Doc. 140

The State of Ohio,)
County of Cuyahoga.) SS:
IN THE COURT OF COMMON PLEAS

Joshua Paramore, A)
Minor, ete., et al.,)
Plaintiffs)
vs.) Case No. 207608
S. H. Butt, M.D.,)
et al.,)
Defendants)

* * *

Deposition of LINDA DiPASQUALE, a Witness herein, called by the Plaintiffs as upon cross-examination, taken before Janine M. Park, Registered Professional Reporter and a Notary Public within and for The State of Ohio, at the offices of Weston, Rurd, Fallon, Paisley & Howley, 2500 Terminal Tower, Cleveland, Ohio, on Friday, August 21, 1992, at 10:15 a.m.

* * *

CAMILLO COURT REPORTERS
COMPUTERIZED TRANSCRIPTION
589 W. BROAD STREET
ELYRIA, OHIO 44035
(216) 323-3381

APPEARANCES:

On behalf of the Plaintiffs:

Janet D. Tomko, Esq.

On behalf of the befendant, Dr. Butt:

NO APPEARANCE

On behalf of the Defendant, Southwest:

Weston, Hurd, Fallon, Paisley & Howley, by

Donald H. Switzer, Esq.

* * *

LINDA DiPASQUALE,

of lawful age, a Witness herein, being first duly sworn and/or affirmed, as hereinafter certified, was examined and testified as follows:

MS. TOMKO: This is the deposition of Linda DiPasquale.

Is that how you pronounce your name?

THE WITNESS: Silent E.

MS. TOMKO: Okay. DiPasquale?

THE WITNESS: Urn-hum.

MS. TOMKO: In Case No. 207608.

Is there any objections to notice, service of notice or qualifications of the Court Reporter?

NR. SWITZER: No. We ought to note that the doctor's counsel did receive notice.

MS. TOWKO: And chose, apparently, not to attend.

WR. SWITZER: He's not here, so I assume he's not.

CROSS-EXAMINATION OF LINDA DiPASQUALE

BY MS. TOHKO:

Q Would you prefer me to call you Linda or --

A That's fine. Please do.

Q -- or Ms. DiPasquale?

A No, Linda.

Q Okay. Linda, we served a notice of deposition; and you were asked to bring with you your complete file in regard to this matter.

Did you do that?

A Yes
Q Could I see that, please, before we start?
A Well, it's all these. I did leave in my car a lot of depositions that I could not carry.
MR. SWITZER: She didn't bring the transcripts.
Q Okay.
A And you want to see all of this, right?
MR. SWITZER: We've made a copy of her notes.
A That's what this is.
Q All right. You're representing these are all the notes which you have in your possession which you took while reviewing this case or subsequently?
A Yes.
Q Okay.
A And, then, these are all the depositions. This one, too.
Q Thank you.
MR. SWITZER: The rest are in the car.
A And then there's some in the car.
Q So you have some transcripts in the car, as I understand?
A They're depositions.

Q Deposition transcripts?
A They are -- the ones that are here, I can't remember which ones I brought, but the rest are in the car.
MS. TOMKO: Why don't we mark this as an exhibit. Can we do that?
(Handwritten notes and draft of report marked
it A for i
(repor ,
which is the report that was given to us that

A Right.
(

A Yes.
(And you've brought some of them with you today and others are in your car --
A Yes.
Q -- is that right? But these are all-inclusive, this list on Plaintiffs' Exhibit A is all-inclusive of the depositions which you have reviewed to date, the transcripts?
A Correct.
Q Okay.
A Plus, at the bottom, the policies and

procedures for Southwest.
Q It also includes the notes on review of the policies. Does that mean your notes which you just gave me, these?
A Yes.
Q And the addendum to summary of medical records?
A Yes.
Q
A

Q Oh, okay.
A
Q
A Yes.
Q And then policies and procedures from Southwest Hospital and No. 40. What is that?
A It was marked Plaintiffs' Exhibit No. 40.
Q Exhibit No. 40?
A Um-hum.
a This review of medical records and perinatal nursing opinion, which is also included in Plaintiffs' Exhibit A, is the report which I ultimately received.
Do you know?

MR. SWITZER: No, that's her first draft.

Q That's your first draft?

A Yea.

Q So there are some differences?

A Yes.

Q Are there any other drafts that you made other than this one?

A No.

Q Was this draft prepared prior to your reviewing any transcripts in the case, and just from having reviewed these 8 items which are contained in your report?

A It was developed just from this list.

Q Okay.

MR. SWITZER: Hold on, Janet. She did have 2 transcripts, the Plaintiffs' transcripts she had.

Q Okay. And so -- what I mean, this draft, in fact, is, as well as the report that I got, were both based on the 8 items which you have first listed in the reports?

A Yes.

Q And it was subsequent to the time that this draft was made: and the final report, which I

received, was made after you received the other items which are listed on the first page of Plaintiffs' Exhibit A; is that correct?

A Correct, um-hum.

Q Can I ask you a general question, so I don't have to ask you specific questions? And, that is, did any of these transcripts or other materials which you read change the initial opinions which are evidenced by either one of these reports, the draft or the report that you --

A Did not change any of the information I have in there.

Q Did it allow you to add to your opinions or further support your opinions?

A Further support.

Q Did you develop new opinions as a result of the further information which you obtained?

A No.

Q I have here a curriculum vitae which has your name on it. Can you tell me whether or not that is, in fact, pour curriculum vitae and whether or not it's accurate and current other than my notes which appear here?

A Yes.

Q Yes to both questions?

A Yes.
Q All right.
MR. SWITZER. What's the date of that? Does it have your new position on it?
THE WITNESS: It has -- yes, it does, right here.
MR. SWITZER: Oh, okay.
MS. TOMKO: Can we mark this as B?
(CV marked as Plaintiffs' Exhibit B for identification.)
Q When you said it has your new position on it, which one were you referring to? This one here, right here, University Hospitals of Cleveland, McDonald's Womens Hospital, Perinatal Clinical Nurse Specialist?
A Yes.
Q Is that the same title as Jo Ann Szwacxkowski, or is that the same type of job?
A Jo Ana is in a different position than I'm in. I think she used to be a Clinical Nurse Specialist, probably still is a Clinical Nurse Specialist, but is in a different position.
Q So, in other words, she used to hold this position?
A Similar position. She was based in labor and

delivery area.

Q Do you know Jo Ann?

A I've met her just this year.

Q Do you know whether or not she has a good reputation among the nurses?

A

Q What are your current duties, could you tell me?

A

the transport of the mother from different hospitals into McDonald.

I'm also a resource person €or the Nursing Staff on the high risk antepartal unit. I provide staff education for the nurses. I have a clientele of patients that I work with in collaboration with Dr. Nancy Judge in her high risk practice. I am supposed to do some research.

Q She smiles.

A *Yes*, that's essentially --

Q When you say you're a resource person, if a nurse is attending a laboring mom and has some questions or isn't getting an appropriate response

A They could.
Q And a nurse is supposed to be able to recognize abnormal heart pa fetal monitor?
A Yes.
Q And, by that, by abnormal fetal heart patterns, do you take me to mean patterns such as an increase in variability or decrease in variability?

object to the phrase, "do you take me to mean."
Q
stumble through this.

variability?
A *Yes.*
Q Do you consider that abnormal heart patterns on a fetal monitor can reflect as bradycardic events or late decelerations?
A Yes.
Q Okay. And, with respect to recognizing abnormal signs or symptoms and findings in a laboring morn, would you consider an abnormal finding to be slow progression of labor?

A Abnormal?
Q Abnormal.
A I wouldn't consider a slow progression of labor to be abnormal.
Q You would consider that to be normal?
A Yes.
Q Any abnormal laboratory values are also something that should be able to be recognized by a nurse caring for a laboring mom?
A Yes.
Q Identification and recognition of significant data, as I understand, is an important part of a nurse's duties and responsibilities, is that pour opinion?
A Yes.
Q And, also, is it your opinion within the duties and responsibilities and obligations of a nurse to effectively communicate those recognized abnormal signs, symptoms and findings to a physician attending the laboring mom?
Do you agree with that?
A Yes, um-hum.
Q That was a yes?
A Yes.
Q Do you agree or is it your opinion that such

significant information including abnormal findings should also be communicated to other nurses who will assume the care of the patient, the laboring mom, from shift to shift?

