

THE STATE of OHIO, :  
 : SS:  
COUNTY of CUYAHOGA. :

-----  
IN THE COURT OF COMMON PLEAS  
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MICHELLE MACK, administratrix :  
of the ESTATE of JENNIFER MACK, :  
 : plaintiff, :  
 :  
vs. : Case No. 322444  
 :  
UNIVERSITY HOSPITAL HEALTH :  
SYSTEM, INC., et al. :  
 : defendants. :  
 :  
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Deposition of SAMUEL IREFIN, M.D.,  
a defendant herein, called by the plaintiff for the  
purpose of cross-examination pursuant to the Ohio  
Rules of Civil Procedure, taken before Constance  
Campbell, a Notary Public within and for the State  
of Ohio, at the offices of Reminger & Reminger, The  
113 Saint Clair Building, Cleveland, Ohio, on  
MONDAY, JUNE 30TH, 1997, commencing at 4:10 p.m.  
pursuant to agreement of counsel.



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CLEVELAND, OHIO 44114-1273

(216) 771-8018

1-800-837-DEPO

1 APPEARANCES:

2 ON BEHALF OF THE PLAINTIFF:

3  
4 Donna Taylor-Kolis, Esq.

5 Ann Garson, Esq.

6 Donna Taylor Kolis Co., LPA

7 1015 Euclid Avenue

8 Cleveland, Ohio 44115

9 (216) 861-4300.

10 -----

11  
12  
13 ON BEHALF OF THE DEFENDANT WILLIAM DOUGLAS, M.D.:

14  
15 Markus Willoughby, Esq.

16 Jacobson, Maynard, Tuschman & Kalur

17 1001 Lakeside Avenue

18 Cleveland, Ohio 44114

19 (216) 736-8600.

20 -----

1 APPEARANCES (continued):

2 ON BEHALF OF THE DEFENDANT DR. IREFIN:

3  
4 Marc W. Groedel, Esq.

5 Reminger & Reminger

6 The 113 Saint Clair Building

7 Cleveland, Ohio 44114

8 (216) 687-1311.

9  
10 -----

11  
12  
13  
14 ON BEHALF OF THE DEFENDANT BEDFORD MEDICAL CENTER:

15  
16 Kevin M. Norchi, Esq.

17 Davis & Young

18 101 Prospect Avenue

19 Cleveland, Ohio 44115

20 (216) 348-1700.

21  
22 -----

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1                   SAMUEL IREFIN, M.D.

2       of lawful age, a defendant herein, called by the  
3       plaintiff for the purpose of cross-examination  
4       pursuant to the Ohio Rules of Civil Procedure,  
5       being first duly sworn, as hereinafter certified,  
6       was examined and testified as follows:

7                   -----

8                   MISS KOLIS:               Dr. Irefin,  
9       we've been introduced, as you know my name is Donna  
10      Kolis, I represent the Estate of Jennifer Mack.

11                   My purpose today is to try to get  
12      an understanding from you as to what actually  
13      happened to this child when she was at Bedford  
14      Community Hospital in September of 1996.

15                   I'm going to ask you a series of  
16      questions; if at any time I ask you a question that  
17      you don't understand, indicate for the record you  
18      don't understand what I'm asking, okay?

19                   THE WITNESS:            Okay.

20                   MISS KOLIS:            If you need to  
21      take a break, respond to a page, I'm going to  
22      assume would be for medical reasons or whatever,  
23      that is okay because we're hoping to be brief.  
24      We're not in a rush to get out of here either.

25                   THE WITNESS:            Okay.

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CROSS-EXAMINATIONBY MISS KOLIS:

Q. Having said that, for the record would you state your name and your current business address?

A. My name is Samuel Irefin. My current business address is Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio.

Q. What is your position at the Cleveland Clinic, Dr. Irefin?

A. I'm a Clinic associate staff in the Department of Anesthesiology.

Q. How long have you held that position?

A. Six months.

Q. I've just been handed your CV. I'm going to briefly go over it so we can get some understanding for the record any questions I need to ask about your education.

I see that you received your Doctor of Medicine from Saint Louis University School of Medicine in 1988; that's an accurate statement?

A. Yes.

Q. At this point you are Board certified in anesthesiology, correct?

A. Yes.

1 Q. You are also Board eligible for critical care  
2 medicine?

3 A. Yes.

4 Q. Is that a subspecialty, that critical care,  
5 that you are Board eligible for that's a part of  
6 the Board of anesthesiology?

7 A. Yes, it's part of the Board of anesthesia,  
8 yes.

9 Q. When did you receive your certification in  
10 anesthesiology?

11 A. I would say it's a process that goes over,  
12 takes about a year. The final certification was  
13 granted this past April, April, 1997.

14 Q. So you actually obtained your full Board  
15 certification in April of 1997?

16 A. Yes.

17 Q. Had you completed, successfully completed any  
18 part of the Board at the time that Jennifer was  
19 under your care in September of 1996?

20 A. I completed the written part of the Board  
21 examination, yes.

22 Q. Following your graduation from medical school  
23 you first did a residency in surgery, that's what  
24 your CV indicates, correct?

25 A. Yes.

1 Q. One year in that specialty?

2 A. Three years.

3 Q. Sorry. One year at Good Sam Hospital in  
4 Cincinnati, then you went on and did another two  
5 years at the Medical College of Wisconsin, right?

6 A. Yes.

7 Q. In 1991 you finished the residency. What did  
8 you do between 1991 and 1993, June of 1993?

9 A. I traveled, I moonlighted, that is all I  
10 did.

11 Q. Traveled meaning for personal?

12 A. Just for personal reasons.

13 Q. Moonlight, were you moonlighting in  
14 Wisconsin?

15 A. Yes.

16 Q. Did you moonlight as an emergency room  
17 doctor, house officer, what kind of things did you  
18 do in the two year period?

19 A. I moonlighted in an occupational health --

20 Q. Occupational health?

21 A. -- facility.

22 Q. People when they use the term moonlight imply  
23 to me that they are not working a 40 hour week at  
24 any one facility; is that what you mean?

25 A. No, I worked in one facility, I worked during



1 the day, during the week most every day.

2 Q. Sort of a 9:00 to 5:00 job for a couple of  
3 years?

4 A. Yes.

5 Q. Somewhere between 1991 and 1993 did you make  
6 a decision that you wanted your specialty to be  
7 anesthesiology?

8 A. Exactly, yes.

9 Q. That's when you came to Cleveland, January  
10 of 1993, began a residency in anesthesiology,  
11 correct?

12 A. Yes.

13 Q. That is a three year program?

14 A. Yes.

15 Q. You completed that in January of '96?

16 A. Yes.

17 Q. Immediately following that then your CV  
18 indicates that you did a Fellowship; is that right,  
19 says Fellow in critical care medicine?

20 A. Yes.

21 Q. That's also at the Cleveland Clinic?

22 A. Yes.

23 Q. When you saw Jennifer Mack as a patient, you  
24 were in your Fellowship year at the Cleveland  
25 Clinic, correct?

1 A. Yes.

2 Q. Were you moonlighting, maybe that is not the  
3 right word -- how is it you came to be working at  
4 Bedford Community Hospital in September of 1996?

5 A. I was moonlighting at Bedford Medical Center  
6 in September of 1996.

7 Q. I'll ask you a few questions about that, we  
8 will mark your CV Plaintiff's Exhibit A, leave it  
9 here.

10 When did you start moonlighting at  
11 Bedford Community Hospital?

12 A. If I recollect very well, I don't know the  
13 actual date, like late Summer, in August or July,  
14 or August, I believe middle of July.

15 Q. How did you come to be employed by them?

16 A. I was employed by Dr. Barsoum who runs the  
17 anesthesia department.

18 Q. Can you spell the last name, I didn't see it  
19 in the records.

20 A. B-a-r-s-o-u-m who runs the anesthesia  
21 department and house officer, moonlighting duties  
22 in the evening.

23 Q. Were you, Dr. Irefin, receiving a paycheck  
24 from the Bedford Community Hospital?

25 A. No.

1 Q. Who paid you?

2 A. Dr. Barsoum paid me from his group.

3 Q. You were maybe working there about three  
4 months at the time you saw Jennifer, did I hear you  
5 correctly?

6 A. Yes, I started mid June, something like  
7 that. I don't remember the actual date. During  
8 the month of September of 1996.

