IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

CHRISTOPHER S. LONG, etc.,)
)
Plaintiffs,)
)
vs) Case No. 321518
)
CLEVELAND CLINIC FOUNDATION)
)
Defendant.)
)

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DEPOSITION OF ANGELIQUE YOUNG, R.N.

FEBRUARY 12, 1999

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The deposition of ANGELIQUE YOUNG, R.N., the Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the state of Ohio, pursuant to agreement of counsel, at the offices of The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio, commencing at 9:30 o'clock a.m. on the day and date above set forth.

APPEARANCES

On behalf of the Plaintiff
Becker & Mishkind
BY JEANNE M. TOSTI, ESQ.
Skylight Office Tower
1660 West Second Street
Suite 660
Cleveland, Ohio 44113

On behalf of the Defendant
Roetzel & Andress
BY JOHN V. JACKSON, III, ESQ.
INGRID KINKOPF-ZAJAC, ESQ.
1375 E. 9th Street
Cleveland, Ohio 44114

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

EXAMINATION OF ANGELIQUE YOUNG, R.N.

BY MS. TOSTI:

Q. Would you please state your full name for us.

A. Angelique Young.

Q. And your home address?

A. 27600 Chardon Road, number 962, Willoughby Hills, Ohio, 44092.

Q. And is that an apartment?

A. *Yes.*

Q. Have you ever had your deposition taken before?

A. No.

Q. I am sure Mr. Jackson has spoken to you about depositions. This is a question and answer session under oath. It's important that you understand the questions that I am asking you.

If you don't understand the question or if I ask the question in a confusing manner, just let me know and I will be happy to reueat it or

rephrase it. Otherwise I will assume that you understood what I asked and you are able to answer it.

I would also ask that you give all of your answers verbally because our court reporter can't take down head nods or hand motions. If at any time you want to refer to the medical records, I see that Mr. Jackson has provided you with a copy. Feel free to do so.

At some point during the deposition, he may choose to enter an objection. You are still required to answer my question unless he instructs you not to. Okay?

A. Okay.

Q. Tell me what you have reviewed for this deposition.

A. I have reviewed the chart for the patient and corresponding nursing notes, physician orders.

MR. JACKSON: So it's not unclear to you, she didn't review the entire chart. I just want the record to reflect that.

Q. The portions that either you dealt with in regard to orders or the portion of the chart that you did charting on?

A. Regarding which orders?

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Q. When you say that you reviewed the patient's chart and reviewed the patient's doctors orders, my question is, in regard to what orders did you review?
A. The orders that corresponding to myself.
Q. Have you reviewed any textbooks or journal articles in preparation for this deposition?
A. No, I have not.
Q. Have you reviewed any hospital policies or procedures?
A. No.
Q. And other than with counsel, have you discussed this case with anyone?
A. No, I have not.
Q. Do you have any personal notes or personal file on this case?
A. No, I do not.
Q. Have you ever produced or generated any personal notes or personal file on this case?
A. No, I have not.
Q. Now, you are a registered nurse in the State of Ohio; is that correct?
A. Yes.
Q. When did you receive your license?
A. I received my license June of '96.

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Q. And what type of basic nursing program did you attend?
A. I attended Case Western Reserve University and graduated with my bachelor of science in nursing.
Q. And since the time of your basic nursing education, have you completed any additional degrees or certifications in nursing?
A. Since receiving my license, I am certified in intraaortic balloon pump.
Q. Do you have ACLS certification?
A. Yes, I do.
Q. When did you obtain that?
A. I obtained that, I believe, August of '97.
Q. And was that before or after you cared for James Long?
A. That was after.
Q. I am sorry, you said '97. So that was after?
A. Yes.
Q. Now, you are currently employed by the Cleveland Clinic; is that correct?
A. Yes.
Q. And what is your current title and position?

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A. Registered nurse.
Q. You are a registered nurse through the State of Ohio. At the Cleveland Clinic, do you have a job category?
A. A staff registered nurse.
Q. And what area do you currently work in?
A. Cardiothoracic intensive care.
Q. When did you first become employed by Cleveland Clinic?
A. July 8th, 1996.
Q. And have you since the time of your employment worked in the cardiothoracic unit?
A. Yes.
Q. Now, in August of 1996, what position did you hold?
A. Staff registered nurse.
Q. In the cardiothoracic?
A. Cardiothoracic intensive care unit.
Q. You indicated that you were hired in July and James Long's surgery was in August. Had you completed your orientation period at the time that you cared for James Long?
A. I do not remember if I had completed my orientation.
Q. How long was your orientation?

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A. Ten weeks. Approximately ten weeks.
Q. Well, if you were hired in July and his surgery was in August, the most that could be would be eight weeks. So was it likely you were still in orientation at the time that you cared for James Long?
A. I would say it is likely.
Q. In August of 1996, what was your usual shift that you worked?
A. Day/night rotation. Meaning two weeks days, two weeks nights.
Q. Now, would you tell me what hours that entailed?
A. That entailed working two, 12 hour shifts and two, eight hour shifts.
Q. If you were working the 12 hours, what hours would you be working?
A. That would be --
Q. Let's start with 12 hours. Did you do 12 hours and eight hours both on days and nights?
A. Yes.
Q. When you worked 12 hours a day on day shift, what would be your hours?
A. On day shift, that would be 7:30 to 3:00 for eight hours and 7:00 a.m. to 7:00 p.m.

