

IN THE MISSOURI COURT OF APPEALS
EASTERN DISTRICT

R.A., a minor, by and
through His Next Friends
and Natural Parents,
SARAH ANYAN and BLAKE
ANYAN,

Respondents,

vs.

Appeal No. ED113824
Cause No. 21SL-CC03944

MERCY HOSPITALS EAST
COMMUNITIES d/b/a MERCY
HOSPITAL ST. LOUIS,
MERCY CLINIC EAST
COMMUNITIES d/b/a MERCY
CLINIC OB/GYN and
DR. DANIEL MCNEIVE,

Appellants.

Appellate Trial Transcript

Volume 1 of 2

March 11-18, 2025

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GUNN | SLATER

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Tuesday, March 11, 2025

Pretrial Motions

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(At 9:27 a.m., the following proceedings were held in open court, outside the presence of the jury panel:)

THE COURT: We are here on the record in the matter of R.A., a minor, by and through his Next Friends and Natural Parents, Sarah Anyan and Blake Anyan, vs. Mercy Hospital East Communities, Mercy Hospital St. Louis, et al., Cause No. 21SL-CC03944.

This matter is set this morning with regards to a jury trial. The Court notes that on behalf of the parties -- on behalf of -- is it all the defendants or just --

MS. KAMYKOWSKI: on behalf of all the defendants.

THE COURT: On behalf of all the defendants. A motion, a renewed motion, for sanctions was filed last night.

And at this time, the Court is addressing that issue before we bring the jurors in.

MS. KAMYKOWSKI: May I, Your Honor?

1 THE COURT: You may.

2 MS. KAMYKOWSKI: So, Your Honor, just so
3 that we can make sure that the record is clear, the
4 defendants are here this morning before we are to
5 start the voir dire process on an extension or a
6 renewal of the motion for sanctions that were argued
7 before this Court last Thursday, on March, I believe
8 that was, March 6th, 2025.

9 That motion is in the file. A hearing was
10 had, a lengthy hearing was had, off the record by the
11 parties at that time. The motion for sanctions dealt
12 with late production of discoverable documents in
13 this case, namely, photographs and videos of the
14 plaintiff from the relevant time frame at issue in
15 this case. The record will reflect the defendants'
16 position with respect to the original motion for
17 sanctions.

18 what was asked for at that time was the
19 sanction with respect to use of any of the
20 photographs that had been produced in this case,
21 particularly those that were produced in March of
22 2025, because they had been requested as far back as
23 December of 2021 in our request for production asking
24 for all photographs, videos, or other statements of
25 the plaintiff relating to any of the claims he has

1 made in this case and the damages therefrom. And a
2 response was provided by the plaintiff without
3 objection that they would timely supplement.

4 with respect to the production, there were
5 photographs that were provided to a neonatology
6 expert, Dr. Kerzner, prior to her deposition in
7 october of 2023, that had also not been previously
8 produced to defense. The first time we got those was
9 the evening before or the day before her deposition.

10 In preparing this case for trial, the
11 defense believes that it's important to evaluate the
12 metadata of those photographs to determine a timeline
13 for the photos that were taken in the immediate
14 post-delivery period in the labor and delivery suite
15 with the baby in the isolette with NICU folks, his
16 parents, and other members of Mercy staff.

17 In doing so for the first time in, I think
18 it was early part of March, less than two weeks
19 before trial, defendants noticed in the metadata that
20 there were thousands and thousands of additional
21 documents, photographs, and videos that had not been
22 previously produced. That was the subject of our
23 first motion for sanctions.

24 At the time of that hearing last week, a
25 specific sanction order was not entered, however, the

1 Court, in an attempt to remedy the late prevention of
2 that data and keep this case on track for the jury
3 trial starting today, the Court fashioned an order
4 that was an immediate production of all of the
5 previously unproduced data, as well as a supplemental
6 deposition of Dr. Kerzner who had previously relied
7 on certain photographs to determine if her opinions
8 had changed. The defendants awaited that production.
9 It was produced last Friday -- of last Thursday
10 evening after the Court's deadline, but it was
11 produced. We endeavored to review those documents,
12 and we did as the Court asked, which was depose
13 Dr. Kerzner yesterday.

14 As the Court recalls part of the order
15 last week, the trial was set to start yesterday, and
16 the Court moved the trial date by one day to attempt
17 to remedy plaintiffs' discovery violation.

18 Dr. Kerzner was deposed yesterday. And
19 despite representations made in this court last week,
20 that the photographs that were late produced would
21 have zero impact on her opinions; they would not
22 change her opinions; they would not alter her
23 opinions; she in fact, for the very first time,
24 disclosing brand new opinions that dramatically
25 altered the evidence in this case.

1 Dr. Kerzner's opinion at this point in
2 time is based on a photograph that was produced on
3 March 6th, showing a mask on this baby's face at a
4 time when he was being resuscitated in the NICU,
5 changes her opinion as to that Apgar.

6 As the Court knows, part of the causation
7 discussion in this case, the contested causation
8 discussion in this case, is whether or not that Apgar
9 was accurately provided and assigned by a nonparty in
10 this case.

11 The Apgar was assigned by a neonatal NICU
12 nurse practitioner who is not a Mercy employee. She
13 is not an employee of Mercy Hospitals. She is not an
14 employee of Mercy Clinics. She is an employee of
15 pediatrics and was in fact a defendant in this case
16 when the lawsuit was filed.

17 Dr. Kerzner's new opinion squarely puts
18 whether or not it was reasonable for that provider to
19 have assigned the Apgar that she did at play in this
20 case. Had those photographs been produced three and
21 a half years ago, when that neonatal nurse
22 practitioner and her employer were still defendants
23 in this lawsuit, very different defenses could have
24 been mounted on behalf of the defendants in this
25 case.

1 Instead, less than 24 hours before trial,
2 we now have a brand new opinion that does not refute
3 Dr. Kerzner's prior testimony but instead bolsters
4 her opinion. I can't imagine a scenario where, if
5 the defendants had withheld responsive documents from
6 the plaintiff until a week or two before trial, were
7 ordered to produce those documents, and then their
8 case got better for them, that a sanction against
9 those defendants for that discovery violation would
10 not be entered. Very likely, the death now sanction
11 that we've seen in much less violative actions,
12 upheld by appellate courts in this state, so striking
13 a pleading or further taking away options of evidence
14 in the trial.

15 So at this point, Judge, there's no way
16 for the defense to be able to adequately, at this
17 late stage, defend the brand new opinion of
18 Dr. Kerzner, to either -- we may have third-partied
19 in the pediatric folks in this case as a contributing
20 cause of the damages in this multimillion dollar
21 lawsuit. We don't have time to do that. There's no
22 way that we can argue she is the sole cause of the
23 damages in this case.

24 There are certain other things that the
25 defense may have done. We haven't even had a chance

1 to talk to our experts about their thoughts on this
2 new opinion. The time for discovery has passed. We
3 should not be doing discovery in the middle of the
4 trial. So at this point, and so the record is clear,
5 there have been numerous discussions previous to
6 today with respect to this Court's February 18th,
7 2025, order mandating that the plaintiffs' rebuttal
8 expert, Dr. Gingras, is a rebuttal expert.

9 Plaintiffs asked for reconsideration of
10 that opinion once formally at our pretrial on
11 February 27th and once formally last week when this
12 motion for sanctions -- at the same time the motion
13 for sanctions was first raised.

14 The defendants do not want a continuance
15 of this trial to then allow plaintiffs' bad actions
16 in this case to force this Court to reconsider its
17 ruling on Dr. Gin -- on Mr. Gingras.

18 So at this point, we think the only proper
19 sanction for this brand new opinion that was
20 disclosed based on material that had been in the
21 plaintiffs' possession since the time of this
22 incident, not -- it predates the filing of the
23 lawsuit, -- that there needs to be a sanction.

24 One other thing that I think is very
25 important here is despite multiple opportunities, we

1 have still never heard from the plaintiff or his
2 attorneys a reason, an explanation, or an excuse for
3 their failure to produce these responsive documents
4 in a timely manner.

5 This case has been litigated for almost
6 four years. And on the eve of trial, brand new
7 opinions that dramatically change the landscape of
8 this lawsuit are now at play. So it's the defense
9 position that all available remedies under Rule 61.01
10 are at play here. We believe that the conduct and
11 the result means prejudice to these defendants, as
12 we've outlined in our motion and in this argument
13 today, warrants a strict sanction that comports with
14 what the Vetter court has instructed and given --
15 empowered trial courts to do for serious discovery
16 violations.

17 And we would ask the Court entertain, in
18 the order they were included in the motion for Official Cou
19 sanctions, every available option, including striking
20 of the pleadings.

21 And if the Court is not inclined to do
22 that, severely limiting the plaintiffs' evidence on
23 this issue of an incorrect Apgar, striking
24 Dr. Kerzner and any other witness from criticizing or
25 otherwise addressing or calling into question the

1 Apgar score, and for any further relief that the
2 Court would entertain.

3 I'm going to turn it over to Mr. Perron
4 because not only in the last 24 hours did we have a
5 violation of -- have further prejudiced the defendant
6 for a discovery violation that has been ongoing for
7 three and a half years, but we have a violation, we
8 believe, of a preliminary motion in limine with
9 respect to new bases of opinions of experts that was
10 disclosed to the defense less than 2 hours before Dr.
11 Liles', plaintiffs' life care planner, trial
12 deposition that occurred over 3 and a half hours last
13 night.

14 So I'm going to turn it over to Mr. Perron
15 for the further issues to address.

16 MR. PERRON: Your Honor, just briefly for
17 a little bit of added context on the issue with
18 Dr. Kerzner and this photo.

19 During the initial fact discovery of this
20 case, when we were taking depositions of providers,
21 there was a lot of focus, as you might imagine, on
22 the Apgar score and circumstances surrounding the
23 Apgar score and calculation of the Apgar score.

24 Plaintiffs' counsel, when they were
25 deposing the NICU nurse who calculated the Apgar

1 score, asked was Remi on a CPAP machine at the time
2 they were calculating the 5-minute Apgar score, and
3 how might that affect the calculation of the Apgar
4 scores when she provided her answers?

5 when they deposed our neonatology expert,
6 he was asked by plaintiffs' counsel, was Remi on a
7 CPAP machine at the time of the 5-minute Apgar score,
8 and how might that have affected the calculations of
9 the Apgar score?

10 All the NICU nurses and our experts are
11 relying upon what was in the medical records. And
12 that was all we could rely upon as to the basis or
13 any fact controversy on this issue.

14 A week before trial, one of the particular
15 photos that was newly disclosed appeared to be some
16 type of mask on Remi, time stamped right around the
17 time that they might have been calculating the Apgar
18 scores.

19 So obviously, in our mind, we were in sort
20 of a trap. You know, if the NICU nurse or our
21 neonatologist doctor looked at this photo and was
22 asked again whether or not Remi was on the CPAP
23 machine at the time of the 5-minute Apgar score, they
24 would not only have to, you know, be trapped by the
25 prior testimony, but also this new information of the

1 photo and how that might change their testimony or
2 they might respond to it.

3 From our perspective, we also didn't know
4 what the plaintiffs' neonatologist expert might say
5 as to how this photo impacted the calculation of the
6 Apgar score.

7 So we had to make a decision whether or
8 not, you know, we initially made our motion, the
9 judge -- the Court allowed us the opportunity to take
10 the deposition or Dr. Kerzner.

11 Dr. Kerzner's original testimony was that
12 the Apgar score was otherwise correct, except for one
13 of the scores with tone, which was 1 off. So instead
14 of an 8, it should have been a 7, which is still in
15 the normal range.

16 When we deposed her yesterday, although it
17 seemed like a week ago now, she said, well, not only
18 is the tone off by 1, but now, because I see the
19 picture of the CPAP, I also believe that the
20 respiratory score was off by 1. So instead of 8, as
21 it was calculated at that time, it should have been a
22 6. So now instead of it being 1 above normal, she
23 believes the correct score is 1 below normal, with 7
24 being the cutoff for normal.

25 Not only that, but Dr. Kerzner said with

1 this different score, if it had been scored correctly
2 at the time, I do believe it would have prompted cord
3 gas, a series of neurological exams, and a full
4 normal exam. So a different course of potential
5 medical treatment if that Apgar score had been
6 calculated below normal, as Dr. Kerzner now thinks it
7 should have been. which, again, creates a very new
8 landscape for us to have to defend and just our
9 theories and our strategies at trial.

10 THE COURT: May I ask a question?

11 So the medical records do not indicate
12 that the child was put on a CPAP, is that correct?

13 MR. PERRON: The medical records, and,
14 again, I would defer to the medical professionals.

15 But in reading the deposition, because I wasn't there
16 for some of these earlier discoveries.

17 My understanding is when asked about the
18 CPAP machine, they relied on the medical records that
19 would suggest that Remi was on the CPAP, but he was
20 not on it at the time of the 5-minute Apgar scores.
21 There's mention of it in the record, of him being on
22 the CPAP machine, but their best interpretation is
23 that he was no longer on it when they calculated the
24 Apgar score.

25 MS. KAMYKOWSKI: In fact, the record does

1 not define the difference between positive pressure
2 ventilation and CPAP. And there's a resuscitation
3 note that was charted by the neonatology nursing
4 folks after the time of the delivery, where it does
5 indicate and had been in the records, that he was on
6 something, whether it was PPV, which is positive
7 pressure ventilation, or CPAP, continuous positive
8 airway pressure -- I think is what it stands for --
9 at both -- at 5 minutes and 10 minutes. So that has
10 been in the case, Your Honor.

11 And Dr. Kerzner didn't rely upon that in
12 any way, shape, or form in her initial deposition.

13 THE COURT: And the medical records were
14 created by the medical professionals that were there,
15 present at the time of the birth, is that correct?

16 MR. PERRON: As far we know, Your Honor.

17 THE COURT: Well, are you telling me
18 somebody else made the medical records?

19 MR. PERRON: Well, I try to be a lawyer in
20 all things. So as far as that, I don't want to -- I
21 don't want to represent that I know with 100 percent
22 certainty, but as far as we know, all of the medical
23 records were entered and made by the medical
24 professionals at or near the time they made them.

25 MS. GUNN: would you like to see the

1 records, Your Honor?

2 THE COURT: Sure.

3 MS. GUNN: with respect to the CPAP, and I
4 think we can take these separately. I did take Nurse
5 Practitioner Mary Spencer Younger -- she was Younger
6 at the time --

7 MS. KAMYKOWSKI: Can you show the record,
8 what that page number is so we have it?

9 MS. GUNN: I don't know --

10 THE COURT: It's 3186 of Exhibit 3, 3185
11 and 3186.

12 MS. GUNN: So that would be -- that's
13 Mercy. That's the chart for Mercy that's been --

14 MS. KAMYKOWSKI: I was just trying to make
15 sure the record is clear.

16 MS. GUNN: So when we have the CPAP, so
17 Mary Younger Spencer was the nurse practitioner who
18 did the CPAP scores. She calculated 3 at one minute
19 and 8 at 5 minutes.

20 And the -- this case has been replete
21 with -- from the very beginning, been replete with
22 that's a really high score, knowing that 9 hours
23 later, Remi was seizing -- well, 9 hours later he was
24 in the NICU, seizing a couple hours after that.

25 So when I took -- and, by the way, they

1 were defendants for a hot minute, and then they were
2 dismissed because the information we had from our
3 experts is that there was no further injury to Remi
4 after he was born. The brain injury occurred before
5 he was born, directly before he was born, but
6 resuscitation efforts by this nurse practitioner was
7 adequate.

8 So I took her deposition, and I went
9 through very clearly every question in the Apgar.
10 How do you get a 1 or a 2 for heart rate? How do you
11 get this? How do you get that? And when we got to
12 CPAP, which she got a 2 for, I asked her to explain
13 it.

14 And she said -- and I'll just read. This
15 is page -- starting at page 48 of her deposition:
16 Infant was clearing breath sounds bilaterally and
17 able to decrease the FIO₂, and that's just the oxygen?

18 "ANSWER: Correct."

19 I asked her a few more questions about
20 respirations. And she -- and I say, so -- this is on
21 page 49, starting at line 7: So after 5 minutes of
22 what you've mentioned here, changing from the PPV to
23 the CPAP, and still suctioning, Remi went from a 1,
24 which was the sum effort but not continuous, to
25 continuous, correct? But still on a CPAP.

1 And Nurse Practitioner Spencer says: At 5
2 minutes, I don't believe we were giving CPAP still at
3 5 minutes. I do not have a time mark in here as far
4 as when I stopped CPAP. But if he had not been
5 breathing well on his own, he would have earned a 2
6 -- he would not have earned a 2 -- excuse me -- she
7 said on line 19. But if he had not been breathing
8 well on his own, he would not have earned a 2.

9 "QUESTION: So that's the definition. You
10 can't get a 2 if you're on CPAP?

11 "ANSWER: If I'm supporting him, and he
12 needs that support, he would have received a 1."

13 So after that testimony, Judge, I had the
14 medical records. And you can see very clearly that
15 he was on CPAP at 5 minutes. So she said if he was
16 on CPAP at 5 minutes, he shouldn't have gotten a 2.

17 So I have had that information since her
18 deposition, before any experts were done, April 28th,
19 2023, regarding the CPAP. So Mr. Perron mentioned
20 that. We had an expert, Nurse Shinn, who's our
21 nursing expert, she testified in her deposition that
22 she believes he should have had 1 off of his Apgar
23 for respiration. She had the medical records, as
24 everyone had these medical records, now proving that
25 he was, in fact, at 5 minutes on CPAP, with or

1 without a picture.

2 And then Dr. Canteley, their neonatologist,
3 was obviously prepped for it because when that
4 question came up in his deposition, his testimony is,
5 well, it doesn't matter, even if he's on CPAP, he
6 should have gotten a 2.

7 So there is nothing new in this case about
8 the CPAP. We knew what the Apgar said. We knew what
9 the medical records said. We knew what Nurse Younger
10 said. We have -- they have an expert talking about
11 it, disputing that even if he were on CPAP he should
12 have gotten a 2 anyway. So there's nothing new about
13 CPAP.

14 Now, and so, I mean, a picture or no
15 picture, CPAP is in this case. And I agree, I agree,
16 because the defense experts, their causation theory
17 is based on this notion that baby got an 8. You
18 can't be brained damaged right out of delivery if you
19 got an 8. They hang their hat on it, and that's
20 where they are.

21 And I'm sorry if the CPAP should have been
22 lower, that they've known about, if they read their
23 own records. Like that's -- that's part of the issue
24 in the case that the jury is going to get to decide.
25 what should the Apgar have been. That is not new.

1 Now, moving on, I think, to this issue of
2 the photographs. There were about 2800 photos and
3 videos taken by this family of their firstborn child
4 starting the day he was born. There were -- some of
5 those were produced in discovery. It is accurate
6 that there was no objection. There should have been
7 an objection for overly broad, there wasn't. That
8 was sloppy.

9 Pictures were produced showing milestones.
10 There are videos that have been produced. Then
11 Dr. Kerzner, our neonatologist, was sent additional
12 photographs that were not produced officially in a
13 pleading, also should have been done, but they have
14 the photographs.

15 And they had some of the photographs.
16 There are 10 or so photographs of Remi from the time
17 he was born in the warmer until he's in his mother's
18 arms. Those have been in the case. They've had
19 them. There are variations of them. It is true that
20 the one with the mask on particularly, which I don't
21 think anybody was thinking how important it was
22 because no one looked at the metadata until two weeks
23 ago. I mean, I didn't even know you had metadata on
24 these pictures that you could still get it.

25 I mean, this is a technology thing, and I

1 admit I could get better at it. But there was never
2 any intention to hide anything. There are many, many
3 times in cases where, by the time you get to trial,
4 you pick some exemplar photographs to help illustrate
5 damages.

6 so with respect to the picture, you know,
7 we produced everything. We sent the 2800 by the time
8 limit. There was a question about additional albums.
9 we sent the additional albums. This is Mr. Anyan
10 trying to figure out what all we needed to do. we
11 sent it all over, thousands of photographs. I didn't
12 send anything to Dr. Kerzner.

13 Ms. Kamykowski said, did you send
14 anything? Or what have you sent to Kerzner? So on
15 her request, we sent the pictures of the 10 or so
16 from the minute he was born to the minute he's in
17 Sarah's arm. They were produced to her, and she was
18 asked about them, and she gave opinions about them.
19 she had already had opinions about tone.

20 So as you can see, the CPAP is one or --
21 respiration is one of the Apgar scores. There are 5
22 total. The other one at issue is tone, which is
23 floppiness. The pictures in the warmer, according to
24 the neonatologist, and she testified about it in her
25 deposition, Dr. Kerzner, showed low tone.

1 In addition to that, Mr. and Ms. Anyan,
2 both of whom are medical professionals, testified in
3 their deposition, years ago, that he was low tone.

4 So Dr. Kerzner, based on the medical
5 records, some of photographs that everybody had, or
6 did have at her deposition, indicated that he
7 shouldn't have gotten a 2 for tone.

8 So we've got the CPAP issue with Nurse
9 Younger and the medical records. We've got tone --
10 and Nurse Shinn. We've got tone issue with Mom, Dad,
11 and Kerzner.

12 So at Dr. Kerzner's deposition yesterday,
13 as I understand it, she was asked, well, what about
14 these photos? So based on the question that was
15 asked and the photos that were provided at the
16 defense attorney's request, she answered the
17 questions and said, yeah. I mean, I still have my
18 tone issues. She's never not had her tone opinions,
19 but she said this looks like the child is on CPAP at
20 5 minutes, and you don't get a 2 if you're on CPAP at
21 5 minutes.

22 which is not what Cantey said. Like
23 they're going to get to argue, even if you're on
24 CPAP, you still get a 1. Fine. I mean, the whole
25 thing is they want to say it was an 8. They want to

1 say it's a 7. And unfortunately, their records allow
2 that. And our experts also have expressed opinions,
3 way before yesterday, of that problem.

4 So in terms of sanctions, first of all, I
5 would appreciate the opportunity to file a written
6 response to the motion. It's a serious motion that
7 was renewed this morning, in addition to the record.

8 I -- there are no new opinions. If Your
9 Honor is inclined to not allow Dr. Kerzner to talk
10 about CPAP opinions, even though they were elicited
11 at the request of the defendant to send pictures that
12 I had no intention to send to her. I don't need her
13 to have them. I didn't want to set up a situation
14 where we were here, but I did so on their request,
15 and they had questions about them.

16 So if Your Honor is inclined not to allow
17 Dr. Kerzner to testify about her CPAP opinions, which
18 she did for the first time express yesterday,
19 technically in a cross-examine situation, then I
20 would obviously object to that, but certainly seems
21 like a reasonable response.

22 And so I think that's where we are with
23 respect to any relief. I don't think there should be
24 any because she was simply answering questions posed
25 by the defense attorney that they now know about.

1 But this idea that the Apgar score being a
2 6 instead of an 8 is brand new and destroys their
3 causation theory is absurd. It has been in the case
4 since the very beginning. We have -- everybody has
5 discussed the CPAP -- or sorry -- the Apgar.

6 Everybody has -- every -- every expert
7 that I've deposed, that I've produced had Apgar
8 opinions. And it was too high; it was too low. Now
9 of course, the only way that -- and not to mention
10 the Apgars are subjective, and all the other evidence
11 the jury is going to hear about the unreliability of
12 Apgar scores alone to predict or not any kind of
13 brain injury. The way we would know that is with
14 cord gas, which were not ordered by the defendant.
15 So that's why we've got so much discussion about CPAP
16 -- I'm sorry -- about Apgar.

17 MS. KAMYKOWSKI: Your Honor, if I may
18 briefly.

19 THE COURT: I don't know that she's
20 finished yet.

21 MS. KAMYKOWSKI: I'm sorry.

22 MS. GUNN: So I would -- I don't have my
23 notes in front of me, and I don't know if I've missed
24 anything. But I will certainly say that in terms of,
25 yes, certainly there should have been objections to

1 overly broad because of course this family had

2 thousands of pictures of their newborn child.

3 The ones that we are focused on today

4 apparently are this 10 or 15, or less, of the first

5 half an hour of his life, most of which had been

6 previously produced.

7 So I'm finished. Thank you.

8 MS. KAMYKOWSKI: I think what we just

9 heard from Ms. Gunn was an attempt to put blame on

10 the defense for a discovery violation that she and

11 her clients have created in this case.

12 what I just heard was this has been in the

13 record. And, yes, we know it was in the record,

14 Judge, which is why we asked their expert, what

15 opinions do you have in October of 2023, when she had

16 the entire record.

17 She had that evidence there at the time,

18 and her opinion was low tone. That's it. There was

19 no opinion critical of the respiratory efforts that

20 she had available, just like we did, just like

21 apparently Ms. Spencer did, and just like everybody

22 has had in this case.

23 The whole point of discovery is to ask the

24 experts, what are your opinions? what are the basis

25 therefore?

1 when we did that in October of 2023, when
2 Dr. Kerzner had all of the same information except
3 this photo, she did not offer that opinion. This is
4 a brand new opinion from this expert. It is not --
5 it doesn't matter if the defense was aware of it, we
6 are entitled to build our case and defend our case
7 based on the plaintiffs' burden of proof.

8 In this case, the only opinion that
9 Dr. Kerzner gave was that she would have rescored him
10 1 less for tone, which would have given him a 7,
11 which is still a normal Apgar.

12 The first time she testified differently
13 was yesterday. That is a brand new opinion that
14 completely changes this case. And it is based upon
15 the plaintiffs' failure to respond accurately and
16 fully and completely to proper discovery requests for
17 over three and a half years. On the eve of trial,
18 it's inappropriate and shouldn't happen, and she
19 should have been stricken.

20 MS. GUNN: The only reason Dr. Kerzner
21 gave -- to have an opinion yesterday was because it
22 was solicited from the defense. The defense said
23 send her the pictures. I had no intention to send
24 her new pictures.

25 I know that I am bound by what she has

1 already said. I had no intentions of asking her on
2 the stand for the first time, hey, by the way,
3 what -- do you have an opinion about CPAP?

4 Because what would have happened,
5 rightfully so, is there would have been a sidebar,
6 motion in limine, new opinions. Likely Your Honor
7 would have sustained it. That's why I wouldn't have
8 asked her to begin with.

9 So it's much adieu about an opinion that
10 they solicited yesterday, but I had no intention of
11 giving to this jury through that witness. I have
12 other witnesses for CPAP. I have the medical records
13 for CPAP. I don't need Dr. Kerzner, nor did I ever
14 need Dr. Kerzner, for the CPAP.

15 MS. KAMYKOWSKI: So, Your Honor, just so
16 the record is clear. Last week we did not have our
17 motion for sanctions hearing on the record. Our
18 request for relief was not to depose this expert.
19 That was a relief crafted by the judge so that we
20 were doing discovery on the -- you didn't want us to
21 do it the weekend before. We moved the trial. That
22 was not our request. We did not want to do it.

23 we have an obligation to our clients to
24 understand exactly every bit of what has happened in
25 this case. So at the Court's order, we took

Dr. Kerzner's deposition.

To reframe it to say, oh, I withheld all these photos and all these videos, but because you're asking me to, I'm going to give them to my expert.

And now, oops, she gives a new opinion, you solicited that. That is absolutely not how this happened.

THE COURT: So at the time that you deposed Dr. Kerzner initially, you had the medical records?

MS. KAMYKOWSKI: We did.

THE COURT: And in the medical records, it very clearly states, positive pressure ventilation, nasal CPAP 5 minutes. Yes. And it appears that it is J.B. -- I don't know who J.B. is -- at 5/4/20, 1700.

That information could have been asked because that is the crux of your defense, as you've talked about, of Dr. Kerzner back then. Just based on this. You didn't need a photographs for that.

MS. KAMYKOWSKI: Judge, I asked her the open-ended question in a discovery deposition to say, how would you -- based on everything that you reviewed in this case, what differences in the Apgar would you have offered? And she said 1 off for tone.

THE COURT: And that's all she's going to

1 say at the trial because the Court is going to
2 exclude the testimony with regards to the CPAP from
3 Dr. Kerzner. That is the sanction.

4 MS. KAMYKOWSKI: So the other problem,
5 though, Judge, is now we have this photo out there.
6 And we just heard, she's going to now -- she
7 subpoenaed Mary Spencer, who was a former defendant
8 in this case, to come and testify in her case. She
9 wants to use a photograph to go ahead and say, oh, we
10 should haven't given her a 2 and hope she recants.
11 Or do something else to try and impeach her with a
12 document that was never produced before. Mary
13 Spencer, we didn't get to ask her about it at her
14 deposition.

15 THE COURT: I don't know that she needs
16 the photograph. She can use the records.

17 MS. KAMYKOWSKI: So we're asking for
18 further sanction of that photograph also.

19 MS. GUNN: Your Honor, I know it's --
20 maybe it's just semantics, but I don't think this is
21 a sanction. I don't -- I take issue with a sanction
22 being they've created the situation where now there's
23 a sanction. They wanted to take Dr. Kerzner's
24 deposition. I had never had an intention of having
25 her talk about the CPAP, and now I've got a sanction

1 order against me?

2 THE COURT: The focus on the word
3 "sanction" right now is probably not the best way to
4 focus because I'm trying to keep this trial moving
5 forward.

6 MS. GUNN: I appreciate that.

7 THE COURT: And you acknowledge that you
8 would not use that information with regards to this
9 witness. Ms. Pfirman says she will not use that.

10 whether or not we consider it a sanction or just a
11 court's ruling with regards to trial strategy.

12 And I will point out I get why an attorney
13 does not want to have an order of sanction against
14 them. It affects them personally and professionally.
15 Much like things like malpractice claims and things
16 like that.

17 So that is the court's ruling with regard
18 to how the court is going to handle the evidentiary
19 issue.

20 The photographs that were originally
21 disclosed may be used, including the metadata for
22 those original photographs. The photographs of the
23 child with the CPAP will not be used.

24 MS. GUNN: Understood. Thank you, Judge.

25 Your Honor, I mean, I certainly don't mind

1 arguing that. But he's not going to be played today.

2 He's probably not going to be played until Monday.

3 It's in the can now. We've got jurors waiting. I

4 would suggest that we put a pin in that, and we can

5 take it up pretty much any time during the rest of

6 the week.

7 THE COURT: Okay. That's fine.

8 MR. PERRON: Refer to the course and

9 scope.

10 THE COURT: So before we bring the jurors

11 in, I did review the jury sheet very quickly. There

12 is at least one juror who purports to be a nurse at

13 Mercy Hospital. I would propose that we bring them

14 in and inquire of them their employment status before

15 we even let them speak in front of the rest of the

16 jury. Because I think that perhaps they may not

17 necessarily be in a position to sit on this case.

18 MR. WILLMAN: That one juror, Judge?

19 THE COURT: Yes.

20 MR. WILLMAN: That makes sense.

21 MS. SLATER: That's fine, Your Honor.

22 THE COURT: Shay Grommet, No. 48.

23 (Venireperson No. 48 entered the

24 courtroom.)

25 THE COURT: Good morning, ma'am.

1 VENIREPERSON NO. 48: Hi. Good morning.

2 THE COURT: So I just wanted to speak with
3 you really briefly before we bring the rest of the
4 jurors in --

5 VENIREPERSON NO. 48: Sure.

6 THE COURT: -- because I noticed that on
7 your juror disclosure information, you indicated that
8 you were a nurse at Mercy Hospital.

9 VENIREPERSON NO. 48: Yeah.

10 THE COURT: Can you tell me exactly what
11 that means?

12 VENIREPERSON NO. 48: Sure. I work at
13 Mercy Family Med in wildwood, a nursing and family
14 practice office.

15 THE COURT: Okay. And does that have you
16 working at all at the hospital?

17 VENIREPERSON NO. 48: No. It's off of
18 olive. It's just a family med -- medical building.

19 THE COURT: Okay. And are you a direct
20 employee of Mercy Hospital, or are you an employee of
21 the Mercy Medical practice?

22 VENIREPERSON NO. 48: Mercy Hospital.

23 THE COURT: Okay.

24 VENIREPERSON NO. 48: I mean, it's -- it's
25 a family practice for the Mercy physicians and -- but

1 Mercy is my employer.

2 THE COURT: Got it.

3 And if this case were to involve a claim
4 of malpractice with regards to Mercy Hospital --

5 VENIREPERSON NO. 48: Sure.

6 THE COURT: -- would that be something you
7 could listen to and determine the evidence based upon
8 the facts that are presented here in court --

9 VENIREPERSON NO. 48: of course.

10 THE COURT: -- and not use the fact that
11 that may be the same employer that you have?

12 VENIREPERSON NO. 48: Sure, absolutely.

13 THE COURT: Thank you very much.

14 VENIREPERSON NO. 48: Thank you.

15 THE COURT: I appreciate it.

16 (Venireperson No. 48 exited the
17 courtroom.)

18 THE COURT: Based on her statements, I'll
19 allow you all an opportunity to question her more
20 with regards to that issue, but I don't see the need
21 to let her loose at this stage.

22 MR. WILLMAN: Thank you, Judge.

23 THE COURT: So are we ready to bring in
24 the jurors?

25 MR. WILLMAN: Can we go off the record?

1 (A discussion was held off the record.)

2 (At 10:37 a.m., the following proceedings
3 were held in open court, in the presence of the jury
4 panel:)

5 THE COURT: Go ahead and be seated,
6 everyone. Good morning.

7 My name is Nellie Ribaudo, and I'm the
8 judge here in Division 18. And I'm going to give you
9 a little bit of background and information about what
10 we're going to be doing here today.

11 I know we're quite crowded in this room,
12 so I apologize for that. As we go through the day,
13 it will get a little bit easier as you come and go.

14 The first thing I'm going to tell you
15 about. You are not going to buy something at an
16 auction. I know the paddle had you confused. You
17 thought you might be getting a puppy or something
18 like that at an auction, but you're not.

19 That paddle is used so that my court
20 reporter, Melissa, who has the most difficult job in
21 this room, bar none. None of the lawyers have a
22 difficult job like she does. Their job is hard; hers
23 is difficult. She has to take down every word that
24 is said and who is saying it.

25 I don't know if you know this, but as a

1 general proposition, we speak too quickly. Have you
2 ever tried to take down in realtime what somebody
3 else is saying? Much less in a room like this? So
4 we use those paddles to help quickly identify who the
5 speaker is.

6 we also use them because we no longer use
7 your names. Not because we want to be disrespectful
8 of you but because as these cases are transcribed,
9 those become matters of the court file which are open
10 in public records.

11 If we used your names, we would have to
12 redact your names from those files. So it's just
13 easier if we use your numbers rather than your names.
14 So please forgive us if we don't call you by your
15 name. It is not intended to be disrespectful in any
16 manner.

17 I've instructed the lawyers with regards
18 to that. It's not their choice how we do this.
19 That's for the court to decide. So we do not mean to
20 be disrespectful in doing that.

21 You will notice that on the paddle, if
22 you're looking at it, on one side there's a number.
23 On the other side there's a court seal. If you're
24 look at the court seal, then I can see the number.
25 If you're looking at the number, I can see the court

1 seal.

2 I don't know how many years I've been
3 saying this comment, but nobody's taken me up on
4 fixing that yet. So please make sure that you're not
5 looking at the number so that we can be looking at
6 the number.

7 Has everybody turned their cell phones to
8 off or silent? If you have one of these handy-dandy
9 little watches that tells you what text messages
10 you're getting, I'm going to ask you to turn it to
11 "do not disturb" or off.

12 The reason for that is what we're doing
13 here in court is extremely important, and it requires
14 everybody paying attention to everything that is
15 being said. So having those cell phones, having that
16 distraction of getting your text messages or your
17 news reports on your watch, may create problems for
18 that. So I'm going to ask everybody to make sure you
19 follow that every time you come into the courtroom,
20 not just here this morning.

21 I'm also going to let you all know that it
22 is not easy to see and hear the people in the back of
23 the room. So far I don't think anybody has had any
24 trouble hearing me, is that fair?

25 I tend to be on the loud side. I don't

1 need a microphone, generally. My mother still is
2 upset about that, but she can't change it. It is
3 what it is.

4 So for those of you who are sitting on the
5 benches, when you're answering a question, I'm going
6 to ask for you to stand up and really project your
7 voice. I know that that's not the most comfortable
8 thing to do from your perspective, but it is
9 imperative that we have that answer heard so that
10 Melissa can take it down.

11 I will turn on some microphones that we do
12 have around the room. I have discovered that they
13 really don't do a whole lot except amplify the sound
14 of crinkling paper and coughing, but it's what I have
15 to turn on, so I will turn those on when we get
16 started.

17 So, again, if we remind you to stand up,
18 it's not us trying to be rude, it's just that we've
19 got to make sure that Melissa is able to take down
20 everything that's being said. And it's easier for
21 her if she can actually see the person speaking.

22 So you may wonder why I'm standing while
23 I'm addressing you all. I do this because I'm really
24 short. And when I sit down, it becomes a real
25 challenge to see me behind -- although my screen is

1 not as big as it used to be, it is still on the
2 bigger side for me up here.

3 So I stand up so that you all can see me
4 when I speak to you. I will sit down at some point,
5 and you will quickly realize I wasn't lying about how
6 short I am. It is what it is.

7 So at this time, I'm going to read to you
8 an instruction. I would like to explain why we are
9 here today. This is a civil case. A civil trial is
10 different from a criminal trial where the defendant
11 is charged with a crime and could go to jail.

12 A civil trial involves a disagreement
13 between the parties where the claims have been
14 brought here to be resolved. At this time, I will
15 give you a brief description of the case that you
16 will hear and the meaning of important legal terms.

17 This is to help you understand the nature of this
18 case and to assist you in evaluating the evidence.

19 The plaintiff is the party who filed the
20 case. Let me introduce the plaintiff to you.
21 Remington Anyan, a minor, who is represented by his
22 appointed next friends and natural parents, Sarah and
23 Blake Anyan.

24 And we have Mr. Blake Anyan here.

25 The Anyans are represented by Ms. Amy

Gunn, Erica Slater, and Liz Lenivy.

The defendants are the parties against whom the case has been filed. Let me introduce to you Mercy Hospital East Communities d/b/a as Mercy Hospital-St. Louis, Mercy Clinics East Communities d/b/a Mercy Clinics Mercy OB/GYN and Dr. Daniel McNeive.

Could you please stand?

And they are being represented by Mr. Phil willman.

MR. WILLMAN: Good morning.

THE COURT: David Perron, Mandy Kamykowski, and Erin Pfirrmann.

This is a medical malpractice case involving labor and delivery care at Mercy Hospital-St. Louis.

The plaintiffs claim the defendants were negligent in failing to timely deliver him, that he was injured, and should be compensated.

Plaintiff also claims that defendant Mercy Clinic East Communities d/b/a as Mercy Clinics Mercy OB/GYN and Dr. Daniel McNeive should be responsible for punitive damages to punish or deter the defendant.

I will determine whether the evidence is

1 sufficient for you to consider and award punitive
2 damages in addition to damages to compensate
3 plaintiff. The defendants dispute the claims of the
4 plaintiff.

5 The legal term "negligent" or
6 "negligence," as used in these instructions means the
7 failure to use that degree of skill and learning
8 ordinarily used under the same or similar
9 circumstances by members of the defendants'
10 profession.

11 The burden of proof is as follows: Your
12 verdict will depend on the facts you believe after
13 considering all the evidence. The party who relies
14 upon any disputed fact has the burden to cause you to
15 believe such fact is more likely true than not true.

16 In determining whether or not you believe
17 any fact, you must consider only the evidence and the
18 reasonable conclusions you draw from the evidence.

19 There is a different burden of proof that
20 applies only to punitive damages. A party seeking to
21 recover punitive damages has the burden to cause you
22 to believe that the evidence has clearly and
23 convincingly established the facts necessary to
24 recover punitive damages.

25 where more than one party has claimed to

1 be negligent and at fault, you the jury will decide
2 if any party is at fault and assess percentages of
3 fault. If appropriate, you will also award damages.

4 Your verdict must be based on the final
5 instructions given to you after all of the evidence.
6 Justice requires that you not make up your mind about
7 the case until all the evidence has been seen and
8 heard and all of you enter the jury room for your
9 deliberations of your verdict.

10 The trial of a lawsuit involves
11 considerable amount of time, effort, and expense.
12 The parties are entitled to have their rights finally
13 determined. The failure on your part to follow the
14 rules and instructions I give to you may result in a
15 miscarriage of justice and a new trial may be
16 required.

17 You have been summoned today as
18 prospective jurors for a civil case. Civil cases
19 begin with a selection of a qualified and impartial
20 jury. You will be asked a series of questions to
21 determine if you have any personal interest in or
22 knowledge of the case that would make it difficult
23 for you to be fair and impartial. The questions
24 asked are not meant to pry into your personal life,
25 they are simply a necessary part of the process of

1 selecting a jury.

2 Your answers must be truthful and
3 complete. Therefore, please listen to the questions
4 carefully and take your time in answering. If you do
5 not understand a question, please raise your hand and
6 it will be clarified. If, later in the questioning
7 process, you remember something that you failed to
8 mention earlier, please raise your hand and let us
9 know.

10 Following the questioning process, some of
11 you will be chosen as jurors and some will not.
12 Please understand that not being chosen does not
13 reflect upon your ability or integrity.

14 You will now take an oath to honestly
15 answer these questions. I'm going to ask for you all
16 to stand up.

17 (The jury panel was sworn by the Court.)

18 THE COURT: Very good. Go ahead and be
19 seated.

20 The parties have a right to have this case
21 decided only on the evidence presented in court. You
22 must not conduct your own research or investigation
23 into any issues in this case. You must not attempt
24 to obtain any outside information whatsoever about
25 the case.

1 You must not comment, discuss, or
2 communicate with anyone by any means, not even
3 amongst yourselves, what you hear or learn in trial
4 until the case is concluded, and then only when all
5 of you are present in the jury room for deliberations
6 of the case under the final instructions I give to
7 you.

8 During the jury selection process, I want
9 to emphasize that you are not allowed to use any
10 electronic communication devices or the Internet to
11 search for, receive, send, or post any information
12 about the parties, the lawyers, the judge, the
13 witnesses, or any evidence or location mentioned.

14 Do not discuss or attempt to research what
15 the law may be in this case. This ban applies to all
16 electronic devices, such as smart phones, laptops, or
17 tablets; all forms of electronic communication such
18 as emails, text messages, blogging, Internet research
19 tools, social media like Google, Chat GPT, Facebook,
20 Instagram, or Twitter, which is now X.

21 Justice depends on careful and fair
22 decisions based on a conscious and unbiased analysis
23 of the evidence in this case. It is the duty of
24 every juror to determine the facts based upon the
25 evidence presented at trial.

Automatic or reflexive responses influenced by conscious or unconscious preconceptions or stereotypes should not enter into that determination.

Bias based upon factors such as race, sex, gender, gender identity, religion, national origin, ethnicity, disability, age, sexual orientation, or marital status has no role in the pursuit of justice.

Your conclusions in this case should be based on a fair and unbiased consideration of the evidence and respect for the views of other jurors whose backgrounds and perspectives may be different from yours.

So the first thing I'm going to talk about is sort of scheduling. I anticipate that this trial is going to take between now, March 11th, 2025, until approximately March 28th, 2025.

Yes, that's approximately three weeks. I understand that is a long period of time.

So for those of you, I'm going to start over in the jury box, and then I'm going to go over to these benches, and then I'll go to the back rows over there.

Is there anybody here who has a travel schedule between now and March 28th of 2025, either

1 by car or by plane that would take you out of the
2 area during the weekdays? We're not going to be
3 working on the weekends, it's only on the weekdays.

4 So I'm going to turn to the jury box.

5 Anybody here have -- Juror No. 1?

6 VENIREPERSON NO. 1: The dates?

7 THE COURT: Yes.

8 VENIREPERSON NO. 1: March 17th, March
9 19th, state of New York.

10 THE COURT: And that's over the weekend,
11 or is that at the beginning of the week?

12 VENIREPERSON NO. 1: Wednesday, Thursday,
13 Friday.

14 THE COURT: Got it.

15 And is that for work or for enjoyment?

16 VENIREPERSON NO. 1: Work.

17 THE COURT: Got it.

18 And could that trip be rescheduled, if
19 necessary?

20 VENIREPERSON NO. 1: It cannot be
21 rescheduled.

22 THE COURT: No. 2, I think you showed your
23 paddle, as well.

24 VENIREPERSON NO. 2: Correct. Trip to
25 Chicago. It's the 20th to 23rd. So that's a

1 Thursday and Friday. The kids are on spring break.

2 THE COURT: And you're taking them
3 somewhere? Do you want to stay here with us?

4 VENIREPERSON NO. 2: Going to get me in
5 trouble.

6 THE COURT: I promise I won't tell.

7 Thank you.

8 No. 3?

9 VENIREPERSON NO. 3: Trip to Ohio 23rd,
10 24th, 25th.

11 THE COURT: And is that for fun or for
12 work?

13 VENIREPERSON NO. 3: My father's 75th
14 birthday.

15 THE COURT: Probably a little bit of both?

16 VENIREPERSON NO. 3: Yeah. A little bit
17 of both, yes.

18 THE COURT: And is that over a weekend, or
19 is that during the week?

20 VENIREPERSON NO. 3: A little bit of both.
21 So it's the weekend and those are the weekdays.

22 THE COURT: Got it. Thank you.

23 NO. 1?

24 VENIREPERSON NO. 1: I put my phone away,
25 so I want to correct my dates: 19, 20, 21.

1 THE COURT: Okay.

2 VENIREPERSON NO. 1: wednesday, Thursday,
3 Friday.

4 THE COURT: Got it. Thank you. I
5 appreciate that.

6 Anybody else in the jury box?

7 NO. 8?

8 VENIREPERSON NO. 8: My kids are on spring
9 break, as well, so I'm scheduled to take them to
10 Chicago to my see my mom this Saturday and return the
11 following Saturday.

12 THE COURT: Thank you.

13 Anybody else?

14 NO. 10?

15 VENIREPERSON NO. 10: I am supposed to
16 leave Friday, March the 14th, and I'll be gone for an
17 entire week. It's to our family farm in southern
18 Missouri because the grandkids are all going to be
19 there.

20 THE COURT: I'm going to guess you want to
21 see the grandkids?

22 VENIREPERSON NO. 10: It's spring break.

23 THE COURT: I'm guessing the moms and dads
24 of the grandkids want you to see the grandkids, too.

25 VENIREPERSON NO. 10: Yes.

1 THE COURT: Anybody else in the jury box?

2 Okay. Now over here in the benches.

3 Anybody that has travel plans?

4 I'm going to start at No. 20. And stand
5 up for me.

6 VENIREPERSON NO. 20: Traveling the 16th
7 through the 21st, taking my son on college tour
8 through Wisconsin, Illinois, Indiana, and Ohio.

9 THE COURT: And could those dates be
10 rescheduled, if necessary?

11 VENIREPERSON NO. 20: No, it's his spring
12 break.

13 THE COURT: Thank you.
14 Anybody else in the first row?

15 I'm going to jump to the second row.
16 I've got 23.

17 VENIREPERSON NO. 23: work trip March 18th
18 through 20th, Philadelphia.

19 THE COURT: Thank you.
20 No. 22?

21 VENIREPERSON 22: spring break, March 24th
22 through the 29th, Mexico.

23 THE COURT: Thank you.

24 No. 24?

25 VENIREPERSON NO. 24: I'm taking my son to

an international competition.

THE COURT: You're taking your son to an international competition?

VENIREPERSON NO. 24: On the 28th.

THE COURT: On the 28th, okay. And other than that, that would go past the date that we're ending potentially.

VENIREPERSON NO. 24: Correct.

THE COURT: So if we were done by the 28th, you would be okay on the travel schedule?

VENIREPERSON NO. 24: I guess so.

THE COURT: Okay.

Anybody in that next row?

No. 31?

VENIREPERSON NO. 31: Yes. Spring break for my kids to Florida to see their grandpa from the 16th through the 21st.

THE COURT: Thank you.

No. 33?

VENIREPERSON NO. 33: March 28th, I have an IEP meeting with my daughter's teacher.

THE COURT: And so that's during the day on the 28th?

VENIREPERSON NO. 33: Yes.

THE COURT: Okay. Thank you.

Anybody else?

NO. 41?

VENIREPERSON NO. 41: Yes. Taking my kids on spring break out of the country on March 15th through the 22nd.

THE COURT: NO. 43?

I'll get back to you NO. 15.

VENIREPERSON NO. 43: 16th through the 23rd, spring break, Florida.

THE COURT: Thank you.

NO. 44?

VENIREPERSON NO. 44: March 24th through the 28th to Chicago for a mandatory work training.

THE COURT: Thank you.

15?

VENIREPERSON NO. 15: I'm not traveling anywhere, but I'm supposed to be watching my grandson who's on spring break from the 17th to the 21st, so I don't know if that counts.

THE COURT: Thank you.

VENIREPERSON NO. 15: I'm not leaving town.

THE COURT: I appreciate that. Thank you.

Anybody else over on this side?

VENIREPERSON NO. 31: I have a few IEP

meetings. I know somebody said they had one.

Do you want to know those dates?

THE COURT: Sure.

VENIREPERSON NO. 31: Okay. There is one on the 12th. There is one on the 22nd. I have a few, I'm sorry. I think that's it.

THE COURT: Thank you.

All right. Starting over here on the other side.

No. 46?

VENIREPERSON NO. 46: I'm going to be in Huntsville, Alabama, from the 20th through the 23rd, for my best friend's engagement party.

THE COURT: Thank you.

No. 52?

VENIREPERSON NO. 52: Traveling to Kentucky to take the kids to see the grandparents on spring break on the 20th, the 21st, 22nd, and 23rd, but it would be a possibility to be rescheduled.

THE COURT: I can see the conversation at home going really well for you. Thank you.

No. 56?

VENIREPERSON NO. 56: Good morning. I actually have a funeral on the 14th. And also I'm on spring break. I work for the school district. My

1 husband planned a surprise trip. I don't know what
2 that is, but I don't want to miss it, from the 17th
3 to the 21st.

4 THE COURT: Thank you. I'm sorry about
5 the funeral, I'm happy about your trip, and I hope
6 that it's somewhere really, really exciting.

7 No. 55?

8 VENIREPERSON NO. 55: I am babysitting my
9 grandchild next Monday, the 18th, that whole week,
10 but the rest of the family has spring break.

11 THE COURT: Thank you.

12 No. 49?

13 VENIREPERSON NO. 49: I am wondering
14 about -- I've got a medical procedure in two weeks.

15 THE COURT: That was going to be my next
16 question, so I promise you I will catch you up on
17 that.

18 Anybody else over here?

19 No. 42?

20 VENIREPERSON 42: I babysit my
21 grandchildren on Tuesdays. May or may not be able to
22 get rescheduled.

23 THE COURT: Thank you.

24 All right. Did I miss anybody with
25 regards to travel?

1 nope? okay.

2 Is there anybody who has a medical
3 appointment, medical procedure, for themselves or
4 somebody they would be taking to that appointment
5 between now and March 28th?

6 So I know I can go with 49 to start.

7 49, why don't you start?

8 VENIREPERSON NO. 49: Yeah. I've got a
9 medical procedure on Monday, the 24th.

10 THE COURT: And does that medical
11 procedure require you to do anything ahead of time?

12 VENIREPERSON NO. 49: No. It would be
13 like a local anesthetic. I have a bacteria -- blood
14 in my urine and have a procedure for that.

15 THE COURT: Thank you. No. 10?

16 VENIREPERSON NO. 10: I have a medical
17 procedure on March the 26th in the morning. I was
18 supposed to have it tomorrow, and when I got the
19 juror summons, I rescheduled.

20 THE COURT: Thank you. Thank you.

21 No. 11?

22 VENIREPERSON NO. 11: My sons are having
23 an appointment on the 24th.

24 THE COURT: And what kind of appointment?

25 VENIREPERSON NO. 11: It's a 5-year

checkup and a one-year checkup.

THE COURT: And could that be rescheduled, if necessary?

VENIREPERSON NO. 11: Yeah.

THE COURT: Okay. Thank you.
No. 5?

VENIREPERSON NO. 5: I have a medical appointment with an immunologist that I have waited quite awhile to have it. That is on the 20th.

THE COURT: Thank you.
Anybody else in the jury box?
Anybody over here in these benches?

No. 26?

VENIREPERSON NO. 26: I'm not sure of my husband's schedule, but he has medical appointments, but I don't know the dates.

THE COURT: Okay. If we were to take a lunch break, could you find out those dates during that time and let us know after lunch?

VENIREPERSON NO. 26: I will try, yeah.

THE COURT: Thank you.

No. 24?

VENIREPERSON NO. 24: I need to take my son to a dental appointment on the 27th because I was kind of trying to plan a trip and having it done

1 before the trip.

2 THE COURT: Thank you.

3 All right. I think No. 27?

4 VENIREPERSON NO. 27: I have a doctor's
5 appointment on the 25th. It's just a regular
6 checkup. I should be able to reschedule if need be.

7 THE COURT: Thank you.

8 No. 33?

9 VENIREPERSON NO. 33: I have an
10 appointment tomorrow with my daughter's -- daughter's
11 appointment.

12 THE COURT: Okay. Can that be --

13 VENIREPERSON NO. 33: It's already been
14 rescheduled.

15 THE COURT: It's already been rescheduled
16 to tomorrow?

17 VENIREPERSON NO. 33: Yes.

18 THE COURT: Can it be rescheduled again if
19 needed?

20 VENIREPERSON NO. 33: I'll try.

21 THE COURT: Okay. Thank you. No. 36?

22 VENIREPERSON NO. 36: Sorry. I have a two
23 year old who I take to speech therapy twice a week.
24 And then I also have a three month old who has a
25 checkup.

1 THE COURT: And when is the checkup for
2 the three month old?

3 VENIREPERSON NO. 36: On the 25th.

4 THE COURT: Okay. And is there anybody
5 else that could take your son to his speech therapy
6 on those other days?

7 VENIREPERSON NO. 36: Not twice a week,
8 no. Unfortunately, no.

9 THE COURT: Okay. Thank you.
10 Anybody else?

11 No. 32?

12 VENIREPERSON NO. 32: I have a
13 cardiologist appointment. I was waiting to hear to
14 schedule me.

15 THE COURT: So there could be a call, and
16 you could be told I'm going to have a procedure
17 anytime kind of thing?

18 VENIREPERSON NO. 32: Yes. Yes.

19 THE COURT: And I'm guessing that's not
20 something that can be rescheduled?

21 VENIREPERSON NO. 32: No.

22 THE COURT: Thank you, sir.

23 Anybody else over on the benches over
24 here?

25 Anybody on the back benches over there?

1 No. 54?

2 VENIREPERSON NO. 54: I have a doctor's
3 appointment tomorrow, I believe.

4 THE COURT: Can that be rescheduled, if
5 necessary?

6 VENIREPERSON NO. 54: Probably, yes.

7 THE COURT: Okay. Thank you.

8 Anybody else?

9 okay. Is everybody here still a resident
10 of St. Louis County? Nobody's moved away? Okay,
11 good.

12 Is there anybody here who has any
13 difficulty with hearing?

14 So we've got one over there. And you are
15 No. -- can you show me your paddle?

16 No. 30, is there anything we can do to
17 assist you? We have some assistive devices and

18 things of that sort. Would that help you?

19 VENIREPERSON NO. 30: You said you have
20 speakers, but you're not using them.

21 THE COURT: I am actually using them. I
22 told you they didn't work very well.

23 VENIREPERSON NO. 30: Oh --

24 THE COURT: Yeah. No. I am using those,
25 and they don't work terribly well.

1 All right. Have you been able to hear so
2 far?

3 VENIREPERSON NO. 30: With effort, I can
4 hear you, yes. Yes.

5 THE COURT: And would you be comfortable
6 letting us know if you were having trouble hearing
7 us?

8 VENIREPERSON NO. 30: Sure.

9 THE COURT: And we do have some hearing
10 aid devices.

11 VENIREPERSON NO. 30: No.

12 THE COURT: Okay.

13 No. 27?

14 VENIREPERSON NO. 27: So far I've been
15 able to hear you very good. I do at times have
16 problems hearing. I also have tinnitus really bad.
17 So when the room gets really full, it's a little bit
18 harder for me to hear than normal.

19 THE COURT: Thank you. But you -- you
20 have been able to hear so far?

21 VENIREPERSON NO. 27: Yes, ma'am.

22 THE COURT: Would you be comfortable
23 letting us know if that changed?

24 VENIREPERSON NO. 27: Yes, ma'am.

25 THE COURT: Thank you.

No. 45?

VENIREPERSON NO. 45: A loss of hearing during the war. A rifle shot off right by my head, so I have a really hard time hearing in my left ear. I can hear you so far, but I may ask you to repeat some.

THE COURT: Thank you. And would it be better if you were able to be positioned so that your correct ear was more towards the speaking -- meaning the witness if the witness was on the witness stand?

VENIREPERSON NO. 45: I can just hear -- I've heard everything so far today. But I might ask you to repeat something.

THE COURT: Thank you, sir.

Anybody else?

No. 57?

VENIREPERSON NO. 57: I wear hearing aids. I've been able to hear you so far.

THE COURT: wonderful. If that changes, will you let me know?

VENIREPERSON NO. 57: Yes.

THE COURT: Thank you.

Is there anybody here that does not speak -- English is not their first language?

Okay. So, No. 11, what is your first

1 language?

2 VENIREPERSON NO. 11: Spanish.

3 THE COURT: And are you comfortable with
4 the English language, or would you need an
5 interpreter?

6 VENIREPERSON NO. 11: I'm comfortable.

7 THE COURT: Thank you.

8 Over here. No. 60?

9 VENIREPERSON NO. 60: Yes, my first
10 language is Spanish.

11 THE COURT: And are you comfortable with
12 the language of English?

13 VENIREPERSON NO. 60: I think so.

14 THE COURT: And would you require an
15 interpreter at all?

16 VENIREPERSON NO. 60: No.

17 THE COURT: Thank you.

18 I saw one other over here. No. 24?

19 VENIREPERSON NO. 24: Mandarin.

20 THE COURT: Mandarin? Are you comfortable
21 enough with the English language, or would you need
22 an interpreter at all?

23 VENIREPERSON NO. 24: No.

24 THE COURT: Thank you.

25 No. 33?

1 VENIREPERSON NO. 33: Chinese. I'm okay.
2 so far I understand very well. But if some hard
3 words pop out, I may need to ask you to explain more.

4 THE COURT: Understood. Thank you very
5 much.

6 Anybody else?

7 Okay. I'm not seeing any other hands.

8 I anticipate that our daily schedule will
9 be that we will start around nine o'clock in the
10 morning, and we will go until approximately 5:00 p.m.
11 in the evening every day so that you can sort of plan
12 things.

13 I usually take a morning recess. That's
14 about 15 to 20 minutes. We take a lunch recess,
15 which is usually about an hour, an hour and 15. And
16 then we take an afternoon recess, which is about 15
17 minutes. Just so you have a sense of how I work
18 things and if you need to do other things and that
19 sort.

20 One thing I didn't ask, and I don't think
21 I recognize anybody, but it's always good to ask, is
22 there anybody here who thinks they know me or Eric,
23 my bailiff, who you already met? Or Melissa, my
24 court reporter?

25 I don't see any hands, so that is probably

1 a good thing for everybody.

2 All right. At this time, I'm going to go
3 ahead and I'm going to turn it over to the plaintiffs
4 to start their questions.

5 MS. GUNN: Thank you, Judge.

6 Plaintiffs' Voir Dire Examination

7 MS. GUNN: Good morning. As Judge Ribaudo
8 mentioned, my name is Amy Gunn. And I am joined by
9 Erica Slater and Liz Lenivy. And we represent the
10 Anyan family.

11 I have Blake Anyan, he's been introduced
12 by the judge as well, Sarah, his wife, and the
13 plaintiff in the case, Remi Anyan, Remington Anyan.
14 And Remi is Sarah and Blake's four-year-old, not
15 quite 5-year-old, son.

16 The judge mentioned a moment ago, we're
17 not allowed to give you lots of information in this
18 stage, but generally this is a medical malpractice
19 claim involving the labor and delivery of Remi
20 resulting in harm to him.

21 The point of this exercise this morning
22 for everyone is to elicit answers from you all to
23 determine whether you all would be right to listen
24 and judge this case. The way we do that is to ask
25 general questions about your life experiences.

1 Everyone has come into this courtroom
2 today with life experiences. And sometimes those
3 life experience, whether you recognize it or not,
4 create bias. And an example would be if, since we're
5 in spring training time here, right? An example
6 would be if you're a lifelong Cubs fan, which none of
7 you are, right? But let's say you were, and you are
8 going to umpire the cards/Cubs series.

9 If you're a lifelong Cubs fan, are you
10 really feeling good about that person doing the
11 series? Right. So that person may feel all day long
12 that they're fair and literally can call balls and
13 strikes, but if you're the team, you have to wonder a
14 little bit about whether that can be set aside. So
15 that's what we're looking for.

16 This is a court of justice. And you all
17 have seen the scales of justice, right? Lady Justice
18 is holding scales, and they're empty and they're
19 even. And the reason they're even and empty is
20 because everybody starts out the same. There's not
21 too much coming in here today in your mind that puts
22 somebody a little higher than the other.

23 So that's why it's important for you all
24 to be brutally honest with us, all of us who will be
25 asking you questions today. It's not going to hurt

1 anybody's feelings. In fact, just the opposite is
2 true. If you are brutally honest with your answers,
3 then it will give us the best idea we can to present
4 the best case to the best people for our clients.

5 Now, some people aren't terribly
6 comfortable with public speaking, so I'm going to try
7 to be really aware of that. If there's anything that
8 my questions elicit in terms of your answers that
9 you're uncomfortable sharing with the entire group,
10 you can merely mention that, and Your Honor will make
11 a decision about whether we can come up or take it
12 privately.

13 So feel free, don't not answer a question
14 because you feel like -- you're not -- you don't want
15 to share it. There's a way to share that without
16 everyone hearing, okay?

17 All right. So I mentioned the trial team
18 here on behalf of Remi. Does anybody recognize me?
19 I've looked around, I am not going to say. Sometimes
20 I get it wrong.

21 Okay. Yes. Okay. Juror No. 41.

22 who do you recognize?

23 VENIREPERSON NO. 41: I recognize you.

24 MS. GUNN: Okay.

25 VENIREPERSON NO. 41: I'm an attorney in

1 St. Louis. I clerked at the Simon Law Firm.

2 MS. GUNN: There it is. I told you, I
3 looked around, and I see faces and names, but we
4 aren't given a ton of time to look at our information
5 here.

6 Okay. So, Juror No. 41, yes. What do
7 you -- and what type of law are you practicing now?

8 VENIREPERSON NO 41: I do litigation work,
9 plaintiffs' work.

10 MS. GUNN: Okay. Now, you know you worked
11 for -- by the way, I have a new firm. No longer with
12 the Simon Firm. Ms. Slater and I have started our
13 own firm. Ms. Lenivy is with the Simon firm.

14 How many years ago were you employed at
15 the Simon Law Firm?

16 VENIREPERSON NO. 41: 2003 through 2004.

17 MS. GUNN: Got you.

18 okay. Obviously we represent the
19 plaintiffs in this case. You've indicated you do
20 that type of work.

21 Is there anything about the fact that we
22 are here representing the plaintiffs that you used to
23 work for Simon 20-something years ago, that would
24 affect your ability to listen carefully and judge
25 this case evenly and fairly?

1 VENIREPERSON NO. 41: Absolutely not. As
2 an officer of the court of law, it would be my duty
3 to listen to the evidence.

4 MS. GUNN: Thank you so much. All right.
5 I appreciate that.

6 Anybody else recognize me or Ms. Slater or
7 Ms. Lenivy?

8 And then the Anyans, Sarah and Blake, they
9 live in Pacific. Blake is a respiratory therapist,
10 now a professor. And Sarah is a former -- she was --
11 I guess once a nurse, always a nurse. Okay. No
12 longer employed. She's taking care of Remi.

13 Does anybody recognize Sarah Anyan or
14 Blake Anyan?

15 Okay. I appreciate that.
16 who has been on a jury before?

17 All right. okay. I will start here in
18 the box.

19 Juror No. 3, what was your service prior?

20 VENIREPERSON NO. 3: I served on the grand
21 jury, 2018.

22 MS. GUNN: okay. Anything past the grand
23 jury? would that be for state or federal?

24 VENIREPERSON NO. 3: It was for here.

25 MS. GUNN: okay. St. Louis County?

1 VENIREPERSON NO. 3: Yes.

2 MS. GUNN: Okay. Anything about that
3 experience serving on the grand jury that sticks in
4 your mind about whether this is the right case for
5 you?

6 VENIREPERSON NO. 3: Not that I can
7 recall.

8 MS. GUNN: Thank you.

9 Anyone else? I saw a few more paddles.

10 Yes, sir, No. 1?

11 VENIREPERSON NO. 1: It was a civil case
12 in the Chicago area in 1992, and I have very little
13 memory of that.

14 MS. GUNN: Do you recall whether you were
15 chosen as the foreperson?

16 VENIREPERSON NO. 1: I was not.

17 MS. GUNN: And do you recall, I don't
18 know, you don't have to tell me the verdict, but was
19 a verdict reached?

20 VENIREPERSON NO. 1: Yes.

21 MS. GUNN: Okay. Thank you.

22 Anything about that experience affect you,
23 sir?

24 VENIREPERSON NO. 1: No, ma'am.

25 MS. GUNN: Thank you.

Continued paddles in the box.

Yes, Juror No. 5?

VENIREPERSON NO. 5: Yes. I was, in the 1990s, on a jury, and it was a traffic court.

MS. GUNN: Like a motor vehicle accident?

VENIREPERSON NO. 5: Uh-huh.

MS. GUNN: Okay. Got it. Anything about that case, ma'am, that affects your ability today?

VENIREPERSON NO. 5: No.

MS. GUNN: Thank you very much.

Anyone else in the box?

We call this the box, by the way.

No. 10? Yes, ma'am?

VENIREPERSON NO. 10: I wasn't on the jury. I was released right before the trial started. I was getting married. It was 1980.

MS. GUNN: Okay.

VENIREPERSON NO. 10: It was a murder trial.

MS. GUNN: Okay. So were you an alternate, then?

VENIREPERSON NO. 10: No. It was like the last questioning before they selected the 14 they were going to use.

MS. GUNN: Kind of like today?

1 VENIREPERSON NO. 10: Yeah. Only it went
2 on for a week before they made the decision. I was
3 questioned for a long time.

4 MS. GUNN: okay. Thank you. We're not
5 going to go a week for this.

6 VENIREPERSON NO. 10: Thank you.

7 MS. GUNN: You all will be excited.

8 okay. Anything about that, ma'am, that
9 would affect your ability to listen carefully to the
10 evidence?

11 VENIREPERSON NO. 10: No. No.

12 MS. GUNN: Thank you very much.

13 Anyone else in the box?

14 okay. We go with the right side.

15 No. 18? Yes, sir?

16 VENIREPERSON NO. 18: I was an alternate
17 on a civil case.

18 MS. GUNN: And where was that, do you
19 remember?

20 VENIREPERSON NO. 18: It was in St. Louis
21 County.

22 MS. GUNN: And do you know how long ago
23 that was?

24 VENIREPERSON NO. 18: Probably about
25 18 years ago.

MS. GUNN: Great.

Anything about that experience that makes you have thoughts about whether or not you're right for this case?

VENIREPERSON NO. 18: No.

MS. GUNN: Thank you very much.

Anyone else on the left side?

No. 44 in the back.

VENIREPERSON NO. 44: Mid 2000s. I don't remember the exact year. A criminal case. I served on a jury down in Cape Girardeau County.

MS. GUNN: Were you the foreperson, do you recall?

VENIREPERSON NO. 44: No.

MS. GUNN: Was a verdict reached?

VENIREPERSON NO. 44: Yes.

MS. GUNN: Anything about that experience, sir? It's different than a criminal case. I'm going to talk about the different burdens of proof.

Is there anything about that case that you think would affect your ability to sit for this one?

VENIREPERSON NO. 44: No.

MS. GUNN: Thank you so much.

No. 15?

VENIREPERSON NO. 15: I served on a civil

1 case. I don't remember, really. It was 20 years
2 ago. I don't really remember. And the plaintiff had
3 to prove negligence which was a unanimous decision by
4 all 12 of us that they did not.

5 MS. GUNN: Perfect. Anything about that
6 experience stick with you that you would bring in
7 here today that makes you think you're leaning one
8 way or the other?

9 VENIREPERSON NO. 15: No.

10 MS. GUNN: Okay. Thank you very much.

11 So -- I'm sorry -- No. 39? Yes, ma'am?

12 VENIREPERSON NO. 39: I was on a criminal
13 case, I think it was 2019. And it was postponed
14 because the defendant didn't have an attorney, so it
15 wasn't -- well, it never went.

16 MS. GUNN: So you were called, but never
17 really --

18 VENIREPERSON NO. 39: I was called. I was
19 in the jury room. They started the trial, but then
20 it was postponed because it was just too disruptive.

21 MS. GUNN: Understood. So, again, the
22 criminal versus civil, and we'll talk about that.

23 Anything about that experience just in and
24 of itself that brings you any pause?

25 VENIREPERSON NO. 39: No. No.

MS. GUNN: Is that a no?

VENIREPERSON NO. 39: No.

MS. GUNN: Thank you so much.

I saw another paddle on the right side.

My right.

Okay. Left side? Anyone been on jury

duty before?

No. 48?

VENIREPERSON NO. 48: Approximately 17

years ago, I was on a criminal case as a juror.

MS. GUNN: Do you know if that was in

the --

VENIREPERSON NO. 48: St. Louis County.

MS. GUNN: Were you chosen as the

foreperson?

VENIREPERSON NO. 48: No.

MS. GUNN: And do you recall whether a

verdict was reached?

VENIREPERSON NO. 48: It was.

MS. GUNN: Anything about that experience

that weighed on you in a way that you bring it with

you here today and don't think you can be fair?

VENIREPERSON NO. 48: No.

MS. GUNN: Thank you, ma'am.

No. 49?

1 VENIREPERSON NO. 49: I was on a criminal
2 case about 10 years ago.

3 MS. GUNN: And were you chosen as the
4 foreperson?

5 VENIREPERSON NO. 49: No.

6 MS. GUNN: Was a verdict reached?

7 VENIREPERSON NO. 49: Yes.

8 MS. GUNN: Thank you so much. Oh, I'm
9 sorry. The wrap-up question.

10 Anything about that experience that you
11 bring here today that you think you couldn't be fair
12 here?

13 VENIREPERSON NO. 49: I can be fair.

14 MS. GUNN: Okay. Thank you so much.

15 Anybody else on the left side?

16 Oh, the very back. Other side. I'm

17 sorry. What's your number?

18 56. Yes, ma'am.

19 VENIREPERSON NO. 56: Two civil trials
20 here in St. Louis County probably 15 years ago.

21 MS. GUNN: Were they -- were you on the
22 jury chosen -- were you chosen as foreperson? Either
23 one?

24 VENIREPERSON NO. 56: No.

25 MS. GUNN: And were you able to render a

1 verdict with your fellow jurors?

2 VENIREPERSON NO. 56: For both trials.

3 MS. GUNN: Thank you so much.

4 Oh, anything about that affect your

5 ability here?

6 VENIREPERSON NO. 56: No.

7 MS. GUNN: Thank you.

8 All right. Anybody else?

9 okay. So we were talking about civil and

10 criminal. we'll go ahead and move into an area of

11 burden of proof.

12 So the way I like to sort of go through

13 that is that there are two separate burdens of proof

14 depending on the case. So Judge Ribaudo let you know

15 that this is a civil case not a criminal case.

16 we talked about the scales of justice a

17 little while ago and how they start out even. It's a

18 similar thought. By the time this case is over,

19 evidence is going to go in from both sides, from both

20 parties, and those scales are going to fill up

21 however the evidence comes in.

22 You all, in order to render a verdict,

23 have to determine three things if you are to render a

24 verdict in favor of plaintiff. we have to prove that

25 there was negligent conduct. And we're going to

1 explain -- there's jury instructions given by the
2 judge that's going to explain that. Negligent
3 conduct that caused harm. Negligence, causation, and
4 damages. Those three things have to be proven by us
5 before a verdict can be rendered in our favor. And
6 their will be evidence that helps you get there.

7 well, then the question is, how certain do
8 I need to be about any of that particular evidence?

9 And the answer is: You have to believe more likely
10 than not that the evidence proves that the defendants
11 were negligent, and that their actions caused Remi's
12 harm. More likely than not. It is a tipping of the
13 scales. Sometimes called preponderance of the
14 evidence. And it is a tipping of the -- more likely
15 than not.

16 So how is that -- the best way I can tell
17 you to explain that is in a criminal case, you are
18 beyond a reasonable doubt. Those scales are really
19 tipped in favor of a verdict if you believe the
20 evidence.

21 That's different. Now, you could say,
22 well, that makes sense because in a criminal case
23 you're taking someone's freedom away, putting them
24 potentially in jail. A civil case is not that. No
25 one is going to jail. And that's why the law looks

at the burden differently. A burden by which you
have to prove things differently.
So knowing that this is a very serious
case and a very important case for all parties,
here's my question: who here -- and I'll start with
the box -- thinks that in order to find a physician
or a hospital negligent for harming a child is going
to need to believe that evidence more than more
likely than not?

Do you understand my question?

So here's my question again: who here in
the box thinks that's just not enough? I'm going to
have to be convinced more than just a preponderance
of the evidence in order to find against a doctor and
a hospital?

Anybody have a problem with that?

And I'm looking at the box.

Does everybody understand where I'm coming
from in terms of making a distinction?

okay. Thank you.

on the right side, again, in order -- we
have the burden of proof. we have to prove that.

The defense doesn't have to prove anything in terms
of the allegations and the elements of this case:
liability, causation, damages. we have that burden,

1 and we have to prove it more likely than not.

2 So on the right side of room, does anyone
3 here believe that that's just really not enough? In
4 order to find a physician or a hospital negligent and
5 award money, I'm going to have to be convinced more
6 than just more likely than not. All right.

7 No. 26, yes, ma'am?

8 VENIREPERSON NO. 26: I just have a hard
9 time making a decision like that. I mean, I can't
10 really express it, but that would be bothersome for
11 me.

12 MS. GUNN: May I follow up?

13 In terms of making that decision, is it
14 based on what I've just described as the certainty
15 with which you have to hold that decision, or is it
16 more about just making decisions in this context?

17 VENIREPERSON NO. 26: I think it's the
18 certainty of it.

19 MS. GUNN: Do you believe that in order to
20 find against a physician or a hospital and find a
21 physician or a hospital negligent, that you'd have to
22 be convinced more than just the tipping of the
23 scales?

24 VENIREPERSON NO. 26: I think so.

25 MS. GUNN: Okay. And is there anything

that you can hear or learn, or do you even think, in this case that would change your mind about that?

VENIREPERSON NO. 26: Possibly, yes.

MS. GUNN: Do you understand why I'm asking these questions? I promise I'm not trying to pick on you.

But when we are carrying the burden of proof and someone tells me they need to be more certain than just a preponderance of the evidence, do you understand why I want to -- why I would want to be certain that you could apply that burden of proof and not a higher burden?

Ma'am, do you believe that that would be hard for you to do, and you wouldn't be able to do it here?

VENIREPERSON NO. 26: I'm not sure about that.

MS. GUNN: Okay. Would it be fair then to say that you're not sure that you could be fair in this case?

VENIREPERSON NO. 26: I guess it would be fair to say, yes.

MS. GUNN: Thank you so much. I appreciate that. And I appreciate -- I don't want anybody to feel like I'm kind of drilling down. But

1 thank so much for that. That's exactly what I'm

2 looking for in terms of answers. Not an Official Court Document

3 There's a paddle in the back, No. 44. Not an Official Court Document

4 Yes, sir? Not an Official Court Document Not an Official Court Document Not an Official

5 VENIREPERSON 44: So Mercy Health, I'm in Not an Official Court Document Not an Official Court Document Not an

6 technology sales. Mercy Health is one of the

7 customers, and one of the best customers. And I have

8 a really good relationship with them in their

9 department. Not an Official Court Document Not an Official Court Document Not an Official

10 And I do have a little bit of concern that

11 it might impact my ability to really weigh that. I

12 might need a little bit more evidence on the side of

13 proof to be able to make that decision, as much as I

14 would like to say it wouldn't create any biases. I

15 just want you to be aware of that. Not an Official Court Document Not an Official Court Document Not an Official

16 MS. GUNN: And I appreciate that. So what

17 I'm hearing you saying is that -- your -- your

18 company, one of its biggest customers is Mercy, who's

19 one of the defendants -- is it Mercy Clinic or Mercy

20 Hospital? I didn't hear you. Not an Official Court Document Not an Official Court Document Not an Official

21 VENIREPERSON No. 44: So it's Mercy --

22 sisters of Mercy Health Systems. Not an Official Court Document Not an Official Court Document Not an Official

23 MS. GUNN: And so because of that business

24 relationship that you have, you feel like it might be

25 hard for you to start out even in this matter?

1 VENIREPERSON NO. 44: Correct.

2 MS. GUNN: And so based on that, and
3 that's not going to change any time soon, you hope at
4 least, right?

5 VENIREPERSON NO. 44: Right.

6 MS. GUNN: Based on that, would it be fair
7 to say, sir, that this is likely not the right case
8 for you?

9 VENIREPERSON NO. 44: I think I can make
10 an unbiased decision. Again, there's such a thing as
11 unconscious bias. I can't say more than that.

12 MS. GUNN: Okay. But you've pointed out
13 the fact that this is something that could very well
14 weigh on your mind throughout the entire case,
15 correct?

16 VENIREPERSON NO. 44: Yes.

17 THE COURT: And you would take that
18 knowledge and that relationship into the jury room
19 with you, correct?

20 VENIREPERSON NO. 44: Yes.

21 MS. GUNN: And you believe that could
22 impact your ability to listen fairly to the evidence
23 in this case?

24 VENIREPERSON NO. 44: I can't rule it out.

25 MS. GUNN: Okay. Thank you so much.

24? Did I see 24 come up?

VENIREPERSON NO. 24: So I'm a nurse and a nurse practitioner for over 20 years. So for me to say a health care provider, and I'd really have to have strong evidence, very objective, strong evidence. Because I know the group of health care workers, like how hard we work and how much we want to avoid malpractice.

MS. GUNN: Okay. Ma'am, thank you so much for that information. Stay standing, if you don't mind.

You are currently a nurse employed where?

VENIREPERSON NO. 24: I'm a nurse practitioner. And I worked on the front lines, and I used to work with Mercy.

MS. GUNN: And how long ago were you affiliated with Mercy?

VENIREPERSON NO. 24: About 5 years ago.

MS. GUNN: And what's the name of your current employer?

VENIREPERSON NO. 24: Esse Health.

MS. GUNN: And how long have you been in the medical field?

VENIREPERSON NO. 24: Over 20 years.

MS. GUNN: And what I'm hearing you saying

1 is based on your experience in the medical field,
2 you're obviously knowledgeable about how medical
3 malpractice cases work. Based on your knowledge of
4 that, do you feel like the plaintiffs, bringing
5 lawsuits against the hospital and its physicians, is
6 starting out behind? Basically the scales are
7 already tipped against us?

8 VENIREPERSON NO. 24: I don't want to say
9 the scales are tipped because I am also the mother of
10 two boys. I also have, you know -- so, personally,
11 my son had surgery. There was some little kinks
12 there, too. But at the end of the day, I think
13 health care, what we really try to do is the right
14 thing.

15 MS. GUNN: And so based on that life
16 experience and, in fact, part of your profession that
17 I'm sure you trained hard for, you believe you would
18 hold the burden of proof to be higher for us to reach
19 in order to find in favor of the plaintiff?

20 VENIREPERSON NO. 24: I can't say that
21 because I still want to be very objective, and I want
22 to be very matter of fact, based on my training and
23 my previous experiences. It's just knowing that, it
24 would be very hard for me to imagine someone suing
25 the practice I'm in.

1 MS. GUNN: So you right now feel a little
2 bit closer to the defendants because you're all
3 medical providers/health care professionals than you
4 would to the plaintiff?

5 VENIREPERSON NO. 24: Not closer. But
6 just from a professional perspective, I guess I have
7 an unconscious bias type of thing.

8 MS. GUNN: Do you fear that -- and I
9 appreciate you saying it. And that tells me that it
10 is something that's on your mind.

11 Do you believe that you would be able to
12 entirely set aside any bias that you would bring in,
13 that you already described to us, to the jury
14 deliberations for this case?

15 VENIREPERSON NO. 24: Yeah, I think so.

16 MS. GUNN: Okay. Do you believe, then,
17 though, that you would be -- in this case everybody
18 would be starting out entirely even, with no leaning
19 or tipping in favor of the defendants?

20 VENIREPERSON NO. 24: I don't think I want
21 to lean towards them. I want to just -- like I want
22 to solve any -- with my profession and my background,
23 to convince me you really need hard, objective
24 evidence.

25 MS. GUNN: So more than just the tipping

of scales?

VENIREPERSON NO. 24: The scale is still equal.

MS. GUNN: I understand. okay. Thank you so much. I really appreciate that.

VENIREPERSON NO. 24: Of course.

MS. GUNN: No. 45.

VENIREPERSON NO. 45: I have a family member that died as a result of a malpractice case when I was young. So I can't lie. It's going to be weighing heavily on my mind. And I don't know if you want to call it emotionally compromised, how that works, but I'd like to say I could stay objective, but you just don't know. Just like this gentleman suffers subconscious bias, so...

MS. GUNN: okay. Do you -- was that something that you said happened a number of years ago?

VENIREPERSON NO. 45: Yes, ma'am.

MS. GUNN: was there any lawsuit that was brought?

VENIREPERSON NO. 45: There was a big lawsuit.

MS. GUNN: And is that resolved?

VENIREPERSON NO. 45: Yes, ma'am.

1 MS. GUNN: Were you involved in that
2 lawsuit personally, or was it a member of your
3 family?

4 VENIREPERSON NO. 45: It was a member of
5 my family. It was my grandfather.

6 MS. GUNN: I'm sorry to hear that.

7 Do you believe, then, though because this
8 is also a medical malpractice case, different, you
9 know, different facts, this is a labor and delivery
10 case. But do you think that based on that fact
11 alone, you would not be able to listen carefully and
12 listen fairly to both sides?

13 VENIREPERSON NO. 45: It might be
14 difficult.

15 MS. GUNN: Do you -- would you like -- is
16 it in your intent to try to do that?

17 VENIREPERSON NO. 45: I mean, I don't want
18 to. I spent time as a police officer. I try to stay
19 as objective as I can. But subconscious biases still
20 exist, and I am certainly suspect of things just
21 because of personal experiences, maybe on the guard a
22 little bit more, absolutely.

23 MS. GUNN: Thank you very much.

24 VENIREPERSON NO. 45: I don't have the
25 intentions to judge something before it's proven

1 beyond a reasonable doubt, but I just want to be
2 honest with you.

3 MS. GUNN: Thank you very much.

4 No. 23.

5 VENIREPERSON NO. 23: Since we opened up
6 the door about medical malpractice cases --

7 MS. GUNN: Of course.

8 VENIREPERSON NO. 23: My niece is a
9 plaintiff in a case that the trial is starting in
10 June of this year. So I would be biased towards the
11 plaintiffs' side.

12 MS. GUNN: Okay. And I appreciate your
13 honesty about that. It sounds like -- I know we're
14 talking about different sets of facts, and what
15 you're saying is that because of that also going on
16 with family and the closeness it sounds like you have
17 with them, that you just -- you wouldn't -- we
18 wouldn't be starting out even?

19 VENIREPERSON NO. 24: We wouldn't.

20 MS. GUNN: Okay. Thank you very much.

21 No. 33?

22 VENIREPERSON 33: So last April, like one
23 of my sons, he was four years old. He all the sudden
24 over the night got some rash on his face and bottom.
25 So we took him to Mercy Urgent Care because it was

1 suddenly. And it looked for me it was like an
2 allergy because I gave him some like medicine the
3 week before, the night. I thought it was an allergy.

4 In the morning I called my friend, invited
5 them to come over to my house because their son also
6 four years old, and I told her it should not be
7 contagious. Yeah. So still come over and play.