A Yes

Q W

I

Q Continuity of care is very important, isn't that right?

A Yes

(

would you agree that all significant abnormal findings must be communicated?

A Yes

(Is timing important on that issue?

A Yes.

Q The nurse has this obligation: and the reason for the need to communicate all significant abnormal findings is so that the physician can have a complete and full basis on which to make an informed decision with respect to the physician or patient care.

Would you agree with that?

A Yes.

Q Would you agree that the nurse in the

physician's absence is the eyes and the ears of the doctor?

MR. SWITZER: Objection. And I can't envision how that can happen.

MS. TOMKO: I had 9 years on the other side.

MR. SWITZER: Eyes and ears, it must be a new type of transplant procedure.

Q Let me say it this way.

MR. SWITZER: No, go ahead, Janet.

Q If the nurse doesn't see or hear it in the absence of the physician, it doesn't get seen or heard, is that right?

A Host probably, *yes.*

Q Do you agree that if a nurse is not adequately communicating all significantly abnormal findings and information to a physician, she's preventing the physician from making fully informed decisions with respect to what is needed for the patient?

HR. SWSTZER: Objection.

A Would you read that again?

MS. TOMKO: Well, I kind of changed it from my notes.

MR. SWITZER: Why don't you go ahead and read the question back.

sure that that communication exists, is that correct?

A Yes.

Q And so, if you, as a nurse, understand that the physician isn't reading the nurse's notes, you would still have an obligation to verbally communicate to them?

A Yes.

Q Does constant attendance -- I notice you used that phrase in your report -- equal good nursing care?

A No.

Q You need someone there who is able to assess, recognize and interpret information available to them, wouldn't you?

A Yes.

Q Do you agree and is it your opinion that a nurse should be trained to determine what is significant information to which a doctor must be made privy?

A Should be trained?

Q Trained like a pit bull.

A Right, educated.

Q Let me rephrase it, okay? Should a nurse be educated, then, and be able to determine what is

significant information to which a doctor must be made privy?

A Yes.

Q And, when charged with the responsibility to monitor a laboring mom or unborn baby, a nurse is trained, wouldn't you agree, to determine abnormal and significant findings which either need nursing intervention or need immediate physician communication or potential physician intervention?

Would you agree with that?

A Yes.

Q A nurse must also determine which abnormal findings are of such importance that they should be communicated immediately to the physician, and which abnormal findings do not create an urgent need to call a physician.

Would you agree with that?

A *Yes.*

Q If you don't agree with these, tell me. I made them up at 4:00 o'clock in the morning, so -- is it true that in order for a nurse to know what is significantly abnormal, a nurse has to know what signs and symptoms and findings in a mom, in a laboring mom, are potential evidence of harm to the patient, either mom or baby?

A Yes.
Q Not only does a nurse have to determine what is abnormal and what is normal in a laboring mom and an unborn baby, but the nurse should have some understanding as to what is or could be causing an abnormal finding in such a situation to determine how serious and immediate the response of the nurse has to be.
Would you agree with that?
A Yes.
Q And whether or not immediate physician intervention is necessary?
A Right.
Q Is it your opinion that the nurse who is unable to recognize significant abnormal findings in a laboring mom is not practicing within the standard of care?
A Correct.
Q Is it pour opinion that the nurse who is able to and does recognize abnormal findings in a laboring mom and communicates those findings to the physician is, or, with respect to that nursing duty, practicing within the appropriate standard of nursing care?
A Yes.

Q Okay. Is it your opinion that the nurse who is unable to toll just what is abnormal versus normal is also not fulfilling her nursing obligations; and, hence, dewiating from an acceptable standard of care?

A Yes.

Q Would you agree that the reason for that as being unable to determine just what is or is not significantly abnormal prevents her from proper and complete communication with the physician?

If she can't, if she doesn't know what she's seeing, then she can't communicate it, is that correct?

A True.

Q And so, if she doesn't know what's normal and what's abnormal, then she surely can't communicate abnormal findings to the physician, is that correct?

A Yes.

Q How many times did you review this chart and the fetal monitoring strips in preparation for your deposition today or in preparation for rendering any reports?

A Oh, let's see.

Q Ballpark.

A 5, 10; 5 times.
Q Okay. As a nurse serving as an expert in the area of appropriate nursing care for the hospital, and having reached conclusions that Dr. Butt was, indeed, kept informed -- which is one of your conclusions, isn't that correct?
A Yes.
Q -- you must have determined, first, as I understand, what information was necessary to communicate to the doctor in order to meet an appropriate standard of nursing care?
A *Yes.*
Q Did you do that?
A Yes.
Q And, then, you must have determined that all of that information was, indeed, recognized and identified by the nurses who took care of the mom and baby on both shifts; is that correct?
A *Yes.*
Q And, then, you must have determined that the information which was recognized and identified was, indeed, communicated to the physician so that the physician was able to make an informed decision?
A Pes.

Q And is that what, in fact, you did in this case? You, first of all, assessed that the information that was necessary -- strike that.

You first determined what information was necessary for the nurses to identify in order for them to meet an appropriate standard of nursing care?

A *Yes.*

Q And then you determined that that information was, indeed, recognized and identified by the nurses who were caring for this mother on the shift, correct?

A *Yes.*

Q And then you determined that that information that was necessary was communicated to the physician?

A Yes.

Q And not only was communicated to the physician, but was communicated in a timely manner?

A Yes.

Q In your mind, are there any -- it has to be in your mind, there's no other place for it to be -- are there any circumstances when a nurse is watching a laboring mother and feels that the baby is in distress that would justify the nurse going

over the head of the physician and seeking help from her supervisor?
A Yes.
Q And what typical situation would that be?
A Where it was obvious that the fetus was in danger or that the mother was in danger.
Q What is the significance, if any, to you, as a nurse, of clear amniotic fluid at 1:40 a.m.?
A In this particular case?
Q In this particular case.
A The significance of clear amniotic fluid?
Q Reassuring?
A *Yes.*
Q Any other significance?
A No.
Q Did this labor progress, did this labor progress on the Friedman curve for a second child, do you know?
A I didn't plot it out. It was probably a little bit slow in the active phase.
Q Does that have any significance for you?
A No.
Q What are the potential causes of slow progression of labor?
A Ineffective uterine contractions, large baby.

Q Anything else?
A Medication.
Q Anything else?
A Not that I can think of.
Q How about chorioamnionitis?
A And slow progression of labor?
Q Yes.
A I don't know if there's a relationship.
Q Is there a way to determine whether or not there's ineffective uterine contractions, or is that circular logic?
A In this particular case, I don't believe she was monitored internally with a pressure monitor to gauge the intensity.
Q You are correct.
A They were certainly frequent enough. I don't know how strong they were, so --
Q Is there anything to determine whether or not this was a large baby? I mean, can you palpate and determine that the baby is apparently or seemingly not too big to be born by vaginal delivery?
A You could. And, speaking of large, you're talking also about bigness of the head or the presenting part.
Q Shoulders?

A Yeah, shoulders.
Q Okay. Is there any indication that this delivery could not have been perfected by vaginal delivery based on any size of the baby?
A I didn't see anything in the record that spoke to size of the baby. It really wasn't spoken to at all.
Q Understanding that you did not have the transcript of the nurses, or the transcripts of the nurses prior to rendering your reports --
A Um-hum.
Q -- and that your opinions have not changed, I want you to assume that there are no entries in the progress notes of Dr. Butt from 1:55 until 8:45.

I want you to assume further that Nurse Sarnicki recognized and testified that, "There were repeated instances of nonreassuring fetal status that had been reported to him," Dr. Butt, and is not reflected in his progress notes.

Based on those assumptions in reaching your conclusion that the nurse met an appropriate standard of care, did you choose to believe the nursing communication only occurred when it is documented in the medical records, and the extent of communication which occurred is only that which

Q And, based on your training and experience going through the record, there were pieces of information as the labor progressed, which, in order for a nurse to meet an appropriate standard of cars, needed communicated to the physician; is that correct?

A Yes.

Q And, as you sit here today, you are not sure exactly what was communicated to the physician each time that the nurse saps, "Patient care discussed with physician," or something of that sort, but you assume that the things that she's writing about in her notes or the conclusions that should have been reached at that point were, in fact, communicated to the physician?

