IN THE COURT OF COMMON PLEAS

LUCAS COUNTY, OHIO

JOSEPH STALMA, a minor, by and through his mother and natural guardian, Norma Stalma,

Plaintiff,

-vs-

TOLEDO HOSPITAL,

Defendant.

CERTIFIED COPY

Case No. CI99-1762

JUDGE LANZINGER

ORAL DEPOSITION OF

JUDITH WRIGHT LOTT, DSN, RNC, NNP

AUGUST 16, 2002

ORAL DEPOSITION OF JUDITH WRIGHT LOTT, DSN, RNC, NNP, produced as a witness at the instance of the Defendant, and duly sworn, was taken in the above-styled and numbered cause on the 16th day of August, 2002, from 9:06 a.m. to 10:53 a.m., before Kimberly A. Clark, Certified Shorthand Reporter in and for the State of Texas, reported by machine shorthand, at the offices of JUDITH WRIGHT LOTT, DSN, RNC, NNP, 3700 Worth Street, Dallas, Texas, pursuant to the Texas Rules of Civil Procedure and the provisions stated on the record or attached hereto.

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EXHIBITS

(NONE)

REQUESTED DOCUMENTS/INFORMATION

(NONE)

JUDITH WRIGHT LOTT, DSN, RNC, NNP,
having been first duly sworn, testified as follows:

EXAMINATION

BY MS. COLWELL:

Q. Ms. Lott?

A. Yes.

Q. This is Angelica Colwell with Marshall Melhorn representing the Toledo Hospital in this case, along with Nancy Moody who is also here in our office in Toledo, Ohio.

A. Hello.

Q. -- also here on behalf of Dr. Buganski. I'm not sure where -- You are in Texas, correct?

A. Yes.

Q. And is David Kulwicki in Texas with *you* as well?

A. No, he's not.

MR. KULWICKI: I'm in my Cleveland office.

MS. COLWELL: Okay. Now that we have everybody straight as to where we are, David, can we have normal stipulations regarding the court reporter and notice?

MR. KULWICKI: That's fine.

MS. COLWELL: Okay.

Q. (By Ms. Colwell) Is it Dr. Lott or Ms. Lott? What are *you* comfortable with?

A. Dr. Lott.

Q. Okay. Dr. Lott, can you state your full name for the record, please.

A. Judith Wright Lott.

Q. And what's your professional address?

A. 3700 Worth Street, Dallas, Texas.

Q. And is that on the campus of Baylor University?

A. It is Baylor University Louise Herrington School of Nursing in Dallas.

Q. How long have you been at this professional address?

A. Just a little over a year.

Q. Now, I have in front of me a copy of a curriculum vitae which was provided to me by Mr. Kulwicki. It does not have a date on it that I can see. It's a 19-page curriculum vitae.

A. Can you tell me on the first page the present rank and position.

Q. It says, "Acting Dean; Baylor University Louise Herrington School of Nursing.

A. That is the most current.

Q. So it is the most current, complete, to your understanding, copy with, like I said, 19 pages?

A. Yes.

Q. You said you've been at Baylor a little over a

year?

A. Yes.

Q. Can you just give me a very brief -- I have it all here, but a brief history of your professional positions or work experience?

A. Yes. I have been primarily in neonatal nursing since January of 1976. I have served in both clinical and academic agencies. I am a certified neonatal nurse practitioner. I am doctorially prepared in nursing.

Q. When did you earn your doctorate in nursing?

A. 1992.

Q. And where did you do that?

A. University of Alabama at Birmingham.

Q. Did you also have a master's degree?

A. Yes.

Q. Did you do that at the University of Alabama also?

A. No. I did that at Troy State University.

Q. And when was that?

A. 1985.

Q. Are you an RN as well?

A. Yes.

Q. When did you earn your RN?

A. July 1975.

Q. Okay. Now, you did say you are a certified

neonatal nurse practitioner?

A. Yes.

Q. When did you do that?

A. That was part of my master's --

Q. So you would --

A. -- degree.

Q. So that was part of your master's in 1985?

A. Yes.

Q. Can you approximate for me the percentage of time you spent in clinical duties versus academic duties in nursing?

A. I have no clinical practice at this time.

Q. When was the last time that you were involved in clinical practice?

A. When I was the director of neonatal nurse practitioners at Children's Hospital and a joint appointment with University of Cincinnati -- and let me see when that last date would have been -- around 2000.

Q. Around 2000?

A. About May of 2000.

Q. Can you approximate for me, with respect to the joint appointment, what was the amount of time you were spending in clinical care versus academic work in 2000?

A. The vast majority -- Wait, just a moment. Let me clarify that to myself. Up until 1998 the majority of

my time was clinical. From '98 on it has been primarily academic.

Q. And in 1998 what kind of clinical duties did yo have, or where were you working? I suppose we can put i that way.

A. At that time I moved into -- in '96 I moved int the university, but my time was pretty evenly split between the hospital and the academic setting. After -- in 1998 I was primarily academic.

Q. Let me just -- in 1996 you said you moved into the university. Are you talking about Cincinnati there?

A. Yes.

Q. And when you say you had an even split between the hospital and academic setting, what were your clinical duties?

A. I was director of the neonatal nurse practitioners.

Q. What does that mean?

A. I was responsible for the supervision, administration, and patient care for a 10-neonatal-nurse-practitioner service. We had a caseload of neonates in the Neonatal Intensive Care Unit.

Q. Does that mean you were primarily doing supervision of the nurses and administration duties of the ten nurses, or were you also involved in the care of

the babies in the nursery?

A. 1 was also involved in care.

Q. How much time do you think was -- were you spending in the care, hands-on patient care?

A. Probably 50/50.

Q. Just so I'm clear, we're talking about -- This is 1996, correct?

A. Yes.

Q. Okay. All right. When were you first contacted to review the case of Joseph Stalma versus the Toledo Hospital?

A. It's been over a year. 1 was still in Cincinnati.

Q. Do you remember who you were contacted by?

A. I believe someone from Mr. Kulwicki's office.

Q. What was it that you were asked to do?

A. If I would just review the medical records of this patient.

Q. Did you at any time generate reports or letters to Mr. Kulwicki regarding your review?

A. No, I did not.

Q. Do you have any notes or anything that you created during the course of your review?

A. No.

Q. Did you bring anything with you, or do you have

anything in front of you at your office today?

A. I brought the medical records and the depositions that I have reviewed.

Q. And can you tell me what those medical records and depositions are exactly?

A. Yes. I have depositions of a Dr. Moriarty. I have the deposition of Dr. Jay Goldsmith. I have the depositions of Norma and Joseph Stalma. I have depositions of the following nurses: Constance Rose, Linda Johnson, Amy Cline, Lucinda Osterhout, Nancy Brothers, and Wendy Zettel, and Myra Zaenger. I also have a copy of the medical records which included both Norma and Joseph Stalma.

Q. I'm assuming you're talking about the labor and delivery records from the Toledo Hospital?

A. Yes, and the newborn nursery records. The focus of my review was on the care of the newborn, Joseph.

Q. Okay. Is that all the medical records you have in front of you?

A. Yes. I have some duplicates of those -- for some of those. I also have the -- some miscellaneous things that I didn't really review, like the hospital bill and the -- I think that's it, actually.

Q. All right. And were there any other records that you reviewed, any of the subsequent care records or

anything of that nature?
A. No, I did not.
Q. Okay. Do you feel you've reviewed all the records you need to review in order to formulate any opinions you may have regarding the care and treatment i this case?
A. Yes.
Q. Do you have opinions regarding the care and treatment in this case?
A. Yes.
Q. I want to start talking about those, and I'm no sure -- it's going to be a little difficult since we're doing this by phone.
A. Yeah. I've never done this this way before.
Q. Have you done a deposition before?
A. Yes.
Q. Okay. Just not by phone?
A. Yes.
Q. Do you know how many depositions you've done before, or can you approximate for me?
A. Probably six.
Q. Were they all in the capacity of an expert witness?
A. Yes.
Q. How many cases are you currently reviewing as an

expert witness?

A. I have two other cases, though I believe one of those must have settled. It has.

Q. Two other cases in addition to this one that we're talking about today?

A. Yes.

Q. How long have you been serving as an expert with respect to medical/legal work?

A. Approximately two years.

Q. Are you associated with any kind of medical/legal expert review service or anything of that nature?

A. No.

Q. Do you do any advertisement for medical/legal review?

A. No.

Q. Do you know how these -- anybody that gets to use your services as an expert, how they contact you or how they get your name?

A. No, I don't.

Q. Okay. You mentioned you're currently working on two other cases. Do you know how many cases you've served as an expert on in total?

A. I'm thinking.

Q. That's fine. Take your time.

A. I have probably reviewed records for approximately ten cases.

Q. Was it mostly for the plaintiffs or mostly defendants, or do you have a recollection?

A. I've done both.

Q. Do you know percentage?

A. I would say maybe 60 percent plaintiff, 40 percent defendant.

Q. Okay. All right. Let's get back to where we were before, which was talking about the opinions that you have in this case. Can you tell me what they are, and if there are a number of them, let's do them one at a time.

A. Okay. Basically, I have two opinions about this case. The first is that the nurses did not meet the standard of care in relation to assessment of the newborn; following orders or guidelines for the medical care; and, three, notification of the physician of abnormalities.

The second opinion is that there was some inappropriate documentation.

Q. I'm sorry. I'm taking notes, so this is taking me a second. Okay. Let's talk about your first opinion. You're saying that you -- It's your belief that the nurses did not meet the standard of care with respect to

the assessment. Can you tell me exactly where it is tha you think that the standard of care was not met?

A. This baby -- and the majority of my opinion is based on care in a relatively short period of this baby's life. Primarily dated on the 23rd, there were numerous signs that they actually observed or charted that each one by itself may not be *a* major problem; but had they looked at this baby and put all these signs together, this would have given them an indication that a physician needed to assess this baby.

Q. And what are the signs that you are speaking of?

A. The baby had a change in feeding. The baby had an elevated temperature. Also, this was a baby who initially had had some cyanosis at delivery. This baby had some cyanosis that day. The baby had also initially been hypoglycemic. The baby had some respiratory distress. All of these put together would indicate a baby who was not experiencing normal transition.

Q. Now, let's talk about the cyanosis that day. The 23rd is the day that there was an episode reported by mom; is that correct?

A. Yes.

Q. And when you're referring to cyanosis, what time are you referring to?

A. Okay. What I'm going to do is go to the medical

records.

Q. That's fine.

A. It might be easier if we just went though those days.

Q. Do you have the record in front of you?

A. Yes. And I'm looking at Nursery Daily Flow Sheet, which is labeled 3/21/91 to 3/22/91.

Q. All right.

A. And what I would like to point out on this day is that there is some inappropriate charting. The date was changed. And if you'll look in the second column under "internal monitor site present," it initially was marked "no," and that was crossed out with an X.

Q. Okay,

A. That's inappropriate documentation.

Q. In what way? How is that inappropriate

A. The standard for making a change on a medical record -- and this has not changed since 1976 when I first became a nurse -- you make one line through it, y o ~ out your initial. If you have entered data incorrectly, not only do you need to cross a line through it and put your initial, you also need to give an explanation. For example, wrong chart.

Q. Were you going to say something else?

A. No. I was going to say that was all on that one

page.

Q. Okay.

A. However, if you'll look -- which shows up as my next page, but it is the continuation of that flow sheet -- at 02:25 -- and this would be on the 21st -- or actually it would be the a.m. of the 22nd -- the baby took one ounce of Similac, and it was noted as fair.

MS. MOODY: Dr. Lott?

THE WITNESS: Yes?

MS. MOODY: Can you describe for us the page that you're referring to?

THE WITNESS: Yes. At the top of this page, and it's the continuation of the Family Center Maternity Care Nursery Daily Flow Sheet, at the top it has Input/Output, health care notes, document response to interventions, teaching, PRN medications, or unusual occurrences. There's a notation at 02:10.

Q. (By Ms. Colwell) Okay. Thank you. We just wanted to make sure we're looking at the same thing you're looking at.

A. Okay. So the first thing I was pointing out is that the baby was noted as having a fair suck at that time.

Q. Are you -- Is this in reference to the word "fair"? I don't see --

A. Yeah. Fair is -- Fair suck is what that refers to.

Q. Okay.

A. The second thing that is an abnormality is the baby's pulse rate, which is 119.

Q. How is that abnormal?

A. Well, it's slightly low. The normal pulse rate for a newborn is 120 to 160, and this baby did maintain a lower heart rate; so even though I don't consider this a critical low number, it is below what is considered normal. The next thing, if you'll look, where it says, Received in the 3 North Nursery --

Q. You're talking about the entry at 02:10?

A. Yes. This baby has circumoral and acrocyanosis. Acrocyanosis is quite common in the term "newborn." However, circumoral cyanosis is a form of central cyanosis, so that is an abnormality. And that was upon admission.

Q. How long had the circumoral and acrocyanosis lasted?

A. The note does not reflect that.

Q. Is it your understanding that this child was seen by a physician prior to admission into the 3 North Nursery?

A. Yes.

Q. Now, in reference to what you've indicated, you believe it indicates a fair suck under the "intake" column?

A. Yes.

Q. How is that -- I'm not sure if you indicated -- or what exactly you are indicating about that entry. What is it about that entry that you find --

A. The fact that fair suck -- you know, there is no standard measure, but you would expect a baby to have a good suck, and this baby did not.

Q. Do you have a time frame for when you would expect a good suck? I guess I'm just not understanding where -- you know, what you're trying to say here.

A. What I'm trying to say is that this was an indication that this baby should be watched because the baby did not have a strong, vigorous suck. The baby took the feeding fair, which doesn't mean they couldn't get him to eat, but he didn't take it easily.

Q. He did take the feed?

A. Yes. He took one ounce.

Q. And is one ounce a fair amount for a newborn child that's approximately six hours old?

A. Yes.

Q. Is there anything else on that page that you wanted to point out?

A. No.
Q. I'm sorry, was that a no?
A. Yes, no.
Q. Okay.
A. Sorry. The next area on the second day, 3/22/91 through /23/91 -- again on the second page of that daily flow sheet -- Are you with me?
Q. We're looking at the intake and output sheet again for that?
A. Yes.
Q. Can you tell me what the first entry is on that page that you're looking at?
A. 8:20 baby undressed by nurse for examination by Dr. -- and I cannot read that name. Doctor-something.
Q. The second page of the flow sheet?
A. Yes. Again, the intake and output page.
Q. Okay. I got it.
A. Now, one thing I just want to point out, if you'll look at all these feedings, the baby took an ounce of Similac at 14:30. He took an ounce well. At 1:45 he took two ounces well. And the last feeding time I can't -- there's something that was over this when it was copied, so I can't tell exactly what that time is, but the baby took one and a half ounces well in the nursery.
Q. Okay.

A. So this was -- At this point the baby was feeding well. That's what I wanted to point out.

Q. All right.

A. At 08:00 the baby still has a low, abnormal pulse rate; but if you'll look at the lines below that, he had a temperature of 99.

Q. Do you know what the time is that you're -- the temperature of 99?

A. Again, there's something over it, but it's 05-something.

Q. The pulse rate that you're referring to, is this the pulse rate of 124?

A. Yes.

Q. That's still within your normal range of 120 to 160?

A. Yes. It's just on the low normal side.

Q. All right.

A. And the reason I point that out is that you expect more variability in a baby's heart rate.

Q. How would you know? What are you talking about variability there?

A. Well, when babies are handled, when they cry, their pulse rate usually goes up.

Q. Do you have any idea what was going on with this baby when the pulse rate was taken?

A. No, I don't.

Q. Is it your understanding that Dr. -- a doctor -- and I'll represent to you that this is the signature -- or the name that's in here looks like Dr. Gladiux. He came in to examine the baby that morning at 8:00, at least according to the notes.

A. Yes. I see that.

Q. Okay. So at that point, or during that examination, Dr. Gladiux would have been made aware or would have had the chart -- should have the chart and made aware of the pulse rate, et cetera?

A. Yes.

Q. All right.

A. If they recorded their vital signs directly on the flow sheet when they took them and didn't wait until a later time to record those.

Q. You don't have any reason to believe that that's --

A. No, I don't.

Q. All right. Anything else on this page that you wanted to point out?

A. Did you understand that when I said that there was a temperature at 05-something of 99.

Q. Well, I can't -- to be honest, I can't tell what time it is on my sheet. It does look like 05-something.

A. Well, that's the way it is on my sheet, so it's sometime around 5:00.

Q. Okay.

A. And the baby had a temperature of around 99. There is not, on this record, any documentation of an intervention or notification of the physician of that temperature elevation.

Q. But you are -- you acknowledge that the doctor was there that morning to examine the baby?

A. It looked -- this begins at 08:00 and ends at 05:00, so I -- I have no idea how close that was in celation. These times -- the time immediately before th 99 temperature was 24:00, so I'm assuming that this is 5:00 a.m. of the next morning.

Q. Okay. So then we would have to look at the nex lay flow sheet to determine anything that happened with espect to a physician being in to examine the child, orrect?

A. No. It should be right over there on that -- In hat column under where the notation of 08:20 is, it hould be recorded there.

Q. Okay.

A. There is no documentation. Okay. The next flow heet is dated 3/23 and 3/24, and there are three times for assessment, 9:00 a.m., 15:55, and 02:0. I think

t.here must be another number missing.

Q. Another number?

A. Well, 15:55 and then --

Q. You're looking at where the column says 02:0?

A. Yes, which is not a standard time, so I don't know -- that's another instance of unclear documentation, That's not military time or regular time. However, if you will look in that third assessment by CR, who I believe to be Constance Rose, the suck is listed as fair, and the baby is listed as hypertonic. He is pale and cyanotic.

Q. You indicated that you've had an opportunity to review Constance Rose's deposition; is that correct?

A. Yes.

Q. All right. So there -- what's your aderstanding of what date and time that this represents, r do you have an understanding?

A. Well, I would need to actually pull out her deposition to say for sure, but this -- this was -- she was the night nurse, basically; so my assumption is that his was 2:00 a.m.

Q. All right.

A. However, I was taught that you cannot make an assumption. You have to go by the documentation, which again points out that there was inappropriate

documentation.

Q. So what is your understanding of what date and time this was?

A. Well, it was the night shift.

Q. All right. I guess I'm looking for a time. I' not sure -- you know, the night shift, in my understanding, could be eight to twelve hours?

A. Well, what I'm pointing out to you is that the time was not documented appropriately by the nurse, so i is not possible to pinpoint that time.

Q. All right. So where are we, then?

A. Then I'm ready to go to the second part of that flow sheet.

Q. Okay. Can you tell me what the --

A. Again, it's the intake and output. The first entry on the right is 07:30.

Q. Okay. I have that page?

A. Okay. If we just look at the intake and output column?

Q. All right.

A. This is a baby who now took an ounce at -- At 15:15 took one ounce fairly well. At another time, whic is obscured -- but it was a time around -- it looks like about 22:30.

Q. Okay.

A. The baby took fairly well one ounce, and then a 02:00 took an ounce again fair. This is a baby who had -- the previous feedings had all been well, which indicate a change in the baby's feeding status. Then immediately under that section in the area for vital signs to be recorded, this is a nursing instructor's worst nightmare of documentation.

Q Well, I'm -- why don't you go ahead and explain to me what you're talking about.

A. Well, the entry was X'd out. What I can still read, though, is that the temperature is 100, and then under that there's a temperature of 99; but that entry was X'd out. I have no -- no initial -- no explanation for that. Under that you can still see a temperature of 100.6, 99.9, 99.8. All of those are abnormal temperatures.

Q. So it does appear to you that there were -- that the temperatures were recorded on the sheet just below that area where you're talking about, the area where the is?

A. Yes.

Q. All right.

A. What you cannot distinguish, however, is the imes, the time those temperatures were recorded.

Q. I'm not sure I understand what you're saying,

because there are times that appear next to the temperatures that are recorded, are there not?

A. Yes, but you cannot read the times in the entry that was X'd out, so I don't know if the times that those temperatures were recorded are the same. I cannot tell that.

Q. Okay. So what is it that you're -- what is it that you're suggesting? I'm not sure I understand.

A. I am not suggesting. I am stating that that is inappropriate documentation.

Q. Okay. Well, with respect to the feeds that are listed in the intake column --

A. Yes.

Q. -- would you agree with me that the baby took, with the feeds that are listed, anywhere between three-quarters of an ounce and one and a half ounce of formula or dextrose water?

A. Yes.

Q. And what is it -- that's the normal amount of formula or fluid for a baby to be taking at a specific feeding, is it not?

A. Actually, I would expect the baby to be taking slightly more feeding -- formula with feedings. On the day before he had taken up to two ounces. Now he's taking less. The first on that page is one and a half,

and then it goes down; and rather than taking it well, it's now fairly well.

Q. Do you have any understanding of whether or not the baby was out with mom at any point during this time and she was giving feedings?

A. The baby was fed in the nursery at 18:30, and at the next feed, the mom fed in the nursery.

Q. Right. I understand that's what the chart says, but you would agree with me that feedings can occur outside of the nursery by mom or someone else?

A. Yes.

Q. And those might not necessarily be documented on this sheet because this reflects what the nurses either witnessed in the nursery or had gotten some reports about, correct?

A. The standard would be that the nurse would inquire about those feedings, and those would be charted on the medical record.

Q. But that would require that the nurse was accurately reported to by whomever gave the feeding, correct?

A. Yes.

Q. Okay.

A. Generally what they do is leave the bottle so that the nurse can actually look at the bottle and tell

how much formula was dispensed.

Q. All right. Sure. Which would still depend on whether or not that was done by whomever gave the feeding?

A. Correct. Then we move to the right side of the page at the entry at 14:30.

Q. Okay. I'm with you.

A. Well, now I can't read the writing on this chart. Can you -- On your copy can you read the entry a 14:30? Can you read that to me?

Q. Sure. What it says -- What I understand it to say is, Dr. Buganski notified of -- there's an arrow up -- increased temp. Orders received. And then there' a signature.

A. Okay. Okay. That's what I -- I wasn't quite sure about that, so this is at 2:30 p.m. that the physician was notified. The entry at 18:35, which by regular clock is 6:35 -- but, again, if you'll notice, that 18:35, that number eight was written over. I do not know exactly what to make of that, but the one, three, and five are quite clear, but the eight appears to be written over. That entry says, Mom states baby has arched back and stiffened extremities while feeding. Cyanosis around mouth and hands noted.

Q. Okay. Do you have another thought that you had

there, or are you just reading it?

A. That is absolutely abnormal behavior for a baby. That entry continues, The baby was suctioned. Continues to have difficulty breathing, slash, expiration, which the only way I can interpret that is expiratory grunting,

Q. And what do you mean? What is that? What does that mean?

A. It means this baby was having difficulty breathing. That is abnormal. Any kind of expiratory sound is abnormal.

Q. Well, what is your understanding of what happened to the baby at that point? Do you have an understanding?

A. My understanding is that this baby demonstrated obvious distress.

Q. Do you have an opinion as to what should have been done in response to the distress?

A. Yes. I think the physician should have been called at that time and said, you know, This baby had -- is cyanotic. He has some respiratory distress. His behavior has changed. He's not taking his feedings well. You know, his temperature was elevated. You better come look at this baby.

Q. Well, you would agree with me that by this point the doctor, or a doctor, had been notified of temperature

elevation, correct, pursuant to the 14:30 charted notes?

A. 14:30 note says -- yes, temperature. Notified of temperature elevation.

Q. All right.

A. However, it does not say that the other components of the assessment were -- that he was notified of those.

Q. Right. You would also agree, though, that by the 18:35 notes, there was formula and mucus that was suctioned at the bedside out of the baby's mouth, correct?

A. Yes. However, that has very little meaning.

Q. In what way?

A. Any baby who has just been fed any amount and you suction it, you're going to get formula or mucus. If the baby had not taken any formula, then what that would mean is that the baby has not digested or absorbed feeding from the previous formula; so that would indicate a problem. That would be another abnormality.

Q. Well, isn't it possible that this baby could have been feeding and choked on the feeding? I mean, babies do choke, correct?

A. Yes. However, even if that had been the case, that the baby choked on the formula, the baby still exhibited respiratory distress, and the physician would

still need to assess this baby to actually investigate whether or not this baby had aspirated formula, which could be the cause of the continued respiratory distress

Q. Isn't respiratory distress something that could be caused by choking in and of itself?

A. Yes, but the problem would be that that formula would be aspirated into the airways, so that would need to be followed up.

Q. All right. So in your opinion, a physician should have been notified of the choking -- of the episode, correct?

A. Of this episode, yes.

Q. All right.

A. And then we continue at 18:40, the baby is still cyanotic around lips. That is circumoral cyanosis. It is a form of central cyanosis. That is not normal.

Q. Well, again, isn't cyanosis something that could be caused by a choking episode where the breathing is interrupted?

A. The cyanosis is caused by decreased oxygen in the blood. This is now five minutes after the -- what you're purporting to be a choking episode, that should have been completely alleviated by this time.

Q. Well, according to the note, it appears that the suctioning is going on -- I mean, we don't really know at

what time specifically the reference to the cyanotic color is pursuant to the note.

A. It was written 18:40.

Q. Right, but it also describes the things that were being done in order to deal with the previous episode, correct?

A. Well, the next note is written at 18:45, so somewhere between 18:40 and 18:45.

Q. And by 18:45 nail beds are pink, color improving with facial oxygen times one minute, lungs clear, according to the note.

A. There is no way that -- in the first place, this baby is on oxygen now. That is an indication of respiratory distress and hypoxemia. A physician needed to be there -- to be called at that point. If not, certainly the physician should have been called sooner.

Q. Well, it appears from the note that the baby was given oxygen for one minute at most, correct?

A. Yes. It is an abnormality for a baby to require oxygen.

Q. Well, if a baby chokes and is having a little trouble after the choking episode in re-establishing his breathing, wouldn't it be appropriate to give the baby oxygen?

A. It is appropriate to give a baby oxygen when

they are cyanotic. I do not agree with your description of this as a choking episode and a little bit of trouble getting his breathing started.

Q. Well, what is it that you think this was?

A. This was an episode of distress with a respiratory component that needed to be evaluated. If the baby was having -- continuing to have cyanosis five minutes after this episode, this baby needed further workup.

