

1 IN THE COURT OF COMMON PLEAS
2 OF CUYAHOGA COUNTY, OHIO

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4 ERIKA EVANS, etc.,
5 Plaintiffs,

6 vs Case No. 444182
 Judge William Coyne

7 LAKEWOOD HOSPITAL, et al.,
8 Defendants.

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10 DEPOSITION OF JANET PIER, R.N.
11 THURSDAY, JANUARY 24, 2002

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13 Deposition of JANET PIER, R.N., a Witness
14 herein, called by counsel on behalf of the
15 Plaintiff for examination under the statute,
16 taken before me, Vivian L. Gordon, a Registered
17 Diplomate Reporter and Notary Public in and for
18 the State of Ohio, pursuant to agreement of
19 counsel, at the offices of Lakewood Hospital,
20 Lakewood, Ohio, commencing at 9:00 o'clock a.m.
21 on the day and date above set forth.

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1 APPEARANCES:

2 On behalf of the Plaintiff

3 Becker & Mishkind

4 KATHERINE A. VADAS, ESQ.

5 Skylight Office Tower Suite 660

6 1660 W. 2nd Street

7 Cleveland, Ohio 44113

8 216-241-2600

9

10 On behalf of the Defendant Lakewood Hospital

11 Moscarino & Treu

12 THOMAS H. ALLISON, ESQ.

13 Hanna Building Suite 630

14 1422 Euclid Avenue

15 Cleveland, Ohio 44115

16 216-621-1000

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18

19 ALSO PRESENT:

20

21 Kathleen Sweeney

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1 JANET PIER, R.N., a witness herein, called
2 for examination, as provided by the Ohio Rules
3 of Civil Procedure, being by me first duly
4 sworn, as hereinafter certified, was deposed and
5 said as follows:

6 EXAMINATION OF JANET PIER, R.N.

7 BY MS. VADAS:

8 Q. Is it okay if I call you Janet?

9 A. Please.

10 Q. Can you state your full name for the
11 record and spell your last name, please.

12 A. Janet S. Pier, P-I-E-R.

13 Q. What is your home address?

14 A. 5100 West 228th in Fairview Park.

15 Q. Your zip code?

16 A. 44126.

17 Q. Is that an apartment or home?

18 A. A home.

19 Q. Have you ever had your deposition
20 taken before?

21 A. No.

22 Q. Basically, I'm just going to explain
23 to you a little about what we are going to be
24 doing here today.

25 A. Okay.

1 Q. I'm going to ask you some questions.
2 This is a question and answer session. Your
3 answers will be taken down and this is under
4 oath. There are no right or wrong answers.
5 It's important that you understand the question
6 that I ask.

7 Sometimes my questions are horrible,
8 so don't be afraid to say I don't understand
9 what you are saying. It happens. Feel free to
10 speak up.

11 If you don't understand a question
12 that I ask, again, ask me to repeat it;
13 otherwise, if you answer the question I ask, I'm
14 going to assume that you understand it, okay?

15 A. Sure.

16 Q. Please give all your answers verbally
17 because the court reporter has trouble taking
18 down nods of heads and that type of thing.

19 This isn't a memory game. If you
20 wish to consult with the medical records, feel
21 free to do so. I have brought with me some of
22 the pertinent medical records that I'm going to
23 ask you about and I will provide them to you
24 when we get to those questions.

25 Also, during this deposition, defense

1 counsel may enter an objection from time to
2 time. You still have to answer my question
3 unless he instructs you not to. Okay?

4 Do you have any questions?

5 A. No.

6 Q. Okay. What have you reviewed for
7 this deposition today?

8 A. I've seen parts of the chart, but I
9 have not specifically reviewed or prepared
10 anything for today.

11 Q. Do you recall what parts of the chart
12 you reviewed? Was it progress notes?

13 A. Progress notes and the flow record.

14 Q. Did you review any policies and
15 procedures of the hospital?

16 A. I looked at them, yes.

17 Q. Do you recall which policies and
18 procedures you reviewed?

19 A. I went over our breast-feeding --
20 what's the word we call it? It's like our care
21 plan, kind of, for that, and also our newborn
22 care.

23 Q. Did you review any materials
24 referencing meningitis?

25 A. No.

1 Q. Neonatal infection?

2 A. No.

3 Q. Neonatal sepsis?

4 A. No.

5 Q. Did you do any type of on-line
6 Internet research?

7 A. No.

8 MR. ALLISON: Make sure you let her
9 finish her question before you answer.

10 Q. Since this case was filed, have you
11 discussed the case with any of the doctors or
12 nurses at Lakewood Hospital?

13 A. Just discussed that we have to come
14 and do this, not discussing any facts of the
15 case at all.

16 Q. So I would assume it was with
17 probably a member of the administration or legal
18 department of the hospital that you had those
19 discussions?

20 A. Yes.

21 Q. Other than with counsel, have you
22 discussed this case with anyone else?

23 A. No.

24 Q. Your husband, friends, family?

25 A. No. I mean, he knows that I am here

1 to do a deposition, but he doesn't know anything
2 about it.

3 Q. Do you have any personal notes or a
4 personal file on this case?

5 A. No.

6 Q. Have you ever generated such notes on
7 this case?

8 A. No.

9 Q. Who is your current employer?

10 A. Lakewood Hospital.

11 Q. Were you an employee of Lakewood
12 Hospital in February of 2000?

13 A. Yes, I was.

14 Q. Are you a registered nurse in the
15 State of Ohio?

16 A. Yes.

17 Q. When did you receive your nursing
18 license?

19 A. 1985.

20 Q. What type of program was your basic
21 nursing program?

22 A. I have a bachelor of science in
23 nursing.

24 Q. And in your program, did you take any
25 courses in pediatrics?

1 A. Yes.

2 Q. Do you recall how long those courses
3 lasted?

4 A. Well, it's a four-year college degree
5 and you do clinicals junior year and senior
6 year, and I did a pediatric rotation my junior
7 year and my senior year. I don't recall how
8 many weeks each rotation was, but I did one
9 rotation each year.

