (See, Link Report, Pltf. Ex. N, at 7; Pltf. Ex. S at 2).

91. In April 1999 (or even now), no organization of any kind published an official standard holding that a health club that does not acquire and maintain an AED falls below the standard of care. (Ex. A, Abbott dep. at 223:4-8.)

Response: Plaintiffs deny this statement. First, the American Heart Association, to which Wellbridge admits looking for "standards of care" (See, No. 92 below), has held since the early 1990s that:

the principle of early defibrillation states that all BLS (Basic Life Support) personnel must be trained to operate, equipped with, and permitted to operate a defibrillator if in their professional activities they are expected to respond to people in cardiac arrest. This concept has now received wide acceptance. BLS personnel include all first responding emergency personnel, whether in-hospital or out-of-hospital (e.g., EMTs, non-EMTs, first responders, fire fighters, volunteer emergency personnel, physicians, nurses, paramedics). Early defibrillation has become the standard of care for patients with either pre-hospital or in-hospital cardiac arrest.

(See, Link Report, Pltf. Ex. N, at 7; Murphy dep., Pltf. Ex. L, at 69-72). More generally, the organizations whose standards the defendants invoke - IHRSA and ACSM - recognized the need for effective and "timely" response to foreseeable medical emergencies which could only mean an AED in 1999, in cases of cardiac arrest. (Pltf. Ex. T at 28-29; SF ¶¶ 29, 41). As for "now", in March of 2002, the American Heart Association and the American College of Sports Medicine issued a joint statement with specific recommendations that:

AED placement is strongly encouraged in those health/fitness facilities with a large number of members...; those that offer special programs to clinical populations (i.e., programs for the elderly or those with medical conditions)...; and those health/fitness facilities in which the time from the recognition of cardiac arrest until the first shock is delivered by the EMS is anticipated to be

greater than five minutes...Therefore, the establishment of a PAD (Public Access Defibrillation) at all health/fitness facilities is encouraged.

(Def. Ex. FF, at 1147, 1149).

92. Wellbridge looks to the health club industry trade group the International Health, Racquet & Sportsclub Association ("IHRSA"), the American College of Sports Medicine ("ACSM"), and the American Heart Association ("AHA") for standards of care that apply to health clubs. (Ex. B, Curtis dep. 63:3-12, 63:23 - 64:13; 98:5-99:12.)

Response: Plaintiffs admit that the three groups above are among those to whom Wellbridge looked for "standards of care" that apply to health clubs. See, Response to Statement No. 91 above.

93. IHRSA is a not-for-profit trade association representing and serving for-profit health, racquet and sports clubs. (Ex. L, McCarthy dep. at 177:14-17.) IHRSA is the largest and one of the leading trade groups for the health club industry. (*Id.* at 178:9-16.)

Response: Plaintiffs admit this statement.

94. To be a member of IHRSA, a health club must comply with certain eligibility standards. (Ex. L, McCarthy dep. at 187:22 - 188:17; Ex. CC, IHRSA Membership Eligibility Standards.) Failure to comply with these standards can result in termination from membership in IHRSA. (Ex. L, McCarthy dep. at 188:18-21.)

Response: Plaintiffs admit this statement. Further answering, Plaintiffs also state that IHRSA members subscribed to a Code of Conduct, which included a pledge that they will "systematically upgrade our professional knowledge and keep abreast of new developments in the field. (See, 1998 IHRSA Standards Facilitation Guide, Pltf. Ex. Y, at "Code of Conduct").

95. Wellbridge is a member of IHRSA and was in 1999. (Ex. B, Curtis dep. at 98:9-11; Ex. I, Idell dep. at 105:14-17.) Wellbridge met or exceeded IHRSA's standards both today as well as in April 1999, and IHRSA considers Wellbridge to be a quality leader in the health club industry. (Ex. B, Curtis dep. at 99:9-12; Ex. L, McCarthy dep. at 188:22 - 189:21; Ex. Q, Turgiss dep. at 101:2-9.)

Response: Plaintiffs admit that Wellbridge is a member of IHRSA, but deny that they met or exceeded IHRSA standards. Plaintiffs specifically deny that Wellbridge employees responded in a timely fashion to a reasonably foreseeable medical emergency affecting the health and safety of a member, as set forth in IHRSA Standard No. 6 or that they kept abreast of new industry developments (Code of Conduct, see Response to Statement No. 95 above). Plaintiffs further deny that defendants met published standards, in accordance with IHRSA Standards. (Pltf. Ex. Y at 5; see, Response to Statement No. 91 above). Plaintiff admits that McCarthy testified that they were a quality leader in the health club industry and Wellbridge has always promoted itself as an industry leader. See, Response to Statement No. 133, below.

96. Wellbridge looks to IHRSA for standards in certain areas of health club operations. (Ex. B, Curtis dep. at 98:5-17.)

Response: Plaintiffs admit that Mr. Curtis testified to this, but deny it as incomplete. See, Response to Statement no. 92 above.

97. In April 1999, IHRSA had no standard requiring health clubs to have AEDs available on site. (Ex. A, Abbott dep. at 214:9-14.)

Response: Plaintiffs object to the phrase “standard” as being confusingly similar to the legal notion of a “standard of care” under familiar negligence principles. Subject to this objection, Plaintiffs deny this statement. See, Responses to Statement Nos. 91 94 and 95 and SF¶ 32.

98. In December 1999, IHRSA issued its first position paper (the "Position Paper") introducing the concept of having AEDs along with individuals trained to use them in its member health clubs. (Ex. L, McCarthy dep. 73:15 - 74:10, 185:4-16; Ex. DD, 12/10/99 IHRSA Briefing Paper re: Defibrillators in Health Clubs.)

Response: Plaintiffs admit this statement.

99. IHRSA has updated the Position Paper twice, most recently in March 2002. (Ex. L, McCarthy dep. at 102:6-16; Ex. EE, 3/6/02 IHRSA Briefing Paper re: Defibrillators in Health Clubs.) The March 2002 revision encourages, but does not require, health club operators to

consider installing AEDs in their facilities. (Ex. EE, 3/6/02 IHRSA Briefing Paper re: Defibrillators in Health Clubs.)

Response: Plaintiffs admit this statement.

100. IHRSA's official position, which has remained constant since its December 1999 Position Paper and is supported by IHRSA's Executive Director, is that fitness centers are not legally required to have AEDs on site. (Ex. L, McCarthy dep. at 48:4-20, 82:10 - 83:5, 185:4-16; Ex. Q, Turgiss dep. at 121:17 - 122:10; Ex. DD, 12/10/99 IHRSA Briefing Paper re: Defibrillators in Health Clubs; Ex. EE, 3/6/02 IHRSA Briefing Paper re: Defibrillators in Health Clubs.)

Response: Plaintiffs object to this statement on the grounds that IHRSA's belief about the legality of having or not having AEDs is not a fact relevant to any issue in the case, or any issue raised by the Defendants' Motion for Summary Judgment. What IHRSA's representative said at his deposition is that it was IHRSA's belief that health clubs would not be liable for failing to have AEDs. (McCarthy dep., Pltf. Ex. H at 83). This sort of testimony is also irrelevant. Subject to this objection, Plaintiffs deny that IHRSA provides a reasonable standard of care. (SF ¶¶ 29-30, 32).

101. In a survey conducted by IHRSA in October 1999, only 16 percent (45 members) of the members who received and responded to the survey (273 members) indicated that they had already implemented an AED program in their facilities. (Ex. L, McCarthy dep. at 42:12-43:19, 45:5-46:3.)

Response: Plaintiffs admit that 16% of the members who responded to the survey indicated that they had already implemented an AED program in their facilities. Another 25% percent indicated that they intended to do so in the near future. (See, Pltf. Ex. S, at 7). Plaintiffs object to the characterization of these numbers as "only" to the extent it suggests that this was a negligible or insignificant number of clubs.

102. Had IHRSA's October 1999 survey been sent to its entire membership of approximately 2500 at that time, the overall percentage of

members with AED programs in place would have been much lower. (Ex. L, McCarthy dep. at 45:5-15.)

Response: Plaintiffs deny this statement and further state that what the entire membership would have done had they received the survey is entirely speculative.

103. IHRSA considered the small group of its members who implemented AED programs to be "early adapters," or industry members who adapt to new technology faster than others. (Ex. L, McCarthy dep. at 124:16 - 125:8.) IHRSA considers Wellbridge to be an early adapter. (*Id.* at 124:22.)

Response: Plaintiffs admit that IHRSA's McCarthy testified to this, much in the same fashion that many ship owners considered those lines which deployed radios to learn about weather conditions to be "early adapters". (See, *T.J. Hooper*, 60 F. 2d 737 (2nd Circuit 1932); *Stone v. Frontier Airlines*, 256 F. Supp. 2d 28, 33 (D. Mass. 2003)).

104. The ACSM and the AHA also are important authorities on the subject of cardiac arrest in the health club setting. (Ex. L, McCarthy dep. at 53:19 - 54:5.)

Response: Plaintiffs admit that the American Heart Association is an important authority on the subject of cardiac arrest in the health club setting, but deny that the American College of Sports Medicine is. (Abbott Report, Pltf. Ex. M, at 8-9).

105. The ACSM publishes a book of standards and guidelines that relate to the operation of health and fitness facilities called the Health/Fitness Facilities Standards and Guidelines, which is considered an authority on the topic. (Ex. A, Abbott dep. at 57:20 - 59:10.) The first edition was published in 1992, and the second in 1997. (*Id.*)

Response: Plaintiffs admit this statement.

106. In April 1999, the ACSM had no standard or guideline requiring health clubs to have AEDs available on site. (Ex. A, Abbott dep. at 213:16-19; 221:19 - 223:3.)

Response: Plaintiffs deny this statement. (See, Response to Statement No. 97). The ACSM guidelines required clubs to be prepared to deal with reasonably foreseeable medical

emergencies, such as cardiac arrest, in a timely manner, which also bespeaks an effective manner. ACSM guidelines, deferring to the AHA, however, defined that “timeliness” of a response to a cardiac emergency which had to include defibrillation, as being within four minutes or less. (See, Pltf. Ex. T at 28-29).

107. In April 1999, the AHA had no standard requiring health clubs to have AEDs available on site. (Ex. A, Abbott dep. at 221:5-12.)

Response: Plaintiffs admit that the American Heart Association did not specifically enunciate a standard specifically addressed only to health clubs. Nor did it have a standard specifically addressed to airplanes, casinos, or specific large buildings. Instead, it had made widely-publicized recommendations, as discussed above, recommending the use of AEDs by health club personnel and requiring that they be used by all persons who were expected to use CPR in the course of their occupations, and frequently mentioned health club members. (See, Murphy dep., Pltf. Ex. L, at 69-72; Pltf. Ex. P at 9-11; Response to Statement No. 91; SF ¶¶ 16-18, 20, 23, 38).

108. In March 2002, two years after Wellbridge rolled its own AED program, ACSM and AHA released a joint scientific statement on the use of defibrillators in health and fitness facilities (“2002 Joint Statement”), recommending that AEDs be placed in high-membership health and fitness facilities. (Ex. L, McCarthy dep. at 55:17 - 56:7; Ex. FF, Gary J. Balady, M.D. et al., “Automated External Defibrillators in Health/Fitness Facilities,” 105 *Circulation* 1147 (Mar. 5, 2002) [hereinafter 2002 Balady].)

Response: Plaintiffs admit that the ACSM and AHA released a joint statement, but deny that the recommendation was only regarding high-membership health and fitness facilities. (See, Response to Statement No. 91).

109. The AHA and ACSM expressly cautioned in the 2002 Joint Statement that their recommendations “are not mandatory or all encompassing.” (Ex. FF, 2002 Balady, supra at 1147.) Similarly, MRSA (sic) did not interpret the AHA/ACSM 2002 Joint Statement as establishing a requirement to acquire and maintain AEDs, legal or otherwise. (Ex. L, McCarthy dep. at 55:17 - 56:3.)

Response: Plaintiffs admit that the quotation is accurate and that Mr. McCarthy testified as quoted. Plaintiffs deny the implication that any health club standards or guidelines were “mandatory” – they are only evidence on the issue of negligence and health clubs are an unregulated industry. (Curtis Dep., Pltf. Ex. I at 63).

110. The 2002 Joint Statement served as a supplement to a 1998 AHA/ACSM joint scientific statement containing recommendations for cardiovascular screening, staffing, and emergency policies at health and fitness facilities ("1998 Joint Statement"). (Ex. FF, 2002 Balady, supra at 1147.)

