

1 IN THE COURT C F COMMON PLEAS

2 LORAIN CC UNTY, OHIO

3

4 JASMINE MERRIWEATHER, et al.,

5 Plaintiffs, Case No.

6 vs. 98 CV 120349

7 ELYRIA MEMORIAL HOSPITAL, et al.,

8 Defendants.

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11 Deposition of THOMAS TREVOR REILEY,

12 M.D., called for examination under the statute,

13 taken before me, Craig L. Knowles, CM, a Notary

14 Public in and for the State of Colorado, by

15 agreement of counsel, at 17229 Rimrock Drive,

16 Golden, Colorado, on Wednesday, September 15,

17 1999, at 2:06 p.m.

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1 APPEARANCES:

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On behalf of the Plaintiffs:

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1 APPEARANCES, continued

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1 EXAMINATION OF THOMAS TREVOR REILEY, M.D.

2 BY MR. NOVAK..... 5:6

3 BY MS. SCHOENLING.....119:6

4 Exhibit 1 was marked.....121:1 ■

5 (Copied and the original returned to the witness)

6 Exhibit 2 was marked.....121:11

7 Exhibit 3 was marked.....121:11

8 Exhibit 4 was marked.....121:11

9 Exhibit 5 was marked.....121:11

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1 THOMAS TREVOR REILEY, M.D., of lawful age,
2 called for examination, as provided by the Ohio
3 Rules of Civil Procedure, being by me first duly
4 sworn, as hereinafter certified, deposed and said
5 as follows:

6 EXAMINATION OF THOMAS TREVOR REILEY, M.D.

7 BY MR. NOVAK:

8 Q. For the record, could we have your
9 name, please?

10 A. Thomas Trevor Reiley.

11 Q. You are a physician, is that correct?

12 A. That's correct.

13 Q. Board certified in neurology?

14 A. Yes.

15 Q. Pediatric, as well as neurology?

16 A. Yes.

17 Q. And I am a little curious about the
18 1991 through '94 master's degree in health care
19 systems. Can you tell me what prompted you to
20 pursue that degree?

21 A. Yes. With the change in the health
22 care environment, many physicians right now are
23 getting training in health systems or M.B.A.s in
24 the economics and sociology of medicine, and I am
25 one of them.

6

1 Q. At the present time I understand you
2 are the Assistant Clinical Professor, Division of
3 Neurology, Department of Pediatrics at the
4 University of Colorado Health Sciences Center, is
5 that right?

6 A. That's correct.

7 Q. At the present time do you have any
8 patients that you are actively treating in the
9 hospital?

10 A. No.

11 Q. During the course of let's say any
12 given month, on an average how many patients do
13 you treat in the hospital?

14 A. None.

15 Q. Do you have an active clinical
16 practice where you treat patients on a regular
17 basis?

18 A. Yes.

19 Q. Where would that be at?

20 A. I have a clinic here in Golden. I
21 also have clinics in Alamosa, Grand Junction,
22 Greeley, Pagosa Springs, Durango and Cortez.

23 Q. When you say you have clinics there,
24 what kinds of clinics are these?

25 A. These are state-sponsored clinics

1 through the Crippled Children's Program, which we
2 call in Colorado the HCP program or Health Care
3 Program for Children with Special Needs. And I
4 see both indigent patients as well as private
5 patients through those clinics.

6 Q. Now at these clinics that you have
7 listed under neurology consultation, how often do
8 you go to each of these clinics?

9 A. I am at the regional clinics for two
10 or three days each quarter. Aside from Greeley,
11 where I am at that clinic on a monthly or
12 every-other-month basis for one day, I am also at
13 the Regional Center for the Handicapped in Grand
14 Junction one day per quarter and here in
15 Colorado, or here on the east slope, the Wheat
16 Ridge Regional Center. I am there for one day
17 per month.

18 Q. How many days a year do you, on
19 average if you can tell me, spend in a hospital
20 setting?

21 A. In the hospital? I am there
22 approximately one month a year.

23 Q. During that one month a year that you
24 are in a hospital setting could you tell me what
25 you do?

8

1 A. Yes. I oversee the clinical
2 activities of the neurology residents at
3 Children's Hospital.

4 Q. And when you say you oversee the
5 clinical activity during that one month, then are
6 you actively involved in the care and treatment
7 of patients?

8 A. Yes.

9 Q. And during your care and treatment of
10 patients, you obviously are familiar with
11 standards of nursing care as they relate to those
12 patients in the nursery, is that right?

13 A. At the Children's Hospital of Denver,
14 yes.

15 Q. I assume at the Children's Hospital
16 of Denver they have nursing care standards or
17 guidelines for the nursery?

18 A. Yes.

19 Q. Would it be fair to state that as an
20 assistant clinical professor at that facility
21 it's well established, is it not, that when a
22 nurse is given an order by a physician or this is
23 a standing order, it's expected that the nurse is
24 to comply with that order, is that right?

25 A. Not always.

1 Q. But if that nurse takes it upon
2 herself to do something which might be injurious
3 to the patient, that is really not good practice,
4 is it?

5 A. As a generalization?

6 Q. Yes.

7 A. If any person does something
8 injurious to a patient it is thought of as not a
9 very good idea.

10 Q. Obviously you must write orders when
11 you are there at the hospital?

12 A. Usually I oversee the residents'
13 orders.

14 Q. When the residents write orders,
15 obviously they would expect that the nurses
16 comply and follow through with their orders,
17 wouldn't they?

18 A. If the orders are appropriate for
19 patient care, certainly.

20 Q. Have you ever been involved in
21 situations where nurses have been peer reviewed
22 for failing to comply with standing orders or
23 hospital guidelines as respects the care of
24 patients?

25 MR. JEFFERS: Objection. Go ahead.

10

1 MS. SCHOENLING: Objection.

2 A. Not personally at any of the
3 hospitals I worked at. I have certainly had the
4 opportunity of reviewing situations like that in
5 law cases.

6 Q. Your web site has a Duke ending to
7 it. Why is that?

8 A. It's actually a Denver University,
9 DU.EDU.

10 Q. I thought it was Duke.

11 A. Yes. I am --

12 Q. Because you were a Duke graduate, I
13 was wondering why.

14 A. I received my master's degree at the
15 University of Denver. I am an ongoing graduate
16 student there, and I also teach a few courses.

17 Q. All right. During the period of time
18 that you spend one month out of a year with the
19 residents in the pediatrics neurology setting, do
20 you actively review CT scans and MRIs?

21 A. Yes.

22 Q. Obviously in the setting of training
23 these physicians they become familiar with
24 Balti's book on child neurology, do they not?

25 A. Yes.

1 Q. What about Menkes' books on pediatric
2 neurology?

3 A. Yes.

4 Q. Those are pretty much staples in what
5 I would call your industry, pediatric neurology,
6 is that right?

7 A. They are two of the four or five that
8 are viewed as being the best.

9 Q. Are you familiar with Vanrobes and
10 Martins' book on neonatology?

41 A. No.

12 Q. Are you familiar with Av Fanaroff?

13 A. No.

14 Q. Are you familiar with Jeffrey
15 Alschuler?

16 A. No.

47 Q. In 1987 and '88 you chaired a
18 malpractice liability insurance task force at the
49 Children's Hospital, Denver, Colorado. Could you
20 tell me what that was about?

21 A. Yes. The hospital was paying huge
22 premiums for its malpractice coverage of its
23 doctors. The hospital paid the malpractice
24 premiums for all of us who were employed there as
25 contract docs, and we looked into whether or not

12

1 the per incident per year coverages were too
2 costly or too wide-ranging and recommended a
3 decrease in coverage for the docs to be more in
4 tune with what our risks were.

5 Q. You also were a member of the
6 Colorado Obstetrics and Gynecological Bar
7 Association Consortium on Tort Reform. Could you
8 tell me what that was about?

9 A. Yes. Prior to tort reform in
10 Colorado the awards for bad baby cases was so
11 high and malpractice rates were going up so much
12 that we recommended that a fund be set up similar
13 to Virginia, where children with disabilities
14 could go to that fund and not have to go through
15 tort.

16 As it turned out, though, tort reform
17 took the form of a limitation of damages here in
18 Colorado, which took the steam out of the engine
19 towards that fund being established.

20 Q. What, to your understanding, is the
21 cap on damages here?

22 MR. JEFFERS: Objection. Go ahead.

23 A. I believe that if a child dies as the
24 result of malfeasance that the award is somewhere
25 around \$45,000. And that, the cap, I am not sure

1 of all the categories, but I know this is one cap
2 at one million. But I am not, I don't know the
3 details.

4 Q. Are you aware that in Ohio we do not
5 have any caps?

6 MR. JEFFERS: Objection.

7 A. No, I didn't know that.

8 Q. Tort reform was struck down.

9 MR. JEFFERS: It hasn't gone to the
10 United States Supreme Court yet.

11 MR. NOVAK: Pigs have wings.

12 Q. Would you tell me about your 1991-92
13 Chairman, Medical Errors Subcommittee QI Team,
14 Children's Hospital.

15 A. In my master's degree training I
16 learned about quality improvement and process
17 analysis, and the first process that Children's
18 Hospital attempted to change was the frequency of
19 medication errors.

20 Q. Okay.

21 A. I chaired that group.

22 Q. How many times have you given
23 testimony for any lawyers in the Cleveland, Ohio
24 area?

25 A. I think this is the first time.

14

1 Q. Do you know how Mr. Jeffers got your
2 name?

3 A. No.

4 Q. Did he ever communicate to you as to
5 how he got your name?

6 A. I believe that he got my name through
7 Robin Leach. Is that the name?

8 MR. JEFFERS: JoEllen Leach.

9 MR. NOVAK: Robin Leach was from
10 Lifestyles of the Rich and Famous.

11 MR. JEFFERS: JoEllen Leach, which
12 came from his articles.

13 Q. How many times have you reviewed
14 cases involving brain damaged babies?

15 A. Over the course of my career,
16 probably 50 times.

17 Q. And on those 50 occasions how many of
18 those reviews were for the plaintiff, as opposed
19 to the defendant?

20 A. Probably 50/50.

21 Q. And out of those 50/50, do you have a
22 recollection as to how many you actually gave
23 testimony on in court?

24 A. I have those records here for the
25 last ten years, and it's 50-50, I believe. I

1 will give you a copy of that if you like.

2 MR. JEFFERS: Do you have some
3 additional ones?

4 THE WITNESS: I could print them off
5 my computer.

6 MR. JEFFERS: Eventually.

7 THE WITNESS: Those cases that you
8 see that went to deposition and trial are a
9 mixture of cases. In this rendition there are
10 only a few that were bad baby cases.

11 Q. Are you familiar with Steven Donn?

12 A. D-O-N-N?

13 Q. Yes.

14 A. Is he one of the persons who has
15 offered an opinion in this case?

16 Q. Yes.

17 A. I have read his opinion.

18 Q. Dr. Michael Johnston, have you read
19 his?

20 A. Yes.

21 Q. Have you read any articles that
22 Dr. Johnston has written?

23 A. I have a very lengthy file that has
24 some of his articles in it.

25 Q. When you say you have a lengthy file

16

1 that has some of his articles in it, what is the
2 purpose of the lengthy file?

3 A. I have a file on, a neonatal file
4 that is very broad. Some of his articles are in
5 the broad file of neonatology. I also have a
6 birth asphyxia file that is thick. Some of his
7 articles are in that file.

8 Q. What is the purpose for having these
9 files?

10 A. For teaching.

11 Q. Prior to today did you review any of
12 Dr. Johnston's articles?

13 A. No.

14 Q. Prior to today could you tell us what
15 literature you did review, other than the
16 materials that you provided us with copies?

17 A. These are the only articles that I
18 reviewed. I read sections of Volpe.

19 Q. Prior to today could you tell us what
20 Mr. Jeffers provided you in the way of materials
21 to review?

22 A. None.

23 MR. JEFFERS: Well, I mean, I sent
24 depositions. Is that what you are asking?

25 MR. NOVAK: Right.

1 MR. JEFFERS: Not articles. He is
2 asking about what I sent to you.

3 THE WITNESS: I am sorry. I reviewed
4 a copy of the complaint, the Elyria Memorial
5 Hospital labor and delivery records from November
6 11th, 1992; the records from the Rainbow Babies
7 and Children's Hospital for the three admissions
8 of Jasmine Merriweather, November 2nd through
9 23rd, 1992, January 4th through February 3rd,
10 1993 and August 2nd through 9th, 1993.

11 I was also sent the records from the
12 Health Hill Hospital, February 3 through March 4,
13 1993, which included the discharge summary. The
14 records of Dr. Max Wiznitzer, W-I-Z-N-I-T-Z-E-R,
15 of the Cleveland Clinic. Office records of
16 Dr. Abrigo, A-B-R-I-(3-0, which included other
17 evaluations and therapy evaluations. The expert
18 reports and depositions of Drs. Joel Engle and
19 Howard Tucker, as well as Dr. Tucker's exam notes
20 of Jasmine Merriweather. The depositions of
21 Mr. and Mrs. Merriweather. The depositions of
22 Dr. Siew, S-I-E-W, and nurses Lancer, Kapronica,
23 K-A-P-R-0-N-I-C-A, Charles and Bartlebaugh. The
24 transport and progress reports from University
25 Hospitals dating from November 11th, 1992. The

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1 MRI scan report of August 5th, 1993. A PT report
2 of September 7, 1993. The discharge summary from
3 the University Hospitals, 2-3-93. And the
4 reports of Drs. O'Grady, Johnston, Donn and
5 Todia, as well as the report of nurse Fink.

6 I also looked at lab reports from
7 University's Rainbow Babies and Children's
8 Hospital as previously mentioned November 2nd
9 through November 23rd, 1992.