10 Q. Do you have any additional medical
11 related training beyond your initial nursing
12 program?

13 A. I am certified as an inpatient
14 obstetric nurse.

15 Q. And what type of program did you go
16 through to receive that?

17 A. It's just taking a test.

18 Q. Did you pass this test the first time
19 you took it?

20 A. Yes, I did.

21 Q. Do you have to review any materials,
22 read a book or anything, before taking the test?

23 A. Oh, I studied very hard to take this
24 test.

25 Q. Do you recall what you studied?

1 A. The name of a book?

2 Q. Possibly books, pamphlets? Was it
3 something produced by the hospital or a school?

4 A. I had one book that I mainly studied
5 from, but I don't remember the name of it.

6 Q. Do you remember what year you were
7 certified?

8 A. I probably have something in my purse
9 if you want me to look and see. I would guess
10 '92 or '93.

11 Q. What pediatric nursing journals do
12 you subscribe to?

13 A. None.

14 Q. Do you own any pediatric nursing
15 texts?

16 A. No, not anymore.

17 Q. Do you have any you refer to on a
18 regular basis?

19 A. Whatever is up on the unit.

20 Q. Do you recall what is on the unit?

21 A. No.

22 Q. When did you first become employed at
23 Lakewood Hospital?

24 A. Well, I worked here just in the
25 summer of 1984. Then I went back and finished

1 my college degree and started here in June of
2 1985.

3 Q. Did you work anywhere else in nursing
4 before becoming employed at Lakewood?

5 A. No.

6 Q. What is your current title and
7 position?

8 A. I'm the assistant nurse manager and
9 I'm a registered nurse.

10 Q. In February of 2000, was that your
11 title?

12 A. Yes.

13 Q. Have you held --

14 A. Actually, at that time they called it
15 a clinical, a PCC, which was like a patient care
16 coordinator, but then they changed the title to
17 assistant nurse manager doing the same job.
18 Nothing in my job description changed.

19 Q. Have you ever held any other titles
20 or positions at Lakewood Hospital?

21 A. No.

22 Q. Have you always worked in the
23 pediatric unit?

24 A. No.

25 Q. What other units have you worked in?

1 A. I don't consider my area right now
2 the pediatric unit, I consider it the birthing
3 center. I worked in intensive care stepdown,
4 which is now called critical care stepdown, from
5 1985 until September 30 or so of 1991.

6 Q. In February of 2000, were you a
7 full-time employee of Lakewood Hospital?

8 A. Yes.

9 Q. In February of 2000, were you a
10 regular staff member in the birthing center?

11 A. What do you mean by regular staff
12 member?

13 Q. Were you assigned to that unit on a
14 regular basis?

15 A. Yes.

16 Q. Can you describe to me what the
17 birthing center is.

18 A. Sure. It's a family oriented, low
19 risk, level one birthing center. We do triage,
20 we do labor and delivery, we take care of
21 routine newborns, some sick newborns if their
22 acuity is under our scope of service. We do
23 cesarean sections, curettages, D&C's on new
24 postpartum patients. Occasionally we do post-op
25 care for antepartum pregnant patients or GYN

1 patients.

2 Q. Were you required to have any special
3 training to work on that unit?

4 A. Yes.

5 Q. What type?

6 A. Well, when I left intensive care
7 stepdown -- at the time the hospital was
8 affiliated with University Hospital, so I worked
9 at University Mac House, their labor and
10 delivery, the month of October, November,
11 December and January, some of January -- and
12 learned labor and delivery, because I had no
13 experience.

14 Q. Did you work with someone?

15 A. I had a preceptor.

16 Q. What did she do?

17 MR. ALLISON: Or he.

18 MS. VADAS: Or he, thank you.

19 A. She, kind of, oversaw my work,
20 answered my questions. She worked side by side
21 with me as I learned this.

22 Q. When you started at Lakewood
23 Hospital, did you go through an orientation
24 program?

25 A. Yes.

1 Q. How long was it?

2 A. As a new grad, I would guess it was
3 ten or 12 weeks. Then I also went through an
4 orientation program when I came back from
5 University in the birthing center. It was maybe
6 two to four weeks, I'm not sure.

7 Q. Do you provide hands-on nursing care
8 of babies and their mothers in the birthing
9 center?

10 A. Yes.

11 Q. Are you the usual one to interface
12 with physicians regarding baby's care?

13 A. Yes.

14 Q. The mother's care?

15 A. Yes.

16 Q. Were you responsible for checking for
17 new orders and initiating appropriate action for
18 the babies and mothers in the birthing center?

19 MR. ALLISON: As part of her
20 responsibilities as a birthing center nurse?

21 MS. VADAS: Yes.

22 A. Yes.

23 Q. What was the usual shift you worked
24 at Lakewood Hospital in February of 2000?

25 A. 7:00 a.m. to 7:00 p.m., occasionally

1 7:00 a.m. to 3:00 p.m., and occasionally
2 rotating to nights on a need basis. But almost
3 always my shift is 7-A to 7-P.

4 Q. Are 12 hour shifts the usual at
5 Lakewood Hospital or is that just for the
6 birthing center?

7 A. I can only speak for the birthing
8 center, and we kind of do a little of
9 everything. I do the schedule, so we have many
10 12 hour people, eight hour people, we have PRN
11 nurses who work four hour shifts.

12 Q. How many babies were usually assigned
13 to you?

14 MR. ALLISON: Since she has been
15 there in 1991?

16 Q. Since you have been there in 1991.

17 A. Anywhere from one to three. Our
18 patient assignments are mother/baby couplets. I
19 would just not be assigned to the baby, unless
20 the baby was in the nursery.

21 Q. So for each baby you are assigned,
22 you are also assigned the mother?

23 A. Uh-huh.

24 Q. So one to three would probably -- if
25 you had one baby, you would have actually two

1 patients, the mother and the baby?

2 A. Correct.

3 Q. Do you know how many beds were in the
4 postpartum birthing center in February of 2000?

5 A. Yes. We have eight **LDRP's** and then
6 we have four additional rooms.

7 Q. Can you tell me what **LDRP** is?

8 A. **LDRP**, labor and delivery recovery
9 postpartum. That would be the room the woman
10 would be admitted to. She would deliver there
11 and complete her postpartum stay in that room.

12 We have four rooms that are too small
13 and we do not do deliveries in them, so we use
14 those rooms for patients not delivering or who
15 have already delivered.

16 Q. What was the usual census in 2000?

17 MR. ALLISON: If you know the answer.

18 a. If you know.

