

MICHELLE KASCHAK, et al.,
Plaintiffs,
vs
UHHS BEDFORD MEDICAL
CENTER, et al.,
Defendants.

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WEDNESDAY, DECEMBER 15, 1999

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Patterson-Gordon Reporting, Inc.
(216) 771-0717

1 APPEARANCES:

2
3 On behalf of the Plaintiffs
4 Becker & Mishkind
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8
9 On behalf of the Defendant University Hospitals
10 Moscarino & Treu
11 BY: KEVIN M. NORCHI, ESQ.
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14
15 On behalf of the Witness
16 Reminger & Reminger
17 BY: PATTIJO MOONEY, ESQ.
18 The 113 St. Clair Building
19 Cleveland, Ohio 44114

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2 (Thereupon, MILLER Deposition
3 Exhibit 1 was marked for
4 purposes of identification.)

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6 MARTHA MILLER, M.D., a witness herein,
7 called for examination, as provided by the Ohio
8 Rules of Civil Procedure, being by me first duly
9 sworn, as hereinafter certified, was deposed and
10 said as follows:

11 EXAMINATION OF MARTHA MILLER, M.D.

12 BY-MR. MISHKIND:

13 Q. Would you please state your name for
14 the record.

15 A. Martha Jane Miller.

16 MR. MISHKIND: Dr. Miller, before we
17 begin the questioning, let me indicate on the
18 record who I am and why we are here and some of
19 the procedural issues that surround your
20 deposition.

21 First, my name is Howard Mishkind and
22 I represent the Kaschak family in connection with
23 a lawsuit that has been filed against Bedford
24 Hospital and certain entities, and a nurse that
25 was involved in the care of the baby in the

1 nursery on the first day of the baby's life.
2 Kevin Norchi represents the defendants in this
3 case.

4 This deposition is being taken today
5 by agreement, recognizing that the case has been
6 voluntarily dismissed with one year to refile,
7 and will be refiled, but we are doing some of our
8 discovery without an actual lawsuit filed.

9 But on behalf of the Kaschak family, I
10 have authority and consent to ask you questions
11 followed by Mr. Norchi, to the extent that he has
12 any questions of you, and your transcript, the
13 answers will be taken down and we may use the
14 testimony in whatever manner, as if this was in
15 litigation, because the case will be refiled.

16 MS. MOONEY: My understanding, for the
17 record, is that the privilege, any potential
18 physician/patient privilege has been waived by
19 virtue of the filing of the lawsuit and also that
20 you do have your client's permission and are
21 representing to us that you have obtained their
22 permission to discuss the care that Dr. Miller
23 rendered to Baby Kaschak.

24 And it's our understanding, and we are
25 here today understanding that that is the

1 situation and also that Mr. Norchi doesn't have
2 an objection and that he will be permitted to ask
3 questions if he so chooses.

4 MR. NORCHI: I have no objection.

5 BY MR. MISHKIND:

6 Q. You are a physician; is that correct?

7 A. Yes.

8 Q. You are a specialist, as I understand
9 it, in neonatology?

10 A. Correct.

11 Q. While I had asked you off the record
12 before Mr. Norchi arrived, we don't have a CV
13 here, but you are going to favor me with one;
14 correct?

15 A. Yes.

16 Q. Have you had your deposition taken
17 before, ma'am?

18 A. Yes.

19 Q. Just give me an idea of the number of
20 times that you have had this kind of a get
21 together.

22 A. I think this might be the fourth time.

23 Q. Have any of those occasions been as an
24 expert witness?

25 A. No.

1 Q. So it's involved situations where a
2 baby that you were treating in some way or
3 another, there was litigation over that?

4 A. Yes.

5 Q. Okay. Very briefly, if you would,
6 trace for me your educational background, if you
7 would, beginning with medical school and tell me
8 a little bit about your postgraduate training up
9 through your board certification.

10 A. Okay. I went to medical school at
11 USC. And from there I went to residency in
12 pediatrics at UCLA. I did a pediatric cardiology
13 fellowship at UCLA. I came here and did a
14 neonatology fellowship, became a faculty member
15 here, passed my boards, oh, that would be --
16 that's a subboard in neonatology -- probably
17 around 1984. You will see that in my CV when you
18 get the copy.

19 Since then I have been a faculty
20 member in the department of pediatrics, division
21 of neonatology, and my current title is associate
22 professor of pediatrics.

23 Q. You are board certified in pediatrics?

24 A. Yes.

25 Q. And board certified in the

1 subspecialty of neonatology?

2 A. Correct.

3 Q. Any other board certifications?

4 A. No.

5 Q. As I understand it, you have done some
6 writing; correct? Published some articles?

7 A. Yes, as part of my academic position,
8 I do publish, correct.

9 Q. And some of the articles that you have
10 published have pertained to issues of neonatal
11 apnea?

12 A. Oh, yes.

13 Q. Is that an area of interest that you
14 have, neonatal apnea or issues surrounding
15 apparent life-threatening events or SIDS, things
16 of that nature?

17 A. Not SIDS particularly, but apnea, yes,
18 that is correct, yes.

19 Q. Okay. And are the articles that you
20 have written set forth in your CV, ma'am?

21 A. Yes.

22 Q. Again, before the deposition started,
23 I asked you -- before Mr. Norchi arrived, I asked
24 you a couple questions, one of which was were you
25 involved in any aspect of the care of the baby

1 once the baby was transferred and admitted to the
2 neonatal intensive care unit.

3 Was that one **of** the questions I asked
4 you **off** the record?

5 A. Yes, it was.

6 Q. And I provided you a copy of the
7 records for you to see whether you were or
8 weren't; correct?

9 A. Correct. I did not find my name as
10 attending **on** any of the days in which the child
11 was hospitalized here.

12 Q. Now, I also presented to you and had
13 marked as an exhibit Plaintiff's Exhibit 1 and
14 asked you off the record whether this was a copy
15 of your consult note from Bedford Medical
16 Center.

17 Did I ask you that, as well?

18 A. Yes, you did.

19 Q. Is Plaintiff's Exhibit 1 the consult
20 note?

21 A. Yes, it is.

22 Q. And with the exception of asking you
23 whether I could have coffee, did you and I
24 discuss anything else before we began the
25 deposition today?