8 But -- they came. Then around noontime,
9 his rash got worse. So we went to Mercy Urgent Care,
10 and then after checking at first a nurse
11 practitioner. Then maybe -- she was not sure what it
12 was so she called the doctor.

13 And after they talked, that was for a
14 while, and she told me it was hand, foot, and mouth.
15 And it was very bad because that is contagious. So
16 then I called my friend and told her, I am so sorry.
17 It could be contagious, watch out for your son.

18 But -- and the second day, Monday morning,
19 I took him to his doctor, and after his doctor
20 examined him, it was not hand, mouth, and foot. It
21 was allergy, actually. So after we gave him some
22 allergy medicine, it was down. It disappeared like
23 three to 5 days.

24 So I, when I heard Mercy today, I think I
25 definitely would believe more because I have this

1 experience, although it's very small. It doesn't --
2 didn't cause any damage. But because of this
3 experience, well, personally, in the future, me and
4 my family would never go back to Mercy for any like
5 clinic, hospital, or urgent care. I would not choose
6 Mercy anymore. But here I'd hear the case, so I
7 would definitely have some bias. I'm sorry about
8 that. I would rather believe it is like hospital --
9 it is a hospital.

10 MS. GUNN: So if I understand, you had a
11 bad experience with Mercy recently with your son,
12 sounds like misdiagnosing your son.

13 Now you know this is an entirely different
14 situation. This is a labor and delivery situation in
15 the hospital, not in the clinic, or not in the urgent
16 care. And it's -- are you not able to set what you
17 just indicated aside in order to listen carefully to
18 all of the evidence in this case?

19 VENIREPERSON NO. 33: I will always try to
20 be fair and listen to all evidence, you know. But I
21 mean, like the subconscious the gentleman just
22 mentioned, maybe influence my decision, uh-huh. But
23 I still try to be like objective and fair.

24 MS. GUNN: Okay. And that's really all we
25 can ask is that you identify these things but still

commit to being fair.

VENIREPERSON NO. 33: Uh-huh.

MS. GUNN: And that's what I'm trying to understand. Is that what you're saying?

VENIREPERSON NO. 33: Yes. I think so. But I feel like, you know, yeah, that happened.

MS. GUNN: Thank you so much.

VENIREPERSON NO. 33: Yeah.

MS. GUNN: Appreciate it.

No. 29.

VENIREPERSON NO. 29: Hello. First, I'd like to say that my mother-in-law does work for Mercy.

Secondly, I have a Ph.D. in biological anthropology, and I work at the Washington University School of Medicine teaching anatomy, including the obstetrics and gynecology portions of anatomy.

I will say that I've also had family members who have been in medical malpractice cases and situations that have never been brought to trial but have still had a major effect on me. One of those was involving obstetrics. It was with a sister-in-law who went through a very difficult miscarriage situation. So I think -- I'm not sure that I could be unbiased in this situation.

MS. GUNN: Let me see if I understand.

Your mother-in-law works for Mercy?

VENIREPERSON NO. 29: Correct.

MS. GUNN: And is she a nurse?

VENIREPERSON NO. 29: She's physical therapy.

MS. GUNN: So are you indicating that you think you're leaning more towards Mercy or leaning towards the plaintiff?

VENIREPERSON NO. 29: Leaning towards the plaintiff.

MS. GUNN: Okay. And I guess all I can try to understand is I heard you say you got medical, I mean, medical experience.

VENIREPERSON NO. 29: Yes.

MS. GUNN: You've got family members who work for Mercy. And how -- maybe I just don't -- how is it that that makes you lean toward the plaintiff?

VENIREPERSON NO. 29: So the medical malpractice experiences in my life have been so bad, I guess, that I would lean toward the plaintiff in this situation.

MS. GUNN: Do you feel like there's a way for you to set that aside and listen carefully to the evidence in this case, knowing that it's, you know, a

1 totally different set of facts, different
2 circumstances?

3 VENIREPERSON NO. 29: Potentially. But
4 I'm just really not sure.

5 MS. GUNN: Thank you.
6 Anyone else?

7 No. 30.

8 VENIREPERSON NO. 30: My daughter had a
9 very bad experience at Mercy Hospital. And so
10 although I believe I can be fair and unbiased, in the
11 back of my mind I know there's a thought that knows
12 this can happen at Mercy. Mercy can do those things.

13 So I'm not trying to say that directly.

14 And right now in the back of my mind that
15 thought is there. I'm not saying this case or
16 anything like that, but in the back of my mind, it
17 will be in my mind that Mercy can be in a position
18 and can be guilty of that.

19 MS. GUNN: Let me ask. Is there --
20 knowing that medical malpractice can happen, is that
21 any different whether it were Mercy or any other
22 physician or hospital?

23 VENIREPERSON NO. 30: In the back of my
24 mind, what I'm thinking is Mercy can commit
25 malpractice because I saw it happen with my daughter.

1 It's just a thought, emotional thought. I believe I
2 can be fair and unbiased, but that's the thought.

3 MS. GUNN: Okay. And I appreciate that.
4 So you've established that's an experience that maybe
5 you've had in your life, but you know this is very
6 important to get fair people on the jury. And
7 despite that experience, you believe you can listen
8 carefully to the evidence in this case and apply the
9 law as it's given to you by the judge to this case?

10 VENIREPERSON NO. 30: Yes, I do.

11 MS. GUNN: Thank you so much.

12 31?

13 VENIREPERSON NO. 31: My best friend,
14 within the last year, had a malpractice case against
15 Mercy. It has not been taken to trial yet.

16 MS. GUNN: Is that a case that's on --
17 that is on file?

18 VENIREPERSON NO. 31: Not at this time.
19 But she's -- everybody's heard from her. I don't
20 know that I would be unbiased.

21 MS. GUNN: well, I mean, if you don't mind
22 if I ask a few more questions. Did it involve
23 anything to do with labor and delivery?

24 VENIREPERSON NO. 31: It did not.

25 MS. GUNN: So what you're saying is that

1 you have a close relationship with this friend, and
2 she shares some facts about that situation with you?

3 VENIREPERSON NO. 31: (Nodding head.)

4 MS. GUNN: And you know that it is against
5 Mercy?

6 VENIREPERSON NO. 31: Yes.

7 MS. GUNN: And because you know that
8 there's -- that's not disproven. There's no lawsuit
9 on file, you've only heard her side of the story.

10 Does that mean you don't think you could
11 be able to hear both sides of the story in this case?

12 VENIREPERSON NO. 31: I don't -- because
13 it's my best friend, and I heard so much, I don't
14 know that I could be unbiased.

15 MS. GUNN: Okay. Is that something you
16 would try to do?

17 VENIREPERSON NO. 31: Absolutely.

18 MS. GUNN: All right. So can you say as
19 you stand there right now, that you wouldn't be fair?

20 VENIREPERSON NO. 31: No.

21 MS. GUNN: You think you could be?

22 VENIREPERSON NO. 31: I would hope so. I
23 would try to be.

24 MS. GUNN: Thank you.

25 All right. Left side. Nobody? Come on.

1 Nobody?

2 It's not that bad.

3 All right. I'm going to go back to the
4 box. Because we've talked for a few minutes, and I
5 knew there were a lot of kind of questioning faces,
6 and so now we've talked about it a little bit, and
7 I'm going to give you all another shot.

8 okay. In the box, No. 13?

9 VENIREPERSON 13: I had an emergency
10 C-section as a child. My face was cut. At the same
11 time, my grandfather's law firm worked for the
12 hospital so we don't believe in suing. And the fact
13 that the doctor ran away, but this -- he cut my eye,
14 or almost cut my eye, and my father simply wanted to
15 thank him because he saved my mother's life and my
16 life. Sometimes doctors have to make tough choices,
17 and so it would be hard for me in that aspect.

18 MS. GUNN: okay. So do you think that
19 life experience gives you an inability to listen
20 carefully and closely to the facts in this case?

21 VENIREPERSON NO. 13: well, it's tough
22 because I understand that doctors have a lot of
23 things going on. And they're literally trying to
24 make the best decision that they can, and especially
25 on birthing. It's crucial, you know, many things

1 that could be there. And the fact that I had a
2 situation where they thought my mother and I were
3 both going to die, the fact that I survived by his
4 miraculous just emergency cut, that, I don't know.

5 MS. GUNN: So are you -- I think I'm
6 hearing you. Are you saying that you're leaning
7 toward the health care providers right now?

8 VENIREPERSON NO. 13: Correct.

9 MS. GUNN: Do you think that that is
10 something you can get past, or is it something you
11 think you're going to continue to think about and
12 take it to deliberations with you?

13 VENIREPERSON NO. 13: It would be kind of
14 hard not to because I've had this mark on my face my
15 entire life.

16 MS. GUNN: Like a daily reminder?

17 VENIREPERSON NO. 13: Correct.

18 MS. GUNN: Then, sir, do you think this is
19 likely not the right case for you?

20 VENIREPERSON NO. 13: That's correct.

21 MS. GUNN: Thank you.

22 No. 3?

23 VENIREPERSON NO. 3: So I'm a therapist, a
24 mental health therapist for first responders, which
25 includes emergency health care and other health care

1 workers. So although I'm not biased, I'm not biased
2 in my practice either, I would not be able to not
3 take that into deliberations. I would certainly take
4 that into, just because of how we operate as humans.

5 MS. GUNN: Okay. And so do you think
6 right now that you would be leaning toward or in
7 favor of the defendants, the hospital and the
8 physician?

9 VENIREPERSON NO. 3: I wouldn't say that I
10 would be leaning toward, but I would have a unique
11 compassion and perspective of their job in the mental
12 prowess that goes into it, into the decision making.

13 MS. GUNN: Is that something that you
14 think would impede your ability to listen carefully
15 and closely to the facts of this case?

16 VENIREPERSON NO. 3: It would not.

17 MS. GUNN: Okay.

18 VENIREPERSON NO. 3: I didn't mean to put
19 a question mark on that. It would not, but it would
20 certainly inform the decision making.

21 MS. GUNN: Do you think that based on what
22 you told me that you could nevertheless be fair?

23 VENIREPERSON NO. 3: I could be fair.

24 MS. GUNN: Okay. Are you confident in
25 that?

1 VENIREPERSON NO. 3: I am confident that I
2 could look into all the facts in the case, yes.

3 MS. GUNN: But knowing what you know about
4 the decision-making process, you know it's hard,
5 would, back to that burden of proof, would you
6 require more proof than just a preponderance of the
7 evidence in order to find, knowing what you know
8 about the decision-making process, would it -- would
9 you require more than just a preponderance of the
10 evidence?

11 VENIREPERSON NO. 3: So just a touch of
12 background that may influence that, I was an
13 investigator for a Title IX, and that was our
14 burden -- you know, was our preponderance of evidence
15 was our proof. So I know that it only takes
16 51 percent to tip that scale. I can't guarantee that
17 I wouldn't default to what I tell my clients, which
18 is you're following protocol. So personally I could
19 follow the burden of proof, but, yet, the knowledge
20 base that I have would probably influence that --
21 that 51 percent.

22 MS. GUNN: In a way that you might require
23 more than 51 percent?

24 VENIREPERSON NO. 3: I think it's in
25 comparison to someone who doesn't have the same

1 practice, probably.

2 MS. GUNN: Okay. Thank you.

3 Anybody else in the box? I'm going to
4 give the left side one more shot. Anybody have any
5 concerns about listening to evidence and holding us
6 to our burden, which is preponderance of the evidence
7 and tipping of the scale at 51 percent? Anyone?

8 okay. Thank you for that.

9 THE COURT: Ms. Gunn?

10 MS. GUNN: Yes, ma'am?

11 THE COURT: Maybe this would be a good
12 time for us if you're going to switch topics.

13 MS. GUNN: Sure. Of course.

14 THE COURT: All right. Ladies and
15 gentlemen, based on the timing it seems like a good
16 time for us to take our lunch recess.

17 (A break was taken at 11:47 a.m., and the
18 jury panel was duly admonished. At 11:50 a.m., the Court
19 following proceedings were held in open court, with
20 venireperson No. 38:)

21 THE COURT: Yes, sir, You're Juror No.?

22 VENIREPERSON NO. 38: 38.

23 THE COURT: Thank you.

24 VENIREPERSON NO. 38: when you were
25 talking about spring break and everything, I didn't

want to go back and slow you guys down that way, but it dawned on me, I have a special needs child that goes to the Special School District in St. Louis County, and he's on spring break next week. And I'm a teacher. I'm on spring break. I think we can cover it. I wanted to let you know that might be an issue.

THE COURT: Thank you, sir. I appreciate that.

(Venireperson No. 38 exited the courtroom, and the following proceedings resumed in open court:)

THE COURT: We are outside the presence of the jury. The Court notes for the record that Ms. Kamykowski asked to address these issues prior to starting jury selection, but due to the nature of timing, we were not able to get that on the record at that time. She did not waive any desire to make that record, and the Court is now hereby allowing that.

MS. KAMYKOWSKI: Thank you, Your Honor.

Just for the record, Monday? I don't know what day of the week it was. We filed, the defense filed as part of our pretrial, a motion to compel the attendance of the plaintiff, Remi Anyan, for a portion of voir dire. And that motion was not taken up with the pretrial on February 27th.

1 we thought we had some things worked out,
2 and then there was an objection raised on March 9th
3 from the plaintiffs. So we had that motion actually
4 heard by the Court yesterday off the record. I don't
5 think that -- we did it by webex, so there wasn't
6 actually a ruling that was entered.

7 So I wanted to make sure that the
8 defendants preserve our record that we requested,
9 because of the nature of this case. And the fact
10 that plaintiffs, we anticipate, are going to in some,
11 way, shape or form, make representation to the jury
12 in either photos, videos, or both of a minor child
13 during the course of evidence in the case, the
14 defendants believed that it was their right and
15 obligation to be able to voir dire the panel members
16 on their respect to sympathy and otherwise biases
17 with respect to Mr. Anyan.

18 we offered to compromise and not have him
19 attend the voir dire for a short period of time in
20 person by utilizing photos or videos, again, to allow
21 the opportunity to subpoena -- I'm sorry -- to voir
22 dire on the sympathy. We cited to Washington -- I
23 think it's -- by and through or v. -- Washington v.
24 Barnes, for the proposition that those, both the
25 request via motion to compel for relief from the

1 Court, as well as attendance in person for the
2 plaintiff, were both valid options.
3 we asked for agreement. The plaintiff did
4 not agree. Because of the timing of the objection
5 that was raised 12 days after our motion was filed in
6 notice of hearing, we were unable to then subpoena
7 the child for attendance.

8 The Court, our understanding is, denied
9 that motion, and we just wanted to make a record that
10 we had raised that issue pretrial and so accept the
11 Court's ruling.

12 THE COURT: The Court did deny the motion,
13 as the Court does not believe it's necessary or
14 appropriate to get into too many of the specific
15 facts of the case. The general question of sympathy
16 and whether or not that is going to be an issue for
17 any juror is something that can be discussed without
18 the child or without videos or photographs of the
19 child.

20 MS. KAMYKOWSKI: Thank you, Judge.
21 And then secondarily, another aspect of
22 this case that's been discussed extensively pretrial
23 off the record relates again to the Court's ultimate
24 ruling in this case that was entered, that was issued
25 on, I think, February 18th, with respect to

1 plaintiffs' rebuttal economic damages expert,

2 Mr. Gingras.

3 The Court, we've had, like I said,
4 extensive discussions about what potentially may open
5 the door for the Court to allow rebuttal testimony
6 from Mr. Gingras to come in, despite the fact that
7 the defendant has withdrawn their economic damage
8 expert to whom Mr. Gingras's opinions were to rebut.

9 And so the record, I think we had a
10 discussion at our pretrial conference or maybe at
11 plaintiffs' motion to reconsider that February 18th
12 order, as to what -- where is the bright line or what
13 is the line drawn for the defense opening the door.

14 we indicated by way of an offer of proof
15 here that we would be asking questions in voir dire
16 about present value time, value of money, the fact
17 that a dollar today, if invested, can grow in certain
18 manners. Those are all standard damages inquiries
19 that we make on voir dire.

20 My understanding from our discussions off
21 the record is that the Court had -- believes that
22 it's best for defense to stay away from those types
23 of questions in voir dire to -- unless we want to
24 risk the Court then letting in evidence allowing for
25 some sort of rebuttal.

1 based on those representations previously
2 made, I don't believe that -- I think that our hands
3 are tied because if we attempt to voir dire the panel
4 on those issues that we believe are appropriate for
5 argument, even if there is no evidence of present
6 value, under the current law which cites to Wickham
7 v. Hummel, Klotz v. St. Anthony's, and the Anglim v.
8 Missouri Railroad Case, I think our hands are tied at
9 this point.

10 But we wanted to make the record that we
11 are going to heed the court's ruling that the talking
12 about present value by the defense in voir dire would
13 likely open the door to that evidence.

14 MR. WILLMAN: Just so it's clear, Judge,
15 we join that motion.

16 THE COURT: Thank you.

17 MS. SLATER: Your Honor, may I make a
18 short record?

19 THE COURT: You may.

20 MS. SLATER: In regards to
21 Ms. Kamykowski's record she just made, we had
22 previously brought our motions before the court prior
23 to the ruling of February 18th. We also raised a
24 motion to reconsider on that issue of Mr. Gingras
25 testifying. And then, in the alternative, asked for

1 leave to supplement Mr. Gingras as an expert in this
2 case.

3 Understanding the Court's rulings on those
4 motions, we pointed out that according to the
5 statute, it says that the jury must express the
6 damages in present value.

7 And so based on the Court's ruling and not
8 waiving any offer of proof that we'll be making later
9 about Mr. Gingras, we would -- it would be our
10 position that any suggestion that expressing present
11 value is a reduction of any dollars awarded by the
12 jury today, would open the door to that.

13 we've also put on the record that we
14 believed the door had been opened by defendants'
15 offering of a jury instruction that is a non-MAI jury
16 instruction on the present value issue.

17 And then would like to state that along
18 with voir dire, had plaintiffs been able to present
19 testimony from Mr. Gingras, we would have also taken
20 the opportunity to discuss present value with the
21 venire panel.

22 THE COURT: Thank you. The Court is going
23 to continue with its previous rulings with regards to
24 these issues.

25 MS. KAMYKOWSKI: Thank you. And just for

1 the record, I think we've fully briefed a lot of what
2 we had discussed in response to the plaintiffs'
3 written motion for reconsideration.

4 THE COURT: Thank you.

5 MS. GUNN: Thank you.

6 MS. KAMYKOWSKI: Thank you, Your Honor.

7 MS. SLATER: Thank you, Judge.

8 (At 11:58 a.m., court stood in recess. At
9 1:09 p.m., the following proceedings were held in
10 open court, in the presence of the jury panel:)

11 THE COURT: Go ahead and be seated,
12 everyone.

13 On behalf of the plaintiff, you may
14 resume.

15 MS. GUNN: Thank you, Judge.

16 I had introduced Blake Anyan and his wife
17 Sarah Anyan and their son Remi. Sarah and Remi will
18 not be here today.

19 And I just want to know is anybody -- is
20 there anyone who thinks, well, I'm going to have to
21 be here every day, and Blake will be here every day,
22 but Sarah and Remi will not be able to be here every
23 day, does that concern anyone who thinks, well, I
24 have to be here every day, why shouldn't they?
25 Anybody have any concerns about that, whatsoever,

1 just raise your hand.

2 I see no --

3 Oh, No. 5?

4 VENIREPERSON NO. 5: I just need to add to
5 my -- I had a medical appointment, and I called home
6 over lunch, and I also have a procedure the following
7 day, a medical procedure, in relation to something,
8 so I'm sorry to --

9 THE COURT: Thank you.

10 MS. GUNN: That's okay. So that would be
11 March 20th and now March 21st?

12 VENIREPERSON NO. 5: Both.

13 MS. GUNN: Okay. Thank you, ma'am.

14 VENIREPERSON NO. 5: Thank you.

15 MS. GUNN: Of course.

16 No. 24?

17 VENIREPERSON NO. 24: And my apologies. I
18 need to change my son's dental appointment time, and
19 I think previously I said March 27th, and that's
20 actually March 25th.

21 MS. GUNN: March 25th, okay. Thank you.

22 And with that, let me just ask you since
23 you -- if you don't mind. With respect to that
24 dental appointment, is that something that you will
25 take your son to?

1 VENIREPERSON NO. 24: Yes.

2 MS. GUNN: And is that an appointment you
3 typically go with him?

4 VENIREPERSON NO. 24: Yes. I have two
5 boys. I take both.

6 MS. GUNN: Okay. And is that something
7 that you wanted to -- that can be rescheduled, or is
8 that something you want to do?

9 VENIREPERSON NO. 24: I want to keep it
10 because my other son has a national competition
11 coming up that I'm taking him to.

12 MS. GUNN: And that's the competition that
13 starts on the 28th?

14 VENIREPERSON NO. 24: Correct.

15 MS. GUNN: So would you be leaving --

16 VENIREPERSON NO. 24: we're leaving on the
17 27th.

18 MS. GUNN: The 27TH. And that's
19 international?

20 VENIREPERSON NO. 24: International.

21 MS. GUNN: so you will be leaving the
22 country on March 27th?

23 VENIREPERSON NO. 24: Not country. I
24 mean, we're just going to New Jersey.

25 MS. GUNN: I'm sorry. I thought

1 international, it's international. But it's in New
2 Jersey.

3 And that's something you want to attend
4 with your son?

5 VENIREPERSON NO. 24: Yeah.

6 MS. GUNN: Okay. Thank you.

7 Okay. Just want to be really clear. when
8 I asked about whether anybody would have a concern
9 about Sarah and Remi not being here every day, I saw
10 no hands.

11 No hands. Thank you.

12 Now, there will be a number of medical
13 providers whose name will come up who were involved
14 in the care during the labor and delivery with Sarah
15 and Remi and after care, so I want to throw out a few
16 names that you may hear in the course of this trial
17 and see if anybody knows them.

18 So I'm just going to give the list, and if
19 a name rings a bell, just hold on for a second, then
20 I'll come around, okay?

21 Dr. April Parker, Dr. Morgan Parker, Dr.
22 kelsey Mckillip, Nurse Practitioner Morgan Miller --
23 did I say Parker? I'm going to start again. I'm
24 going to start a list. Sorry, ya'll.

25 Dr. April Parker, Dr. Morgan Miller, Dr.

kelsey Mckillip, Nurse Practitioner Mary Younger --
and now she's married now -- Spencer. Nurse Alex
Greenwald, and Nurse kelsey Blanton.

okay. Do those names ring any bells for
anybody?

we're going to start with No. 2.

Yes, sir?

VENIREPERSON NO. 2: Mary Younger.

MS. GUNN: And how do you know Ms.
Younger?

VENIREPERSON NO. 2: She's my wife's
friend.

MS. GUNN: okay.

VENIREPERSON NO. 2: They both worked at
Mercy. My wife is currently an at-home mom, retired.

MS. GUNN: okay. Do you know whether they
have mentioned, you know -- you don't know. Has your
wife ever mentioned to you that she or Ms. Younger or
Spencer have ever spoken about this case or any of
the facts?

VENIREPERSON NO. 2: I have not heard any
details, no.

MS. GUNN: okay. The fact that
Ms. Younger Spencer -- she goes by Spencer now,
right?

1 VENIREPERSON NO. 2: Yes, ma'am.

2 MS. GUNN: So can I call her Spencer?

3 VENIREPERSON NO. 2: Yes, ma'am.

4 MS. GUNN: Nurse Practitioner Spencer
5 is -- was involved in the care and treatment of Remi,
6 would that have an effect on you to be able to listen
7 to that?

8 VENIREPERSON NO. 2: I'd have probably a
9 bias, yes.

10 MS. GUNN: A bias in favor of Ms. Spencer?

11 VENIREPERSON NO. 2: Yes.

12 MS. GUNN: And how long have your wife and
13 she been friends?

14 VENIREPERSON NO. 2: Since they started
15 nursing together, so 20 years. Maybe?

16 MS. GUNN: Thank you.

17 All right. So based on that, you'd have a
18 hard time believing that you could not set that
19 aside?

20 VENIREPERSON NO. 2: Correct.

21 MS. GUNN: Okay. Thank you.

22 I saw another paddle.

23 Yes, ma'am?

24 VENIREPERSON NO. 8: I saw Dr. Parker a
25 few times. And my insurance changed, so I changed

providers.

MS. GUNN: And how long ago was that?

VENIREPERSON NO. 8: About a year ago.

MS. GUNN: She's not a defendant in this case.

VENIREPERSON NO. 8: Okay.

MS. GUNN: Is there anything about you seeing her as a patient, that you would put her opinions or her care in a different area than anyone else?

VENIREPERSON NO. 8: No.

MS. GUNN: And you no longer see her, but that's not because you didn't like her, it's because the situation changed, is that correct?

VENIREPERSON NO. 8: Correct.

MS. GUNN: Do you think that that would affect your ability to listen to all the facts in this case?

VENIREPERSON NO. 8: No.

MS. GUNN: Anybody else in the box? Right side? Did any of those names ring a bell to anyone?

No?

Okay. Thank you.

And the left side?

1 okay. Thank you.

2 Now, we've had a few folks talk about
3 medical malpractice lawsuits, and that's what this
4 is, as you all know now.

5 People, whether they're in the medical
6 practice or not, sometimes can have feelings about
7 medical malpractice lawsuits. I'm going to start
8 kind of at a higher, you know, a 30,000-foot view,
9 which would be does anybody here have any automatic
10 thoughts, good or bad, about that this is a medical
11 malpractice lawsuit?

12 So anybody in the box?

13 All right. I know we've heard from a few
14 people, so if I haven't heard for you, anybody on the
15 right side that just, you know, this is a med mal
16 case. I read about them. I hear about them. I just
17 don't -- I don't like them? Or I do like them?

18 Anything, if automatic, about medical mal practice
19 cases?

20 On the right side?

21 No. 38?

22 VENIREPERSON NO. 38: My father had a knee
23 replacement where he got staph and MERS and a bunch
24 of other things. There was no lawsuit involved, but
25 it was an issue. I don't think that it would keep me

1 from keeping an open mind.

2 MS. GUNN: Okay. So you --

3 VENIREPERSON NO. 38: That's what comes to
4 mind when you're saying that.

5 MS. GUNN: So you have had an experience
6 in life that you think could have been malpractice.
7 No one -- you didn't -- it was your father?

8 VENIREPERSON NO. 38: Yes. Yes. He
9 didn't discuss it, so...

10 MS. GUNN: And do you think, you've said
11 it already, but do you think that that alone would
12 cause you to be -- problems listening to this case?

13 VENIREPERSON NO. 38: (Shaking head.)

14 MS. GUNN: You're shaking your head no.

15 VENIREPERSON NO. 38: No. No, I don't
16 think it would.

17 MS. GUNN: Appreciate it.

18 I saw a couple more paddles.

19 28?

20 VENIREPERSON NO. 28: Dealing in primary
21 care, when I hear about med malpractice, I feel for
22 both sides. No one's like, God, I can't wait to
23 screw it up. So I do realize that there's a series
24 of things that can happen that lead to something
25 traumatic. I also feel for the other side, something

1 traumatizing has happened to them. So just to let
2 you know. I'm neutral, but, yeah.

3 MS. GUNN: May I, since you are up, may I
4 ask you a couple of questions?

5 You're a physician's assistant. Where do
6 you practice?

7 VENIREPERSON NO. 28: At the VA.

8 MS. GUNN: Okay. And do you -- what's
9 your field?

10 VENIREPERSON NO. 28: Internal medicine/
11 primary care.

12 MS. GUNN: And you don't treat children?

13 VENIREPERSON NO. 28: No, I don't treat
14 children.

15 MS. GUNN: Okay. All right. And how long
16 have you done that?

17 VENIREPERSON NO. 28: As a PA, 22 years.

18 As a VA, 12. I do have a kid with high special
19 needs, so my heart goes out.

20 MS. GUNN: In your training, did you have
21 any labor and delivery training?

22 VENIREPERSON NO. 28: Yes.

23 MS. GUNN: Would that have been early in
24 your career?

25 VENIREPERSON NO. 28: 22 years. And I was

never at Mercy, it was SSM, yeah.

MS. GUNN: And so the full extent of your labor and delivery training would have been like during --

VENIREPERSON NO. 28: During rotations, yes, as a student.

MS. GUNN: All right. And so it sounds to me like you can kind of see both sides right now. I know we really don't have any evidence in there, but it sounds like you are willing to listen to both sides and weigh that evidence.

VENIREPERSON NO. 28: Yes.

MS. GUNN: Thank you so much.

Anyone else on the right side?

And the question again was specifically anybody with medical malpractice just thought like, oh, this is the way I feel about it, without knowing anything else?

Left side? Anyone have any --

Yeah. No. 46?

VENIREPERSON NO. 46: Yeah. My grandmother had an issue with her, I think it was a knee or hip replacement that happened when I was young. She just was never the same person. So I have kind of bias against the health care provider.

1 MS. GUNN: okay. You're biased against
2 that particular health care provider or all the
3 health care providers?

4 VENIREPERSON NO. 46: I just think there's
5 such a responsibility to do things right, it can
6 affect somebody's life.

7 MS. GUNN: Is there -- from that situation
8 that happened, do you think that you, without hearing
9 any of the evidence or knowing, you know, what the
10 allegations are or not, you wouldn't be able to
11 listen carefully or listen evenly to any of that
12 evidence?

13 VENIREPERSON NO. 46: Yeah. Absolutely I
14 think I could listen to the evidence evenly. But
15 it's still going to weigh on my heart, yeah, just
16 seeing the emotional side of it.

17 MS. GUNN: Okay. And I think in this
18 case, there's going to be a lot of people feeling one
19 way or the other about all these parties.

20 Is that something that you don't think
21 you'll be able to set aside when you go in to
22 deliberate and listen to everybody else talk?

23 VENIREPERSON NO. 46: It will be
24 difficult, yeah.

25 MS. GUNN: Thank you.

1 okay. I have a note here that 26 raised
2 your hand. And then maybe -- yes?

3 VENIREPERSON NO. 26: I have similar -- my
4 mother-in-law was misdiagnosed and died. Because of
5 that, the family didn't sue because they wanted her
6 life, they didn't want the money. So that weighs on
7 me every time I hear something like this.

8 MS. GUNN: And do you mean that you're
9 relating that to a medical malpractice claim?

10 VENIREPERSON NO. 26: No. No. It was a
11 misdiagnosis, so that -- but it still -- I understand
12 it's different. But it's still -- they decided not
13 to sue because they wanted her, they didn't want
14 money.

15 MS. GUNN: Do you have any thoughts about,
16 I mean, the Anyans have sued, and your family decided
17 not to sue?

18 Does that affect the way you feel about
19 this case at all?

20 VENIREPERSON NO. 26: Not without knowing
21 any more than just that, you know, that doesn't
22 change my mind about them, no.

23 MS. GUNN: All right. And then that
24 experience that you had that you just told us about,
25 is that something that you can set aside, or do you

1 think it is going to affect your ability to listen
2 fairly in this case?

3 VENIREPERSON NO. 26: Again, it would
4 depend on more information, you know.

5 MS. GUNN: You're willing to listen to all
6 the evidence?

7 VENIREPERSON NO. 26: I'm willing to
8 listen.

9 MS. GUNN: Thank you so much.
10 Left side? Anybody have any automatic
11 thoughts about medical malpractice?

12 Okay. No. 59, I'm going to pick on you,
13 sir.

14 we have -- yes, sir, if you don't mind.
15 we have very little information about
16 everybody, but my information is that you're a
17 physician?

18 VENIREPERSON NO. 59: I'm a retired
19 physician, yes.

20 MS. GUNN: Okay. And is there anything
21 about being -- having been a physician -- what type
22 of physician were you?

23 VENIREPERSON NO. 59: Emergency/urgent
24 care.

25 MS. GUNN: And obviously your career, your

1 life's work, was in medicine, you're a physician,
2 retired of course. But anything about the fact that
3 this is a medical malpractice case that gives you,
4 you know, any pause?

5 VENIREPERSON NO. 59: No. Physicians can
6 make mistakes, and some physicians can be negligent,
7 so...

8 MS. GUNN: Do you think that because
9 you're a physician, and, for example, Dr. McNeive is
10 a physician, that you automatically lean or feel for
11 him in that way?

12 VENIREPERSON NO. 59: No.

13 MS. GUNN: All right. Thank you so much.

14 Okay. Anybody else on the left side?

15 All right. Appreciate that.

16 Now, one of the things that we have to do.

17 I told you about the three things: liability, which
18 is the negligence; causation, which we have to prove
19 that the negligent act that we believe the physicians
20 and the nurses did that was negligent, actually
21 caused harm. So liability, causation, and damages.

22 You're going to hear a lot of medical
23 evidence about the causation and all that stuff. But
24 I want to focus now on damages. You're also going to
25 hear evidence about the damages that have been

1 incurred. And there's two types of damages:
2 compensatory, which are noneconomic, that's one. And
3 economic.

4 So economic is kind of what you think
5 about, in this case medical bills, medical bills that
6 had been incurred up until this point, and medical
7 bills and care that will be needed for Remi for the
8 rest of his life. And that comes with a price. And
9 you're going to hear evidence that that is millions
10 of dollars to take care of him.

11 In addition to the economic part, we've
12 got, like I said, the noneconomic, and that's
13 traditionally what you hear would be pain and
14 suffering. And you're going to get an instruction
15 about all the things that noneconomic could be: pain
16 and suffering, loss of enjoyment of life, disability,
17 various things like that.

18 we will be asking for tens of millions of
19 dollars from the noneconomic, as well. So aside from
20 the economic loss, we'll be asking for millions of
21 dollars for the noneconomic loss.

22 So what I want to know is, is there
23 anybody -- we'll start in the box, without hearing
24 anything else, that, knowing that's where we're
25 going, does anybody have a problem with those kinds

1 of numbers?

2 so looking at everybody in the box, I
3 don't see any hands.

4 Thank you.

5 okay. On the right side, let's focus on
6 noneconomic.

7 Does anyone on the right side feel like,
8 I'm not really sure what you can tell me, Ms. Gunn,
9 that would make me give you millions of dollars for
10 pain and suffering?

11 So that's what I'm asking. And it's an
12 important part of the case. So does anybody on the
13 right side feel like not knowing anything else,
14 that's just too much?

15 All right. I see no hands. I see no --
16 all right. Okay.

17 Now, the left side? Again, you know, it's
18 kind of hard to quantify. We're not going to have a
19 calculator estimating, you know, medical bills, we
20 will on the economic part. But on the noneconomic
21 part, part of your job is going to be to decide if
22 you believe we've proved our case, the damages that
23 are owed to Remi, and we're going to ask for millions
24 of dollars.

25 Does anybody believe that they're --

that's too much, I can't consider it?

No one?

Okay. Thank you.

The -- one of the things that -- punitive damages. The judge told you that one of the elements that you're going to hear evidence about is punitive damages which is different than compensatory. The compensa -- the economic and noneconomic are the compensatory -- we'll do the section of punitive.

And we believe that we will be able to show you evidence of punitive conduct.

Does anybody -- let's just start with the box. Does anybody in the box know anything in particular about punitive damages? Have an idea of what punitive damages are, or an idea of what acts have to be shown to be, quote, "punitive"?

Anybody have any preconceived notions about that?

Okay. Does anyone believe that, I don't care what you show me, Ms. Gunn, I cannot find a doctor liable for punitive damages? There's really nothing you can show me. Does anyone have a feeling about that in the box?

Okay.

On the right side. Does anybody have any

1 feelings about, you know, we're talking about a
2 doctor doing a job. I just don't see that there's
3 really -- I just don't see it -- without hearing
4 anything?

5 Does anybody on the right side of the room
6 feel like just by the nature of a physician being
7 sued, punitive damages are just not something that
8 you can consider? The right side?

9 okay. What about the left side? Anyone?

10 Yes. Ms. 55?

11 VENIREPERSON NO. 55: Can you identify by
12 what you mean by "punitive damages"?

13 MS. GUNN: Yes. Punitive damages are
14 meant not to compensate, per se, but to punish and
15 deter conduct. So it's a different area. There is a
16 higher burden of proof, the judge mentioned that in
17 the statement that she read earlier. So it's not
18 just a preponderance of the evidence, it's more than
19 that: clear and convincing evidence.

20 So it is a different standard, and you'll
21 hear more about it. Again, I can't go into it in all
22 the details, but you will be able to read the jury
23 instruction that the Court gives you and apply that
24 to the facts of the case and make that determination.

25 Does that help?

VENIREPERSON NO. 55: Uh-huh.

MS. GUNN: Does that help make you believe one way or the other about whether you can?

VENIREPERSON NO. 55: well, I just knew that I needed to have more of a definition in order to answer the question, so...

MS. GUNN: You did. Thank you for that. I thank you for making me ask a better question.

VENIREPERSON NO. 55: I'm the only one that asked this, so...

MS. GUNN: Knowing now that a punitive damage claim is to punish and deter, does that change anybody's mind about whether they feel like that's something they could do against a physician?

Okay. I see no hands.

Oh, yes, 32?

VENIREPERSON NO. 32: I couldn't do it because you said punish. I mean, you're punishing a physician when he has to make a decision based on where he is at that present time, and sometimes both decisions might be wrong or wrong at that time. If he doesn't make those decisions, that means real life or death. I mean, if he's going to be punished at a later point for making a decision based on his expertise, I don't agree with that.

1 MS. GUNN: All right. So if the judge
2 allows punitive damages to be submitted, and the jury
3 is to consider them, you're indicating that that's
4 not something you could do, correct?

5 VENIREPERSON NO. 32: Correct.

6 MS. GUNN: Okay. Thank you, sir.

7 Anyone else feel the same way as Juror No.
8 32, that just without hearing anything else, that's
9 just where you are, I can't do punitive damages
10 against a physician? Anyone?

11 okay. I see no other hands.

12 Thank you, sir.

13 okay. Are you -- are you or any members
14 of your family employed by or have a financial
15 interest in the Mercy Health Pool Liability Program
16 or in the Medical Protective Company.

17 Did everybody hear that?

18 yeah, No. 3?

19 VENIREPERSON NO. 3: My husband's an EMT
20 with Abbott who works with Mercy. They have a direct
21 contract.

22 MS. GUNN: Thank you. Anybody else?

23 48?

24 VENIREPERSON NO. 48: Mercy Nurse -- can
25 you go over liability again?

1 MS. GUNN: Are you a member or employed by
2 or have a financial interest in the Mercy Health Pool
3 Liability Program or in the Medical Protective
4 Company?

5 VENIREPERSON NO. 48: So as an employee,
6 yes.

7 MS. GUNN: Understood.

8 Anyone else?

9 44?

10 VENIREPERSON 44: When you say "Medical
11 Protective Company," are you talking about Mercy, the
12 company, or the insurance, health practice insurance?

13 MS. GUNN: Are you -- but you're not
14 employed by Mercy, right?

15 VENIREPERSON 44: I'm not employed, but,
16 yeah. Okay.

17 MS. GUNN: Got it. Thank you.

18 Anybody else?

19 okay. The -- I'm talking about burden of
20 proof connected to liability, causation, damages.
21 I'm going to go back to causation for a minute. We
22 have to prove that the medical errors that we're
23 going to show actually caused harm.

24 The way I try and describe it is you can
25 drive your car through a red light, and that could be

1 considered careless, right? And, again, unless you
2 cause an accident, you might get a ticket, but you're
3 not going to get sued. So in order to have all those
4 elements, you have to run the red light and cause an
5 accident. And the running of the red light has to be
6 a cause of the accident.

7 So the same thing applies here. We have
8 to prove more likely than not that the acts or
9 inactions of the defendants actually caused harm.

10 Now, the law that will be read to you by
11 the judge will say that specifically the acts or
12 nonacts directly caused or directly contributed to
13 cause harm. So it may seem like a lot of mumbo
14 jumbo. The reason why it's important is, there can
15 be more than one cause to a harm to a damage to an
16 injury. There could be more than one.

17 And the law in Missouri, as the judge will
18 tell you, is it -- what the acts or inactions can
19 cause or contribute to cause that harm. It doesn't
20 have to be the only cause.

21 So I've seen people, you know, put a
22 bucket or a bowl of water on the table and pour cups
23 of water into it. Say you put 5 cups of water on the
24 table, and then you pour one more cup in and it
25 overflows, which cup contributed to the overflow?

1 VENIREPERSON NO. 8: All of them.

2 MS. GUNN: Right. So that's kind of what
3 I'm trying to get at is, can everybody agree that
4 when you have a cause or contributed to cause, that
5 it doesn't have to be one thing? It could be many
6 things?

7 And I'll just talk to the box. I'm not
8 being terribly articulate about this. But does
9 anybody have any concerns about this notion of cause
10 or just contributed to cause? Anyone?

11 Okay. No hands.

12 On the right side, does anyone have any
13 concern that merely contributing to harm isn't
14 enough? That I need to know that what was -- what
15 you're accusing them of actually caused -- directly
16 caused the harm? And if it's just directly
17 contributed to, that's not enough?

18 Does anyone feel that way on the right
19 side of the room?

20 VENIREPERSON NO. 20: Well, using your
21 fifth cup overflowing, I don't know if you can say
22 that the first four people really caused it because
23 when they did it, it really didn't overflow. So the
24 fifth person probably should have looked and seen it
25 was almost full. To me that seems like they are the

1 one who caused the overflow.

2 MS. GUNN: All right. So in that scenario
3 you say the last person that came in to the situation
4 that ended up in damage is really the one
5 responsible?

6 VENIREPERSON NO. 20: I wouldn't say --
7 let's say you got together and knew that they were
8 going to overflow together, then they would all be
9 part of it. Independently they had no idea of what
10 was going to happen next, the last person.

11 MS. GUNN: Okay. I appreciate that. So
12 the law again, as it's going to be read, will direct
13 you and the rest of the jury that the standard is
14 caused or contributed to cause, whether you're the
15 first cup or the last cup.

16 Is that going to cause you any problem?

17 VENIREPERSON NO. 20: I could work through
18 it.

19 MS. GUNN: well, I appreciate that, but
20 you know what I'm going to ask you.

21 VENIREPERSON NO. 20: Right.

22 MS. GUNN: which is I appreciate all of us
23 want to believe that we can work through it and be
24 fair, but the fact that you brought that up, is that
25 something you're really going to have a problem with,

1 do you think?

2 VENIREPERSON NO. 20: It depends upon the
3 person and the actions that they took and how big
4 that sphere is that you're kind of wrapping around
5 this.

6 MS. GUNN: Do you think it could cause you
7 concern?

8 VENIREPERSON NO. 20: Maybe, you know, if
9 it's like the person painting the stripe on the
10 parking lot at the hospital that the person pulled
11 into to go to the emergency room, that would be
12 pretty hard reaching.

13 MS. GUNN: So yours is sort of a temporal
14 relationship as far as when this -- these actions
15 occurred?

16 VENIREPERSON NO. 20: Right.

17 MS. GUNN: All right. I appreciate that.
18 Now, again, the judge's instructions are
19 going to be that the standard is caused or
20 contributed to cause.

21 So the question, then, is, do you think
22 you could follow those instructions?

23 VENIREPERSON NO. 20: Yes. Yeah.

24 MS. GUNN: Usually when I say the judge is
25 going to tell you, then...

VENIREPERSON NO. 20: Sure.

MS. GUNN: Okay.

Anybody else on the right side?

Yes, No. 22?

VENIREPERSON NO. 22: I feel the same way.

This is too vague to say everybody caused it. I would have to go along with that.

MS. GUNN: Okay.

Anybody on the left side?

okay. Thank you.

Now, as I mentioned a minute ago or a few times, Remi is -- he's 4 years old, going on 5, and he suffers what's known as hypoxic ischemic encephalopathy or HIE. It is permanent brain damage.

Does anybody in this box know or had a relationship with anybody who has a child or a family member who suffers from HIE or permanent brain damage?

Nobody?

okay. On the right side?

Now, I've heard a few people mention they have special needs children. And I want to just get more specific.

Does anyone on the right side -- same question -- know anyone or care for anyone, know

anyone or just in passing, who has a child with permanent brain damage?

No. 23, yes?

VENIREPERSON NO. 23: My niece has anoxic brain traumatic injury.

MS. GUNN: And I think you told us about that. I appreciate that. I'm sorry about that.

No. 15?

VENIREPERSON NO. 15: I am a retired early childhood special ed teacher, so I have worked with children with traumatic brain injuries, so I've known them for some years and their families.

MS. GUNN: Do you think that having that experience in your profession, and working with children and families suffering from that same condition, will cause you to lean more towards the Anyans in this matter?

VENIREPERSON NO. 15: I don't know. I mean, I think -- I mean, I think it can be the truth, I think, doctors can be negligent in situations. And then, you know, I also think that sometimes they're not negligent and that maybe people's emotions and whatnot take over the suffering. It's a family suffering in a situation like this. So, I mean, I'd have to see the evidence, I guess, to see which way

1 to go with that.

2 MS. GUNN: Thank you.

3 Mr. 20? Yes, sir?

4 VENIREPERSON NO. 20: Yeah. My cousin has
5 permanent brain damage from an umbilical cord being
6 wrapped around his neck during childbirth. Yeah.

7 You saw impact. They did not sue. He was a doctor
8 or physician at the hospital. But I am aware of
9 that.

10 MS. GUNN: Does having that experience in
11 your life cause you any concern about whether, you
12 know, you would be leaning towards the Anyans in this
13 case?

14 VENIREPERSON NO. 20: No. It -- I would
15 still have to see the facts of the case and then what
16 happened at that time. But the financial part of
17 the, you know, doctor bills and the other part, the
18 impact on the rest of their life, certainly I'm more
19 aware of because of that experience with my cousin.

20 MS. GUNN: Thank you.

21 No. 29?

22 VENIREPERSON NO. 29: Yes. My cousin has
23 a daughter who was born prematurely at 24 weeks. She
24 has cerebral palsy, so she's not even talking. She's
25 about 5 years old and can just sort of walk.

1 MS. GUNN: Do you think having that
2 experience in your life makes you lean more toward
3 the Anyans?

4 VENIREPERSON NO. 29: Yes. Because I
5 understand the medical practitioners that she saw
6 through the child's birth were not effective and
7 didn't make the right decisions when they should
8 have.

9 MS. GUNN: No. 31?

10 VENIREPERSON NO. 31: I teach, and we deal
11 with children that have traumatic brain injury.

12 MS. GUNN: Do you think that that
13 experience, the fact that you teach and see children
14 with brain damage, makes you --

15 VENIREPERSON NO. 31: I think it just
16 makes me empathetic.

17 MS. GUNN: Empathetic?

18 VENIREPERSON NO. 31: Yes.

19 MS. GUNN: Anyone else?

20 38?

21 VENIREPERSON NO. 38: I taught for 30
22 years. I taught TBI and CP kids.

23 MS. GUNN: Do you think that that fact
24 alone will make you lean toward the Anyans?

25 VENIREPERSON NO. 38: No.

1 MS. GUNN: Thank you.

2 Anyone on the left side?

3 No. 52?

4 VENIREPERSON NO. 52: I work at the

5 special school district, so I deal with children on
6 all kinds of spectrums.

7 MS. GUNN: Does that fact make you feel

8 like you're leaning towards the Anyans?

9 VENIREPERSON NO. 52: I definitely think

10 it tips the scale a little bit. I would like to be
11 as objective as possible to hear all of the facts and
12 information, but I do care for a lot of children and
13 they go without, that families have to deal with.

14 MS. GUNN: Do you think that care will

15 prevent you from being able to listen carefully and
16 fairly to the evidence in this case?

17 VENIREPERSON NO. 52: I think I'll be able

18 it listen, but knowing myself, my heart's like I
19 don't think my scale would be balanced.

20 MS. GUNN: Do you think that would be

21 based on sympathy or empathy?

22 VENIREPERSON NO. 52: It's hard to tell

23 without all of the facts.

24 MS. GUNN: Okay.

25 VENIREPERSON NO. 52: with teaching, it's

1 hard to separate it.

2 MS. GUNN: I understand. Thank you.

3 Anyone else?

4 All right. Picking up on that. Thank you
5 for the segue.

6 Sympathy. We don't want it. Don't need
7 it. You can't give it. You cannot base your

8 decision in this case on sympathy. So, however,
9 obviously from the very little that you know about

10 this case, there is a lot of things that will tug at
11 your heart. No question about it.

12 So empathy is one thing. Empathy is fine.

13 Empathy just means you can understand, and you can
14 relate, but it doesn't mean you're going to let your

15 emotions and your feelings take over. That is
16 sympathy, and we don't want it.

17 So in the box, does anybody in the box,

18 knowing what you know about this case, Remi is --

19 suffers from hypoxic ischemic encephalopathy, HIE,

20 and needs full-time care and will for the rest of his
21 life.

22 Does anyone in the box feel like that's

23 just more than they can handle? That they won't be

24 able to listen closely and fairly to the facts of the

25 case? Anybody in the box think that they would let

1 sympathy overrun their decisions?

2 I see no hands.

3 Same for the right side?

4 Does anyone on the right side of the room

5 feel like sympathy they may have for this family and

6 this child would be overrun by their ability to

7 listen carefully to the facts and circumstances of

8 this case and judge it fairly? Anybody on the right

9 side?

10 No. 33?

11 VENIREPERSON 33: Because my son is

12 actually the same age as this son, so I feel like I

13 can feel the pain.

14 MS. GUNN: Thank you.

15 Anybody else on the right side?

16 I see no further hands.

17 On the left side, anybody on the left side

18 feel like that, based on what they've heard so far,

19 this is just going to be too much for them to listen

20 carefully to the facts, and they'd let sympathy get

21 in the way?

22 okay. 12, did you have your hand up?

23 VENIREPERSON NO. 12: No.

24 MS. GUNN: Or paddle, I should say.

25 okay. I see no further hands.

1 I know we have a number of -- obviously,
2 well, I was going to say women, but men, also. Labor
3 and delivery. This case is about a labor and
4 delivery. And what I want to understand, but not too
5 many facts about it, but did anybody here themselves
6 or a close loved one have what they believed was a
7 very lengthy labor?

8 Anybody?

9 okay. We'll start with 11, and I'll come
10 back around.

11 Yes, ma'am? Tell me about that.

12 VENIREPERSON NO. 11: I had a 36-hour long
13 labor with my first son.

14 MS. GUNN: Okay. Let me -- I'm going to
15 break that down a little bit.

16 There are different stages of labor. The
17 first stage is before you're complete, so before your
18 cervix is a hundred percent and effaced. 10
19 centimeters and effaced. So that's the first stage.

20 The second stage is pushing. The second
21 stage of labor is when you're fully dilated, and
22 you're told to push.

23 Do you have a recollection of how that 36
24 hours was divided up?

25 VENIREPERSON NO. 11: I pushed for like

1 5 hours.

2 MS. GUNN: And everything okay?

3 VENIREPERSON NO. 11: Uh-huh.

4 MS. GUNN: Do you think that having a
5 similar experience in terms of a lengthy labor, which
6 is what we're dealing with here, would cause you to
7 lean one way or the other?

8 VENIREPERSON NO. 11: (Shaking head.)

9 MS. GUNN: No? At any point in that time,
10 were you offered a C-section?

11 VENIREPERSON NO. 11: I did. But I didn't
12 want it.

13 MS. GUNN: Thank you.

14 Anybody on the right side?

15 No. 21? Yes, ma'am?

16 VENIREPERSON NO. 21: My best friend had
17 8 hours of pushing, but there were no complications,
18 and she was offered a C-section but wanted to do it
19 naturally.

20 MS. GUNN: Okay. So that was her choice
21 to decline a C-section?

22 VENIREPERSON NO. 21: Yes.

23 MS. GUNN: Okay. Do you think that
24 situation would play into any of the facts that you
25 would listen to in this case?

1 VENIREPERSON NO. 21: No. I could hear
2 everything.

3 MS. GUNN: Okay. Thank you.
4 Your neighbor.

5 No. 22?

6 VENIREPERSON NO. 22: Sort of. I had
7 preeclampsia at 28 weeks, so I was hospitalized for 6
8 weeks in and out of labor and delivery probably four
9 or 5 times. But then I was put on Pitocin and told I
10 needed to have an emergency C-section, and I did.

11 MS. GUNN: Okay. Do you think that that
12 experience, not exactly the same, but I guess a
13 difficult kind of first experience, would that affect
14 your ability to listen --

15 VENIREPERSON NO. 22: No.

16 MS. GUNN: No. 31?

17 VENIREPERSON NO. 31: I pushed for
18 5 hours: empathy but not sympathy.

19 MS. GUNN: Anything about that, ma'am,
20 that would affect your ability to be fair?

21 VENIREPERSON NO. 31: No.

22 MS. GUNN: Anyone else on the right side
23 or the left side?

24 Yes. No. 52?

25 VENIREPERSON NO. 52: Labored at home for

1 8 hours and got to the hospital. And when they did
2 check, I was actually only 1 centimeter dilated, but
3 they were like, you're experiencing all the symptoms,
4 so we are not quite sure what to do with you. And
5 they ended up admitting me. They had to break my
6 water. They maxed me out on Pitocin. It was
7 15 hours in the hospital, and I only ever got to 6,
8 and then it was a C-section.

9 MS. GUNN: okay. so you never actually
10 got to the pushing stage?

11 VENIREPERSON NO. 52: No. They kind of
12 said we're not at this point to -- I was just
13 physically at midpoint, plus, I was late on it.

14 MS. GUNN: so you were given an option for
15 a C-section? or they said, we're going to do a
16 C-section?

17 VENIREPERSON NO. 52: They -- they
18 strongly recommended it.

19 MS. GUNN: Thank you.

20 Anybody else?

21 No. 24? Yes, ma'am?

22 VENIREPERSON NO. 24: I feel like this is
23 getting -- so I had delivered a set of twins, and it
24 was a very lengthy process. And I was induced
25 initially, so I was in labor and delivery over like

1 24 hours, and pushed for over 5 or 6 hours because it
2 was a set of twins. And I remember clearly that my
3 physician at that time said, I could offer you a
4 C-section, and we really still wanted to keep pushing
5 because, you know, it's just because of a lot of
6 other things. So it turned out fine. And I just
7 wanted to share this. I don't know like -- like the
8 other person was saying, they pushed for however long
9 and delivered, and it was just an hour, like...

10 MS. GUNN: Do you think that -- I
11 appreciate that. Do you think that experience will
12 weigh in your ability to listen carefully to the
13 evidence in this case --

14 VENIREPERSON NO. 24: No. I would
15 just --

16 MS. GUNN: -- and apply the law?

17 VENIREPERSON NO. 24: -- listen to the
18 evidence.

19 MS. GUNN: Okay.

20 Anybody else?

21 Okay. Now, the -- we go first. Anybody
22 who has the burden of proof goes first, so we will be
23 presenting our evidence first. The defendant will
24 have an opportunity to cross our witnesses. But the
25 defendant won't start its case until we rest ours.

1 So what I want to know is can you wait
 2 until the defense does put on its evidence and then
 3 you weigh it all together? Can you wait to hear all
 4 the evidence before you reach any conclusions?

5 So that's -- if you can't, or you don't
 6 think you'd be able to do that, then raise your hand
 7 in the box.

8 Same question for the right side of the
 9 room. If anybody thinks that they'll be terribly
 10 persuaded by the fact that our evidence goes first to
 11 the point they won't be able to listen to evidence
 12 after that, then raise your hand.

13 All right. Same question on the left
 14 side. Does anybody think that it's just not going to
 15 be possible for me to listen, or I'm going to make up
 16 my mind based on what I hear first and not what I
 17 hear last or anything in between?

18 Any hands?

19 Okay. Thank you.

20 All right. Thank you so much for your
 21 time. I appreciate it.

22 THE COURT: Thank you.

23 On behalf of the defendants?

24 MS. KAMYKOWSKI: Thank you, Your Honor.

25 Defendant Mercy Hospitals East Communities

1 d/b/a Mercy Hospital St. Louis voir Dire Examination

2 MS. KAMYKOWSKI: Good afternoon, everyone.

3 My name is Mandy Kamykowski, as the judge

4 told you this morning, and I'm here with my partner,

5 Erin Pfirrman. And Ms. Gunn did a great job of

6 covering a lot of the topics that we would normally

7 talk about, so I'm going to try to keep this as brief

8 as I can.

9 As she said this morning, and as the judge

10 said, what we're here to do is to try to find the

11 jurors who are best for this case. And if somebody

12 has that nagging feeling just in the back of your

13 mind, and you haven't already told us about that

14 because I know now we've heard a lot from a lot of

15 you, that just hearing what you heard from Ms. Gunn

16 so far today that, man, I think jury duty is a great

17 thing, everyone should do it, but this really does

18 not sound like the case for me.

19 If you've already told us, I don't want

20 you to raise your hand. But over the lunch hour, has

21 anybody thought about this and thought, man, I just

22 really don't -- I don't think I can be fair to either

23 side in this case?

24 I'll start in the box. Does anybody

25 start -- has anybody had that thought?

1 I see lots of heads shaking, but no hands
2 raised.

3 How about over here on the right side?

4 Anybody have that feeling in the back of their mind
5 that they haven't already told us?

6 All right.

7 And over here on the left?

8 All right. No. 53, why don't you tell us
9 about that.

10 VENIREPERSON NO. 53: well, I pay a lot of
11 professional liability insurance, and so that leads
12 me to maybe have a little bit of bias as to -- I'm a
13 designs professional. I pay a lot of professional
14 liability insurance, and I have occasionally been
15 called to defend myself or into question, and -- and
16 it affects how I feel about other people who are in
17 that same boat.

18 MS. KAMYKOWSKI: And for the fact that you
19 are a professional who may have had your judgment
20 called into question at some time in your career,
21 does that make you maybe lean more towards the
22 defense?

23 I represent Mercy Hospital. Mr. Willman
24 and Mr. Perron represent Dr. McNeive and Mercy
25 Clinics. Are you leaning more towards our side

1 because we're professionals, as well, or --
2 VENIREPERSON NO. 53: I'm not sure I lean
3 towards a side, but it certainly puts a perspective
4 on it.

5 MS. KAMYKOWSKI: So the question, and as
6 everybody's heard so far, the standard for really
7 whether a juror -- it's whether you can be fair and
8 impartial, if you will listen to the evidence in this
9 case and listen to the instructions and the law that
10 are given from the judge after you hear the evidence,
11 and be able to fairly render a verdict in this case.

12 Do you feel like you could do that?

13 VENIREPERSON NO. 53: Probably could.

14 MS. KAMYKOWSKI: Okay. Thank you so much.

15 As I mentioned, I represent Mercy
16 Hospital. Mercy Hospital in this case had acted
17 through two labor and delivery nurses who were
18 involved in this labor and delivery.

19 I want to introduce you first to one of
20 the labor and delivery nurses. Her name is Maggie
21 Hilt-McLeland. Maggie worked, back in 2020, when
22 this occurred, she worked at Mercy Hospital on
23 Ballas. Big Mercy, St. John's -- whatever you want
24 to call it -- the big nonprofit hospital up that way
25 that's got 850 beds. Some people call it the baby

1 factory.

2 Maggie was training there, Maggie worked
3 there, and now she works at Mercy South, which used
4 to be St. Anthony's Health Center, down off of Tesson
5 Ferry Road, okay? She's still working in labor and
6 delivery.

7 Does anybody recognize Maggie? I think
8 she lives in Jefferson County with her family. Mercy
9 South is probably a better commute than Mercy -- big
10 Mercy was.

11 I don't see any hands that anyone
12 recognizes Maggie.

13 At the time, again, back in May of 2000,
14 Maggie was working with a preceptor, another
15 experienced labor and delivery nurse, whose name was
16 Jessie Brown at the time. Her name now is Jessie
17 wagner.

18 Anybody think they recognize the name
19 Jessie Brown-wagner, a labor and delivery nurse, at
20 Mercy?

21 Looking around, I see no hands.

22 I know we kind of talked a little bit
23 about people in the room, and you saw everyone at
24 these tables. We're also -- I've got some other
25 folks here in the room. I just want to make sure

nobody knows them.

Connie Gouldin, she works at Mercy. She's going to be here throughout the trial.

Does anybody think they recognize Ms. Gouldin?

I see no hands.

And then we've got, from my office, Emma Howe, and from Mr. Perron and Mr. Willman's office, Ms. Narrow. They're paralegals who will also be helping us.

Does anybody think they recognize either of them?

Can you go ahead and stand up so the rest of the jurors can see you?

Thank you.

Everyone's taking a look at Ms. Narrow and Ms. Howe, and I don't see any hands.

I know Ms. Gunn asked about her team. I didn't ask about myself. I know there is a lawyer on the panel, I don't believe that I know her.

But does anybody recognize me? My name is Mandy Kamykowski. We have a law firm here in Clayton. Our law firm is called Kamykowski & Taylor. Anybody think they recognize that name?

All right. I see no hands.

1 we talked just -- well, this is another
2 question that sometimes I forget to ask in this
3 process: Does anyone here know anyone else on this
4 panel?

5 Anybody at lunch, you walked around, you
6 thought, oh, I see you? We go to the same church.
7 Or are children worked together.

8 No. 21?

9 VENIREPERSON NO. 21: One of my old school
10 teachers -- one of my teachers is here.

11 MS. KAMYKOWSKI: Oh, back there. No. 38
12 is one of your teachers?

13 okay. This is the way I ask this
14 question: If No. 21 and No. 38, you were both picked
15 on the jury, and you have diametrically opposed
16 opinions about what the evidence shows, would either
17 of you have a problem standing up to each other and
18 debating the issue and coming to a verdict?

19 VENIREPERSON NO. 21: No.

20 MS. KAMYKOWSKI: No. 38?

21 VENIREPERSON NO. 38: She told me what she
22 thought in 7th grade, so I don't think so.

23 MS. KAMYKOWSKI: I like to hear that.

24 Thank you so much.

25 Anyone else with a similar type of

1 relationship? Anyone recognize anyone else on the
2 panel?

3 okay.

4 It's always good when I get to make marks
5 through.

6 we talked just a little bit about Mercy
7 Hospital. And I'm going to ask some very broad
8 questions.

9 we talked about Mercy Hospital versus
10 Mercy Clinics. And I'll kind of explain the
11 difference.

12 when we are talking about Mercy Hospital,
13 we are talking about the physical hospital where you
14 go and you have, you know, inpatient rooms, the ER.

15 This case is about labor and delivery where people
16 are in the hospital.

17 Mercy Clinics are a lot of the providers
18 who have their own standalone clinics throughout the
19 community. There are the, you know, Tower A and
20 Tower B on Mercy's campus there at Ballas. That's
21 Mercy Clinics.

22 So I'm going to ask -- I'm going to start
23 with employees.

24 we'll start with the box.

25 Does anybody have, themselves, or a close

1 friend or family member, who is an employee of either
2 Mercy Hospitals or Mercy Clinics?

3 And, No. 2, we talked about that before.
4 Your wife, correct?

5 VENIREPERSON NO. 2: Yes.

6 All right. No. 3?

7 VENIREPERSON NO. 3: My husband. He's an
8 EMT contracted by Mercy through Abbott.

9 MS. KAMYKOWSKI: And so as an EMT, is he
10 actually working like in the emergency department?
11 Or does he drive a bus or both?

12 VENIREPERSON NO. 3: He is now an
13 instructor, so he used to drive a bus.

14 MS. KAMYKOWSKI: And as an instructor for
15 Abbott, contracted with Mercy, is he teaching at
16 Mercy Hospital?

17 VENIREPERSON NO. 3: No. He transferred
18 to work there, though.

19 MS. KAMYKOWSKI: Okay. And the fact that
20 you have that background and your husband has that
21 tie to Mercy Hospital, do you think that that would
22 have any bearing on your ability to listen to the
23 evidence in this case and follow the law and the
24 instructions the judge gives you and render a fair
25 and impartial verdict?

VENIREPERSON NO. 3: No.

MS. KAMYKOWSKI: Anybody else in the box?
Mercy Hospitals or Mercy Clinics?

All right. we'll go to this side over
here, my right side.

Anybody on this side have a friend, close
friend, family member, or themselves as an employee
of Mercy Hospitals or Mercy Clinics?

No. 28?

VENIREPERSON NO. 28: It was in the past.
I was an occupational therapist.

MS. KAMYKOWSKI: At Mercy Hospital?

VENIREPERSON NO. 28: Correct.

MS. KAMYKOWSKI: And how long ago was
that?

VENIREPERSON NO. 28: Longer. 45 years.

MS. KAMYKOWSKI: I was going to say you
told us you've been a physician's assistant for 20
plus years, correct?

VENIREPERSON NO. 28: For a while, yeah.

MS. KAMYKOWSKI: Okay. So the fact that
you were at some point were employed at Mercy
Hospital in occupational therapy, would that in any
way make you unable to fairly and impartially listen
to the evidence in this case?

VENIREPERSON NO. 28: No.

MS. KAMYKOWSKI: Not at all?

VENIREPERSON NO. 28: No.

MS. KAMYKOWSKI: okay. Thank you.

No. 17?

VENIREPERSON NO. 17: My mom used to work at Mercy South as an ultrasound technician.

MS. KAMYKOWSKI: As an ultrasound technician?

did she work in labor and delivery, do you know?

VENIREPERSON NO. 17: No, I don't think so.

MS. KAMYKOWSKI: And how long did she --

VENIREPERSON NO. 17: She's retired now.

MS. KAMYKOWSKI: Did she retire from Mercy?

VENIREPERSON NO. 17: Uh-huh. Yes.

MS. KAMYKOWSKI: And the fact that -- and how long did she work for Mercy, do you know?

VENIREPERSON NO. 17: Awhile. I don't know how many years.

MS. KAMYKOWSKI: And so the fact that you have your mom who was and still is a health care provider that is retired and worked her career for a

1 long time at Mercy, with Mercy South, is there
 2 anything about that relationship that you think might
 3 make you either maybe lean more towards Mercy as a
 4 defendant in this case?

5 VENIREPERSON NO. 17: No.

6 MS. KAMYKOWSKI: Do you think you could
 7 listen to the evidence and the law and instructions
 8 from the judge?

9 VENIREPERSON NO. 17: Yep.

10 MS. KAMYKOWSKI: No. 44?

11 VENIREPERSON NO. 44: I worked for St.
 12 Anthony's Medical Center from 2013 to 2017. Then it
 13 was acquired by Mercy.

14 MS. KAMYKOWSKI: Okay. And so when you
 15 worked at St. Anthony's at the time, and I know you
 16 told us that you work at an IT company, were in
 17 Health Information Management or something like that?

18 VENIREPERSON NO. 44: Yeah, I was in
 19 information systems.

20 MS. KAMYKOWSKI: Okay. And then when
 21 Mercy purchased that facility, were you part of a
 22 workforce reduction, or did you choose to leave? Or
 23 what happened?

24 VENIREPERSON NO. 44: I chose to leave.

25 MS. KAMYKOWSKI: And now you work with a

1 company that still contracts through Mercy, correct?

2 VENIREPERSON NO. 44: Correct.

3 MS. KAMYKOWSKI: I hope the opportunity
4 was better for you.

5 VENIREPERSON NO. 44: It was.

6 MS. KAMYKOWSKI: Okay. And we've talked
7 about this, how you feel about Mercy Hospital and
8 that it was one of your employer's large contracts,
9 right?

10 VENIREPERSON NO. 44: Uh-huh.

11 MS. KAMYKOWSKI: Thank you.

12 Anyone else on this side over here?

13 Relationship with Mercy Hospital?

14 No. 34? we haven't heard from you today.

15 All right.

16 VENIREPERSON NO. 34: I don't know if it's
17 relevant, but two of my friends work for Mercy, but
18 for IT, though.

19 MS. KAMYKOWSKI: okay. You have two
20 friends who work in IT. so not health care
21 providers?

22 VENIREPERSON NO. 34: No.

23 MS. KAMYKOWSKI: All right. And this is
24 the way I like to ask this question: If you were
25 picked for this jury, and you had to sit in the

1 deliberation room and decide whether to render a
2 verdict against Mercy Hospital or not, would the fact
3 that you have friends who work there, be in any part
4 of your mind making you think that maybe you would
5 not be able to render a verdict?

6 VENIREPERSON NO. 34: No. I would able to
7 render a verdict.

8 MS. KAMYKOWSKI: All right. And you would
9 able to wait and listen to the evidence that comes in
10 at trial and listen to the instructions from the
11 judge?

12 VENIREPERSON NO. 34: Yes.

13 MS. KAMYKOWSKI: Thank you so much.

14 Anyone else on my right side?

15 Moving over to the left side.

16 I know we have someone who is a current
17 Mercy employee.

18 No. 48, you are a nurse there, correct?

19 VENIREPERSON NO. 48: Yes. I've been a
20 nurse for Mercy in wildwood for six years, and I'm
21 currently a patient at Mercy OB/GYN at Clarkson in
22 Clayton.

23 MS. KAMYKOWSKI: Dr. McNeive is not your
24 obstetrician.

25 VENIREPERSON NO. 48: No.

1 MS. KAMYKOWSKI: Okay. Congratulations to
2 all of that.

3 And I think we talked to you a little bit
4 about that. And you don't think the fact that you're
5 employed at an outpatient clinic would in any way
6 impact your ability to be fair and impartial?

7 VENIREPERSON NO. 48: No, not at all.

8 MS. KAMYKOWSKI: Thank you so much.
9 Anybody else? And we're talking about
10 employment with any Mercy entities.

11 I see no further hands.

12 Now I'm going to expand that. We talked
13 about employment because, again, if you're getting a
14 paycheck, we want to know if that's going to be a
15 bias you might have, as Ms. Gunn talked about.

16 Now I just need to know who's had
17 experiences with Mercy.

18 Patients who have current doctors there.
19 And I'm going to start narrow and get a little
20 bigger, because I think we may not have to go this
21 big.

22 who has either themselves or their spouse,
23 children, very close family members, had a baby at
24 Mercy Hospital?

25 okay. So we'll go through that.

1 No. 2, how many -- is it your children
2 that were born there?

3 VENIREPERSON NO. 2: I have three kids.

4 MS. KAMYKOWSKI: Three kids? When was the
5 last one?

6 VENIREPERSON NO. 2: 2022.

7 MS. KAMYKOWSKI: Okay. Congratulations,
8 you made it. COVID baby. 2022, so your youngest is
9 going to be 3 sometime this year?

10 VENIREPERSON NO. 2: She is 3 now.

11 MS. KAMYKOWSKI: I'm not trying to test
12 you.

13 So you have a 3-year-old?

14 VENIREPERSON NO. 2: Yep.

15 MS. KAMYKOWSKI: Okay. So when we talked
16 about the fact that your wife works at Mercy, and you
17 now have three children born there, any complications
18 with any of the labors and deliveries?

19 VENIREPERSON NO. 2: My first daughter was
20 probably 12 hours. And with the last one, she had
21 hemorrhaging.

22 MS. KAMYKOWSKI: Your wife did?

23 VENIREPERSON NO. 2: My wife, yeah.

24 MS. KAMYKOWSKI: Did your -- your wife is
25 still with us?

1 VENIREPERSON NO. 2: Yes.

2 MS. KAMYKOWSKI: So had a complication,
3 but it was resolved?

4 VENIREPERSON NO. 2: A complication, but
5 it resolved.

6 MS. KAMYKOWSKI: And when you say your
7 first one was 12 hours, what do you mean by that?

8 VENIREPERSON NO. 2: It just -- labor, we
9 got there in the morning. It was a -- I don't know
10 the push hours or whatever that is, but it was 12
11 hours.

12 MS. KAMYKOWSKI: Seem like a long time?

13 VENIREPERSON NO. 2: Yeah.

14 MS. KAMYKOWSKI: And the fact that your
15 three children were born at Mercy, coupled with the
16 fact that your wife works there, and this is going to
17 be a case where the plaintiff is going to be asking
18 for Mercy Hospitals/Mercy Clinics to award them
19 millions of dollars, does that cause you any concern
20 that you may not be fair and impartial?

21 VENIREPERSON NO. 2: It will be in the
22 back of my mind, yeah.

23 MS. KAMYKOWSKI: Okay.

24 Let's go on to the rest of the box.

25 other folks who have experiences of labor

1 and delivery at Mercy.

2 No. 3?

3 VENIREPERSON NO. 3: I feel like I'm
4 raising my paddle all the time.

5 My doctors are at Mercy, but I did not
6 deliver at Mercy. So I don't know if that qualifies
7 that question.

8 MS. KAMYKOWSKI: Oh, no. That's fine. I
9 will expand it. But the fact that you have current
10 treating providers at Mercy?

11 VENIREPERSON NO. 3: I do. My OB/GYN is a
12 Mercy doctor.

13 MS. KAMYKOWSKI: Okay. And the fact that
14 you have a current women's health doctor at Mercy,
15 and we know that this case involved a labor and
16 delivery at Mercy Hospital, is there anything about
17 that that would make you not be able to listen to the
18 evidence, follow the law and the instructions from
19 the judge, and be able to attempt to render a fair
20 and impartial verdict in this case?

21 VENIREPERSON NO. 3: No. We're good.

22 MS. KAMYKOWSKI: Let's keep going.

23 And anybody else in --

24 No. 8?

25 VENIREPERSON NO. 8: I delivered both my

1 daughters at Mercy.

2 MS. KAMYKOWSKI: Okay. How long ago was
3 your youngest born?

4 VENIREPERSON NO. 8: She's going to be 8
5 in May.

6 MS. KAMYKOWSKI: And the fact that you --
7 tell me about your experiences with labor and
8 delivery at Mercy.

9 VENIREPERSON NO. 8: I had an emergency
10 C-section with my first daughter. And then I just
11 opted for a C-section with my second. She was coming
12 late, and I was like, I'm done with this, so...

13 MS. KAMYKOWSKI: The first delivery that
14 you had with the emergency C-section, if you don't
15 mind, can I ask you do you remember what the
16 indication was?

17 VENIREPERSON NO. 8: She was breech, and
18 she was sitting -- she never moved from like 20 weeks
19 on. So we were going to try to flip her, and they
20 wanted to check her heart rate. And I went for just
21 a regular check-up, and her heart rate had
22 accelerated quite a bit in the past 24 hours.

23 Because we were awake 24 hours when we were going to
24 try and flip her, and her heart rate had gotten so
25 fast, that they got scared, and said, let's just get

1 her out now.

2 MS. KAMYKOWSKI: Everything go okay?

3 VENIREPERSON NO. 8: Yeah, everything went
4 fine. Like, I don't have any opinions strongly about
5 any of it.

6 MS. KAMYKOWSKI: Yeah. And the fact that
7 you delivered your babies at Mercy, do you think that
8 in any way you're thinking, maybe I'm going to hold
9 Mercy a little bit by the scales of justice, they're
10 going to be starting a little ahead?

11 VENIREPERSON NO. 8: Yeah, no. Huh-uh.

12 MS. KAMYKOWSKI: That's kind of where
13 we're going that we're talking about we want to make
14 sure we start this case, and the opening statements
15 start, and the evidence comes in, both parties are at
16 the starting line.

17 we don't want somebody to be a hundred
18 yards ahead. we don't want somebody to be a hundred
19 yards behind. we want somebody to be right at that
20 starting line with us, right?

21 So those are kind of the questions.

22 Anybody has their own life experiences, you can't
23 check those at the door. we just need to make sure
24 that if you have them, that, in this case, you can be
25 fair and impartial.

1 Anybody else in the box, a Mercy labor and
2 delivery experience?

3 No further hands.

4 Okay. I know there were a lot on the
5 right-hand side. See if we can start there.

6 No. 22?

7 You told us a little bit about -- the
8 delivery that you told us about before was your --

9 VENIREPERSON NO. 22: Yes. But that was
10 not at Mercy.

11 MS. KAMYKOWSKI: Okay.

12 VENIREPERSON NO. 22: So I was transferred
13 to St. Mary's at SSM. So I spent 6 weeks there or 7
14 weeks. It was a complicated pregnancy. But the two
15 after that were delivered at Mercy, no issues.

16 MS. KAMYKOWSKI: Okay. No C-section?

17 VENIREPERSON NO. 22: They were both
18 C-section.

19 MS. KAMYKOWSKI: They were --

20 VENIREPERSON NO. 22: One, I tried v-back,
21 didn't work out, I had a C-section. So obviously the
22 third was C-section.

23 MS. KAMYKOWSKI: Well, I'm sorry to hear
24 that. But, again, the same question: Is there
25 anything about the fact that you had an experience of

1 labor and delivery at Mercy that would make you
 2 either, whether it was a good experience or bad
 3 experience, hold one side or the other a little bit
 4 in the lead at this point?

5 VENIREPERSON NO. 22: No.

6 MS. KAMYKOWSKI: Thank you so much.

7 No. 23?

8 VENIREPERSON NO. 23: Three children all
 9 at big Mercy. And then two grandchildren.

10 MS. KAMYKOWSKI: oh, well,
 11 congratulations.

12 And your grandchildren were also born at
 13 Mercy?

14 VENIREPERSON NO. 23: Correct.

15 MS. KAMYKOWSKI: Anything that -- let me
 16 ask you this: Anything about those experiences that
 17 was negative, even if it's a nitpick, that I need to
 18 know about?

19 VENIREPERSON NO. 23: No.

20 MS. KAMYKOWSKI: But Nothing specific to
 21 your experience with Mercy Hospital?

22 VENIREPERSON NO. 23: No.

23 MS. KAMYKOWSKI: Thank you so much.

24 so I'll keep going down the line.

25 No. 15?

1 VENIREPERSON NO. 15: I mean, my
2 granddaughter was born -- she's 3 -- at Mercy, and
3 everything was great. I don't have any complaints,
4 and all good.

5 MS. KAMYKOWSKI: Thank you so much.
6 Were you present for the delivery?

7 VENIREPERSON NO. 15: No.

8 MS. KAMYKOWSKI: It's always a fun thing
9 to figure out if you get to be there or not, right?

10 VENIREPERSON NO. 15: Yes.

11 MS. KAMYKOWSKI: All right. Okay. Good.
12 Anybody else?

13 No. 28?

14 VENIREPERSON NO. 28: My two kids. Had
15 them there -- 11-year-old and 14-year-old -- both a
16 month early. I had the first one in the prelabor
17 area so it was quick, yeah.

18 MS. KAMYKOWSKI: Oh, you had the first one
19 early in the prelabor area?

20 VENIREPERSON NO. 28: Almost. Almost.
21 They didn't realize I wasn't faking the comfort.
22 They thought I was being dramatic.

23 MS. KAMYKOWSKI: Your husband thought you
24 were being dramatic?

25 VENIREPERSON NO. 28: No. They thought I

1 was being dramatic.

2 MS. KAMYKOWSKI: I thought you said your
3 husband. And I thought that sounds familiar, but,
4 yeah. okay.

5 so let me -- and I don't want to belabor
6 this. The people that I haven't talked to right now,
7 can you just raise your paddle if you had a labor --

8 okay. I'm just going to read these for
9 the record: No. 31, 38, 34, 41, 40, 42, 44 -- this
10 is the auction type thing. Thank you, Judge -- 48,
11 53, 52, 51, 58, and 59.

12 Rather than ask each of you, I'm trying to
13 move this along a little bit. can you tell me --
14 anybody have a negative experience with Mercy labor
15 and delivery that we have not already talked about?

16 VENIREPERSON NO. 51: Question.

17 MS. KAMYKOWSKI: Yes. No. 51?

18 VENIREPERSON NO. 51: Had my son at the
19 factory, but I think that was right prior to Mercy
20 taking over St. John's?

21 MS. KAMYKOWSKI: so it's still the same,
22 they just changed names. so the entity has always
23 been --

24 VENIREPERSON NO. 51: Yes. The answer is
25 yes.

1 MS. KAMYKOWSKI: So did you have a
2 negative experience there?

3 VENIREPERSON NO. 51: Yes.

4 MS. KAMYKOWSKI: And have we already
5 talked about that?

6 VENIREPERSON NO. 51: No.

7 MS. KAMYKOWSKI: Do you want to talk about
8 it in front of everybody, or would you like --

9 VENIREPERSON NO. 51: Sure.

10 MS. KAMYKOWSKI: well, let me ask you
11 this, rather than saying that, the fact that you've
12 now told us that you had a negative experience with
13 the birth of your son at St. John's Hospital, now
14 Mercy Hospital, do you think that might make you
15 already be leaning toward you can't be fair to Mercy
16 Hospital in this malpractice case?

17 VENIREPERSON NO. 51: Not at all.

18 MS. KAMYKOWSKI: Not at all, okay.

19 Then maybe I do need to know a little bit
20 about the facts. Maybe can you give me a thumbnail
21 of what happened?

22 VENIREPERSON NO. 51: He was born at 3:25
23 in the morning. My wife was having bad headaches
24 right after. She's not a complainer. She's very
25 good with pain. And I kept asking the nurse -- there

1 was one nurse working at 4:00, 5:00 in the morning.

2 And I asked to give her pain medicine, they gave her
3 Tylenol. Nothing was happening.

4 She, again, is not a complainer. I said,
5 she needs -- I was pretty demanding -- she needs
6 something stronger. After about an hour, they gave
7 her Demerol. She started to feel better, or at least
8 she was finally getting tired, and she was starting
9 to fall asleep.

10 So I go home, get a call at 8:00 in the
11 morning from the assistant pastor, said I need to get
12 back to St. John's quickly. She made it. She seized
13 badly three times. They almost lost her. But I
14 didn't litigate. I was thankful that the baby was
15 fine. My wife was going to be fine. But it did seal
16 the decision not to have another child.

17 MS. KAMYKOWSKI: I am so sorry to hear you
18 and your wife went through that experience. I am
19 glad to hear that everything is fine. And I really
20 appreciate you being honest and sharing that with us.
21 And thank you so much.

22 All right. Anybody else?

23 No. 41?

24 VENIREPERSON NO. 41: Yes. When I had my
25 son in 2013, when I got my epidural, the spinal fluid

1 came out, and I immediately starting having
2 deliberate headaches. I had to two blood patches
3 subsequent to that. I could barely walk for a month
4 after he was born.

5 MS. KAMYKOWSKI: You had complications at
6 Mercy Hospital labor and delivery from your epidural,
7 correct?

8 VENIREPERSON NO. 41: Yes.

9 MS. KAMYKOWSKI: Okay. And there won't be
10 any evidence in this case that there were
11 complications with an epidural.

12 The fact that you had that complication --
13 I've heard it is awful. I'm so sorry with the
14 patches and everything that you had to go through
15 that -- is there anything about that experience that,
16 looking back on it now, understanding that if you
17 were picked for this jury, you would be responsible
18 for hearing, basing a verdict just on the evidence in
19 this case, not your prior experience with Mercy, do
20 you think you could do that in a fair and impartial
21 way?

22 VENIREPERSON NO. 41: Yes.

23 MS. KAMYKOWSKI: Thank you.

24 All right. Ms. -- I think Ms. Gunn talked
25 a little bit about the fact that Mrs. Anyan and Remi

1 Anyan are not going to necessarily be in the
2 courtroom all the time.

3 That's the same for some of our witnesses.

4 Jessie wagner, the other labor and
5 delivery nurse, who I talked to you about earlier,
6 she retired from nursing to be at home with her young
7 children, and she is going to testify in this case,
8 at some point, either in person or potentially by a
9 videotaped deposition.

10 Does anybody think that one of the main
11 labor and delivery nurses in this case needs to be
12 here all the time to defend her care, and if she's
13 not, you're going to hold that against Mercy
14 Hospital?

15 I'll start here again in the box.
16 Anybody think that these nurses need to be
17 here every single day in this three-week trial?

18 I see heads shaking and no hands.

19 How about on the right-hand side?

20 Anybody, again, you guys, if you're picked
21 for the jury, you're going to be stuck with us for
22 the duration, and some of these witnesses aren't
23 going to be here.

24 Anybody going to hold that against us?

25 No?

1 okay. On the right-hand side, I see no
2 paddles.

3 Same question here on the left. Anybody
4 on the left?

5 All right. No paddles.

6 Ms. Gunn talked about hypoxic ischemic
7 encephalopathy. And then someone in response talked
8 about the term "cerebral palsy."

9 Remi Anyan has been diagnosed with
10 cerebral palsy, as well. So I wanted to make sure
11 that we talked about that condition that he has. And
12 I know a couple of folks have already responded with
13 their experience with either close friends, family
14 members, spouses, things like that, that they have
15 experiences.