MR. SWITZER: Wait a minute. Let me just make an objection here. You're now extending -- pour earlier questions had to do as of the time she prepared her report.

MS. TOHKO: And 3 said as you sit here today.

WR. SWITZER: So now we have deposition testimony, so she's talking about August 21st, I guess.

MS. TONKO: Can you read back my

question?

(Question read.)

Q Did you understand that or is that too long?

A It's long.

Q Did you understand it?

A Yes.

Q Can you answer it or should I rephrase it?

A Well, rephrase it.

Q Thank you. Shoot, the ball's in my court.

As a nursing expert in this case, you identified the times that communication was made with the physician as the labor progressed, did you not?

A Yes.

Q And, even though a note may not have said exactly what was discussed with the patient's physician, you assumed during each of those discussions that all necessary and significant information was communicated to the physician; is that correct?

A Yes.

Q And your assumption is based on what significant information was there in the chart to be seen; is that correct?

A Yes.

Q And, when the nurse doesn't specify in the chart that she recognized a condition or finding of significance, and when you recognized in the chart if there was ever a difference, did you take that to mean the nurse would not have communicated that specific finding? In other words -- strike that.

Did you have to see the nurse record a specific finding in the chart for you to assume that when she talked with the doctor, she ultimately told him about it?

A The nurse could tell the doctor more than she wrote.

Q Okay. Do you assume that she told the doctor everything she wrote?

A *Yes.*

Q If, in fact, there were late decelerations, which are not noted in the chart or identified, did you assume anything with respect to whether or not those were communicated to the physician?

A Did I assume they were communicated to the physician? No, if it was not documented.

Q What are the causes of variable decelerations, can you tell me?

A Cord compression.

Q Anything else?

A No.
Q Cord compression could also include vasocontraction, potentially; and that's a form of cord compression, isn't it?
A Vasoconstriction, yes, in the cord.
Q Well, all the experts have been using vasocontraction, but -- vasoconstriction?
A Um-hum, yes.
Q Okay. Should a nurse be expected to know the potential cause of variable decelerations to discern whether or not it's important enough to tell the doctor about? Strike that.
Should a doctor be notified of persistent patterns of variable decelerations?
A Yes.
Q And what's the reason for that?
A Persistent patterns of variable decelerations cause constriction of blood flow to the fetus.
Q Could limit the oxygen that the baby's getting?
A Sure, urn-hum.
Q What do you call persistent?
A Hours.
Q Hours of variable decels?
A Yes.

Q How many would you need to see in an hour in order to call it a persistent pattern of variable decels?

A That's very individualized. It would have to be in connection with the number of contractions that she was having and other parameters along with the variable decelerations.

Q Can you tell me what the standard of care is with respect to informing a doctor of variable decelerations, late decelerations or bradycardic events?

We had testimony from one of the nurses that all late decelerations should be communicated to the physician. Do you agree with that?

A No.

Q What is pour standard with respect to communication to the physician on each of those subjects, late decelerations, variable decelerations and bradycardic events, if you want to consider that a different --

A Could I take each one of those?

Q Sure, that's what I want you to do.

a Okay. Variable decelerations, if they were a typical variable deceleration with poor variability in between decelerations and lasting for more than

30 minutes and not responding to any interventions, I would do -- I would contact the physician.

Q Okay.

A Late decelerations that were not responding to interventions that I did would be reported.

Q By not responding to interventions, if you, in fact, correct a late deceleration and then have that pattern recurring, would you contact the physician even though you were getting a resolution at each late deceleration?

Do you understand what I mean?

A Probably.

Q Probably. You do understand what I mean, you would probably?

A Yes, I would probably contact the physician.

Q Okay. Can you look in the chart -- do you have the chart there? Is that it?

MR. SWITZER: Yes.

A It's in that stack of stuff, too.

Q Oh, I have it, too?

A I didn't have a band or anything around it.

Q Why don't we refer to pages which are marked. That will be a lot easier, and we'll use that.

A Do you want me to take those?

Q Would you take that back? I mag need to copy

those down and check them to make sure I have every one, but otherwise --

MR. SWITZER: What page are you looking at?

MS. TOMKO: 58.

MR. SWITZER: Okay.

Q As I understand, it says, "Dr. Butt called, informed of patient's status," is that correct?

A Yes.

Q

what information should be communicated during that

A

Q If the nurse does not communicate all of that information which you said meets an acceptable standard of care, is she deviating from an acceptable standard?

A She's not communicating all that?

Q I asked you what information is necessary to meet an acceptable standard of care.

A Um-hum.

Q And so you would agree that she would be deviating from an acceptable standard if, in fact, that information which you just considered

significant was not communicated to the physician; is that correct?
A Right.
Q Do you come to the conclusion that Nurse Sarnicki reported a11 of those items?
A Sarnicki, I don't think she was the one who had written this page.
Q Oh, I'm sorry. The nurse who wrote the note, did you come to the conclusion that that was, in fact, probably communicated?
A Yes.
Q And the basis of that opinion?
A What's here in the record.
Q What it saps is, "Informed of patient's status," you would assume --
A Well, all that's in front of that, I would assume she would tell the physician.
Q Would you consider the long-term variability on admission or once the monitor's placed to be moderate?
A I'd have to look at it again. Should I look at mine?
Q Please.
A Okay. They're in pieces, so I have to get the right time.

MR. SWITZER: Why don't you just look through here. Here's where it starts.

A To be moderate? No, it's average long-term variability.

Q What's your definitions of average and moderate long-term variability?

A Average is 6 to 10, moderate is 11 through 15, I think, and then over that is marked.

Q Does average variability imply anything other than a healthy, normal baby? Is there any cause for concern?

A Is there any cause? No, no cause for concern.

Q Did you read the transcript of Dr. Post?

A Yes, the first part of his. I understand it was 2 days.

MR. SHITZER: I just got the second half.

Q Okay. As I understand, Dr. Butt comes in and does an amniotomy. And that is at 1:40. Is that correct? Is that your understanding?

A I'd have to look at the time.

Q Page 80.

MR. SWITZER: Oh, you're looking at the strip, okay.

A "Amniotomy per Dr. Butt."

Q All right?
A "Clear fluid."
Q All right.
A 1:40.
Q The next time, as I understand it, Dr. Butt comes in at 2:17, where it saps, "Dr. Butt here." And that's on Page 59, is that correct?
A Um-hum, pes.
Q To meet an appropriate standard of cars, and with everything that's gone on during that time period, what should the nurse communicate to the physician?
A From the time of the amniotomp until 2:17?
Q Well, if you feel that the nurse should recommunicate anything that went before the last time she saw the doctor, you can tell me that, too, but I'm asking you in total, what should the nurse communicate to Dr. Butt when she saw him at 2:17?
A If there's any change in the patient or the fetal status.
Q Well, that's what I'm asking you. In this chart, specific to this case, can you tell me at 2:17 what specific information a nurse should have communicated to Dr. Butt when she sees him at 2:17 in order to meet an appropriate standard of nursing

care?
A Well, let's see. She would say that she noted some decelerations and she attempted to place an internal fetal monitor on the patient.
Q Would that be it?
A That the patient continues to leak large amounts of amniotic fluid. What I'm doing is reading off the strip.
Q Okay. But you are answering my question, is that right?
A Yes, urn-hum. That she placed oxygen on the patient. That she took the oxygen off about, let's see -- 15 minutes she had had the oxygen on, she took it off.
Maybe she would tell what the vital signs were if she had taken them. That's on another piece of pager here.
Q If she didn't communicate that information to the physician, would she be deviating from the acceptable standard of care? And that's just the reverse of the question I asked you.
A Would she be deviating from the standard of care, *yes.*
Q Okay. Now, why is an internal fetal monitor needed at this point in time, can you tell me?

A Well, evidently, Miss Sarnicki thought that she probably needed it because of, let's see, because the amniotomy was done. So there was access, probably, to get a better strip.

Q Okay. Why is there -- why is it significant that there's large amounts of amniotic fluid?

A Probably she wrote that because she was unable to get tho IFM on, and that could be a reason she couldn't attach it to the fetal scalp if there was a lot of fluid.

a Rather than guessing her thought process, can you tell me what reasons there may be for documenting large amounts of amniotic fluid or what the significance of that may mean?