Q. Is it your understanding that this episode was something that was witnessed by the nurses?

A. The first episode was reported to the nurse by the mother and father. However, at 18:40 the baby was returned to the nursery. This was happening in the nursery with the nurse.

Q. All right. But the initial episode was not something that was witnessed by the nurses personally, correct?

A. No. It was told to the nurse by the mother and father.

Q. Okay. So the note reflects what the mother and father would have reported to the nurse at that time?

A. Yes.

Q. All right. And it's possible that if a baby chokes, the amount that was -- suctioning out a mouthful

of formula and mucus is something that you would expect to do?

A. As an initial effort, but you do need to realize that anytime you suction a baby who has had formula, there will be formula. You can actually compound the problem by doing too much suction.

Q. Well, the note reflects that the first thing that was done at the bedside was that there was suctioning and that mucus and formula was obtained, which would be expected?

A. Yes.

Q. All right. Okay. What else? Is there anything else on the page that you wanted to point out?

A. Well, yes. Finally at 21:00 the physician was notified.

Q. Okay.

A. So basically there has been a period of about almost 12 hours -- because the physician was notified of that temperature at 2:30. Then if you'll look at 2:15, the baby had a high-pitched cry.

Q. You're talking about 2:15 a.m.?

A. Yes. At that time the baby had a high-pitched cry, rigidity, arms outstretched upward with circumoral cyanosis, dusky, undertones pale, and had to receive oxygen again; so basically there was a period --

Q. 02:15 note, correct?

A. Pardon me? 02:15, yes.

Q. You're just reading that note?

A. Yes. So basically there was a period of almost 12 hours in which this baby demonstrated increasing distress, and my chief criticism is that this baby could have been -- should have been evaluated much sooner. It is my opinion that at 2:30 when the physician was notified of the elevated temperature, there was other information that could have been presented. Certainly by the 18:35 episode the physician should have been immediately notified and the other information provided to him.

Q. Would you agree with me that it appears from the chart that by 18:45, 18:50 this baby is breathing normally, had pinked back up, and appears to be doing okay?

A. I would agree with you that he does not appear to be in acute distress.

Q. Right. And then between 18:50 and 21:00 there is really no entry that suggests he's doing anything but normal newborn behavior, correct?

A. There is nothing documented. However, that episode was acute enough and the baby had other signs. The baby -- you know, the temperature is elevated. The

baby is not eating well. This episode that was reported by the parents and then what was observed in the nursery are all signs of distress that warranted an evaluation.

Q. Well, I understand what your overall opinion is. I'm just asking you if whether or not you agree with me that the entries in the chart indicate that this baby between approximately 18:45 and 21:00, there's nothing -- or even further out than 21:00 -- nothing indicates he's doing anything unusual, correct?

A. All it indicates is that --

Q. Yes or no? There's no entry in there. There's no entry that appears anywhere in there after the entry at 18:35, 18:40 that indicates this baby is having anything -- any kind of respiratory difficulties, any kind of difficulties whatsoever.

A. I cannot agree with you on that.

Q. Well, there's no entry?

A. That's correct.

Q. Okay. And, in fact, he's even -- by -- what time is that? His temperature is back to normal by 19:50; isn't that correct?

A. Yes, it's within normal limits.

Q. Okay. So he appears to have done rather well?

A. I would not agree with that.

Q. Why not?

A. Because you can't be -- this baby had obvious distress. Just because the baby is not exhibiting more distress or continuous distress does not abrogate the fact of the distress that the baby has already demonstrated.

Q. It is possible that -- I mean, babies do choke, and it's possible that he was choking on formula at the time the report was made to the nurses, isn't it?

A. If the baby -- if you want to attribute that distress to choking, then the only thing that I can think of that would cause that severe of an episode would be aspiration of formula. That in itself would require an evaluation by a physician.

Q. Is there anything else on this page, then? I'm --

A. The one other entry is the progress under that -- under the nurse's narrative that says, Baby nipples slowly.

Q. All right. I see what you're talking about. Okay. What significance is that to you?

A. Well, again, a baby that had been feeding well and is now not feeding well.

Q. Do you know what time that entry was put in there?

A. No.

Q. The entry does reflect that the child took -- was retaining all the formula he was taking, correct?

A. Yes.

Q. Is that all on that page?

A. Yes. However, I do want to point out to you that those two -- if the baby was retaining what was -- that makes it unlikely that this baby had choked and had that much formula. That just doesn't fit together well.

Q. I'm not sure I understand that, particularly because we are not really sure just by the chart what time that injury -- if that injury refers to a specific time.

A. Well, that's what I'm pointing out to you, is that probably this "nipple slowly" was written before this -- what you're purporting as a choking episode.

Q. Yeah, but you don't know that.

A. Well, it -- if the baby had an excessive amount that they had to suction out, then the baby was not retaining; so that doesn't make sense, so I -- The only way that that injury could be accurate was if it was written before this purported choking episode.

Q. All right. But that still reflects that he was taking the formula and taking his feed. You would agree with me at least about that?

A. Yes, until this -- the 18:35 episode.

Q. Do you have any other criticisms or anything else to point out on that page?

A

Q Okay. Why don't we move on to your next --

A Well, my next note is on the health care notes continued at 2:30

Q. All right.

A. The pulse rate was 116 and irregular. Blood pressure was done, and at this point the baby was pale and cyanotic, coarse breath sounds, and the baby was taken to the NICU after going to visit the mom. The baby received plasmanate at 2:30.

Q. What's significant about that note to you?

A. What's significant is that it was extreme distress.

Doesn't the note indicate that a physician was in and examined the baby at this time?

And that Dr. Buganski was notified of the episode?

Q. All right. What's your criticism?

Well, that that occurred much too late.

Q. What do you mean by that?

A. Well, just as I said, if the physician had been

notified at 18:35, which is 6:35, rather than at -- this was done at 2:30, 2:15 was when it actually began.

Q. All right.

A. So from 6:00 p.m. to 2:00 a.m., that's eight hours.

Q. In your opinion, was the care and treatment by the nurses up until the 18:35 entry reasonable?

A. Well, they did not follow the guidelines for th physician about notification of temperature elevation. This physician wanted to be notified for temperatures of 99 or higher.

Q. Well, what's your basis for saying that the guidelines weren't followed?

A. Well, there were temperatures that met that criteria that were not -- and he was not notified.

Q. What temperature are you talking about?

A. Well, let me -- let me find the graph sheet. That will be the easiest way to -- Oh, I know a good way to find it. Just a minute. There was an order given on 3/23, Strip the baby of clothes, retake temperature in one hour and call me. That was not done.

Q. Do you know the time of that order?

A. 14:30, 2:30, 3/23.

Q. And what do you mean when you say it wasn't done?

A. The temperature was not recorded and he was not notified.

Q. You're talking about the subsequent temperature that was taken?

A. Correct.

Q. It appears from the record that he was notified of the increased temperature that prompted that order, though?

A. Correct, But he was not notified of that temperature -- or they actually did not retake the temperature in one hour. If they did, they did not record it; so they did not notify him. There were other elevated temperatures that they did not notify him, or there is no documentation that they did.

Q. You would agree that the temperatures that are reported indicate that the temperature was coming down from the time Dr. Buganski was notified of increased temperature?

A. Yes, but they were not normal.

Q. How many of them are you considering not normal?

A. Anything above 99, according to his request, his guideline. He wanted to be notified of any temperature above 99, so if the temperature was above 99, he should have been called.

Q. Okay. So that order was given by Dr. Buganski

at 14:30, you said.

MR. KULWICKI: Wait. Wait. Wait. Wait. Let me interrupt. What order are you talking about?

MS. COLWELL: I'm talking about the order she was talking about: that was given by Dr. Buganski. All I'm saying is, it was done at 14:30.

THE WITNESS: Okay. There are two things that I'm saying here. Let me clarify. There was a specific order written on the chart 3/23 at 14:30.

Q. (By Ms. Colwell) Right.

A. Strip baby of clothes, retake in one hour and call me.

Q. That's the order I'm talking about.

A. Yes. That order was not done. The temperature was not retaken in an hour, and he was not notified. His general guideline, however, stated that he wished to be notified of any temperature of 99 or higher.

Q. Correct.

A. Thus any temperature on this baby's chart of 99 or higher warranted a phone call to the physician.

Q. All right.

A. That did not occur.

Q. Okay. According to the temperatures that we have recorded, Dr. Buganski would have been aware of the increased temperature at 14:00 and 14:30?

A. Correct.

Q. And then the subsequent temperature that's recorded looks like 15:55. Would you agree with me on that?

A. Well, I thought it was 15:15, but ...

Q. Okay. 15 -- I'm just looking at the actual chart page. Is that what you're looking at?

A. Yes.

Q. I mean, there is a temperature between 14 -- after 14:30. Whether or not it's 15:55 or 15:15, the temperature that appears in there?

A. One that's 99-something and then 99.8.

Q. Okay. And then by 19:15 we're at 98.6?

A. Yes.

Q. And the baby's temperature was coming down after 14:00?

A. Yes. However, the 9:15 temperature was the first one that was not outside normal limits.

Q. Okay. All right. Anything else on this page?

A. No.

Q. Is there anything else, any other criticisms that you have?

A. No. We've covered the areas for my opinion, which, again, was that they did not meet the standard of care in relation to assessment of the newborn, following

orders and guidelines for the medical care and for notification of the physician, and that there was inappropriate documentation.

Q. If we put aside what we've been discussing, the notification of the doctor of the increased temperature, is there anything else that you're critical of with respect to the nurses' care and treatment prior to the 18:35 entry?

A. Would you repeat that?

Q. Sure. We were just talking about the notification to the physician of increased temperature, correct?

A. Correct.

Q. And put that aside. Is there anything else that you're critical of with respect to the nurses' care and treatment prior to that 18:35 time frame?

A. Prior to the 18:35? No.

Q. Okay.

MR. KULWICKI: Well, let me just interject that at trial I'm going to ask Dr. Lott her opinion with regard to the lack of temperature between -- or the lack of vitals between 7:30 a.m. and 14:00 on March 23. I apologize. I have a terrible cold today.

THE WITNESS: I do have a criticism of that, but I thought we were covering that with the

temperature discussion. Because this baby was under phototherapy, they were required by their protocol to assess the temperature every three to four hours.

Q. (By Ms. Colwell) All right.

A. And they did not do that.

Q. Is that the only other criticism that you have?

A. Yes.

Q. Anything else that you're critical of?

A. No.

Q. Is there anything else that you're critical of up to the 18:35 or the 6:00 p.m., let's say, note?

A. No. That is covered by -- what I mean -- That is what I mean by assessment and notification of the physician, that these things that we went through page by page, the baby's feeding, et cetera, that information should have been relayed to the physician so that he could get a more accurate picture of this baby.

Q. Okay. It's my impression we've already talked about that criticism.

A. I think so too, but I just wanted to make sure.

Q. Do you have any additional criticisms other than the ones we've already discussed that you plan on testifying about at trial?

A. No.

Q. No?

A. No.

Q. Okay. Have you discussed this case with any other nurses or any physician?

A. No.

Q. Did you reference or search any literature in formulating your opinions on this case?

A. No. This was based on my experience and knowledge and the medical records of this baby.

Q. Hold on a second. I'm just going through my notes. Have you ever taken care of a baby that had group B strep meningitis or was diagnosed with it?

A. Yes.

Q. How many or how often?

A. I cannot give you a number, but it's a very prevalent -- the most common newborn infection. I have taken care of many babies with --

Q. Do you remember when the last one was?

A. No. It would have been when I was at Children's Hospital.

Q. When you were in Cincinnati?

A. Yes.

Q. So that was, like, in 1996?

A. Yes.

Q. So that's something that you've seen frequently?

A. Yes.

MS. COLWELL: I'm going to let Mr. Wasung ask you whatever questions he may have.

THE WITNESS: All right.

MR. WASUNG: Dr. Lott, do you need a short break?

THE WITNESS: No, I'm fine.

MR. WASUNG: Hopefully I won't be too long.

EXAMINATION

BY MR. WASUNG:

Q. First of all, you would agree that you are not qualified to comment on the standard of care of a board certified pediatrician, correct?

A. Correct.

Q. And you haven't reviewed Dr. Buganski's depo? Is that my understanding?

A. Correct.

Q. So you wouldn't have any basis for knowledge of Dr. Buganski's involvement with the patient beyond the hospital record and whatever you picked up from the nurses' depositions, correct?

A. Correct.

Q. Is there any indication of anything you've seen of any calls to Dr. Buganski after he saw the patient at 7:30 on September -- on March 23rd, besides 14:30 and 21:00?

A. No.

Q. And then none on the early morning of the 24th until 02:30 when the patient was all right in the NICU, correct?

A. Correct.

Q. When the doctor saw the patient at 07:30 on March 23rd, what were the vitals recorded?

A. 98.4, 138, respiratory rate 48, no blood pressure recorded.

Q. Normal picture there?

A. Those vital signs are within normal limits.

Q. And at that time all the feedings had been -- the prior day had been well, you indicated, correct?

A. Correct.

Q. There's no indication of contact with Dr. Buganski until 14:30, you indicated, right?

A. Correct.

Q. At that point there's no indication of contact again until 21:00, correct?

A. Correct.

Q. Let me talk about the 21:00 contact. At that point, do you know by whom Dr. Buganski was contacted?

A. Osterhout.

Q. What were the vital signs of 21:00, the last taken prior to Dr. Buganski being contacted?

A. Well, the only vital sign that was recorded at -- which was at 19:15 was 98.6.

Q. Is that normal temperature?

A. Yes.

Q. The last entry that made other observations at 18 -- at least at 18:50 there's an entry indicating that the baby's color and nail beds are pink, correct?

A. Correct.

Q. The last entry before 21:00 would indicate that the lungs were clear, correct?

A. Yes.

Q. I've got a couple of questions. You were talking about that entry and the assessment on the flow sheet. Again, the 3/23 to 3/24 flow sheet, you made some reference to that 02:0 assessment time?

A. I'm not sure where you are. Which date?

Q. Prior, as you described your record.

A. What date are you looking for?

Q. Daily flow Sheet 3/23 to 3/24/91?

A. Okay.

Q. The times were 09:00, 15:55, and 020, correct?

A. Correct.

Q. You believe CR to be Constance Rose, correct?

A. Correct.

Q. And do you have any -- I'm not sure whether this

was ever clarified. Do you have any idea what that 020 means? Have you made any determination in your mind as to when that would have been recorded?

A. Well, it is really not possible to know that by reading the documentation. However, the other two vital signs -- you know, the other two assessment times were done at the beginning of a work shift.

Q. Okay. Do you know when Constance Rose began her work shift?

A. I believe at 11:00 p.m.

Q. Okay. That would have been after Dr. Buganski was last notified -- or last contacted before the NICU admission?

A. Yes.

Q. Am I correct in understanding that the references you made to that 020, hypertonicity and cyanotic are the first references in the daily flow sheets to those findings by any nurse, correct?

A. Correct.

Q. What do you know about any -- After that 21:00, when was Dr. Buganski next contacted in relation to this, to your knowledge?

A. Let me see if there's -- well, sometime at 2:15 to 2:30, Dr. Buganski was notified of above. That's written in the 2:30 a.m. note.

Q. After the NICU had been notified and the patient had been taken to NICU where --

A. Correct. Correct.

Q. Doctor, you talked about in 1996 that you were at the University of Cincinnati doing 50/50 hospital and academic, correct?

A. Up until, yes.

Q. And then the clinical aspect that you were doing -- or actually I think you split 50/50 hospital and academic, correct?

A. Correct.

Q. The hospital side included your clinical performance, right?

A. Correct.

Q. Your clinical performance was within your capacity as director of neonatal nurse practitioners, correct?

A. Yes.

Q. And then you described how your clinical practice would be involved within that directorship, right?

A. Yes.

Q. And how long had that been your course of practice? How long before 1996 had you been doing that?

A. I think --

Q. Just a breakdown.

A. Let me just check, but I believe I moved there in 1992.

Q. Okay. So that would have been your nature of practice from '92 to '96, as you can tell?

A. Yes. Prior to that, from '90 to '92, I was in the similar position at Carolinas Medical Center.

Q. Was your breakdown of hospital/academic clinical/nonclinical about the same in that time period too?

A. No. At the Carolinas Medical Center, it was primarily clinical and administrative for the NNP team. In other words, there was no academic component.

Q. Okay. Just checking to see whether there's anything else I need to cover.

A. Okay.

Q. I know you were critical of the nurses at 18:35. That seemed to be much of your focus for that specific episode, correct?

A. Yes.

Q. Apparently, differing from your opinion, the nurses were not sufficiently concerned about that episode at 18:35, of what you saw a subsequent cyanosis, to notify the physician, correct?

A. Yes.

Q. Apparently, they didn't interpret it as a distress by those nurses present as you're interpreting it now, correct?

A. Correct.

Q. And it's your opinion that the nurses making that observation should have contacted Dr. Buganski at that time, at 18:35, right?

A. Correct.

Q. And that's based upon your perception of the urgency of what was not in your interpretation of those notes, correct?

A. Correct.

Q. And those notes were seen the first time with the knowledge of what the end result is, correct?

A. That's correct.

Q. Can you look at the second page of the daily flow sheet, the one that recorded those temperatures of 14:00 and 14:30? Are you with me?

A. I'm looking for it. I had closed mine. Okay.

Q. At the 14:30 what appears to be possibly a 99.9 temperature, there's an arrow going to something. Do you know what that means or what it is?

A. Wait. I'm sorry. I must not be on the same page. I don't see an arrow.

Well, we're looking at the page that has the

A. Right. I'm on the page that the first assessment starts at 7:30 with 98.4, 138, and 48.

Q. Correct. And there's that area that's crossed out that you were critical of, right?

Q. And then there's the recording which is 14-something and 14-something?

A. Correct.

Q. And do you see -- what's to the right? First of all, I guess the BP and time -- There's no BP and time recorded over there, but what's in those columns; do you know?

A. Under BP there it looks like a tilde.

Q. A what?

A. A line, a scraggily line.

Q. Okay.

A. Like the tilde on the computer.

Q. Oh, I never knew what that was named.

A. And under that it says, Four lights next to. Oh, I see your arrow now. I understand what you're talking about. The 99.9 they have an arrow going to the four lights.

Q. Right. Any significance to that? Do you know what that means?

A. It means that they thought the 99.9 was related to the four lights. They were describing the environment of the baby when the temperature was taken.

Q. You mentioned that the physician had what you understood to be a standing order for a call of a temperature above 99 degrees; is that right?

MR. KULWICKI: Object. That's not what she said.

MR. WASUNG: Okay.

MR. KULWICKI: It's called a guideline.

MR. WASUNG: I know. Okay. I'm sorry.

THE WITNESS: Correct.

Q. (By Mr. Wasung) And just from your experience, a guideline call at 99 degrees, is that, from your experience, the normal or low or high?

A. I think that is -- that's an acceptable number.

Q. Okay. Would a guideline for a temperature of a hundred with call be acceptable?

MR. KULWICKI: Well, I'm going to object. You're asking her to --

MR. WASUNG: I'm just trying to get her -- She had termed it acceptable, and I'm just trying to get from her experience where it fits in her perception of

what she's seen or used to.

MR. KULWICKI: No. But you're asking pediatric standards of care, and she's not a pediatrician.

MR. WASUNG: I didn't ask her one. She volunteered one, and then I was asking her if a hundred fit into what she's already expressed --

Q. (By Mr. Wasung) And I don't even want it as pediatric standard of care, ma'am. I just want it as your experience.

A. In my experience 99 is a frequently used reference point.

Q. Okay. Do you see 100s as well?

A. Not in my experience.

Q. Okay. What else do you see? Do they vary by -- with a tenth of a point between there too?

A. No. I am most familiar with a 99 taken axi1lary.

Q. You're not familiar with any lower than that, would you be?

A. No.

Q. Ma'am, what documents do you have in front of you?

A. I have a binder with the medical records. I have the depositions of Mr. and Mrs. Stalma. I have the

depositions of the nurses, and I have a deposition of Richard Moriarty.

Q. Besides the depositions, do you have any additional copies of medical records?

A. I do have some duplicate copies.

Q. Have you been working with those, as we've been going through this testimony, for reference purposes?

A. No.

Q. Do they have any notes or highlightings on them?

A. No.

Q. What are the duplicates of?

A. There's some duplicates of the medical records of the newborn flow sheets. I think at one point I had requested an additional copy because I couldn't read something. And I have the NICU flow sheets there. None of those have any markings on them.

MR. WASUNG: Thank you. I think that's all I have right now.

MS. COLWELL: Dr. Lott, I just have a few follow-up questions.

EXAMINATION

BY MS. COLWELL:

Q. Have you received or did you receive anything in writing from Mr. Kulwicki that you reviewed, or his office?

A. Just some correspondence.

Q. What is the nature -- I don't want to know exactly what it says. Is it anything that would be like a chronology or report of the events in this case?

A. Just some general comments and description of what they wanted me to do, which would be to review the medical record focusing on the newborn care.

MS. COLWELL: I would like the court reporter to copy everything that Dr. Lott is referring to right there with respect to what came from Mr. Kulwicki. 1 don't want copies of the medical records again --

THE WITNESS: I don't have --

MS. COLWELL: -- depositions, notes or highlightings on any page.

THE WITNESS: I don't have any correspondence with me.

Q. (By Ms. Colwell) There is some that you reviewed?

A. Well, I mean, it was basically a letter that says, These are the medical records.

Q. Are you in your office right now?

A. Yes.

Q. Do you have that letter in your office?

A. No, I do not.

Q. Can you get that letter to -- I am not sure.

You can't get it to the court reporter?

A. No. I mean, really there's nothing that -- it just says, These are the medical records. Review them and then call me.

Q. Okay. There's no chronology or no report of the events?

A. No.

Q. I'm sorry. 1 think I lost you.

A. No.

Q. Just to go back to your work experience, your last hospital experience was in 1996. Were you employed full-time at that time?

A. Yes.

Q. When was the last time you were employed full-time strictly in a clinical role? By that I mean like in a newborn nursery?

A. Well, that Children's Hospital was a Neonatal Intensive Care Unit.

Q. When were you -- What was the year that you were doing that?

A. Up until 1996.

Q. Okay. But I think that you -- you're telling me you were employed full-time then?

A. Yes.

Q. But were you -- but at that time you also

testified that you were doing 50 percent clinical duties only, correct?

A. Correct.

Q. You split that between 50 -- it's 50/50 clinical and administrative/academic, some other kind of -- not patient care?

A. Correct.

Q. Okay. When was the last time you were employed a hundred percent doing patient care in a newborn nursery or as the floor nurse?

A. 1983.

Q. What were you doing in 1983?

A. I was the head nurse of newborn and special care nurseries in Albany, Georgia.

Q. How long -- Prior to 1983 how long had you been employed full-time doing one hundred percent patient care as a floor nurse or in the nursery? Do you understand what I'm asking you?

A. Do you mean as a staff nurse?

Q. Yes.

A. As a staff nurse, that would have been 1978.

Q. That was the last time you were employed as a staff nurse?

A. Yes.

Q. Between '78 and '83 what were you doing?

A. I was the high risk infant care coordinator in Columbus, Georgia.

Q. What does that mean?

A. I ran two clinics for patients discharged from the neonatal intensive care units.

Q. Discharged? Is that what you just said?

A. Yes.

Q. What was the nature of what you were doing in the clinic?

A. My first role was making -- deciding which babies were ready for discharge, and then I coordinated the two clinics. One was a follow-up clinic for developmental intervention. The other was a primary care clinic for patients without a private physician for babies discharged from our Neonatal Intensive Care Unit.

Q. I'm not sure -- I don't want to mischaracterize this, but when you were working in the clinics then, that wasn't 100 percent patient? It sounds like you had administrative duties. Would that be correct?

A. Correct.

Q. Would it be correct, then, to also state that the last time you were employed as a staff nurse with no administrative duties whatsoever was 1978?

A. That's correct.

Q. Okay. How many years were you employed as a

staff nurse or a floor nurse where you had no administrative duties at all?

A. Two.

Q. I'm sorry?

A. Two years.

Q. Two years?

A. (Witness moves head up and down.)

Q. Have you ever testified before this case in a group B strep case?

A. Yes.

Q. When was that?

A. It was about three years ago.

Q. Do you have a copy -- where was that case?

A. In West Virginia.

Q. Do you know, what was the outcome of that case? Did it go to trial?

A. It did go to trial and it settled during trial:

Q. Did you testify at the trial?

A. Yes, I did.

Q. Do you remember who it was that contacted you, the lawyer that you were testifying -- that you did your work for?

A. Yes. George McLaughlin.

Q. Is he in West Virginia?

A. He was at that time. I understand he has moved:

I don't know where.

Q. Do you remember the parties' names or the county where it was?

A. Oh, I'm sorry, I don't.

Q. Is there any other group B strep case that you have besides that one and this one?

A. No.

Q. Do you have a copy of any deposition that you gave for that case?

A. No.

Q. Do you take care of any babies -- have you taken -- when you were working in a nursery, a staff nurse or floor nurse in the nursery, did you take care of babies under phototherapy?

A. Yes.

Q. That West Virginia case, were you testifying on behalf of the plaintiff or the defendant; do you recall?

A. Plaintiff.

MS. COLWELL: I think that's all I have. Is there anything else that you have, John?

MR. WASUNG: Just a couple of questions.

EXAMINATION

BY MR. WASUNG:

Q. What are you charging for your review time in this case?

A. Up until today it was 150 an hour for review, deposition is 250, and then preparation for trial is 250 an hour.

Q. Preparation for trial is 250 an hour as well?

A. Yes.

Q. What about the actual trial testimony?

A. 350 per hour.

MR. WASUNG: Thank you. That's all I have.

EXAMINATION

BY MS. COLWELL:

Q. Dr. Lott, I want to make sure I'm understanding when we were talking about your prior employment.

A. Yes.

Q. You said you worked two years as a staff nurse. Is that -- can I assume that when we're talking about that, we're talking about a position that would be comparable to what the nurses in this case were doing?

A. Yes.

Q. That's hands-on patient care in the nursery?

A. Yes. However, as head nurse I also performed patient care.

Q. What was your percentage of time that you were doing patient care as opposed to any other type of administrative work?