10 And then more recently I received and
11 reviewed the prenatal records of Mrs.
12 Merriweather from her obstetrician, Dr. Siew.
13 The lab reports from Elyria Memorial Hospital
14 from Jasmine's birth. And finally, photographs
15 of Jasmine with her family taken prior to January
16 19th, 1999.

17 Q. Have you ever spoken to Dr. Siew or
48 any of the nurses whose depositions were taken?

19 A. No.

20 Q. As part of your analysis do you feel
21 that it was necessary or not necessary to speak
22 to any of these individuals be it by phone or be
23 it on an interview basis to determine whether or
24 not these individuals could appropriately and
25 adequately communicate orders, signs and symptoms.

1 between one another?

2 A. No.

3 Q. Based upon your review of the
4 depositions, do you feel that these individuals
5 could adequately communicate orders between each
6 other, as well as changes in patients'
7 conditions?

8 A. I have no opinion.

9 Q. Have you reviewed the Elyria Memorial
10 Hospital Newborn Nursery Transitional Guidelines?

11 A. No.

12 Q. I am going to hand you a copy of
13 these guidelines.

14 A. Thankyou.

15 Q. I would like you to take a quick look
16 at those.

17 (Witness examines document.)

18 MR. NOVAK: While the doctor is
19 looking at those, John, could I take a look at
20 his notes?

21 MR. JEFFERS: Sure.

22 MR. NOVAK: Thanks, that will save
23 some time.

24 THE WITNESS: I will be happy to give
25 you copies of those, too, if you want them.

20

1 Q. I am looking at your notes here. It
2 says Howard Tucker not a fellow member of the
3 AAN. What is the AAN?

4 A. American Academy of Neurology.

5 Q. He is board certified. . You have a
6 note: Therefore may not have his boards.

7 A. Right. That was a note to myself.

8 Q. He has been board certified. I think
9 we all agree on that. Is there a reason why you
10 have some question on this?

11 MS. SCHOENLING: Which board
12 certification are you referring to, Bill?

13 MR. NOVAK: He is a board certified
14 neurologist.

15 Q. I am going to ask, are there
16 different certifications?

17 A. The fact his name was in last year's
18 Child Neurology Society membership and was not in
19 last year's American Academy of Neurology
20 membership raised the possibility that he was not
21 boarded, because the only requirement for being
22 an AAN member is board certification. And that
23 is not a requirement for the Child Neurology
24 Society, you can be a pediatrician and be a
25 member of the Child Neurology Society. So I

1 thought it was peculiar enough to at least raise
2 the question.

3 Q. You have a note about Dr. Siew. It
4 says: This memo demonstrates the doctor's poor
5 grasp of the English language. Otherwise, no
6 comment, no criticism. What does that mean?

7 A. I thought that his use of English in
8 his depo was reflective of his nationality and
9 was not as good as perhaps a native American.

10 Q. Does that create problems with
11 respect to communications between nurses and a
12 physician such as Dr. Siew, where he does not
13 have the grasp of the language as you have
14 described which would be like a native American?

15 MR. JEFFERS: Objection.

16 MS. SCHOENLING: Note my objection.

17 A. This is a potential for that whenever
18 this is a person not using his or her native
19 language.

20 Q. We will get back to these.

21 In looking at these Elyria Memorial
22 Hospital Medical Center newborn nursery
23 transitional phase notes, I want to ask you a few
24 questions. It indicates that all infants are to
25 be observed and cared for in the transitional

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1 nursery phase for the first 24 hours or longer if
2 deemed necessary.

3 Then it has a heading for vital
4 signs, color, activity. Then it says:
5 Respirations, 32 to 60, with no symptoms of
6 distress, grunting, flaring or retracting. Then
7 under 4 it says: Document. Report any variation
8 from the above normals and report on nursery flow
9 records.

10 You have had an opportunity, have you
11 not, to read the Polly Kapronica's deposition?

12 A. Yes.

13 Q. By the way, I will also want to
14 mention to you in line with what I just read, I
15 am sure you are familiar with the nursing care
16 plan that was in effect for baby girl
17 Merriweather for November 11, 1992, is that
18 correct?

19 A. No, I am not.

20 Q. But you indicated you reviewed the
21 Elyria Memorial records?

22 A. Certainly did.

23 Q. Under number 2 it says potential for
24 ineffective breathing pattern/cardiac output.

25 Under C, nurse action intervention, it says

1 record and report significant findings, somewhat
2 consistent with the transitional phase
3 guidelines, is that right?

4 A. Yes.

5 Q. Then under number 4 it says potential
6 for altered nutrition; nursing action
7 intervention letter D says observe and report
8 respiratory distress with feeding.

9 Is that pretty much standard in every
10 hospital that you have worked in?

11 A. Certainly.

12 Q. Now you are aware, are you not, that
13 at 1:30 a.m., Polly Kapronica was the only R.N.
14 available to see Jasmine Merriweather as she was
15 being fed by an L.P.N., and at the time that
16 Jasmine had a spell of apnea, nurse Kapronica
17 took it upon herself not to call any physician.
18 Are you aware of that?

19 (The record was read as requested.)

20 MR. JEFFERS: I am not sure all your
21 facts in your long statement are accurate, that
22 is the only problem with it.

23 If your question is is he aware of
24 what the record shows at that time, 1:30, that
25 may be another question.

24

1 A. I think that it's possibly, if not
2 probably true. And if it is true, it has no
3 bearing on the case.

4 Q. Well, let me ask you this: Here was
5 a question asked of her on page 16 of her
6 deposition. The question was: At any time at
7 1:30 when this episode took place, is there any
8 note in the chart that you reported this to any
9 physician?

10 Answer. No, I didn't think it was
11 necessary.

12 Wouldn't you agree with me that based
13 upon the newborn nursery transitional guidelines,
14 based upon the nursing care plan and the order in
15 the nursing care plan, that nurse Kapronica when
16 confronted with apnea and this episode that
17 occurred at 1:30 was required pursuant to the
18 guidelines and pursuant to the plan to report
19 this?

20 MR. JEFFERS: Objection.

21 A. I don't know.

22 Q. Well --

23 A. It depends on how severe the episode
24 was, how long-lasting it was, whether it was --

25 Q. We really don't know how long it was,

1 do we?

2 A. No.

3 Q. Because nurse Kapronica doesn't know
4 how long it was, does she?

5 A. No.

6 Q. In fact, she didn't write down how
7 long it was, did she?

8 A. Let me look at my notes.

9 Again, it makes absolutely no
10 difference to the case. But I believe that the
11 note that was written was that the infant was
12 being fed by the L.P.N., became cyanotic in
13 color, starting circumorally. Then the entire
14 body became blue and the infant stopped
15 breathing. Held the infant upside down and
16 patted the back, and the infant began to cry and
17 color became normal. Pulse ox was 98 percent
18 before and after the episode.

19 MR. JEFFERS: I think it says 98,
20 actually, in the record.

21 THE WITNESS: That is what I said, I
22 believe. 98 percent before and after the
23 episode. Went down to 84 percent during the
24 cyanotic episode. Because the child recovered so
25 rapidly, whether or not it was a nurse's

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1 prerogative to either record it or to notify the
2 doctor is subjective and again plays no role in
3 this case.

4 Q. Well, you are assuming that the child
5 recovered rapidly, aren't you?

6 A. Certainly.

7 Q. Because the fact of the matter is
8 that Polly Kapronica has no recollection of the
9 amount of time that this patient spent in this
10 apneic state, isn't that correct?

11 A. I guess it would depend how soon
12 after the event she was deposed as to how long it
13 lasted.

14 Q. She doesn't record it, does she?

15 A. She recorded it in a nursing note.

16 Q. But she doesn't record the length of
17 time that this episode lasted?

18 A. That's correct.

19 MR. JEFFERS: Other than by
20 inference.

21 Q. It could have lasted a half an hour,
22 couldn't it?

23 MR. JEFFERS: Objection. This is the
24 could be, Chicken Little, sky will fall.

25 MR. NOVAK: You make the objections

1 only, otherwise you get a sock in your mouth
2 today.

3 MR. JEFFERS: I am going to explain
4 something to you. You have been a permanent open
5 mouth, totally vocal individual on everything.

6 MS. SCHOENLING: Testifying
7 individual. Come on, John.

8 MR. JEFFERS: Testifying. Forgot
9 that. If I choose to make any comment, I am
10 going to make it and you can say objection and
11 then you can do whatever you want to do.

12 MR. NOVAK: I have only picked up on
13 your verbosity and foul-mouthed garbage from the
14 depositions I took of your nurses when you
15 realized they were going into the tank.

16 MR. JEFFERS: Your self-serving
17 comment is noted, as usual.

18 MS. SCHOENLING: You have got to give
19 them credit, Doctor, they do it with civility.

20 THE WITNESS: Never happens in the
21 doctor community.

22 Q. I guess my question is you made a
23 comment, you said, well, there was a 98 percent
24 pulse ox before the episode and a 98 percent
25 after.

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1 But the fact is that the 98 percent
2 that is recorded after as recorded in the chart,
3 the next one was at 4 o'clock, wasn't it?

4 A. I don't know. Again, assuming that
5 that's the case, it makes no difference to this,
6 to this case.

7 Q. So I guess my question is --

8 MR. JEFFERS: I am going to object,
9 because I see what you are trying to do. But it
10 says on that second one at 4 o'clock, pulse ox
11 dropped again to 84, which is again an inference
12 that it was back to 98 for the entire time
13 between those two. So you are taking it out of
14 context.

15 MR. NOVAK: John, are you telling me
16 that the one under column 4 a.m. 98 percent is
17 really a fudge because it was really 84 percent?

18 MR. JEFFERS: Say that again?

19 MR. NOVAK: Are you saying the nurse
20 fudged in the column?

21 MR. JEFFERS: No, I am not saying --

22 MR. NOVAK: I heard that.

23 MS. SCHOENLING: I didn't hear that.

24 MR. JEFFERS: You hear things only

25 Walt Disney writes about.

1 THE WITNESS: For the record the
2 answer is that the note dated 1:30 a.m. which
3 ends with nurse Kapronica's signature tells that
4 the pulse ox returned to 98.

5 Then this is a nurse's note following
6 her note that states that the pulse ox went down
7 to 84 percent during the cyanotic episode. And
8 then in a completely different entry at 4 o'clock
9 in the morning this is an entry that the pulse ox
10 again dropped to 84 percent and went to
11 98 percent.

12 Q. But once again, my question is this
43 is no evidence in this case as to how long these
14 episodes lasted, isn't that correct?

15 A. That is absolutely correct. And it's
16 irrelevant to the case.

47 Q. Let me ask, if it's irrelevant--
18 let's assume hypothetically that up to 1:30 a.m.
19 on the 12th, this child was perfectly normal and
20 had an apneic spell which lasted an hour.

21 MR. JEFFERS: Are you saying
22 perfectly normal in all respects, or in terms
23 of --

24 MR. NOVAK: All respects between the
25 time of delivery and time of the apneic spell.

30

1 MR. JEFFERS: Your experts have
2 already testified that is not so.

3 MR. NOVAK: I am asking a question.

4 THE WITNESS: Let's let the apneic
5 spells go for three hours. Let's say that that
6 is what happened here.

7 Q. Did it cause cerebral palsy?

8 A. No.

9 Q. Brain damage?

10 A. No.

11 Q. So a child can have a spell of
12 cyanosis, stop breathing for three hours, and you
13 have no damage?

14 MR. JEFFERS: Objection.

15 A. A child would certainly expect to
16 have cerebral palsy as a result of that. This
17 child could not have had that happen to her.

18 Q. Now --

19 A. As we will see from the remainder of
20 the testimony.

21 Q. We now have a 1:30 episode and a
22 4 o'clock episode. In your notes you wrote
23 down: Not reported as a seizure.

24 A. Yes.

25 Q. Do you know if Polly Kapronica would

1 know the difference between a seizure or not a
2 seizure?

3 MR. JEFFERS: Objection.

4 A. She is an R.N. in a neonatal unit. I
5 am sure she is very capable.

6 Q. Do you know what experience she had?

7 A. No.

8 Q. When you use the words "very
9 capable," aren't you maybe giving her a little
10 more credit than she is due?

11 A. Well, we have done a study here in
12 Colorado of school children and their ability to
13 recognize seizures. And school children, with no
14 medical training, are absolutely, one
15 hundred percent accurate in recognizing a true
16 seizure.

17 Q. Do you know what Polly Kapronica's
18 educational background was before she saw this
19 episode at 1:30 on November 11th, 1992?

20 A. Higher than grade school.

21 Q. Do you know what level of nursing she
22 was in?

23 A. No.

24 Q. Would it make a difference to you to
25 find out that she was in an orientation program

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1 and this was kind of like her first round through
2 the nursery?

3 A. No.

4 Q. It wouldn't make any difference to
5 you?

6 A. Not at all, not in this case.

7 Q. So you are telling me then that a
8 rookie nurse who didn't report a change in
9 respiration pursuant to the guidelines, a rookie
10 nurse who didn't report change in respiration
11 pursuant to the nursing care plan that is a
12 standing order in this chart, it wouldn't make
13 any difference to you that she violated both of
14 those orders and you honestly believe that this
15 woman knew what a seizure was, is that right?

16 A. It makes, it makes absolutely no
17 difference in this case whether her care of this
18 infant was appropriate or not or whether she
19 followed the rules or not, because no damage
20 occurred to the baby because of whatever mistakes
21 she may or may not have made.

22 Q. Doctor, that is not my question. My
23 question for you is --

24 A. That will be the question for the
25 jury.

1 Q. That is for Mr. Jeffers to ask, and
2 you can go to down with him in front of the jury
3 all you want.

4 My question for you is, when a nurse
5 violates a guideline and a nurse violates a
6 standing nursing care plan order, when a baby
7 stops breathing, and doesn't report it to anybody
8 until 8 o'clock in the morning and she has two
9 episodes before that of apnea, isn't that a
10 violation of good nursing practice?