9 Q. What were your work responsibilities at the  
10 Cleveland Clinic?

11 A. I was a Fellow in the intensive care unit at  
12 the Cleveland Clinic.

13 Q. As a Fellow, what number of hours were you  
14 required to work at the Cleveland Clinic?

15 A. There was no requirement to number of hours  
16 that I have to be there. I do have clinical  
17 responsibility in the intensive care unit.

18 Q. I probably didn't ask the question too well.  
19 Let's give it another try.

20 During your Fellowship in critical  
21 care at Cleveland Clinic, of course you had a  
22 clinical responsibility in September of 1996,  
23 correct?

24 A. Sure.

25 Q. What was your call schedule at the Cleveland

1 Clinic? I don't have happen to have a calendar  
2 with me, maybe I can dig one out of my purse,  
3 during the week of September 13th?

4 A. I do not recollect what my call schedule  
5 during that week is.

6 Q. As a general matter, I'm not going to hold  
7 you to this precisely, at or about the time you saw  
8 Jennifer at the Bedford Community Hospital,  
9 customarily what was your rotation like through  
10 critical care through the Cleveland Clinic, were  
11 you on 48, off 24?

12 A. I don't take in-house call as the Fellow, I  
13 take my call from home. I do have residents  
14 in-house that do stay in the intensive care unit  
15 overnight, if they have problems they call me at  
16 home. I do take my call from home, that is the way  
17 it goes.

18 Q. I realize I'm beating this, I really need to  
19 understand it.

20 A. That's fine.

21 Q. As you are telling me the way the program is  
22 set up as a Fellow you were at home in the evening,  
23 if a resident under your supervision in that  
24 critical care setting needed help, they could call  
25 you?

1 A. Yes.

2 Q. Does that also then imply that you were  
3 normally required to be there during daytime hours?

4 A. Yes.

5 Q. How many days a week were you required to be  
6 there?

7 A. If I'm not -- I'm required to be there Monday  
8 through Friday. To cover I'm always there Monday  
9 through Friday.

10 Q. Monday through Friday were you required to be  
11 in the hospital?

12 A. To be in the hospital.

13 Q. For coverage, during that same time period  
14 then, were you the on-call doctor every single  
15 night?

16 A. No.

17 Q. Would you have access to documents showing  
18 me -- that you could show to me that would indicate  
19 on September 13th if you were on call or not?

20 A. I can tell you right now I was not on call.  
21 Every time I moonlight on Bedford I'm not on call  
22 at the Clinic.

23 Q. Fair enough answer. You would pick up your  
24 moonlighting responsibilities on nights when you  
25 were not on call?

1 A. That's exactly true.

2 Q. Would you have access to documents that could  
3 show me whether you were on call on the night of  
4 September 12th at the Cleveland Clinic?

5 A. I'm not too sure whether I can. I can try.

6 Q. I'll draft it in the form of a request to  
7 your attorney, we will see what we can find out  
8 about that.

9 On average, from the time you  
10 started through the time that Jennifer Mack became  
11 your patient on that evening, I'm phrasing it that  
12 way, the time you saw her as a patient, how many  
13 nights a week were you moonlighting?

14 A. I can't tell you precisely. I can't tell you  
15 precisely how many nights a week.

16 Q. Did you have an agreement you would work a  
17 certain number of nights a week?

18 A. No.

19 Q. How would you get called in to work as a  
20 house officer then?

21 A. I picked the dates I wanted to work. I  
22 picked my own dates.

23 Q. You would advise --

24 A. Dr. Barsoum.

25 Q. What nights you were not going to be on call,

1 see if he had staffing needs?

2 A. At the beginning of the month a schedule  
3 would come out which nights can you work. I looked  
4 at my schedule, based on that I will let him know  
5 exactly which nights I can work, which nights I  
6 cannot.

7 Q. Doctor, in preparation for today's  
8 deposition, have you reviewed any documents?

9 A. Yes, I reviewed the medical records.

10 Q. When you say you reviewed the medical  
11 records, can you specifically tell me which medical  
12 records you reviewed?

13 A. I reviewed the medical records from the  
14 Bedford Medical Center, the one from University  
15 Hospitals.

16 Q. You reviewed both charts?

17 A. Yes.

18 Q. Have you seen the death certificate?

19 A. I might have seen it, I don't recollect  
20 exactly what it says.

21 Q. As we sit here today, do you have a  
22 recollection what this child's cause of death was?

23 A. No.

24 Q. Have you reviewed Dr. Douglas' deposition?

25 A. No.

1 Q. Do you know what Dr. Douglas testified to at  
2 his deposition?

3 A. No, I have no idea.

4 Q. Exclusive of looking at the medical records  
5 themselves, do you have an independent recollection  
6 of this particular child?

7 A. I have an independent recollection of what  
8 happened, exclusive of the medical records.

9 Q. So you do have a recollection of the events?

10 A. Yes, I do have a recollection of the events.

11 Q. Fair enough.

12 Let's do this in a very broad  
13 general way first I guess if I can. Would you  
14 agree with me that on the evening -- I'm calling it  
15 September 13th, I think I'm right, sorry.

16 A. Should be the 14th.

17 Q. Or the 14th. I keep saying September 13th  
18 for some reason.

19 A. Very early in the morning on the 14th I  
20 believe.

21 Q. The evening of September 13th, turning into  
22 the 14th at midnight, perhaps that is why I'm  
23 saying it.

24 A. We didn't see Jennifer until after midnight,  
25 that would make it September 14th.



1 Q. Would you agree with me there was not a  
2 successful intubation of this child to establish a  
3 good airway until the trach was performed?

4 A. No, I disagree with that.

5 Q. You indicated in your previous answer that  
6 you do have an independent recollect of what  
7 happened with this child. Can you tell me what you  
8 recall about Jennifer Mack?

9 A. Well, I was called to see Jennifer by  
10 Dr. Douglas, she was hypoxic, very agitated when  
11 she presented to the emergency room. I believe the  
12 initial medical treatment was not very successful  
13 to give Epinephrine, according to the chart, which  
14 is the standard treatment for croup.

15 That wasn't very successful, so I  
16 was called because -- he called me, said I know you  
17 are anesthesiologist, can you come down here, help  
18 me intubate this patient.

19 I went down there, saw the patient,  
20 she was severely hypoxic, cyanotic, very agitated,  
21 then I asked for intubation kit, for intubation  
22 instruments, then proceeded to intubate this  
23 patient.

24 Q. I'm going to interrupt you at that point. I  
25 have reviewed medical records supplied to me by

1 Bedford Community Hospital, I find only one note  
2 written by you.

3 A. Yes.

4 Q. You agree that's the situation, that there is  
5 only actually one note in your writing?

6 A. Yes.

7 Q. We're going to mark your note Exhibit B. I'm  
8 going to hand it to you at the moment so you can  
9 read along with me.

10 Doctor, you degree this is the only  
11 note in the chart by yourself?

12 A. Yes.

13 Q. Are there any other writings in the chart  
14 created by yourself, by way of filling in  
15 medications or anything else?

16 A. No, this is the only thing I have in the  
17 chart.

18 Q. Can you tell me when you believe you wrote  
19 this note in the chart?

20 A. I wrote this note probably approximately I  
21 would say between 25 past 1:00, 1:30, around that  
22 time, just before she left.

23 Q. So your testimony is, so the record is clear,  
24 you did in fact prepare the note when Jennifer was  
25 here, shortly after she was discharged to go to

1 Rainbow Babies?

2 A. Exactly.

3 Q. Would you agree with me that the note that  
4 you have written does not reflect all of the events  
5 which you participated in, in the care of this  
6 child?

7 A. Yes.

8 Q. Can you tell me today as you sit here why at  
9 1:20 or 1:25 in the morning September 14th you did  
10 not write a note reflecting all of your interaction  
11 medically with this child?

12 A. The note I have in front of me, the note I  
13 wrote did reflect exactly, it's just like a  
14 synopsis of what I did.

15 As far as the situation goes, the  
16 reason for the note being so short was because they  
17 were about to transport the patient to Rainbows  
18 Childrens Hospital, they were asking me -- they  
19 wanted to send all the notes and medical records  
20 with her, so they know exactly what we did at the  
21 other hospital. That was the reason I quickly  
22 write this note.

