Roger Sullivan
Allan M. McGarvey
John F. Lacey
Ethan Welder
Dustin Leftridge
Jinnifer Jeresek Mariman
McGarvey, Heberling, Sullivan & Lacey, P.C.
345 First Avenue East
Kalispell, MT 59901
(406) 752-5566

Attorneys for MHSL Plaintiffs

IN THE ASBESTOS CLAIMS COURT FOR THE STATE OF MONTANA

IN RE ASBESTOS LITIGATION, *Consolidated Cases*	Cause No. AC 17-0694 PLAINTIFF'S RESPONSE TO BNSF'S MOTION SEEKING ACTIVE STATUS *MacDonald v. BNSF Railway Company*, Cascade County Cause No. DV-16-549

INTRODUCTION

In its *Order Re: Plaintiffs' Motion for Deferred Docket* ("Order re: Deferred Docket") the Court ordered that the following cases be placed on the Deferred Docket:

> Referring to the Plaintiff's Master Claim List, the following cases will be placed on the deferred docket:
>
> (a) The Plaintiff has been diagnosed with a nonmalignant ARD; and
> (b) The Plaintiff has a mild or normal disease severity.

Order Re: Deferred Docket, p. 16. As such, Plaintiff Jason MacDonald's case was placed on the Deferred Docket. *See* Order re: Joint Motion for New Trial Date and Scheduling Order (*Ward et al. v. International Paper et al.*), p. 1 (noting the MacDonald matter "has since been placed on the Deferred Docket"). Defendants BNSF Railway Company and John Swing (collectively "BNSF") do not dispute that fact.

Instead, BNSF alleges that outdated 2016 PFT testing requires the transfer of Mr. MacDonald's case to the Active Docket. In making that argument, BNSF ignores: 1) this Court's stated criteria for deferred cases to be transferred to the Active Docket, and 2) Mr. MacDonald's most recent 2018 PFT testing which confirm he is in the "Normal" disease category. As such, maintaining Mr. MacDonald's presence on the Deferred Docket comports with rationale underlying the Court's *Order Re: Deferred Docket*, which specifically recognized Mr. MacDonald's right to be made whole. For the reasons explained herein, Mr. MacDonald's case should remain on the Deferred Docket.

ARGUMENT

I. Activating Mr. MacDonald's Case Belies the Rationale Behind the *Order re: Deferred Docket.*

The Court's *Order re: Deferred Docket* placed on the Deferred Docket all Plaintiffs on Plaintiffs' Master Claims List who had been diagnosed with nonmalignant ARD and who had Mild or Normal disease severity. Order re: Deferred Docket, p. 16. BNSF does not dispute this.[1] At the October 3, 2018, hearing with the Court, clarity was provided regarding the criteria for the combined "Mild/Norm[al]" disease severity category used by Plaintiffs in creating the initial Master Claims List. As a result, Plaintiffs were directed to create a Master Claims List that separately identified Normal Plaintiffs (≥ 80% of FVC, TLC, DLCO) and Mild Plaintiffs (70%-79% of FVC, TLC, DLCO). Those designations were based on generally accepted medical guidelines for the assessment of pulmonary disease severity. *See* American Thoracic Society, *Lung Function Testing: Selection of Reference Values and Interpretative Strategies,* Am. Rev.

[1] Although not explicitly stated in the *Order re: Deferred Docket*, it is logically presumed that all cases on the Deferred Docket are stayed.

Respir. Dis., 144:1002-1218 (1991), Table 13; American Medical Association, *Guides to the Evaluation of Permanent Impairment (6th Edition* 2009), Table 5-4.