11 MR. JEFFERS: Objection. You loaded
12 the question in the beginning. It's an
13 impossible question. You ought to read it back.
14 It's really a lousy question.

15 MR. NOVAK: I will read it back for
16 dense people like you.

17 MR. JEFFERS: I need a lot of help,
18 Bill, because you are an intellect.

19 Q. Assume the following: That this is a
20 nursing care plan in effect that requires the
21 nurse to report findings or changes in breathing
22 respirations.

23 I want you to assume that this is a
24 newborn nursery transitional phase guideline for
25 Elyria Memorial Hospital that requires reports of

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1 any variations from normal in respirations.

2 I want you to assume that at 1:30 and
3 at 4 o'clock nurse Kapronica took it upon herself
4 not to call the physician because she didn't feel
5 it was necessary.

6 I want you to assume that the first
7 time she reported it to anybody was the nurse
8 R.N. who came on at about 7 or 8 o'clock in the
9 morning and that was the first time she did
10 anything about those two spells.

11 Would it be fair to state, forget the
12 causal issues, that when a nurse does what she
13 did, in fact when a nurse doesn't do what she
14 did, it's a violation of good nursing practices,
15 isn't that right?

16 MR. JEFFERS: Objection.

17 Q. Forget the cause issue.

18 MR. JEFFERS: Objection.

19 A. Well, I don't know whether it would
20 be or not in this circumstance.

21 Q. I mean, Doctor, I love you dearly,
22 but you know and I know that if a nurse doesn't
23 follow guidelines, if a nurse doesn't follow
24 standing orders, that is bad nursing practice,
25 isn't it?

1 MR. JEFFERS: That is a separate
2 question, a hypothetical question unrelated to
3 what she knew.

4 MR. NOVAK: I am asking you that
5 now.

6 A. Generally speaking, most hospitals do
7 the best work when people are following work
8 orders that are well thought out and have been
9 agreed upon by medical staff. And people who are
10 not following work orders are not doing a good
11 job,

12 On the other hand, if the work order
13 itself is improperly written and if a nurse is
14 using her own judgment as to what would be best
15 for the patient, then standing orders can be
16 abridged by professional persons including nurses
17 if they feel in their professional judgment those
18 standing orders are not in the best benefit of
19 their patient.

20 Q. But professional judgment is based on
21 education, training and knowledge, isn't that
22 right?

23 A. That's correct.

24 Q. So assuming those factors to be in
25 place, you have to assume Polly Kapronica knew

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1 what she was looking at, is that right; had good
2 training and understood what an apneic spell was,
3 isn't that correct?

4 A. That is correct.

5 Q. You would not want nurses to violate
6 standing orders and hospital guidelines of
7 patients under your care, would you?

8 A. As a general sense, no.

9 Q. Now--

10 A. Certainly, no, if it made any
11 difference in the patient's outcome, which of
12 course it didn't in this case.

13 Q. I understand that is what you want to
14 sell. But my question for you is, apart from the
15 causation issue, the fact of the matter is that
16 this nurse violated the guidelines and the
17 standing orders, did she not?

18 MR. JEFFERS: Objection. You asked;
19 he answered. Why should he bother answering
20 again?

21 MR. NOVAK: Because he didn't answer
22 the question I just asked.

23 The fact of the matter is she
24 violated both the standing order and
25 guidelines --

1 MR. JEFFERS: He just explained why
2 it might not be.

3 MR. NOVAK: I am --

4 MR. JEFFERS: So it's tough.

5 MR. NOVAK: Are you telling me you
6 are not going to let him answer the question? Do
7 you want to fly back out here?

8 MR. JEFFERS: I am telling you you
9 are getting ridiculous. This is repetitious.

10 Q. This is very simple. We will move
11 on.

12 The fact of the matter is she
13 violated the guidelines and she violated the
14 standarding orders, didn't she?

15 MR. JEFFERS: Objection. Asked and
16 responded.

17 Q. Whether you believe it had anything
18 to do with the cause.

19 MR. JEFFERS: Objection.

20 A. If the child's episode was momentary,
21 with a very brief fall of the pulse ox 02 from 98
22 to 84 to 98, she may have met the intent of the
23 guideline and standards by recording it in her
24 nursing note and not notifying anyone.

25 If it was a more prolonged episode

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1 she certainly would have abridged both the
2 guideline and the nursing orders by not having
3 notified anyone or recorded it as such.

4 Q. But the problem is in this case we
5 really don't know how long it is. So maybe you
6 think it's a violation then, and maybe you don't,
7 right?

8 MR. JEFFERS: Objection.

9 A. That's correct.

10 MR. NOVAK: At least I got that out
11 of him, John.

12 MR. JEFFERS: Give yourself a gold
13 star.

14 MR. NOVAK: I am going to put it
15 right on your forehead.

16 MR. JEFFERS: You can't miss. But
17 you are much younger, and you will be there soon.

18 Q. Let me ask you this: Regarding this
19 communication issue --

20 MR. JEFFERS: Objection. This is no
21 communication issue. Go ahead.

22 MS. SCHOENLING: I will join in the
23 objection.

24 Q. Regarding the language issue --

25 MR. JEFFERS: Objection.

1 Q. -- you have reviewed the chart of
2 Jasmine Merriweather's mother, did you not?

3 A. Yes.

4 Q. Prior to the delivery did you see any
5 progress notes written by Dr. Siew?

6 A. Id have to look back at the notes.
7 But let me look at what notes I took of those
8 records.

9 What I wrote from my review of
10 Dr. Siew's notes was good monthly follow-ups
11 throughout the pregnancy.

12 Q. But was that a progress note?

13 MS. SCHOENLING: I think he said
14 those were his notes.

15 MR. NOVAK: I know.

16 Q. I am asking, in the chart is there
17 any progress note of Dr. Siew evaluating the care
18 and treatment of this patient once she commenced
19 labor up to the time of delivery?

20 MS. SCHOENLING: I am sorry. You are
21 not talking prenataally, you are talking when she
22 went into labor?

23 MR. NOVAK: Right. Once she went
24 into labor, up until the time of delivery.

25 A. I see a series of notes that are

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1 very, very difficult for me to read, with the
2 date of November 11th.

3 MR. JEFFERS: It says delivery note.

4 THE WITNESS: November 12th and
5 November 13th.

6 Q. I want you to assume the first note
7 you are looking at is a note post delivery, and
8 there was no note between the time of the onset
9 of labor and the delivery?

10 MS. SCHOENLING: Objection.

11 Q. Does that surprise you?

12 MS. SCHOENLING: Objection.

13 MR. JEFFERS: Objection. By the way,
14 it should be noted for the record that Dr. Reiley
15 is not here and has not been asked to make
16 judgments relative to Dr. Siew.

17 MR. NOVAK: I understand.

18 MR. JEFFERS: Just so you know.

19 MR. NOVAK: I understand.

20 MR. JEFFERS: So I object.

21 A. I have no opinion.

22 Q. So you have no opinion about this
23 physician's failure to put down any progress
24 notes of the, from the period of time, the onset
25 of labor up to the time of delivery, is that

1 right?

2 MS. SCHOENLING: Objection.

3 A. I don't know what the requirements
4 were for physician entries at this hospital for
5 admitting obstetricians, nor do I think I want to
6 know.

7 Q. You read the report of Dr. John
8 Patrick O'Grady, is that right?

9 A. Yes.

10 Q. Have you had a chance to look at his
11 book entitled Operative Obstetrics?

12 A. No.

13 Q. Mr. Jeffers has filed a pleading with
14 the court indicating that he also intends to use
15 Dr. O'Grady as one of his experts. I just wanted
16 to ask you a question as a general principle --

17 MR. JEFFERS: What year is that
18 book?

19 MR. NOVAK: I don't know.

20 MR. JEFFERS: Tell me.

21 MR. NOVAK: I don't know. I don't
22 know.

23 MR. JEFFERS: That apparently must
24 have been after 1992.

25 MR. NOVAK: Yes, it is. It is.

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1 MR. JEFFERS: It is after 1992?

2 MS. SCHOENLING: 1995.

3 MR. NOVAK: Whatever.

4 MS. SCHOENLING: John.

5 MR. JEFFERS: It's 1995?

6 MS. SCHOENLING: Yes.

7 MR. JEFFERS: I object.

8 MR. NOVAK: You can object because it
9 has to do with Dr. O'Grady's book.

10 Q. Anyway, the question I have for you
11 is the following:

12 MR. JEFFERS: Are you going to
13 preface your reading?

14 Q. I want you to tell me if you agree or
15 disagree with the general proposition in the
16 preface that Dr. O'Grady writes', let me read this
17 to you: In the preparation of this text our
18 purpose is to promote thoughtful, compassionate
19 and technically and ethically competent clinical
20 practice with close attention to patient
21 communication and meticulous record-keeping.

22 MS. SCHOENLING: Object.

23 Q. Would you agree as a general
24 statement?

25 MS. SCHOENLING: Note my objection

1 based on the reference to the publication and any
2 other reference to this publication.

3 MR. JEFFERS: Object.

4 MR. NOVAK: I am going to blow these
5 pages up for the trial.

6 MS. SCHOENLING: We were hoping you
7 would.

8 Q. As a general principle in a teaching
9 hospital that you are in would you agree with
10 that --

11 MR. JEFFERS: In his teaching
12 hospital?

13 A. The answer is certainly.

14 Q. All right. Do you feel an OB/GYN who
15 doesn't write a progress note from the onset of
16 labor to the time of delivery is comporting with
17 the notion of meticulous record-keeping?

18 MR. JEFFERS: Objection.

19 MS. SCHOENLING: Objection.

20 MR. JEFFERS: Already asked and
21 answered.

22 MS. S~HOENLING: He's already told
23 you he doesn't have any opinions on that.

24 MR. NOVAK: That is not what he said.

25 MS. SCHOENLING: Yes, it is what he

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1 said.

2 MR. NOVAK: Well, I am changing it a
3 little bit now, this is a different question.

4 MR. JEFFERS: The subtleties are too
5 much. Go ahead and answer if you can.

6 A. I don't remember the question. .

7 (The record was read by the
8 reporter.)

9 A. The answer is that there are
10 circumstances in certain deliveries where the
11 only time to write the note is at the time of
12 delivery.

13 Q. Now, I would also ask you a question
14 from Dr. O'Grady's book, page 333. And I would
15 ask you if you agree with this statement in
16 general: It is imperative to an effective
17 defense that the medical records adequately
18 reflect the physician's ongoing thought process
19 in providing obstetric care. Do you agree with
20 that?

21 MR. JEFFERS: Objection.

22 (Discussion off the record.)

23 Q. It is imperative to an effective
24 defense that the medical records adequately
25 reflect the physician's ongoing thought process

1 in providing obstetric care.

2 MS. SCHOENLING: Note my objection.

3 Q. As a general statement do you agree
4 with that?

5 MR. JEFFERS: Objection.

6 MS. SCHOENLING: Note my objection.

7 MR. JEFFERS: Page 333?

8 MS. SCHOENLING: Yes, 333.

9 MR. NOVAK: Yes.

10 A. As a general statement I think that
11 is true for any, any physician.

12 Q. When you looked at this chart, during
13 the period of time of her labor are you able to
14 glean anything from that chart of Dr. Siew's
15 thought process?

16 A. I wasn't asked to do that and I
17 didn't attempt to do that.

18 Q. I understand that. But you did
19 review the chart, didn't you?

20 A. I did.

21 Q. I guess is there anything, progress
22 notes, handwritten notes of Dr. Siew, anything in
23 the way of records that would document --

24 MR. JEFFERS: Orders, for example,
25 things of that nature, anything?

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1 Q. Document his thought process as to
2 how he was to approach this patient from the time
3 she was admitted to the time she delivered?

4 MR. JEFFERS: Objection.

5 MS. SCHOENLING: Objection.

6 A. I have no recollection.

7 Q. You indicated earlier -- by the way,
8 there were some questions in Dr. Tucker's
9 deposition about cerebral edema. Would you agree
10 that this is no mention of cerebral edema either
11 at Elyria Memorial Hospital or at the first
12 admission at University Hospital?

13 A. That's correct.

14 Q. Now would you also agree that you
15 don't have to have cerebral edema in every
16 instance of hypoxic ischemic encephalopathy?

17 A. I think that that is false.

18 Q. Now are you familiar with Chapter 7
19 of Dr. Volpe's book, the chapter dealing with
20 hypoxic ischemic encephalopathy, 1987 edition,
21 page 182, where he indicates the following after
22 he goes on to discuss the experiments with the
23 animals and he says the following: Our own
24 experience and that of others leads to the
25 conclusion that brain swelling per se is not a

1 prominent feature of hypoxic ischemic
2 encephalopathy in the human newborn.

3 A. In the selective neuronal necrosis
4 and in the pontocerebellar tract necrosis, the
5 edema may be very subtle. But whenever this is
6 destruction of or damage to brain cells there are
7 site toxic edema either within the cell or
8 surrounding the cell that may or may not be
9 prominent to testing.

10 Q. That could be why the CT scan didn't
11 show anything in the first admission, isn't that
12 right?

13 A. If we are assuming that this child's
14 injury occurred because of hypoxic ischemic
15 encephalopathy that occurred intrapartum, then
16 there had to have been some evidence of either
17 injury or edema on one of the early films.

18 Q. But you don't have to have that
19 happen all the time?

20 A. You have to have it happen all the
21 time. It may not be edema, but it will be
22 evidence of some softening, some change in brain
23 structure.

24 Q. Doctor, I have handled a number of
25 these cases and I have to tell you, my personal

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1 experience is that I have not seen edema on all
2 of the CT scans. So I guess my question for you
3 is --

4 Let me finish, John.

5 MR. JEFFERS: I know. I am just, I
6 find your statement amazing.

7 MR. NOVAK: Let me finish.

8 Q. Are you telling me, then, that every
9 time this is a hypoxic ischemic insult during the
10 labor and delivery process, perinatal, that you
11 will always see edema on a CT scan taken within
12 24 hours?