Response: Plaintiffs admit this statement.

111. The 1998 Joint Statement did not address AEDs in health and fitness facilities or in any other context. (Ex. A, Abbott dep. at 214:15-215:12; Balady et al., "Recommendations for Cardiovascular Screening, Staffing, and Emergency Policies at Health/Fitness Facilities," 97 Circulation 2283 (June 9, 1998) [hereinafter 1998 Balady].) In fact, the only specific equipment mentioned as mandatory to be included and available for use in a health club's emergency plan was a telephone, with a stethoscope and sphygmomanometer as recommended equipment. (Ex. GG, 1998 Balady, supra at 2291.)

Response: Plaintiffs deny this statement. The recommendation specifically called for defibrillators to be used in Level 5 facilities, containing persons who are undergoing cardiac rehabilitation programs. (See, IHRSA briefing paper, Pltf. Ex. S at 1). There were Wellbridge facilities with cardiac rehab programs which had AEDs on site. (See, Turgiss dep., Pltf. Ex. B, at 46-51) Wellbridge also had members undergoing cardiac rehab who exercised regularly at the Wellbridge facility at 695 Atlantic Ave. in Boston. (See, Patjane dep., Pltf. Ex. F, at 81-82; Idell dep., Pltf. Ex. KK at 56-57; Marini dep., Pltf. Ex. AAA, at 52-53).

112. The overall risk of death from exercise generally is very low. (Ex. GG, 1998 Balady, supra at 2284.) Approximately 6 in 100,000 middle-aged men die during exertion. (Ex. GG, 1998 Balady, supra at 2284.)

Response: Plaintiffs deny this statement. Even assuming that the figure of six deaths per 100,000 is accurate, this is not a low risk. In fact, Wellbridge executives themselves have testified that the risk of cardiac arrest during exercise increases 10-15%. (Curtis dep., Pltf. Ex. I, at 88-89; see, Abbott Report, Pltf. Ex. M, at 3-4; SF ¶ 37). Furthermore, there is no requirement in the health club industry that records be kept of deaths or cardiac emergencies. (Curtis dep.; Ex. I at 55-56, McCarthy, Ex. H at 35-36).

113. The AHA started its first certification course in operating AEDs in September 1998. (Ex. M, Murphy dep. at 22:21 - 23:1, 72:14-22.)

Response: The Plaintiffs admit that the first official certification course started by the American Heart Association began in September 1998. Prior to that time, however, in the city of Boston and elsewhere, other organizations and businesses were available and training individuals in the use of AEDs. (See, Murphy dep., Pltf. Ex. L, at 8-12, 64-66; SF ¶¶ 45-47; Pltf. Exs. Z, AA and BB.

114. The American Red Cross did not start its certification course in operating AEDs until 2000. (Ex. M, Murphy dep. at 25:2-4.)

Response: The Plaintiffs admit that the first official certification course started by the American Red Cross began in 2000. Prior to that time, however, in the city of Boston and elsewhere, other organizations and businesses were available and training individuals in the use of AEDs. (See, Response to Statement No. 113).

115. In April 1999, Wellbridge was not aware of any statement or position by the AHA, ACSM, or IHRSA that required health clubs to install AEDs and train their staff to use AEDs. (Ex. B. Curtis dep. at 22:4-14,49:2-7, 63:23-64:13.)

Response: The Plaintiffs deny this statement. Wellbridge employees read materials from the American Heart Association, and, presumably, understood them, as discussed above. (See, Response to Statement Nos. 97 and 106).

116. In April 1999, it was not the health club industry norm to have AEDs on site. (Ex. A, Abbott dep. at 216:9-16.)

Response: The Plaintiffs object to the phrase “industry norm” as being vague and subject to a variety of interpretations. If the Defendants mean that the majority of health clubs did not have AEDs on site in April 1999, Plaintiffs admit this Statement. Otherwise, and subject to the objection, the Plaintiffs deny this statement. Further responding, the Plaintiffs state that surveys taken by a large health club industry trade group showed that significant percentages of health clubs either had or were considering installing AEDs at their health clubs in 1999. (IHRSA Briefing Paper, Pltf. Ex. S, at 7).

117. In April 1999, no health club company larger than Wellbridge had an AED program in its facilities. (Ex. L, McCarthy dep. at 192:8-12.)

Response: The Plaintiffs admit this statement.

118. No health clubs in Boston had AEDs on site before August 1999. (Ex. M, Murphy dep. at 33:5-8.)

Response: The Plaintiffs deny this statement. A number of hotels, including the Seaport Hotel, with affiliated health clubs, had AEDs before August, 1999. Furthermore, Captain Murphy testified that he was not aware of any health clubs which had AEDs on site before August, 1999. He further testified, however, that Massachusetts law at that time did not require owners of AEDs to notify Boston EMS upon purchase and deployment of such devices. (Murphy dep., Pltf. Ex. L, at 74-75; SF¶¶ 46-47).

119. When Wellbridge rolled out its AED program in early 2000, it was the first or second health club company of its size in the United States to initiate such a program. (Ex. L, McCarthy dep. at 191:20 - 192:7.)

Response: Plaintiffs object to this statement on the grounds of relevance. Without waiving this objection, the Plaintiffs admit this statement.

120. Of the five largest health club operators in the industry, only two have currently adopted AED programs: Wellbridge and the Tennis Corporation of American (n/k/a "TCA"). (Ex. L, McCarthy dep. at 157:16-23.) Three significantly larger operators - 24-Hour Fitness, Bally's and Town Sports International ("TSI") - have not. (*Id.* at 157:16-23; Ex. A, Abbott dep. at 117:18- 118:15.)

Response: Plaintiffs object to this statement on the grounds of relevance. Without waiving this objection, the Plaintiffs admit this statement, at least as of the dates of the depositions cited to.

121. Boston ambulances first started carrying AEDs in 1993. (Ex. M, Murphy dep. at 8:1-12.)

Response: The Plaintiffs admit this statement.

122. Certain vehicles in the Boston fire department started carrying AEDs in 1996. (Ex. M, Murphy dep. at 8:15 - 9:24.)

Response: The Plaintiffs admit this statement.

123. Boston police cruisers do not carry AEDs. (Ex. M, Murphy dep. at 38:6-7.)

Response: The Plaintiffs admit this statement, but only as of the date of the Murphy deposition which was taken April 1, 2003.

124. Other than fire trucks and ambulances, the only other public vehicles that carry AEDs are some Boston Park Rangers, and these AEDs were not installed until 2000. (Ex. M, Murphy dep. at 38:10-16.)

Response: The Plaintiffs admit this statement. Further responding, Plaintiffs state that the vehicle owned and operated by the mayor of Boston has an AED. (Murphy dep., Pltf. Ex. L, at 43).

125. The AED programs put initially in place by the Boston Police Department, Fire Department, and EMS were voluntary. (Ex. M, Murphy dep. at 46:13-47:1.)

Response: The Plaintiffs admit that the initial AED programs put in place by the Boston Police Department, Fire Department, and EMS were not required by any applicable regulation, law or statute.

126. Boston regulations only started requiring ambulances, both publicly and privately owned, to carry AEDs as standard equipment beginning in April 2002. (Ex. M, Murphy dep. at 47:2-19.)

Response: The Plaintiffs admit this statement.

127. No City of Boston regulations or other requirements currently oblige any public building to have AEDs available. (Ex. M, Murphy dep. at 46:8-12.)

Response: The Plaintiffs admit this statement.

128. Boston City Hall currently has two AEDs in the building. (Ex. M, Murphy dep. at 43:3-6.) It obtained its first AED in 1997, but it had a nurse on staff at the time, and its second in 2000. (*Id.* at 43:7-20.)

Response: The Plaintiffs admit this statement.

129. Boston Police Stations first had AEDs available on site and Boston police officers first became trained in the use of AEDs in 2000. (Ex. M, Murphy dep. at 37:18- 38:5, 38:23-39:1.)

Response: The Plaintiffs admit this statement.

130. Not all Boston public schools have AEDs available. (Ex. M, Murphy dep. at 41:20-42:3.)

Response: The Plaintiffs admit this statement.

131. The first public restaurant to install an AED was the Chart House, and it did so in 2000. (Ex. M, Murphy 45:14 - 46:7.)

Response: The Plaintiffs deny this statement. Captain Murphy so testified, but, again, his knowledge was limited to those restaurants that had notified Boston EMS of placement of an AED. Furthermore, since 1996, several large public buildings which contained restaurants had AEDs deployed, with their security guards trained by Boston EMS personnel. (See, Murphy dep., Pltf. Ex. L, at 8-12, 64-66; SF, ¶¶ 45-47; Response to No. 113).

132. A few Boston hotels have AEDs available now, the first obtaining its AED perhaps as early as 1999 with others following suit in 2000-2002. (Ex. M, Murphy dep. at 64:22 - 65:23.)

Response: The Plaintiffs deny that “few” Boston hotels have AEDs available now. Plaintiffs further deny that the first AEDs were obtained by Boston hotels as late as 1999. Further responding, Plaintiffs state that the Seaport Hotel, with affiliated health club had an AED on the premises as early as 1997-98. (See, Response to Statement No. 131 and SF¶¶ 45-47).

G. WELLBRIDGE'S ADVERTISING AND PROMOTIONAL MATERIALS

133. Wellbridge's advertising that was in effect around the time that Mr. Fruh joined the Atlantic Center in the mid-1990s says nothing about AEDs or other any specific equipment that would be available. (Ex. HH, Promotional Materials; Ex. Q, Turgiss dep. at 89:13- 90:3.)

Response: The Plaintiffs deny this statement. The materials published by Wellbridge, to the public and to members, including its membership handbook, proclaimed Wellbridge's leadership in, and superiority to, others in the health club industry and stated that (1) Wellbridge was equipped and ready to timely respond to cardiac events; (2) it met or exceeded published standards; and (3) systematically kept itself informed of new industry developments. (See, Idell deposition, Pltf. Ex. KK, at 47-51, 108-110; Idell recorded statement, Pltf. Ex. CCC at 23-25; SF¶¶ 115-116). These statements were false and misleading even though they did not specifically mention AEDs.

134. AEDs were mentioned neither in Wellbridge's other promotional materials distributed around 1995 nor in any documents distributed to members such as the Member Handbook or the membership contract. (Ex. HH, Promotional Materials; Ex. V, Membership Contract.)

Response: The Plaintiffs incorporate herein their response to Statement No. 133 as and for their response to Statement No. 134.

135. Mr. Fruh does not remember receiving any promotional materials from Wellbridge in 1995 when he joined the Atlantic Center. (Ex. S, H. Fruh Int. Resp. No. 31.)

Response: The Plaintiffs admit this statement. As stated above, Mr. Fruh’s memory is severely impaired by his injuries (See, Response to Statement Nos. 8 and 9). Further responding, the Plaintiffs say that Wellbridge employees and executives admitted that membership and promotional materials, such as those relied upon by the Plaintiffs for their c. 93A and warranty claims, were distributed to members after 1995.

**PLAINTIFFS’ FURTHER STATEMENT OF FACTS IN OPPOSITION TO
DEFENDANT’S MOTION FOR SUMMARY JUDGMENT**

Introduction

Whether Wellbridge acted reasonably in the circumstances, in failing to have an AED on its premises, is the central fact question presented by the Defendants’ Motion for Summary Judgment. The Plaintiffs’ case is that the Defendants acted unreasonably. The Defendants contend that they acted reasonably, pointing to circumstances such as certain industry guidelines.

The Plaintiffs’ burden in responding to a motion for summary judgment is to identify disputed facts. The Defendants’ recitation of the facts, not surprisingly, omits almost all of the relevant circumstances which tend to show that its conduct was unreasonable. Plaintiffs set out these circumstances in the paragraphs that follow, to satisfy their burden of identifying disputed facts. Most of the facts, individually, are likely not to be disputed, but their cumulative effect in demonstrating unreasonableness is (presumably) disputed.

A. Wellbridge Background

1. Wellbridge was founded in 1989. (Answer, Pltf. Ex. A, ¶ 9). At the time Herbert Fruh joined the Wellbridge facility as a member, in October 1995, Wellbridge was a division of the NutraSweet Company (“NutraSweet”), based in St. Louis. (*id.*). Monsanto Company

(“Monsanto”) owned NutraSweet. (*id.* at ¶¶ 7 and 8). There were four Wellbridge health club facilities in the Boston area and two in St. Louis in 1995. (Turgiss dep., Pltf. Ex. B, at 47, 51).