A No, I don't know what the significance would be.

a As I understand, the next time Dr. Butt's conferred with, and I may be wrong, is 4:21, where it saps, "Conferred with Dr. Butt re patient's status. Orders received." And that's on Page 60, as I understand.

Tell me, to meet a minimum acceptable level of nursing care, and based on everything you see in the chart that's gone on before 4:21, what needs to be communicated to the doctor at this point?

A She would communicate what the vagina1 exams indicated; that the patient was 3 centimeters, that the base1ine was -- the baseline of the fetus was right around 150 to 160 with some decelerations that wore probably head compressions. If I remember, that's what she called those.

What the vital signs were, that she gave the patient Demerol and Vistaril, and she probably should have indicated to the physieian how the patient reacted to the medication. And it looks like that she didn't react well, so they had to give her some more at 4:17.

Q If she didn't communicate all those things which you stated meets an acceptable standard or level of care, was she then deviating from an acceptable standard of care?

A *Yes.*

Q Should she have concerned herself and told the doctor regarding the slow progression of labor by 3:30 in the morning?

A By 3:30, the slow progression of labor -- let's see, that the patient was just dilated to 3 centimeters?

Q Yes.

A I moan, she probably told him that the patient

was 3 centimeters. I don't know that she told him it was slow.

Q So is it your testimony, then, that she has to simply tell him that the patient is 3 centimeters dilated, or does a nurse hawe an obligation to look at the whole picture and remind the doctor that the patient has only dilated so much, or, to her, it's slow, or some other communication other than just giving him a number?

A I think it's appropriate for the nurses to give him the number, the feel of the cervix or whatewer.

Q Okay.

A Especially, if he's not doing it himself.

Q Did you agree, as you reviewed this chart, with Nurse Sarnicki that at the change of shift the baby was showing signs of nonreassuring status?

A There were some changes in the fetal status that I noted, also. I don't know that I would call them nonreassuring.

There were certainly changes from what had gone on earlier in the night or earlier in the morning; baseline had changed, there were some late decelerations, maternal temperature was obvious.

Q Are any of those reassuring to you?

A We11, if you look at the tota1 picture, I wouldn't eall them nonreassuring, because there was still some variability in the fetus, and I looked at that.
Q So, with all of those things, you would have had to see a loss of variability in order to call it a nonreassuring status?
A Sure.
Q Do you agree that a nonreassuring fetal status can be assessed by a scalp pH being obtained by a physician?
A That's one way of evaluating a fetus, yes.
Q Do you agree that nurses have a professional responsibility to protect their patients from harm?
A *Yes.*
Q Is it pour opinion that if a nurse is not reassured by a physician's assessment or care plan that nurse has the right and obligation to question a physician's order?
A Yes.
Q What if there's a lack of an order which may be harmful to the mother or the fetus, would you question the lack of that order?
A Yes.
Q Did you take into consideration when deciding

whether or not Nurse Sarnicki met an acceptable level of nursing care, her testimony that she frequently went out to Dr. Butt and told him what her findings were every time that she noted them in the progress records and probably sometimes that are not noted?

Did you take that into consideration when you determined that she met an acceptable standard of care?

A Yes.

Q If a nurse is that concerned, as evidenced by her testimony, with respect to fetal status, would it be appropriate to communicate that concern to the physician?

A Yes.

Q If a nurse believes that her patient is not receiving medical care which a patient should be receiving, what is the nurse's responsibility?

A To contact her supervisor.

Q I want you to assume for the purposes of my next question that Nurse Sarnicki testified that she reached the conclusion that, "As a consequence of these nonreassuring signs, additional information should be obtained."

I want you to assume further that she

testified, "You would get further information about fetal status that you could not obtain merely by looking at the strip, which would be a scalp pH."

Do you agree with Nurse Sarnicki, if that is, in fact, her testimony, that such information was necessary the morning of 6-29?

A Yes.

Q So you would agree that the medical care which Nurse Sarnicki recognized as being necessary, that is, obtaining a scalp pH to further assess the baby's needs, was an appropriate concern of Nurse Sarnicki?

A Yes.

MR. SWITZER: Objection.

Q Can you tell me what the effect of 17 vaginal exams has on increasing the possibility of infection?

A I don't know.

Q Do vaginal exams increase the possibility of infection?

A I've heard conf1 cting reports from physicians about that. I would think that it probably would, but I don't know if there's anything in the literature that supports that.

Q As you reviewed this chart a number of times,

did you share the same concerns that Nurse Sarnicki testified to with respect to or for the welfare of this baby by 6:00 a.m.?

MR. SWITZER: Objection. I think you're mischaracterizing, but You can answer that question.

A Was I concerned, is that what you're asking? Yes.

Q As you reviewed the chart, and now that I've understood that you've reviewed Nurse Sarnicki's transcripts, did you come to the same conclusions Nurse Sarnicki did when she testified, "I was concerned when I saw the rise in fetal heart tones, the baseline rise in fetal heart tones, that there was a possibility of incipient chorioamnionitis"?

A Yes.

Q Did you come to that concern?

A Yes.

Q Did you, when reviewing the chart, recognize this possibility as early as 6:00 o'clock?

A That there was a possible infection?

Q Yes.

A Yes.

Q What is chorioamnionitis?

A An infection of the chorion and the amnion.

Q Is it within appropriate standards of nursing care to be able to recognize these signs that she recognized as signs of possible chorioamnionitis?
A I think a nurse, a prudent nurse, would recognize the signs of infection, whether it's chorioamnionitis or whatever.
Q When you say prudent, you're saying a nurse practicing within an acceptable standard of care?
A Yes; an elevated temperature and a rising baseline, something's going on.
Q And a nurse has an obligation to know what potentially dangerous conditions would be reflected by a fetal heart rate pattern or a rise in maternal temperature, is that correct?
MR. SWITZER: Objection.
A Would you ask that again?
(Question read.)
A I don't understand the question.
Q Let me see. Is chorioamnionitis a potentially dangerous problem?
A Potentially dangerous, yes.
Q Do you know if, in fact, a diagnosis is made of chorioamnianitis whether or not physicians would instruct nurses to prepare for an immediate C-section?

chorioamnionitis, can you tell me whether or not there would be, as a nurse, any other considerations in a differential diagnosis, a differential diagnosis of a nurse?

MR. SWITZER: Objection, I don't think there's any such thing under Ohio Law, but go ahead and answer that.

A If the nurse is thinking of all the things that could be wrong, the patient might be dehydrated, and that's why the elevated temperature.

Q Okay. Any other explanation for these symptoms as they're documented by Nurse Sarnicki and testified to by Nurse Sarnicki around the 6:00 o'clock period?

A Just that there's infection or that the woman is dehydrated.

Q Is there any indication in this chart that this woman is dehydrated?

A Oh, let me look. Let me see if she ate before she came in. She had an IV going. Let me see. They usually put it down here. Last oral intake 6-28, 6:00 p.m.; liquid 6-28, 9:30, she had pop at 9:30. She was working very hard with her contractions. She had an emesis sometime in here,

I remember seeing that.

Yes, could be, she could be dehydrated.

Q What's the nursing intervention for dehydration?

A Providing the intravenous fluids or allowing the physician to know the signs and symptoms that she's picking up; the elevated temperature, the fact that the woman had an emesis, her urine output.

Q As a nurse practicing within an acceptable standard of care, would you assign chorioamnionitis at 6:00 p.m. as having a high probability of being the explanation for these signs and symptoms which are being reported by Nurse Sarnicki?

HR. SWITZER: Objection.

A I would say infection. I wouldn't say chorioamnionitis.

Q Okay. If there is an infection, would you, as a nurse, expect that more, as Nurse Sarnicki did, that more information was needed to assess fetal status?

A Yes.

Q Would you consider, as a nurse, that a scalp pH was necessary to assess oxygenation to the baby at this time?

A That's one of the ways.

Q I want you to assume hypothetically that Nurse Sarnicki by 4:20 went to the physician and said, "I'm concerned here. She's pushing against the cervix. I'm concerned that the cervix may be edematous. And I'm wondering, you know, with the strength of these contractions why she's not progressing faster. And I'm basically concerned because of her involuntary pushing that she may retard the progress of the labor, because the cervix is not well dilated."