13 MS. SCHOENLING: Objection.

14 A. No.

15 Q. You won't?

16 A. No.

17 MS. SCHOENLING: You mischaracterized
18 his testimony.

19 THE WITNESS: No, you won't see it
20 within **24** hours.

21 MR. NOVAK: I think I did.

22 MS. SCHOENLING: You think you did
23 mischaracterize his testimony?

24 MR. NOVAK: Yes.

25 MS. SCHOENLING: I do, too.

1 Q. Let's talk a little bit about the
2 timing of the episodes. The delivery occurred I
3 believe at 1:10 p.m. on the 11th, is that right?

4 A. 1:10 on November 11th.

5 Q. The first episode occurred at 1:30
6 a.m. on the 12th, the next episode occurred at 4
7 a.m., and I believe the next episode occurred at
8 8:00 a.m.

9 MS. SCHOENLING: Will you tell me the
10 page in Volpe referenced in the set of
11 questions?

12 MR. NOVAK: 182.

13 Q. Would you agree with this general
14 statement, that generally one sees seizure
15 activity within a period of 12 to 24 hours
16 following what I will call an HIE insult?

17 A. Yes.

18 Q. Would you agree with me that the
19 timing of the seizure activity in this newborn
20 does fall within the parameters of that 12 to 24
21 hours?

22 A. Yes.

23 Q. In fact, Dr. Johnston has written the
24 HIE, you will see the neurologic manifestation
25 within a 12- to 24-hour period, is that right?

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1 A. Yes.

2 Q. Dr. Volpe has written about that,
3 hasn't he?

4 A. He has written about seizures as
5 being one of the signs of HIE in the first 24
6 hours.

7 Q. Dr. Menkes has done the same, isn't
8 that is right?

9 A. Yes, one of the signs.

10 Q. So in terms of the seizure activity
11 this patient does fit the picture, is that right?

12 A. Just -- yes.

13 Q. If we are talking about this 12- to
14 24-hour period, when we are able to then relate,
15 assuming that this is a hypoxic ischemic insult
16 that occurred during labor and delivery, we are
17 able to relate that back to the labor and
18 delivery time, aren't we?

19 MR. JEFFERS: Objection.

20 MS. SCHOENLING: Objection.

21 Q. Assuming that is the case.

22 MS. SCHOENLING: Note my objection.

23 Q. Based upon this clinical
24 manifestation.

25 A. I can't make that assumption,

1 therefore it's ridiculous to answer your
2 question.

3 Q. My question is this: From a timing
4 standpoint you have indicated that you agree with
5 Johnston, Volpe and Menkes that you generally see
6 seizure activity within 12 to 24 hours after an
7 insult, is that right?

8 A. An HI insult, yes.

9 Q. Seizure activity which this child had
10 followed from a period 12 to 24 hours, isn't that
11 right?

12 A. Yes.

13 Q. You would agree with me that the
14 episode at 8:00 a.m. was a seizure activity, was
15 it not?

16 A. No.

17 Q. The reason is?

18 A. The child was described as having
19 circumoral cyanosis with intercostal
20 retractions. There was no description of a
21 seizure.

22 Q. Would you agree with me apnea is a
23 manifestation of a seizure?

24 A. It can be manifestation of a
25 seizure. It can also be a manifestation of many

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■ other types of alterations in neonate's
2 physiology.

3 Q. We know the patient had apnea at 1:30
4 a.m., 4 a.m. and 8:00 a.m., isn't that correct?

5 A. I am not aware there was apnea at 4
6 a.m.

7 Q. But we do know there was apnea at
8 1:30?

9 A. Yes, sir.

10 Q. And apnea at 8:00 a.m.?

11 A. Yes.

12 Q. And we agree with the notion that
13 apnea is a clinical manifestation of seizure
14 activity. The question then becomes whether or
15 not the observer understands whether or not the
16 apnea they are seeing is related to the seizure
17 activity, is that right?

18 MR. JEFFERS: Objection.

19 MS. SCHOENLING: Join in the
20 objection.

21 A. That is true. However, I am going to
22 have an apneic episode right now, and I'd like to
23 have you tell me whether it's a seizure.

24 Q. I am not a nurse. Okay. But you are
25 not -- --

1 MR. JEFFERS: But you graduated from
2 high school.

3 Q. You are not sticking your tongue out,
4 are you? And you haven't arched your back. And
5 I don't think you are having a seizure.

6 A. But I did have an apneic episode for
7 20 seconds.

8 Q. At 4 a.m. when the infant's back
9 became stiff. You would agree with me, would you
10 not, that that can be a clinical manifestation of
11 seizure activity?

12 A. Yes, I would call that a possible
13 seizure.

14 Q. Would you agree that poor suck is a
15 manifestation of seizure activity?

16 A. No.

17 Q. How about gagging?

18 A. Possibly.

19 Q. How about a patient who is fussy?

20 MR. JEFFERS: Fussy?

21 MR. NOVAK: Fussy.

22 A. No.

23 Q. I guess the bottom line, Doctor, is
24 what it all boils down to is whether or not what
25 is described here is an accurate portrayal of

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1 what was going on between the period of 1:30 a.m.
2 and 8 o'clock, isn't that right?

3 A. What it all boils down to is whether
4 or not the questioning that I have been getting
5 from you for the last hour and 20 minutes has any
6 relevancy to the case. That is what it boils
7 down to.

8 Q. But, see, what you think is relevant
9 to the case is his defense. What I think is
10 relevant may be totally different. Could we
11 agree?

12 A. I work enough for plaintiffs to know
13 what is relevant and this is irrelevant.

14 Q. How much are you being paid by
15 Mr. Jeffers?

16 A. \$550 an hour.

17 Q. How much has he paid you to date?

18 A. I don't know. Probably \$5,000.

19 Q. Then he will pay you for preparation
20 time before trial, right?

21 A. Yes. Probably similar to the amounts
22 that you are spending on your own experts.

23 Q. Okay. Now you think this is
24 irrelevant. Let me ask you this: I want you to
25 assume that this patient had an insult prior to

4 the 1:30 episode of apnea. I want you to assume
2 that. I want you to assume that the episode at
3 1:30 was seizure activity. Can you do that for
4 me, just assume those facts?

5 A. I will make a hypothetical leap with
6 you.

7 MS. SCHOENLING: Note my objection.

8 Q. Would you agree with me that assuming
9 an insult occurred during labor and delivery,
10 which is going to be the testimony of our
11 experts, and assuming that there was seizure
12 activity that occurred at 1:30, that early
13 recognition of seizure activity and prompt
14 treatment at 1:30 was mandatory on the part of
15 that nurse?

16 MR. JEFFERS: Objection.

17 A. Absolutely not.

18 MS. SCHOENLING: Objection to the
19 question.

20 Q. Are you familiar with Dr. Johnston's
21 article written also by Dr. Donn on birth
22 asphyxia issues in neurologic management, did you
23 ever see that one?

24 A. Not that article, but I am familiar
25 with his opinions.

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1 Q. Would you agree with this general
2 statement?

3 MR. JEFFERS: Can I have the year and
4 date on that?

5 MR. NOVAK: 1989.

6 MR. JEFFERS: I should say the
7 article.

8 MR. NOVAK: I gave you the article.

9 MS. SCHOENLING: What is the title?

10 MR. NOVAK: The article is called
11 Birth Asphyxia Issues in Neurologic Management.

12 MS. SCHOENLING: Thank you.

13 MR. JEFFERS: And the publication?

14 MR. NOVAK: Blackwell Scientific
15 Publications, and it's on page 106.

16 Q. This is what the comment is. It
17 says: Aside from maintenance of adequate
18 cerebral perfusion, prevention of convulsions or
19 their rapid control when they occur has the
20 strongest rationale of any intervention in the
21 asphyxiated infant. As outlined above seizures
22 are likely to add a major insult to the
23 preexisting injury, and vigorous but safe
24 anti-convulsive therapy is strongly indicated.
25 Attention needs to be given to the identification

1 of infants who should be placed on prophylactic
2 anticonvulsants after asphyxia since the seizures
3 are difficult to stop once they begin.

4 Do you agree with that statement?

5 A. Absolutely not.

6 Q. So you don't agree with Mr. Jeffers'
7 two experts that he is going to use, Dr. Donn and
8 Dr. Johnston, right?

9 MS. SCHOENLING: Actually, they are
10 my experts.

11 MR. NOVAK: They are his experts,
12 too.

13 A. I believe that comment in that
14 article is dated by it being 1989. And
15 subsequent writings by virtually all experts on
16 seizures in HIE would dispute that 1989
17 interview.

18 Q. But at the time this patient was at
19 Elyria Memorial Hospital in '92, this would have
20 been the standard, wouldn't it?

21 MS. SCHOENLING: Objection.

22 A. No, I don't believe so.

23 Q. Well, let me ask you this.

24 A. I know what I have just said is
25 controversial, but that is just not modern

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1 thinking about the danger of seizures in the
2 asphyxiated newborn.

3 Q. Dr. Donn, in an article called
4 Asphyxia Neonatorum --

5 A. Date?

6 Q. 1986, Journal of Family Practice,
7 page 545, said: Early identification -- I am
8 sorry. Anticipation of the sequelae of asphyxia
9 neonatorum and aggressive treatment of problems
10 as they first arise will be the key to reducing
11 the high morbidity associated with this
12 unfortunate event.

13 A. That is absolutely false.

14 Q. So the two statements the two experts
15 that have been retained by Dr. Siew and
16 Mr. Jeffers has incorporated into his own case,
17 you believe these two statements are false?

18 MR. JEFFERS: 1989 and 1986.

19 A. Let me clarify what I said. They are
20 referring to seizures which were due to hypoxic
21 ischemic encephalopathy based on the science of
22 1986 and 1989. We now know that thinking was
23 false. It is irrelevant to this case because
24 this particular child, now getting back from the
25 leap of -- into fantasy that we had a few minutes

1 ago, this child did not have seizures that were
2 related to intrapartum asphyxia. So regardless
3 of whether or not their writings were true or
4 false, it made absolutely no difference in this
5 case.

6 Q. Assuming that this newborn did have a
7 hypoxic ischemic event, would you agree with the
8 general statements that I read to you from those
9 two articles?

10 A. No.

11 Q. As the standard existed in 1992?

12 A. No.

13 Q. And you feel those statements are
14 false, is that right?

15 A. That's correct.

16 MR. JEFFERS: You will be able to get
17 to ask both of them their opinions on that.

18 MR. NOVAK: Sure. They will probably
19 say, gee, I think I am going to change my mind
20 now.

21 MS. SCHOENLING: I doubt that is what
22 they are going to say.

23 MR. JEFFERS: We have not progressed
24 in medicine, you have to understand.

25 MR. NOVAK: I know. You haven't

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1 progressed)either.

2 MR. JEFFERS: Of course not, I am a
3 regressive person, all Marines are.

4 Q. Let's talk a little bit about
5 multi-organ failure, multi-organ injury. Do you
6 feel it has to occur in every case?

7 A. No.

8 Q. Then you would agree with me that,
9 are you familiar with Perlman's studies that
10 indicated that out of all of the instances of
11 perinatal asphyxia that he studied, only about
12 67 percent had multi-organ failure and out of
13 that, 70 percent, it was really into one organ,
14 that being the kidney?

15 A. That's correct, the kidney with or
16 without involvement of the lung.

17 Q. Are you aware that Dr. Johnston has
18 also written in instances of hypoxic ischemia
19 encephalopathy if you see multi-organ injury it's
20 generally the kidney and it exhibits a rise in
21 the serum creatinine, is that right?

22 A. I am not aware of that article.

23 Q. But would you agree that if you have
24 some injury to the kidney you will see a rise in
25 the serum creatinine?

1 A. No. I can't agree with that.

2 Q. Would you tell me what a rise in the
3 serum creatinine is indicative of?

4 A. It can either mean a laboratory error
5 or it can mean a renal dysfunction.

6 Q. Can you have a rise in the serum
7 creatinine in the face of an hypoxic ischemic
8 event that occurred 24 hours earlier?

9 MR. JEFFERS: Objection.

10 A. You can.

11 Q. You can?

12 A. You can.

13 Q. Are you aware that this newborn had a
14 serum creatinine at University Hospitals, .9, as
15 recorded on the 12th?

16 A. Yes.

17 Q. And a .9 recording in a newborn a
18 little over 24 hours of age is not a normal
19 recording, is it?

20 A. That's correct.

21 Q. Are you also aware when we are
22 talking about multi-organ injury that this infant
23 had grossly bloody stools at University
24 Hospitals?

25 A. No.

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1 Q. And that this patient also had some
2 anemia, you are aware of that, aren't you?

3 A. Yes.

4 Q. Grossly bloody stools can lead to
5 blood lab results that demonstrate anemia, isn't
6 that correct?

7 A. Yes.

8 Q. And grossly bloody stools can be a
9 manifestation of an underlying enteritis, isn't
10 that correct?

11 A. Yes.

12 Q. This patient had an increase in the
13 serum creatinine, this patient had grossly bloody
14 stools and, by the way, this patient also had
15 bouts of tachycardia at University Hospitals,
16 isn't that correct?

17 A. Yes. This is all true.

18 MR. JEFFERS: Two questions. Okay.
19 All right. You just asked him two questions. I
20 don't know whether you were just responding to
21 the latter half.

22 THE WITNESS: I think all those were
23 true.

24 Q. Now to have multi-organ injury
25 doesn't mean permanent injury to each of the

1 organs necessarily, but it can mean some
2 compromise to those organs, isn't that right?