1 A. No.

2 Q. Now, you had called after a subpoena
3 had been issued to you some time ago and I sent
4 you a copy of the Bedford records; correct?

5 A. Correct.

6 Q. We didn't discuss any aspect of the
7 care that you had provided, did we?

8 A. No.

9 Q. Okay. So presumably I am going to be
10 asking you some questions about the baby's care
11 or at least what you were involved in. This will
12 be the first time that you and I have talked
13 about that; correct?

14 A. This is correct.

15 Q. All right. Before the deposition
16 started, you were introduced to Mr. Norchi and
17 you indicated to him, nice to see you again.

18 You have met Mr. Norchi before?

19 A. Yes, on previous matters regarding
20 previous cases.

21 Q. Okay. Have you ever had occasion to
22 talk to Mr. Norchi about Baby Kaschak, Megan
23 Kaschak?

24 A. I do not recall.

25 THE WITNESS: Is that correct?

1 Q. He can't answer for you.

2 A. I don't recall that we did, no, not
3 certainly about the substantive issues in this.

4 MR. NORCHI: I will represent to you
5 that we did not, Howard.

6 MR. MISHKIND: All right.

7 Q. In glancing at the record, once the
8 baby was admitted to RB&C, who were you able to
9 derive from the record was the attending
10 neonatologist upon admission to Rainbow Babies
11 and Childrens?

12 A. The first day's note was written by
13 Dr. Izatt. There are a number of different names
14 in the chart on subsequent days. I do not know
15 who the attending was of record on admission.

16 That would be, if you look on the
17 chart, in the chart, at the top where the stamp
18 is, here, that name will be the attending of
19 record.

20 Q. Okay.

21 A. But there were a number of different
22 people.

23 Q. Okay. But suffice it to say, based
24 upon your recollection and your review of the
25 records, you weren't the attending, nor do you

1 believe you were involved in any aspect of her
2 care at RB&C; correct?

3 A. Correct.

4 Q. Now, it's my understanding that you
5 were the on call neonatologist the night and
6 early morning of the day in question, which is
7 January 25, 1997; is that correct?

8 A. Yes. Isn't that the 26th? Was that
9 not the morning of the 26th? Am I incorrect?

10 Q. The morning of the 25th.

11 A. Okay. That's correct, yes.

12 Q. Okay. Where were you physically
13 located when you were first contacted relative to
14 a situation in the nursery at Bedford?

15 A. At home.

16 Q. Were you awakened by a telephone call
17 from someone?

18 A. Yes, that's correct.

19 Q. And who procedurally or technically
20 would that have been who would have been calling
21 you?

22 A. A nurse from the nursery at Bedford.

23 Q. Do you recall who he or she was?

24 A. No.

25 Q. Do you recall the substance of any

1 conversation that you had with him or her?

2 A. Not at this time.

3 Q. Okay. Suffice it to say, though, they
4 called you for a specific reason; correct?

5 A. Correct.

6 Q. And why you as opposed to someone
7 else?

8 A. Because my responsibility in that role
9 is to respond to emergencies. And I don't
10 remember the substance of what I was told that
11 morning, but that the baby was very sick and was
12 being resuscitated by the house officer and I
13 should come right away. So that's my job.

14 Q. Home is located where?

15 A. Lyndhurst. Do you want the street
16 address?

17 Q. Might as well.

18 A. Countryside Road in Lyndhurst.

19 Q. When you were contacted, recognizing
20 that you don't remember the specifics of the
21 conversation, is there a routine that you
22 normally follow, if and when you get these type
23 of telephone calls?

24 A. Yes.

25 Q. Tell me what is the routine that you

1 normally follow under those circumstances.

2 A. I put my clothes on, find my keys and
3 get in my car and drive to the hospital.

4 Q. Is there anyone else that you contact
5 as part of the neonatal team to participate or
6 assist you in whatever it is that you are about
7 to do?

8 A. No.

9 Q. Is it reasonable to conclude that once
10 you got whatever information you got from the
11 nurse that you did exactly what you just said,
12 got dressed, got in your car and drove to the
13 hospital?

14 A. Correct.

15 Q. Do you have a recollection of driving
16 to the hospital in this situation?

17 A. Yes.

18 Q. Okay. From Countryside to Bedford,
19 how long did it take you or how long
20 approximately would it take you?

21 A. I don't know how long it took me that
22 night. I have no idea. Approximately it takes
23 me 30 to 40 minutes, depending upon the traffic.

24 Q. Were you in communication with the
25 hospital at all en route to the hospital?

1 A. No.

2 Q. Are there situations where you will be
3 on a cell phone talking with the hospital?

4 A. No. That service is not provided to
5 us.

6 Q. What service?

7 A. A cell phone for professional use is
8 not provided to us.

9 Q. So in other words, if any orders or
10 suggestions were needed from you as a
11 neonatologist, they would have to wait until you
12 physically arrived, unless someone else could do
13 what it was that you would otherwise do? In
14 other words, there wasn't any on board
15 communication between you and the hospital?

16 A. No.

17 Q. And as far as recollecting anything
18 that was told to you during the conversation
19 between the nurse and when you were awakened, you
20 don't remember anything other than there was a
21 sick baby --

22 A. No, I don't.

23 Q. -- that was being resuscitated?

24 A. That's correct.

25 Q. Okay. Have you at any time seen the

1 autopsy on this baby?

2 A. No.

3 Q. While you were the neonatologist that
4 arrived at the hospital and then involved in the
5 neonatal transfer from Bedford to RB&C, did there
6 ever come a time before I issued a subpoena to
7 you that you became aware of the fact that the
8 baby had died?

9 A. Yes.

10 Q. When was that?

11 A. Shortly after the baby died.

12 Q. Were there discussions that you had
13 with other of your colleagues about the
14 circumstances surrounding the baby's death?

15 A. We discussed the evaluation of the
16 baby. I mean the evaluation at Rainbow.

17 Q. And who is "we"?

18 A. One of the attendings and myself. It
19 might have been Dr. Izatt, but being two and a
20 half years ago, I can't be absolutely sure who it
21 was.