16 But expanding beyond hypoxic ischemic
17 encephalopathy and talking about cerebral palsy.

18 starting here in the box, does anybody have a close
19 friend, a family member, a spouse? Anything like
20 that?

21 VENIREPERSON NO. 8: I grew up across the
22 street from a little boy who had cerebral palsy, and
23 my mom and his mom owned a restaurant, they are still
24 best friends. But he had had something that happened
25 at birth, I don't know exactly what because I was

1 pretty young. I mean, I probably haven't seen him
2 since I was like 15, maybe. But my mom still sees
3 the family quite often, and I know it was from a
4 complication at birth. That's all.

5 MS. KAMYKOWSKI: And the fact that you
6 have an experience with close friends of your family,
7 who have a child who had cerebral palsy, and I
8 presume you saw --

9 VENIREPERSON NO. 8: We actually grew up
10 with him from elementary school until we were in
11 middle school, so we spent every day with him, and we
12 sometimes went to their house in the country on the
13 weekend.

14 MS. KAMYKOWSKI: And the fact that, then,
15 you likely have witnessed firsthand the struggles
16 that a child with cerebral palsy has, the needs that
17 they have, the care needs, the therapy needs, the
18 devices that they might need, all of those things,
19 those are going to be in evidence in this case for
20 Remi.

21 Is the fact that you have that experience
22 with a close family member, do you think that if and
23 when you see Remi, and you hear the things that he
24 needs, then you're going to have that sympathy that
25 can go unchecked? You won't --

1 VENIREPERSON NO. 8: Yes, honestly, I do
 2 feel that way. I'm just a pretty emotional person.
 3 And once you started talking about it, cerebral palsy
 4 over there, I feel like I need to support them.

5 MS. KAMYKOWSKI: It would be really hard
 6 for the defense to get a fair shake from you just
 7 because of your personal experience?

8 VENIREPERSON NO. 8: Absolutely.

9 MS. KAMYKOWSKI: And you would more likely
 10 be leaning toward the plaintiff because of your
 11 experience?

12 VENIREPERSON NO. 8: Absolutely.

13 MS. KAMYKOWSKI: So the ultimate question
 14 is do you think you could be fair and impartial,
 15 knowing you have that experience in your background?

16 VENIREPERSON NO. 8: No. I mean, it's --
 17 it's -- it was very hard to have seen.

18 MS. KAMYKOWSKI: And I so appreciate you
 19 being very honest. These are the types of questions
 20 and answers that we are really looking for because
 21 this probably isn't the right case for you, right?

22 VENIREPERSON NO. 8: (Nodding head.)

23 MS. KAMYKOWSKI: Is that a yes?

24 VENIREPERSON NO. 8: Yes. I agree, yes.

25 MS. KAMYKOWSKI: And I'll open it up to

1 the rest of you. Anybody who has that same type of
2 experience, either as a teacher of special needs
3 kids, as someone who has cared for, as a therapist or
4 other provider, of special needs kids. or as close
5 friends or family members?

6 Does anybody else feel like Juror No. 8
7 here? Because you know you're going to see a child
8 who was devastatedly injured and has cerebral palsy
9 as his diagnosis. Are you not going to be able to
10 think that this is the right case for you, just by
11 hearing that very brief information?

12 Yeah, No. 61?

13 VENIREPERSON NO. 61: Sorry.

14 MS. KAMYKOWSKI: You don't get a paddle?

15 VENIREPERSON NO. 61: I don't get a
16 paddle.

17 Yes. My uncle, after my grandmother died,
18 had cerebral palsy and lived with us up until we were
19 able to get him into a home, so, yes.

20 MS. KAMYKOWSKI: You have similar feelings
21 as Juror No. 8?

22 And so no matter what I would say, those
23 personal experiences that you have would very likely
24 have you leaning towards the Anyan family because
25 they have a child that was similar to your

1 experience?

2 VENIREPERSON NO. 61: I would try to be
3 fair and impartial.

4 MS. KAMYKOWSKI: You would try to, but you
5 don't think you could?

6 VENIREPERSON NO. 61: I think I could.

7 MS. KAMYKOWSKI: You think you could?

8 So what -- typically what we have to ask
9 for is can you unequivocally assure me -- okay? --
10 that's the standard. Can you unequivocally assure us
11 and the Court that you could be unbiassed, check that
12 at the door, and be fair and impartial in this case?

13 VENIREPERSON NO. 61: I think it's been
14 enough time.

15 MS. KAMYKOWSKI: Okay. Thank you.

16 Same question starts -- I believe we're
17 here in the box. We've got No. 8.

18 Anybody else on the right-hand side with
19 the same question about cerebral palsy and special
20 needs children and the ability to unequivocally
21 assure the defense and the Court and the plaintiff,
22 because that's what we all want is that equal
23 starting line, right? That you would put us all at
24 the same starting line.

25 Anybody have a problem with that on the

right-hand side?

I see no hands -- oh, No. 31?

VENIREPERSON NO. 31: I have several students that have cerebral palsy, and I'm definitely empathetic.

MS. KAMYKOWSKI: Yeah. And can I talk to you about that just a little bit more, No. 31?

VENIREPERSON NO. 31: Sure.

MS. KAMYKOWSKI: And we talked about a little bit with Ms. Gunn about empathy versus sympathy. And I think there's a pretty fine line.

Could you agree with that?

VENIREPERSON NO. 31: Absolutely.

MS. KAMYKOWSKI: And could you stand up. I'm sorry. I know you were getting a drink, and I didn't mean to interrupt in the middle of it.

So empathy is you can feel for the people, right? That you can understand the situation they're in. And sympathy is a little bit more than that. As Ms. Gunn said, you can't -- the instructions don't allow you to bring your sympathy into this courtroom.

It's hard to check your empathy. Are you sure you've only had empathy, and that won't cross over in to sympathy that you can't get beyond?

VENIREPERSON NO. 31: When I see Remi,

1 will I probably cry? yeah. But I feel like, as
2 other teachers in this room, I think any teacher
3 would cry if you had students in similar needs.

4 MS. KAMYKOWSKI: And that visceral
5 response, because you guys have given your life at
6 being trained, and you've now been experienced
7 educators of children that are going to be very
8 similar to Remi, do you think maybe this isn't the
9 best case for you if you think the first time you see
10 him, you're going to cry?

11 No. 52?

12 VENIREPERSON NO. 52: I -- I would say
13 it's probably not the best case for me.

14 MS. KAMYKOWSKI: Thank you. I really
15 appreciate your honesty.

16 No. 31, how do you feel about that?

17 VENIREPERSON NO. 31: I would agree.

18 MS. KAMYKOWSKI: okay.

19 And, No. 11?

20 VENIREPERSON NO. 11: I'm with them, too,
21 yeah.

22 MS. KAMYKOWSKI: okay. You're with them?

23 VENIREPERSON NO. 11: Yeah.

24 MS. KAMYKOWSKI: okay. So you're
25 concerned, based just on what you've heard, very

1 limited today, about the limitations that the child,
2 that Remi, has that when the evidence comes into the
3 case, that you won't be able to be unbiased? That
4 you will lean towards him automatically?

5 VENIREPERSON NO. 11: Yes.

6 MS. KAMYKOWSKI: And is there anything
7 that the judge can -- the judge gives you evidence
8 and says you have to check your sympathy card -- the
9 judge gives you instructions that don't allow
10 sympathy to come into that, can you listen to the
11 instructions and set that aside, or do you think
12 that's too hard for you as someone who has those
13 feelings?

14 VENIREPERSON NO. 11: It would be hard.

15 MS. KAMYKOWSKI: It would be hard? Okay.
16 Anybody else?

17 Oh, sorry. No. 38?

18 VENIREPERSON NO. 38: Full disclosure.

19 Besides teaching special needs children, I have three
20 special needs children myself. Their neurologists
21 are in -- was in Mercy. And my wife also -- we
22 delivered all three of them there. And my wife did
23 her cancer treatments, so -- and I don't think
24 anything will keep me from being biassed one way or
25 the other.

1 MS. KAMYKOWSKI: And I'm not trying to
2 pry. And, again, if any question that we ask makes
3 you feel uncomfortable, and you want to have a
4 sidebar, that's totally fine.

5 Do any of your special needs children have
6 cerebral palsy?

7 VENIREPERSON NO. 38: No, autism.

8 MS. KAMYKOWSKI: Autism, okay.

9 And so you, having all of those personal
10 experiences, plus your teaching and your children, do
11 you still think that you could listen to the evidence
12 in this case, listen to the law and the instructions
13 the judge gives you, and you can unequivocally assure
14 me that you will be unbiased?

15 VENIREPERSON NO. 38: (Nodding head.)

16 MS. KAMYKOWSKI: Was that a yes?

17 VENIREPERSON NO. 38: Yes. Yes. Sorry.

18 MS. KAMYKOWSKI: Yeah. Melissa, she
19 probably can see you nodding, but I want to make sure
20 that she can get it clear.

21 All right. Yes, No. 5?

22 VENIREPERSON NO. 5: Well, it's probably
23 being one of the oldest people here, I have been
24 retired for 14 years.

25 MS. KAMYKOWSKI: From doing what?

1 VENIREPERSON NO. 5: From being a
2 pediatric dietician at Rankin Jordan Bridge Hospital.
3 So for all those years, I did see all of these
4 horrific complex medical issues with children. I
5 also enjoyed tremendously working with medical staff
6 and had all of the respect in the world for them.
7 But as I am sitting here as I am
8 listening, as you age, many people get less
9 sympathetic. I think I am getting more sympathetic.
10 So I'm just having probably a harder time than I
11 thought I would.
12 MS. KAMYKOWSKI: I'm -- and this is a very
13 serious case where this child is very injured. And
14 we're, you know, the liability, the causation, and
15 the damages are contested. That's why we're here.
16 VENIREPERSON NO. 5: Yes.
17 MS. KAMYKOWSKI: So we understand that.
18 And I understand that emotion comes into these
19 things, and I will also tell you I haven't gotten to
20 my list of other providers that you may hear from in
21 this case, but Remi has been treated at Rankin
22 Jordan.
23 VENIREPERSON NO. 5: Yes.
24 MS. KAMYKOWSKI: It is the rehabilitation
25 hospital for pediatrics in St. Louis, right? So the

1 fact now you hear he has been a patient there, and
2 your response now, you got teary when you were
3 telling us about how maybe in your golden years,
4 you're getting a little more sympathetic than maybe
5 my mom who is not. She's one of the opposites.
6 which is fine. I probably will be the same way. I'm
7 not there yet --

8 VENIREPERSON NO. 5: Well, in that
9 position, you know, I can easily separate, but you
10 don't ever forget.

11 MS. KAMYKOWSKI: And so now knowing that
12 who -- there are going to be 12 members of this jury.
13 That's the number to decides this case. If you would
14 be one of those 12, do you think when you got back
15 into that jury room with your experience knowing that
16 you're going to be deciding whether or not to award
17 Remi Anyan millions of dollars, or send him home with
18 zero, the fact that you are going to know that he is
19 a child with severe limitations, would that be
20 something that you would -- maybe this isn't the
21 right case for you, you don't think you would be able
22 to decide one way or the other?

23 VENIREPERSON NO. 5: I don't think I would
24 be fair in my decision.

25 MS. KAMYKOWSKI: You would lean more

1 towards Remi with your sympathy, you don't think you
2 would be fair?

3 VENIREPERSON NO. 5: Because I have seen
4 so many.

5 MS. KAMYKOWSKI: And I appreciate that.

6 Again, that is the kind of honest full
7 frank discussion that we need to have. I really
8 appreciate you telling us that.

9 It doesn't mean that you're not qualified
10 to be a juror in some case, but it sounds like this
11 maybe isn't the right one for you.

12 Does anybody else, again, have that
13 feeling, knowing what we've talked about that now
14 with No. 5, No. 8, No. 1? You know, about the fact
15 that in this case, where serious claims have been
16 made, a lot of money is going to be asked for, and
17 somebody is going to make a decision to award
18 millions of dollars, or send this child home with
19 zero.

20 Does anybody have qualms about that, that
21 this is just, I don't think I can do it. If I see
22 him, I'm going to cry, and I can't send him home with
23 zero?

24 Anybody have that?

25 No. 44?

1 VENIREPERSON NO. 44: You said -- when you
2 said potentially send him home with zero, that kind
3 of tugged at me a little bit.

4 MS. KAMYKOWSKI: And tell me about that.
5 why?

6 VENIREPERSON NO. 44: well, I just feel
7 like knowing that, I think I would feel like I would
8 question myself for a long time after that, if that
9 were the verdict we came to, if I did the right
10 thing, how that family's future is on me.

11 MS. KAMYKOWSKI: And, as Ms. Gunn told
12 you, the plaintiff, Remi, he has the burden of proof.
13 They have to prove more likely than not a breach in
14 the standard of care. Something these health care
15 providers did or not do that other providers, so
16 other labor and delivery nurses like Maggie, other
17 obstetricians like Dr. McNeive, would not do under
18 the same or similar circumstances.

19 That's the first element. That that then
20 caused damage to Remi, and that he sustained -- that
21 caused damage to Remi.

22 If we prove our case, if we -- if
23 plaintiff doesn't meet that burden, the law will tell
24 you you have to turn him away with zero.

25 It sounds like you would have a hard time

1 with that, even if the law told you that's what you
2 had to do.

3 VENIREPERSON NO. 44: Potentially, yes.

4 MS. KAMYKOWSKI: Anybody else feel the
5 same way as Juror No. 44?

6 Juror No. 29?

7 VENIREPERSON NO. 29: I worry about my
8 cousin's daughter who has cerebral palsy. And, yes,
9 seeing all of the difficulties that she goes through
10 on a daily basis with her daughter, as well they want
11 to travel and how difficult it is to do that. And
12 knowing that a lot of the decisions she makes, is
13 dictated by the financial situation and her access to
14 health care and Medicaid.

15 MS. KAMYKOWSKI: So I think you kind of
16 told us this probably isn't the right case for you,
17 right?

18 VENIREPERSON NO. 29: Yeah.

19 MS. KAMYKOWSKI: I really appreciate you.
20 I'm not trying to cut you off, but I really
21 appreciate you.

22 There were a couple more back here.

23 No. 26?

24 VENIREPERSON NO. 26: Yeah. I feel the
25 same way. It's too hard to make that decision. I

1 really have a hard time with that.

2 MS. KAMYKOWSKI: And the folks of you that
3 have raised your hand, similar to what the
4 conversation I had with Juror No. 44, again, not
5 going through each of you, I'm going to kind of
6 collectively do this.

7 Is anybody going to say -- let me ask. So
8 Juror No. 44 said, all right? I understand what the
9 law might be. The law is going to tell me that if
10 the plaintiff doesn't meet their burden of proof more
11 likely than not on any of those elements, so you may
12 think that the nurses were negligent, but you may
13 think that they didn't cause the damage, okay?

14 Any of those. If the answer is, no, the
15 plaintiff didn't meet his burden, you must turn him
16 away with zero.

17 Tell me again who cannot -- who does not
18 think they can do that?

19 No. 32, No. 33, and No. 39.

20 No. 39, can I talk to you about that?

21 Tell me your feelings.

22 VENIREPERSON NO. 39: Just feel like once
23 I see this child, I don't have anybody close to me
24 that's in that situation, but I feel like it would be
25 hard to go away with zero.

1 MS. KAMYKOWSKI: Okay. And so maybe this
2 is not the right case for you? Is that how you're
3 feeling?

4 VENIREPERSON NO. 39: Yes.

5 MS. KAMYKOWSKI: Because it would be hard
6 to turn a child, who's not quite 5, who relies on his
7 parents for everything, who has a brain injury, who
8 will have it permanently for the rest of his life, to
9 turn him away with nothing, even if the plaintiff
10 doesn't meet their burden, and the judge instructs
11 you that you have to find in favor of the defense?

12 VENIREPERSON NO. 39: It would be very
13 hard, yes.

14 MS. KAMYKOWSKI: Anybody else feel
15 anything other than what we heard now from 39 and No.
16 44?

17 No. 55?

18 VENIREPERSON NO. 55: I just have a
19 question. I think there's so many unanswered
20 questions. I think there's so many unanswered
21 questions, and I think it's really difficult to sit
22 here and answer the way I want to answer because I
23 really don't know.

24 For example, if we would -- if the
25 situation were to just be what was said about turning

1 away with zero, I don't know enough about birth that
2 could a child have cerebral palsy in the womb
3 already? Or is it always because of an inaction at
4 birth? I don't know that. So, to me, that would be
5 something I would need to understand more in order to
6 answer your questions.

7 MS. KAMYKOWSKI: And that's a great point.
8 So what we have been trying to figure out today is
9 who can have that same open mind, right? We're
10 talking about an open mind, checking your sympathy,
11 being able to get over your personal biases, right?

12 You sound like you will -- you want to
13 wait and hear the evidence, right?

14 VENIREPERSON NO. 55: Well, I feel like I
15 have to, right? Because if it's something that could
16 happen, I mean, I'm like the biggest cryer. And I'm
17 very empathetic and sympathetic. But I also realize
18 there are things that may or may not be contributing
19 to something. And I don't know. And I'm on the side
20 of justice, and the right decision is really hard to
21 do that.

22 MS. KAMYKOWSKI: And so it sounds like
23 what I heard you say, you understand there is a
24 plaintiff who has an injury, a very severe injury.
25 You understand there are defenses that are going to

1 be placed into evidence in this case. And you want
2 to listen to both sides. You want to start us off at
3 the same starting line. You want to hear both sides.
4 You want to then listen to the law that the judge
5 gives you, and you think you can wait and reserve
6 judgment, regardless of whether you have empathy.
7 You want to listen to the evidence. And can you
8 unequivocally assure us that we're both starting at
9 the same place right now?

10 VENIREPERSON NO. 5: Yes, I do.

11 MS. KAMYKOWSKI: With that discussion,
12 does that change anybody else's mind who talked to me
13 about this before?

14 It sounds like the rest of you are
15 pretty -- it's hard to get over the turning the child
16 away with zero.

17 okay. I see no hands.

18 I'm going to talk a little bit -- we
19 talked about what is -- in the judge's first
20 instruction this morning, she told you what the
21 definition of negligence is.

22 And what she said negligence is is the
23 failure to use that degree of skill and learning
24 ordinarily used by members of the defendants'
25 profession. So in this case the defendants are an

1 obstetrician, Dr. McNeive, and two labor and delivery
2 nurses, Jessie wagner and Maggie, okay?

3 So if they failed to use that degree of
4 skill or learning ordinarily used by members of their
5 profession under the same or similar circumstances --
6 okay? -- that means they have to be judged at the
7 time with their prospective view, that's means
8 looking forward, okay?

9 who here has heard the term "Monday
10 morning quarterback"?

11 I heard some laughs.

12 No. 59, when I say "Monday morning
13 quarterback," why don't you enlighten us to what that
14 is.

15 VENIREPERSON NO. 59: well, what it is, is
16 it's easy to come to the right decision down the road
17 when you can see all of the things that happened
18 before.

19 MS. KAMYKOWSKI: Right. And the law in
20 this case is not going to allow any of the 12 who are
21 picked for this jury to look with a hindsight, you
22 know, that Monday morning quarterback.

23 I like football. That's an analogy I use.
24 There's probably lots of other sports analogies that
25 I use. But the way I look at it is this: The

1 quarterback is in the huddle with his team, and he
2 calls a play, right? And then they go to the line of
3 scrimmage, and they're getting ready to snap the
4 ball.

5 That quarterback should be judged on the
6 play call at that time, right? Not 10 seconds later
7 when he throws an interception that they run back for
8 a touchdown. Because everybody can say, oh, geez, if
9 they just wouldn't have called that play, we know
10 that they wouldn't have scored, right?

11 So does everybody -- can everybody agree
12 to follow the law in this case that defines
13 negligence as that time the ball is on -- the play
14 has been called, and the ball's on the ground before
15 it snaps?

16 We all know that we are here because of a
17 bad outcome. We wouldn't be here if there wasn't a
18 bad outcome, right? But the law doesn't allow the 12
19 members of this jury to judge the defendants with the
20 knowledge of that outcome, okay?

21 Anybody think that they can't --
22 understanding I know it, everyone now here knows
23 that, we're here because Remi Anyan has a brain
24 injury, right? But the standard of care, whether or
25 not these defendants were negligent, they didn't know

1 he had a brain injury at the time. So they had to be
2 judged before that knowledge existed.

3 Anybody think they can't follow that law?
4 we'll start here in the box.

5 I see no hands.

6 On the right-hand side. No Monday morning
7 quarterbacking. Everybody agree that they will not
8 Monday morning quarterback this?

9 All right. I see on the right-hand side
10 no hands.

11 Here on the left, anybody have a problem
12 with that being the law that you will be instructed
13 in this case, to hold the plaintiff to that burden of
14 proof, okay? More likely than not on a prospective
15 view, no one has a problem with that?

16 Thank you very much.

17 Another analogy, specific I think for this
18 case, I think my kids are probably too young for
19 this, but anybody remember the book where's waldo?

20 Okay. And the concept of where's waldo is
21 you can't see him, you can't see him, you can't see
22 him, and then you can find him. You know, I spent --
23 I think it took me forever sometimes, hours, you
24 know, when I was a kid taking hours trying to find
25 waldo. You find him, and then don't ever forget

1 where he is, right?

2 You have that hard time understanding,
3 like your mind can't unlearn it. That -- that also
4 is part of retrospect. You've got this retrospective
5 eye that you know the outcome, or you know where
6 waldo is, you're going to go find waldo when you go
7 to look, right?

8 Again, that's not how you're allowed to
9 judge health care providers in a negligence claim.

10 Everybody here knows where waldo is. The doctors and
11 the nurses didn't know where waldo was.

12 Can anybody not set that aside, the fact
13 that we all -- we all know where waldo is?

14 Anybody have that problem in the box here?

15 How about over here on the right? I
16 presume no.

17 And the same thing over here on the left.

18 I see no hands to my where's waldo analogy.

19 quickly want to go through just a couple
20 more of the potential providers you might hear from
21 in this case.

22 There was a certified midwife in this
23 case. Her name is Tamsin Lewis. She was at Mercy
24 Hospital. Anybody think they recognize Ms. Lewis's
25 name? Tamsin Lewis, the midwife?

1 All right. I see no hands.

2 A couple of neonatologists at Mercy
3 Hospital. They're not Mercy employees. They are
4 contracted out with a company called Pediatrix, along
5 with Ms. Spencer, she works for that group, and a
6 couple of neonatologists. One's name is Gary Dreyer,
7 Dr. Dreyer.

8 Anybody think they recognize his name?

9 I see no hands.

10 And then Dr. Sandy Thakadiyil, I think is
11 how you say here name. Sandy Thakadiyil is also a
12 neonatologist who practices with Pediatrix at Mercy
13 Hospital.

14 Anyone recognize her name?

15 And the reason we ask is because if
16 somebody has -- these are all pediatric providers.

17 If your grandchildren, your children, anybody you
18 know is treating with them, we just want to make sure
19 that if evidence comes in that they were involved in
20 this case, then you could listen to it and not have
21 any biases.

22 Say, oh, I believe everything Dr. Dreyer
23 said. Or, I don't really like Dr. Dreyer, and I
24 would never listen to what he has to say. So that's
25 the reason why we ask these questions.

1 Dr. Rohit Aswani is also a neonatologist
2 in that same group. Anybody recognize Dr. Aswani's
3 name?

4 And then I'm going to go through a few of
5 Remi's current -- folks who have treated him since
6 he's been born.

7 We talked about Rankin Jordan. Anybody
8 have experiences with Rankin Jordan? He's received
9 therapies there.

10 We've already talked with you, No. 5.

11 Anybody besides No. 5 with Rankin Jordan
12 that would impact your ability to be fair and
13 impartial in this case?

14 They have therapists and other folks who
15 treat Remi. And I say, I think it was No. 21, 23,
16 and 28.

17 You're nodding your head that it would not
18 be a problem for you, is that correct?

19 VENIREPERSON NO. 28: Correct.

20 MS. KAMYKOWSKI: All right.

21 He had seen a couple of neurologists at
22 Children's Hospital. One, her name is Dr. Judith
23 Weisenberg.

24 Does anybody recognize Dr. Weisenberg's
25 name?

1 The pediatrician was Dr. Kent Killian.

2 Anybody have Dr. Killian as their family
3 pediatrician?

4 All right. I don't think we've talked to
5 you today, have we?

6 VENIREPERSON NO. 9: No.

7 MS. KAMYKOWSKI: What number are you? Are
8 you No. 8?

9 VENIREPERSON NO. 9: 9.

10 MS. KAMYKOWSKI: No. 9. Dr. Killian.

11 Tell me how you know Dr. Killian.

12 VENIREPERSON NO. 9: Well, he -- both my
13 children went to Mercy at the Wildwood location, and
14 Dr. Killian was our pediatrician. I now have a
15 5-month-old granddaughter --

16 MS. KAMYKOWSKI: Congratulations.

17 VENIREPERSON NO. 9: -- who is seeing Dr.
18 Killian.

19 MS. KAMYKOWSKI: And Dr. Killian is
20 Dr. Remi's current, I think, pediatrician. There
21 might be some records in this case that are shown
22 talking about care and treatment.

23 Dr. Killian's care is not at issue in this
24 case. I don't anticipate anybody disputing the
25 things that Dr. Killian has in his records. The fact

1 that you might hear his name, does that cause you any
2 concern about if you were picked for this jury about
3 being on this jury?

4 VENIREPERSON NO. 9: It does not.

5 MS. KAMYKOWSKI: Okay. Because I haven't
6 talked to you yet, you haven't said a whole lot.

7 Do you work currently?

8 VENIREPERSON NO. 9: I do.

9 MS. KAMYKOWSKI: Tell us what you do.

10 VENIREPERSON NO. 9: I'm in property
11 management. I work for a property management
12 company, very small, in Chesterfield valley.

13 MS. KAMYKOWSKI: What types of property do
14 you help maintain?

15 VENIREPERSON NO. 9: Commercial office
16 buildings.

17 MS. KAMYKOWSKI: And how long have you
18 done that?

19 VENIREPERSON NO. 9: Ten years.

20 MS. KAMYKOWSKI: Thus far, you've been
21 here for quite a few hours today.

22 Is there anything that's been asked so far
23 by either lawyer that there's a thought you might
24 want to answer something?

25 VENIREPERSON NO. 9: I would like to

1 inform you, just the question wasn't asked, I thought
2 it might be, whether it will make a difference or
3 not. I worked at a malpractice law firm for medical
4 malpractice for plaintiffs in St. Louis.

5 MS. KAMYKOWSKI: For plaintiffs in St.
6 Louis?

7 VENIREPERSON NO. 9: Yes.

8 MS. KAMYKOWSKI: which firm?

9 VENIREPERSON NO. 9: From '98 to 1993.

10 MS. KAMYKOWSKI: so for 13 years?

11 VENIREPERSON NO. 9: Yes.

12 MS. KAMYKOWSKI: which firm?

13 VENIREPERSON NO. 9: Hullverson,
14 Hullverson & Franklin.

15 MS. KAMYKOWSKI: Okay. And the fact that
16 you worked at a law firm for 13 years that does the
17 same type of law that Ms. Gunn and her partners do,
18 do you think that that makes you think you might
19 already think I'm suspect as a defense lawyer,
20 Mr. Willman is suspect as a defense lawyer, or
21 anything like that?

22 VENIREPERSON NO. 9: Not at all.

23 MS. KAMYKOWSKI: Okay. You can listen to
24 the evidence in this case, follow the law and the
25 instructions as the judge gives them to you?

1 VENIREPERSON NO. 9: Yes.

2 MS. KAMYKOWSKI: And you can unequivocally
3 assure me you're not going to hold it against me if I
4 ask tough questions in this case?

5 VENIREPERSON NO. 9: I'm sure.

6 MS. KAMYKOWSKI: Okay. All right.

7 Anybody else?

8 We were talking about Dr. Killian.

9 And there are a couple here on the
10 left-hand side.

11 No. 48, same question --

12 And something else, too, Dr. Killian.

13 -- any reason that Dr. Killian's name
14 being in this case that would cause you to think, oh,
15 I'm really either one way or the other? Because he's
16 in it for the plaintiff, I want to side for the
17 plaintiff automatically? I assume not.

18 But, No. 48, you said no?

19 VENIREPERSON NO. 48: No.

20 MS. KAMYKOWSKI: And you're No. 51?

21 VENIREPERSON NO. 51: Yes, ma'am.

22 MS. KAMYKOWSKI: Okay. Thank you.

23 Anybody else Dr. Killian?

24 Remi also sees a neurologist at Children's
25 called Dr. Amy Viehoever or Viehoever.

Does anybody recognize her name?

I see no hands.

And his pediatrician is also Dr. Cassandra Pruitt. I may have gotten it wrong. They may have seen Dr. Killian first and now Dr. Pruitt.

Mr. Anyan is telling me I'm correct.

Sorry about that.

But Cassandra Pruitt is his current pediatrician.

Anyone recognize her name?

He goes to school at Meramec Valley School District.

Anyone have any relationship with Meramec Valley School District?

I know we have lots of teachers on this panel, so I see no hands.

Like I said, when I'm crossing things off, it's a good thing.

Juror No. 4, you've been able to be very quiet through hundreds of questions.

Can you tell us just a little bit about you. Tell us just a little bit about yourself.

Do you work?

VENIREPERSON NO. 4: No, I'm retired.

MS. KAMYKOWSKI: Okay. What did you

1 retire from?

2 VENIREPERSON NO. 4: I worked for SLU
3 Hospital in protective services for 29 years. So
4 just enjoying life.

5 MS. KAMYKOWSKI: How long have you been
6 retired?

7 VENIREPERSON NO. 4: Oh, since 2010.

8 MS. KAMYKOWSKI: And when you say
9 "protective services," can you tell me a little bit
10 more about what your job entails?

11 VENIREPERSON NO. 4: That's -- protective
12 services is security in the hospital.

13 MS. KAMYKOWSKI: It's a big job at SLU
14 hospital, isn't it?

15 VENIREPERSON NO. 4: Well, yes, it was.
16 It was then.

17 MS. KAMYKOWSKI: And how about now that
18 you've been sitting here for a few hours listening to
19 just a little bit about what the jurors in this case,
20 if selected, would be charged with deciding?

21 Is there anything that you've heard that
22 or maybe there's a question that either Ms. Gunn or I
23 haven't asked, that you thought, man, if they ask me
24 this question -- I got that from No. 9 -- I might --
25 they might want to hear this from me? That would let

1 us evaluate whether you are a good juror for this
2 case?

3 Is there anything like that that you can
4 think of?

5 VENIREPERSON NO. 4: No, not really.

6 MS. KAMYKOWSKI: Nothing in the back of
7 your mind that thinks this might not be the case for
8 you?

9 VENIREPERSON NO. 4: No, I'm good with it.

10 MS. KAMYKOWSKI: All right. That sounds
11 great. Thank you so much.

12 Same with No. 6. We haven't heard from
13 you either. I'm going to take just a minute on you.

14 Tell us a little bit about yourself.

15 Do you currently work?

16 VENIREPERSON NO. 6: No. I'm retired from
17 St. Mary's being a nurse.

18 MS. KAMYKOWSKI: what kind of nurse were
19 you? what kind of nurse were you?

20 VENIREPERSON NO. 6: I was working with
21 the psyche ward.

22 MS. KAMYKOWSKI: And how long were you a
23 psychiatric nurse at St. Mary's?

24 VENIREPERSON NO. 6: 30 years.

25 MS. KAMYKOWSKI: Oh, my goodness.

1 How long ago did you retire?

2 VENIREPERSON NO. 6: About 15 years ago.

3 MS. KAMYKOWSKI: All right. And the fact
4 that you were in health care for that long, working
5 at St. Mary's, and this case involves a malpractice
6 claim against the other health care providers,
7 anything about what you heard so far makes you think
8 either one side or the other is not starting out on
9 an even foot?

10 VENIREPERSON NO. 6: No.

11 MS. KAMYKOWSKI: You think you can listen
12 to the evidence in this case?

13 VENIREPERSON NO. 6: Yes, I can.

14 MS. KAMYKOWSKI: Did you ever work in
15 labor and delivery?

16 VENIREPERSON NO. 6: No. But I did --
17 right now I do home care for kids. I do work with
18 disabled kids.

19 MS. KAMYKOWSKI: You work for a home care
20 company.

21 VENIREPERSON NO. 6: At my home. In our
22 home.

23 MS. KAMYKOWSKI: So disabled children come
24 to your home, and you help care for them during the
25 day?

1 VENIREPERSON NO. 6: Yes, they do.

2 MS. KAMYKOWSKI: Do you provide them any
3 overnight care?

4 VENIREPERSON NO. 6: If I have to. But I
5 haven't did that since I retired.

6 MS. KAMYKOWSKI: Do you work with a
7 private company? Or do you work with a state agency?

8 VENIREPERSON NO. 6: I work for the State.

9 MS. KAMYKOWSKI: How many children do you
10 take care of?

11 VENIREPERSON NO. 6: I have four.

12 MS. KAMYKOWSKI: You have four children
13 all at the same time?

14 VENIREPERSON NO. 6: Uh-huh.

15 MS. KAMYKOWSKI: Any of those children
16 have any type of disabilities that we've been talking
17 about here that Remi has, which are developmental
18 disabilities --

19 VENIREPERSON NO. 6: I only have one.
20 That was my grandson.

21 MS. KAMYKOWSKI: Your grandson has -- and
22 what type of developmental disability?

23 VENIREPERSON NO. 6: He has -- he started
24 out slow. And at first we thought he was disabled,
25 but right now he's 15. Good as new. I work with him

1 every day.

2 MS. KAMYKOWSKI: That's great. Good for
3 you.

4 And the fact that you work currently and
5 have for the past -- since you've been retired for 15
6 years with children with disabilities, knowing that
7 we're going to have that at issue in this case, is
8 there any reason why you think you couldn't set aside
9 your personal experiences, listen to the evidence in
10 this case, and if the evidence shows that, and the
11 plaintiff doesn't make their burden of proof, turn
12 this child who has disabilities away with no money?

13 Can you do that?

14 VENIREPERSON NO. 6: I think I can listen
15 to both sides and be fair.

16 MS. KAMYKOWSKI: And like I've said
17 before, the standard is whether you can give us your
18 unequivocal assurance that you can be fair.

19 Can you give me that?

20 VENIREPERSON NO. 6: Yes, I can.

21 MS. KAMYKOWSKI: Thank you.

22 No. 7, I don't know that we've talked to
23 you yet either. Tell us a little bit about yourself.
24 Do you work? Do you have kids?

25 VENIREPERSON NO. 7: Okay. I -- my degree

1 is in marketing, so I work for T-Mobile wireless
2 marketing for a couple of different cities. I am a
3 stay-at-home mom now, so I do not work. I -- my
4 mother is a retired pediatric nurse. And
5 unfortunately my sister has a case. Her daughter
6 fell over, and between -- when the ambulance got
7 there, and three days later she had passed. So I
8 lost my niece.

9 So I see both, being raised by a health
10 care professional, a pediatric health care
11 professional. And then seeing the other side where
12 what can happen to a child, I see both sides.

13 MS. KAMYKOWSKI: As you've sat there for
14 all these hours, is there anything in your mind, are
15 you putting one side or the other in front to start
16 before you hear any evidence?

17 VENIREPERSON NO. 7: No at all. I didn't
18 even think that my sister would do litigation, or I
19 didn't even take that route, so I don't know. I'm on
20 both sides. You know, I see, you know, whose fault
21 is it, I have no idea. The child has passed, you
22 know --

23 MS. KAMYKOWSKI: I am very sorry for the
24 loss of your niece and that your family is going
25 through that. It's unimaginable.

1 But it sounds like you will wait to hear
2 the evidence once it comes in?

3 VENIREPERSON NO. 7: Yes. Yes.

4 MS. KAMYKOWSKI: You can listen to the law
5 and the instructions from the judge?

6 VENIREPERSON NO. 7: Yes.

7 MS. KAMYKOWSKI: And wait -- and wait till
8 you hear both sides, and start both at the same
9 place?

10 VENIREPERSON NO. 7: Yes. It was a virus
11 that attacked the heart, so it was zero, you know,
12 there was nothing wrong with the child. She was a
13 perfect 8-year-old. Attacked her heart. Again,
14 within 36 hours, she had passed, so...

15 MS. KAMYKOWSKI: I'm very sorry to heart
16 that.

17 VENIREPERSON NO. 7: Yes.

18 MS. KAMYKOWSKI: And I thank you for
19 sharing that.

20 VENIREPERSON NO. 7: Yes.

21 MS. KAMYKOWSKI: No. 12. We haven't
22 talked to you, yet.

23 VENIREPERSON NO. 12: Yes.

24 MS. KAMYKOWSKI: Tell us how are you
25 feeling about sitting here for this many hours,

1 having lawyers pry into your personal information,
2 and then you just sit there and don't give us an
3 answer at all?

4 How do you feel about that?

5 VENIREPERSON NO. 12: Uh, I don't have
6 much experience with -- but I am the oldest of seven
7 kids. So from a kid standpoint, I do have sympathy
8 and empathy. But as far as malpractice and problems
9 with doctors, family members close to doctors, I
10 don't really have connections.

11 MS. KAMYKOWSKI: Nothing that you heard
12 today makes you think, oh, man, I could never turn
13 this kid away with zero? Or, oh, man, there's no way
14 I could ever find this doctor and nurses...

15 VENIREPERSON NO. 12: When I heard about
16 turning the kid away with zero, it did tug, but I'm
17 trying to stay neutral and really open to it.

18 MS. KAMYKOWSKI: So as you know, my
19 question is can you give us your unambiguous,
20 unequivocal assurance, that at this moment, we're all
21 starting in the same place, and if the evidence does
22 not support the plaintiffs' claim, that you would
23 turn Remi Anyan away with zero dollars?

24 VENIREPERSON NO. 12: (No audible
25 response.)

1 MS. KAMYKOWSKI: So you're hesitating.

2 That makes me think you are equivocating.

3 Does that sound right?

4 VENIREPERSON NO. 12: Yes. Yeah.

5 MS. KAMYKOWSKI: I really -- I appreciate
6 your honesty. Oldest of seven, what do you do for a
7 living?

8 VENIREPERSON NO. 12: I'm a chef.

9 MS. KAMYKOWSKI: okay.

10 VENIREPERSON NO. 12: At Old warson County
11 Club.

12 MS. KAMYKOWSKI: That's fantastic. All
13 right. well, I really appreciate you being honest.

14 The only other one, No. 14, we haven't
15 really heard from you either.

16 Can I talk to you for a minute?

17 VENIREPERSON NO. 14: (No audible
18 response.)

19 MS. KAMYKOWSKI: Can you hear me?

20 VENIREPERSON NO. 14: Me?

21 MS. KAMYKOWSKI: Yes. Can you tell us a
22 little bit about yourself?

23 VENIREPERSON NO. 14: I'm sorry?

24 MS. KAMYKOWSKI: Can you hear me okay?

25 VENIREPERSON NO. 14: Barely, but go

1 ahead.

2 MS. KAMYKOWSKI: Okay. Do you have
3 problems with hearing? Is that something that's been
4 a problem?

5 VENIREPERSON NO. 14: Yes.

6 MS. KAMYKOWSKI: Have you been having
7 troubles all day listening to the questions?

8 VENIREPERSON NO. 14: Picked it up. I'll
9 grab some hearing devices going forward.

10 MS. KAMYKOWSKI: Do you think you need one
11 now to finish out today?

12 VENIREPERSON NO. 14: I'm sorry?

13 MS. KAMYKOWSKI: Would it help you to have
14 one now to finish out today?

15 VENIREPERSON NO. 14: It would probably
16 help.

17 THE COURT: So why don't we go ahead and
18 take our afternoon recess.

19 (At 2:56 p.m., the jury was duly
20 admonished, and a break was taken. At 3:17 p.m., the
21 following proceedings were held in court, in the
22 presence of the jury:)

23 THE COURT: Okay. Go ahead and be seated,
24 everyone.

25 Ms. Kamykowski, you may resume.

1 MS. KAMYKOWSKI: Thank you, Judge.

2 Juror No. 14, will you be able to hear us
3 better now?

4 VENIREPERSON NO. 14: Not really.

5 MS. KAMYKOWSKI: Oh, no. well, I'm sorry
6 about that.

7 I'm about ready to sit down. But since we
8 took a 15-, 20-minute break, any question that you've
9 been asked thus far by either Ms. Gunn or myself
10 trigger something you have not already shared with us
11 that you think, man, I really need to tell these
12 lawyers that because they're trying to make sure
13 everybody is going to be fair and impartial, and
14 we're all starting out at the same starting line?

15 Anybody have any changes or anything?

16 No. 54?

17 VENIREPERSON NO. 54: It's not exactly
18 been in a category, and I feel very, I guess, callous
19 saying this, but I am trying to get a promotion at
20 work. I can't miss three weeks of work. I'm sorry
21 to put it like that.

22 I can you tell you I have a little bit of
23 empathy, too. I don't really know what else to say.
24 I am just very surprised by this. I mean, I believe
25 I can be impartial, but I -- this is a hard ask.

1 MS. KAMYKOWSKI: What is your job?

2 VENIREPERSON NO. 54: I work as a quality
3 assurance technician.

4 MS. KAMYKOWSKI: And the fact that if you
5 were stuck here with us for three weeks, and you'd be
6 sitting in this box up here listening to complicated
7 evidence, medical evidence, from experts, from the
8 parties, would your mind be wandering -- do you
9 think? -- and you might not be able to focus on the
10 task at hand, which is deciding the case in which
11 multimillions of dollars are going to be at stake?

12 VENIREPERSON NO. 54: My mind would
13 probably not be as focused as you'd like it to be,
14 and I won't be able to look back on this as a
15 positive experience.

16 MS. KAMYKOWSKI: Well, I really appreciate
17 you taking the time thinking about it and sharing
18 that with us. We will definitely keep that in mind.

19 Thank you so much.

20 Anyone else?

21 With that, I'm going to give Melissa a
22 break. She told me I talk too fast, and I'm going to
23 let Mr. Willman start with his questions.

24 Thank you, Your Honor.

25 THE COURT: Thank you.

1 Mr. Willman?

2 MR. WILLMAN: Yes. Thank you, Judge.
3 Defendants Mercy Clinic East Communities d/b/a Mercy
4 Clinic OB/GYN and Dr. Daniel McNeive

5 Voir Dire Examination

6 MR. WILLMAN: So good afternoon. Let me
7 tell you my name again because it's been awhile since
8 you heard my name: Phil Willman. And I'm here with
9 David Perron. We are representing Dr. McNeive and
10 his employer, Mercy Clinics.

11 I think you all are aware that the
12 questions that we're asking, we're not trying to pry
13 or embarrass you. But we just want to find out about
14 your life experiences, your background, your
15 attitudes to see whether this particular case is a
16 good case for you to be sitting in on a jury.

17 So I introduced myself. I don't think the
18 question's been asked, but does anybody know me? Or
19 Mr. Perron?

20 I didn't think so because I looked around,
21 and I didn't recognize anybody.

22 Also, with respect to Dr. McNeive, let me
23 give you a little more information about him. He's
24 been at Mercy practicing as an obstetrician/
25 gynecologist since 2021.

Is that right?

Almost 24 years, he's been at that hospital, the main hospital.

Giving you additional information about Dr. McNeive, does anybody think they know him or have had a family member treated by him? He's involved with the labor and delivery family.

Anybody have that experience?

okay. Thank you.

so we talked a little bit about labor and delivery and some of your experiences.

I want to make sure that we've covered this. Have any of you had a difficult labor and delivery or had a family member or a close family member who's had a difficult labor and delivery that we haven't already talked about?

Have we discussed all of those experiences?

Yes. No. 15?

VENIREPERSON NO. 15: well, my nephew's wife, I'm very close to, she has nothing to do with Mercy. I mean, they didn't get their care from Mercy. But she almost died during childbirth. She had to have several blood transfusions. She shouldn't have been allowed to go into labor. She

1 started hemorrhaging. All this happened.

2 And so it was a traumatic experience for
3 all of us. And it was just something that should
4 have -- that could have been prevented and wasn't.

5 She's alive and the baby is fine. But it was
6 traumatic. She had more than one blood transfusion.

7 And she's at this point scared to have any more

8 children, once she had those two, you know. That's

9 an experience she's been through, but Mercy was not

10 the care.

11 MR. WILLMAN: Sounds like it's fresh in
12 your mind.

13 VENIREPERSON NO. 15: Well, it was two
14 years ago.

15 MR. WILLMAN: Anything about that
16 experience that you feel would affect your ability to
17 be a juror on this case?

18 VENIREPERSON NO. 15: No. No, I don't
19 think so.

20 MR. WILLMAN: A little bit of hesitation
21 there.

22 Is there something you're thinking about?

23 VENIREPERSON NO. 15: Yeah, I think, you
24 know, to me I look at, when I'm here, what I'm
25 getting out of this is, you got this plaintiff on one

1 side, this child, who had a bad outcome, and that's
2 very traumatic. And it affects their lives and will
3 forever affect their lives.

4 MR. WILLMAN: That's true.

5 VENIREPERSON NO. 15: And then on the
6 other hand, there are other lives that will be
7 affected by the outcome of this, whatever the outcome
8 is. Their lives are all going to be affected, so we
9 want to make sure, if I was on the jury, I just want
10 to make sure that the law -- that they meet the
11 burden of the law. And if there is neglect there,
12 there's neglect, then that's how it should go. If
13 they don't prove it, they don't prove it. But
14 there's more than just one life here that's affected.

15 MR. WILLMAN: So you'd be guided by the
16 instructions in the case?

17 VENIREPERSON NO. 15: By the instructions
18 of the judge and the law, is kind where I would go
19 because in our civilized society, the law is the law.

20 MR. WILLMAN: So just to conclude, then,
21 we're both starting, both parties, are starting at
22 even playing fields, in your view?

23 VENIREPERSON NO. 15: Yeah. I don't know
24 anything about anything. I mean, I don't know
25 anything. So until I get more information, you start

1 out evenly.

2 MR. WILLMAN: Based on the information we
3 have so far, are we on a level playing field?

4 VENIREPERSON NO. 15: Sure. I don't know
5 enough yet.

6 MR. WILLMAN: And you will look at that
7 case that way at -- if you were picked as a juror on
8 this case?

9 VENIREPERSON NO. 15: Yes.

10 MR. WILLMAN: Okay. Thank you.
11 Anyone else?

12 So while we're on the topic, let's talk
13 about any bad experiences that you've had, or close
14 family members had, with a health care provider: a
15 doctor, a nurse, a hospital.

16 We've talked about some of those
17 experiences, but I want to make sure that we've
18 covered that anyone else here who's had a bad
19 experience where you felt like you just weren't
20 treated in a way that you should have been treated,
21 or your close family member has not been treated the
22 way that he or she should be treated?

23 Anyone else have that experience?

24 No. 45?

25 VENIREPERSON NO. 45: You heard the story

1 about my grandfather who died because of malpractice.
2 on the other side of my family, there was
3 another case of malpractice that my aunt was guilty
4 of and took part of. It was negligence in both cases
5 on both sides of the family.

6 My grandfather died because of pure
7 negligence. It was a high profile case. Came out
8 because there was a question of what happened. And
9 my aunt, as embarrassing as it is to say, was guilty
10 of negligence in her job which resulted in somebody
11 dying.

12 So it's -- I never thought in a million
13 years the case would turn into this. But I'm just
14 letting you know that's what I've experienced
15 personally, and it's affected both sides of our
16 family up to this day still.

17 So whether you want me here or not, that's
18 up for you guys to decide. Do I believe a fair and
19 impartial trial needs to exist? Absolutely. You
20 can't condemn somebody without all the evidence being
21 out there. But I just wanted to be fully
22 transparent.

23 MR. WILLMAN: I appreciate that. I'm
24 sorry for your experience.

25 would that affect you if you were picked

1 as a juror? would you be affected by those two
2 different experiences, which sound like they're very
3 fresh in your mind and fresh in your experience?

4 VENIREPERSON NO. 45: I mean, I would like
5 to say no. But you never know until you get there.
6 That's the best answer I can give you, sir.

7 MR. WILLMAN: I appreciate that.

8 Can you commit to us that you would set
9 those experiences aside if you were picked as a
10 juror, or is that something that you'd be thinking
11 about?

12 VENIREPERSON NO. 45: Like I say, I could
13 try. But I've had so many family and friends, some
14 of the stuff I've seen it's to say that negligence
15 doesn't exist, and malpractice doesn't exist, is
16 naive and ignorant. And stuff I've seen from them
17 and still here, it's just on a continuous basis, it's
18 just they're not equal. So it's up to you whether
19 you guys want to strike me or not. Like I said, I'm
20 trying to be fully transparent.

21 MR. WILLMAN: Are we starting out on an
22 even playing field?

23 VENIREPERSON NO. 45: I would like to say
24 yes.

25 MR. WILLMAN: Sounds like your answer is

1 no?

2 VENIREPERSON NO. 45: Yes and no. That's
3 the best I can -- I know that's a convoluted answer.
4 Sorry about that.

5 MR. WILLMAN: No, I appreciate it.
6 Anyone else?

7 No. 41, I think you had your paddle up.

8 VENIREPERSON NO. 41: Yes. My husband,
9 he's deceased now, but in 2019, he was diagnosed with
10 cancer at 41 years old. And for 6 months he was
11 dismissed on having the pain he was having. Finally
12 they did a scan and saw a tumor. It turns out it
13 metastasized over his spine. But I think, you know,
14 what I went through for 3 years with him, I feel like
15 because of his age, he wasn't taken seriously.

16 MR. WILLMAN: How about that experience,
17 would that affect you if you're picked as a juror in
18 this case?

19 VENIREPERSON NO. 41: I mean, I don't
20 think so. I think that I have a lot of empathy
21 because I've been a caregiver for a number of
22 years -- or was a caregiver. And I credit the
23 doctors at Siteman Cancer Center for keeping him
24 alive for 3 years, so I think I can be fair.

25 MR. WILLMAN: All right. So while I have

1 you up, you're a practicing attorney?

2 VENIREPERSON NO. 41: Yes.

3 MR. WILLMAN: Do you work in this field,
4 that is, in personal injury and medical malpractice?

5 VENIREPERSON NO. 41: I do not do any
6 medical malpractice, but I do personal injuries.

7 MR. WILLMAN: Personal injuries, is that
8 your field?

9 VENIREPERSON NO. 41: Yes.

10 MR. WILLMAN: So I've been in your shoes.
11 I've been picked as a juror in St. Louis City a
12 number of times for criminal cases.

13 So I'm going to ask you the question that
14 I was asked when I was on the panel: Do you feel
15 that because of your experience as a litigator, as a
16 trial lawyer, do you believe you would have more
17 influence in the jury box or on the jury than other
18 jurors that you would be deliberating with?

19 VENIREPERSON NO. 41: I don't know that I
20 would have any influence, but just with my
21 understanding of the law because of the career I do
22 for a living, if I was asked that question, I can
23 tell you the truth.

24 MR. WILLMAN: So you don't feel that it
25 would be uncomfortable for you to be a juror in this

1 case because of your legal experience?

2 VENIREPERSON NO. 41: No.

3 MR. WILLMAN: Thank you.

4 All right. Any other bad experiences with
5 health care providers that we haven't already talked
6 about?

7 No. 46?

8 VENIREPERSON NO. 46: Yeah. It was, I
9 believe, late last year, my wife had a misdiagnosis.

10 I think it was actually out of Mercy. It caused a
11 lot of distress, and that's just really fresh.

12 MR. WILLMAN: A suit was not filed?

13 VENIREPERSON NO. 46: No.

14 MR. WILLMAN: How about that experience,
15 is that something that would be on your mind if you
16 were picked as a juror in this case?

17 VENIREPERSON NO. 46: Yeah. It was
18 dragged out over a couple of months, kind of always
19 on my mind. Kind of just a bad experience overall.

20 MR. WILLMAN: So would it affect your
21 ability to sit as a juror in this particular case?

22 VENIREPERSON NO. 46: Given that it's
23 Mercy, yeah, it's similar, yeah. It's still recent,
24 and I think it would be hard for me to take out of my
25 mind.

1 MR. WILLMAN: It would be hard for you to
2 set that aside?

3 VENIREPERSON NO. 46: Yeah.

4 MR. WILLMAN: okay. Thank you.

5 Anyone else?

6 No. 22.

7 VENIREPERSON NO. 22: So I did have a bad
8 experience. I had a surgery at Mercy, but the bad
9 experience was not necessarily against the surgeon.

10 It was against the product that was put in me, and
11 therefore resulted in two revision surgeries to take
12 it back out.

13 MR. WILLMAN: Okay. That was at Mercy,
14 you did say?

15 VENIREPERSON NO. 22: Yes.

16 MR. WILLMAN: How about that experience?

17 Is that something you would be thinking about if
18 you're picked as a juror? Or something you can just
19 put aside and say, no, I'm not going to worry about
20 that? That's not going to influence my decision
21 making?

22 VENIREPERSON NO. 22: No. I don't think
23 it would influence it. It has nothing to do with
24 labor and delivery. It was a gynecologic surgery,
25 but it was unrelated. So I don't -- again, it wasn't

1 Mercy, it wasn't a physician, it was a flawed
2 product.

3 MR. WILLMAN: So something that you won't
4 be thinking about if you're picked as juror in this
5 case?

6 VENIREPERSON NO. 22: No.

7 MR. WILLMAN: All right. Thank you.

8 No. 16, did you have your paddle up?

9 VENIREPERSON NO. 16: This did not happen
10 at Mercy.

11 MR. WILLMAN: I'm sorry. I think the
12 Court wants you to stand up.

13 VENIREPERSON NO. 16: This did not happen
14 at Mercy. It was a situation that happened with my
15 father a few years ago. He had a planned heart
16 surgery, and he was a very athletic person. So all
17 of the effects that happened after surgery, a lot of
18 bad things happened, and perhaps some mistakes were
19 made in the hospital. A stroke resulted. He was in
20 the ICU for a long time.

21 I was in the ICU with him a lot of that
22 time. And I saw a lot of things that I feel like if
23 I hadn't been there, could have resulted in serious
24 things happening. It would just give me an empathy
25 for both sides.

1 I saw how hard the health care workers
2 were. I saw how devastating things can become when
3 things go wrong. So I don't feel it changes like my
4 own scale of the playing field for either side. But
5 I just mention it because you guys know what you're
6 looking for and what our experiences are in relation
7 to this. Again, it wasn't at Mercy, but it was like
8 some people said, just traumatic to go through those
9 difficult experiences. That's about it. That's my
10 contribution.

11 MR. WILLMAN: I'm sorry about that
12 experience.

13 So is that something that would be
14 affecting you if you were picked as a juror in this
15 case?

16 VENIREPERSON NO. 16: I don't believe so.

17 MR. WILLMAN: Anyone else?

18 All right. While we are on the topic,
19 let's talk about lawsuits. We're here today because
20 a lawsuit's been filed.

21 Anyone here who has filed a lawsuit
22 against anyone else for any reason except divorce,
23 custody, nothing to do with domestic relations, but
24 anyone here file a lawsuit against anyone else?

25 No. 49?

1 VENIREPERSON NO. 49: It was a car
2 accident, and it was settled out of court.

3 MR. WILLMAN: Was it resolved to your
4 satisfaction?

5 VENIREPERSON NO. 49: Yes.

6 MR. WILLMAN: Anything about that
7 experience that would affect you if you were picked
8 as a juror?

9 VENIREPERSON NO. 49: No.

10 MR. WILLMAN: Okay. Thank you.
11 No. 42?

12 VENIREPERSON NO. 42: It was very minor.
13 It was a hit and run. Totaled out our car we were
14 in. Thankfully some witnesses saw it and took down
15 the information, and we resolved it in small claims
16 court. So I was very thankful for that process and
17 the witnesses.

18 MR. WILLMAN: And you were satisfied with
19 the outcome?

20 VENIREPERSON NO. 42: Yes.

21 MR. WILLMAN: All right. Thank you.
22 No. 38?

23 VENIREPERSON NO. 38: Same thing: car
24 wreck. It was settled out of court.

25 MR. WILLMAN: And was it resolved to your

1 satisfaction?

2 VENIREPERSON NO. 38: Yes.

3 MR. WILLMAN: Okay. Thank you.

4 Anyone else?

5 No. 22? You had your paddle up?

6 VENIREPERSON NO. 22: So a car accident,
7 same thing: very minor, settled out of court.

8 And then with the surgery that I had, that
9 was a class action. It was not against a person.

10 MR. WILLMAN: Has than been resolved?

11 VENIREPERSON NO. 22: Yes.

12 MR. WILLMAN: To your satisfaction?

13 VENIREPERSON NO. 22: Yes.

14 MR. WILLMAN: Thank you.

15 Anyone else?

16 Let me ask a more specific question: Have
17 any of you or a close family member filed a lawsuit
18 against a health care provider for any reason?

19 No. 2?

20 VENIREPERSON NO. 2: I believe so. My
21 wife's side of the family, her aunt, I think, has a
22 case against Mercy. Her aunt had breast cancer, and
23 they left some devices in there.

24 MR. WILLMAN: Is that something you were
25 close to?

1 VENIREPERSON NO. 2: I'm not close to it.

2 I've heard, you know, hearsay and that, but I don't
3 know the details.

4 MR. WILLMAN: So that's not something that
5 you would be thinking about if you're picked as a
6 juror in this case?

7 VENIREPERSON NO. 2: Well, I know about
8 it.

9 MR. WILLMAN: Sure.

10 VENIREPERSON NO. 2: But, yeah, try to put
11 it aside and make a clear decision.

12 MR. WILLMAN: So you could put that aside
13 if you're picked as a juror?

14 VENIREPERSON NO. 2: Yes.

15 MR. WILLMAN: All right. Thank you.

16 Anyone else?

17 No. 23?

18 VENIREPERSON NO. 23: It's already been
19 discussed.

20 MR. WILLMAN: All right. Thank you.

21 Anyones else?

22 All right. How many of you, in your work
23 experience, have guidelines that are there to help
24 you do your job?

25 Show of hands.

1 All right. Does anyone feel that it is
2 appropriate -- do you feel it's appropriate for an
3 employee or yourself to follow those guidelines? To
4 be guided by those?

5 Does anyone have a different attitude
6 about guidelines?

7 Okay. Thank you.

8 I'm sorry. No. 15?

9 VENIREPERSON NO. 15: well, I do a little
10 bit. I mean, there are guidelines that I had when I
11 worked, but I also have a conscience. And if the
12 guidelines go against my conscience, then that for
13 me, that's conflict. So I'm just going to put that
14 out there. I mean, my conscience to me is more
15 important than any guidelines given.

16 MR. WILLMAN: So what you're saying is
17 taking an action, you would let your conscience be
18 your guide?

19 VENIREPERSON NO. 15: My conscience would
20 be my guide. Because I had an instance when I didn't
21 allow my conscience to be my guide, and I regretted
22 it. And so I swore that's never happening again.

23 And when I looked forward in my career, my
24 conscience was my guide. And I was better, and I
25 felt like I faired better.

MR. WILLMAN: Thank you.

Anyone else?

No. 31?

VENIREPERSON NO. 31: I would agree.

Sometimes especially when we feel like we have to advocate for our kids --

MR. WILLMAN: Sure.

VENIREPERSON NO. 31: Because the guidelines necessarily aren't clear, and it's not what's best for children. So I advocate for what's best for children, whether the guidelines are there or not.

MR. WILLMAN: Do the guidelines help you in some instances?

VENIREPERSON NO. 31: Yeah. Within education, just honesty.

MR. WILLMAN: That's what you're experiencing, No. 15?

VENIREPERSON NO. 15: Same experience.

MR. WILLMAN: Okay. All right.

Show of hands -- or actually paddles -- how many of you see yourself as a leader? Either in your family, your community, your workplace, your church? How many of you feel that about yourself?

Quite a few of you.

1 All right. Thank you.

2 So as you've heard, we are contesting that
3 Dr. McNeive was negligent and that he caused or
4 contributed to cause any injury to Remi Anyan.

5 But we are going to be presenting evidence
6 to you, and I wouldn't be doing my job if I didn't do
7 this, we're going to be presenting evidence to as
8 what -- if you don't believe those things. If you
9 find that plaintiff met the burden of proof on both
10 of those elements, that is negligence and causation,
11 we're going to be presenting you an alternative for
12 damages for Remi Anyan.

13 Does anyone feel that's weird? Out of the
14 ordinary? Unusual? You know, unsuspected?

15 Anyone bothered by that, the fact we're
16 going to be presenting that kind of evidence?

17 Okay. Ms. Gunn talked about punitive
18 damages. And she did tell you what the burden of
19 proof is. It's clear and convincing evidence.

20 So if you think about the burden of proof
21 in a negligence claim, preponderance of the evidence,
22 more likely than not, and beyond a reasonable doubt,
23 which is what the criminal burden of proof is. Clear
24 and convincing evidence is in between those. It's a
25 high burden.

1 Does anyone here feel that they would not
2 be able to follow the Court's instruction on that
3 burden of proof? On punitive damages? You all
4 commit you will follow that instruction?

5 You also hear that the instruction is that
6 you will have to find that Dr. McNeive intended to
7 cause harm, or that he acted with malicious
8 misconduct. That's what you will have to find if you
9 say there are punitive damages in this case.

10 Anyone feel, sitting here today, that you
11 could not be guided by that instruction by the Court?
12 That that is what the evidence that you will have to
13 find to award punitive damages?

14 Anyone not be able to do that?

15 All right. I take it by your silence,
16 that everyone will be able to follow that.

17 okay. A couple of questions of individual
18 jurors.

19 No. 17 -- excuse me -- No. 19, we haven't
20 heard from you.

21 what do you do for a living?

22 VENIREPERSON NO. 19: I'm retired.

23 MR. WILLMAN: And what did you do before
24 you retired?

25 VENIREPERSON NO. 19: I was a marketer and

1 a salesman.

2 MR. WILLMAN: And how long have you been
3 retired?

4 VENIREPERSON NO. 19: 10 years.

5 MR. WILLMAN: Enjoying it?

6 VENIREPERSON NO. 19: Sort of. Bored.

7 MR. WILLMAN: All right. You've heard a
8 lot of questions during the course of this day. Any
9 answers that you have for any of the questions I've
10 been asking of the panel?

11 VENIREPERSON NO. 19: I had difficulties
12 with the companies that I represented with their
13 guidelines. And on two occasions, I left the
14 company. And that's the only thing I can think of.

15 I --

16 MR. WILLMAN: I'm sorry.

17 VENIREPERSON NO. 19: I just felt that
18 they were uninformed and arbitrary about -- and
19 realized, didn't realize, what the cost was going to
20 be to them if we carried them out.

21 MR. WILLMAN: What company was this?

22 VENIREPERSON NO. 19: I represented a
23 company here in St. Louis which is Maritz.

24 MR. WILLMAN: Sure.

25 VENIREPERSON NO. 19: And they just didn't

1 understand the circumstance and weren't about ready
2 to listen to it.

3 MR. WILLMAN: Did that cause you to leave?

4 VENIREPERSON NO. 19: Yes.

5 MR. WILLMAN: Okay.

6 VENIREPERSON NO. 19: Started my own
7 company. I got to dissipate my own laws.

8 MR. WILLMAN: All right. Any other answer
9 you have to any of the questions that have been asked
10 during the course of this day?

11 VENIREPERSON NO. 19: No, I don't.
12 They're very thorough.

13 MR. WILLMAN: All right. Thank you.

14 No. 25, we haven't heard much from you.
15 what do you do for a living?

16 VENIREPERSON NO. 25: Retail sales manager
17 for Dobbs Tire and Auto Center. They do have quite a
18 bit of stringent guidelines that I have to follow on
19 a daily basis.

20 MR. WILLMAN: All right. And how long
21 have you been working for Dobbs?

22 VENIREPERSON 25: I've been with Dobbs for
23 going on three years now.

24 MR. WILLMAN: Any responses to any of the
25 questions that have been asked during this day?

1 VENIREPERSON 25: No, sir.

2 MR. WILLMAN: All right. All right.

3 Thank you.

4 No. 35, we haven't heard from you, as
5 well.

6 Stand up.

7 what do you do for a living, sir?

8 VENIREPERSON NO. 35: Digital marketing
9 for Granger Industrial Supplies.

10 MR. WILLMAN: All right. How long have
11 you been doing that?

12 VENIREPERSON 35: 10 years.

13 MR. WILLMAN: Any responses to any of the
14 questions that been asked here today?

15 VENIREPERSON NO. 35: No.

16 MR. WILLMAN: All right. Thank you.

17 No. 38 -- 37 -- excuse me -- we haven't
18 heard from you.

19 Yes, sir?

20 VENIREPERSON NO. 37: Hello. Sorry. Like
21 any questions I had about today or anything?

22 MR. WILLMAN: Yes. So tell us about
23 yourself. what do you do for a living?

24 VENIREPERSON NO. 37: I work retail in
25 retail management for American Eagle here at the

Galleria.

MR. WILLMAN: How long have you been doing that?

VENIREPERSON NO. 37: About 10 years.

MR. WILLMAN: Do you like it?

VENIREPERSON NO. 37: It's a job.

MR. WILLMAN: Okay. Same question: Any responses to any of the questions that have been asked today?

VENIREPERSON NO. 37: The only thing that I have like thought of, just how often I hear like the moral quandary of like how much sympathy do I have? or like when I see those things, sometimes that like, a conglomerate of like big health care, so like Mercy Hospital, like, that's millions of dollars that they just get every year.

It's just like a drop -- it's just like -- the way I think of it is, it's just a drop in the bucket to them. But this person, this family that's suffered gets awarded several million dollars. Like how does that really affect Mercy?

But then I also think, no, that's a wrong way to think of it. I also have an obligation to consider the physician and the people that have worked on this and make sure they're being evaluated

1 fairly.

2 MR. WILLMAN: So what you're telling me is
3 that you, on the one hand, you think that Mercy has
4 money, and this would be a drop in the bucket if
5 there was an award --

6 VENIREPERSON NO. 37: In some ways like
7 why not just let's give them compensation? But then
8 I know I have an obligation to evaluate both sides
9 and be impartial that way, so I would try my very
10 best to do that, but...

11 MR. WILLMAN: So will you commit to us
12 that you would do that? You would follow the
13 instructions and not be guided by kind of what you
14 think they might have like piles of money swirled
15 away somewhere?

16 VENIREPERSON NO. 37: Yeah. I think I
17 could separate it and be fair.

18 MR. WILLMAN: Thank you.

19 Anything else? Any other responses to any
20 of the questions?

21 VENIREPERSON NO. 37: No.

22 MR. WILLMAN: Okay.

23 No. 40? How are you, sir?

24 VENIREPERSON NO. 40: Doing good. A
25 little sore. I'm in construction work. I'm a

1 carpenter by trade.

2 MR. WILLMAN: I bet you're busy these
3 days?

4 VENIREPERSON NO. 40: Yes, I am. I've
5 been doing it for 40 years.

6 MR. WILLMAN: Good for you.
7 Do you like what you're doing?

8 VENIREPERSON NO. 40: I like what I'm
9 doing, but it wears you out by the end of the day.

10 MR. WILLMAN: Sure. All right. Any
11 responses to any of the questions that we've been
12 asking today?

13 VENIREPERSON NO. 40: I have really no
14 questions. The only thing I don't know, I have two
15 grandchildren that were born at Mercy within the last
16 12 years, so it's possible the doctor was my
17 grandchildren's OB/GYN.

18 MR. WILLMAN: But sitting here today,
19 that -- his name doesn't ring a bell?

20 VENIREPERSON NO. 40: No, it doesn't ring
21 a bell, no.

22 MR. WILLMAN: Thank you.

23 No. 47, we haven't heard from you.

24 VENIREPERSON NO. 47: I'm a retired
25 boilermaker, heat treater.

1 MR. WILLMAN: How long were you doing
2 that?

3 VENIREPERSON NO. 47: 36 years.

4 MR. WILLMAN: And enjoying retirement?

5 VENIREPERSON NO. 47: Yeah, first year.

6 MR. WILLMAN: Congratulations. I hope I
7 get there.

8 VENIREPERSON NO. 47: Yeah.

9 MR. WILLMAN: Any responses to any of the
10 questions I asked?

11 VENIREPERSON NO. 47: No, no responses. I
12 think it's got to happen. Something's going to
13 happen.

14 MR. WILLMAN: Meaning what?

15 VENIREPERSON NO. 47: well, I mean, it's a
16 kid, you know. And it's in response for the kid, and
17 it's always my heart. It's good. But you got to
18 listen to the evidence. All right.

19 MR. WILLMAN: So do you think that would
20 present a difficulty for you if you were picked as a
21 juror?

22 VENIREPERSON NO. 47: If you will be able
23 to present the evidence, you won't have no problem.

24 MR. WILLMAN: All right. Thank you.

25 No. 50, I don't think we've heard for you

1 either.

2 VENIREPERSON NO. 50: Hi.

3 MR. WILLMAN: Good afternoon.

4 VENIREPERSON NO. 50: Good afternoon.

5 MR. WILLMAN: what do you do for a living?

6 VENIREPERSON NO. 50: I'm in outside
7 sales.

8 MR. WILLMAN: And how long have you been
9 doing that?

10 VENIREPERSON NO. 50: For -- it will be
11 two years for my current company and six years with a
12 prior company.

13 MR. WILLMAN: Any responses to any of the
14 questions that have been asked today?

15 VENIREPERSON NO. 50: Not that I can think
16 of, no.

17 MR. WILLMAN: okay. Thank you.

18 VENIREPERSON NO. 50: Thank you.

19 MR. WILLMAN: Last, No. 58. we haven't
20 heard from you, as well.

21 what do you do for a living, sir?

22 VENIREPERSON NO. 58: Financial planning
23 specialist for stifel.

24 MR. WILLMAN: How long?

25 VENIREPERSON NO. 58: Eight years.

1 MR. WILLMAN: All right. Any responses to
2 any of the questions that have been asked today?

3 VENIREPERSON NO. 58: No, no questions.

4 MR. WILLMAN: All right. Thank you.

5 so we've been going at this for a while.

6 I'm sort of the cleanup hitter. I'm third. That's

7 not batting fourth. So I don't have a lot more

8 questions to ask you, but anything that you're

9 sitting on now that you think, oh, I need to tell Mr.

10 willman, Ms. Gunn, and Ms. Kamykowski about this

11 experience or belief or this feeling that I have?

12 Anyone sitting on anything that they haven't already

13 told us about?

14 Yes, No. 3?

15 VENIREPERSON NO. 3: So I'm a, as I said,

16 I'm a therapist.

17 MR. WILLMAN: Sure.

18 VENIREPERSON NO. 3: And I work with first

19 responders and military who have severe PTSD and in

20 crisis currently. I'm concerned that if I'm out for

21 three weeks, that my clientele will suffer. So that

22 will be on my mind, and I feel obligated by my own

23 guidelines, health care guidelines, to disclose that

24 because I think it might hinder my patients.

25 MR. WILLMAN: So you're saying it would be

difficult for you to serve for three weeks because of your job?

VENIREPERSON NO. 3: It would be. I don't have a backup, yeah.

MR. WILLMAN: All right. Thank you.
Anyone else? No. 9, yes?

VENIREPERSON NO. 9: Just one thing I didn't mention earlier, but my husband does volunteer with a special need organization, a special needs soccer association. So he's been doing that for 30-some odd years. It started with him and other people, so -- and so he is very involved in that.

And so, as a result, obviously I've gone to a lot of -- attended a lot of events, as well, and sessions that they have. So I haven't mentioned that earlier. Didn't cross my mind.

MR. WILLMAN: Anything about that experience that would affect you if picked as a juror in this case?

VENIREPERSON NO. 9: No.

MR. WILLMAN: Thank you.

Anyone else? No. 19, yes, sir?

VENIREPERSON NO. 19: Now I speak up.

MR. WILLMAN: I'm glad to hear from you.

VENIREPERSON NO. 19: Is age a factor

1 here? I'm 85. And I heard that there's a cutoff at
2 75. And does that affect the debate or?

3 MR. WILLMAN: I can't answer that, but,
4 no, there's not an official individualized age deal.

5 THE COURT: We'll address that issue
6 later, all right?

7 MR. WILLMAN: All right. Is it going to
8 be difficult for you to serve as a juror?

9 VENIREPERSON NO. 19: No. I'm here
10 primarily because I'm curious. I'd love to serve.

11 MR. WILLMAN: And you're bored, too.

12 VENIREPERSON NO. 19: And bored.

13 MR. WILLMAN: All right.

14 Anyone else?

15 No. 29?

16 VENIREPERSON 29: So I'm currently

17 unemployed, and I understand that we make \$18 a day

18 to be here. That's 10 -- no 18 to be chosen, right?

19 whatever it is, it's not enough money. And, you

20 know, if it's supposed to go three weeks as stated

21 earlier, that's a long time to not be able to apply

22 for jobs, really. I have to pay rent. It's just a

23 long time.

24 MR. WILLMAN: So you're looking for a job

25 right now?

1 VENIREPERSON NO. 29: Yeah. Are you
2 hiring?

3 MR. WILLMAN: It depends. Sure.
4 So that you would be spending time looking
5 for jobs, is that what you're telling us?

6 VENIREPERSON NO. 29: Yes.

7 MR. WILLMAN: All right. And is that a
8 difficulty for you, not being able to spend that
9 time?

10 VENIREPERSON NO. 29: I think it would,
11 but I would be here all day and thinking about this
12 case, as well as then going home and having to spend
13 time applying for jobs, which is already kind of
14 draining.

15 MR. WILLMAN: Okay. Thank you.
16 No. 31?

17 VENIREPERSON NO. 31: I think we already
18 said that I have too big of a heart because I'm a
19 teacher. But in case that wasn't the case, I'm an
20 ESL teacher, and they cannot get a sub for me for my
21 own children, which I call my kids, would not be
22 having a sub. Just something to keep in mind that,
23 yes, I care about all children, but they would not be
24 getting help at school.

25 MR. WILLMAN: So is that a difficulty for

1 you? A hardship?

2 VENIREPERSON NO. 31: Yes.

3 MR. WILLMAN: Okay.

4 No. 39?

5 VENIREPERSON NO. 39: It's a hardship for
6 me, as well. I'm a hairstylist and nobody -- there's
7 nobody that can substitute for me, and I have a full
8 book of clients. So it would be hard for me to take
9 three weeks.

10 MR. WILLMAN: Anyone else?

11 okay. No. 17?

12 VENIREPERSON NO. 17: I just wanted to say
13 I have a special needs sister. My parents are her
14 primary caregiver now, but a lot of times that will
15 be passed on to me when they are unable to do that,
16 so...

17 MR. WILLMAN: So you're saying it's a
18 family hardship?

19 VENIREPERSON NO. 17: Yes.

20 MR. WILLMAN: Okay. All right. Thank
21 you.

22 Yes? No. 33?

23 VENIREPERSON NO. 33: Same here. I have a
24 3-year-old, and I'm a stay-at-home mom. I take care
25 of her. My husband took this day off. He cannot

1 take day off that many.

2 MR. WILLMAN: Thank you.

3 And then 44. Yes, sir?

4 VENIREPERSON NO. 44: So we're a single
5 income family, and being in sales, if I'm not able to
6 work for three weeks, I'm not able to make certain
7 sales for that period of time either so that would
8 affect our income.

9 MR. WILLMAN: All right. Thank you.

10 All right. Anyone else sitting on
11 anything that we haven't talked about?

12 Yes. No. 53?

13 VENIREPERSON NO. 53: Just that same
14 thing. I mean, I got -- I got three guys that work
15 for me, and they may not be working after three weeks
16 if I'm not able to work. I've never taken three
17 weeks off in my life in a row, so I had to volunteer
18 that.

19 MR. WILLMAN: I'm sorry. What do you do
20 for a living?

21 VENIREPERSON NO. 53: I'm a civil
22 engineer.

23 MR. WILLMAN: All right. That's right,
24 you told us that.

25 And you have three employees that work

under you?

VENIREPERSON NO. 53: Yes.

MR. WILLMAN: All right. Thank you.

No. 50?

VENIREPERSON NO. 50: while we're throwing it out there, selfishly I'm at the president's club level pay. So this is our last quarter. This would greatly impact my sales numbers for the end of the year, so if it was three weeks off...

MR. WILLMAN: okay. All right. Thank you.

24?

VENIREPERSON NO. 24: while we're talking about this, my husband works from Chicago. So I, from Monday through Friday, I'm acting solo parent for my two boys. I just wanted to put it out there because transportation needs from school, to practice, you know, dental appointment, and then a lot of stuff.

MR. WILLMAN: Is it possible to get help from family members and friends for some of those things?

VENIREPERSON NO. 24: Not for three weeks.

MR. WILLMAN: Not for three weeks. Okay.

1 Anything else?

2 All right. I'm going to shut up and sit
3 down. Thank you.

4 THE COURT: All right. Ladies and
5 Gentlemen of the jury, at this time, I'm going to
6 work with the attorneys to whittle down our number to
7 the correct number for the trial.

8 (At 3:55 p.m., a break was taken, and the
9 jury panel was duly admonished. At 3:58 p.m., the
10 following proceedings were held in open court,
11 outside the presence of the jury panel:)

12 THE COURT: We are outside the presence of
13 jury.

14 Other than the one that won't stop talking
15 to Eric.

16 All right. On behalf of the plaintiff,
17 cause strikes?

18 MS. SLATER: Do you want to do hardships
19 first?

20 THE COURT: Those are cause strikes, in my
21 mind.

22 MS. SLATER: Okay. Got it. So our first
23 hardship we show is No. 1.

24 THE COURT: Is there any objection?

25 MR. PERRON: No, Your Honor.

1 THE COURT: No. 1 will be struck for

2 cause.

3 MS. SLATER: No. 2 for hardship.

4 THE COURT: Any objection?

5 MR. WILLMAN: No, Your Honor.

6 MS. SLATER: No. 3 --

7 THE COURT: I haven't gotten --

8 MS. KAMYKOWSKI: No, Your Honor.

9 THE COURT: Thank you.

10 MS. SLATER: No. 3 for hardship.

11 MS. KAMYKOWSKI: No objection.

12 THE COURT: No. 3 will be struck for

13 cause.

14 MS. SLATER: No. 5 for hardship.

15 THE COURT: Any objection?

16 MR. PERRON: No objection.

17 MS. KAMYKOWSKI: No objection.

18 THE COURT: 5 will be struck for cause.

19 MS. SLATER: No. 8 for hardship.

20 THE COURT: Any objection?

21 MS. KAMYKOWSKI: No objection.

22 THE COURT: 8 will be struck for cause.

23 MS. SLATER: No. 10 for hardship.

24 THE COURT: Any objection?

25 MS. KAMYKOWSKI: No objection.

1 MR. PERRON: No, Your Honor.

2 MS. SLATER: No. 13 for cause, Your Honor.

3 That was the gentleman in the top corner
4 up here. He talked about the situation where he was
5 delivered by emergency C-section, and it saved both
6 his mother and his life, and he said that they don't
7 believe in suing, that doctors have a lot going on,
8 and they make the best decision.

9 He thought that he and his mother were
10 going to die and that the doctor saved them. And he
11 quoted that it's not the right case for him. He was
12 leaning towards the doctor. And it would be hard to
13 set aside his experience with the fact that he has a
14 mark on his face that reminds him of it daily.

15 THE COURT: Any objection?

16 MR. PERRON: Sort of a bubble case. I
17 think there's both that are on the bubble on both
18 sides. But if the Court is inclined on that
19 language, no objection.

20 MS. PFIRMAN: We would agree with Mr.
21 Perron.

22 THE COURT: Thank you.

23 The Court does believe the fact that he
24 specifically referenced that he would be leaning
25 toward the plaintiff -- I'm sorry -- toward the

1 defendant in this context. It rose to the level of
2 cause, so the Court is going to grant that request as
3 to No. 13.

4 MS. SLATER: Your Honor, we have No. 20
5 for hardship.

6 THE COURT: Any objection?

7 MS. PFIRMAN: No objection.

8 MR. PERRON: I don't have any.

9 MS. PFIRMAN: The college --

10 MR. PERRON: Oh, that's 20. No objection.

11 THE COURT: No objection. 20 will be
12 struck for cause.

13 MS. SLATER: 22, Your Honor, for hardship.

14 MS. PFIRMAN: No objection.

15 MR. PERRON: No objection.

16 THE COURT: 22 will be struck for cause.

17 MS. SLATER: No. 23, Your Honor, for
18 hardship.

19 MS. PFIRMAN: No objection.

20 THE COURT: Any objection?

21 MR. PERRON: No, Your Honor.

22 THE COURT: 23 will be struck for cause.

23 MS. SLATER: Your Honor, No. 24 for
24 hardship.

25 THE COURT: Any objection?

1 MR. PERRON: No objection.

2 MS. PFIRMAN: No objection.

3 THE COURT: 24 will be struck for cause.

4 MS. SLATER: Your Honor, No. 31 for
5 hardship.

6 THE COURT: Any objection?

7 MS. PFIRMAN: No objection.

8 MR. PERRON: No, Your Honor.

9 THE COURT: 31 will be struck for cause.

10 MS. SLATER: 32 for hardship, Your Honor.

11 THE COURT: Any objection?

12 MS. PFIRMAN: No objection.

13 MR. PERRON: No objection.

14 THE COURT: 32 will be struck for cause.

15 MS. SLATER: Give me just a moment.

16 (Pause in proceedings.)

17 MS. SLATER: Your Honor, No. 41 for

18 hardship.

19 THE COURT: Any objection?

20 MS. PFIRMAN: No objection.

21 THE COURT: Is that a double no objection?

22 MR. PERRON: No objection, sorry, Your
23 Honor.

24 THE COURT: 41 will be struck for cause.

25 MS. SLATER: 43 for hardship, Your Honor.

MS. PFIRMAN: No objection.

MR. PERRON: No objection.

THE COURT: 43 will be struck for cause.

MS. SLATER: No. 44 for hardship, Your Honor.

MS. PFIRMAN: No objection.

MR. PERRON: No objection.

THE COURT: 44 will be struck for cause.

MS. SLATER: No. 46 for cause, Your Honor.

MR. PERRON: No objection.

MS. PFIRMAN: No objection.

THE COURT: 46 will be struck.

MS. SLATER: And I meant hardship, but you're interpreting.

we have 49 for hardship, Your Honor.

MR. PERRON: No objection.

MS. PFIRMAN: No objection.

THE COURT: 49 will be struck for cause.

MS. SLATER: we have No. 52 for hardship.

MS. PFIRMAN: No objection.

MR. PERRON: No objection.

THE COURT: 52 will be struck for cause.

MS. SLATER: Your Honor, No. 53, in response to basically an unprompted question, reported that he pays a lot of premiums for

1 professional liability insurance, he would be biassed
2 towards others who also pay premiums for professional
3 liability insurance.

4 when he was asked if he could be fair, he
5 was very equivocal in his answer. And he responded
6 again in this last round about how it would affect
7 his income, that he has people working for him, and
8 he is -- that comes from his perspective of being
9 self-employed, as well.

10 THE COURT: Any objection?

11 MR. PERRON: Your Honor, he said he could
12 probably be fair. Again, I think it's a bubble case
13 that's going to have examples on both sides debating
14 on how we're judging "probably" and "I hope," and "I
15 think maybe I could."

16 And, Your Honor, in terms of -- I haven't
17 been keeping count so far, but I don't know how hard
18 you want to push on hardships before we get the final
19 number.

20 THE COURT: I count at least 29 people,
21 before we get to the benches on the left, that have
22 not been struck for cause at this time.

23 Now I know I haven't given you an
24 opportunity to request any, but...

25 MR. PERRON: Okay.

1 THE COURT: So I'm going to strike him for
2 cause, not because of the hardship with work because
3 I don't believe that's a proper basis for it, but I
4 do believe the fact that he decided to inject
5 insurance and paying high deductibles, and he has
6 sympathy for people who have to pay large amounts of
7 money in insurance because of things like this, so
8 the court is going to grant that request.

9 MS. SLATER: Your Honor, our next one, 54,
10 is for hardship. The only time that he spoke today
11 was at the end when he felt compelled to share with
12 the courtroom that he can't miss three weeks of work
13 because it would negatively affect his employment.