A. Probably 80 percent patient care.

Q. Now, you're just talking about when you were a head nurse?

A. Yes.

Q. How long were you a head nurse?

A. Three years.

Q. Three years total?

A. Yes. And I would also point out to you that my experience as a neonatal nurse practitioner is also at the bedside.

Q. When were you employed as a neonatal nurse practitioner?

A. Well, when I was NNP coordinator in North Carolina and the director at Children's Hospital.

Q. How much time, then, when you were at Children's Hospital were you spending in patient care versus your other responsibilities as director?

A. We've already gone through that, but --

Q. I'm just not sure -- I'm not straight on that.

A. Well, 50/50.

Q. Okay. When were you in North Carolina?

A. 1990 to 1992.

Q. Okay. I think there's a blank, then, on your CV. The only reason I'm asking is because your CV skips from University of Florida to the LSU College of Nursing.

A. My work experience is divided into two areas:

academic and administrative.

Q. All right. I see it under there.

A. So that's --

Q. Okay. So what you're telling me, then -- because that's under administrative. It's spelled out several things that you're doing that is really an administrative role as the NNP coordinator?

A. Yes.

MS. COLWELL: Okay. I think that's it. Thank you very much.

Dave, do you want signature?

MR. KULWICKI: Yeah, we'll read.

Court reporter, I'm not sure how you guys do it down there, but we have a rule up here that permits the deponent an opportunity to review the transcript and make changes in the transcription if there are errors. We would like to avail ourselves of that. And typically the way the court reporters here do it is that they contact the deponent and give them a week or two weeks to come down and review the transcript and fill out an errata sheet.

(Proceedings concluded at 10:53 a.m.)

CHANGES AND SIGNATURE

PAGE	LINE	CHANGE

I, JUDITH WRIGHT LOTT, DSN, RNC, NNP, have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____
JUDITH WRIGHT LOTT, DSN, RNC, NNP

THE STATE OF _____)

COUNTY OF _____)

Before me, _____, on this day personally appeared JUDITH WRIGHT LOTT, DSN, RNC, NNP, known to me (or proved to me under oath or through _____) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 2002.

_____
NOTARY PUBLIC IN AND FOR THE

STATE OF _____

MY COMMISSION EXPIRES: _____

C E R T I F I C A T E

STATE OF TEXAS)

COUNTY OF DALLAS)

I, Kimberly A. Clark, Certified Shorthand Reporter in and for the State of Texas, certify that the foregoing deposition of JUDITH WRIGHT LOTT, DSN, RNC, NNP was reported stenographically by me at the time and place indicated, said witness having been placed under oath by me, and that the deposition is a true record of the testimony given by the witness.

I further certify that I am neither counsel for nor related to any party in the case and am not financially interested in its outcome.

Certified to by me this 18th day of August, 2002.

KIMBERLY A. CLARK, CSR, RPR
STATE OF TEXAS, NO. 6694
2201 Long Prairie Road
Suite 107-397
Flower Mound, Texas 75022
(214) 282-3191
Commission Expires: 12-31-01

CERTIFICATE OF CERTIFIED COPY

I, *Rebecca Thomas-Coleman,* an employee of Atkinson-Baker, Inc., Court Reporters, certify that the foregoing pages 1 through 68, constitute a true and correct copy of the original deposition of JUDITH WRIGHT LITT taken on AUGUST 16, 2002.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated this 27TH day of AUGUST, 2002.

Rebecca Thomas-Coleman

REBECCA THOMAS-COLEMAN

THE TOLEDO HOSPITAL

PHYSICIAN PROGRESS RECORD

0000046331371
MRN 0000000413170
STALMA, NORMA J
OLLEY, ANDREW S 0084
OLLEY, ANDREW G 0084
03/20/91 SEMI 027
10/30/1963 289-66-2234
ADDRESSOGRAPH STAMP

DATE

23 MARCH

Doing well. Ok 2 SS' Anem. time?
Clear Fluids. Intact: Pt has not had BM.
Expect BM today. MSW

3-21-91 9 PM 6/8

SVD Healthy ♂ Term (+) APGAR 8.9
Uterus exercises. EBL 400. No episiotomy.
AMW

3/22/91 Post circumcision note
Pt tolerated SVD + epidural well. No complaint
of pain or bleeding. Penis looks good.
Circumcision

22 March Pt doing well - will D.C IV.

23 March Pt doing well - no problems.

24 March Home today. no problems
Instructions given.

5202817 REV 8/80

DR. K. Torsekar

THE TOLEDO HOSPITAL

TOLEDO, OHIO

EEG LABORATORY

Electroencephalographic Examination

MAXI 8

00503
00503

03/21/91 000
03/21/91

ADDRESSOGRAPH STAMP

Requested by Dr. Carlson Date

Indication for EEG [redacted] Strep meningitis ; Seizures

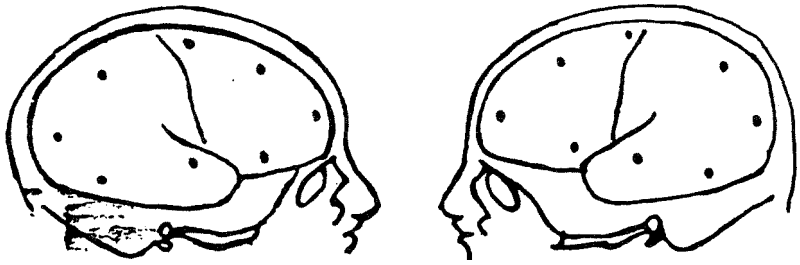
Resume of History and Findings

%

Medication Ampicillin, Gentamycin Phenobarbital

REPORT

Name Joseph Stalma Age 4 days gest age 39 wks Date 3-25-91 EEG No. 39422



This is an abnormal EEG demonstrating lateralized sharp and spike discharges in the waking portion of the recording. This is compatible with bihemispheric dysfunction and suggests increased lability.

Edward J. Orecchio M.D.

PERMANENT

The Toledo Hospital
Clinical Laboratory
Cumulative Summary

DATE: 4/12/91
TIME: 1610
PAGE: 1

PATIENT NAME: STALMA, JOSEPH J WARD: NIBB ROOM: CONV46
PATIENT NUMBER: 566728
SEX: M AGE: <1 PHYSICIAN: CARLSON, KATHLEEN

**** PERMANENT COPY. DO NOT REMOVE FROM CHART ****

General Hematology I

TEST NAME	WBC	RBC	HGB	HCT	PLAT
UNITS	X10E9/L	X10E12/L	g/dL	%	X10E9/L
NORMALS	7.0-19.0	3.79-6.29	12.7-18.7	42.0-62.0	150-400
DATE TIME					
4/11 0640	14.9	3.59 L	11.4 L	32.2L	761. H
4/06 1030	23.3 H	3.43 L	10.9 L	31.4L	970. H
0920					
4/03 1650	21.6 H	4.10	13.0 L	37.7L	1080. * (A)
1300					
4/01 0720	25.2 H	4.43	14.0	41.5L	980. H
3/29 0645	28.4 H	4.13	13.2 L	38.6L	636. H
3/28 0645	43.2 H	4.24	13.8	39.7L	531. H
3/27 0710	20.4 H	4.47	14.7 L	42.5L	350.
3/26 0700	17.9	4.47	14.6 L	42.6L	328.
3/25 0650	24.2 H (C)	3.92 L	13.2 L	37.6L	255.
24 0730	9.4 (C)	4.15 L	13.5 L	40.0L	259.
0315	8.3	4.24	13.9 L	40.9L	265. (D)
3/21 2210	20.3	5.76	19.5	55.8	368. (D)

(A): NO SPECIMEN RECEIVED IN LAB
(B): RESCHEDULED FOR ANOTHER TIME
(C): CORRECTED FOR NUCLEATED RBCS
(D): PLATELET CLUMPS PRESENT

TEST NAME	MCV	MCH	MCHC	RDW
UNITS	fL	pg	g/dL	%
NORMALS	84-128	25.0-38.0	26.0-34.0	15.3-18.8
DATE TIME				
4/11 0640	89.	31.8	35.4H	14.1 L
4/06 1030	91.	31.8	34.8H	14.3 L
4/03 1650	92.	31.7	34.5	15.0 L
4/01 0720	93.	31.6	33.8	15.1 L
3/29 1645	93.	32.0	34.2	15.9 L
3128 0645	93.	32.5	34.7	15.7 L
3/27 0710	93.	32.9	34.6	15.7 L
3/26 0700	95.	32.7	34.3	16.2 L
3/25 0650	95.	33.7	35.1	15.5 L
24 0730	96.	32.5	33.8	15.9 L
0315	96.	32.8	34.0	16.4 L
21 2210	96. L	33.9	35.0	16.7 L

(PATIENT REPORT CONTINUED ON PAGE: 2)

CHART COPY

PERMANENT

The Toledo Hospital
Clinical Laboratory
Cumulative Summary

DATE: 4/12/91
TIME:1610
PAGE: 2

NT NAME: STALMA/JOSEPH J WARD: NIBB ROOM: CONV46
PAT NT NUMBER: 566728
SE M AGE: <1 PHYSICIAN: CARLSON, KATHLEEN

**** PERMANENT COPY. DO NOT REMOVE FROM CHART ****

General Hematology I

TEST NAME / UNITS / NORMALS / DATE TIME								
4/11 0640					MICROTAINER			

TEST NAME / UNITS / DATE TIME	MYELO %	META %	BANDS %	SEGS %	LYMPHS %	MONOS %	EOSIN %
4/11 0640			[illegible]	[illegible]	55	8	8
4/06 1030			[illegible]	56	31	8	3
4/03 1650			[illegible]	44	32	12	4
4/01 0720			[illegible]	56	33	5	3
3 0645			[illegible]	42	36	8	4
2 0645			[illegible]	59	15	12	5
27 0710			[illegible]	51	27	8	4
3/26 0700			[illegible]	42	35	11	3
3/25 0650			[illegible]	55	23	14	1
3/24 0730			[illegible]	[illegible]	43	6	
0315			[illegible]	40	37	16	
3/21 2210			[illegible]	33	59	6	1

TEST NAME / UNITS / DATE TIME	BASO %	ATYPICAL LYMPHS %	NRBC /100 WBC	ANISO	POIK	POLY	RBC FRAGS
4/11 0640	1			SLT	SLT		
4/06 1030				SL-MOD	SLT		
03 1650		2		SLT	SLT	SLT	
4/01 0720				SLT	SLT	SLT	
3/29 0645				SLT	SLT	SLT	
3/28 0645				SLT	SL-MOD		
3/27 0710				MOD	MOD		
3/26 0700		4		MOD	SLT	SLT	
3/25 0650			1	MOD	MOD	SLT	
3/24 0730			1	MOD	MOD	MOD	SLT
0315				SLT	SL-MOD	SLT	
3/21 2210				MOD	MOD	MOD	SLT

ENT REPORT CONTINUED ON FACE: 3)

CHART COPY

PATIENT NAME: STALMA, JOSEPH J WARD: NIBB ROOM: CONV46
PATIENT NUMBER: 566728
SEX: M AGE: <1 PHYSICIAN: CARLSON, KATHLEEN

**** PERMANENT COPY. DO NOT REMOVE FROM CHART ****

TEST NAME	SPHERO CYTES	BURR CELLS
UNITS		
DATE TIME		
3/25 0650		SLT
3/21 2210	SLT	

GENERAL CHEMISTRY

* = New Methodology and Normal Values as of 08/21/90

TEST NAME	SODIUM	POTASSIUM	CHLORIDE	CO2
UNITS	mmol/L	mmol/L	mmol/L	mmol/L
NORMALS	134-146	4.0-6.0	98-109	21-30
DATE TIME				
3/29 0645	147.H	5.0	116.H	22.
3/27 0710	144.	5.1	113.H	22.
3/26 0700	142.	5.4	116.H	18.L
3/25 1313		6.3 *		

TEST NAME	GLUCOSE	CALCIUM
UNITS	mg/dL	mg/dL
NORMALS	50-100	7.5-12.0
DATE TIME		
3/25 0100		7.7
3/21 2210	68.	

TEST NAME	TOTAL BIL
UNITS	mg/dL
NORMALS	0.2-1.0
DATE TIME	
3/28 0645	(*A>
27 1900	(*A)
0710	3.8 H
3/26 1920	4.9 H
1837	(*B)
0700	6.2 H
3/25 1910	6.5 H
1900	(*B)
3/24 1900	(*B)
1900	(*B)

(PATIENT REPORT CONTINUED ON PAGE: 4)

PERMANENT

The Toledo Hospital
Clinical Laboratory
Cumulative Summary

DATE: 4/12/91
TIME: 1610
PAGE: 8

PATIENT NAME: STALMA, JOSEPH J
PATIENT NUMBER: 566728
AGE: <1
WARD: NIBB ROOM: CONV46
PHYSICIAN: CARLSON, KATHLEEN

**** PERMANENT COPY. TO NOT REMOVE FROM CHART ****

ROUTINE URINALYSIS

TEST NAME	4/06/91 (1930)	UNITS
TIME	(1930)	
COLOR	YELLOW	
TURBIDITY	CLEAR	
SPECIFIC GRAVITY	1.007	
PH	7.0	
KETONES	Neg	Qual
BILIRUBIN	Neg	Qual
UROBILINOGEN	Normal	Qual
GLUCOSE	1+	Qual
LEUKOCYTE ESTERASE	Neg	Qual
WBC	1-5	/hpf
NITRITE	Neg	Qual
BLOOD	2+	Qual
RBC	1-5	/hpf
PROTEIN	Neg	Qual
FINE GRANULAR CAST	1-5	/lpf
AMORPHOUS SEDIMENT	2+	

SPINAL FLUID

TEST NAME	CSF PROTEIN	CSF GLUCOSE	SPCT	CSF COLOR	CSF CLARITY
UNITS	mg/dL	mg/dL			
NORMALS	15-45	40-70			
COLLECTED TIME					
4/12 1245	183.H	51.*	T/F	Person moved @ same time	
4/09 2000	168.H	27.*		YELLOW	HAZY
3/26 1032	196.H	28.*			
3/24 1643	340.H	14.*		YELLOW	CLOUDY
1628					

TEST NAME	CSF SUPERNATANT	CSF RBC	Nucleated Cells	CSF Neut
UNITS		/uL	/uL	%
NORMALS				
COLLECTED TIME				
1032	XANTHOCHROMIC	21.	3290.	
1628	YELLOW	90.	7965.	86.

PATIENT REPORT CONTINUED ON PAGE: 9)

PERMANENT

The Toledo Hospital
Clinical Laboratory
Cumulative Summary

DATE: 4/12/91
TIME: 1610
PAGE: 9

PATIENT NAME: STALMA, JOSEPH J WARD: NIBB ROOM: CONV46
PATIENT NUMBER: 566728
SEX: M AGE: <1 PHYSICIAN: CARLSON, KATHLEEN

**** PERMANENT COPY. DO NOT REMOVE FROM CHART ****

SPINAL FLUID

TEST NAME	CSF Lymph	CSF Mono
UNITS	%	%
NORMALS		
DATE TIME		
3/26 1032		SEE SEPARATE REPORT REVIEWED BY A. RABINOVITCH M.D.
3/24 1628		BACTERIA PRESENT REVIEWED BY A. RABINOVITCH M.D.
1628	1	13

CHEMISTRY COMMENTS

3/21 2200
CORD BLOOD

ANTIBIOTIC LEVELS

TEST NAME	4/03/91	3/29/91	3/25/91	UNITS	NORMALS
	(1650)	(1740)	(0550)		
GENT-TROUGH	2.0	1.9	1.4 L	ug/mL	1.5-2.0
	(2005)	(2010)	(0850)		
T-PEAK	6.0	6.0	5.2	ug/mL	4.0-8.0

BARBITURATES

TEST NAME	PHENOBARB
UNITS	ug/mL
NORMALS	15.0-35.0
DATE TIME	
4 9 1535	25.2
4 6 2305	31.1
4 2315	35.9 H

(PATIENT REPORT CONTINUED ON PAGE: 10)

PATIENT NAME: STALMA, JOSEPH J WARD: NIBB ROOM: CONV46
PATIENT NUMBER: 566728
SEX: M AGE: <1 PHYSICIAN: CARLSON, KATHLEEN

**** PERMANENT COPY: DO NOT REMOVE FROM CHART ****

MICROBIOLOGY
ANTIGEN DETECTION

3/24/91 1030 25455
DIRECT ANTIGEN TEST
SPECIMEN: URINE
H. INFLUENZAE B Negative, no antigen detected
N. MENING. A,C,Y,W135 Negative, no antigen detected
STREP. PNEUMONIAE Negative, no antigen detected
GROUP B STREPTOCOCCI POSITIVE, ANTIGEN DETECTED
N. MENING. B / E. COLI Negative, no antigen detected

MICROBIOLOGY
CSF CULTURES

/91 1120 29079
GRAM STAIN:
NO ORGANISMS SEEN

4/12/91 1120 29078
CSF CULTURE T/F
REPORT STATUS PRELIMINARY
SOURCE: CEREBROSPINAL FLUID

4/09/91 1940 23711
GRAM STAIN:
NO ORGANISMS SEEN

4/09/91 1940 123710
CSF CULTURE T/F
REPORT STATUS PRELIMINARY
SOURCE: CEREBROSPINAL FLUID
RESULT: NO GROWTH IN 2 DAYS

(PATIENT REPORT CONTINUED ON PAGE: 13)

PT NT NAME: STALMA, JOSEPH J WARD: NIBB ROOM: CONV46
PAT NT NUMBER: 566728
M AGE: <1 PHYSICIAN: CARLSON, KATHLEEN

**** PERMANENT COPY. DO NCT REHCVE FRCM CHART ****

MICROBIOLOGY
CSF CULTURES

4/04/91 1450 14633
CSF GRAM STAIN:
MANY RBC;FEW WBC
NO ORGANISMS SEEK

4/04/91 1450 14632
CSF CULTURE
REPORT STATUS FINAL
DATE OF FINAL 4/11
SOURCE: CEREBROSPINAL FLUID
RESULT: NO GROWTH IN 7 DAYS

91 1021 29128
GRAM STAIN:
RARE GRAM POSITIVE COCCI
NOTE: (A)
(A): GRAM POSITIVE COCCI WAS INTRACELLULAR.

3/26/91 1021 29127
SF CULTURE
REPORT STATUS FINAL
DATE OF FINAL 4/02
SOURCE: CEREBROSPINAL FLUID
RESULT: NO GROWTH IN 7 DAYS

3/24/91 1530 26026
SF GRAM STAIN:
FEW GRAM POSITIVE COCCI IN PAIRS

3/24/91 1530 26025
CF CULTURE
REPORT STATUS FINAL
E OF FINAL 3126

PATIENT REPORT CONTINUED ON PAGE: 14)

PERMANENT

The Toledo Hospital
Clinical Laboratory
Cumulative Summary

DATE: 4/12/91
TIME: 1611
PAGE: 14

ENT NAME: STALMA, JOSEPH J WARD: NIBB ROOM: CONV46
PA ENT NUMBER: 566728
S M AGE: <1 PHYSICIAN: CARLSON, KATHLEEN

**** PERMANENT COPY: DO NOT REMOVE FROM CHART ****

MICROBIOLOGY
CSF CULTURES

3/24/91 1530 26025
SOURCE: CEREBROSPINAL FLUID
RESULT: A RARE COLONY IDENTIFICATION CONFIRMED BETA STREPTOCOCCUS GROUP B
COMMENT: RESULT GIVEN BY PHONE AM

A RARE COLONY IDENTIFICATION CONFI

AMPICILLIN	<=0.12 ug/mL Susceptible
CEPHALOTHIN	<=0.5 ug/mL Susceptible
CIPROFLOXACIN	<=0.5 ug/mL Susceptible
CLINDAMYCIN	<=0.12 ug/mL Susceptible
ERYTHROMYCIN	<=0.12 ug/mL Susceptible
GENTAMICIN	8 ug/mL MODERATELY SUSCEPTIBLE
OXACILLIN	<=0.25 ug/mL Susceptible
PENICILLIN	.06 ug/ml Susceptible
TETRACYCLINE	>16 ug/mL RESISTANT
VANCOMYCIN	<=0.5 ug/ml Susceptible

MICROBIOLOGY
BLOOD CULTURES

4/06/91 1000 16197
BLOOD CULTURE
REPORT STATUS: FINAL
DATE OF FINAL: 4/10
RESULT: NO GROWTH AT 5 DAYS

3/26/91 0600 28879
BLOOD CULTURE
REPORT STATUS: FINAL
DATE OF FINAL: 3/30
RESULT: NO GROWTH AT 5 DAYS

3/24/91 0300 25121
BLOOD CULTURE
REPORT STATUS: FINAL

:PATIENT REPOKT CONTINUED ON FACE: 15)

PATIENT NAME: STALMA, JOSEPH J WARD: NIBB ROOM: CONV46
PATIENT NUMBER: 566728
SEX: M AGE: <1 PHYSICIAN: CARLSON, KATHLEEN

**** PERMANENT COPY. DO NOT REMOVE FROM CHART ****

MICROBIOLOGY
BLOOD CULTURES

3/24/91 0300 25121

DATE OF FINAL	3/26
RESULT:	BETA STREPTOCOCCUS GROUP B THIS IS A PRESUMPTIVE SUSCEPTIBILITY
	BETA STREPTOCOCCUS GROUP B THIS IS A CONFIRMED MIC
RESULT:	RESULT GIVEN BY PHONE PM

BETA STREPTOCOCCUS GROUP B THIS IS A PRESUMPTIVE

AMPICILLIN	Susceptible
CEPHALOTHIN	Susceptible
CIPROFLOXACIN	MODERATELY SUSCEPTIBLE
CLINDAMYCIN	Susceptible
ERYTHROMYCIN	Susceptible
PENICILLIN	Susceptible
TETRACYCLINE	RESISTANT
VANCOMYCIN	Susceptible

BETA STREPTOCOCCUS GROUP B THIS IS A CONFIRMED MI

AMPICILLIN	<=0.12 ug/mL Susceptible
CEPHALOTHIN	<=0.5 ug/mL Susceptible
CIPROFLOXACIN	<=0.5 ug/mL Susceptible
CLINDAMYCIN	<=0.12 ug/mL Susceptible
ERYTHROMYCIN	<=0.12 ug/mL Susceptible
PENICILLIN	.06 ug/mL Susceptible
TETRACYCLINE	16 ug/mL RESISTANT
VANCOMYCIN	<=0.5 ug/mL Susceptible

MICROBIOLOGY

4/06/91 1530 18780
URINE CULTURE

REPORT STATUS	FINAL
DATE OF FINAL	4908
SOURCE:	URINE
RESULT:	NO GROWTH

PERMANENT

The Toledo Hospital
Clinical Laboratory
Cumulative Summary

DATE: 4/20/91
TIME: 1425
PAGE: 1

NT NAME: STALMA, JOSEPH J
NT NUMBER: 566728
M AGE: <1

PHYSICIAN: CARLSON, KATHLEEN
DISCHARGED: 041391

**** PERMANENT COPY. DO NOT REMOVE FROM CHART ****

SPINAL FLUID

TEST NAME	CSF PROTEIN	CSF GLUCOSE	CSF COLOR	CSF CLARITY	CSF SUPERNATANT
UNITS	mg/dL	mg/dL			
NORMALS	15-45	40-70			
DATE TIME					
/12 1245	183.H	31.*	STRAW	CLEAR	SL-XANTHO

TEST NAME	CSF RBC	Nucleated Cells	CSF Neut	CSF Eos
UNITS	/uL	/uL	%	%
NORMALS				
DATE TIME				
4/12 1245	50.	40.	30.	1

TEST NAME	CSF Lymph	CSF Mono
UNITS	%	%
NORMALS		
DATE TIME		
/12 1245	39	30

BACTERIA REVIEWED BY PATHOLOGIST

MICROBIOLOGY
ANTIGEN DETECTION

4/12/91 1120 129080
DIRECT ANTIGEN TEST

SPECIMEN:	CEREBROSPINAL FLUID
H. INFLUENZAE B	Negative, no antigen detected
N. MENING. A, C, Y, W135	Negative, no antigen detected
STREP. PNEUMONIAE	Negative, no antigen detected
GROUP B STREPTOCOCCI	POSITIVE, ANTIGEN DETECTED
N. MENING. B / E. COLI	Negative, no antigen detected

(PATIENT REPORT CONTINUED ON PAGE: 2)

max 2 MAXI 8

. 00000541

CONSULTANTS IN LABORATORY MEDICINE
THE TOLEDO HOSPITAL
Toledo, Ohio 43606

MRN 0000005667
STALMA, BABY B
TORSEKAR, K P
TORSEKAR, K P
03/21/91 SEMI 3'

PATIENT NAME: STALMA, Baby Boy
GENDER: Male
DATE OF BIRTH: 3/21/91
DATE/TIME COLLECTION: 3/26/91, 1032h
SAMPLE NUMBER: 29126

MRN: 5667
ACCOUNT: 5413745
UNIT/ROOM: NIBB/MAXI
ATTENDING PHYSICIAN:
Kathleen Carlson, M.D.

BODY FLUID
SMEAR EVALUATION

CLINICAL HISTORY: CSF from 3/24/91 positive for intracellular Gram-positive cocci identified as group B *β-streptococcus*, resistant to tetracycline and moderately susceptible to ciprofloxacin.

ANATOMIC SITE: CSF

RBC = 21/uL Nucleated Cells = 3,290/uL

CYTOCENTRIFUGE NUCLEATED CELL DIFFERENTIAL COUNT:

Neutrophils	-	92%
Lymphocytes	-	2%
Plasma cell	-	occ
Monocytes	-	6%

As compared to the previous CSF 2 days earlier, there is considerable neutrophil degeneration and a significant reduction in the numbers of streptococci seen with Wright's stain.

OTHER LAB DATA: Present CSF continues to show rare intracellular Gram-positive cocci. Elevated CSF protein (196 mg/dL) and low glucose (28 mg/dL).