2. When Wellbridge was founded, its mission read:

The face of health care in this country is changing by the minute. Every seven and a half seconds, another citizen turns 50. To meet the special health and wellness needs of this growing market, Monsanto Corporation has created Wellbridge—a rapidly expanding network of health and fitness centers designed to work in active partnership with hospitals. (Wellbridge Marketing Materials, Pltf. Ex. C, Bates 01277).

3. Describing the purpose of Wellbridge, Monsanto’s chairman and CEO of its Life Sciences Company, Robert Shapiro, stated as follows:

With Wellbridge, we have created a new kind of company dedicated to meeting the growing need for better nutrition and health of maturing adults—not just in this country, but worldwide. It is fast-moving, technology-driven, intensely competitive, and global in scope. We’re committed to meeting the challenges of an ever-changing market with continuous innovation and unprecedented speed. The culture and systems required for sustained success are in place. The future has just begun. (Wellbridge Marketing Materials, Pltf. Ex. C, Bates 01285).

B. Dramatis Personae

4. Herbert Fruh signed his initial membership agreement with Wellbridge Health and Fitness Center, located at Atlantic Avenue in Boston, on October 30, 1995. (Fruh Membership Agreement, Pltf. Ex. D, Bates 00001-2). The annual fee for membership paid by Herbert Fruh was \$814. (*id.*) Herbert Fruh was age 49 when he joined Wellbridge in 1995. (ParQ++, Pltf. Ex. E, Bates 00004).

5. William Patjane was Wellbridge’s regional fitness manager, in Massachusetts, with authority over the four Wellbridge clubs located in Boston, including the one on Atlantic Avenue of which Herbert Fruh was a member. (Patjane dep., Pltf. Ex. F, at 9). The fitness manager acted as safety officer, among other duties. (Idell dep. Pltf. Ex. KK at 25).

6. Wellbridge has identified Jennifer Turgiss as a former Wellbridge National Fitness Manager, “responsible for the investigation, development, and preparation of the Wellbridge programs”. (Defendants’ Answers to Plaintiffs’ First Set of Interrogatories, Pltf. Ex. G, Answer to Interrogatory No. 2).

7. As of April, 1999, Jennifer Turgiss was the Director, Whole Person Health, prior to the combined Club Sports International/Wellbridge merger; Cheryl Rankin was the general manager of the Atlantic Avenue club in which Herbert Fruh was a member; Jennifer Idell was a fitness manager at the Atlantic Avenue Wellbridge facility. (Turgiss dep., Pltf. Ex. B, at 45, 46, 47).

8. Wellbridge was a member of the International Health, Racquet and Sports Club Association (“IHRSA”), the most prominent trade organization for the health and fitness club industry. (McCarthy dep., Ex. H, at 50). John McCarthy founded IHRSA in 1981 and has been its chief executive since that time. (McCarthy dep., Pltf. Ex. H, at 20).

9. Before March, 1999, Club Sports International (“CSI”) was a health club chain with clubs around the country, but mainly in Minnesota, New Mexico and Colorado. (Defendants’ Answers to Plaintiffs’ Second Set of Interrogatories, Pltf. Ex. G, Answer to Interrogatory No. 24 and Exhibit A thereto, see ¶12 below). CSI’s chief operating officer was Art Curtis. (Curtis dep., Pltf. Ex. I at 5).

10. By agreement dated December 31, 1998, CSI acquired the Wellbridge assets (the health club business and the trademarks) from Monsanto. As part of the agreement, CSI agreed to assume all of Monsanto’s liabilities arising from the Wellbridge clubs, and to indemnify Monsanto as to these liabilities. (Pltf. Ex. J).

11. At the time CSI acquired the Wellbridge clubs, CSI was the third largest health club chain in the United States. (Curtis dep., Pltf. Ex. I at 29).

12. Art Curtis became the Chief Operating Officer of the combined companies. (Curtis dep., Pltf. Ex. I at 5). The CSI entity which had acquired the Wellbridge facilities ultimately adopted the Wellbridge name for all of its clubs. (*id.* at 97).

13. As of March, 2000, the merged Club Sports/Wellbridge companies had 42 health clubs around the country, with a significant presence in Massachusetts, Minnesota, New Mexico, and Colorado. (Ex. K, Bates 00313-315).

14. George Murphy is the Captain for the Boston Emergency Medical Services (“EMS”), which includes oversight of the area AED program in which free AED training has been offered for employees of “corporate partners” since 1996. (Murphy dep., Pltf. Ex. L at 10-11, 64-66). Murphy is currently the Basic Life Support national faculty person for Massachusetts in the American Heart Association. (*id.* at 78).

15. For sudden cardiac arrest, the American Heart Association (“AHA”) is considered to be the “veritable authority.” (Abbott Report, Pltf. Ex. M at pp. 8-9). Arthur Curtis relied for most of his information about sudden cardiac arrest and public access defibrillation on the AHA. (Curtis dep., Pltf. Ex. I, at 48, 68). IHSA recognized the American Heart Association as an “important authority” on cardiac arrest issues. (McCarthy Dep., Pltf. Ex. H, at 53-54). The three statutory provisions in Massachusetts law which address CPR, AEDs or use of defibrillators, all explicitly designate the American Heart Association as providing the training standard to be met or exceeded. M.G.L. c. 111, § 201 (first aid training for police, fire and lifeguard; has sanctioned defibrillator training since 1992); M.G.L. c. 112, § 12V (exempting from civil liability trained lay responders who use a defibrillator in an emergency; enacted in May, 1998); M.G.L. c. §12V1/2 (exempting from civil liability AED providers and users if stated requirements met).

C. Cardiac Arrest and Automated External Defibrillators (AEDs)

16. As early as 1986 both the American Heart Association and the American Medical Association recognized that health club personnel could be trained as first responders capable of using AEDs. (1986 Joint AHA/JAMA Statement, Pltf. Ex. U). In the “Standards and Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care” jointly published by the American Heart Association and the Journal of the American Medical Association in 1986, recognition is given that:

Defibrillation using automatic, automatic advisory, or semiautomatic defibrillators has been shown to be effective... They could be used by family members, health club personnel, first responders or designated individuals in public and commercial locations. ...Health club personnel or other such first responders must have a medical director who is responsible for the use of the device. (*id.* at 2976).

17. In October 1992 the American Heart Association and the Journal of the American Medical Association issued joint Guidelines for CPR and Emergency Cardiac Care (ECC). In that statement, both organizations asserted that:

Community and in-hospital ACLS [Advanced Cardiac Life Support] must be supported by a well-established BLS program that provides immediate emergency cardiopulmonary resuscitation (CPR) capability. The 1992 National Conference strongly endorsed the principle of early defibrillation, which states that all personnel whose jobs require that they perform basic CPR be trained to operate and to use defibrillators, particularly automated external defibrillators (AEDs). (Pltf. Ex. O, at 2199).

18. By 1998, health clubs were seen as obvious locations for AEDs:

Because of the success of the AED in recognizing and treating ventricular fibrillation the American Heart Association has called for increasing access to these devices. Locations where these devices were most likely to be utilized in a cost effective manner were International airports, county jails, shopping malls, public sports venues, larger industrial sites, golf courses, shelters, train terminals, health clubs and senior centers. (Link Report, Pltf. Ex. N, at 7).

* * *

The 1994 Basic Life Support handbook for CPR states: “The principle of early defibrillation states that all BLS personnel must be trained to operate, equipped

with, and permitted to operate a defibrillator if in their professional activities they are expected to respond to people in cardiac arrest. This concept has now achieved wide acceptance. BLS personnel include all first-responding emergency personnel, whether in-hospital or out-of-hospital (e.g. EMTs, non-EMT first-responders, firefighters, volunteer emergency personnel, physicians, nurses and paramedics). Early defibrillation has become the standard of care for patients with either prehospital or in-hospital cardiac arrest.” (1994 Basic Life Support for Health Care Providers, Pltf. Ex. P, at 9-1; Link report, Pltf. Ex. N at 7).

19. Since at least as early as 1994, the American Heart Association has recognized that the terms Basic Life Support (BLS) and CPR are interchangeable. (1994 Basic Life Support for Health Care Providers, Pltf. Ex. P, at 1-2). Captain George Murphy of Boston EMS defines basic life support as CPR, AED, and foreign body airway obstruction (choking). “In basic life support for the Heart Association, there’s no drugs.” (Murphy dep., Pltf. Ex. L, at 69-70).

20. Since at least as early as 1994, the American Heart Association has recognized that:

Defibrillation was once a skill reserved for emergency care providers trained in all aspects of ACLS (Advanced Cardiac Life Support), but is now often performed by lesser-trained, BLS personnel. ...AEDs were originally conceived as devices that would be used by emergency personnel and by family members and associates of people at high risk for sudden cardiac death. Now the range of personnel who may be trained in the use of these devices is much broader... (1994 Basic Life Support for Health Care Providers, Pltf. Ex. P, at 9-1).

Because of the intrinsic simplicity of AEDs a markedly expanded range of individuals can now be trained to provide early defibrillation. Individuals who may want training in the use of AEDs include general hospital floor nurses, general office nurses, oral surgeons...security and law enforcement personnel, ship and airplane crews, *supervisory personnel at senior citizen centers and exercise facilities*, and the entire range of professional prehospital providers, including first-responders, firefighters and EMTs. (*id.* at 9-11). (emphasis supplied)

21. In its pamphlet entitled “When Every Second Counts: Cardiac Arrest and the Need for Early Defibrillation,” copyrighted in 1996, the American Heart Association describes Sudden Cardiac Arrest:

Sudden Cardiac Arrest: A Major Cause of Death

Sudden cardiac arrest, also known as sudden cardiac death, is a major cause of death in the United States. It claims an estimated 250,000 lives each year.

Abnormal heart rhythms called arrhythmias cause most sudden cardiac arrests. Ventricular fibrillation (VF) is the most common arrhythmia that causes cardiac arrest. It's a condition in which the heart's electrical impulses suddenly become chaotic, often without warning. This causes the heart to stop abruptly. Victims collapse and quickly lose consciousness. Death usually follows unless responders restore a normal heart rhythm within 5-7 minutes.

* * *

The basic cause of sudden cardiac arrest is not well understood. Many victims have no history of heart disease, or the underlying heart disease has not affected their lives. It may even happen to people in the prime of their lives – like Hank Gathers, the Loyola Marymount University basketball star who collapsed and died during a game several years ago.

Unlike other life-threatening conditions such as cancer or AIDS, there is a definitive therapy for sudden cardiac arrest: defibrillation (de-fib"rah-LA'shun). As dramatized in many television shows, paddles are placed on the unconscious person's chest and the doctor yells, "clear!" Then, an electric shock is delivered to the heart. This shock stops the abnormal rhythm and allows a coordinated rhythm and normal pumping action to resume. ("When Every Second Counts: Cardiac Arrest and the Need for Early Defibrillation," Pltf. Ex. Q, at 2).

22. Since 1992, the American Heart Association has publicized the concept of the "Chain of Survival", which refers to the four crucial links in the emergency treatment of sudden cardiac arrest. (*id.* at 3). These links are: (1) "Early Access to Care," dialing 911 in most communities to activate the Emergency Medical System; (2) "Early Cardiopulmonary Resuscitation," which can, if performed properly, provide an additional few minutes to the time available for defibrillation to be successful; (3) "Early Defibrillation," the critical treatment for victims in ventricular fibrillation; and (4) "Early Advanced Care," including airway control or medications prior to arriving at the hospital.

(*id.*). Each minute of delay in returning the heart to its normal pattern of beating decreases the chance of survival by 10 percent. (*id.*).

23. In the final pages of the 1996 pamphlet, the AHA describes AEDs as “new technology for widespread deployment:”

AEDs were developed in the 1980s after advances in solid-state circuitry and microcomputers allowed defibrillators to recognize VF. These AEDs were the first to identify VF, advise the operator that a shock was indicated, and deliver the shock. Safety records for the patient and operator are excellent.

However, AEDs have not been deployed widely to many groups of emergency responders. The barriers include cost, size, maintenance needs and integration into existing EMS systems.

Recent breakthroughs in technology will mean AEDs are:

- easier to use and maintain;
- smaller, lightweight and rugged; and
- lower in cost.

The new generation of AEDs will make it more practical to train and equip a wider range of responders, including fire department personnel, police officers, lifeguards, flight attendants, security guards, and others responsible for public safety.

“Anyone who can learn CPR can learn to use AEDs,” says Dr. Richard Cummins, a pioneer in the treatment of out-of-hospital sudden cardiac arrest.