23 Q. Let me follow this through to make certain I  
24 understand you.

25 You are indicating you wrote this

1 note quickly in response to a request by the Life  
2 Flight team to take records with Jennifer to RBC?

3 A. Life Flight team, the nurses, so that they  
4 can have something to go on when they get to RBC.

5 Q. When you say they have something to go by,  
6 let's go through this. Whatever I say you don't  
7 agree with, you let me know.

8 This note indicates you were called  
9 in to evaluate the patient for respiratory  
10 distress, correct, for an evaluation?

11 A. For evaluation of respiratory distress or  
12 endotracheal intubation.

13 Q. Do you have a recollection today when you  
14 initially received the call from -- did you receive  
15 the call from Dr. Douglas first of all?

16 A. Yes, I received a call directly from  
17 Dr. Douglas.

18 Q. Do you know approximately what time it was  
19 you were called by Dr. Douglas to evaluate this  
20 patient for intubation?

21 A. I do not recall the exact time.

22 Q. You have reviewed the other notes in the  
23 chart that were written by both Dr. Douglas and the  
24 nurse, Tom Sharp, correct?

25 A. Yes.

1 Q. Do those notes give you a sense of what time  
2 you would have actually been called?

3 A. It did not.

4 Q. Did not give you a sense?

5 A. No.

6 Q. Do you recall if there was anything which  
7 delayed your arrival to the emergency room in  
8 response to that phone call?

9 A. I do not recall that.

10 Q. Do you recall where Jennifer was when you  
11 first saw her?

12 A. She was in the emergency room, one of the  
13 treatment rooms, I don't know which room exactly  
14 she was in.

15 Q. Might sound like I'm picking at nits, I'm not  
16 trying to. Do you have a recollection she was in  
17 what was known as the cardiac room?

18 A. I don't work -- I do not work in the  
19 emergency room, so I don't know exactly one room  
20 from the other, I don't know which one is the  
21 cardiac room, which one is not. I can't tell you.

22 Q. When you say you don't work in the emergency  
23 room, you bring up an issue I would like to ask you  
24 about.

25 Customarily your responsibility as

1 the house officer at Bedford Community Hospital is  
2 being there on call for patients who are on floors;  
3 am I accurate in that?

4 A. Yes.

5 Q. Prior to Jennifer Mack's situation, had you  
6 ever been called to the emergency room in the  
7 hospital for any purpose?

8 A. Yes.

9 Q. What kinds of things would you get called to  
10 the emergency room for?

11 A. Difficult I.V. access, endotracheal  
12 intubation.

13 Q. Had you met Dr. Douglas before?

14 A. No, that was the first time I met him.

15 Q. You were called for difficult I.V. placement  
16 because of your three years surgical residency  
17 background?

18 A. No, they call because they know  
19 anesthesiology we do a lot of I.V.'s, we do lots  
20 and lots of I.V.'s. When they have a problem  
21 starting I.V., they call us to help them out.

22 Q. Doctor, you said that you don't usually work  
23 in the emergency room so you're not familiar with  
24 the different rooms, correct?

25 A. Yes.

1 Q. Were you, however, by the evening of  
2 September 14th of 1996, familiar with what  
3 equipment was available in the emergency room or  
4 the suites of the emergency room that would have  
5 been in existence to assist you in doing an  
6 intubation?

7 A. I don't understand that question.

8 Q. Neither did I. We will ask it a different  
9 way.

10 On the evening of September 14th,  
11 was there any piece of equipment that you needed to  
12 use on this child that was unavailable to you?

13 A. No.

14 Q. When you came down and first saw Jennifer,  
15 was your sole purpose at that point go ahead and do  
16 the intubation, or physically evaluate her to see  
17 if she needed one?

18 A. When Dr. Douglas called me, I got to  
19 emergency room, my first -- I wasn't going to do an  
20 examination or redo the whole thing, I was just  
21 there to do the intubation.

22 Q. You functioned on the medical premise she  
23 absolutely needed intubation, correct?

24 A. Plus my clinical impression tells me she  
25 needed to be intubated. She was hypoxic, she was

1 agitated, she was cyanotic.

2 Q. Once again I didn't ask the question great.

3 I want to know if you do an  
4 independent confirmation in the clinical setting in  
5 fact this child needs to be intubated?

6 A. Clinically looking at the first very time I  
7 see her, yes, I do believe she required  
8 intubation.

9 THE WITNESS: Excuse me for a  
10 second, I have a dry throat.

11 -----

12 (Interruption in proceedings.)

13 -----

14 Q. At the point in time when you first saw this  
15 child, had she already received medications?

16 A. I don't know that.

17 Q. Would you have asked at that point what have  
18 you given this child in terms of medications?

19 A. I did not ask that. I don't know whether she  
20 received any medication.

21 Q. Did you upon seeing the child order  
22 medication to aid and assist you with intubation?

23 A. If I recollect very well, Dr. Douglas was in  
24 the process of giving her some Versed at that  
25 point, just to calm her down. He told me that,



1 yes, we're about to give her some Versed, she has  
2 an I.V. which I believe is in the left arm, they  
3 were about to give her some Versed at that point to  
4 help her with agitation.

5 Q. You could observe the child was clearly  
6 agitated?

7 A. She was very agitated, cyanotic.

8 Q. Was she coughing?

9 A. No, she was not coughing. She was really,  
10 really agitated.

11 Q. How was her color when you saw her?

12 A. She was cyanotic.

13 Q. When you say she was cyanotic, describe for  
14 me the best you can. I'm going to give you an  
15 example: Sometimes when people tell me someone is  
16 cyanotic, the nail beds have turned bluish purple.  
17 What about her are you describing as cyanotic?

18 A. She was the color -- the color in her face,  
19 because I didn't get a chance to examine the nail  
20 beds or whatever, the color in her face tells me  
21 she is hypoxic, she looks cyanotic. It may be a  
22 subjective finding, that is my clinical impression.

23 Q. You didn't record that finding, you are  
24 telling me you recollect that's what you saw?

25 A. Yes, that is my recollection.

1 Q. How many times did you intubate this child  
2 before there was a trach?

3 A. Twice.

4 Q. Let's go through what happened. Initially  
5 you saw the child -- once again going back, you  
6 clinically assessed she appeared cyanotic, in need  
7 of intubation, correct?

8 A. Yes.

9 Q. Was respiratory therapy there when you were  
10 there?

11 A. Yes.

12 Q. Do you do your intubations with assistance of  
13 respiratory therapy?

14 A. Yes.

15 Q. In what way does respiratory therapy assist  
16 you?

17 A. They hand me all the instruments that I  
18 need.

19 Q. That's the extent of their involvement?

20 A. They do whatever I ask them to do.

21 Q. Does your retrospective analysis of the  
22 situation with this child cause you to have any  
23 criticisms of anything done by any respiratory  
24 therapist that evening?

25 A. No.

1 Q. Initially I think you told me, maybe five  
2 minutes ago, you were handed a kit, an intubation  
3 kit; is that right, I may have misheard you?

4 A. I don't understand that. The kit is already  
5 there.

6 Q. I was asking you what happened. You were  
7 sort of going through a narrative, you indicated to  
8 me they handed you an intubation kit?

9 A. It's not a kit. I ask for a laryngoscope,  
10 laryngoscope blade, size I want, ask for the  
11 endotracheal tube, for the size I want, that is the  
12 way.

13 Q. That's fine, I need to know what you mean by  
14 that.

15 So you asked for the laryngoscope  
16 blade, correct?

17 A. Yes.

18 Q. What size blade did you ask for?

19 A. I don't remember what size I used.

20 Q. Originally what size tube did you ask for?

21 A. Size 5.

22 Q. Size 5 would have been appropriate for this  
23 child chronologically, correct?

24 A. Yes.

25 Q. I assume that you attempted to intubate her

1 with a size 5 tube?

2 A. Yes.

3 Q. That was unsuccessful?

4 A. Yes.

5 Q. That was unsuccessful due to?

6 A. Due to the fact that she does have some sort  
7 of obstruction past the vocal cords, the true vocal  
8 cords. It went through the vocal cords, wouldn't  
9 go past that.