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for 12 hours.
Q. If you worked night shift?
A. For night shift that would be 11:00 p.m. to 7:00 a.m. and 7:00 p.m. to 7:00 a.m. for 12 hours.
Q. Who was your immediate supervisor at that time?
A. At that time --
Q. And I am speaking of August of '96.
A. Okay. The supervisor was Lily Hicks.
Q. Now, did you have anyone from the education department or any type of a clinician that was overseeing your orientation when you were in the cardiothoracic unit, aside from the normal staff members?
A. Yes.
Q. Who was that?
A. Kathy Zilka.
Q. How do you spell her last name?
A. Z-I-L-K-A.
Q. And in August of '96 when James Long had his valve surgery, were you being supervised directly by Kathy Zilka?
A. Yes.
Q. Was she in the unit with you that evening?
A. I don't specifically remember, but she did

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oversee my clinicals.
Q. Was she working directly With you on a day-to day basis, eight hours a day, 12 hours a day?
A. She worked with me.
Q. I understand she worked with you. But did she work with you, if you were there for a 12 hour shift, was she with you the whole 12 hours?
A. Yes, she was.
Q. Was there any time that you were working during your orientation that Kathy was not with you?
A. No.
Q. Was Kathy Zilka with you on the night that James Long had his surgery?
A. If I was in orientation, yes, she would have been.
Q. Now, in August of 1996, on the evening shift, how many patients would you usually be assigned?
A. Two.
Q. And would these be post-op patients?
A. Yes.
Q. And in that time period, what was the usual nurse to patient ratio in the intensive care unit?

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A. Usually two patients to one nurse.
Q. Now, in your orientation that you received, did you receive a special orientation for the intensive care unit?
A. Yes, I did.
Q. Tell me what that orientation entailed. What type of things were you taught in that program?
A. It entailed going to critical care classes and being -- specifically what do you mean? What was taught in those classes?
Q. Yes, just the subject matters covered.
A. Hemodynamic monitoring, chest tube monitoring, trends in hemodynamic monitoring, different drugs used.
Q. And how many class hours were involved in that orientation?
A. I don't specifically remember.
Q. Can you tell me approximately?
A. No, I cannot.
Q. In your orientation class, were you taught how to recognize abnormal parameters for a patient?
A. Yes.
Q. And were you also taught to keep

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supervising physicians informed of significant changes in trends in hemodynamic monitoring?
A. Yes.
Q. And as a cardiothoracic intensive care nurse working with these post-op patients, were you also trained to watch patients for signs of postoperative excessive bleeding?
A. Yes.
Q. Now, if you were informed that a patient had had bleeding problems during surgery, would that cause you to watch this patient any more closely for signs of hemodynamic trends that may indicate bleeding?
A. Yes, it would.
Q. Now, I would like you just to describe generally for me what your duties and responsibilities were in the cardiothoracic intensive care unit in August of 1996 when James Long was in the unit.
A. My responsibilities would include documenting vital signs, documenting IV drugs the patient was on, monitoring urinary output, monitoring chest tube drainage and alerting physicians to any types of abnormalities.
Q. Do you have an independent recollection of

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James Long aside from what you reviewed in the medical records?
A. No, I do not.
Q. Now, on August 20th of 1996, what hours were you working?
A. 7:00 p.m. to 7:00 a.m.
Q. And were you working full time at that time?
A. Yes, I was.
Q. Do you recall who else was working in the unit with you that evening?
A. No, I do not.
Q. How many registered nurses would usually be in the unit on a typical 7:00 p.m. to 7:00 a.m. shift?
A. If the census was full, which was ten patients, it would be five.
Q. What time did you begin care for James Long on the evening of August 20th?
A. 7:00 p.m.
Q. And at the time that you were caring for James Long, did you have any other assigned patients?
A. I do not remember if I did.
Q. Do you recall if you had any other assigned

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duties aside from patient care that night?
A. No.
Q. No, you don't recall, or no, you did not have any such additional duties?
A. No, I didn't have any such duties.
Q. Do you recall who your charge nurse was that evening?
A. No, I do not recall.
Q. Did you receive a report on James Long when you assumed his care?
A. Yes, I would have.
Q. Who gave you that report?
A. Denise Hrobat.
Q. And what was the content of that report?
A. The content of the report would have included the patient's OR, what kind of surgery he had. If anything significant happened in OR. His current vital signs, any parameters that I needed to Q the patient within. What his IV drips were, what his chest tube drainage had been, any other specific medications he was given. Urinary output.
Q. Were you aware that James Long had had a bleeding episode in surgery that evening?
A. That would have been reported to me.

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Q. Now, when you assumed care of a patient, was it your routine to review the post-op orders?
A. Yes.
Q. What was your understanding as to why James Long's systolic blood pressure was to be kept below 100 systolic?
A. Because he did have some bleeding intraoperatively.
Q. Is it your routine when you assume care of a patient to review the flow sheet and the record of hemodynamics when you begin care for a patient?
A. Yes.
Q. And when you reviewed James Long's flow sheet, did you find anything that raised the level of concern in your mind for this patient regarding bleeding?
A. Can you repeat the question? I'm *sorry.*
Q. When you began caring for the patient, I had asked you if it was your routine to review the hemodynamics of the patient that occurred prior to the time that you came in.
And my question to you, looking at the hemodynamics that are recorded on the flow sheet, prior to the time that you came in, is there anything in those hemodynamics that would raise