19 A. I don't know. I mean, it changes
20 every day.

21 Q. Who was your immediate clinical
22 supervisor?

23 A. Chris Ward.

24 a. Is that a he or she?

25 A. She.

1 Q. And she is a nurse?

2 A. Yes.

3 Q. Would she be considered the head
4 nurse?

5 A. A clinical nurse manager.

6 Q. What does the clinical nurse manager
7 do, duties and responsibilities; do you know?

8 A. I mean, I know a lot of what she
9 does, but you would really need to ask her what
10 her duties and responsibilities are.

11 Q. Fair enough. Did you also have a
12 head nurse or a nurse manager at that time?

13 A. She is the nurse manager.

14 Q. Is she still the head nurse?

15 A. Yes.

16 Q. Nurse manager, I'm sorry.
17 How many registered nurses are
18 usually working in the birthing center?

19 A. Three to four. Our minimum is three.

20 Q. Would that be consistent for all
21 shifts?

22 A. Yes.

23 Q. Are all the nurses providing direct
24 patient care?

25 A. Yes.

1 Q. Besides RN's, were there any other
2 personnel assigned to the maternity -- I'm
3 sorry, birthing center, that were providing
4 patient care?

5 A. No.

6 Q. Do you have any residents?

7 A. No.

8 Q. Any registered nurse clinicians?

9 A. I don't know what that term is.

10 Q. In February of 2000, if one of the
11 babies had symptoms of infection which you
12 believe required a physician's evaluation, was
13 there a procedure you would follow?

14 A. Of notifying the physician? I don't
15 understand your question.

16 Q. A procedure -- if you believe there
17 was a baby who was having problems, were there
18 certain steps that you would immediately take?
19 Would you notify a physician? Were there things
20 that you did personally to help the baby? What
21 action plan --

22 MR. ALLISON: A whole range of
23 questions, Kathy. Do you want to try to narrow
24 it down for her so we can make sure we are all
25 talking about the same thing.

1 Q. In February of 2000, if you came upon
2 a child who you believed had an infection, what
3 would be the first thing you would do?

4 A. I would do vital signs to assess the
5 baby.

6 Q. Assuming that those vital signs
7 compounded your suspicions of a possible
8 infection, what would be the second step you
9 would take?

10 A. I would notify the physician.

11 Q. On average, in February of 2000, how
12 long would it take for a physician to arrive on
13 the unit to assess the baby?

14 MR. ALLISON: Objection. Go ahead
15 and answer if you can.

16 A. We have house physicians, so they are
17 always in the hospital, so there would usually
18 be a minimal delay.

19 Q. On arrival of the physician, would
20 your duties and responsibilities end at that
21 point or would you do something further?

22 A. No. Then you work with the physician
23 to assess the baby.

24 Q. Is there a written policy explaining
25 this procedure?

1 A. Which procedure?

2 Q. Well, we kind of went through a
3 step-by-step approach on how you would deal with
4 a baby that you had a suspicion may have an
5 infection: Vital signs, notify a physician,
6 physician arrives, you work with the physician.
7 Is that just the way things are done or is there
8 a policy to that effect?

9 A. I don't know that there is a specific
10 policy. We have standards of care that we
11 adhere to and there is a standard of care on
12 newborn care.

13 Q. Is this a written standard?

14 A. Yes.

15 Q. Are you aware of what the specific
16 title of this standard would be?

17 A. It's a low risk newborn.

18 Q. In your training and education, did
19 you learn how to do a physical assessment of a
20 neonate?

21 A. Yes.

22 Q. And were you taught to recognize
23 deviations from normal?

24 A. Yes.

25 Q. Are there certain American Pediatric

1 Association standards that the hospital follows?

2 MR. ALLISON: Objection. Go ahead
3 and answer.

4 A. All of our standards are based on
5 research and are referenced in the standard.

6 Q. Is there a policy or is there a
7 standard of care on how often a newborn's
8 temperature should be taken?

9 A. Yes.

10 Q. Do you know how often that is?

11 A. Yes. Newborn's temperatures are
12 taken Q 30 minutes times three, Q 1 hour until
13 stable, and if no risk factors and stable, then
14 Q 8 hours.

15 Q. And for those us of not medically
16 trained, the Q stands for?

17 A. Every.

18 Q. Thank you. Is there a standard of
19 care on how often a newborn's respirations
20 should be counted?

21 A. When we assess a temperature, we
22 assess heart rate and respirations, so all three
23 of those are measured at those intervals.

24 Q. Is there a standard of care on when a
25 newborn should be attempted to be fed for the

1 first time after birth?

2 A. Yes.

3 Q. And when is that?

4 A. With breast-feeding, we want to
5 attempt within the first five hours of life, and
6 I'm not exactly sure if we specifically
7 mention -- I'm sure we do -- bottle feeding, but
8 that's so easily done that I don't know what the
9 exact standard says.

10 Q. Is there a standard of care on how
11 often a nurse should chart on a newborn?

12 A. We chart to exception, so if
13 everything is normal on our assessment sheet,
14 then you need to chart at least once every eight
15 hours when you are assessing vital signs on a
16 baby. And you don't need to chart in the
17 progress notes. If everything is normal just on
18 the newborn flow record, you have assessed
19 color, tone, the infant status, so if that's
20 normal, you do not need to chart in the progress
21 notes.

22 Q. Is there a standard of care for
23 making late entries in medical records?

24 A. There is not a standard of care. I'm
25 sure there is a hospital-wide policy. We don't

1 have a different policy than the rest of the
2 hospital.

3 Q. Can you explain what that policy is?

4 A. You just write the correct date or
5 the current date and time and late entry and
6 what time you are writing that from.

7 Q. When you say current date and time,
8 you mean the time that you are writing it and
9 not the time that the incident occurred?

10 A. Right. You write the current date
11 and time first, then write late entry and what
12 time you are writing your entry from.

13 Q. Would it be a violation in the
14 hospital's policy to add a late entry that
15 didn't bear the current date and time?

16 MR. ALLISON: Objection.

17 A. Yes.

18 Q. Is there a policy or standard of care
19 on how to deal with newborns that are not
20 breathing and have no pulse?

21 A. Yes.

22 Q. You look confused. Did you
23 understand?

24 A. I understand the question. I mean,
25 all of the nurses on the birthing center are

1 code pink certified and have completed a
2 neonatal resuscitation course, so we go by the
3 American Heart Association's guidelines on how
4 to resuscitate a newborn. It's not a specific
5 hospital policy on how to do that.