I want you to assume that Nurse Sarnicki testified that at 5:50, "When I get the first evidence of an increased temperature, I'm saying now we have an edematous cervix, still no progress, I'm getting bradycardia here, and I have a rising temperature. I'm putting all these elements together before him and saying, this is what I'm seeing in the course of this labor. And 3 or 4 of those are not reassuring. What orders do you have for me?"

Based on those assumptions that she will testify that those communications were had with the physician, and that she recognized what she said she recognized, to meet an acceptable standard of

nursing care, was it necessary for Nurse Sarnicki to communicate that which she said she communicated to the physician at that time?

A Was it necessary?

Q Yes.

A Yes.

Q Okay. And, to meet an acceptable standard of nursing care, was it necessary to give him each piece of that information which she claimed she gave him?

A Yes.

Q And, as a nurse, assuming what I just asked you to assume, was it appropriate for Nurse Sarnicki to make her own nursing assessments and communicate those assessments?

A Yes.

Q And was it appropriate based on those assumptions and good nursing care to reach conclusions that additional information was needed and communicate that concern to Dr. Butt?

A Yes.

Q Okay. Does Nurse Sarnicki have an obligation to make sure she's adequately communicating her concerns to Dr. Butt in this situation?

A What was the first part of the question?

Q Does Nurse Sarnicki have an obligation to make sure she is adequately communicating her concerns to Dr. Butt?
A Yes
Q Do you agree with Nurse Sarnicki that based on those assumptions of what she told the doctor that she had done all she could do without further orders?
A *Yes.*
Q What is the obligation of a nurse when she concludes, as Nurse Sarnicki did, that she needed additional information; and that for the well-being of the mom and baby more information is needed with respect to fetal status: and that she has no orders which allow her to obtain more information; and because of her determination that there may be infection in the mom, there is a possibility or risk of harm to the baby if the situation is permitted to continue without further information?
A What is her obligation?
Q What is her obligation?
MR. SWITZER: You're asking her to assume that as being true?
Q I want you to assume that as being true.
A To make sure that Dr. Butt understands where

she's coming from, that's her obligation; and for him to realize her concern; and then to discuss the plan of care with him and see what he has to say.

Q And, if she communicates what she said she communicated to the physician, including her concerns and including her concern especially of infection or incipient chorioamnionitis and the need for further information, and communicates no further than that, and gets no response from the physician, what is her obligation at that point?

A Probably to inform her supervisor.

Q If we are to believe Nurse Sarnicki had those concerns, and she said to Dr. Butt what she said she said, and got no order which would allow her to obtain additional information which she said she needed, did she then have an obligation at that point to go to her supervisor?

MR. SRITZER: I'll just object to the characterization of the evidence, but go ahead.

A *Yes.*

Q Is there any indication in the chart that she did go to her supervisor at any time during her shift?

A In her chart, in this medical record, I don't --

Q Strike that. Without going through the chart, I don't want to do that right now.

Let me ask you this: When you said she had an obligation to go to her supervisor, rather than just going to her supervisor and saying, hello, how are you today, what obligation does she have to communicate?

A To communicate her concerns to her supervisor or her charge nurse.

Q And, based on what you see in the record and based on what she said happened in her deposition transcript, can you tell me what information would have been communicated to a supervisor at that tirne?

NR. SWITZER: What time are you talking about?

Q Well, we're talking about 6:00 o'clock when she has --

A This is based on her deposition and all of the information that we have?

Q That's right. Based on her deposition, based on the chart, knowing what she was thinking now that you've road her transcript, and knowing what she was thinking at the time, and knowing that she determined that more information was needed, and

knowing that she got no response, or assuming that she got no response from Dr. Butt for more information, and knowing, as you've just told me she would have, under those circumstances, had an obligation to go to her supervisor, what should she have said to her supervisor?

MR. SWITZER: Let me just note an objection. That is mischaracterizing her testimony, but go ahead. You're assuming what the attorney says is true.

A She would inform her supervisor of all of those things that we just talked about.

Q Of all of her concerns?

A *Yes.*

Q Okay.

A And I think that she did. It seems like I remember that she did that.

Q Do you know what time she did that?

A No, I can't remember without looking at the records.

Q Wow, I want you to assume for this next hypothetical that all of her concerns -- let me strike that.

I want you to assume that nurse Sarnicki had the concerns to which she testified in her

transcript.

I want you to assume that she communicated all the information which she says she communicated to Dr. Butt at approximately 6:00 o'clock, 6:20, and I want you to further assume that Dr. Butt neither ordered antibiotics, nor ordered a C-section, nor did Be order a fetal scalp.

If, in fact, Nurse Sarnicki had then gone to her supervisor with the information which you say she should have given her, what would be the appropriate response of the supervisor?

MR. SWITZER: Objection. Go ahead.

A To review all of the circumstances. That would have been the response of the supervisor; discuss the plan of care with Eileen and Dr. Butt, probably involve him.

Q Would the supervisor have had any further obligation?

A That's hard to say. I mean, if she reviewed the strips and came to similar conclusions as Eileen, and then discussed with Dr. Butt, maybe he reassured her, and there would be no further need to do anything else.

Q If you were, in fact, the supervisor, and this nurse came to you with her concerns to which you've

already testified, and if you reviewed this chart which you've now reviewed at least 5 times, first of all, you've told me you would have shared the same concerns; is that right?

A Yes.

Q As the supervisor, would you then have taken the additional step and gone to Dr. Butt to discuss his care plan?

A Yes.

Q And, in this hypothetical situation, had you discussed Dr. Butt's care plan, and still did not receive an order which would allow you mors information regarding this fetus, what would you have done?

A Well, it depends on what Dr. Butt would tell me.

a Can you think of anything in this chart that he could tell you that would convince you that more information was not necessary?

Can you think of any set of circumstances that he could tell you which would convince you that more information was not necessary?

MR. SWITZER: Are you talking about 6:00?

A Her temperature is up to 38, and fetal heart

is only 60.

Q I'd like --

A He might say to me hypothetically, Linda, the variability looks okay to me. What do you want me to do?

And I would say how about a scalp pH. And I don't think he did those, because I read his deposition. That was not something that he routinely did.

Then I might say what about a vibroacoustie stimulation. And 1 don't know if Southwest had that.

And then I might say, well, how about just a vaginal stimulation of the fetal scalp to see if you get any accelerations. Or what is pour idea about starting antibiotics on a woman who has an elevated temp. Those are things that I might say to him.

Q You would suggest a treatment plan?

A Sure.

Q What if he still did nothing?

A Well, it would depend on our conversation.

Q Well, I mean, your conversation is suggesting to him. I'm asking you what if, in fact, you get no positive response?

that said I would be satisfied with him doing nothing until I saw, correct me if I'm wrong, nonreassuring signs or something else on the fetal monitor, at what point in time would that have been to where you would have not been satisfied then with Dr. Butt doing nothing?

MR. SWITZER: Objection. He didn't do nothing.

A I don't think there's anything in here that I would see -- I mean, he later did some cultures.

Q If the baby is in an infected amniotic fluid, and there's a risk of sepsis in the baby or meningitis, and you, as a nurse, understand those risks, would you be content with a doctor obtaining another culture as opposed to direct physician intervention?

MR. SWITZER: Objection.

Q I'm just asking. If you would, tell me.

MR. SWITZER: Objection.

A No, I wouldn't be satisfied.

Q I want you to assume that Nurse Sarnicki has testified that around 5:06, 5:07, during an attempt to place an internal monitor, there was an episode of bradycardia. And one of Nurse Sarnicki's responses was to yell down the hall to Bonnie

Mistak, "Bonnie, I'm going down, I have heart tones going down."

And she testified that the purpose of that communication was that if it had not corrected, we would need to go for immediate crash section

My question, based on that hypothetical testimony that I'm giving you, first of all, have you ever personally been in that situation?

A Yes.

Q Would you agree that a nurse's duties during such an event is to inform the physician immediately, and the charge nurse, so that a C-section could be performed immediately, if necessary?

A Yes.

Q When the temperature increases at 5:50, did you understand that the last temperature taken had been almost 2 hours prior at 4:00 o'clock? Did you understand that from the record?

A I didn't put any significance to it.

Q Is that what you understand the record to reflect?

A I would have to go and look and see.