Public Access Defibrillation is the ultimate goal as a result of this new technology. This will mean the general public will have access to defibrillators in highly populated areas such as office buildings, stadiums and airplanes, where survival rates from sudden cardiac arrest are less than 1 percent.

A next step will be to place AEDs in the homes of high-risk patients and to train family members to use them. Other citizens will also be trained to use AEDs to extend bystander-initiated defibrillation in rural and congested urban areas. These settings often have low survival rates because defibrillators do not reach victims in time. (*id.* at 6-7).

24. By 1997, the American Heart Association was incorporating information about public access defibrillation (PAD) and automated external defibrillators in its “Heart Saver Guide, A

Student Handbook for Basic Life Support and Cardiopulmonary Resuscitation and First Aid for Choking.” In an appendix, the AHA stated that

Early defibrillation would reach even more people if lay rescuers could use AEDs in the home and workplace...AEDs should be available for lay rescuers to use before EMS personnel arrive. The strategy could help in cities where traffic congestion often delays the response of EMS personnel...

The airline industry has begun to carry AEDs on regular flights. During the next few years, more industries concerned about safety will probably follow the example of the airlines by starting early defibrillator programs.

To save more lives, early defibrillation must become the standard of care for all...It is now possible for minimally trained lay rescuers to operate an AED and the price of AEDs has become reasonable. (Basic Heart Saver Guide, Pltf. Ex. R, at 77-78).

25. CPR alone cannot restart a heart in ventricular fibrillation, the most common heart arrhythmia of cardiac arrest. (Murphy dep., Pltf. Ex. L, at 77; Curtis dep., Pltf. Ex. I, at 56). A responder cannot determine if a person is in ventricular fibrillation without the aid of a machine. Statistically, the American Heart Association estimates that 70 percent of cardiac arrest begins with ventricular fibrillation. (Murphy dep., Pltf. Ex. L, at 86-87).

26. Someone who is breathless, pulseless and non-responsive is essentially dead, and no resuscitative efforts worsen the condition of a person in such a condition. (IHRSA Briefing Paper, Pltf. Ex. S, at 3).

D. Cardiac Arrest Response Standards Before 1999

29. By 1996, the American College of Sports Medicine standard provided that “a facility must be able to respond in a timely manner to any reasonably foreseeable emergency event that threatens the health and safety of facility users. Towards this end, a facility must have an appropriate emergency plan which can be executed by qualified personnel in a timely manner.” (Pltf. Ex. Y, at 4). These standards have always represented “minimal performance criteria that

each facility must meet in order to satisfy its obligation to provide users with a relatively safe environment in which every physical activity or program is conducted in an appropriate manner.” (IHRSA board memo, June 11, 1996, Pltf. Ex. T, p. 25-26).

30. In the discussion of its guidelines for emergency cardiac care and citing to the AHA, the ACSM states:

what is a proper time frame when dealing with an emergency? Obviously, ‘timeliness’ is a relative term that has to be applied to each situation. Some formal guidance exists, however, regarding what constitutes ‘timeliness.’ According to the American Heart Association guidelines for dealing with cardiovascular incidents, four minutes is considered the maximal allowable time for a first response. (IHRSA board memo, Pltf. Ex. T, at 29).

31. By the late 1980s, IHRSA recommended that member health club personnel be trained in CPR as a “precautionary measure” against cardiac arrest. (McCarthy dep.; Pltf. Ex. H, at 58-59). Member health club personnel were recommended to be trained in CPR, as opposed to other emergency response techniques, because cardiac arrest was likely to be fatal, unlike other less serious medical conditions. (McCarthy dep.; Pltf. Ex. H, at 62-63).

32. Citing articles from as early as 1987, Plaintiffs’ expert Dr. Abbott states:

Recognition of AEDs and the “standard of care” within fitness facilities was addressed as far back as January 1987 in the “Exercise Standards and Malpractice Reporter”, a publication to which many fitness professionals subscribe. In an article entitled “The Use of Automated Defibrillators: Implications to the Standard of Care”, the author William G. Herbert, PhD and Fellow of the ACSM, states “Exercise personnel certified in basic cardiopulmonary resuscitation techniques by the American Heart Association (AHA) will always be present in close proximity to clients during all phases of the exercise classes and thus are most likely to immediately witness any episodes of ventricular fibrillation. In a medico-legal sense, such persons have not always been considered capable of performing emergency defibrillation. However, no matter who actually performs the procedure, it should be emphasized that defibrillation is less likely to be effective when it is not delivered within the first 4-6 minutes after an arrest.” He further goes on to state “In fact, centers which are presently operating without the means for rapid defibrillation at all times during high-risk exercise by clients are operating below the accepted national standard of care”. This article was originally directed at those centers providing

exercise programming for known high-risk and cardiac patients. However, due to the fact that facilities were knowingly selling memberships to such clients, it would seem that this same standard should apply.

Regarding AEDs and Standard of Care, the American Journal of Emergency Medicine addressed this topic (1998; 16:315-319) with an article entitled "Prepare To Be Shocked: The Evolving Standard of Care in Treating Sudden Cardiac Arrest". As stated in this article "A significant number of deaths from sudden cardiac arrest can be prevented by using Automatic External defibrillators in the out-of-hospital setting. These devices have become cost effective, reliable, and readily available and the standard of care requiring their use in the out-of-hospital setting has arrived". Although this article is directed at the EMS system, it does note an AHA position which has obvious application to fitness instructors who have a duty to provide CPR in cases of SCA. *As stated, "The AHA's position is that all personnel whose jobs require that they perform basic CPR (should) be trained to operate and permitted to use defibrillators, particularly automated external defibrillators (AEDs)"* (Emphasis supplied).

(Dr. Abbott's Report, Pltf. Ex. M, at 5-6).

33. IHRSA recognized that health clubs were required to train their employees in CPR. (McCarthy dep., Pltf. Ex. H, at 198). IHRSA recognized that health club personnel had a duty to use CPR on a member who was stricken with sudden cardiac arrest. (*id.* at 87).

34. IHRSA agreed that health clubs were under a duty to take readily available, reasonable means to assist members stricken with a cardiac emergency. (McCarthy dep., Pltf. Ex. H, at 199). However, IHRSA has been "very cautionary" and "almost conservative" in its stance with any new technology. (*id.* at 25-26).

35. According to IHRSA, club members over the age of 60 are considered "deconditioned," and a club catering to such members is more likely to be negligent if it does not have an AED, than clubs catering to younger people. (McCarthy dep., Pltf. Ex. H, at 84-87).

36. In November, 1997, the Medical Advisory Committee of the YMCA of the USA recommended that YMCAs consider having AEDs in their facilities and programs:

The Use of Automated External Defibrillators in YMCAs

A Statement of the YMCA of the USA Medical Advisory Committee:

Sudden cardiac arrest is a major cause of death in the United States. It claims an estimated 225,000 lives each year. Early use of cardiopulmonary resuscitation (CPR) and rapid defibrillation are the two major contributors to the survival of adult victims of sudden cardiac arrest. As an organization dedicated to the health and safety of its constituents, many of whom participate in activities requiring physical exertion, YMCAs have long required staff to be certified in CPR in the event of a cardiac emergency in a YMCA activity. With the development of automated external defibrillators (AEDs), YMCAs and other community organizations have access to a new tool, which can significantly increase the survival rate of adult cardiac arrest victims.

AEDs that accurately analyze cardiac rhythms and, if appropriate, deliver an electric counter shock were introduced in 1979. AEDs are widely used by trained emergency personnel and first-responders, and have proven accurate and effective. A logical extension of the AED concept is “public access defibrillation”, the widespread use of AEDs by nonmedical, minimally trained personnel.

Recent technological breakthroughs have made AEDs easier to use and maintain, smaller and more lightweight, and lower in cost. The new generation of AEDs make it more practical to train and equip a wide range of emergency first-responders in the community, including selected YMCA staff members. Safety is ensured by the built-in computers, which allow the unit to recognize ventricular fibrillation (an arrhythmia that causes cardiac arrest), advise the operator that a shock is indicated, and deliver the shock as a safe level.

The American Heart Association has published a statement endorsing the use of AEDs in public places, stating that “Automatic external defibrillation is one of the most promising methods for achieving rapid defibrillation. In public access defibrillation, the technology of defibrillation and training in its use are accessible to the community”. It should be noted that the AHA recommends the use of AEDs only with persons over the age of eight.

The Medical Advisory Committee of the YMCA of the USA endorses the American Heart Association’s position on the use of automated external defibrillators, and suggests that YMCAs may want to consider having them available in their facilities and programs. Following are guidelines regarding the use of AEDs in the YMCA:

- a. The AED equipment should be purchased from a manufacturer who has met FDA standards.
- b. YMCA staff should be trained in the procedures and use of the AED. Supplying a training program in the use of the equipment is one of the benchmarks of a reputable vendor. As a minimum, on-going staff training on a yearly basis is recommended, either from the equipment manufacturer or

from a nationally recognized organization such as the American Heart Association, the American Red Cross, or the National Safety Council. YMCAs should check their state law regarding training requirements and guidelines.

- c. In conjunctions with their Medical Advisory Committee, YMCAs should establish and follow specific procedures for using the AED.
- d. YMCAs should establish a regular maintenance and testing schedule for the AED equipment.

The American Heart Association recommends the following manufacturers who have met FDA standards for automated external defibrillators:

Philips Medical Systems/Heartstream, 800-934-7372

Laerdal Medical Corporation, 800-431-1055

Physio-Control Corporation, 800-426-8047

SurVivalink, 800-991-5465

November 1997

(Pltf. Ex. V).

37. The Joint Position Statement of the AHA/ACSM entitled “Recommendations for Cardiovascular Screening, Staff, and Emergency Policies at Health/Fitness Facilities,” published in June of 1998, reads partially as follows:

Efforts to promote physical activity will result in an increasing number of persons with and without heart disease joining the more than 20 million persons who already exercise at health/fitness facilities. Current market research indicates that 50% of health/fitness facility members are older than 35 yr, and the fastest-growing segments of users are those older than 55 yr and those aged 35-54 yr. With increased physical activity, more people with symptoms of or known cardiovascular disease will face the cardiovascular stress of physical activity and possible risk of a cardiac event. More than one fourth of all American have some form of cardiovascular disease. The prevalence of coronary heart disease for American adults aged 20 yr and older is 7.2% in the general population, 7.5% for non-Hispanic whites, 6.9% for non-Hispanic blacks, and 5.6% for Mexican Americans. The prevalence of myocardial infarction in older Americans aged 65-69 yr is 18.0% and 9.7% for men and women, respectively.

Moderately strenuous physical exertion may trigger ischemic cardiac events, particularly among persons not accustomed to regular physical activity and exercise. Siscovick et al. examined the incidence of primary cardiac arrest in men aged 25-75 yr after excluding those with a history of clinically

recognized heart disease. Although the risk was significantly increased during high-intensity exercise, the likelihood for primary cardiac arrest during such activity in a clinically health population was estimated at 0.55 events/10,000 men per year. Maron et al. studied causes of sudden death in competitive athletes. In persons younger than 35 yr, 48% of deaths were due to hypertrophic cardiomyopathy. Coronary artery anomalies, idiopathic left ventricular hypertrophy, and coronary heart disease each accounted for 10-20% of deaths. In those over 35, coronary artery disease accounted for approximately 80% of all deaths. Overall, the absolute incidence of death during exercise in the general population is low.

Cardiovascular events other than death during exercise have also been studied. Data from the Framingham heart study indicate that the baseline risk of myocardial infarction in a 50-yr-old man who is a nonsmoker and does not have diabetes is approximately 1% per year, or approximately 1 chance per million per hour. Heavy exertion [=6 METs (metabolic equivalents)] within 1 h of symptomatic onset of acute myocardial infarction has been reported in 4.4-7.1% of patients. The adjusted relative risk is significantly greater in persons who do not participate in regular physical activity, with an approximate threefold increase in risk during the morning hours. The relation of physical activity to acute myocardial infarction in the thromolytic era was examined among 3339 patients in the TIMI II trial, in which moderate or marked physical activity preceded myocardial infarction in 18.7% of patients.

(1998 AHA/ACSM Joint Statement, Pltf. Exhibit W, at 3).