10 Q. Could you visualize what the obstruction was  
11 past the vocal cords?

12 A. No.

13 Q. Approximately how long did it take you to  
14 attempt or how many attempts did you make at  
15 passing the size 5 tube?

16 A. Just one attempt, that is it.

17 Q. In reviewing the records, based on your  
18 recollection, the child did not have epiglottitis  
19 at that point?

20 A. Yes, I don't believe she had epiglottitis at  
21 that point.

22 Q. What size tube did you then ask for?

23 A. Then I asked for the smallest tube I can  
24 find, which is size 3.

25 Q. So you went from a 5 to a 3; why did you make

1       that decision? I'm just asking?

2       A.       The reason why I made the decision is if I  
3       can get a 3 through, we would have an airway, we  
4       would be able to establish airway. That's the  
5       smallest tube I can lay my hands on, I asked for  
6       a 3.

7       Q.       From the time you first looked at her,  
8       approximately how long did it take you to get that  
9       size 3 tube in?

10      A.       Less than a minute.

11      Q.       Did Jennifer Mack vomit before she was  
12      trached?

13      A.       Yes.

14      Q.       Can you tell me chronologically, I know you  
15      can't tell me time, unless you can, chronologically  
16      in the sequence of intubations by yourself, her  
17      course, when did she vomit?

18      A.       She vomited after the second intubation.  
19      Wait a minute, let me think about that.

20      Q.       We have lots of time.

21      A.       The first intubation was done, the pulse  
22      oximeter, before then there was no reading on the  
23      pulse oximeter.

24                   Then after the first intubation,  
25      pulse oximeter we got reading on that, shows she

1 has been oxygenated at this point.

2 At this point we called for x-ray,  
3 she became agitated. She became agitated, called  
4 for x-ray. Do the x-ray, after the x-ray was done  
5 I found out that tube has become dislodged, was the  
6 time I did the second intubation.

7 During the process of trying to do  
8 the second intubation that she vomited. She  
9 vomited, I quickly turned her face to the side,  
10 suctioned her mouth. Suctioned emesis from her  
11 mouth, quickly intubated her.

12 Q. I'm going to see if I can understand some of  
13 things you told me.

14 First let's address this issue:  
15 You're indicating for the record that prior to the  
16 time you placed the first tube, that there was no  
17 pulse ox reading?

18 A. Yes.

19 Q. Are you stating she didn't have any pulse  
20 ox? No you are not stating that, are you? In  
21 other words, when you say pulse ox, what were you  
22 looking at?

23 A. We are looking at oxygenation level of blood.

24 Q. Oxygenation level wasn't zero, wasn't it?

25 A. I don't know that. The machine wasn't

1 reading.

2 Q. The machine wasn't reading, that is what I'm  
3 getting at.

4 A. They put it on her, there was no sign that --  
5 they can't pick up any sign she does have a pulse  
6 oximeter reading. There was none.

7 Q. The child was conscious at that point?

8 A. Yes, relatively depending on what you call  
9 consciousness. She was awake. She wasn't like --  
10 she wasn't talking to anybody. She was agitated,  
11 she was thrashing all over the place. I don't know  
12 whether you can call that conscious or not.

13 Q. She stopped thrashing after Dr. Douglas gave  
14 her medication, didn't she?

15 A. For a little while. That wasn't going to  
16 allow me to do the intubation. That is the time I  
17 asked for succinylcholine to be given.

18 Q. You told me you recall Dr. Douglas ordered  
19 something?

20 A. Versed, which is a vasodiazepine.

21 Q. By the time you got there then it was you --

22 A. He gave it when I was there.

23 Q. He gave it when you were there?

24 A. Yes.

25 Q. You ordered an additional medication?

1 A. Yes.

2 Q. You ordered that additional medication before  
3 you intubated her?

4 A. Yes.

5 Q. How long did it take the succinylcholine to  
6 be effective?

7 A. 60 seconds.

8 Q. So then she was calm, she wasn't thrashing  
9 around anymore?

10 A. She wasn't thrashing around so I was able to  
11 intubate her.

12 Q. You intubated her. At that point can you  
13 please tell me specifically what you did to confirm  
14 the placement of the endotracheal tube?

15 A. I listened for the breath sounds. There is  
16 bilateral breath sounds, the pulse oximetry reading  
17 came up very nicely, tells me she's been  
18 oxygenated. We used end tidal CO<sub>2</sub>.

19 Q. Do you see any end tidal CO<sub>2</sub> readings  
20 recorded within the medical chart?

21 A. No. No, it's not a number.

22 Q. You use colorimetric?

23 A. Yes.

24 Q. Do you see any indication other than  
25 narrative by Dr. Douglas the end tidal CO<sub>2</sub>'s were



1 used in the code, it was in use prior to the time  
2 she arrested?

3 A. There was no documentation. The reason why  
4 we're using that during the code was because it's  
5 already there, not something you ask for during the  
6 code. It's not Epinephrine or bicarbonate. It's  
7 already there. I was at the head of the bed, I was  
8 right there, it was already there, that is the  
9 reason why we are able to use it during the code.

10 Q. Explain to me what the colorimetric coding  
11 for the end tidal CO<sub>2</sub> machine was like. You are  
12 teaching me.

13 Who is watching the colorimetric  
14 scale, is it yourself or someone else?

15 A. It's me. I'm right there, it's attached to  
16 the endotracheal tube, the color changes every time  
17 she exhales.

18 Q. Anyone else watching it with you?

19 A. If somebody else is watching it, I don't  
20 know, I can't tell you that.

21 Q. It's not a matter of is there a backup, two  
22 sets of eyes watching?

23 A. I don't know. If someone else is watching  
24 it, I don't know. I was there, I was in charge of  
25 airway, I was standing right there.

1 Q. How did you become aware that the tube had  
2 dislodged after the first intubation?

3 A. The chest wasn't rising, the pulse oximeter  
4 starting -- numbers started going down. I listened  
5 to her.

6 At this point she started waking up  
7 from the succinylcholine medication given her,  
8 because succinylcholine, the amount we gave her  
9 probably lasts two to three minutes anyway before  
10 it wears off, they start thrashing around again.

11 Chest wasn't rising, pulse oximetry  
12 was going down. I said something, I listened to  
13 her, I wasn't hearing breath sounds in the lungs, I  
14 immediately asked for the laryngoscope again, I  
15 looked in there, low and behold, it's dislodged,  
16 yes.

17 Q. How did the tube become dislodged?

18 A. I don't know. It might be she was thrashing  
19 around, might be when they moved her for the  
20 x-ray. I can't tell you.

21 Q. Let's slow this down a little.

22 First question I asked you, I sort  
23 of led you into another area, I asked things you do  
24 to confirm initially the tube was properly placed.  
25 Let's go through what I think you told me. Breath

1 sounds, pulse oximetry went up very nicely, do you  
2 have a recollection independent of what is in the  
3 chart how high the pulse ox went after you  
4 intubated her?

5 A. I don't remember exactly how high it went.  
6 If I can recollect, very close to 100. It's not  
7 100 percent.

8 Q. In the 90's?

9 A. In the 90's, yes.

10 Q. End tidal CO<sub>2</sub>, were you using that?

11 A. I used that to confirm it's in the right  
12 place, yes.

13 Q. That's a good tool for confirmation, isn't  
14 it?

15 A. Yes.

16 Q. Color changes pretty rapidly on the  
17 colorimetric end tidal CO<sub>2</sub> machine in response to  
18 lower oxygenation; would you agree with that?

19 A. Can you reframe that question?

20 Q. I made a statement, I asked you a question  
21 how quickly does the color change on the end tidal  
22 CO<sub>2</sub> colorimetric machine in response to lowered  
23 oxygenation?

24 A. Lowered oxygenation?

25 Q. I'm sorry, let's try this again.

1                   When you are using this as a  
2                   confirmation that you have the tube correctly in  
3                   the trachea, so that you're getting proper air into  
4                   the lungs, if for any reason the tube is dislodged,  
5                   how quickly does that show on the end tidal CO<sub>2</sub>  
6                   colorimetric scale?

7           A.       I still don't get your question. Let me --

8           Q.       Go ahead.

9           A.       Let me tell you something here. We use end  
10           tidal CO<sub>2</sub> monitor to monitor the carbon dioxide  
11           level. That is what we use it for. After we do  
12           that we check the endotracheal tube to make sure  
13           each time the patient exhales, carbon dioxide comes  
14           out, the color changes on the indicator paper.  
15           That is exactly what it's used for.