3 A. Yes.

4 Q. Would you agree with me that grossly
5 bloody stools is indicative of some compromise in
6 the GI?

7 A. No.

8 Q. Are you telling me that grossly
9 bloody stools in an infant that is **48** hours old
10 is a normal finding?

11 A. No. But you didn't qualify that. A
12 child who swallowed a lot of maternal blood and
13 has rapid transit can have grossly bloody stools
14 from the mother's blood.

15 Q. A child who has had a hypoxic
16 ischemic event can have enteritis manifested by
17 grossly bloody stools, isn't that correct?

18 A. That's correct.

19 Q. A child who has a hypoxic ischemic
20 event can have a compromise of kidney function
21 which can lead to elevated serum creatinine,
22 isn't that correct?

23 A. That's correct.

24 Q. We know this patient had both grossly
25 bloody stools and an elevated serum creatinine,

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1 is that correct?

2 A. I am not aware of the grossly bloody
3 stools.

4 Q. I am going to show you a chart from
5 University Hospitals' record that is a physical
6 assessment chart and -- under gastrointestinal,
7 and it's dated 11-14. Take a look at that.

8 (Witness examines document.)

9 A. This is a, there are two entries in
10 the chart on this page.

11 Q. Yes.

12 A. Dated November 14th. Stool sent for
13 SSYC in roto virus, positive grossly bloody
14 stools. Then the next note at 2200, continues to
15 have grossly bloody stools.

16 And then the next entry at 0400,
17 11-15-92, no stools so far.

18 Q. No stools?

19 A, No stools. Yes.

20 Q. Okay. Are you aware this newborn
21 also had positive guaiac at University Hospitals?

22 A. I wasn't aware of that, but it
23 wouldn't surprise me if the stools were bloody.

24 Q. Did Mr. Jeffers tell you anything
25 about what happened to the cord blood in this

1 case?

2 A. I believe it was sent to the
3 laboratory to be held in a cooler for three days.

4 Q. How did you find that out?

5 A. He told me.

6 Q. When you say to be held in a cooler
7 for three days -- when did he tell you that,
8 today?

9 A. Yesterday, perhaps.

10 Q. Did he tell you that I might be
11 asking you about the fact it was refrigerated?

12 A. Yes.

13 Q. Given the fact that this patient was
14 transferred to University Hospitals as a high
15 risk patient, wouldn't it have been appropriate
16 to analyze that cord blood?

17 A. I believe that the purpose for
18 holding cord blood, at least at Children's
19 Hospital, if we are sent it from the outlying
20 hospital, you have to remember that no babies are
21 born at Children's, they are always sent in from
22 the outside birth, so the cord blood is held
23 elsewhere. The reason for holding that blood is
24 usually for Rh typing, programs for culture. And
25 I see no reason why this child's blood should

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1 have been saved or analyzed at birth.

2 Q. Well, everything I read in terms of
3 metabolic acidosis, and sometimes I don't read
4 things too accurately because I try to put my own
5 spin on them, but everything I read tells me what
6 you really want to do is have the cord blood pH'd
7 because that is the most accurate assessment of
8 metabolic acidosis of the newborn, isn't that
9 correct?

10 A. It's correct that is the most
11 adequate assessment. But it's not correct every
12 child should have an ABG on cord blood.

13 Q. Right. But this child at 1:10 p.m.
14 was assessed as a newborn who had fetal distress,
15 are you aware of that?

16 A. Yes, I am.

17 Q. So wouldn't it be nice for the
18 doctors who you say were struggling with what the
19 cause was of this seizure activity, wouldn't it
20 be nice for them to know whether or not the cord
21 blood was in fact below 7.0?

22 MR. JEFFERS: Object.

23 A. It theoretically would have been
24 wonderful for this lawsuit. But given the fact
25 the child had Apgars of 6 at 1 minute and 8 at 5

1 minutes is absolutely no reason for cord blood to
2 have been analyzed.

3 Q. You and I know Apgar scores are
4 entirely subjective, aren't they?

5 A. Yes.

6 Q. So the only scientific demonstration
7 of metabolic acidosis would have been the cord
8 blood?

9 A. That's correct. But it's simply not
10 a standard of care for cord blood to have studies
11 done when the Apgars are 6 and 8.

12 Q. Right, I understand that. Except
13 that is assuming that the person who records the
14 Apgars is recording them accurately, is that
15 correct?

16 A. That's correct.

17 Q. We also know that the more accurate
18 assessment of Apgar scores in determining whether
19 or not this is any neurologic issue would be the
20 ten-minute and 20-minute Apgar score, isn't that
21 right?

22 A. That is not true.

23 Q. You are familiar with ten- and
24 20-minute recordings, aren't you?

25 A. Absolutely. When the five-minute

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1 Apgar score is low you are obliged to do ten. If
2 the ten is low you are obliged to do 15, and if
3 the 15-minute is low you are obliged to do a 20.
4 When the five-minute Apgar score is normal as it
5 was in this case you're under no obligation to
6 continue performing Apgar scores.

7 Q. That is assuming that in the face of
8 the bruises on this child's face, in the face of
9 the notation of fetal distress, in the face of
10 the meconium, that Dr. Siew or staff at Elyria
11 Memorial Hospital did not engage in a
12 self-serving rendition of the Apgar scores, isn't
13 that right?

14 MS. SCHOENLING: Objection.

15 MR. JEFFERS: Objection.

16 A. I have no opinion on that. That
17 never occurred to me.

18 Q. It never occurred to you that a
19 physician or a nurse could create an Apgar
20 score?

21 MR. JEFFERS: Objection. This is so
22 far out, you know, this is bad of you.

23 MR. NOVAK: Bad of me?

24 MR. JEFFERS: It really is.

25 MR. NOVAK: Do you want to take me

1 out back and spank me or something?

2 THE WITNESS: We have a spanking room
3 downstairs, actually.

4 MS. S~HOENLING: I was hearing
5 conversation by Bill yesterday about morality.
6 He was preaching to me.

7 MR. NOVAK: I obviously was not
8 preaching to the choir, was I?

9 MS. SCHOENLING: I am not sure what
10 the obviousness of this is.

11 Q. I guess what is concerning to me,
12 Doctor, is that there are reports from Drs.
13 Johnston and Donn and yourself and Dr. O'Grady
14 and Dr. Todia and they talk about metabolic
15 acidosis. But the fact of the matter is that the
16 only true indicator as to whether you have it or
17 not would have been the cord blood which the
18 hospital did not analyze, is that right?

19 A. The hospital did not analyze this,
20 nor were they obliged to.

21 Q. I understand. But that was the true
22 indicator of metabolic acidosis, wasn't it?

23 A. That is true. Had it been measured
24 we would not be sitting here.

25 Q. And this hospital somehow disposed of

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1 it, didn't they?

2 A. No, they kept it for three days.

3 Q. And then disposed of it?

4 A. That was the, apparently as it is in
5 most hospitals, the policy.

6 Q. You say in your report the doctors at
7 University Hospitals were struggling with whether
8 or not this was from an infection, whether or not
9 this was from beta antagonists, whether or not it
10 was from hypoxic ischemic encephalopathy, is that
11 right?

12 A. They never assumed it was from
13 hypoxic ischemic encephalopathy.

14 Q. They never assumed that this
15 newborn's neurologic manifestations at University
16 Hospitals were secondary to hypoxic ischemic
17 encephalopathy, is that what you are telling me?

18 A. What I am telling you is that the
19 people asked to come in and give opinions about
20 what the cause were, child neurologists, have
21 never been of that opinion.

22 Q. By the way, you're familiar with the
23 cord blood reporting are you not that was taken
24 at Elyria Memorial Hospital, not cord blood, but
25 blood gas at 1359 hours?

1 A. Yes.

2 Q. It was 7.21, was it not?

3 A. 7.21 on 11-11-92.

4 Q. And 7.21 is acidotic, is it not?

5 A. Yes.

6 Q. By the time that recording was done
7 this patient was receiving 02, isn't that
8 correct?

9 A. That's correct.

40 Q. 02 is given to reverse acidosis,
11 isn't it?

12 A. It was being given to reduce
13 respiratory acidosis.

14 Q. Right. But if you have metabolic
45 acidosis it would help reverse it, wouldn't it?

16 A. Yes, to a certain extent.

17 Q. I have a couple questions to ask you
48 about your report.

19 A. Certainly.

20 Q. Did you get a letter from Mr. Jeffers
21 outlining this case?

22 A. I received a cover letter with the
23 material sent to me.

24 Q. Could I see it?

25 MR. NOVAK: May I, John?

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1 MR. JEFFERS: Sure.

2 MR. NOVAK: I was just curious if
3 there were interesting spins.

4 MR. JEFFERS: No, I didn't even write
5 it.

6 Q. You know what, I am going to take a
7 look at your whole file before we are done.

8 A. Sure.

9 MR. JEFFERS: What is the date on
10 that?

11 THE WITNESS: That is not the first
12 one. The first one was in January. Here it is.

13 Q. This is a note in here that says
14 there seemed to be some questionable genetic
15 factors related to this child. It's signed by
16 JoEllen Leach. Did she tell you what she felt
17 were the questionable genetic factors?

18 A. Yes, the extra digit.

19 Q. Are you aware today that there was no
20 extra digit?

21 A. Yes.

22 Q. Kind of a red herring.

23 A. Yes? Like others.

24 THE WITNESS: There were several red
25 herrings. That was a pink herring.

1 Q. By the way, you did see the

2 photographs of the child, as well?

3 A. Yes.

4 Q. You would agree with me that the

5 picture as presented by this child today is a

6 pretty catastrophic one?

7 A. Yes.

8 Q. Thankyou.

9 A. You are welcome.

10 Q. Let's look at your report. You say

41 here that this report reviews the facts of this

12 case and my opinion on probable cause, is that

13 right?

14 A. Yes.

15 Q. Okay. Now at the time that you wrote

16 this report, did you have available to you the

17 three articles which you gave us today on

18 intrapartum asphyxia and cerebral palsy?

49 A. Yes.

20 Q. And the Perlman article and the other

21 Karin Nelson article?

22 A. Yes.

23 Can I take a break?

24 MR. NOVAK: Sure.

25 (Recess.)

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1 Q. What is Synapse Consultation, P.C.?

2 A. That is the name for what I am. I do
3 my neurology through it. I bill whatever
4 medicolegal I do through Synapse using my federal
5 ID number and in any consultation work I do on
6 community health or ISO 9000 or utilization
7 management, I bill all through Synapse.

8 Q. This is all through your home
9 address?

10 A. Uh-huh.

11 Q. You don't have an office per se?

12 A. I have clinical offices --

13 Q. At each of those clinics?

14 A. Yes. Then I have my business office
15 here at home.

16 Q. But in terms of having an office
17 where you actually pay rent for an office space,
18 you don't have that?

19 A. I do down here in Golden at the
20 Health First office, I pay rent for that practice
21 site.

22 Q. Okay.

23 A. But the reason for using this as my
24 business site is that I actually do all the
25 prework on all my patient care here preparing the

1 charts. There is just no reason for the
2 correspondence to go to that office.

3 Q. During the course of let's say the
4 last year, 1998, what percentage of income did
5 you derive from medical/legal versus your other
6 work?

7 A. 30 percent medical/legal, 70 percent
8 everything else.

9 Q. I want to get back to the initial
10 newborn profile at Elyria Memorial Hospital.

11 A. Okay.

12 Q. You are aware of the note of fetal
13 distress number 1 and meconium fluid number 2, is
14 that right?

15 A. Yes.

16 Q. Is there a reason why you didn't put
17 the fetal distress or mention it in paragraph 2
18 of your report, although you did mention the
19 meconium stain.

20 A. No.

21 Q. Obviously someone at Elyria Memorial
22 felt that the fetal distress was significant
23 enough to write it down. Is there a reason,
24 then, why you didn't pick that up and put that in
25 there?

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1 A. If the Apgar scores were abnormal I
2 would have included it.

3 Q. Okay. I will get to the next
4 paragraph. We have already agreed that Apgar
5 scores are subjective, is that right?

6 A. Yes.

7 Q. And so were you stating improvement
8 in Apgar scores from 1 to 5 minutes is not
9 suggestive of intrapartum hypoxic ischemic
10 injury, that is based on the assumption that the
11 Apgar scores that are recorded for this infant at
12 about 1:10 p.m. to 1:30 p.m. are in fact
13 accurate, isn't that right?

14 A. No, that is not true. That is just
15 one of the reasons that I feel that this was not
16 HIE.

17 Q. I understand. But this one reason is
18 based on the assumption that the Apgar scores
19 that were recorded were in fact accurate?

20 A. That's correct.

21 Q. Okay.

22 MR. JEFFERS: Now we have said that I
23 think 13 times.

24 MR. NOVAK: I think 15 times.

25 THE WITNESS: No, I think it was only

1 ten, actually.

2 MR. NOVAK: I saw the Big Labosky 45
3 times; I am going to watch it another time.

4 MR. JEFFERS: You will probably miss
5 your plane.

6 MR. NOVAK: Because I am the dude.

7 MR. JEFFERS: I don't care.

8 MR. NOVAK: The dudarino.

9 MS. SCHOENLING: That is really what
10 this is all about.

11 Q. Then we go to the next paragraph
12 where you talk about the arterial blood gasses
43 being never in the range associated with hypoxic
14 ischemic injury, but the fact of the matter is
45 that the literature in general talks about
16 metabolic acidosis as being related to cord
47 blood, isn't that right?

48 A. That's correct.

19 Q. Although arterial blood gasses are
20 helpful, it's kind of nice to have the cord blood
21 recording as well, isn't it?

22 MS. SCHOENLING: Objection.

23 MR. JEFFERS: Object. Object to the
24 commentary. Is that a question?

25 MR. NOVAK: It's kind of nice.

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1 MR. JEFFERS: You already asked it.