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your level of concern for this patient regarding excessive postoperative bleeding?
A. No.
Q. Okay. I would like you to take a look at the hemodynamics at 1750 hour. That was prior to your time of your care; correct?
A. Yes.
Q. And there is a blood pressure, I believe, of 75 over 46, and a mean arterial pressure of 55, and a cardiac index of 2.0 listed at that time.
MR. JACKSON The time again, Jeanne?
A. You mean 1850?
Q. I am sorry, you are correct. It's 1850.
A. Okay.
Q. Now, looking at those parameters, do those parameters raise any concern that this patient may be having bleeding?
A. The only concern would be the low blood pressure. But looking at his chest tube drainage, no, I wouldn't be concerned that he was bleeding.
Q. Now, when you assumed care, you were aware that James Long's chest tube drainage had increased from 50 cc's an hour to 100 cc's an hour; correct?

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A. Yes.
Q. And you would have seen that on the flow sheet when you reviewed it?
A Yes.
Q Did you do an assessment of this patient when you took over his care?
A. Yes, I did.
Q. Were there any changes in your assessment from the previous assessment?
A I do not see any major changes from the previous assessment.
Q. I didn't ask you for major changes. I asked you for changes.
A No, I don't see any changes.
Q Now, you are looking at a check off sheet that has at the top of the first column assessment; is that correct?
MR. JACKSON: She was looking at a written note.
Q Did you fill out a checklist sheet on this patient in regard to assessment?
A. Yes, I did.
Q. Okay. And when did you do that in your shift? Was that done at the beginning or in the middle?

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A. It would have been done at the beginning of my shift.
Q. Okay. Now, comparing the assessment that is on that sheet to the previous assessment, are there any changes that you noted?
A. No changes that I have noted.
Q. Okay. Under the area marked muscular, the assessment that is noted by Ms. Hrobat has an asterisk next to it. However, yours has a check mark next to it. Is that a change in this patient's condition?
A. Under which heading?
Q. Under neuromuscular, moves extremities.
A. Okay. Can you repeat the question?
Q. Yes. I am asking you if there was a change in this patient's condition in regard to his ability to move his extremities from what the previous assessment was? Ms. Hrobat has put an asterisk there and you have put a check mark there.
A It looks like there was a change.
Q. Okay. Under the area of cardiorespiratory, there is a line marked breath sounds clear bilaterally and Ms. Hrobat has put a check mark there, but you have put an asterisk there; is that

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correct?
A. Yes.
Q. Why is an asterisk there under your charting?
A. Well, that would denote that the breath sounds were not clear bilaterally and I did note on my charting that the patient did have some bronchi bilaterally.
Q. So that would indicate a change in this patient's condition for that item?
A. Yes.
Q. In that same area, cardiorespiratory, under no peripheral or dependent edema, Ms. Hrobat has put a check mark and you have an asterisk there; correct?
A. Yes.
Q. What was your finding there?
A. My finding would have been that the patient did have some edema.
Q. And that would be a change in this patient's condition from the previous assessment; correct?
A. In the previous assessment, she doesn't denote anything about edema. I know that she check marked it; however, that could be considered

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achange.
Q. And a check mark indicates that everything is okay with the patient in regard to that particular item, if you check it off?
A. Yes.
Q. Under the area marked gastro, there is an item indicating bowel sounds present.
A. Yes.
Q. And Ms. Hrobat has checked that one off, but you have an asterisk there. What was your findings in regard to bowel sounds for this patient?
A. My findings were that I did not hear any bowel sounds.
Q. And that was a change in condition for this patient also; correct?
A. Yes.
Q. Now, when you have a narrative note written here at 2100 hour -- and what was your neurological assessment of the patient at 2100 hour?
A. This assessment was from 7 P until 900 o'clock. And during that time, neurologically, at one point, he did follow commands when I asked him a question and he did move all extremities.

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Q. And your assessment was he was neurologically intact at that point in time?
A. *Yes.*
Q. Who was the surgical physician on call that night in the unit?
A. I believe it was Dr. Muellbach.
Q. Now, at, I believe, 1930 hour on the line G, James Long's chest tube drainage increased to 250 cc's an hour, would chest tube drainage that increases from 50 to 100 to 250 cc's an hour in the first two hours in the ICU raise a concern in your mind that the patient was having excessive post-op bleeding?
A. That would raise a concern that the patient had a potential to bleed.
Q. Why do you say potential?
A. Well, at this point, the 250 had been the highest that he had put out. He had been in the unit for approximately three hours, so from that I couldn't necessarily determine that he was actively bleeding.
Q. At 1930 hour, he would have been in the unit approximately two hours; correct?
A. *Yes.*
Q. I think you mentioned three hours?