16                   So it's used initially to confirm  
17           that the tube is in the trachea, not in the  
18           esophagus or oropharynx or anywhere else. That is  
19           what it's used for initially.

20                   It can be used continuously like we  
21           used during the code situation to make sure the  
22           patient is being oxygenated while the code is going  
23           on. Usually after the first confirmation is done  
24           we usually don't -- sometimes we take it off,  
25           reconnect the endotracheal tube to the oxygen

1 supply, if that answers your question.

2 Q. No. That helps why you don't understand the  
3 way I'm asking it.

4 After what is your initial  
5 confirmation by end tidal CO<sub>2</sub>, did you disconnect  
6 the colorimetric or did you leave it on, using it  
7 as an aid to confirm the tube --

8 A. No, I use -- I didn't use as a continuous  
9 confirmation.

10 Q. You didn't use it continuous?

11 A. No, I took it off.

12 Q. My second question was an information  
13 question. As you are watching when she breathes  
14 out, the colors are changing in response to CO<sub>2</sub>,  
15 correct?

16 A. Um-hum.

17 Q. If a tube becomes dislodged, you are using  
18 the CO<sub>2</sub> colorimetric system scale, whatever you  
19 want to call it, how quickly will that change be  
20 noted in the color?

21 A. The system is not sensitive for that. You  
22 have to have the other type in order for you to do  
23 that. It's not sensitive for the question you are  
24 asking for.

25 Q. That's fine. That's a good enough answer.

1                   Had you used the colorimetric  
2 before?

3       A.       Yes.

4       Q.       You were trained on it at the Clinic?

5       A.       Yes.

6       Q.       So that is what you initially did, correct?  
7 There was an order, correct, for a chest x-ray?

8       A.       (Indicating affirmatively.)

9       Q.       Chest x-rays, do you agree with me, Doctor,  
10 are useful in confirming placement of the ET tube?

11      A.       I don't agree with that.

12      Q.       You don't agree with that?

13      A.       No.

14      Q.       Why do we do a chest x-ray then?

15      A.       We do a chest x-ray to make sure we're not  
16 missing something like pneumothorax, foreign body,  
17 any other pathology that is going on that we're not  
18 aware of. We wanted to know why she is in this  
19 situation.

20                   Also using it for endotracheal tube  
21 is something that is incidental. We use it to  
22 confirm, see exactly where the tip of the  
23 endotracheal tube is.

24      Q.       When the portable x-ray film was developed,  
25 did you look at it with Dr. Douglas?

1 A. I looked at it very briefly.

2 Q. Do you recall having a conversation with  
3 Dr. Douglas that the ET tube seemed too high, based  
4 on that film?

5 A. Yes. We've already corrected the situation  
6 before the film came back.

7 Q. Now you are giving me context of remembering  
8 things differently.

9 Are you telling me now the tube was  
10 corrected before you actually saw the film?

11 A. Before we saw the film, yes.

12 Q. You indicate that there was this time  
13 sequence that went by, she was intubated, you are  
14 saying you confirmed placement, there were  
15 bilateral breath sounds, et cetera.

16 When I asked you how you became  
17 aware the tube was dislodged, I think you told me  
18 the chest wasn't rising, the pulse ox was dropping?

19 A. Yes.

20 Q. At this point she began thrashing around,  
21 that's the sequence of things?

22 A. That is what happened in the context of --  
23 yes. Obviously that is probably very close to what  
24 happened, yes.

25 Q. At any point between when you initially saw

1 Jennifer and the time she had a trach, did you  
2 leave the room?

3 A. No.

4 Q. At any point during that initial presentation  
5 of the child to yourself, before the trach, did you  
6 and Dr. Douglas disagree about whether or not the  
7 tube was dislodged, she needed to be reintubated?

8 A. No.

9 Q. What was the pulse oximetry reading at the  
10 point at which you reintubated the child?

11 A. I remember it dropped from the mid 90's to  
12 the 80's, probably the low 80's. I can't remember  
13 exactly what the number was. I can point to where  
14 she was reintubated. They were going down, chest  
15 wasn't rising.

16 Q. At what point in the scenario did her pulse  
17 ox go to 50?

18 A. I don't remember. I don't recollect that.  
19 So many things happening at one time, I can't  
20 recollect exactly when the pulse ox went to 50.

21 MR. GROEDEL: Do you want to  
22 look at the record?

23 Q. You can look at the chart.

24 A. Sure. We reintubated her, giving her Pavulon  
25 I.V. after the second reintubation, the intubation



1 was confirmed, then all of a sudden she became  
2 bradycardic, pulse ox went into the 50's. At that  
3 point the pulse ox started going down.

4 MR. GROEDEL: She wanted to  
5 know what time you think that happened.

6 A. I would say around 12:50, 12:52, around that  
7 time, just before she coded.

8 Q. You are telling me, Doctor, you intubated  
9 her, she went up into the 90's, she started going  
10 down into the 80's, then you reintubated her?

11 A. Um-hum.

12 Q. After that reintubation, but before she went  
13 into arrest, bradycardic --

14 A. Um-hum.

15 Q. The sats or at least according to  
16 Dr. Douglas' note, his discharge note says ET tube  
17 became dislodged, had to be replaced, became  
18 difficult to get the patient's sat up above 60,  
19 even after the ET tube was replaced. At that point  
20 did you think the tube was in the trachea?

21 A. Yes.

22 Q. Why wouldn't the sats come up above 60?

23 A. It might have to do with the pathophysiology  
24 with what was going on in her lungs. The chest  
25 x-ray shows she does have bilateral pulmonary

1       infiltration, which may be secondary to that, some  
2       sort of a dynamic obstruction past the tube, I  
3       don't know, the tube is in the trachea.

4       Q.       Were you concerned about the sats not going  
5       up above 60?

6       A.       I was very concerned about the patient, I was  
7       doing everything that needed to be done at that  
8       point. I checked the tube again to make sure it's  
9       in the right place, yes.

10      Q.       At that point what did you do to confirm that  
11      was in the right location?

12      A.       I performed direct laryngoscope. The patient  
13      is not moving, I performed a direct laryngoscope,  
14      the tube was in the right place.

15      Q.       Could you see past the true vocal cords at  
16      that point?

17      A.       No. It's so difficult unless you do  
18      bronchoscopy to see past the vocal cords.

19      Q.       Just asking.

20                      MR. GROEDEL:               Just answer her  
21      question.

22      Q.       What you just told me about, you didn't write  
23      this in a note in the hospital chart?

24      A.       I did not write this, yes.

25      Q.       When did this child go bradycardic, do you

1 know?

2 A. I don't know.

3 Q. If Dr. Douglas testified that Jennifer  
4 arrested because she was underventilated, would you  
5 agree or disagree with that?

6 A. I don't know. I don't know whether I agree  
7 or disagree with that, I don't know. She may be  
8 underventilated for so many reasons. I don't  
9 believe the ET tube is the reason why she was  
10 underventilated.

11 Q. When you initially intubated her, but before  
12 they came to do the chest x-ray, how did you secure  
13 the ET tube?

14 A. The ET tube was secured with tape.

15 Q. Who taped that tube?

16 A. I did.

17 Q. Are you certain you taped it?

18 A. Yes.

19 Q. The difference between a size 5 tube and  
20 size 3 tube is what?

21 A. The diameter of the tube.

22 Q. Diameter. Is the length any different?

23 A. Yes.

24 Q. It's narrower, shorter, correct?

25 A. Yes.

1 Q. Would you agree with me that when you need to  
2 use a narrower and shorter tube because of  
3 swelling, that there is a higher risk of  
4 dislodgement into the esophagus?

5 A. I will agree with that.

6 Q. It's a known risk, something you should be  
7 watching for?

8 A. Yes.

9 Q. You intubated her a second time just before  
10 she coded, right?

11 A. Yes.

12 Q. You were in attendance at the code, correct?

13 A. Yes.

14 Q. Since I know now from this note that the CO<sub>2</sub>  
15 monitor was not in use during the arrest, did you  
16 hook it back up when she arrested?