DIAGNOSIS/IMPRESSION: **ACUTE BACTERIAL MENINGITIS**

Albert Rabinovitch, M.D., Ph.D.
Director, Clinical Labs

xc: Hematology, Cytology, Physician(s), CLM, (original - chart)

REPORT DATE: March 26, 1991
CPT: 88104, 89051

PATIENT NAME: STALMA, JOSEPH J
PATIENT NUMBER: 566728
M AGE: <1
WARD: NIBB ROOM: CONV46
PHYSICIAN: CARLSON, KATHLEEN

General Hematology I

MICROTAINER

TEST NAME / UNITS / NORMALS / DATE	TIME	MYELO	META	BANDS	SEGS	LYMPHS	MONOS	EOSIN
		%	%	%	%	%	%	%
4/11	0640			[illegible]	[illegible]	55	8	8
4/0o	1030			[illegible]	56	31	8	3
4/03	1650			[illegible]	44	32	12	4
4/01	0720			[illegible]	56	33	5	3
3/29	0645		[illegible]	[illegible]	42	36	8	4
3/28	0645			[illegible]	59	15	12	5
3/27	0710		[illegible]	[illegible]	51	27	8	4
[illegible]	0700	[illegible]	[illegible]	[illegible]	42	35	11	3
	0650			[illegible]	55	23	14	1
/24	0730		[illegible]	[illegible]	[illegible]	43	6	
	0315		[illegible]	[illegible]	40	37	16	
3/21	2210			[illegible]	[illegible]	59	6	1

TEST NAME / UNITS / DATE	TIME	BASO	ATYPICAL LYMPHS	NRBC	ANISO	POIK	POLY	RBC FRAGS
		%	%	/100 WBC				
4/11	0o40	1			SLT	SLT		
4/06	1030				SL-MOD	SLT		
4/03	1650		2		SLT	SLT	SLT	
4/01	0720				SLT	SLT	SLT	
3/29	0645				SLT	SLT	SLT	
3/28	0645				SLT	SL-MOD		
3/27	0710				MOO	MOD		
3/26	0700		4		MOO	SLT	SLT	
3/25	0650			1	MOD	MOD	SLT	
3/24	0730			1	MOO	MOD	MOO	SLT
	0315				SLT	SL-MOD	SLT	
3/21	2210				MOD	MOO	MOD	SLT

TEST NAME / UNITS / DATE	TIME	SPHERO CYTES	BURR CELLS
3/25	0650		SLT
3/	2210	SLT	

PATIENT REPORT CONTINUEC ON PAGE: 3)

The Toledo Hospital
Physician's Orders

T/ E/TIME

3/20 DC Pit
Reg diet until 4pm
10 D Knebel/B Nurse

00000463313?

U. CLERK | NURSE | DIET VERIFICATION

21 Mond – Restart IV at.
Protocol II –

21. mons no time

1 Internal Electrode

2 Internal pressure monitor

3 Clear AJ lab.

3/21
1545 May have Nubain 10mg IVq1hr pm
p.o. Dr. A. Folley / Augustin RN

00000463313?

U. CLERK | NURSE | DIET VERIFICATION

3/21 May have epidural
1900 vo for Dr. Folley / S. Nosal RN

00000463313?

U. CLERK | NURSE | DIET VERIFICATION

00000463313?

U. CLERK | NURSE | DIET VERIFICATION

Toledo Hospital
Toledo, Ohio 43606

COMBINED FACE SHEET AND DISCHARGE SUMMARY

NO. 566728 NAME STALMA, Joseph V

BIRTHDATE 3-21-91 SEX M DAYS OF STAY 23

ADMITTING DATE 3-21-91 DISCHARGE DATE 4-13-91

READMISSION WITHIN: _____ DAYS _____ MOS. _____ YRS. _____ NONE OR UNKNOWN

MRN 00000000
STALMA, BA
TORSEKAR, K
TORSEKAR, K P
03/21/91 SEMI 000
03/21/991

ADDRESSOGRAPH STAMP

1. PRINCIPAL DIAGNOSIS: TERM BIRTH LIVING MALE — CODES ① V30.00
DX DETERMINED TO BE CHIEFLY RESPONSIBLE FOR ADMISSION.

2. SECONDARY DIAGNOSES: CO EXISTING ON ADMISSION OR DEVELOPING AFTER ADMISSION + AFFECTS TREATMENT IN ORDER OF IMPORTANCE.

	CODES
Group B Beta Hemolytic Streptococcal Sepsis	771.8
Neonatal Seizures secondary to Infection.	041.0
X	—
	② 320.2

4. DISPOSITION
- ☒ HOME
- ☐ HOME HEALTH CARE
- ☐ SHORT TERM
- ☐ ICF
- ☐ SNF
- ☐ OTHER INST.
- ☐ AMA
- ☐ EXPIRE
- ☐ AUTOPSY

3. PROCEDURES

	DATE	CODES
LUMBAR PUNCTURE x 3	3-24-91 3-25-91 4-4-91	—
Circumcision	3/23/91	① 64.0

DRG 389/34 84

I certify that the narrative description of the principal and secondary diagnoses and the major procedure performed are accurate and complete to the best of my knowledge.

V. Kar Signature 5-20-91 date

DISCHARGE SUMMARY

Not required on uncomplicated deliveries, normal newborns and uncomplicated stays of less than 48 hours.

RECAPITULATE REASON FOR ADMISSION: [redacted]

SUMMARY ATTACHED

SIGNIFICANT FINDINGS:

V. Kar

CONDITION OF PATIENT ON DISCHARGE:

SPECIAL INSTRUCTIONS:

RECOMMENDATIONS:

CAUSE OF DEATH:

SIGNATURE _____ M.D.

0 998 B Approved by Executive Committee 12/89 White Copy-Medical Record Yellow Copy-Insurance Pink Copy-Physician

The Toledo Hospital
Division of Neonatalogy

Discharge Summary

Patient: Joseph Stalma
Medical Record #: 566728
Date of Birth: 03/21/91
Time of Birth: 21:31
Date of Admission: 03/24/91
Time of Admission: 03:45

Birthweight: 3560 gms
Race: White
Sex: Male
GA by Exam: 38 wks
GA by Dates: 38 wks
Intrauterine Growth: AGA

One Minute Apgar: 6
Five Minute Apgar: 8
Coombs: Positive
Blood Type: A
Rh: Positive
Birth Sequence: 1/1

Anti D 3+

Mother:
Mrs. Norma Stalma
1658 Dartmoor
Toledo, OH 43612
(419)476-4065

Father:
Mr. Joseph Stalma
1658 Dartmoor
Toledo, OH 43612
(419)476-4065

Maternal Perinatal History

Medical Record #: 413170
Age: 27

Race: White
Marital Status: Married

Gravida: 3
Para: 2
Fullterm: 2

Live Births: 2

Blood Type: A

Rh: Negative

EDC: 04/04/91
Prenatal Care: began 2nd Trimester

LMP: 06/27/90

Maternal/Fetal Conditions

Maternal/Fetal Conditions: Rhesus Isoimmunization
Prenatal Medications: Vitamins

Labor & Delivery

Rupture of Membrane: AROM and <12 hours ?
Labor Onset and Length: Induced and <12 hours
Fetal Monitoring: Internal

Analgesics: Nubain

Delivery Obstetrician: Andrew Folley, M.D.
Anesthesia: Epidural
Delivery Type: Vaginal
Presentation: Vertex
Complications: Nuchal Cord X1 without Compression
Resuscitation: Oxygen

Admission Physical

Vital Signs:
- Temperature: 99.4 F
- HR: 162 bpm
- RR: 48 bpm
- Systolic BP: 61 mmHg
- Diastolic BP: 40 mmHg
- MAP: 51 mmHg

Growth Parameters:
- Weight: 3560 gms
- Length: 55.00 cms
- Head: 34.00 cms

General: Poor feeding, squealing and turned ridged and arched back, developed RDS. Dusky around mouth, gave oxygen and he gradually pinked up.
Chest: grunting, mild retractions.
[illegible]r: Decreased [illegible] 3 seconds.
Extremities: Tone increased in all four extremities.
Abdomen: Full, firm.
Neurological: Moro symmetric.
Other: Awake and crying.

Admitting Impressions (ICD-9): Sepsis (038.9)
Seizures (779.0)
Abdominal Distention (787.3)
Rh Incompatibility in Newborn (773.0)
Term Neonate (V39.0)

Hospital Summary

Primary Admitting Diagnosis: Sepsis - Beta Strep Group B

	From	To
Problem 1: Hyperbilirubenemia		
Hyperbilirubinemia/774.6 (2 Days Total)	03/24/91	03/25/91
Phototherapy (X2 Total)	03/24/91	03/25/91
Bilirubin Blood Level (5 Days Total)	03/24/91	03/27/91
	03/31/91	-
Problem 2: Infectious Disease		
Sepsis - Beta Strep Group B/038.0 (13 Days Total) .	03/24/91	04/05/91
Meningitis - Streptococcal/320.2 (13 Days Total) ..	03/24/91	04/05/91
Ticarcillin (1 Day Total)	03/24/91	-
Claforan (1 Day Total}	03/24/91	
Gentamicin (12 Days Total)	03/25/91	04/05/91
Ampicillin (12 Days Total)	03/25/91	04/05/91

6b 3/21

	From	To
Blood Culture (1 Day Total)	03/24/91	-
Cerebrospinal Fluid Culture (3 Days Total)	03/24/91	03/25/91
	04/04/91	-

[redacted]

Suspected	
Seizures Secon	03/24/91
Encephalopathy	04/03/91
	03/24/91
	03/24/91
	03/24/91

Bilirubin Blood Level						
Total Bilirubin	03/31/91	0.5	03/24/91	9.0	03/31/91	0.5
Blood Hgb / Hct						
HCT	03/25/91	38	03/26/91	43	04/01/91	42

	Minimum Date	Minimum Value	Maximum Date	Maximum Value	Most Recent Date	Most Recent Value
Blood Culture						
+/-	03/24/91	+	03/24/91	+	03/24/91	+
Cerebrospinal Fluid Culture						
+/-	03/24/91	+	03/24/91	+	03/25/91	+
Blood Count						
WBC	03/24/91	[redacted]	03/28/91	43.2	04/01/91	25.2
Hct	03/25/91	38	03/26/91	43	04/01/91	42
PLT (000)	03/25/91	255	04/01/91	980	04/01/91	980
POLY	03/24/91	26	03/28/91	59	04/01/91	56
BAND	03/26/91	2	03/24/91	[redacted]	04/01/91	3
Blood Chemistry						
Na	03/24/91	133	03/29/91	147	04/03/91	139
K	03/24/91	4.7	03/25/91	6.0	04/03/91	5.5
Calcium (total)	03/25/91	7.4	04/03/91	9.8	04/03/91	9.8
Cl	04/03/91	108	03/26/91	116	04/03/91	108
Creatinine	03/26/91	0.8	04/03/91	1.1	04/03/91	1.1
BUN	04/03/91	9	03/24/91	20	04/03/91	9
Glucose	03/26/91	70	03/24/91	138	04/03/91	85
Phenobarbitol blood level						
Peak	04/04/91	35.90	03/31/91	36.60	04/04/91	35.90

Growth Parameters	Date	Value	Date	Value
Weight (gms)	03/24/91	3560	04/05/91	3460 gm
Length (cms)	03/24/91	55.00	03/25/91	55.00 cm
Head (cms)	03/24/91	34.00	04/05/91	34.50 cm

Attending Physician

The Toledo Hospital
The Reuben Center for Women and Children
NEWBORN ADMISSION ASSESSMENT

0000054137 45
MRN 0000005566728
STALMA, BABY BOY
TORSEKAR, K P
TORSEKAR, K P
03/21/91 SEX COD
ADDRESSOGRAPH STAMP

ADMISSION NOTES

WEIGHT 7 POUNDS 13 OZ 3560 G
ADMISSION T 97
HEAD 34 CM CHEST 32 CM LENGTH 56 CM
13 1/4 INCHES 12 3/4 INCHES 21 1/2 INCHES

MATURITY EVALUATION
GESTATIONAL AGE BY EXAM: 39 WEEKS
INFANT CLASSIFIED:
☐ SGA ☒ AGA ☐ LGA

VITAL SIGNS:

T [illegible] 100 R 40 BP [redacted] MEAN
RESPIRATORY SCORE
TIME 2400
T 98.2P R BP MEAN
RESPIRATORY SCORE
TIME
T P R BP MEAN
RESPIRATORY SCORE
TIME
P R BP MEAN
RESPIRATORY SCORE

APGAR SCORES: 6 1 MINUTE 8 5 MINUTES
9 1 HOUR: HR 2 RESP EFFORT 2
TONE 2 COLOR 1 CRY 2
(SEE NEWBORN DELIVERY ASSESSMENT)

NEWBORN PHYSICIAN: BRTC
NOTIFIED BY:
TIME:

AQUAMEPHYTON 1.c MG IM AT 2335
BY S. Finat, RNC
TRIPLE DYE TO CORD YES ☐ NO
BETADINESCALPSCRUB ☒ YES ☐ NO

FEEDINGS: 1 1045 D5 D/W 50cc
2
3

VOIDINGS 0 STOOL

LABORATORY DATA
CHEMSTRIPS:
TIME: 2 RESULTS:

BLOOD SUGAR
TIME: 2210 RESULTS 48

GASTRIC ASPIRATE SENT YES NO
RESULTS:

BLOOD CULTURE SENT YES NO
OTHER 2210 CBC & diff, total Bili 3.1 (Cord Blood).
Type A+
Coombs +

55
20.3 / 19 368

RESPIRATORY DATA: 33 1/2 lb

BLOOD GAS
CAPILLARY ARTERIAL
TIME:
PO2 PCO2 PH BE

PULSE OXIMETER/TCP02
TIME READING

NOTES: 1005 lab here to draw CBC + glucose 1040 Feed d/t ↓BS - no
2345 Labs reported to Dr. Knipke.

INFANT TRANSFERRED TO Death Nursery TIME 0140 CONDITION AT TRANSFER stable
T 98.1 P 112 R 44 RN SIGNATURE S. Finat, RNC

CONSULTS

The Toledo Hospital
Consultation

[redacted] 13745
STATMA, BABY BOY
TO SERAK, K P 00503
03/21/91 SEMI 000 00503
03/21/1991

Department of: Peds (1) /N. Bhumbra

ADDRESSOGRAPH STAMP

Last Name	First Name	Physician	Unit History #	Date	Room
Statma, Joseph		Bhumbra		3/27/91	

Hx: This 34 wk EGA was born to a $G_3P_{2\to3}$ 274.0 WF who is Rh sensitized. Apgars were 6'9'. First 2 days were uneventful except for hyperbilirubinemia treated c phototherapy. At 2 days of age he had a temp elevation to 100.6 and on day 3 he had an apparent generalized seizure. CSF obtained at that time showed a Glucose of 14, protein of 340, WBC ct >7,000 and Gram +1 cocci on gram stain. He was started on Claforan and Amp and then switched to Ampicillin (200 mg/kg/d) and Gentamicin. LP was repeated and gram stain yesterday also still had gram + cocci. Culture at 24 hrs. showed no growth. He was started on Ø bact for the seizures

not meningitic dose

P.E. Pt. sleepy but responds to noxious stimuli
T - 97.2
Ant. fontanel soft & flat Neck - supple
Ht - RR
Lungs - Clear - bilat.
Abdomen - soft c nl B.S.; no hepatosplenomegaly;
Skin - no rash on front of body; good
Ext - good perfusion and pulses;

3/26 CSF Chemistries / Cells
Protein - 196
Glucose - 28
RBC - 21
Nucleated Cells - 3290

Imp. - Gp. B Strep Meningitis

Recommend -
1. Ampicillin 4 to 400 mg/kg/d in 4 divided doses
2. Continue gentamicin and monitor levels
3. If culture of CSF from 3/26 is positive, repeat L.P. at 48 hrs. of higher dose amp. If CSF negative on culture, repeat L.P. p 14 days of higher dose ampicillin (i.e. day 2 today) to assess adequacy of therapy.
4. BAER p therapy completed.
5. Monitor for complications.

Pt. seen c Dr. Bhumbra.
R. Gross MD

Pt seen. Agree c above. Case discussed c Dr Gross. N. Bhumbra MD

The Toledo Hospital

CONSULTATION

MAXI 8

[redacted]005413745
[redacted]000000566728
STALMA, BABY BOY
[redacted]EKAR, K P
[redacted]EKAR, K P
3/21/91 SEMI OOD
3/21/91
ADDRESSOGRAPH STAMP

PATIENT NAME	DICTATED BY	ADMISSION DATE	UNIT HISTORY #	ROOM
STALMA, Baby Boy Joseph	Mary Toth, M.D.	03/21/91	566728	MaxiNS [redacted]

This is a 30-week gestational age infant born to a gravida III para II, 27-year-old mother who is Rh sensitized. Apgars at birth were 6 at one minute and 9 at five minutes. There were no complications in labor and delivery except for cord around the neck x1. The patient was doing well in the Newborn Nursery except for hyperbilirubinemia possibly associated with the Rh sensitization. Phototherapy had been going for three days, and the patient had been feeding well. On March 23, the patient spiked a temperature to 100.6' and developed a seizure on March 24. The seizure consisted of arching of the back and stiffening of the extremities. A sepsis workup was performed and lumbar puncture performed on 3/24/91 and showed a glucose of 14 and protein 340, white blood cell count greater than 7,000 and gram-positive cocci in the cerebrospinal fluid. Group B strep was found in the counterimmune electrophoresis. The patient was treated with Claforan for group B strep meningitis. The patient had many episodes of the above seizures and was started on phenobarbital 2.5 mg/kg per dose every 12 hours. Phenobarbital level was 21. There has been no reported seizure in the last 12 hours. Mother tested group B strep negative in the past.

a4 A— P temp elevation

On physical examination, head circumference is 34 cm, weight 3.5 kg, length 55 cm. General exam while under phototherapy, this is a well-developed, well-nourished term infant in no distress. The anterior fontanel is soft and nonbulging. Sutures are opposed; however, the child has a high-pitched cry when agitated. Eyes: PERRL. Normal oculocephalic reflex and positive red reflex. There is a good suck, There is normal grip and a positive plantar reflex, poor Moro reflex, no clonus or Babinski. Lungs are clear to auscultation bilaterally. Abdomen is soft and nontender without masses or organomegaly.

ASSESSMENT: Group B strep meningitis with seizures as a result of increased meningeal irritability. High-pitched cry is also a sign of increased meningeal irritability.

(continued)

THE TOLEDO HOSPITAL

PHYSICIAN PROGRESS RECORD

[redacted]0005413745
MRN [redacted]0566728
STALMA, BABY BOY
TORSEKAR, K P
ADDRESSOGRAPH STAMP

000

DATE

3/23/91 / 3+ Coombs Rh neg — no mention of temp elevation
0800 Double phototherapy
Baby alert, good cry
Bilirubin 7.0. bid light.
Bryant

3/24 Called stat to see infant, for poor feeding and
0230 squealing and turned rigid, + arched his back & developed loop diuresis, drushy around mouth, gave him facial O2 & he gradually pinked up.
O/e Abd full & firm, perfusion ✓ cap refill — > 3 secs.
awake, crying, sucking mild retractions, icteric, tone T mildly all 4 extremities. AF soft. Moro sym
Hx — G3 P2 27 yo A negative blood type, Rh sensitized pregnancy c 3+ Coombs.
EDC 4/4/91
Meds in pregnancy — vitamins
Spont. Vertex delivery — 3/24/91 at 2131 hrs. CAN x 1
Apgar 6' 9'. — 39 wks 3560 gms
Facial O2 for resuscitation.
Infant blood type A+ve c Anti D 3+. ~~bili phototherapy~~ 3/22
Start phototherapy.

5202617 REV. 8/80

THE TOLEDO HOSPITAL

PHYSICIAN PROGRESS RECORD

DATE

On admission nursery vitals stable cord bili 3.1 mg%.
Slight circumoral cyanosis noted, disappeared c crying. Feeding well & stooled in N nursery.
Phototherapy started 3/21 Double PT 3/22
Stools till 3/23.
Spiked temp to 100 on 3/23 & was at that time under double PT & blanket etc. - removed & temp wnl.
At 6:00 p.m. feed c mucus had ? episode c stiffening & extension while feeding. After that stools
On 3/24 at 0230 had been fed & had similar episode c abd distension & had fed very poorly & regurgitated. I was called stat. Af soft, Muscle tone reaction good Moro Sym.
Dx ① Term 37-3/7 wks AGA 3.56 kg NVT male
& Plan ② Icteric clinically - ? 2° Rh sensitization ? 2° Sepsis
③ Abd distension - firm almost tense abdomen c ↓ bowel sounds. Rlo perforated bowel? Ascites
Abd too tense to feel liver/spleen due to abd pain
④ Rlo Sepsis - cultured + started antibiotics Tica/Gent
L.P. deferred due to destended abdomen - could not hold the infant or sit him up for LP
BP wnl 40's Abd After pleasants pad better
⑤ NPO IV fluids TONICA
⑥ Rlo seizures - none noted by me

5202817 REV. 6/80

THE TOLEDO HOSPITAL

PHYSICIAN PROGRESS RECORD

05413745
000000566728
[illegible], BABY BOY
[illegible] KAR, K P
[illegible] SEKAP, K P
[illegible]/21/91 SEMI 000
[illegible] ADDRESSOGRAPH STAMP

DATE

3-24-91 Wt = 3.56

Cardioresp: Pink in RA Clear = BS
No (m)

FLN Abd soft, full & hypoactive BS
- Fluids: 110 cc/kg/day - will keep restricted
D10 2NS + 1mEq KCl/50cc given? meningit
KUB today - normal (see below
130 | 103 | 20/1.2
4.4 | 13

SGOT 43 Ca = 7.1
SGPT = 12 P = 5.7
GGT = 49 Wafer feeds

Will Δ to D10 3NS + since BS↓ & ?, sepsis
1mEq KCl/50cc ✓ CP - 2 tonight

Hemat: WBC today 9400 76 seg 23 band 2 Meta
Hct 40 plt 256,000

ID: Spoke to father RE need for LP given (L) shift & episodes arching & stiffening
LP performed 23-24 using aseptic technique & 22g Spinal needle 4cc cloudy CSF

5202817 REV. 8/80

Meningitis — need meningitic doses

THE TOLEDO HOSPITAL

PHYSICIAN PROGRESS RECORD

MR# 7145

TOLSE
TOLSEKAR, [illegible] 000
03/21/91 ADDRESSOGRAPH STAMP

DATE

Obtained + sent for gm stain, C+S, Chem, coags, cell count Tolerated procedure well.

After discussing need for LP c father, urine coags called back to ICN as (+) GBS

ABX Δ Ticar / Gent (And Ticar? Why benign + suspect had clues 2° sepsis) to Amp (200 mg/kg/day) + Claforan given Cloudy CSF Neuro AF Soft Good tone

30 sec episode arching this afternoon c stiffening of ext's ? Sz EEG ordered No anticonvulsants started yet. Spoke c father RE ? Sz.

Bili ↑ to 6.7 under photo ✓ Bili q 12h Double PT q > 12

K Carlson

5202817 REV. 8/80

THE TOLEDO HOSPITAL

PHYSICIAN PROGRESS RECORD

ADDRESSOGRAPH STAMP

DATE	
3/25/91	Neurology Consult - Full Note dictated 39 week wf and born to G3P2 27y/o mother who was Rh Sensitized Apgars at birth 6' 9J. No complications labor & delivery except CANX Mother tested Group B strep + in past. Infant was doing well in newborn nursery except for hyperbilirubinemia - Phototherapy x 3 days. Had been feeding well. Started temp 3/23 and developed a seizure on 3/24 consisting of arched back & stiffening of extremities. LP on 3/24 glu 14 prot 340 WBC >7000 and gram (+) cocci on CSF. (+) Group B strep in CSFs. Pt. treated = Amp and Claforan for Group B strep meningitis. Pt. had many episodes of above seizures and was started on PB 2.5 mg/kg/dose q 12° yesterday. PB. level pending. No reported seizures since 12°. P.E. HC 34cm wt. 3.5 Kg length 53cm Sutures opposed Stirred under Isolette WDWN term infant in no distress. Ant fontanelle soft nonbulging Eyes PERRL nl Dolls eye Good suck nl grasp (+) plantar (+) moro reflex no clonus Lungs clear bilaterally Abd soft nontender & mass organomegaly A- Group B strep meningitis + Seizures as a result of ↑ meningeal irritability P- Continue phenobarbital monitor levels until v. ccc.	2 day induction AROM ~12 hrs

High pitched cry

Poor Moro

THE TOLEDO HOSPITAL

PHYSICIAN PROGRESS RECORD

ADDRESSOGRAPH STAMP

DATE

3-2791 Wt = 3.55 (↓50gm)

Cardioresp: Pink on RA ~ Sats 94-98
Clear = BS ↓ on ~ No apnea
FLN Abd Soft, not distended
-~ active BS Tippling
bitter Tolerating 25 cc q 3h
Sim 20 Will continue to
advance per feeding scale
Hemat: Less jaundiced ~
Hct ↓ 4.9
3/26 WBC 17,900 42 segs 2 bands
Hct 42.6 plt 328,000
ID Day 4 Amp/Gent
2nd LP yesterday showed
↓'ing protein + WBC but
gm stain still (+) so Amp ↑
~~to 400 mg/kg/day~~ while awaiting
~~yesterday~~ CSF cx per Dr
Shumbair ree. If 3/26 CSF
still growing will need F/U
LP - this discussed ~ family
✓ CBC today

finally to App dose

5202817 REV. 8/80

MAXI 8

THE TOLEDO HOSPITAL

PHYSICIAN PROGRESS RECORD

0005413745
0000020566728
[illegible], BABY BOY
[illegible]KAR, K P
[illegible]KAR, K P
[illegible]/21/91 SEMI 000
[illegible]/21/91 ADDRESSOGRAPH STAMP

DATE

38/ Still floppy
↑ pitched cry
↑ WBC
keep up Abx

Peds ID. Seems sleepy to mom.
Temp 1 to 101 rx [illegible], will isolette temps of 93.
PE: Ant. fontanel soft + flat
HT - RRR joints - no swelling/erythema
Lungs - CTA laterally perineum - ø rash
Abd - soft c nl B.S.
Labs - 43.2 / 13.3 / 34.7 / 531 B⁹ Segs⁵⁹ L¹⁵ M¹² E⁵ ?

CSF Culture - (3/24) - NG at 48 hrs
Imp/Recommendations -
- Increased fever and WBC ct ? 2° increased isolette temp? ? drug fever?
- Watch closely for ?° focus of infection
- Suggest C.T scan - to R/o abscess if fever recurs or WBC ct. remains elevated. Pt. seen c D. Bhumbra.