22 Q. Was there some type of a formal
23 meeting or was this an informal get together that
24 you had with someone?

25 A. This was a discussion in the hallway.

1 There was no meeting.

2 Q. Okay. Was an opinion expressed by
3 anyone to you as to the cause of the baby's
4 death?

5 A. No.

6 Q. Was an opinion expressed to you by
7 anyone as to the cause of the baby's cardiac
8 arrest?

9 A. No.

10 Q. Who is Dr. Arthur Zinn?

11 A. Dr. Zinn is a member of the genetics
12 faculty here.

13 Q. Are you aware of the fact that at the
14 time of the autopsy that he did a number of
15 metabolic tests to determine whether or not there
16 was any type of inborn error of metabolism that
17 caused the baby's arrest?

18 A. No, I'm not aware that he completed
19 that evaluation.

20 Q. Are you aware that he had done some
21 evaluation?

22 A. How should I put it? It might have
23 been Dr. Izatt that spoke to me regarding the
24 fact that they were going to do the evaluation.

25 If you look in my note, it says must

1 consider metabolic disorders in the
2 differential. So that would have been expected
3 to be part of the evaluation of the baby.

4 Q. And as to whether or not inborn errors
5 of metabolism or metabolic disorders were ruled
6 out as a likely cause of the baby's cardiac
7 arrest, do you know whether it was or whether
8 they were or were not?

9 A. No, I do not.

10 MS. MOONEY: Let him finish his
11 question before you start your answer. It makes
12 it easier to follow along, so I know what you are
13 talking about.

14 (Thereupon, a discussion was had off
15 the record.)

16 Q. Do you specifically have any
17 recollection of ever talking with Dr. Zinn at any
18 time during the preliminary analysis that he was
19 doing of any of the metabolic testing as to why
20 he was doing it or what he was finding in the
21 metabolic tests?

22 A. No.

23 Q. There is also a pediatric neurologist
24 that came over from The Cleveland Clinic,
25 Dr. Bruce Cohn. Do you know Bruce?

1 A. No.

2 Q. Did you know that he was brought over
3 from The Cleveland Clinic to sort of provide an
4 outsider's view of what were some of the possible
5 explanations for the cardiac arrest and what some
6 of the possible explanations were for why the
7 child had suffered the severe encephalopathy that
8 the child had suffered?

9 A. No, I didn't know he was consulted.

10 Q. Okay. The record suggested Dr.
11 Berenson was actively involved in the care of the
12 baby upon admission. Is Dr. Frank Berenson still
13 here at RB&C?

14 A. I believe so.

15 Q. Is he?

16 A. I believe so. We have a rapid
17 turnover of faculty. I expect so.

18 Q. And Dr. Fanaroff's name is on the
19 record, as well. Is Dr. Fanaroff still here?

20 A. Yes.

21 Q. Would you just for purposes of my
22 edification tell me what apnea is.

23 A. Apnea is a cessation of respiration.

24 Q. And in an otherwise healthy neonate,
25 what are some of the possible causes of apnea?

1 A. Infants may have apnea as a normal
2 part of their respiration during sleep and
3 sometimes during waking. **So** apnea may be a
4 normal phenomenon, even prolonged apnea, more
5 than 20 seconds, may occur.

6 Apnea may occur as a manifestation of
7 immaturity of the brain in a premature baby. It
8 may occur as a manifestation of a number of
9 disorders, including infection, seizures,
10 respiratory disorders. The list is quite long.

11 Q. Okay. And I know that there was some
12 consideration of infection being an etiology for
13 the baby's cardiac arrest. **Do** you know whether
14 infection was ultimately ruled out in this case?

15 A. No. I have not seen the complete
16 medical record. I don't know what the final
17 results were.

18 Q. Certainly you would expect in a
19 careful workup that evaluation **of** infection as
20 well as evaluation of potential inborn errors of
21 metabolism would be considered; correct?

22 MR. NORCHI: Objection.

23 A. Yes.

24 Q. Is apnea more or less common in a
25 premature infant than in a full-term infant?

1 A. It's more common in premature infants.

2 Q. Is it common in premature infants to
3 have some type of cardiorespiratory monitoring of
4 the neonate during the newborn period?

5 MS. MOONEY: You are talking about
6 generally speaking, Howard?

7 MR. MISHKIND: Yes.

8 A. I can't answer yes or no to that,
9 because you have to define prematurity in order
10 to answer that. For children less than 35 weeks,
11 it is common. You may choose to monitor.

12 Q. Okay.

13 A. For children over 34 to 35 weeks, a
14 monitor may or may not be necessary.

15 Q. And in this case, you know that Baby
16 Megan was less than 35 weeks at the time of
17 delivery; correct?

18 A. Correct.

19 Q. And also that there had been an order
20 for continuous cardiorespiratory monitoring?

21 A. Yes. I saw that the order had been
22 written by Dr. Abu-Shaweesh.

23 Q. Is cardiorespiratory or
24 cardiopulmonary monitoring of some clinical value
25 in monitoring a child for potential episodes of

1 apnea?

2 A. Yes.

3 Q. What does cardiopulmonary monitoring
4 tell the clinician in a situation where there is
5 an apneic event?

6 A. That depends on the configuration of
7 the monitoring. It depends on, in other words,
8 on the monitor that's used. It can tell you if
9 the heart rate lowers, it can alarm for
10 particular settings.

11 In other words, if the heart rate goes
12 less than 100, a bell, a monitor alarm will go
13 off. If configured with oxygen saturation, it
14 tells you what the baby's oxygen saturation is
15 and what it was during an apnea event.

16 Q. When monitors are used, including
17 monitoring of pulse oximetry, should the
18 clinician be able to recognize central
19 obstructive, as well as mixed apnea, as they
20 occur?

21 A. The word recognize is not applicable.
22 You cannot distinguish those three classes with
23 standard cardiopulmonary monitoring. You can
24 recognize that an apnea of some form occurred,
25 but you cannot distinguish which of those three

1 it was, with the standard configurations.

2 Q. Okay. Are there any more
3 sophisticated or sensitive measures that can
4 differentiate between those?

5 A. There are, but they are not in common
6 practice in nurseries. They are more research
7 tools than common practice tools.

8 Q. Is it fair to say then that the key
9 from a clinical perspective is if
10 cardiorespiratory monitoring is used, along with
11 pulse oximetry, from a clinical standpoint, the
12 early recognition of the apneic event is what is
13 important?