6 Q. Does the American Heart Association
7 require that CPR be initiated immediately in the
8 place where the newborn is found?

9 MR. ALLISON: Objection. Go ahead
10 and answer.

11 A. No.

12 Q. Do most resuscitations on newborns in
13 February of 2000 take place in the nursery?

14 A. It would depend. If the
15 resuscitation were occurring at a delivery, we
16 have all the equipment to do a resuscitation in
17 the delivery room, or in the labor room. So we
18 would do the resuscitation there. If a
19 resuscitation was required at any other time,
20 there is minimal equipment in the mother's room,
21 because all the delivery equipment is removed
22 after she is delivered, so you would go to the
23 nursery.

24 Q. Is there a copy of the standards of
25 care kept on the unit to reference?

1 A. Yes.

2 Q. Are you aware of the exact title
3 and/or name **of** the standard of care manual?

4 MR. ALLISON: Objection. Go ahead
5 and answer.

6 A. I don't know the exact name. It's in
7 a maroon binder. I know where to find it.

8 Q. And is it kept at the nurses'
9 station?

10 A. Yes.

11 Q. What is a normal body temperature of
12 a newborn?

13 A. We measure temperature in Celsius,
14 which we look for a temperature between 36.5 and
15 37.5.

16 Q. **So** any temperature below 36.5 would
17 be considered low?

18 A. Yes.

19 Q. Any temperature above 37.5 would be
20 considered high?

21 A. Yes.

22 Q. In newborns, is it normal for a
23 temperature to fluctuate?

24 A. Fluctuate where?

25 Q. What would a stable bodied

1 temperature be considered? Would it be the same
2 temperature all the way across?

3 A. No. Any measurement between 36.5 and
4 37.5 is considered stable and normal.

5 Q. Okay. **So** a fluctuation would be if,
6 say, for instance, it was 35 and then it went to
7 38, and then that would be considered a
8 fluctuation?

9 A. 35 is cold. I mean abnormal.

10 Q. What body temperature is considered
11 hypothermic for a newborn?

12 A. Less than 36.

13 Q. Is there a standard of care for
14 treating a newborn with a low body temperature?

15 A. I mean, I know what to do. I'm sure
16 it's addressed in the standard. I can't say for
17 sure.

18 Q. What would you do to treat a newborn
19 with a low body temperature?

20 A. Well, you would probably test the
21 blood sugar on the baby. You would look at the
22 whole baby. You would look at your respiratory
23 rate, heart rate, you could -- not necessarily
24 you would have to -- but you could apply a pulse
25 oximeter to the baby, and you would see what the

1 blood sugar was to see if the baby needed to be
2 fed. We have different warming devices that we
3 can use to warm the baby. We have like a warm
4 air mattress, open crib, that we can put the
5 baby under, stablets that we can heat to warm
6 the baby, and a portable heat lamp to warm the
7 baby.

8 Q. Is testing for a low blood sugar
9 something that you could do on your own devices
10 as a nurse?

11 A. Yes. It's covered in our preprinted
12 orders on newborns as a standing order to test
13 the infant's blood sugar.

14 Q. Would you test all babies' blood
15 sugar or just babies who, for instance, have a
16 low temperature?

17 A. We have a standard that we apply.
18 Babies of less than 37 weeks, greater than 42
19 weeks gestation, infant size, and it is not
20 appropriate for gestational age. We test small
21 babies, large babies.

22 Q. How is this test performed?

23 A. A heel stick and there is a One Touch
24 blood glucose machine.

25 Q. Are there any other tests that can be

1 performed on a newborn to determine the cause of
2 a low body temperature?

3 MR. ALLISON: Objection. She didn't
4 say that was a test to determine the cause.
5 What she said, as part of the assessment there
6 was a test that could be done, not necessarily
7 indicating that it was the cause of a low body
8 temperature.

9 Q. Are there any tests that can be
10 performed on a newborn to determine the cause of
11 a low body temperature besides the glucose test?

12 MR. ALLISON: Same objection. Go
13 ahead and answer.

14 A. You would, in order to test for
15 infection, you would want to draw a **CBC** and dif
16 and do blood cultures on the baby. Depending on
17 what else was going on clinically, they might
18 want to do a spinal tap on the baby.

19 Q. What other clinical factors would you
20 look for before doing a spinal tap on the baby?

21 MR. ALLISON: Objection. That
22 indicates that she would do the spinal tap.

23 A. That's a physician decision.

24 Q. Is there a standard of care regarding
25 when a physician should be informed of a low

1 body temperature?

2 A. I would have to look at the standard
3 to see if it is specifically referenced.

4 Q. Whose responsibility would it be to
5 notify the physician of a newborn who has a low
6 body temperature?

7 A. It would be the primary nurse taking
8 care of the infant, and if she were involved in
9 caring for that infant, then the charge nurse
10 would take that responsibility.

11 a. What is a normal apical pulse in a
12 newborn?

13 A. Usually 120 to 160.

14 Q. Can you define newborn for me?

15 A. I mean, just a new born infant. What
16 are you looking for?

17 Q. When I'm using the term, I'm using it
18 as a baby in the first 48 hours of life, okay?
19 So would the answer still hold up for a baby in
20 the first 48 hours of life?

21 A. I mean, I would consider, yes.

22 Q. What would be considered high?
23 Anything over 160?

24 A. 120 to 160 is your average range.
25 Some infants have a normal higher rate, some

1 infants have a lower normal rate, just like
2 everyone.

3 Q. What is a normal number of
4 respirations per minute in a newborn?

5 A. Normal is 40 to 60.

6 Q. Can you define acrocyanosis for me,
7 please?

8 A. Sure. It's where the hands and feet
9 are whitish purple. They can be a bluish color,
10 whitish. It usually occurs soon after or at
11 delivery and resolves within a few hours.

12 Q. Would acrocyanosis that persists for
13 approximately two and a half hours be considered
14 abnormal?

15 MR. ALLISON: Objection.

16 A. No.

17 Q. Is there a standard of care on when
18 to contact the physician if the acrocyanosis
19 persists?

20 A. Acrocyanosis is very different from
21 central cyanosis, so I don't know that
22 acrocyanosis is specifically mentioned.