THE TOLEDO HOSPITAL

PHYSICIAN PROGRESS RECORD

DATE

4/8/91 (Cont.)

#4. I.D - Day #4 Amp & Gent for GBS meningitis ; blood (4/6) pending
~~C~~ Urine Coags from 4/6 ⊕ for GBS ; gram stain & culture (-)
PLAN - D/c antibiotics ☆ today ; retap tomorrow

#5 Neuro - ⌀ bands level - 31

PLAN - ↓ ⌀ bands to keep levels in high 20's
-schedule MRI, BAER tomorrow.

R. Craig MD

~~C ERROR~~ KC Examined & agree.

4/9/91 No seizure but EEG seconds ominous
(R) occipital / temporal / cerebral sutures overlapping / cont. fontanel
H/C 34 cm
All seconds as if the brain has taken a major insult & has regulles.

The Toledo Hospital

Nursing Care Plan

Primary Nurse	Associate Nurses
	Wanda RN CCU

ADDRESSOGRAPH STAMP

Admitting Medical Diagnosis and other pertinent data

NO Beads

Date and No	From Nursing Assessment Identify - needs problems limitations	Plans or Goals to meet needs, problems. limitations & target dates	Intervention or approach - (who, what where, when and how)	Evaluation and Patient Response with date	Initial
3/24 #2				3/24 temp. [illegible]	
				[illegible]	
				[illegible]	CV
				[illegible]	
				[illegible]	
				[illegible]	
				[illegible]	
				3/29 WBC ↑, NO	
				Clinical S/S of	
				Sepsis. Amp & Gent.	
				4/4 CBC on 4/3	
				WBC 21.6 Bands 6	
				Amp + Gent	
				restarted VS stable	
				on O/C. ICU	
				4/8 ANTIBIOTIC'S	
				D/C'd today - will	
				watch for S/S of infect.	S.K
				4/11 CBC this AM.	
				off Abx. No organisms	
				seen on GS Gram stain 4/9	

Discharge Planning Goals - (as identified by patient. family, nurse and physician)

THE TOLEDO HOSPITAL

371

FAMILY CENTERED MATERNITY CARE

NURSERY DAILY FLOW SHEET

Date 3/21/91 – 3/22/91

Weight 6 13

Change Box
Δ in condition/time

MRN [illegible] 566228
STARR, BABY GIRL
TORSTAR, R P
TORSTAR, R P

00503
00503

000

-Addressograph Stamp

Assessment Time	0200					
Diet (type)						
Breast						
Formula						
Nipple Regular						
Premie Soft Nipple						
Gavage PRN						
Hygiene						
Complete						
Staff						
Mother						
Safety						
Bassinette						
Isolette						
Continuallly Attended						
by Mother or Staff						
Neuro-Behavioral						
Reflex Irritability						
Vigorous Cry						
* Lethargic						
Suck						
Good						
Fair						
* Poor						
Fontanells						
Flat						
* Other						
Moro						
Good						
Fair						
* Other						
Muscle Tone						
Good						
* Flaccid						
* Hypertonic						
Moves All Extremities						
Yes						
* No						
Cardio-Vascular						
Mucous Membranes						
Pink						
* Other						
Murmur Present						
* Yes						
No						
AP						
Regular						
Irregular						

Respiratory						
Quality						
* Unlabored						
* Nasal Flaring						
* Retractions						
* Grunting						
Sounds						
Clear						
* Other						
Skin						
Temp.						
Warm						
* Hot						
* Cool						
Turgor						
Good						
* Poor						
Moisture						
Dry						
* Diaphoretic						
Color						
WNL						
Pale						
Ruddy						
Jaundiced						
* Cyanotic						
Cord						
Clamped						
Dry						
* Other						
Caput						
Yes						
No						
Cephalohematoma						
Yes						
No						
Internal Monitor Site Present						
No						
Yes						
REEDA WNL						
* Other						
Circumcision						
No						
Yes						
REEDA WNL						
* Other						

GI						
Abdomen Soft						
* Distended						
Bowel Sounds						
Present						
* Absent						
Additional Assessments						

Tests/Labs

Time						
Test Results						
Metabolic Screening						
Test #						
Time						
Per Heelstick						
Signature						

	D	E	N
Treatment			
Eye Care:			
Cord Care:			
Turn/Reposition:			
Ea. Feed See I&O			
Betadine Scrub:			
to Internal Monitor Site Daily			
Circ Care: with each			
Diaper Change			
Phototherapy 0130			
Eye Patches			
Gonad Protection			
Lambs Wool Pad			
Weight AC.& PC			
Equipment			
Isolette (temp)			
Pelvic Harness			
Triple Diaper			
Perineal Roll			

Time	intake PO	Comments	Output Urine	Stool
07				
08				
09				
10				
11				
12				
13				
14				
15				
Totals				
16				
17				
18				
19				
20				
21				
22				
Totals				
24				
01				
02 25		1 oz ice chips	✓	
03				
04				
5		102		
Totals				
24 Totals				

Time	Health Care Notes document response to interventions teaching, PRN medications or unusual occurrences.
0210	Received into 3 North Nursing from admission nursery. Quiet, blue bracelet has uncircumcised adhesions. No nasal flaring, grunting or retractions noted. Appears in stable condition. Jaundice. Has bruised middle finger.

TIME	TEMP	PULSE	RESP	BP	*TIME	PHYSICAN NOTIFIED	INITIALS
0210	98	119	44				

Shift	Initials	Signature/Title

Patient Goals	Outcomes A	Outcomes U	Progress Needs - to adapt to extrauterine life (EUL)
1. (Physical) A - achieved U - unachieved			
Mutually set with pt./family	Yes	NA	
Will maintain temp 97.5-99	11-7	JH	See temp area
2. (Physical)			
Mutually set with pt./family	Yes	NA	
Will void & stool in 1st 24.	11-7	JH	Voided 0225 - Has not stooled as of 0500

Discharge Planning Progress:

Time	Intake PO	Intake Comments	Output Urine	Output Stool	Time	Health Care Notes: document response to interventions, teaching, PRN medications or unusual occurrences.
07					0720	Baby undressed by nurse for temperature by Dr Gladieux - DMC
08						
09						
10 345	Sim	Nsy.				
11						
12						
13						
14 30	Sim	Nsy well	✓	Yes		
15						
Totals						
16						
17						
18 30	1½ oz		✓			
19						
20						
21						
	1 oz.		✓			
Totals						
24						
01 45	2 oz.	well	✓	mec		
02						
03						
04						
Totals	fed on 1 hour - well					
24 Totals						

TIME	TEMP	PULSE	RESP	BP	TIME	PHYSICAN NOTIFIED	INITIALS
TU?	98.4	124	44				
200	97.6						
515	96.4	132	40				
830	98.4						
2(01)	98.4	140	40				
05	99						

Patient Goals	Outcomes A	Outcomes U	Progress adapt to ELL
4. (Physical) A - achieved U - unachieved			
Mutually set with pt./family	(Yes)	NA	See P&O
Well stool in 24 hrs.	1-7 mg		

Shift	Initials	Signature/Title
7-15	[illegible]	[illegible]
7-11	[illegible]	[illegible]
11-7	[illegible]	[illegible]
23-07	[illegible]	[illegible]

4. (Physical) Mutually set with pt./family	A	U	
	Yes	NA	
Bilirubin levels will decrease			See title grid

Discharge Planning Progress: See Mother's chart

3/22/

temp elevation no doc. of MD validation or intervent

THE TOLEDO HOSPITAL

3 21

[illegible] 2745 1

STALMA, BABY BOY
TOSCHAK, KP
TOSCHAK, KP
03/23/91 SEMI 000
03/24/1991

FAMILY CENTERED MATERNITY CARE

NURSERY DAILY FLOW SHEET

Date 3/23 & 3/24/91

Weight 7lb

Change Box
Δ in condition/time

Assessment Time 09 1553 2200

Addressograph Stamp

Diet (type) SMM

Breast			
Formula			
Nipple Regular			
Premie Soft Nipple			CR
Gavage PRN			

Hygiene

Complete			
Staff			
Mother			

Safety

Bassinette			
Isolette			
Continuallly Attended			
by Mother or Staff			

Neuro-Behavioral

Reflex Irritability

Vigorous Cry			
* Lethargic			

Suck

Good			
Fair			CR
* Poor			

Fontanells

Flat			
* Other			

Moro

Good			CR
Fair			
* Other			

Muscle Tone

Good			
* Flaccid			CR
* Hypertonic			

Moves All Extremities

Yes			
* No			

Cardio-Vascular

Mucous Membranes

Pink			
* Other			

Murmur Present

* Yes			
No			CR

AP

Regular			
Irregular			

Respiratory

Quality			
* Unlabored			
* Nasal Flaring			
* Retractions			
* Grunting			

Sounds

Clear			
* Other			

Skin

Temp.

Warm			
* Hot			
* Cool			

Turgor

Good			CR
* Poor			

Moisture

Dry			CR
* Diaphoretic			

Color

WNL			
Pale			CR
Ruddy			
Jaundiced			CR
* **Cyanotic**			CR

Cord

Clamped			
Dry			
* Other			

Caput

Yes			
No			

Cephalohematoma

Yes			
No			CR

Internal Monitor Site Present

No			
Yes			
REEDA WNL			
* Other			

Circumcision

No			
Yes			
REEDA WNL			
* Other			

GI

Abdomen Soft			
* Distended			CR

Bowel Sounds

Present			
* Absent			

Additional Assessments

Tests/Labs

0700 Bili 12 called to Dr Bugarski /s

1900 Bili 8.0 called to Dr. Bugarski /s.

0300 Blood drawn for CBC - CBG - PH.

Time	
Test	Results
Metabolic Screening	
Test #	
Time	
Per Heelstick	
Signature	

	D	E	N
Treatment			
Eye Care:			
Cord Care:			
Turn/Reposition:		XO	
Ea. Feed See I&O			Q
Betadine Scrub: to Internal Monitor Site Daily	2D9		
Circ Care: with each Diaper Change		XO	
Phototherapy			
Eye Patches	09	XO	
Gonad Protection		XO	
Lambs Wool Pad		XO	
Weight AC.& PC			

Equipment

Isolette (temp)			
Pelvic Harness			
Triple Diaper			
Perineal Roll			

5004841 Approved by Executive Committee 8/90

Pale suck noted
Hypertonic by
Cyanotic CR on 3/23

Time	Intake PO	Intake Comments	Output Urine	Output Stool
07				
08				
09				
10				
11	1½			
12				
13				
14			✓	
15	1 oz	fairly well		
Totals				
16			✓	
17				
18 30	3/4 oz	dex - fed in nsy		
19				
20				
21				
30	1 oz	fairly well (Mom fed in nsy)	✓	
Totals				
24				
01				
02	1 oz	fair	✓	
03				
04				
06				
Totals				
24 Totals				

TIME	TEMP	PULSE	RESP	BP	*TIME	PHYSICIAN NOTIFIED	INITIALS
1720	98.4	138	48	~			
~~1820~~	100	160	-	4 lights next to			
~~1920~~	~~99.7~~						
1420							
1000	100.6						
	99.2						
~~1055~~	~~99.8~~	~~140~~	46				
1915	98.6						
2400	99.9	136	40				

Time	Health Care Notes: document response to interventions teaching, PRN medications or unusual occurreaces.
0730	Dr. Bugarski D/C'd baby & updated by phone
1430	Dr. Bugarski not having ~~D/C~~ PE - D/C orders received
1508	One liq stool ~~D/C~~ diaper changed
1835	Mom states baby has arched backed and stiffened extremities while feeding. Cyanosis around mouth & palms noted. Baby suctioned @ bedside & mouthful of formula & mucus. Continues to have difficulty breathing - expiratory.
1840	Baby returned to nursery. A Johnson RN Color cyanotic especially around lips. D/C'd x 3 & baby bulb syringe packed. Is producing a lot of thick mucus. Is receiving suctioned upon D/C
1845	Lungs clear. Nail beds pink. Color improving. Apical 102 x 1 minute. W Zettel RN
1850	Color pink. Is tenderly cycling. Dr. Bugarski notified of above episode. L Osterhoudt RN
2100	Dr. Bugarski notified of above episode. L Osterhoudt RN
2400	Remains under Phototherapy quiet & sleepy, color pink. Fed 1oz formula fair - PSB. Burped frequently. Voided under Phototherapy. Bottom on abdomen. Lights to head high pitched cry. Trembling arms outstretched upward. Circumoral cyanosis noticed + dusky ~~conditions~~ nails and pale. O2 given @ 3-5 Liters became flaccid. NICU notified. STAT
0215	

Patient Goals	Outcomes A	Outcomes U	Progress
4. (Physical) A - achieved U - unachieved			Adaptive EEG CKose RN
Mutually set with pt./family	Yes	NA	
Will take 1-1½ oz q 3-4 hr	15-23	~~40~~	See t.o nipples slowly but retaining. 30

Shift	Initials	Signature/Title
7-15	[illegible]	[illegible]
1-3	[illegible]	[illegible] CNII
15-23	[illegible]	L Osterhoudt RN
23	[illegible]	[illegible] RNA
23	[illegible]	W Zettel RN
2400	[illegible]	[illegible] RN
2	[illegible]	[illegible] RN

4. (Physical)	A	U	
Mutually set with pt./family	Yes	NA	
Bilirubin Levels will decrease	15-23	~~40~~	See Bili Graph - one lite x/d @ 1500. 30

Discharge Planning Progress: See Mothers Chart

230 PM

215 AM

~12 hrs between

1st temp elevation at 0500

D/C'd/g status - not addressed

MD notified of temp elevation (Next temp) @ 1430 ~ 9 hrs from 1st temp elevation

Seizure-like activity & cyanosis, & difficulty breathing @ 1835. - Req O2 & Suction

MD notified at 2100 - ~3 hrs later

21 hrs from 1st Sign (temp)

Next seizure-like s/s at 0215 - 5 hrs later - 8 hrs lost re seizure Activity

.e **Health Care Notes: (continued)**

0230 Apl. 1/6 Irregular @ the time, R. 40 – Grunting – Subcostal Retractions. O2 per mask given. Contains rigidity for 5 min. Relaxed somewhat @ the time NICU Nurse moved here @ the time. Color central Pale grey – cyanotic. Breath sounds coarse – Bagged per NICU Nurse. Dr Satish in and examined – Orders received. Dr Burgansky notified of above. Chest X-Ray Done. BP drop 62/42/43 mean II 69/42/mean 43. Blood Culture drawn Plasmanate given by. NICU Nurse. Lab work done. – – – – – – – M Zaeyen

0330 Taken to visit mother. Transfered to NICU in Isolette c – Portable O2 hygen following another dusky episode. M Zaeyen – – – – 3:30 am

The Toledo Hospital

Physician's Orders

DATE/TIME

3-21 2130 R Cord blood to Blood bank STAT for Blood type & Coombs

R Cord blood to Lab for STAT Total Bili

R STAT: CBC, Diff, glucose

R Bili q 6h 1-7-1-7

N Start phototherapy when bili ≥ 5

Krupps

0000054 13745

U. CLERK	NURSE	DIET VERIFICATION
SKO	DS	

0000054 13745

U. CLERK	NURSE	DIET VERIFICATION
SKO	DS	

0000054 13745

U. CLERK	NURSE	DIET VERIFICATION

0000054 13745

The Toledo Hospital
Physician's Orders

DATE/TIME

3/23 Discontinue one [illegible] bili light @ 1500
1100
11am TO Dr Buganski
[signature]

00000541374S 1
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P 00503
TORSEKAR, K P 00503
03/21/91 SEMI 000
03/21/991

U. CLERK	NURSE	DIET VERIFICATION
	[initials]	

1430 Strip baby of clothes
Retake temp in one hour
+ call me

TO Dr Buganski
[signature]

00000541374S 1
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P 00503
TORSEKAR, K P 00503
03/21/91 SEMI 000
03/21/991

U. CLERK	NURSE	DIET VERIFICATION
	[initials]	

3/23/91 2100 Continue phototherapy until 0300 3/24; then dc lite.
Repeat bili @ 0700 3/24/91
t.o. Dr. Buganski
[signature]

00000541374S 1
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P 00503
TORSEKAR, K P 00503
03/21/91 SEMI 000
03/21/991

3/24 2:40 AM

U. CLERK	NURSE	DIET VERIFICATION
	[initials]	

3/24/91 ① Blood gas, CP2, CBC c diff + plts stat
0240 ② CP, - 7:00 AM
③ Abdomen x-ray AP + decubitus c (R) side up to [illegible]
④ Continuous pulse oximeter
⑤ CBC ASAP
⑥ Continuous Dinamap
⑦ Urine coags
⑧ I.V. Ticarcillin 260mg q 8 hrs [illegible]
⑨ Gentamicin 8.75 mg q12 hrs IV stat
[signature]

00000541374S 1
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P 00503
TORSEKAR, K P 00503
03/21/91 SEMI 000
03/21/991

U. CLERK	NURSE	DIET VERIFICATION

The Toledo Hospital
Physician's Orders

MAXI 8

DATE/TIME

3-24-91 ① CSF for
#1 Gm stain & C+S
#2 glucose
protein
coags
#3 cell count
R ② Ampicillin 240 mg
IV q8h
③ Claforan 180 mg
IV q12h
R ④ D/C Ticar + Gent
⑤ bld q12h
#11 Double PT bld >14
⑥ Change IV to
D10.3NS + 1mEq KCl/50cc
#13/14 ⑦ CP-2 } AM 3/25
CBC c diff, plt
R ⑧ VC MD on AM RE
doing EEG

U. CLERK | NURSE | DIET VERIFICATION

MAXI 8

Karl

MAXI 8

3/24-91 ① CP-2 7p
3p

Karl

U. CLERK | NURSE | DIET VERIFICATION

MAXI 8

3/24/90 ① Phenobarbital
5p 70 mg IV x 1, then
8.9 mg IV q 12h
c level qm 3/25
② Change to Gentamicin
8.75 mg IV q 12h c
levels around 3rd dose
③ D/C Claforan

U. CLERK | NURSE | DIET VERIFICATION

DATE/TIME

The Toledo Hospital
Physician's Orders

MAXI

3/26/91 ① Start CSF gram stain C/S protein glucose cell count latex agglutination

3/26/91 ② CBC plt diff Chem-7 AM

③ May nipple feed as tolerated

U. CLERK | NURSE | DIET VERIFICATION

3/26/91 ① Ampicillin 340 mg IV q 6 hrs

② Gentamicin 8.7 mg IV q 12 hrs Gent levels after 3rd dose

③ Continue Cefotaxime till AM + CSF C&S Dr Carlson re: further therapy

④ Consult ID Peds Dr Bluemle re: persistence of true gram stain despite >48 hrs of therapy for meningitis

MAXI

3/26/91 ① D/C Cefotaxime (as the order error)

MAXI

3/27/91 ① Phenobarb level 0600 AM 3/28

② CBC & diff, plt AM 3/28

③ 2% Formula 30 cc q 3 hr x 03 feeds, advance per scale q 12 hr

Feeds	IV
35 cc q 3 hr x 4 feeds	4.4 cc/hr
40 cc q 3 hr x 4 feeds	2.8 cc/hr
45 cc q 3 hr x 4 feeds	1.2 cc/hr

U. CLERK | NURSE | DIET VERIFICATION

ORIGINAL

IN THE COURT OF COMMON PLEAS

LUCAS COUNTY, OHIO

JOSEPH STALMA, a minor,
by and through his mother and :
natural guardian, Norma Stalma, :

Plaintiff,

-vs- : Case No. CI99-1762

TOLEDO HOSPITAL, : JUDGE LANZINGER

Defendant.

- - -

Deposition of *AMY* **M. CLINE,** a Witness herein, called by the Plaintiff for Cross-examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Kristie L. Birch, a Notary Public in and for the State of Ohio, pursuant to agreement and stipulations of Counsel as hereinafter set forth at Toledo Hospital Education Center, Room G, Toledo, Ohio, on Thursday, March 30, 2000, at 11:05 o'clock a.m.

CLASSIC REPORTING SERVICE
1450 National City Bank Building
405 Madison Avenue
Toledo, Ohio 43604
(419) 243-1919

- - -

sure that that's, that I did that in the morning, I don't recall.

Q Okay. Well, let me ask you a question about that. Looking at the vitals over here did you, does that appear to be your handwriting at 7:30?

A Um, appears to be.

Q Okay. Let me ask you, in 1991 was it standard practice to record vitals at any particular time during your shift?

A Yes.

Q What was it, when you first came on?

A Right.

Q Is that when you did it?

A Right.

Q And after you first came on were you doing eight hour shifts at the time?

A Yes.

Q And then was there another time in the newborn nursery where you were supposed to record vitals?

A For me it was once a shift. need Policy re: VS

Q Okay. And for you, what do you mean by that?

A Well, I worked an eight hour shift so when I came in usually I would take the vitals beginning of the shift, that's all that was required at that point.

Q Now, did you have an understanding in 1991 that the RN that was also on duty would be taking the vitals as well at different times during your shift?

A Yes.

Q And what did you understand to be the time periods at which the RN would take the vitals?

A I wouldn't have known then.

Q Okay. As you were trained in 1991 what was your understanding of what vitals were to be taken and recorded?

A Well, again, with my knowledge I was just concerned with my job description which would have been the vitals when I came on.

Q Okay. Were you trained to take and record the temperature at the beginning of your shift?

A Yes.

Q Were you trained to take and record the pulse?

A Yes.

Q And were you trained to take and record the respirations?

A Yes.

Q Okay. Any other vitals signs that you were trained to take and record? BP?

A No.

A Uh-huh.

Q I'm sorry, strike that. I was actually going to ask something different.

Under the reflex irritability you have noted vigorous cry. Tell me what you mean or what you meant by vigorous cry in 1991.

A Vigorous cry would mean if you stimulated the baby you would obviously hear him cry.

Q Okay.

A Strong cry when he was hungry, when you moved him.

Q Is that normal?

MS. BAER: Objection. Go ahead.

A What do you mean normal?

Q Is that considered to be a normal finding, reflex irritability with a response of a vigorous cry?

A Yes.

Q Okay. There's no notation of the moro reflex being tested. Was it your practice in 1991 not to test moro reflexes?

A Right.

Q And why was that, because of not having been trained?

Anyone responsible for working with babies - professional or NON-prof should know how to elicit a Moro & know if it is normal or abnormal

A My limited knowledge, yes.

Q And then down below that there's a notation for AP, do you know what that refers to?

A I do now, I wouldn't have then. Should have known

Q What does it refer to?

A Apical pulse, I believe referring to heart, the heart tones.

Q Now, in 1991 did you have an understanding that when a child was undergoing phototherapy they were not to be covered with a blanket or wrapped in a blanket?

A If they were underneath the lights?

Q Yes.

A Right, yes, they should not have been covered.

Q Okay.

MR. KULWICKI: That's all the questions I have. Attorney Baer is going to tell you about your rights with regard to this transcript.

MS. BAER: If the transcript is ordered and typed up you've got the ability to read it and check for spelling errors and typographical errors and things of that sort. If that's something you wanted to do before it's put in final form

IN THE COURT OF COMMON PLEAS

OF LUCAS COUNTY, OH

CIVIL DIVISION

* * * * * * * * *

JOSEPH STALMA, a minor, by and through his mother and natural guardian, NORMA STALMA,	*	Case No. CI99-1762 Judge Lanzinger
Plaintiff	*	
vs.	*	
TOLEDO HOSPITAL,	*	
Defendant	*	

* * * * * * * * *

DEPOSITION OF

RICHARD W. MORIARTY, M.D.

DECEMBER 12, 2000

COPY

Sargent's Court Reporting Service, Inc.
(814) 536-8908

comment by Doctor Buganski come into play at all in terms of your analysis of this case or the nursing care that's at issue here?

A. No.

Q. Okay. And you have read Doctor Buganski's deposition?

A. Yes.

Q. Did his sworn testimony come into play at all in terms of your analysis of this case or any opinions that you formulated?

A. No.

Q. Okay. Tell me, briefly, what your understanding of the facts. And by that I mean on the particular day at issue in Joey's newborn course, what is your understanding of the facts of this case?

A. Well, we have a youngster who's born on the 21st of March, 1991. The delivery seems to be okay. We know that the mother, who I think had at least two other children, maybe three, two, whatever.

that the mom had had a history of having youngsters with bilirubin problems secondary to an unusual RH incompatibility that she happens to have and her husband happened to have.

Because of that problem, the bilirubin problem, by the 22nd of March the youngster is placed under bilirubin lights. And the initial order is to put him under what they say are double bili lights, and I take that to mean two banks of lights. That occurs, as I said, on the 22nd.

Then on the 23rd, we have a couple of things happen. At 5:00 a.m. it's noted in the nurse's notes that the youngster has a temperature, an axillary temperature of 99. At 7:00 a.m. it's noted in the nurse's note that a bilirubin level of 7.2 is called to somebody. I assumed that was either a resident in the hospital or possibly to the attending

pediatrician's group or maybe to Doctor Buganski. It's not clear who was called from the notes. There's an order written at 11:00 on that morning that one of the bili lights is to be discounted at 3:00 p.m. that day. At 2:00 p.m. on the nurse's note, it's noted that the youngster has an axillary temperature of 100.6 degrees Fahrenheit. As an aside there's sort of like a double entry where this thing is written twice. I'm not quite sure why it had to be written twice. It's sort of interesting.

Q. Do you mean a recording of the temperature itself or --- I guess I want to make sure I'm clear what you mean by something was --- there was a double entry?

A. The note was like written twice as I recall.

Q. When you say the note --- let me just show you. This is a page from the 23rd for the nursing notes

where there is a recording of the temperature. Were you referring to something on that page or something else? I just want to make sure.

A. Let me just grab my notes. I don't have that.

Q. Well, then perhaps we can curtail this. I understand you've got something noted, but was it ---?

A. Yeah. The note I have is of the fact that the youngster had this temperature elevation to 100.6 degrees had been noted twice within the nurse's note. We didn't find the exact thing. Then ---.