17 A. Just to make sure that the tube is in there,  
18 endotracheal, I put the CO<sub>2</sub> monitor on after  
19 listening to the breath sounds. I have bilateral  
20 breath sounds, I hook the CO<sub>2</sub> monitor back on to  
21 make sure it's in the endotracheal at all times.

22 Q. Did you leave it on?

23 A. Yes.

24 Q. Now on continuous monitoring, correct?

25 A. Yes.

1 Q. Let me move for a moment to a different  
2 area. When I asked you about why the sats didn't  
3 come back up over 60, you related it perhaps had  
4 something to do with lung pathology, correct?

5 A. It's possible I think.

6 Q. You've read the Rainbow Baby and Childrens  
7 records, haven't you?

8 A. Yes.

9 Q. Did you see anything in terms of lung  
10 pathology consistent with your theory the sats  
11 didn't come up because of lung pathology?

12 A. I didn't see anything that says that. That  
13 doesn't mean it's not there when I saw the  
14 patient.

15 Q. Do you have some training in pediatric  
16 pulmonology?

17 A. No, I don't.

18 Q. Just asking.

19 A. Okay.

20 Q. The narrative note written by Dr. Douglas  
21 indicates that during the code the tube became  
22 dislodged again; is that right?

23 A. I didn't see that.

24 Q. Why don't we find that part.

25 A. If you can tell me where it is.

1                   MISS KOLIS:                   Ann, pull that,  
2           I'll make it C.

3           Q.       I'm going to mark this C, it's the same one  
4           your attorney has. 12 to 14 minutes into the  
5           arrest the airway became dislodged, you see that?

6           A.       Yes.

7           Q.       You agree it became dislodged again?

8           A.       Yes.

9           Q.       This time the child wasn't thrashing around,  
10          was she?

11          A.       No.

12          Q.       How did it become apparent that the airway --  
13          that the tube had become dislodged?

14          A.       Because I was very vigilant, watching the  
15          patient, listening to the breath sounds, that is  
16          how I found out it became dislodged again.

17          Q.       I probably was not listening well enough, I  
18          do apologize. You became aware that the tube was  
19          dislodged because you were listening to the breath  
20          sounds?

21          A.       Yes, I was listening to the breath sounds in  
22          between CPR, to make sure I was looking at the CO<sub>2</sub>  
23          monitor. Something must have told me from the CO<sub>2</sub>  
24          monitor or listening to the breath sounds the tube  
25          is not in the proper place, so I quickly performed

1 a direct laryngoscope again, saw the tube has been  
2 dislodged at this point.

3 Q. This time I did listen. You are not sure  
4 whether it was the breath sounds or CO<sub>2</sub> monitor; is  
5 that right?

6 A. Something must have told me this tube was not  
7 in the proper place. I don't remember what exactly  
8 I used as an indicator.

9 Q. That is what I'm saying, Doctor, you don't  
10 know as we sit here today what it was?

11 A. What tells me something is wrong?

12 Q. Once again, that is not in this five or six  
13 sentence short note you wrote?

14 A. Yes, it's not.

15 Q. Nothing in the record indicating what really  
16 transpired, you can't refresh your memory from your  
17 note?

18 A. From my note, I can't refresh my memory from  
19 the note.

20 Q. Did you tell Dr. Douglas the tube was  
21 dislodged again?

22 A. Yes.

23 Q. Then what happened?

24 A. At this point he made the decision to go with  
25 the definitive airway, to perform the tracheostomy.

1 Q. Did it occur to you given that the sats  
2 wouldn't go up past 60 and the child arrested, to  
3 do a definitive trach prior to that time?

4 A. That's a decision that Dr. Douglas has to  
5 make. He's the doctor in the emergency room. He's  
6 the person actually taking primary care of this  
7 patient.

8 Q. What happened to this child's sats after the  
9 trach?

10 A. You have to remember that tracheostomy was  
11 performed after we adequately resuscitated her from  
12 the code. It's not during the code. Wasn't done  
13 during the code, was done after the code. So it's  
14 after the code was done, after the code, everything  
15 looks stable, she was about to be transported, that  
16 is when the tracheostomy was done.

17 Q. Doctor, how do you glean, take all the time  
18 you want, I'm sitting here, we've got the records,  
19 from where do you discern your information that  
20 this trach occurred after the code was over?

21 A. Dr. Douglas approximately 12 to 14 minutes  
22 into the code, we coded her for probably that  
23 period of time, before she came back from the  
24 code.

25 Q. If the testimony from Dr. Douglas is that the



1 code was still going on, she became well, in other  
2 words her blood pressure and her sats improved  
3 after the trach, will you be disputing that?

4 A. I don't know what Dr. Douglas said, I'm not  
5 going to speculate on what he said or what he was  
6 going to say about that. It was after the code  
7 that the definitive airway was done. We coded for  
8 12 to 14 minutes. During that period of time she  
9 still had the endotracheal tube in. When the  
10 endotracheal tube came out could have been during  
11 CPR or all the movement that goes on during the  
12 code, then the definitive made decision to do the  
13 tracheostomy.

14 Q. Assuming that the following is the  
15 testimony: That in accordance with Dr. Douglas'  
16 note, that the trach was done by himself, a 5.0  
17 cuffed ET tube was placed, that after that was done  
18 the patient clinically improved, achieved stable  
19 rhythm, quickly weaned off the Epi drip that she  
20 was placed on. Within two minutes after that off  
21 all pressors, BP 130 over 60, pulse 160, sat of 99;  
22 that's what this record says, correct?

23 A. That is what the record says.

24 Q. So if I'm asking you, you don't recall it  
25 happening that way, is that what you are telling

1 me?

2 A. No, I'm not saying that. I'm not saying that  
3 this is wrong. I'm not saying that. What I'm  
4 saying is I know when the tracheostomy was done the  
5 code was over because we were still doing CPR, you  
6 can't do CPR and start doing a tracheostomy at the  
7 same time. I'm saying it's not impossible,  
8 especially in a very small kid it's --

9 Q. You could at that point -- I'm asking sort of  
10 as a lay person who thinks they know something  
11 about medicine, which wouldn't be much obviously --  
12 if you discern you don't have an airway, you've got  
13 to do a trach, you stop doing CPR because it takes  
14 30 seconds approximately to do the trach, doesn't  
15 it?

16 A. I wouldn't say it takes 30 seconds to do a  
17 trach.

18 Q. How long does it take?

19 A. Depends on how knowledgeable, how technically  
20 experienced the surgeon is who is doing it, how  
21 fast he or she can do it.

22 Q. How long did it take Dr. Douglas to do this  
23 trach?

24 A. I would say about two minutes. They have to  
25 get a blade, all that took him about two minutes.

1 Q. When did you find out Jennifer Mack had died?

2 A. After I got the summons from you, from your  
3 office.

4 Q. Did you ever discuss the situation of what  
5 occurred with Jennifer Mack with Dr. Douglas before  
6 I filed a lawsuit against you?

7 A. The only time I talked with Dr. Douglas was  
8 right after the incident happened, I haven't seen  
9 him or talked to him since then.

10 Q. Did you have an opportunity to work with him  
11 again?

12 A. No.

13 Q. When you talked with him immediately  
14 following the incident, what did the two of you  
15 talk about?

16 A. We just reviewed what happened, that was it.  
17 We said we will see what happened.

18 Q. I asked you a little earlier if you had seen  
19 the death certificate, you indicated you had not?

20 A. I said I might have seen it, I don't  
21 recollect what it says.

22 Q. I'm going to hand it to you, mark it Exhibit  
23 D, does that refresh your recollection whether  
24 you've ever seen that document before?

25 A. Yes, I've seen it.

1 Q. Do you have any reason, based on your review  
2 of the University Hospitals records, to dispute the  
3 coroner's findings as to the cause of death?

4 MR. GROEDEL: I'll object to  
5 what the coroner's finding are or not.

6 Q. Sorry. The finding on the death  
7 certificate.

8 MR. GROEDEL: I forget, was  
9 an autopsy --

10 MISS KOLIS: There was not  
11 an autopsy, you are correct about that,  
12 Mr. Groedel.

13 A. Since they didn't do an autopsy, I don't  
14 know.

15 Q. My question wasn't whether or not they did an  
16 autopsy, I'm asking you this is what Dr. Lia Lowrie  
17 certified to be the cause of death. Have you now,  
18 based upon your review of the RBC records, a  
19 different opinion other than the one written by  
20 Dr. Lowrie on the death certificate?

