IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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ERIKA EVANS, etc.,
Plaintiffs,
vs
Case No. 444182
Judge William Coyne
LAKEWOOD HOSPITAL, et al.,
Defendants.

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

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

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APPEARANCES:

On behalf of the Plaintiff

Becker & Mishkind
KATHERINE A. VADAS, ESQ.
Skylight Office Tower Suite 660
1660 W. 2nd Street
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant Lakewood Hospital

Moscarino & Treu
THOMAS H. ALLISON, ESQ.
Hanna Building Suite 630
1422 Euclid Avenue
Cleveland, Ohio 44115
216-621-1000

ALSO PRESENT:

Kathleen Sweeney

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

EXAMINATION OF JANET PIER, R.N.

BY MS. VADAS:

Q. Is it okay if I call you Janet?

A. Please.

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

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

Q. What is your home address?

A. 5100 West 228th in Fairview Park.

Q. Your zip code?

A. 44126.

Q. Is that an apartment or home?

A. A home.

Q. Have you ever had your deposition taken before?

A. No.

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

A. Okay.

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

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

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

A. Sure.

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

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

Also, during this deposition, defense

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

Do you have any questions?

A. No.

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

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

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

A. Progress notes and the flow record.

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

A. I looked at them, yes.

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

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

Q. Did you review any materials referencing meningitis?

A. No.

Q. Neonatal infection?
A. No.
Q. Neonatal sepsis?
A. No.
Q. Did you do any type of on-line Internet research?
A. No.
MR. ALLISON: Make sure you let her finish her question before you answer.
Q. Since this case was filed, have you discussed the case with any of the doctors or nurses at Lakewood Hospital?
A. Just discussed that we have to come and do this, not discussing any facts of the case at all.
Q. So I would assume it was with probably a member of the administration or legal department of the hospital that you had those discussions?
A. Yes.
Q. Other than with counsel, have you discussed this case with anyone else?
A. No.
Q. Your husband, friends, family?
A. No. I mean, he knows that I am here

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

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

A. No.

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

A. No.

Q. Who is your current employer?

A. Lakewood Hospital.

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

A. Yes, I was.

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

A. Yes.

Q. When did you receive your nursing license?

A. 1985.

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

A. I have a bachelor of science in nursing.

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

A. Yes.
Q. Do you recall how long those courses lasted?
A. Well, it's a four-year college degree and you do clinicals junior year and senior year, and I did a pediatric rotation my junior year and my senior year. I don't recall how many weeks each rotation was, but I did one rotation each year.
Q. Do you have any additional medical related training beyond your initial nursing program?
A. I am certified as an inpatient obstetric nurse.
Q. And what type of program did you go through to receive that?
A. It's just taking a test.
Q. Did you pass this test the first time you took it?
A. Yes, I did.
Q. Do you have to review any materials, read a book or anything, before taking the test?
A. Oh, I studied very hard to take this test.
Q. Do you recall what you studied?

A. The name of a book?
Q. Possibly books, pamphlets? Was it something produced by the hospital or a school?
A. I had one book that I mainly studied from, but I don't remember the name of it.
Q. Do you remember what year you were certified?
A. I probably have something in my purse if you want me to look and see. I would guess '92 or '93.
Q. What pediatric nursing journals do you subscribe to?
A. None.
Q. Do you own any pediatric nursing texts?
A. No, not anymore.
Q. Do you have any you refer to on a regular basis?
A. Whatever is up on the unit.
Q. Do you recall what is on the unit?
A. No.
Q. When did you first become employed at Lakewood Hospital?
A. Well, I worked here just in the summer of 1984. Then I went back and finished

my college degree and started here in June of 1985.

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

A. No.

Q. What is your current title and position?

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

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

A. Yes.

Q. Have you held --

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

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

A. No.

Q. Have you always worked in the pediatric unit?

A. No.

Q. What other units have you worked in?

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

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

A. Yes.

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

A. What do you mean by regular staff member?

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

A. Yes.

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

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

patients.

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

A. Yes.

Q. What type?

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

Q. Did you work with someone?

A. I had a preceptor.

Q. What did she do?

MR. ALLISON: Or he.

MS. VADAS: Or he, thank you.