Q I want you to assume for the purposes of my question --

A Assume?
Q No, I'm just making it easier. I want you to assume for purposes of my question that the temperature was taken at 4:00 o'clock, and that temperature was noted to be 37.2.
A Um-hum.
Q And then the next temperature was taken at 5:50. Would you consider that appropriate nursing care?
A Yes.
Q Do you have any opinion as to what the temperature would have been had it been taken at 5:00 o'clock?
A No.
Q Is it your opinion that a nurse communicating with the second shift coming on has a duty to make sure that second shift understands the signs and symptoms which were perceived the previous shift?
A Yes.
Q And the nurse who is giving report to the other nurse coming on in the second shift has a duty to make sure that nurse understands the concerns of the previous shift with respect to fetal status?
Would you agree with that?

A Yes.
Q And she should also communicate to that nurse coming on, in this case, Ellen Jewell, Nurse Sarnicki doing the communicating, the prior communications that have been held between physician and herself; is that correct?
A Yes.
Q Okay. Should she also communicate to -- should Nurse Sarnicki also have communicated to Ellen Jewell the response of Dr. Butt in the previous shift or the lack of response?
A Yes.
Q Should the second shift nurse, in this case, Ellen Jewell, be able to depend on the adequacy of the communication from the prior shift as to whether or not the baby was in potential trouble?
MR. SWITZER: Objection.
A Yes.
Q Can you tell me based on the record and based on the testimony of Nurse Sarnicki, what Nurse Sarnicki should have communicated to Ellen Jewell as Ellen Jewell came on her shift at 7:00 o'clock on that morning to meet an appropriate level of nursing care?
A Dilatation of the cervix, contraction

patterns, how much fluid had been given to the patient, what the baseline fetal heart was, and any interventions that she might have done for any deceleration patterns.

Q When you say contraction patterns, how specific should she have gotten? And, that is, should she have said there were some late decels, or should she have described not only what she saw, but her concerns with respect to that information?

A Probably what she saw, that there were some decelerations.

Q Should she have communicated the maternal temperature information?

A Urn-hum, yes.

Q I don't know if you said that, I didn't write it down.

A Yes, the vital signs.

Q Okay. Should she have, in the event that Ellen Jewell did not look through the whole strip, have communicated not only the baseline, but any rises or falls in fetal baseline?

A Yes.

Q Should she have communicated to Ellen Jewell her concern with respect to potential infection?

A Yes.

Q Is it your opinion that a nurse has an obligation to be able to recognize a late deceleration?
A Yes.
Q Could you tell me your definition of a late deceleration?
A It's a deceleration from a baseline that happens after the peak of the contraction and returns to the baseline after the contraction has ceased.
Q Do you believe that a nurse has an obligation to communicate to the physician when there is a late deceleration?
A Not every late deceleration, no.
Q In this particular situation, with the pattern which is represented by the fetal monitor strips for the first 7 to 8 hours -- or, excuse me, let me start over,

In this particular case, and assuming the course of the strips as they appear in your exhibit and with the history, that Nurse Sarnicki should have communicated to Nurse Jewell with respect to what had been perceived and known the shift before, based on that history, should Nurse Jewell communicate any further late decelerations when

late decelerations as they appear on her shift to the physician?
A No.
Q If the nurse communicates to a physician that the patient was having variable decelerations with good recovery, when, in fact, they were late decelerationa, would that be inappropriate?
A Would it be inappropriate that she was telling the physician there were variable decelerations with good recovery when, in fact, they were lates?
Q Pes.
A Is that inappropriate that she misnamed them? That's inappropriate. That she told the physician there were decelerations, no, that's not inappropriate.
Q Would it be a deviation from an acceptable standard of care to inappropriately label a late deceleration as a variable with good recovery, and communicate that inappropriate communication to the physician?
A My understanding is people have different definitions. And I think that's what was happening with this. Ellen Jewell's definition of a variable and a late was different than some other people.
Q Did you reach an opinion when you reviewed

this chart as to whether or not Nurse Jewell was competent and qualified to observe and interpret fetal monitoring strips?

First of all, did you reach an opinion?

A If she was competent, I can't speak to her competence. We probably disagreed on some of the decelerations' nomenclature.

Q Did you reach an opinion based on -- first of all, did you read her deposition transcript?

A *Yes.*

Q In general, did you reach any opinion as to whether or not she was qualified to interpret fetal monitoring strips?

A She'd had a course.

Q That's not what I'm asking you, and you know it.

A I had some question about her knowledge base.

Q Can you tell me the basis of that opinion?

A Just that we disagreed on calling those variable decelerations. And there were -- a number of them were late decelerations.

Q Would you expect a nurse practicing within an acceptable standard of care to be able to distinguish those decelerations which you saw as being late decelerations?

A From what I understand in reading the testimonies, there were varying opinions.
Q I'm asking you your opinion. You're the nursing expert. Would you expect a nurse, if you were practicing in the same hospital with that nurse and being her supervisor, would you expect her to be able to distinguish those patterns which you're referring to in the second shift as late decelerations, in some instances where Nurse Jewell distinguished them as variable decelerations?
MR. SWITZER: She didn't call them patterns, first, but go ahead.
A *Yes.*
Q In order for a nurse to be able to communicate significantly abnormal or significant and abnormal information to a physician, she has *to* first be able to interpret what is significant and what is abnormal, do you agree?
A Yes.
Q I may have asked you this. You would agree when a nurse cannot assess well-being of a baby in utero from information being obtained, then she needs to communicate to the OB that concern?
A Urn-hum, yes.
Q Do you want to take a break for 5 minutes?

A I'm okay.

MR. SWITZER: I can go to the restroom.

(Short recess taken.)

A I just wanted to clear up something in one of the previous questions. You were speaking about Ellen Jewell and her knowledge base or her competence. I don't want it to sound like I think she's incompetent, because I don't.

Q Did you discuss this with Mr. Switzer at our break?

A Yes.

Q All right. And can you tell me what that conversation consisted of?

A Just that the way the questions or the answers were phrased, it might have sounded like I was saying that Ellen Jewell was incompetent.

Q Did Mr. Switzer bring that to your attention?

A Yes.

Q Okay.

A Can I continue?

Q Oh, you have more to say?

A Just that there are different definitions of deceleration patterns. And, because she called something different from the way that I would call

it, doesn't mean that she's incompetent. That's all.

MS. TOMKO: I read your report. And, in the last paragraph, you gave an opinion with respect to causation.

And what my question is now, do you plan to or are you going to give her any questions on direct examination with respect to causality?

MR. SWITZER: That was my -- in fact, you'll see in the draft, I asked her to take out the questions on causation. And I would have -- the first sentence would have been deleted, too, but I just didn't catch that.

MS. TOMKO: Do you expect to ask any questions with regards causation?

MR. SWITZER: What caused the child's condition, neurological condition, brain damage, I can't ask that question.

MS. TOMKO: But do you plan to ask her questions on direct with respect to causation?

MR. SWITZER: Well, I can't. Neither can your nurse -- neither 1 of the 2 nurses can testify on causation.

This doesn't have to be on the record.

(Discussion had off the record.)

MS. TOMKO: Do you plan to ask this witness any questions on direct with respect to life expectancy?

L.R. SWITZEL, D.O.

Q Do you have any opinions on life expectancy?

A No.

Q Did you, at any of the jobs which you've held, including your current job, have any responsibilities for developing policies with respect to laboring moms and their babies?

A Yes.

Q And what job were you when you had those responsibilities? What was your title, in other words?

A The job before this one, I was Clinical Nurse Specialist at Fairview General, and I was involved in policy writing, as I am in this position, also.

Q I want you to assume hypothetically that there is a policy that states, in the event the charge nurse retains a reasonable concern regarding the appropriateness of an order, she or he may delay implementation until the order is evaluated by the appropriate Medical/Surgical Officer. This option is void in situations of life or limb consequence.