Based on his current 2018 PFTs, Mr. MacDonald is "Normal." Even using the outdated 2016 PFTs used by BNSF, Mr. MacDonald is "Mild." If the Court's intent was indeed for all "Mild" and "Normal" Plaintiffs to remain on the Deferred Docket unless and until they progress to "Moderate," then Mr. MacDonald must remain on the Deferred Docket. Moreover, maintaining Mr. MacDonald's presence on the Deferred Docket comports with rationale underlying the Court's *Order Re: Deferred Docket*, which specifically recognized Mr. MacDonald's right to be made whole:

> Because less than fifty percent of these Plaintiffs may progress to severe disease, Plaintiffs argue that adjudication of such claims would infringe the constitutional guarantee to be made whole….
>
> * * *
>
> Defendants' *Collective Response* addresses this concern only by stating "future damages adequately account for the phenomenon" and that Plaintiff pled for them in his *Complaint.* But, as discussed above, these Plaintiffs likely cannot recover future damages for the risk of a severe illness—it is not reasonably certain their diseases will progress to lung cancer or mesothelioma. A deferred docket, Plaintiffs assert, provides the opportunity for those who may become severely ill to recover fully if their unimpaired condition progresses to cancer or mesothelioma.
>
> The Court agrees.

Order Re: Deferred Docket, at pp. 11-12 (footnotes omitted, underlining added).

II. BNSF Does Not Present Necessary Evidence of the Court's Criteria to Transfer Mr. MacDonald to the Active Docket.

Even if Mild and Normal cases can be activated, BNSF failed to present evidence required to activate Mr. MacDonald's case. The *Order re: Deferred Docket* provides the following criteria to transfer a given Plaintiff from the Deferred Docket to the Active Docket:

> **(2) Transfer to Active Docket**
>
> A case on the deferred docket is "activated" and will be placed on the active docket when the Plaintiff meets the following criteria:
>
> (a) The Plaintiff receives a diagnosis of a malignant ARD;
>
> (b) The Plaintiff dies and there is competent and credible medical evidence that an ARD was a substantial factor in the cause of death;
>
> (c) The Plaintiff has a diagnosis of a nonmalignant ARD; and
>
> (i) a Total Lung Capacity (TLC) measurement of less than 80% of predicted, or
>
> (ii) a Forced Vital Capacity (FVC) of less than 80% of predicted, and a FEV1/FVC ratio greater or equal to 65%; or
>
> (d) The Plaintiff elects to be placed on the active docket.

Order re: Deferred Docket, p. 17.

At issue in BNSF's *Motion* is the criteria in subsection (c). That criteria provides two options for a given Plaintiff to be transferred to the Active Docket: 1) diagnosis of nonmalignant ARD and TLC less than 80% predicted; or 2) diagnosis of nonmalignant ARD and FVC less than 80% of predicted and FEV1/FVC ration great or equal to 65%. Required by both options is a "diagnosis of nonmalignant ARD." The Court provided the following additional criteria regarding the diagnosis of nonmalignant ARD:

> This Court will not impose nonmalignant ARD diagnostic criteria that is more specific than that endorsed by the American Thoracic Society. However, in presenting a diagnosis of a nonmalignant ARD, the Court will expect to see competent and credible evidence from a qualified medical provider of the following:
>
> > (a) Evidence of structural pathology consistent with asbestos related disease as documented by imaging or histology;
> >
> > (b) Evidence of causation by asbestos as documented by the occupational and environmental history, markers of exposure (usually pleural plaques), recovery of asbestos bodies, or other means; and
> >
> > (c) Exclusion of alternative plausible causes for the findings.[99]
>
> Failure to provide evidence regarding these three categories will result in the diagnosis being rejected.

Order re: Deferred Docket, p. 17 (footnote omitted here).

Thus, "in presenting a diagnosis of nonmalignant ARD," the party seeking to transfer a Plaintiff's case from the Deferred Docket to the Active Docket must present the Court with "competent and credible evidence from a qualified medical provider" of a diagnosis of ARD that complies with ATS diagnostic criteria. "Failure to provide evidence regarding these three [ATS] categories will result in the diagnosis being rejected." Order re: Deferred Docket, p. 17.

The burden of presenting evidence of nonmalignant ARD consistent with the Court's criteria must be met by the party seeking to activate a Plaintiff's case. If a Plaintiff seeks activation of their case, he/she will present a diagnosis consistent with the Court's order. Defendants must do the same and cannot simply submit a medical finding they consider invalid. There are legitimate policy reasons for this procedure. As applied to a Plaintiff, he/she will not seek to, nor want to, activate a case unless there is a nonmalignant ARD diagnosis that meets the Court's criteria. Likewise, as applied to Defendants, this burden will ensure that judicial time and

resources are not being spent on cases that Defendants activate upon a Plaintiff barely meeting the PFT criteria only to immediately dispute the ARD diagnosis. The Court's valuable time and resources are best spent resolving the sickest Plaintiffs' cases. Moreover, if Defendants intend to dispute the underlying ARD diagnosis, the better and more efficient solution is to refuse to settle Plaintiff's cases with disputed ARD diagnoses. As has always been the case, Plaintiffs would prefer not to settle these cases in order to allow time to pass to see if more severe disease develops.