14 He said his focus would not be able to be
15 with this important case. And that if he were made
16 to serve in the way it would affect his job, he would
17 not look on this as a positive experience. We think
18 that's very prejudicial to the plaintiff in the sense
19 that we would be asking for someone's focus and to be
20 listening to our evidence as we have the burden of
21 proof.

22 THE COURT: If I strike everybody who
23 claims that they have a work-related issue, we won't
24 have a jury. I don't believe the fact that he wants
25 a promotion is sufficient, and he didn't indicate

1 that he couldn't pay attention, he just said that it
 2 might not be what you want it to be. I don't know
 3 what that means, but I'm going to deny that request.

4 MS. SLATER: Your Honor, our next one is
 5 56 for hardship.

6 THE COURT: Any objection?

7 MR. PERRON: No objection.

8 MS. PFIRMAN: No objection.

9 THE COURT: 56 will be struck for cause.

10 MS. SLATER: And those are plaintiffs'
 11 cause strikes, Your Honor.

12 THE COURT: Thank you.

13 On behalf of the defense, Mercy Hospitals?

14 MS. SLATER: Oh, Your Honor, if you don't
 15 mind, let me check my notes. Oh, Your Honor, 59 we
 16 would move to strike for cause, as well. He is a
 17 physician with -- he's a retired physician with St.

18 Luke's. And Mr. willman asked questions about being
 19 involved in litigation, and we have found some
 20 information that he has been a party to a lawsuit
 21 twice, which he did not disclose. So we --

22 THE COURT: That question was never asked.
 23 They asked whether or not they had filed a lawsuit.
 24 So did he file this lawsuit, or was he the
 25 respondent?

1 MS. SLATER: I believe he was the
2 defendant in this lawsuit.

3 THE COURT: Then that may not have been
4 responsive to the question.

5 MS. SLATER: So as far as his experience
6 being similar to the defendant's experience, being a
7 physician at a hospital system, we would move to
8 strike him for cause. He shared that, throughout
9 this, that when he was answering questions, that he
10 had an experience that was similar to plaintiffs.

11 THE COURT: I'm going to deny that request
12 for cause. He indicated that he could be fair and
13 impartial. And the fact that he did not disclose
14 being sued, was not responsive to the question that
15 was asked.

16 MS. SLATER: Thank you, Your Honor.

17 THE COURT: On behalf of Mercy Hospitals?

18 MS. KAMYKOWSKI: And, Your Honor, we're
19 now just talking about our cause? we're done with
20 hardships? Or do we also do them both?

21 THE COURT: Unless you have a hardship, I
22 consider -- I consider a hardship cause.

23 MS. KAMYKOWSKI: Okay.

24 THE COURT: So I don't distinguish between
25 the two.

1 MS. KAMYKOWSKI: Well, we would start with
2 No. 11. I believe that when I was asking her
3 questions, she very clearly said that she would not
4 be able to, even if the plaintiff didn't meet their
5 burden of proof, turn Remi away with no money. And I
6 don't think that makes her someone who would not
7 follow the, not follow the instructions.

8 THE COURT: Any objection?

9 MS. SLATER: No, Your Honor.

10 THE COURT: 11 will be struck for cause.

11 MS. KAMYKOWSKI: Your Honor, I think No.

12 14, I'm not really sure what happened. 12 first?

13 MS. PFIRMAN: Your Honor, we'd also like
14 to move to strike No. 12 for cause. She was the one
15 that was the oldest of seven kids, and she was
16 equivocating about turning Remi away with any money.

17 THE COURT: Any objection?

18 MS. SLATER: Yes, Your Honor. She exactly
19 was equivocating about that, and was not asked a
20 follow-up question saying that she -- she just said,
21 I'm equivocating if I could send him away with zero,
22 and she said, it tugged at my heart, but I'm trying
23 to be neutral.

24 So I don't think she was properly
25 questioned enough to have expressed a bias that would

1 make her unable to serve. And she was also called
2 out by defense counsel. She did not answer any of
3 those questions or volunteer when those questions
4 were originally asked.

5 THE COURT: The Court is going to deny the
6 request for cause as the Court does not believe that
7 she ever indicated she could not follow the Court's
8 instructions, and, therefore, it does not rise to
9 that level. So that will be denied.

10 MS. KAMYKOWSKI: The next would be, Your
11 Honor, hardship for No. 14. I'm not really sure. We
12 spent the first 4 hours of voir dire with him not
13 indicating that he couldn't hear us -- could not hear
14 us. And then we had a pretty big issue with that.
15 And I'm not sure if the offered remedy of the Court's
16 assistive devices would fix the problem.

17 THE COURT: Any objection?

18 MS. SLATER: Your Honor, we don't have
19 much information beyond that.

20 THE COURT: The Court is going to grant
21 the request for cause. The Court did ask about
22 hearing issues, he did not volunteer that
23 information. Now, that begs the question of whether
24 or not he heard the question, but out of an abundance
25 of caution, we'll strike him for cause.

1 MS. KAMYKOWSKI: The next would be No. 15.

2 She indicated that although she is not going on
3 spring break, she is watching her youngest grandson
4 for the next week of trial while the rest of their
5 family is out of town on spring break.

6 THE COURT: I don't think it was quite
7 that they were out of town, they were working.

8 MS. KAMYKOWSKI: Oh, she was watching her
9 grand kids the 17th through the 23rd.

10 THE COURT: I -- I believe she was never
11 asked whether or not she could figure out any
12 alternatives to that care, so the Court is not going
13 to grant that request.

14 MS. KAMYKOWSKI: No. 26, Judge, for the
15 same reasons as No. 11. She was -- there were
16 multiple people on that side of the panel who, in
17 their questions with respect to whether they could
18 turn the plaintiff away with no money if they had not
19 met their burden of proof, she very clearly said she
20 would not be able to do it. She also had a hard time
21 with the burden of proof when Ms. Gunn was asking her
22 questions. That it was possible that she could
23 change her mind, not sure --

24 THE COURT: Let me short circuit this.

25 Is there any objection?

1 MS. SLATER: No, Your Honor.

2 THE COURT: She will be struck for cause.

3 MS. KAMYKOWSKI: Thank you.

4 No 29, Your Honor. This was the woman
5 whose mother-in-law works as a physical therapist at
6 Mercy, but she has all kinds of issues. She doesn't
7 have a job, which I know we're not looking at
8 specifically, but she has obstetrical complications
9 with her sister-in-law. She just thinks that -- she
10 had a lot of issues of prior malpractice issues and
11 did not think that she could be unbiased in the
12 situation, and she would lean toward the plaintiff.

13 THE COURT: Any objection?

14 MS. SLATER: Yes, Your Honor. I have down
15 that she could potentially set the medical
16 experiences that she's had aside. She -- just
17 reviewing my notes very quickly.

18 The information that she shared seemed to
19 be other family members, and I don't believe that she
20 said she couldn't be fair or that she couldn't listen
21 to the court's instructions and follow the law. So
22 this one, in particular, I don't think it rose to the
23 level of being able to say she couldn't be fair. And
24 it sounds like she was communicating that she would
25 work to be putting those things aside.

1 MS. KAMYKOWSKI: And I think on top of her
2 malpractice issue, she had experience with her cousin
3 whose child had cerebral palsy, and she was very
4 emotional about that and very similar to the
5 situation in this case, and she wouldn't be able
6 to -- that experience would make her lean toward the
7 Anyans, and she would have a hard time turning them
8 away with zero, but she said this is not the right
9 case for her.

10 THE COURT: The totality of the
11 circumstances with regards to No. 29 rose to the
12 level of cause, so the Court is going to grant that
13 request.

14 MS. KAMYKOWSKI: Similarly, No. 33, Your
15 Honor.

16 THE COURT: Any objection?

17 MS. SLATER: No, Your Honor.

18 THE COURT: No. 33 will be struck for
19 cause.

20 MS. KAMYKOWSKI: No. 36, Judge. She has
21 a 2-year-old she takes to speech therapy twice a
22 week. She said she had no one else to take that
23 child. She does have another child with an
24 appointment. I think she might have been able to
25 reschedule that. She has a bias against health

1 care providers. This weighs on her. She thought she
2 might be able to listen to the evidence. But when
3 she was asked about whether she could unequivocally
4 assure, she was unable to do so.

5 THE COURT: Response?

6 MS. SLATER: Your Honor, I don't have
7 those notes for her. She talked about speech therapy
8 and the child with a wellness appointment, but we
9 don't have any -- two of us, who were taking copious
10 notes, don't have any notes. I think that's confused
11 that she said she had a biased against health care
12 professionals.

13 As far as the speech therapy appointments,
14 I'm not sure that that was followed up with very
15 completely, and we had other parents who had
16 appointments that were being rescheduled.

17 THE COURT: She did indicate she couldn't
18 reschedule them, and that there wasn't anybody else
19 who could take the child. And as much as I agree
20 with you, that I don't recall her saying any of the
21 other things, I don't know that I can force her to
22 not be able to take her children for 3 weeks in a row
23 to speech therapy. So the Court is going to grant
24 that request.

25 MS. KAMYKOWSKI: No. 37, Judge, for cause.

1 This gentleman talked about his moral quandary where
2 he had sympathy for the plaintiff, and it was a drop
3 in the bucket for Mercy to just pay the family
4 millions and millions of dollars.

5 THE COURT: He indicated very clearly that
6 he could set that aside. The Court does not believe
7 that it rose to the level of cause.

8 when asked whether or not he had anything
9 to contribute, essentially that was the only thing
10 that he could think of to contribute. And he
11 understands that he has to hold the plaintiffs to
12 their burden. So the Court is going to deny that
13 request.

14 MS. KAMYKOWSKI: No. 38, the special needs
15 teacher who has three special needs children at home
16 who are all on spring break. I think I said it might
17 be possible to get people to cover for him, but he
18 didn't say that he would be able to find that. He --
19 I think that's it, Judge:

20 THE COURT: He indicated that he could
21 probably figure it out. He did not follow up with us
22 with regards to that afterwards, and he spoke
23 numerous times after he told us that at the lunch
24 hour. So the Court is going to deny that request for
25 cause.

1 MS. PFIRMAN: Your Honor, No. 39, we move
2 to strike for cause. She said that once she sees the
3 child, Remi Anyan, she won't be able to turn him down
4 with zero. She said it's not the right case for her,
5 even if plaintiff doesn't meet their burden.

6 MR. PERRON: I had down that she said it
7 would be very hard for her to follow the law.

8 THE COURT: In response to which question?

9 MR. PERRON: Just the follow-up to that
10 same one. Once she saw the child, she wouldn't be
11 able to give zero. It would be very hard for her to
12 follow the law.

13 THE COURT: The only thing I show is that
14 she said it may not be the right case for her. And I
15 don't think that meets the legal standard for cause.
16 And although she may be desirous of working, I don't
17 know that her work schedule is something that the
18 court is going to be able to honor. So the Court is
19 going to deny that request.

20 MS. KAMYKOWSKI: Your Honor, just to make
21 sure the record's clear, your notes don't indicate
22 that she was one of the respondents who said that she
23 couldn't send the child down with zero.

24 THE COURT: No. Maybe I'm wrong. I don't
25 see that in my notes.

1 MS. KAMYKOWSKI: There was one point in
2 time when I was cleaning it up, and I just went
3 through and just asked them to raise their paddles,
4 and I just wrote down all of the -- we had 5 or six
5 people in a row that I didn't individually voir dire,
6 and she was one of them that raised her hand with
7 what paddle that she could not turn him away with
8 zero.

9 THE COURT: No. No. The question was
10 would you have a hard time sending him home with
11 zero? It wasn't that you couldn't do it, and you did
12 have them raise their paddles. And she said that it
13 may not be the right case for her, but that's all
14 that was said. That doesn't rise to cause.

15 Next?

16 MS. KAMYKOWSKI: No. 45, Your Honor. He's
17 the one with very significant malpractice history in
18 his family. He was almost crying.

19 THE COURT: Any objection?

20 MS. SLATER: No objection.

21 THE COURT: 45 will be struck for cause.

22 MS. KAMYKOWSKI: I'm sorry. I did get
23 something incorrect, Your Honor. No. 55 was the
24 grandparent who's able to watch the child next week
25 while the rest of them are on spring break, so it's a

1 hardship for her.

2 THE COURT: Any objection?

3 MS. SLATER: I'm sorry. We're on 55?

4 THE COURT: Correct.

5 MS. KAMYKOWSKI: Yes.

6 MS. SLATER: So, Your Honor, our notes
7 conflicted. I wasn't sure whether she said for the
8 whole or just on the 17th, she was babysitting.

9 MR. PERRON: Through the 18th.

10 MS. GUNN: I wrote down March 18th.

11 what day of the week is that?

12 MS. PFIRMAN: That's a Tuesday.

13 MS. SLATER: She's here on a Tuesday, so I
14 don't know. I don't think defendants followed up
15 with her, and she responded many times when asked and
16 said that she could be fair to both sides. In fact,
17 she said she's on the side of justice.

18 MS. KAMYKOWSKI: I wrote down she was
19 babysitting 3/17, the week of spring break, while the
20 rest of her family was going on spring break.

21 THE COURT: I do believe that she's
22 watching grandchildren, so the court is going to
23 grant that request for cause.

24 MS. KAMYKOWSKI: I think that's all on
25 behalf of us, Judge.

1 THE COURT: On behalf of Mercy Clinics and
2 Dr. McNeive?

3 MR. PERRON: Your Honor, No. 42 for
4 hardship responded that she was babysitting on
5 Tuesday. Again, I don't know if the court followed
6 up on whether or not she could find a replacement.
7 This is 42.

8 THE COURT: Does anybody else have any
9 notes with regards to that?

10 MS. SLATER: Yes, Your Honor. I have that
11 she babysits grand kids on Tuesday, and she can't
12 reschedule. Today is Tuesday. She was able to
13 accommodate the court today. And defendants -- and
14 no other parties followed up with her. We have no
15 other explanation about that. So she stated it and
16 expressed she could reschedule, as evidenced by
17 today.

18 THE COURT: That will be denied for cause.
19 Anyone else?

20 MR. PERRON: No, Your Honor.

21 THE COURT: By my count, Juror No. 1 would
22 be Chapman. No. 2 would be Dixon. No. 3 would be
23 Moore. No. 4 would be Schneider. No. 5 would be
24 Keith. No. 6 would be Sproull. No. 7 would be
25 Spurr. No. 8 would be Grant. No. 9 would be

Williams. No. 10 would be Durham. No. 11 would be Reinhardt. No. 12 Taormina. No. 13 Waldrup. 14 O'Neill. 15 Rootz. 16, I'm not going to try to say, but is No. 34 on our chart. No. 17 would be Mr. Smith. 18 would be Adams. 19 would be Hill. 20 would be Levinson. 21 would be Morgan. And 22 would be Sullins.

Does anybody else get a different count?

MS. GUNN: No, ma'am.

And that's with the two alternates?

THE COURT: Correct.

MS. GUNN: Got it.

THE COURT: You each get one pick for the alternate pool, so we need four people. You pick one, they pick one.

Because you guys only do things as a unit, so you only get three strikes for peremptory.

MS. GUNN: Yes.

THE COURT: As do you.

So do you need 5 minutes?

MS. PFIRMAN: Yes, please.

MS. GUNN: Thank you.

THE COURT: Have them go back.

(At 4:26 p.m., the Court duly admonished the jury panel, and proceedings stood in recess. At

1 4:48 p.m., the following proceedings were held in
2 open court, outside the presence of the jury panel:)

3 THE COURT: So we are outside the presence
4 of the jury.

5 On behalf of the plaintiff, the proposed
6 peremptory strikes are Juror No. 15, which would be
7 Sproull and No. 21, which would be Reinhardt, and 35,
8 which would be Smith.

9 Are there any motions with regards to
10 those strikes?

11 MS. KAMYKOWSKI: No, Your Honor.

12 THE COURT: That will be granted.

13 with regards to defendants' strikes, it
14 would be No. 12, Keith; No. 28, O'Neill; and 36,
15 Adams.

16 Are there any motions with regards to
17 those?

18 MS. SLATER: No, Your Honor.

19 THE COURT: And then on behalf of the
20 plaintiff, their alternate strike is No. 40, Morgan.
21 Any motions with regards to that?

22 MS. KAMYKOWSKI: No, Your Honor.

23 MR. PERRON: No, sir.

24 MR. WILLMAN: No, Your Honor.

25 THE COURT: On behalf of the defendants,

1 their alternate strike is 38, Hill.

2 Any motions with regards to that?

3 MS. SLATER: No, Your Honor.

4 THE COURT: Those will all be granted.

5 Are we ready to bring the jury in so we
6 can get them seated and get them on their way for the
7 evening?

8 MR. WILLMAN: Yes, Your Honor.

9 MS. SLATER: Yes, Your Honor.

10 MS. KAMYKOWSKI: Yes, Your Honor.

11 THE COURT: Juror No. 1 is Chapman. Juror
12 No. 2 is Dixon. No. 3 is Moore. No. 4 is Schneider.
13 No. 5 is Spurr. No. 6 is Grant. No. 7 is Williams.
14 No. 8 Durham. No. 9 is Taormina. No. 10 is Waldrup.
15 No. 11 is Rootz. No. 12 is that name I'm not going
16 to try to say. And our alternates are Levinson and
17 Sullins.

18 (At 4:55 p.m., the following proceedings
19 were held in open court, in the presence of the
20 jury:)

21 THE COURT: All right. On behalf of the
22 plaintiffs, does the jury as seated comport with your
23 legal strikes?

24 MS. SLATER: Yes, Your Honor.

25 THE COURT: On behalf of Mercy Hospitals,

1 does the jury as seated comport with your legal
2 strikes?

3 MS. KAMYKOWSKI: Yes, Your Honor.

4 THE COURT: On behalf of Mercy Clinics and
5 Dr. McNeive, does the jury as seated comport with
6 your legal strikes?

7 MR. WILLMAN: Yes, Your Honor.

8 THE COURT: Very good.

9 All right. Ladies and gentlemen of the
10 jury, at this time it's now almost 5 o'clock, so we
11 are going to go ahead and end for the evening.

12 (At 4:56 p.m., the hour of adjournment
13 having arrived, the jury, being duly admonished by
14 the court, by agreement, is allowed to separate for
15 the evening, under the usual instructions of the
16 court, until wednesday, March 12, 2025, at 9:00 a.m.)

17 o o o

18 Wednesday, March 12, 2025

19 o o o

20 (At 8:48 a.m., the following proceedings
21 were held in open court, outside the presence of the
22 jury:)

23 THE COURT: We are here on the record
24 outside the presence of the jury in the matter of
25 R.A. vs. Mercy Hospitals, et al., Cause No.

21SL-CC03944.

At this time, on behalf of the defendant, Mercy Clinics, as well as Dr. McNeive, there was a motion, is that correct?

MR. PERRON: Yes, Your Honor.

Your Honor, there were two separate pretrial rulings regarding the punitive damages claims, and we just wanted to preserve our objection before we started into evidence with the jury.

Number one, with regards to the punitive damages against Dr. McNeive, we'll rest on our previously filed memoranda in opposition that leave should not have been granted to amend the punitive damages against Dr. McNeive.

If I could spend just a minute on the substantive argument with regards to punitive damages against Mercy Clinics. I went back and reviewed the motion we took up last week, the motion to amend the previous order and to amend petition by interlineation.

The prayer for relief in that motion to amend by interlineation, I went back and reread it.

It was in two parts. Plaintiff asked the Court, number one, to amend the previous order by interlineation, and also to allow them to amend the

petition by interlineation.

I brought it to the Court's attention.

And I just wanted to re-bring this process issue to

the Court's attention. The only thing the court

granted with the relief requested in their pleading,

which was, in part, to amend their previous order by

interlineation.

Interlineation, in legal concept, is

literally, in Latin, writing between the lines, going

back to the days when there wasn't e-filing and word

processing and things like that. Interlineation is a

proper process for amending a pleading.

Amending a previously made order by

interlineation is simply not proper process. All

that is on the record right now is an order granting

a prayer for relief to amend a previous order by

writing in between the lines, which is, in my opinion

and review of the case law, simply is not a proper

way, not a proper process, to change a previously

made order, especially in the substantive way that

adds a new significant substantive claim against an

additional party.

I believe that it is improper process and

invites significant substantive prejudicial error in

these proceedings.

1 MS. SLATER: Your Honor, we -- the motions
2 and request for leave that we filed previously, we
3 believe are legally sound to the extent that we
4 understand the Court's ruling granting that motion
5 for leave to amend, both the order and petition by
6 interlineation.

7 We -- the discussion off the record in
8 front of the Court was that the original order should
9 have always included both the doctor and his
10 practice, Mercy Clinics.

11 And to the extent the record needs to be
12 clear whether it is a motion to amend by
13 interlineation or a motion to the Court to amend the
14 order, we would follow what the Court's original
15 ruling was, that is the relief the plaintiffs
16 requested and was granted by the Court.

17 To the extent that that order then allows
18 us to amend our petition by interlineation, that is
19 what we sought to do to correct the record in that
20 manner, but all parties understood what the Court's
21 original intent was in the granting of our original
22 motion for leave to add punitives.

23 THE COURT: Thank you. The Court is going
24 to deny the defendants' motion and will allow it to
25 stand as it is.

1 MS. SLATER: Your Honor, we have one brief
2 other matter to put on the record before we get
3 started with evidence today.

4 we would like to make an oral motion in
5 limine to -- and I don't believe this was taken up at
6 the pretrial -- the way in which the questions have
7 been asked of witnesses based on discovery issues,
8 such as the photograph issue we've been talking
9 about, have been extremely accusatory in the sense
10 of, and these pictures that we just received, and
11 comments to that nature.

12 So we would ask orally for a motion in
13 limine that the Court restrict any argument or
14 suggestion to the jury of any discovery disputes in
15 the case, which is common practice. But to this
16 issue specifically about the pictures, we ask that
17 any discovery issues, and the Court's rulings on
18 those issues, not be suggested or argued to the jury
19 in the form of questioning of the witnesses and any
20 other manner by defense counsel.

21 THE COURT: Since the photographs are not
22 coming into evidence, I don't see how they would be
23 able to say that in their questioning.

24 MS. KAMYKOWSKI: And that was my
25 understanding of the ruling, was that nothing that

1 was late produced is going to be utilized in the
2 case.

3 THE COURT: Correct.

4 MS. SLATER: And from the perspective
5 of -- and we have had a lot of discovery issues
6 pretrial -- our request would be that we did not file
7 a specific motion in limine stating, do not bring up
8 discovery issues. We would ask that that be a
9 blanket order of the court.

10 MS. KAMYKOWSKI: I believe that was a
11 defense motion. That was agreed.

12 THE COURT: Yeah.

13 MS. SLATER: We just want to make sure we
14 understand the ruling.

15 THE COURT: Understood.

16 MS. SLATER: Thank you.

17 MS. KAMYKOWSKI: Your Honor, I have a copy
18 of defendants' exhibit list for the Court and
19 counsel, if you'd like it.

20 THE COURT: Thank you.

21 And do we have a copy of any transcripts
22 that we anticipate getting to today or tomorrow?

23 MS. GUNN: Yeah. Greenwald, I think, is
24 the only one --

25 THE COURT: That's fine. And will you get

1 a copy of that for my court reporter?

2 MS. GUNN: Of course we'll get her a copy.

3 THE COURT: Let's go off the record.

4 (A discussion was held off the record.)

5 THE COURT: The question was whether or
6 not the plaintiff could require the defense to

7 remove, from their opening argument, a notation that

8 Dr. McNeive has had no prior lawsuits for medical

9 malpractice.

10 The Court has ruled that they do not need

11 to take that out of their PowerPoint, in that

12 punitive damages are at issue. The plaintiffs are

13 not waiving, in any respect, their objection to that

14 issue.

15 (At 9:07 a.m., the following proceedings

16 were held in open court, in the presence of the

17 jury:)

18 THE COURT: Good morning, everyone.

19 Before I let you all sit --

20 And you all can sit.

21 Before I let you sit, let me go ahead and

22 have you swear the oath.

23 Please raise your right hand.

24 (The jury was sworn by the Court.)

25 THE COURT: Thank you.

1 very good. Go ahead and have a seat.

2 (A discussion was held off the record.)

3 THE COURT: All right. Ladies and
4 gentlemen, at this time, I'm going to read to you an
5 instruction.

6 (The instructions were read to the jury by
7 the Court.)

8 THE COURT: I want to impress upon you
9 that although sometimes it seems like it would be
10 really easy, when you go back to deliberations, to
11 just ask for a copy of the transcript of what was
12 said during a particular portion of the trial, it
13 doesn't work like that. So we need everybody to pay
14 attention. If that means taking notes, wonderful.
15 If it means just listening, that's fine too.

16 But just know that -- that if you are not
17 keeping up with paying attention, you may miss
18 something. And in this case, that may be something
19 important. So do your best to keep yourself focused.

20 All right. On behalf of the plaintiff,
21 you may make your opening statement at this time.

22 Opening Statement on Behalf of Plaintiffs

23 MS. GUNN: Thank you, Your Honor.

24 May it please the Court?

25 THE COURT: It does.

1 MS. GUNN: Ladies and gentlemen of the
2 jury, good morning. I want to say good morning to
3 everyone. As you know, my name is Amy Gunn, and I
4 represent Remi Anyan by and through his mother and
5 father, Blake and Sarah.

6 Obstetricians and labor and delivery
7 nurses must act when a baby such as Remi shows signs
8 of repeated distress through their fetal monitoring
9 strips. And if they don't, and the baby's brain is
10 damaged from lack of oxygen or blood flow because the
11 signs were neglected or purposefully ignored, the OB
12 doctors and the labor and delivery nurses should be
13 responsible.

14 This trial is about Dr. McNeive and two
15 Mercy nurses, who together, purposefully and with
16 knowledge of the consequences, told Sarah to continue
17 pushing in the second stage of labor for over 12
18 hours, which is 8 hours after it is considered
19 prolonged by the American College of Obstetricians
20 and Gynecologists, also known as ACOG.

21 It is the longest, by 4 hours, by Dr.
22 McNeive's experience, which included over 3,000
23 deliveries over his career. And it is the longest
24 either of the Mercy nurses had ever seen, also by at
25 least 4 hours. 12 hours is 200 times longer than

1 4 hours, which, again, is what the American College
2 of Obstetricians and Gynecologists considers
3 prolonged.

4 Dr. McNeive and the two Mercy nurses
5 disregarded hospital protocols with respect to the
6 administration of Pitocin, which is a high-risk
7 medication used to increase the strength of
8 contractions. When contractions occur, the uterus
9 compresses and compresses the baby. That decreases
10 the baby's blood flow. The baby doesn't breathe in
11 utero.

12 The baby's brain stays alive, his body
13 stays alive because of the blood flow that goes to
14 the brain and carries oxygen to the brain. When a
15 baby is going through pushing, in the second stage of
16 labor, the contractions themselves compress and
17 reduce that blood flow. When the contractions end,
18 there's a recovery period. When you add Pitocin to
19 that mix, those contractions get stronger, the
20 pressure gets higher.

21 All of those things: the Pitocin, the
22 protocols that say Pitocin should be discontinued if
23 there's stress on the baby. I'm going to show you
24 all of the fetal monitor -- well, not all of them at
25 this moment -- but I'll show you signs on the fetal

1 monitoring strips that the baby was in distress.
2 The policy, the protocol of Mercy
3 Hospital, indicates that if the baby shows a Category
4 II tracing, shows distress, Pitocin is supposed to be
5 discontinued. It never was by either of the nurses
6 or Dr. McNeive over a 14-hour period. It was set at
7 18, which our nursing expert will explain those
8 doses. It was never discharged.

9 And, ladies and gentlemen, despite the
10 multiple and recurrent signs of distress over a
11 period of hours and hours, the defendants in this
12 case failed to act. And as a direct result of those
13 failures, Remi Anyan suffered hypoxic ischemic
14 encephalopathy -- I'm going to call it HIE from now
15 on -- which is a permanent brain damage that will
16 affect him for the rest of his life.

17 Let me tell you the story of Remi Anyan.
18 Sarah and Blake -- this is Remi in the middle --
19 Sarah and Blake -- we have Blake here -- they live in
20 Pacific, Missouri. Sarah was born in 1989, she's now
21 39 -- sorry -- 35 years old, grew up in Fenton, went
22 to Maryville University, got her Bachelors of Science
23 in nursing in 2011.

24 She did an internship at Missouri Baptist
25 and worked for St. Clare Hospital in the cardiac lab

1 for a number of years before she started working for
2 Mercy in 2018. She worked above the emergency
3 department in the clinical decision unit. It's kind
4 of low acuity patients above the ED. And she did
5 really that job. She was an employee of Mercy, which
6 is why she chose her care at Mercy Clinic with
7 Dr. Daniel McNeive and why she chose to have her baby
8 at Mercy Hospital. She stopped working after Remi
9 was born to take care of him. That's what she does
10 now, as well.

11 Blake was born in 1988. He grew up in St.
12 Louis County. He did his undergrad at Missouri State
13 Southern University. And in 2008, he completed his
14 training in respiratory therapy. He's a respiratory
15 therapist. Went to work for the University of
16 Missouri in 2008, at the University Hospital and
17 Clinic where he was a staff respiratory therapist,
18 where he ran life support systems, managed all the
19 patients' respiratory needs, did some pediatric care,
20 but that wasn't his focus. He stayed there until
21 2010, when he went to SSM Health Care. And then he
22 started working with Mercy in 2014.

23 At the same time, though, he earned his
24 Bachelors of Health Science from Missouri Southern in
25 2017, and went to work for St. Louis Community

1 College as an assistant professor in respiratory
2 care, and he's been in that role since 2018.

3 Blake and Sarah went to high school
4 together. They are high school sweethearts. They
5 went to Rockwood Summit High School -- go, Falcons --
6 and got married on October 6, 2012, where they moved
7 to Pacific where they live now.

8 This was their first pregnancy. They
9 found out around Labor Day 2019, that they were
10 pregnant. They were thrilled for that of course.
11 Sarah had never done labor and delivery as a nurse.
12 She had never been pregnant before. They did all of
13 their prenatal care with Dr. McNeive. She never
14 missed an appointment, took all of her vitamins, and
15 she had absolutely no concerns, whatsoever, during
16 her entire pregnancy. There was an ultrasound that
17 showed a low-lying placenta early. Dr. McNeive will
18 tell you that he repeated the ultrasound, and there
19 was nothing to worry about.

20 They were excited about having their first
21 baby. So on Sunday, May 3rd, her water broke at
22 home. They gathered their things, they went on to
23 Mercy, and they admitted to Mercy at about two -- a
24 little bit after two o'clock. She was 39 weeks, 4
25 days. She was full-term on that May 3rd. Her

1 estimated delivery date was May 7th. Everything was
2 in line. Got to Mercy, as I said, at 2:04.

3 And so what happens when she got to Mercy?
4 well, the way Mercy works is you have an attending
5 physician, an OB/GYN hospitalist, that does a 12-hour
6 shift. So from 7:00 a.m. to 7:00 p.m., on Sunday,
7 May 3rd, Dr. April Parker was the attending. Dr.
8 Parker and Dr. McNeive were partners.

9 But even though Dr. McNeive was Sarah's
10 main OB, Dr. Parker was on call on service, and so
11 she took care of Sarah after Sarah got there on
12 Sunday afternoon, all the way through seven o'clock
13 the next morning.

14 So what happens when you go in? Go in,
15 you get triaged, and you get a room. They do all of
16 your signs. You get the fetal monitoring strips --
17 or fetal monitors on. We'll talk about that.

18 And the -- so this is the representation
19 of Sarah's fetal monitoring strips. In the bottom
20 corner, you'll see -- this is early on, okay? Early
21 on. This is a Category I strip. So there are three
22 categories of fetal monitoring strips. The top ones
23 are -- is the baby's heart rate. That's what they're
24 monitoring. Is this baby's heart rate within the
25 right range? And how does it differ when there's a

1 contraction?

2 You see those humps on the bottom? Those
3 are contractions. And this is a beautiful strip.

4 And later on this afternoon, we'll have Heidi Shinn,
5 our nursing expert, who can explain this better.

6 This looks great. This is a Category I looks great.

7 This is what Remi looked like when he got to the

8 hospital, all the way through the afternoon and into

9 the evening, into the next morning, on these fetal

10 monitoring strips.

11 This -- a fetal monitoring strip is a way

12 for a baby to speak to the providers. This is

13 telling his story. This is how he speaks to them,

14 and it's their job to watch this and listen.

15 So there are other -- two other categories

16 of fetal monitoring strips. Category No. II is

17 included. It's called indeterminate. It's not good,

18 it's not bad. We don't know. You got to watch them.

19 could be good, could be bad. We don't know. Now, a

20 lot of labors have a lot of Category IIs. What you

21 have to watch is how long does the baby stay in

22 Category II? What else is going on? Is the baby

23 progressing? And then Category III is bad. Category

24 III is danger.

25 what you're going to hear is that Remi

1 went from Category I, Category II, Category III over
2 this time frame. And people are watching this all
3 day long. People are watching. They let it happen.

4 In addition to the fetal monitoring
5 strips, another way to check the mom and make sure
6 things are progressing, is to give Pitocin. And it's
7 a high-risk medication that includes squeezing that
8 uterus to get the baby closer to being done.

9 So she gets there. Here's Pitocin. It
10 starts at about three o'clock, and that's typical --
11 right? -- this is all good. Started at three
12 o'clock. It titrates up. It titrates all the way up
13 to 18. That's a pretty normal dose at this stage, by
14 12:29 a.m. on May 4th.

15 so all afternoon on Sunday, the 3rd, into
16 the morning of May 4th, this is all going on, and
17 she's progressing through the first stage of labor.
18 That is when you go in, and your cervix -- your
19 cervix has to thin out, and it has to get 10
20 centimeters. By the time it thins out to zero,
21 and -- or sorry -- thins out a hundred percent, and
22 you get 10 centimeters dilated, that's when it comes
23 to the second stage and pushing, so we'll get there.

24 The Category I, the fetal monitoring
25 strips, that's FMS, and an epidural is administered

1 at 10:41. So she does the best she can. The
2 contractions are coming stronger. The Pitocin is on,
3 so she asks for an epidural. No problem.

4 okay. So what happens next is that she
5 reaches that second stage. By 3:50 a.m., she is
6 complete. So the cervix is a hundred percent effaced
7 or gone. There's no longer a barrier for the baby to
8 come out. And 10 percent -- sorry 10 centimeters
9 dilated. She's dilated to the point where she's
10 considered complete.

11 So that night, the night nurse, there was
12 a 7:00 a.m. -- 7:00 p.m. to 7:00 a.m. night nurse,
13 Alex Greenwald. And when -- at Mercy, when a mom
14 becomes in the second stage, is complete, and ready
15 to push, they have a policy of a one-to-one. One
16 nurse to one patient. That nurse is by that
17 patient's side. So at 3:50, she's complete, they she
18 start pushing around this 3:50/four o'clock time
19 frame.

20 Now, in addition to being a hundred
21 percent effaced, 10 centimeters dilated, the baby was
22 at zero station. The baby is at -- pardon -- the
23 baby is at zero station, and this is a diagram
24 roughly of what those stations look like. Sorry.
25 And so this is the bony pelvis on the outside, and

1 the baby's coming down, obviously baby has to come
2 through.

3 So you see these marks: negative 3,
4 negative 2, 1, 0, 1, 2, 3. So this distance from
5 plus 3, which is high, to -- sorry -- negative 3,
6 which is high to plus 3 which is low. Plus 3 is
7 basically where you are, is about 10 centimeters. 10
8 centimeters. And I've asked for my tape measure.

9 Thank you, Claudia. Thought I had it all.

10 okay. So 10 centimeters is what a baby
11 has to go through. Okay. I just have this tape
12 measure here. It's about that distance at 10
13 centimeters. When Remi was assessed at 3:50/four
14 o'clock and ready to push, he was at zero station.
15 So zero station is half that distance: 5
16 centimeters. 5 centimeters. And remember: It took
17 12 hours to go this distance: 5 centimeters. So
18 that's where he was when she starts pushing.

19 pushed for -- Sarah pushed, Sarah and
20 Blake, pushed for an hour and a half, and, by the
21 way, this second stage of labor, remember that 4-hour
22 window that 95 percent of women deliver within that
23 4-hour window? Now, remember also she was a
24 first-time mom and had an epidural.

25 So what you're going to see is that the

1 American College of Obstetricians and Gynecologists
2 have guidelines. And they have indicated that
3 actually 3 hours is an appropriate second stage of
4 labor for a first-time mom, but if you get an
5 epidural, we're going to give you an extra hour. So
6 that's where you get to that 4 hours.

7 If you've had a baby before, you don't get
8 that long, right? You're a tested pelvis, and
9 they're, like, okay, it's going to work or not, so
10 the hours are shorter. So he's at zero station at
11 3:50 a.m. They push for an hour and a half, and
12 Alex -- Alex thinks that there's something that needs
13 to be evaluated because an hour and a half of
14 pushing, the baby is not moving. Baby's not moving
15 from that zero station.

16 So she calls Dr. Mckillip. Dr. Kelsey
17 Mckillip is a resident who was on the shift that
18 night, and she was called. And you'll see that this
19 is part of Sarah's medical chart, directly from her
20 medical records that you'll see.

21 And it is -- it -- Alex Greenwald calls
22 for it. Kelsey Mckillip comes and called per RN. So
23 that is Kelsey saying, Alex called me for an
24 evaluation, and -- because Sarah's been pushing for
25 an hour and a half, and the baby is still at zero

1 station.

2 And Alex said, let's try some things. You
3 know, I don't know. I mean, when I had my baby, you
4 roll over this way. You roll over that way. There
5 was a ball you get on. There's things to do to move
6 things along. And so that's maternal position
7 changing, and Alex was doing that. She tried
8 bilateral sides, with handlebars, with towel pushing.
9 And patient denies excessive fatigue or pain.

10 All right. That's a key to this because
11 Sarah says, I'm good. I can keep doing this.
12 whatever you need me to do, I'm going to do. So
13 she's pushing. She denies excess fatigue upon
14 evaluation. Before Dr. Mckillip starts pushing with
15 Sarah, she is still at 10 centimeters dilated, a
16 hundred percent effaced, and zero station. After an
17 hour and a half, baby hasn't moved.

18 Now, they also talk about caput. You're
19 going to hear about caput. So when a baby is trying
20 to be born, and you're being kind of shoved into this
21 space, your head can swell. Your scalp can swell.
22 And so caput is basically that swelling on top.

23 So what Dr. Mckillip sees is caput,
24 swelling present to plus 1 or plus 2 station. So
25 let's go back to this. So what happens is -- what

1 happens is with caput, the baby's head gets to a
2 lower station because the scalp is swollen. That
3 doesn't count. No one is going to tell you that
4 counts by way of progress. That is not movement
5 down. That is simply swelling.

6 No one counts this, including Dr. Mckillip
7 because caput is present, plus 1, plus 2 station.

8 The fetus is ROP. All right. Part of why it takes
9 long for me to get through my preliminary stuff is I
10 get to teach a few things.

11 So position of the head is important. The
12 best position for a baby to be born it head down.

13 Head down. And that's because it's called occipital
14 anterior. Everything is measured against the mother.

15 It's anterior even though the head is down, is the
16 best way to see how it fits the best. The other way
17 is occipital transverse. That's kind of like that

18 way, turned to the side, also considered malposition.

19 Can babies be born that way? Yes. Is it the best
20 way? No. The other position, occipital posterior,
21 that's face up, that's what Remi was after an hour
22 and a half of pushing. He's malpositioned.

23 So ROA just means to the right -- to the
24 mother's right. So there's a little bit of face up
25 to the mother's right, but it's malpositioned. And

1 Dr. Mckillip sees it. Writes it down. And so what
2 she says is that, fetus is right OP, ROP. So
3 malpositioned face up to the right. But when they
4 push, he rotates back to the ROP -- okay. It's ROA
5 when they're pushing. So pushing gets them to a
6 little bit better position. But when they stop
7 pushing, he rotates back to malposition, to the
8 occipital posterior, all right?

9 So what you have is at the bedside pushing
10 for approximately 20 minutes. So Dr. Mckillip is
11 like checking this out. And she's noting, this is a
12 malposition. We're pushing. Now we're getting close
13 to 2 hours pushing, it's malposition. And minimal
14 descent with pushing. So he's not moving down.

15 Now, remember: It's important because the
16 pushing efforts are good. They are good. She's
17 giving it her all, and she's on Pitocin. So there's
18 nothing wrong with the contractions. That's not
19 what -- that's not what is keeping Remi from
20 progressing.

21 So Dr. Mckillip talks to Dr. Parker. And
22 Dr. Parker says, let's have her labor down for 30
23 minutes and see how that goes. So that's not
24 unusual. Laboring down is a term of art. And what
25 it means is, mom, stop pushing. It doesn't mean the

1 contractions are going to stop. No one is turning
2 off the Pitocin, but, mom, let's just rest. Let's
3 just rest and see if the baby can figure this out
4 because sometimes they do.

5 So that occurred, that laboring down
6 occurred, between about 6:15 and 6:45. And remember:
7 Alex Greenwald is still on until 7:00 a.m. They
8 resume pushing, and then there's a shift change.
9 Shift change at seven o'clock. What happens? Dr.
10 McNeive comes on for his 24-hour call. So he is
11 relieving April Parker. His -- he's going to be on
12 call between 7:00 a.m. on May 4th and 7:00 a.m. on
13 May 5th. So a 24-hour call.

14 And in that time frame, Dr. McNeive is
15 responsible for his patients and his clinic's
16 patients, which would be Sarah. And let me tell you,
17 they were happy. They're like, oh, our guy is here.
18 This is good. He can't leave the hospital, which is
19 also a good thing, but you're also managing and
20 overseeing any residents that are dealing with
21 patients. Any women that come in the door that don't
22 have attending physicians of their own. You're
23 delivering any patients that are transferred from
24 other hospitals for any reason. You're handling
25 walk-ins, anyone from the ED. You are managing all

1 the clinic's patients in the hospital, not just the
2 ones that are yours because remember Parker was also
3 covering. So there's a lot of things to do.

4 And so what happens is, there's also a
5 change of nurses. So we've got Dr. McNeive coming in
6 seven o'clock, and we've got Jessie Brown Wagner.
7 She was Jessie Brown at the time, she's Wagner now.

8 She received her nursing degree in 2016,
9 and started at the labor and delivery floor at Mercy
10 in January 2017. Mercy has a 16-week orientation, so
11 their nurses go through almost an orientation, a
12 preceptorship, with another nurse for 16 weeks.

13 And by the time they're done with that,
14 then they are fully trained. And Jessie had been
15 fully trained in that program since the summer of
16 2017. The other was Nurse Maggie. So Margaret
17 Hilt-McLeland. Maggie. And she was in her
18 orientation. So she was a nurse. She was in her
19 orientation starting in this time frame, so she was
20 training under Nurse Jessie.

21 They come on. They come in. Now, the
22 Pitocin is still running, and there had been a
23 laboring down. So they come on, they take report
24 from Alex. All very standard, all very normal. And
25 now, though, we're get to eight o'clock.

1 So remember our time frame: we are now
2 4 hours into the second stage of labor. we started
3 at 3:50 a.m. So now we are at eight o'clock. we're
4 4 hours in. And Dr. McNeive is at the bedside.

5 So what we have is a note that indicates
6 that Dr. McNeive is at the bedside, quote, discussing
7 plan of care with patient. There's no documentation
8 other than that. Dr. McNeive is discussing plan of
9 care with patient. And you're going to hear no one
10 here on either side is going to say that Sarah Anyan
11 was told she needed a C-section at any time of the
12 day. No one here is going to say that. No one here
13 is going to say she ever refused a C-section at any
14 time.

15 Sarah and Blake will tell you that it
16 never came up at all. And, remember: first child.
17 Never came up at all. we're now 4 hours in. ACOG
18 says, yeah, we are at the -- we're prolonged now.
19 Eight o'clock, something else happens. Now we're
20 in -- we're considered prolonged, now we're in
21 Category II. Fetal monitoring strips, okay? I will
22 show you that.

23 This is another part of Sarah's chart.
24 when I took the depositions of all the people
25 involved, I had them all show me Category II strips.

1 when was he in Category II? We're not going to fight
2 about this later. You tell me when you think he was
3 in Category II.

4 Here we are. This is page 120. And if
5 you look at the top here -- pardon me again -- these
6 are time frames. And this is ending at 7:17. So
7 every page of this is 8 minutes? 8 minutes. So
8 we've got 8 minutes of strips every time a page
9 turns. That's not what they look like when they're
10 coming out. They're just coming out. But that's how
11 we have to look at them.

12 So by 7:17, 45 minutes before Dr. McNeive
13 gets to the room, we've Category II that's
14 noncontiguous. What that means is it's kind of hard
15 to read, you don't know because it loses its signal.
16 That happens sometimes. And you've got decels. And
17 you're going to hear about what decels mean. Decels
18 mean that there is some compromise to the baby of
19 blood flow or oxygen.

20 And they happen. Again, if you have a
21 decel, you are Category II, period. Those are the
22 rules. And, remember, the protocol for Mercy
23 Hospital is you have decels, you need to turn off
24 that Pitocin. It never happened.

25 So you've got Category II. At eight

1 o'clock, we've got Category II, indeterminate. we
2 have prolonged second stage of labor. we have a baby
3 that is not coming down. we have a baby that's
4 malpositioned. All those things were known at 8 a.m.

5 So what happened? These are more strips.
6 This is almost eight o'clock. This one ends at 7:59.
7 So if Dr. McNeive was in the room at eight o'clock,
8 this is what he's looking at. Oh, this is a lot.
9 I'm going to come back to it. This is how I think
10 I think chronologically. This is a chronological
11 look at this starting at 3:50 going through the
12 laboring down.

13 The lates are red. The variables -- these
14 are decelerations. These are Category IIs. These
15 are all of the red flags. This is how Remi is
16 speaking to them saying, hey, something's going on
17 here. They happened all the way from this 6:45, all
18 the way through eight o'clock, all the way through
19 nine o'clock, up through 10:00, up through 11:00.
20 They keep coming and coming.

21 And what happens? Prolonged -- at 9:42 --
22 at eight o'clock, other than the note that says Dr.
23 McNeive's at the bedside discussing plan of care with
24 patient, we have no further notes. Nothing.

25 we have nurse -- we have flow sheets from

1 the nursing talking about these late decels. And
2 they're continuing to position change, but no turning
3 off the Pitocin. We have no other intrauterine
4 resuscitation going on. And instead what happens
5 between nine o'clock? We know he leaves the room
6 without any discussions of a C-section or what's
7 going to happen next other than, let's just keep
8 going. Sarah says, I'm up for it. I can do that. I
9 can do that for my baby.

10 So what happens? Dr. McNeive delivers
11 another baby by C-section at 9:42 a.m. Remember:
12 He's on call for the whole floor. And between 9:42
13 and 10:24, Sarah labors down again. So he's
14 delivering another baby. And she's, take a break.
15 Take a break. So that's another 40 minutes. That's
16 the second time she's labored down.

17 At 10:27, we know from the -- I think it's
18 called an audit trail. It's sort of the metadata for
19 the hospital chart. And it shows everybody that
20 comes in and looks at the chart for any reason. It's
21 thousands of lines.

22 And Dr. McNeive, we know, was in her
23 chart, not in her room, not communicating with the
24 nurse, but in her chart reading a message about
25 Sarah -- we don't know what the message is -- at

1 10:27.

2 And at 10:45, Mercy has what's known as a
3 safety round. Okay. Let's talk about a safety
4 round. The safety round is where a number of
5 professionals, there's a midwife, there's an OB
6 anesthesiologist, there's Dr. McNeive, the nurse, so
7 Maggie and Jessie or Jessie and Maggie or one or the
8 other, get together around a nursing station to look
9 at strips.

10 So all these strips are coming out. They
11 used to come out. I guess they're electronically,
12 and they look at 15 minutes of strips. And so this
13 is like a meeting of the minds. They look at 15
14 minutes of strips, and they say Category II.

15 Category II at 10:45. And Dr. McNeive is there, and
16 he knows it. And now what does he know? What did
17 Maggie and Jessie know? We know at 10:45, we are
18 getting close to 7 hours of the second stage of labor
19 pushing. And laboring down is still in the second
20 stage. You don't go back. The clock is ticking. So
21 almost 7 hours in, and Dr. McNeive is there and says
22 good. We're good. Let's just keep going.

23 Jessie and Maggie do not at that time
24 advocate for Remi or Sarah and say, we're at 7 hours.
25 We've got Cat II strips. The last time anybody

1 checked, the baby was still at zero station. We

2 don't have that. They kept on keeping on.

3 So what happens at noon? well, at noon,

4 we've got more late and variable decels. More

5 speaking. Remi is still speaking to them. And then

6 we've got another laboring down between 12:12 and

7 1:32. And this time, for an hour and 20 minutes.

8 And what happens? Dr. McNeive delivers

9 another baby at 12:41 by C-section. And then at

10 1:44, another one by C-section. And there's nothing

11 in the records, ladies and gentlemen, that you're

12 going to see, any documentation, whatsoever, that Dr.

13 McNeive was in Sarah's room or communicating with the

14 nurses. Yes, they will say, I think we were talking.

15 He's popping in and out. But it's not documented.

16 So -- but and, you know, you're going to

17 hear this, that a baby was born at 12:41 via

18 C-section, a different baby, the second baby, but it

19 doesn't take -- it takes more than a minute to run in

20 and do a C-section, right? That time frame is 38

21 minutes, an hour.

22 So we've got -- this is my second page of

23 my time line. And we've got noon 1:00, 2:00, 3:00,

24 4:00. So at noon, you see the greens are the time

25 frames within which Dr. McNeive is in an OR

1 delivering another baby by c-section. we've got an
2 hour and 40 minutes of laboring down. Still had late
3 decels.

4 And he gets to her room, and this is
5 documented. This is the first time it's documented
6 that he had been there since 8:00 a.m., and at two
7 o'clock, we are 10 hours in the second stage of
8 labor, the longest he's ever been involved in in his
9 entire career. And he comes in and says, How you
10 doing, sarah? How you doing? what do you think
11 sarah says? I'm here for you. what do you need me
12 to do?

13 He says -- and they'll tell you there's no
14 c-section discussion. 10 hours into the second
15 stage -- I'm sorry -- 10 hours into the second stage,
16 there's no discussion. And, instead, they start
17 pushing together.

18 And there's also so documentation of baby
19 was at that point. But remember, I mean, this is how
20 far he needed to go. we're 10 hours later. This is
21 it. And he had that caput. That didn't get any
22 better. so they -- and he'll tell you -- Dr. McNeive
23 will tell you -- I don't mean to point. I apologize
24 for that -- Dr. McNeive will tell you that at two
25 o'clock, he could have done a c-section, but by 3:50,

1 it was too late. The baby was too low, too engaged.
2 And why does that matter? what happens at
3 3:50? Category III. Bad. A hundred percent
4 predictable. At 3:50, now we're not only Category
5 III, we're tachycardic. So, ladies and gentlemen,
6 tachycardia is when your heart beats so fast, this
7 baby -- anything over 160 beats per minute is
8 tachycardic. When your heart is beating that fast,
9 it is not pumping blood sufficiently to your brain to
10 give it the oxygen it needs not to be damaged.
11 His heart rate goes up to 160, it goes up
12 to 175. The heart rate goes up over 175. And this
13 time frame is over 20 more minutes. Category III.
14 Tachycardic. Now it's too late for a C-section.
15 Entirely predictable, entirely preventable.
16 NICU gets called at 4:12. Why? Forgot to
17 mention this. When your -- when a woman's water
18 breaks, it -- it -- it opens a woman up for
19 infection, and it's called prolonged ruptured
20 membranes. You get about 24 hours before the science
21 says you're going to be at risk for infection. So,
22 again, clock starts. She's 28 hours now. Remember
23 at noon on Sunday, we're four o'clock on Monday.
24 She's 28 hours and spikes a temperature. So that's
25 why NICU it called because Sarah had a temperature.

1 That's at for 4:12. And then, oh, by the
2 way, by the way, pardon me. When Dr. McNeive gets to
3 the bedside after two o'clock, in the 10-hour stage
4 of labor, even though the protocol for Mercy Hospital
5 is to turn off the Pitocin in Category II strips, he
6 turns it up, and Jessie and Maggie do it.

7 So they do it. It goes up to 20 and then
8 22 and then 24? And then 26. Remember what that
9 does: stronger contractions against the baby.
10 Reduces blood flow, reduces oxygen. No oxygen means
11 brain damage. Turn it up because now we've got to
12 get this baby out. Now we've got to get this baby
13 out.

14 when he turns it up to 26, that's exactly
15 the same time we're starting to get tachycardic and
16 Category III. And finally at the end, he cuts a
17 third-degree episiotomy, and he gets the baby out.

18 The baby is born floppy. You're going to
19 hear about this. I feel like I'm way behind on my
20 time frame here, and I apologize. This is, again, I
21 think very chronologically. Here's what's happening
22 in the moment. No one is judging this in retrospect.

23 This is what's happening in the moment. He gets to
24 the NICU -- okay, NICU -- this is Nurse Practitioner
25 Mary Younger. She now goes by Spencer. She got

1 married.

2 So she comes in from the NICU. She's a
3 nurse practitioner. And her job is to work on the
4 baby. The baby is born. The baby is taken to the
5 warmer. Baby is not breathing. Baby is blue.
6 Baby's heart rate is under a hundred. Baby has poor
7 tone. That's the floppiness about him. And he gets
8 a 3 on his Apgar. I'm going to talk about Apgars a
9 little bit later on. But suffice it to say, that he
10 got -- he got a 3, and that's not great.

11 She institutes resuscitation. That's her
12 job. So she does positive pressure ventilation to
13 get him breathing and puts a CPAP on him, that's a
14 mask on him. It works. He starts -- he starts
15 breathing, and he pinks up a little bit. And then at
16 5 minutes, you do another Apgar score. And at 5
17 minutes, Nurse Younger gave Remi an 8.

18 Now, I'm going to say 8, okay? My little
19 air quotes. My kids hate that. But, okay, air
20 quotes. I'm 8. Because we're going to show you
21 evidence in this case that that was generous based on
22 the fact that he was still on a CPAP mask and that he
23 was floppy. So I'm going to get to that.

24 We've got -- so the reason that's
25 important -- and I'll get to this -- but basically

1 what happens is resuscitation effort help Remi. He
2 is breathing. He eventually breathes on his own. He
3 does pink up. And Blake gets to go over and cut his
4 cord. And you'll see some pictures about that. And
5 they are just so thankful that he is alive. He's a
6 respiratory therapist, you-all, he knows what's going
7 on. Sarah's a nurse.

8 They take him over, and they are able to
9 give them -- give Remi to Sarah and Blake.
10 Skin-to-skin contact is super important. So after 10
11 minutes, 15 minutes, he gets to go over. They're
12 just so thankful. But they also notice, they're
13 going to tell you, that his tone was low. And they
14 know these things. His tone was low, still kind of
15 floppy. And they -- it doesn't seem right. And
16 they're going to tell you that he was fussy. He was
17 agitated. He wouldn't feed. And this was all in
18 this time frame.

19 So it's also very important to note,
20 ladies and gentlemen, that we're all going to be
21 talking about his HIE. And no one disputes, by the
22 way, that -- that Remi has HIE. That is the source
23 of his brain injury. Encephalopathy is the
24 overarching term. It's brain damage. And there are
25 lots of things that can cause that in a newborn. You

1 can -- it can be infection, which it was not. It can
2 be genetic, which it was not. It can be metabolic,
3 which it was not. And it can be hypoxic and ischemic
4 related to the delivery, and that's what it was, and
5 everybody agrees.

6 You're going to hear from the defense that
7 the timing, we'll talk about the timing, but everyone
8 agrees that it's HIE, okay? So how do you determine
9 if a baby is -- has low -- what's the best way to
10 determine after a baby is born whether he's got low
11 oxygenation and low -- hypoxic ischemia? It's a
12 blood test. It's called cord blood gases.

13 It's done all the time. It's a simple
14 blood draw, not even of the baby, okay? And it would
15 say with certainty, objectively with certainty, the
16 baby was brain damaged at that moment from the labor
17 and delivery.

18 Dr. McNeive didn't order it. It was his
19 job to order it. He didn't order the cord blood
20 gases. Didn't get ordered. He'll tell you it
21 slipped his mind. That's what he told me at his
22 deposition. We don't have that. That's why you're
23 going to hear about the Apgar score a lot because
24 that's all we have.

25 well, that's not really all we have. We

1 have the clinical appearance, we have the fetal
2 monitoring strips. we have a lot of things,
3 actually. what happens, though? Remi does go to the
4 regular nursery. He stays with Sarah and Blake.
5 They don't think -- they think this is not right,
6 that's not normal. They've never had a newborn
7 before. They tried to do what they were being told
8 about him, about Remi.

9 He goes to the newborn nursery. He --
10 his -- his temperature fluctuates. The nurses there
11 are kind of looking at him. By the way, there's also
12 not a full neuro exam done. He goes to the newborn
13 nursery. And eventually about 9 hours in, he starts
14 being tachypneic: shallow, fast breathing. It's not
15 normal. He's fussy. He won't eat. Nothing is
16 normal about the baby. He goes to the NICU. They
17 take him to the NICU. Transferred to the NICU at
18 9 hours of life at 1:35 a.m., and not surprisingly,
19 but really tragically, starts seizing a few hours
20 later.

21 Now, the NICU is trying to figure out
22 what's happening. so they order some brain scans,
23 and they determined that it's hypoxic ischemic
24 encephalopathy, HIE. Remi is in the NICU for
25 46 days. He came home on June 18th. Sarah and Blake

1 celebrated both of their birthdays with Remi in the
2 NICU in May. And those are the facts of this case.

3 Now, I know I spent a lot of time on
4 those. The facts are what you-all get to decide.

5 The law the judge gives you. What we try to do is to
6 apply the facts to the law to get to a result. Help
7 you get to a result. In this case, as I said

8 yesterday, there are three things we have to prove by
9 a preponderance of the evidence.

10 Liability, and that's the negligence.

11 That's the breach of standard of care. Causation, we
12 have to prove that that -- that those errors,

13 inactions, actions caused harm, and then what that
14 harm is. That's the hardest part, ladies and

15 gentlemen, showing you that harm. And I'm not going
16 to do it because I enjoy it. I'm not going to do it

17 because you-all enjoy it. I'm doing it because it's

18 my job. And it's your job if you believe our case to
19 fully compensate Remi for his injuries.

20 So what is the evidence we're going to

21 show you? We're going to bring experts to you. The

22 first one -- not the first one. He'll be here

23 tomorrow. Dr. Warsof is an OB/GYN who has 40 years

24 of experience, and he's going to tell you, based on

25 his experience as an OB/GYN, that Dr. McNeive was

1 negligent.

2 That it is simply inexcusable to have a
3 woman go through the second stage of labor for 12
4 hours. Dr. McNeive failed to deliver Remi in a
5 timely fashion. We believe everything we know by
6 9:30, we're going to go past that four o'clock -- 4
7 hours because they're going to tell you, and
8 everyone's going to agree, it's not a cutoff.

9 There's not a timer that goes off and says, let's do
10 a C-section now. You have to use your clinical
11 judgment of what's going on.

12 So at 9:30, there was plenty of time and
13 plenty of red flags to say, it's time to deliver.

14 And every minute after that was negligence. Every
15 minute after that was intentional. He chose not to
16 deliver her. He chose that for her.

17 Dr. Warsof is going to explain it was also
18 error to fail to deliver Remi by that 3:55 time
19 frame. He was back at two o'clock. He was back at
20 two o'clock at her bedside. Forget everything that
21 happened -- but don't because it's a part of the
22 case -- but he's there at two o'clock. Let's just
23 keep pushing. Let's keep going. Below the standard
24 of care. Negligence. Turn down the Pitocin, turn it
25 off? Never. Turned it up. Danger. You know why.

1 So does he.

2 Red flags. We've gone through this. Head
3 malpositioned. He had been malpositioned since the
4 minute this started 12 hours ago. Failing to
5 descend. There was never, by the way, a check by Dr.
6 McNeive in the records as to what the station was of
7 Remi, whether it was eight o'clock or two o'clock.

8 Never. It was never documented. We don't know.

9 Failing to descend, prolonged second stage
10 of labor pushing, Pitocin running at 18. Brain
11 damage was caused by low oxygen and low blood flow.

12 That is not new. That is known facts, known

13 consequences for actions. Red flags at two o'clock.

14 The heart rate was showing recurrent late and
15 variable decels. This is Remi saying, hey, not good
16 here. Remi's head was still malpositioned.

17 By Dr. McNeive's own testimony, he was

18 still OT by two o'clock which that is sideways.

19 Failing to descend 6 hours later. Now, Dr. McNeive
20 will say, well, I think he was about plus 2.

21 Remember that caput? Sarah's was the prolonged

22 second stage now 10 hours. Longest he'd ever seen in
23 his entire career.

24 There was time to do a C-section. He
25 chose not to do it. Why does that matter? Well,

1 we'll get to it. So then we go through all of these
2 other things I've already told you about. What he
3 knew, chose not to do.

4 The cord blood gases, Dr. Warsof is going
5 to tell you below the standard of care. Got about
6 10 hours in, 12 hours in, you don't do cord blood gas
7 so you know is this baby brain damaged? Does this
8 baby have low oxygen? You know what you could do if
9 you know? You could cool that baby. There's a
10 protocol called head cooling that if you have a baby
11 with injury, hypoxic ischemic injury, you can cool
12 their brain and put the fire out. Didn't do cord
13 gas. Didn't do it.

14 Heidi Shinn, negligence of the nurses.
15 All right, you-all, nurses are not potted plants.
16 Nurses do not just take orders from the doctors.
17 Nurses' jobs are trained -- highly-trained to
18 advocate for the patient.

19 Nurse Jessie and Nurse Maggie had an
20 obligation and a duty if Dr. McNeive wasn't going to
21 do anything, they had a duty to say something to him
22 or run it up their own chain of command. They didn't
23 do it, and they were boots on the ground. They're
24 the ones documenting the late decels, the variable
25 decels, the hour after hour after hour. They didn't.

1 There's a Pitocin policy I told you about
2 earlier. This is embedded in Sarah's chart. This is
3 not on the dusty shelf somewhere, this is in her
4 medical chart. And it says intrauterine
5 resuscitation. And this applies to doctors and
6 nurses. It's kind of hard to see. We'll do better.

7 If you have a pattern, an indeterminate
8 pattern, with Category II, which was all of this time
9 frame essentially -- oh, these are the things, it
10 says, will be initiated. Now, I cannot explain why
11 discontinuation of oxytocin is tabbed out like that.
12 I can't get an explanation for that. Nevertheless,
13 it's right there. You also can do fluid bolus. That
14 sometimes helps. That wasn't done.

15 The most the nurses did was move mom
16 around. And, again, even that documentation stopped
17 at around noon. Never discontinued the oxytocin.

18 You'll hear the failures of the nurses that Nurse
19 Shinn is going to be here this afternoon to talk
20 about. They never turned down or turned off the
21 Pitocin, which was against the protocols of Mercy.

22 Never -- they did not invoke all the resuscitation
23 requirements, again, against the policy. They never
24 went up the chain of command, and never advocated for
25 a C-section for Remi.

1 They turned up the Pitocin four times.

2 Again, they're not a potted plant, just because a
3 doctor tells you to do it. And you know what Pitocin
4 does after all this time? He did it.

5 All right. Liability, causation, damages.
6 we're through liability, you'll be glad to know,
7 we're going to move on. Causation. why does it
8 matter. It doesn't seem obvious? well, no. I can't
9 take it at that. I can't say it's obvious. The
10 baby's brain was damaged at this time frame because
11 look at the Category IIs and Category IIIs and the
12 Pitocin wide open and the malposition. we can't rely
13 on that.

14 So what do we do? we bring you a
15 neonatologist. A neonatologist, Dr. Leslie Kerzner,
16 she'll be here. But she's a neo -- a staff
17 neonatologist at Mass General for Children. She's
18 the Assistant Professor of Pediatrics at Harvard and
19 the Director of Newborn Developmental Follow-Up
20 Clinic.

21 A neonatologist is sort of a specialized
22 pediatrician who works with newborns and children
23 with concerns or problems, newborn babies. She's
24 read all of Remi's records and all the depositions in
25 this case, and she's going to explain better than I

1 have HIE and how it happens and the brain damage that
2 was caused by that through this time frame.
3 She's going to tell you that when you have
4 Category II strips, and you have a long prolonged
5 second stage of labor, what happens in this baby is
6 they're taking punches. Babies take punches while
7 they're in second stage pushing contractions. And
8 they're meant to do that. They're meant to do that.
9 They recover from those punches when the contractions
10 are over. They're amazing. But you can only take so
11 many hour after hour.

12 The last 30 minutes, Dr. Kerzner will
13 explain, was the knockout punch. The tachycardic
14 Category III. Just didn't have it in him to continue
15 to take those punches. And that's what you get when
16 that happens.

17 So she's going to explain the kind of
18 injury that he has. It is an acute profound injury
19 and a partial prolonged. He has injury on the
20 perimeter of his brain and in the middle of his brain
21 because of these -- because of the time that went by
22 when he was taking those punches. She's going to
23 explain that to you. Here she is.

24 You know, I talked about the head cooling
25 a minute ago. If there had been a cord blood gas,

1 knowing what had been going on, it would have shown
2 metabolic acidosis. She'll explain that. And that,
3 with evidence of the hypoxia, he would have been
4 eligible for cooling. No cord blood gas, no
5 opportunity for cooling.

6 Couldn't find the encephalopathy. Again,
7 you're going to hear from the defendant. He's fine.

8 He got an 8. He went to the regular nursery. He's

9 fine. You're going to hear from Sarah and Blake and

10 from the records themselves he had poor feeding,

11 inconsolable crying, tachypneic, temperature

12 instability, and went to the NICU at 9 hours of life.

13 And then he started seizing at 13.5 hours of life.

14 She's going to explain what's called

15 reperfusion injury. Sometimes when you don't have

16 blood coming in, and then it does start coming in,

17 that can cause a delay in this reperfusion. She's

18 going to explain that to you way better than I could.

19 Then we have a neuroradiologist, a physician who

20 specializes in reading brain images. Dr. Gordan Sze

21 will be here to tell you about the brain imaging that

22 Remi had.

23 He had a head ultrasound at 16 hours of

24 life. So he's in the NICU, he's seizing. He does an

25 EEG. They're going to explain that. And they're

1 like, what's going on? We're going to look at his
2 brain. An ultrasound is not a very powerful tool to
3 really discern things. But an ultrasound was done at
4 16 hours of life, and it was negative. That seems
5 strange. We know he has injury.

6 An MRI was done at 46, 47 hours of life
7 that showed all of the injuries on Remi. So why was
8 the ultrasound negative at 24 hours of life? You're
9 going to hear all of the experts say because an
10 ultrasound is not very sensitive, it just didn't see
11 the breakdown. Not that it wasn't there, it just
12 didn't see it. It's like a microscope that doesn't
13 have enough high-powered focused.

14 You're also going to hear, though, that if
15 the brain damage was older than 24 hours, if the
16 brain damage was older than 24 hours, it likely would
17 have been positive because the brain damage like
18 comes up, and you can see it better.

19 So why is that important? Because the
20 timing of this injury is going to be in dispute. The
21 defense experts are going to say, look, yes, he has
22 HIE, but it happened before Sarah got to the
23 hospital. It must have happened before she became
24 the responsibility of the defendants.

25 Based on what? An Apgar of 8, which is 8.

1 And went to the regular nursery, and, yeah, okay.

2 So if that ultrasound, we're going to agree if it's

3 positive, it means it's -- or is it -- or if it's

4 positive -- I'm going to mess this up. If it's

5 negative, it doesn't mean it's within 24 hours.

6 Dr. Sze is going to look at the head

7 ultrasound as a piece of the puzzle. And the MRI,

8 which two days later that shows all of the damage,

9 and puts those together, and say, the timing of this

10 injury is during the labor and delivery. If it were

11 older, if the brain injury were older than 24 hours,

12 and it didn't happen before she walked in the doors

13 at the hospital, the ultrasound would have been

14 positive, older than 24 hours. It's negative.

15 Put those pieces together, you get to the

16 time frame. Again, it fits clinically the puzzle we

17 have to put together which could have been put

18 together at the time. Should have been put together

19 at the time.

20 We've got the ultrasound, we've got the

21 brain MRI, which was unfortunately terribly abnormal.

22 It shows a prolonged diffuse injury to the white

23 matter, the periphery. Because what happens is your

24 brain is amazing. It's like being out in the cold

25 unfortunately. Like if you're out in the cold too

1 long, your fingers are going to freeze before your
2 body does, before your heart stops from all that
3 stuff.

4 Your brain -- the baby's brain, what Remi
5 was doing, his body was shunting blood because that's
6 what carries the oxygen to the central part of the
7 brain, just to save itself. So what happens first is
8 the periphery starts to go first. His went on for so
9 long, and that knockout punch at the end also
10 affected the central part. Dr. Nelson is a pediatric
11 neurologist. He's going to explain that brain
12 injury. He's also going to explain what it means for
13 Remi. Most useful evidence of HIE is cord gas.

14 Don't have it. Remi's brain damage is globally --
15 global and permanently -- he'll be impaired for the
16 rest of his life.

17 All right. So, you know, before we came
18 here to present this case to you, we looked at all of
19 the facts and all of the evidence, spoke to experts,
20 and we're confident about what we'd be able to show
21 you in this case.

22 The defense is, too. So they're going to
23 bring you experts, as well. One of their experts for
24 standard of care is Dr. Mark Landon. He's going to
25 sit here and tell you that Dr. McNeive was attentive.

1 He was attentive. He read the strips correctly.
2 Nothing to see here. No breach of the standard of
3 care. And he didn't need to order cord blood gases.
4 He did everything right.

5 Okay. You can judge that. Adriane
6 Burgess is an RN. She will also be here, and she
7 will say the same thing: Nothing to see here.

8 Everybody did everything right. No breach of the
9 standard of care. No worries. This was good care.
10 Good care.

11 Now, the focus of course is going to be on
12 causation, like I said, the timing because they know,
13 their experts know, that if they believe -- if you
14 believe that anything these defendants did
15 contributed -- because remember we talked about
16 contribution yesterday? -- if anything they did
17 contributed to this brain damage, then the law says
18 it's their responsibility. So they have to bring
19 evidence to the case instead of a coincidence.

20 Because if anything contributes to it, the law says
21 it's their responsibility. So it has to be a
22 coincidence. So how can it be a coincidence? It
23 happened before she walked in the door. That's it.

24 So they will spend time bringing you
25 experts talking about how that must have been what it

1 was based on an Apgar of 8. And based on he went to
2 the regular nursery. But also listen carefully
3 because they also say that they -- that he has HIE.

4 And we don't -- by the way, we don't know,
5 they don't know. They can't explain what happened
6 before Sarah walked in the door. Like what was that?
7 what did cause that profound brain damage before he
8 got hooked up on the monitor that showed Category I
9 tracings, everything is fine here? what was that?

10 They can't tell you. They won't tell you. They
11 don't know.

12 And then we've got -- but, but, but Dr.
13 Cantey is another neonatologist that the defense
14 ordered -- that defense hired, and they'll say that,
15 well, yeah, I guess it also kind of fits that it
16 could be right before delivery. Could be before she
17 walked in the door or right before delivery. But I
18 think it's before she walked in the door because he
19 had an Apgar.

20 And then Dr. Tekes is their
21 neuroradiologist, and she's going to discard the
22 ultrasound. She's going to toss it out entirely.

23 That piece of the puzzle doesn't count. She's going
24 to say that it was poor quality. Nothing in the
25 actual medical chart gives an indication that it was

1 poor quality or needed to be redone.

2 These practitioners, the radiologist who
3 read that, was trying to investigate what was causing
4 this baby's seizures. And one of the pieces to
5 figure that out was -- to figure that out was the
6 ultrasound. And they want to throw it out as poor
7 quality.

8 Now, I'm just going to say that it seems
9 to me that if it was poor quality, that this board
10 certified radiologist --

11 MS. KAMYKOWSKI: Well, Your Honor, I'm
12 going to object that this is now getting into
13 argument. It's argumentative at this point.

14 MS. GUNN: All right. I apologize.

15 THE COURT: The Court will sustain that.

16 MS. GUNN: You can judge the quality of
17 that ultrasound whether if it were poor quality it
18 would have said -- or maybe it would have been
19 repeated if it were.

20 So back to the Apgar. Here it is. The
21 Apgar, the baby got 2 for heart rate. So I may have
22 misspoke earlier. If it's more than a hundred, you
23 get -- so his heart rate was good. His heart rate
24 was good both times. His respiratory effort was a 1
25 at birth. So that's how he got a 3. He had a zero

1 for skin color, he was blue; reflex/muscle tone,
2 floppy.

3 Then at 5, the skin color goes up to 1.

4 His heart rate stays a 2. His reflex eligibility,
5 that's like did he grimace? You know, you're poking
6 him, is he responding? It's a 1; muscle tone, 2; and
7 respiratory effort, 2. Those are the ones that we
8 believe are incorrect.

9 And here are the definitions: Apgar of 8
10 is too high. Muscle tone, you get a zero if you're
11 floppy, no muscle tone. If they demonstrate some
12 tone or flexion, you get a 1. If there's active
13 motion, he was an active baby screaming, crying, you
14 get a 2. What you're going to hear from everybody is
15 that there was no active baby motion at any time.

16 In this time frame up to 5 minutes where
17 the Apgar was actually scored, there's going to be
18 pictures. And here's another way to look at it: 0,
19 1, and 2. This is from the ACOG guidelines. Muscle
20 tone, you get zero if you're limp. You get 1 if you
21 have some flexion. You get 2 if you have active
22 motion. Again, you're going to hear evidence, the
23 baby should have never gotten a 2.

24 The next one is respiration. You get a
25 zero if there are no respirations. You get a 1 if

1 they're weak or gasping. You get a 2 if they're
2 crying vigorously. At no point was Remi crying
3 vigorously.

4 we have Nurse Practitioner Younger, and
5 I'm going to paraphrase this for you because I know
6 we're getting late here. Basically I asked her, do
7 you get -- how did you get 2 for CPAP -- I'm sorry --
8 how did you get 2 for respiratory effort? She says,
9 well, the baby at first was on CPAP, but I don't
10 think he was on CPAP at 5 minutes. And if he was on
11 CPAP at 5 minutes, shouldn't have gotten a 2.

12 I said, okay. So then I go through the
13 records, you-all. I go through all of the 3,000
14 pages of records. Here's what you're going to see:
15 5 minutes. There's resuscitation after, as I said, 5
16 minutes from the chart, the baby's chart. This is a
17 totally different nurse who is documenting what's
18 happening. This is important. And in 5 minutes,
19 positive pressure ventilation, nasal CPAP 5 minutes.
20 Yes. Yes.

21 He was on CPAP at 5 minutes. Never should
22 have gotten a 2. At best, he should have gotten a 6.
23 why is it important? Because it would have triggered
24 more attention. It would have triggered analysis for
25 head cooling. we know what that means. It would

1 have triggered -- maybe it would have triggered cord
2 gas. I don't know.

3 The point is, that the defense relied
4 heavily on an Apgar of 8 to say this baby was fine at
5 birth. And the evidence will show you that's not the
6 case. Because if the baby was fine at birth, it
7 makes it more likely that the injury happened two
8 days earlier. You can decide.

9 Here's Remi at 10 minutes. Again, muscle
10 tone never vigorous. You see Blake is taking his big
11 hand to grasp -- he's not grasping his fingers. His
12 legs are butterflyed, and all -- he's floppy. This
13 is -- I'm sorry I should have -- I know. But here's
14 the baby at 13 minutes of life. This is an active,
15 vigorous crying baby at 13 minutes?

16 So I talked about the timing. We don't
17 have to go over that again. So now the hard part,
18 ladies and gentlemen, I'm going to wrap it up. Part
19 of what you're going to do, the judge is going to
20 instruct you to fully compensate Remi for his
21 injuries.

22 There are two components, like I said
23 yesterday, the economic loss and a noneconomic loss.
24 Economic loss means damage like past medical bills.
25 That's about \$600,000. And then we get to future

1 medical bills. You're going to hear from Dr. Richard
2 Liles. He's a life care planner. You'll see him by
3 video. And he's going to explain the care that Remi
4 needs for the rest of his life and what's that going
5 to cost. And there's a range for that, depending on
6 how long you think Remi's going to live.

7 The evidence will be that the life tables
8 in the United States of America for Remi on his date
9 of birth is 75 years old. The judge will take
10 judicial notice of a life care table -- I'm sorry --
11 a life table.

12 Unfortunately, though, based on his
13 injury, Dr. Liles will testify that no one knows how
14 long -- I mean, no one can predict exactly how long
15 someone will live, but likely his injuries have
16 reduced his life expectancy. And so you will look at
17 the frame between around 14 and a half million to 21
18 million of what the damages are to take care of him
19 for the rest of his life, whatever it is. You-all
20 will get to determine that. We will give you some
21 help with that, but you'll get to make the final
22 decision.

23 Noneconomic loss, I mentioned yesterday,
24 pain and suffering. There's a whole litany of things
25 that you can determine to reach that number. I'm

1 going to help you do that with some evidence, and

2 here's Liles' life care plan.

3 So how do you do the noneconomic?

4 Dr. Nelson, a pediatric neurologist, here's what he

5 says: It's like being trapped in a body that doesn't

6 work. So the basal ganglia is the part of the brain

7 in the middle, and that is a group in the middle that

8 sends signals out.

9 So Remi can think, and it's amazing what

10 you're going to hear he can do. How he can

11 communicate. But he can't act. So you have to have

12 both things. I have to think about walking, and then

13 my body has to walk. He can think about it, but he

14 can't do it.

15 So Dr. Nelson describes it as being

16 trapped in your own -- a body that doesn't work. And

17 we're still learning what he can do. what he can

18 think. He's not even 5 years old. There's a lot

19 that can be done, a lot of care, a lot of progress, a

20 lot of things that can be done that make him the best

21 he can be.

22 There's some pictures of what Remi is

23 doing. This is his first birthday. He's learning to

24 walk in a gait trainer. Here he is -- you're going

25 to hear it. He laughs. He responds. He cries. He

1 can do things. Here's his third birthday and his
2 fourth birthday. I love the sunglasses. I think
3 that's for you-all. I think that's for you-all.

4 Blake's a fisherman. You're going to hear
5 that. He loves to go out, throw the line it. Blake
6 helps him reel it in. Sarah stays with him every
7 day. They're amazing. They have a new baby that was
8 born in November. They really struggled with that
9 decision. And here it is: They love each other.

10 Remi, I've seen it. It's really -- the response is
11 really cute. They do a lot of things. Sarah works
12 with him on his light sensory, his OT, PT, speech
13 therapy. She does all these things.

14 Again, you know, I think we talked a
15 little bit about sympathy yesterday. We don't want
16 it. They don't want it. They want justice. And
17 that's what we're here to get.

18 So, ladies and gentlemen, I appreciate
19 your time and your attention this morning. On behalf
20 of Remi and Sarah and Blake and Liz and Erica and
21 Zack, we appreciate what I am going to hope and
22 assume is your attention, and we appreciate that.

23 Thank you.

24 THE COURT: All right. Based on the
25 timing and my expectation of how long the other side

1 is going to take, this seems like a good time for us
2 to take our morning recess.

3 (At 10:29 a.m., the court duly admonished
4 the jury, and proceedings stood in recess. At
5 10:47 a.m., the following proceedings were held in
6 open court in the presence of the jury:)

7 THE COURT: Go ahead and be seated,
8 everyone.

9 on behalf of the defendant?

10 Opening Statement on Behalf of Defendants Mercy

11 Clinic East Communities d/b/a Mercy Clinic

12 OB/GYN and Dr. Daniel McNeive

13 MR. WILLMAN: Yes. Thank you, Judge.

14 May it please the Court?

15 THE COURT: It may.

16 MR. WILLMAN: Good morning, folks.

17 Delivering a baby today requires a team
18 effort. And on May 3 and May 4, 2020, that team from
19 Mercy, along with the active participation of Sarah
20 Anyan, the mother, followed established hospital and
21 professional guidelines, called on their accumulated
22 experience, you know, Dr. McNeive, over 24 years
23 practicing as an OB/GYN, and their specialized
24 training, to achieve a vaginal delivery of Remington
25 Anyan.

1 At that time, Daniel McNeive, Dr. McNeive,
2 was a leader of the team, no question about that,
3 who's brought thousands of babies into the world,
4 thought that they had been able to successfully
5 deliver Remington Anyan. And Mrs. Anyan thought so,
6 too, because she thanked Dr. McNeive for giving her
7 the vaginal delivery that she wanted. As an active
8 participant, as a part of the team, that's what Mrs.
9 Anyan said.

10 But much to the shock and dismay of Dr.
11 McNeive, days later, he discovered and learned that
12 Remington Anyan had experienced a brain damage. It
13 didn't make sense to him because everything that he
14 and the team had done was following guidelines and
15 following their experience over the years. And it
16 didn't fit with the way that Remi Anyan appeared at
17 birth.

18 Now, years later, we put pieces of the
19 puzzle together and have learned, the evidence tells
20 us, that Remington Anyan experienced an injury to his
21 brain several days before the delivery because the
22 injury that he has does not fit what the team did and
23 saw on May 3 and May 4.

24 So each member of the team had a role to
25 play and fulfilled that role. Dr. McNeive, of

1 course, was the leader wearing two hats, as Ms. Gunn
2 said. He was both her treating OB, has seen her
3 before delivery, knew her. They had a good
4 relationship. Good patient-physician relationship.

5 But he was also there as a hospitalist,
6 meaning it was his responsibility to take care of
7 deliveries on May 4, starting his shift at 7:00 a.m.,
8 and he did so. He examined her frequently. And at
9 2:00 in the afternoon, he was by her bedside for
10 every single minute until delivery happened, every
11 single minute.

12 Now, the nurses, the trained nurses, were
13 there as his eyes, his ears, and his hands. They
14 were continuously monitoring the baby during the
15 entire time that there was labor. There was a nurse
16 always by her side, continually watching that monitor
17 that Ms. Gunn talked about, changing her positions
18 when it was warranted, when it helped, administering
19 this medication called Pitocin, which is an accepted
20 medicine for labor and delivery. It's not a
21 dangerous drug when it's used for these purposes.

22 In the middle of the morning, and then in
23 the afternoon, residents, who are doctors in training
24 to become obstetricians/gynecologists, did review
25 those fetal heart strips and the monitoring, along

1 with other OBs and other specialists, on both a
2 safety round and a strip round. It was like a belt
3 and suspender system. It's done there to make sure
4 that this baby was being delivered safely.

5 so all of these people had roles to play.
6 The nurses, you'll hear from the nurses, that's what
7 they were doing. They were there by her bedside
8 every single minute, watching that -- what was going
9 on, taking care of her, making decisions about
10 positioning, and of course watching that monitor.

11 The residents, I just talked about what
12 their role was, what they did. In addition to what
13 Dr. McNeive was doing, they were there to participate
14 in what are called safety rounds and strip rounds and
15 as other OBs and other specialists.

16 So, ladies and gentlemen -- and then of
17 course Mrs. Anyan. She has an active role in this
18 labor and delivery. She wanted a vaginal delivery,
19 and that's what Dr. McNeive accomplished for her.

20 what this case is about --

21 (Pause in proceedings.)

22 MR. WILLMAN: Can you just advance it for
23 me?

24 Thank you, Justin.

25 Okay. what this case is about, two

1 points: One is that these team members, the nurses
2 and Dr. McNeive, used accepted hospital and
3 professional guidelines. Ms. Gunn talked about the
4 American College of Obstetrics and Gynecologists.
5 They have guidelines. And those guidelines were
6 followed in this case. It's about...

7 Judge, may we have a moment?

8 (Pause in proceedings.)

9 MR. WILLMAN: Okay. My apologies.

10 okay. So what this case is about two
11 points: One is that these team members, the nurses
12 and Dr. McNeive, as trained specialists, used
13 accepted guidelines. They called on their
14 accumulated years of experience: Dr. McNeive,
15 24 years. And they were especially trained in taking
16 care of patients in labor and delivery. That's the
17 first point. That's the evidence you're going to
18 hear.