23 Q. What is central cyanosis?

24 A. That would be where the lips and
15 tongue are blue and cyanotic.

1 Q. What factors do you take into
2 consideration as a nurse when evaluating a
3 newborn to determine whether they are in a deep
4 sleep or asleep?

5 MR. ALLISON: In a deep sleep versus
6 asleep?

7 MS. VADAS: Yes.

8 A. When we chart, we chart light sleep
9 and deep sleep. In a deep sleep, when I'm
10 assessing a newborn, when you take the
11 temperature, you can lift up the arm and stick
12 the probe under and they don't really move or
13 respond when you are kind of moving them and
14 manipulating them to test them.

15 A light sleep, they move around a lot
16 more, kind of wake up, but then go back to
17 sleep.

18 Q. What factors do you take into
19 consideration as a nurse when evaluating the
20 quality of intake for a baby?

21 A. Well, you look at, if it's a bottle
22 fed baby, you can look at volume and that's
23 measured and easy to assess. On a breast-fed
24 baby, you are looking at quality of suck,
25 sustained breast-feeding suck, you know, length

1 of time.

2 Q. Is it normal for a newborn to be a
3 poor feeder?

4 A. Yes.

5 Q. How often do newborns usually eat?

6 A. Usually between every three to four
7 hours.

8 Q. How many cc's and/or ounces do
9 newborns usually eat during a single feeding in
10 the first 24 hours of life?

11 MR. ALLISON: Objection. If there is
12 a range, or if you know.

13 A. I consider it normal anywhere from 15
14 to 30, but again, there are a lot of variations
15 on that.

16 Q. What would a plus sign indicate in
17 the reflexes row on what I'm terming the
18 neonatal flowsheet?

19 A. That they are present.

20 Q. Is a lack of reflexes normal in a
21 newborn?

22 A. No.

23 Q. Are newborns kept in the nursery at
24 Lakewood Hospital?

25 A. Occasionally. Most newborns are in

1 the rooms with the mothers. That is the norm.

2 Q. If a physician is concerned that a
3 mom may injure her newborn, would the newborn be
4 housed in the nursery or in the mom's room?

5 A. Well, it would be in the mother's
6 room with supervision if there was a fear of
7 injury, or in the nursery.

8 Q. Would a physician make that
9 determination where the baby is housed?

10 A. I don't ever recall an incident of
11 that being a factor. It would be a collaborative
12 effort between nursing and medicine and social
13 work.

14 Q. What signs and symptoms would a
15 newborn have to display to be kept in the
16 nursery instead of mom's room?

17 A. A rapid respiratory rate. You know,
18 any indication that a physician wants the infant
19 watched closer. Usually that only occurs *if* the
20 infant -- certainly if the infant is requiring
21 oxygen, that infant needs to be in the nursery.
22 If the infant is just being observed on room air
23 with IV fluids, that infant could be in the
24 mother's room with closer supervision by a
25 nurse.

1 Q. Where is a nursery located in the
2 birthing center?

3 A. Just past the nursing station.

4 Q. And where is the nurses' station?

5 A. Right as you walk in the door.

6 Q. How are the rooms situated around the
7 nursing station? A long hall?

8 A. A long hall. The nursing station is
9 first and then the rooms go in order around the
10 hall. You know, 1 to 12.

11 Q. So room 303 would be relatively close
12 to the nursing station?

13 A. It's halfway, about halfway down the
14 hall. 305 is the end of the hall.

15 Q. Is there a nurse in the nursery at
16 all times?

17 A. No. If there are babies in the
18 nursery, there is a nurse.

19 Q. Is a baby kept in the nursery
20 assessed more frequently than one kept with mom?

21 MR. ALLISON: Objection. Go ahead
22 and answer if you can.

23 A. Assessed by vital signs or what do
24 you mean by assessed?

25 a. Vital signs, respirations counted,

1 their pulse taken.

2 A It depends on why the baby is in the
3 nursery. If the baby is in the nursery so the
4 mother can sleep, the vital sign routine is
5 completely unchanged. And I would say that that
6 baby is probably looked at more often just
7 because it's right there. But if the baby is in
8 the nursery for another reason -- I mean, it
9 depends on the reason.

10 Q If a baby is having health
11 problems --

12 A. Yes.

13 Q Then it's assessed more frequently?

14 A. Yes.

15 Q Is there a standard of care to say
16 how often that baby should be assessed?

17 A No. It's usually by physician order
18 or nursing judgment.

19 Q As a newborn nursery nurse, have *you*
20 been trained to recognize signs and symptoms of
21 newborn sepsis?

22 A. Yes.

23 Q What is sepsis?

24 A Sepsis is infection.

25 Q What are the signs and symptoms of

1 newborn sepsis?

2 A. There is either a low temperature or
3 an elevated temperature. Signs and symptoms
4 would be color would be pale; respiratory rate
5 could be increased. If there is a fever
6 present, you could have an elevated heart rate.
7 Often tone would be diminished. The infant
8 could be lethargic.

9 Q. Is poor feeding a sign of newborn
10 sepsis?

11 A. No, not just poor feeding, in and of
12 itself.

13 Q. Can it be a sign of one of the signs
14 and symptoms of newborn sepsis?

15 MR. ALLISON: Objection. Go ahead
16 and answer.

17 A. I would consider it a part of the big
18 picture, but I wouldn't consider poor feeding,
19 in and of itself, a sign of sepsis if that were
20 the only factor present.

21 Q. Can jaundice be a sign of newborn
22 sepsis?

23 MR. ALLISON: Objection.

24 A. Jaundice is a different problem.

25 Q. Have you ever treated a newborn with

1 sepsis?

2 MR. ALLISON: Objection. What do you
3 mean has she ever treated? You mean on a
4 physician's order?

5 Q. In your experience as a nurse, have
6 you ever been responsible for caring for a baby
7 with newborn sepsis, carrying out physician's
8 orders?