In filing their *Motion*, BNSF simply states "MacDonald alleges he was diagnosed with nonmalignant ARD." Motion, p. 2. BNSF fails to present evidence, as required by the *Order re: Deferred Docket*, that the diagnosis complies with ATS diagnostic criteria.[2] As a result of that failure alone, BNSF has failed to meet the Court's criteria to transfer Mr. MacDonald's case from the Deferred Docket to the Active Docket

III. Mr. MacDonald's Current PFTs Do Not Support Activation of His Case.

Even if BNSF presented the requisite evidence to meet the nonmalignant ARD diagnostic criteria, which it did not, BNSF failed to meet the PFT criteria because it is relying on outdated PFTs. Mr. MacDonald's first PFT was taken when he was self-referred to the CARD Clinic for an initial screening. Order re: Deferred Docket, p. 5. Since that time he has had four additional PFTs. Mr. MacDonald's five PFTs are summarized as follows:

[2] BNSF can remedy this particular failure by stipulating that Mr. MacDonald's diagnosis of nonmalignant ARD is supported by competent and credible evidence from a qualified medical provider that there is: (a) evidence of structural pathology consistent with asbestos related disease as documented by imaging or histology; (b) evidence of causation by asbestos as documented by the occupational and environmental history, markers of exposure (usually pleural plaques), recovery of asbestos bodies, or other means; and (c) exclusion of alternative plausible causes for the findings.

Date Location	Age Height	Bronchodilator Testing	FVC - L (% predicted)	FEV1 - L (% predicted)	FEV1/ FVC - %	TLC - L (% predicted)	Conversion Standard	Disease Severity per ATS Criteria
7/8/13 CARD	36 70.2 in.	Pre	4.31 (79%)	3.47 (80%)	80%	Not Tested	NHANES III	Mild
7/6/15 CARD	38 70.2 in.	Pre Post	4.10 (76%) 4.37 (81%)	3.30 (77%) 3.56 (83%)	81% 81%	6.13 (88%)	NHANES III	Mild
6/10/16 Providence Alaska	39 71 in.	Pre	4.36 (79%)	3.21 (73%)	74%	Not Tested	Not Reported	Mild
6/13/16 Providence Alaska	39 71 in.	Pre Post	4.21 (76%) 4.05 (73%)	3.03 (69%) 3.11 (71%)	72% 77%	Not Tested	Not Reported	Mild
6/18/18 CARD	41 70.2 in.	Pre Post	4.51 (85%) 4.49 (85%)	3.62 (86%) 3.65 (86%)	80% 81%	Not Tested	NHANES III	Normal

Mr. MacDonald's most recent PFTs done in 2018 confirm that the criteria to transfer of Mr. MacDonald's case to the Active Docket is not met as his FVC is 85% of predicted (which must be less than 80% predicted to be eligible for activation). Those PFTs confirm Mr. MacDonald is in the "Normal" disease category.

Instead, BNSF relies upon Mr. MacDonald's outdated 2016 PFTs taken in Alaska showing he is in the "Mild" disease category. The most recent PFTs are the most accurate evidence of a Plaintiff's condition and should be used as support for any motion to transfer a case from the Deferred Docket to the Active Docket.[3] The Deferred Docket should address a Plaintiff's current condition such that if he/she progress their case may proceed. Administering the Deferred Docket based on outdated PFTs makes no sense. For example, if a party could pick any PFT they liked, then they could pick an outdated PFT taken at a time when a Plaintiff had an acute respiratory issue, despite the fact all other PFTs, including current PFTs, support Plaintiff remaining on the

[3] For this reason, it is the policy of MHSL to utilize the most recent PFTs on the Master Claims List on file with the Court.