14 A. Yes.

15 Q. And what measures from a clinical
16 standpoint need to be taken if alarms sound
17 indicating that there is an apneic event
18 occurring?

19 A. You examine the baby.

20 Q. Okay. And then what do you do?

21 A. You do what is appropriate. Initiate
22 resuscitation if necessary, or treat whatever
23 condition might have resulted in the apnea.

24 Alarms may occur on monitors due to
25 other events than apneas.

1 Q. Such as?

2 A. A lead coming off, a movement may
3 trigger an alarm.

4 Q. Assuming it's not a false alarm, if
5 you will, in terms of the lead coming off, but a
6 true concerning event, heralding an apneic event,
7 is it important that timely ventilation be
8 provided to the neonate?

9 A. Yes.

10 Q. You were not present when Megan
11 arrested, I understand that.

12 A. That's correct.

13 Q. You were at home. If Megan was on
14 cardiopulmonary alarms when she arrested, and the
15 leads didn't come loose, should the alarms have
16 sounded at the time of the event when her heart
17 rate dropped and she went into cardiac arrest?

18 MS. MOONEY: Objection.

19 MR. NORCHI: Objection.

20 MS. MOONEY: Are you going to define
21 the settings for her?

22 Q. Assuming the settings were properly
23 set in accordance with whatever the order was at
24 the time that the baby was on the cardiopulmonary
25 monitors, with the leads connected, and the baby

1 experienced the cardiac arrest with the heart
2 rate dropping down, under normal circumstances,
3 should the alarms sound?

4 MS. MOONEY: Doctor, don't guess. If
5 you know, you can tell him.

6 A. I do not know what happened to this
7 child at all. And so I can't guess as to whether
8 the alarm would have -- whether that
9 configuration would have effectively picked up
10 the beginning of this event. That's why I can't
11 answer your question substantively because I
12 don't know what happened to her. I wasn't there.

13 Q. Well, under what circumstances might
14 there be something that caused the baby to stop
15 breathing, to become hypotensive, such that if
16 the baby was on the alarms, under normal
17 circumstances, the alarms wouldn't sound? Does
18 that make sense that the alarms wouldn't sound
19 under that kind of a scenario?

20 MS. MOONEY: I'm going to object. Are
21 you talking in this infant or generally
22 speaking?

23 MR. MISHKIND: Start with generally
24 speaking.

25 Q. If a neonate, a premature baby that's

1 on monitors that's pursuant to orders, supposed
2 to be on continuous **CP** monitoring, if the baby
3 stops breathing, becomes hypotensive and is on
4 the monitors at the time, do you know **of** any
5 reason under normal circumstances that the alarms
6 wouldn't sound?

7 A. Yes.

8 Q. Okay. And what would be the
9 circumstance?

10 A. If with the photo sensitive pulse
11 oximeter, if a light, a strong light is shining
12 on it, it may register a normal saturation even
13 though it's not even attached to the child.

14 Q. Okay.

15 A. Some monitors, some monitoring
16 equipment will give a heart rate even when the
17 leads have fallen off.

18 Q. Okay. You say a photo, some type **of** a
19 light shining?

20 A. Yes. Like a light or a bed lamp. A
21 bedside lamp.

22 Q. Absent that, do you know of any other
23 circumstances under normal procedures, normal
24 circumstances, where the alarms would not sound
25 with that type **of** scenario?

1 A. No.

2 Q. Okay. Now, when you arrived at the
3 hospital, I presume you asked a lot of questions?

4 A. Yes.

5 Q. Did you ask questions of the nurse,
6 the neonatal nurse in terms of what happened to
7 this baby?

8 A. Yes.

9 Q. Okay. Do you remember having the
10 conversation with the neonatal nurse?

11 A. Yes.

12 Q. Okay.

13 A. Yes, I remember speaking to her. I
14 don't remember all of what we said, being two and
15 a half years ago.

16 Q. Fair enough. And I understand that.
17 But some of the things -- let me help you perhaps
18 with the nature of my questions so you can then
19 carry it through to the balance of my questions.

20 I recognize you have a note that you
21 have written --

22 A. Correct.

23 Q. -- that at least in part you are
24 relying on?

25 A. Correct.

1 Q. There may be things that you have a
2 recollection of independent of this note that
3 maybe the note triggers or you just remember
4 anyway; correct?

5 A. Yes.

6 Q. All right. And there may be things
7 that because of the passage of time, you just
8 would be guessing at?

9 A. Correct.

10 Q. When I ask you questions, if you
11 remember something that's not reflected in the
12 record, but for some reason something that stuck
13 in your mind, tell me that. If on the other hand
14 you have no recollection of it, then tell me
15 that, as well.

16 A. Sure, that's fine.

17 Q. Okay. Let's start with an easy one.
18 Do you remember the name of the nurse that you
19 spoke with?

20 A. No.

21 Q. Are you able to describe her in any
22 way?

23 A. Not at all.

24 Q. Okay. So if PJ happened to be the
25 nurse other than --

1 A. I would know if it was PJ, but it was
2 not PJ. I recall three people in the room, but I
3 do not know the names of the two nurses who were
4 there.

5 Q. You recall two nurses and who was the
6 third?

7 A. The third was, I believe, the
8 gentleman who did the resuscitation, whose name
9 we were attempting to spell.

10 MS. MOONEY: Abu-Shaweesh?

11 THE WITNESS: No.

12 A. I know where it is. It's on the front
13 page here. It was D-A-W-O-U-D. I believe that's
14 correct. That's who is attributed to the
15 resuscitation by the Bedford record.

16 Q. And he is, to your knowledge, or was
17 to your knowledge the house staff doctor?

18 A. That's what I know.

19 Q. Now, Dr. Dawoud wrote a note
20 indicating that chest compressions were in
21 progress, as well as bagging, which he described
22 as inefficient.

23 Do you recall seeing that note from
24 the doctor?

25 A. Yes. It's somewhere here, yes.

1 Q. It's right there.

2 A. Thanks.

3 Q. What does that mean to you when one
4 describes the bagging as being inefficient?

5 MS. MOONEY: Objection.

6 A. I don't know the specific problem he
7 is referring to. I can't say.

8 Q. Do you use the term inefficient in
9 describing any type of ventilatory or perfusion
10 attempts?

11 A. I would be more specific.

12 Q. If you were having difficulty
13 ventilating and oxygenating a baby, what
14 terminology would you use?

15 A. Poor chest rise, or lack of change in
16 color. Those are specific aspects of the change
17 in physiology that occur when unventilating a
18 patient.