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

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

A. Yes.

Q. How long was it?
A. As a new grad, I would guess it was ten or 12 weeks. Then I also went through an orientation program when I came back from University in the birthing center. It was maybe two to four weeks, I'm not sure.
Q. Do you provide hands-on nursing care of babies and their mothers in the birthing center?
A. Yes.
Q. Are you the usual one to interface with physicians regarding baby's care?
A. Yes.
Q. The mother's care?
A. Yes.
Q. Were you responsible for checking for new orders and initiating appropriate action for the babies and mothers in the birthing center?
MR. ALLISON: As part of her responsibilities as a birthing center nurse?
MS. VADAS: Yes.
A. Yes.
Q. What was the usual shift you worked at Lakewood Hospital in February of 2000?
A. 7:00 a.m. to 7:00 p.m., occasionally

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

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

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

Q. How many babies were usually assigned to you?

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

Q. Since you have been there in 1991.

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

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

A. Uh-huh.

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

patients, the mother and the baby?
A. Correct.
Q. Do you know how many beds were in the postpartum birthing center in February of 2000?
A. Yes. We have eight LDRP's and then we have four additional rooms.
Q. Can you tell me what LDRP is?
A. LDRP, labor and delivery recovery postpartum. That would be the room the woman would be admitted to. She would deliver there and complete her postpartum stay in that room.
We have four rooms that are too small and we do not do deliveries in them, so we use those rooms for patients not delivering or who have already delivered.
Q. What was the usual census in 2000?
MR. ALLISON: If you know the answer.
a. If you know.
A. I don't know. I mean, it changes every day.
Q. Who was your immediate clinical supervisor?
A. Chris Ward.
a. Is that a he or she?
A. She.

Q. And she is a nurse?
A. Yes.
Q. Would she be considered the head nurse?
A. A clinical nurse manager.
Q. What does the clinical nurse manager do, duties and responsibilities; do you know?
A. I mean, I know a lot of what she does, but you would really need to ask her what her duties and responsibilities are.
Q. Fair enough. Did you also have a head nurse or a nurse manager at that time?
A. She is the nurse manager.
Q. Is she still the head nurse?
A. Yes.
Q. Nurse manager, I'm sorry.
How many registered nurses are usually working in the birthing center?
A. Three to four. Our minimum is three.
Q. Would that be consistent for all shifts?
A. Yes.
Q. Are all the nurses providing direct patient care?
A. Yes.

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

A. No.

Q. Do you have any residents?

A. No.

Q. Any registered nurse clinicians?

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

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

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

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

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

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

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

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

A. I would notify the physician.

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

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

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

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

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

Q. Is there a written policy explaining this procedure?

A. Which procedure?
Q. Well, we kind of went through a step-by-step approach on how you would deal with a baby that you had a suspicion may have an infection: Vital signs, notify a physician, physician arrives, you work with the physician. Is that just the way things are done or is there a policy to that effect?
A. I don't know that there is a specific policy. We have standards of care that we adhere to and there is a standard of care on newborn care.
Q. Is this a written standard?
A. Yes.
Q. Are you aware of what the specific title of this standard would be?
A. It's a low risk newborn.
Q. In your training and education, did you learn how to do a physical assessment of a neonate?
A. Yes.
Q. And were you taught to recognize deviations from normal?
A. Yes.
Q. Are there certain American Pediatric

Association standards that the hospital follows?

MR. ALLISON: Objection. Go ahead and answer.

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

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

A. Yes.

Q. Do you know how often that is?

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

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

A. Every.

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

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

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

first time after birth?

A. Yes.

Q. And when is that?

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

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

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

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

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

have a different policy than the rest of the hospital.

Q. Can you explain what that policy is?

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

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

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

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

MR. ALLISON: Objection.

A. Yes.

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

A. Yes.

Q. You look confused. Did you understand?

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

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

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

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

A. No.

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

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

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

A. Yes.
Q. Are you aware of the exact title and/or name of the standard of care manual?
MR. ALLISON: Objection. Go ahead and answer.
A. I don't know the exact name. It's in a maroon binder. I know where to find it.
Q. And is it kept at the nurses' station?
A. Yes.
Q. What is a normal body temperature of a newborn?
A. We measure temperature in Celsius, which we look for a temperature between 36.5 and 37.5.
Q. So any temperature below 36.5 would be considered low?
A. Yes.
Q. Any temperature above 37.5 would be considered high?
A. Yes.
Q. In newborns, is it normal for a temperature to fluctuate?
A. Fluctuate where?
Q. What would a stable bodied

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

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

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

A. 35 is cold. I mean abnormal.

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

A. Less than 36.

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

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

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

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

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

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

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

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

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

Q. How is this test performed?

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

Q. Are there any other tests that can be

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

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

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

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

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

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

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

A. That's a physician decision.

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

body temperature?