38. In 2002, the American Heart Association and the American College of Sports Medicine issued a joint position statement entitled “Automated External Defibrillators in Health/Fitness Facilities,” published in *Medicine & Science in Sports & Exercise*. Under the heading “Cardiovascular Risks of Exercise,” this article provides many statistics related to cardiac arrest in health clubs:

The AHA/ACSM Recommendations provide details regarding the cardiovascular risks of exercise. It is clear that the risk of adverse cardiovascular events including death is greater among those individuals with cardiovascular disease than among presumably healthy individuals. As the demographics of the more than 30 million individuals who exercise at health/fitness facilities demonstrate a steady increase in the number of members older than 35 yr (approximately 55% of current membership), it is reasonable to presume that the number of members with cardiovascular disease (and other comorbidities) is rising as well. Although there are no data regarding the incidence of cardiac arrest at health/fitness facilities, two recent surveys provide some important insight. A large database consisting of more

than 2.9 million members of a large commercial health/fitness facility chain demonstrates 71 deaths (mean age 52 ± 13 yr; 61 men, 10 women) occurring over a 2-year period, yielding a rate of 1 death/100,000 members/year. The death rate was highest among those members who exercised less frequently, such that nearly half of exercise-related deaths were in those who exercised less than once/week. The cardiac arrest rate was not reported but was presumably higher than the death rate. A recent survey of 65 randomly chosen health/fitness facilities in Ohio reports that occurrence of sudden cardiac arrest or heart attack in 17% of facilities during a 5-year period. Notably, only 3% of facilities had an AED on site. Thus, it is prudent to conclude that health/fitness facilities should be considered among the site in which PAD programs should be established.

(2002 AHA/ACSM Joint Statement, Pltf. Ex. X, at 2-3).

E. IHRSA Standards

39. All IHRSA members, including Wellbridge, subscribe to the “code of conduct,” in which they pledge to: “...systematically upgrade our professional knowledge and keep abreast of new developments in our field; that we design our facilities and programs with the members’ safety in mind.” (IHRSA’s 1998 Standards Facilitation Guide, Pltf. Ex. Y, at 2).

40. IHRSA issued its second edition, “Standards Facilitation Guide,” which provided “health & safety, legal & ethical standards for U.S. IHRSA Clubs as of 1998.”

41. “Standard 6” is one of the “health and safety standards” in the IHRSA second edition of the Standards Facilitation Guide. The standard states as follows:

A club must be able to respond in a timely manner to any reasonably foreseeable emergency event that threatens the health and safety of club users. Toward this end, a club must have an appropriate emergency plan that can be executed by qualified personnel in a timely manner.

(Pltf. Ex. Y, at 5, 15).

42. The Second Edition, Standard Facilitations Guide, includes a sample form physical activity readiness questionnaire (Par-Q), which asks a series of questions designed to identify potential members with coronary or cardiac disease or conditions. If the Par-Q reveals any

indications of cardiac or heart problems, the IHRSA second edition Standards recommend that a physician be consulted, and, generally, that a physician approve or restrict exercise activity. In the absence of such indications, the IHRSA guidelines indicate a “reasonable assurance” of “suitability” for a graduated exercise program and a fitness appraisal. (Pltf. Ex. Y at 19).

F. Massachusetts Area AED Programs

45. The Boston EMS AED Program began in 1993 when EMS installed AEDS on ambulances and trained its EMTs to use them. In 1995, the program was expanded to include the Boston and Logan Fire Departments, installing them on the “pumper trucks” and training all of their employees. In 1996, Boston EMS began training “corporate partners” in CPR and AED use. (Murphy dep., Pltf. Ex. L, at 8-11, 64-66; “Automated External Defibrillators, Time for Federal and State Advocacy and Broader Utilization”, Pltf. Ex. Z, at 1321).

46. By December 1998, 20 companies in Boston, beginning with the John Hancock Building and including the Seaport Hotel, had AEDs on-site, together with employees trained to use them. Many of these buildings had health club facilities in them. (Murphy dep., Pltf. Ex. L, at 10-12; “Bill Would Protect People Who Aid Heart Attack Victims,” Pltf. Ex. AA, at 1). By February 15, 2000, before Wellbridge began its deployment, at least 45 companies had joined in partnership with the Boston EMS cardiac defibrillation program, including several tennis, health and fitness, and athletic businesses. (“Boston’s Sudden Cardiac Death Survival Rate Continues to Improve,” Pltf. Ex. BB, at 2). As of the time of George Murphy’s deposition (April, 2003), Boston EMS had trained the employees of 130 private businesses in Boston in AED use. (Murphy dep., Pltf. Ex. L, at 10-12, 44).

47. The Seaport Hotel in Boston, which has a health club available to members and guests, deployed an AED in September, 1998. Its security guards and other personnel were trained, free

of charge, by Boston EMS services, using a ForeRunner AED. (“Boston’s Sudden Cardiac Death Survival Rate Continues to Improve,” Pltf. Ex. BB).

48. There was no legal impediment, in 1999, for a Massachusetts health club to acquire and use AEDs on the premises of its club. The two basic requirements were a prescription from a medical doctor and training of the staff. (Murphy dep., Pltf. Ex. L at 79-80; Affidavit of Stephen Clay, Pltf. Ex. CC, at ¶ 3; IHRSA Briefing Paper, Pltf. Ex. S, at 4). These requirements were not difficult for a health club such as Wellbridge to comply with. (Curtis email to IHRSA, Pltf. Ex. EE; IHRSA Briefing Paper, Pltf. Ex. S, at 4; Clay Affidavit, Pltf. Ex. CC, at ¶ 3).

49. The Springfield, Massachusetts YMCA purchased and acquired an AED in February 1999. They had no trouble finding a doctor to sign the prescription and act as medical director. Training was provided free of charge by Boston EMS. (Murphy dep., Pltf. Ex. I, at 52-53). A single four hour session was necessary. The Springfield YMCA has used its AED twice since it was acquired to save a member from death by cardiac arrest. (Clay Affidavit, Pltf. Ex. CC at ¶¶3-5).

50. The doctor’s prescription and oversight requirement was easily met. (IHRSA Briefing Paper, Pltf. Ex. S at 4; Clay Affidavit, Pltf. Ex. CC at ¶3). Training was also fairly short and could be obtained for free. (IHRSA Briefing Paper, Pltf. Ex. S, at 4; Curtis email to Durkin, Pltf. Ex. EE; Clay Affidavit, Pltf. Ex. CC at ¶3; Murphy dep., Pltf. Ex. L at 80).

51. In August, 1999, Boston EMS began training employees at Fitcorp, a health club chain with ten public clubs, in Boston. (Murphy dep., Pltf. Ex. L, at 28-30; see, Pltf. Ex. III, at 1). The program was implemented approximately 30 days after Fitcorp first contacted Boston EMS. (Murphy dep., Pltf. Ex. L, at 28-30). This was the first Boston health club that Boston EMS trained. (*id.* at 32).

52. There were no reasons why Fitcorp or any other Boston health club could not have trained its employees in 1997 rather than 1999. The AEDs that Fitcorp purchased were available in 1997; the types of employees hired had not changed. (Murphy dep., Pltf. Ex. L, at 84-85).

G. Health Club Industry Knowledge & Developments Before April, 1999

53. There is no regulatory body that requires anything for the health club industry. (Curtis dep., Pltf. Ex. I at 63).

54. Health club executives knew or reasonably should have known in the period of 1994 through 1999, that exercise increases the risk of cardiac arrest at least by factor of approximately 10 to 15%. (Curtis dep.; Pltf. Ex. I, at 88-89).

55. Health club executives knew or should have known by the mid 1980s that defibrillation must ideally occur within four minutes, and that with each passing minute after that, the chances for survival decrease, and that, generally, defibrillation must occur within five minutes. (Curtis dep.; Pltf. Ex. I, at 53). By the mid 1990s, health club executives knew, or should have known, that the odds of survival in the absence of defibrillation more than five minutes after the onset of cardiac arrest were less than 50%.

56. Before 1999, health club executives knew or should have known that defibrillation was the only effective means for restoring a heart in ventricular fibrillation to its normal rhythm after a cardiac arrest. (Curtis dep.; Pltf. Ex. I, at 65), that CPR was ineffective to treat cardiac arrest without defibrillation (*id.* at 56), and that death was the probable outcome if the heart's rhythm could not be restored within five to seven minutes. (*id.* at 90).

57. Health club executives knew, or should have known, before 1999, that the perfusion of oxygenated blood, through the use of CPR (following a cardiac arrest) is "very low" compared to

a functioning heart; and that tissues would start to die even with CPR within five minutes. (Curtis dep., Pltf. Ex. I, at 56-57; Turgiss dep., Pltf. Ex. B, at 38-39).

58. Beginning in 1995 and through 1999, health club executives were considering, or should have been considering, whether AEDs were a useful addition to a health club, and would have reviewed American Heart Association materials including “When Every Second Counts, Cardiac Arrest and the Need for Early Defibrillation” (Curtis dep., Pltf. Ex. I, at 23, 76-77); sports medicine materials, including an article published in 1998 by Dr. Cantwell in a “widely read” sports medicine publication (*id.* at 76-77, 48-51, 89-90); and articles in the lay press on the subject of defibrillation. (*id.* at 76-77; see also, ¶¶64-66 below).

59. In the period of 1996 through 1998, health club executives were aware that AEDs performed more functions than to simply shock a victim of cardiac arrest in ventricular fibrillation, but also perform a monitoring function for the heart. (*id.* at 82). They knew, or should have known, in 1996-1997, that health club employees could learn to effectively use an AED. (*id.* at 92-93).

60. A survey reported to the American Heart Association’s 69th scientific session in November, 1996 found that, of 204 randomly selected health clubs in Massachusetts which collectively had more than 76,000 members, fewer than 4% had an on-site defibrillator, including clubs offering special programs for people with heart disease. (“Many Health & Fitness Clubs Do Not Pre-screen Members for Cardiovascular Disease”, Pltf. Ex. FF).

61. In 1999, Bally’s was the biggest health club chain in the United States, with approximately 4 million members. At the same time, the YMCA had approximately 3 million members. (McCarthy dep.; Pltf. Ex. H, at 114-115).

62. IHRSA was not aware, in 1997, of the YMCA USA's Medical Advisory Committee recommendation, published in 1997, advocating deployment of AEDs in YMCA facilities. (McCarthy dep.; Pltf. Ex. H, at 116-118; Pltf. Ex. V). IHRSA recognized that the judgment of the YMCA on such matters was considered "important" within the industry. (*id.* at 118).

64. Qantas Airlines of Australia carried AEDs on its passenger planes beginning in 1991. In Fall, 1994, Qantas saved its first two passengers with AEDs. The first major U.S. carrier, American Airlines, announced it would deploy AEDs in November, 1996. American was, and still is, one of the country's top three carriers. American's medical director, Dr. David McKenas, was one of many to testify before the U.S. Congress in May, 1997 on the subject of AEDs in passenger aircraft. (Link Report, Pltf. Ex. N, at 7).

65. United Airlines and Delta Airlines announced in early 1998 that they would carry AEDs on their passenger aircraft. (Article from *The Boston Globe*, November 26, 1998, Pltf. Ex. QQ). United Airlines had announced, in Denver (Club Sports' hometown), as reported in the *Denver Post* in February of 1998, that it would be deploying AEDs and Enhanced Emergency Medical Kits on all of its flights in the very near future. (See, *Denver Post* Exhibits, Pltf. Ex. LL; Article from *The Boston Globe*, Pltf. Ex. QQ). United, American and Delta accounted for more than half of U.S. passenger miles, a measure of total passenger miles. These three airlines and many others recognized the need for and effectiveness of AEDs by early 1998, and publicly embraced them with public announcements and press coverage. (*id.*)

66. During the period 1996 to 1999, the national media regularly reported on the use of AEDs, including in passenger aircraft. Attached as Pltf. Group Exhibit MM are representative articles carried in such periodicals as *Readers Digest*, *Better Homes & Gardens*, the *New York Times*, and *USA Today*.

67. By March, 1997, casinos in Nevada and Mississippi had installed AEDs and trained security guards in their use. Ten of the casinos, with over 1350 trained security guards, participated in a study later published in the *New England Journal of Medicine*, which surveyed AEDs in the casino setting. (Pltf. Ex. GG). Among the results later published was a survival rate of 74% for cardiac arrest victims defibrillated within three minutes (Link Report, Pltf. Ex. N, at 7).

68. *Fitness Management* magazine is a well-respected publication in the health club industry. (McCarthy dep., Pltf. Ex. H, at 126). The January, 1999 issue of *Fitness Management* featured a story on the Little Rock Athletic Club, which described the success of an athletic club in Little Rock, Arkansas in saving the life of a member with an AED. According to the story, the health club purchased the unit in September, 1997, after consultation with the AED's manufacturer, Physio-Control. (Pltf. Exhibit NN).