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A. Oh, okay.
Q. When he put out the 250 cc's, did you do anything? Did you take any action?
A. It looks like I did give platelets for that, and additionally volume LR and I autoed back the 250 he dumped out.
Q. Did you notify any doctor about the increasing chest tube drainage?
A. I believe I would have, because I would not have been able to give platelets without a doctor's order.
Q. Is it your testimony that those platelets were ordered as a result of the 250 cc's of chest tube drainage?
A. *Yes.*
Q. Could you take a look at the doctor's orders and tell me in regard to this particular patient where you received those orders?
A. I received those orders verbally from Dr. Muellbach.
Q. And did you call him, do you believe?
A. *Yes.*
Q. Now, there is no indication under the significant events that you put a phone call into Dr. Muellbach. If you contacted him, would that

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be something that would usually be written into the significant events?
A. Usually it would have.
Q. And in this instance, do you know why you didn't?
A. No, I do not know.
Q. Were any physicians in to see James Long between the time that you assumed his care and 1930 hours when it was recorded that he had 250 cc's of chest tube drainage?
A. It looks like Dr. Yared came by the bed space.
Q. Now, the time period I am talking about is when you came on duty.
A. Okay.
Q. And 1930 hour.
A. And 1930?
Q. Yes. When he had the 250 cc's of drainage recorded over that hour, did any physician come in to see the patient?
A. I do not remember.
Q. As a nurse in the ICU, when you are assessing a patient for signs and symptoms of postoperative bleeding, what do you look for?
A. I look at the chest tube drainage and I

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also look at the blood pressure.
Q. Anything else?
A. No.
Q. Okay. And what is it that you are looking at in regard to the blood pressure?
A. If a patient is bleeding, I would be looking to see if his blood pressure is dropping.
Q. And in regard to chest tube drainage, what are you looking for?
A. I am looking for any excessive amounts of chest tube drainage which could be anything greater than 150.
Q. Per hour?
A. *Yes.*
Q. So in this case, when he had a 250 cc drainage over the course of an hour, would that be an indicator to you that he was having some bleeding problems?
A. Yes. It would have indicated to me that he had a potential to bleed, for having some bleeding problems.
Q. Now, when you talked to Dr. Muellbach and received the order for, I believe, it was platelets --
A. Yes.

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Q. -- what information did you give Dr. Muellbach?
A. I would have told him how much chest tube drainage he had out and I would have told him the blood pressure, and any other questions that he had.
Q. And what did Dr. Muellbach tell you in regard to this patient's condition?
A. I don't specifically remember what exactly he told me.
Q. Was he concerned, based on your impressions from the conversation, about post-op bleeding in this patient at that time?
A. I don't specifically remember the conversation, so I don't remember.
Q. Did you ask Dr. Muellbach to come and take a look at the patient?
A. I don't remember if I did.
Q. Did you think at that time he needed to be seen by a physician?
A. At that time, no.
Q. Do you know, was Dr. Muellbach in the hospital at the time that you called him?
A. Yes, he would have been.
Q. Now, at 2010 on the flow sheet, which I

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believe is on line I --
A. Yes.
Q. -- James Long's pulse is recorded at 1034 and his blood pressure fell to 72 over 42 with a mean arterial pressure of 55.
From your perspective as an ICU nurse, were those values alarmingly low for this patient?
A. I would not say alarmingly low. They were low.
Q. Did that raise your level of concern that this patient may be bleeding when those values were recorded?
A. I believe so.
Q. Did you do anything in response to those low values?
A. Yes. It looks like I went up on Levophed from one meg to five megs.
Q. And was there any response in his blood pressure when you did that?
A. 20 minutes later at 2030, it looks like there was no response.
Q. Did you notify anyone about his falling blood pressure and failure to respond to the Levophed?
A. I don't have anything charted that I did.

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Q. Wouldn't that be an instance that you would normally contact a physician and let him know that the patient was not responding to the vasopressors?
A. Not necessarily. I would have gone up on Levophed and it looks like he didn't respond initially, but the next instance at 2050, he did. His pressures did go up.
Q. How long was his blood pressure below 90 systolic?
A. It looks like -- well from 2010 to 2130.
Q. So about an hour and 40 minutes?
A. Yes.
MR. JACKSON: That's not an hour and 40 minutes.
MS. TOSTI: From 1950 to 2130.
MR. JACKSON She said 2010.
MS. TOSTI: Well, I asked her below 90 systolic.
Q. Isn't the patient below 90 systolic at 1950 hour?
A. Yes, he is 88.
Q. And he doesn't return to above 90 until 2150. So he is still at 2130 below 90 systolic. Isn't that an hour and 40 minutes from 1950 to

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2130?
A. Yes.
Q. Did any physician see James Long at or about 2010 to 2030 hour?
A. I don't have a physician documented on here except for Dr. Yared was there at 2050, approximately.
Q. Do you know why Dr. Yared was in the unit at that particular time?
A. I don't specifically know. I know that he does round on patients, every patient in the unit.
Q. You don't have a specific recollection of calling him to see this patient?
A. No, I don't.
Q. Now, during the evening, you received verbal orders from Dr. Muellbach for an Epinephrine drip; is that correct?
A. Yes.
Q. What time did you receive those orders?
A. There is not a time documented.
Q. If you received those orders, would you have carried them out with in close proximity to the time you received the order?
A. Yes, I would have.
Q. And looking at the flow sheet when the

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Epinephrine drip was started, can you give me an approximate time that you think you received an order for the Epinephrine?
A. It looks like approximately 2010.
Q. Were those orders given over the phone?
A. Yes.
Q. What is your understanding as to why James Long was placed on Epinephrine?
A. My understanding was that his -- it looks like his indexes, looks like 2010 was 2.2. I can't make out the 2030, but it looks likes to increase his cardiac index.
Q. Do most postoperative aortic valve patients require Levophed and Epinephrine to support their blood pressure?
A. Some valve surgeries do, yes.
Q. And my question was, do most?
A. I would not say most.
Q. Now, in the Levophed column are some small numbers that are written in the upper left-hand comer of the boxes, and then additional numbers off to the right. Can you tell me what those numbers represent?
A. Yes. The numbers in the left-hand corner within the box is the rate at which the IV drip is