Deferred Docket. In short, that outdated PFT could be used to transfer a case to the Active Docket at any time, regardless of the Plaintiff's current condition. Using outdated PFTs in assessing current pulmonary function is illogical.

As applied here, BNSF ignores Mr. MacDonald's 2018 PFTs because they do not support activation of Mr. MacDonald's case and because they are an improvement on his previous PFTs.[4] That improvement is easily explained. "Actual" values (measured in Liters) are compared to "predicted" values, which are primarily a function of a patient's height, sex, ethnicity, and age. American Thoracic Society/European Respiratory Society Task Force: Standarisation of Lung Function Testing (R. Pellegrino et al.), *Interpretive Strategies for Lung Function Testing,* Eu. Respir. J., Vol. 126, No. 5, p. 949 (2005). While Mr. MacDonald's "actual" lung volumes measured in the PFTs taken at the CARD Clinic have remained nearly the same, when those volumes are converted to "predicted" values, they get better over time because Mr. MacDonald continues to age. Also, Mr. MacDonald lost 12 pounds between his 2016 PFTs and his 2018 PFTs which typically correlates to better conditioning as indicated in his 2018 PFTs, which show slightly increased lung volumes. This is simply another example why the most recent PFTs should be used in support of any motion to activate a case from the Deferred Docket to the Active Docket.

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[4] There is no factual basis to support BNSF's implication that the CARD Clinic was somehow altering the June 18, 2018 PFTs trying to make patients appear better than they are due to Plaintiffs then pending *Motion for a Deferred Docket*. Notably, in that *Motion*, Plaintiffs were advancing the position that no criteria should be applied for a Plaintiff to seek to have their case moved to the Active Docket. Thus, even assuming arguendo the CARD Clinic knew of Plaintiffs' *Motion*, there was no criteria for the CARD Clinic to try to achieve.

IV. The CARD Clinic Properly Documents PFTs.

The CARD Clinic is the only provider of full PFTs (i.e. spirometry, DLCO, and lung volumes) in Lincoln County. BNSF claims the CARD Clinic PFTs should not be used in transferring cases from the Deferred Docket to the Active Docket. If that position were to be countenanced by this Court, that would be an incredible burden on Plaintiffs.

To support their position, BNSF takes issue with the CARD Clinic's documentation of its PFTs. BNSF concedes the CARD Clinic created complete graphic results of Mr. MacDonald's 2013 and 2015 PFTs but alleges that CARD did not create complete graphic results of Mr. MacDonald's 2018 PFTs (and instead only mentioned the improved condition in a clinical note). Motion, p. 3. Apparently, BNSF did not receive an update of Mr. MacDonald's medical records before filing its *Motion*. Attached hereto as **Exhibit A** are the complete graphic results of Mr. MacDonald's 2018 PFTs which Plaintiffs' counsel previously received from the CARD Clinic at the same time they received the corresponding June 2018 clinical note referenced by BNSF. Those graphic results were going to be produced to BNSF as part of Plaintiffs' responses to BNSF's second discovery requests, but those never became due.[5] Pertinent to the issues here, the CARD Clinic does create documentation of its PFTs that exceeds the general practice among most pulmonary function labs. *Cf.* Exhibit A (2018 CARD PFTs) hereto with BNSF's Motion Exhibits A and B (2016 Alaska PFTs).

[5] With respect to discovery, Plaintiffs have responded to BNSF's Master Discovery Requests as well as BNSF's case specific requests (i.e. 30 interrogatories and 14 requests for production). Before the responses to BNSF's second set of case specific discovery requests (i.e. 21 additional interrogatories and 46 additional requests for production) were due, the inadvertently filed *Order* regarding the deferred docket was entered on August 30, 2018. Thereafter, the Court entered its *Order re: Deferred Docket* staying Mr. MacDonald's case on September 13, 2018.

CONCLUSION

In its *Order Re: Deferred Docket* the Court ordered that the following cases be placed on the Deferred Docket:

> Referring to the Plaintiff's Master Claim List, the following cases will be placed on the deferred docket:
>
> (a) The Plaintiff has been diagnosed with a nonmalignant ARD; and
> (b) The Plaintiff has a mild or normal disease severity.

Order Re: Deferred Docket, p. 16.