69. Generally, this article extolled the virtues of AEDs for health clubs—that they were small, unobtrusive, easy to carry, and effective. The article also recited the basic principles of defibrillation in the case of a cardiac arrest, namely, that it must be done within a few minutes after the cardiac arrest to be effective. The article featured the resuscitation of a man who collapsed, was shocked by the club's AED to restore his heart to a normal rhythm, until paramedics arrived twelve minutes after he collapsed. He made a full recovery. (Pltf. Ex. NN, Bates 00158). According to the manager of the health club featured in the *Fitness Management* article, "every fitness center should have one—with a staff properly trained in using the equipment," Escola says. "You need to be able to handle such a situation." (*id.* at Bates 00159).

70. In March of 1999, *Fitness Management Magazine* awarded recognition to the Little Rock Athletic Club in Little Rock, Arkansas, for its purchase and use of a LifePak 500 AED (the

same model which Wellbridge would later purchase) in September, 1997. (Pltf. Ex. PP; Turgiss dep., Pltf. Ex. B, at 79).

71. In 1999, *Circulation*, a journal by the American Heart Association, published an article entitled “Comparison of Naïve Sixth-Grade Children with Trained Professionals in the Use of an Automated External Defibrillator.” This article tested the time it took for 15 children and trained EMTs to correctly place the electrode pads and successfully “defibrillate” the mannequin. The children’s mean time was 90 seconds, whereas the EMTs averaged 67 seconds. “It was noted that the ‘difference between the groups was surprisingly small, considering the naivete of the children as untutored first-time users.’” (Abbott Report, Ex. M, at 5; Pltf. Ex. DDD).

72. *Club Industry Magazine*, in September, 1999, published its article entitled “The New Age,” “addressing the needs of older adults”. (“The New Age”, Pltf. Ex. OO, at 1). It includes many statistics about the aging population:

- Every eight minutes, someone turns 50.
- Over the next 10 years, the 55-to-59-year-old population is expected to increase by 54 percent, and the 60 to 64 age group will increase by 58 percent.
- By 2020, the number of people in their 40s, 50s and 60s will triple.
- For the first time in the history of the developed world, the older population will soon outnumber the younger population.
- Older adults comprise a busy and vital group that is looking for more ways to be active; for example, they represent 53 percent of adventure travelers.

(*id.*). The article also says that “[t]oday [September, 1999], three in 10 health club members are 50 and over; in 1998, this figure was two in 10.” (*id.* at 3)

73. At a health club company the size of Wellbridge, the rate of cardiac arrest fatalities is at least two per year. Mr. Patjane recalled about two cardiac events per year at the smaller pre-CSI Wellbridge. (Patjane dep., Pltf. Ex. F, at 94). The CSI records, understated though they admittedly were, show three and possibly four deaths in an 18 month period. (Curtis dep., Pltf.

Ex. I, at 54-56, 84-86; Defendants' Answers to Plaintiffs Interrogatories, Pltf. Ex. G., Answer to Interrogatory No. 12). Ms. Turgiss testified that her next employer after Wellbridge, with about 250,000 members, used its AEDs seven times, saving four members' lives, over a period of less than a year. (Turgiss dep., Pltf. Ex. B, at 177-178). After it installed AEDs itself, Wellbridge reported to IHRSA that it had saved two of its members from cardiac arrest death with its AEDs over a period of one year. (Curtis dep., Pltf. Ex.I, at 101; Curtis email to IHRSA, Pltf. Ex. EE at 1).

H. Wellbridge's Knowledge of Cardiac Arrest and AEDs Before April, 1999

74. Wellbridge provided the membership totals for all of its facilities, as well as the Atlantic Avenue facility only. In 1996, Wellbridge and CSI had a total of 42,328 members, 1426 of whom were at the Atlantic Ave. facility. In 1997, Wellbridge & CSI's total membership rose to 138,592, with 1455 being at the Atlantic Ave. facility. In 1998, Wellbridge and CSI had a total of 155,883 members, of which 1512 were at the Atlantic Ave. facility. (Defendants' Answers Plaintiffs' Second Set of Interrogatories, Pltf. Ex. G, Answer to Interrogatory No. 24, Exhibit A thereto).

75. Before Mr. Fruh's cardiac arrest, Wellbridge trained its staff in CPR because of the risk, acknowledged by Mr. Patjane, of cardiac arrest during exercise. Mr. Patjane was aware of this increased risk before 1999. (Patjane dep., Pltf. Ex. F, at 39-42; Turgiss dep., Pltf. Ex. B, at 51). Wellbridge's policy regarding cardiac arrest was to require its employees to respond with CPR, to have in place an emergency procedure, and to drill employees on that procedure. (Patjane dep., Pltf. Ex. F, at 76; Turgiss dep., Pltf. Ex. B, at 74-75).

76. Failure of a person to “cool down” following exercise increases the risk of cardiac arrest. This increased risk was described in Wellbridge literature, and members and staff were advised of this increased risk. (Turgiss dep., Pltf. Ex. B, at 108-109).

77. Wellbridge recognized that the sub maximal exercise consent form alerted a member to the risk of cardiac arrest during exercise. (Turgiss dep., Pltf. Ex. B, at 107). Turgiss believed that some Wellbridge members had coronary artery disease due to age or other factors, and she knew that people with coronary artery disease are more likely to have a cardiac arrest. (*id.* at 74).

78. At the Wellbridge Newton facility near Boston, there were approximately two member heart attacks or cardiac events per year, during the period of 1994 to 1999. (Patjane dep.; Pltf. Ex. F, at 93-95).

79. In her position as Director, Whole Person Health, for the Wellbridge chain, during and before April, 1999, Turgiss’ responsibilities included oversight of two St. Louise health clubs affiliated with SSM [Sinai hospital], a joint venture which provided cardiac rehabilitation services. The St. Louis health clubs, of which Turgiss had oversight, had defibrillators as part of a crash cart on the premises of the health club, because of the possibility that a health club member could experience cardiac arrest during exercise. (Turgiss dep.; Pltf. Ex. B, at 46-51; Curtis dep., Pltf. Ex. I, at 29-30).

80. As a licensed emergency medical technician, during the years 1988 through 1992, Mr. Patjane saw AEDs used on multiple occasions. His understanding was that AEDs could restart the heart’s rhythm following certain kinds of cardiac arrest. (Patjane dep.; Pltf. Ex. F, at 21-24).

81. In November, 1998, Mr. Patjane saw on television and read in the local newspapers in Boston about the resuscitation of Boston resident Michael Tighe, who was saved over Denver (Club Sports’ hometown) by an AED used by flight attendants on an American Airlines flight.

This event was widely publicized. (Tighe dep., Pltf. Ex. HH, at 56-60; Tighe Affidavit, Pltf. Ex. QQ; Patjane dep.; Pltf. Ex. F, at 52-53). As of that point, at least, Patjane knew that lay (as opposed to a medical professional) person use of AEDs was possible to resuscitate cardiac arrest victims. (*id* at 54; Article from *The Boston Globe*, Pltf. Ex. QQ).

82. Turgiss was trained in CPR with American Heart Association materials, while a Wellbridge employee, during the years 1994-1999. Turgiss had heard of the concept of Public Access Defibrillation, such as the publicly available defibrillators at the O'Hare airport and in Seattle before April, 1999. (Turgiss dep., Pltf. Ex. B, at 35). Before April, 1999, Turgiss had heard of the use of AEDs on airplanes. (Turgiss dep., Pltf. Ex. B, at 36; Curtis dep., Pltf. Ex. I at 14, 98-99).

83. Turgiss knew, before April, 1999, that ventricular fibrillation was an electrical disturbance for which CPR was little to no help, and that only defibrillation could restore a regular rhythm to the heart. (Turgiss dep.; Pltf. Ex. B, at 38-40).

84. Before April, 1999, Turgiss was aware of the problem of delay in responding with defibrillation after a cardiac arrest, namely, that the victim's prognosis gets progressively worse with the passage of time. (Turgiss dep., Pltf. Ex. B, at 40-41).

85. For many years prior to April, 1999, Turgiss knew that AEDs could be used by lay people, *i.e.* non-medical by trained people. (Turgiss dep., Pltf. Ex. B, at 37).

86. Club Sports International, beginning at least by 1989, required that its staff be trained in CPR. (Curtis dep., Pltf. Ex. I, at 61). The requirement of CPR training was intended to address foreseeable cardiac arrests. (Curtis dep., Pltf. Ex. I, at 63).

87. Since the early 1990s, Club Sports International used a Par-Q test to screen potential members for coronary disease risk factors. (Curtis dep. Pltf. Ex. I, at 41-42; Patjane dep., Pltf. Ex. F, at 84-86).

88. In 1996, 1997 and 1998, Club Sports International thought it was more likely than not that any of its club member cardiac arrest victims would die if not defibrillated within 7 minutes. (Curtis dep., Pltf. Ex. I, at 129-130). A reasonable health club executive knew, or should have known, in 1996, that response time of less than five minutes would be “critical” in the case of a cardiac arrest. (Curtis dep., Pltf. Ex. I, at 138).

89. Records were kept by Club Sports International, during the period June, 1997 through January, 1999 of what appeared to be cardiac or heart-related medical emergencies of its members. There were twelve events documented, seven of which occurred in Minnesota. Of the twelve events, two were fatal, and three may have been fatal. In twelve cases, the member was taken to the hospital with chest pains, tingling or similar symptoms. In one case, no treatment was administered after the initial report of difficulty. (CSI Incident Reports, Pltf. Ex. RR). Club Sports did not track instances where CPR was administered in any of its facilities prior to April, 1989. (Curtis dep., Pltf. Ex. I, at 54-56). Mr. Curtis, of Club Sports International, admitted that the record keeping was not complete, and did not include all fatalities or cardiac-related events. (Curtis dep., Pltf. Ex. I, at 84-86). In June, 1997, Club Sports International instituted a substantial change in its record-keeping policies (*id* at 88).

I. Health Club Industry Trade Group Response to Proposed AEDs

90. It is the mission of IHRSA to promote and protect the interest of its member health clubs. (McCarthy dep., Pltf. Ex. H, at 76). IHRSA’s mission was to look after the “best interests

of the industry long term.” (*id.* at 187). The interests of health club members was only one consideration among many comprising the interests of the health club industry. (*id.*).

91. In IHRSA’s internal records of discussions of its proposed emergency response standard, on July 11, 1996, the question of timing in responding to a medical event, and the importance of a response time within four minutes, was discussed. (McCarthy dep. Pltf. Ex. H, at 173-174). This discussion was not publicized or disseminated to member clubs from IHRSA, but was part of its internal deliberations in arriving at an emergency response standard. (*id.* at 173).

92. IHRSA’s founder and chief executive, John McCarthy, personally first heard about AEDs in 1997, speaking with people in the industry. At the time, a few IHRSA member health clubs had AEDs. (McCarthy dep., Pltf. Ex. H, at 16-17).

93. Mr. McCarthy of IHRSA does not recall being aware of a 1997 American Heart Association recommendation for AEDs in health clubs. (McCarthy dep., Pltf. Ex. H, at 57). McCarthy was also not aware of American Heart Association statements on the subject of AEDs in health clubs before 1999. Mr. McCarthy was not aware of a 1986 joint statement by the American Heart Association and the American Medical Association discussing the use of AEDs at health clubs. (McCarthy dep., Pltf. Ex. H, at 56-57).

94. AEDs were first presented at an IHRSA trade show in March, 1999, when Agilent participated at the IHRSA trade show. (McCarthy dep., Pltf. Ex. H, at 27). Philips Medical, an AED manufacturer, joined IHRSA on March 12, 1999. MedTronics, another AED manufacturer based in Minnesota, joined IHRSA on March 11, 1999. (*id.* at 172).

95. IHRSA surveyed its members about AEDs in October, 1999. Of the 273 clubs responding, 16% (45) already had at least one installed. 25% (71) were planning to purchase one

and 58% (157) had no plans to obtain an AED. (IHRSA Briefing Paper, Pltf. Ex. S, at 7). At that time, IHRSA had 2500 member clubs. (McCarthy dep., Pltf. Ex. H, at 45).