9 MR. ALLISON: Objection. Go ahead
10 and answer.

11 A. I have cared for babies with
12 infection or suspected infection.

13 Q. Do you have an idea of approximately
14 how many babies you have cared for?

15 A. No. A lot.

16 Q. As a newborn nursery nurse, have you
17 ever treated a newborn with meningitis?

18 MR. ALLISON: Objection. Go ahead
19 and answer.

20 A. I think we have had babies with
21 meningitis. Chances are, if the baby were sick,
22 it would be transferred to Fairview's NICU, so
23 we would just stabilize the baby upon transport.

24 Q. Are you aware of whether there were
25 any newborns in the nursery in February of 2000

1 that may have had meningitis?

2 MR. ALLISON: At any time during
3 February of 2000?

4 MS. VADAS: February 11th of 2000.

5 MR. ALLISON: Objection. Go ahead
6 and answer.

7 A. I was not aware of any babies.

8 Q. What responsibilities do you have as
9 a nurse if you suspect neonatal sepsis?

10 A. I have a responsibility to notify the
11 physician and care for the baby.

12 Q. As a nurse, what care would you
13 provide for a baby that you suspect of being
14 septic?

15 MR. ALLISON: Objection. Go ahead
16 and answer.

17 A. I would follow the plan of care of
18 the physician. So if they suspect sepsis, a CBC
19 and dif is done, blood cultures are done, and as
20 soon as that lab is done, antibiotics are
21 started on the baby.

22 MR. ALLISON: Generally speaking.

23 THE WITNESS: Right.

24 Q. Now, we are going to just go to the
25 specific facts of this case and the medical

1 record.

2 A. Okay.

3 Q. Do you have a recollection separate
4 from the medical records of Baby Jasmine Evans?

5 A. I remember I took care of Erika and
6 Jasmine the day that she was born. I was not
7 working the day that the baby died. I worked
8 the day after the baby died. So I very much
9 remember taking care of Erika and the baby
10 because of the circumstances that happened.

11 Does that answer your question?

12 Q. Yes.

13 A. Okay.

14 Q. Do you remember what shift you worked
15 on February 10th of 2000?

16 A. 7-A to 7-P.

17 Q. When you start your shift, how do you
18 learn which patients you will be caring for that
19 day?

20 A. When I am working, I am generally in
21 charge and I make out the assignments. A charge
22 nurse makes out the assignments.

23 Q. Okay. Before assuming care of the
24 patients that you take as yours to care for, do
25 you review the patient's medical records from

1 the last shift?

2 A. No. We get a verbal report from the
3 nurse who is leaving. Often I do review the
4 chart before I go. I mean, part of my care is
5 reviewing the chart, but I don't feel I need to
6 do that before I care for the patient.

7 Q. Do you remember anything that, I
8 believe it would have been Nurse Garcia, may
9 have said to you in her verbal report on Erika
10 and Jasmine Evans?

11 A. I don't specifically recall what
12 Delicia said to me in report. I remember
13 knowing a lot about Erika's social history; that
14 she had a lot of social things that aren't our
15 typical patient.

16 Q. Okay.

17 A. I don't specifically remember
18 anything other than the usual mother and baby
19 report that I would have received.

20 Q. Okay. Do those social factors impact
21 how you care and treat Jasmine and Erika?

22 A. They impact on how I care for her in
23 my approach to teaching. It was her first baby,
24 she was a young mom, she did not have much
25 social support, so it impacted that aspect of my

1 care.

2 - - - - -

3 (Thereupon, Plaintiff's Deposition
4 Exhibit 1 was marked for
5 purposes of identification.)

6 - - - - -

7 Q. I'm handing you what has been marked
8 as Plaintiff's Exhibit 1. Can you tell me what
9 that is, please?

10 A. It's the progress notes on Baby Girl
11 Evans.

12 - - - - -

13 (Thereupon, Plaintiff's Deposition
14 Exhibit 2 was marked for
15 purposes of identification.)

16 - - - - -

17 Q. I'm handing you what has been marked
18 as Plaintiff's Exhibit 2. Can you identify that
19 for the record, please?

20 A. The newborn flow record for Baby Girl
21 Evans.

22 Q. Can you tell us by looking at these
23 items when you first checked on Baby Jasmine and
24 Erika?

25 A. Well, I have the baby's vital signs

1 entry as 7:40.

2 Q Is it your usual procedure to check
3 and record the baby's vital signs the first time
4 you check them in your shift?

5 MR. ALLISON: I missed that.

6 Q Is it your usual procedure to check
7 and record a baby's vital signs the first time
8 you check them during your shift?

9 A. Yes.

10 Q Do you recall how the baby looked to
11 you?

12 A. Not specifically, no.

13 Q Did you take Jasmine's temperature?

14 A. Yes.

15 Q What was it, please?

16 A. Probably 36.7.

17 Q Did you take her pulse?

18 A. 160. I didn't write in her
19 respiratory rate.

20 Q Do you know whether Jasmine was
21 asleep or drowsy?

22 A. I have it as light sleep.

23 Q Can you go to Exhibit 1. Can you
24 read your first entry into the record for us,
25 please?

1 A. 8:10, attempted to breast-feed.

2 Infant sleepy. Mother reassured, and then my
3 signature.

4 Q. Do you consider it unusual that
5 Jasmine hadn't eaten by this point?

6 A. No.

7 Q. The note says mother reassured; is
8 that correct?

9 A. Yes.

10 Q. Do you recall why Erika was
11 concerned?

12 MR. ALLISON: Objection. Go ahead
13 and answer.

14 A. Any new mother whose infant doesn't
15 breast-feed right away is concerned. I was
16 supporting her in our plan to continue to
17 breast-feed and that this is normal.

18 Q. Do you think that Erika's concern was
19 appropriate?

20 MR. ALLISON: Objection. Go ahead
21 and answer.

22 A. Yes.

23 Q. If you would look at Plaintiff's
24 Exhibit 2.

25 Was anyone else present in the room

1 during the assessment whose name does not appear
2 in the record; any medical personnel?

3 A. Not that I remember. No, I'm sure
4 not.

5 Q. Do you recall whether Erika had any
6 visitors at that point in time?

7 A. She had her friend who, I believe her
8 name was Sara, was present much of the day. I
9 couldn't say for sure that she was present in
10 the room, but I remember her presence most of
11 the day there.