Q. Did that play any significance in terms of the sequence of events here to you?

A. I just thought it was an interesting little quirky thing in which I didn't quite understand in the record.

Q. Okay. All right. Continuing on.

A. Okay. Then at 2:30, the

nurse's note that the temperature, the youngster's temperature, is 99.9 degrees Fahrenheit, axillary. And again that also written a double entry where that's in there twice. About the same time, the nurse's note indicates ---.

BRIEF INTERRUPTION

A. It's noted that Doctor Buganski was notified of the elevated temperature and that orders were received from him. There's an order in the youngster's chart noted at 2:30 p.m., which basically says, stripped the baby of clothes, retake the temperature in one hour and call Doctor Buganski. At 3:00 p.m., the one bili light is discontinued and that reflects the order of earlier in the morning at 11:00 saying to do that. At 3:23 the nurses note that the youngster is --- they've written nipples slowly. In other words --- my interpretation of that is that the youngster is taking time to take

formula, is being slow.

At 3:55 in the nurse's note the youngster's temperature is noted to be 99.8. Then the next nurse's note doesn't occur until 6:35 p.m. the same day. And this note reflects the fact that the youngster had been taken out to the mother. And the mother state that the baby had arched his back, had stiffened the extremities while they were trying to feed the youngster, that there was some cyanosis of the youngster's hands and mouth and he was having difficulty breathing and the baby was returned to the nursery.

At 6:40, the nurse's note says that the youngster's color was cyanotic, especially around his lips and that the youngster was suctioned. At 6:45, the nurse's note that the youngster's color was improving with oxygen. And at 6:50, it was noted the youngster's color was pink.

At 7:00 p.m., Doctor Buganski

is called about a bilirubin level. At 9:00 p.m., there's a nurse's note that Doctor Buganski is called to be told about the 6:40 p.m. episode that had occurred earlier that evening. The business of the youngster arching back, stiffening and being cyanotic. There is an order given at that time I assume by Doctor Buganski over the phone that the phototherapy was continued to 3:00 a.m. the morning of the 24th of March and then the bili lights would be discontinued.

BY ATTORNEY BAER:

Q. Okay.

A. On the 24th of March, there is a 12:20 'a.m. note that the youngster had a fair suck, the youngster was noted to be pale, cyanotic and to have a distended abdomen. At 2:15 a.m., a nurse's note that the youngster had a high pitched cry, arms were rigid, had circumoral cyanosis, was flaccid, oxygen was given and that the NICU people were

notified.

At 2:30 there's a progress note written by I believe a house officer for Toledo Hospital that had came down to see the youngster. And basically, summarized what all had been happening. I think it's a male physician. And he had been called because of the fact that this youngster had had this arched back, respiratory problems. Now, I guess he's referring to the 6:30 episode in that, despite the temperature on 3/23 was under double phototherapy and a blanket. When these were removed the temperature became normal, supposedly.

At 6:00 p.m. on he 23rd, he had this episode supposedly while feeding. And the house officer at that point felt that the youngster could very well, I guess, be septic and so cultured the youngster and started the youngster on a couple antibiotics, however, was unable to

do a spinal tap on the child because of abdominal distention. His note saying that he wasn't able to bend the youngster over raised the question that the youngster might be having seizures. And that the youngster was transferred at that point to the NICU.

There's a 2:30 nurse's note that basically recapitulates what we just said that Doctor Buganski had been notified of this event. The next series of notes basically deal with the youngster receiving antibiotics, having various blood work done. Ultimately though, it is determined at 10:30 p.m. on the 24th, that indeed the youngster has --- I'll take that back there was a urine --- here it is. At 10:00 a.m. on the 23rd, a urine test done for group B strep antigen was positive, which indicated that the most likely cause that the youngster was septic was, in fact, the most likely organism was a

did you have any standing orders for your nursing staff in terms of when you were to be contacted about an elevated temperature?

A. I believe we did.

Q. Do you recall what that was in 1995?

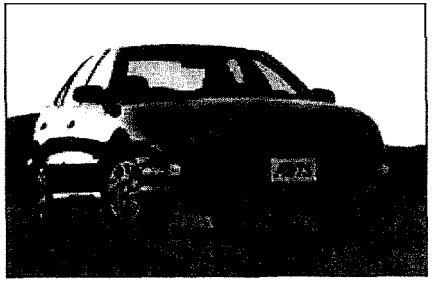
A. Yeah. Basically, we wanted to be contacted with any temperature elevation, axillary temperature elevation, axillary temperature reading of 99 degrees Fahrenheit or above. Most nurseries had moved away from taking rectal temperatures and so they were basically using the axillary temps.

Q. And why was it that that was the standing order at that time?

A. Because with any newborn, the signs of sepsis can be very, very subtle. The signs of infection can be very subtle. Obviously one of the first things that may tell you that there is something going on is a change in the youngster's

to that?
A. Yeah, that's been my experience.
Q. Would it be of any concern if the child's temperature took a rapid fluxuation?
A. I don't understand the question.
Q. Sure. It went from being 99 axillary to all of a sudden dropping to 98, 97.5 in a very short period of time.
A. Because we had changed the room temperature or something like that?
Q. Assuming we were correcting environm'ental factors, would it have been a concern over a very sudden change in temperature or would that be expected in your experience?
A. That's what you're after. I mean, you want to see if indeed the temperature elevation that you've noted is a function of the environment, therefore, by changing

would it be reasonable for the nurses to then contact you directly?
A. Possibly. It would be a function of what we knew about the mother. Okay. Sometimes we deal with crazy mothers.
Q. Sure. Because what we have is a symptom reported by mother; correct?
A. Exactly.
Q. Okay.
A. Would you let me finish?
Q. Sure. Absolutely.
A. But we also then have very well put together moms and moms who have had other kids and are veterans at this 'sort of thing. And so if I had a mom, as we have in this case, who's at least one other kid, who appears, I have no evidence that Mrs. Stalma had any psychological or emotional problems, that seemed to me a fairly well intact mom, that that happens. If you're saying that episode in and of itself?



MapQuest Results – Driving Directions USA

Directions	Mileage
Start out going East on LEXINGTON AVE towards GERAULT RD.	0 miles (0 km)
Turn RIGHT onto GERAULT RD.	1.6 miles (2.6 km)
Turn LEFT onto FM 2499 S.	0.2 miles (0.3 km)
FM 2499 S becomes GRAPEVINE MILLS PKWY.	1.2 miles (1.9 km)
Take the TX-121 S ramp towards D/FW AIRPORT/FT WORTH.	0.5 miles (0.9 km)
Merge onto TX-121 S.	1.7 miles (2.8 km)
Take INTERNATIONAL PKWY S towards D/FW AIRPORT:	0.3 miles (0.5 km)
Take the TX-114 E exit towards DALLAS.	0.3 miles (0.5 km)
Merge onto TX-114 E.	10.8 miles (17.4 km)
Take TX-183 E.	2.5 miles (4.1 km)
Take I-35E S.	4 miles (6.4 kin)
Take the I-45/US-75 exit towards HOUSTON.	0.6 miles (1 km)
Merge onto WOODALL RODGERS FRWY E.	0.5 miles (0.8 km)

Take the PEARL ST exit.	0.2 miles (0.3 km)
Stay straight to go onto N PEARL ST.	0.5 miles *(0.8* km)
Turn RIGHT onto N PEARL EXWY.	0.1 miles (0.1 km)
Turn LEFT onto PACIFIC AVE.	*0.3* miles (0.5 km)
PACIFIC AVE becomes GASTON AVE.	0.4 miles (0.7 km)
Turn RIGHT onto N HALL ST.	0.2 miles *(0.3* km)
Turn LEFT onto WORTH ST.	0.2 miles (0.3 km)
Total Distance:	26.1 miles (42 km)
Estimated Time:	0 hours, *38* minutes

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ORIGINAL

IN THE COURT OF COMMON PLEAS

LUCAS COUNTY, **OHIO**

JOSEPH STALMA, a minor,
by and through his mother and :
natural guardian, Norma Stalma, :

Plaintiff,

-vs- : Case No. CI99-1762

TOLEDO HOSPITAL, : JUDGE LANZINGER

Defendant.

- - -

Deposition of WENDY **ZETTEL,** a Witness herein, called by the Plaintiff for Cross-examination under the Ohio Rules **of** Civil Procedure, taken before me, the undersigned, Kristie L. Birch, a Notary Public in and for the State of Ohio, pursuant to agreement and stipulations of Counsel as hereinafter set forth at Toledo Hospital Education Center, Room G, Toledo, Ohio, on Thursday, March 30, 2000, at 1:06 o'clock p.m.

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- - -

October of '89 probably.

Q Okay. And why did you ultimately leave Riverside?

A Well, I lived in Perrysburg and we moved out to Wauseon and to get from Wauseon to Riverside is a good entire hour drive and so Toledo was closer. Ideally I would have gone to St. Luke's but they didn't have an OB department at that point, **so** --

To let you know too, January '89 to April of '98 I did lamaze class, like a childbirth educator out to Fulton County Health Services.

Q Your medical teaching experience, what did that involve?

A Basically it was just a good med/surg floor. I mean, we termed it kind of the floor from the other side of the earth, it was terrible. You had ventilator cases, you had diabetic people who went bad on you, seemed like we coded a person every shift that we worked. It was a terrible -- real intense.

Q When you talk about medical teaching are *you* referring to teaching patients?

A Residents.

Q Teaching residents?

A Right.

ongoing training program or procedures that they followed for the nursing staff and the newborn baby nursery?

A Every year.

Q What did you do every year for training purposes?

A You had to go through CPR for adults, children, infants. And we had a separate CPR training that we did for our unit that was a little different than what the Red Cross said to do for CPR.

Q Okay. And besides the yearly CPR training was there any other annual --

A We went over things like the normal vital signs, medications that were commonly used in our department, like fire safety, things you do in emergency, like for tornadoes or bomb threats. We still do it, it's the same standard kind of training. And you spend like the whole, they set you up to be there like from 8:00 to 4:00. It was an all day thing that we all did every year.

I always thought it was good because it kept you on the ball about what to do, so --

Q Did you have any, what I refer to as in-service training where you would have meetings with an instructor and you sit down for a period of time and the instructor would go over current medical technology or explain to

A Correct.

Q And would that assessment of vital signs include an assessment of temperature?

A Correct.

Q Would it include an assessment **of** blood pressure?

A No, not on a newborn.

Q Would it include an assessment of respirations?

A Uh-huh, yes.

Q And how is that performed?

A Basically we would, you know, you had to have a second hand either on your watch or the clock and count them for 30 seconds and multiply by two or you could do it the whole minute, either one.

Q I asked you earlier whether the vitals had to be done at the beginning of the shift and you said it did not. Was there a certain time that you were supposed to perform the assessment of vitals during the eight hour shift? Could it be anywhere from the beginning of the shift to the end of the shift?

A Right, just so it was done one time during.

Q And let me ask you with regard to children undergoing phototherapy, was there a practice that you followed for assessing vitals on those children?

down to just one blanket, I mean, things like that. Then we recheck the temperature --

Q Okay.

A -- some time that shift at least to make sure that it came back down or if you called the doctor and they said, I mean, you told them the temp and they said well, do these things and recheck it in an hour, whatever their order was then you did it however they told you to do it.

Q Okay. And with regard to contacting the doctor upon finding an elevated temperature, did you understand in 1991 that the doctors had different temperatures that they wanted to be called at or -- I'm asking that question poorly but did doctors have a different temperature that they set as being one high enough for which you should call them?

MS. BAER: Did you get that?

A I mean, there were standing orders if that's what you're talking about.

Q Yes.

A There were standing orders that they had. Each different? They had them down in standing orders, whether they were all different I'm not sure. But I know if it was 100 or more you always notified anybody, so --

Q And if you failed to do that would you agree that that would not be a safe practice?

MS. BAER: Objection.

Do you want to know which particular physician they should be contacting?

A That's what I don't understand.

Q Let's say **Dr.** Buganski's standing order requires that he be contacted if the child's temperature is recorded at 99 or above. And would you agree with me that if, in fact, the temperature was noted at 99 or above that it would not be a prudent or cautious practice to fail to contact **Dr.** Buganski and let him know about that?

A We would just notify them.

Q Okay. *And* would you agree that it would not be a safe or cautious thing to do to fail to notify them under those circumstances?

A Right, if that's their order that's what you did

Q Okay. And with regard to the temperature taking of newborns, was it the practice to do that axillary as opposed to rectal?

A We did them axillary.

A Yes.
Q Is it important to recognize sepsis early?
A If you can. If you can do it.
Q Is it important to recognize meningitis early?
A Yes, if you can do that too.
Q Do you agree that signs of sepsis can be subtle?
A I could say yes and no to that one. Sometimes you can get symptoms that are subtle that don't lead to anything near meningitis, sepsis or meningitis that any baby would have, but once they are septic they're sick and they get bad quickly
Q Okay. Would you agree that temperature elevation above 99 degrees is unusual in a child less than 48 hours of age?
A I, mean, it's elevated but again you have to look at what's going on in the room, are they under three blankets, has it been with its mother under a bunch of covers. But it can be an indication of sepsis.
Q Would you agree that early detection of sepsis offers the best chance for optimal outcome?
MS. BAER: Objection. Go ahead,
A Like I said yes, if you can detect it.
Q And would you agree that failure to detect

A Jaundice wouldn't necessarily have to go along with sepsis.

Q Okay. Pallor?

A Yes.

Q Grunting or flaring?

A Yes.

Q Hypoglycemia?

A Yes.

Q Blood pressure instability?

A That one's hard. We just didn't do the blood pressure, so --

Should have been - SOC

Q Hypotonia?

A It could potentially go along with it, yeah.

Q And hypertonia?

A Yes, that could go along with it, too.

Q And would you agree that the child need not have all of these signs in order to be symptomatic for sepsis?

A Right, correct

Q And would you agree that there's not one particular sign that the child must have in order to be deemed symptomatic for sepsis?

A Yes.

Q In 1991 were you aware of or were you made aware of a higher than usual rate of meningitis or sepsis in

around the lips?

A It could have been. It would have been around the lips and probably like the fingers or the hands.

Q And is that an unusual finding in an infant?

A No, not an infant that's choking because their airway's obstructed.

Q Would obstruction of the airway for five minutes, would that be a matter that is of concern?

A I mean, if it was complete obstruction it would be a concern. A partial obstruction no, because they'd still be getting some oxygen.

Q Is the administration of 02, is that something that normally would be done by doctors order as opposed to a matter of nursing judgment?

A Could be either one.

Q When you DeLee a child how far is the tube placed into the airway?

would make anyone choke

A For this? For this to the back of the throat.

Q How long in your judgment would it be appropriate to allow a newborn to remain cyanotic before you would contact the attending pediatrician?

A I'm not -- do you mean like completely cyanotic, the whole body or around the lips and the --

Q Let's take the acrocyanosis and circumoral

cyanosis.

A I mean, just two or three minutes.

Q Okay.

A You're going to be doing something in that period of time if the child's not responding after two or three minutes of oxygen and suction you would be calling someone or like a neonatologist or someone to come in and take a look at the baby.

Q Okay. So after a couple minutes of acrocyanosis and circumoral cyanosis it would be appropriate to contact the attending pediatrician or a neonatologist?

A If they didn't respond. This child responded, that's why we didn't, that's why I didn't call anyone, he turned around on what we were doing for him at that time.

Q Let me just see this one more time, I'm sorry, I'm just going to mark these times down here. Thanks.

Okay. We've identified your signature under the shift notation lower left-hand corner and we identified your handwriting from 18:40 to 18:50. From the lower right-hand corner where patient goals, outcome and progress are charted, are any of those items your handwriting?

A No.

Q And during the lunch or dinner breaks is the

A And then over here down in the lower right.

Q And in 1991 was it the practice that once phototherapy was started that it was continued continuously without interruption from the beginning of the phototherapy until where it's charted that it's ended?

A No. Yes, it would be but no, the only time you would take it out, the child out of it, you know, out from underneath the lights would be for a bath or feedings, the baby to go -- normally they went directly out to mom for a feeding and the parents were told as soon as you're done with the feeding we need the baby back underneath the light.

Q And in 1991 was it the practice to generally use one phototherapy light and sometimes two?

A Right, that would be correct.

Q Okay. Are you aware of any circumstances where three or four lights were used?

A No. Sometimes you have, you have more than one, not directly directed at that child, one or two but then like usually put them in one corner of the nursery so you may only have one, one baby but you may have two or three or four or whatever that are all lined up. So you might have, I'm sure there's some overlapping of the light onto

that baby just from the other babies

Q Okay.

MR. KULWICKI: I think I'm done.

Q Is it standard practice when a baby comes under an RN's care in the newborn nursery that the RN will read the notes that are recorded prior to the nurse taking over care of that child?

MS. BAER: Objection. Go ahead.

A No, not -- no. Mostly you get report, so no, we didn't always go back and read. You just couldn't. We didn't normal do that.

Q Okay.

MR. KULWICKI: That's all the questions I have. Attorney Baer will advise you regarding your rights to signature.

MS. BAER: If the transcript is typed up before it goes in final form it can be sent to you to review it for spelling errors, typographical errors, things of that nature. If that's something you'd like to do I suggest you do it to

ORIGINAL

IN THE COURT OF COMMON PLEAS

LUCAS COUNTY, OHIO

JOSEPH STALMA, a minor, by and through his mother and natural guardian, Norma Stalma,	:	
Plaintiff,	:	
-vs-	:	Case No. CI99-1762
TOLEDO HOSPITAL,	:	JUDGE LANZINGER
Defendant.	:	

- - -

Deposition of **NANCY BROTHERS,** a Witness herein, called by the Plaintiff for Cross-examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Kristie L. Birch, a Notary Public in and for the State of Ohio, pursuant to agreement and stipulations of Counsel as hereinafter set forth at Toledo Hospital Education Center, Room G, Toledo, Ohio, on Thursday, March 30, 2000, at 3:02 o'clock p.m.

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- - -

A Correct, uh-huh.
Q And the vitals that you recorded at 15:55, does the temperature appear to be elevated?
A Slightly, yes.
Q And what about the pulse or respirations, do those appear to be within normal limits?
A Yes.
Q Did you report the slightly elevated temperature to the child's attending physician?
A No, the nurses aids do not call physicians.
Q Did you report the elevated temperature to either of the RNs that were on duty?
A That **would** have been standard procedure.
Q Okay. Is that charted anywhere?
A That I would report it to her?
Q Yes.
A No.
Q Do you, sitting here today do you know which one of the two nurses you would have reported that information to?
A I have no idea which one
Q Do you have any notes or an affidavit that would contain any information about the care of this particular patient that's not part of the medical chart?

allowed to contact the doctors; is that right?

A Correct.

Q And where did that directive or order come from? Was that something that you were trained in the course of learning how to do your duties as a nurse assistant or was it a standing order or where did that come from?

A That's just a hospital policy because nursing assistants can't take orders from a physician, so --

Q Okay. Now, let me just ask you hypothetically if you reported something to an RN and she, or LPN Class Two and she refused to report something that you thought was significant or forgot to or failed to report something that you thought was significant to the attending pediatrician, was there something that you were trained to do in that event? Was there someone else that you should contact or some other way that you should communicate that information?

A Would most likely talk to my supervisor.

Q Okay. In 1991 did you understand that meningitis is a potentially life-threatening condition?

MS. BAER: Objection.

A Yes.

Q And sepsis is a potentially life-threatening condition?

A One per eight hour shift with vitals every four.

Q And my understanding is that the vitals were routinely tested TPR or the temperature, pulse and respirations, correct?

A Uh-huh, correct.

Q It was not standard practice to test the child's blood pressure, correct, during routine assessments?

A No. That would not have been one of my duties anyways, that would -- if it would have been ordered it would have been done by the RN.

Q Okay.

MR. KULWICKI: I think I'm done but why don't we go off the record for a second

- - -

Whereupon, a break was taken off the record.

- - -

MR. KULWICKI: Let me go back on real quickly.

Q Do you know by any chance Nurse Linda Johnson or Lauren Talb?

A I know of Linda Johnson, yes.

Q Do you have any idea where she is currently?

A No idea.

ORIGINAL

IN THE COURT OF COMMON PLEAS

LUCAS COUNTY, OHIO

JOSEPH STALMA, a minor,
by and through his mother and
natural guardian, Norma Stalma,

Plaintiff,

-vs-

Case No. CI99-1762

TOLEDO HOSPITAL,

JUDGE LANZINGER

Defendant.

- - -

Deposition of **DIANE MCKEE,** a Witness herein, called by the Plaintiff for Cross-examination under the Ohio Rules *of* Civil Procedure, taken before me, the undersigned, Kristie L. Birch, a Notary Public in and for the State of Ohio, pursuant to agreement and stipulations of Counsel as hereinafter set forth at Toledo Hospital Education Center, Room G, Toledo, Ohio, on Thursday, March 30, 2000, at 2:11 o'clock p.m.

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- - -

Q Let me stop you and let's go to the first page of Plaintiff's Exhibit 2 and I think you indicated at 700 hours that's your note?

A Yes.

Q Okay. And what did you chart at 700 hours?

A Well, it was a bilirubin that was drawn at 700 hours.

Q Okay.

A And I did not write anything down as to what time I called it to Dr. Gladieux, but I did call it to Dr. Gladieux. And they usually came up, we got results like between 9:00 and 10:00, but I did not put a notation down as to what time.

Q Okay. And is this the only note contained on page one of Plaintiff's Exhibit 2 that you made?

A Well, 13:00 bili is my writing but I would not swear to the 5.9.

Q Okay. Now, it's my understanding that it was your practice of the nursing staff back in March of 1991 to report bili results to the attending physicians whether they are elevated or not, correct?

A Yes.

Q And was Dr. Gladieux in 1991, do you know if he was a resident or was he an attending at the time?

Q Okay. And then this note here of temperature at 5:00 a.m. on the 23rd would be after your shift or -- no, before your shift began, correct?

A No, it starts --

Q Your shift ended at 3:00 o'clock on the 22nd, right?

A Well, I don't know about that.

MS. BAER: Yes.

A Yes.

Q Okay. All right,

A I mean, we start at the top and work to the bottom, we don't -- mine's the first name because I was there at 7:00 a.m. in the morning and the rest of the day went through until 7:00 a.m. the next day when I got a new sheet of paper to start.

Q Gotcha, okay. Let's turn to page three of Plaintiff's Exhibit 2. Is your handwriting anywhere on that document?

A Yes. The 07:00 bilirubin or bili, 7.2 call to Dr. Buganski, and that's my little D behind it. That's the only thing on that page that is my writing.

Q Okay. And then let's go to page four. Any notes on there yours?

A 07:00 Dr. Buganski observed baby with update by

nurse.

MS. BAER: I'm sorry, is that 07:00 or 07:30?

THE WITNESS: I'm sorry, 07:30. I guess I should put my glasses on.

A By nurse D. McKee, RN. With that I'm not saying that I was the nurse that updated him.

Q Okay.

A Which because I can't remember about this baby, I cannot swear to that.

Q And then at --

A 14:30.

Q -- 14:30 that would be your signature as well?

A Yes.

Q Can you tell me what you charted at that time?

A Dr. Buganski notified of increased temp, orders received, D. McKee. 15:00 then one light, in parentheses, bili, discontinued D. McKee.

Q Okay. So according to your note at 14:30 Dr. Buganski was notified by yourself about an increased temperature?

A Yes.

Q Okay. Where would it be recorded by Dr. Buganski, in the physicians orders or progress notes that

and the respirations?

A Once a shift.

Q Okay. But you would record all three of those items, correct?

A Once a shift.

Q Okay. And where it says four lights next to, is that your handwriting?

A I'm not positive. Looks like it might be but I would not swear to it.

Q Okay. Recognizing that it may or may not be your handwriting, do you know what that means?

A This baby had two lights on him, bilirubin lights. I am assuming that there were babies next to him that had a bilirubin light above them so that there were four lights in the same vicinity.

Q Okay.

A As in next to.

Q Now, there are some temperatures or some other notes crossed out in the vitals, and again I ask, do you recognize that handwriting as your own?

A No, that's not mine,

Q Besides yourself who was working during that shift?

A Well, the only name I see here is Mills and I

pressure or assess the blood pressure back in 1991, correct?

A Not unless it was ordered, no.

Q Did that change after 1991?

MS. BAER: Objection.

A Not as a general rule.

Q Okay.

A They had to be ordered specifically.

Q And it's my understanding that the vitals or the temperature was taken axillary as opposed to rectally, correct?

A Absolutely.

Q Okay. In the right-hand corner box where it says patient goals, outcomes and progress, are there any notations by yourself in that area?

A The only notation that's mine is upon discharge planning progress see mother's chart.

Q Okay. It appears from the vitals that the first time that there was an elevated temperature noted was at least on March 23rd -- strike that.

During your shift it appears that the first time that the child's temperature is noted as being elevated is at 14:00 hours, correct?

A That's what it says.

A Yes.

Q And if Dr. Buganski's group had posted a standing order that temperature over, at 99 or above should be reported to him -- first of all, does that refresh your recollection that that was Dr. Buganski's groups standing order in 1991?

A I can't say, but it's written here so I assume it was but there's no date on this paper.

Q If that was their standing order in 1991 would you agree that it would be prudent and reasonable to follow and comply with that standard? In other words, report to Dr. Buganski that a temperature was at 99 or above?

A Yes. But if it were coming down I don't know that I would call him every temperature that we took as long as we were making progress in a decreased temp. If it went up further, yes, I would have called him no matter what.

Q Well, would you agree that elevated temperature can be a sign of sepsis?

A Depends on the circumstances but yes, it could be.

Q Let me have you turn to the last page of Plaintiff's Exhibit 2, page five of Exhibit 2. Is any of

that your handwriting?

A No.

Q And what is your basis for deciding if the child's temperature was coming down as you say but remained above 99 that it was not necessary to contact the attending physician?

MS. BAER: Objection. I'm not sure that's what she said earlier but go ahead.

A I would probably be more concerned if the temperature dropped from 100.6 down to 98.6 within the next hour. They come down gradually and that's --

Q Okay. Let me have you turn back to page three of Plaintiff's Exhibit 2. During your eight hour shift from 7:00 to 3:00 is there a -- strike that.

I got confused because Mills name changed to Cline and now I remember that Mills is Cline.

MS. BAER: She was Mills then.

MR. KULWICKI: That's right, okay.

MS. BAER: Amy Mills.

Q Okay, strike that question.