96. The consensus within IHRSA, as of November, 1999, was that CPR was ineffective without defibrillation. (McCarthy dep.; Pltf. Ex. H, at 32-33). It was the consensus within IHRSA in November, 1999, as its draft statement on the question of AEDs was being considered, that the timing in responding to cardiac arrest with defibrillation was “crucial”. (*id.* at 34).

97. Still, according to IHRSA, reasons not to have AEDs required in health clubs included that there was no reliable evidence available on the subject, and that studies that had been made were “flawed”. (McCarthy dep., Pltf. Ex. H, at 153-154). IHRSA never investigated the question of cardiac arrest in its member health clubs, or elsewhere. (*id.* at 35-36).

98. The consensus within IHRSA regarding AEDs is outlined in its briefing paper dated December 10, 1999. This paper was presented to and edited and consented to by its board members. (McCarthy dep., Pltf. Ex. H, at 88, 91; IHRSA Briefing Paper, Pltf. Ex. S). Among the statements in this briefing paper are:

Are AEDs safe to use?

According to the American Heart Association, an AED is safe to use by anyone who has been trained to operate it, and using one is easier than administering CPR. Studies have shown the devices to be 90% sensitive (able 90% of the time to detect a rhythm that should be defibrillated) and 99% specific (able 99% of the time to recommend not shocking when defibrillation is not indicated). Because of the wide variety of situations in which it will typically be used, the AED is designed with multiple safeguards and warnings before any energy is released. The AED is programmed to deliver a shock only when it has detected ventricular fibrillation.

A June 1998 *Golf Course Management* article addressed safety fears this way. “If someone is in cardiac arrest, nothing you can do will make the situation any worse. The heart will not spontaneously regain a normal rhythm, and without defibrillation an SCA victim will die.”

* * *

Who is legally allowed to use an AED?

Under current Food and Drug Administration (FDA) regulations and the law in most states, only doctors or people authorized by doctors (via a prescription) may buy and operate AEDs. This is a quality control mechanism. The licensed physician or medical authority will ensure that all designated responders are properly trained and that the AED is properly maintained. A club operator wishing to purchase an AED would need to work with a physician (or in some states a nurse or other medically trained individual) both before and after the purchase. Some clubs that already have AEDs have a physician member of their club who was willing to provide this service. Also, some AED suppliers offer programs that match clubs with physicians in their state that will, for a fee, act as that club's medical authority for a designated period of time.

Emergency Medical Technicians (EMTs) are allowed to use AEDs in all states. Most states allow first responders, such as police, fire fighters and other law enforcement personnel to use AEDs. More and more states are allowing lay rescuers with proper training and medical supervision to use them.

* * *

Will obtaining an AED increase our responsibility and therefore our liability risk?

...According to Medtronic Physio-Control Corporation, as of October 1999 there had been no lawsuits involving the use of an AED in a business setting, and most firms carry liability insurance as protection should such a lawsuit arise.

* * *

Agilent Technologies offers an indemnification program for users of its ForeRunner® AED. It protects users from claims or actions arising from “the mechanical or electrical failure or malfunction of the ForeRunner.” There are exceptions in cases of negligence, gross negligence, or improper acts, and in cases of AEDs that are not properly maintained or operated.

Medtronic Physio-Control Corporation offers an indemnity program to users of its LIFEPAK® 500 AED. The only exceptions are if the user is grossly negligent or intentionally misuses the device. Participants must agree to periodic inspection of the devices and ensure that the operator has received training from an American Heart Association Basic Life Support level trainer (or equivalent). For an additional charge, club operators can purchase a policy protecting themselves and AED users from liability for improper actions or even failure to act.

Will obtaining an AED mean that my club is “getting into the medical field?”

Not necessarily. An AED is only used if a cardiac arrest incident occurs. Given that an event occurs, a club employee either uses an AED, if the club has one, or someone performs CPR until an ambulance or other response vehicle arrives. Either way, the club is providing medical attention. However, in the case of a

cardiac arrest, CPR is generally ineffective without another link in the American Heart Association's "chain of survival": early defibrillation.

* * *

Will having an AED affect my liability insurance coverage?

It may. According to Fitness Pak—InterWest Insurance Services, Inc., "The standard commercial liability policy provides protection for the insured club against bodily injury caused by negligence with employees included as additional insureds. Employees are generally not covered for their performance of 'health care professional services;' however the exclusion does not apply to an employee providing first aid." Fitness Pak recognizes the use of an AED as first aid response, so non-physician club employees are covered.

If you are considering obtaining an AED, contact your insurance agent to determine if there are any potential coverage issues specific to your insurance policy.

(Pltf. Ex. S).

99. IHRSA acknowledged in December, 1999 that health clubs had often been mentioned as a location for AEDs. (McCarthy dep., Pltf. Ex. H, at 90; IHRSA Briefing Paper, Pltf. Ex. S). According to IHRSA, approximately one in four adult Americans have coronary artery disease, and the risk of a cardiac event is approximately ten times higher in people with coronary artery disease. (McCarthy dep. Pltf. Ex. H, at 91; IHRSA Briefing Paper, Pltf. Ex. S).

100. On February 23, 2001, Helen Durkin, in charge of public policy at IHRSA, distributed an email to executives of health clubs which stated the following:

IHRSA is working to slow/stop the drive to make it a legal standard of care to put AEDs in health clubs. Given the legislative, legal and American Heart Association type pressure we think that it is important to draft a position paper that points out all the reasons why it isn't or shouldn't be a standard of care. (Durkin Email to IHRSA Industry Council Leaders, Pltf. Ex. SS, Bates no. 00213; Curtis dep., Pltf. Ex. I, at 102-103).

101. The cost of AEDs is a factor considered by IHRSA and by most clubs:

While AEDs have dropped in price over the years (the figure often quoted is \$3,000 – or the price of a treadmill, as AED proponents put it), some clubs balk at the cost.

IHRSA's Helen Durkin explains it like this: Obviously, everyone agrees that \$3,000 is a small price to pay to save a life; however, "the margins in this business are not great." So an AED may not find space on a club's shopping list.

"I'm an operator trying to decide what's going to bring someone in the door," Durkin says. "And probably I'm going to be better off spending money on a treadmill. Most people aren't going to base their decision on whether or not there is an AED."

Durkin also points out that the \$3,000 figure may be misleading. Defibrillators only have value if they are spaced three minutes apart, she claims. Therefore, a larger club may end up buying more than one.

The thought of buying multiple defibrillators – let alone one – could discourage some club operators. ("Life Saver or Cash Waster?" Pltf. Ex. II, at 4-5; IHRSA Briefing Paper, Pltf. Ex. S, at 8).

102. IHRSA's goal in combating efforts to make AEDs mandatory at health clubs was to buy time, believing that the "lawyers" would "like the industry to cave". (McCarthy dep., Pltf. Ex. H, at 158; Pltf. Ex. HHH). According to IHRSA, in a publication dated February, 2001, trial lawyers and legislators wanted AEDs required in health clubs. (*id.* at 151-153). The legislatures of six states, in 2001 and 2002, introduced bills to require AEDs at health clubs. (*id.* at 161-165). None of these bills were enacted due, in part, to opposition from IHRSA lobbyists. (*Id.*).

103. Arthur Curtis described Wellbridge's experience to IHRSA in November, 2000:

Kristen,

Annbeth asked me to follow-up on this with you.

Wellbridge did go ahead and install AED's at all locations. We started in 4th Q of '99 and completed the installation and training in the 1st Q of 2000. We have had a number of instances where we had to use the AED's. On at least one occasion the AED was responsible for the successful resuscitation of one of our members.

We decided to put AED's into our clubs, even though none of the states where we operate require them, because we wanted to be proactive. Our membership base is aging, with an average age of about 40 to 44 and the largest growing segment of members in the 55 + age group. Primetime for CHD. With over 200,000 adults using our clubs every year and over 50,000 visits to our clubs on a daily basis, the chances of a coronary event occurring [sic] in one or more of our

clubs annually is very likely. Having an AED available in the event of a cardiac emergency is, in our opinion, the responsible thing to do.

Let me know if you have questions.

Art Curtis

(Pltf. Ex. DD).

104. From the mid-1990s to the present, the major AED manufacturers, including Physio-Control, whose model Wellbridge acquired in 1999, typically provided an indemnification in favor of the purchaser for any problems or malfunctions in the device, in connection with any AED sale. As of 2000, according to IHSA, there has never been a lawsuit based on use of an AED. (IHSA Briefing Paper, Pltf. Ex. S, at 5-6, 10).

J. Wellbridge/Club Sports International's Policy in 1999 for Responding to Cardiac Arrests

105. At the Atlantic Avenue Wellbridge facility, through the years 1995 to 1999, the club's procedure in the case of a member losing consciousness and not breathing was to require health fitness employees to have CPR certification, to maintain "appropriate first aid materials and equipment at the club", establish and maintain first aid policies and procedures, and to educate and train its employees on first aid, including periodic drills. (Defendants' Answers Plaintiffs' First Set of Interrogatories, Pltf. Ex. G, Answer to Interrogatory No. 11).

106. Wellbridge used Red Cross and American Heart Association training materials for certifying and training its employees and staff in CPR. (Patjane dep., Pltf. Ex., at 25-26).

K. Herbert Fruh's Joining of Wellbridge in 1995

107. According to the Membership Agreement, the "operation and management" of the facility was under the "complete control" of Wellbridge (Pltf. Ex. D; Bates No. 00002).

108. In accordance with Wellbridge's policy, Herbert Fruh's physician, Dr. Michael Guidi, was required to clear Herbert Fruh for participation in the Wellbridge program. At the time of

Mr. Fruh's joining in October, 1995, Dr. Guidi cleared Herbert Fruh to exercise without restriction. The referral form itself, signed by Dr. Guidi for Mr. Fruh, identified Wellbridge as "a center designed to provide scientifically based health, fitness and nutrition programs to maintain optimal health." (Pltf. Ex. E, Bates no. 00012).

109. In accordance with Wellbridge's policy, Herbert Fruh executed a "Physician Release of Information," authorizing Wellbridge to obtain copies of Herbert Fruh's medical records which, according to the release, were those which Dr. Guidi would "believe could be useful in evaluating my health condition as it relates to participation in the exercise programs and nutritional counseling at the Wellbridge Health and Fitness Center." (Pltf. Ex. E, Bates no. 00013).

110. Wellbridge developed marketing materials and advertisements for its health clubs, including handout and pamphlet materials provided to prospective members. (Defendants' Answers to Plaintiffs' First Set of Interrogatories, Pltf. Ex. G, Answer to Interrogatory No. 5).

111. In a brochure describing its programs, Wellbridge identified itself in the following way:

- A state of the art health and fitness center designed to meet the needs of adults 45 and older.
- The center provides exercise programs and nutritional counseling developed by Tufts University, recognized leaders in exercise, nutrition and aging.
- The Wellbridge Center was developed by The NutraSweet Company, a company dedicated to helping consumers live a more healthful lifestyle.
- The Wellbridge exercise programs and nutritional counseling are specifically designed to slow or reverse some of the physical and physiological changes associated with aging such as muscle loss, reduced strength, flexibility and endurance and to reduce risk factors that can lead to chronic disease. (Pltf. Ex. C, Bates no. 01244).

112. The Wellbridge Health and Fitness Center specialized in medically sophisticated health and fitness training. Tufts University, a recognized leader in exercise, nutrition and aging,

developed a variety of programs for Wellbridge members addressing specific health problems such as high blood pressure, arthritis, cardio-vascular deficits, and other conditions generally associated with aging. (Wellbridge Marketing Materials, Pltf. Ex. C, Bates nos. 01243-01249). These programs included initial protocols and screening procedures. (Turgiss dep., Pltf. Ex. B, at 27-28). Wellbridge had a specific program for “achieving and maintaining fitness in adults 45 and older.” (Wellbridge Marketing Materials, Pltf. Ex. C, Bates no. 1243).

113. Before 1999, in order to investigate or research appropriate services to be provided to health club members with heart disease or heart problems, Wellbridge “reviewed exercise literature and consulted with, among others, Dr. Gail Brown, Tufts University, Stanford University, and Kennedy Brothers Physical Therapy Group, to compile information concerning appropriate exercise routines to fit within physician parameters.” (Defendants’ Answers Plaintiffs’ First Set of Interrogatories , Pltf. Ex. G, Answer to Interrogatory No. 9).