2 MR. NOVAK: I did, and I think he
3 agrees. Okay.

4 THE WITNESS: Previously answered,
5 not necessarily the way you thought I did.

6 Q. You said this is no evidence of
7 multi-organ hypoxic ischemic injury, same
8 paragraph?

9 MS. SCHOENLING: Fourth paragraph.

10 Q. But we went through this patient's
11 chart and we did see bloody stools, did we not?

12 A. Yes.

13 Q. And we did see an elevated serum
14 creatinine, did we not?

15 A. Yes.

16 Q. We also saw neurologic
17 manifestations, did we not?

18 A. We saw a seizure.

19 Q. Well, there was also seizure activity
20 at University Hospitals, wasn't there?

21 A. That's correct.

22 Q. It was recorded on EEGs, was it not?

23 A. That's correct.

24 Q. The next paragraph says --

25 A. However, we did not, we did not see

1 evidence of multi-organ hypoxic ischemic injury.

2 That statement is still true.

3 Q. Whatever. The next paragraph is

4 Jasmine's initial child neurologic exam performed

5 11-12-92 revealed head circumference of 32

6 centimeters.

7 I am going to show you a recording on

8 11-12-92, and it's different than --

9 A. 33.5.

10 Q. Yes.

11 A. Yes.

12 Q. You are also aware that the Elyria

13 Memorial Hospital chart has a recording on this

14 child as being appropriate for gestational age at

15 32.5, aren't you; you are aware of that?

16 A. I did not have that sheet in my

17 file. I would love to see it.

18 Q. Did Mr. Jeffers kind of like pull

19 that sheet out before he sent it to you, is that

20 what he did?

21 MR. JEFFERS: You know what, Bill,

22 your suggestions are really bad again. That is

23 all I am going to say. You don't care what the

24 hell you are saying.

25 Q. I guess my question, let me ask it,

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■ Doctor. Did Mr. Jeffers send you this sheet?

2 MS. SCHOENLING: Can I see that when
3 you are done?

4 A. Yes. Yes, he did. I don't know
5 where it is in my file. I have seen this
6 before.

7 Q. And it does indicate that that
8 newborn is appropriate for gestational age, isn't
9 that correct?

10 A. In the 25th percentile, yes.

11 Q. In fact, appropriate for gestational
12 age is anywhere between, what, the 10th and 90th
13 percentile?

14 A. That's correct.

15 Q. That is the Lubchenko chart which a
16 lot of hospitals use?

17 A. Yes.

18 Q. Also, at 4:15 there was an additional
19 exam at University Hospitals which you don't
20 mention in your report which was an SAR admit
21 note?

22 A. That's correct.

23 Q. Did you see in that admit note where
24 there was lethargy and hypotonia?

25 A. Yes.

1 Q. Would you agree with me lethargy and
2 hypotonia are neurologic manifestations of
3 hypoxic ischemic encephalopathy?

4 A. They can be.

5 Q. But you did not mention those in your
6 report, did you?

7 MS. SCHOENLING: Objection to the
8 question.

9 Q. Now --

10 A. Just a moment, I haven't answered the
11 question. The transport note indicated the child
12 was moving all extremities with good suck,
13 positive Moro without focal deficits.

14 The SAR note noted symmetrical
15 posture, lethargy, hypotonia, equal movements of
16 all extremities, cranial nerves grossly intact.

17 Q. My question simply was lethargy and
18 hypotonia can be clinical manifestations of
19 hypoxic ischemic encephalopathy, isn't that
20 correct?

21 A. They can be, yes.

22 Q. You go on to say Jasmine was born
23 significantly anemic, but her anemia, we know --

24 MR. JEFFERS: What we are referring
25 to is the head size graph. It's right here, in

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1 the materials.

2 MR. NOVAK: Mr. Jeffers, I would

3 never accuse you of skulduggery.

4 MR. JEFFERS: I would hope not.

5 MR. NOVAK: Because you are a

6 gentleman and a scholar.

7 MR. JEFFERS: You know what? Finally

8 you spoke the truth. Except maybe not so

9 scholarly.

10 Q. In the first full paragraph you write

11 that Jasmine was born significantly anemic, a

12 finding not suggestive of acute hypoxia or

13 ischemia.

14 You would agree with me, however, the

15 anemia could be related to the bloody stool she

16 was having?

17 A. The anemia was present prior to the

18 diagnosis of bloody stools by two days.

19 Q. Right. One day. Twodays?

20 A. Twodays.

21 Q. But there was a positive guaiac on

22 the 12th?

23 A. I don't know that.

24 Q. It says Jasmine's treating physicians

25 had great difficulty treating seizures, you go on

1 to talk about that.

2 Then you say seizures due to
3 peripartum asphyxia most commonly begin during
4 the first 72 hours of life.

5 Seizures did begin during the first
6 72 hours of life, did they not?

7 MR. JEFFERS: This is a comma after
8 that.

9 MR. NOVAK: I will finish.

10 A. Yes.

11 Q. But metabolic infection, we don't
12 have that here, do we?

13 MR. JEFFERS: It's metabolic, comma,
14 infection --

15 Q. Is there supposed to be another word
16 following metabolic?

17 A. No.

18 Q. Is there any infection in this case?

19 A. Not proven.

20 Q. Was there any trauma?

21 A. Not --

22 Q. Was there any proven remote hypoxic
23 ischemic injury?

24 A. No.

25 Q. Were there any cerebral

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1 malformations?

2 A. No, not diagnosed.

3 Q. Were there any placental issues?

4 A. Not diagnosed.

5 Q. The reason there weren't any, because
6 for some reason Dr. Siew and the hospital decided
7 not to do an analysis of the placenta, is that
8 right?

9 MR. JEFFERS: Objection. You know
10 damn well the hospital doesn't --

11 MR. NOVAK: John, don't cuss during
12 the deposition, please.

13 MR. JEFFERS: Well, you do.

14 MR. NOVAK: No, I don't.

15 MR. JEFFERS: in past depositions.

16 MR. NOVAK: I have used "hogwash" and
17 "horse apples", but never "damn."

18 MR. JEFFERS: Whatever. I am sorry I
19 offended your sensitivities, whatever that might
20 mean.

21 A. I believe the placenta was not
22 examined in this case.

23 Q. If this is an instance of fetal
24 distress, let me ask you from the standpoint of a
25 physician who works in a teaching hospital who

1 sees on occasion patients who arrive in a nursery
2 as a result of fetal distress. Do you know how
3 it comes about that the placenta is sent to
4 pathology, who makes the decision?

5 MR. JEFFERS: Objection.

6 A. I don't know that. However, I know
7 that it -- when I am reviewing a clinical case
8 and trying to figure out what happened to the
9 child, if the child had evidence of peripartum
10 asphyxia as evidenced by low Apgar, persistent
11 low Apgar scores, evidence of HIE on the clinical
12 exam, it is always useful to look retrospectively
13 at the placenta. There not being any of those
14 signs in this child, it was probably not thought
15 of as being appropriate to save the placenta.

16 Q. Are you familiar with a corporation
17 called Placental Evaluations, Inc.?

18 A. No.

19 Q. Are you familiar with any
20 corporations on the West Coast or in the central
21 region of the country where you are located where
22 hospitals will, when they think there may be a
23 risk problem, send the placentas out to a private
24 corporation to be analyzed for risk analysis and
25 then have the placental analysis sent back to the

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1 risk manager of the hospital? Are you familiar
2 with that at all?

3 MR. JEFFERS: Objection. That
4 depends on who is ordering it to be done.

5 A. We have a placental registry here in
6 Colorado.

7 Q. Did Mr. Jeffers at any time tell you
8 that this placenta was sent to Placental
9 Evaluations, Inc., by Eiyria Memorial Hospital,
10 given that this corporation is located in Toledo
11 in close proximity to Elyria?

12 A. No.

13 Q. You say that Jasmine's treating
14 physicians did not assume that her intractable
15 seizures were due to hypoxic ischemic injury. I
16 guess my question, I want to kind of look at a
17 couple of these here.

18 In the first neurologic exam didn't
19 the physician say the infant may have suffered
20 from asphyxia although Apgar scores were fairly
21 good, this is the most likely cause?

22 MR. JEFFERS: We are reading from
23 which one now, University --

24 MR. NOVAK: , First neurologic exam.

25 A. That exam was --

1 MR. JEFFERS: That was on the 12th,
2 wasn't it?

3 MR. NOVAK: ~~On~~ the 12th.

4 A. Not a neurologic exam, that was the
5 NICU exam. Written by Troy Dominguez.

6 Q. So when you refer to a neurologic
7 exam on 11-12-92 on page 1, your description as a
8 neurologic exam is incorrect, isn't it?

9 A. The neurologic exam on 11-12 that I
10 am referring to is the exam by the child
11 neurologist.

12 Q. Yes, but the neurologic exam that has
13 the 32 centimeter measurement is the one done by
14 Troy Dominguez?

15 A. No, the one done by the child
16 neurologist

17 Q. I am looking at --

18 A. Next page. Next page.

19 Q. Hold on. Here it is. HC 32, Troy
20 Dominguez' exam.

21 A. Right. But this is also a child
22 neurology exam several pages back.

23 Q. Here is a neurology exam. And this
24 one, that is the --

25 MR. JEFFERS: Why don't you give --

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1 Q. Can you find where it was?

2 A. It says child neurology.

3 Q. Neuroconsult?

4 A. That's it.

5 Q. Would you agree with me that a true
6 knot in the cord can cause cord compression and
7 can lead to perinatal asphyxia?

8 A. Yes.

9 Q. We do know that this infant had a
10 cord that had a knot?

11 A. Yes.

12 Q. At various stages it was recorded as
13 having a true knot?

14 A. Yes.

15 Q. Would you also agree with me that
16 cord compression can produce elevated fetal heart
17 recordings?

18 A. Yes.

19 Q. I want to get to this thing about the
20 head circumference and your opinion that you say
21 that at birth it was at or below the
22 third percentile indicating congenital
23 microcephaly, do you see that there?

24 A. Yes.

25 Q. That ultimately becomes your final

1 conclusion in the case, doesn't it?

2 A. It's one of the pillars of my
3 opinion.

4 Q. Right.

5 Q. With respect to one of those pillars
6 you took the 32 centimeter recording even though
7 at the same time there was a recording done of
8 33.2, is that right?

9 A. That's correct.

10 Q. And another of 32.5, right?

11 A. Correct.

12 Q. Now the 32.5 was at Elyria Memorial.
13 You have already testified that this recording
14 was appropriate for gestational age, was it not?

15 A. That's correct.

16 Q. That would not be indicative, would
17 it, of congenital microcephaly?

18 A. Only as a relative term.

19 Q. And then, by the way, are you aware
20 this child had two nucleated red blood cells as
21 recorded at University Hospitals?

22 A. In what specimen? I mean two
23 nucleated red blood cells --

24 Q. An erythrocyte profile was done on
25 11-12 and 11-13. Were you aware of that?

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1 A. No.

2 Q. That there were two nucleated red
3 blood cells?

4 A. No.

5 Q. Are you familiar with the studies
6 done on the number of nucleated red blood cells
7 and the number as being related to when an
8 asphyxia event takes place?

9 A. I am very much of aware of that
10 research. I am also aware that the researcher
11 who reported that has now been discredited and is
12 no longer being asked to do that sort of work.

13 Q. Do you know who that researcher is?

14 A. Naeye.

15 Q. N-A-E-Y-E?

16 A. Yes.

17 Q. The head circumference charts at
18 University Hospitals, you have seen those, I am
19 sure. This is one --

20 A. Yes.

21 Q. Okay. The one at birth on the chart
22 that I am looking at now is within normal limits,
23 is it not?

24 A. Yes.

25 Q. Okay.

1 A. With the plot of the head being at --

2 Q. 33 -- that is the weight.

3 MR. JEFFERS: Do you want --

4 THE WITNESS: Right. This one is
5 plotted at 33.3, rather than at the 32, which two
6 of the examiners measured it at.

7 Q. Okay. And then this is --

8 A. Which by the way is, in retrospect
9 makes absolutely no difference, as we will see.
10 We can plot them anywhere you want.

11 Q. Then this is a head circumference at
12 three months that is recorded on the chart.

13 A. That is actually a length and weight
14 there. There you go.

15 Q. Of 40.

16 A. Yes.

17 Q. That is above the 50 percentile,
18 isn't it?

19 A. That is the point.

20 Q. Wait a minute now.

21 A. That is the point.

22 Q. Then--

23 MR. JEFFERS: What month was that?

24 THE WITNESS: Actually, I have them
25 all plotted out for the first many months.

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1 Q. I know you do, I saw them. I did my
2 own plot. It's a little different than yours.
3 Then this is one reported at nine months that is
4 just a hair below the 50th percentile, is it not?

5 A. That's correct.

6 Q. Now would it be fair to state that
7 each one of those in and of themselves do not
8 indicate congenital microcephaly?

9 A. The grouping of head circumference
10 that were noted during the first day or two of
11 birth of 32.5, 33.2, 32 and 32 are almost, well
12 are either at or just above the third percentile
13 for the patient's age.

14 Q. What about the Lubchenko chart at
15 Elyria Memorial Hospital, are you telling me they
16 didn't know what they were measuring there?

17 A. The only thing that can be said about
18 the Lubchenko charting at Elyria was the head
19 circumference was on a lower percentile than
20 either weight or length. And because the head
21 size was measured at a lower level the next day,
22 that may or may not have been an accurate head
23 circumference.

24 Q. Except that the growth record at
25 University Hospitals as recorded for birth has

1 the head circumference, the length and weight
2 virtually in the same percentile grouping, don't
3 they?

4 A. But they had the head circumference
5 plotted at 33.2 centimeters rather than 32. If
6 they had plotted it at 32 it would have been on
7 the third percentile.