I may have asked you this and I apologize, when

a child was under phototherapy was it the standard practice to perform two assessments of vitals during the eight hour shift?

A Temperature was checked twice during the shift.

Q Okay.

A It was not policy to do the pulse and respirations more than once a shift.

Q And to clarify, was it the policy to do the temperature check every four hours?

A Hopefully.

Q While the child's under phototherapy, right? You understand that I meant while the child's under phototherapy?

A (Indicating.)

Q Yes? You have to verbalize so she can get it down.

A Yes.

Q What was the condition of your health in 1991, fine?

A Good.

Q Have you ever had your deposition taken before? That's what this is.

A No.

Q Is there somewhere in Plaintiff's Exhibit 2

A Not necessarily talk to the doctor, there might be I told the nurse, the nurse talked to the doctor, the nurse talked to me.

Q Looking again at Plaintiff's Exhibit 2 at page four, the notes that you charted at 7:30, 14:30 and 15:00. Does it appear that you contacted or spoke with Dr. Buganski only two times during your shift at 7:30 and at 14:30?

A As I said before Dr. Buganski was updated by a nurse, not necessarily myself, Dr. Buganski was notified of the elevated temp, not necessarily by my voice *to* voice to him.

Q Okay. And that was at 14:30?

A That's what it says.

Q booking at the records do you see when the next time that Dr. Buganski was contacted?

MS. BAER: Objection. *Go* ahead. You may go ahead.

A 21:00.

Q Okay. Do you know the Stalma family by any chance?

A Not at all.

Q After the lawsuit was filed did you talk to any members of the Stalma family?

ORIGINAL

IN THE COURT OF COMMON PLEAS

LUCAS COUNTY, OHIO

JOSEPH STALMA, a minor,
by and through his mother and natural guardian, Norma Stalma,

Plaintiff,

-vs- : Case No. CI99-1762

TOLEDO HOSPITAL, : JUDGE LANZINGER

Defendant.

- - -

Deposition of **LUCINDA J. OSTERHOUT**, a Witness herein, called by the Plaintiff for . Cross-examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Kristie L. Birch, a Notary Public in and for the State of Ohio, pursuant to agreement and stipulations of Counsel as hereinafter set forth at Toledo Hospital Education Center, Room G, Toledo, Ohio, on Thursday, March 30, 2000, at 9:33 o'clock p.m.

CLASSIC REPORTING SERVICE
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405 Madison Avenue
Toledo, Ohio **43604**
(419) 243-1919

- - -

Q Well, first of all on page three of Plaintiff's Exhibit 2 are there any notations that were recorded by yourself?

A Yes.

Q Okay. There's an assessment time listed there. Under what assessment time are your initials?

A My initials are under the assessment time of 15:55.

Q Okay.

A I did not complete the assessment, that was done by the nurses care assistant working with me. My initials appear under circumcision to knowledge yes, she had done the assessment for redness and edema. And then on the far right-hand column under treatments.

Q Let me stop you for a second. Before we go on I see the notation to circumcision where it says yes, it looks like LO, that's your signature?

A That's my initials.

Q Okay. And the notation it looks like *AB?*

A NB, Nancy Brothers.

Q All right. Is there anything else that you recorded on page three of Plaintiff's Exhibit 2?

A Yes, 19:00 under the test and lab section, bili 8.0 called to Dr. Buganski, that is my handwriting.

opportunity to inform MD of baby's status re temp, feeding Ss, seizure-like activity, cyanosis

A Fourth page.

Q Fourth page. Are there any notes contained in the fourth page that were made by yourself?

A Under the feeding session at 15:15 I recorded the baby took one ounce of formula fairly well. Top left at 15:15, that's my handwriting.

Q Okay.

A At 18:30 three-fourths ounces of dex fed in nursery, that's my handwriting. At 22:30 the one ounce fairly well is not my handwriting but the parentheses mom fed in nursery, that is my handwriting.

Q Anything else on that page?

A Okay, I'll just move on. Um, 2100, Dr. Buganski notified of the above episode in the narrative section, that is my handwriting.

Q Hang on one second. Where is that at, under 2100?

A 2100 in the narrative notes.

Q Okay, gotcha.

A The care plan section below the narrative notes, my handwriting for 15 to 23 LO, the outcome, nipple slowly but retaining.

Q Let me stop you, I'm sorry, I was making a note here. After 2100 hours when is,--

shift that was the heaviest responsibility because the baby's fed enough, mother wanted to sleep and if there were 18 babies in the north nursery with an RN, two nurses assistants, RN, LPN and nursing assistant, it would depend on the number of babies. And so for an evening shift 18 babies in the north nursery, two people, RN and nurse assistant.

Q Okay. And I assume you don't have any independent recollection of what the staff was like on, like in 1991, in March of 1991?

A No.

Q Okay. Now, this note here on page three of Plaintiff's Exhibit 2 at 1900 hours where you note the bilirubin is at 8.0. First of all, how would you have determined the bilirubin, based on lab reports that are being posted?

A Right, the labs. The time of draw is 7:00 p.m., 1900 bili the lab would draw all the bilis, that was one of the standard draw times for anything a physician wanted, 7:00 o'clock was a prime time, 7A, 7P. They would draw the bilirubin, they would call results or the nurse would call them for results because you want to get your physicians notified. The normal practice for bilirubin from lab if they were drawn and 7 by the time

they were all finished 7:30, 7:40 the actual draw time. I'm speaking to both nurseries, all of the bilirubins are drawn and they were taken to the lab and run at 7:00. The normal report back time would be 8:30, 8:40 that you could get your bilirubin results. But the time of draw would have been, it was ordered for 7:00.

Q Okay. So the 7:00 o'clock reflects the time of draw?

A The time it was drawn.

Q Not the time it was reported?

A No, the time the lab was ordered.

Q Back in 1991 was there a standard protocol for when the attending pediatrician should be contacted based on the results of a bilirubin draw?

A There was no standing protocol. You would notify the physician of any lab draw unless they gave specifics, call me if temperature is below this or if above this start phototherapy. And that was up to each individual physicians preferences. But there was no standing. If there was nothing specified you would call each physician.

Q Gotcha. Now, this individual NB, you gave me here name and I forgot already.

A Nancy Brothers.

Q Was she an RN?

A She was a nursing care assistant.

Q Was it standard practice in 1991 to fill out the nursery daily flow sheet completely either by the RN or the nursing care assistant?

A No.

Q Okay.

A There were certain criteria that were necessary and it's different. If a nursing care assistant did an assessment she couldn't do a higher skill, there were respiratory muscle tone, mucous membrane, there were expectations, I probably cannot quote you every specific one right this minute. But all of the perimeters are there if the nurse chose.

Now, normal, when the baby would first come to the nursery an RN would do the initial assessment when it comes from the admission nursery as it was called at the time and then that would be a more extensive assessment and was a detailed assessment. You're verifying everything is A-Okay.

After that point in time there were basic criteria that were required and if you didn't do the assessment, for example, this is a nursing care assistant with my shift did the assessment and if there was nothing

significant or reportable there would be no reason for the RN to go back in. The only time I would go back in is if I saw something negative and wanted to reference it and then I would enter a different assessment time.

Q Okay.

A ***So*** it's used more for the nurse to have all the perimeters she would need to use without narrative detail. Nursery documentation was very simple, was very basic, was very minimal because they were normal newborns.

Q Okay.

A But you had the perimeters there should you need to document further.

Q On page four of Plaintiff's Exhibit 2 where you've charted the child's feeding from 15:15 through 22:30, would you consider that to be normal intake?

A Yes.

Q What in 1991 would you consider to be the perimeters for normal intake for a newborn?

A A newborn's first day is very rough, a lot of them are soupy, mucousy, they spit up a lot. Your expectations if you can get a half ounce to an ounce down. Usually what we teach mothers in the general practice as nurses expect an ounce the first one to two

recollection of this case but I would be confident in saying the fact that it's not my documentation or able to speak to this issue here, I was not on the nursing unit at the time so when you're recording in the intake and output column normal practice in the nursery the babies would have a clipboard and it was **the** responsibility of whoever picked **up** the documentation and wrote it, they're writing what they read off of a flow sheet.

So I have recorded the baby took three ounces of dex just to record the intake and output at that period of time.

why not investigate more fully why baby received Dex

Q That would have been --

A That wouldn't have meant that I fed that infant. The documentation here does not reflect that. It will be whoever has picked up and recorded off of a flow sheet unless there was something reportable.

Q What are reasons or were reasons in 1991 for the nursing staff to feed a child dex, I don't even know the proper term, is it dextrose?

A Dextrose water. There could be several. There could be several, many, many, many.

Q Okay. What were some common reasons?

A Breast-fed babies, which it doesn't appear that this was a breast-fed baby. Breast-fed babies would get

dextrose water if they were soupy, mucousy rather than the formula.

Q When you say soupy?

A Gagging, spitting, if they had some mucous.

Q Gotcha. Any other reasons that tome to mind? And I don't want to hold you to a set list.

A No, I can only just give -- there are several. Sometimes to help ensure when a baby's under phototherapy just to give him the extra supplement sometimes physicians will order it but not even -- sometimes a nurse will opt to if they seem soupy or gagging with a feeding of formula or have spit, they'll give them water just to see the nipple and how they suck. Just a matter of preference. I cannot speak to why the baby was given water.

RN should know the reason — should investigate

Sometimes another illustration, if the mother was off the unit for a tubal ligation, not feeling well herself or whatever was going on with the mother, they would say would you feed the baby in the nursery and we give the baby, could be formula, it could be formula. If it was a formula, if it was a breast baby definitely it would just be a dextrose water. Different perimeters for each.

Q You mentioned dinner break. When you normally

took a dinner break in 1991 is there a standard time you would take, a half hour or an hour or did it vary?

A Normal was, that particular shift was 45 minutes because you're allowed two breaks and a lunch period, most people took both of them together and then we take a break later in the evening, a short break later. Normally 45 minutes.

Q Now, the note that appears at 18:40 on the right-hand column there appears to be signed by D Lee. Do you see that or does that reference a Dr. Lee, I guess?

A No, DeLee is a mucous trap, a suction where you would put like a straw tube to the baby. That's a piece of equipment. The nurse who made that documentation appears to be Wendy Zettel.

Q Okay. Now, going back to the feedings, you use the terminology in your first note fairly well and then I think you told me that the third note there at 22:30 the fairly well was actually charted by someone else, correct?

A Uh-huh.

Q When you say fairly well what do you mean by that?

A It could mean different things as well. Were

BINGO!
Must describe this baby

A Point me, I'm sorry.

MS. BAER: I'm sorry, was the question whether these categories would equate to her definition of fairly well in any way?

MR. KULWICKI: Correct, yeah.

A Um, that would correlate, I mean, the description where you're saying **good**, fair or poor would correlate the quality of the baby's suck. Assessments being done, not particularly addressed here but when someone is completing assessments when they're not feeding an infant **or** that, it's what you observe part at that time. But if you're asking to these words am I correlating what we would count on the other side, yes, yes.

Q .Okay. So on page three here where you have the term fair for suck and you **use** the term fairly well, is that the equivalent of fairly well to fair suck?

MS. BAER: Objection. *Go* ahead.

A Fair suck would be fair, fairly well, went a little better than fair, fairly well. I don't know how to be more clear.

Q I'm just trying to understand your terminology.

A Okay.

Q Okay. What were the -- were there protocols in 1991 for when a baby's temperature should be assessed how often in the nursery?

A I don't know if there were. I can get you a written protocol. Babies were assessed every eight hours other than a baby under phototherapy would require every four hours simply because their body's exposed.

Charting does not reflect 4° assessment

Q Okay. And how were the temperatures recorded in 1991 in the nursery, done axillary or rectal?

A Axillary.

Q Okay. And what type of instrumentation was used to record temperatures in 1991? What type of monitor, temperature monitor, standard mercury-based thermometer --

A Um --

Q -- or electronic?

A Yeah, I've been out of the clinical field but where you have a probe, digital and you put a cover on it, use it, it beeps when it is finished. I think they were called IVAC, the company that would make them.

Q Okay. In 1991 were there protocols in place or standing orders in place for when you should contact the attending pediatrician relative to a newborn in the

newborn nursery?

A No. To have a specific protocol, standing, standing guideline, temperatures above 100 would be reportable but then other pediatricians you could have specific requests by different pediatricians. You're working with a versified group of people.

So in a normal newborn nursery you would have very, very basic minimal standing procedures because different physicians preferred it different ways. It was very hard to have a standard when you're dealing with different groups. So any nursing judgment besides temperatures, feeding difficulties, problems, anything significantly reportable.

Q Let me hand you what we've marked as Plaintiff's Exhibit 8. Why don't you take a look at that. Have you seen that document before?

A This particular one I'm aware that that was a way nurses were trying to get guidelines. Some physicians didn't want dex for their babies and others wanted you to give them dextrose regardless. And this was to try to get some kind of reference for nurses to use and not offend anyone.

Q Do you remember these, these forms for the various pediatricians, prepared and on hand in 1991?

A Yes, in ,newborns. Yes, anyone.
Q All this refers to newborns.
A Okay.
Q Is it important to recognize sepsis early?
A Yes.
Q Is it important to recognize meningitis early?
A Yes.
Q The signs of sepsis can be subtle, correct?
A Actually my professional expertise I don't think they're subtle at all. Having the years of experience in the nursery I think what you're dealing with are babies not able to localize an infection like an adult, so when an infant has sepsis, by the time they exhibit symptoms from the time they become acutely critically ill is a short time span. It's not something that gradually precipitates. In the best of my expert opinion when you see a baby become mottled and a baby become ill with some of those adverse signs and symptoms; not feeding, general mottling, lethargy, there's a whole vast perimeters.
Q I'm going to go through that in a sec.
A Not one specific symptom.
Q I'm going to get that.
A By the time they do that you have a --
Q I think you answered the question, you don't

consider that to be subtle?

A It's not a slow developing --

Q Okay. Would you agree that elevated temperature in the first 48 hours of life is unusual?

A Depends. No, I don't agree with that at all. There are too many perimeters that affect a baby's temperature. They aren't stable, that's why they're there for observation. Some babies need to be dressed less. A consistent temp would be significant but no, that's why baby's temps are checked. A mother can easily overdress an infant. Infants that have a little less round fat keeping them warn you need an extra blanket. You have hats for 24 hours. So no, I do not agree with that.

ANY temp elevation in a NB is UNusual.

Q ,Would you agree that a temperature elevation in the first 48 hours of life raises the index for suspicion, warrants closer evaluation of that child?

A You would want -- as a nurse I would want to recheck, re-evaluate the temperature and not ignore the fact. Whatever measures I have done in the assessment, if I have taken off an extra blanket because the mother put on two fuzzy blankets will make a difference. A thin warm blanket compared to a big fuzzy one will make a very big difference. So how they're swattled can make a

difference. I think the key is not ignore temperature and recheck the infant. & NOT just recheck temp - check INFANT

Q Would you agree that early detection of sepsis offers the best chance for optimal outcome?

A Yes.

Q And would you agree that the failure to detect sepsis early on puts the child at risk for morbid injury or death?

MS. BAER: Objection. Go ahead. Go ahead.

A Yes. But can I clarify?

Q Sure.

A I don't think there's a lot of, I think you have a narrow perimeter to determine it, it's not an early on From my years of expertise and I was a transport nurse and we were called many times to institutions and by the time it would take for them to recognize it and call you, you get there, intervene on that child, you have a very narrow margin, that child is very sick.

Q Would you agree that it's the duty **of** the nurse in the newborn nursery to perform periodic assessments and report any unusual or abnormal findings to the attending physician?

A Would you repeat that?

Q Would you agree that it's the duty of the nurse in the newborn nursery to perform periodic assessments of the patients and report any unusual or abnormal findings to the doctor?

A Yes, definitely.

Q Would you agree that the following are signs of sepsis. First poor feeding?

A I want to make sure I understand, each can be a symptom but it's not necessarily a symptom in itself?

Q Okay, that's perfectly, perfectly correct of you to ask for clarification.

A Okay.

Q Would you agree that each of the following signs can be signs of sepsis.

A Okay.

Q Poor feeding?

A Yes.

Q Weak suck?

A Yes.

Q Vomiting?

A It's not a significant, no.

Q Tachypnea?

A Yes.

Q Cyanosis?

A Yes.

Q Temperature instability?

A Yes.

Q Abnormal cry?

A Yes.

Q And what would you describe as an abnormal cry or how would you characterize an abnormal cry?

A An abnormal cry, a high pick shrill, shrieking cry. My first response if I heard that was to feel the fontanel to make sure there wasn't any increased cranial pressure. The relevance of the cry could indicate something else neurologically. That cry, that type of cry would be symptomatic.

Q Again, continuing with signs that can be signs of sepsis. Diarrhea?

A I would say perhaps. Diarrhea's more of a common, it's such a common symptom to anything and to actually be able to -- it's not the first thing I would look for or if I saw a child with diarrhea, sepsis is not the first thing I would think of immediately. I would want to go a step further because there is things, there's so many factors, feeding intolerances and formula intolerances it could be. It wouldn't be one of my focus points.

it should be

Q Decreased moro sign?
A Yes.
Q Floppiness?
A Yes.
Q Lethargy?
A Yes.
Q Jitteriness?
A Yes.
Q Apnea?
A Yes.
Q Irritability?
A Again, that would go with the cry and it would be reflex irritability, muscle tone, but yes.
Q Abdominal distention?
A Again, it wouldn't be my first question or my first suspect with that symptom would not go to sepsis. But it could be associated if the infant actually is in a generalized state of sepsis.
Q Petechia?
A Yes, I would not expect to see that in an -- I think that's more, perhaps a more significant symptom. I mean, as, as a professional, a baby with Petechia, I would trigger me as a nurse to say something really wrong other symptoms DICO, something significant going on if it

was related to sepsis.

Q Jaundice?

A Jaundice I would not -- it could be. If you're asking me could these be symptoms?

Q Yes.

A And that's the most you want me to answer?

Q Correct.

A Okay, could.

Q Pallor?

A Yes, definitely.

Q Grunting or flaring?

A Yes.

Q Hypoglycemia?

A Yes.

Q Blood pressure instability?

A Yes, definitely.

Q Hypotonia?

A Yes.

Q And you would agree with me that a newborn would not have to have all of these signs in order *to* be septic or have sepsis?

A Yes.

Q And you'd likewise agree with me that there's not one particular one of these signs that must be

present in order for the child to be symptomatic for sepsis, correct?

A Repeat that again.

Q There's not one particular one of these signs that must be present in order for the child to be symptomatic for sepsis?

A **No.** I hope I understand that correctly. We don't have specific -- if they're not palloris, if they're not apneic then they couldn't be septic, that's what you're asking?

Q We understand each other, yes.

A Okay, okay.

Q In 1991 were you aware of any higher than usual rate of GES infection, Group E strep infection in the NICU or nursery at Toledo Hospital?

A No.

Q Are you aware of that ever occurring'?

MS. BAER: Objection. Go ahead.

A No, I am not.

Q In 1991 what did you consider to be an elevated temperature?

A Over 100 degrees axillary. Over 99 degrees I would sort of assess the surroundings, do the blanket,

take one blanket off. Likewise, under 97.6 I would add a blanket or put a hat on. But again, each, each infant and each vital sign you had to assess the infant and the environment from which the infant came. Was the infant nestled with mother, like I prefaced before. Babies have a very difficult time during that transitional period, it takes them 48 hours to get their little thermostats but definitely 100 degrees at that point I would notify a physician.

Q Would you agree that axillary temperature differs from rectal temperature by approximately two degrees?

A Yes, definitely. That's why we would use 100, we would call a physician where on an adult patient perhaps not because we were doing it axillary temperature.

Q Are you critical of anyone relative to the care of this child?

A I don't understand.

Q Were you critical relative to care that any nurse or doctor provided to this child?

A Am I critical?

Q Critical in the sense that you criticize or you think they could have done a be'tter job or they failed to

hours, Dr. Buganski was notified of the above episode. What above episode are you referring to?

A What I'm referring to is what I see documented. I can only, like I said, I don't, I wouldn't have -- I have no recollection but I would not, if these two nurses were documenting on this infant as floor nurses, I was out of the nursery when the mother reported an episode I would say babies come into the nursery at 7:00 o'clock to 8:30 in the evening, that was the one time in the nursery by the negative I can only go on the negative, the lack of there isn't any additional documentation that the infant was pink and stable at that time in the nursery. 2100, notifying Dr. Buganski is simply baby has a 7:00 o'clock bilirubin. When I get my bili results I want to make sure that the doctor is aware of mother reported these symptoms. So I am letting him know my assessment, that since I've been in the nursery which would be negative that's all I can -- or there would be something more documented here if the baby had additional symptoms or problems while in the nursery or during visiting hours there would be more documented here. I'm very confident of that. So it is simply making him aware of this.

Q I'm not sure I followed you. The first question

result, called to report it to the physician and say I'd also like to let you know what transpired earlier, mother states the baby had this when she was feeding the baby. That would be the normal contact as I can go from the documentation here.

Q In your notation in the lower right-hand corner under progress where it says nipples slowly, what does that mean?

A Is not an enthusiastic f e e s . Isn't an aggressive eater, but does nipple and retains a feeding once they have nippled the feedings. So it's telling you that the baby is sucking and retaining feedings, but isn't over-aggressive.

Q Would that be the equivalent of weak suck?

A No. If it was a weak suck, having a weak suck to me or a poor suck would warrant this baby, you literally would massage them to help them eat and at that point considering would they need a gavage feeding. Poor suck, nipples slowly does not say anything negative, it simply says the baby is not an eager beaver sucker. They are the gourmet type, slow, slow feedings. Some babies will complete an ounce, ounce and a half in six to eight minutes, other babies it might take 15, doesn't mean they didn't eat, just means they nippled slowly.

Q Okay. In 1991 when you did phototherapy was there a standard that was followed with regard to the number of lights?

A Um, the number of lights used?

Q The number of bili lights that are used

A At that time to the best of my recollection, because there's so many changes in phototherapy and different things, we would use, I don't remember what they're called but a bili light and the trend was if the baby had a high bili an aggressive treatment you would use an additional two lights, one above and one under tilt the light down and shine it in

Q Were there ever times when you used four bili lights or three bili lights?

A Not on one infant. Not on one infant.

Q Okay. During 1991 were there efforts made to monitor the temperature of the ambient air when a child was receiving phototherapy in a bassinet?

A I don't understand ambient.

Q The air around the child in the bassinet.

A No.

Q There wasn't any temperature monitor placed inside the bassinet or inside the yellow sheets that you described earlier to try to confirm how warm the air

3

A Okay. No, there is not.

Q I may be wrong.

A There is not.

Q Let me hand you Plaintiff's Exhibit 7 which is a two page document, the health care plan. I assume you didn't record any notes on that as well but if will you please look and tell me if that's the case.

A No.

Q And going back to Plaintiff's Exhibit 2, I'm just about done here. Page four when you talk about at 2100 hours notifying Dr. Buganski as a courtesy to him. I'm not sure I fully understand that, what you mean by a courtesy to him, what sort of courtesy?

A It's a nurses responsibility and courtesy, I don't mean, I don't mean it in the sense of grace and cordiality. I mean it as a professional respect to the physician to keep him abreast of what's going on with this infant. And this is something that could be out of the normal circumstance, definitely not your normal circumstance. If I was not there to witness it I can only state to him, I have this information.

And again, I can't speak, I have no recollection of this child but what would be normal for me is anything that was going on, if the baby was having poor feedings

or was persistently vomiting or had coffee-ground mucous, even though they are normal during a transitional phase out of courtesy, professional courtesy you're talking to the physician you're going to keep him abreast and let him know.

Q Let me ask it a different way. **Don't** you think that the nurse, that this Nurse Johnson at 18:35 should have contacted the doctor at that time and reported these findings of arching the back and stiffening of the extremities, the cyanosis and the difficulty breathing? Don't you think that would have been proper procedure to notify the doctor immediately about those findings?

MS. BAER: Objection

A No, I do not. May I clarify? I mean **I** don't want to -- UNQUESTIONABLY

Q No, that's okay. Go ahead, you can.

A Truly mom stating something happened. There could be several things going on with an infant in a cyanotic state. You can become cyanotic just by swallowing down the wrong tube, choking on something. The symptoms as described, and truly, out of respect to, and with no criticism to the nurse at hand, if the nurse had observed it herself then the nurse would be obligated to call the physician and say this is happening because

she recognized there was some, whatever symptoms. When a mother would state that your next step would be keep a close watch on this baby because you don't negate what a mother has said, but a mother is not medically trained and sometimes the anxiety or the fear or for whatever reason isn't really -- when somebody describes I was bleeding, I'm sorry, I don't mean to be dramatic, I was bleeding and when you assess it as a professional it's a very small amount than the lay person would determine. You know, the mother would become frightened.

I do not necessarily think at that time the nurse had to call the physician. It would wsrrant let's watch this baby and see what happens and determine what it is, if there's something going on with this child, if it was a choking spell or what.

Q Well, let me ask you about five minutes later when the child continues to be cyanotic do you think at that point in time the nurse should have contacted the doctor and said we have a reported choking incident and five minutes later the child continues to be cyanotic?

MS. BAER: Objection.