114. In the mid and late 1990s, the Wellbridge health clubs targeted older adults, aging baby boomers and adults over 40 as their intended members. (Curtis dep., Pltf. Ex. I, at 32-33, 36-38). At the outset, Wellbridge’s primary target audience for membership was people over the age of 50. (Patjane dep., Pltf. Ex. F, at 80-81). The International Health and Racquet Sports Association (“IHRSA”), the industry’s major trade group, agreed that the fastest growing segment of the health club population is the 55 and over group. (McCarthy dep., Pltf. Ex. H, at 149-150).

115. In its Member Handbook, given to new members, WellBridge Company promised and warranted to its members and contracted with them that it would conform to “...and in many areas surpass,...” the “standards of quality” of the International Health Racquet & Sports Club Association (IHRSA) including:

Our club conforms to all relevant laws, regulations and published standards;

Our club is able to respond in a timely manner to any reasonably foreseeable emergency event that threatens the health and safety of club users. Toward this end, our club has an appropriate emergency plan that can be executed by qualified personnel in a timely manner.

Our club posts appropriate signage alerting users to the risks involved in their use of those areas of our club that present potential increased risk(s).

(Patjane dep., Pltf. Ex. F, at 70-72; Turgiss dep., Pltf. Ex. B, at 95-96; Member Handbook, Ex. JJ at 8).

116. Wellbridge also pledges to “systematically upgrade our professional knowledge and keep abreast of new developments in our field.” (IHRSA 1998 Standards Facilitation Guide, Pltf. Ex. Y, at 2).

117. Wellbridge stated in its membership handbook that it had adopted, and in some cases, exceeded, the IRHSA standards for health clubs, as set forth in the Wellbridge Member Handbook. (Patjane dep., Pltf. Ex. F, at 70-74).

118. Before March, 1999, Wellbridge employed initial medical screening and physical evaluation procedures for new members. (Turgiss dep., Pltf. Ex. B, at 21-25). In a brochure copyrighted in 1992 by NutraSweet, Wellbridge highlights its dedication to the fitness needs of the over-45 member, describes its “Health and Fitness Evaluation”:

With safety in mind, the Center provides exercise programs and nutritional counseling in a supervised environment.

The Wellbridge Center exercise programs and nutritional counseling were developed by Tufts University, a recognized leader in scientific research and exercise, nutrition and aging. The programs offered at the Wellbridge Center have a firm foundation in scientific research...

The Wellbridge Center offers its members the opportunity to apply what is known about exercise, nutrition and aging to improve the quality of their lives...

Prior to becoming a member, an individual must undergo a health and fitness evaluation. The health and fitness evaluation is an integral part of the Wellbridge program and is used as the basis for exercise and nutritional recommendations... The health and fitness evaluation consists of laboratory testing, complete histories and a physical assessment...

An interdisciplinary team of health practitioners reviews the data. An exercise program and nutritional counseling are then tailored to meet the member's specific needs. The exercise program will be designed to address specific risk factors and chronic conditions, such as cardiovascular disease, osteoporosis, arthritis, adult-onset diabetes, hypertension and frailty that may respond to exercise intervention. (Pltf. Ex. C, Bates nos. 1246).

Wellbridge continues in this brochure:

The Wellbridge Center professional staff instructs members in the proper use of equipment and is available to supervise the members while they exercise. The fitness staff is certified by such organizations as the American College of Sports Medicine, International Dance Exercise Association and the American Red Cross. They also participate in a training program, designed by Tufts University, that emphasizes the unique needs of people age 45 and over. (Pltf. Ex. C, Bates no. 01247).

119. Herbert Fruh's "Personal Program" for "cardiovascular" provided for various types of exercise which are to be monitored in terms of heart rates, duration and frequency. The only "special consideration" identified in the program was "cholesterol a little high." (Fruh's Membership documents, Pltf. Ex. E, Bates no. 00015).

120. As part of the fitness evaluation undergone by Herbert Fruh, as a condition to his joining Wellbridge, he signed a "Consent for Submaximal Fitness Evaluation," on October 27,

1995. Among the representations made in that consent by Wellbridge were the following:

During and immediately following the sub-maximal exercise test, I understand that there exists the possibility of unusual cardiovascular and/or cerebral changes occurring. These may include but are not limited to abnormal blood pressure changes, fainting, dizziness, very rapid, or very slow, or irregular, heart beat and rare instances of heart attack. National statistics indicate serious, but rarely catastrophic, complications in approximately .5 per 10,000 exercise tests. Every effort will be made to minimize this by preliminary examination and constant surveillance during the test. Emergency and trained personnel are available to deal with unusual situations which may arise. (Pltf. Ex. E, Bates no. 00019).

121. Wellbridge relied on 911 emergency medical services in the event that a sub maximal exercise test resulted in a cardiac arrest, but no effort was made by Wellbridge to learn what the response time was. (Turgiss dep., Pltf. Ex. B, at 110). Wellbridge's emergency response plan was to do compressions, as called for by CPR training, until outside help arrives. (*id.* at 42). According to Turgiss, if the response time had been 15 minutes, this would have had no effect on the medical emergency response plan; this was irrelevant to the Wellbridge emergency response plan. (*id.* at 43). No special arrangements were made by Wellbridge to have any emergency personnel on hand or on alert when these tests were administered. (Curtis dep., Pltf. Ex. I, at 139-140).

122. On October 27, 1995, Herbert Fruh took the "Submaximal Cycle Ergometer Test", a type of cardiac stress test, at the Wellbridge premises. His resting heart rate was 66 beats per minute, and, through the test, his heart rate was increased through monitored exercise to 145 beats per minute. The data collection sheet reflecting the test is Exhibit E, Bates 00017. The summary of the test was described as "test norm., reached 85%," (Exhibit E, Bates no. 00017).

123. According to Wellbridge records, beginning in 1996, Herbert Fruh made over 500 visits to the Atlantic Avenue facility in Boston between January, 1996 and April, 1999. He typically exercised between six and seven in the morning, three or four, and sometimes five, days per week. (Exhibit TT, Bates no. 00022).

L. Wellbridge Investigates and Installs AEDs after Fruh's Cardiac Arrest

124. On April 27, 1999, almost two weeks after Mr. Fruh's incident, and after considering the issue since at least 1996, Arthur Curtis, Club Sports/Wellbridge's chief operating officer, recommended to the company's executive committee that installation of AEDs should proceed (Curtis dep., Pltf. Ex. I, at 72-76).

125. The decision to finally move forward with installation of AEDs was triggered by a letter Mr. Curtis received from the widow of a club member in Minnesota who had died of sudden cardiac arrest while exercising in January, 1999. (*id.*; Rush Letter to Curtis dated April 17, 1999, Pltf. Ex. Q).

126. Accompanying the widow's letter was the pamphlet from the American Heart Association, copyrighted 1996, entitled "When Every Second Counts." (Pltf. Ex. Q). (See, ¶ 125 above).

127. In his letter to the widow of the club member, Mr. Curtis expressed his hope that installation of AEDs could begin in the summer of 1999. (Curtis Letter to Mrs. Rush dated April 27, 1999, Pltf. Ex. Q).

128. Mr. Curtis later gave his reasons for finally deciding, in April of 1999 to deploy AEDs:

Our membership base is aging with an average age of about 40-44 and the largest growing segment of members in the 55+ age group. Primetime for CHD. With over 200,000 adults using our clubs every year and with over 50,000 visits to our clubs on an annual basis, the chances of a coronary event occurring in one or more of our clubs annually is very likely. Having an AED available in the event of a cardiac emergency is, in our opinion, the responsible thing to do. (Pltf. Ex. DD).

129. Jennifer Turgiss began the investigation of AEDs for use in clubs when Arthur Curtis requested that she do so. (Turgiss dep., Pltf. Ex. B, at 59-60).

130. According to Turgiss, her investigation of AEDs, from May through September, 1999, was mostly spent on the telephone. She spent approximately 20% of her time on the AED

investigation during this time. (Turgiss dep., Pltf. Ex. B, at 145-146). At the same time that Turgiss was “investigating” AEDs (May through September, 1999), she was also merging the emergency procedures of the various clubs in the combined Club Sports International/Wellbridge entity and developing “best practices” for programs offered by those clubs. She placed these other projects on an equal footing with the investigation of AEDS. Turgiss was not concerned during this period about the possibility of a cardiac arrest at a Wellbridge facility occurring without an AED. (Turgiss dep., Pltf. Ex. B, at 147-148).

131. Turgiss initially recommended to Curtis implementing the ForeRunner biphasic AED, which was approved for use and sale to the public in September, 1996. (Turgiss Letter to Curtis, Pltf. Ex. VV, Bates 274; ForeRunner’s FDA 510K, Pltf. Ex. UU).

132. Wellbridge also considered purchase of another brand of AED, the SurvivaLink, which was approved and available to the public in February, 1995. (*id.*)

133. By late September, 1999, Art Curtis was requesting final pricing on AEDs from manufacturers. (Curtis Letter to HP, Pltf. Ex. VV, Bates no. 00285). He received a quote from Complient for the Lifepak 500 3D Biphasic AEDs and from Hewlett Packard for the ForeRunner AEDs.

134. On October 19, 1999, Mr. Curtis, of Club Sports International, notified regional managers of the health club chain that PhysioControl had been selected as the vendor for the AEDs. The Lifepak 500 was first approved and available to the public in 1996. (LifePak 500’s FDA 510K, Pltf. Ex. UU).

135. Deployment of AEDs at the clubs of the combined Club Sports International/Wellbridge entity was completed in March, 2000, during which most of the training

was done. 40 AEDs were acquired and approximately 600-700 employees were trained. (Curtis dep., Pltf. Ex. I, at 120).

136. Wellbridge's installation of AEDs and training was "not overly difficult," as Curtis explained to IHRSA when it sought support of health club industry leaders to "stop/slow the drive" to make AEDs standard equipment in health clubs in February, 2001:

Helen,

We are probably not much help for IHRSA on this topic. We have already put AEDs in all of our clubs and feel strongly that it is the "right thing to do." We also believe that in the 1 year that we have had them in place, that we have had two successful (sic) resuscitations in our clubs that would not have been possible without the use of the AED. In both instances we were able to confirm the member was in Ventricular Fibrillation.

Going forward as our primary market, the aging baby boomers enter their 5th and 6th decades of life, the risk of a coronary event, including SCA, will increase significantly. It is our position that the responsible thing to do is be prepared. The rollout (sic) of AEDs across our company was not overly difficult, no more difficult that (sic) the rollout (sic) of any of our other new program (sic), the cost did not cause a hardship to the business (the cost of an AED is about the same as a weight machine and less than most CV pieces), and training of staff was not much more difficult that (sic) what we already were doing with CPR training.

Helen, I (sic) our view IHRSA should take the high road on this issues (sic) and support the inclusion of AEDs in clubs as a part of the IHRSA Standards.

See you in San Francisco.

Art Curtis.

(Email from Curtis to Durkin, Pltf. Ex. EE).

137. In February, 2001, Mr. Curtis was interviewed by Club Industry, a respected health and fitness industry periodical concerning the reasons for deployment. He identified an aging membership base as one reason and stated that "...as you are dealing more and more with older adults the chances of having to deal with coronary events within a club become increasingly greater and greater and greater. And so it just seems to make sense that we should have these

things available in our clubs to serve and protect our members.” (“Life Saver or Cash Waster?” Pltf. Ex. II, at 2).

138. In the same article, Mr. Curtis urged other clubs to show initiative and stated “this is a good example of something where, as an industry, we should be...taking a position of responsibility rather than pushing it onto someone else to legislate it for us or create laws that require us to do these things.” (“Life Saver or Cash Waster?” Pltf. Ex. II, at 6-7).

THE PLAINTIFFS, HERBERT FRUH,
VIRGINIA FRUH, INDIVIDUALLY AND
AS PARENT AND NEXT FRIEND OF
TRACEY FRUH AND KEVIN FRUH

By _____
Paul S. Weinberg, Esq. BBO No. 519550
John E. Garber, Esq. BBO No. 635313
Weinberg & Garber, P.C.
71 King Street
Northampton, MA 01060
(413) 582-6886

By _____
Ronald C. Kidd, Esq. BBO No. 270720
Robinson Donovan, P.C.
1500 Main Street, Suite 1600
Springfield, MA 01115
(413) 732-2301

CERTIFICATE OF SERVICE

I, Paul S. Weinberg, Esq., hereby certify that on this 30th day of July, 2003, I served a copy of the above upon the parties in this action, via hand delivery, to counsel, Michael Giunta, Esq., Donovan Hatem and via priority mail Peter Korneffel, Esq. Brownstein Hyatt & Farber, PC.

Subscribed under the penalties of perjury.

Paul S. Weinberg, Esq