It is undisputed Mr. MacDonald's case was placed on the Deferred Docket and that Mr. MacDonald's most recent PFTs show he is in the "Normal" disease category. As such, maintaining Mr. MacDonald's presence on the Deferred Docket comports with rationale underlying the Court's *Order Re: Deferred Docket*, which specifically recognized Mr. MacDonald's right to be made whole.

Moreover, BNSF has not presented this Court with evidence demonstrating that Mr. MacDonald's most recent PFTs meet the Court's criteria to transfer his case to the Active Docket nor has BNSF submitted evidence of a diagnosis meeting the criteria set forth by this Court. For the reasons stated herein, BNSF's *Motion* should be denied.

Respectfully submitted this 12th day of October, 2018.

McGARVEY, HEBERLING, SULLIVAN & LACEY, P.C.

By: /s/ Jinnifer J. Mariman
ROGER SULLIVAN
ALLAN McGARVEY
JOHN F. LACEY
ETHAN WELDER
DUSTIN LEFTRIDGE
JINNIFER JERESEK MARIMAN
Attorney for MHSL Plaintiffs

CERTIFICATE OF SERVICE

I, Jinnifer Jeresek Mariman, hereby certify that I have served true and accurate copies of the foregoing Response/Objection - Response to Motion to the following on 10-12-2018:

Amy Poehling Eddy (Attorney)
920 South Main
Kalispell MT 59901
Representing: Amy Eddy
Service Method: eService

Roger M. Sullivan (Attorney)
345 1st Avenue E
MT
Kalispell MT 59901
Representing: Adams, et al
Service Method: eService

Allan M. McGarvey (Attorney)
345 1st Avenue East
Kalispell MT 59901
Representing: Adams, et al
Service Method: eService

Jon L. Heberling (Attorney)
345 First Ave E
Kalispell MT 59901
Representing: Adams, et al
Service Method: eService

John F. Lacey (Attorney)
345 1st Avenue East
Kalispell MT 59901
Representing: Adams, et al
Service Method: eService

Ethan Aubrey Welder (Attorney)
345 1st Avenue East
Kalispell MT 59901
Representing: Adams, et al
Service Method: eService

Dustin Alan Richard Leftridge (Attorney)
345 First Avenue East
Montana
Kalispell MT 59901
Representing: Adams, et al
Service Method: eService

Jeffrey R. Kuchel (Attorney)
305 South 4th Street East
Suite 100
Missoula MT 59801
Representing: Accel Performance Group LLC, et al, MW Customs Papers, LLC
Service Method: eService

Danielle A.R. Coffman (Attorney)
1667 Whitefish Stage Rd
Kalispell MT 59901
Representing: Accel Performance Group LLC, et al, MW Customs Papers, LLC
Service Method: eService

Gary M. Zadick (Attorney)
P.O. Box 1746
#2 Railroad Square, Suite B
Great Falls MT 59403
Representing: Honeywell International
Service Method: eService

Gerry P. Fagan (Attorney)
27 North 27th Street, Suite 1900
P O Box 2559
Billings MT 59103-2559
Representing: CNH Industrial America LLC
Service Method: eService

G. Patrick HagEstad (Attorney)
PO Box 4947
Missoula MT 59806
Representing: Crane Co., United Conveyor Corporation, Riley Stoker Corporation et al
Service Method: eService

Rachel Hendershot Parkin (Attorney)
PO Box 4947
Missoula MT 59806
Representing: Crane Co.
Service Method: eService

Mark Andrew Thieszen (Attorney)
Poore Roth & Robinson, P.C.

1341 Harrison Ave
Butte MT 59701
Representing: The William Powell Company, Atlantic Richfield Company, et al
Service Method: eService

Patrick M. Sullivan (Attorney)
1341 Harrison Ave
Butte MT 59701
Representing: The William Powell Company, Atlantic Richfield Company, et al
Service Method: eService

Jennifer Marie Studebaker (Attorney)
210 East Capitol Street
Suite 2200
Jackson MS 39201
Representing: Goulds Pump LLC, Grinnell Corporation, ITT LLC, et al, International Paper Co.
Service Method: eService

Joshua Alexander Leggett (Attorney)
210 East Capitol Street, Suite 2200
Jackson MS 39201-2375
Representing: Goulds Pump LLC, Grinnell Corporation, ITT LLC, et al, International Paper Co.
Service Method: eService