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

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

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

Q. What is a normal apical pulse in a newborn?

A. Usually 120 to 160.

Q. Can you define newborn for me?

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

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

A. I mean, I would consider, yes.

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

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

infants have a lower normal rate, just like everyone.

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

A. Normal is 40 to 60.

Q. Can you define acrocyanosis for me, please?

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

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

MR. ALLISON: Objection.

A. No.

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

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

Q. What is central cyanosis?

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

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

MR. ALLISON: In a deep sleep versus asleep?

MS. VADAS: Yes.

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

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

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

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

of time.

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

A. Yes.

Q. How often do newborns usually eat?

A. Usually between every three to four hours.

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

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

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

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

A. That they are present.

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

A. No.

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

A. Occasionally. Most newborns are in

the rooms with the mothers. That is the norm.

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

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

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

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

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

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

Q. Where is a nursery located in the birthing center?
A. Just past the nursing station.
Q. And where is the nurses' station?
A. Right as you walk in the door.
Q. How are the rooms situated around the nursing station? A long hall?
A. A long hall. The nursing station is first and then the rooms go in order around the hall. You know, 1 to 12.
Q. So room 303 would be relatively close to the nursing station?
A. It's halfway, about halfway down the hall. 305 is the end of the hall.
Q. Is there a nurse in the nursery at all times?
A. No. If there are babies in the nursery, there is a nurse.
Q. Is a baby kept in the nursery assessed more frequently than one kept with mom?
MR. ALLISON: Objection. Go ahead and answer if you can.
A. Assessed by vital signs or what do you mean by assessed?
Q. Vital signs, respirations counted,

their pulse taken.

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

Q. If a baby is having health problems --

A. Yes.

Q. Then it's assessed more frequently?

A. Yes.

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

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

Q. As a newborn nursery nurse, have you been trained to recognize signs and symptoms of newborn sepsis?

A. Yes.

Q. What is sepsis?

A. Sepsis is infection.

Q. What are the signs and symptoms of

newborn sepsis?

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

Q. Is poor feeding a sign of newborn sepsis?

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

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

MR. ALLISON: Objection. Go ahead and answer.

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

Q. Can jaundice be a sign of newborn sepsis?

MR. ALLISON: Objection.

A. Jaundice is a different problem.

Q. Have you ever treated a newborn with

sepsis?

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

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

MR. ALLISON: Objection. Go ahead and answer.

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

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

A. No. A lot.

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

MR. ALLISON: Objection. Go ahead and answer.

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

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

that may have had meningitis?

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

MS. VADAS: February 11th of 2000.

MR. ALLISON: Objection. Go ahead and answer.

A. I was not aware of any babies.

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

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

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

MR. ALLISON: Objection. Go ahead and answer.

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

MR. ALLISON: Generally speaking.

THE WITNESS: Right.

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

record.

A. Okay.

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

A. I remember I took care of Erika and Jasmine the day that she was born. I was not working the day that the baby died. I worked the day after the baby died. So I very much remember taking care of Erika and the baby because of the circumstances that happened. Does that answer your question?

Q. Yes.

A. Okay.

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

A. 7-A to 7-P.

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

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

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

the last shift?

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

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

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

Q. Okay.

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

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

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

care.

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

- - - - -

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

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

- - - - -

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

- - - - -

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

A. The newborn flow record for Baby Girl Evans.

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

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

entry as 7:40.

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

MR. ALLISON: I missed that.

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

A. Yes.

Q. Do you recall how the baby looked to you?

A. Not specifically, no.

Q. Did you take Jasmine's temperature?

A. Yes.

Q. What was it, please?

A. Probably 36.7.

Q. Did you take her pulse?

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

Q. Do you know whether Jasmine was asleep or drowsy?

A. I have it as light sleep.

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

A. 8:10, attempted to breast-feed. Infant sleepy. Mother reassured, and then my signature.

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

A. No.

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

A. Yes.

Q. Do you recall why Erika was concerned?

MR. ALLISON: Objection. Go ahead and answer.

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

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

MR. ALLISON: Objection. Go ahead and answer.