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going, and the numbers outside is the megs per minute.
Q. And you as a nurse in the ICU had the authority to adjust these drip rates of Levophed and Epinephrine to control the blood pressure at the level that the doctors had ordered; is that correct?
A. Yes.
Q. And what range were you to keep James Long's blood pressure at?
A. I was to keep his systolic below 100.
Q. And what about the bottom number, the diastolic blood pressure? I'm sorry, strike that.
What was the lowest systolic blood pressure that you were to keep him at?
A. There isn't one documented for lowest.
Q. I would like you to take a look at the orders that you previously referenced. And I believe there is an order that you took off from Dr. Muellbach in regard to the Levophed drip.
A. Okay. Yes.
Q. What does that say in regard to the systolic blood pressure?
A. It says titrate for systolic greater than

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90.
Q. So for this patient, you were to keep his blood pressure between 90 and 100 systolic; correct?
A. Yes.
Q. Now, the flow sheet indicates that James Long's systolic blood pressure was in the 70s and 80s for an hour and 40 minutes between 1950 hour and 2130 hour with Levophed and Epinephrine running. Were you making adjustments in the flow rates of these drugs to try to maintain his blood pressure --
A. Yes, I was.
Q. Let me finish my question. -- within the range that the doctors had ordered?
A. Range, meaning his systolic blood pressure?
Q. Yes, between the 90 and the 100.
A. Yes.
Q. Were you making adjustments in the medication during that time period of 1950 through 2130 to try to get his blood pressure within the range of 90 to 100 systolic?
A. Yes, I was.
Q. How many times did you have to adjust the

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flow rates on these drugs?
A. For the Levophed, it looks like starting from 1950, looks like five times.
Q. And how about the Epinephrine?
A. It looks like twice.
Q. Now, during that time period of 1950 through 2130, you were unable to maintain his blood pressure at the ordered level; correct?
A. Yes.
Q. Did you notify anyone that you were unable to keep his pressure up to 90 systolic?
A. I don't have anything documented here.
Q. And if you had called anyone, wouldn't it be your normal routine to document it on the significant events list?
A. Yes.
Q. So is it likely that you didn't call anyone between 1950 and 2130?
MR. JACKSON: Objection. Go ahead and answer.
A. I am sorry, can you repeat the question?
Q. Yes. I said, your normal routine was to document if you made a phone call under the significant events area. And in this instance, since you didn't document, isn't it likely that

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you did not make any calls to a physician during that time period of 1950 through 2130?

MR. **JACKSON:** Objection, but go ahead and answer.

A. Yes.

Q. Now, when you were unable to maintain this patient's blood pressure above 90 for a period of an hour and 40 minutes, did you have any concerns that the reasons may be that he was bleeding excessively?

A. It was a concern. Along with the Levophed I was also giving LR. I was autoing back his blood that he had out, along with going up on the Levophed. But at that time, according to, looking at my chest tubes, from 2010 on, up until like 2210, I don't see a concern for bleeding.

Q. At the time that you were caring for James Long, had you received any training in observing chest tubes for clotting?

A. *Yes.*

Q. Had you been taught how to milk or squeeze the tubes to remove clots from a chest tube?

A. Yes.

Q. And in James Long's case, did you note any clotting in his chest tubes?

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A. I don't specifically remember, but it would have been my routine to consistently milk and make sure that the chest tubes were patent.

Q. How often would you do that?

A. Well, being that he did have out 250 at 7:30, I would have probably done that every 15, 20 minutes, making sure that the chest tubes were patent.

Q. And would you have to see a clot in the tube or would you just go ahead and routinely do it every 15 or 20 minutes?

A. I would routinely assess and see if there were any clots in the chest tubes.

Q. So if there were no clots, would you milk the tubes or would you not milk the tubes?

A. If I did not see any clots, I would not have milked the tubes.

Q. So you would assess the tubes and then only do squeezing or milking of the tube if you felt it was indicated?

A. *Yes.*

Q. Okay. Is there a protocol or a written procedure for using vasopressors in the intensive care unit?

A. I am not for sure.

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Q. How do you decide when to call a physician when you are using vasopressors on a patient to maintain the blood pressure?

A. If I am having to consistently go up on the vasopressors, then I would call the physician and let him know that I am having to go up to maintain a blood pressure.

Q. Now, you have previously testified that you were increasing the Levophed, increasing the Epinephrine, and that this patient's blood pressure remained below 90 systolic for an hour and 40 minutes.

Wouldn't that all be indications that a physician should have been called to see this patient?

A. Along with just the Levophed and Epi, I was also giving volume to assess and see if that would help the blood pressure, and once that did not indicate the blood pressure, or did not help elevate the blood pressure, it looks like I did notify Dr. Muellbach that my Levophed drip was having to -- I would have to titrate up for the Levophed drip.

Q. What time did you do that?

A. That was approximately, it looks like,

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9:30.

Q. At 2150 hour?

A. 21 -- yes, approximately, yes.

Q. 2150 hour. That was after an hour and a half. I am *sorry,* an hour and 40 minutes of problems with this patient's blood pressure, though; correct?

MR. **JACKSON:** I am going to object. When you are talking about these conversations, she told you earlier that the epi probably started shortly after she talked with Dr. Muellbach, and that falls within that time frame. So although not documented, there was a conversation within that time frame between 1950 and at least, what, 2010.