Vernon M. McFarland (Attorney)
200 South Lamar Street, Suite 100
Jackson MS 39201-4099
Representing: Goulds Pump LLC, Grinnell Corporation, ITT LLC, et al, International Paper Co.
Service Method: eService

Jean Elizabeth Faure (Attorney)
P.O. Box 2466
1314 Central Avenue
Great Falls MT 59403
Representing: Goulds Pump LLC, Grinnell Corporation, ITT LLC, et al, Borg Warner Morse Tec LLC, International Paper Co.
Service Method: eService

Jason Trinity Holden (Attorney)
1314 CENTRAL AVE
P.O. BOX 2466
Montana
GREAT FALLS MT 59403
Representing: Goulds Pump LLC, Grinnell Corporation, ITT LLC, et al, Borg Warner Morse Tec LLC, International Paper Co.
Service Method: eService

Chad E. Adams (Attorney)
PO Box 1697

Helena MT 59624
Representing: Weir Valves & Controls USA, Cyprus Amex Minerals Company, Fischbach and Moore, Inc. et al, American Honda Motor Co., Inc., Harder Mechanical Contractors, Nissan North American Inc.
Service Method: eService

Katie Rose Ranta (Attorney)
Faure Holden, Attorneys at Law, P.C.
1314 Central Avenue
P.O. Box 2466
GREAT FALLS MT 59403
Representing: Borg Warner Morse Tec LLC
Service Method: eService

John Patrick Davis (Attorney)
1341 Harrison Avenue
Butte MT 59701
Representing: Atlantic Richfield Company, et al
Service Method: eService

Stephen Dolan Bell (Attorney)
Dorsey & Whitney LLP
125 Bank Street
Suite 600
Missoula MT 59802
Representing: Ford Motor Company
Service Method: eService

Dan R. Larsen (Attorney)
Dorsey & Whitney LLP
111 South Main
Suite 2100
Salt Lake City UT 84111
Representing: Ford Motor Company
Service Method: eService

Peter L. Helland (Attorney)
311 Klein Avenue, Suite A
P.O. Box 512
Glasgow MT 59230
Representing: Ford Motor Company
Service Method: eService

Kelly Gallinger (Attorney)
315 North 24th Street
Billings MT 59101
Representing: Maryland Casualty Corporation
Service Method: eService

Charles J. Seifert (Attorney)
P.O. Box 598
Helena MT 59624
Representing: Ford Motor Company, Maryland Casualty Corporation
Service Method: eService

Robert J. Phillips (Attorney)
Garlington, Lohn & Robinson, PLLP
P.O. Box 7909
Missoula MT 59807
Representing: BNSF Railway Company
Service Method: eService

Emma Laughlin Mediak (Attorney)
Garlington, Lohn & Robinson, PLLP
P.O. Box 7909
Missoula MT 59807
Representing: BNSF Railway Company
Service Method: eService

Daniel Jordan Auerbach (Attorney)
201 West Railroad St., Suite 300
Missoula MT 59802
Representing: Weir Valves & Controls USA, Cyprus Amex Minerals Company
Service Method: eService

Leo Sean Ward (Attorney)
PO Box 1697
Helena MT 59624
Representing: Weir Valves & Controls USA, Cyprus Amex Minerals Company, Fischbach and Moore, Inc. et al, American Honda Motor Co., Inc., Harder Mechanical Contractors, Nissan North American Inc.
Service Method: eService

Robert B. Pfennigs (Attorney)
P.O. Box 2269
Great Falls MT 59403
Representing: Stimson Lumber Company, Zurn Industries, Inc., Mazda Motor of America, Inc.
Service Method: eService

Rick A. Regh (Attorney)
P.O. Box 2269
GREAT FALLS MT 59403
Representing: Stimson Lumber Company, Zurn Industries, Inc., Mazda Motor of America, Inc.
Service Method: eService

Mark Trevor Wilson (Attorney)
300 Central Ave.
7th Floor

P.O. Box 2269
Great Falls MT 59403
Representing: Stimson Lumber Company, Zurn Industries, Inc., Mazda Motor of America, Inc.
Service Method: eService