19 Q. Okay. I asked you what apnea was
20 before. Would you also tell me what apparent
21 life-threatening event or events in a newborn,
22 what is that syndrome or what is that condition?

23 A. The term ALTE as used in **SIDS**
24 vernacular is not applied to newborns. It's
25 applied to children generally over a month of

1 age. If that's the context of your question.

2 Q. You would not apply apparent
3 life-threatening event to a neonate?

4 A. Correct.

5 Q. Apparent life-threatening events used
6 to be referred to as near SIDS death?

7 A. Correct.

8 Q. But that is sort of shunned now in
9 terms of the terminology; is that correct?

10 A. The two terms are, as far as I am
11 concerned, interchangeable.

12 Q. But it's more commonly now referred to
13 as apparent life-threatening event than as a near
14 SIDS?

15 A. Correct.

16 Q. Michelle Kaschak's deposition was
17 taken, and she indicated that she recalled having
18 a conversation with you and her husband Michael
19 where you came in and talked with them about the
20 events that you were aware of within the limited
21 context of your involvement.

22 A. Correct.

23 Q. Do you remember having a conversation
24 with the mom and the dad or the mom or the dad?

25 A. Yes.

1 Q. Do you recall which hospital that
2 would have been at?

3 A. Bedford.

4 Q. Okay. Tell me as best as you can
5 recall, either generally speaking or with
6 specificity, what it is that you remember saying
7 to mom and dad.

8 A. I absolutely don't remember any **of** the
9 context of my conversation, not at all. Not one
10 word.

11 Q. Do you recall telling them that you
12 had a special interest in how babies breathe?

13 A. I don't recall that.

14 Q. Would that possibly have been
15 something that you would have said to them?

16 A. It's possible.

17 Q. So if that's Michelle's recollection
18 of that, that certainly would not be inconsistent
19 with something you might have said?

20 A. It is possible.

21 Q. Okay. **Do** you recall telling Michelle
22 or the dad that you do not know how long the baby
23 had experienced this hypoxic event before the
24 baby was provided with resuscitation?

2E MR. NORCHI: Objection.

1 A. I don't remember the conversation well
2 enough to answer that.

3 Q. Okay. In a neonate, can you tell me
4 how long in a premature neonate, otherwise
5 healthy, but less than 35 weeks, that experiences
6 cardiorespiratory arrest, how long does it take
7 before a baby can experience severe hypoxic
8 ischemic encephalopathy without being
9 appropriately ventilated and oxygenated?

10 A. I cannot answer that. Just by 20
11 years of work, I can't give you a specific
12 number, at all.

13 Q. When a neonate is deprived of oxygen,
14 is the metabolic process greater than in an older
15 child?

16 A. The term metabolic process is too
17 vague. I can't answer it because that's not
18 specific enough.

19 Q. When a neonate becomes hypoxic, is
20 there a greater likelihood of injury than in an
21 older child?

22 A. To my knowledge, that is not the
23 case. I cannot -- that's as far as I can go with
24 that.

25 Q. Do you know how long the baby had been

1 -- how long the arrest had occurred before the
2 baby received appropriate cardiorespiratory
3 resuscitation?

4 A. No.

5 Q. In the newborn period, are babies, do
6 they breathe through their nose or do they
7 breathe through their mouths?

8 A. They can do either or both.

9 Q. During the newborn period, aren't
10 neonates obligate breathers?

11 A. There are three groups of physician
12 physiologists in the world who have shown that
13 newborns are able to breathe through their nose
14 as well as their mouth. Not all can, but there
15 are newborn infants who are able to contribute
16 through their mouth, as well as their nose.

17 Q. Okay. When you came on the scene, was
18 the baby already experiencing seizures?

19 A. When I came on the scene, the baby was
20 experiencing clonic movements of the upper and
21 lower extremities, which I interpreted as
22 possible seizures. It is not, without an EEG,
23 possible to be sure they are.

24 Those were the movements I observed,
25 and which I wrote in my note I was concerned were

1 seizures.

2 Q. Do you know whether the EEG confirmed
3 the clinical picture of the seizures?

4 A. No. I have not seen the record, the
5 whole record from Rainbow, so I don't know.

6 Q. From a physiological standpoint, if,
7 in fact, what you saw were seizures, what in a
8 neonate that has experienced cardiac arrest would
9 precipitate seizure activity?

10 A. In a child who had an arrest, ischemic
11 brain injury would, could.

12 Q. Do all babies that experience cardiac
13 arrest experience ischemic brain injury?

14 MS. MOONEY: Cardiac arrest or
15 cardiopulmonary arrest?

16 MR. MISHKIND: Cardiopulmonary
17 arrest.

18 A. No.

19 Q. How do you determine, what factors do
20 you look at in terms of evaluating a child that
21 has experienced a cardiopulmonary arrest in
22 evaluating whether the child has experienced --
23 strike that.

24 What factors influence which neonates
25 will experience an ischemic encephalopathy that

1 have experienced cardiopulmonary arrest and which
2 ones will not?

3 A. The word factors is too vague. Be
4 more specific and then I can get to the point.

5 Q. I would be happy to.

6 You told me that not all neonates that
7 have experienced a cardiopulmonary arrest
8 experience ischemic encephalopathy; correct?

9 A. Correct.

10 Q. Some do and some don't?

11 A. Correct.

12 Q. What are the variables that influence
13 the likelihood of a child that has experienced a
14 cardiopulmonary arrest of having some ischemic
15 encephalopathy?

16 A. The underlying cause of the arrest.

17 Q. Okay.

18 A. The duration of the arrest.

19 Q. Now, just so that we are not dealing
20 with hypotheticals, is it your opinion, based
21 upon the review of the records, that Megan
22 Kaschak suffered a cardiopulmonary arrest?

23 MS. MOONEY: Based on her review of
24 the Bedford medical records only?

25 MR. MISHKIND: Based on the review of

1 whatever information she has.