19 The second point is that this injury
20 occurred days before the delivery. All of the
21 evidence points to the injury occurring before
22 delivery unfortunately.

23 Now, the burden of proof is a very
24 important instruction that you are going to get.
25 we've talked about that. we talked about that when

1 we were picking you to be jurors. The burden of
2 proof is on the party who relies upon any disputed
3 fact that is more likely true than not true, that
4 preponderance of the evidence, the tipping of the
5 scales.

6 And we believe that Ms. Gunn does not meet
7 that burden of proof with the evidence that she's
8 going to be putting together today. There's not
9 going to be enough evidence that Dr. McNeive was
10 negligent, and that Dr. McNeive caused or contributed
11 to cause any injury Remington Anyan.

12 Now, you are going to get to know Dr.
13 McNeive during the course of the next couple of
14 weeks. You're going to hear about him, who he is.
15 Here's who he is: He received his Bachelor of Arts
16 from the University of Notre Dame in 1993. He then
17 decided he wanted to serve others in the field of
18 medicine.

19 So he went to medical school at St. Louis
20 University and obtained his medical degree in 1997.
21 He then made the decision that he wanted to
22 specialize in obstetrics and gynecology. So he then
23 enrolled and completed a residency in OB/GYN. Now, a
24 residency is where you get specialized training in a
25 particular field of medicine. And that's what Dr.

1 McNeive did. He completed that in 2001.

2 He has completed thousands of labors and
3 deliveries during his time, the 24 years he's been at
4 Mercy. He's had responsibility to teach other
5 doctors about the practice of obstetrics and
6 gynecology.

7 In addition, he's spent 15 years as a
8 hospitalist, and one of his duties as a hospitalist
9 was to help other OBs with very difficult
10 pregnancies. He'll tell you about what his
11 experience has been doing that. That's who he is.
12 That's who he has been in the last 24 years at Mercy.

13 He is also board certified by the American
14 College of Obstetrics and Gynecology. We heard about
15 that earlier. So he is a specialist recognized by
16 ACOG in that specialty of OB/GYN.

17 Now, before delivery, they had a good
18 relationship, Dr. McNeive and Sarah Anyan. She was
19 not a stranger to him. Her first office visit with
20 him was on October 28, 2020.

21 MS. KAMYKOWSKI: 2019.

22 MR. WILLMAN: I'm sorry. 2019.

23 Okay. And she continued to see him during
24 the course of her prenatal care. She was
25 experiencing a low-risk pregnancy. There were no

1 complications. Now, she was approaching the date of
2 delivery, and the decision was made to schedule her
3 for an induction. But that didn't have to happen
4 because nature took its course, and her water broke,
5 and she came to Mercy on May 3rd in the afternoon.
6 So good relationship. They knew each other. He knew
7 her as a patient. Knew her -- what was going on with
8 her before her labor and delivery.

9 So now she begins her labor at Mercy. Now
10 these are the things, the factors that this team
11 evaluates to determine how and whether this baby is
12 going to be delivered safely. The first thing that
13 they look at is the size of the baby. And there were
14 no red flags in this case as to the size of the baby
15 in terms of safely navigating through that birth
16 canal.

17 The second thing that they looked at was
18 the pelvic size, Mrs. Anyan's pelvic size, and
19 determined what factor that was going to play in her
20 safe delivery.

21 Third, they evaluated her pushing ability.
22 Throughout the entire time that she was in labor, she
23 was pushing without fatigue, without complaining.
24 She was an active participant. She was doing her job
25 in this labor and delivery.

1 They also evaluated the contractions, both
2 the strengths and the frequency of the contractions.
3 And they were also monitoring the progression of the
4 delivery during this time period. And you're going
5 to hear testimony that though slow, Remington Anyan
6 was making progress throughout the entire time that
7 she was in labor.

8 So fetal heart rate monitoring. What is
9 that? I'm going to talk about tools the team used to
10 determine and make sure that this baby was being
11 delivered safely. The first tool is this monitoring,
12 fetal heart rate monitoring, which is pictured here.
13 It has transducers that are picking up signals of a
14 heart rate here but also picking up signals as a
15 uterine contraction. So this gives the health care
16 providers, especially the nurses who are the eyes and
17 ears for Dr. McNeive, as to what is going on with the
18 baby.

19 Here is a graph. You've seen this
20 earlier. It shows a sampling of the kind of
21 information that the nurses and Dr. McNeive had
22 during the time that she was in this second stage of
23 labor. What it does is measures both the heart rate
24 and the rhythm, and it also gives information about
25 averages of the heart rate, changes that are

1 happening with the heart rate, and variability in
2 that heart rate, that is, there are things going up
3 and down.

4 And you're going to hear a lot about these
5 terms deceleration, acceleration, variability, mild
6 to moderate variability, all of those will be defined
7 for you. But the point that you -- will be made that
8 you will hear is that throughout the entire time that
9 she was in the second stage, it was -- the second
10 stage was indeterminate, but she was making progress,
11 and she was doing fine.

12 Now, three categories in the fetal heart
13 monitoring. You heard from Ms. Gunn that the first
14 category is normal. The second stage is
15 indeterminate. And that's what most of the time that
16 she was in labor was showing in terms of the fetal
17 heart rate. Indeterminate means it's not -- it's
18 neither good or bad, it's just there.

19 And you have to match that with the way
20 the baby looks and appears and the way the mom is
21 progressing. And throughout the entire time of stage
22 2, there was reassuring fetal heart rate information
23 that was there for the nurses and for Dr. McNeive, so
24 three categories.

25 Dr. Warsof, who is plaintiffs' expert

1 OB/GYN, who is going to be testifying before you, he
2 will agree and concede that during this Category II,
3 there were repeated returns to Category I. And there
4 were accelerations which were reassuring and were
5 reassuring to Dr. McNeive and to the nurses.

6 The ACOG guidelines, they will tell you,
7 and we're going to be relying on those ACOG
8 guidelines because they guide what these specialists
9 do. They'll tell you that stage 2 does not mean that
10 you have to do something different. That you take
11 actions such as repositioning the patient, giving
12 Pitocin, other things that you can do to get the baby
13 through that Category II.

14 You're also going to hear from Dr. McNeive
15 and from the nurses, that up until 4:00 p.m.,
16 everything that they saw on those strips was
17 reassuring, telling them that the baby was going to
18 be delivered safely. It was only till 4:00 p.m.,
19 that the strips then went into this Category III. By
20 that time, at 2:00 p.m., Dr. McNeive was by her
21 bedside, was there every minute until delivery,
22 examining her, talking to her, coaxing her, helping
23 her, watching the monitoring, and 4:00 p.m., it went
24 into this Category III. The delivery happened just
25 24 minutes later, which everyone agrees was an

1 appropriate and prompt delivery time.

2 okay. The second tool that was being used
3 was continuous observation. Pretty straightforward.

4 But there was always a nurse at her bedside. There
5 was always a nurse who was watching those strips.

6 And it was continuous and being reported to Dr.

7 McNeive from time to time.

8 There were also other providers that I

9 talked about earlier who came in and saw Mrs. Anyan

10 on the safety rounds and on the strip rounds. Dr.

11 Mckillip, you heard about her, but she examined Mrs.

12 Anyan at the very beginning of stage 2. She was an

13 OB resident. And also April Parker, who was a

14 colleague of Dr. McNeive's, also examined and made

15 decisions about the care and treatment of Sarah

16 Anyan.

17 All right. Safety round: 10:45 a.m.

18 Now, this was a hospital protocol just to make sure

19 that all these deliveries are happening and are doing

20 so safely. And in this case, safety rounds were

21 followed by these two nurses and by the midwife,

22 Tamsin Lewis. And also, in addition to the safety

23 rounds, which is the belts and suspenders, someone is

24 looking at it from a neutral observation, making sure

25 that things are being done safely.

1 At 2:48 p.m., there were strip rounds.

2 And the strip rounds involved the chief resident, a
3 fourth-year resident, an in-house attending, a
4 midwife, a nurse midwife, a charge nurse, a bedside
5 nurse, and a high-risk OB attending or a
6 maternal-fetal medicine attending.

7 Many of those people had nothing to do
8 with the care and treatment, other than doing these
9 independent observations. And they're looking at the
10 strips to make sure that things are going the way
11 they should, and they determined that they were both
12 at 10:45 a.m. and 2:48 p.m. So observation, watching
13 the fetal heart rate monitor, and the safety rounds,
14 the strip rounds, all tools they used to make sure
15 that this delivery was proceeding smoothly and
16 successfully.

17 All right. Fetal station. In this case,
18 Dr. McNeive and the nurses will tell you she was
19 making progress, that this fetus was moving down the
20 birth canal. It was slow. There's no question about
21 that, but there was always movement towards plus 3
22 station. So she went from minus 3 to plus 3 station
23 during the time she was at Mercy. And by the time
24 she was at plus 3, that was the time to deliver.

25 Another tool that's used is Pitocin. Now,

1 what is Pitocin? It's a synthetic medication that
2 mimics a hormone that allows for increased
3 contractions, and it's used often in labor and
4 delivery. In this case, it helped induce her labor
5 to keep that labor going. It was used in gradual
6 doses.

7 And Ms. Gunn talked about the hospital
8 policy. That hospital policy is implemented if, in
9 the clinical situation, there is not progress being
10 made. Here, progress was being made. The nurses
11 used some of the things that were suggested in the
12 guidelines such as repositioning her and giving her
13 Pitocin, all things that were done pursuant to
14 hospital policy.

15 Pitocin was being used because her
16 contractions were weakening and spacing out, and so
17 Dr. McNeive, in his training and in his experience,
18 decided that we needed to keep giving her gradual
19 doses of Pitocin, and it was done appropriately.
20 Throughout the entire time that Mrs. Anyan was in
21 this second stage, Dr. McNeive was fully aware of
22 what was going on.

23 Now, we heard a lot about the time of
24 stage 2 labor, the length of time. It was a long
25 time. But no one is going to come in here and tell

1 you that there is a ceiling as to how long this
2 second stage should occur. No one. I'll repeat
3 that. Nothing in the medical literature, none of the
4 experts will say there's an absolute ceiling by which
5 you must do a C-section or do something different
6 during that second stage.

7 The ACOG guidelines will tell us that,
8 that there's no set limit. These are the guidelines
9 that govern what OBs do in this situation. And those
10 OB guidelines and the ACOG guidelines will say
11 there's no set limit to the duration of the second
12 stage, so long at the patient is making progress,
13 which she was doing.

14 During the time that she was in the second
15 stage, she went into periods what are called laboring
16 down, and Ms. Gunn referred to that. Laboring down
17 means she takes a break. And she did this a couple
18 of times in this case at the suggestion of the
19 nurses. So for a half an hour or so, she would stop
20 pushing and was not in active labor. So actually the
21 time of the second stage was not 12 hours, it was
22 more like 8 or 9 hours. But, again, the important
23 point is there's no set time limit for the second
24 stage.

25 All right. So Dr. McNeive's involvement

1 on May 4th, what was it? His first visit with her
2 was at 8:00 a.m., when he came on shift. And he took
3 information from Dr. Parker as to what had been going
4 on with Sarah Anyan before he arrived. He was at her
5 bedside talking to her, examining her, asking how she
6 was doing, and she was reassuring. She said, I'm
7 pushing. I still want to push, and I'm doing fine.

8 There were frequent visits that Dr.
9 McNeive made during that afternoon. How do we know
10 that? Mr. Anyan will tell you that, that he came in
11 and out frequently to check on Mrs. Anyan. Now,
12 2:07 p.m. is documented that Dr. McNeive is at her
13 bedside, and there he remained until delivery at
14 4:24 p.m., constantly examining her, talking to her,
15 making sure that she is comfortable and able to push.
16 She hasn't fatigued out and doing what she was
17 supposed to be doing. And so the delivery was at
18 4:24 p.m., and it was a vaginal delivery.

19 Now, cesarean sections, you've heard a
20 little bit about them. It's a procedure that can be
21 done to deliver a baby other than by vaginal
22 delivery. It's cutting into the belly and extracting
23 the baby. There are risks and complications that
24 everyone agrees are associated with doing a
25 C-section. And everyone will agree that the

1 preference is for vaginal delivery because of those
2 risks and complications of C-section.

3 Dr. McNeive did have discussion with Mrs.
4 Anyan about doing a C-section. That discussion was,
5 Mrs. Anyan, Sarah, we could do a C-section. I don't
6 recommend it because you're making progress. You're
7 continuing to do okay and push and deliver this baby.
8 But if you want it, you can have it, but I don't
9 recommend it. And she agreed with his plan at that
10 time.

11 Now, by midafternoon, as you heard, it no
12 longer became an option because the baby became too
13 low and too engaged in the birth canal, and he
14 wouldn't be able to scoop that baby out of the uterus
15 with a C-section.

16 So second point, those are the things that
17 Dr. McNeive and the team did to make sure that this
18 delivery was safe, and by all measures, they thought
19 that it was successful. But we have learned, putting
20 the pieces of the puzzle together, that this injury
21 occurs days before the delivery. How do we know
22 that? There are four factors that we looked at to
23 determine that this delivery was not the cause of the
24 birth injury, but it was days before.

25 First of all, normal Apgar score. And

1 I'll talk about what that means in just a minute.

2 Second, the NICU team assessment. Neonatal intensive
3 care unit, NICU, that's what that means. That team
4 comes in and assesses a baby when there's a question
5 about whether that baby needs additional medical care
6 and treatment. That team did that and determined
7 that Remington Anyan could go to the normal nursery.

8 The third factor is an MRI that was
9 performed on May 6th. And you're going to hear from
10 Dr. Tekes, who was a neuroradiologist, about the
11 interpretation of that study, and what it shows in
12 terms of the timing of the brain injury, an
13 unfortunate and tragic brain injury.

14 And the fourth factor are liver tests that
15 were done at the same time on May 6th.

16 So Apgars, you've heard that description,
17 is an acronym standing for A for activity, P for
18 pulse, G for grimace, meaning reflexes/irritability,
19 A for appearance, skin color, and R respiration.

20 This is a universally-accepted test that's done
21 immediately after a baby is born. And it's done at 1
22 minute and then at 5 minutes.

23 The Apgar score here was performed by Mary
24 Spencer, who is a nurse practitioner with that NICU
25 team that I was just talking about, not an employee

1 of Dr. McNeive, not an employee of Mercy. We have
2 no -- she has nothing to gain by her testimony. She
3 is the living memory of what happened on that day,
4 May 4, in during the Apgar scoring. She's the one
5 who scored that for Remington Anyan.

6 She came there, along with the NICU team,
7 because Mrs. Anyan had developed a fever. Something
8 that happens. It's a known complication. He wanted
9 to make sure that everything was all right, so he
10 called the NICU team. A good thing for him to do.

11 So Ms. Spencer starts the timer at the
12 very moment that the baby is delivered and then does
13 the scoring that we talked about. And you'll see
14 that there was a substantial improvement from the 1-
15 minute Apgar score to the 5-minute Apgar score.

16 Very significant. Because what it tells
17 us, and this is the scoring that Nurse Spencer did,
18 is that this baby was doing okay at the time of
19 delivery. Here are the different scorings that Mary
20 Younger Spencer gave. This is the living memory of
21 what the Apgar score was and should be, not looking
22 at it four years later. But she is the one, a
23 neutral, independent observer, giving this score for
24 all the treating physicians and health care
25 providers.

1 so that's the first point, a normal Apgar
2 score, a score of 8. Above 8 is fine. Means the
3 baby is doing fine. The second factor is the NICU
4 assessment. This NICU team came in and examined
5 Remington Anyan and determined that he was able to go
6 to the regular nursery. He did not need to go to the
7 NICU to get additional medical treatment. That he
8 was doing fine at the time that they saw him.

9 Marry Spencer is going -- well, she'll
10 talk about the examination that was done by the NICU
11 team, the assessment that was done, and the decision
12 was made to send Remington to the regular nursery.

13 All right. Third factor: the May 6 MRI.
14 What is an MRI? Some of you may have gone through
15 that test or had family members who have gone through
16 that test. It's the use of magnets and radiation and
17 computer to evaluate organs within the body. And in
18 this case, it was an evaluation of the brain. It
19 gives you a three-dimensional picture of the brain.
20 It's the gold standard. It is a very significant and
21 very accurate test.

22 That MRI shows that there was one acute
23 injury that happened days before delivery, not two
24 injuries, which is what some of the experts that Ms.
25 Gunn is bringing in. But one acute injury, meaning

1 it happened quickly, and it happened days before
2 delivery.

3 The final factor is that May 6th test, lab
4 test, looking at a different -- giving a different
5 analysis of the blood. So what does the body do when
6 there is hypoxia, meaning there's a shortage in
7 reduction in oxygen? Well, the body is smart, it
8 shuts down other organs before it shuts down the
9 brain, protecting the brain, which is very important.

10 In this case, liver tests show that the
11 liver was mildly elevated. You'll hear from experts
12 that that tells us that the injury occurred days
13 before delivery, because if it happened at the time
14 of delivery, which is what Ms. Gunn is suggesting,
15 those liver tests would have been elevated, would
16 have been very, very abnormal. That was the
17 situation that indicates to us again that this injury
18 occurred days before delivery.

19 All right. So after delivery, blood gases
20 were not obtained. Now, you could question, well,
21 why not? When Apgar scores are normal, which was
22 what happened in this case, was not something that
23 Dr. McNeive did, but Mary Spencer Younger and the
24 members of the NICU team did.

25 when those Apgar scores are normal, it is

1 not necessary to get a blood gas. why is that? Not an O
2 Because Apgar tells us that the baby was normal at
3 that very time of delivery. So the NICU did their
4 team assessment, and the baby was transferred to the
5 newborn nursery. Now, 9 hours later, Ms. Gunn talked
6 about the unfortunate change of his condition. He
7 was then transferred to the NICU for the additional
8 and specific medical treatment that he can get in the
9 NICU. Not an Official Court Document

10 All right. One of the things that we're
11 going to have to talk about is what is the life
12 expectancy for Remington Anyan? It's a distasteful
13 thing to have to talk about, but that's a real factor
14 that you need to take into account. Not an Official Court Document

15 Now, we believe that the evidence is that
16 Dr. McNeive met the standard of care, and that he did
17 not cause or contribute to cause this injury. But if
18 you don't believe that, it is our obligation, my
19 obligation, my responsibility, to suggest to you what
20 needs to be done to take care of Remington Anyan for
21 the rest of his life. Not an Official Court Document

22 This is a good, caring, loving family. Not an Official Court Document

23 They're doing a wonderful job with him taking care of
24 him. And they're going to talk about what they need
25 for the future. The evidence is going to be that

1 because of his limitations, that rolling over,
2 sitting, crawling, walking, and feeding himself, that
3 he is not -- he's going to have 27 years of
4 additional life.

5 This comes from Dr. Robert Shavelle, who
6 is an expert in life expectancy. This is what he
7 does for a living, and he's going to tell you that
8 unfortunately, because of those factors, he has an
9 additional 27 years of life on his plan.

10 All right. Let me talk about the experts
11 that we have asked to look at this case to give a
12 neutral, independent evaluation, assessment, and
13 opinions about what happened.

14 And the first one I'm going to talk about
15 is Dr. Tekes. She is a pediatric neuroradiologist at
16 Johns Hopkins in Baltimore, Maryland. She has
17 reviewed that MRI, and she will tell you that those
18 images, and she'll show you what she sees, those
19 images show an old injury that happened three to four
20 days before delivery.

21 The second expert you're going to hear
22 from is Joseph Canteley. He's at the University of
23 Texas in San Antonio, a neonatologist and specialist
24 in taking care of babies right around the time of
25 birth. That's what he does for a living. And he's

1 on faculty at the University of Texas and received
2 his medical degree from Johns Hopkins. Official Court Document
3 He's going to give the opinion that this
4 injury occurred before admission to the hospital,
5 most likely. what he did is he looked at this case,
6 without knowing anything else, he just looked at the
7 medical records to see what happened. And at first
8 he thought, well, this case must be about infection
9 because I see that there was a fever. He learned it
10 wasn't about infection, that it was about this brain
11 injury, and giving his neutral, independent
12 evaluation that this injury occurred before hospital
13 admission.

14 The third expert you're going to hear from
15 is Brian woodruff who is on faculty, teaches at
16 Michigan State University, and his expertise is as a
17 pediatric neurologist studying the brain and nerves
18 of babies. He's at Michigan State. He will give the
19 opinion that, based on his review of the records, the
20 injury happened before delivery.

21 And, finally, Mark Landon, who was an
22 OB/GYN at Ohio State University. All of these
23 experts are coming from institutions that are
24 respected in the field of medicine, and that includes
25 Dr. Landon from Ohio State. His opinion is that the

1 Anyan team approach, the way that they approached
2 this labor and delivery, that it met the standard of
3 care.

4 That what Dr. McNeive did was appropriate
5 under the circumstances, that he was following
6 guidelines, that he was there watching her,
7 monitoring her, that he did what he was supposed to
8 do to make sure that there was a vaginal delivery,
9 what everyone, including Mrs. Anyan, wanted.

10 All right. I ask you to compare this to
11 the experts that Ms. Gunn is bringing in. Dr. Sze,
12 she talked about. He's retired. He doesn't practice
13 medicine anymore. Compare that to Dr. Warsof, who's
14 done only a handful of deliveries since that
15 unfortunate time that we were in COVID. That's been
16 almost 5 years now. He has done only a handful of
17 deliveries, unlike Dr. McNeive, who continues to
18 practice every day and deliver babies at Mercy
19 Hospital.

20 And Dr. Nelson and Dr. Kerzner, both of
21 them are frequent experts for plaintiffs in cases
22 like this. This is what they do as part of their
23 living, not all of it, but part of their living.

24 Okay. Let me talk about punitive damages.
25 All of what I just talked about is in the context of

1 that burden of proof of the preponderance of the
2 evidence, meaning more likely than not, which is Ms.
3 Gunn's burden.

4 But there's a separate burden. They're
5 also wanting you to award punitive damages to punish,
6 to punish Dr. McNeive and his employer Mercy Clinic.
7 That burden of proof, though, is clear and convincing
8 evidence. I talked to you about that when we were
9 picking you as jurors. That it is much higher than a
10 preponderance of the evidence. It's between that
11 level of burden of proof and the criminal burden of
12 proof, which is beyond a reasonable doubt. It's very
13 high.

14 You must be guided by that instruction as
15 to the burden of proof. And if you find that there
16 was enough information for you to punish Dr. McNeive,
17 you must find that he intentionally caused damage or
18 that he demonstrated malicious conduct.

19 Now, let me ask you some questions. Is it
20 intentionally causing damage when he is by her
21 bedside for several hours examining her, coaxing her,
22 is that intentionally causing damage? Is it
23 intentionally causing damage when he learned that
24 this baby had experienced this tragic brain injury,
25 and he visited this family frequently, wanting to

1 make sure they were okay, doing what he could to help
2 them out, feeling terrible, feeling like this is not
3 something that he, as an OB, would ever want to
4 happen to any of his patients.

5 Is it demonstrating malicious conduct when
6 he has never been a defendant in a lawsuit, other
7 than this one, doing over 3,000 labors and deliveries
8 in his career? He's never had a lawsuit until this
9 one. Is that malicious conduct? Ask yourself that
10 when you're deliberating and talking about punitive
11 damages. Ask yourself what evidence is there that he
12 was intentional in causing damage to Remington Anyan
13 or that he was malicious, mean-spirited, that he was
14 monovalent, that he was doing something that was evil
15 and not accepted.

16 okay. So frequent visits with Sarah Anyan
17 during labor, does that fit into the picture of
18 punitive damages? You'll hear from Mr. Anyan that
19 she was being visited frequently by Dr. McNeive.
20 Minute-to-minute attention to Remington Anyan for
21 2 hours, is that punitive damage conduct? Is that
22 intentionally causing injury to Remington Anyan?

23 Frequent visits with and concerns about
24 her and Remington after learning of the injury when
25 he learned that this had happened. And that's when

1 he had the discussion with Mrs. Anyan where she said,
2 I thank you for giving me the vaginal delivery that I
3 wanted.

4 And, finally, no other lawsuits, other
5 than this one, with 3,000 or so labors and deliveries
6 over the course of 24 years, is that somebody who
7 would be malicious in his conduct?

8 So at the end of the case, I'll be asking
9 you to return a verdict on behalf of Dr. McNeive.

10 It's going to be hard. It's going to be very hard.

11 This is a wonderful family. You will not hear
12 anything from any of our witnesses or from me that
13 will question them. They love that child. They're
14 taking care of him. And they really care about him
15 deeply. And that's not an issue.

16 What is the issue is did Dr. McNeive use
17 that degree of skill and learning that's ordinary
18 used? Certainly. Did he follow accepted guidelines?

19 The evidence will be yes. Did he use his years of
20 experience, 24 years? Yes, he did. Did he use his
21 training as a specialist as an OB? Yes, he did. And
22 is there evidence that this injury occurred days
23 before delivery? Yes, there is.

24 That will put in doubt the burden of proof
25 that Ms. Gunn has. And for those reasons, at the end

1 of the case, I will be asking you to return a verdict
2 on behalf of Dr. McNeive and his employer, Mercy
3 clinic. Thank you for your time.

4 THE COURT: Thank you.

5 on behalf of Mercy Hospitals?

6 MS. KAMYKOWSKI: Yes, Your Honor. If I
7 can have a minute to just pull it up?

8 Fast, Justin.

9 Opening Statement on Behalf of Defendant Mercy
10 Hospitals East Communities d/b/a Mercy Hospital
11 St. Louis

12 MS. KAMYKOWSKI: May it please the court?

13 THE COURT: It does.

14 MS. KAMYKOWSKI: Counsel?

15 It's been a long morning, ladies and
16 gentlemen. And I'm the third one you're going to
17 hear different parts of this story about. I'm going
18 to try not to recap a lot of what you already heard
19 over the past hours, but there are certain things
20 that I still need to tell you.

21 The objective evidence in this case shows
22 that Remington Anyan's brain injury occurred no
23 earlier than 4:30 p.m. on March 3rd of 2020. That's
24 24 hours before he was born, and almost 15 hours
25 before Nurse Jessie and Nurse Maggie and Dr. McNeive

1 came on shift.

2 You're not going to hear a criticism from
3 the plaintiff of any health care provider involved in
4 this case prior to 8:00 a.m., 8:00 a.m. on May 4th,
5 16 hours after the objective evidence in this case
6 shows this unfortunate brain injury occurred. We're
7 here not because of that. We're here because we have
8 tainted two experts on the burden of proof, on
9 liability, on standard of care. As you heard from
10 Mr. Willman, we have Dr. Warsof. He's an MFM expert
11 hired by Ms. Gunn.

12 We also have Heidi Shinn. Ms. Shinn is
13 actually here in the courtroom today because she's
14 going to testify this afternoon. They were both
15 hired by Ms. Gunn and are giving the only opinions
16 offering criticisms, breaches of the standard of
17 care, of any defendant in this case, based on their
18 hindsight review. We talked about that yesterday.
19 They Monday morning quarterbacked this case because
20 they knew the outcome.

21 You're going to hear that knowing the
22 outcome taints their review. It's unreliable.

23 Monday morning quarterbacking, as I told you, you're
24 not going to be allowed -- they're not allowed to do
25 it, but they do. The law does not allow it. You

1 have to judge, and they should have judged, these
2 nurses and Dr. McNeive on what the standard of care
3 was, which is under the circumstances as these
4 existed on May 4th, not as they existed in 2021 or
5 2022, when they were contacted by Ms. Gunn and told
6 the outcome of this case.

7 You can't unring that bell. That's the
8 Waldo. They saw the Waldo before they looked at a
9 record. We will present to you the objective facts
10 and the data that was available to that bedside team
11 that Mr. Willman just talked about at the time it was
12 available to the two nurses who are at issue in this
13 case and Dr. McNeive. And it will show that Nurse
14 Maggie and Nurse Jessie appropriately monitored and
15 assessed Sarah Anyan at all times when they were her
16 nurses on May 4th, 2020, when she was in the second
17 stage of labor.

18 They were working alongside Dr. McNeive so
19 that he and Sarah Anyan could effectuate the vaginal
20 delivery that she wanted, despite what everyone
21 agrees was a long second stage of labor. We're not
22 disputing that. This is a long second stage.

23 Nothing the nurses or Dr. McNeive did caused or
24 contributed to cause the damage in this case. And
25 that's because his injury occurred before 4:30 p.m.

1 on May 3rd.

2 And I'll try to go through some of this
3 quickly. Ms. Gunn did a good job at introducing my
4 clients. On behalf of Mercy Hospital, we've got two
5 nurses who were employed: Jessie Wagner, who we told
6 you will testify probably late next week. And she
7 accurately explained her education and experience.

8 By the time Jessie was involved in Mrs.
9 Anyan's labor and delivery, she had been involved in
10 over 400 prior deliveries. She was supervising
11 Maggie, who was still in her last months of a
12 four-month-onboarding orientation on-the-job training
13 program. And she was certified in reviewing,
14 interpreting, monitoring, reassessing, and addressing
15 things seen on fetal monitor strips. She'll tell you
16 that.

17 And as you know, Maggie was still in her
18 training. She had been in the health care industry
19 for a very long time but decided she wanted to become
20 a nurse and decided she wanted to work in labor and
21 delivery. So this was her first job. She started in
22 January of 2020. And at that time, she just went
23 through what anybody else, any employee, regardless
24 of whether they were a health care provider, at Mercy
25 Hospital had to do: She had to sit for a month and

1 listen about how do you put your time in? where do
2 you park your car? You know, all those things.
3 And then in February, she got boots on the
4 ground. She got to meet up with Jessie. Jessie was
5 per preceptor. And she and Jessie were a team on
6 every single shift she had from February through the
7 beginning of June.

8 So by May 4th of 2020, when she shows up
9 for her shift at 7:00 a.m., she had already been
10 through about 90 days of three shifts a week
11 approximately, because they work 12-hour shifts, so
12 three, 12-hour shifts a week with Jessie by her side
13 teaching her, encouraging her, and showing her the
14 ropes on how to be a great labor and delivery nurse.

15 She estimated, when she was deposed by Ms.
16 Gunn, that during that time frame, she was probably
17 delivering about six babies a week during her
18 training. I'm pretty bad at math. Lawyers are
19 classically known not to be good at math. But I
20 think if you say 90 days, that's about four months --
21 I'm sorry -- three months, four months -- four weeks
22 in a month, twelve weeks times six, I'm roughly going
23 to say about 75 babies that she had already helped
24 bring into the world at that time.

25 so let's talk about May 4th. Again,

1 you're not going to hear -- you're going to hear
2 about May 3rd, and we're going to talk about May 3rd
3 because the Anyans were in the hospital. Sarah's
4 water broke about noon on May 3rd, and they arrived.
5 They got put into the hospital, she was in a room
6 around 2:30ish on May 3rd. So you're going to hear
7 about May 3rd. But you're not going to hear any
8 criticism until May 4th, and that's when Jessie and
9 Maggie were the only nurses for Sarah Anyan.

10 You heard Ms. Gunn say the policy is
11 one-on-one nursing when a woman is in the second
12 stage. Sarah Anyan got two nurses. Two nurses
13 double-checking each other, making sure they were
14 doing what needed to be done to evaluate, surveil,
15 and reassess everything that was going on in that
16 room.

17 So as you heard, they were working a
18 12-hour shift. They started at 7:00 a.m. The first
19 thing that they do is they have a huddle. They get
20 together -- well, they find out, we're going to have
21 one patient today because we've got this one lady who
22 is in second stage, and she's pushing. And you're
23 going to be here, and you're going to get this baby
24 delivered.

25 So they go into the room -- or maybe right

1 outside the room because she's still pushing with
2 Sarah. So they have a conversation around 7:15. And
3 you'll see it documented. And they took her report
4 from Alex. And that just means Alex tells them kind
5 of the who, what, when, orient me to the situation.
6 what's going on with this patient?

7 And she tells them, Sarah's a first-time
8 mom, and this is all based on standard reporting,
9 right? No one really remembers the exact words that
10 were said at that minute, but they can tell you what
11 they were always told, or if they were the nurse
12 handing off to someone else, information they would
13 tell that nurse.

14 So we know Maggie and Jessie knew Sarah
15 was a first-time mom who was in her second stage of
16 labor, that she had had her labor augmented by
17 Pitocin -- and you heard about that. And at that
18 time, it was running at 18 microunits. It was never
19 turned up by these nurses before ordered by Dr.
20 McNeive after two o'clock.

21 And they knew that she was in the second
22 stage and that she had been pushing since around
23 4:30. You'll see documentation that right after this
24 report was given, Maggie goes into the chart, and she
25 says, pushing on bed, 4:28 a.m. Pretty specific. It

1 was likely because she was told that from notes that
2 Alex had at the time of the handoff.

3 And you heard that one of them was in the
4 room with her at all times she was pushing. Ms. Gunn
5 showed you her graphic that talked about the laboring
6 down period in that morning and afternoon of this.

7 There may have been a time when the laboring down
8 that I think totalled close to 3 hours. I'm not
9 really sure. That Jessie and Maggie met at the
10 nurses' station to work on charting.

11 You'll see different times that they're in
12 the chart putting in their notes. They're supposed
13 to be documenting every 15 minutes when a patient's
14 in second stage. But you're holding a leg, or when
15 you're at the foot of the bed watching efforts of
16 pushing, you're really worried about watching and
17 helping your patient, not getting documentation into
18 the chart. But when she wasn't laboring down, they
19 were in that room with her the entire time.

20 So, again, not a one-on-one pushing
21 situation, she's got two nurses with her. And while
22 they're -- let me go back, maybe. Well, and while
23 they're there, if they're at the nurses' station
24 charting, the nurses' stations have monitors for
25 every person in that pod. So there are a few

1 different labor rooms that could be active at one
2 time. So they would have her strips up to watch,
3 even if they weren't in the room.

4 So just to go back and recall. The second
5 stage of labor is -- and Ms. Gunn talked about this,
6 and I'll go through this quickly -- fully dilated,
7 pushing, and it ends when the baby is delivered. And
8 then there's a third stage that happens after that.

9 And you've heard this multiple times, that
10 the guidelines in this case recommend at least 4
11 hours -- okay? -- of pushing in this second stage.
12 And those guidelines specifically contemplate what
13 happened in this case, a baby was malpositioned.

14 And you heard all about the malposition.
15 He was OA. That's occiput -- I'm sorry -- OP,
16 occiput posterior: sunny side up. That means that
17 if he would have come out, he would have been looking
18 straight up at his mama's face. Most babies come out
19 looking at the floor, okay?

20 So he's in a position that -- and he
21 started in a position sunny side up. And that
22 guideline allows this at least 4 hours to see if a
23 baby, traversing down through those stations and
24 through mom's birth canal, can turn himself. It's a
25 known phenomenon. Spinning babies happen. It

1 happens all the time. And I think it sounds like Ms.
2 Gunn agreed that there's no upper limit to the length
3 of a second stage.

4 She admitted that everyone agrees that you
5 have to use your clinical judgment, based on the
6 situation in front of you. Guess what? That's the
7 standard of care. What would a reasonable provider
8 do under the same or similar circumstances? And
9 that's what we're here to talk about.

10 In a second stage, you're going to hear
11 the literature supports it, and no expert in here is
12 going to disagree, fetal heart rate patterns, the
13 vast majority of them, are Category II,
14 indeterminate.

15 So what do you have to do? Let's talk
16 about the fetal monitoring, and then we'll talk about
17 the categories. It's been around for 40 years. I
18 think it's the early '80s -- makes me realize how old
19 I am -- but the early '80s. 40 years to assist
20 doctors and nurses. And as you heard before, it has
21 the two parts. We look at the fetal heart rate, and
22 we look at the uterine contractions.

23 Those have to be looked at in conjunction
24 with each other. You cannot isolate them. Because
25 if you have a fetal heart rate that looks great and

1 no contractions, you just have a good fetal heart
2 rate, you're not progressing to delivery. You have
3 to have good contractions.

4 You also have to look at what is going on
5 with the heart rate directly in relation to a
6 contraction when it happens. When moms push, heart
7 rates go down. No one is going to disagree with
8 that. A baby's head getting squished as it goes
9 through down those stations and through the vagina to
10 come out, the head, compression on the head, causes
11 an early deceleration. If a baby's body part or part
12 of mom's hips or pelvis pinch the cord, sometimes
13 babies grab them themselves, you might have a
14 variable deceleration, which is a sharp dip in there.

15 You can have a late deceleration, which
16 does show if the uterus is contracted, if mom takes a
17 breath, my oxygen goes through to your -- the oxygen
18 mom takes in goes down through her bloodstream, into
19 the placenta, crosses over the fetal-maternal
20 barrier, into the baby through the umbilical cord,
21 yes, that is a natural process. Every baby who is
22 pushed out of the vagina goes through decelerations
23 of his heart rate, every single one, and everyone
24 here knows it.

25 So we looked at this -- Mr. -- I think

1 everybody shows what this is. I'm not going to go
2 through that again. But I do want to talk just a
3 little bit more about what you guys -- you're going
4 to see these strips a lot, and you're going to have a
5 copy of them if you want them when you go deliberate,
6 so I want to make sure when you're able to get them
7 close to you, you understand what we're talking
8 about.

9 So this is actually a page from Remington
10 Anyan's fetal heart strips. And you'll see there
11 that it's at 1326, military time. That's 1:26,
12 right? 1:26 in the afternoon, right? And each of
13 these boxes on this screen, if you're going from left
14 to right, if you're looking at horizontally, is 10
15 minutes, okay? So a box is 10 seconds wide, and then
16 obviously six of them would make up 1 minute of time.

17 Each of the boxes vertically, so up and
18 down, shows a variation of heart rate of 10 beats per
19 minute, okay? You're going to hear a lot about this.
20 So on this -- on this particular page, the heart
21 rate, and, again, we're only 8 minutes, you're going
22 to hear you can't judge anything by 8 minutes. The
23 guidelines require you to look at 10, okay?

24 So when you look at a single page that we
25 show you, remember we should be looking at at least 2

1 minutes before or 2 minutes after before we make any
2 real conclusions. But this is the best we've got
3 because when we get the electronic monitoring printed
4 out for us, it's going to be 8 minutes.

5 So this page shows us a baseline, meaning
6 what is this kind of average with those peaks and
7 valleys that are happening, and that's called
8 variability. This is about 155 -- 155, I think. And
9 the nurses and the doctor in this case can tell you.

10 I'm not an expert at this.

11 So what you're looking for is that as the
12 baseline. Then the nurses will watch what is going
13 on on the bottom. So on the bottom, as Ms. Gunn told
14 you, is the contraction pattern. So that's from a
15 totally different piece of equipment: two -- two
16 different things on the belly at the same time, and
17 it's going to check what mom's uterus is doing.

18 And what it does, it has the same 10
19 seconds across -- right? -- the box is 10 seconds
20 wide. But the up and down has nothing to do with
21 heart rate. The up and down on that part of the
22 graph is talking about the strength of the
23 contractions, okay? And this patient always had an
24 external monitor. And so you'll hear from everyone
25 here that the external monitors are not necessarily

1 the best for assessing how strong the contractions
2 are.

3 And the reason why that's important is
4 because when you're looking at progressing labor to a
5 delivery, you have to have lots of things with a
6 contraction pattern. They have to be of sufficient
7 duration, which is the number, right? You can't just
8 have one contraction every 10 minutes. That's not
9 going to get the job done.

10 They have to be of sufficient intensity,
11 which is how strong they are. And that's measured
12 here on this up and down part. They have to be of
13 sufficient -- also, further duration, so number and
14 then duration. While the uterus is contracted, how
15 long is it actually? So you have to have a certain
16 number of them to progress things, and then each of
17 them has to be long. Because if the uterus is just
18 weakly contracting, that's -- you need to have a
19 certain number, a certain length of time, a certain
20 strength, and then you also have to have rest time.

21 Think about your muscles. The uterus is a
22 giant muscle. It's a very strong and powerful
23 muscle. And just like your other muscles, you can
24 get a cramp, or they don't work, and they're
25 contracting too long. So it needs to relax, and it

1 needs to do that on a regular basis.

2 And the nurses know this. And part of
3 that that they assess, when you have an external
4 monitor, you can't tell really how strong they are.

5 You can't really tell how much relaxation time there
6 is. And you might not even be able to tell
7 frequency, of how many number there are. So they put
8 their hand on her. It's called palpation. It's the
9 way people did it for hundreds of thousands of years
10 before 1980, when they had electronic fetal
11 monitoring, right?

12 Put your hand on the belly, and at that
13 time, and before 1980, here in this country, take a
14 stethoscope, listen to the heart rate on mom's belly.
15 You can hear mom's heart rate and baby's heart rate,
16 right? This is not something new, this concept of
17 monitoring a mom. We just now have electronic
18 options.

19 So you're going to hear more about
20 baselines and variability and accelerations and
21 decelerations as we go through this. But the
22 interesting thing about baby fetal heart rate
23 patterns in labor is that they fluctuate, they're
24 dynamic, they don't stay the same, and they're
25 transient, right? So they change all the time, and

1 there's no prediction as to what a baby might do.

2 So what that does is it requires the

3 people who know what they're doing to frequently

4 monitor what's going on here with what's going on at

5 the bedside, particularly in the second stage, right?

6 These nurses, in the second stage, they're not just

7 standing at the head of the bed and watching a

8 monitor, they're watching as these pushes happen.

9 They're watching the baby's head. They're looking

10 You know, I don't know who has actually

11 seen a baby be delivered, but most people don't want

12 to watch it. That's their job. They have to do

13 that, and that's what they're doing. And so they're

14 doing that to get the overall clinical concept.

15 You cannot isolate, in Monday morning

16 quarterback, looking at just fetal heart rate

17 tracings. There are only three people you're going

18 to hear from in this trial who were in that room.

19 And they're going to tell you the entirety of the

20 clinical context that they were working under with --

21 I'm sorry -- there are not three, there are 5: three

22 health care providers and two patients -- right? --

23 Mr. and Mrs. Anyan. And you're going to hear from

24 them where everybody was and what everybody was

25 doing.

1 The fetal heart rate, as I said, can be
2 affected by the baby. There are things the baby can
3 be doing in there. They sleep. And, yes, babies
4 sleep even when their mom is pushing. It's weird,
5 but it happens, and the nurses know what that is. It
6 looks like decreased variability on a fetal monitor,
7 right? They're aware of that.

8 The baby can grab the cord, like I told
9 you. There are reasons for various types of fetal
10 heart rate decelerations. And moms, moms can impact
11 babies. If mom has a fever, baby has a fever.
12 Baby's inside mom. Baby has mom's temperature. If
13 mom has a fever, baby is going to have a fever. What
14 does fever cause? Increased heart rate, right? So
15 that's one thing that everybody knows. If mom gets
16 sick, you'll hear that at one point in time, Mrs.
17 Anyan was getting sick in this case, it happens.
18 People pushing throw up.

19 And that can change what the monitor looks
20 like for baby and mom's contraction pattern, right?
21 Because external monitors get moved around. If mom
22 sits up, if mom moves from left to right, if mom lays
23 back on her back, all of those things can take --
24 every one's taken into account. Even mom has
25 anxiety, which anybody who's had a baby, it has a lot

1 of anxiety-inducing moments.

2 You heard about Category I. The one thing

3 you haven't heard yet is what the literature

4 supports. A baby whose fetal heart rate is Category

5 I, is strongly predictive that that baby is well

6 oxygenated. Said fancily, it's got a normal fetal

7 acid base status. So remember that: Category I,

8 normal, green, good, right? Because everyone is

9 reassured that that baby is not hypoxic. And the

10 literature is what guides us on that.

11 Category III, yes, bad. Category III does

12 not mean emergency C-section. Category III means,

13 let's figure out if we can convert this. What is

14 causing that? You have some time. And the

15 guidelines also support that. There is time to

16 address a Category III, but it means, we need to be

17 moving to delivery.

18 And then Category II is everything in

19 between, right? And as -- there's no dispute here

20 that the majority of fetal heart rate patterns in

21 labor and delivery, including in the second stage,

22 are Category II. And every nurse knows that. And

23 every OB knows that. And it can include all kinds of

24 characteristics of a fetal heart rate pattern, and

25 these nurses knew that.

1 Interestingly the literature says Category
2 II fetal heart rate tracings are not, not evidence
3 that the baby has an abnormal oxygen status. You
4 cannot say reliably that simply because there's a
5 Category II, the baby is hypoxic. No one can find a
6 piece of literature to support that.

7 And all they do simply is -- and you're
8 going to see the algorithm -- they produce these kind
9 of decision trees to help these nurses at the bedside
10 to help the doctors decide, okay, we got a Category
11 II, what do we need to do about this, right? And all
12 of those say you evaluate it, you reevaluate it, and
13 you continue to monitor them, and you take into
14 account everything that's going on. That's what
15 happened in this case over and over and over again
16 with the nurses at the bedside.

17 Other things about electronic fetal
18 monitoring. Of course the plaintiff wants to lock in
19 on this is a be-all-end-all. This is the greatest
20 thing that could ever have happened to labor and
21 delivery because we now have objective evidence of
22 exactly what the baby's talking to you, right?
23 That's what he heard.

24 Well, guess what? In studies, you're
25 going to hear that since the advent of electronic

1 fetal monitoring, the incidence of HIE and the
2 incidence of cerebral palsy have not gone down. If
3 it was the be-all-end-all to prevent all of these
4 awful brain injuries from happening to children,
5 wouldn't that number have gone down? It hasn't.

6 You're also going to hear that when people
7 review strips, whether it's in training situations,
8 so Jessie and Maggie. Maggie is not certified for
9 electronic fetal monitoring. When they had to take a
10 course from a company called -- a group called
11 AWHONN. And you're going to hear that from Ms.
12 Shinn. She teaches these courses. They make them
13 review retrospectively, right?

14 And I told you we're not supposed to do
15 that when we're talking about standard of care, but
16 that's how they train them, right? They teach them
17 how to distinguish between what's minimal
18 variability? What's marked variability? And they go
19 through long bouts of training beyond their boots on
20 the ground training, right?

21 And there's studies that have looked at --
22 they've asked people to reinterpret old strips. And
23 what they find is there's high variability, high.
24 Differences in people reinterpreting strips.

25 Two ways: If Dr. McNeive looked at a

1 hundred different strips today, and somebody asked
2 him to mark variability, baseline, decelerations,
3 contraction patterns, and he looked at the same
4 hundred strips in 70 days, or some other period of
5 time, he himself would have inter -- intrareviewer
6 reliability issues because that's just the way it is.

7 But even worse, is the studies show interobserver.

8 So if I look at the same strips as a provider as

9 Maggie or Jessie, we are all going to have some

10 subjective differences in how we look at those.

11 But the worst part of it is, is if you

12 look at a strip when you know the outcome, Ms. Shinn,

13 Dr. warsof, plaintiffs' experts, that review is not

14 reliable. The literature is going to tell you that.

15 It is not reliable because you overcall things. The

16 waldo -- the waldo effect, guys. Hindsight is not

17 20/20.

18 So you've already heard this. Throughout

19 the day, Nurse Jessie and Nurse Maggie were

20 communicating with Dr. McNeive. They were doing what

21 the algorithm requires in a Category II, ongoing

22 surveillance and monitoring of those patterns that

23 they were watching while they were pushing with her

24 or while she was laboring down.

25 And they were performing nursing

1 interventions, which are required in Category II
2 tracings. They -- and there's not -- it doesn't --
3 you don't start with turning off the Pitocin. That
4 is an option, but you're going to hear that's like
5 the last one because if you need Pitocin to move to
6 delivery, you know to get this baby to come down,
7 turning it off is going to thwart your plans. There
8 are other things you do first, right?

9 And these are all within the nurses'
10 judgment and discretion, based on the mom and the
11 baby's response, okay? You're going to hear a lot
12 about the whole clinical context. You have to take
13 the whole response. And it's not a do an
14 intervention, wait a minute, and move to the next
15 intervention. These interventions take time because
16 remember if we're talking about what is the baby's
17 status, it's based on mom. Because you've got to
18 move mom to then move baby, right?

19 There is an allowance of 30 and 30 minutes
20 to an hour to see if these interventions are working.
21 And they did tons of them here, and you're going to
22 see it: position changes, multiple, multiple
23 position changes. Lateral, meaning left to right;
24 head up, head down, fully sitting, okay? You're
25 going to see those, and the nurses did all of those.

1 And every time they got to wait to see if there's a
2 response, and I'm going to show you there was.

3 Modification of pushing effort is also
4 considered an intrauterine resuscitation for the
5 baby, okay? It is addressing what you're seeing on a
6 Category II. That means if mom has contractions
7 every 2 minutes, maybe you have her push every other
8 contraction. Also, laboring down, that is a
9 resuscitative effort.

10 So we know in this case the nurses were
11 doing position changes, which are essentially the
12 first line of addressing a Category II. And then
13 they were having her labor down or otherwise
14 modifying her pushing effort. Those were all
15 appropriate. They were necessary. And they did
16 their job.

17 We also have the safety rounds, and I
18 think Mr. Willman may have gotten them switched up.
19 They happened at 10:45 and 2:48. At 10:45 in the
20 morning, Mrs. Anyan is either laboring down or just
21 started pushing after laboring down. This large
22 team, a multidisciplinary team, is going around labor
23 and delivery looking at every patient, okay? This
24 team at that time in the morning included Dr. McNeive
25 as the OB hospitalist, that was his role, either or

1 both Jessie and Maggie. I think it was just one of
2 them because one of them stays in the room to push,
3 right?

4 A maternal-fetal medicine specialist.
5 That person's job is obstetrician and neonatologist
6 combined, right? They do moms and babies.

7 Maternal-fetal specialist. That person was there.

8 An OB anesthesiologist, and a chief resident, who was
9 a resident, a fourth-year-almost-graduated resident,
10 in obstetrics and gynecology, and a nurse midwife.
11 we have a nurse midwife who we know we will need. We
12 have one of the baby nurses that was -- or one of the
13 nurses taking care of Sarah, and then Dr. McNeive,
14 and then three other doctors.

15 And at 10:45 in the morning, they looked
16 at 15 minutes of strips. That's not all they did,
17 that's what the note shows. But Dr. McNeive and
18 Maggie will tell you this, and everybody else that
19 gets asked by Ms. Gunn when she plays their
20 depositions about what these strips and safety rounds
21 entail, they would know Sarah's clinical picture.

22 So at that point she's already over
23 6 hours in the second stage, and everyone on that
24 team, so there are a nurse and Dr. McNeive, and then
25 there are four other unrelated people, saying the

1 plans here are appropriate, second stage, continue
2 pushing.

3 And there's not a single expert who's
4 going to come into this case and offer any opinions
5 that that MFM doctor, the nurse midwife, the OB
6 anesthesiologist, or the chief resident breached the
7 standard of care or were negligent when they made
8 those recommendations.

9 Then a strip review happens with a smaller
10 team at 2:48. Remember: At that point in time, Dr.
11 McNeive is at the bedside. He had been at the
12 bedside. He had already ordered the nurses, and they
13 complied, to increase the Pitocin to kick start to
14 kind of give a little boost to the uterus to see if
15 this baby can be delivered.

16 And outside of that room, again, three
17 separate people review these strips. They don't just
18 do a 15-minute strip review, and we're going to talk
19 about that. So it is again the certified nurse
20 midwife, the chief resident, and now the charge
21 nurse. This is the nurse supervisor who is on --
22 there's one on every shift, okay?

23 And they, again, know the clinical
24 scenario, and they run through a new algorithm,
25 right? An algorithm that lets them know, can we keep

1 going? It's called a Clark algorithm. You're going
2 to hear from it. So although the notes from the
3 midwife might say 15 minutes of strips review, when
4 you look at the algorithm, they have to assess the
5 last hour.

6 So they're documenting it at about 2:48,
7 and I'm going to walk you through in what happened in
8 that 1:48 to 2:48 time line. And in that time line,
9 this algorithm created by OB/GYNs, by labor and
10 delivery nurses, and by MFM doctors says observe her.
11 It does not say deliver her. It does not say
12 C-section immediately. It allows observation,
13 surveillance, reevaluation. All the things the
14 nurses were doing.

15 what we know is that Sarah Anyan made
16 slow -- yes, 12 hours is a long time to push or a
17 long to be in second stage. I think it's a little
18 over 8 hours of pushing, but total, no one is
19 disputing she was complete around 3:50, and he
20 delivered at 4:24 -- right? -- so over 12 hours.

21 But the progress is not just -- and I
22 don't have the tape measure -- it's not just 5
23 centimeters or 10 centimeters. That's not -- that's
24 not the only barometer of progress. This baby was
25 rotating, as we talked about. You're going to hear a

1 lot about that. And he went from that sunny side up,
2 to when Dr. McNeive comes to the bedside, he's now
3 OT.

4 I don't have that on there, but Ms. Gunn
5 showed you her graphic. That's the transverse. To
6 then at the time he was delivered, he was OA. He was
7 facedown, as most babies do. That is also in that
8 consideration of progress. So we know progress is
9 being made, and he came out vaginally, so he did
10 descend, even though it was slow. And throughout
11 this entire time frame, his heart rate pattern was
12 fluctuating between Category I and Category II.

13 Now, I'm not going to tell you it was
14 Category I half the time, but it went into Category I
15 multiple times that day. And, as we told you, that
16 means at that time, and as late in the three o'clock
17 hour, he's in Category 1. We know his acid base
18 status, his oxygenation, is good.

19 We know that the contractions were
20 moderate in strength. You're going to see the
21 documentation in the chart from the nurses. You're
22 going to see that they documented that they were of
23 sufficient strength, and they also had good resting
24 tones. They were soft in between. They were not too
25 close together. They were appropriately spaced

1 apart. And that the Pitocin wasn't turned up by our
2 nurses until Dr. McNeive was there, and he had a
3 reason for that, and it makes sense. And there was
4 no reason for them to question that.

5 You heard this already: Dr. McNeive, when
6 he gets to the bedside, he had been aware of
7 everything that had gone on, and he's going to tell
8 you that. He's -- he's not trying to run away from
9 what these nurses were doing at the bedside. He knew
10 what was going on. They were a team. We agree with
11 that.

12 And that we know that she had a long
13 stage. He progressed through his malposition, which
14 is a huge part of this delay. She had great pushing
15 efforts. She wanted this baby to be born vaginally.
16 She was heroic, you guys. And she had Category I or
17 II all the way up until three o'clock -- or until
18 four o'clock. And everyone agrees that there was no
19 category III until right before delivery, and that
20 delivery was timely after that.

21 So we believe the evidence will show that
22 the nurses were not negligent in this case. They
23 appropriately monitored Sarah for progress. They
24 were measuring that by visualizing the fetal rotation
25 and descent. Again, yes, there is documentation of

1 the station change. And looking back, I'm sure
2 Maggie and Jessie wished one of them would have taken
3 the time to do that.

4 But, again, that's not their --
5 documentation is not their priority. Documentation
6 is not patient care. Documentation is good for
7 lawsuits four years later to be picked apart. They
8 were there watching what was going on. They watched
9 the rotation progress, and they watched the descent
10 progress. It was slow but steady. And they
11 appropriately monitored the heart patterns. Not only
12 they, but you heard the other folks who weren't even
13 in the room who aren't being criticized in this case
14 who thought it was appropriate.

15 The Pitocin policy. You're going to hear
16 about it, Ms. Gunn showed it to you. What Ms. Gunn
17 didn't talk about, though, was that policy said what
18 options there are, potential interventions for a
19 category II based on the maternal-fetal responses,
20 right? So we don't start with turning the Pitocin
21 off. You have options that, in their nursing
22 judgment, they utilized. And in this case, it was
23 position changes and changes to her pushing effort
24 and her pushing patterns.

25 And in doing that, you're going to see the

1 heart rate resolve -- or it didn't resolve -- it
2 improved, and then it wouldn't improve. And it would
3 go back to Category II, and then they would do new
4 interventions. That's what we do, we evaluate and
5 surveil, we intervene if necessary, and then we
6 reassess. And then it starts all over again. And
7 that's what they did throughout this labor.

8 The policy -- what Ms. Gunn talked to you
9 about is what's called an order, a standing order for
10 vaginal delivery, that got pulled into the Epic
11 electronic medical records. There is a standalone
12 policy that these nurses -- that Mercy has in labor
13 and delivery that the nurses are trained on. And
14 that policy was not violated, nor was the standing
15 order within the hospital chart.

16 The policy requires, if you have Category
17 II, fetal heart rate tracings, you notify the
18 physician. Dr. McNeive is going to say he knew it.
19 He knew she was in Category II. So check that one
20 off. They met the policy. They also have to
21 document their interventions to resolve the clinical
22 situation. I already told we're going to see times
23 when she labored down, times when they turned her.
24 The documentation of their interventions were there.
25 They met the policy.

1 we're going to talk about tachysystole
2 with Ms. Shinn later today. She's the only person
3 you're going to hear from who used that word. You
4 didn't hear it from Ms. Gunn. Maybe she's not going
5 to say it exists anymore. I don't know.

6 Tachysystole is when you have too many contractions
7 in too short of a period time, okay?

8 It was not documented by Maggie or Jessie.

9 It was not documented by anybody on the safety

10 rounds. It was not documented by anybody on the
11 strip reviews. It was not documented -- she says it

12 started and persisted from 2:30 in the morning

13 through delivery.

14 So remember I told you we were going to

15 talk about March 3rd -- or May 3rd -- 2:30 a.m.,

16 that's Dr. Parker. Dr. Mckillip was the resident.

17 And Alex Greenwald was the nurse. No one's critical

18 of them. She said it existed, but no one criticized

19 them.

20 She's the only who says that. And, in

21 fact, Dr. warsof doesn't mention it at all. He

22 doesn't think it's an issue at all in this case.

23 Isn't that interesting? They also might think that

24 the nurses violated the nursing chain of command. We

25 didn't hear a whole lot about that, but that's

1 basically just the supervisory chain that nurses have
2 within a hospital if they disagree with a doctor's
3 orders or a plan of care or a fellow nurse. And the
4 only claim here is that they should have done
5 something differently after the two o'clock hour,
6 when Dr. McNeive wanted to jump start the uterus with
7 more Pitocin.

8 First, they're going to tell you they
9 didn't disagree with that. So even to invoke the
10 chain of command, they have to disagree. They
11 didn't. But even if they did, their chain includes
12 the charge nurse. The charge nurse knew what was
13 going on. She was there at 2:28 for those strip
14 reviews -- right? -- that strip round?

15 She didn't change the plan of care. And
16 no one's critical of her. So the chain of command,
17 even if it's invoked, let's just say they did it,
18 wouldn't have changed. Because what was doing on at
19 that time, taking the entire clinical case into
20 context, was appropriate. The goal was a vaginal
21 delivery, and we still have those heart rates mostly
22 Category II, but even around those times, converting
23 to Category I.

24 Advocating for a C-section. That's a fun
25 word, "advocate." That's what I do, right? Advocate

1 for a C-section. Nurses are advocates for their
2 patients. And I would submit that these nurses were
3 advocates for their patient. You're going to hear
4 that C-section was discussed in that room.

5 Nurses cannot order a C-section. Nurses
6 can't perform a C-section. If it was discussed,
7 someone's already advocating for it. They don't need
8 to do something else. And, by the way, the
9 circumstances, the total circumstances, did not
10 warrant a C-section in this case.

11 You've already heard this from a causation
12 standpoint. We're going to talk about burden of
13 proof in a second. But Remi's brain injury occurred
14 at least 24 hours from when he was born. That's
15 objective. No one can say that that's a subjective
16 thing. You're going to hear about it from Dr. Tekes,
17 all right?

18 The other thing that we haven't talked
19 about is the evidence for causation for plaintiff,
20 but Remi wasn't permanently injured until after
21 3:57 p.m. So it was in the last half an hour before
22 he was born, the permanent brain injury occurred, and
23 that's what the plaintiffs' theory is. Well, at that
24 time, the nurses are prepared for delivery, the
25 baby's too far down, Dr. McNeive will tell you, to be

1 delivered. There's nothing that anybody can do, if
2 that's their theory.

3 But this is supported by his condition at
4 brith. we talked about the Apgar. I'm not going to
5 go through it again. But one thing we didn't really
6 overtly tell you, though, is the scale of that. Each
7 of the A-P-G-A-R is 2 points for full function. So
8 it's a scale of 10.

9 So at 5 minutes, he got an 8. And, once
10 again, you're going to hear from Nurse Practitioner
11 Spencer, who's not my employee, she's not Mercy
12 Hospital's employee. Her job is to decide if babies
13 need to go to the NICU. No one -- despite the fact
14 that now, in this lawsuit, the plaintiff wants to
15 argue about what she did, they're not criticizing
16 her.

17 You're going to hear Dr. Kerzner, the
18 neonatologist, that she was supervised or worked in
19 tandem with Nurse Practitioner Mary Spencer she said,
20 well, in looking at a still photo, in the context of
21 me being an expert in this lawsuit, and the parents'
22 description of their baby at unknown times, I think
23 maybe she overestimated it, but I'm not going to say
24 that this breached the standard of care. Seems a
25 little farfetched.

1 you're going to hear that an Apgar of 7 or
2 more, 7 or more at 5 minutes is a normal baby.
3 You're going to hear that babies are blue. So a zero
4 for color at 1 minute is nothing. You're going to
5 hear that the 1-minute really is not reliable to
6 predict anything. So his 3-minute at 1, yes, does
7 not sound good, but lots of babies are born with 3s
8 or less who then have some help from the NICU team
9 who gets to normal status at 5 minutes and need no
10 further help, right?

11 we're going to talk a lot about what that
12 help was and what was ongoing and when it happened,
13 why Nurse Practitioner Spencer was accurate at the
14 time, despite she's going to get picked apart in this
15 lawsuit.

16 And, again, if you have a strip that has
17 Category I or II tracings associated with a 5-minute
18 Apgar of 7 or greater, the literature says it is not
19 consistent with an acute hypoxic ischemic event.
20 That is plaintiffs' whole theory, which is why they
21 have to run away from the independent Apgar. which
22 is why they have to make a big deal about there not
23 being a cord blood gas.

24 And don't forget: At first the NICU team,
25 you're going to hear from Nurse Spencer, they're

1 conservative. Their job is to make sure babies are
2 well taken care of right after birth. There is a
3 transition period. They know how babies transition
4 to this new world. You know, they've been relying on
5 mom for nine months, and now they have to figure out
6 how to do things themselves in a very quick fashion
7 in this world.

8 If they had thought that Remi Anyan had
9 any evidence of neurological damage of neonatal
10 encephalopathy, which Ms. Gunn showed you some of the
11 indicators for, they would not have hesitated to tell
12 these parents, you know what? We'd like to watch
13 him, let's take him to the NICU. What did they do?
14 They put him in the newborn nursery.

15 You already heard about this brain MRI.
16 The only other thing I'm going to say about that is
17 there's a difference in our experts' opinions
18 obviously. The plaintiff has a neuroradiologist, Dr.
19 Sze. We have a pediatric neuroradiologist. She has
20 further subspecialty to look at the brains of babies.
21 She's going to tell you all that. She's written tons
22 and tons on this.

23 There are inconsistencies about that, and
24 as I've already pointed out, and what you'll see is,
25 that their retrospective interpretation of the fetal

1 monitor strips is not consistent between Dr. warsof
2 and Nurse Shinn. They can't get on the same page as
3 to whether there was or was not too much uterine
4 activity. And they can't even decide if there was a
5 Category I return at any time. Dr. warsof says yes,
6 Ms. Shinn says no.

7 The other experts can't agree on the
8 actual timing of when this injury occurred. When did
9 it become permanent? Was it earlier in the day? Was
10 it minutes before he was born? Was it up to an hour
11 before he was born? You're going to hear they can't
12 get on the same page, and, therefore, I'm going to
13 tell you plaintiff will not meet their burden of
14 proof.

15 we've got our expert. I have -- the only
16 one you haven't heard about, we do have a nursing
17 expert. She's eminently qualified. She also teaches
18 labor and delivery nurses. She has a doctorate
19 degree. This is what she does. She reviews -- or
20 she teaches labor and delivery nurses how they should
21 appropriately monitor, surveil, evaluate, and
22 intervene.

23 She looked at this case. We didn't tell
24 her anything about it. She knew it was a lawsuit.
25 But I just sent her the strips and said, can you look

1 at the strips and talk to me about this? You're
2 going to hear what her out -- what she said. So,
3 yes, everybody is going to have -- well, I have a
4 lawsuit about that, but she didn't know if we were
5 talking about an infection, if we were talking about
6 an acute, like, uterine rupture or some other
7 obstetrical emergency.

8 she didn't know, and she was going to tell
9 you that in her -- as close as she could get to
10 prospectively looking at this, putting herself in the
11 shoes of Maggie and Jessie, she found that they were
12 appropriate in what they did in this case, despite
13 what everyone agrees was that long second stage.

14 Mr. Willman already told you about Dr.
15 Cantey and Dr. Woodruff. I wrote down a note from --
16 that Ms. Gunn was trying to, I think maybe burden
17 shift a little bit here --

18 MS. GUNN: Your Honor, I'm going to object
19 to argumentative.

20 THE COURT: Sustained.

21 MS. KAMYKOWSKI: So I'll remind you, the
22 burden of proof in this case is on the plaintiff.

23 There is no question of why that the defense ever has
24 to answer. The plaintiff has the burden of proving
25 more likely than not that there was a breach of the

1 standard of care that caused or contributed to cause
2 damage to Remi.

3 The defense does not have to pinpoint an
4 exact cause. Because guess what? The vast majority
5 of patients, of babies, who develop cerebral palsy
6 from hypoxic ischemic injury are from an unknown
7 cause. I think it's something in the range of 70
8 percent unknown cause, okay?

9 So if Dr. Cantey was asked a question, or
10 will be asked a question, could this injury have
11 occurred at the time of delivery? Sure. Anything is
12 possible. But what the standard for an expert
13 opinion in this courtroom is, is what is more likely
14 than not to a reasonable degree of medical certainty.
15 And Dr. Cantey's opinion on that is that more likely
16 than not, Remi suffered a hypoxic injury before May
17 4th.

18 And then we talked about Dr. Tekes. We
19 talked about -- I just, at the end of this day -- at
20 the end of this trial in two weeks, three weeks, how
21 ever long it is, we don't think plaintiff will meet
22 their burden of proof. We don't think they're going
23 to meet it on liability. The nurses were
24 appropriately trained. They were doing what they
25 needed to do. They were surveilling, reassessing,

1 giving interventions. They were working in tandem
2 with Dr. McNeive.

3 They had other people who didn't have
4 bedside blinders on evaluating this patient and
5 agreeing with them. They're being second guessed now
6 based on hindsight bias. They're not going to be
7 able to prove a breach of the standard of care. The
8 objective evidence is that this injury occurred May
9 3rd, at least prior to 4:30, before my nurses were
10 ever on duty.

11 And any unfortunate -- we all know it was
12 unfortunate. That's not in dispute, all right? No
13 one is going to come in here and say it's not. What
14 we are defending this case on, and what we believe
15 the evidence supports, is that plaintiff will not
16 meet their burden of proof that the nurses or Dr.
17 McNeive breached the standard of care or that that
18 caused this specific injury.

19 So at the end of the day, we're going to
20 ask you for a verdict in favor of Mercy Hospital on
21 behalf of Jessie and Maggie. Thank you.

22 THE COURT: All right. Ladies and
23 gentlemen of the jury, this is a good time for us to
24 take our lunch recess.

25 (At 12:19 p.m., the Court duly admonished

1 the jury, and proceedings stood in recess. At
2 1:57 p.m., the following proceedings were held in
3 open court in the presence of the jury:)

4 THE COURT: Go ahead and be seated,
5 everyone.

6 On behalf of the plaintiff, you may call
7 your first witness.

8 MS. GUNN: Thank you, Judge.
9 If it may please the Court?

10 THE COURT: It does.

11 MS. GUNN: I call Nurse Heidi Shinn.

12 THE COURT: Ma'am, if you'll step up to be
13 sworn.

14 Please raise your right hand.

15 HEIDI SHINN, R.N.,
16 having been duly sworn, was examined, and testified
17 as follows:

18 DIRECT EXAMINATION

19 BY MS. GUNN:

20 Q. Please state your name.

21 A. My name is Heidi Shinn.

22 Q. What is your profession?

23 A. I am a registered nurse in labor and
24 delivery.

25 Q. And how long have you been a registered

1 nurse in labor and delivery?

2 A. I've been a registered nurse since July of
3 2000. And I've been in labor and delivery since
4 January of 2003.

5 Q. what is your current position? Current
6 employment?

7 A. Sure. I am a full-time staff nurse, labor
8 and delivery nurse, at The Ohio State University
9 Wexner Medical Center in Columbus, Ohio.

10 Q. How long have you been in that position?

11 A. Since January of 2023.

12 Q. Can you generally describe your job duties
13 in that position.

14 A. Sure. So I function in three different
15 areas as a staff nurse. About a third of my shift, I
16 function as a charge nurse. A third of my shift, I
17 work in an OBED, so assessing women who think they
18 may be in labor or their water may be broken. And
19 then the last third of the time, I've spent caring
20 for women, like Ms. Anyan, either in labor or during
21 a C-section and in the immediate postpartum period.

22 Q. And is that a full-time position?

23 A. It is.

24 Q. How many labors and deliveries have you
25 attended in your time as a labor and delivery nurse?

1 A. Over the course of 22 years, I would say
2 it's in the thousands, by some capacity, either as a
3 primary nurse doing the delivery, caring for a
4 laboring woman, or as a helper during the delivery
5 process, or as a charge nurse by some intervention
6 having to respond to an emergency. Something like
7 that.

8 Q. And in those thousands of deliveries,
9 Nurse Shinn, have you ever had a woman go for more
10 than -- go more than 8 hours in a second stage of
11 labor?

12 A. Never.

13 Q. Can you recall a time that anyone even got
14 close to that?

15 A. One particular delivery that stands out,
16 it was about a six-hour second stage or so, that's
17 the one that stands out the most, I would say.

18 Q. And what were the circumstances of that?

19 A. That particular patient was a patient who
20 was trying for a home birth. She had a lay or a
21 community midwife and had spent some time pushing at
22 home. Upon the recommendation of her lay midwife,
23 she was sent to the hospital for evaluation.

24 Once she arrived at Ohio State, she was
25 evaluated, found to be completely dilated, not making

1 progression with her pushing efforts, and she was
2 offered a C-section but refused a C-section.

3 Q. And in this case, I want to be very clear,
4 Nurse Shinn: Is there any evidence from any source
5 anywhere that Sarah Anyan ever refused a C-section?

6 A. No.

7 Q. Or that she ever indicated that she didn't
8 want a C-section, whether it was before she got to
9 the hospital or while she was at the hospital?

10 A. Not that I saw, no.

11 Q. And have you heard anything about that
12 from any of the evidence in this case, records or
13 testimony or otherwise?

14 A. No.

15 Q. You were asked to review materials in the
16 case.

17 Can you tell us generally about your
18 process of reviewing records to prepare to render a
19 conclusion to juries such as this.

20 A. When I'm sent records, once I've
21 determined that I don't have any conflicts, I don't
22 know any of the parties, it's not been a nurse that
23 I've taught before or that I've worked with, or a
24 physician that maybe I know or know personally,
25 something like that, then I will assess the records.

1 I start with prenatal records to determine
2 if there's any identifiable risk factors like growth
3 restriction, high blood pressure, diabetes, anything
4 like that that would be significant from a nursing
5 perspective that might alter the way that the nurse
6 should care or should think about caring for that
7 particular mother.

8 After going through the prenatal records,
9 I go through the labor and delivery admission from
10 start to finish. So from the minute she's hooked up
11 to the monitor, her IV is started, I go through the
12 records and make a general time line, and compare
13 that to the fetal monitor tracings to determine,
14 based on my interpretation as an instructor, as a
15 longtime labor and delivery nurse, whether or not I
16 see anything that the nurses should have responded to
17 and didn't, or any communications that may or may not
18 have occurred, or something like that.

19 Then I put some information about the
20 birth of the baby: the Apgar scores, the birth date,
21 time, any potential diagnoses that the baby's chart
22 reflects.

23 Q. Do you review records for patients, as
24 well as for doctors and hospitals, if you're asked?

25 A. If I'm asked, I don't have a conflict, and

1 I have time to review it, yes, I have reviewed both
2 cases that were on behalf of a plaintiff, like in
3 this case, and also those on behalf of a health care
4 provider or a defendant.

5 Q. Does your process change depending on
6 whether you are asked to review records on behalf of
7 a patient or a hospital or a doctor?

8 A. No. It's the same objective process from
9 start to finish.

10 Q. And when you look at those records, do you
11 look at the medical records, and are they usually
12 done at the same time as the event recorded?

13 A. Yes. In most cases, the documentation is
14 what we call contemporaneous, meaning something
15 happens, the nurse sits down and documents it, an
16 exam happens, it gets documented. Conversation
17 happens, it gets documented. Something like that.

18 Sometimes, if there's an emergency, or the
19 delivery is happening, there may be entries later.
20 with electronic medial records, it does create a
21 realtime date and time stamp, or an audit of when
22 someone says it happens versus when it was actually
23 put into the medical record.

24 Q. And when you're looking at those records,
25 did you expect the documentation of what's happening

1 to this patient clinically to be accurate?

2 A. Yes.

3 Q. And documented in realtime or close
4 thereto?

5 MS. KAMYKOWSKI: Your Honor, can we
6 approach?

7 THE COURT: You may.

8 (The following proceedings were held at
9 sidebar, outside the hearing of the jury:)

10 MS. KAMYKOWSKI: I'm heading this off at
11 the pass that there is going to be a new opinion.
12 This witness did not offer any opinions about any
13 sort of documentation --

14 MS. GUNN: There's no new opinion. I'm
15 just describing her process. Ms. Kamykowski had
16 indicated that the only way an expert can be
17 legitimate, and in fact indicated it's against the
18 law, to look at something in hindsight. I am trying
19 to have her explain her process.

20 MS. KAMYKOWSKI: So this is not about the
21 process. She's asking whether the medical records,
22 she said, do you expect stuff to be documented at the
23 time that it happened? That was never an opinion.
24 And her expectation as an expert is going to be
25 perceived, well, it could be perceived, as an

1 opinion. It is not an opinion that she gave before.

2 And it will be a brand new opinion now.

3 It is not now that she does never review

4 from a retrospective. If she wants to ask her about

5 her review, I don't have an objection to that. But

6 to ask her, do you expect the documentation in the

7 medical record to happen as it occurs, that was never

8 an opinion that she gave in her deposition.

9 MS. GUNN: It's not an opinion that she's

10 making right now. She's simply indicating her

11 process to get to her opinions, which we will get to

12 eventually.

13 (Proceedings returned to open court.)

14 Q. (By Ms. Gunn) Nurse Shinn, as I was

15 asking, with respect to records that you're

16 reviewing, and in particularly records in this case,

17 when you're reviewing them, are you expecting them to

18 be accurate and in realtime?

19 A. Yes.

20 Q. And when you review those, you're looking

21 for the actions of the nurses as it is documented

22 accurately and in realtime?

23 A. Correct.

24 Q. Now, because ultimately what you're doing

25 is you're concluding whether those actions by those

nurses, as they are documented in realtime, were following the standard of care?

A. Correct.

Q. Okay. And, again, with respect to whether you're hired by a plaintiff or a defendant, that's your process?

A. It is.

Q. Now, you can agree that any conclusions or opinions that you render today, will be to a reasonable degree of nursing certainty?

A. Correct.

Q. And that the standard of care is defined under Missouri law as that failure to use that degree of skill and learning, ordinarily used under the same or similar circumstances, by members of the defendants' profession, in this case nurses?

A. That is my understanding.

Q. And can you agree to that?

A. I will.

Q. As I understand it, you hold conclusions about the actions or inactions of Mercy nurses, specifically Jessica Brown-Wagner, Nurse Jessie; and Margaret Hilt-McLeland, Nurse Maggie; is that correct?

A. Yes.

1 Q. Can you give us your headline opinions?

2 And then we'll walk through those.

3 A. Sure. So in a very 30,000-foot view, I
4 have opinions about these two nurses who were working
5 simultaneously to care for Ms. Anyan during the birth
6 of her baby. That they failed to act and advocate
7 for a primary C-section with Dr. McNeive around
8 8:00 a.m. and thereafter.

9 That they failed to properly follow
10 hospital protocols that were reasonable standards
11 while taking care of this patient in regards to
12 Pitocin and intrauterine resuscitation. We'll talk
13 more about that later. A failure to properly manage
14 Pitocin in the setting of failure to progress,
15 malposition, persistent Category II tracing, and a
16 prolonged second stage of labor.

17 And then ultimately, or lastly, a failure
18 to invoke or initiate the chain of command when it
19 was clear that there was no response by a physician
20 to call for a C-section, to stop the labor process
21 during those conditions.

22 Q. Now, I'm going to go back to your
23 education and training really quickly.

24 MS. GUNN: Could we have Exhibit 135-2?

25 Q. (By Ms. Gunn) And, Nurse Shinn, this is

1 going to be shown to the jury, and I'm going to try
2 not to be in anybody's way. It's hard.

3 Is this your -- your CV?

4 A. Yes. It appears to be.

5 Q. And can you tell us either from of course
6 your memory, or from reviewing this CV, about -- tell
7 us about your education and training.

8 A. Sure. So the education part comes later
9 in the CV. But from 1996 to 2000, I attended the
10 University of Toledo Medical College of Ohio
11 Consortium. That particular program has two years at
12 an undergrad university and two years at a medical
13 college where the nursing college is also at, where
14 we do clinical and the different specialties like
15 pediatrics, community, med surge, OB, those types of
16 things.

17 In June of 2000, I graduated with a
18 bachelor in science of nursing, so a four-year
19 bachelorette degree. I then took my NCLEX, N-C-L-E-X
20 test, which is the nursing and licensure exam for the
21 board of nursing, passed that, and started on a med
22 surge unit taking care of surgical patients at Ohio
23 State in July of 2000.

24 From July 2000 to January of 2023, I was
25 there as a full-time staff nurse, charge nurse,

1 preceptor, transferred to labor and delivery, and
2 continued performing those types of roles but
3 obviously in a new area, taking fetal monitoring
4 classes and being re precepted or oriented to the new
5 area, and continued to be a charge nurse once I was
6 out of orientation.

7 From there, I received two certifications.

8 In 2005, I became certified by the National
9 Certification Corporation in Inpatient Obstetrics,
10 just a further certification of being an OB nurse.

11 In 2011, I obtained my fetal monitoring
12 certification from the same organization and renew
13 those every three years.

14 In 2010, so to back up just a bit, I got
15 my instructor status from AWHONN, A-W-H-O-N-N. It's
16 an acronym for the nursing professional organization
17 for nurses like myself, nurses Jessie and Maggie, who
18 care for OB patients.

19 Q. Now, you told us a little bit about your
20 employment now and about the AWHONN.

21 How often are you teaching nurses to learn
22 how to read fetal monitoring strips?

23 A. So I've been on a pretty consistent
24 schedule of teaching two advanced classes a year and
25 three intermediate classes per year: two in the

1 spring and one in the fall. At our hospital, we try
2 to avoid the summer months. That way our staff can
3 attend and not infringe on vacations.

4 But those classes are considered national
5 courses, so they are searchable on the AWHONN website
6 by region. And I get nurses from other institutions,
7 other health systems, from small hospitals, big
8 hospitals, whatever. But I've been teaching those
9 classes consistently. Last class was taught in
10 February. Next class, I have two actually I'm
11 teaching in April.

12 Q. And how long have you done that?

13 A. Since January of 2010.

14 Q. Are you also involved in any hospital
15 policy procedure writing/drafting?

16 A. Yes.

17 Q. Tell us about that.

18 A. So in addition to working full-time and
19 teaching classes and doing administration things for
20 that, I'm on a couple of different committees within
21 the department, one of which we work on different
22 things, but one of the tasks within that group is to
23 work on policies and procedures.

24 Every three years, the policies are up for
25 at least a review. And if we determine there's

1 nothing different that needs to be changed with the
2 policy or the protocol, then it gets a new date, a
3 review date.

4 If there's some change, it gets a new edit
5 date. And then it's signed off and goes back into
6 practice. The staff is educated about it. We talk
7 about it in staff meetings. And then it goes out
8 into publication for the staff to refer to.

9 In addition to that, I also help our
10 educator, and have for a number of years, with annual
11 competencies, drills, those types of things.

12 Q. Have you told us about all your
13 certifications?

14 A. Yes.

15 Q. Okay. Now, when was the last time you had
16 a shift on labor and delivery?

17 A. Last shift was this past Monday. The two
18 before that was Sunday and Saturday.

19 Q. Okay. So is it true, then, Nurse Shinn,
20 that you have the same responsibilities and duties
21 that Jessie and Maggie did, you currently do, the
22 same ones that they had when they were taking care of
23 Sarah?

24 A. That is correct.

25 Q. Now, part of what you somehow have time

1 for is this kind of thing, to review medical records
2 in the litigation setting. We call that expert work.

3 How long have you been doing that?

4 A. I started reviewing cases in the summer of
5 2010.

6 Q. So can you give us an idea of how many
7 times you have been in a setting like this at a trial
8 to testify?

9 A. I would say at least a couple dozen over
10 the last 15 years or so.

11 Q. And is that -- has that been on behalf of
12 patients? And some have been on behalf of patients,
13 and some have been on behalf of physicians or
14 hospitals?

15 A. Of those that went to a trial stage, I
16 think one was on behalf of a health care provider,
17 and the rest were on behalf of a patient.

18 Q. Do you have a sense of the time frame over
19 the next however many years you've been doing this,
20 14 or 20, as to the percentage of time you've worked
21 for patients versus hospitals?

22 A. So in terms of records received, initially
23 it was pretty 50/50. I've never advertised for
24 services, so it's just word-of-mouth work if I've
25 worked with a firm or the lawyer before or someone

1 gave my name to them. But I would say for the last 5
2 or six years, at least, it's been about 70 percent on
3 behalf of a plaintiff or a patient bringing a
4 lawsuit. And the other 30 percent of reviewing cases
5 has been on behalf of the health care provider.

6 Q. And do you charge for your time?

7 A. I do.

8 Q. And what do you charge?

9 A. My current review rate is \$300 per hour
10 for this type of work.

11 Q. And what about charging to come to trial?

12 A. It's a flat fee for the day. It's \$2,000
13 for the day.

14 Q. And I know that you have been preparing to
15 come here to share your conclusions with this jury.
16 what have you reviewed?

17 A. A lot of things.

18 Q. I have a list. You can tell me if this,
19 and I know you've seen everything, have you reviewed
20 the entire chart of Sarah Anyan from her Mercy labor
21 and delivery admission?

22 A. Yes.

23 Q. Have you seen her entire chart from her
24 prenatal care with the Mercy Clinic and Dr. McNeive
25 and his partners?

1 A. I believe it was a complete chart, yes.

2 Q. And have you also seen Remi Anyan's
3 hospital chart when he was at Mercy, including in the
4 NICU?

5 A. Yes.

6 Q. Have you reviewed depositions, as well?

7 A. I have.

8 Q. And has that included Sarah and Blake
9 Anyan?

10 A. It did.

11 Q. And Dr. McNeive?

12 A. Correct.

13 Q. As well as the deposition of Dr. April
14 Parker?

15 A. Yes.

16 Q. Dr. Kelsey McKillip?

17 A. Yes.

18 Q. Dr. Morgan --

19 A. Miller.

20 Q. -- Miller.

21 A. Yes.

22 Q. I have trouble with that.
23 Nurse Alex Greenwald?

24 A. Yes.

25 Q. Nurse Maggie -- Nurse Maggie and Nurse

1 Jessie?

2 A. Yes.

3 Q. As well as a Nurse Kelsey Blanton?

4 A. Yes.

5 Q. And have you also reviewed expert
6 depositions from Adriane Burgess, the nurse --

7 defense's expert nurse?

8 A. I did.

9 Q. And Dr. Warsof and Dr. Cantey?

10 A. Yes.

11 Q. Can you think of any other medical records
12 or depositions that you reviewed?

13 A. No, not off the top of my head.

14 Q. Now, with respect to other materials, have
15 you seen policies and protocols from Mercy, as well?

16 A. Yes.

17 Q. When were you first contacted, do you
18 recall?

19 A. I believe I was first contacted at the end
20 of the year in 2021, and reviewed records in early
21 2022.

22 Q. And do you -- you've told us about your
23 process -- when you received those medical records,
24 it would have just been the medical records at that
25 time?