Robert M. Murdo (Attorney)
203 N orth Ewing
Helena MT 59601
Representing: Mine Safety Appliance Company LLC
Service Method: eService

Murry Warhank (Attorney)
203 North Ewing Street
Helena MT 59601
Representing: Mine Safety Appliance Company LLC
Service Method: eService

Ben A. Snipes (Attorney)
Kovacich Snipes, PC
P.O. Box 2325
Great Falls MT 59403
Representing: Backen et al, Sue Kukus, et al
Service Method: eService

Mark M. Kovacich (Attorney)
Kovacich Snipes, PC
P.O. Box 2325
Great Falls MT 59403
Representing: Backen et al, Sue Kukus, et al
Service Method: eService

Ross Thomas Johnson (Attorney)
P.O. Box 2325
Great Falls MT 59403
Representing: Backen et al, Sue Kukus, et al
Service Method: eService

Randy J. Cox (Attorney)
P. O. Box 9199
Missoula MT 59807
Representing: A.W. Chesterson Company
Service Method: eService

Zachary Aaron Franz (Attorney)
201 W. Main St.
Suite 300
Missoula MT 59802
Representing: A.W. Chesterson Company
Service Method: eService

M. Covey Morris (Attorney)
Tabor Center
1200 Seventeenth St., Ste. 1900
Denver CO 80202
Representing: FMC Corporation
Service Method: eService

Robert J. Sullivan (Attorney)
PO Box 9199
Missoula MT 59807
Representing: Ingersoll-Rand, Co.
Service Method: eService

Dale R. Cockrell (Attorney)
145 Commons Loop, Suite 200
P.O. Box 7370
Kalispell MT 59904
Representing: State of Montana
Service Method: eService

Vaughn A. Crawford (Attorney)
SNELL & WILMER, L.L.P.
400 East Van Buren
Suite 1900
Phoenix AZ 85004
Representing: The Proctor & Gamble Company et al
Service Method: eService

Tracy H. Fowler (Attorney)
15 West South Temple
Suite 1200
South Jordan UT 84101
Representing: The Proctor & Gamble Company et al
Service Method: eService

Martin S. King (Attorney)
321 West Broadway, Suite 300
P.O. Box 4747
Missoula MT 59806
Representing: Foster Wheeler Energy Services, Inc.
Service Method: eService

Maxon R. Davis (Attorney)
P.O. Box 2103
Great Falls MT 59403
Representing: Continental Casualty Company
Service Method: eService

Tom L. Lewis (Attorney)
2715 Park Garden Lane
Great Falls MT 59404
Representing: Harold N. Samples
Service Method: eService

Keith Edward Ekstrom (Attorney)
601 Carlson Parkway #995
Minnetonka MN 55305
Representing: Brent Wetsch
Service Method: eService

William Rossbach (Attorney)
401 N. Washington
P. O. Box 8988
Missoula MT 59807
Representing: Michael Letasky
Service Method: eService

Kennedy C. Ramos (Attorney)
1717 Pennsylvania Avenue NW
1200
wash DC 20006
Representing: Maryland Casualty Corporation
Service Method: eService

Edward J. Longosz (Attorney)
1717 Pennsylvania Avenue NW
Suite 1200
Washington DC 20006
Representing: Maryland Casualty Corporation
Service Method: eService

Chad M. Knight (Attorney)
929 Pearl Street
Ste. 350
Boulder CO 80302
Representing: BNSF Railway Company
Service Method: eService

Anthony Michael Nicastro (Attorney)
401 North 31st Street
Suite 770
Billings MT 59101
Representing: BNSF Railway Company
Service Method: eService

Nadia Hafeez Patrick (Attorney)
929 Pearl Street Suite 350

Boulder CO 80302
Representing: BNSF Railway Company
Service Method: eService

Kevin A. Twidwell (Attorney)
1911 South Higgins Ave
PO Box 9312
Missoula MT 59807
Representing: Libby School District #4
Service Method: eService

Stephanie A. Hollar (Attorney)
P.O. Box 2269
Great Falls MT 59403
Representing: Stimson Lumber Company
Service Method: eService

Electronically Signed By: Jinnifer Jeresek Mariman
Dated: 10-12-2018