And, based on that assumption, as I understand

and they don't like the language.
Q And they have the right to strike it?
A Well, they have approval in some institutions of policies that are developed for their department, yes.
MS. TOMKO: The policy just reminded me of something, and I'm looking for it. Because I'm not Tom, it will take me a few minutes.
MR. SWITZER: Which one are you looking for?
MS. TOMKO: I'm looking at, I believe, when Nurse Sarnicki attempted to place the fetal monitor and did, in fact, get it placed, which would be 5 --
MR. SWITZER: You're talking 5-something, yes.
Q 5:44. It's my understanding that there were late decels right before that time, which is one of the reasons why Nurse Sarnicki again attempted and succeeded this time in placing the fetal monitor.
Is that your understanding? I believe she testified at 5:37 and 5:39 a.m., which is on Page 115.
WR. SWITZER: Why don't you just give her the interpretation? Is that what you

want?

Q Is it your understanding -- I guess my question is, is it your understanding that the IFM was attempted to be placed, and was, in fact, placed after these late decelerations which are noted on Page 115 of your exhibit?

A I see 2 late decelerations on Page 115, and I see that the IFM was placed at 5:44 on Page 116.

Q Is it your understanding from reading the testimony of Nurse Sarnicki that that was one of the considerations as to why she again attempted to glace the fetal monitor?

A To get a better reading on the monitor, yes.

Q Okay. Is it the obligation of a nurse, pursuant to standard nursing practice and pursuant to the policies of this particular hospital, which you reviewed, to monitor the fetal heart rate between repetitive attempt at catheter placement and immediately following placement?

MR. SWITZER: Clarify what you mean by catheter placement?

Q I'm sorry.

A Epidural catheter?

Q Yes, okay.

A Yes.

Q All right. Was an epidural catheter placed in this patient?
A Yes.
Q What time, do you remember?
A You want to know what time that was?
Q Yes. Do you have it?
A Page 112 at, let's see, 5:07.
Q Is it your understanding from this chart that the fetal heart rate was not again monitored when the belt was off after the --
MR. SWITZER: Wait, that's not right. 5:07 is not right.
Q 5:14.
MR. SWITZER: Because this is 5:10 right here.
Q Okay, 5:14.
A Yeah.
Q Is it your understanding, then, that the fetal heart monitor was off for the epidural at 5:14?
A Yes.
Q And is it further your understanding that the fetal heart rate was not again monitored by the electronic fetal monitor until 5:32?
A Correct.
Q Did the nurse have an obligation during this

time period pursuant to policy and pursuant to appropriate nursing care to monitor the patient and the fetal heart rate during this period?

A Before and after placement of the catheter, yes, she did.

Q Was it done in this instance?

A Yes.

Q Also, as I understand, pursuant to nursing policy that -- strike that.

What's your definition of ominous?

A Oh, bad.

Q So, when you say, "I saw no ominous fetal heart patterns in the fetus during the time 1:49 to 4:57," you're saying you saw no bad fetal heart patterns, is that correct?

A Um-hum, yes.

Q Did you see then, when you limit that statement from 1:49 to 4:57, did you see then after 4:57, bad fetal heart patterns?

A Occasionally, here and there.

Q Okay.

A I think I was responding to somebody's ominous words in some report that there was some ominous patterns during that time frame.

Q But you'd take ominous to be bad, and that's

how you use the word?
A Um-hum.
Q That's a yes.
As a nurse, after 9:40, and with the pattern improving, is that any significance to you? Does it, to you, demonstrate fetal well-being?
A I just -- I saw improvement in the fetal monitor strip. I wouldn't go as far as to say there was fetal well-being. But deceleration patterns had improved, variability was present.
Q Did you see anything in the monitoring strip after 9:40, up unto the time that the fetal monitor was removed, to show you that there was not fetal well-being?
A No. Well -- no.
Q No?
A No.
Q Is the answer no?
A *Yes*, no.
MS. TOMKO: Okay. Let me see, did I forget anything? That's it. I'm done.
Are you going to waive signature?
MR. SWITZER: No, she'll read it.
(Deposition concluded.)

Linda DIPasquale

Date

CERTIFICATE

The State of Ohio,)
County of Lorain.) SS:

I, Janine M. Park, Registered Professional Reporter and a Notary Public within and for The State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness:

LINDA DiPASQUALE,

was by me duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid.

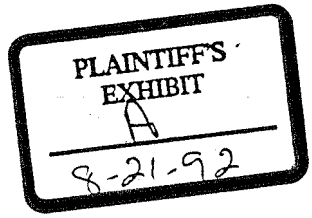
I do further certify that this deposition is a true record of the testimony given by the witness.

IN WITNESS WHEREOF, I have set my hand and affixed my seal of office at Elyria, Ohio, this 25th day of August, 1992.

Janine M. Park

Janine M. Park, R.P.W.
Notary Public, State of Ohio
589 W. Broad Street
Elyria, Ohio 44035
My commission expires 3-22-94.

Amie Report dated February.
Depositions of
Dr. Butt
Karen Cesary
Eileen Sarnicki
Ellen Jewell
Dr. Post 1 day
Joann Szymczykowski
Notes on review of policies
Addendum to summary of med. records
Policies & Procedures from S.W. H
#40



Draft

Review of Medical Record and Perinatal Nursing Opinion

I have reviewed the following information related to Joshua Paramore versus S. W. Butt, et al:

1. Medical records of Carolyn Paramore (Southwest General Hospital 6/29/90 - 6/30/90)
2. Medical records of Joshua Paramore (Southwest General Hospital (6/29/90)
3. Fetal monitor strips (Southwest General Hospital (6/29/90)
4. Deposition of Carolyn Paramore (12/14/91)
5. Deposition of Thomas Paramore (12/14/91)
6. Report of Dr. Herbert Keyser
7. Report of Dr. Arnold Medaris
8. Report of JoAnn Szwaczkowski, MSN

It is my opinion that the nurses who cared for Mrs. Paramore and her infant used appropriate judgment and skills in their assessments and interventions throughout her labor and subsequent delivery.

It was obvious from the thorough documentation starting at 0045 on 6/29/90 that a nurse was in constant attendance. Mrs. Paramore stated in her deposition that a nurse was with her most of the time. In addition to the constant assistance of a nurse, Mrs. Paramore was continuously monitored throughout her labor. From the nurse's documentation, the fetal heart monitor and the uterine monitor strips, a wealth of information was available. All of this information assists one to understand the fetal response to labor.

After Dr. Butt performed an amniotomy at 0140, the fetus responded by exhibiting variable decelerations, early decelerations and an increase from average long term variability to moderate long term variability. The cushion of amniotic fluid for the fetus was now gone and he responded predictably to an increase in contractile pressures on the cord (variable decelerations) and on the head (early decelerations). The nurse responded appropriately in giving care to Mrs. Paramore and her fetus by changing her position, administering oxygen, increasing the intravenous rate and informing the physician. Mrs. Paramore was obviously uncomfortable. The nurse indicated in her notes that Mrs. Paramore was having strong uterine contractions and feeling the urge to push. The nurse responded appropriately by acquiring an order for medications from the physician as well as assisting Mrs. Paramore and her husband in techniques for relaxation.

I saw no ominous fetal heart patterns in this fetus during the time 0149-0457. The deceleration patterns from 0316-0457 are early decelerations caused by head compression frequently seen in active labor from 4-7 cm. dilatation and are typically benign. There was however at 0458 a significant deceleration -- most probably related to the position of the mother and three contractions within

four minutes. The nurse took appropriate action -- Mrs. Paramore's position was changed, oxygen was administered, and her intravenous rate was increased. The fetal heart rate responded. Dr. Butt was informed of the happenings.

During the time period from 0538-0700 there were significant changes in the fetal heart rate pattern: 1) Baseline rate changed from 150 to 170, 2) Evidence of occasional late decelerations, 3) Evidence of some variable decelerations, **4)** A change in variability of the baseline. **All** of the above were noted by the nurse and appropriate interventions were administered. These interventions included position change, oxygen administration, application ***of*** an internal electrode and informing the physician. The fetus was reacting to this environment and all of the above changes can be explained by understanding the physiology. The maternal temperature was elevated, therefore the fetal heart rate increases -- a normal response. Late decelerations indicate utero placental insufficiency and can happen when Mrs. Paramore was in the supine position (vaginal exams, bed pan use, and insertion of the **IFM).** The change in variability can be related to a sleep cycle of the fetus, or the epidural anesthetic which had a narcotic added. The documentation by the nurse indicated all of the above, appropriate interventions were administered and the physician was kept informed.