21 MR. GROEDEL: That question,  
22 wait a minute, that question implies that he would  
23 agree with the death certificate opinion if he  
24 didn't have any other opinion. I'm not sure that's  
25 true.

1 Q. Do you have any other opinion there is some  
2 other cause of death?

3 A. I believe there is something else that went  
4 on, I don't know.

5 Q. What did you base that belief on, Doctor?

6 A. Given the pathology, given the patient's past  
7 history. Given what we saw on the chest x-ray I  
8 don't know. We don't have an autopsy report to  
9 tell us exactly some of the things that might have  
10 happened, so I don't know.

11 Q. So is your answer you don't know?

12 MR. GROEDEL: Objection.

13 Q. You don't have an opinion. I'm asking if you  
14 have an opinion as to what the cause of death is  
15 that is different than what appears on the death  
16 certificate?

17 MR. GROEDEL: I'll object.

18 Why don't you ask him if he has an opinion.

19 Q. Do you have an opinion, we will start with  
20 that?

21 A. My contact with Jennifer is so short I can't  
22 form an opinion on what happened to her.

23 Q. You don't have an opinion?

24 A. I don't have an opinion what happened after I  
25 saw her because I wasn't the one taking care of

1 her. I don't have any clinical -- I can't say  
2 anything as far as that goes.

3 Q. You told me you read the University Hospital  
4 records I supplied to your counsel, correct?

5 A. Yes.

6 Q. So the question I asked you was did anything  
7 in those records that you saw suggest something  
8 other than the cause of death listed by Dr. Lowrie?

9 A. I can't form an opinion on that, I don't have  
10 an opinion on that.

11 Q. I think that answer is pretty clear.

12 A. I can't base my opinion on what is in here, I  
13 have to have more information.

14 Q. Doctor, since you've become recently Boarded,  
15 you can tell me back last September, what is the  
16 percentage risk of an esophageal intubation in a  
17 child who has got a swollen airway?

18 A. I don't know. I don't know the percentage  
19 risk of that.

20 Q. Do you have your ACLS certification?

21 A. Yes.

22 Q. Can you tell me when you got it?

23 A. I've had it since I came out of medical  
24 school.

25 Q. I was going to assume that was correct. I

1 was curious if you had it.

2 Are you familiar with the standards  
3 for basic anesthetic monitoring set forth by the  
4 American Society of Anesthesiologists?

5 A. Yes.

6 Q. Do you believe that the American Society of  
7 Anesthesiologists requires continuous monitoring of  
8 CO<sub>2</sub> during the intubation of a child with a  
9 difficult airway?

10 A. They do require, if I'm in a situation where  
11 I'm actually taking care of the patient for  
12 surgery. My role in this situation is to intubate  
13 this kid, it's not like she came to my operating  
14 room or I'm taking care of her operating room, I  
15 have to have continuous monitoring of CO<sub>2</sub> at that  
16 point.

17 Q. Was the x-ray taken to the best of your  
18 recollection following the first intubation?

19 A. Yes.

20 Q. Not following the second?

21 A. No, not following the second one because at  
22 that point she was stable enough for us to do  
23 that.

24 Q. You're indicating, at least what I thought I  
25 heard you say about continuous monitoring, your

1     only role was to come in, intubate the patient, you  
2     were done basically?

3     A.     Basically that's how I understand it, yes.

4     Q.     How quickly did this happen between the first  
5     and second intubation? You would have still been  
6     in the room; do you understand what I'm asking?

7     A.     No.

8     Q.     Then I didn't ask it well. That means I need  
9     another cup of coffee.

10                    You consider that the first  
11     intubation was successful, correct?

12     A.     Yes.

13     Q.     How shortly or how longly, whatever word I  
14     can get you to answer the question, following an  
15     intubation, do you monitor the patient to insure  
16     that the placement is proper?

17     A.     I confirmed the placement of the endotracheal  
18     tube with CO<sub>2</sub> monitor. Also I listened for breath  
19     sounds bilaterally and pulse oximetry came up.

20     Q.     So that took how much time?

21     A.     Between one minute or two minutes.

22     Q.     One to two minutes following initial  
23     intubation you were certain you had properly placed  
24     the tube?

25     A.     Yes.



1 Q. Why didn't you just leave at that point?

2 A. At that point the x-ray was just called, I  
3 wanted to see the chest x-ray to make sure that  
4 this is not -- let me backtrack a little bit here.

5 Patient is being ventilated  
6 manually with 100 percent oxygen, she was not on  
7 the ventilator, it's my responsibility to stay with  
8 the patient at that point until something  
9 definitive, put on ventilator or transferred to the  
10 intensive care, wherever she's going before I leave  
11 the patient. Since I participated in the care, at  
12 that point I'm responsible to stay until I feel  
13 confident she can be adequately managed from then  
14 on.

15 Q. Because she is being manually oxygenated by  
16 ambu bag?

17 A. 100 percent oxygen.

18 Q. You've got the tube in, the tube is not  
19 giving her all the oxygenation she needs, is that  
20 what you are telling me?

21 A. I didn't say that.

22 Q. This is what I'm trying to figure out why you  
23 are still staying there. If you told me you are  
24 simply there to do the intubation, you did it,  
25 confirmed it was correct, we're with each other so

1 far, then you told me you didn't want to leave  
2 because the chest x-ray was coming, you wanted to  
3 confirm what pathology?

4 A. Just to make sure -- to make sure we're not  
5 missing something, hemothorax, any other pathology  
6 in the lungs we don't know about that can be easily  
7 corrected.

8 Also, I function in this role as a  
9 consultant, I'm not just a technician out there to  
10 do an intubation and leave. I believe as soon as I  
11 have contact with a patient, put an endotracheal  
12 tube, it's my responsibility to make sure that  
13 everything is okay. That she is in the proper  
14 hands that can actually care for her before I  
15 leave. I can't just intubate her.

16 Q. Were you worrying about Dr. Douglas'  
17 experience level?

18 A. I'm not worried about it.

19 Q. I'm just asking.

20 A. Not at all.

21 Q. Were there any indications that a  
22 pneumothorax was in existence in this child, was  
23 that a concern for you?

24 A. It's a possibility. We have to check all  
25 possibilities, pneumothorax, foreign body, anything

1 that may be treatable.

2 Q. Were you looking for a foreign body?

3 A. We probably if a kid swallowed a coin that is  
4 causing her to be hypoxic, we can probably see that  
5 on the x-ray, that is a foreign body.

6 Q. If there was anything other than pneumothorax  
7 on that chest x-ray, what medical assistance could  
8 you have been? Do you know what I'm asking you?

9 In other words -- now I'm asking  
10 six questions at once. Let's back up, take a deep  
11 breath.

12 You are saying you wanted to see  
13 what the pathology was, maybe a pneumothorax, maybe  
14 something else, exclude the pneumothorax. You saw  
15 the scan, right, of the lungs?

16 A. I saw the chest x-ray.

17 Q. It was whited out?

18 A. Whited out.

19 Q. Was it whited out due to pathology or was it  
20 whited out due to an exposure issue?

21 A. It was whited out due to pathology I  
22 believe.

23 Q. You've just related in testimony that you  
24 considered yourself to be a consultant, you were  
25 called in to consult, not merely a technician,

1 right?

2 A. Yes.

3 Q. What were Bedford Community Hospital's  
4 requirements in terms of what kind of a report a  
5 consultant should put in the chart?

6 A. I don't know that.

7 Q. Did you ever dictate a consultation report  
8 while you were moonlighting at Bedford?

9 A. No.

10 Q. Do you know if there was a requirement for  
11 you to do so?

12 A. I don't know that.

13 Q. Just asking.

14 MISS KOLIS: I'm going to  
15 take a two minute break, talk to Mrs. Garson, see  
16 if we have a lot of questions.

17 -----

18 (Recess had.)

19 -----

20 MISS KOLIS: I just have a  
21 couple more questions.

22 Q. Contrary to Dr. Douglas' note that Jennifer  
23 vomited at the time of the original intubation,  
24 it's your testimony she vomited after the second  
25 intubation, correct?