12 Q. Your next entry appears to be at
13 10:00 a.m.; is that correct?

14 A. Yes.

15 Q. Could you read the progress note for
16 us, please.

17 A. Infant remains sleepy. Not
18 interested in breast-feeding. Mother given
19 Breast is Best video to watch.

20 Q. On the flowsheet you recorded that
21 Jasmine was in a deep sleep; is that correct?

22 A. Yes.

23 Q. Do you consider that normal for a
24 baby that is approximately seven hours old?

25 A. Yes.

1 Q. In your experience, does this cause
2 any concerns regarding Jasmine?

3 A. **No.**

4 MR. ALLISON: Objection. **Go** ahead
5 and answer.

6 Q. In your progress note you recorded
7 that it was not, that Jasmine was not interested
8 in breast-feeding. Was breast-feeding
9 attempted?

10 A. Yes.

11 Q. Do you remember if Erika watched the
12 video you provided her?

13 A. Yes, I'm sure she did.

14 Q. Did she ask you any questions
15 concerning the video?

16 A. I don't recall any questions that she
17 asked.

18 Q. Was Erika concerned about Jasmine's
19 deep sleep and poor feeding?

20 MR. ALLISON: Objection. **Go** ahead
21 and answer.

22 A. Erika wanted to breast-feed the baby,
23 so she was concerned that that was not going to
24 happen. I don't recall her being specifically
25 concerned about the sleeping as more of the

1 feeding.

2 Q. Your next progress note appears to be
3 at 12:00 noon on February 10th; is that correct?

4 A. Yes.

5 Q. Could you read your note into the
6 record, please.

7 A. Infant cup fed 20 cc's colostrum.
8 Swallowing well.

9 Q. What is colostrum?

10 A. Pumped initial breast milk.

11 Q. Is colostrum feeding normal in a
12 newborn?

13 A. Cup feeding is done to avoid what
14 they call nipple confusion. With a newborn who
15 is not successfully breast-fed, if you get a
16 nipple, it's much easier to suck from a nipple
17 than it is from a mother's breast. So if you
18 have an infant that you really want to
19 breast-feed, you don't get a nipple.

20 Q. In your experience as a nurse, would
21 you have expected the baby to eat more at
22 approximately nine hours of life than 20 cc's?

23 MR. ALLISON: Objection. Go ahead
24 and answer.

25 A. No. Now, when I do this process with

1 the mother, the standard way that I do it is
2 first we always attempt to breast-feed with the
3 infant. The infant was sleepy and we couldn't
4 get her to drink. And so then I had Erika pump
5 with the breast pump, and actually 20 cc's of
6 colostrum is a great amount. It's very often
7 that mothers get zero pumped colostrum, but
8 that's besides the point.

9 I cup fed the infant and I remember
10 laughing at Erika how well she drank and how
11 strong her suck was, because I said, she is
12 going to be fine, look at how strong this suck
13 is.

14 She was very sleepy. As soon as you
15 put her up close to the mom, she would just go
16 right to sleep. So it's a very positive sign to
17 have with good swallow and suck with the cup.

18 a. The next record of your assessing
19 Jasmine appears on the flowsheet at 1500 hours;
20 is that correct?

21 A. Yes.

22 Q. Did you record pulse or respirations
23 at that time?

24 A. No.

25 a. What was Jasmine's behavior state at

1 this time?

2 A. 3:00 o'clock, she was in a deep
3 sleep. Now, I did chart as part of my
4 assessment that her respiratory rate appeared
5 normal. I didn't chart a number, but her
6 respiratory status is normal and her color was
7 pink.

8 Q. Is it normal that a newborn will
9 spend a majority of a shift in a deep sleep?

10 A. Yes, it is normal.

11 This is the infant's first 24 hours
12 of life. I think you need to define that as
13 part of it.

14 Q. So it's normal that in the first 24
15 hours of life that a newborn will spend a
16 majority of that time in a deep sleep?

17 A. Yes.

18 Q. Did you have, after your shift ended
19 on the 10th, did you have any further
20 interactions with Erika and Jasmine while
21 Jasmine was alive?

22 A. No.

23 - - - - -

24 (Thereupon, Plaintiff's Deposition
25 Exhibit 3 was marked for

1 purposes of identification.)

2 - - - - -

3 Q. Can you identify that for the
4 record, please?

5 A. Erika Evans' postpartum flowsheet.

6 Q. On this sheet, there is a description
7 of the condition of Erika's breasts; is that
8 correct?

9 A. Yes.

10 Q. Does it appear from the markings
11 under 0800 and 1600 that Erika's breasts were
12 ready to breast-feed?

13 A. What do you mean?

14 MR. ALLISON: That's all right. If
15 you don't understand the question, then I'm sure
16 Kathy will rephrase it so you do understand.

17 Q. Is there anything marked on that
18 sheet that would indicate that there was
19 something wrong with Erika physically that would
20 prevent breast-feeding from being successful?

21 A. No.

22 Q. Are your initials on this page?

23 A. Yes.

24 Q. Under 0800?

25 A. And 1600.

1 Q. Can you read the letters under next
2 to the assessment for breast-feeding, needs
3 minimal to no assist to get babe on breast under
4 0800?

5 A. That would be NN, which would be
6 nurse's note.

7 Q. Thank you. Can you turn to page
8 three. There is a place on this form to assess
9 whether the nurse observes good latch-on.
10 Baby's mouth wide open, centered on breast, good
11 grasp of the areola. At 0800 did Jasmine have a
12 good latch on?

13 A. No.

14 Q. What factors would cause this?

15 A. Well, she didn't breast-feed. If you
16 don't breast-feed, you don't latch.

17 Q. In your experience as a nurse, how
18 many attempts does it usually take until a
19 newborn mom and a baby get the hang of
20 breast-feeding?

21 MR. ALLISON: Objection.

22 Q. Is there an average?

23 A. No.

24 Q. The postpartum flowsheet contains a
25 section psychosocial attachment assessment; is

1 that correct?

2 A. I'm sorry.

3 Q. Psychosocial. I believe it's on
4 the --

5 MR. ALLISON: Second page.

6 Q. -- second page.

7 MR. ALLISON: Toward the bottom.

8 A. Okay, yes.

9 a. What factors are taken into account
10 in this assessment?