2 MS. MOONEY: Which I think we
3 established is only the medical records from
4 Bedford.

5 MR. MISHKIND: And any kind of
6 curbside conversation she may have had with
7 doctors at Rainbow Babies and Childrens.

8 A. The answer is yes.

9 Q. Okay. There wasn't anything magical
10 about the question. I just wanted to make sure.

11 A. No, just be careful and thoughtful and
12 the answer is yes.

13 Q. Okay. I appreciate that.

14 The record seems to suggest that you
15 arrived around 7:00 a.m.

16 Does that --

17 A. Well, let's see. The note at 7:00
18 a.m. by Dr. Dawoud says that I arrived. So there
19 we are.

20 Q. Okay. And would you then have taken
21 over the care of the baby at that point?

22 A. Yes.

23 Q. Do you remember physically taking
24 charge?

25 A. Yes.

Q. Tell me what you did at that point when you took charge.

MS. **MOONEY:** Do you want to look at your notes here?

Q. Doctor, let me interrupt you for one second. As you are answering this, tell me whether you are recalling what you did independently or whether you are exclusively relying on your note.

A. Okay.

Q. Go ahead.

A. I will tell you what I recall. I recall walking in the room, seeing the baby on the warming table, seeing that the child, I believe, had been intubated. Dr. Dawoud was there. I believe there were two nurses. Now, that's not in the record, but I am recalling three people in the room.

I asked them to tell me what had happened and what they had done, and I wrote in my note what information they gave me regarding the events that had occurred prior to my telephone call, the telephone call to me. And I examined the baby.

Now, I am going to refer to my note

because I wrote the physical exam. That was my first point of effort there.

She was flaccid, not breathing, with no withdrawal to pain. Blinking, had no pupillary reflexes and she had agonal respirations.

Q. Okay. And what therapy or interventions did you then administer?

A. We did an arterial blood gas, culture and chest X-ray, which I reviewed myself. I do not recall who was bagging her, but we adjusted the pressure on the monitor to which she was bagged, as well as the respiratory rate to confirm what would give you an appropriate chest rise.

We evaluated her glucose status, her arterial pressure. We gave her normal saline because her mean arterial pressure was lower than I would have expected for a 35 week old infant. We looked at her white count. I sent a CBC on her.

22 We gave her -- she had a metabolic
23 acidosis and I gave her two milligrams of
24 bicarb. I am reading that from my note.

25 Q. That's fine.

1 A. I called -- let's see, she exhibited
2 clonic movements of extremities and was loaded
3 with phenobarbital for presumed seizures.

4 The transport team was called from
5 Rainbow Babies and Childrens Hospital. I
6 discussed the transport with her family and also
7 notified her pediatrician. Dr. Emery had been
8 the pediatrician of record for this child at
9 Bedford Hospital. And the transport team
10 arrived. And the baby was successfully placed in
11 the transport vehicle and transported to Rainbow.

12 Q. Were you in the vehicle during the
13 transport?

14 A. No.

15 Q. What would you have done while the
16 baby was being transported? Did you then go to
17 your car and drive to the hospital or go home?

18 A. I don't remember where I went.
19 Responsibility for the infant is transferred to
20 the transport team at the time the baby is put in
21 the ambulance, so that child would then be cared
22 for by the attending physician at Rainbow. I
23 don't remember what I was doing that day, other
24 than this.

25 Q. Would a physician have been on board

1 in the ambulance en route to the hospital?

2 A. I don't remember who was on the
3 transport team. This was two and a half years
4 ago, and the composition of our team has changed
5 during that time, so I don't recall who was
6 there.

7 There could have been, or it might
8 have been a paramedic, a nurse specialist,
9 respiratory therapist. I don't remember who was
10 on the team.

11 Q. You say the composition of the team
12 has changed. Just so I can try to get a
13 parameter as to when the change occurred and what
14 type of change and composition occurred, can you
15 explain that to me?

16 A. Oh, we had residents -- years ago we
17 had residents on our transport service and those
18 no longer go on the service. A number of changes
19 have occurred. I can't tell you what date the
20 resident stopped going on transports. I don't
21 know if it was before or after this date. I just
22 don't remember.

23 Q. Fair enough. So the composition of
24 the team may or may not have included a resident?

25 A. Yes. That's my point.

1 Q. Fair enough.

2 A. It may or may not have included a
3 fellow also, I don't know, I don't remember.

4 Q. What was the cause of the metabolic
5 acidosis?

6 A. I cannot tell you.

7 Q. What factors did you consider?

8 A. I considered she might have an
9 infection. She was on appropriate antibiotics.
10 I considered that this might have been due to a
11 cardiopulmonary arrest. I considered also a rare
12 metabolic disorder, and those are the things that
13 I considered at the time.

14 Q. And in terms of the cause of the
15 cardiopulmonary arrest, what factors did you
16 consider at that time as potential etiologies?

17 A. They would encompass the things that
18 we just mentioned. Those would include
19 infection; metabolic disorder can cause an
20 arrest. Also reflux could cause a respiratory
21 arrest.

22 There was no evidence of that in the
23 history from the nurse on the examination of the
24 baby. An arrest may be caused by a large, large
list of events.

1 Q. Okay. A baby can experience an arrest
2 due to a number of factors. The more critical
3 issue, and correct me if I am wrong, is timely
4 recognizing the arrest and providing appropriate
5 ventilation and oxygenation once the arrest
6 occurs?

7 A. This is correct.

8 Q. There was some reference, and I may be
9 wrong, but there was some reference to -- strike
10 that.

11 Did you have any conversations with
12 one or both of the nurses as to the timing of the
13 discovery of this baby's cessation of breathing?

14 A. Yes. I recall asking them when she
15 was found to be ill, what were the
16 circumstances. And I wrote down what I could
17 discover. That was at 6:30 in the morning, after
18 trying breast feeding, she became pale and
19 apneic. That's all the timing that I was able to
20 find out and put in my note.

21 Q. Do you recall independently or do your
22 notes reflect at the time that the baby was
23 breast feeding whether the baby was on or off the
24 CP monitors?

25 A. I remember asking about that. I don't

1 remember finding a specific answer. And my
2 reading of the chart record doesn't give me that
3 information either.