A. Yes.

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

Was anyone else present in the room

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

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

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

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

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

Q. In your experience, does this cause any concerns regarding Jasmine?
A. No.
MR. ALLISON: Objection. Go ahead and answer.
Q. In your progress note you recorded that it was not, that Jasmine was not interested in breast-feeding. Was breast-feeding attempted?
A. Yes.
Q. Do you remember if Erika watched the video you provided her?
A. Yes, I'm sure she did.
Q. Did she ask you any questions concerning the video?
A. I don't recall any questions that she asked.
Q. Was Erika concerned about Jasmine's deep sleep and poor feeding?
MR. ALLISON: Objection. Go ahead and answer.
A. Erika wanted to breast-feed the baby, so she was concerned that that was not going to happen. I don't recall her being specifically concerned about the sleeping as more of the

feeding.

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

A. Yes.

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

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

Q. What is colostrum?

A. Pumped initial breast milk.

Q. Is colostrum feeding normal in a newborn?

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

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

MR. ALLISON: Objection. Go ahead and answer.

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

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

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

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

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

A. Yes.

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

A. No.

Q. What was Jasmine's behavior state at

this time?

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

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

A. Yes, it is normal.

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

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

A. Yes.

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

A. No.

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

purposes of identification.)

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

A. Erika Evans' postpartum flowsheet.

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

A. Yes.

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

A. What do you mean?

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

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

A. No.

Q. Are your initials on this page?

A. Yes.

Q. Under 0800?

A. And 1600.

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

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

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

A. No.

Q. What factors would cause this?

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

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

MR. ALLISON: Objection.

Q. Is there an average?

A. No.

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

that correct?
A. I'm sorry.
Q. Psychosocial. I believe it's on the --
MR. ALLISON: Second page.
Q. -- second page.
MR. ALLISON: Toward the bottom.
A. Okay, yes.
Q. What factors are taken into account in this assessment?
A. Observation of the mother's interaction with the baby.
Q. Is it normal for a first time mom to need support to participate in baby care?
A. Yes.
Q. Is this more or less prevalent in younger first time moms?
MR. ALLISON: Objection. Go ahead and answer.
A. I mean, each person is an individual. Sometimes younger women have a lot of women or other family members in there supporting them and some don't.
Q. Is there anything recorded in this section that would lead you to believe that

Erika acted inappropriately towards Jasmine?

A. No.

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

A. No.

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

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

MS. VADAS: Yes. Anything that she reviewed.

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

Q. Do you have an understanding as to

the cause of Jasmine's death?

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

Q. Did you hear anything about possible meningitis?

A. I heard possible GBS infection.

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

MR. ALLISON: Objection. Go ahead and answer.

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

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

MR. ALLISON: Objection. Go ahead and answer.

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

Q. Was that around the time of the death

or just recently?

A. Just recently.

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

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

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

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

MR. ALLISON: Objection.

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

Q. How would you define lethargic?

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

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

MR. ALLISON: Objection. Go ahead and answer.

A. Yes.
Q. Can we agree that poor feeding can be a sign of neonatal sepsis and infection?
MR. ALLISON: Objection. Asked and answered. Go ahead and answer it again.
A. Yes.
Q. Can we agree that irregular sleep patterns can be a sign of neonatal sepsis or infection?
MR. ALLISON: Objection. Go ahead and answer.
A. Define irregular sleep pattern.
Q. A sleep pattern that would not be normal in a newborn infant.
MR. ALLISON: Objection. Go ahead and answer.
A. I think Jasmine's sleep pattern was normal as an infant. Is that not answering your question?
MR. ALLISON: That's fine.
THE WITNESS: Okay.
Q. Can we agree that if the signs of neonatal sepsis and infection are present that it's your responsibility to immediately notify a physician?

MR. ALLISON: Objection. Go ahead and answer.

A. If signs and symptoms are present, yes.

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

A. Yes.

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

MR. ALLISON: We will read it.

Can we agree that the transcript can be sent to me, I will then get it to her, and we can waive the seven days?

MS. VADAS: Yes.

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(Deposition concluded at 10:20 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

JANET PIER, R.N.

Subscribed and sworn to before me this day of , 2002.

Notary Public

My commission expires

CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

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

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

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

Vivian L. Gordon

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

My commission expires June 8, 2004.

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DEPOSITION OF JANET PIER. R.N.