1 A. Yes. I believe that's what I received
2 first.

3 Q. And the depositions were all taken after
4 that?

5 A. Correct.

6 Q. So when you got those medical records, did
7 you engage in the process that you told us about
8 earlier?

9 A. Yes.

10 Q. Was there anything different about this
11 case?

12 A. No.

13 Q. And did you start at the end and work your
14 way in hindsight backwards to your conclusions?

15 A. No.

16 Q. How did you do it?

17 A. Just as I said: Started with the prenatal
18 care that was received in the clinic from Dr.
19 McNeive. I always create a time line of her age, her
20 gravida, her parity, of how many pregnancies she's
21 had. If she's had any losses. Anything that might
22 be significant in terms of medical history, surgical
23 history, delivery history.

24 In this case, it was her first baby. So
25 she had what we called an unproven pelvis, or was

1 otherwise uncomplicated and healthy.

2 Q. Okay. Now, let's go through some
3 background in terms of labor and delivery.

4 what are the different stages of labor?

5 A. We have stage 1, stage 2, and stage 3.

6 Q. And I'm going to ask Zack to bring out
7 Exhibit 346 and ask you, Nurse Shinn, whether this is
8 something that can help illustrate your testimony to
9 the jury.

10 A. Yes.

11 Q. Okay. So what are we looking at here?

12 A. So stage 1 can be broken down between the
13 latent phase, the onset of uterine contractions, up
14 until 6 centimeters of dilation, so close to 6
15 essentially.

16 The active phase is from 6 centimeters,
17 some will say 6 to 10, but the transition phase,
18 which is broken down a little bit specifically at
19 that push at the end.

20 So oftentimes the 8, 9, 10 centimeters,
21 there is a surge of internally released oxygen, the
22 natural, not the synthetic form, that will get
23 contractions closer together, stronger. And so women
24 often progress very quickly through those last few
25 centimeters. So that's often referred to as the

transition stage.

Q. All right. And what about the other stages?

MS. GUNN: Let's pull up Exhibit 347.

A. So stage 2 is when the patient becomes completely dilated, so 10 centimeters. That will start a second stage. And that ends when the baby is delivered. And then third stage is the delivery of the placenta. So after the baby's out, then the delivery of the placenta is the third stage.

MS. GUNN: And, Your Honor, I apologize. I failed to ask for the admission of Nurse Shinn's cv, which is marked as Exhibit 135-2.

THE COURT: Any objection?

MS. KAMYKOWSKI: No objection, for demonstrative purposes.

MR. PERRON: No, Your Honor.

THE COURT: 135-2 will be admitted.

Q. (By Ms. Gunn) Now, with respect to Sarah, you've read the prenatal records.

Were there any concerns that you identified with respect to her prenatal care?

A. From a nursing perspective, nothing that I saw.

Q. Okay. It appeared that she was following

directions of the physicians?

A. It appeared to be.

Q. And she was on her prenatal vitamins?

A. Yes.

Q. She went to all of her appointments?

A. All that I saw. It appears to be a standard number of appointments, yes.

Q. Now, what happened on May 3rd, 2020?

A. On May 3rd, the record would reflect that around noon, her water broke for clear fluid.

Q. All right. Let's go to Exhibit -- well, do you know what time she got to the hospital, Mercy Hospital?

A. I think her arrival time was around 2:02 in the afternoon, so a couple hours after her water broke.

Q. Now, let's go to Exhibit 1, page 96.

And, Nurse Shinn, you've read the records. There was a history and physical performed.

Can you tell us what that is?

A. So a history is a physical done by a provider. It could be a midwife or a resident, an attending physician, in which they run through the patient's history prenatally, surgically, medically. And then of their assessment. Whether a physical

1 assessment of the patient, a cervical exam, what the
2 patient presents with, if there's anything of concern
3 on admission, and what the potential plan would be
4 moving forward.

5 Q. Okay. And we're looking at Exhibit 1 page
6 96.

7 And you recognize this as part of Sarah's
8 chart from Mercy Hospital?

9 A. Correct.

10 Q. It indicates that she's 30 years old.
11 Can you tell us what the Gs and the Ps
12 mean?

13 A. So the gravida is referencing that this is
14 pregnancy number one. And all the zeros after the P,
15 or the parity, means that the baby -- she's never had
16 a baby delivered before. So this is the very first
17 baby. She's not had any miscarriages or losses.

18 Q. And 39W3D. what is that referring to?

19 A. 39 weeks and 3 days, full-term.

20 Q. She presents SPPRON. Tell us about that.

21 A. So that is post premature or prelabor
22 rupture of membranes. So preceding labor. Her water
23 was broken, but she was not in active labor at the
24 time. It was the time of noon, and the fact that the
25 fluid was noted to be clear.

1 Q. what's the significance of clear fluid?

2 A. Clear fluid is what we consider to be
3 normal. That's what we would expect. If it was
4 foul-smelling, yellowish-green, like meconium
5 staining, bloody, those would not be normal findings.

6 Q. what's the significance of documenting the
7 time that a woman's water breaks?

8 A. Oftentimes the time is kept track of so
9 that if there's a prolonged labor, or what we call a
10 prolonged rupture of membranes, the pediatricians may
11 want to watch the baby for signs of infection, draw
12 blood work, potentially start antibiotics. Each
13 hospital has a little bit different protocol that
14 they may follow based on that. But it is something
15 that we want to know how long the water has actually
16 been broken.

17 Q. what's the worry?

18 A. That you could develop an infection.

19 Q. She is not feeling contractions.

20 Is that what you mean by prelabor rupture
21 of membranes?

22 A. Yes. So even if there are contractions
23 picking up on the fetal monitor, she wasn't noting
24 them or feeling them. She wasn't in any pain at that
25 time.

Q. She reports good fetal movement.

Is that a good thing?

A. It is a good thing.

Q. What does that mean?

A. So sometimes when women come with decreased fetal movement or no fetal movement, the concern would be that the baby is either sick, or the baby could be passed away or deceased in utero. So if a patient is reporting normal or adequate fetal movement, positive fetal movement, those are things that we would expect. So the baby is moving as it should in utero. It hasn't stopped moving.

Sometimes the concern would be that if the baby is not moving or is moving much less, there may be something neurologic going on.

Q. And good fetal movement was reported?

A. Correct.

Q. Denies vaginal bleeding.

What's the significance of that?

A. If there is vaginal bleeding on presentation, it could mean that the placenta, which is somewhat of the lifeline of the baby, is sheering away from the wall of the uterus or the uterine muscle. And so a woman may present with bleeding if that has happened.

1 Q. And that didn't -- there was no concern
2 about that?

3 A. Correct.

4 Q. Her pregnancy is uncomplicated.
5 You would agree with that, based on your
6 review of her prenatal records?

7 A. Yes.

8 Q. And she -- her primary physician is who?

9 A. Dr. Daniel McNeive.

10 Q. Now. Let's go to Exhibit --

11 MS. GUNN: Let's go further down, Zack,
12 please, to just assessment and plan. Perhaps that's
13 the next page. Yes. Thank you.

14 Q. (By Ms. Gunn) This is just a repeat of
15 what I think you've already said.

16 I want to ask you about GBS negative.
17 What's that mean?

18 A. So Group B strep is a bacteria that some
19 women harbor in their pregnancies. It may be present
20 in your urine earlier in pregnancy. Or it could be
21 present on the swab we do around 36 weeks of
22 pregnancy.

23 So we swab around a woman's bottom, any
24 opening to their vagina. If she's positive, it just
25 means we need to treat her with antibiotics during

1 the course of labor so that the baby doesn't pick
2 that up and develop Group B strep sepsis. If she's
3 negative, then we would not prophylactically treat.

4 Q. So being GBS negative is a good thing?

5 A. Correct.

6 Q. Fetal status HR -- or, excuse me -- FR1
7 tracing Category I.

8 what is that?

9 A. So the fetal heart rate tracing was noted
10 to be a Category I, which is normal and indicative of
11 a well oxygenated baby.

12 Q. It says -- well, let's go to the -- let's
13 go back here to Exhibit 1 page 193.

14 what I want to ask you next, Nurse Shinn,
15 is what was physically being done with Sarah at this
16 time. And my understanding was there was what's
17 called an SVE?

18 what is that?

19 A. A sterile vaginal exam.

20 Q. And what -- what happens when a sterile
21 vaginal exam is done?

22 A. So either the nurse or provider would put
23 sterile gloves on their hands and reach their hand in
24 the vagina. And with their fingers, they would asses
25 to see how open the cervix is, how thin or effaced

1 the cervix is, and what the station of the presenting
2 part, in this case, the fetal head, would be at.

3 MS. GUNN: Let's go to the next page, 194.

4 Q. (By Ms. Gunn) And this was, I believe,
5 the results of the SVE for the time frame that Sarah
6 got into the hospital.

7 MS. GUNN: And I'm hoping that I gave the
8 right number. Maybe one more number, one more page.

9 okay. The very top of that, Zack.

10 Q. (By Ms. Gunn) So let's start with
11 cervical -- dilation cervical.

12 what does that mean?

13 A. So that is how open the cervix is. The
14 cervix normally is -- does a very good job staying
15 closed and fixed and firm to keep the baby inside the
16 womb.

17 As you get closer to the due date, or in
18 the third trimester, the cervix will get soft or
19 ripe, will start to open and thin or dilate and
20 efface.

21 Q. Coming into the hospital a couple hours
22 after your water breaks, is a cervical dilation of
23 1.5 expected normal?

24 A. For a first-time mom, it would not be
25 unexpected to see that cervical exam.

1 Q. And what about effacement?

2 what is that?

3 A. That's how thin or thick the cervix is
4 based on feel. So a hundred percent effaced would be
5 paper thin. It's is just very, very thin. Thick
6 would be something very, very thick, like my fist.
7 And then 70 percent is, you know, three-quarters of
8 the way to being fully effaced.

9 Q. And then it marks fetal station.

10 what is fetal station?

11 A. Fetal station is relevant to the
12 presenting part. So the bony part of this baby's
13 head was felt at minus 2 or 2 centimeters above the
14 ischial spine, that little bony prominence that's
15 felt in the maternal pelvis, again, during the exam,
16 by feel.

17 Q. Can you determine a baby's station by --
18 in any way other than by looking in the vagina?

19 A. Looking in would be very difficult because
20 the baby's very high up. There's a lot of tissue to
21 look through. So it really is by feel, during a
22 sterile vaginal exam by feel.

23 Q. Okay. So you can't just look to see where
24 a baby's station is?

25 A. No, you cannot.

1 Q. You have to physically feel for it?

2 A. Yes. Because you're putting it in context
3 of the maternal pelvis, and her bony prominences
4 should determine where that station or where that
5 presenting part is, the bony part of the baby's head.

6 Q. So anyone who says, well, I saw the head
7 progress, wasn't actually seeing it with their eyes?

8 A. They would not see it with their eyes.

9 They would have felt it during exams if they were

10 being done. Until the head is on the perineum, or
11 the opening of the vagina, parting of the labia, you
12 really wouldn't see any progression at that point.

13 Q. So to measure station and to document
14 station, you have to do it through a physical exam?

15 A. Correct.

16 MS. GUNN: Let's go to Exhibit 342, just
17 to get an idea again of the station.

18 Q. (By Ms. Gunn) And I used this, Nurse
19 Shinn, in my opening statement.

20 would you say that Exhibit 342 is an
21 accurate depiction of drawing of stations that a baby
22 goes through?

23 A. Yes.

24 Q. Now, this particular one is negative 3,
25 which is a high station; plus 3, which would be a low

station, is that accurate?

A. Correct.

Q. And then there's zero right in the middle, correct?

A. Yes.

Q. So at this point in time, this 2:15-ish, when Sarah gets to the hospital, gets hooked up on fetal monitoring strips, and a nurse at that time does a sterile vaginal exam, Remi, Baby Remi, is at negative 2 station. So that would be a higher station than where this baby is, correct?

A. Correct.

Q. And this baby in Exhibit 342 is actually looking like what station?

A. Around plus 1.

Q. Okay. But, again, we can see this because this is a drawing. If you're just looking at the woman, even looking toward the area where the baby is, you're not seeing this, right?

A. You would not see that station, correct, until -- certainly anatomy plays into that. But until the baby is at a much lower station and starting to crown or part the woman's labia, you would not see progression of the head. You would have to feel it on an exam.

1 Q. So when we talk about the cervix being
2 opened, that is way up high, versus the labia, which
3 is down low?

4 A. Correct.

5 Q. Okay. Thank you.

6 So you mentioned, I think you mentioned,
7 Pitocin, or perhaps maybe it is in -- yeah, it was on
8 the assessment which indicates augment with Pitocin

9 PRN.

10 So let's talk about Pitocin. What is
11 Pitocin?

12 A. Pitocin, as we use it, is the synthetic
13 form of oxytocin which is the internally circulating
14 naturally born stuff. But it is a peptide hormone
15 that we give to strengthen contractions, get them
16 closet together or augment the labor, sometimes
17 induce the labor.

18 And then we use it for other things like
19 postpartum hemorrhages or to help deliver the
20 placenta. Those types of things, as well.

21 Q. And, in this case, in Sarah's case, was
22 Pitocin augmentation appropriate?

23 A. Yes.

24 Q. And do you know what it was set at -- or
25 let me -- that's a bad question.

1 who is in charge of determining what to
2 set the Pitocin to?

3 A. The provider. So either a nurse midwife
4 who's putting orders in or a physician, could be a
5 resident, could be an attending. They would put the
6 admission and/or any induction or augmentation orders
7 in. And the initial decision to start Pitocin to
8 augment this labor and the rate and concentration
9 that was ordered were all very standard and typical
10 and not of a concern.

11 Q. with respect specifically with Sarah?

12 A. with respect to Sarah in this case, yes.

13 Q. Now, can Pitocin be dangerous?

14 A. It can be.

15 Q. Does it have a distinction in that
16 category?

17 A. It does.

18 Q. what is that?

19 A. So in around 2010, an organization called
20 the Institute for Safe Medication Practices, or IFMP,
21 put oxytocin or Pitocin on their high alert
22 medication list. So similar to Heparin and
23 epinephrine and insulin, it's a drug that we use a
24 lot in medicine, especially in the OB world. We use
25 it all the time for various reasons. But if used

1 incorrectly, it has a high incidence of harm.

2 And what they found from that
3 organization, is that most of the time the --

4 MS. KAMYKOWSKI: Your Honor, I'm going to
5 object. This is hearsay. No foundation has been
6 laid for this.

7 THE COURT: Overruled.

8 MS. KAMYKOWSKI: Thank you.

9 Q. (By Ms. Gunn) You may go.

10 A. So what has been found is that why it is
11 deemed a high alert is most of the time it's a
12 dose-related problem. So it was given when it
13 shouldn't have been, more was given than it should
14 have been. Run when it shouldn't have been running.
15 That type of thing.

16 Q. So how is it that it can be dangerous?

17 MS. KAMYKOWSKI: Well, Your Honor, can we
18 approach?

19 THE COURT: You may.

20 (Proceedings were held at sidebar, outside
21 the hearing of the jury.)

22 MS. KAMYKOWSKI: Once again, we're getting
23 into a new opinion. She talked about Pitocin in her
24 deposition. She never offered any opinion about any
25 entity claiming it seemed dangerous or high risk or

1 anything like that. And now she's asking her what
2 does an unnamed, unidentified, presuming
3 authoritative agency might say, which was my hearsay
4 objection.

5 Now she's asking what did they say about
6 that? And now she's getting ready to talk about an
7 FDA black box warning, which we all know exists and
8 was never asked about. And so this is specifically a
9 new opinion about this witness talking about Pitocin
10 and its high risk effects.

11 MS. GUNN: I am not asking about the FDA
12 warnings. Pitocin was mentioned all throughout her
13 deposition. She is a nurse, a labor and delivery
14 nurse, in charge of Pitocin. And I'm asking her if
15 she understands how Pitocin works and how it can be
16 dangerous.

17 And that was discussed in her deposition.
18 I'm not asking her about the FDA warning. I'm not
19 asking whether the institute that gave it the high
20 level alert medication distinction has any opinions.
21 I'm asking her about her opinion with respect to
22 Pitocin and how it affects babies.

23 MR. PERRON: She's bolstering her opinion
24 with references to this entity and all of these
25 studies that she never mentioned in her deposition,

1 which is an additional bases for an opinion, an
2 additional support outside authority which we now
3 have no way to cross examine on. And she's
4 disclosing it, and if the actual studies say
5 something different, we are unable to adequately
6 prepare a cross-examination of that particular basis
7 of this opinion.

8 THE COURT: Did you ask her in her
9 deposition everything that she reviewed, including
10 all authorities?

11 MS. KAMYKOWSKI: Of course, Judge.

12 My last question to her was: What my job
13 here is to learn every opinion that you have and
14 every bases, therefore. Have you given me every
15 opinion? Yes. Have you given me all the bases that
16 support your opinion? Yes.

17 She brought eleven articles with her to
18 her deposition. Nothing about Pitocin was brought to
19 her deposition.

20 THE COURT: What I asked was, whether or
21 not you asked her the question of what everything
22 that she actually reviewed, not just the medical
23 records, but every article --

24 MS. KAMYKOWSKI: Yeah.

25 THE COURT: And did she give you a list of

1 them?

2 MS. KAMYKOWSKI: She did not. She brought
3 them.

4 THE COURT: And did she say that that was
5 an exhaustive list?

6 MS. KAMYKOWSKI: We -- we asked her -- we
7 went through the deposition riders. Did you bring
8 everything in response to this? And she said yes.

9 MS. GUNN: I am really asking her opinion
10 about the Pitocin. That is like the question
11 pending. Is Pitocin dangerous? And how does Pitocin
12 affect babies? And that was absolutely discussed in
13 her deposition. It is the cornerstone of her
14 testimony.

15 I will not ask her about the FDA warning.
16 I have no intention about the FDA warning. She
17 doesn't -- her experience, education, and training is
18 all encompassing. She understands what Pitocin is
19 and why it's dangerous. And she's answering that
20 question.

21 MS. KAMYKOWSKI: I think it's appropriate
22 for her to offer her personal opinion based on her
23 experience as to Pitocin. But to then bring in new
24 pieces of literature that were not previously
25 provided to us, is inappropriate. I do think the

1 question has gone beyond what it means, MS. Gunn has
2 represented here is what is pending.

3 THE COURT: The Court is going to overrule
4 the objection. I can indicate that the jury
5 disregard that study.

6 MS. KAMYKOWSKI: I would love for the
7 Court to Grant that --

8 MS. GUNN: What study?

9 THE COURT: The one that she spoke of.

10 MS. GUNN: That is the institution that
11 considers it a high alert medication.

12 THE COURT: Correct. And that was not
13 asked about in the deposition, and she did not
14 discuss that specific opinion in the deposition, is
15 what they're saying.

16 MS. GUNN: I don't think it's at issue
17 that Pitocin --

18 Are you disputing that Pitocin is a high
19 dose -- or a high alert medication?

20 MS. KAMYKOWSKI: That has never been an
21 issue in this case. She said she thought it should
22 be turned down based on the fetal monitor strips.
23 She didn't say that it was actually from the Pitocin.
24 It has absolutely been an issue in other labor and
25 deliveries I have tried. It was not to be an issue

1 by this witness in this case.

2 MS. GUNN: But what is it that -- I
3 don't -- she's answering the question about Pitocin
4 and whether it's dangerous.

5 MS. KAMYKOWSKI: It's a new opinion. She
6 never offered opinions in her deposition, yeah.

7 MS. GUNN: Yeah. Well, it's also because
8 in openings, Mr. Willman indicated that it was a safe
9 medication. And there's no dispute that it is not a
10 safe medication.

11 MS. KAMYKOWSKI: Opening is not evidence,
12 Judge. And this is a new opinion from this witness.

13 THE COURT: But the Court does find that
14 that would open the door to the issue --

15 MS. KAMYKOWSKI: Did he do --

16 THE COURT: So I'm going to overrule the
17 objection.

18 He did do that.

19 MS. KAMYKOWSKI: Thank you, Judge.

20 (Proceedings returned to open court.)

21 Q. (By Ms. Gunn) As I was asking, Ms. Shinn,
22 can you tell the jury why Pitocin is a dangerous
23 medication?

24 A. It has potential to be dangerous because
25 you can overstimulate the uterus and cause a uterine

1 rusher. You could overstimulate the uterus to the
2 point that the placenta could sheer off that lifeline
3 to the baby. Or you overstimulate the uterus, and it
4 could contract frequently enough or strong enough
5 that we could see signs of fetal intolerance to
6 labor, also referred to as fetal distress.

7 Decelerations, changes in the fetal heart
8 rate over time, is always a concern, moving through
9 the categories from a I to a II to a III, dropping
10 the baby's heart rate to a bradycardia. But those
11 are really the concerns. The biggest concerns really
12 for a labor and delivery nurse to be aware of is that
13 overstimulation of the uterus could cause both fetal
14 and maternal effects that could be catastrophic.

15 Q. with respect to what Pitocin actually does
16 to the uterus, can you explain that to us?

17 A. So I think you heard earlier that the
18 uterus is a big muscle. And the upper part of the
19 uterus is the more active portion that has
20 contractility. Those muscle fibers contract down,
21 shortening and pushing the baby's body down so that
22 the head in this case would be pushed against the
23 cervix to further dilate, thin the cervix, and also
24 progress the baby's head or descend the baby's head
25 into the pelvis.

1 Q. And now the uterus itself is contracting;
2 correct?

3 A. Correct.

4 Q. So Pitocin makes those contractions
5 stronger?

6 A. It can make them stronger individually.

7 It can bring them closer to together if they're

8 irregular or further apart. So oftentimes, in

9 studies, it's been shown that most women need 6

10 milliunits or less to achieve active labor or 6

11 centimeters dilation.

12 Rarely do women need more than 10. But,

13 again, taking into consideration each patient, any

14 potential risk factors, uterine muscle problems,

15 drugs that may counteract the contractility of

16 Pitocin use, all of those things factor in.

17 Q. When was it that Sarah began receiving

18 Pitocin approximately?

19 A. It was 3:00 p.m. on May 3rd.

20 Q. And do you recall from the records when it

21 was that she reached the dose of 18?

22 A. I believe it was before midnight, like

23 11:30, something like that, is my recollection.

24 Q. Would 12:30 be also possible?

25 A. It would be possible. There's thousands

1 of patient records, so to the extent that it was
2 around midnight, I wouldn't dispute that.

3 Q. Now, it was -- it was -- from 1 to 18,
4 does it get titrated up?

5 A. I gets titrated up later, and so it was
6 titrated from 1 up to 18 milliunits from around
7 3:00 p.m. to midnight. It stayed at 18 until the
8 next afternoon.

9 Q. Okay. Now, as a labor and delivery nurse,
10 what description -- and you've seen the Mercy
11 policies -- what discretions do the labor and
12 delivery nurse have with respect to upping, turning
13 off, anything with respect to Pitocin?

14 A. There are a couple of things. You've seen
15 some images of the fetal heart monitoring strip.
16 There's an upper grid, which would generally reflect
17 the fetal heart rate. There's a lower grid that
18 reflects the uterine activity or the contractions.

19 So you're titrating to both a maternal and
20 fetal effect. You're trying to get the contractions
21 close enough, strong enough, regular enough to cause
22 cervical change and descent of the head, while
23 maintaining as normal of a fetal heart rate tracing
24 as you can.

25 Q. Let's look -- I want to talk about fetal

1 monitoring strips.

2 So let's look at Exhibit 135-11.

3 This was a part of your file and provided
4 at your deposition, is that correct?

5 A. Yes.

6 Q. Everybody has had that, correct?

7 A. Correct.

8 Q. What are we looking at? And let's start
9 at the top there.

10 A. So this is the exemplars of different
11 types of variability. This particular page comes
12 from an AWHONN publication called "Principals and
13 Practice of Fetal Monitoring."

14 But these exemplars are the same exemplars
15 that have been accepted by both ACOG, the physician
16 group; AWHONN, the nursing group; National
17 Certification Corporation for the purposes their
18 teaching and their certification courses, as well as
19 NICHD, or the National Institute of Child Health and
20 Human Development. That is the organization that got
21 together and came up with the categories, the new
22 definition and the different exemplars by which all
23 of us use if we're interpreting tracings.

24 Q. All right. So this is just an exemplar.
25 This is what it's supposed to look like.

1 So number one is what is called
2 undetectable. So what does that mean?

3 A. So it's also referred to as absent
4 variability. So there's some different components of
5 fetal monitoring tracing interpretations of different
6 steps that clinicians are taught to use.

7 The first one is establishing a baseline.
8 The next step is establishing the variability at
9 baseline. So knowing what those exemplars are, as
10 you can see in number one, or absent, it's
11 undetectable from baseline.

12 Meaning, I can't tell you just by looking
13 at it from here if that's 152 to 153 or 150 to 151.

14 There aren't a lot of peaks and troughs or amplitude
15 and oscillations across the baseline. It appears
16 pretty flat. And the fetal monitors themselves have
17 something called an internal logic. So you've heard
18 flat line is not a good thing. We've seen that on
19 TV. In fetal monitoring, a flat line is also not a
20 good thing. And so the internal logic sometimes will
21 offer some variation. It's not drawn straight like a
22 ruler in most cases.

23 Q. Let's go to the next one. This one is
24 called minimal.

25 What does that mean?

1 A. So you can see there's a little more
2 oscillation or peaks and troughs that can be
3 identified. If we put a line at the top of all the
4 peaks, and a line at the bottoms of all the troughs,
5 the range in between in beats per minute would be our
6 range of variability. So greater than undetectable
7 but less than six beats.

8 Q. And is minimum variability -- how does
9 that rate? Is that good? Is that bad?

10 A. Minimal variability is diminished. It
11 could be present in something as benign as a fetal
12 sleep cycle. They do go in and out of fetal sleep
13 cycles while they're in the womb. It could be
14 related to certain medications. It could be related
15 to prematurity.

16 So none of those things seemed to be
17 identified here, prematurity or medications. It can
18 also be absence of the baby that is having hypoxia at
19 that moment. We can't reliably exclude that as a
20 possibility. So it's something you would look at in
21 context with other findings.

22 Q. And number three is moderate.

23 A. Correct.

24 Q. What is that?

25 A. Moderate is what we consider to be average

1 or normal. So when a clinician sees -- and I say "a
2 clinician" because nurses, doctors, midwives, all use
3 the same exemplars, definitions, and categories. So
4 it's not different rules or different interpretations
5 for different disciplines.

6 But moderate variability at the time that
7 it is observed, can reliably exclude metabolic
8 acidemia. So that means if the baby were delivered
9 at that moment, the blood gas or the cord gas should
10 reflect a normal Ph.

11 Q. And then the other -- the last two -- four
12 is marked, and 5 is sinusoidal.

13 Can you just real quickly -- were either
14 of those in this case?

15 A. No.

16 Q. All right. So just real quickly round it
17 out.

18 A. So marked variability is often referred to
19 as exaggerated. That term has changed a little bit
20 over time. That is greater than 25 beats. So,
21 again, if you put a line at the top of all the peaks,
22 and a line at the bottom of all the troughs, the
23 range would equate to greater than 25 beats.

24 Sometimes that's seen with -- in acute times of
25 stress, preceding abnormal tracings, or just a very,

1 very active baby that's moving around, and the heart
2 rate is bouncing around.

3 Q. Okay. All right. So with respect to Remi
4 Anyan, and when Sarah was hooked up to the monitors
5 at Mercy, I want to show Exhibit 5 page 14.

6 And you've seen the fetal monitoring
7 strips. Those were part of Sarah's chart at Mercy,
8 correct?

9 A. I have.

10 Q. And you've had time to review those, as
11 well?

12 A. I have.

13 Q. And you've -- you look at those from start
14 to finish, correct?

15 A. Yes. The intention is to put myself in
16 the nurses' shoes to see what they're seeing at each
17 moment. Of course as time passes, something has to
18 pass before a nurse can document about it or
19 interpret it. So even in realtime, nurses caring for
20 patients would be looking backwards at a prior 15,
21 30, 60 minutes for the purpose of documentation.

22 And once time has elapsed, providers also
23 have the opportunity to look backwards to see what
24 does it look like on admission an hour ago, 4 hours
25 ago, whatever the case may be.

1 MS. KAMYKOWSKI: Your Honor, before get
2 too far into this exhibit, can we have a sidebar?

3 THE COURT: You may.

4 (The following proceedings were held at
5 sidebar, outside the hearing of the jury:)

6 MS. KAMYKOWSKI: Your Honor, this exhibit
7 has been utilized throughout the deposition, and I
8 know part of it was shown in opening statement. I
9 don't have an objection specifically to Exhibit 5
10 because we have had, I think, 5 different providers
11 have marked on it.

12 But as was discussed during multiple
13 depositions of these providers, the copy of this
14 exhibit did not come to the depositions free of other
15 markings. There are markings from someone somewhere
16 from Ms. Gunn or Ms. Lenivy's office that have been
17 there that we would object to them showing at all
18 because they are hearsay.

19 I don't have a problem -- most of them are
20 in the upper right margin, if they're there exactly
21 like that, but they say things like "add" and
22 "decel" and other things that are not attributable
23 to any witness who was sworn under oath in this case.
24 So part of this exhibit would be hearsay, and I would
25 be object to that.

1 MS. GUNN: Yeah. Just so, Ms. Kamykowski,
2 so all you had to say is, you need to take that off,
3 and I would have done that.

4 MS. KAMYKOWSKI: well, I did see that on
5 multiple depositions and an ultrasound.

6 MS. GUNN: I don't know what you're
7 talking about, but I'll do whatever you want me to do
8 on that. And before I show anything like that, they
9 will be redacted.

10 MS. KAMYKOWSKI: And that's fine, as long
11 as it is not shown to the jury.

12 THE COURT: Thank you.

13 (Proceedings returned to open court.)

14 Q. (By Ms. Gunn) All right. Sorry about
15 that.

16 Exhibit 5 page -- actually, let's look at
17 13. If we look at 13 and 14. So let's talk for a
18 second. This, again, this is Remi's heart rate at
19 the top.

20 A. At the top grid, yes.

21 Q. And then what's on the bottom here?

22 A. The bottom would be the uterine activity
23 that is being reflected from the pressure sensitive
24 button. That's the second monitor piece that was
25 placed on the abdomen at the top of the uterus. And

1 it essentially is calculating an image based on
2 changes in contour or tightening of the uterine
3 muscle.

4 Q. And this is -- there's a time in the top
5 right-hand corner, it says 050320 at 1620.

6 So what time is that?

7 A. That's 4:20 p.m. on May 3rd.

8 Q. I'm sorry. May 3rd. We're going to talk
9 about military time basically.

10 A. Yes.

11 Q. 4:20 p.m. All right.

12 A. Yes.

13 Q. What pattern are we seeing on page 13 of
14 Exhibit 5?

15 A. So we see, again, we only have 8 minutes
16 of a tracing. When these tracings are stored like
17 this and printed, it's a little bit different format
18 than what a nurse may see up on a computer screen or
19 printing on grid paper out of the box itself.

20 So you can see that we're on a continuum.
21 This is just a slightly different format. But for
22 this eight-minute page, I would say that we have
23 normal baseline, around 130 beats, moderate or
24 average variability, the presence of accelerations
25 that meet gestational in each criteria. Though, if

1 this persisted for another couple of minutes before
2 or after, then it would be considered a Category I
3 tracing or a normal tracing.

4 Q. So let's look at the next page, 14. And
5 this is 8 minutes per page?

6 A. Correct.

7 Q. All right. Same kind of pattern?

8 A. Yes.

9 Q. All right. Let's go to 15.

10 All right. What are we seeing here?

11 A. I believe she was up to the bathroom. So
12 we can see there's a disconnect of the monitors. We
13 don't have a fetal tracing or a uterine tracing about
14 halfway through. And then it picks back up at the
15 end of the page.

16 Q. Okay. So looking at that two and a half
17 or so pages, what category would you put this in?

18 A. Category I.

19 Q. And that's about 4:20, a couple hours
20 after she reaches the hospital, correct?

21 A. Correct.

22 Q. Now, based on your review of the entire
23 strip, was Sarah in -- generally in -- what category
24 was she in in the 8 hours of being on the monitor?

25 A. It was predominantly Category I.

1 Q. So that would be from the two o'clock to
2 the midnight time frame, correct?

3 A. Correct.

4 Q. Did that also continue after midnight?

5 A. It did.

6 Q. All right. We will talk about -- we're
7 going to complete our jaunt through her stage 1,
8 okay?

9 A. Okay.

10 Q. So we've learned about the Pitocin that's
11 running, we've learned about her fetal monitoring
12 strips, and that she's Category I.

13 And after that, she progressed into her --
14 did she have any further of the vaginal exams?

15 A. Yes. She was being examined from the time
16 that she arrived at the hospital until about
17 6:00 a.m. on May 4th.

18 Q. Was she progressing?

19 A. She was.

20 Q. Did you -- did you notice that she was
21 progressing pretty normally or pretty standardly?

22 A. Yes. The first 6 centimeters were slow.

23 That's not uncommon for a first stage mom or
24 first-time mom. And then she started making more
25 rapid progress: 6, 8, 10 centimeters.

1 Q. Okay. Now, we know that Sarah was
2 complete at 3:50.

3 So what does it mean for her to be
4 complete?

5 A. It means that she was completely dilated
6 or 10 centimeters, completely thinned out or effaced,
7 or a hundred percent effaced. And I believe the
8 station that was documented at that time was zero, so
9 level with those little pointy prominences in the
10 pelvis.

11 Q. Now, I want to do a real quick review of
12 Exhibit 1, page 105. Well, let's -- yeah, let's go
13 to 105. Let's just get through the records here.

14 And, Nurse Shinn, this is going to be a
15 note at 8:40 p.m. in the middle there. That shows a
16 safety round, and it shows Category I, correct?

17 A. Correct.

18 Q. So at 8:40 p.m., there's a safety round,
19 and it shows that the strips are at Category I,
20 correct?

21 A. That's what it says.

22 Q. That's good.

23 A. Correct.

24 Q. That's reassuring.

25 A. Yes.

Q. Everything looks good.

A. At that point, yes.

Q. Was there any point in time in all this time, from the time that Sarah got hooked up, until later in the day on 4th, when she turned into Category II, at this time with Category I, was there any concern for Remi?

A. No.

Q. Any concern about his health at that point?

A. No.

Q. Any concern or evidence that he was already brain damaged?

A. Not anything documented in the medical record and not anything beyond the fetal tracing itself.

Q. Okay. So then let's go to second stage of labor.

You noted at 3:50, she is complete. So there is going to be discussion, or has already been discussion, about the timing of a second stage of labor.

So what is your understanding of a -- the standard, typical, routine time frame for a second stage of labor?

1 A. So it is individualized. If someone has
2 had a baby before vaginally, so they have a proven
3 pelvis, or someone like Sarah Anyan, who never had a
4 baby before or an unproven pelvis, whether they do or
5 don't have an epidural. So some of the guidelines
6 would say that at least 2 hours of pushing for a
7 multip, or someone who has had a baby before. At
8 least three of pushing with a first-time mom with an
9 epidural.

10 Q. Now, are there guidelines that help
11 practitioners understand the time frames for this
12 stages of labor?

13 A. Yes.

14 Q. And what would that include?

15 A. So there are some OB consensus statements
16 and practice bulletins that are put forth from ACOG.
17 In nursing literature there are also some
18 publications that would -- or some of the literature
19 that reflects a reiteration of the ACOG consensus
20 statements talking about how long is too long? How
21 long is enough? Those kind of things.

22 Q. By the time Sarah reaches 3:50, and is
23 complete, is that when the second stage time clock
24 starts?

25 A. Yes.

1 Q. Do you have to be pushing for the second
2 stage time clock to tick?

3 A. No. The second stage starts when this
4 patient reaches 10 centimeters dilation, whether
5 they're laboring down or resting along for passive
6 rotation and descent of the fetal head with
7 contractions, or if they're actively pushing.

8 Some providers may make a distinction
9 between active second stage versus passive second
10 stage, but the second stage still starts when the
11 patient is 10, and it doesn't end until the patient
12 is delivered.

13 Q. So you don't get a pause if somebody's
14 laboring down or not actively pushing?

15 A. No.

16 Q. Why? Why not?

17 A. The baby is still being subjected to
18 contractions. The uterus is still pushing the baby
19 into the bones of the pelvis, and so with what we
20 know physiologically and also factually with this
21 case, this patient was still on Pitocin at 18
22 milliunits. She was still actively contracting. Her
23 uterus had done its job and gotten her to 10
24 centimeters dilation. So even if she's not adding to
25 the contractions itself by actively pushing, those

1 contractions are still pounding that baby into the
2 bones of the pelvis.

3 Q. And what happens to the baby every time
4 there's a contraction?

5 A. So during a contraction, we know that
6 physiologically the tiny, little blood vessels in the
7 meat of the placenta in a space called the
8 intervillous space, that's where the blood exchange
9 happens. So the deoxygenated blood coming from the
10 body and the oxygenated blood coming from the mother
11 sort of switch out, and the baby gets sort of
12 recyclable blood, new blood, that is reoxygenated.

13 When there is a contraction, and the
14 uterus muscle is contracting, that intervillous space
15 has stasis. So the stronger the contraction, the
16 more often it's contracting, there's more and more
17 stasis that is happening, and so there may be some
18 interruption of blood flow to the baby.

19 In most cases, babies tolerate that just
20 fine. When there is -- we don't really know how long
21 a baby can tolerate different things before the risk
22 increase for brain damage. We don't know how long
23 until there's some kind of trauma. So there are
24 standard guidelines as to how long a second stage
25 typically lasts, under which conditions, and we are

1 certainly putting that in clinical context of the
2 fetal heart rate tracing, the fetal response, as
3 well.

4 Q. And have you seen studies of babies and
5 what the effect of 8, 10, 12 hours of second stage of
6 labor is on the baby?

7 A. I have not seen any studies where babies
8 have been intentionally subjected to long second
9 stages to see what potential injuries they may or may
10 not have --

11 Q. would that be an ethical study?

12 A. Not in my mind, it wouldn't.

13 Q. So does it surprise you that there aren't
14 studies that have been conducted that subject babies
15 to 8, 10, 12 hours of second stage of labor just to
16 figure out exactly what that oxygenation levels are?

17 A. No.

18 Q. with respect to that second stage of
19 labor, you've already told us that the longest ones
20 that you've seen, you've read Dr. McNeive's
21 depositions?

22 A. Yes.

23 Q. Do you recall what he said about the
24 longest second stage of labor he's ever been involved
25 in his 3,000 plus deliveries?

1 A. I believe it was this one, but prior to
2 that?

3 Q. Yeah.

4 A. I think it was somewhere consistent of the
5 nurses' testimony of around 5 hours.

6 Q. Now, let's talk about the different phases
7 on the fetal monitoring strips that can give us an
8 idea how that baby is doing.

9 So what I want to show you now is
10 exhibit -- give me a second. It's way beyond my
11 motion here -- Exhibit 5, page 120.

12 MS. GUNN: Hang on a second, Zack.

13 Q. (By Ms. Gunn) Okay. Yeah. Page 5 --
14 Exhibit 5, page 120.

15 Now, Nurse Shinn --

16 MS. GUNN: Okay. Sorry. That's where the
17 problem with the two pages. One more page. I'm
18 looking at the further one on the bottom on page 121.

19 (Pause in proceedings.)

20 MS. GUNN: Okay. One more page.

21 How about one more?

22 Q. (By Ms. Gunn) So the time frame for
23 this -- okay. Let's move on because that's not the
24 version I want. That's different.

25 So with respect to the different

1 categories, you've told us earlier, Category I is
2 normal, Category II -- what is Category II called?

3 A. Category II is called indeterminate,
4 meaning that some of those tracings might be
5 problematic. Some of those traces might not be
6 problematic. But because fetal monitoring is meant
7 to be a screening tool, not a diagnostic tool, we
8 can't know exactly which of those babies all run in
9 that category.

10 So we have to treat with intervention,
11 reduction of contraction causing agents like Pitocin,
12 cessation of those drugs, position changes, fluid
13 bolus, sometimes oxygen, sometimes medication to get
14 the uterus to quiet down and not contract as much.
15 But there are different interventions that can be
16 performed to try to improve oxygenation or improve
17 blood flow to the baby to try to get it back to a
18 Category I.

19 Q. And then what about Category III?

20 A. Category III is the other somewhat well
21 defined category.

22 We had talked about Category I being
23 normal. The components of it has to be a normal
24 baseline, normal variability. You might have accels,
25 you might not. You could have early decelerations,

1 which are thought to be benign, just related to the
2 head getting squeezed. But you can't have any other
3 type of decel.

4 Inversely, Category III is absent
5 variability, so undetectable, relatively flat for
6 baseline, with the presence of recurrent, meaning
7 with 50 percent or more of the contractions in a
8 20-minute period, recurrent variable, V-shaped or
9 abrupt decels indicative of cord compression. Or
10 recurrent late decelerations, gradual decelerations,
11 that are offset from a contraction, indicative of
12 utero placental insufficiency with some perfusion
13 issue. Or a bradycardia, or a sinusoidal. That
14 smooth, undulating pattern that we saw at the end of
15 the variability.

16 So it's very distinct. It's very black
17 and white. You have to check a lot of very specific
18 boxes to be in a Category III. And everything else
19 falls in category II. Like the shades of gray. You
20 could have some very, very close to a I and
21 reassuring. Some that are nonreassuring, close to a
22 III, but not a III by definition. And everything in
23 the middle. And unfortunately babies don't read
24 books and publications and monographs, so they don't
25 know what they're supposed to do or not supposed to

1 do to get people to react.

2 Q. Okay. Let's talk about decelerations.
3 what are decelerations?

4 A. Decelerations are drops in the baby's
5 heart rate. And we have some different kinds of
6 decelerations that we teach on to interpret.

7 Q. And what are those?

8 A. Early decelerations would be those gradual
9 contractions that essentially mirror -- or I'm
10 sorry -- gradual drops in the heart rate that mirror
11 the contraction. So the contraction rises like a
12 hill, goes down very smooth. And when the
13 contraction is over, the baby's heart rate is back.

14 So it's like putting your head in a vice.
15 Our heart rate would go down, too, while our head is
16 being squeezed, and then when the vice is done, the
17 heart rate goes back up.

18 variable decelerations are just like they
19 sound, they're variable. They can occur with
20 contractions, without contractions, they're very
21 abrupt, so they drop quickly. Sometimes they recover
22 quickly. They can often be V-shaped or W-shaped or
23 sometimes even U-shaped if they're abrupt enough.

24 And those are related to cord compression, and that
25 could be the cord's around the neck, around the body.

1 There's a knot. It's very short. It's being
2 stretched. Is the baby being pushed in the pelvis?
3 we don't always know. what we do know is the
4 mechanism is some type of obstruction or compression
5 of the cord by some mechanism.

6 And then, lastly, we would have late
7 decelerations. Again, gradual, smooth, have to be
8 related with a contraction, but they are slightly
9 offset. so you will see a contraction, and the heart
10 rate starts to go down. Recovers after the
11 contraction is over, in most cases.

12 And the reason for that is that the baby's
13 brain has to sense that there is a reduction of
14 oxygenation of blood from some source, and then it
15 starts to shunt blood to the places it needs to be
16 like the baby's brain or the baby's heart. And then
17 the heart rate starts to fall. so it's a pretty
18 unique mechanism by which the baby preserves its
19 available oxygen. The heart rate falls, the
20 contraction is over, the stressor is done, the heart
21 rate goes back up. so they're slightly offset.

22 And then we do have one more. A prolonged
23 deceleration would be any drop in the baby's heart
24 rate that drops by at least 15 beats and persists for
25 greater than 2 minutes, or less than 10 would be

1 considered prolonged, regardless of the shape or the
2 timing or whether it's with or without a contraction.

3 Q. So let's look at page 120 or 121 of
4 Exhibit 5.

5 And, Nurse Shinn, I want you to, if you
6 could show us what we're looking at -- there we go.
7 Okay.

8 So with respect to the right, what is your
9 understanding of the notations at the top there and
10 the initials?

11 A. So that was an exhibit to the various
12 depositions. The different colored pen was used for
13 different defendants for their interpretation, and
14 then they initialed what their interpretations were.

15 Q. All right. So let's look at that whole
16 page --

17 MS. GUNN: Scroll up just a little bit,
18 zack, if you don't mind. I'm sorry. The other way.
19 Scroll down.

20 Q. (By Ms. Gunn) And so what are we looking
21 at? You've just described those, but how do they
22 look?

23 A. Sure. So some of those decelerations are
24 in context with contractions. As you can see on our
25 bottom grid, we don't have that pretty humped pattern

1 that we saw in some of the earlier examples.

2 The reason for that, is there's a pressure
3 sensitive button that's being used on the outside of
4 the belly that can be moved or be disturbed from
5 patient movement, fetal movement, the position of the
6 button itself. The position of the mother as she's
7 being moved to other positions.

8 And so we know she's contracting. The
9 chart reflects she's contracting. She's actually
10 pushing for part of this. We see the spikes that
11 look like little skyscraper buildings near the end in
12 the last couple of minutes. And those decelerations
13 more likely than not are related to a contraction, we
14 just aren't getting a good pick up of the contraction
15 read itself.

16 Q. Okay. Now, let's move to -- so everybody
17 I think except for me can actually read these and
18 what they mean.

19 So let's go to the record and see what's
20 happening with Sarah now that we are complete, and
21 she's starting to push.

22 MS. GUNN: So, Zack, let's go to Exhibit 1
23 page 106.

24 Q. (By Ms. Gunn) So do you recall in this
25 time frame was there any concern that Nurse Greenwald

1 had with respect to Sarah's pushing in this first
2 couple of hours of her second stage after 3:50 a.m.

3 A. So not in the first hour and a half or so.

4 MS. GUNN: Keep going.

5 A. She was not concerned by way of her
6 documentation of the fetal heart rate or fetal
7 status. And it appears that Sarah was pushing
8 effectively with contractions or pushing strong with
9 the contractions at the right time as she was
10 instructed.

11 But around 6:15 or so in the morning, the
12 resident was brought to the bedside for a pushing
13 evaluation and to assess for position. So her
14 concern was not that the patient wasn't doing her
15 part or that her effort wasn't strong enough. It was
16 that the baby felt like it wasn't coming down, or it
17 wasn't coming down in the right direction, and she
18 was asking for assistance.

19 Q. And as a labor and delivery nurse, is that
20 something that you do from time to time?

21 A. Yes.

22 Q. And why would you do that?

23 A. For a couple of reasons. Number one, a
24 manual rotation of the baby's head, if it's thought
25 that the baby's head is somewhat asynclitic or

1 crooked in the pelvis, is not something that's within
2 the nurse's scope of practice. So the nurse can't
3 reach her hand up there and manually rotate the
4 baby's head, but a physician can.

5 In addition to that, if it appears that
6 there is a malposition or a failure to descend or
7 some type of objective issue with the delivery
8 process, a nurse can't call for a C-section. They
9 understand circumstances that might indicate a more
10 prompt delivery or a different mode of delivery, but
11 they can't do that on their own, they can advocate
12 for those things.

13 Q. All right. So Nurse Greenwald felt it was
14 appropriate to get a pushing evaluation and position
15 based on what she's seen for the last hour and a half
16 with Sarah?

17 A. That's right.

18 MS. GUNN: And then let's go down a little
19 bit more perhaps to the next page.

20 Q. (By Ms. Gunn) Dr. McKillip came, correct?

21 A. She did.

22 Q. And she made a note to the chart which is
23 pretty typical. If you're going to be in a patient's
24 chart doing things for the patient, you typically
25 document what you do, correct?

1 A. Yes.

2 Q. And she did?

3 A. She did.

4 Q. And she noted that, called per the nurse,
5 that would be the call from Alex Greenwald, to
6 evaluate maternal pushing for the last 1.5 hours.

7 And per the nurse, fetus zero station upon initiating
8 pushing.

9 So we knew that because when she first
10 became complete, it was noted that the baby was zero
11 station, correct?

12 A. Correct.

13 Q. And after patient had pushed on bilateral
14 sides with handlebars and towel pushing, what is all
15 that?

16 A. So if the thought is by the nurse that
17 maybe the baby is a little bit crooked or needs to
18 rotate differently in the pelvis, we can try
19 different position changes.

20 So to account for anatomy, size of pelvis,
21 shape of pelvis, shape of baby, size of baby, if we
22 push on the side, that may literally, that could open
23 the pelvis in a different manner. Pushing the other
24 side, could do the same thing.

25 Towel pulling adds some additional

1 strength, so it's essentially playing tug-of-war with
2 a patient so that their pushing efforts are even
3 stronger. Handlebars so she can pull like she's
4 rowing a boat or on a water rower to try to get more
5 oomph or more increase and row around her abdomen
6 while she's pushing.

7 Q. So is it clear to you from this note that
8 Nurse Greenwald was doing all these position changes
9 to try to get this moving?

10 A. Yes.

11 Q. And then patient denies excessive pain or
12 fatigue. So that's Sarah saying, I'm okay. I'm
13 okay.

14 A. Right.

15 Q. Now, this, the next paragraph, is what Dr.
16 Mckillip is documenting after she was there.

17 Does that sound right?

18 A. Yes.

19 Q. Upon evaluation, fetus is near 10 of 100,
20 zero station, that's everything we've said.

21 A. Correct.

22 Q. 10 centimeters dilated, a hundred percent
23 effaced, zero station.

24 A. Exactly the same as where she started.

25 Q. 2 hours earlier?

A. That's right.

Q. After pushing with changing positions and doing all those things and denying excess fatigue.

A. Correct.

Q. with caput -- so what is caput?

A. Caput is the soft part of the scalp. So swelling, sometimes that can indicate a fit issue.

Some caput may be normal just with the process of pushing and the baby coming into the pelvis. If you see the head is not coming down, the body part, which of course has to come through the birth canal to deliver the rest of the baby, and it's just swelling of the top of the head, but the head is still at zero station.

Q. Can you count -- you just said that. You cannot count caput, right? You cannot count caput as progression?

A. Correct.

Q. Now, what is fetus ROP with rotation to ROA with maternal pushing efforts?

A. So the R is related to the side of the mother, so right or left of the mother. O refers to occiput or the back part of the baby's head, and then position of that. Is it anterior? Is it transverse? Is it posterior? You heard something called sunny

1 side up.

2 If the baby was direct OP, the baby would
3 be coming into the pelvis with its head extended. So
4 the occiput, or back part of the head, is facing
5 mom's posterior or her back.

6 Similarly, if it's ROA, the baby would be
7 tucking its chin, and the smaller part of the head or
8 the occiput would be coming through the birth canal
9 in that direction. But it's generally more

10 preferred. So ROP means that the back of the baby's
11 head was posterior and toward mom's right. Trying to
12 be anatomically here. Toward mom's right. And when
13 she pushed with Dr. Mckillip, the head rotated
14 towards ROA. And when she stopped pushing, it
15 rotated right back.

16 Q. And is OP a malposition?

17 A. It can be for some women. It's not
18 impossible to deliver vaginally with an OP baby. But
19 it means more pushing, and there is a wider anterior
20 diam -- the posterior diameter to fit through the
21 pelvis.

22 So it's not as optimal as OA. And
23 certainly, if you're seeing signs that the bony part
24 is not descending, the soft tissue is swelling, the
25 head is sort of rotating in place but not descending

with pushing efforts, that could be of concern.

Q. would that be indicative of a fit problem?

A. Yes.

Q. The baby is not fitting correctly?

A. It can be.

Q. Now, Dr. Mckillip notes that at bedside for pushing for approximately 20 minutes, in which we pushed multiple positions. So it sounds like she was kind of doing what Dr. -- or sorry -- Nurse Greenwald was doing?

A. Correct.

Q. And then minimum descent noted with pushing.

I want to ask you: How would Dr. Mckillip know there was minimum descent?

A. She would be using her fingers during an exam with sterile gloves to establish, A, if the pushing effort seemed effective. So when mom pushes and bears down and curls around with the handlebars of the towel, you can actually feel the presenting part push down into the pelvis.

And you can assess does it stay there?

Does it retract back? Is it rotating so sort of in place but not coming down any further? So that would have to be something she would do and assess for --

1 with her fingers and sterile gloves.

2 Q. Okay. So same thing: She's not
3 visualizing this rotating back and forth, right?

4 A. No. In that station, we certainly haven't
5 seen Sarah Anyan's anatomy, but in the thousands of
6 women I have, I don't think anyone would be able to
7 see a zero station with caput to plus 1, plus 2.

8 Q. That's a feel.

9 A. That's a feel.

10 Q. Only if you're actually doing an exam?

11 A. Correct.

12 Q. And she's doing the exam while she's doing
13 this pushing. That's how she would know?

14 A. Yes.

15 Q. All right. What does she do in response
16 to noting minimal descent after pushing for 20
17 minutes?

18 A. She had a discussion with the attending,
19 Dr. April Parker, and the plan was to break for 30
20 minutes, reposition, and then resume pushing at that
21 time.

22 Q. Okay. But what about this last part?

23 Fetal heart turn remains assuring with baseline 140,
24 moderate variability: accels, rare variable decels.

25 A. It's essentially her interpretation of the

1 fetal tracing. So even though she's acknowledging
2 that there are some rare variable decels, they were
3 those abrupt v-shaped, w-shaped decels. They are
4 rare. They're not recurrent. They're not coming
5 frequently enough to cause a concern for fetal lobing
6 at that time. And this baseline was normal, between
7 110 and 160 beats. And the variability was moderate
8 or normal, and they also saw the presence of
9 accelerations.

10 Q. So how does Remi look right now?

11 A. Reassuring.

12 Q. Let's go to 3:43. Just want to go over
13 these positions with you really quick. You described
14 occipital anterior, occipital transverse, and
15 occipital posterior, which is OA/OP.

16 And OP, does this illustration
17 appropriately or accurately depict generally what
18 position the baby would be in under those
19 designations?

20 A. Yes. And it could be various versions
21 between one and the other. But in the direct OA, the
22 baby is tucking its chin looking down. In the direct
23 OT that one, that one, in particular, has happens to
24 be an ROT, where baby's nose was towards mom's left
25 hip, and the back of the head is towards mom's right

1 hip. And then direct OP, would be baby looking sunny
2 side up, with the back of the head being straight
3 down to the floor.

4 Q. Okay. Now, again, I think the reason why
5 I kept asking about, can you see it? is because I've
6 seen these. I'm like, oh, I can see it. But this is
7 not what anybody would be looking at?

8 A. No.

9 Q. You can't see like this.

10 A. Correct.

11 Q. You can't see it at all.

12 A. No.

13 Q. Okay. All right. What is laboring down?

14 A. So laboring down is to allow women to rest
15 in the second stage. So if they're either not
16 pushing effectively, or they are getting tired, which
17 the chart doesn't reflect that.

18 But if the thought is that the baby is
19 malpositioned, or maybe not in the right position to
20 optimally deliver vaginally, you would put the mother
21 on her side or in a comfortable position and just let
22 her keep trying to push and rotate the baby into the
23 pelvis to a more optimal position for delivery
24 without her getting herself tired and actively
25 pushing.

1 Q. Is laboring down a pause on the second
2 stage of labor?

3 A. It's not a pause on the second stage of
4 labor. It's just a pause on pushing to allow for
5 passive descent and rest for the mother.

6 Q. Is it your understanding that there was
7 about a 30-minute period of laboring down?

8 A. Yes.

9 Q. At this time frame.
10 And that gets us to I think close to seven
11 o'clock.

12 A. Correct.

13 Q. On May 4th.
14 what happens at seven o'clock?

15 A. At seven o'clock, pushing had resumed at
16 that point, and there was a shift change, and Nurses
17 Maggie and Jessie took over care at that time.

18 Q. What about for the attending? Did that
19 shift change, as well?

20 A. Yes.

21 Q. And who came on call?

22 A. Dr. McNeive took over for Dr. Parker.

23 Q. So at 7:00 a.m., I want to talk a little
24 bit about documenting. I want to look at Exhibit 1,
25 page 226.

1 Again, Exhibit 1 is Sarah's chart.

2 Can you tell us real quickly what a --
3 what a flow sheet is?

4 A. A flow sheet is essentially part of the
5 electronic medical record. Used to be paper
6 charting, now everything -- most hospitals have gone
7 to a full integration electronic. But it would
8 reflect vaginal exams, nurses notes, vital signs,
9 other things like Pitocin rates, that type of thing.

10 Q. This is the documentation in realtime, or
11 pretty close to what's happening clinically with this
12 patient?

13 A. Yes.

14 Q. This is what you're reviewing when you
15 review cases to draw your conclusions?

16 A. Correct.

17 Q. The notes of the nurse themselves.

18 A. The entire chart, actually. But, yeah,
19 but I'm most interested of course in what the nurses
20 are saying, where their location is, whether it's
21 accurate or not, what their interventions are, if
22 they're timely, if they're complete or not. And then
23 any conversations that they may have had for the
24 patient.

25 Q. So the bottom here, I think these are a

1 little bit tough to follow.

2 MS. GUNN: There we go.

3 Q. (By Ms. Gunn) Okay. I want to look at
4 this kind of highlighted part or bolded part. These
5 are -- this is the time frame within which something
6 is actually happening, right?

7 A. Yes.

8 Q. Okay. So let's just look at this random
9 one for example. It's called rounding tasks. It's
10 May 4th at 7:15 a.m., because we're dealing with
11 military time, correct?

12 A. Correct.

13 Q. And it says, caregivers introduce self per
14 their name, placed on the whiteboard. And then it
15 says MH at 5420 0911. So what's the difference
16 between these two numbers?

17 A. So the bold date and time that's
18 highlighted at the top, is the date and time that
19 it's -- you're telling the chart, this is when this
20 happened. If you look at the -- if you look at the
21 date and time and the initials that follow the note
22 itself, so Margaret Hilt-McLeland at May 4th, 2020,
23 at 0911. So that is the actual audit of when she
24 entered it into the medical records. She sat down at
25 a computer, logged in, and put that note in at 9:11

1 in the morning.

2 Q. Okay. So even though it got logged in a
3 little bit later, the idea is that that happened at
4 7:15?

5 A. Correct.

6 Q. Okay. All righty. So let's go to the
7 next page.

8 And the issue that makes things a little
9 bit difficult is that you have to keep your columns
10 so they don't -- when the page turns, they don't
11 bring the time back.

12 So I'm going to tell you that we were
13 looking at 0715. And I want to go down actually to
14 the one before that -- not before it -- but the --
15 let's see. Page 227. That is correct.

16 okay. Okay. This column. So we're still
17 in the 0715 column. And I want to go to this area.
18 so we've got, on the left side -- hang on just one
19 second -- the left side FHR.

20 what is that?

21 A. That's referring to Baby A. So there was
22 only one baby in this case, not twins or triplets.

23 This was Baby Remi and the interpretation of the
24 fetal heart rate baseline.

25 Q. Okay. And 140, how's that on baseline?

1 A. Normal.

2 Q. Okay. Mode: external. what does that
3 mean?

4 A. we have two -- well, three -- ways to
5 monitor. we have the external monitors, which is the
6 two monitors on the belly held in place by belts. we
7 have internal monitors that actually go into the
8 womb. One attaches to the baby's scalp and gives us
9 a direct read of the fetal heart rate. The other one
10 is a catheter fed next to the baby which gives us
11 pressure readings similar to a blood pressure of the
12 actual strength and resting tone of contractions in
13 between and during.

14 And then, lastly, we have something called
15 a Bluetooth. Some hospitals have it, some don't.
16 But it is also an option on market.

17 Q. All right. Variability. That is what?

18 A. Moderate, normal.

19 Q. All right. yeah, right. we've already
20 learned about that. That's good. That's good.
21 Moderate good.

22 okay. Pattern. what is pattern?

23 A. So as you can see, they're going through
24 that systematic step, the different components of
25 fetal monitoring interpretation. Established the

1 baseline. 140. Established the variability at

2 baseline, which is moderate.

3 Determined if there are accels or decels.

4 So when there are patterns, there usually is a

5 drop-down that will scroll and open other options

6 that the nurse can document from.

7 In this case, late decelerations were

8 chosen from the drop-down as a pattern that was

9 recognized or seen on the fetal monitor tracing.

10 Q. And it's plural, right?

11 A. Correct.

12 Q. So this isn't just a single late decel?

13 A. Correct.

14 Q. All right. And it's documented at 10:23

15 by Nurse Maggie, so we know from the heading before

16 it's 7:15 a.m.

17 A. Correct.

18 Q. All right. And the prevent minimize

19 Category II, indeterminate Category III. What does

20 that say?

21 A. So essentially the chart -- most of the
22 programs will prompt you to do different things like

23 preventative Category II or Category III tracings.

24 And, again, there are drop-downs that can be as to

25 what the nurse is doing in realtime to prevent a

1 Category II, to fix a Category II, to prevent a
2 Category III. And in this case they were monitoring
3 the baby's well being. They were changing the
4 maternal position, and I think prepared for delivery,
5 is what the rest of that says in the actual medical
6 record.

7 Q. Okay. Let's go back to what we know the
8 definition of Category II is.

9 If you have late decelerations, is that a
10 Category II?

11 A. It is. Whether it's one or plural, it's
12 don't follow -- even if everything is normal and
13 perfect, the presence of a singular late deceleration
14 for the period of time that you're interpreting,
15 kicks it out of a I and into a II.

16 Q. All right. And to your knowledge, were
17 there previous late decelerations way back in the
18 strip at some point?

19 A. I don't recall there being any patterns of
20 decelerations that were of concern from my review,
21 no.

22 Q. Okay. So this is a pattern of
23 deceleration that was noted by Nurse Maggie at 7:15
24 a.m., according to the chart?

25 A. Correct.

1 Q. All right. Let's look at Exhibit 1, page
2 100 again.

3 This is part of Sarah's chart. And it is
4 embedded into her chart the STL LD vaginal birth
5 protocol. Right there. Okay.

6 So this, again, is just unfortunately the
7 way these things printed out, but this is -- let's go
8 on to the next page.

9 What is this?

10 A. So these are orders that automatically
11 populate into the patient's chart based on a
12 medication that they may be on.

13 So if they're not on Pitocin, or they
14 aren't being admitted for induction augmentation,
15 this wouldn't be in that patient's chart. But
16 because this patient was being augmented in her
17 labor, and she was ordered Pitocin, this is something
18 that would populate as part of an order set.

19 Q. Okay. And you see there, and this is a
20 Mercy Hospital St. Louis Medical Executive Committee.
21 That's who this protocol was approved by?

22 A. Correct.

23 Q. And it was approved on 8/15/19, correct?

24 A. Yes.

25 Q. All right.

1 MS. GUNN: So let's go down through this
2 the next page, Zack. And let's go to intrauterine
3 resuscitation.

4 Q. (By Ms. Gunn) And I showed this to the
5 jury in opening.

6 So, Nurse Shinn, I was hoping you could
7 explain exactly what we're looking at.

8 A. So under the communication orders to the
9 nurse, it lists some specific things called
10 intrauterine resuscitation.

11 These are physiologic interventions that
12 are aimed at improving fetal blood flow or fetal
13 oxygenation.

14 From a nursing perspective, most of the
15 interventions are going to be exactly the same for
16 all abnormal conditions. If there's a Category II
17 with concern, we do these interventions. If there's
18 a Category III, we do these interventions.

19 If there's some other emergent problem
20 with the fetal tracing or clinical concern, we would
21 do these interventions. Too many contractions, we
22 would often do these interventions.

23 That really is all a nurse has in her
24 wheelhouse that she can go do with autonomy, meaning
25 independently, without Dr. McNeive standing there

1 saying, this is what you do. This is what you do.
2 Now, he can be elsewhere, and nurses can
3 use these standardized protocols to help guide their
4 care from minute-to-minute.

5 Q. And it says: The following measures will
6 be initiated based on maternal-fetal response,
7 correct?

8 A. If the fetal heart rate pattern is either
9 Category II instrument, or abnormal Category III.

10 Q. And what is listed here?

11 A. Lateral positioning, so left side, right
12 side. Sometimes hands and knees is also a position
13 that's used. It's a little more difficult if they
14 have an epidural, but it is something that can be
15 used.

16 But we could, in that case, if we thought
17 there was a concern with the fetal heart rate, stop
18 pushing, stop Pitocin. There are other interventions
19 that can be done like a fluid bolus.

20 If this patient was on a cervical ripening
21 drug called cervidil, that can be removed from the
22 vagina. Not relevant in this case.

23 A nurse can give oxygen if -- depending on
24 the variability and whether it's a Category II or
25 Category III. There's some things about that. And

1 then modification of maternal pushing efforts during
2 the second stage. So push every other, push every
3 third, or stop pushing altogether, if that appears to
4 be the stress for the baby.

5 Q. All right. So you've got the positioning,
6 is one thing.

7 A. Correct.

8 Q. And the modification of maternal pushing
9 would be what you're saying like could that be a
10 laboring down scenario, as well?

11 A. It's not exactly the same as laboring
12 down. While there is some benefit to just stopping
13 pushing altogether, in this case, it was being done
14 to allow for passive rotation and descent because of
15 the malposition and the higher station.

16 If you're doing modified pushing, if she's
17 making progress, she's doing what she needs to do for
18 the pushing efforts, but the baby maybe isn't
19 tolerating each of the pushing efforts, so you could
20 wait out two contractions.

21 In studies it's been shown that even if
22 the baby's heart rate still drops, the oxygen level
23 is likely to remain in a more normal range if you
24 don't push without contraction. So there is some
25 benefit during the time that she's not actively

1 pushing that the baby would get a little better
2 perfusion, but, again, everything is in context of
3 stage of labor, length of labor, presence or absence
4 of decels. That type of thing.

5 Q. Does this list include specifically
6 laboring down?

7 A. No.

8 Q. Does that surprise you?

9 A. No.

10 Q. Why not?

11 A. Because in all of the teaching,
12 publications, literature, that talk about
13 intrauterine resuscitative measures, which are
14 typically performed, they can be performed by
15 anybody, but typically performed by nursing.
16 Laboring down is not one of the -- it's just not
17 listed in the list.

18 Q. Okay. What about the one that's kind of
19 awkwardly tabbed over?

20 A. I think that's just an oversight of the
21 format. They probably aren't as text savvy as we.
22 But discontinuation of oxytocin is infusing. So this
23 particular protocol has taken the stance to just turn
24 it off until you get improvement of the fetal heart
25 rate rather than a reduction or turning it in half or

1 something like that.

2 Q. All right. So in Category II, this
3 protocol indicates discontinuation of oxytocin?

4 A. It does.

5 Q. And is that something you'd see, or in
6 your profession, you've heard of before?

7 A. Yes.

8 Q. Is it pretty typical?

9 A. Yes.

10 Q. Why?

11 A. For a couple of reasons: Number one,
12 because the surge is endogenous or internally
13 circulating oxytocin -- it happened around the time
14 of transition -- will help labor to be
15 self-sustaining. So even if the Pitocin is turned
16 off, the likelihood that the contractions will keep
17 coming. They may be less strong. They may be a
18 little less close. But they will still keep
19 occurring because of what we know happened
20 physiologically.

21 In addition to that, if the thought is
22 that stimulating the uterus, making stronger, closer
23 contractions is what is prompting some type of fetal
24 response, that's not normal, progression to Cat II or
25 Cat III tracing, then we want to eliminate all

1 sources of stress that we can.

2 So stop pushing, roll her on her side,
3 modify her pushing, turn the Pitocin off, give her
4 extra fluids through the IV. If the thought is maybe
5 she's dehydrated or the contractions have gotten a
6 little too close, or her blood pressure is low from
7 the epidural, whatever the case is, these are not
8 magical interventions.

9 Those are typically done in the succinct
10 togetherness in a bundle because there is no
11 literature that points to doing them one in isolation
12 or how many minutes it would take to correct a fetal
13 heart rate tracing problem, or that it would ever
14 even work.

15 So the thought is go big or go home. Do
16 all of them in a bundle, correct the problem. And if
17 it's corrected, fine. If it's not corrected, then
18 you need to tell somebody and advocate.

19 Q. Okay. So is there anything unclear about
20 this Mercy protocol that applies to nursing and to
21 doctors about what is to be done in a Category II
22 tracing?

23 A. No.

24 Q. When that record we showed a minute ago
25 showed late decelerations, that's a Category II

1 tracing?

2 A. Correct.

3 Q. Was Pitocin turned down?

4 A. No.

5 Q. Was Pitocin turned down at any point until
6 it was turned off after Remi was born?

7 A. No. Not only was it not turned down, it
8 wasn't turned off either, so it was, in fact, later
9 it was actually turned up.

10 Q. Do you think -- and you've been on
11 hospital policies and procedures committees, right?

12 Are they important?

13 A. They are.

14 Q. Are they well-documented research?

15 A. In most cases, I would say yes.

16 Q. Are they expected to be followed for a
17 patient's safety?

18 A. Yes. If there are policies that are not
19 well written that are somewhat vague, confusing, or
20 following the policy would increase the risk of harm
21 to a patient, then the nurse would, in that case,
22 have good reason not to follow policy.

23 If it's a well-written policy, then it's
24 consistent with standard of care, what's reasonable
25 and typical and prudent with evidence-based practice

1 and reasonable authorities on the topics, then
2 following the policy would not increase the risk of
3 harm. It would, in turn, increase the risk of
4 safety, or the likelihood of safety, I should say.

5 Q. And when you talk about safety, you're not
6 just talking about mom, are you?

7 A. No.

8 Q. And with Pitocin, you're specifically
9 talking about baby?

10 A. Well, both. There is the potential that
11 you could overstimulate the uterus and cause some
12 concern to the mother. That's not the concern here.

13 There are a few places in which the uterus is
14 contracting very frequently.

15 At some point, the baby tolerates it, and
16 then it goes away. Sort of comes and goes. Other
17 places, it comes, and the baby doesn't tolerate it,

18 but then it doesn't continue contracting that
19 frequently. So there is a concern you're looking at
20 two patients. The nurses always have two patients in
21 this case: the mother and the unborn baby.

22 And you're looking at both the maternal
23 and the fetal response to see, do I need to do some
24 intervention to help mom or some intervention to help
25 the baby or both?

1 Q. okay. Let's go to page -- Exhibit 1, page
2 230.

3 These are more flow sheets, Nurse Shinn,
4 with respect to between 7:00 a.m. and 8:00 a.m.,
5 actually through the 8:30 time frame of Sarah Anyan's
6 chart through the second stage of labor. So this was
7 easier because it's all the same page.

8 You see, we're looking at the same
9 descriptions here on the left: FHR, mode,
10 variability, pattern, etc.

11 Do you see that?

12 A. Yes.

13 Q. So looking down on 7:30, what's the
14 pattern?

15 A. Lates. They continue to document late
16 decelerations.

17 Q. And remind us what late decelerations --
18 why a late deceleration is concerning.

19 A. Late decelerations occur with
20 contractions. They are offset in timing, and they
21 reflect uteroplacental insufficiency.

22 So somewhere along the oxygen pathway from
23 the air that the mother breathes, through her
24 vasculature, delivered to that little intervillous
25 space of the meat of the placenta, there is some

1 disruption. So the baby is not getting enough oxygen
2 in its blood at that point in time. whether there's
3 too many contractions or very few contractions, the
4 baby's heart rate is dropping, evidence that there is
5 some decreased perfusion.

6 Q. Okay. And that can affect and run the
7 risk of brain damage?

8 A. It can.

9 Q. Now, we have late decelerations noted at
10 7:30, correct?

11 A. Correct.

12 Q. There's nothing in there for 7:45.

13 what about eight o'clock?

14 A. Same: late decelerations.

15 Q. what about 8:15?

16 A. Nothing's noted.

17 Q. what about 8:30?

18 A. Late decelerations.

19 Q. So this is an hour of time with multiple
20 late decelerations noted?

21 A. Yes. I think actually there was a notion
22 at 7:15 that we already looked at, so a little over
23 an hour.

24 Q. Thank you.

25 And at no point is Pitocin turned off?

1 A. Correct. It's not turned down. It's not
2 turned off. There's nothing other than position
3 changes being performed.

4 Q. Are they working?

5 A. No.

6 Q. How do you know?

7 A. Because the nurses in this case continued
8 to identify late decelerations, and their
9 interpretation was correct.

10 Q. What else is happening at eight o'clock?

11 A. Eight o'clock, Dr. McNeive came to the
12 bedside.

13 Q. And so let's go back in our time line.

14 Mom is complete, Sarah is complete at
15 3:50. That clock starts on the second stage of
16 labor. ACOG gives us guidelines on what they
17 typically see and would be considered normal versus
18 prolongs. And that gets us to 7:50?

19 A. Correct.

20 Q. So at eight o'clock, we're already past --
21 we're already into a prolonged second stage of labor?

22 A. Correct.

23 Q. Is there any doubt about that?

24 A. No.

25 Q. That's just time, correct?

1 A. Correct.

2 Q. So do you know how many women deliver,
3 even one first-time moms with an epidural, deliver
4 before or within 4 hours?

5 A. It's a fairly high number, like
6 95 percent, or something like that.

7 Q. So is it, needless to say uncommon, even
8 for a first-time mom on an epidural, not to have
9 delivered her baby within 4 hours?

10 A. I would be more of an outlier.

11 Q. All right. And is that something that
12 labor and delivery nurses generally know?

13 A. Yes.

14 Q. And in this case, you've read the
15 testimony of Maggie, Nurse Maggie, and Nurse Jessie.
16 Did they know that?

17 A. Yes.

18 Q. So at eight o'clock, Dr. McNeive comes in
19 to discuss the plan of care with the patient.

20 And directly before eight o'clock, what do
21 we see in terms of the pattern? We just looked at
22 it.

23 A. Multiple late decelerations.

24 Q. So if anybody were actually looking at
25 this strip, what would they see?

1 A. Late decelerations -- or a decrease of
2 perfusion to the baby.

3 Q. And what category?

4 A. Category II.

5 Q. And what's the Pitocin doing?

6 A. It's still running at 18.

7 Q. And when was the last time someone checked
8 the station of Remi?

9 A. The last time it was documented, it was
10 around 6:15 in the morning with Dr. McKillip.

11 Q. And where was he?

12 A. Zero station.

13 Q. How far had he gotten after 2 hours of
14 pushing?

15 A. Nothing.

16 Q. Where was his head positioned?

17 A. It was ROP. And was sort of rotating with
18 the pushing efforts, but not descending any further.

19 Q. Would that be considered malpositioned?

20 A. Yes.

21 Q. Nurse Shinn, do you have opinions with
22 respect to the standard of care that applied to Nurse
23 Maggie and Nurse Jessie at this 8:00 a.m. time frame?

24 A. Yes.

25 Q. And what are they?

1 A. At eight o'clock in the morning, they had
2 taken reports, they had been caring for this patient
3 for approximately an hour. They would have known
4 what the tracing had shown. They would have known
5 when the patient became 10 centimeters, or the start
6 of the second stage.

7 They would have known she was a first-time
8 mom with an epidural, and they would now have seen an
9 hour of interpretation of fetal monitor strip in
10 which they themselves saw late decelerations, with no
11 deceptive fetal head.

12 So at eight o'clock, when Dr. McNeive came
13 to the bedside, it was incumbent that one or both of
14 these nurses advocate to Dr. Mckillip -- or I'm
15 sorry -- Dr. McNeive for a primary C-section. This
16 was a patient that was falling out of the normal
17 trajectory, on average, and there were abnormalities
18 in the tracings. Even though I'm critical that they
19 didn't perform more intrauterine resuscitative
20 measures per their protocol and per their standard,
21 the position changes they were doing were not
22 correcting the pattern that they were seeing.

23 Q. But what if Sarah said that she was still
24 feeling good? Shouldn't that matter?

25 A. I mean, patients feeling good or having

1 energy or being willing to keep pushing, doesn't
2 necessarily set or designate the standard of care.
3 So what you're looking at is the labor progression,
4 the fetal response to what's happening to the baby:
5 the Pitocin running, the pushing efforts, the
6 contractions, whether interventions are helping or
7 not helping.

8 And, in this case, the labor was not
9 progressing. It was a prolonged second stage. It
10 was a malpositioned, either on documentation. The
11 Pitocin this still running, and the baby was being
12 subjected to the effects of stronger, closer
13 contractions and pushing efforts.

14 And so she had, both those nurses had, a
15 captive audience to make nursing recommendations
16 based on their education, their training, their
17 backgrounds, and the information they knew that was
18 typical and not typical.

19 Q. Is there any evidence in this case that
20 Sarah Anyan knew what a prolonged second stage of
21 labor is or whether they told her anything about a
22 prolonged second stage of labor or that Remi had a
23 failing to descend?

24 A. No.

25 Q. Or that his head was malpositioned?

1 A. NO.

2 Q. Now, Dr. McNeive was in the room. I mean,
3 he was the attending physician. And it was his
4 assessment, according to the records, that they had
5 discussion, plan of care with patient, and obviously
6 there was no C-section done or any other operative
7 delivery done.

8 what's a nurse to do if the physician is
9 the one standing there making the decisions?

10 A. It's still the responsibility of the
11 primary bedside nurse to be an advocate or a voice
12 for the patient.

13 They have specialized education for a
14 reason. They have specialized training and
15 onboarding for a reason. They are taught how to read
16 a fetal monitor strip for a reason.

17 And so it is within the nurses' scope of
18 practice to make nursing recommendation on the
19 plaintiff care. whether Dr. McNeive at that time
20 would have followed it, not followed it. He had
21 other patients he was responsible for that day that
22 he was delivering. So if he was unavailable, or if
23 he was unresponsive, it then would have been
24 incumbent that the nurses utilize their chain of
25 command or chain of escalation.

1 Q. I think I've said this in opening. Are
2 nurses potted plants?

3 A. Definitely not.

4 Q. what's the job?

5 A. The job is to continue to be a patient
6 advocate. So that role, that responsibility, that
7 duty, doesn't change because somebody with different
8 letters after their name walks in the door.

9 It still is up to the nurse to use her
10 education, her training, her background, her
11 knowledge to advocate on the patient's behalf of what
12 is typical, customary, and reasonable, and what she
13 knows to be typical, customary, reasonable.

14 Q. And do you hold that criticism, that
15 breach of the standard of care, at 8:00 a.m., as to
16 Nurse Maggie and Nurse Jessie to a reasonable degree
17 of nursing certainty?

18 A. I do. And from eight o'clock onward.

19 Q. well, let's look at that.

20 MS. GUNN: Page -- Exhibit 1, page 231.

21 THE COURT: Ms. Gunn, this may be a good
22 time for us to take our afternoon recess.

23 MS. GUNN: Of course.

24 THE COURT: All right. Ladies and
25 gentlemen.

1 (At 3:51 p.m., the Court duly admonished
2 the jury, and proceedings stood in recess. At
3 4:09 p.m., the following proceedings were held in
4 open court in the presence of the jury:)

5 THE COURT: Go ahead and be seated,
6 everyone.

7 You may resume.

8 MS. GUNN: Thank you, Your Honor.

9 Zack, may I have Exhibit 1, page 231?

10 Q. (By Ms. Gunn) And, Nurse Shinn, I'm going
11 to show you another page from Sarah's chart. And
12 this time frame is at 8:45, 9:00, 9:15, 9:30, and
13 9:45.

14 Are you with me?

15 A. I am.

16 Q. All right. So let's look at this.

17 we've got -- let's look at variability
18 first.

19 So that variability is the heart rate, and
20 that's a good thing, right?

21 A. That is the regular peaks and troughs
22 along the baseline, so moderate would be what is
23 considered normal.

24 Q. All right. So he had, Baby Remi, had
25 moderate variability through this hour, correct?

1 A. Per the documentation, yes.

2 Q. All right. What about the pattern? What
3 are we seeing in terms of the decels?

4 A. Still the nurses have identified late
5 decelerations with all of their entries other than
6 the last one.

7 Q. And that doesn't say late, early,
8 variable, acceleration. It's just blank, right?

9 A. Correct.

10 Q. Okay. So late decels are noted by Maggie
11 at 8:45, nine o'clock, 9:15, and 9:30.

12 A. Correct.

13 Q. And was the Pitocin turned off?

14 A. No.

15 Q. Were IV bolus given?

16 A. No.

17 Q. There's one under the --

18 MS. GUNN: Go down just a little bit,
19 Zack.

20 Q. (By Ms. Gunn) Under the nine o'clock, it
21 does say --

22 MS. GUNN: Maybe you have to go to the
23 next page. Okay.

24 Pardon me, you all.

25 Q. (By Ms. Gunn) So this, again, is that

1 nine o'clock time frame.

2 And what does -- can you read that?

3 A. It says left side, head of bed elevated,
4 pushing.

5 Q. Okay. So that is under the column
6 maternal -- under that column fetal well-being being
7 monitored, maternal position change, right?

8 A. Correct.

9 Q. So would that be a resuscitation effort
10 under the protocol?

11 A. It's not a resuscitation under the
12 protocol. Being on the left side does help tilt the
13 uterus, the weight of the uterus, so that the large
14 blood vessels that run behind it, continue to perfuse
15 the uterus well.

16 But the head of the bed was elevated, and
17 she was continuing to push. So it doesn't appear
18 that this was for fetal resuscitation as much as it
19 was for labor progression to facilitate vaginal
20 delivery. Even if by some miracle the benefit of a
21 position change helped both of those, you can't have
22 your foot on the gas and your foot on the brake at
23 the same time. So by continuing to push and
24 continuing the Pitocin, but turning to the left side,
25 that isn't going to correct the problem. It's not

1 proper resuscitation.

2 Q. So now at nine o'clock, we've entered hour
3 5 of the second stage?

4 A. Correct.

5 Q. If you look at 9:30, it says, hands and
6 knees pushing.

7 And I know it was entered at 119. But
8 under the 9:30 time frame, right?

9 A. Correct.

10 Q. So is that an intrauterine resuscitation?

11 A. No. That is -- the hands and knees
12 position could be a position that would better
13 perfuse the baby and the placenta and the uterus.

14 But continuing to push, this appears more to be -- to
15 facilitate rotation and descent and moving toward
16 vaginal delivery because, again, the pushing didn't
17 stop, the Pitocin didn't stop. This was just a
18 different position but continued pushing.

19 Q. So at this point, 9:30, 5 and a half hours
20 into the second stage, now prolonged, even by ACOG
21 standards by an hour and a half. She's gotten on her
22 hands and knees pushing. And you think that that
23 indicates it's because they're trying to get the baby
24 rotated?

25 A. It would appear so, yes.

1 Q. As opposed to resuscitate the baby?

2 A. Correct. The position itself is a
3 position that we oftentimes will put mothers in if
4 they're able to get in that position to better
5 perfuse the baby. So it is an acceptable position
6 for perfusion.

7 But in this case, they're continuing to
8 run the Pitocin at 18 milliunits. They're continuing
9 to actively push and pound the baby into the pelvis.

10 And they're not getting descent of the baby's head.

11 So whatever benefit the hands and knees
12 and the left lateral positioning would have done,
13 it's not going to be affected by continuing to run
14 the Pitocin and push.

15 Q. All right. So we're still obviously
16 dealing with no descent of the baby here, not coming
17 down, not progressing?

18 A. As far as we can tell from the records,
19 yes.

20 Q. And at 9:45, we're back to left side, head
21 of bed elevated, and no pushing?

22 A. Correct.

23 Q. Okay. So are we in another potentially
24 laboring down? Is that what that no pushing means?

25 A. Yes. There were several periods of time

where they just stopping pushing altogether and were attempting laboring down.

Q. And are you aware of how long that -- or when that laboring downtime frame was?

A. It was, I believe, roughly an hour, like 9:10 to 10:15. Or something like that.

Q. Okay. I know you can read it from the strips, but I'm trying to save time. I have it as 9:44 to 10:24.

would that seem to match with this?

A. Yes.

Q. 9:45. So they just started laboring down right at that time.

Are you aware, from the records or from the deposition testimony in this case, what Dr. McNeive was doing at 9:42?

A. I believe he was doing a C-section for another patient.

Q. Okay. So the 9:44 to 10:24 time frame, still Pitocin going?

A. Correct.

Q. Going into the sixth hour of the second stage of labor?

A. Correct.

Q. Okay. Let's look at page -- Exhibit 1,

1 page 231 and 232. so start with 231. we're going to
2 that heading again.