MS. TOSTI: 2010 was when the Epinephrine was started, so sometime prior to that.

MR. **JACKSON:** Sometime prior she said she would have spoken to him and taken that order down and started it.

Q. So from 2010 when the Epinephrine was started through 2130, you didn't contact any physician; correct?

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MR. JACKSON: Object to that. She said it's not documented.
Q. You have no recollection of contacting any physician between 2010 when the Epinephrine was started and 2130; correct?
A. Correct.
Q. Why was an Amicar infusion resumed on this patient at 2030 hour?
A. Probably, I would assume because of his chest tube drainage for the 7:30 hour of 250.
Q. Now, you, as a nurse, do you make the decision to initiate that?
A. No.
Q. I would like you to take a look at the orders for the Amicar that were written. I think there is one at 1830 hour.
A. Okay.
Q. Now, at 1910, did this patient receive a dose of Amicar?
A. An IV, continuous N?
Q. Yes.
A. Yes.
Q. Was that a drip that was running or was that a bolus dose?
A. That was a drip running.

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Q. Now, at -- I don't see anything recorded in the 1930 box or the 1950 box. What does that indicate for the 2010 box, what does that indicate in regard to this Amicar drip? Was the patient receiving it or was it turned off?
A. Yes. I have the initial rate of 10 in that, 10 cc's an hour.
Q. So this was from 1910 on, it was an Amicar drip was continuing?
A. Yes.
Q. Now, there is charting that again begins under the Amicar column at 2030. Why does charting begin then?
A. Okay. At 1910, it was going at a rate of 10 cc's an hour. Which according to the concentration -- let's see here.
It looks like the rate changed. So I documented the change in the rate.
Q. And that would have been at 2030 hour?
A. Yes.
Q. What was the change in the rate in the Amicar at 2030 hour?
A. It looks like it was two grams an hour.
Q. And what had it been previously?
A. It was going at 10 cc's an hour. I do not

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recall the grams an hour.
Q. Rut you think that this was an increase in the medication at that point?
A. Yes.
Q. What does the 50 in the corner of the box at 2030 hour under the Amicar column mean?
A That's how many cc's an hour it's going at.
Q. So we went from 10 cc's an hour to 50 cc's an hour at 2030?
A. Yes.
Q. For the Amicar?
A. Yes.
Q. Okay. Now, were you the one that decided to increase that particular medication?
A. No, it would have been a doctor.
Q What doctor told you to increase that medication?
A. I don't specifically remember, but I assume it would be the doctor on call.
Q. And is it likely that -- well, strike that.
During the course of time that you cared for James Long on the evening of August 20th, was a transesophageal echo ever done on him?
A. Not that I can recall.

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Q. Was there any discussion by anyone about doing one in the unit?
A Not that I can recall.
Q. Now, under the pulmonary artery pressures that are listed, at 2110, there are numbers in the column that look like 83 over 52. And then just below that in that same column there is numbers listed at 73 over 53. *Are* these valid parameters?
A. No. It looks like they are arterial pressures.
Q. So these are not pulmonary artery pressures?
A No.
Q. And when you say arterial pressures, why would they be listed in that column?
A. It looks like I recorded instead of recording the PA pressures, I recorded arterial pressures there.
Q. Now, is that different than your column that has blood pressures in it?
A. No, it's the same.
Q. Why did you not have arterial, pulmonary artery pressures? Why weren't you recording those at that time?
A. I do not remember.

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Q. Why are these particular pressures circled?
A. To denote that that is not where it should be.
Q. Now, at 2110 hour, there is a cardiac index of 2.0 listed on the flow sheet. Was a cardiac index of 2.0 cause for heightened concern about this patient at that time?
A. I wouldn't say heightened concern. There would be a concern. And it looks like I would have upped my Epi to correspond with that.
Q. Now, Dr. Yared is noted at the bedside at 2110 hour. Did you have any conversations with Dr. Yared regarding this patient's condition at that time?
A. I don't specifically remember what.
Q. Did Dr. Yared or anyone else tell you that James Long was having bleeding problems?
A. I don't remember him specifically telling me that.
Q. Why are there no more pulmonary artery pressures taken after 2050 hour?
A. I do not remember.
Q. Are you required to do pulmonary artery pressures on patients that are in the cardiothoracic intensive care unit that are fresh

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post-ops?
A. Yes.
Q. Would this be a deviation from the policies and procedures of the unit not to do pulmonary artery pressures on a patient?
A. Yes. I should have placed or should have recorded the pulmonary artery pressures along with that, but I was still recording the other values, as well, still recording blood pressure, indexes and other corresponding values with that.
Q. Do you know any reason why you wouldn't continue to do them on this patient?
A. No, I don't. I don't remember.
Q. Now, under line N at 2150 hour, under the significant events, you have indicated Dr. Muellbach aware of Levophed up to 40 drops; is that correct?
A. Yes.
Q. Why was it necessary to turn this Levophed up to 40 drops at that point in time?
A. At that point in time, his systolic was still not at between 90 and 100 where they wanted it to be, so I increased Levophed and Dr. Muellbach knew that it was at 40 drops.
Q. Did you call him on the phone to tell him

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this?
A. Yes.
Q. Was he in the hospital at the time that you called him?
A. Yes, he would have been.
Q. Did you ask him to come and see the patient?
A. I don't specifically recall asking him to see the patient.
Q. At that point in time, did you think that James Long should have been seen by a physician?
A. At that time, no.
Q. Do you recall what the content of your conversation with Dr. Muellbach was at that particular time?
A. I don't specifically recall the conversation.
Q. Generally, do you recall?
A. I would have let him know what the blood pressure was, what my Levophed was at and I would have told him the chest tube drainage.
Q. Do you recall any response from Dr. Muellbach in regard to the information that you provided to him?
A. Any response from him?