4 Q. Okay. Do you recollect who you were
5 asking for that information? Would it have been
6 one or either of those nurses?

7 A. I suspect so, but I don't recollect
8 who it was among the people that were there.

9 Q. Dr. Dawoud, is this an individual that
10 you knew previously?

11 A. I had met him, yes.

12 Q. Have you ever talked to Dr. Dawoud
13 since the arrest of Megan Kaschak about the
14 events that occurred that evening?

15 A. No.

16 Q. Do you remember any conversation that
17 you had with him at the scene, including but not
18 limited to any aspects about his note about the
19 bagging being inefficient or anything along those
20 lines?

21 A. I don't recollect specific
22 conversations with him there. It is possible I
23 did have a conversation, but I don't recollect
24 the content.

25 Q. Okay. Are you able to picture in your

1 mind Mrs. Kaschak?

2 A. Yes.

3 Q. Is it true that when you talked to
4 her, she was back in her room, as opposed to in
5 the nursery where all of the events were
6 occurring when you arrived?

7 A. I recall a lady sitting in a chair in
8 the nursery. I could be incorrect in that. I
9 certainly spoke to the mother and father in the
10 room, but I also recall a lady in a chair. This
11 has been two and a half years ago. I am not sure
12 that was Mrs. Kaschak, but I do believe that she
13 might have been in there.

14 Q. At the time that you arrived?

15 A. I could be incorrect, but I remember a
16 lady in a chair.

17 Q. But you do specifically remember
18 having a conversation with Mrs. Kaschak back in
19 the room?

20 A. Yes.

21 Q. Okay. You don't remember any of the
22 specifics of that conversation?

23 A. No. It's been more than two years.

24 Q. That's fine.

25 Do you recall anything that mom or dad

1 might have said to you during the course of that
2 conversation?

3 A. No. I would have written, if it was
4 apropos to the case of this baby, I would have
5 written it in my note. I wrote what information
6 I got from both the family and the nurses.

7 Q. Did you ever have any communication
8 with Mrs. Kaschak that you can recall at any
9 other time after that evening at Bedford Medical
10 Center?

11 A. No, I don't remember her speaking to
12 me after that.

13 Q. It's conceivable that you did, just
14 that you don't remember?

15 A. I just don't recall that, no.

16 Q. We talked a moment ago about seizures
17 and you indicated that you certainly would want
18 to have an **EEG** to correlate with your clinical
19 findings; correct?

20 A. Correct.

21 Q. The **EEG** showed -- and this is
22 something that you may or may not be aware of --
23 but it showed severe diffuse cerebral
24 dysfunction. Would that be consistent with the
25 seizures that you witnessed?

1 A. Severe diffuse cerebral dysfunction
2 are not seizures, they are separate entities.

3 Q. Would that be consistent with some
4 form of hypoxic ischemic encephalopathy?

5 A. The description?

6 Q. Yes.

7 A. The written description?

8 Q. Yes.

9 A. Yes.

10 Q. What would **you** expect to see on an EEG
11 in terms of a description that would be the
12 heralding description of the clinical seizures
13 disorder?

14 A. I do not read EEGs. I am not trained
15 to read them and I can't even begin to describe
16 them to you.

17 Q. I won't even ask you any further
18 then.

19 There was some reference -- and if you
20 can help me with this fine; if not, we will move
21 on -- but there was some reference to lactate
22 pyruvate ratio of 35. Do you know of what
23 significance that ratio is?

24 A. I am not a metabolic -- I am not a
25 specialist in metabolic disorders. I would refer

1 you to someone who is in regard to interpretation
2 of that.

3 Q. One of the docs referenced in the
4 records would be Dr. Michelle Walsh-Suyks.

5 She is a neonatologist?

6 A. Yes, she is.

7 Q. Is she still here at RB&C?

8 A. Yes.

9 Q. There is also Dr. Rosemary Robbins.
10 Is she a neonatologist?

11 A. No, no. She might have been one of
12 the residents.

13 Q. Do you have any recollection of
14 talking with Dr. Walsh-Suyks about Baby Kaschak?

15 A. I do not know if I did. I might
16 have. I just don't remember.

17 Q. The nurse that was caring for this
18 baby, her name is Cheryl Davenport. That may or
19 may not mean anything to you. But let me ask
20 you, having said that name, does that ring a bell
21 at all?

22 A. It reminds me of her, but I can't say
23 that that makes me recall that she was, in fact,
24 there.

25 Q. Did you know Cheryl Davenport?

1 A. I have met her during my work at
2 Bedford, correct, in the past, yes.

3 Q. How frequently would you cover or
4 would you be the on call neonatologist for
5 Bedford Medical Center?

6 A. Once or twice a month.

7 Q. Cheryl Davenport's deposition was
8 taken and she talked about her discovery of the
9 baby as well as her attempts to ventilate and
10 oxygenate the baby and her attempts to sound an
11 alarm to get help.

12 Do you have any recollection, first,
13 of her telling you about what she tried to do in
14 terms of calling out for help and what happened
15 or didn't happen?

16 A. No, I don't.

17 Q. Do you have any recollection of her
18 telling you anything about her attempts to
19 establish or to provide ventilation and
20 oxygenation to the baby and whether she was
21 encountering any mechanical or equipment
22 difficulties?

23 A. No. I am looking at my note to see if
24 there is something here that will trigger my
25 memory or be an answer to your question. You

1 just asked about mechanical difficulties. No, I
2 don't recall that.

3 Q. Okay. Is there anything from your
4 conversation with Cheryl Davenport, now having
5 mentioned her name, that you recall that she may
6 have told you when you were at the hospital
7 concerning the baby that we haven't already
8 talked about?

9 MS. MOONEY: Assuming it was Cheryl
10 Davenport she talked to.

11 MR. MISHKIND: Correct.

12 A. Well, no. That's a very broad
13 question.

14 Q. You told me different things that you
15 asked and information that you were provided.

16 A. Correct.

17 Q. And I am just wondering now that I
18 mentioned Cheryl Davenport's name, does that
19 cause you to remember anything more relative to
20 any conversations?

21 A. No.

22 Q. There is another nurse, Terri Urban.
23 Do you know Terri Urban?

24 A. The name is familiar, but I can't
25 place a face to the name.

1 Q. Does that help in any way in terms of
2 causing you to remember any additional
3 conversations with the nurses other than what you
4 have told me about?