3 MS. GUNN: Yeah. Keep going to 232.
4 Right there.

5 Q. (By Ms. Gunn) Okay. See 10:00, 10:28,
6 10:30, 10:43, 11:02.

7 A. Correct.

8 Q. You see at 10:30, patient's pushing?

9 A. Yes.

10 Q. okay. so that's about -- so that sort of
11 bookends that, quote, laboring down?

12 A. Correct.

13 Q. okay. so going to the ten o'clock,
14 though, we've got more position changes: left side,
15 head of bed elevated, no pushing.

16 You see that, ma'am?

17 A. Yes.

18 Q. okay. And that was documented at ten
19 o'clock. And then at 10:28, what are we seeing?

20 A. At 10:28, more late decelerations.

21 Q. All right. so those had not resolved
22 through these position changes?

23 A. Correct.

24 Q. Maybe they did for a short time, but not
25 actually resolved?

1 A. It didn't markedly improve the tracing.
2 The late decelerations were still identified, and
3 variable decelerations were still identified
4 throughout the course of the morning and into the
5 afternoon.

6 Q. All right. And so just to be clear: At
7 this 10:28, this is Maggie, Nurse Maggie. She's
8 documenting what she and Jessie are seeing on those
9 strips?

10 A. Yes. She is documenting later, but that
11 was based on her interpretation. But by their own
12 testimony, they were present at the bedside, one or
13 the other, so they would have been in realtime
14 interpreting the tracing so if they thought if
15 there's something different, they certainly could
16 have entered that in the afternoon when they did
17 their documentation.

18 Q. And if a nurse is putting this in the
19 chart, that is her interpretation of it?

20 A. Correct.

21 Q. Okay. And so then at 10:43, we've got
22 variable decelerations, is that correct?

23 A. That's what it says.

24 Q. And what -- can you remind us about what
25 causes a variable deceleration?

1 A. variable decelerations are caused by cord
2 compression, by some mechanism. So there's a knot,
3 there's a clot, there's a short cord being stretched
4 thin impeding perfusion. The cord around the neck or
5 around the body part, or it could just be up near the
6 head, so as the baby is being pushed down by the
7 uterine forces, it's compressing the cord and causing
8 some disruption or reduction in blood flow.

9 Q. So I think maybe our jury aren't familiar
10 with cords wrapped around baby necks.

11 Is that what this is?

12 A. I don't believe there was a nuchal cord or
13 a cord around the neck in this case, but we can't see
14 into the womb. So when you're putting yourself in
15 the shoes of the providers who are interpreting the
16 tracing, when you see that, when you know the
17 mechanism of cord compression of some sort.

18 So the interventions are position changes,
19 reduction, or cessation of medication that is causing
20 contractions, fluid bolus. There are some other
21 interventions that we could maybe do that are a
22 little more evasive like medications to stop the
23 labor or instilling fluid up into womb to cushion the
24 cord so it's more free-floating.

25 But in this case, there was no documented

1 after-the-fact or at the of birth cord around the
2 neck or cord around the body parts. So we don't
3 really know where that cord was at the time it was
4 being impinged or compressed, but that is the
5 mechanism that we know etiologically causes that type
6 of decel.

7 Q. But as you say, there's no evidence in
8 this case that that is what caused -- was causing
9 ultimately his HIE?

10 A. The variable decels?

11 Q. The cord wrapped around the neck.

12 A. Correct. Correct.

13 Q. Okay. Just to be clear on that.

14 So now we've got the 10:43 with the
15 variable decels, and now we're entering almost to 7
16 hours of second stage of labor?

17 A. Correct.

18 Q. Extremely prolonged?

19 A. Yes.

20 Q. Beyond ACOG's guidelines?

21 A. That is typically correct.

22 Q. Okay. And then we've got some more hands
23 and knees pushing at 10:43, correct?

24 A. Correct.

25 Q. Okay. Well, let's talk about what

1 happened at 10:45. And that is Exhibit 1, page
2 107-A.

3 And this is the safety round that was just
4 discussed.

5 MS. GUNN: We're talking about 107-A,
6 Zack.

7 Q. (By Ms. Gunn) What's your understanding
8 of the safety rounds?

9 A. That is not the note for the safety
10 rounds.

11 MS. GUNN: No. I think it's further down
12 the page. Keep going. Okay. That's where it
13 starts.

14 Q. (By Ms. Gunn) So what is your
15 understanding, Nurse Shinn, of the safety rounds that
16 are occurring at Mercy Hospital here?

17 A. That it's multidisciplinary. There's
18 different personnel who spend 15 minutes looking at
19 the fetal heart rate tracing and discussing the plan
20 of care. It doesn't say who was present specifically
21 by name or what the conversation was about the
22 tracing, about the plan of care, or about the prolong
23 second stage, malposition, anything like that.

24 It just would indicate that a group of
25 people got together and talked about this particular

1 patient for roughly 15 minutes.

2 Q. Okay. And we know from what we just
3 looked at that there were variable decels and a
4 history of recurrent late decels in the few hours
5 ahead of that, correct?

6 A. Correct.

7 Q. And we know, just based on time, that
8 she's coming into the seventh hour of her second
9 stage of labor, right?

10 A. Correct.

11 Q. And these folks, whose names are not in
12 this chart, right?

13 A. Right.

14 Q. Say Category II.

15 A. Correct.

16 Q. And you -- at least you can agree with the
17 Category II, right?

18 A. Yes.

19 Q. The indeterminate category?

20 A. Correct.

21 Q. And we know that, at least we know, we
22 believe we know, that Dr. McNeive is the in-house
23 attending at that time, right?

24 A. Correct.

25 Q. So he would have been involved in that

1 discussion, right?

2 A. Yes.

3 Q. And then we've got the bedside nurses,
4 bedside nurse, and that could have been Maggie or
5 Jessie?

6 A. Correct.

7 Q. And they were in this safety round, as
8 well?

9 A. Correct.

10 Q. So what could have been done -- what could
11 Jessie and Maggie have done at that meeting, that
12 safety rounds meeting, that was happening at 10:45?

13 A. During this safety rounds meeting, when
14 they were looking and talking about this patient, the
15 substance of the conversation and who said what or
16 who was there specifically, we don't know.

17 But during this time, it was a captive
18 audience for these autopsy nurses to be on stage,
19 present this patient's clinical picture, present the
20 fact that the head was not descending. She was in
21 hour 7 of her second stage of labor.

22 The head was noted to be malpositioned
23 hours before that. They had identified late and
24 variable decelerations on the fetal heart rate
25 tracing. And whatever benefit to their position

1 changes may have occurred, wasn't actually improving
2 what they were identifying on the fetal tracing.
3 So, again, continuing to advocate for a
4 change in the plan, moving toward C-section based on
5 all the typical and standard things we know about
6 first-time moms with epidurals. How they labor. How
7 long they labor. And what is typical and reasonable
8 of a fetal heart rate response.

9 Q. And that didn't happen?

10 A. It did not.

11 Q. Pitocin wasn't turned down?

12 A. It was not turned down.

13 Q. Let's look at Exhibit 1, page 233.

14 Look at the time frame here. Starting at
15 11:17. Same kind of time frame here -- not time
16 frame -- but grid here, if you will. 11:17 was the
17 pattern?

18 A. At 11:17, they still note late and also
19 variable decelerations.

20 Q. Okay. So two issues going on?

21 A. Correct.

22 Q. Both of which can relate -- or can cause
23 low oxygen to the baby?

24 A. Yes. Either a disruption of blood flow
25 through the umbilical cord or a disruption of the

1 delivery of oxygen and blood from the placenta. Both
 2 of those conditions over time could deplete fetal
 3 reserve, lead to a depletion of oxygen stores of the
 4 baby, and the baby that is more at risk for
 5 developing brain damage.

6 Q. At 11:32, now we're 7 and a half hours in
 7 the second stage of labor. what does the pattern
 8 show?

9 A. No late and variable decelerations.

10 Q. 11:47, just right at the cusp of starting
 11 8 hours of second stage of labor.

12 what do we see as far as the pattern is
 13 concerned?

14 A. Late deceleration.

15 Q. And, again, this is now recurrent?

16 A. Correct.

17 Q. Continuous?

18 A. Correct.

19 Q. At 11:55, what do we see?

20 A. Late decelerations.

21 Q. At 12:25, is anything noted there?

22 A. No.

23 Q. And that's 8 and a half hours in?

24 A. Correct.

25 Q. Was the Pitocin turned down?

A. No.

Q. was it turned off?

A. No.

Q. Has the baby been delivered?

A. No.

Q. what's the station?

A. we don't know.

Q. There's no documentation of anybody checking to see where this baby has gone in the last 8 hours other -- that's not fair. where this baby had progressed since about six o'clock?

A. Correct. There's no note about it. There's no documented vaginal exam. There's no documented station.

Q. Or whether he was -- Remi's head was malpositioned or not still 6 hours, 6 and a half hours, after the last time someone looked?

A. Correct.

Q. were you aware that Dr. McNeive had other C-sections: one at 12:41 and one at 1:44?

A. Yes.

Q. well, let's look here at what was happening with Sarah at that time.

MS. GUNN: Let's look at page 213 of Exhibit 1.

1 Q. (By Ms. Gunn) we've got -- and, again,
2 these are what the nurses are documented that they're
3 seeing, the nurses at the bedside are documenting
4 what they are seeing, with their patients, correct?

5 A. Correct.

6 Q. And you've got at 12:43 --

7 MS. GUNN: I think we're going to have to
8 go to the next page.

9 Q. (By Ms. Gunn) okay. That column, we
10 are -- what are the -- what's the pattern there?

11 A. variable decelerations.

12 Q. And the next time frame, which you can't
13 see, but it was on the other page, was 1300, which is
14 1:00 p.m.?

15 A. Late decelerations.

16 Q. Okay. Those are continuing, then?

17 A. Correct.

18 Q. still Category II?

19 A. Correct.

20 Q. Because there's still moderate
21 variability?

22 A. Per their documentation, yeah.

23 Q. So that at least is a decent sign, right?

24 A. The moderate variability is a decent sign.

25 There were some places in which I thought the

1 variability was a little more normal than what the
2 nurses documented, but I do think their
3 interpretation of the decels themselves were
4 accurate.

5 Q. And at one o'clock, we're now in 9 hours
6 of second stage of labor?

7 A. Correct.

8 Q. I believe there may have been some
9 laboring down.

10 Do you recall seeing that in the record
11 between 12:15 and 1:30?

12 A. Yes.

13 Q. The third time she's labored down?

14 A. Correct.

15 Q. Do you -- I mean, in your experience, in a
16 second stage of labor, do you have patients labor
17 down three separate times?

18 A. Not in a scenario like this, no. If a
19 patient wasn't pushing well, they weren't pushing
20 strongly, they had too much pain to push through,
21 maybe we needed to redose their epidural. Or they
22 were very tired, they weren't pushing effectively,
23 but over the course of 9-plus hours, it sort of run
24 its course of whatever benefit any passive rotation
25 and descent would have made.

1 Q. Page 215. This is going to show the time
2 frame between 1:16 and 1:46.

3 And we have the -- the variability is
4 still moderate. But the pattern, no indication of
5 what it is, and then at 1:46, we've got, what?

6 A. More late decelerations identified by the
7 nurse.

8 Q. All right. So let's go on to the next
9 page, page 216. We're looking at 1:00 -- sorry --
10 now we're at two o'clock. So now we're at two
11 o'clock, right? 1401 is 2:01.

12 A. It is.

13 Q. And now we're in the tenth hour of the
14 second stage?

15 A. Yes.

16 Q. What are we seeing at 2:01 and 2:15?

17 A. Variable and they note early. It would be
18 unusual, given that this baby has had late
19 decelerations, to suddenly be producing early
20 decelerations this late in the game, and also
21 variable decelerations at the 2:15 entry.

22 Q. Okay. So we are in hour ten, and the
23 pattern here is not reassuring, right?

24 A. Correct. I would agree.

25 Q. How long has it been since it's been

1 reassuring?

2 A. within an absence of decels, hours.

3 Q. And then the 2:31, we've got late decels,
4 variable decels, correct?

5 A. That's what it says, yes.

6 Q. So now we know, though, that Dr. McNeive
7 is back in the room, correct?

8 A. Around this time period, yes.

9 Q. Was that the first documentation in the
10 medical record in her entire chart that showed he was
11 in the room since eight o'clock?

12 A. Yes.

13 Q. Okay. And is there any documentation of
14 Dr. McNeive checking the station at this time?

15 A. There's nothing documented, no.

16 Q. So I want to go back because, you know,
17 our station graph, and I just want to make sure -- I
18 showed this to the jury earlier today, Nurse Shinn --
19 and I want to make sure that I've got evidence for
20 it.

21 This is stopped at 5 centimeters. Do you
22 see that?

23 A. I do.

24 Q. Is that generally what you would see at 5
25 centimeters from zero station to plus 3?

1 A. Roughly. Anatomy plays in a little bit.

2 Q. Sure.

3 A. But in a very general sense, I would say
4 that's pretty close.

5 Q. So this is how far Remi's head -- his head
6 had to go?

7 A. Correct.

8 Q. Between zero station and plus 3, which is
9 that crowning coming through the labia that you
10 mentioned?

11 A. Correct.

12 Q. And since 3:50 a.m., we know that he
13 didn't -- well, we don't -- we don't know. we don't
14 know. we don't know.

15 we just know that by 2:00 something, when
16 Dr. McNeive got in there, it still wasn't -- he still
17 wasn't at plus 3 station, right?

18 A. Correct.

19 Q. All right. Okay. So we know that at some
20 point, he, Remi, his heart became tachycardic.

21 what does that mean, that his heart rate
22 became tachycardic? what does that mean?

23 A. So the baby's heart rate had gone up and
24 out of the normal range, the 110 to 160 range, that
25 we consider to be normal. The baby's heart rate has

1 now gone beyond that. That can be a sign that the
2 baby is developing hypoxemia or low oxygen. And that
3 the preservation, the heart rate, increases, so that
4 the heart is pushing more blood out to perfuse its
5 organs better. So it can be a protective mechanism.
6 That can be an early sign.

7 Q. of what?

8 A. Hypoxemia or low oxygen in the blood.

9 Q. And what did he order to be done with the
10 Pitocin?

11 A. To be increased.

12 Q. And who increased it?

13 A. The nurses did.

14 Q. The records seem to indicate that it was
15 increased to 20 at 2:21, to 22 at 2:44, to 24 at
16 3:10, and to 26 at 3:56.

17 Is that your understanding?

18 A. Yes.

19 Q. And it's your understanding that each and
20 every time the nurses did that without question?

21 A. Correct.

22 Q. Are you critical of Nurse Maggie and Nurse
23 Jessie for that?

24 A. Yes.

25 Q. And tell us specifically why.

1 A. Because this patient had been in an
2 extremely prolonged second stage of labor, well
3 beyond anything that either of these two nurses had
4 seen before, well beyond any typical or accepted
5 guideline for a first-time mom with an epidural.

6 There hadn't been good progression. There
7 had been notable malposition and evidence of caput or
8 soft swelling in a baby's head that wasn't
9 descending. There had been decels identified by the
10 nurses for hours in the medical record that was
11 unresponsive or unrelenting to their position
12 changes.

13 And so to increase the Pitocin when that
14 drug is known to stimulate the uterus to make
15 stronger, closer contractions, the only thing it's
16 going to do is increase the risk or harm to that
17 baby, increase the risk of brain damage, increase the
18 risk that there's a depletion of oxygen levels.

19 Q. Do you believe that those increases were
20 breeches of the standard of care?

21 A. Yes.

22 Q. And do you hold that opinion, those
23 opinions, to a reasonable degree of nursing
24 certainty?

25 A. I do.

1 Q. And do you believe that those, and the
2 other breeches of the standard of care that you
3 mentioned at eight o'clock and following, caused or
4 contributed to cause, directly cause, or directly
5 contributed to cause harm to Remi?

6 A. Yes.

7 MS. KAMYKOWSKI: Your Honor, object. This
8 witness is unqualified to give a foundation opinion.
9 There's been no foundation for that.

10 And she also cannot give this opinion to
11 causation now because she didn't give it in her
12 deposition.

13 MS. GUNN: Yes, she did.

14 THE COURT: The Court is going to overrule
15 the objection.

16 Q. (By Ms. Gunn) You may answer.

17 A. Yes. There was a direct relation between
18 the initiation of Pitocin, the continued running of
19 Pitocin, and the presence of the decelerations that
20 we saw on the fetal monitor tracing.

21 In increasing, we saw further abnormal
22 changes to the fetal heart rate arise in fetal heart
23 baseline, a further deterioration from a Category II
24 to a Category III in the last 3 minutes or so before
25 birth. And that was all around the time of

1 increasing Pitocin.

2 So continued pushing, continued Pitocin,
3 continuing the second stage of labor. And these
4 nurses were managing this labor independent of Dr.
5 McNeive. He was seeing other patients, he was doing
6 his other responsibilities. And he was relying on
7 them to be their eyes and ears in his absence while
8 he's doing other things.

9 So to continue moving forward in an unsafe
10 manner when they're identifying abnormalities on the
11 tracing, and then increasing Pitocin, which is a drug
12 known to stimulate the uterus with a result of
13 abnormal fetal findings.

14 Q. Thank you.

15 Baby Remi was born at 4:24 p.m.

16 A. Correct.

17 Q. And a third-degree episiotomy or
18 laceration was done.

19 Can you help us understand what that is?

20 A. So as the head is delivering, oftentimes
21 if it feels that the head is big for the anatomy for
22 this woman's outlet, sometimes the soft tissue is
23 expanded with either an episiotomy, or, if left,
24 allowed to tear. Sometimes the episiotomy will then
25 expand further into a further laceration. So there

1 were both noted in the medical record.

2 Q. You're aware of Remi's impression at
3 birth?

4 A. Correct.

5 Q. In terms of how he looked. And were you
6 aware of his Apgar score?

7 A. I am.

8 Q. And do you believe that the Apgar score of
9 8 was accurate?

10 A. No.

11 Q. Could you tell us why?

12 A. In looking at the description entered into
13 the medical record of the baby, the baby is -- an
14 also the description the parents gave, the baby was
15 limp or floppy. The baby had poor feeding, poor
16 tone, poor suck, those are typically neurologic
17 findings when they aren't feeding and sucking and
18 doing the things that they should do.

19 In addition to that, this baby required
20 oxygen supplementation and ventilation support, which
21 normal spontaneous respirations, bigger and pink
22 crying babies don't often need any kind of
23 respiratory support. They get dried. They get
24 stimulated. They put a hat on them. They put them
25 under the warmer or leave them on the mom's chest.

1 so the fact that this baby up into 10
2 minutes of life was still receiving, not just
3 supplemental oxygen, but also ventilation support,
4 would seem to imply that the 8 at 5 minutes was an
5 inflated or assisted Apgar score. It was being given
6 with the assistance of the respiratory effort and the
7 ventilation support of the NICU team.

8 Q. Do you know what cord gas blood is or cord
9 blood gases are?

10 A. Yes.

11 Q. What do they show?

12 A. There were none, so I can't tell you what
13 they would show.

14 Q. If they had been done, I'm not asking you
15 for an amount, but what could they have showed?

16 A. So there's some different values that are
17 looked at. The cord gas results, or cord blood gas
18 results, are taken directly from a segment of
19 umbilical cord that is collected after the baby is
20 born.

21 so the cord is clamped. There are three
22 vessels typically. I believe this cord had three
23 vessels: two arteries, which bring deoxygenated
24 blood from the baby back to that placenta. And one
25 vein which brings the oxygenated blood back to the

1 baby.

2 So there are generally two samples taken:
3 one arterial and one venous. The venous blood
4 essentially tells us how functional the placenta was,
5 if it was sending oxygenated blood to the baby. And
6 the arterial sample will tell us how acidotic this
7 baby is at the time of birth.

8 So it reflects at the time of birth when
9 the cord is clamped. But I couldn't predict what it
10 would be. I can only tell you that fetal tracing was
11 a Category III. It was abnormal in the roughly 30
12 minutes prior to the birth. The first Apgar was
13 abnormal. And I believe the 5 minute to be inflated
14 because the baby was actively being resuscitated with
15 oxygen and ventilation support and those types of
16 things. So I don't think it would have been normal,
17 but I wouldn't speculate to say what the values
18 themselves would show.

19 Q. Understood. So, Nurse Shinn, by way of
20 kind of wrapping it up, have you given your
21 conclusions with respect to the breaches of the
22 standard of care that you believe Jessie and Maggie
23 were responsible for?

24 A. Yes. The failure to advocate for
25 C-section and invoke chain of command as needed to

1 get a proper response from a nursing perspective.

2 The failure to stop Pitocin by way of protocol, as
3 well as standard of care and what they were seeing on
4 the fetal monitor tracing.

5 By continuing to push and allow the second
6 stage of labor to continue on well beyond accepted
7 standards, typical labor course, or anything these
8 nurses had seen. And then further increasing Pitocin
9 when they had seen hours of decelerations, failure to
10 progress, malposition.

11 Q. Do you believe those failures directly
12 caused or directly contributed to cause harm to Remi?

13 A. Yes.

14 MS. KAMYKOWSKI: Same objection, Your
15 Honor.

16 THE COURT: Overruled.

17 Q. (By Ms. Gunn) Nurse Shinn, thank you so
18 much for your time. I really appreciate it.

19 THE COURT: So, ladies and gentlemen,
20 based on the timing and my anticipation as to the
21 length of the two cross-examinations that I'm
22 anticipating, it probably makes sense for us to take
23 our break for the evening and come back tomorrow and
24 start fresh in the morning.

25 (At 4:41 p.m., the hour of adjournment

1 having arrived, the jury, being duly admonished by
2 the Court, by agreement, is allowed to separate for
3 the evening, under the usual instructions of the
4 Court, until Thursday, March 13, 2025, at 9:00 a.m.)

5 o o o

6 Thursday, March 13, 2025

7 o o o

8 (At 9:03 a.m., the following proceedings
9 were held in open court, in the presence of the
10 jury:)

11 THE COURT: Good morning, everyone. Go
12 ahead and be seated.

13 And I apologize for not getting my letters
14 correct. I was trying to do them in a hurry last
15 night, so I didn't quite get everything changed, but
16 hopefully I've got them all fixed up for today.

17 All right. On behalf of the defense?

18 MS. KAMYKOWSKI: Yes, Your Honor. We
19 would entertain our cross of Ms. Shinn.

20 THE COURT: Very good.

21 CROSS-EXAMINATION

22 BY MS. KAMYKOWSKI:

23 Q. Good morning, Ms. Shinn.

24 A. Good morning.

25 Q. You brought your glasses like I did.

1 A. I did.

2 Q. I try to print my things in large font so
3 I can see them. But if you ever need to take a break
4 to put those on or need to see something close up,
5 just let me know, okay?

6 A. Will do.

7 Q. It's good to see you again. I know we saw
8 you yesterday, and you saw me in person when I took
9 your deposition in October of 2023, in this case,
10 correct?

11 A. Correct.

12 Q. And you and I have seen each other on
13 another case, have we not?

14 A. I believe that's true.

15 Q. And, in fact, that case, if all goes as
16 planned, you and I will see each other in this same
17 scenario next month in Franklin County, Missouri,
18 correct?

19 A. I'm not sure of the actual trial date, but
20 I believe it is coming up, yes.

21 Q. You don't have plans yet to come back to
22 Missouri to give more expert testimony on behalf of a
23 plaintiff in a malpractice case involving labor and
24 delivery?

25 A. I don't have any flights booked yet. So

1 that would be after discussion with the firm
2 themselves.

3 Q. Okay. But you and I know that we have
4 another case that's set for trial in the recent
5 future, correct?

6 A. Correct.

7 Q. Here in the state of Missouri?

8 A. Correct.

9 Q. And that case, as you are here, you are
10 testifying on behalf of the plaintiff?

11 A. That is correct.

12 Q. And you've told us yesterday that you've
13 been testifying as an expert since, I think, 2011, is
14 that correct?

15 A. Yes. I started reviewing in 2010, and the
16 first testimony I gave was in 2011.

17 Q. Okay. And I remember that you qualified
18 your testimony yesterday with Ms. Gunn to talk about
19 the reviews that you have done. And you've indicated
20 that reviewing, which means somebody sends you
21 records, and you look at the records, that's what a
22 review is, correct?

23 A. Correct.

24 Q. So a review of a case when you started in
25 2010, I think you told us yesterday was initially

1 about 50 percent plaintiff/50 percent defense. And
2 it's more now to be about 70 percent of your reviews
3 are on behalf of plaintiff, and 30 percent on behalf
4 of the defense, correct?

5 A. That is correct.

6 Q. But when we talk about testimony, that
7 means where you've done what you've done here
8 yesterday and today, sworn to tell the truth, and
9 you're sworn under oath to give testimony, that
10 percentage dramatically goes up in favor of the
11 plaintiff, does it not?

12 A. To about 90 or 95 percent, yes.

13 Q. I think when I took your deposition, you
14 provided us with a copy of your testimonial list that
15 went back to 2011. And I counted up, I think it was
16 20 pages long, and I counted up, at least in October
17 of 2023, you had given 240 depositions.

18 Does that sound right?

19 A. At that time, yes.

20 Q. And that averaged to about 17 a year, if
21 they were all equal. And I know that that's just an
22 average. Since I took your deposition in October of
23 2023, have you given additional depositions as a
24 medical legal expert witness?

25 A. I have.

1 Q. Have any of the depositions, since I took
2 yours in 2023, been on behalf of a defendant?

3 A. I think there was one since that time.

4 Q. Okay. And at the time I took your
5 deposition, of those 240 depositions, that you had
6 previously given in a malpractice case, all but ten
7 of them were for the plaintiff. Now we can add one
8 more, so 240-plus, and 11 on behalf of the defense,
9 correct?

10 A. That's likely correct.

11 Q. And then you told us yesterday that you
12 testified at trial a couple of dozen times before
13 this trial, correct?

14 A. Correct.

15 Q. Okay. So it's fair to say, and you told
16 us only one time previously, had you testified on
17 behalf of a defendant in a trial, correct?

18 A. That is correct.

19 Q. And if we -- if next month's trial goes,
20 we'll add another potentially deposition on behalf of
21 a patient that's already been given -- correct? -- in
22 that case?

23 A. Yes.

24 Q. And if you go to trial, another trial
25 testimony on behalf of plaintiffs, correct?

1 A. I don't know when that deposition was
2 given in relation to 2023, but, yes, that would be
3 inclusive of total depositions. And there would be
4 another trial appearance of course.

5 Q. And I remember it being accurate just
6 because I took your deposition. Because I think this
7 case was the first time that you and I had met.
8 That's my recall, so...

9 So fair to say, Nurse Shinn, that the vast
10 majority of cases you've reviewed have been on behalf
11 of the plaintiff? And the vast majority of cases in
12 which you've testified under oath have been on behalf
13 of the plaintiffs?

14 A. I would say that's true.

15 Q. And you said 90 to 95 percent. When I
16 calculated it, it was really close to 97 percent.
17 Would you disagree with that?

18 A. If the math works out to that, no, I
19 wouldn't disagree.

20 Q. And, in fact, I think you told me in your
21 deposition that the vast majority of cases you've
22 reviewed as an expert witness, have to do with issues
23 similar to those that you are terrifying to in this
24 case, correct?

25 A. Yes. Fetal monitoring interpretation,

1 running Pitocin, interventions that were performed or
2 not performed.

3 Q. And that makes sense because you're a
4 labor and delivery nurse, right?

5 A. Correct.

6 Q. Okay. And you also told us that the
7 medical legal work that you do: reviewing cases,
8 giving depositions, coming to trial like this, that
9 makes up to a third to 40 percent of your total
10 annual income, correct?

11 A. Correct.

12 Q. Is that still accurate?

13 A. It is.

14 Q. Let's talk about your review in this case,
15 okay?

16 In this case, well, let me hand you --
17 prior to your deposition, we were provided with
18 copies of communications that you had with either Ms.
19 Gunn or Ms. Lenivy, their offices, with respect to
20 this lawsuit.

21 So I'm going to hand you so you can follow
22 along with me what I've marked as Defendants' Exhibit
23 H4-H.

24 MS. KAMYKOWSKI: Your Honor, may I
25 approach the witness?

1 THE COURT: You may, so long as you start
2 speaking slowly.

3 MS. KAMYKOWSKI: I will.

4 Q. (By Ms. Kamykowski) Sorry. You're going
5 to get large piles of paper.

6 And you'll see, Ms. Shinn, at the bottom
7 of Exhibit E4-H are handwritten page numbers to help
8 you follow along, okay?

9 A. Okay.

10 Q. Before we talk about this, I do want to
11 ask you to prepare to testify yesterday and today,
12 did you undertake to review the file materials that
13 you had provided to Ms. Gunn's office and that they
14 had been provided to us?

15 A. Yes. So what I had in my DropBox folder,
16 which is an electronically stored method of storing
17 records, records, depositions -- I didn't go through
18 all of the depositions in their entirety again -- my
19 deposition, fetal monitor tracings, some of the
20 exhibits, those types of things. I don't think I had
21 this particular document or packet of information
22 stored in my file.

23 Q. Okay. So I put this together. I think it
24 was provided to us in a -- it might have been a
25 single, or it might have been each email chain, but

1 separate, but we put it into one PDF as Exhibit E4-H.

2 So since you may not have seen it for a
3 while, if you'd like to take some time to review,
4 you're welcome to, but I'm going to point out some
5 specifics that I think, as we go through it, you take
6 all the time you need to review it, okay?

7 A. Okay.

8 Q. And so is it fair to say that Exhibit E4-H
9 contains communications between various people at the
10 Simon Law Firm, where Ms. Lenivy currently works, and
11 where Ms. Gunn and Ms. Slater worked at the time of
12 your deposition between them and you?

13 A. That's correct.

14 Q. Okay.

15 MS. KAMYKOWSKI: So if we could pull up
16 Exhibit E4-H, page 1.

17 Q. (By Ms. Kamykowski) Do you see page 1
18 there?

19 A. I do.

20 Q. All right. And this is the first email
21 that we have from Ms. Lenivy to you dated April 4th
22 of 2021.

23 And in that email, she says: Good
24 morning, Ms. Shinn, I got your contact information
25 from a colleague and was wondering if you would have

1 any interest and time in reviewing a potential
2 medical malpractice case. I am available at your
3 earliest convenience if you would like to discuss
4 further. Thank you in advance.

5 Do you see that? And did I read that
6 correctly?

7 A. You did. But if I heard you correctly, I
8 think you said April 4th?

9 Q. Oh, I'm sorry. November 4th of 2021, is
10 that correct?

11 A. That's correct.

12 Q. Okay. And then if you look at page 4 of
13 this document, on the bottom, we have another email
14 from Ms. Lenivy dated November 8th, four days later,
15 that starts with: Good afternoon. Thank you for
16 returning my call today. I have received your CV and
17 fee schedule. My paralegal, Claudia, will be sending
18 over records of Sarah Anyan's, our client's mother --
19 go to the next page -- and Remington Anyan, our
20 client, to you via share file.

21 Please let me know if there is anything
22 you need further. Thank you again for your prompt
23 response. I look forward to speaking with you after.

24 So sometime between Ms. Lenivy's initial
25 email advising that she was referred by a colleague

1 and asked if you could review this case, you
2 contacted her. And now she's responding four days
3 later saying, thank you for your prompt response.
4 we're going to give you records, correct?

5 A. Yes.

6 Q. Okay. And if we look back at page 3 of
7 that on document, later that same day, just not even
8 10 minutes later, it looks like, Ms. Jenkins from Ms.
9 Lenivy's office, it goes on to page 4: Please find
10 the records for your review.

11 Do you see that?

12 A. I do.

13 Q. And as you told us yesterday, as your
14 custom and practice is, you received records from Dr.
15 McNeive, which were the prenatal records, right?

16 A. Correct.

17 Q. The FMS, those are the fetal monitor
18 strips, correct?

19 A. Yes.

20 Q. The hospital records, page 1 to 288,
21 correct?

22 A. Those were for Sarah, yes.

23 Q. And then the 2,066 full set. were those
24 for Remington?

25 A. Correct.

1 Q. So you had those, or they were sent to
2 you, November 8th of 2021, correct?

3 A. That's correct.

4 Q. And when I deposed you back in October of
5 2023, I asked you kind of what information was
6 related to you by Ms. Lenivy during that initial
7 call.

8 You told me you really didn't recall, but
9 it likely included that you would have known the
10 outcome of this case, correct? That they were
11 investigating, that there was a child who had a brain
12 injury after delivery?

13 A. I don't know if I said that I would have
14 known the outcome, or that I would have known they
15 were a plaintiffs' firm, and they were sending me
16 records.

17 As any expert, when they receive records
18 from a plaintiff or a defense firm, they know there's
19 at least been a claim or an attempt to file a claim.
20 It doesn't mean there is or is not any negligence.

21 Q. You told me in your deposition, it was
22 possible that you were told this case involved a
23 twelve-hour second stage of labor. You just don't
24 recall one way or the other, correct?

25 A. If that was in response to your question,

1 yes.

2 Q. Okay. And at least by the time that you
3 spoke to Ms. Lenivy before November 8th, you would
4 have learned that her client was the child plaintiff
5 in this case, correct?

6 A. That was likely.

7 Q. So that was before you got records?

8 A. Correct.

9 Q. Okay. If you could look, then, to page 7
10 of Exhibit E4-H. At the bottom of that page, about a
11 month later, on December 6th, Ms. Lenivy followed up
12 with you. And she said: I want to follow up and
13 confirm that you have received the records for Remi
14 and Sarah and check whether you have had an
15 opportunity to review.

16 Did I read that correctly?

17 A. Yes.

18 Q. And the next day, your response was: I
19 did receive the records on 11/8. I have not been
20 able to review them yet. Please advise if there is a
21 deadline upcoming on this one, correct?

22 A. Correct.

23 Q. And then a month later, above that, on
24 page 7, Ms. Lenivy replies again.

25 She says: I apologize for the delayed

1 response. For some reason, your email went to my
2 junk inbox, and I did not see it until today. Please
3 let me know if you have had a chance to review the
4 records and have time to discuss your opinions. We
5 do have an important deadline next month.

6 Do you see that?

7 A. On page 7?

8 Q. On page 7 at the top, yes.

9 A. Yes.

10 Q. Okay. Do you recall what important
11 deadline Ms. Lenivy was talking about in that email?

12 A. No.

13 Q. Prior to January 6th, though, that was Ms.
14 Lenivy because for whatever reason, your reply in
15 early December went to her junk inbox. But her
16 paralegal, Ms. Jenkins, was actually able to reach
17 you.

18 I'm going to go back to page 3, please.

19 So on December 14th, Ms. Jenkins sent you
20 a message: I wanted to follow up to see if you had
21 gotten a chance to review the records and if you
22 needed anything else from me. I did just call and
23 leave you a voicemail but thought email might be
24 easier to do. Please let me know if you have any
25 questions.

1 Did I read that correctly?

2 A. Yes.

3 Q. All right. And then it looks like I think
4 we might have been on a time change. The email time
5 stamps are strange, right? But her email went at
6 12:54, and then your response the same day shows
7 12:11. I presume that's because of the time change,
8 I don't know.

9 And your response at that time, could you
10 read that to us?

11 A. It says: I have not gotten through all of
12 the records, but I can tell you that there appears to
13 be tachysystole from approximately 2:30 in the
14 morning through delivery.

15 Also the tracing gets more concerning with
16 a rising baseline and decels with diminished
17 variability. There are some points in time in which
18 I think there's also signal ambiguity in which they
19 are tracing the maternal heart rate rather than the
20 fetal heart rate. That is what I can tell you at
21 this point. And once I've done a complete review,
22 I'll be in touch.

23 Q. Okay. So yesterday you told Ms. Gunn that
24 you approach every case that you review in the same
25 step wise manner.

1 Do you remember that testimony?

2 A. Yes.

3 Q. And what you told us is that you first
4 would look at the prenatal records to make sure that
5 there was nothing concerning in the prenatal period
6 that you might want to consider as potentially what
7 went on in the case that you're reviewing.

8 That's the first step that you told us,
9 correct?

10 A. Correct.

11 Q. And then after that, you take the,
12 generally speaking, the flow sheets or the nursing
13 documentation, correlating with your review of the
14 fetal monitor strips, to start developing your
15 opinions, correct?

16 A. Correct.

17 Q. This email from December 14th, says
18 nothing about your review in the step wise manner
19 that you went through the prenatal records first,
20 correct?

21 A. It is a very brief synopsis of what I had
22 gotten to at that point. It doesn't list any other
23 time other than 2:30 in the morning. I obviously
24 have a lot more of that case factually beyond that
25 time period. So you are correct. It doesn't

1 reference the prenatal records -- it doesn't -- which
2 were relatively uncomplicated. There was nothing in
3 terms of risk factors other than the fact that she
4 was a first-time mom with an unproven pelvis. But
5 you're correct. It is very brief. It doesn't
6 include a synopsis of my review, as my review was not
7 done.

8 Q. And if this case had involved a prenatal
9 problem, you certainly would have glossed over that
10 in getting to your initial opinions here that the
11 first of which there appears to be tachysystole from
12 approximately 2:30 in the morning through delivery.

13 So that would have been an afterthought,
14 if this case actually turned out, and you were
15 prospectively looking at it -- right? -- to have a
16 prenatal problem?

17 A. I'm not sure I understand your question
18 because if there had been a prenatal problem,
19 something like growth restriction, diabetes, high
20 blood pressure, something of that nature, that would
21 have likely been included in this email.

22 That wasn't an issue in this case. And so
23 there was not a point in saying, oh, I've reviewed
24 these records, or, I'm at this point in the records,
25 and the prenatal care was standard with no

1 complications.

2 I was looking at it from the nursing
3 perspective. Someone else may have an opinion about
4 whether her prenatal care from the physician
5 standpoint was standard or uncomplicated or not. But
6 purely from a nursing perspective, there was no point
7 in including that in this email.

8 Q. You certainly could have, if you followed
9 your typical always step wise fashion of reviewing
10 cases that, I haven't gotten through everything. I
11 don't see anything wrong in this email, but when I
12 got to the hospital chart, this is what I did see.

13 you didn't do that, right?

14 A. In this synopsis, you're right. I did not
15 include things that were normal.

16 Q. All right. And so this was on
17 December 14th. Then we know from later, or page 7,
18 that by January, Ms. Lenivy is telling you: Please
19 let me know when you've had a chance to review
20 everything and have time to discuss because there's
21 an important deadline coming up next month, right?

22 Do you remember that from page 7?

23 A. That's correct.

24 Q. All right. And you don't know what that
25 important deadline was?

1 A. I don't.

2 MS. KAMYKOWSKI: If you can put a pin in
3 Exhibit E4-H, please.

4 And if I may approach again, Your Honor.

5 THE COURT: You may. Slow down again.

6 MS. KAMYKOWSKI: Exhibit E4-E.

7 Q. (By Ms. Kamykowski) Do you recognize that
8 document, Ms. Shinn?

9 A. Yes. This is a cover letter and the first
10 invoice that was issued in this case.

11 Q. Okay. Page 1 is the cover letter, and
12 page 2 is the invoice.

13 And I'd like, for right now, to look at
14 page 2 of Exhibit E4-H.

15 And I think you told me at your deposition
16 your standard practice is to do your reviews, and if
17 you can, you know, you keep track of the dates of
18 which you review, dates on which you speak with
19 lawyers, the kind of activities that you do in your
20 medical legal practice, and that's how you create
21 these invoices, correct?

22 A. Right. Either the date that I start the
23 review, or the date that I end the review. Not more
24 specific usually than that.

25 Q. All right. And so at least from this

1 invoice by -- on January 2nd of 2022, you noted time
2 spent of 4 hours reviewing records that you had been
3 provided through that date, correct?

4 A. Correct.

5 Q. And whether you reviewed them on that date
6 and forward, before this invoice was sent, or had you
7 reviewed them before, the only record review that
8 totalled this 4 hours were those records we saw that
9 were -- went to you in November of 2021.

10 A. That's correct.

11 Q. All right. And then when you have phone
12 conversations with lawyers, and I'm a lawyer, I have
13 to keep track of my time, too, to try to be pretty
14 accurate, is when you speak with counsel on the cases
15 that you're working on, are you trying to invoice
16 accurately the dates of those conversations?

17 A. Yes. The date of a phone conversation, a
18 meeting on zoom, something like that, would be the
19 actual date that that occurred.

20 Q. Okay. And so then you spoke with, it
21 says: phone discussion, parentheses, LL. I presume
22 that's Liz Lenivy?

23 A. Correct.

24 Q. And that date would have been January 28th
25 of 2022?

1 A. That's correct.

2 Q. And you had a conversation with Ms. Lenivy
3 over the course of a half an hour?

4 A. That's right.

5 Q. And then if we go to page 1, we did talk
6 about this in your deposition. It looks like either
7 the date at the top of this correspondence

8 transmitting that invoice, might be carried over from
9 a prior date. Or it just took you awhile to get your

10 invoice out in this case, and it was finally sent to
11 Ms. Lenivy in November of '22, is that correct?

12 A. Correct.

13 Q. Okay. All right. Getting back, then, to
14 Exhibit E4-H.

15 we just saw that you invoiced for records
16 review or 4 hours of February 1st of 2020 -- I'm
17 sorry -- that you invoiced for a call with Ms. Lenivy
18 of January 28th of 2022, correct?

19 A. Correct.

20 Q. It looks like Ms. Lenivy and you had a
21 call, if you look at page 9 of E4-H.

22 The letter dated February 1st of 2020.

23 Do you see that?

24 A. Correct.

25 Q. And the first sentence says, Ms. Shinn, in

1 a telephone conversation. So sometime, I presume,
2 that is referencing the only conversation we have a
3 record of from your invoicing from January 28th,
4 correct?

5 A. I believe that's correct.

6 Q. Okay. So this letter is in follow-up to
7 that 30-minute conversation on January 2022, January
8 28th, 2022?

9 A. Correct.

10 Q. All right. And I will reference for you,
11 you don't need to read this entire thing into the
12 record, but this letter -- and I'll give you time to
13 look at it -- essentially has Ms. Lenivy giving you
14 instructions on how to prepare a written statement
15 the Missouri law requires so she could file an
16 affidavit of merit to support the claims that she
17 made in this lawsuit against Mercy Hospital for the
18 conduct of its nurses.

19 Do you agree with that?

20 A. Yes.

21 Q. And, in fact, the last paragraph on page 1
22 of this document, page 9 here, she enclosed a sample
23 written statement of your review and consideration,
24 correct?

25 A. Correct.

1 Q. All right. Let's look at page 11 of this
2 exhibit.

3 Is this a sample written statement that
4 Ms. Lenivy sent to you with her February 1st
5 correspondence?

6 A. Yes.

7 Q. And in there, she leaves -- she actually
8 drafts it for your signature, correct?

9 A. Correct.

10 Q. It's not a plain or template sample
11 written statement. It's a statement of Heidi Shinn,
12 isn't it?

13 A. Correct. That's fairly common for lawyers
14 to do that for experts.

15 Q. Maybe not in my experience.
16 well, let's then look at page 12.

17 MS. KAMYKOWSKI: Can you put page 11 and
18 page 12 side-by-side, Justin, please.

19 Q. (By Ms. Kamykowski) So on February 1st,
20 Ms. Lenivy sent you her draft written statement
21 specific to you and your opinions in this case,
22 correct?

23 A. Correct.

24 Q. And on February 14th, you signed that
25 statement word-for-word with no changes?

A. Correct.

Q. All right. So then let's look at just below page 12, the one that was signed, please.

So the written statement that was prepared by Ms. Lenivy that you adopted in whole with no changes, identifies in paragraph 2, after you reviewed the medical records, that the sentence that says: Based on any review of the records.

Do you see that?

A. Yes.

Q. And this is, as of February 22, your opinion in this case, correct?

A. A generalized opinion, yes.

Q. And then at that time, it was your opinion that the nurses at Mercy Hospital-St. Louis -- that's my clients -- including Alex Greenwald, Kelsey Blanton, Margaret Hilt-McLeland, and Jessica Brown individually and/or as agents, employees, or representatives of Mercy Hospital-St. Louis, who treated Sarah Anyan on or about May 4, 2020, failed to use such care as reasonably prudent and careful health care providers would have under the same or similar circumstances.

Do you see that?

A. I do.

1 Q. And you held that opinion when you signed
2 this written statement drafted by Ms. Lenivy
3 February 14th, 2022?

4 A. That's correct.

5 Q. That's not opinions that you hold -- you
6 don't hold all of those opinions today because you
7 now are not critical of Alex Greenwald and Kelsey
8 Blanton in this case, correct?

9 A. Correct. And that was expressed at my
10 deposition in 2023.

11 Q. Right. So sometime between signing this
12 document in February of '22, and when I deposed you
13 in October of 2023, you changed your mind?

14 A. I didn't change my mind. I omitted the
15 first two nurses.

16 Q. So you're saying an omission is not -- you
17 still hold those opinions, you just don't hold them
18 to some degree that is required under Missouri law?
19 Or why is it not a change?

20 A. Well, it's not a -- I haven't changed my
21 opinions about Nurse Maggie and Jessie. There was
22 discussion with the lawyers as to which nurses should
23 be included and some other factors as to causative
24 damages and that type of thing. And so after more
25 discussion, it was determined that Nurses Blanton and

Greenwald would be excluded.

Q. Okay. So when you did your perspective, as close as you could try to be, fair and balanced in this case, you held opinions against two other nurses. And then after discussion with the lawyers, you have now omitted them from your opinions, correct?

A. Correct.

Q. Okay. So we're going to talk about your opinions. That's what we are here to do today. And we're going to see if we're still on the same page from what you told Ms. Lenivy in January of 2022, or February of 2022, what you told us in October of 2023, and what you told the jury yesterday, okay?

A. Okay.

Q. First, though, I want to talk about some of the topics you already testified to on direct to see if we can agree with some general concepts and what the literature says in this case, okay?

A. Okay.

Q. All right. I want to talk generally about fetal monitoring.

A. Okay.

Q. You would agree, would you not, Ms. Shinn, that interpretation of fetal -- electronic fetal

1 monitored data -- we call those strips, right? -- we
2 said that?

3 A. Correct.

4 Q. It's not a perfect science?

5 A. It's not a perfect science, no.

6 Q. It's subjective, meaning different people
7 looking at the same strip can interpret it
8 differently, true?

9 A. Within reason, I would agree with that.

10 Q. And that you agree that strips aren't to
11 be reviewed in isolation, correct?

12 A. Very much so.

13 Q. They must be viewed in conjunction with
14 the available clinical data, correct?

15 A. Labor progress, vital signs, all those
16 type of things.

17 Q. And, here, there were multiple providers,
18 including Nurse Jessie, Nurse Maggie, Dr. McNeive,
19 who -- those three were at the bedside, but others
20 who were also reviewing the strips and correlating
21 other clinical data available to them in realtime on
22 May 3rd and 4th of 2020?

23 A. If you're referencing the safety rounds of
24 the other disciplines: the midwife, the MFM, those
25 unnamed people, I don't know what the sum and

1 substance of those conversations were of the safety
2 rounds, how much of the tracing was looked at, or
3 what was actually discussed about her labor progress,
4 her stage of labor, how long she had been in second
5 stage. But does the chart reflect that there was
6 some review with other disciplines? Yes.

7 Q. Well, we know that Dr. McKillip and Dr.
8 Parker reviewed data at around the six o'clock in the
9 morning time frame, correct?

10 A. Correct.

11 Q. And you reviewed depositions of all of the
12 nurses and all of the physicians who have been
13 deposed in this case, correct?

14 A. Correct.

15 Q. And do you remember what they said the
16 typical practice was? Dr. McNeive was at that safety
17 round, was he not?

18 A. I believe that's correct.

19 Q. And do you remember what he said the
20 typical custom is or how those safety rounds are
21 presented to that group of people?

22 A. Specifically, no.

23 Q. Okay. We'll let him tell the jury.

24 You agree, though, that you weren't there
25 on May 4th of 2020, right?

A. That is correct.

Q. Just like I wasn't there, correct?

A. Also correct.

Q. And there was no other experts retained by any party in this case, was present at Mercy Hospital on May 4th of 2020, correct?

A. Correct.

Q. So other than the Mercy providers involved in the care, as well as the neonatal providers who are not Mercy employees, every other one -- every other witness that the jury is going to hear in this case has performed a retrospective review of the fetal heart monitor tracing, correct?

A. On both sides, that's correct.

Q. Knowing that the reason they were reviewing them is because a lawsuit was either being contemplated in your case or had been filed, correct?

A. Correct.

Q. And in doing your retrospective review, you reached certain conclusions that initially were critical of four nurses, but as of sometime before October of 2023, were critical of Nurse Jessie and Nurse Maggie, correct?

A. Correct.

Q. And now you told us, in going through your

1 CV, about your teaching responsibilities. So you
2 still had teaching responsibilities for AWHONN?

3 A. Correct.

4 Q. And I think you told me in your deposition
5 part of those responsibilities include teaching
6 nurses not just from Ohio State, but nurses from all
7 over the country who take AWHONN electronic fetal
8 monitoring surveillance courses.

9 A. Correct.

10 Q. When is the last time you taught one?

11 A. February.

12 Q. This February?

13 A. Correct.

14 Q. To how many students?

15 A. I think there were six in the class.

16 Q. And I think at your deposition, you told

17 me that the materials that are provided to you as a

18 teacher from AWHONN, and the materials provided by

19 AWHONN to students whom you teach, you consider that

20 specifically on the fetal heart monitoring

21 surveillance program to be generally accepted and

22 relied upon within your profession?

23 A. Correct.

24 Q. And, in fact, you brought a lot of AWHONN

25 materials with you to your deposition, did you not?

1 A. I did.

2 Q. You took the -- we didn't get to see your
3 book. And I tried to get that book. It's hard to
4 get. It's that fourth edition, no longer available.

5 But you took, I think, maybe photos from your phone
6 of some pages from the actual book you keep from
7 which you teach people, right?

8 A. Those are my personal copies that I have
9 on the shelf. But, yes, that is the sister book to
10 the course. There's a newer edition, as they've
11 changed the materials or a renew copyright, those
12 types of things, but, yes.

13 Q. And the fact that I think what you
14 provided me, or what you provided to Ms. Lenivy and
15 Ms. Gunn, is what's turned over to us in litigation.
16 There were, from your personal copy of the fourth
17 edition of the AWHONN fetal monitoring book, maybe
18 some from the fifth edition. And I understand
19 there's a current version, a sixth edition?

20 A. Yes. Might be coming with a seventh, too.

21 Q. And as far as the concept on fetal
22 monitoring, though, in those editions, because I
23 don't have the sixth edition, and I don't know what
24 the group may be publishing as far as the seventh
25 edition, have the concepts changed drastically?

1 A. Not since that time, no. Since the new
2 definition came out and categories came out, pretty
3 much everything's been status quo. So from edition
4 to edition, for the most part, it maybe on a
5 different page number, or the chapter's slightly set
6 up slightly different, but the content is relatively
7 the same.

8 Q. okay. So if we review the literature that
9 you brought that either was from the old edition or
10 from the fifth, you can still accept that as reliable
11 and authoritative under AWHONN?

12 A. I think you asked me about authoritative,
13 and I said I didn't like that word. That's kind of a
14 lawyer word. Authoritative to me means I agree with
15 every printed word, and I don't know that it's always
16 applicable or maybe that that is true, but, for the
17 most part, AWHONN publishes very reliable and
18 reasonable documents.

19 Q. And those are relied upon by not only
20 folks like you who teach nurses how to learn and
21 interpret fetal heart monitoring traces, but also the
22 students themselves?

23 A. Correct.

24 Q. And it's -- the status and the materials
25 provided by AWHONN, the reason why you consider them

1 reasonable and reliable, because you believe they
2 help establish that standard of care?

3 A. They help speak to what standard of care
4 is, yes.

5 Q. And then you told me at your deposition
6 that the basic AWHONN fetal monitoring course, and I
7 know you teach -- there's staggered versions of that,
8 correct?

9 A. Correct.

10 Q. So there's a basic course, an intermediate
11 course --

12 A. Correct.

13 Q. -- and then an advance course?

14 A. That's right.

15 Q. But the basic course is for -- why don't
16 you tell me what students would be doing what level
17 of course.

18 A. Sure. So typically nurses who have never
19 practiced in labor and delivery would take a basic
20 fetal monitoring course. It's usually about 4 hours
21 long, teaching them the definitions, pattern
22 recognition, so being able to recognize what's an
23 acceleration, what's a deceleration.

24 The intermediate course goes one step
25 further: more complex case studies, looking at

1 communication, chain of command, more strips, more
2 things like that. And also looking at the
3 physiology. So not just what the pattern looks like,
4 but it means to a nurse and what she's supposed to do
5 about it, and then evaluating whether or not her
6 interventions are effective or not effective. And
7 then the advance course is a little more advance
8 beyond intermediate.

9 we have more complex things that have to
10 do with maternal risk factors. So moms who have
11 health conditions that might present problems during
12 the pregnancy. Babies that are growth restricted or
13 have heart conditions or anomalies. That type of
14 thing.

15 Q. And you told me at your deposition that
16 the basic fetal monitoring course from AWHONN
17 operates off of an ACOG Practice Bulletin No. 106.

18 Do you remember that?

19 A. Somewhat, yes.

20 Q. Okay.

21 A. ACOG 106 is a practice bulletin that was
22 put out that mimics the definitions that actually
23 were put out from the National Institute for Child
24 Health and Human Development or NICHD. And AWHONN
25 and ACOG both adopted those. So it's not so much

1 that AWHONN adopted ACOG Practice Bulletins. Both of
2 those professional organizations adopted what NICHD
3 put out from their conference and their monograph and
4 put it into their own subsequent publication.

5 Q. And ACOG Practice Bulletin No. 106,
6 because it incorporates the same NICHD information
7 that AWHONN adopted, they adopted the same
8 principles, would you consider AWHONN Practice
9 Bulletin 106 to be reasonably reliable?

10 A. Do you mean ACOG?

11 Q. Sorry. ACOG publication.

12 A. Generally, yes. Same answer: There may
13 be some portions that wouldn't apply in some cases
14 like we were discussing. Or some points of maybe I
15 would slightly disagree with, but in general, I would
16 say the practice bulletins are relied upon, and they
17 are generalized guidelines that are used in OB.

18 Q. Guidelines that are generally accepted in
19 obstetrics and gynecology?

20 A. Correct.

21 MS. KAMYKOWSKI: May I approach, Your
22 Honor.

23 THE COURT: You may.

24 Q. (By Ms. Kamykowski) I'm going to hand you
25 what I have marked as Exhibit I9 which is a copy of

1 that ACOG's Practice Bulletin No. 106.

2 Do you recognize that document?

3 A. I do.

4 Q. I want to go through it just a little bit.

5 And if there's something you disagree with me, let me
6 know, okay?

7 A. Okay.

8 Q. So the title of this document is

9 "Intrapartum Fetal Heart Rate Monitoring:

10 Nomenclature, Interpretation, and General Management
11 Principles," correct?

12 A. That's correct.

13 Q. All right. And on page 1 on the left-hand
14 side in that margin --

15 MS. KAMYKOWSKI: Can you pull that up for
16 me, Justin?

17 Q. (By Ms. Kamykowski) Do you see that it

18 says: This practice bulletin was developed by the

19 ACOG committee on practice bulletins with the

20 assistance of George A. -- I think it says --

21 Macones.

22 Is that how you say his name?

23 A. That's correct.

24 Q. The information is designed to aid

25 practitioners in making decisions about appropriate

1 obstetric and gynecologic care. These guidelines
 2 should not be construed as dictating an exclusive
 3 course of treatment or procedure. Variations in
 4 practice may be warranted based on the needs of the
 5 individual patients, resources, and limitations
 6 unique to the institutions or type of practice.

7 Did I read that correctly?

8 A. You did.

9 Q. Do you agree with that?

10 A. I do.

11 MS. KAMYKOWSKI: Let's go to page 2 of
 12 this document, if you could.

13 Q. (By Ms. Kamykowski) At the very top of
 14 this page, do you see where it says: Despite the
 15 frequency of its use, limitations of EFM, which is
 16 shorthand for electronic fetal monitoring, is that
 17 right?

18 A. It is.

19 Q. Include poor interobserver and
 20 intraobserver reliability, uncertain efficacy, and a
 21 high false positive rate.

22 Did I read that correctly?

23 A. You did.

24 Q. Do you agree with that?

25 A. In a general sense, yes.

1 Q. Okay. Further down on the page under the
2 classifications, under Category I of fetal heart
3 tracings, it says: Category I fetal heart tracings
4 are normal. Category I fetal heart rate tracings are
5 strongly predictive of normal fetal acid base status
6 at the time of observation.

7 Do you agree with that?

8 A. Yes.

9 Q. Category I fetal heart rate tracings may
10 be monitored in a routine manner, and no special
11 action is required.

12 Do you see that?

13 A. Yes.

14 Q. Fetal -- then that means based on the
15 fetal heart rate tracing in Category I, when it talks
16 about a normal fetal acid base status at the time of
17 observation, that means the baby is being well
18 oxygenated at that moment?

19 A. At that moment, correct.

20 Q. Category II, it defines as tracings are
21 indeterminate.

22 Do you see that?

23 A. I do.

24 Q. And it says: Category II fetal heart rate
25 tracings are not predictive of abnormal fetal acid

1 base status. Yet, presently, there is not adequate
 2 evidence to classify these as Category II or Category
 3 III.

4 Did I read that correctly?

5 A. You did.

6 Q. And do you agree with that statement?

7 A. Yes. As I said yesterday to the jury,
 8 fetal monitoring is not a predictive or diagnostic
 9 tool. So Category II tracings, some could be
 10 indicative of a baby that has acidemia, some may not.
 11 You just don't know. You have to do other things, as
 12 the paragraph continues to state.

13 Q. That's correct. It says: Category II
 14 fetal heart rate tracings require evaluation and
 15 continue to surveillance and re-evaluation, taking
 16 into account the entire associated clinical
 17 circumstances.

18 Did I read that correctly?

19 A. You did.

20 Q. Do you agree with that?

21 A. I do.

22 Q. All right. Let's go on to page 4 of this
 23 document.

24 Under the clinical considerations and
 25 recommendations, there's a carrot that asks the

question: How efficacious is intrapartum electronic fetal heart rate monitoring?

Do you see that?

A. I do.

Q. And it states: The efficacy of EFM during labor is judged by its ability to decrease complications such as neonatal seizures, cerebral palsy, or intrapartum fetal deaths, while minimizing the need for unnecessary obstetrics interventions such as operative vaginal delivery or Cesarean delivery.

Did I read that correctly?

A. Correct.

Q. And do you agree with that?

A. To a degree. I think that this is a generalized statement that doesn't reflect other patients that we might do monitoring for, like patients that have babies incompatible with life, anomalies, periviable babies at 22 weeks. We sometimes will monitor those babies, but they inherently have a more high risk of poor outcomes if they're born that early.

Though to the extent that it's being judged by its ability to prevent neonatal seizures, while not contributing the human element: how long

1 you watch a tracing, how long you watch a patient in
2 the second stage of labor as an example. I think
3 this is just a very generalized statement that
4 doesn't take into account all pieces of the puzzle.

5 Q. And I appreciate that qualification. And,
6 like I said, if there's something you don't agree
7 with in the ACOG bulletin, just let us know.

8 MS. KAMYKOWSKI: Let's go to page 5 in the
9 first full paragraph after the bullet point there.

10 Q. (By Ms. Kamykowski) This guideline
11 continues under the question about the efficacy of
12 fetal heart rate intrapartum surveillance: There is
13 an unrealistic expectation that a nonreassuring fetal
14 heart rate tracing is predictive of cerebral palsy.

15 Did I read that correctly?

16 A. You did.

17 Q. And it goes on to say: The positive
18 predictive value as a nonreassuring pattern --

19 Nonreassuring is one of the old
20 definitions that we tried to get away from, correct?

21 A. Tried to. But it's still used quite
22 frequently.

23 Q. And that would -- and nonreassuring, I
24 think, in the old nomenclature would be Category II
25 or Category III, correct?

A. Correct.

Q. Okay. So it goes on to say: The positive predictive value of a nonreassuring pattern to predict cerebral palsy among singleton newborns with birth weights of 2500 grams or more --

And that takes care of your prematurity, right?

A. Correct.

Q. Most babies born at term are 2500 grams or more, correct?

A. Correct.

Q. And Remi Anyan was more than 2500 grams.

A. That is correct.

Q. So the positive predictive value of that type of pattern for cerebral palsy in terms of large, you know, not small babies, of greater than 2500 grams, is 0.14 percent. Meaning that out of a thousand fetuses with a nonreassuring fetal heart rate pattern, only one or two will develop cerebral palsy.

Did I read that correctly?

A. You read it correctly.

Q. It goes on to say: The false positive rate of ESM for predicting cerebral palsy is extremely high at greater than 99 percent.

1 Did I read that correctly?

2 A. You read it correctly.

3 Q. And then do you agree with it?

4 A. Again, I think in a very general sense,
 5 they're looking retrospectively at data analysis of
 6 births in babies that were born looking at the
 7 tracing, looking at their outcomes, cerebral palsy is
 8 not something that can be diagnosed until after the
 9 baby's born. So to try to make a prediction or a
 10 diagnosis based on the tracing alone would be a
 11 falsehood.

12 In addition to that, it doesn't take into
 13 account with the statement. It's just saying the use
 14 of fetal monitoring in and of itself, not taking into
 15 account clinical risks factors, stage of labor,
 16 length of labor, and the human element.

17 Q. Understood.

18 The next paragraph reads: Available data,
 19 although limited in quantity, suggests that the
 20 use -- the use of EFM does not result in a reduction
 21 of cerebral palsy.

22 Did I read that correctly?

23 A. You did.

24 Q. Have you reviewed any of that data that
 25 they qualify as being in limited quantity?

A. Yes.

Q. Okay. Do you agree with the data that is available in limited quantities that suggested that the use of EFM has not resulted in a reduction of cerebral palsy?

A. That's what the data says.

Q. This is consistent with data, it goes on to say, that suggests that the occurrence of cerebral palsy has been stable over time, despite the widespread introduction of EFMs.

Did I read that correctly?

A. You did.

Q. Are you aware of that data that makes that suggestion, that despite the widespread use of EFMs, the occurrence of CP has been stable over time?

A. Yes.

Q. The principal explanation for why the prevalence of cerebral palsy has not diminished, despite the use of EFMs, is that 70 percent of cases occur before the onset of labor. Only 4 percent of cases of encephalopathy can be attributed solely to intrapartum events.

Did I read that correctly?

A. You did.

Q. Are you aware of that principal

1 explanation being from data that shows the prevalence
2 of cerebral palsy has not diminished is because 70
3 percent of cases occur before the onset of labor?

4 A. Well, I've read this document before, so,
5 yes, I've seen this. It does beg the question were
6 the other 26 cases, what are those attributed to?
7 But that is what this document says.

8 Q. Okay. Continuing on page 5 of the ACOG
9 Bulletin 106, under the next carrot, we talked about
10 efficacy or fetal heart rate monitoring.

11 Now, the next question that ACOG posed and
12 answered was: what is the interobserver and
13 intraobserver variability of intrapartum electronic
14 fetal heart rate monitoring assessment?

15 Do you see that question?

16 A. I do.

17 Q. And they responded to that question in
18 this bulletin, maybe. There is a high interobserver
19 and intraobserver variability in the interpretation
20 of fetal heart rate tracings.

21 Do you see that?

22 A. I do.

23 Q. Did I read that correctly?

24 A. You did.

25 Q. And do you agree with that?

1 A. I think in a general principle, again,
2 this is a general statement looking retrospectively
3 at a study that they performed in which they had
4 providers looking at the same strip at two different
5 times, and then comparing what certain providers
6 interpreted the strip as with someone else.

7 what they didn't take into account was if
8 there was a subtle difference, but the overall read
9 of the tracing was relatively the same. Then, in my
10 mind, that is essentially the same interpretation,
11 while there may be subtle differences.

12 It would be like saying red and magenta
13 and sienna. Those are all shades of red. So are we
14 all saying red, or is it really something different?

15 So, in a general sense, that's what it
16 says. I don't disagree there were some differences,
17 but it doesn't take into account subtle differences.

18 Q. And it goes on to then kind of explain
19 essentially what you just told us when it says: For
20 example, when four obstetricians examine 50 -- and
21 it's cardiotocograms. Can I just say strips?

22 A. You can.

23 Q. Okay. They agreed in only 22 percent of
24 the cases. So that means 1 in 5, essentially 1 in 5,
25 1 in 4 and half times they agreed, is what? 22

percent? 1 in 4 is 25 percent?

A. Essentially.

Q. Two months later, during the second review of the same 50 tracings, the clinicians interpreted them 21 percent differently than they did the first time.

So they disagreed with each other 21 percent of the time. Then they looked at the same 50 two months later and disagreed again with their own re-review another 21 percent of the time, correct?

A. That's what it says.

Q. Okay. So in another study, 5 obstetricians independently interpreted 150 strips. The obstetricians interpreted the tracings similarly in only 30 percent of the cases, suggesting poor interobserver reliability, meaning obstetrician to obstetrician, correct?

A. That's what it says.

Q. The interpretation of strips is more consistent when the tracing is normal.

Do you see that?

A. Yes.

Q. Do you agree with that?

A. Yes.

Q. With retrospective reviews, the

1 foreknowledge of neonatal outcomes may alter the
2 reviewer's impressions of the tracings.

3 Do you see that?

4 A. That's what it says.

5 Q. Do you agree with that?

6 A. Well, it is a phenomenon known as
7 hindsight bias. And so efforts have to be made on
8 both sides by experts that are retained on both sides
9 to blind themselves from the end outcome.

10 So it's not looking at the end or the
11 condition of the baby or the condition of the mother
12 and working backwards. But that is essentially what
13 that's implying.

14 Q. And it says: Given the same intrapartum
15 tracings, a reviewer is more likely to find evidence
16 of fetal hypoxia and criticize the obstetrician's
17 management if the outcome was poor versus good,
18 correct?

19 A. That's what it says.

20 Q. And that means experts reviewing strips in
21 hindsight with knowledge of the outcome are more
22 likely to find evidence of fetal hypoxia and
23 criticize the treating providers, correct?

24 A. I think that's what the implication is.
25 Again, there's consistencies in the interpretations

1 in this case as in many cases of Category II or
2 Category III or the presence of decelerations like
3 late and variable. So the consistencies seem to far
4 outweigh the differences.

5 Q. And then it finally concludes with:
6 Therefore, reinterpretation of the fetal heart rate
7 tracings, especially if neonatal outcomes is known,
8 may not be reliable.

9 Do you see that?

10 A. That's what it says.

11 Q. And that's ACOG's conclusion that starts
12 with their "therefore" and answering the question
13 about the inter- and intraobserver variability,
14 correct?

15 A. In relation to the studies that they just
16 talked about, yes.

17 Q. Okay. Let's go to page 6.

18 Another question that they asked in this
19 practice bulletin is: what findings on EFM are
20 consistent with normal fetal acid base status?

21 Do you see that?

22 A. Yes.

23 Q. And it says: The presence of fetal heart
24 rate accelerations generally ensures that the fetus
25 is not acidemic.

1 Do you see that?

2 A. I do.

3 Q. Do you agree with that?

4 A. I do.

5 Q. The last part of that sentence or that
6 paragraph is: However, in most cases, normal fetal
7 heart rate variability provides reassurance about
8 fetal status and the absence of metabolic acidemia.

9 Do you see that?

10 A. I do.

11 Q. So ACOG has included in this practice
12 bulletin that if you have fetal rate accelerations on
13 a strip, that generally ensures that the fetus is not
14 academic. And that if you have normal variability,
15 which would be what we talked about yesterday, in
16 that moderate category, it provides reassurance about
17 the fetal status and the absence of metabolic
18 acidemia, correct?

19 A. All it tells you is at that moment, the
20 baby is likely not academic. If those two, one or
21 the other, is present, it doesn't ensure that the
22 baby is not at risk for developing it, or that there
23 is some presence of the hypoxia related to decel or
24 something like that.

25 Q. And, sure, that's why -- what we talked

1 about that you teach your nurses, and what ACOG has
2 said in this guideline, what you do with fetal heart
3 rate monitoring is you take that clinical context,
4 all of the data, and you surveil, you evaluate, and
5 you reevaluate. It's an always ongoing process,
6 correct?

7 A. Yes. But I would add to that that even
8 though it is surveil, assess, intervene, re-assess,
9 it doesn't mean -- nowhere in that circular pattern
10 does it say do nothing. So at some point something
11 is usually required to be done.

12 Q. All right. I'm finished with that
13 exhibit.

14 MS. KAMYKOWSKI: If I may approach, Your
15 Honor?

16 THE COURT: You may.

17 Q. (By Ms. Kamykowski) I'm going to hand you
18 what's been marked as Exhibit I10.

19 MS. KAMYKOWSKI: Your Honor, if I may make
20 some -- I have one extra copy. I don't have one for
21 myself.

22 THE COURT: Go ahead.

23 MS. KAMYKOWSKI: Are you sure?

24 THE COURT: Yes.

25 MS. KAMYKOWSKI: Okay. Thank you.

1 Q. (By Ms. Kamykowski) Do you recognize this
2 document, Ms. Shinn?

3 A. I do. It's an excerpt from my personal
4 copy of fourth edition: "Fetal Heart Monitoring
5 Principles and Practice from AWHONN."

6 Q. And, again, fourth edition, that just came
7 off your bookshelf at home?

8 A. Correct. I have several editions, but
9 that was the one that I grabbed.

10 Q. Or at your office or wherever it is. It's
11 just a resource you have available, correct?

12 A. Correct.

13 Q. So I want to review -- you just said,
14 again, this is a booklet, right? It's a published
15 book, maybe this thick?

16 A. It's about an inch thick, yes.

17 Q. Okay. And this document, as it was
18 produced to us from your file in this case, is the
19 cover so that we can see the source, and just two
20 pages, correct?

21 A. Correct.

22 Q. Okay. And it's from -- if we look at page
23 2 of Exhibit I10, it starts at pages 138 and 139. At
24 the top there, it says: Section 3: Fetal
25 Monitoring: Diagnosis and Intervention, correct?

1 A. It does.

2 Q. And on this page 2, the bottom left
3 corner -- let me ask you this: since this is your
4 personal copy, were these markings that are on here,
5 the pen and the star and the highlight, those were
6 done by you, not specific to taking photos and
7 sending them in this case, were they?

8 A. That's correct. That they were not
9 starred or bracketed or highlighted specifically for
10 this case. The information on these two pages was
11 information I specifically wanted to send as it
12 related to this case and the issues in this case. It
13 just so happened to already have the markings on it
14 from prior use.

15 Q. Okay. And so on the right-hand side where
16 the bullet points are, this is referencing
17 interventions for Category II and Category III,
18 "Fetal Heart Rate Patterns: Intrauterine
19 Resuscitation Techniques."

20 That's what the title of this section is,
21 correct?

22 A. Correct.

23 Q. And on the right-hand column where it
24 says: These assessments and data can guide
25 appropriate interventions to attempt to resolve the

1 pattern.

2 So a Category II or a Category III, Document
3 correct?

4 A. Correct.

5 Q. The physiologic goal for intrauterine
6 resuscitation include the following.

7 And then we have 5 bullet points.

8 Do you see those there?

9 A. I do.

10 Q. Do you agree with those outlined
11 intrauterine resuscitative techniques?

12 A. Yes. Just to make it make a little more
13 sense, the first bullet point supports maternal
14 coping and labor progress. If someone was in a lot
15 of pain. They were screaming. They were
16 hyperventilating, they themselves may not be taking
17 in enough oxygen, and, therefore, that could, I
18 guess, predispose the baby to developing a low oxygen
19 environment.

20 To maximize uterine blood flow, if there
21 were too many contractions, if there's low blood
22 pressure in the mother, and she's not perfusing the
23 uterus, she will not in turn perfuse the placenta as
24 well, and, therefore, the flow or the oxygenated
25 blood getting to the baby could be diminished.

1 so things like position changes, treating
2 low blood pressures, not letting mom lay flat on her
3 back. If you had a baby or you've known someone
4 pregnant, you hear you lay on your left side for
5 better perfusion. It's better for the baby.

6 Umbilical circulation, maximizing that is
7 essentially identifying on the tracing that there's
8 some evidence of cord compression, those V- or W- or
9 U-shaped abrupt decelerations we talked about
10 yesterday.

11 so if that's identified, the physiologic
12 goal that a nurse would identify and try to improve,
13 would be maximizing flow through the umbilical cord.

14 So this is part of the course that we teach. So
15 making it make sense. Not just to recognize, oh, it
16 looks like a V, it must be a variable.

17 It's actually understanding the
18 definition: How it presents, how long it takes to
19 get to the lowest point of that heart rate drop, and
20 what the nurse is supposed to do about it. What it
21 means, what the underlying cause could be, and how
22 she can improve that situation.

23 Q. And so it says: Intrauterine
24 resuscitation refers to a series of techniques that
25 include but may not be limited to the following. And

1 then it says maternal repositioning.

2 we talked about that a little bit
3 yesterday, right?

4 A. Correct.

5 Q. Reduction of uterine activity, we didn't
6 talk about that yesterday, but we will today. An
7 intervenous fluid -- a bolus, you talked about that
8 yesterday, correct?

9 A. I did.

10 Q. Correction of maternal hypotension.
11 we didn't have that in this case, right?

12 A. We did not.

13 Q. Okay. Oxygen administration, that was not
14 done in this case, but there's also been some
15 question more recently, I think, about the efficacy
16 of that recommending intrauterine resuscitation,
17 correct?

18 A. It is still a recommendation by AWHONN.
19 ACOG has taken a slightly different position from the
20 physician side. The nursing organization, or AWHONN,
21 says that there are still some situations like
22 concerning Category II, loss of variability, late
23 decels that are recurrent or Category III tracings,
24 that would be appropriate to apply oxygen to the
25 mother in an effort to improve the oxygenation to the

1 baby.

2 The problem is, we can't quantify how much
3 oxygen is really being delivered. There may be some
4 factors that impact that. So it is still a
5 reasonable intervention at some times, yes.

6 Q. An amnioinfusion, that means inserting a
7 catheter up into the uterus to put fluid to kind of
8 replace that mom's bag of water to help potentially
9 take some pressure off the cord. If variables are
10 being seen, that's a possible intrauterine
11 resuscitation, correct?

12 A. In some cases, yes.

13 Q. And in this case, as far as the opinions
14 you have, that's not an issue?

15 A. Correct.

16 Q. And then the last one is modification of
17 maternal pushing efforts during the second stage of
18 labor.

19 And you talked a little bit about that
20 yesterday, too, correct?

21 A. Correct.

22 Q. Okay. This goes on to say the type of
23 resuscitative techniques is based on the specific
24 characteristics of an FHR pattern. In some cases, a
25 combination of techniques will be required to resolve

1 the pattern.

2 Do you see that?

3 A. I do.

4 Q. Okay. And then it references a table on
5 the next page, which is why I presume you took a
6 picture of the following page.

7 A. Correct.

8 Q. And that just puts the recommendations
9 into a table form, right?

10 A. It does.

11 Q. All right. We're done with I10.

12 MS. KAMYKOWSKI: Your Honor, may I
13 approach?

14 THE COURT: You may.

15 Q. (By Ms. Kamykowski) And I have for you
16 what's been marked as I11.

17 Do you recognize that AWHONN publication?

18 A. Yes.

19 Q. And can you just tell us what -- you've
20 seen this before, correct?

21 A. I have.

22 Q. Can you just tell us what this is.

23 A. This is AWHONN's response to ACOG's
24 practice advisory on oxygen supplementation in the
25 setting of Category II or Category III fetal heart

1 rate tracings.

2 Q. And on page 2 of this exhibit, under the
 3 discussion of the background, it says: The goal of
 4 intrauterine resuscitation is to promote
 5 maternal-fetal exchange by minimizing or correcting
 6 factors that may be problematic such as impaired
 7 ureteroplacental blood flow, maternal hypotension,
 8 umbilical cord compression, and/or excessive uterine
 9 activity.

10 Did I read that correctly?

11 A. You did.

12 Q. And you agree that's the goal of
 13 intrauterine resuscitation?

14 A. Yes. So interpreting the strips,
 15 identifying the problem, and doing the physiologic
 16 intervention to try to improve it.

17 Q. And then it goes on to say: Generally
 18 maternal position change to right or left is
 19 initiated first followed by other measures such as an
 20 IV fluid bolus of approximately 500 milliliters of
 21 nonglucose-containing solution.

22 Did I read that correctly?

23 A. You did.

24 Q. You don't -- yesterday you told the jury
 25 that with respect to the protocol in Mercy's vaginal

1 birth medical record --

2 we went through that yesterday, do you
3 remember?

4 A. we did.

5 Q. That you have to go big or go home.

6 If you have a Category II tracing, you
7 have to do all of those things in a bundle.

8 Do you remember giving that testimony?

9 A. I don't think that was quite exactly how I
10 said it.

11 what I said is oftentimes they are done in
12 a bundle. So the left and repositioning are very
13 easy to do, they're low intervention. So it's not
14 messing with the pump, it's not getting an oxygen
15 mask, it's not instilling fluid up into the wound.
16 So it's very easy to do.

17 If that in and of itself quickly corrects
18 the tracing, then that's fine. Sometimes that's all
19 that needs to be done, if it's a blood pressure
20 issue, a positioning issue.

21 In this case what I specifically said was
22 that it didn't correct the pattern in this case. And
23 Pitocin was allowed to run, and pushing was allowed
24 to commence. And so the pattern continued. And
25 continued to be identified as abnormal by the nurses.

1 But, yes, I did use the words "go big or
2 go home," and I said typically we go big or go home
3 as nurses, meaning we just start doing that because
4 there is no good data that says which one will work
5 or how many minutes to wait between doing the next
6 thing.

7 Q. Well, I wrote in my notes that go big or
8 go home was because you concluded that the Mercy
9 Hospital protocol, this part of the standing order
10 that goes in for every women who is admitted for a
11 potential vaginal delivery, included, first, stop the
12 Pitocin, and then do everything else in a bundle.

13 That was your "go big or go home."

14 Did I misunderstand what you said
15 yesterday?

16 A. I think you did.

17 Q. Okay.

18 A. There were several questions about
19 standard of care and interventions, as well as the
20 policy itself, and those were not part of the same
21 testimony.

22 But, in general, yes, I am of that opinion
23 or conclusion that go big or go home. In reading the
24 Mercy Hospital protocol, it does say the nurse will
25 do these things. It doesn't say, try one then wait.

1 I think there was some implication that waiting 30
2 minutes or 60 minutes, which there's no evidence that
3 that can be found anywhere.

4 In addition to that, you have a pattern
5 that continued to persist. So the language in the
6 protocol doesn't say, will or might or could
7 consider. It just says will.

8 Q. We're going to get back to the protocol.
9 But I think when you said there was some evidence you
10 could wait 30 or 60 minutes, that wasn't evidence.
11 That was what you heard me say in my opening
12 statement when you sat back there yesterday and
13 listened to me, is it not?

14 A. I believe so.

15 Q. Okay.

16 A. I believe you were the one that said it.

17 Q. And the jury was already told that opening
18 statements are not evidence, right?

19 A. Well, I wasn't here for the jury
20 instruction, so I apologize if that was a misstate.

21 Q. All right. Getting back to this document.
22 The sentence, it talked about amnioinfusion next.
23 Not relevant to this case.

24 Then it says: Effect of recurrent
25 variable decelerations in second stage can be reduced

1 by modification of maternal pushing efforts; e.g. --
2 which means for example -- pushing every other or
3 every third contraction or stopping pushing
4 temporarily to allow the fetus to recover.

5 Do you agree with that?

6 A. To some extent, yes. We talked about that
7 yesterday whether the laboring down was in effect a
8 stopping of pushing or a modification of pushing.

9 Q. Well, and I think what you told Ms. Gunn
10 on direct was this description that your teaching
11 body uses as an intrauterine resuscitative measure,
12 you said that can be called laboring down, right?

13 A. Yes. If you completely stop pushing, it
14 could be considered laboring down, so modification
15 can be interpreted in a number of ways, how you stop
16 pushing.

17 In this case, the continued Pitocin,
18 continued second stage, for an absurd amount of time,
19 hours and hours and hours later, that's where that
20 comes in. So when we talk about individualized care
21 and taking into account all of the clinical facts and
22 circumstances that we know about this patient and her
23 labor, that also factors in. So we're not just
24 looking at just a text or just a recommendation, it
25 has to be applied to the patient.

1 Q. Sure. And when you went through the flow
2 sheets that Maggie and Jessie were documenting for
3 their care of Sarah Anyan yesterday, you did that
4 with Ms. Gunn during your direct, correct?

5 A. I did.

6 Q. And I think we started at sometime 7:15,
7 when -- Maggie's first assessment after taking report
8 or while taking report from Jessie -- I'm sorry --
9 from Alex Greenwald was occurring. You went all the
10 way through those flow sheets yesterday, right?

11 A. We did.

12 Q. Okay. And you -- we pointed out the
13 documentation by Maggie of the multiple position
14 changes that included later changes, left side,
15 correct?

16 You saw that?

17 A. I did.

18 Q. You saw that head of bed. That means not
19 supine, not on your back. We don't want that in
20 labor, right?

21 A. Well, supine is flat on her back. Head of
22 bed elevated, but left tilt, I believe, was what the
23 entry was, and she was continuing to push.

24 So what I said was even if there were some
25 benefit to the position change of left tilt, which

1 left tilt in and of itself would be a reasonable
2 position change to improve perfusion, continuing to
3 push and continuing to run Pitocin is like having
4 your foot on the gas and your foot on the brake. So
5 it's somewhat counterintuitive and counterproductive.

6 Q. So your testimony to this jury is that you
7 cannot, as a nurse, employ intrauterine resuscitative
8 position changes at the same time as pushing because
9 it won't work?

10 A. No. I'm saying in this case it didn't
11 work.

12 Q. Okay. We're going to talk about that,
13 too.

14 But there were multiple position changes
15 left side, head of bed up, hands and knees, as well
16 as the multiple hours that we -- that you went
17 through with Ms. Gunn of laboring down, which was, as
18 AWHONN describes it, modification of her pushing
19 efforts by having her stop pushing, correct?

20 A. Correct.

21 Q. Those all occurred in this case?

22 A. They did.

23 Q. And at times, did you also see that the
24 modification of the pushing efforts, while Maggie and
25 Jessie were responsible for and caring for this

1 patient, including not having her push with every
2 contraction?

3 A. There were some times in which they did
4 either every other or every third, yes.

5 Q. And so you agree that position changes
6 that were done in this case and modifications of the
7 maternal pushing efforts, either not with every push
8 or laboring down, can and do and are utilized by
9 nurses at the bedside taught by folks like you from
10 AWHONN to both effectuate position changes, meaning
11 if the baby needs to be rotated or descent or for
12 preparing for delivery, as well as intrauterine
13 resuscitation, correct?

14 A. They can be in some cases, yes.

15 Q. And you have concluded, as an expert for
16 the plaintiff in this case, reading the depositions
17 and gathering on your experience in this case, that
18 they were not being done by Maggie and Jessie for
19 intrauterine resuscitation.

20 That's your opinion in that case?

21 A. Based on some of their testimony that they
22 were trying to facilitate a vaginal delivery and
23 rotate the baby and help descend the baby, yes, that
24 was based on their testimony.

25 Q. You read their depositions, correct?

A. I did.

Q. Do you remember what Jessie said specifically when she was asked about this very issue, this conundrum that you created?

Do you know what she said?

A. No.

Q. Okay. Let's look at it.

MS. KAMYKOWSKI: Can you pull up F16, which is Jessie's testimony, starting at page 98, line 17.

Q. (By Ms. Kamykowski) This is Ms. Gunn asking Ms. Wagner, the nurse that you're critical of in this case, a question.

And she says: And I know you mentioned this a moment ago about how you didn't -- you said the repositioning appeared to work, and that's why we didn't decrease the Pitocin.

Answer from Jessie: Correct.