11 A. Observation of the mother's
12 interaction with the baby.

13 Q. IS it normal for a first time mom to
14 need support to participate in baby care?

15 A. Yes.

16 Q. Is this more or less prevalent in
17 younger first time moms?

18 MR. ALLISON: Objection. Go ahead
19 and answer.

20 A. I mean, each person is an individual.
21 Sometimes younger women have a lot of women or
22 other family members in there supporting them
23 and some don't.

24 Q. Is there anything recorded in this
25 section that would lead you to believe that

1 Erika acted inappropriately towards Jasmine?

2 A. No.

3 Q. Is there anything that you remember
4 about Erika and Jasmine which would lead you to
5 believe that Erika could have injured Jasmine?

6 A. No.

7 Q. Is there anything written in any of
8 the medical records that you have reviewed that
9 would lead you to believe that Erika was
10 anything other than a loving mom in the 30 hours
11 of Jasmine's life?

12 MR. ALLISON: Objection. You are
13 talking about those things that she reviewed,
14 which was her narrative nursing notes and the
15 flowsheet; is that right?

16 MS. VADAS: Yes. Anything that she
17 reviewed.

18 A. I did not review any of Erika's chart
19 prior to this. And I very clearly remember
20 Erika's interaction with Jasmine, and it was
21 very loving, very appropriate, very much wanting
22 to learn how to take care of her baby. She was
23 very calm. You know, the breast-feeding, the
24 sleepiness didn't upset her.

25 Q. Do you have an understanding as to

1 the cause of Jasmine's death?

2 A. I have heard from my nurse manager in
3 a confidential meeting that there was a skull
4 fracture, and I also needed to answer questions
5 from the Lakewood police about that.

6 Q. Did you hear anything about possible
7 meningitis?

8 A. I heard possible GBS infection.

9 Q. Have you given any statements to
10 anyone concerning any information about the
11 death of the baby besides the Lakewood police?

12 MR. ALLISON: Objection. Go ahead
13 and answer.

14 A. I'm not sure I understand exactly
15 what you mean.

16 Q. Have you given any statements to
17 hospital staff, the legal department, anything
18 like that, about the information concerning the
19 death of the baby?

20 MR. ALLISON: Objection. Go ahead
21 and answer.

22 A. I met with one of the attorneys just
23 to go over my recollection of what happened, but
24 I only discussed it in that venue.

25 Q. Was that around the time of the death

1 or just recently?

2 A. Just recently.

3 Q. Can we agree that during your shift
4 on February 10th, Jasmine was never alert and
5 active?

6 MR. ALLISON: Objection. If you know
7 how she was for the entire shift.

8 A. I would not say she was never alert
9 and active. She did not actively breast-feed,
10 yes, but I recall her being awake and trying to
11 put her to breast and having her go right back
12 to sleep.

13 Q. Can we agree that during your shift
14 on February 10th Jasmine was lethargic?

15 MR. ALLISON: Objection.

16 A. I would define Jasmine as sleepy, not
17 lethargic.

18 Q. How would you define lethargic?

19 A. I would define lethargic as really
20 unable to awake, without reflexes, without a
21 good strong suck present.

22 Q. Can we agree that lethargy can be a
23 sign of neonatal sepsis and infection?

24 MR. ALLISON: Objection. Go ahead
25 and answer.

1 A. Yes.

2 Q. Can we agree that poor feeding can be
3 a sign of neonatal sepsis and infection?

4 MR. ALLISON: Objection. Asked and
5 answered. Go ahead and answer it again.

6 A. Yes.

7 Q. Can we agree that irregular sleep
8 patterns can be a sign of neonatal sepsis or
9 infection?

10 MR. ALLISON: Objection. Go ahead
11 and answer.

12 A. Define irregular sleep pattern.

13 Q. A sleep pattern that would not be
14 normal in a newborn infant.

15 MR. ALLISON: Objection. Go ahead
16 and answer.

17 A. I think Jasmine's sleep pattern was
18 normal as an infant. Is that not answering your
19 question?

20 MR. ALLISON: That's fine.

21 THE WITNESS: Okay.

22 Q. Can we agree that if the signs of
23 neonatal sepsis and infection are present that
24 it's your responsibility to immediately notify a
25 physician?

1 MR. ALLISON: Objection. Go ahead
2 and answer.

3 A. If signs and symptoms are present,
4 yes.

5 Q. Can we agree that at **no** time during
6 your care and treatment of Jasmine Evans did you
7 notify a physician?

8 A. Yes.

9 MS. VADAS: I think that's all the
10 questions that I have.

11 MR. ALLISON: We will read it.
12 Can we agree that the transcript can
13 be sent to me, I will then get it to her, and we
14 can waive the seven days?

15 MS. VADAS: Yes.

16 - - - - -

17 (Deposition concluded at 10:20 a.m.)

18 (Signature not waived.)

19 - - - - -

20

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22

23

24

25

1

AFFIDAVIT

2

I have read the foregoing transcript from

3

page 1 through 55 and note the following

4

corrections:

5

PAGE LINE

REQUESTED CHANGE

6

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17

JANET PIER, R.N.

18

Subscribed and sworn to before me this

19

day of , 2002.

20

21

Notary Public

22

23

My commission expires

24

25

1 CERTIFICATE

2

3 State of Ohio,

4

SS :

5 County of Cuyahoga.

6

7

8 I, Vivian L. Gordon, a Notary Public within
and for the State of Ohio, duly commissioned and
9 qualified, do hereby certify that the within
named JANET PIER, R.N. was by me first duly
10 sworn to testify to the truth, the whole truth
and nothing but the truth in the cause
11 aforesaid; that the testimony as above set forth
was by me reduced to stenotypy, afterwards
12 transcribed, and that the foregoing is a true
and correct transcription of the testimony.

13

I do further certify that this deposition
14 was taken at the time and place specified and
was completed without adjournment; that I am not
15 a relative or attorney for either party or
otherwise interested in the event of this
16 action. I am not, nor is the court reporting
firm with which I am affiliated, under a
17 contract as defined in Civil Rule 28 (D).

18 IN WITNESS WHEREOF, I have hereunto set my
hand and affixed my seal of office at Cleveland,
19 Ohio, on this 30th day of January, 2002.

20

21

22

Vivian L. Gordon

Vivian L. Gordon, Notary Public
23 Within and for the State of Ohio
24 My commission expires June 8, 2004.

25

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