The time from 0730 to 0940 on the monitor strip did show decelerations and a tacycardia. Appropriate nursing interventions were accomplished and in fact the nurse notified the nursery and respiratory. She obviously realized the fetus was stressed and did follow policy by alerting the appropriate personnel.

After 0940 a reassuring pattern was evident -- decelerations no longer appeared and variability was average. At 1055 variable decelerations became apparent. Variable decelerations are present in many labors and are not unusual. The added presence of short term and long term variability was indicative of fetal reserves and is considered to be the most important fetal heart characteristic in predicting fetal status.

Mrs. Paramore was taken to the delivery room at 1140. At 1226 the monitor was removed as ordered by the physician. Mrs. Paramore was completely dilated and pushing, she was near delivery. From the records the fetal heart rate was recorded at 1230-160; 1245-145; 1250-142;1258-78-84; 1300-78. Delivery was at 1313. During that time pitocin was administered to augment delivery and fundal pressure was administered. Both of these procedures done to expeditiously deliver the fetus. Epidural anesthesia inhibits the response to push, plus Mrs. Paramore was exhausted having labored all night. It was certainly appropriate and necessary to quickly deliver this fetus. The infant was born with no heart rate, no spontaneous respiratkons, meconium stained and foul smelling. Immediate resuscitation resulted in Apgar scores of 0 at 1 minute, 0 at 5, 1 at 10 minutes, 3 in 15 minutes and 4 in 20 minutes. The infant was sent to a level III nursery for treatment.

The nurses who cared for Mrs. Paramore identified stressful times for the infant and acted and intervened appropriately. They obviously kept Dr. Butt informed and followed policy in alerting the resuscitation team.

It is my opinion based on the facts within this medical record, Joshua Paramore suffered a catastrophic reaction to the beta strept carried by his mother. Her elevation in temperature, elevated WBC, foul odor at delivery and positive cultures indicate an infectious process. It is also my opinion that based on the monitor strip and delivery notes, there was significant cord compression during the last 15 minutes of delivery that probably added to this adverse outcome.

Linda DiPasquale, RNC. MSN
Perinatal Clinical Nurse Specialist

Linda DiPasquale
2/10/92.

7/15/92 meeting @ Switzer 3:00-5:45

7/17/92 1400 — 1600

Get some definitions of late — Murray. OK
p. 51 - look at tracing 06:40
p. 54 source for definition STV

0628 - panel 37118 look at it. minimal to absent
Review this urban area — for STV

p. 61 panel 02671
p. 64 0630 - 710 3 7128

Look at strip where she describes Varnish & late components — No way -

p. 74 uses terms "appears", "somewhat"

WPCOG standards - advocate p. 79-80

Carlson p. 90 - look at all those -

7/20/92 1700 - 1740 -

p. 33 - definition of late Ty #18 -
p. 34 different terms of when late
p. 35 #8, 9 - don't believe do!!

1900 - 1930

1) induction / fragmentation of labor
dosage adjusted - implied 2-3 minute apart - but true no guidelines specific to interval or increments
AC OC standards - no hospital unit worked in need that 0.5 - 1 mU - 30 m / 1 hr. Lots of documentation - research and literature

2) Date '87
Venous blood obtained usually - should have highest pH value!

3) "Should be" evaluated - 5 min - Just a guideline - Lab that distinguish about risk category. "What is high risk People differ in their opinions

4) Persistent late decelerations and decreased variability are signs to evaluate the fetus further - most delivery rooms who have associated with are not that specific - There are other diagnostic tools to use VAS, Scalp pH - Stimulation.

1) Pitocin was given to assist c̄ pushing [illegible] - delivery imminent - didn't matter about cont monitor. FHR was already ↓ ·
1258 78-84

2) When she was admitted [illegible]
she did not labor longer than 24 hours
[illegible] risk when temp elevated →
Are the nsg interventions appropriate

3) They did appropriate interventions

4) Not persistent

5) monitor between [illegible] attempts
and following placement - done —

6) [illegible] of documented [illegible] [illegible]:
Check this
to chart —

[illegible] page Addendum
[illegible]/91 2045-2145

clearly deceleration patterns were thought to be a problem — from position changes, O_2 + IV fluids.

Need to ask nurses —
~~was there a time when you thought~~
~~of~~
? When Dr. Batt called and no new orders received what could they do.

Was it practice to call their supervisor and why not?

Yes fetus is stressed —
Variability is okay —

What are P&P related to documenting FH during second stage — ?
If physician says remove monitor does nurse have ~~to~~ keep to monitor fetus —
how often?

Notified several hours before delivery

nurses kept Dr Butts informed

~~Should they have gone over his head –~~

they identified deceleration patterns and did app. nsg. intervention

[illegible] 13 th — They knew import stressed mat temp – fetal tachycardia decels – variability remained average –

---

called at 4 pm 4[10] pm — Support what nurses did until take off belts –

How often did they take FHR – ?

Did it ever occur to call someone else – or did supervisor know – NO!!!

830 — What prompted 8[30] call to nursing sup care –

nurses kept Dr Butts informed >

Should they have yelled over his head —

They identified decelerations patterns and did appr. nsg- interventions

They knew expect stressed
not temp — fetal tachycardia
decels — variability remained
average —

Support what nurses did until
taking off belts —
How often did they take FHR — ?

Did it ever occur to call someone else - or Ad supervisor know —
No!!!

What prompted (8:30) call to nursing mgr care —

CURRICULUM **VITA**

OF

LINDA DIPASQUALE

Educational Preparation:

Institution	Degree	Year
Medical College of Georgia School of Nursing Augusta, Georgia	BSN	**1966**
Frances Payne Bolton School of Nursing Case Western Reserve University Cleveland, Ohio	MSN Major: Perinatal Nursing	**1985**

Professional Experience

University Hospitals of Cleveland
MacDonald Womens Hospital
Perinatal Clinical Nurse Specialist (High Risk Obstetric Unit and Ob/Gyn Specialties, Inc.)

Institution:

Fairview General Hospital 18101 Lorain Avenue Cleveland, Ohio	Clinical Nurse Specialist Womens & Childrens Service	1988-1991
Akron University College of Nursing Akron, Ohio	Instructor in N 320 Diminished Health--Clinical Instructor-Obstetrical Nursing	1985-1988
Akron General Medical Ctr. Akron, Ohio	Staff Nurse/PRN New Life Center (L&D)	Summer, 1987
Cuyahoga Community College Metro Campus, Nursing Cleveland, Ohio	Part-time Instructor Lecturer & Clinical Inst. in Maternity Nursing	1984-1985
Akron City Hospital Idabelle Firestone School of Nursing Akron, Ohio	Instructor, Nursing of the Childbearing Family, Medical-Surgical Nursing, Senior-Clinical Instructor in Team Leading & Management	1981-1983
Fort Sanders Hospital School of Nursing Knoxville, Tennessee	Instructor, Maternity & Gynecologic Nursing	1977-1981

PLAINTIFF'S EXHIBIT B 8-21-92

significant recent accomplishments: 1989 - 1991

- Developed electronic fetal monitoring class that provides 7.5 ONA contact hours.
- Developed neonatal resuscitation course that provides 16 ONA contact hours.
- Coordinated advanced fetal monitoring class for experienced labor and delivery nurses.
- certification as hospital based neonatal resuscitation instructor (American Heart and American Academy of Pediatrics)
- Coordinator for Perinatal Symposium (1989, 1990, 150 attendance)
- Provide neonatal resuscitation classes for nurses and physicians.
- Provide outreach education for several smaller hospitals in western Cuyahoga County.
- Coordinated a change in nursing documentation for 5 patient care units.
- Certified by NAACOG in Inpatient Obstetric Nursing.
- Developed competency exams for intrapartal nurses and high risk antepartal nursing staff.
- Coordinator and facilitator for support group (Families Experiencing [illegible]y Loss)
- Have attended numerous seminars and workshops related to professionalism, high risk obstetrics, legal issues and electronic fetal mnitoring.
- Committee member of FGH policy and Procedure, Documentation and Quality Assurance Committees.
- Conducted, and planned numerous inservice programs related to high risk obstetrical care.
- Initiated prenatal diagnostic counseling for clients who experience negative outcomes.
- Assisted in planning two day perinatal medical update symposium (Coprovidership with March of Dimes)
- Coordinator of a service oriented research committee.