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Q. Yes.
A. No, I don't recall one.
Q. Was there any discussion as to what was causing his low blood pressure?
A. No, I don't remember an exact cause.
Q. Well, do you remember a general cause?
A. No, I don't.
Q. Did you have any discussion about James Long having excessive postoperative bleeding?
A. At that time, with Dr. Muellbach in conversation?
Q. Yes.
A. Regarding bleeding, no, I don't remember having a conversation regarding bleeding.
Q. Now, you've totaled up chest tube drainage in the chest tube drainage column at 750 cc's.
A. Yes.
Q. At 2210. And on line S of the significant events, you've indicated another, let's see, chest tube increased to 350 milliliters, Dr. Hernandez aware. Is that 350 cc's in addition to the 750 cc's that you have got recorded at line zero?
A. No. That would have been additional 100 on top of the 250.
Q. I am sorry, an additional 100?

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A *Yes*.
Q You have recorded 350 milliliters?
A Yes. The last value that I have recorded is 2050 and then I write chest tube drainage increase to 350.
Q So additional 100 at that particular time?
A Yes.
Q After that, did James Long continue to bleed from his chest tubes after the 350 that you have, the additional 100?
A I would think so, yes.
Q Why is there no blood pressure after 2310 on this patient?
A Because it looks like the patient went back to OR
Q The patient went back to OR at 2330, though, didn't he?
A That's an approximate time. It could be anywhere between 2310, 2330.
Q If the patient was still in the ICU, though, until 2330, wouldn't this patient have required that blood pressures be taken on him?
A Yes. If he was still in the intensive care. That could have been a value while he was leaving out the door.

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Q There is recorded under the mean arterial pressure a mean arterial pressure of 45 at 2330?
A Yes.
Q Did you record that?
A *Yes,* I did.
Q Was the patient still in the unit at the time?
A I can't recall if he was still in the unit. He could have been on his way out the door to the OR That was an important value to me, so I just recorded it.
Q But you don't have any blood pressures recorded for the 20 minutes before that for this patient; correct?
A Between 2310 and 2330?
Q *Yes*.
A There are none. But like I said, he could have been on his way to OR during that time.
Q But you were able to record a mean arterial pressure on this patient?
A Yes. That could have been an important value that I saw before he left to OR so I went ahead and recorded it.
Q But that was before he left for OR, the 45?
A Yes.

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Q. Why are there no cardiac outputs and cardiac indexes after 2210 on this patient?
A. Well, we record outputs and index approximately every two hours.
Q. Well, you are doing them more frequently on the patient during this evening, though?
A. Yeah. His last index at 2210 was 2.9, which is an acceptable index, and I didn't feel like he needed to have another index drawn. But I would have recorded one at least every two hours.
Q. You didn't feel that he needed to have another index drawn.
Did you feel this patient was in stable condition?
A. No. Regarding to his index, specifically his index, it was an acceptable value, so I didn't feel that he needed to have another cardiac index drawn.
Q. How is it that Dr. Hernandez came to be at the bedside at, it looks like 2330? I am *sorry,* 2310.
A. I believe he was the chief for the service.
Q. The surgical service?
A. I believe he was the chief resident on call.

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Q. Did you call him to come see the patient?
A. I don't specifically remember if I called or if Dr. Muellbach called.
Q. And what was the reason that Dr. Hernandez came to the bedside?
A. It looks like after the patient had initially 250 and then he had another 100, so he would be called for potential, if a patient was potentially bleeding.
Q. Do you know if Dr. Hernandez spoke with Dr. Muellbach before coming to the unit?
A. I don't remember that.
Q. What did Dr. Hernandez do when he came to the unit?
A. From what I have Written here, it looks like he decided to take the patient back to OR.
Q. Did he do an assessment?
A. He would have.
Q. Did he tell you what his assessment was of James Long?
A. I don't specifically recall him telling me one.
Q. Is that the first time that Dr. Hernandez saw James Long that evening?
A. I don't remember, but -- no, I don't

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remember.
Q. After Dr. Hernandez arrived, did he call Dr. Muellbach or Dr. Cosgrove?
A. If he were taking the patient back to OR, he would have called Dr. Cosgrove.
Q. But my questions is, do you have any recollection of him specifically calling Dr. Cosgrove or Dr. Muellbach after he came to the unit?
A. No, I don't have any recollection.
Q. Did you see or speak to Dr. Cosgrove about James Long at any time during the evening on August 20th?
A. No. If I did, I would have documented that.
Q. Did you make any calls to Dr. Muellbach in regard to the 100 cc drainage that was noted in addition to the 250?
A. It looks like I called him regarding the 250 of chest tube drainage.
Q. And then after that, when he had the additional 100, did you call him again?
A. Let's see. I believe he would have been at the bed space along with Dr. Hernandez with that.
Q. Okay. You have a specific recollection of