5 A. No.

6 Q. As you sit here today, do you have an
7 opinion to a reasonable degree of medical
8 probability as to the cause of the
9 cardiopulmonary arrest?

10 A. No.

11 Q. As you sit here today, do you have an
12 opinion as to the cause of the severe hypoxic
13 ischemic encephalopathy that the baby experienced
14 secondary to this cardiopulmonary arrest?

15 MR. NORCHI: Objection. Go ahead. If
16 you know that to be true, the fact that the
17 patient did have all these things.

18 A. No.

19 Q. As you sit here today, do you have an
20 opinion to a reasonable degree of medical
21 probability as to the cause of the baby's death?

22 A. No.

23 Q. Have any doctors given you or
24 expressed any opinions to you on the cause of the
25 cardiopulmonary arrest, the cause of the hypoxic

1 ischemic encephalopathy and/or the cause of the
2 baby's death?

3 A. To my knowledge, no one has told me
4 what caused this child's death.

5 Q. Okay. And you weren't involved in the
6 clinical care at the hospital upon transferring
7 and then leading up to the time of the death;
8 correct?

9 A. Correct.

10 MR. MISHKIND: I don't believe I have
11 any further questions for you. I thank you for
12 taking the time to talk to me, ma'am.

13 THE WITNESS: That's not a problem.

14 EXAMINATION OF MARTHA MILLER, M.D.

15 BY-MR. NORCHI:

16 Q. Doctor, I just have a few questions.

17 A. All right.

18 Q. Turning to your consultation report,
19 you recorded a little bit of information
20 regarding the pregnancy history; correct?

21 A. Yes.

22 Q. Okay. And you have some other
23 additional information regarding the delivery;
24 correct?

25 A. Correct.

1 Q. And, in fact, I think those, let's
2 see, that's all the information contained in your
3 note right before it begins the sentence with at
4 6:30 a.m.?

5 A. Correct.

6 Q. Up until that point.

7 Did you have any other information
8 other than this available to you when you first
9 got in to examine this child?

10 A. No.

11 Q. Okay. Is there anything contained in
12 that history that you received regarding the
13 pregnancy and the baby's delivery that would lead
14 you to believe that the baby was at risk for an
15 arrest of some sort; whether it's respiratory or
16 cardiac?

17 A. No.

18 Q. Did you examine the child for
19 dysmorphic features?

20 A. Yes.

21 Q. Did you find any?

22 A. Not that I recall.

23 Q. The medical records from Rainbow
24 Babies and Childrens reveal that there was an
25 examination by a physician who identified some

1 minor dysmorphic features. Were you aware of
2 those findings at any time?

3 A. No.

4 MR. NORCHI: I think that's about it.
5 Thank you.

6 EXAMINATION OF MARTHA MILLER, M.D.

7 BY-MR. MISHKIND:

8 Q. One and a half additional questions
9 for you.

10 A. Sure.

11 Q. I don't say only one question because
12 inevitably there is something more, so I leave
13 myself sort of a catch-all.

14 MS. MOONEY: I am already formulating
15 my objection to the half question.

16 A. Go ahead.

17 Q. Can you tell me why a baby would be
18 placed on cardiopulmonary monitors in the newborn
19 period that is less than 35 weeks gestation if,
20 in fact, the baby is not at increased risk of
21 cardiopulmonary arrest?

22 A. They use the word cardiopulmonary
23 arrest. Monitors most commonly are used for
24 other purposes in addition to monitoring of
25 oxygen content. And you notice that was the case

1 for this child -- and the nursing notes clearly
2 indicate that -- as well as for tachypnea or
3 hypopnea.

4 So the use of a monitor is for diverse
5 clinical conditions. A cardiopulmonary arrest is
6 the most rare event that might occur.

7 Q. So that the cardiopulmonary
8 monitoring, including pulse oximetry, would be
9 used to monitor for untoward, potential untoward
10 events that a premature baby of less than 35
11 weeks is at an increased risk of?

12 A. Correct.

13 Q. So that in the event that one or more
14 of those items, one or more of those events that
15 occurs -- if one of those events occur, the
16 purpose of the monitoring is so that prompt
17 clinical intervention can be provided at the time
18 that those events take place; correct?

19 A. Yes.

20 Q. Okay. And cessation of breathing,
21 prolonged hypoxia, can lead to cardiopulmonary
22 arrest; correct?

23 A. Yes.

24 MR. MISHKIND: Thank you.

25 MR. NORCHI: Thank you.

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MS. MOONEY: We will read it.

- - - -

(Deposition concluded at 10:25 a.m.;
signature not waived.)

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AFFIDAVIT

I have read the foregoing transcript from
page 1 through 55 and note the following
corrections:

PAGE LINE	REQUESTED CHANGE
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MARTHA MILLER, M.D.

Subscribed and sworn to before me this _____
day of _____, 1999.

Notary Public

My commission expires _____

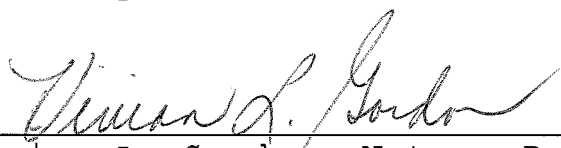
1 CERTIFICATE

2 State of Ohio,)
3 County of Cuyahoga.) SS:

4
5 I, Vivian L. Gordon, a Notary Public within
6 and for the State of Ohio, duly commissioned and
7 qualified, do hereby certify that the within
8 named MARTHA MILLER, M.D. Was by me first duly
9 sworn to testify to the truth, the whole truth
10 and nothing but the truth in the cause aforesaid;
11 that the testimony as above set forth was by me
12 reduced to stenotypy, afterwards transcribed, and
13 that the foregoing is a true and correct
14 transcription of the testimony.

15
16 I do further certify that this deposition
17 was taken at the time and place specified and was
18 completed without adjournment; that I am not a
19 relative or attorney for either party or
20 otherwise interested in the event of this action.

21
22 IN WITNESS WHEREOF, I have hereunto set my
23 hand and affixed my seal of office at Cleveland,
24 Ohio, on this 28th day of December, 1999.

25

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.

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