A I can't speak to that documentation when I wasn't there. I have no knowledge what she means by cyanosis. I can't put words into her mouth and I know I

The Toledo Hospital
The Reuben Center for Women and Children
NEWBORN ADMISSION ASSESSMENT

0000054137 45
MRN 0000056672 8
STALMA, BABY BOY
TORSEKAR; K P
TORSEKAR, K P
03/21/91 SEX COD
ADDRESSOGRAPH STAMP

ADMISSION NOTES
WEIGHT: 7 POUNDS 13 OZ 3560 G
ADMISSION T 97
HEAD 34 CM CHEST 32 CM LENGTH 55 CM
13 1/4 INCHES 12 3/4 INCHES 21 1/2 INCHES

MATURITY EVALUATION
GESTATIONALAGE BY EXAM. 39 WEEKS
INFANT CLASSIFIED:
☐ SGA ☒ AGA ☐ LGA

VITAL SIGNS:
TIME 10:00 am
T 97.4 P 128 R 40 BP — MEAN —
RESPIRATORY SCORE
TIME 2400
T 98.3 P R BP MEAN
RESPIRATORY SCORE
TIME
T P R BP MEAN
RESPIRATORY SCORE
TIME
P R BP MEAN
RESPIRATORY SCORE

APGAR SCORES: 6 1 MINUTE 8 5 MINUTES
9 1 HOUR: HR 2 RESP EFFORT 2
TONE 2 COLOR 1 CRY 2
(SEE NEWBORN DELIVERY ASSESSMENT)

NEWBORN PHYSICIAN: BRTC
NOTIFIED BY:
TIME

AQUAMEPHYTON 1.0 MG IM AT 2335
BY L. Finet, RNC
TRIPLE DYE TO CORD ☒ YES ☐ NO
BETADINESCALPSCRUB ☒ YES ☐ NO

FEEDINGS: 1 10% D/R (1) 50cc PRN - well
2
3

VOIDINGS 0 STOOL 0

LABORATORY DATA
CHEMSTRIPS:
TIME 2 RESULTS

BLOOD SUGAR
TIME 2210 RESULTS 48

GASTRIC ASPIRATE SENT YES NO
RESULTS

BLOOD CULTURE SENT YES NO
OTHER 2210 CBC & diff, total
Bili 3.1 (Cord Blood).
Type: A+
Coombs + 20 55 368 19.5

RESPIRATORY DATA: 33p/b

BLOOD GAS:
CAPILLARY ARTERIAL
TIME.
PO2 PC02 PH BE

PULSE OXIMETER/TCP02
TIME. READING

PLAINTIFF'S EXHIBIT 5
KB 3-30-00

NOTES: 10:05 lab here to draw CBC + glucose 1040 Feed d/t VBS - WNL
2345 Labs reported to Dr. Knipke.

INFANT TRANSFERRED TO North Nursery TIME 0140 CONDITION AT TRANSFER stable
T 98.1 P 112 R 44 RN SIGNATURE L. Finet, RNC

T-BRT

Center for Women and Children

The nurses of The Toledo Hospital Normal Newborn Nurseries would like to improve communications with the physicians. You will help us achieve that goal by answering the following questions. We would also appreciate one group response from those physicians in a group praccice.

1. What do you consider an elevated temperature for which you wish to be notified?

99°

2. Do you wish to be notified after office hours if an infant appears jaundiced?

only if significant

3. Do you wish to be notified aftsr office hours of a positive coombs test?

yes

4. Do you want breast fed babies to be supplemented with dextrose water?

no

5. When a mother is breastfatding, she is given th2 option of breastfeeding during the night or having her baby fed in the nursery. if her decision is to have the baby fed in the nursery, do you want the baby to receive dextrose water or formula? whatever mother infant

_____ Dextrose OR formula you prefer (Specify the kind of

6. If a breastfeeding infant is under phototherapy, do you want to pc with dextrose or formula? no

Dextrose OR

7. If baby's bottom becomes reddened and/or raw, what do you want applied, if anything? diaper cream

8. If mom is O+ do you want a type and Coombs ordered? not necessarily

If you have any questions and/or concerns, please include them.

Sincerely,

Pat Clay, R.N.

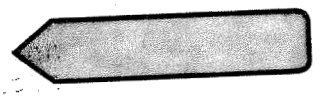
JT Crossley

PLAINTIFF'S EXHIBIT 8

KB 3-30-00

c. Infant is well with no outstanding physical difficulties. Care should be taken to shield surrounding cribs from phototherapy - distance of eight (8) feet is recommended.

7. Monitor and record intake and output every shift.
8. Bilirubin levels should be done every 12 hours or as ordered while infant is under phototherapy.
9. A Bilirubin level should be done 12 hours after phototherapy is discontinued to determine amount of "rebound" bilirubin rise.



NURSING RESPONSIBILITIES:

1. Check placement of eye shields frequently
   a. Check for signs of eye irritation or drainage
2. Check temperature every 3-4 hours for elevation. Infant may require **Servo** control on the isolette to regulate temperature.
3. Observe and note any alterations in the infant's activity pattern as a result of this treatment.
   a. Lethargy
   b. Loose, explosive, bright green stools
   c. Rash with bronzing
   d. Signs of dehydration; e.g., sunken fontanels, dry mucous membranes or poor skin turgor
4. Observe infant's color frequently, especially if under blue light, since recognition of cyanosis may be difficult. Turn light off for feedings.
5. Turn infant frequently to provide maximum amount of exposed surface. Use "fuzzy" pads to prevent skin breakdown.
6. Do not use ointment or lotions to exposed skin areas when infant under phototherapy.
7. Reinforce physician's instructions and explanations about jaundice, bilirubin levels and use of phototherapy to parents.
8. Notify physician of rapidly rising bilirubin levels as an exchange transfusion may be necessary.

CHARTING:

1. Chart and plot bilirubin on bilirubin graph for term or preterm infant, whichever the case may be.
2. Record on Kardex date phototherapy started and date discontinued.

ORIGINAL

IN THE COURT OF COMMON PLEAS

LUCAS COUNTY, OHIO

JOSEPH STALMA, a minor,
by and through his mother and :
natural guardian, Norma Stalma, :
Plaintiff,

-vs- : Case No. CI99-1762

TOLEDO HOSPITAL, : JUDGE LANZINGER
Defendant.

- - -

Deposition of **LINDA JOHNSON,** a Witness herein, called by the Plaintiff for Cross-examination under the Ohio Rules *of* Civil Procedure, taken before me, the undersigned, Kristie L. Birch, a Notary Public in and for the State of Ohio, pursuant to agreement and stipulations of Counsel as hereinafter set forth at Toledo Hospital Education Center, Room B, Toledo, Ohio, on Monday, June 5, 2000, at 12:54 o'clock p.m.

CLASSIC REPORTING SERVICE
1450 National City Bank Building
405 Madison Avenue
Toledo, Ohio 43604
(419) **243-1919**

- - -

A Record?

Q Anywhere is it recorded that tells us how long the child had difficulty breathing?

A Not that I reported.

Q Okay. Do you know given your personal recollection of what happens back then, do you know whether the child continued to have difficulty breathing up until the time that you returned him to the nursery?

A Well, you would have to define difficulty breathing.

N R — reported it — she should have documentation.

Q Well, let me just say any unusual respiration pattern.

A The reason that I returned the baby to the nursery is that he was continuing to inhale but he was not exhaling and his color was not improving.

Q Okay. So at the time that you returned him to the nursery he was still having that unusual breathing pattern?

A Yes.

Q Okay. After you made the exchange with Nurse Zettel did you then return to your station or did you stick around at all?

A Um, I stayed in the nursery, I am not sure on the length of time because I wanted to give her report on

instance such as we have described here at 18:35 ana 18:40 is the type of thing that a nurse in the context of the newborn nursery ought to report to the attending pediatrician?

MS. BAER: Objection. *Go ahead.*

A Um, that is something -- I'm sorry, rephrase the question.

Q Okay. The question is we have your note of what you recorded here and what I'm asking is is based on your current knowledge, current experience level, would you agree that an incident like that if reported to a newborn nursery nurse, a reasonable and prudent newborn nursery nurse would report that incident to the attending pediatrician or should report that?

A My knowledge level now is not the same as it was then. It would be speculation on my point.

Q What I'm asking is under your current level of knowledge would you agree that's something that should be reported to the attending pediatrician?

MS. BAER: Objection. *Go ahead*

A There are a lot of other circumstances that are useful in using whether this is something that should

reported to the nurse that the baby is having arching of the back --

MR. KULWICKI: Right, exactly.

MS. BAER: -- stiffening of extremities?

MR KULWICKI: Exactly as it appears on the note

A It would -- I need just a second to think about this

Q Sure.

A I'm sorry, but the length of your question is what is -- I'm trying to formulate an answer but the length of your question is what is -- I feel that you're asking too many things at one time

Q All right. We can save this if you want to just --

MS BAER: He wants to know if you think this particular event in an of itself without looking at anything else as noted should have been reported to the pediatrician?

A By itself probably not

Q Okay.

WRONG

MS. BAER: That's fine, you've answered it.

A Okay.

Q Why not?

A Um, when I walked into the room this is what the mother told me had happened, this is not what I observed. Not knowing what the mother actually observed and possibly her interpretations of the situation would make it difficult to say that yes, this is definitely what happened and it should have been reported.

Q Okay.

A I'm not discounting what the mother said but unless I directly observe it I'm not sure what she's reporting.

Q Okay. Again, under your current understanding of newborn nursery standards of practice would you agree that this incident with a backdrop of temperature instability as set forth in these records would be enough to have a reasonably prudent newborn nursery nurse report that to the attending pediatrician?

MS. BAER: Objection.

A How are you defining temperature instability?

Q Just as recorded is what I said, as set forth in the notes with the first --

Children's
MEDICAL CENTER OF NORTHWEST OHIO

Clinical Nursing procedures

Index No. 89
Date December 1989
Supersedes:. 3/88

Subject: PHOTOTHERAPY

BACKGROUND :

Phototherapy is commonly used for treatment of rising bilirubin levels (hyperbilirubinemia). Bilirubin is broken down by the light to a decolorized, water soluble, apparently non-toxic product. It is not known how the light affects bilirubin metabolism.

EOUIPNENT :

1. Phototherapy light with blue light (free standing) or the Wallaby Blanket or Ohmeda Bili Blanket (as ordered by physician)
2. Ophthalmic eye pads or bili mask
3. Measuring tape
4. Yellow plastic shields, if needed

PROCEDURE :

1. Obtain phototherapy light according to physician's order.
2. Completely undress infant and place in isolette or bassinet, cover perineum with diaper or disposable face mask with noseguard removed.
3. Cover baby's eyes securely with disposable bili mask to prevent retinal or corneal damage/ulceration.
4. Place light over isolette or bassinet. Plug in cord and turn on lights. Distance from lights to infant should be approximately 18 inches. When using the Wallaby, or Ohmeda, cover the pad with a disposable cover and place infant directly on the Wallaby pad.
5. If desired, obtain and fasten yellow plastic sheets around edges of light to prevent scatter of blue light. Plastic sheets are reusable and should be cleaned with A-33 between uses.
6. Infants may receive phototherapy in open cribs provided:
   a. Infant is of term gestation
   b. Temperature is stable

T-BRT

Center for Women and Children

The nurses of The Toledo Hospital Normal Newborn Nurseries would like to improve communications with the physicians. You will help us achieve that goal by answering the following questions. We would also appreciate one group response from those physicians in a group practice.

1. What do you consider an elevated temperature for which you wish to be notified?

99°

2. Do you wish to be notified after office hours if an infant appears jaundiced?

only if significant

3. Do you wish to be notified after office hours of a positive coombs test?

yes

4. Do you want breast fed babies to be supplemented with dextrose water?

no

5. When a mother is breastfeeding, she is given the option of breastfeeding during the night or having her baby fed in the nursery. If her decision is to have the baby fed in the nursery, do you want the baby to receive dextrose water or formula? — what ever mother wants

_____ Dextrose OR _____ (Specify the kind of formula you prefer)

6. If a breastfeeding infant is under phototherapy, do you want to pc with dextrose or formula? no

7. If baby's bottom becomes reddened and/or raw, what do you want applied, if anything? ——— &*

8. If mom is O+ do you want a type and Coombs ordered? not necessarily

If you have any questions and/or concerns, please include them.

Sincerely,

Pat Clay, R.N.

J T Cooley

Becker & Mishkind Co., L.P.A.

Attorneys at Law

REPLY TO:

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* Certified Civil Trial Specialist
By: National Board of Trial Advocacy

TO: Ms. Judy Lott, RNC, DSN, NP

FAX NO.: (214) 818-8692

FROM: David A. Kulwicki's Office

DATE: August 16,2002

RE: Stalma v. Buganski, et al.

FOLLOWING THIS COVER SHEET, THERE WILL BE 7 PAGE(S) TRANSMITTED.

The original of this fax will be forwarded by:

1. ____ Ordinary Mail
2. ____ Certified Mail
3. ____ Overnight Delivery
4. __X__ This fax will be the only form of delivery

specifically is when you were on duty as an LPN was there an RPN, I'm sorry, an RN that was supervising you?

A Yes.

Q And was that the floor nurse or was that an actual -- who was it?

A It would be like, I always worked nights then and it would be the RN in charge of, it was normal nursery, there was in RN in there and then on the floor there would be an RN. But I was, she was in charge of me, the nursery was in charge of me, the RN.

Q Let me make sure I understand. The floor nurse or the charge nurse was supervising you?

A Well, overall on nights there would be like one main charge nurse like through the whole third floor.

Q Okay.

A There's, you know, a north and south, and, you know, we were in the north part.

Q Okay.

A And she, you know, the RN would go to her if there was a problem or --

Q Okay.

A She was in charge of the whole floor.

Q All right. And what about the RN who had direct patient care responsibilities, did she also have

Q And were you trained to take and record the blood pressure?

A Just, it was temperature and heart rate and respiration rate, TPR we'd call it.

Q But not blood pressure?

A No, that was not practice. Well, for the -- I mean, if I took care of mothers you would take blood pressure but not a baby's you would not do that.

Q Okay. And with regard to phototherapy were there standard practices regarding what procedures were to be followed during phototherapy in 1991?

MS. BAER: By the LPNs?

MR. KULWICKI: Yes.

A I don't know. I don't recall anything being written down that we'd follow by the book, you know, it was just common practice. There's so many babies under the light that, you know, you just would kind of like, a given.

Q Okay. Let me ask you a couple questions about those common practices. Was -- well, first of all, before I ask you about those common practices let me hand you Plaintiff's Exhibit 9, a three page clinical nursing procedures sheet. Have you ever seen that document before?

A I'm not really sure, I might have glancing, you know, maybe, but nine years ago it's hard to say.

Q That's fair enough. Going through that sheet let me ask you if some of these items were what you would have considered common practices in March of '91.

First of all, was it common practice to use only one bili light or were there times when more than one bili light was used during the course --

A There was common times with one or more, depends on how high the level was.

Q What did you consider to be a high level --

MS. BAER: Objection.

Q -- bilirubin in 1991?

A I wasn't trained, you know, LPN was not that trained in the values.

Q In other words those definitions were made by the physician?

A Right.

Q Rather than by the LPN on the floor?

A Right.

Q When there was more than one bili light -- well, let me ask you this, did you ever see when there was as many as four bili lights at a time?

A Yes. Well, not really. I don't recall. I

might have not worked. I work, I was working part time.

Q Okay. Would you agree that it was a common practice in 1991 during phototherapy to unclothe the child except for eye patches and covering of the genitalia?

A Yes, that's common, uh-huh.

Q And it would be, it would not be common practice to cover the child or wrap the child with a blanket during the course of phototherapy, correct?

A Right.

Q Do you know whether in 1991 there was any effort made to monitor the temperature of ambient air around a child undergoing phototherapy when the child was in a bassinet rather than an isolette?

A I don't recall.

Q In assessing a child's temperature, a newborn's temperature what did you consider to be an elevated temperature in 1991?

A We were trained anything like over 99.

Q 99 axillary?

A Axillary, yes. We were not allowed to do rectally.

Q Okay. And did you understand in 1991 that the axillary temperature of 99 would be the equivalent of 101

rectally?

A Right, add a degree.

Q Well, I added two degrees.

A Right. Yeah, yeah. I was always just kind of round out and add one.

Q One degree?

A Right.

Q Okay. And let me hand you Plaintiff's Exhibit 8, a one page document. Have you seen that before?

A What I recall, I remember there was like a kind of standing order protocol that we would go back and what doctors wanted what. I'm not sure if I seen this, per se, this paper, but I remember there was like a break, go and see if the doctor wants dex water.

Q Okay, Fair enough. And was it the practice of the nurses in the newborn nursery to follow the standing orders that were posted by the attending pediatricians?

A Oh, yes. Oh, yeah.

Q And you would agree that it would not be cautious or prudent to ignore a standing order by a physician that requires that an elevated temperature of above 99 be reported, too, it would not be prudent or cautious to ignore that, correct?

A Right.

Q Do you agree that the signs of sepsis can be subtle?

A Yes.

Q Do you agree that [illegible] ture elevation within the [illegible] of is [illegible] ual?

A I w uld s it's unusual, it s not uncommon. yo t is

Q Woul yo agree t : ear 1 ction f sepsis offers the best chance for optimal outcome?

MS. BAER: Objection. Go ahead.

THE WITNESS: I'm supposed to answer that?

MS. BAER: Go ahead. You may go ahead.

A Yes.

Q Would you agree that the failure to detect sepsis early on puts the child at risk for morbid injury or death?

MS. BAER: Objection. Go ahead.

A Yes.

Q Would you agree that it's the duty of the nurse in the newborn nursery to perform periodic assessments of the newborns and report any unusual or abnormal findings

to the doctor?

A Yes.

Q Let me ask you this, would you agree that the following can be signs of sepsis. Poor feeding?

A Um, can. Can be but could, could be sleepy baby, could be, you know, immaturity.

Q Okay. Can weak suck be a sign of sepsis?

A Yeah, it can but then it also can be sleepy baby and immaturity and sleepiness.

Q Okay. To make this go quicker let me sort of clarify. I'm not asking whether, you know, if you see this sign in a child that it automatically means that the child has sepsis, but what I'm asking is whether or not these are recognized as signs that can be signs of sepsis, okay? Do you understand what I'm asking?

A Yes'. Okay, right.

Q Vomiting?

A Yes.

Q Tachypnea?

A Yeah.

Q Cyanosis?

A Yes.

Q Temperature instability?

A Yes.

Q Abnormal cry?

MS. BAER: Objection. Go ahead.

A Yes.

Q Decreased moro sign?

A Yes.

Q Floppiness?

A Yes.

Q Lethargy?

A Yes.

Q Jitteriness?

A Yes.

Q Apnea?

A Yes.

Q Irritability?

A Yes.

Q Abdominal distention?

A Yes.

Q Petechia?

A I'm not sure about abdominal distention.

Q That's fine. Don't just fall into line, if you don't agree just voice that, please.

How about petechia?

A I'm not sure on that.

Also bradycardia tachycardia

Baby had borderline slow heartrate

Q [redacted]e?

A I'm not sure on that.

Q [redacted]?

A Well, possible.

Q Grunting or flari[redacted]g?

A Possible.

Q Hypoglycemia?

A I'm not sure on that.

Q [redacted]

A Possible.

Q [redacted]

A Possible, uh-huh, yes.

Q And would you agree that a child with sepsis need not have all of these signs, correct?

A Right.

Q And likewise, there's not one of these signs that the child must have in order to be symptomatic for sepsis?

A Right.

Q In 1991 were you aware or were you made aware of a higher than usual rate of Group B strep infection at the newborn nursery or NICU at Toledo Hospital?

A No.

Q All right. I'm going to turn to the records

morning on March 24th, correct?

A Right, uh-huh.

Q Okay. Now, and the initial CR would be yours, right?

A Correct.

Q You record premie soft nipple, correct?

A Yes.

Q What would be the purpose of that note?

A Well, probably we have report when we come in on midnights and, um, you know, the baby was using a regular nipple or a premie soft nipple.

Q And under what circumstances were premie soft nipples used?

A It was like a little softer with a bigger hole and if a baby, you know, his suck was not real strong or a baby with a lot of mucus it would take this formula, he would grab the formula, suck on the nipple a little easier.

Q All right. Under suck you've noted fair, correct?

A Yes.

Q And what would be the purpose of that note?

A Probably going, you know, just from the report that he had a fair suck.

A No, I don't recall back then, nu-huh

Q What was your shift in 1991?

A Night shift.

Q Was it --

A I think it was back then 11:00 to 7:00.

Q 11:00 to 7:00?

A Uh-huh.

Q Okay. And then under muscle tone your initials appear next to hypertonic, correct?

A Yes.

Q And what does hypertonic mean?

A Um, hyper, hyper tone.

Q And do you recall sitting here today whether or not that was an observation that you made or whether that was something that was reported to you?

A Back nine years ago, I'm not sure.

Q Okay. And then on the second column under color, your initials appear in the column next to pale, correct?

A Uh-huh.

Q Yes?

A Yes.

Q And cyanotic, correct?

A Yes.

A Yes.

Q And again, do you know whether or not that notation reflects that the child's abdomen was distended at the time you did your assessment or whether that was reported to you by the previous shift at the shift change?

A And again, I don't recall --

Q Okay.

A -- on that one.

Q Now, under tests slash labs is any of that your handwriting?

A No.

Q And then down below where it references treatment, doesn't appear that any of that's your handwriting either, correct?

A Just the night column there's one there.

Q Next to the each feed see I&O, is that your notation?

A Yes.

Q What is that, looks like a number? My copies cut off. It's a CR?

A Yes.

Q Okay, I see. And what is that?

A Just change diapers, feed, intake and output

record, which is what you feed the baby.

Q Okay. And 'is that intake and output on page four of Plaintiff's Exhibit 2?

A Yes.

Q Now, where did you record something on the intake and outtake?

A At 2:00 a.m.

Q Could you just point to it? This right here?

A Yes.

Q Okay. And at 2:00 a.m. you recorded one ounce fair, correct?

A Right.

Q And **what** did you mean by fair?

A Just probably, you know, wasn't very eager, just you know, sometimes it's hard a lot of newborn babies we put down fair, fairly well.

Q Okay.

A It's not an uncommon word to put. – Should use descriptor on chart

Q **Is** that a reference to the suck, as in fair suck?

A Yes.

Q Okay. What else on page four of Plaintiff's Exhibit **2** bears your handwriting?

A Under the -- well, the signature, the shift from

23 to starting -- I can't read that. 23 to 3 or 7. Right there. CR, my initials and my name, signature and title.

Q Oh, under signature?

A And then the health care notes at 24:00 starting.

Q All right. Why don't you take us through the note that's done at 12:00 o'clock. Would you read your handwriting?

A Yes. 24:00, remains under phototherapy quiet and sleeping color pink.

Q Okay. And why don't you tell us what you recorded at 2:15 in the morning of March 24th.

A 0215, fed one ounce formula fair with premie soft nipple, burped frequently, placed under phototherapy on abdomen, infant had high-pitched cry with rigidity, arms outstretched upward circumoral cyanosis noted with dusky undertones and pale, 02 given at three to five liters became flaccid and NICU notified stat. And then C. Rose, LPN.

Q Let me stop you there and then we'll go to the continuation. Well, let's go to the continuation.

A It's when my RN, you know, she takes over for me then.

A I didn't do all the babies.

Q I understand. You would be assigned to eight to ten babies for instance?

A Right, however many babies there are.

Q For the babies that you're assigned to was it your understanding that you were the only person that was performing vital assessments or did you understand that there would be another nurse that was also performing assessments of vitals of the same babies that were assigned to you?

A Um, that was not common practice.

Q Okay. I'm going to hand you what we've marked as Plaintiff's Exhibit 5.

A Did I clarify that? Did that make sense?

Q Yes,

A Okay.

Q Do you feel like you need to clarify?

A I don't know if you were asking me --

Q Let me try to flush it out. My understanding is that during your eight hour shift you would perform an assessment at the beginning of the shift of the vitals?

A Right.

Q And if the child was under phototherapy that you would perform an assessment usually twice during the

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IN THE COURT OF COMMON PLEAS

LUCAS COUNTY, OHIO

JOSEPH STALMA, a minor,
by and through his mother and :
natural guardian, Norma Stalma, :

Plaintiff,

-vs- Case No. CI99-1762

TOLEDO HOSPITAL, JUDGE LANZINGER

Defendant.

- - -

Deposition of ***MYRA*** **ZAENGER,** a Witness herein, called by the Plaintiff for Cross-examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Kristie L. Birch, a Notary Public in and for the State of Ohio, pursuant to agreement and stipulations of Counsel as hereinafter set forth at the Toledo Hospital Education Center, Room B, Toledo, Ohio, on Monday, June 5, 2000, at 12:36 o'clock p.m.

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A (Indicating.)
Q Okay. Any other notes on that page that appear to be your handwriting or your signature?
A No, I don't believe so.
Q Okay. And why don't we go to the next page, page six.
A All right.
Q Any notes on there that appear to be your handwriting?
A Again, the signature from 23 to 03:40 I think.
Q Okay. Anything else?
A No.
Q Okay. Let's go to the next page and that should be the last page of that document.
A Yes.
Q Anything on there recorded by yourself?
A The entire portion --
Q Okay
A -- is recorded by me
Q Why don't I have you go through and read what you wrote there in 1991.
A 02:30 apical pulse 116 irregular at this time, respirations 40, grunting, subcostal retractions, 02 per mask given continuous, rigidity for five minutes, relaxed

somewhat, color --

MS. BAER: I think you skipped a line, relaxed somewhat and then --

A Oh, excuse me. Relaxed somewhat, color at this time -- NICU nurse Maureen here at this time. Color continues pale green, cyanotic, breath sounds coarse, bagged per NICU nurse, Dr. Satish in and examined, orders received. Dr. Buganski notified of above, chest x-ray done, blood pressure done, 62 slash 42 slash 43 mean, 43 was the mean dash 69 slash 42, the mean was 43. Blood culture drawn, plasmanate given by NICU nurse, lab work done, M. Zaenger, RN.

Q Why don't we go to the entry at 3:30 on that same date.

A Taken to visit mother, transferred to NICU in isolette with portable oxygen following another dusky episode.

Q Okay.

A M. Zaenger, RN.

Q And I think that's the last page of Exhibit 1. Okay. Let me have you go back to page, page four of Plaintiff's Exhibit 1. There is an entry here, at let me get my copy, entry at 5:00 o'clock in the morning which

indicates temperature of 99.

Let me ask you, was it your practice in 1991 to report any axillary temperature in the grade of 99 or above to the attending pediatrician?

A Yes, if they so ordered it.

Q Okay. And how would you find out if the doctor ordered that be reported to him or her?

A I didn't understand your question.

Q You said if the doctor ordered that a temperature of 99 or above be reported to then? then you would. And my question was a follow up to that which was how would you know whether or not the doctor ordered that temperature of 99 or above be reported to him or her?

A We had a, I believe it was in a notebook at that time that gave us guidelines for what the doctors preference was.

Q All right. Now, who else according to this record if you could just help me decipher it, and if you can't just tell me that you can't. But who else would have been on this shift at the time that this temperature of 99 was recorded at 5:00 a.m.?

A The other person caring for this baby was, I think it might be J. Green, I can't be certain of her signature, and she was a nursing'care assistant.