8 Q. So what you want to do to make your
9 theory work is to discard the 33.2 and 32.5, is
10 that right?

11 A. No, not at all true. I will allow
12 you any of those measurements. The child had a
13 low-normal or absolutely no head circumference at
14 birth. It makes absolutely no difference whether
15 it was low-normal or low.

16 The point of how we interpret the
17 head size at birth relates only to what then
18 happened after birth.

19 Q. But we all know that as this child
20 progressed, the brain gets necrosis and it
21 shrinks, doesn't it?

22 A. The brain gets necrosis and doesn't
23 grow.

24 Q. It doesn't grow in proportion to the
25 rest of the body?

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1 A. No, it doesn't.

2 Q. That is why your plotting is recorded
3 the way it is?

4 A. That's correct.

5 Q. And you can have lack of brain growth
6 from hypoxic ischemic encephalopathy, can't you?

7 A. Absolutely. And there was no absence
8 of growth in this child's brain. This child's
9 brain continued to grow at or above
10 the percentiles that were present at birth,
11 whereas in virtually every child with significant
12 hypoxic ischemic injury at birth the head stops
13 growing for a period of time and then grows at a
14 lower percentile than it was at the time of
15 birth, every single time.

16 Q. But that is what your chart
17 indicates, doesn't it?

18 A. Absolutely not.

19 Q. If I were to draw dots on your chart,
20 that is what would occur, wouldn't it?

21 A. No. Not at all. The child's head
22 grew normally to, at an advanced rate for the
23 first five months.

24 Q. Then what happened?

25 A. Then the, then for as yet unexplained

1 reasons the head stopped growing at about seven
2 or eight months for about four months as if an
3 injury occurred at six or seven months.

4 Q. You know, Doctor, I reported at about
5 25 months a 47-centimeter circumference and then
6 I reported at 30 months a 46-centimeter
7 circumference. And I guess the bottom line is
8 doesn't it all depend who is doing the
9 measurement? I mean, you and I could go in and
10 try a pair of pants on, and depending where the
11 guy puts the tape measure on us is going to
12 depend on how we get our suit fit.

13 A. All I can say is, if that is what you
14 are assuming, then we are going to have a very
15 interesting time in court with the jury.

16 Q. Well, I guess when I blow these
17 charts up and make them ten-by-ten they are going
18 to be really interesting, because the fact of the
19 matter is that the three graphic charts in
20 University Hospitals all have the head
21 circumference within normal limits, don't they?

22 A. Yes. When we show the other
23 measurements and show the plot over time you are
24 going to wish you stopped.

25 Q. Oh, God, Doctor, I am shaking in my

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■ boots, believe me. But let me ask you this
2 question. Let me ask you this: Are you telling
3 me that the 33.2 was an inaccurate measurement?

4 A. It may have been.

5 Q. Are you telling me the 32.5 at Elyria
6 Memorial was an inaccurate measurement?

7 A. May have been. Doesn't make any
8 difference. The child's head circumference
9 continued to grow above the rate it grew in utero
10 after birth for nine months.

11 Q. Your statement says the head
12 circumference at birth was at or below the
13 third percentile indicating congenital
14 microcephaly.

15 My question for you is, we have two
16 measurements at birth which have this child
17 appropriate for gestational age, don't we?

18 MS. SCHOENLING: Objection.

19 A. Yes. I will yield that this may have
20 been a typo, because clearly the head
21 circumference was at or slightly above the
22 third percentile, indicating relative congenital
23 microcephaly.

24 Q. Would you agree with me the word
25 "typo" means a misspelling? This is an

1 inaccurate statement, isn't it?

2 A. Yes, it is.

3 Q. Let's go down to the next paragraph.

4 A. Let's stay with the paragraph that we
5 were just talking about first.

6 Q. I am kind of asking the questions.

7 MR. JEFFERS: But he hasn't finished
8 his answer.

9 MR. NOVAK: What was the question? I
10 asked him if it was an inaccurate statement. He
11 said yes, it was.

12 MR. JEFFERS: He continued on to
13 describe it. He is going to finish his
14 sentence.

15 Q. Goahead.

16 A. The child's head circumference
17 subsequently grew at or above the
18 third percentile for at least the next four
19 months. Had any kind of brain damage occurred at
20 the time of birth, head growth would have
21 plateaued, followed by growth on lower
22 percentiles. This did not happen in this child.
23 Had it occurred I wouldn't be sitting on this
24 side of the table.

25 Q. But that is based on the recordings

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1 you did on the measurements of the head
2 circumference, right?

3 A. It's based on a plotting of all of
4 the various recordings of head circumference from
5 the chart.

6 Q. You didn't miss any, did you? You
7 plotted every one out?

8 A. I hope I did.

9 Q. I want to know under oath today did
10 you plot every head circumference noted in every
11 document Mr. Jeffers sent you so when we blow
12 that thing up for the jury that is going to be
13 one hundred percent accurate, is that what you
14 did?

15 A. I **am** going to take a moment to be
16 sure that that is what I did.

17 (Pause.)

18 THE WITNESS: I did not plot the
19 October 15th, 1993 head circumference of 34
20 centimeters.

21 Q. Okay.

22 A. Because I believe it was miswritten.
23 It should have been written 44 centimeters. This
24 is no way it could have been 34 centimeters at
25 ten months.

1 Q. You know --

2 A. But I will certainly plot it now.

3 Q. That takes your chart a little out of
4 whack, doesn't it?

5 A. Certainly does.

6 Q. Let me ask you, Doctor, you said --

7 A. I believe that I have plotted every
8 head circumference that is available on the chart
9 except for the October 15, 1993 head
10 circumference of 34 centimeters which is
11 impossible.

12 Q. Did you plot the 33.2 that was
13 recorded?

14 A. Yes.

15 Q. Did you plot the 32.5?

16 A. Yes.

17 Q. Did you plot the 46 at 30 months?

18 A. I don't have that one.

19 Q. Did you plot the --

20 A. Wait a minute. Let me do it now. 46
21 at 30 months?

22 Q. Yes.

23 MR. JEFFERS: Where do you have that,
24 Bill, do you have it right in front of you?

25 MR. NOVAK: I did this on my own

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1 extrapolations.

2 THE WITNESS: Okay.

3 Q. Did you plot at 25 months the 47?

4 A. No.

5 Q. So --

6 A. But I have now.

7 MR. JEFFERS: What is that last one?

8 MR. NOVAK: 47 at 24 months. 25

9 months.

10 Q. So today you have made it as complete
11 as we think it can be, right?

12 A. I think so.

13 Q. Now you say that the cause of her
14 brain condition has never been determined.

15 A. That's correct.

16 Q. I am going to ask you how do you
17 reconcile that statement with the analysis we
18 have already been through? You would agree we
19 don't know if it was placental, right?

20 A. That's correct.

21 Q. We don't know if it was maternal,
22 right? Is there anything maternal that could
23 have caused this?

24 A. We don't know.

25 Q. Diabetes?

1 A. There were no high risk --

2 Q. Maternal indicators?

3 A. Maternal indicators that would
4 indicate this was a high risk pregnancy or high
5 risk labor.

6 Q. How do you reconcile that
7 statement --

8 MS. SCHOENLING: Which statement?

9 Q. That it's never been determined, with
10 the records of the Cleveland Clinic where they
11 say etiology perinatal asphyxia?

12 A. That I believe is an EEG report.

13 Q. Would you agree it says etiology,
14 perinatal asphyxia?

15 A. That is a clerical entry based on
16 whoever phoned in the report.

17 MR. JEFFERS: What date was that?

48 MR. NOVAK: March 31st, 1994.

19 Q. Doctor, you would agree with me you
20 don't know if it was a clerical entry?

21 A. I have done and performed and read so
22 many EEGs to know exactly how that is recorded
23 and it's done by the phone, as for the existing
24 complaint, as since it was the mother that set up
25 that appointment she probably was asked what the

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1 indication was.

2 Q. Do you think that this mother knows
3 what the word "etiology" is? Do you know that?

4 A. I am sure that she knows what the
5 word "reason" means.

6 Q. Or cause, right?

7 A. Or cause.

8 Q. It says perinatal complications. You
9 would agree with me the words "hypoxia" and
10 "asphyxia" and "hypoxemia" all have different
11 meanings, don't they?

12 A. Yes.

13 Q. The word "asphyxia" has a specific
14 meaning, doesn't it?

15 A. Yes, it does.

16 Q. Now on page 5 of that very same
17 report of the clinic it says perinatal
18 complications asphyxia. Now your statement that
19 the cause has never been determined is not
20 consistent with that statement, is it?

21 A. Well, again, it's a clerical entry.
22 It has nothing to do with a physician's
23 impression.

24 Q. As far as you know?

25 A. As far as I know.

1 Q. It says --

2 A. There had been no child neurologist
3 that ever stated this was perinatal asphyxia or
4 hypoxic ischemic encephalopathy. As a matter of
5 fact, every child neurologist that has reviewed
6 the case has said the opposite or not made an
7 opinion.

8 Q. Who were those?

9 MS. SCHOENLING: Except for Howard
10 Tucker, of course.

11 Q. Who were those?

12 A. David Rothner did not offer an
13 opinion as to cause.

14 Q. Did not offer?

15 A. Was not asked. The two child
16 neurologists who saw the child during the
17 hospitalization in November of 1992 and in
18 January 1993 both stated in their reports that it
19 could not be hypoxic ischemic encephalopathy or
20 asphyxia.

21 Q. Do you know anything about
22 Dr. Hotwitz?

23 A. I don't know who Dr. Hotwitz is.

24 Q. He is the pediatric neurologist you
25 are talking about who was Dr. Wiznitzer's

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1 superior at the time those records would have
2 been documented in 1992, do you know that?

3 A. I don't know anything about that.

4 Q. He has since retired from the
5 University Hospitals. But do you know what his
6 leanings have been historically regarding issues
7 of birth related brain damage?

8 A. No.

9 Q. Now you say a rare cause of neonatal
10 encephalopathy is likely to have caused the
11 disability. We already indicated that we can't
12 document a placental cause, we don't have any
13 maternal causes. What is this rare cause?

14 A. Well, every year at the Child
15 Neurology Society meetings a new cause for
16 neonatal encephalopathy is commented upon. I
17 can't remember a year when we haven't had that.

18 For example, five years ago Darrell
19 DeVivo reported on a disorder that did not allow
20 glucose to be metabolized normally in the brain,
21 whereas it did allow for glucose to be
22 metabolized everywhere else. That had never been
23 reported before.

24 There are metabolic disturbances that
25 are only now being elucidated that someday we

1 will have answers for all neonatal disasters.

2 Q. When you say it's a rare cause, as
3 you sit here today you don't know or have a
4 cause, do you?

5 A. No. And as has been pointed out by
6 virtually every authority on neonatal neurology,
7 only 20 percent of children with cerebral palsy
8 today can have that cause be blamed on perinatal
9 factors. And of the causes of birth asphyxia, 20
10 to 30 percent are completely unknown.

11 Q. Dr. Johnston has on occasion
12 testified for the defense in cases providing
13 testimony very similar to what you said regarding
14 the statistics on cerebral palsy. In those cases
15 juries have come back with verdicts in excess of
16 \$2 million. Does that surprise you?

17 MR. JEFFERS: Objection.

18 MS. SCHOENLING: Objection.

19 MR. JEFFERS: That again is
20 inappropriate questioning. I don't know why you
21 keep this stuff up.

22 Go ahead. It doesn't matter whether
23 it surprises you or not, it's a totally
24 irrelevant question, an improper question. In
25 fact, an idiotic question.

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1 MS. SCHOENLING: Note my joining in
2 Mr. Jeffers' objection.

3 MR. NOVAK: I never make personal
4 attacks on you.

5 MR. JEFFERS: Oh, today I heard three
6 or four of them. Pretty cruel.

7 A. I was not aware of that situation.

8 Q. Let me ask you, in looking at
9 Dr. Todia's report who is going to be deposed on
10 Friday.

11 A. Yes.

12 Q. You said the following?

13 MR. JEFFERS: Let him get the
14 report. Do you have it?

15 A. I have got his report opinion notes,
16 I have got it.

17 Q. He says: It should be noted in
18 making a diagnosis of intrapartum asphyxia causes
19 a neonatal neurologic deficit requires all the
20 following:

21 1. Profound umbilical acidosis.

22 Well, we couldn't have profound
23 umbilical acidosis in this case because the cord
24 blood was gone, is that right?

25 A. That's correct. We couldn't have it

1 either because the Apgars were 6 and 8.

2 Q. I will get to that.

3 2. Persistence of an Apgar score of
4 0 to 3 for longer than five minutes, except we
5 don't have any scores recorded longer than five
6 minutes, do we?

7 A. Right. Because we had an attainment
8 of 8 at five minutes so there would be no way to
9 have a 0 to 3 beyond that.

10 Q. You and I at least both agreed on one
11 thing today, that is that Apgar scores are
12 subjective?

13 A. Just as this deposition is.

14 Q. Now he also says: 3. Neonatal
15 neurologic sequelae. We have already gone
16 through this, and we have indicated, have we not,
17 that this infant did have at University Hospitals
18 hypotonia, isn't that correct?

19 A. He had one notation of hypotonia on
20 one time.

21 Q. He had a notation of lethargy, is
22 that right?

23 A. On one occasion.

24 Q. Had issues relating to his gaze,
25 sight?

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1 A. On one occasion.

2 Q. And seizure activity throughout?

3 A. That's correct.

4 Q. You would agree with me that those
5 are neurologic sequelae?

6 A. There are neurologic sequelae of many
7 different types of neurologic embarrassment. One
8 rarer cause in this case would be proposed HIE.

9 Q. Then he says multi-organ symptom
10 dysfunction. We had tachycardia as recorded in
11 cardiovascular studies at University Hospitals,
12 didn't we?