1 MR. GROEDEL: I'll object to  
2 the question, asked and answered. You can answer  
3 it again.

4 Q. I'm setting up another question. I want to  
5 reconfirm your testimony today was this child  
6 aspirated at the time following the second  
7 intubation?

8 MR. GROEDEL: I'll object to  
9 the use of the word aspiration.

10 Q. Let's withdraw the word aspiration, vomited  
11 at the time of the second intubation?

12 A. According to the nurses' notes, according to  
13 my recollection, patient had an emesis after the  
14 second.

15 Q. Based on your training as an  
16 anesthesiologist, do you have an explanation what  
17 caused the child to vomit at that time?

18 A. I do not have any explanation why she  
19 vomited.

20 Q. If an ET tube has been in a person's  
21 esophagus for a brief period of time, or any period  
22 of time I guess, we will start with brief, are you  
23 not aware of a phenomenon based on that event that  
24 will cause someone to vomit?

25 A. I don't get the question. Can you rephrase

1 the question?

2 Q. I'll try to make it as simple as I can. We  
3 will see what you don't understand about it.

4 In your training in anesthesia --

5 A. Okay.

6 Q. -- is there anything which you learned which  
7 would explain to you why a person with a tube in  
8 their esophagus will vomit?

9 A. I still don't get your question, I don't  
10 think I can answer it the way you want me to answer  
11 it, that's the point.

12 Q. I'm not sure I know how I want you to answer  
13 it. I'm curious if you know what would make that  
14 happen?

15 A. If you have a tube in the esophagus why  
16 somebody would vomit?

17 Q. Um-hum.

18 A. I see no reason why somebody should vomit if  
19 you have a tube in the esophagus.

20 Q. Physiologically tell me what happens to a  
21 patient that is intubated in the esophagus.

22 A. If it's intubated in the esophagus it can  
23 insufflate his stomach.

24 Q. If it's insufflated the stomach, can that not  
25 cause a person to vomit?

1 A. Yes, you can cause someone to vomit.

2 Q. Do you happen to know based on your training  
3 and experience how long you need to have the tube  
4 in the esophagus before that stomach insufflation  
5 will cause vomiting?

6 A. It depends how much gas flow you have to the  
7 stomach.

8 Q. Between the time Jennifer Mack arrived -- do  
9 you agree that the record reflects she arrived at  
10 Bedford Community at 12:15 a.m. on September 14th?

11 A. I don't know that. I wasn't there when she  
12 got to the emergency room.

13 Q. Obviously you weren't there when she arrived  
14 in the ER room. Do you agree with me the record  
15 indicates the admission was at 12:15?

16 A. I don't know when she arrived.

17 MR. GROEDEL: She wants to  
18 know based upon what the record says.

19 A. Yes, what the record says. That's what the  
20 record says.

21 Q. Between 12:15 and 12:52, do you know what  
22 period of time Jennifer went with an unprotected  
23 airway?

24 A. Between 12:15 and 12:52 I would say about  
25 25 minutes.

*Oxygenation  
impaired*

1 Q. How long does it take for a child to have a  
2 cardiac arrest without a protected airway?

3 MR. GROEDEL: I'll object.  
4 Go ahead, you can answer.

5 Q. Can you answer it?

6 A. It will depend how long the patient has been  
7 hypoxic.

8 Q. What markers would you use to indicate  
9 hypoxia?

10 A. Cyanosis, agitation, patient very restless,  
11 by using things like pulse oximetry, looking at the  
12 pulse, the pulse would be very high.

13 Q. Are blood gases helpful in evaluating that  
14 issue?

15 A. Yes, blood gas is helpful.

16 Q. Do you see any blood gases in this case?

17 A. No.

18 Q. You indicated that the child vomited, this  
19 was after you place the second tube?

20 A. Just in the process of placing the second  
21 tube.

22 Q. Sort of simultaneous as you are putting the  
23 tube down she is vomiting?

24 A. As you are performing direct laryngoscope.

25 Q. As you perform it?



1 A. As I am performing.

2 Q. Before you put the second tube in?

3 A. Yes.

4 Q. You have that clear, you have that memory?

5 A. Yes, because I had to suction here before I  
6 reintubated her very quickly.

7 Q. There is no notes about suctioning her?

8 A. Yes.

9 Q. I'm just asking do you recall anything about  
10 the aspirate, the appearance of it, color,  
11 anything?

12 A. Greenish colored fluid.

13 Q. You are sure it was greenish colored fluid?

14 A. Looked like.

15 Q. Wasn't blood tinged?

16 A. No.

17 Q. Wasn't pink and foamy?

18 A. No.

19 MISS KOLIS: Doctor, I don't  
20 think I have any further questions.

21 MR. GROEDEL: These gentlemen  
22 may have a few.

23 MR. NORCHI: No questions.

24 MR. WILLOUGHBY: I represent

25 Dr. Douglas.

-----

CROSS-EXAMINATIONBY MR. WILLOUGHBY:

Q. You are not critical of anything Dr. Douglas did in this case?

A. No.

Q. You are not critical of the timing in which Dr. Douglas chose to perform a tracheostomy?

A. No.

Q. If Dr. Douglas stated the actual tracheostomy took 30 seconds to perform, you wouldn't disagree with that?

A. Yes, the actual surgery about 30 seconds. To get to that point took more then 30 seconds.

MR. WILLOUGHBY: I don't have anymore questions.

MR. GROEDEL: We're done.

-----

(Plaintiff's Exhibits A through D  
marked for identification.)

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(Deposition concluded; signature not waived.)

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ERRATA SHEETNOTATIONPAGE/LINE

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I have read the foregoing  
transcript and the same is true and accurate.

\_\_\_\_\_  
SAMUEL IREFIN, M.D.

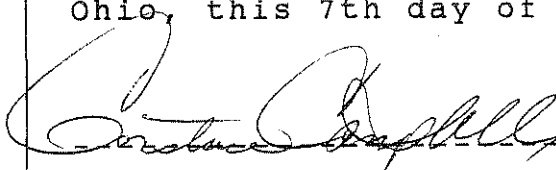
1 The State of Ohio, :

2 County of Cuyahoga. : CERTIFICATE:

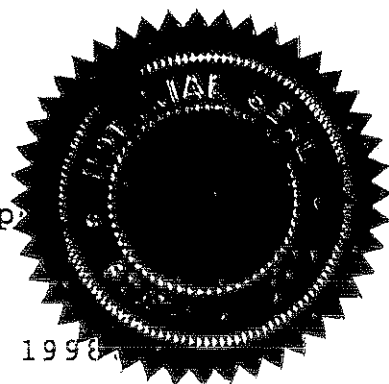
3 I, Constance Campbell, Notary Public within  
4 and for the State of Ohio, do hereby certify that  
5 the within named witness, SAMUEL IREFIN, M.D. was  
6 by me first duly sworn to testify the truth in the  
7 cause aforesaid; that the testimony then given was  
8 reduced by me to stenotypy in the presence of said  
9 witness, subsequently transcribed onto a computer  
10 under my direction, and that the foregoing is a  
11 true and correct transcript of the testimony so  
12 given as aforesaid.

13 I do further certify that this deposition was  
14 taken at the time and place as specified in the  
15 foregoing caption, and that I am not a relative,  
16 counsel or attorney of either party, or otherwise  
17 interested in the outcome of this action.

18 IN WITNESS WHEREOF, I have hereunto set my  
19 hand and affixed my seal of office at Cleveland,  
20 Ohio, this 7th day of July, 1997.

21   
22 -----  
23 Constance Campbell, Stenographic Rep  
24 Notary Public/State of Ohio.

25 Commission expiration: January 14, 1998



## Look-See Concordance Report

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 UNIQUE WORDS: 1,015  
 TOTAL OCCURRENCES: 3,187  
 NOISE WORDS: 385  
 TOTAL WORDS IN FILE: 10,901  
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 SINGLE FILE CONCORDANCE  
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 CASE SENSITIVE  
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 PHRASE WORD LIST(S):  
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 NOISE WORD LIST(S): NOISE.NOI  
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 COVER PAGES = 5  
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 INCLUDES ONLY TEXT OF:  
 QUESTIONS  
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 PARENTHETICALS  
 EXHIBITS  
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 DATES ON  
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 INCLUDES PURE NUMBERS  
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 POSSESSIVE FORMS ON  
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 MAXIMUM TRACKED OCCURRENCE  
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