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Dr. Muellbach being at the bedside?
A. Let's see. No, I don't.
Q. What was your understanding as to why James Long had to return to surgery?
A. For bleeding.
Q. Did you remain in the ICU when he was in route to the surgical suite?
A. Yes.
Q. Now, there are some hemoglobins and hematocrits that are listed on the flow sheet under the lab result column.
And James Long's hemoglobin is listed at, I believe, 12.1 on admission to the unit, and then goes down to 10.5 at, I think it's 2110, and down to 9.2 at 2250. Does that drop indicate anything to you as a nurse in regard to this patient's condition?
A. From when he was first admitted at 1730 until 2250, yes, that would be a concern.
Q. And what would your concern be?
A. Bleeding.
MR. JACKSON Off the record.
(Thereupon, a discussion was had off the record.)
Q. Prior to Dr. Hernandez's arrival in the ICU

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about 2310, had anyone else suggested that James Long should return to surgery?
A. No.
Q. Did you have contact with James Long's family at any time on the evening of August 20th?
A. It looks like when he came back from surgery, I talked with his son.
Q. But in regard to before he had his second surgery, did you speak to the family at all?
A. I don't specifically recall. I know that I have noted here family updated by phone. However, that could have been a doctor also.
Q. And you don't have a specific recollection of speaking to anybody?
A. No.
Q. During the time that you were in the ICU on the evening of August 20th, other than the visit that you have noted by Dr. Yared at 2110 and the visit noted by Dr. Hernandez at 2310, were there any other physicians that saw James Long during the evening?
A. Not that I can recall.
Q. Did you consider James Long to be hypovolemic at any time on your shift?
A. *Yes.*

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Q. And at what point in time did you think he was hypovolemic?
A. It looks like at 2010 when his mean BP was 55 it looks like, 500 LR were given, platelets given, he was autoed 50 and again at 2050 when his mean BP was 58 he was given 500 of LR.
Q. And do you have a protocol for IV intakes that allows you to add or subtract fluids for patients if you think they are hypovolemic?
A. We need to get a physician's order if volume has to be given to a patient.
Q. When you noted this patient to be hypovolemic, did you notify anybody about it?
A. **Yes.** I couldn't have given the LR without a physician's order, so I would have notified the doctor.
Q. Do you know who you talked to?
A. Looks like Dr. Muellbach.
Q. When you look over the hemodynamic parameters on this flow sheet during the time tha you were caring for this patient, do you see any trends that would cause a heightened concern that this patient was bleeding?
A. Not until he had out 250 cc's at 2210, which I did call the doctor.

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Q. Okay. My question is in regard to the hemodynamic parameters, not the chest tubes.
A. Okay.
Q. I am asking, if there is anything that looks to you as a trend that would make you suspicious that this patient was bleeding?
A. No, not necessarily bleeding, no.
Q. Is there any point in time during the evening of August 20th in your assessment as a nurse that you believed this patient's condition began to change for the worse?
A. I would say that it looks like at 2210 when he did have the 250 cc's out that that was a change for the worse.
Q Did you feel that his condition was stable prior to that time?
A Somewhat stable. We were still trying to work on his blood pressure.
Q. Now, you were in the intensive care unit when he returned from the surgery; is that correct?
A Yes.
Q. What was his condition when he returned?
A. 'when he returned, it looks like his condition was stable. He had a good blood

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pressure, index, and his chest tubes were minimal.
Q. What time did you leave the unit that night?
A. The end of my shift was at 7:00 a.m.
Q. And did you care for him at any time after that night?
A. I don't remember.
Q. Did you have any conversations with anyone that cared for James Long that night regarding what happened to him?
A. Conversations with who?
Q. The doctors or nurses.
A. When he came back, I would have gotten a report from anesthesia about his readout.
Q. And do you recall that report that you received?
A. I don't specifically recall the report.
Q. Do you recall any conversations with any of the physicians that rendered care to James Long that evening about the bleeding problems that he had?
A. I don't recall any specific conversations, no.
Q. Do you have any recollection of any conversations with James Long's family after his

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second surgery?
A. It looks like there is documented the son was notified, but not necessarily by me.
Q. But you don't specifically remember talking to anyone in the family?
A. No.
Q. Now, you had mentioned that during your orientation, you were working with someone that would oversee the care that you were giving, and you don't recall specifically whether that person was with you the evening of August 20th; is that correct?
A. No, I can't recall that.
Q. Okay. If that person was with you, do they do any charting in the chart?
A. No, the charting is my responsibility.
Q. Okay. If that person is with you, do they interact with the physicians at all?
A. They could. They could if they wanted to, yes.
Q. And looking over all the charting in the records, can you tell me whether it's your impression that there likely was or was not somebody with you from the education department or a person supervising you in your orientation that

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night?
A. I can't recall just looking at the chart if there was or was not.
Q. Did those people normally work the night shift through to 7:00 a.m. with you?
A. Yes.
Q. Was James Long's case ever discussed at any staff meeting in the ICU?
MR. JACKSON: I'll object, but you can answer. If we are talking about morbidity, mortality, you can say that it did or didn't happen. Just tell her whether or not you recall such a conversation.
THE WITNESS: No, I do not recall.
Q. Are you critical of anyone regarding critical of anyone that rendered care to James Long on the evening of August 20th?
A. No, I'm not.
MS. TOSTI: I don't have any further questions.
MR. JACKSON: She will read it.

(Deposition concluded at 11:00 o'clock a.m.; signature not waived.)

Angelique Young, **R.N.**

CERTIFICATE

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, **on this 16th day of March, 1999.**

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

My commission expires May **22,** 1999.

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