13 A. In an anemic child.

14 Q. You could also have tachycardia in a
15 child who has had a hypoxic ischemic event, isn't
16 that correct?

17 A. Possibly.

18 Q. Gastrointestinally he says, we know
19 we had bloody stools, is that right?

20 A. On two occasions.

21 Q. Pulmonary, the child did have mild
22 respiratory distress on its transfer to UH,
23 didn't it?

24 A. That's correct.

25 Q. Then renal, we had an elevated serum

1 creatinine, did we not?

2 A. On one occasion.

3 Q. 'Then Dr. Donn, he doesn't say
4 anything about congenital microcephaly in his
5 report. You have observed that, didn't you?

6 A. Yes.

7 Q. So did that trouble you, that
8 Mr. Jeffers is using Dr. Johnston and Dr. Donn as
9 experts who may not necessarily agree that this
10 child had congenital microcephaly?

11 A. I am not sure that they plotted the
12 head circumferences and, therefore, may not be
13 aware of the fact that this child's head
14 circumferences were low at birth and became
15 improved after birth.

16 Q. Except there was no indication in
17 Dr. Donn's report of congenital microcephaly, was
18 there?

19 A. That's correct.

25 Q. Then he lists on page 2 some
21 numbers. He says that there is no evidence of
22 any significant fetal distress leading to
23 neonatal depression, except we saw the neonatal
24 transfer form which listed one fetal distress and
25 two meconium stains, didn't we?

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1 A. I believe Dr. Donn was also privy to
2 the neonatal heart rate monitoring strips and the
3 nurses' notes from this patient and, therefore,
4 formed his own opinion as to whether there was
5 fetal distress.

6 Q. He says there should have been
7 profound metabolic acidosis. Once again, we have
8 the problem where we don't have this cord blood,
9 right?

10 A. Right.

11 Q. Okay.

12 A. He also said normal Apgars.

13 Q. But --

14 A. No multi-organ involvement, no HIE.

15 Q. Right.

16 A. In addition he also said no
17 neuroimaging evidence of edema or damage.

18 Q. You know, I guess I am having a
19 little trouble. First off you are not a
20 neuroradiologist, right?

21 A. Correct.

22 Q. That is a real highly technical
23 specialty which requires a lot of training,
24 doesn't it?

25 A. That's correct. But I think, didn't

1 you ask me earlier whether or not when I was
2 training the residents whether or not I reviewed
3 films with them? And I said I did.

4 Q. Right. But in terms of reviewing
5 films as a neuroradiologist can, they are on a
6 different level, aren't they?

7 A. Yes.

8 Q. That is what they get trained for?

9 A. That is true.

10 Q. The thing that I am having trouble
11 with is, if there was some injury or insult that
12 antedated labor and delivery, then why is it that
13 we have a normal CT scan and normal MRI that is
14 recorded in January of '93?

15 A. Right.

16 Q. Why is that?

17 A. Well, could it be that this child had
18 a difference in brain development rather than an
19 injury, and perhaps the problem in this baby lies
20 at the microcellular level that would never show
21 up on a CT or MRI scan until years and years and
22 years of intractable seizures.

23 Q. Except it didn't take years and
24 years, it took eight months, didn't it, for an
25 MRI to come back demonstrating an abnormal MRI in

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1 August of '93?

2 MR. JEFFERS: Can you just give him
3 the date?

4 MR. NOVAK: I believe it is '93. It
5 indicates myelination of the white matter. Here
6 it is, August 9th, '93.

7 Q. I am sorry. Demonstrates diffuse
8 atrophy. Do you see it there, delayed
9 myelination?

10 A. Yes.

11 Q. Okay.

12 A. After nine months of continuous
13 seizures.

14 Q. Nine months. I guess the thing that
15 troubles me is, can't you have an MRI like this
16 as being related to hypoxic ischemic
17 encephalopathy?

18 A. Certainly, if earlier scans prior to
19 nine months of nearly continuous seizing had also
20 demonstrated earlier evidence of injury and if
21 the head size had slowed its growth because of
22 this purported serious injury, which did not
23 happen in this case.

24 Q. We do know there was something going
25 on with this infant during labor and delivery

1 because the fetal heart rate was elevated, wasn't
2 it?

3 A. I don't recall.

4 Q. The fetal heart rate was elevated. I
5 think we all agree on that.

6 MR. JEFFERS: You can say it. I am
7 not agreeing.

8 Q. There was a true knot in the cord,
9 wasn't there?

10 A. There was a knot in the cord,
11 apparently loose at the time of birth but may
12 have been tighter at other times.

13 Q. What happens with a true knot is, at
14 various stages during labor the knot can get
15 tight and loosen up and tight and loosen up based
16 on the contractions, right?

17 A. Yes.

18 Q. Last two questions I am going to ask
19 you; I will get out of your hair.

20 A. Okay.

21 Q. The basis of your opinion. These
22 articles, right?

23 A. Yes.

24 Q. Your training. And what else?

25 A. That is it.

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1 Q. So if I study these articles and
2 based on what you have told me so far today, I
3 should have a grasp as to why you are going to
4 testify the way you are that there was some rare
5 cause that precipitated this, right?

6 MR. JEFFERS: Not necessarily will
7 you be able to mentally come to that conclusion.

8 MR. NOVAK: I may not, because I am
9 rather dense.

10 A. That will be the source of my
11 opinion.

12 Q. Also, your plotting on the chart of
13 the head circumference sizes?

14 A. Yes.

15 Q. Is there anything else that you
16 haven't told me that you would like to tell me
17 before we quit?

18 MR. JEFFERS: Objection. You have to
19 put a specific question.

20 THE WITNESS: I like that question.

21 MS. SCHOENLING: Objection.

22 Q. The reason I ask that question is
23 because in case I miss something in your opinion
24 that you haven't told us somewhere along the line
25 I should know.

1 MR. JEFFERS: I guess that is your
2 problem for not asking the right question.

3 But go ahead, if you want to answer
4 that one.

5 Q. Mr. Jeffers is going to ask you the
6 following question.

7 MR. JEFFERS: Okay. He will answer
8 your question.

9 Q. This is the Rule 26 (b)(4)(b)
10 question that would normally be asked: Do you
11 have an opinion as to what the cause was of her
12 disability?

13 MR. JEFFERS: I thought we discussed
14 that ad nauseam.

15 A. Like the very thoughtful doctors at
16 the University Hospitals during Jasmine's first
17 year of life, I have no knowledge of what caused
18 her problem.

19 But what you didn't ask me, which is
20 what I would like to answer, is why you might
21 have asked did the doctors at the University
22 Hospitals take so much time and trouble to be
23 working this child up for rare causes of
24 seizures.

25 Q. I know the answer to that.

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1 A. Yes, I think I do, too.

2 Q. Okay.

3 A. And that is that there was no history
4 suggestive of definitive hypoxic ischemic
5 encephalopathy, there was no evidence of injury
6 on the early neuroimaging films and, therefore,
7 the child had a relatively high probability of
8 having an inborn error of metabolism or even a
9 degenerative disease. And a series of metabolic
10 tests were performed. When those tests came back
11 negative, a metabolism consult was then called
12 in.

13 In addition, the child was given a
14 trial of Pyridoxine. At our hospital if a child
15 has a history of perinatal asphyxia, none of
16 those tests are ever done. They are only done
17 when the cause is unknown.

18 And so we would have to say that I am
19 no more wise than the good doctors at the
20 University Hospitals. The cause of this child's
21 encephalopathy, which somehow allowed for her
22 head to grow normally for four to nine months,
23 has yet to be elucidated.

24 MR. JEFFERS: You say you knew the
25 cause, Bill.

1 MR. NOVAK: I think I do, but I am
2 not going to tell him. I will save that one for
3 trial.

4 MR. JEFFERS: We would like to know.

5 MS. SCHOENLING: That is the first
6 time Dr. Novak has been speechless.

7 MR. NOVAK: I have got to hold
8 something back.

9 MR. JEFFERS: This is repetition.

10 Q. One thing that bothers me. In the
11 charts that you got was an infant hearing
12 assessment reporting form. Those forms go to the
13 Ohio Department of Health for purposes of
14 qualifying this child for some state support.
15 And presumably, you don't want to put fraudulent
16 statements on those reports which go to state
17 agencies.

18 This is a statement that says seizure
19 disorder secondary to birth asphyxia, dated
20 January 13th, 1993.

21 MR. JEFFERS: Who is it signed by?

22 Q. Wait. It's signed by Gale Murray,
23 Ph.D., at University Hospitals. It says the
24 above information was obtained from, there is a
25 box crossed off that says medical records.

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1 Now we don't like people to send
2 fraudulent reports to state agencies, do we?

3 A. No. In fact, it's probably against
4 the law.

5 Q. Yes.

6 A. I remember a movie starring Jimmy
7 Stewart, where they were trying to prove the
8 existence of Santa Claus. And they got a number
9 of people to write letters to the U.S. Post
10 Office attesting to the existence of Santa
11 Claus. And when the government then unloaded all
12 those reports or letters to Santa Claus in front
13 of the judge, the judge was forced to admit that
14 there was Santa Claus. That reminds me somehow
15 of this case.

16 Q. I hate to tell you, you are wrong
17 again. It wasn't Jimmy Stewart, it was William
18 Payne and Maureen O'Hara and Miracle on 34th
19 Street?

20 A. No, it wasn't.

21 MR. JEFFERS: It was.

22 THE WITNESS: You are right. Miracle
23 on 34th Street.

24 MR. JEFFERS: The principle still
25 applies.

1 THE WITNESS: If you can prove to a
2 jury that was HIE it will be like a miracle on
3 34th Street.

4 Q. I have done it many times.

5 A. I know you have.

6 BY MS. SCHOENLING:

7 Q. Doctor, I represent Dr. Siew, and I
8 just have a very quick set of questions for you.
9 You have reviewed Dr. Donn's report,
10 yes?

11 A. Yes.

12 Q. Dr. O'Grady's report?

13 A. Yes.

14 Q. And Dr. Johnston's report, is that
15 correct?

16 A. Yes.

17 Q. My question to you is, after
18 reviewing their reports, do you have any
19 fundamental disagreements with anything contained
20 within any of those three reports?

21 A. No.

22 Q. As I have listened to your testimony
23 and I have read your report and I have tried to
24 comprehend the opinions that you have offered
25 here today, I want to make sure that my

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1 understanding is correct. And that is, it is my
2 understanding that you have no criticisms of the
3 care and treatment that was rendered by Dr. Siew,
4 that is the obstetrician in this case, is that
5 correct?

6 A. Let me say that I was not asked to
7 review his care. Whether his care was good, bad
8 or indifferent, it had absolutely no impact on
9 this child's Apgar. Therefore, the question is
40 irrelevant to me.

11 Q. In follow-up to that then, we are
12 talking about not only his care and treatment
13 during labor and delivery, but I assume you're
14 also talking about his care and treatment during
15 the prenatal care?

16 A. I would answer the same way.

17 MS. SCHOENLING: That is all I have.
18 Thank you.

19 MR. NOVAK: Doctor will send you the
20 bill and you will give me the bill so I can give
21 him a check, right?

22 MR. JEFFERS: Whatever you like.

23 MR. NOVAK: I prefer you send it to
24 him. I feel awkward when I get it direct.

25 MR. JEFFERS: Sure.

1 THE WITNESS: Wouldn't want that.

2 THE REPORTER: Read and sign?

3 (Discussion off the record.)

4 MR. NOVAK: I would like the reporter
5 to mark the notes Exhibit 1.

6 MR. JEFFERS: Yes.

7 MR. NOVAK: He can give the original
8 back to him.

9 The graph is Exhibit 2. And the
10 photographs, 3.

11 (Thereupon, Plaintiffs' Deposition
12 Exhibits 1, 2, 3, 4 and 5 were
13 marked for purposes of
14 identification.)

15 (Recessed at 4:34 p.m.)

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1 SIGNATURE OF WITNESS

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3 The deposition of THOMAS TREVOR
4 REILEY, M.D., taken in the matter, on the date,
5 and at the time and place set out on the title
6 page hereof.

7 It was requested that the deposition
8 be taken by the reporter and that same be reduced
9 to typewritten form.

10 It was agreed by and between counsel
11 and the parties that the Deponent will read and
12 sign the transcript of said deposition.

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1 DEPOSITION ERRATA SHEET

2 RE: MERRIWEATHER -v- ELYRIA MEMORIAL HOSPITAL, et
3 al.

4 Deponent: THOMAS TREVOR REILEY, M.D.

5 Deposition Date: September 15, 1999

6 To the Reporter:

7 I have read the entire transcript of my
8 Deposition taken in the captioned matter or the
9 same has been read to me. I request that the
10 following changes be entered upon the record for
11 the reasons indicated. I have signed my name to
12 the Errata Sheet and the appropriate Certificate
13 and authorize you to attach both to the original
14 transcript.

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1 CERTIFICATE

2 The State of Colorado,)

3 SS:

4 County of Teller.)

5

6 I, CRAIG L. KNOWLES, a Notary Public

7 within and for the State of Colorado, duly

8 commissioned and qualified, do hereby certify

9 that the within named witness, THOMAS TREVOR

10 REILEY, M.D., was by me duly sworn to testify to

11 the truth and nothing but the truth in the cause

12 aforesaid; that the testimony then given by the

13 above-referenced Witness was by me reduced to

14 stenotype in the presence of said witness;

15 afterwards transcribed, and that the foregoing is

16 a true and correct transcription of the testimony

17 so given by the above-referenced witness.

18 I do further certify that I am not a

19 relative, counsel or attorney for any of the

20 parties or otherwise interested in the event of

21 this action.

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IN WITNESS WHEREOF, I have hereunto
set my hand and affixed my seal of office at
Teller County, Colorado, this 16th day of
September, 1999.

Craig L. Knowles /RDS

Craig L. Knowles, CM

Notary Public within and for
the State of Colorado

My commission expires June 25, 2002



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