"QUESTION: And is this the way you felt the entire shift between 7:00 a.m. and 2:20, when Dr. McNeive increased it?

"ANSWER: Yes. Because overall Remington had --

MS. KAMYKOWSKI: And go onto the next page.

1 Q. (By Ms. Kamykowski) -- moderate
2 variability, which is another great sign of
3 oxygenation. And I agree that our interventions
4 worked, and that whenever we needed to do something
5 else, then we would do another intervention to make
6 him look better. And he always responded to the
7 interventions. Each time was just a different time
8 frame of whenever he stayed Category I."

9 Did I read that correctly?

10 A. I can't see behind your back. But I
11 would -- yes, you read it correctly.

12 Q. And in that first question and answer
13 between Ms. Gunn and Nurse Wagner, there's no mention
14 of position change or descent or anything. It's all
15 talking about resuscitation for Remi and how he
16 looked, correct?

17 A. In that question and answer segment, yes.

18 Q. All right. Let's keep going.
19 She then was asked: And when you say it
20 worked, define what it means.

21 The maternal repositioning that you have
22 worked.

23 So, again: In the context of
24 repositioning, correct?

25 She answered: To resolve the

1 decelerations that were happening prior to
2 intervention.

3 Is that the question and answer, and did I
4 read it correctly?

5 A. You did.

6 Q. And despite that question and answer under
7 oath by -- the answer by Nurse Wagner: It's still
8 your opinion, when you reviewed this, that they
9 weren't doing position changes in this case to
10 resolve the decelerations?

11 A. In a general sense, yes, because their
12 documentation supports that they continued to see
13 decelerations like late and/or variables.

14 And when she simply did another
15 intervention, it was just another position change
16 while continuing to push or allowing Pitocin to
17 continue to run.

18 Q. And then she keeps going and she says:
19 How long were the decelerations resolved?

20 "ANSWER: That varied, just depending on
21 which time you're referring to.

22 "QUESTION: Okay. And that's what I'm
23 trying to understand. So you would reposition --

24 "ANSWER: Uh-huh.

25 "QUESTION: -- based on a decel?

1 "ANSWER: For multiple reasons. Yes,
2 decels for sure, but also just pushing efforts in
3 general."

4 And then she goes on to talk about more.

5 So this nurse, when explaining her thought
6 process as the nurse whose care is at issue in this
7 case, told you, when you read this deposition, that
8 what those position changes were for was twofold,
9 correct? Intrauterine resuscitation, as well as to
10 help with position of the baby while she pushed.

11 A. Based on that answer, yes.

12 Q. Okay. But you --

13 MS. KAMYKOWSKI: You can take that down.

14 Q. (By Ms. Kamykowski) You have decided, or
15 you did, at least when I took your deposition,
16 despite that question and answer that we just went
17 through, those paragraphs, that these nurses were
18 only doing position changes to try to get the baby's
19 position to change or for him to move down in the
20 birth canal, correct?

21 A. I think what I said yesterday is any
22 benefit to those position changes, that they are
23 appropriate position changes, generally speaking, the
24 ones we looked at.

25 Any benefit to those would have been

1 negated by the times that they were continuing to
2 push and/or continuing running Pitocin, which we know
3 ran the entire time. And then was subsequently
4 increased by order of Dr. McNeive.

5 So, yes, I've determined or concluded that
6 any benefit that in their mind they thought they were
7 getting from the occasional position changes, which
8 certainly does not exceed the number of entries of
9 decels that they documented, I've concluded that they
10 were not effectively resuscitating this fetus.

11 Q. Well, what you told us yesterday was they
12 absolutely were not doing them for intrauterine
13 resuscitation. The only thing you believed they were
14 doing position changes for was to change the
15 malposition of the baby or affect descent. You
16 didn't even consider that they were doing it for
17 intrauterine resuscitation.

18 Do you remember that testimony yesterday?

19 A. I don't think that's verbatim, but
20 basically that is what I said yesterday.

21 Q. Okay. So now you're changing it when
22 confronted with the actual testimony from a nurse,
23 correct?

24 A. I'm not changing it. She said she was
25 doing it for multiple reasons, one of which was to

1 help facilitate the malposition of the baby, which
2 had been present for hours. So I don't think that
3 can be excluded. They weren't just simply doing
4 resuscitative measures to improve fetal oxygenation.
5 And the only interventions, quote/unquote, if you
6 will, were position changes.

7 Again, while keeping your foot on the gas
8 with pushing most of the time and also with running
9 Pitocin the entire time while still identifying
10 abnormal findings with late or variable decelerations
11 on the fetal monitor tracing.

12 So, again, you can keep pounding that head
13 into the pelvis. It's like a square peg in a round
14 hole. It may eventually fit --

15 Q. well, I was waiting for you to say that.
16 I mean, I knew you wanted to. You said it in your
17 deposition a bunch of times. But that's not
18 responsive to my question. You answered my
19 question --

20 MS. GUNN: Your Honor, I'm going to
21 object. I don't think the witness was done with her
22 answer.

23 MS. KAMYKOWSKI: It's cross-examination,
24 and Ms. Gunn can come and re-ask the witness
25 questions if she'd like.

1 THE COURT: But the Court is going to
2 sustain it as to you interrupted the completion of
3 the answer. You can ask her the next question after
4 she finishes answering it.

5 MS. KAMYKOWSKI: well, I would move to
6 strike the question being nonresponsive to my
7 question. She answered my question.

8 THE COURT: Overruled. Overruled.

9 Q. (By Ms. Kamykowski) All right. Go ahead.

10 A. So as I was saying, you know, you can keep
11 pushing and pitting and pounding the baby into the
12 bones of the pelvis. It is like a square peg in a
13 round hole. It may eventually fit, and you may wedge
14 it in there at some point. But it's not going to fit
15 safely or as it should.

16 Q. All right. So you've changed your
17 testimony from yesterday to today. we all got that.
18 Let's move on.

19 MS. KAMYKOWSKI: Can I approach, Your
20 Honor?

21 THE COURT: You may. But you need to
22 start slowing down.

23 MS. KAMYKOWSKI: I will.

24 Q. (By Ms. Kamykowski) I'm going to hand you
25 what's been marked as Exhibit I13.

1 Do you recognize that document?

2 A. I do. This is the next edition of the
3 same text we were just looking at, just a different
4 portion that was scanned in.

5 Q. All right. And in the text before we talk
6 about the algorithm, we're going to talk about the
7 text first.

8 It starts with a 2006. Do you see that
9 paragraph?

10 A. Yes.

11 Q. Okay. A 2006 review of the published
12 literature on the association between fetal heart
13 rate patterns and fetal acidemia. Moderate fetal
14 heart rate variabilities was strongly, parentheses,
15 98 percent, associated with an umbilical pH of
16 greater than 7.15, or newborn vigor 5-minute Apgar
17 score of 7 or higher.

18 Did I read that correctly?

19 A. You read it correctly.

20 Q. And you agree with that statement in this
21 book?

22 A. Yes. And I think that's what we just
23 talked about last text that -- and also in the ACOG
24 practical -- that moderate variability is a reliable
25 indicator that at that moment, the baby is not

1 acidotic. So the pH, if it has been drawn, in cord
2 gases, at that moment, when there was moderate
3 variability, would likely have shown a pH level of
4 7.15 or higher for a vigorous newborn with a 5-minute
5 Apgar of 7 or higher.

6 we don't have a gas in this case. We
7 don't have moderate variability right before the
8 delivery, and I certainly have questions about the at
9 5 minutes, but that is what this text says.

10 Q. We're going to talk about the Apgar later
11 in your cross-examination. But what you told me in
12 your deposition, you didn't give your number to
13 Ms. Gunn yesterday. You said you disagreed with the
14 5-minute Apgar at 8.

15 But when we deposed you, I specifically
16 asked you if you believe it's inaccurate, what would
17 you have given the 5-minute Apgar. And do you
18 remember telling me a 7?

19 A. I remember telling you exactly that I was
20 not there. I did not assess this particular newborn.
21 But based on the description of the nurse
22 practitioner of the baby's respiratory effort, the
23 baby at max should have gotten a 7, is what I
24 actually said.

25 Q. And the nurses' description, that's not

1 what you told us yesterday. You told us yesterday
2 you based it on the parents' descriptions.

3 Do you remember that?

4 A. well, the parents' description, as well as
5 the description of the respiratory effort and the
6 need for continued respiratory assistance. And that
7 was described by not the parents but by the nurse
8 practitioner.

9 Q. And you told me in your deposition that
10 the 5-minute Apgar of 8 -- well, first, let's just
11 back up a second.

12 we'll just -- I'll just do my Apgar
13 discussion now. Of Apgar of 7 or greater at 5
14 minutes is considered normal, correct?

15 A. Typically.

16 Q. And that's what you could have given him
17 based on your review of this case with the data and
18 the deposition testimony that you have, correct?

19 A. Correct. And the mask, yes.

20 Now, again, if I had been present as
21 someone who initiates and participates in
22 resuscitation and assigns Apgars almost on a
23 shift-to-shift basis, it may not have been a 7, on my
24 interpretation.

25 The Apgar score is an assessment in

1 realtime to guide resuscitation. Does the baby still
2 need help with respiratory effort with intubation,
3 with medication, those kinds of things. And so it
4 was a realtime assessment as to how vigorous or not
5 vigorous the baby is. But, again, based on the
6 description of those involved in this case, I would
7 say a 7 would be the maximum I would give the baby at
8 5 minutes.

9 Q. And you admitted, and already told us
10 today, you weren't there, you didn't have your hands
11 on the baby. You have to rely upon the neonatal
12 nurse practitioner who has different training than
13 you, correct?

14 A. In regards to resuscitation, or just in
15 general as a nurse practitioner?

16 Q. In general as a nurse practitioner, she
17 has different training than you, correct?

18 A. Yes.

19 Q. And the jury is going to hear from her in
20 this case.

21 But you told us in your deposition, you
22 can't rectify how this baby got an 8, 5-minute Apgar
23 other than to say, based on your review and your
24 experience, the Apgar might have been slightly
25 inflated or assisted.

1 Do you remember saying that?

2 A. Yes.

3 Q. All right. Let's go back to Exhibit I13,
4 if you can.

5 continuing after that first sentence of
6 the paragraph that begins a 2006 review.

7 So it talks about moderate variability
8 having to be very strongly, almost a hundred percent,
9 associated with umbilical pH greater than 7.5.

10 I don't know if the jury's heard this yet.
11 The normal pH for a baby who is born is what?

12 A. Generally it's 7.20 or higher.

13 Q. So this study says almost a hundred
14 percent of babies born that have had moderate
15 variability would have umbilical pH that would be
16 normal, correct?

17 A. Yes. I mean, different hospitals may have
18 different ranges as to what their lab considers
19 normal or not normal, but most of the literature has
20 a consensus that 7.2 or higher is considered normal.
21 What this is saying, it's not saying that it's
22 normal, per se, it's just saying that it's more
23 likely than not it would be greater than 7.15. 7, as
24 you mentioned earlier, which I said is essentially
25 normal. But a 7 would likely still be guiding some

1 type of resuscitation at the time that it's assigned.

2 Q. You think a 7 Apgar at 5 minutes would
3 still be guided by resuscitation?

4 A. would still be guiding a resuscitation?

5 Yes. You wouldn't just leave the baby lying on the
6 warmer and do nothing. You'd still be drying,
7 stimulating, clearing the airway, making sure that
8 the baby is breathing okay. The color is okay. The
9 tone is okay.

10 Q. It goes on to say: In this review, the
11 most consistent predictor of newborn metabolic
12 acidemia was absent or minimal fetal heart rate
13 variability with recurrent late or variable
14 decelerations, parentheses, although the association
15 was only 23 percent.

16 See that?

17 A. I do.

18 Q. And there was a positive relationship
19 between the degree of acidemia and the depth of the
20 decelerations or bradycardia.

21 Did I read that correctly?

22 A. You did.

23 Q. There was never bradycardia in this case,
24 correct?

25 A. There was not. There was absent

1 variability with recurrent decels at the end, but,
2 again, we don't have a gas to correlate with.

3 Q. Understand.

4 Then it goes on to say in this AWHONN,
5 this page from your AWHONN book on fetal monitoring
6 diagnosis and intervention: The authors, therefore,
7 conclude that in the absence of a catastrophic event
8 or a sudden profound bradycardia.

9 Neither of those occurred in this case,
10 correct?

11 A. They did not.

12 Q. Newborn metabolic acidemia expressed as
13 decreasing variability, so that means the heart rate
14 is, instead of going from 6 to 25, which is moderate,
15 would go something lower from a beat-to-beat change,
16 correct? That's what we're talking about?

17 A. Correct.

18 Q. In combination with deceleration -- and we
19 talked about those yesterday -- developed over a
20 period of time approximating one hour, suggesting
21 that there is usually time for attempting to improve
22 fetal oxygenation through intrauterine resuscitative
23 measures.

24 Did I read that?

25 A. You did.

1 Q. And then it goes on to then talk about --
2 and I don't know that we proposed this consensus
3 approach.

4 Do you see that?

5 A. I do --

6 Q. I didn't get, since your page is kind of
7 skipped, what that consensus approach, is that the
8 Clark algorithm, if we can call it that collectively?

9 A. Yes.

10 Q. okay. And that is the algorithm at the
11 top of the page on page 2? Sorry. I'm sorry. The
12 Clark algorithm is on page 3.

13 Do you see that?

14 A. Yes.

15 Q. okay. The algorithm on page 2 is what
16 supports what we just went through, right?

17 MS. KAMYKOWSKI: Can you go back to the
18 page before, Justin?

19 Q. (By Ms. Kamykowski) It starts with
20 assessment of intrapartum fetal heart rate tracings,
21 correct?

22 A. Correct.

23 Q. And it starts with Category II, and it has
24 an asterisk, and the asterisk says: Given the wide
25 variation of FHR tracings in Category II, this

1 algorithm is not meant to represent assessment and
2 management of all potential FHR tracings, but provide
3 an action template for common clinical situation.

4 Do you see that?

5 A. Yes.

6 Q. So it's just saying, hey, this is kind of
7 generally speaking how we recommend you look at this,
8 but you've still got to have your individualized
9 approach to every patient, taking into account the
10 entire clinical context, right?

11 A. 100 percent.

12 Q. Okay. So what it says with that asterisk
13 is category II, you start with evaluation and
14 surveillance, correct?

15 A. Correct. That's essentially monitoring
16 and interpreting.

17 Q. Okay. And then it has, as all algorithms
18 do, "choose your own adventure" based on the clinical
19 situation, correct?

20 A. Correct.

21 Q. All right. And so if we go to the
22 left-hand side, if there are fetal heart rate
23 accelerations or moderate fetal heart rate
24 variability, what does it tell the bedside nurses to
25 do?

1 A. Generally continue to survey and perform
2 resuscitative measures.

3 Q. Okay. Let's go to the other side.

4 If you don't have -- so the first on the
5 left-hand side, the choosing of the adventure was
6 acceleration or moderate variability, correct?

7 A. Correct.

8 Q. On the right-hand side, it says no
9 accelerations or absent accelerations, and absent for
10 minimal variability.

11 A. It does.

12 Q. And if that happens, you have to do
13 intrauterine resuscitative measures. And if that
14 doesn't improve, that no acceleration and absent for
15 minimal variability, and it progresses to Category
16 III, consider delivery, right?

17 A. That's what it says.

18 Q. And this algorithm, you teach as a
19 representative of AWHONN to labor and delivery nurses
20 all over the country.

21 A. Correct.

22 Q. Okay. Let's go to the next page.

23 Figure 515 at the top, and it's titled
24 "Algorithm for Management of Category II Fetal Heart
25 Tracing Suggested by Clark, et al."

1 Have you read that document or that
2 publication that was published in 2013 by Dr. Clark
3 and his colleagues that AWHONN then adopted?

4 A. Yes. AWHONN and ACOG adopted it. And
5 it's actually incorporated in a later practice
6 bulletin, No. 116.

7 Q. You're getting ahead of me, and I like it.
8 So I'm going to hand you just what you
9 have -- actually, I'll hand all of them to you, okay,
10 Nurse Shinn?

11 Exhibit 116?

12 MS. KAMYKOWSKI: Your Honor, may I
13 approach?

14 THE COURT: You may.

15 Q. (By Ms. Kamykowski) I'm sorry. This is
16 I16.

17 Do you recognize that document, Nurse
18 Shinn?

19 A. Yes.

20 Q. Is that the Clark publication that we were
21 just talking about?

22 A. Yes.

23 Q. All right. I'm also going to hand you
24 what's been marked I1.

25 Do you recognize that document?

1 A. Yes.

2 Q. And what is that document?

3 A. This is the practice bulletin I was just
4 referencing from ACOG Practice Bulletin No. 116.

5 Q. Okay. And if you can go to 116, which is
6 the Clark publication from 2013, we'll start with
7 that.

8 And this clinical opinion "Intrapartum
9 Management of Category II Fetal Heart Rate Tracings
10 for the Standardization of Care."

11 That's the title, correct?

12 A. Correct.

13 Q. And you have read this, have you not?

14 A. I have.

15 Q. And it starts with this introductory
16 statement that says: Interpretation and management
17 of fetal heart rate patterns during labor remains one
18 of the most problematic issues in obstetrics.

19 Do you see that?

20 A. I do.

21 Q. Unfortunately this body of work has
22 primarily served to raise more questions than it has
23 answered. As a medical community, we seem to know
24 less than we thought we did 30 years ago regarding
25 the utility of this ubiquitous technique.

1 Did I read that correctly?

2 A. You did.

3 Q. And it's my understanding, from reading
4 this, and correct me if my understanding is not the
5 same as yours, is that Dr. Clark and his colleagues
6 that included obstetricians, maternal-fetal medicine
7 physicians, I think in one case a PhD nurse like
8 yourself, decided that they wanted to see if they
9 could come up with a way, a decision tool, to help
10 bedside providers get the most that they could out of
11 fetal heart rate monitoring to maybe try to slow the
12 increasing rate of C-sections.

13 Is that a fair assessment of what kind of
14 the hypothesis or the thought of coming up with this
15 in 2013 was?

16 A. I think it was twofold: Number one,
17 because Category II represents the vast majority of
18 category tracings, it was an attempt to try and
19 figure out which of those represent more concern and
20 what to do about them, in addition to when or how to
21 deliver. So, yes, in essence, that was the plan.

22 Q. Okay. And then it continues in this
23 introduction: In recent years, several specific
24 issues relating to interpretation and management of
25 fetal heart rate patterns have received considerable

1 attention in the medical literature.

2 These include the lack of agreement and
3 interpretation, even among recognized experts. The
4 role of fetal heart rate patterns as a primary driver
5 of a rising cesarean rate. And the explosion of
6 litigation involving fetal heart rate patterns,
7 despite the consistent absence of scientific evidence
8 to support the contention that intervention, based on
9 any single fetal heart rate pattern, or combination
10 of fetal heart patterns, in fact prevents cerebral
11 palsy or other types of neurological impairment.

12 Did I read that correctly?

13 A. You did.

14 Q. Do you agree with those statements?

15 A. I mean, in a general sense, yes. I think
16 that that goes back to the early conversation we were
17 having several minutes ago about the human element.

18 certainly if we take it from a 30,000-foot
19 view, that if we monitor most women in this country
20 continuously while they're birthing a baby, and we
21 just generally look at how many of those babies go on
22 to develop cerebral palsy trying to tie it to one
23 particular event, or series of events, some of that
24 take into account -- or doesn't take into account, I
25 should say, the human element.

1 How long was something abnormal watched?
2 How long was someone outside the trajectory of the
3 labor course? So, again, it's making general
4 statements about the efficacy of fetal monitoring,
5 the intention of fetal monitoring, and retrospective
6 evidence when they've done data analysis of different
7 birth, without taking specific factors of each birth.

8 Q. And it goes on to page 2 and talking about
9 what? Up until 2013, when Dr. Clark and his
10 colleagues were trying to come up with a solution
11 for, we have this tool, how can we make it more
12 reliable? How can we utilize it so that we might not
13 be having women undergo C-sections unnecessarily
14 based on the false positive prediction of fetal heart
15 rate tracings?

16 They say: Although useful, these
17 recommendations remain insufficient since 80 percent
18 of fetuses in labor demonstrate fetal heart rate
19 patterns that fall into Category II, patterns for
20 which, at that time, no specific ACOG management
21 recommendations exist, correct?

22 A. Yes.

23 Q. And that was what they tried to do with
24 this paper.

25 A. Correct.

1 Q. They came up with, at the top of the page
2 here: Figure 1: "Algorithm for Management of
3 Category II Fetal Heart Rate Tracings."

4 MS. KAMYKOWSKI: Your Honor, I may be at a
5 good -- I don't know.

6 THE COURT: why don't we go ahead and take
7 our morning recess.

8 (At 10:37 a.m., the Court duly admonished
9 the jury, and proceedings stood in recess. At 10:57
10 a.m., the following proceedings were held in open
11 court, in the presence of the jury:)

12 THE COURT: Go ahead and be seated,
13 everyone.

14 On behalf of the defendant, you may
15 proceed.

16 MS. KAMYKOWSKI: Thank you, Your Honor.

17 Q. (By Ms. Kamykowski) All right. Ms.
18 Shinn, right before our break, we were talking about
19 Exhibit I16 and this Figure 1. And we started to
20 talk about this: "Algorithm for Management of
21 Category II Fetal Heart Rate Tracings."

22 Now, it's here in I16. It's also an
23 algorithm that has been adopted and placed into
24 publications by AWHONN, correct?

25 A. Correct.

1 Q. And it's also been placed into the ACOG
2 guidelines, as well?

3 A. Correct.

4 Q. Okay. So we're going to reference it in
5 here, but as we've seen, it's in a couple other
6 exhibits that I've handed you this morning, as well,
7 correct?

8 A. Correct.

9 Q. Okay. And at the bottom, it cites Clark,
10 Category II FHRT.

11 So when that's reprinted elsewhere,
12 they're referencing this document, Exhibit I16,
13 correct?

14 A. Correct.

15 Q. Okay.
16 MS. KAMYKOWSKI: If you go to page 3 of
17 this document, Justin. If you put them side-by-side,
18 please, the algorithm and the table.

19 So page 2's algorithm and table, if you
20 could put those side-by-side.

21 Q. (By Ms. Kamykowski) while he's doing
22 that, the table on page 3, Nurse Shinn, is titled
23 "Management of Category II Fetal Heart Patterns:
24 Clarifications of Use in the Algorithm."

25 So we have the "choose your own adventure"

1 on page 2. That's the algorithm. And then we have
2 ten things that Clark authors say: Here are some
3 clarifications on how we recommend you use our
4 algorithm, correct?

5 A. Correct.

6 Q. Okay. And one of those, if you look at
7 No. 4, says: Application of Algorithm may be
8 initially delayed for up to 30 minutes while attempts
9 are made to alleviate Category II patterns with
10 conservative therapeutic interventions, parentheses;
11 e.g., correction of hypotension, position change,
12 amnioinfusion, tocolysis. That's a new word. That
13 means slowing down uterine contractions or stopping
14 uterine contractions.

15 A. Yes. Specifically it's referring to
16 giving a medication called terbutaline, the shot in
17 the patient's sub-Q tissue that can flow or stop
18 contractions.

19 Q. And then the last sentence: Reduction or
20 discontinuation of oxytocin, in parentheses.

21 Did I read that correctly?

22 A. You did.

23 Q. And it also says at No. 8: If at any time
24 tracing reverts to Category I status, or deteriorates
25 for even a short time to Category III status, the

1 algorithm no longer applies. However, algorithm
2 should be reinstituted if Category I patterns again
3 revert to Category II.

4 Did I read that correctly?

5 A. You did.

6 Q. And you agree with that clarification for
7 the use of this algorithm?

8 A. I think everything is context. So this is
9 one algorithm that's in use. It has been adopted.
10 It has been put out in publication. But how it
11 applies, that is certainly somewhat subjective. It
12 has been adopted. It has been put out in
13 publication.

14 But how it applies, certainly that is
15 somewhat subjective whether or not you would wait 30
16 minutes to even start using the algorithm. Whereas,
17 the algorithm somewhat implies that you would take
18 into consideration whether there are decels or not,
19 and whether to seek conservative measures like
20 intrauterine resuscitative measures have helped the
21 path or not.

22 So I think there is some subjectivity as
23 to how it is applied or how it is interpreted because
24 certainly, if you apply it to this case, there are
25 many points in time in which the algorithm would

1 suggest that they should have been delivered by

2 surgical delivery.

3 Q. Okay.

4 MS. KAMYKOWSKI: Can you pull up Exhibit

5 A3, page 108.

6 Q. (By Ms. Kamykowski) This algorithm you

7 know was part of the strip rounds that the three-

8 person team in the afternoon of May 4th utilized in

9 this case, correct?

10 A. I believe that's what's referenced in the

11 medical record when it says "Category II algorithm."

12 MS. KAMYKOWSKI: I'm sorry. A2 not A3.

13 That's my bad.

14 Q. (By Ms. Kamykowski) So the note there

15 from 248.

16 Do you see that, Nurse Shinn?

17 A. Barely.

18 MS. KAMYKOWSKI: Can you blow that up for,

19 us?

20 Q. (By Ms. Kamykowski) Okay. Now can you

21 see it?

22 You've seen this note before?

23 A. I have.

24 Q. And you talked about it yesterday.

25 And it says: Strips rounds note at 2:48.

1 This is authored by Nurse -- Nurse-Midwife Tamsin
2 Lewis. She put this note in at 2:48. And her note
3 starts with 15 minutes of fetal heart tracings and
4 plan of care review with the charge nurse, the
5 faculty nurse, midwife, Ms. Tamsin, and the chief
6 resident.

7 Do you see that?

8 A. That's what it says.

9 Q. And I think you told me in your deposition
10 something similar, a process like this does happen at
11 your hospital, right?

12 A. Yes.

13 Q. Okay. This is not unfamiliar. It's
14 something that hospitals, who have labor and delivery
15 departments, it's something that happens around the
16 country?

17 A. Yes. Ours is slightly different. We call
18 it the daily domino. We've done it a couple of
19 times --

20 Q. I remember domino.

21 A. Yeah.

22 In addition to change of shift report and
23 passing off from nights to days or days to nights,
24 the different disciplines: nurses, doctors,
25 midwives, residents, that type of thing, we don't

1 really sit down and look at the algorithms. There is
2 discussion as to what the patient was brought in for,
3 what risk factors she has, where she's at in her
4 stage, and discussion as to how long she's been
5 there, or what the tracing shows.

6 Q. Okay. And so this algorithm that was
7 applied by this team of three, the chief resident,
8 who's a physician, correct?

9 A. Correct.

10 Q. And then, if necessary, and then a nurse
11 midwife and the charge nurse. And you've acted in
12 that role?

13 A. Correct.

14 Q. The charge nurse is the supervisor of the
15 beside nurses for that shift, correct?

16 A. Correct.

17 Q. Okay. And you agree that when this is
18 pulled into the chart, that's them applying this
19 Clark algorithm for what they're doing at that time
20 of the day, correct?

21 A. Presumably.

22 Q. Okay. And it says: Category II fetal
23 heart rate tracing algorithm. And then it starts --
24 and we'll pull that -- in a minute I'll pull the
25 actual picture back up.

1 But the first question is: Moderate
2 variability or acceleration present?

3 And their answer was yes, correct?

4 A. That's what it says.

5 Q. Yes. And then the next question, so that
6 starts at the first box, and you will see the
7 algorithm in a second. Takes us to the left-hand
8 side.

9 And then the next question is:
10 significant decelerations with greater than or equal
11 to 50 percent of contractions for 60 minutes.

12 Do you see that? That's the next part of
13 the algorithm, correct?

14 A. I do.

15 Q. And their answer was no, correct?

16 A. That's what they said.

17 Q. And then back on the algorithm, we see it
18 again, drops down to the line that says "observe,"
19 correct?

20 A. That's what it says.

21 Q. Okay. And then from that, there's a
22 15-minute, they apply the algorithm with them looking
23 at an hour worth of strips, and the recommended
24 action is second stage and pushing, correct?

25 A. That's what it says.

1 Q. Okay. You disagree with what they
2 concluded, based on your review of the strips at this
3 time, correct?

4 A. And the recommended action.

5 Q. Yes.

6 A. Continuing pushing when, at this point in
7 time, we were about 11 hours to the second stage
8 looking like that.

9 Q. Okay. So at your deposition, Nurse Shinn,
10 I handed you a blank copy of fetal monitor strips and
11 asked you to help me understand your opinions in this
12 case.

13 Do you remember that?

14 A. Yes.

15 Q. And I only have one copy because this is
16 the original that was marked at your deposition.

17 For the purposes of trial, this is
18 referencing Exhibit E4-B. And I'm going to hand that
19 to you.

20 MS. KAMYKOWSKI: Okay. Justin, can you
21 please pull up that algorithm from page 2 of Exhibit
22 I16 again?

23 Q. (By Ms. Kamykowski) So I'll reference to
24 you -- what I'd like to do is go through the same
25 time period that that strip round team did at 2:48.

1 So it starts, if we talk about trying to apply this
2 algorithm to your retrospective review in this case,
3 that would take us back to an hour before, which
4 would be 1:48 p.m. on May 4th.

5 And we can start at page 168. And you are
6 welcome to take that clip off if that's easier for
7 you. I don't know how it is.

8 But before we get to that, going back to
9 the algorithm, as we saw with the strip review team,
10 they found at the top moderate variability or
11 acceleration.

12 Do you agree that at 2:48, based on your
13 review, at that hour or at that time, there was
14 moderate variability or accelerations?

15 A. I think there was both moderate and
16 minimal variability. But there are some points, as I
17 talked about during my deposition, that, depending on
18 where you isolate the baseline, there may be some
19 moderate variability during that hour of time.

20 Q. And if you tell me based on your review
21 here today, what do you see as the baseline in that
22 hour?

23 And if there's multiple baselines, let me
24 know, and then we can talk about that.

25 A. If we go back to page 167, the baseline is

1 right around 155 to 160.

2 Q. So hold on a second.

3 So now you're talking about one page. I

4 want you to do this like you would if you were a

5 bedside nurse, because we've already heard a baseline

6 is not 8 minutes, right?

7 A. That's correct.

8 Q. Right. So I would like for you to tell me

9 how you would have, if you were the bedside nurse,

10 how -- don't give me a page number -- just tell me

11 what the baseline is because you can't determine the

12 baseline based on 8 minutes, correct?

13 A. Well, you can't determine the baseline, if

14 we're doing the principles of interpretation. We

15 need 10 minutes of interpretable tracing, but at

16 least 2 minutes of identifiable baseline.

17 So, again, in 8 minutes, there may be, on

18 some patients, 2 minutes, but as we talked about,

19 this is a much different exercise than in realtime.

20 But what you just asked me was to look over the

21 course of an hour, which is not what the nurses were

22 doing in realtime. They would have looked at 30

23 minutes at a time for purposes of -- or 15 minutes

24 for the purposes of their interpretation. And you

25 also asked me if there was different baselines, due

1 to the different baselines.
2 So initially, at the beginning of that
3 hour, from roughly 1358, the baseline is around 155
4 to 160. It stays in that range until about 2:30 or
5 so, and then it's closer to 160 consistently. And
6 then it gets a little higher, but that's slightly
7 after the strip round, so somewhere in the
8 neighborhood of 155 to 160, over the course of this
9 hour.

10 Q. All right. And I'm going to block -- I
11 know, I'm sorry -- your view of the screen, but you
12 have the algorithm in paper form in front of you,
13 correct?

14 A. I do.

15 Q. Okay. I know we're sort of cramped in
16 this court room, so it's hard for me to do that.

17 And so we know what we're talking about
18 later, I'm going to write on this paper "Shinn."
19 Today's date is 3/13. Yep. And we'll do Category
20 III -- or Cat II algorithm, okay? we'll do 1:48 to
21 2:48.

22 okay. So we started with baseline of
23 what? 155 to 160?

24 A. Correct.

25 Q. And you said there are periods of moderate

1 and periods of minimal variability?

2 A. Correct.

3 Q. So you have both. Which side of the
4 algorithm do we start in?

5 A. Well, it depends on what the predominant
6 variability is in between the decelerations that are
7 present.

8 Q. Okay.

9 A. So, again, if you're looking at an entire
10 hour, which is typically the second stage of labor
11 longer than you would be looking at just for the
12 purposes of documentation. But, I mean, I would say
13 really it's about 50/50. Although, in this case, if
14 they were taking the best case scenario, saying
15 there's some moderate variability, then that would
16 start them on the left side of the algorithm.

17 Q. Okay. So -- but the next step, whether we
18 answer yes or no, is to determine whether there are
19 significant decelerations with greater than or equal
20 to 50 percent of contractions on the left side for an
21 hour, on the right side for 30 minutes, okay?

22 A. Correct.

23 Q. Okay. So let's start on the left side.

24 And I want you to assume for me that
25 there's moderate variability or accelerations, and

1 that's why we start over here, okay?

2 A. okay. we'll assume.

3 Q. okay. And now we're talking about this
4 60-minute period. And I've done this in advance, and
5 I'm going to let you do it with me.

6 MS. KAMYKOWSKI: Justin, can you pull up
7 Exhibit E4-B, starting at page 168.

8 Q. (By Ms. Kamykowski) Are you there on the
9 exhibit, Ms. Shinn?

10 A. I am.

11 Q. okay. Just to orient the jury, and I'll
12 move this, sorry, Ms. Shinn, move this out of your
13 way for a second.

14 MS. KAMYKOWSKI: Your Honor, may I just --
15 all the way over here.

16 Q. (By Ms. Kamykowski) You can see it up
17 there?

18 A. I can.

19 Q. And you have that exact page in front of
20 you, do you not?

21 A. I do.

22 Q. okay. So for the jury's purposes, the
23 circles, the numbers, and the handwriting that says
24 "Cat II," those are those markings you did when you
25 reviewed this case -- or these strips -- at your

deposition in October of 2023?

A. Correct.

Q. And we'll go back to this page in a second, but on the top, where the fetal heart rate is, you were circling what you identify as decelerations of the fetal heart rate.

A. Correct.

Q. And either a VD, which is you calling a variable deceleration?

A. Correct.

Q. Or an LD, as a late deceleration?

A. Correct.

MS. KAMYKOWSKI: If you go back one page for me, Justin.

Q. (By Ms. Kamykowski) This one started with a PD.

A. For prolonged --

Q. Prolonged decelerations, correct.

So those are three types of accelerations. There is another called an early, correct?

A. Correct.

Q. So if we happen to see an ED at this time frame, that would be early deceleration?

A. Correct.

Q. I can tell you, I don't think those exist.

1 I think these are the three categories that you have
2 identified, correct?

3 A. That is correct.

4 Q. Okay. So at the end of this page, page
5 167, starts at 1348, which would be exactly an hour
6 before the strip review, right?

7 A. That's the top.

8 Q. It's hard to see, but the 1:48 doesn't
9 start in this line like this. It's in the middle of
10 your prolonged deceleration, correct?

11 A. Correct.

12 Q. Okay. So let's first start -- the other
13 thing we started on that page, on the bottom on the
14 contraction side of things, at this time, I -- you
15 had started at 6:30 in the morning, counting
16 contractions that you saw, correct?

17 A. Correct.

18 Q. Do you remember doing that with me?

19 A. Yes.

20 Q. And at that time, the point of you
21 counting contractions was to show me your opinion
22 that her uterus was tachysystolic at times. That it
23 was contracting too frequently too close together,
24 correct?

25 A. which was likely the result of the decels,

1 yes.

2 Q. Okay. And so when we talk about the
3 algorithm, if we go back to that, it said: Are there
4 significant decelerations greater than or equal to
5 50 percent of the contractions over an hour period,
6 correct?

7 A. Correct.

8 Q. All right. So let's first start with
9 that. And we have to talk about how many
10 contractions. So let's do the number of contractions
11 in that hour. I'm going to put "CX" as contractions,
12 okay?

13 A. Okay.

14 Q. I counted them, and I'm going to let you
15 count them and see if you disagree with me.

16 On page 160, if we start at 167, right?

17 The contraction you marked, when does it end? Does
18 it end before 1:13:48?

19 A. The contraction actually starts to proceed
20 back to one of deceleration. So I think we can't
21 exclude that from the number of contractions. Again,
22 this being a much different exercise because when we
23 use the term "recurrent," we're looking at a
24 20-minute period of time, not an hour.

25 Q. We're going to apply the algorithm, and if

1 you want to talk about it later with Ms. Gunn, you
2 can, okay? This is the exercise I'd like to do at
3 this point.

4 A. Okay.

5 Q. So because the algorithm is what the
6 nurses did at that time, and you disagreed with that.

7 So -- all right. Starting on page 168,
8 let's count the contractions.

9 Next page. All right. So we have, on the
10 left-hand side you were, again, you were trying to
11 count up how many contractions in 30 minutes were in
12 the middle of a 30-minute period. So it's not going
13 to start with one, but we have one reference to
14 eleven. So if you look at your handwritten or this
15 page 168, I count four contractions, right?

16 A. Sorry. I was counting ahead.

17 Yes. There are four.

18 Q. Okay. Let's go to the next page.

19 Four more on here: 15, 16, 1 and then a 2
20 in the grid, right?

21 A. Correct.

22 Q. Page 170. Four more.

23 Do you see that?

24 A. I do.

25 Q. Okay. Page 171?

A. An additional four.

Q. All right. And I want to note that around this time, the end of this page, it's 1421. That's 2:21, correct?

A. Correct.

Q. And at this point in time, Dr. McNeive is in the room with the nurses at the bedside. He has been since -- this is the last -- two o'clock, right?

A. I believe that's roughly correct.

Q. And at this point in time, he is ordering additional Pitocin, correct?

A. He did.

Q. Okay. Go to the next page at 172. Another four contractions on this page?

A. Correct.

Q. Page 173.

A. An additional four.

Q. Page 174?

A. 5.

Q. And then if we get to 175, as long as we're in that hour before the next -- the first 2 minutes, how many do we count?

A. Two.

Q. All right. So I'm leaving this here. I had to do it before I got here because I'm real bad

1 at math. But I counted up the total contractions

2 that you counted in this hour are 32.

3 Do you agree with that?

4 A. I think it would have probably been easier
5 to just count along, but I can see your math. But if
6 the math it correct, then...

7 Q. 6 times 4 is 24.

8 A. Correct.

9 Q. Plus 5 is 29 -- oh, 30, 31. Maybe I
10 counted the first one.

11 Again -- okay. Now, we got to talk about
12 contractions, right? We're applying the algorithm.
13 We've got the number of contractions. And we're
14 trying to see if there are significant decelerations
15 greater than 50 percent of them, right?

16 A. Correct.

17 Q. So let's go back and look at -- starting
18 back at page 168. And I'm going to do this so we
19 know what we're doing later when we look at this.

20 I'm going to put a "P" for prolonged, a "V" for
21 variable, and an "L" for late, okay?

22 A. Okay.

23 Q. And I will tally these because tallies are
24 easier than numbers.

25 okay. So if we look here at page 168,

1 because we start in the middle of a prolonged, we're
2 going to count that as a prolonged, okay?

3 A. Okay.

4 Q. All right. And then we have one variable
5 and two late, is that correct?

6 A. Correct.

7 Q. Okay.

8 MS. KAMYKOWSKI: The next page, Justin.

9 Q. (By Ms. Kamykowski) Question: decels.
10 when I asked you about that in your
11 deposition, you're like I don't know if I would call
12 it. It may or may not be mom's heart rate.

13 But do we include that, or do we not?

14 A. I don't think there's enough information
15 to quantify it as one versus the other. So that's
16 why I said it's a possible decel, but I wouldn't be
17 able to assign a name.

18 Q. Okay. So I'll note on this part -- so the
19 other two are late, correct? Right?

20 A. Correct.

21 Q. And we don't know what that may or may
22 not.

23 All right. Page 170. we have one late,
24 right?

25 A. Correct.

1 Q. One prolonged?

2 A. Correct.

3 Q. And one variable?

4 A. Correct.

5 Q. Page 171.

6 we have one prolonged and one variable?

7 A. Correct.

8 Q. Page 72.

9 we have two variables?

10 A. Correct.

11 Q. Page 73.

12 One prolonged?

13 A. Correct.

14 Q. And, again, these are correlating to those

15 flow sheets that you went through with Ms. Gunn

16 yesterday where it was decelerations were noted by

17 the nurses throughout various time frames, right?

18 A. Correct.

19 Q. Okay. So page 173.

20 we've got one prolonged.

21 Let's go to page 174.

22 we have three lates and one variable?

23 A. Correct.

24 Q. And 175 for the first 2 minutes. You have

25 VD/LD, correct?

1 A. Correct.

2 Q. So one deceleration.

3 As you look at it now, can you decide
4 which it is?

5 A. No. Because it spans over the page. So
6 from the prior page. So initially, when I called it
7 as a variable because it appears to be abrupt, but
8 the lowest point of the deceleration, which is how we
9 determine whether it's gradual or abrupt, seems to be
10 longer than 30 seconds and is on the next page, and
11 it certainly is late in recovery.

12 So I think it would not be wrong to call
13 it either one of those. I wouldn't argue with
14 someone because there seems to be a physiologic
15 component of both a late and a variable in that same
16 type of decel.

17 Q. Okay. Well, just to make sure that I'm
18 not shortchanging you, I'll call that a late, okay?

19 A. Okay.

20 Q. Though it could be either.

21 All right. So three prolonged -- I feel
22 like a teacher -- six variables, and nine lates.

23 That's 15, right? Sorry, 18.

24 A. There you go.

25 Q. But first --

1 A. I'm not good at math.

2 Q. -- let's talk about some more
3 qualifications within the algorithms, specifically as
4 it talks about what variable decelerations are, okay?

5 A. Okay.

6 MS. KAMYKOWSKI: So if you'd pull back up
7 I13, page 3, please.

8 And clarification No. 3. Can you blow
9 that up, the next page -- or on the bottom, yeah --
10 clarification No. 3.

11 Q. (By Ms. Kamykowski) So, again, the start
12 of the algorithm says you have to have significant
13 decelerations greater than or equal to 50 percent of
14 the time -- 50 percent of the contractions over an
15 hour. And now it further is telling us what they
16 need by significant decelerations, okay? Right?

17 A. Right.

18 Q. So it says -- I want to do the second
19 bullet point -- well, let's start at the bottom.

20 Any prolonged, right? It says any
21 prolonged.

22 A. Correct.

23 Q. So we're counting those.

24 And then above that, it's any lates of any
25 depths.

1 And we counted that, including one that
2 you said could be either a late or a variable, right?

3 A. Correct.

4 Q. Okay. Then these other two continuing to
5 go up.

6 So variable decelerations lasting longer
7 than 60 seconds -- so I have to go a whole minute --
8 and reaching the nadir less than 60 beats per minute,
9 regardless of the baseline.

10 There are no variable decelerations you
11 called in that hour that the nadir, meaning the
12 bottom, the peak of the trough of that heart rate,
13 was below 60 beats per minute, correct?

14 A. Correct.

15 Q. Okay. So now we're talking about are
16 there variable decelerations lasting longer than
17 60 seconds, and reaching a nadir more than 60 beats
18 per minute below the baseline.

19 I don't believe that any of those exists
20 in what we just looked at, but I'd be happy to have
21 you look at it.

22 And, again, that means we're talking about
23 if 60 beats per minute from this baseline, we have to
24 have a spot on those strips that would be either
25 below a hundred or below 95 at the nadir.

1 A. Correct.

2 Q. Okay.

3 A. So, again, if you look at page -- we can
4 just go by page-by-page as I see these --

5 Q. Hold on a second. Let's get it up.

6 A. Okay.

7 Q. Pull up --

8 A. 168? So I'm looking at, I said the
9 baseline is around 160 beats at that point, somewhere
10 between 155 and 160 on this particular page. The
11 second decel, the first full one on that page that's
12 marked VD --

13 Q. Hold on. This one right here?

14 A. Correct.

15 Q. Okay.

16 A. That one, even though the baseline is not
17 up to 170, where you see the fetal heart rate drop
18 from is 170. So, again, there's some subjectivity in
19 how you interpret whether or not the -- it's dropping
20 by 60 beats.

21 If the heart rate was at 170, and now it's
22 down to a hundred, that particular variable does in
23 fact drop at least 60 beats. It doesn't drop down to
24 or below 60 beats.

25 Q. Nurse Shinn, I started this by asking you

1 to give me the baseline. You gave me the baseline,
2 not as transient heart rate of 170, you gave me the
3 baseline, which is what the algorithm requires you
4 assess --

5 A. Correct.

6 Q. -- of 155 to 160.

7 So with that definition that you gave me,
8 not looking at a transient rise, you told me the
9 baseline in this whole time frame never used 170.

10 You said 155 to 160.

11 Are you changing that now?

12 A. No.

13 Q. Okay.

14 A. I'm not changing that --

15 Q. So this --

16 A. Can I --

17 Q. No. If the baseline that you told us is
18 accurate, 155 to 160, none of the variables you
19 called meet the Clark definition of a significant
20 deceleration.

21 A. Of that particular algorithm, I believe
22 that that is correct.

23 Q. Okay.

24 A. There may be one on page 172 that does
25 because the baseline, I said, was 160, and it does

1 drop down to a hundred at the nadir. The rest of
2 them, of the ones that are variables, probably don't
3 meet that definition.

4 Q. Okay. So I'll give you one, just to make
5 sure I'm not being unfair.

6 So rather than 18, we have 9 lates that
7 the possible late/variable -- but we'll give it --
8 one potential, if you say the baseline is 160, of a
9 significant deceleration that meets the definition of
10 a variable, and three prolonged. So that's 13. So
11 if we take 31 contractions, divided by 13, that is
12 not greater than or equal to, it's less than
13 50 percent, right?

14 A. Correct.

15 Q. And so based on your review and these
16 Clark definitions that have been adopted by ACOG and
17 then adopted by your group, AWHONN, your own
18 retrospective review of 2:48 -- 1:48 to 2:48 -- of
19 this labor, this algorithm recommends observe, right?

20 A. If you're just using the algorithm to take
21 care of the patient, yes.

22 Q. Okay. Now, the algorithm also, on the
23 clarifications reviews, says I think you're supposed
24 to then if you stay in Category II, reapply it every
25 half an hour, right?

1 A. That's what it says.

2 Q. Okay. Now, I'm not going to do the
3 same -- you have the strips, we're not going to go
4 through this exact same exercise, but I did it for
5 the next half an hour, which would take us starting
6 at 3:18 to 2:18, right? We stopped at 2:48, plus a
7 half an hour is 3:18, right?

8 A. Correct.

9 Q. And I reviewed Exhibit E4-B, which is
10 yours. And I counted, oh, first of all, let me ask
11 you this first. I want you to look at that again and
12 now tell me what the heart rate is.

13 Is it still in the 150 to 160 baseline? I
14 think at this time the nurses are saying it's about
15 160.

16 A. Yes. As I said, it starts to go up just
17 after that last segment we looked at. So it's 160,
18 and there's some pages where it's a little above
19 that.

20 Q. Okay. So we're going to go through the
21 nadir again of the significant decelerations
22 characterized by variables. We have to be below a
23 hundred -- well, 100 to 105, right?

24 A. If we're just using the baseline, yes.

25 Q. Okay. So I counted up your contractions

1 and did 2:18 to 3:18 -- and I got 38. we talk about
2 the decels. Again, we'll do prolonged, variable, and
3 late. I counted no lates -- I'm sorry, that's
4 wrong -- 2 prolonged, 12 lates, and 7 variables that
5 you labeled. And, again, so that's 14 plus 7 is 21,
6 right?

7 A. Correct.

8 Q. But if we look at the definition -- if our
9 baseline heart rate is 160, there are no nadirs below
10 60 beats per minute. So we take that off the
11 algorithm. We're talking about anything that's less
12 than a hundred that's for 60 seconds or longer, none
13 appear again?

14 A. There's actually two -- I'm sorry -- that
15 one is a late deceleration. But I think there was
16 one variable that does meet that criteria that drops
17 down to a nadir of a hundred. So it's not that it
18 has to be at the nadir for greater than 60 seconds.
19 The duration of the decel from where it drops to
20 where it finally recovers back to baseline, that
21 duration has to be 60 seconds.

22 Q. Well, it says variable decelerations
23 lasting longer than 60 seconds and reaching a nadir
24 more than 60 beats per minute below the baseline. So
25 if they just hit the hundred, it's not more than 60

1 beats based on the 160, right?

2 A. If it's 160, 165, it would be.

3 Q. Well, we'll give you one, okay? So
4 instead of 21, now we have 15. So if we take 38
5 divided by 15, still not more than 50 percent, right?

6 A. No.

7 Q. And the algorithm says observe?

8 A. If you're using the algorithm to care for
9 this patient, yes.

10 Q. Okay. Let's do it one more time.
11 This is the last half an hour. So if we
12 go from -- let's see. Start from the very
13 beginning -- because I'm real bad at this -- start at
14 3:48 and go back 2:48. So this is right after the
15 strip review folks have finished applying the
16 algorithm based on their review. We've done it now
17 another half an hour, which is what it says to do.
18 We're going to do it again, okay?

19 In that time frame, 2:48 to 3:48, what's
20 the baseline heart rate?

21 A. Around 160. Around 155 to 160. Some
22 pages it's a little higher, but for the most part, I
23 would say that's the average.

24 Q. Okay. So somewhere if we're talking again
25 about what's a significant variable deceleration,

1 we've got to get to below a hundred, below 95, right?

2 A. Correct.

3 Q. Okay. And I counted them up again. And I
4 counted 37 contractions: 16 late decelerations, 1
5 prolonged, and 7 variables to start. So that's 24.

6 And, again, I didn't see any of those
7 variables that meet the definition that Clark

8 included in the algorithm clarification as
9 significant. Nothing that would have dropped below a
10 hundred or below 95.

11 Do you agree?

12 A. Yes.

13 Q. So 17? Is that right?

14 So now we get to 17.

15 So we've got 37 contractions, divided by
16 17 significant decelerations, again, less than 50
17 percent of the time, the algorithm says observe,

18 right?

19 A. If you're using the algorithm to care for
20 this woman, yes.

21 Q. And now that takes us all the way to 12
22 minutes before four o'clock.

23 He's born at 4:24, correct?

24 A. Correct.

25 Q. And after this time, is when I think you

1 first say Category III because now we have
2 tachycardia, and we're getting the minimum
3 variability.

4 Dr. McNeive recognized that and moved
5 forward to effectuate delivery in the next 40
6 minutes -- 35 minutes.

7 A. I mean, the tachycardia has nothing to do
8 with Category III. It just happens to be another
9 abnormal finding that the baby's heart rate has risen
10 in that way. It's the absent variability with the
11 presence of recurrent decels. That's what makes it
12 Category III by definition. But, yes, the
13 spontaneous vaginal delivery did occur within 30
14 minutes of it becoming Category III.

15 Q. Okay.

16 MS. KAMYKOWSKI: We can be done with this
17 exhibit.

18 Now, to move on, can you pull --

19 Q. (By Ms. Kamykowski) Let's talk about the
20 Mercy's policies that you talked about yesterday,
21 right?

22 A. The protocol?

23 Q. The vaginal birth protocol, that, in your
24 deposition, you talked to me at length about a
25 written policy.

1 Do you remember that?

2 A. Yes. There's both a separate and a
3 protocol that's embedded in the records.

4 Q. And we -- we're going to look at both.
5 But I'm going to hand you --

6 MS. KAMYKOWSKI: May I approach, Your
7 Honor?

8 THE COURT: You may.

9 Q. (By Ms. Kamykowski) -- what's been marked
10 as Exhibit G1.

11 You recognize that as part of the
12 documents you reviewed in this case?

13 A. Yes.

14 Q. And we talked about it pretty extensively
15 at your deposition.

16 Do you remember that?

17 A. Yes.

18 Q. We didn't talk about it yesterday, did we?

19 A. No.

20 Q. Okay. You remember from this morning
21 earlier, when you were going through your

22 communications with Ms. Lenivy's office, your first
23 opinions back in either, it was like either late
24 December or early January, 2021/2022, that first
25 note.

1 MS. KAMYKOWSKI: And it's, Justin, it's
2 Exhibit E4-H, page 7, I believe. Not 7, maybe 3.
3 Page 3.

4 Q. (By Ms. Kamykowski) At the top, do you
5 remember sending this with your initial opinions
6 after you haven't had a chance to fully review the
7 case, but you said: I haven't gotten through all of
8 the records, but I can tell you there appears to be
9 tachysystole from approximately 2:30 in the morning
10 through delivery, correct?

11 A. Yes.

12 Q. And we talked about that at your
13 deposition, and that's why I had you show me what you
14 meant, right?

15 A. Correct.

16 Q. And so starting -- and we started because
17 by the time I was there taking your deposition, you
18 no longer had opinions critical of anyone who was
19 providing care from 2:30 in the morning until Jessie
20 and Maggie came on duty, correct?

21 A. Because the tracing was reassuring at that
22 time, yes.

23 Q. And there -- but there was, as you saw it,
24 uterine tachysystole. Too many contractions in too
25 short a period of time, right?

1 A. Yes. Not consistently. There are some
2 places, because of the type of monitoring, it's
3 difficult to ascertain how many contractions, but
4 that was the first place that I saw it. And then
5 there were other places throughout.

6 And so you had asked me to do the exercise
7 of numbering the contractions 30-minute segments, to
8 determine if there was or wasn't tachysystole.

9 Q. But to shorten things at your deposition,
10 because you told me at the very beginning you no
11 longer had criticisms of the care provided before
12 7:00 a.m., we started that exercise of me saying:
13 Nurse Shinn, please tell me where you see
14 tachysystole, meaning too many contractions.

15 And I want to make sure that the jury
16 understands what AWHONN and ACOG define as
17 tachysystole. And does that -- can you tell us how
18 you teach your nurses how to define tachysystole:
19 number of contractions over a period of time.

20 A. Sure. So in a 30-minute segment, we would
21 count up how many contractions are there. If there
22 are more than 5 in 10 minutes, averaged over 30
23 minutes, then it meets the definition clinically of
24 tachysystole, or too many contractions.

25 The concern is that as the contractions

1 increase in frequency, so we're not even talking
2 about strength or the resting time or the resting
3 tone, just the number of contractions, that that
4 allows for less time of reperfusion in between in
5 that intervillous space, where those tiny, little
6 blood vessels we talked about yesterday, where the
7 baby is able to recycle and get the reoxygenated
8 blood.

9 If they get close together, that's the
10 concern. So when there are places that there are too
11 many contractions, and so just for the sake of math,
12 since we're doing a lot of math today, if there are
13 16 in 30 minutes, we've met that definition, even if
14 there's only 5 in the first 10 and 5 in the second
15 10.

16 If, for that 30-minute segment that the
17 nurse is evaluating, there's more than 15 total, that
18 meets the definition. So there are interventions
19 that can be done like position changes, fluid bolus,
20 a reduction or cessation of Pitocin, so that those
21 contractions will space out and allow better
22 perfusion for the baby.

23 Q. And so your initial opinion in this case
24 back in December of 2021, was that you thought there
25 appeared to be tachysystole from approximately 2:30

1 in the morning through delivery, correct?

2 A. Correct.

3 Q. Okay. And in your deposition, when we --

4 because I focused on that -- because I've had cases

5 where tachysystole is a huge component of the driving

6 claim in the case, I needed to know what your

7 opinions were, and you told me that you would

8 disagree with anyone who didn't see tachysystole

9 during that time frame, meaning from 2:30 in the

10 morning until delivery, correct?

11 A. I don't think I said from the entirety. I

12 think actually the verbiage I used was that it noted

13 first around 2:20 or 2:30 in the morning, and

14 intermittently it was noted throughout the rest of

15 the time until she was delivered.

16 And there certainly, as we just did your

17 math exercise, places in a one-hour window of time

18 where there are 37 or 38 contractions, that,

19 mathematically speaking, would have met the

20 definition of too many in a 30-minute period of time.

21 Q. But at least back when you were working

22 under Ms. Lenivy's deadline to help get your report

23 to her so she could file an affidavit in this court

24 asserting that she had meritorious claims against my

25 client, you believe that there was tachysystole from

1 approximately 2:30 in the morning through delivery,
2 correct?

3 A. Yes.

4 Q. Okay.

5 A. As you can see, it doesn't clarify to
6 which nurses to whom I may have had opinions or
7 whether it was consistent or not consistent. It was
8 a general synopsis. And I let her know I would
9 complete my review, and then we would talk about my
10 actual opinions.

11 Q. All right. And then I took your
12 deposition in 2023, which is the way that the law
13 allows us to discover opinions of experts in
14 Missouri. I'm not allowed to learn -- then you don't
15 have to do a report, like you did, but that's the
16 time frame I get to ask you all of your opinions.

17 And at that point in time, you told me
18 that there was -- we went through the strips -- and
19 you told me the times where you believed tachysystole
20 existed. And that formed a basis, not all of them,
21 but a basis for your criticisms of Nurse Maggie and
22 Nurse Jessie, correct?

23 A. Correct.

24 Q. Yesterday you sat back there, where Dr.
25 warsof is right now, listening to my opening

1 statement.

2 Did you not?

3 A. I did.

4 Q. And you heard me tell this jury in opening
5 that you were the only witness they would hear from
6 that would say there was tachysystole on those fetal
7 heart patterns.

8 Did you not?

9 A. I heard you say that.

10 Q. And then I said, because I wasn't sure
11 what might happen once you were sworn in to give
12 testimony here today and yesterday, maybe you
13 wouldn't.

14 Did you hear me tell them that, too?

15 A. I did.

16 Q. And then you didn't yesterday use the word
17 "tachysystole" one time, did you?

18 A. We actually didn't talk about the
19 contraction pattern at all yesterday in direct. So
20 I'm not a lawyer. I'm not sure how far I can expand
21 out of the questioning I'm being asked. But, no, I
22 was not asked specifically whether there was
23 tachysystole present. I marked an exhibit. We've
24 talked about it today. I've certainly talked about
25 it today. So I'm not sure exactly what your question

1 is or if that's just commentary.

2 Q. My question is when Ms. Gunn gave --
3 directed your examination yesterday, and she elicited
4 the opinions upon which this Court will instruct the
5 jury as to bases of potential negligence against
6 Nurse Jessie and Nurse Maggie, you did not offer that
7 tachysystole was included in any part of those
8 opinions, correct?

9 A. I did not use the word "tachysystole." I
10 believe what I said was there are times in which the
11 contractions were too close together or too many. I
12 did not use the term "tachysystole."

13 Q. You actually never even said that, Nurse
14 Shinn, but we'll let the jury remember what you said.

15 And then rather than -- and we're going to
16 talk about Exhibit G1 -- talk about Exhibit G1, which
17 was the basis of your opinion in your deposition that
18 my nurses violated the Mercy policy on augmentation
19 of labor with Pitocin, you didn't even talk about
20 that policy, did you?

21 A. It was not brought up yesterday.

22 Q. Okay. Instead you focussed on -- and
23 let's start --

24 MS. KAMYKOWSKI: Take that one down,
25 Justin. I'm going to go back what we did focus on on

1 direct.

2 Q. (By Ms. Kamykowski) Exhibit A2, page 102.

3 what you were asked by Ms. Gunn yesterday
4 about this protocol -- and let me ask you this: This
5 is the system here that Mercy utilizes for electronic
6 medical records. It's called Epic.

7 You understand that, correct?

8 A. Yes. We use Epic at Ohio State.

9 Q. Okay. And what you said yesterday is --

10 MS. KAMYKOWSKI: Justin, can you go back
11 those two pages so we can see the very beginning.

12 Okay.

13 Q. (By Ms. Kamykowski) At the bottom of page
14 100, STLLD Vaginal Birth Protocol, Mercy Hospital,
15 St. Louis.

16 You see that, correct?

17 A. I do.

18 Q. And what you told us yesterday is that's a
19 standing order. So any patient who comes in who they
20 think is going to have at least a trial of labor to
21 attempt a vaginal delivery, standing order gets
22 pulled in when they get admitted, right?

23 A. That's part of an order set.

24 Q. Okay.

25 MS. KAMYKOWSKI: So then go back to page

1 102.

2 Q. (By Ms. Kamykowski) So yesterday, in
3 concluding that my nurses violated the Mercy policy
4 or protocol, you based that on intrauterine
5 resuscitation.

6 Do you remember that?

7 A. Yes.

8 Q. When I took your deposition, that was not
9 the basis of your opinion. In fact, your opinion at
10 your deposition --

11 MS. KAMYKOWSKI: Keep going down, Justin.
12 Stop. Go back up. Right there.

13 Q. (By Ms. Kamykowski) -- was focussed
14 solely on treatment of tachysystole indeterminant
15 Category II or abnormal Category III fetal heart rate
16 pattern.

17 Do you remember the hours we spent
18 discussing that at your deposition?

19 A. I remember it was a long deposition. And
20 we discussed both the protocol and this separate
21 policy, which one speaks to just tachysystole, and
22 the other one speaks to management of Category II and
23 Category III in the absence of tachysystole.

24 Q. Which one speaks to what?

25 A. Well, this separate Mercy policy speaks

1 more to tachysystole and what the nurse is supposed
2 to do when Pitocin is being administered for
3 induction or augmentation.

4 This order set or protocol, that is in the
5 medical records themselves, speaks to -- to both.
6 There's a section that speaks to just Category II or
7 III, what the nurse will do, and also gives them some
8 direction -- what you have highlighted -- of when
9 there is also tachysystole present. That portion of
10 tachysystole mirrors this separate Mercy policy, G1.

11 Q. We're going to -- I'm going to show them
12 here in just a second. And it does, it says exactly,
13 you're correct, G1, when we see it, we're going to
14 find it.

15 But in the medical records that pulls in
16 what this order says, when I deposed you to get your
17 opinions in this case, you focussed on the section
18 that had treatment of tachysystole because, as you
19 said, as far back as December of 2021, that was a
20 first basis of your opinions against the nurses in
21 this case, correct?

22 A. I gave a synopsis in an email. That was
23 not a list of opinions to whom or to when or to what
24 they applied to. I said, there appears to be
25 tachysystole. That was, again, a part of a synopsis

1 in an email exchange. That was not my discussion
2 with the attorney.

3 Q. Well, we'll never know that because it
4 wasn't recorded.

5 But the indeterminant -- the policy that
6 you told me about for hours at your deposition,
7 indeterminant Category II, what you told me was this,
8 they violated this policy because it says: First
9 discontinue oxytocin. That was your opinion at your
10 deposition, correct?

11 A. I believe so.

12 Q. And that was where you said, oh, my gosh.

13 I can't believe these nurses did that. And then we
14 went through the rest of them, and you had to admit
15 that they did do maternal repositioning. But you
16 believed, based on the wording and order of this part
17 of this order set, that Mercy's policy demands when
18 there's tachysystole, that you turn off the oxytocin,
19 right? That's what you told me in your depo. You
20 did not offer that opinion yesterday. You did not
21 offer an opinion at all about tachysystole, correct?

22 A. I don't think the term "tachysystole" came
23 up yesterday.

24 Q. All right. Instead, you went to the top.
25 And that's where you talked about "go big or go

1 home," you know, do it in a bundle. We all heard
2 that yesterday. And you believe that this
3 intrauterine resuscitation nursing communication
4 order required, as it says, all you were read and all
5 you talked about yesterday was will be initiated.
6 You didn't read the qualifier of based on the
7 maternal-fetal response. So the policy mandates
8 initiation of the following measures based on
9 maternal-fetal response, correct?

10 A. That's what it says.

11 Q. And it starts with lateral positioning,
12 which, as we just went through, your group, AWHONN,
13 says that is oftentimes what you start with, and it
14 oftentimes resolves it, correct?

15 A. It doesn't say oftentimes it resolves it.
16 It says oftentimes that is the first because it is
17 the easiest to perform. We don't have to mess with
18 the pump. We don't have to do an exam. We don't
19 have to get an oxygen mask. That's why it's looked
20 to first.

21 Q. All right. But your opinion here at
22 8:00 a.m., keeping the Pitocin running at 18
23 microunits, was a breach of the standard of care
24 because it was a breach of this policy, correct?

25 A. Both portions of it, yes.

1 Q. All right. Well, we're going to go look
2 at that.

3 MS. KAMYKOWSKI: Let's pull up G1. It's
4 page 4, Justin.

5 Q. (By Ms. Kamykowski) This policy defines
6 tachysystole, correct? And that's consistent with
7 your understanding of what it is. It actually cites
8 to AWHONN and ACOG.

9 A. Just looking for the actual definition.

10 Yes. On page 4 of 6, they define
11 tachysystole, and they actually include these other
12 conditions that AWHONN recognizes but ACOG does not.

13 So contractions that are especially long or 2 minutes
14 or longer. Normal duration, but within one minute of
15 each other. So not allow for sufficient rest.

16 Insufficient return of resting tone, so
17 high tone. And then it gives some qualifiers as to
18 whether it's by palpation or with an internal
19 catheter.

20 Q. You don't disagree with what Mercy policy
21 identifies as a tachysystole?

22 A. No. I think it's entirely accurate
23 because all of those conditions have the potential to
24 deplete fetal reserve, whether it's too many, too
25 long, too close together.

Q. All right.

MS. KAMYKOWSKI: Back out of that, Justin.

Q. (By Ms. Kamykowski) And right under that it says: Clinical interventions to resolve tachysystole, may be initiated at the discretion of a labor nurse.

It says that, right?

A. That's what it says.

Q. And you agree with that, correct?

A. I mean, which they choose to do first or which order of things, I think that is at the discretion of the labor nurse. I think the standard of care requires tachysystole to be resolved because of the implications we know it can cause to the baby. And, certainly, if a tracing is not normal, that's even more reason that a nurse would do it, not just consider it.

Q. Okay. And then if you keep going down, the next part, the potential clinical interventions, and the first one is for oxytocin-induced tachysystole during normal Category I. And then potential clinical interventions for oxytocin-induced tachysystole during intermediate or Category II or abnormal Category III.

Those are the ones you say were pulled in

1 or identical in the vaginal birth protocol within the
2 medical record, correct?

3 A. For the tachysystole portion, yes.

4 Q. Correct.

5 And then you told me that policy, and
6 that's why you focused on it in your deposition, only
7 addresses potential interventions for tachysystole
8 for oxytocin-induced tachysystole.

9 That's what you just told me maybe 5
10 minutes ago.

11 Do you remember that?

12 A. Yes.

13 Q. So let's keep going.

14 How about the bottom here? Indeterminant
15 Category II/abnormal Category III fetal status, and
16 then it goes onto the next page.

17 Mercy's policy for when there is a
18 category II, which you apparently didn't read or
19 didn't understand existed says: Identification of
20 indeterminant Category II/abnormal Category III fetal
21 status requires two things: notification of the
22 physician and documentation in the medical records of
23 interventions to resolve the clinical situation.

24 Do you see that now?

25 A. I certainly see that. I saw it at the

1 time. And other than the times that Dr. McNeive came
2 to the bedside on his own volition, she was -- the
3 nurses did not ever request his presence or have a
4 separate conversation about the Category II status.

5 And, in fact, the fact that much of their
6 documentation, which I'm not even critical of, that
7 they documented three or 4 hours later, if he had
8 gone to the medical records and reviewed what they
9 were documenting and what their interpretation was,
10 it wouldn't have been in there timely for him to
11 review it.

12 Q. You -- we'll let the jury hear from Dr.
13 McNeive and the nurses about their communication.
14 But if the jury hears later that Dr. McNeive was
15 aware that Sarah labored in and out of Category II
16 all day on May 4th of 2020, that part of the policy
17 is met. He was notified. He knew himself, correct?

18 A. There is some different implication
19 between a nurse -- this is the nursing policy -- a
20 nurse requiring notification of the physician
21 documenting his medical record versus he was aware
22 because he was looking at the strip independently.

23 So I'm not saying he wasn't aware. What
24 I'm saying is if we're looking at this policy, what
25 the language says, and words matter, it says the

1 nurses are required to notify the physician. That is
2 not the same as him being aware generally of what the
3 status of this patient or the status of the fetal
4 tracing are.

5 Q. we'll come back to that in just a second.

6 I don't disagree with you on that. I think that's
7 exactly what it says: Requires notification of the
8 physician. I get that. So your belief is that there

9 was not notification from Jessie or Maggie, either
10 orally or in the chart, for Dr. McNeive to understand
11 that Sarah Anyan was in Category II, correct?

12 A. Consistently based on their documentation,
13 and having a conference or advocacy about what was
14 going on with the second stage in relation to the
15 tracing, what they were seeing, what interventions
16 they had or had not done, correct.

17 Q. All right. And then the second thing that
18 the nurses have to do to meet Mercy's policy when
19 there is a Category II fetal heart rate tracing is
20 document in the medical records interventions they
21 did to resolve them.

22 They did document their interventions. I
23 know you disagree with what those interventions did,
24 how frequently they did them, or other ones that you
25 believe the standard of care required them to do, but

1 will you give me that they did document in the
2 medical records their intervention?

3 A. Their position changes, yes.

4 Q. Okay. Going back to the notification.
5 what the plaintiff has to prove in this case, is that
6 a breach of the standard of care from you caused or
7 contributed to cause damage to Remi, okay?

8 A. Do you mean Nurses Maggie and Jessie?

9 Q. Yes.
10 what the plaintiff has to prove is that
11 the nurses, the breaches of the standard of care that
12 you offer in this case, the opinions you hold --

13 A. Correct.

14 Q. -- caused or contributed to cause damage
15 to Remi, right?

16 You understand that to be true?

17 A. I do.

18 Q. Okay. You believe that if they did not
19 notify Dr. McNeive, that's a breach of the standard
20 of care and a violation of this policy, right?

21 A. Correct. And it's not just notifying.

22 It's not a matter of just disseminating the
23 information. And just so you know, it's Category II,
24 it's advocating because it was still Category 2, and
25 what they were documenting was their own

1 interpretation, etc.

2 Q. I'm not trying to say you don't -- you're
3 not going to give an opinion that says you're
4 critical of them not advocating. I heard that
5 yesterday.

6 You had an opinion that they violated this
7 policy, and that caused harm in this case.

8 If Dr. McNeive knew this was in Category
9 II, then not telling him or not notifying him in the
10 appropriate way that you believe was required, did
11 not, could not, have caused any damage to Remi,
12 correct?

13 A. The absence of notification, no.

14 Q. All right. Now, we've talked a lot about
15 whether or not this policy, the protocol in the
16 chart, is -- has been violated in this case.

17 You didn't talk to me, like I said, at
18 your deposition about the policy and any violation of
19 the policy or the protocol simply for Category II
20 tracings. That was something you focussed on here
21 yesterday with Ms. Gunn.

22 what we talked about was violations of the
23 policy when there's oxytocin-induced tachysystole.

24 You would agree with that, correct?

25 A. I recall that we did talk about the

1 Category II tracing, what was required under the
2 standard of care. And that was consistent with the
3 protocol. we did spend quite a bit of time talking
4 about tachysystole and this policy, you are correct.

5 Q. Your whole opinion was based on
6 tachysystole.

7 And I'm going to pull up -- do you
8 remember giving your deposition, Ms. Shinn?

9 A. From a year and a half ago, not
10 specifically.

11 Q. Let me hand you a copy of this.

12 Let's mark this for the record with

13 Exhibit E4. And let's look at page 84, starting at
14 line 22.

15 MS. KAMYKOWSKI: Can you pull that up,
16 please, Justin. We're going to go through page 86,
17 line 14.

18 Q. (By Ms. Kamykowski) So when I deposed
19 you, this was this many pages in. And we're on page
20 84. we have been talking about tachysystole and the
21 policy for a very long time. And I asked you this
22 question, Nurse Shinn:

23 other than the tachysystole that you
24 believed existed in that -- in this initial time
25 frame from, I think you started at 6:30 to 7:30,

1 what -- and you said: If the baby looks fine, what
2 about the baby during that? His heart rate at that
3 time doesn't look fine.

4 And your answer was: I mean, we are
5 talking about Category II tracings -- I think this
6 might be a typo. It probably meant indeterminant not
7 and determinant.

8 A. Correct.

9 Q. Okay. And an indeterminant tracing is not
10 Category III until later, but there had been
11 decelerations, mild variables that occurred at that
12 time. I didn't just take the task. My opinions were
13 not about the night shift nurses. We've already
14 established that.

15 So there are decelerations that precede
16 their shift that is Category II. There are also
17 periods of tachysystole which have been identified in
18 the manner that I have identified them, and the
19 Pitocin is continuing. So, you know, the policy in
20 this case is written really well.

21 I'm going to stop there. When you
22 reference the policy in this long answer, that is
23 policy that I have marked as Exhibit G1, correct?

24 A. Yes. And because I just referenced
25 tachysystole in part of that answer.

1 Q. Right.

2 And then so you say: The policy in this
3 case is written really well. It is consistent in its
4 verbiage with the -- what the standard of care would
5 be. So by proxy, if the nurses follow their own
6 policy, then they would have, by default, been
7 following the standard of care.

8 And this is where you bring in the
9 protocol. In addition to that, there is also
10 embedded within the medical records an oxytocin
11 intrauterine resuscitative protocol that really
12 handholds or hold hands and is, I think it's page 28
13 of the record, that is also consistent with the
14 policy.

15 So either way, had they followed the
16 policy, the order, had they followed the policies,
17 had they followed the standards of care, the Pit
18 should have been turned down and resuscitative
19 techniques should have been employed.

20 Did I read those parts of your deposition
21 correctly?

22 A. I think there were a couple of words that
23 you flip-flopped, but essentially the essence, yes.

24 Q. Okay. And so at the time we were talking
25 about, that's the only time I can find in your

1 deposition, which I presume you reviewed in some
2 detail before you came to testify here at this case?

3 A. Correct.

4 Q. The only time I found in your deposition
5 where you talked about that STLLD vaginal Birth
6 Protocol, was to reference its portion of the
7 oxytocin-induced tachysystole.

8 Do you remember any other time you would
9 have told me about that?

10 A. I don't recall specifically mentioning it
11 separately. Again, it references the orders. The
12 orders set, the policies, the protocol, all of that
13 is in that very lengthy answer. So I don't think
14 that there was a distinction that that's only the
15 section of the protocol that was being referenced,
16 was just the tachysystole. It's referenced in both
17 the separate policy and what's embedded in the
18 record.

19 Q. Okay. My point, probably long-winded, and
20 I apologize for that, is that yesterday on direct
21 exam, we didn't talk about oxytocin-induced
22 tachysystole protocols, which you and I talked about
23 extensively at your deposition.

24 we didn't talk about tachysystole at all.
25 what we talked about was Category II and what you

1 believed in your interpretation of the -- both the
2 protocol, and now we've gone through the policy
3 itself, what Mercy Hospital's protocol told these
4 nurses to do with Category II.

5 when we talked at your deposition, your
6 opinion was at 8:00 a.m., because of the ongoing
7 tachysystole, which was what you identified to Ms.
8 Lenivy in December of 2021, the Pitocin needed to be
9 turned off. You didn't tell the jury that opinion
10 yesterday.

11 Because you heard in my opening statement
12 and needed to address that your opinion was
13 inconsistent, your opinion calling tachysystole at
14 all at any period of time in this case was
15 inconsistent. You heard me tell the jury I would
16 prove that, and then you decided to omit it from your
17 opinions, or maybe Ms. Gunn did. I don't know,
18 correct?

19 A. That's incorrect.

20 Q. well, we'll let the jury decide that.

21 Going back to the actual intrauterine
22 resuscitative efforts that were done by the nurses in
23 this case, we've already talked about your
24 disagreement with whether they were done to help move
25 the baby down for delivery, or whether they were done

1 to actually address some things they saw on the
2 strips which were concerning to decelerations of his
3 heart rate.

4 But you didn't -- you didn't show the jury
5 to undertake to correlate the timing of those
6 position changes, the timing of those breaks in the
7 pushes, the timing of the laboring down to see what
8 actually happened with his heart rate, did you?

9 A. No. We didn't look at the specific
10 portions after that. We looked at the portions that
11 the nurses documented and their interpretation. So
12 there were position changes that were being employed
13 with pushing efforts and continued Pitocin until, I
14 think, 11:55, was maybe the last position change that
15 was recorded.

16 And I'm talking about position changes
17 that aren't typically thought of as those to improve
18 perfusion: left side, right side, hands and knees.
19 And beyond that, there was nothing else in terms of
20 resuscitation performed. So, yes, we talked about
21 what the nurses documented in realtime or as close to
22 realtime, what was their interpretations that they
23 saw clinically significant decels, and that they
24 continued to do other things.

25 Q. And one of the things that you talked with

1 Ms. Gunn yesterday about was repeating documentations
2 that Nurse Maggie or Nurse Jessie was doing, and I
3 think she made a point of having you note that the
4 Epic, the electronic medical record says
5 decelerations, plural, remember?

6 A. Correct.

7 Q. Okay. Do you know whether Mercy's Epic
8 program allows the nurse to chart in the flow sheet,
9 not with free text, but in the flow sheet, a single
10 deceleration?

11 A. Typically, it does not.

12 Q. So that was something you could have
13 explained yesterday, and you didn't?

14 A. I --

15 Q. It's not like every time they documented,
16 they were showing decelerations, plural?

17 A. Well, my recollection of their exhibits
18 that they marked and also my interpretation of the
19 tracings, there were in fact multiple decelerations.
20 So as far as I'm aware, Epic does not allow you to
21 chart decelerations, singular, in the drop-down. But
22 you could certainly put a free text. There's many
23 places that have an opportunity to put free text if
24 it is a singular deceleration, and you want to note
25 that in the medical record.

1 Q. And I think you also told me in your
2 deposition that you don't think that after Nurse
3 Maggie and Nurse Jessie came on duty at 7:00 a.m. on
4 May 4th, that there was any improvement or changes
5 for a sustained period of time in his fetal heart
6 rate, right?

7 A. Correct.

8 Q. And so you say I think it was always
9 Category II until close to four o'clock, when we
10 talked about it was Category III.

11 A. Actually what I said was there are some
12 portions if we isolate, then we were just very
13 specific exercise. But what I said in my deposition
14 is certainly if we shift the time back and forth,
15 someone may be able to find a period of time 6, 7, 8
16 minutes in which there's moderate variability and a
17 normal baseline.

18 But over the context of the hours and
19 hours of tracing, I find it to be predominantly
20 Category II because that is not what you're looking
21 at retrospectively, as you pointed out, to try to
22 find 6 minutes to reassure yourself in the global
23 context of what was happening with this labor and
24 delivery.

25 Q. And, in fact, what you told me was you

1 don't -- you actually told me you don't think that
2 after 7:00 a.m., there was ever a period of time
3 where the fetal monitor showed a Category I fetal
4 heart rate pattern. And by that I think you were --
5 kind of got stiff in your answer a minute ago.

6 Because there may be isolated minutes,
7 they didn't meet the AWHONN, ACOG, the new NCIHE's --
8 I said that wrong -- because it has to be averaged
9 over a 10-minute time frame, right?

10 A. Correct.

11 Q. Okay. So no 10 minutes in your review,
12 your retrospective review, that you ever revert back
13 to Category I. Maybe isolated to 5, six, seven, 8
14 minutes, but not definition Category I, right?

15 A. Correct.

16 Q. Okay. And you're so confident in that
17 opinion that you testified -- and I'm going to quote
18 this -- no reasonable careful provider would look at
19 a period of time, a minute or 30 seconds or 8
20 minutes, when preceded and followed by Category II
21 and say, aha, this is Category I.

22 You say no reasonable provider could come
23 up with that, the interpretation of these strips,
24 correct?

25 A. I did say that.

1 Q. All right. You were aware that Dr. warsof
2 was hired by Ms. Gunn to offer opinions against Dr.
3 McNeive and my nurses, correct?

4 A. Yes.

5 Q. And you've read his deposition?

6 A. I did.

7 Q. And you recall that he testified to
8 various times when he saw the fetal heart rate
9 patterns in Category I after 7:00 a.m.?

10 A. I don't recall specifically when he said
11 or for what portion of time or if he qualified that
12 answer the same as I did. But, again, he's entitled
13 to his opinion and his interpretation. But, as I
14 said, I don't think that there was a portion of time
15 that it resolved back to a sole by category, Category
16 I.

17 Q. You said no reasonably careful provider
18 would reach that conclusion, correct?

19 A. I did say that.

20 Q. All right. And Dr. warsof is going to
21 be -- is going to come out here talk and talk to the
22 jury probably this afternoon, and he's going to be
23 forced to stick with his deposition where he said
24 between 8:00 and 9:30, there was -- I think he
25 actually identified a 12-minute period. That would

1 meet the definition of Category 1, right?

2 A. It would.

3 Q. And then from 9:30 to 2:00 a.m., there
4 were periods of time where the fetal strips could be
5 described as Category I.

6 Do you remember reading that in his
7 deposition?

8 A. Not specifically, no.

9 Q. You're not going to disagree with that,
10 are you?

11 A. If that's what he said, I'm not going to
12 disagree with what he said in his deposition.

13 Q. And he also said from 2:00 to 4:00, there
14 are instances where the fetal heart rate could be
15 described as Category I. So is he not a reasonably
16 careful provider if he reached a different conclusion
17 than you?

18 MS. GUNN: Your Honor, I'm going to
19 object. It's improper conclusion, a different expert
20 having this opinion --

21 MS. KAMYKOWSKI: I'll withdraw, Your
22 Honor.

23 THE COURT: Very good.

24 Q. (By Ms. Kamykowski) And if there is at
25 least -- if there is Category I in this strip, from

1 all the literature we talked about before the break
2 this morning, that is something that we can be
3 reassured it ensures that at that time Remi had good,
4 normal acid base status. He was not acidotic,
5 correct?

6 A. If there was moderate variability at that
7 time, yes. It doesn't mean there wasn't some degree
8 of hypoxia, if the decel or the heart rate had risen
9 or something like that, but at least at that
10 moment -- and we won't know about cord gases because
11 we don't have them -- but at least at that moment, if
12 he had been delivered in hour 10 or 11, he would not
13 have been acidotic.

14 Q. All right. Quickly getting to the second
15 stage. That's another opinion that you have in this
16 case that these nurses didn't advocate for something
17 different to have happened sooner because of the
18 length of the second stage. I'm not going to belabor
19 that point.

20 Just to say, Nurse Shinn, you agree that
21 ACOG and AWHONN, there is no upper limit published
22 anywhere that says: At this hour, you must advocate
23 or affect a C-section, correct?

24 You agree with that?

25 A. I don't believe I've seen any

1 documentation or publications that says there is an
2 upper limit. Everything must be individualized based
3 on the patient, their progress, their wishes,
4 refusals, those types of things.

5 Q. And I remember asking you in your
6 deposition, your opinions in this case are limited
7 solely and exclusively to the breach of the standard
8 of care of Nurse Jessie and Nurse Maggie, right?

9 A. That is correct.

10 Q. On advocating for a C-section, you can't
11 provide any evidence that if Jessie and Maggie had
12 ever done that at any time in the conversations in
13 the room with Dr. McNeive and Sarah and Blake, that
14 any party, Sarah, Blake, Dr. McNeive, would have
15 taken them up on their advocacy and actually
16 performed a C-section sooner, correct? That would be
17 pure speculation?

18 A. Well, we know a C-section wasn't
19 performed. So to say it was done any sooner, I think
20 is somewhat of a misnomer from the facts of the case.
21 But invoking chain of command, those are things that
22 typically work. That's why hospitals have a policy
23 like that and train their nurses on doing something
24 like that.

25 But can I say at what minute Dr. McNeive

1 would have said, yes, I agree, or that's reasonable,
2 or the conversation would have been had with Mr. and
3 Mrs. Anyan about the length of labor, the potential
4 risks for injury moving forward or trauma or shoulder
5 dystocia or any of those potential things, some of
6 that would be speculative for me to guess what time
7 that would have been effective.

8 Q. So you can't tell this jury more likely
9 than not to a reasonable degree of nursing certainty
10 that if the nurses had done what you believe the
11 standard of care required and advocated for a
12 C-section at any time prior to 8 a.m., that that
13 would have prevented Remi's injuries?

14 You can't state that opinion, can you?

15 A. Well, given I am not a specific causation
16 expert and a timing expert to the baby's injuries, I
17 can't say that.

18 Q. Because you -- but I understand that part
19 of it, you talked about that yesterday, too. But you
20 can't say that advocating or going up the chain of
21 command would more likely than not have changed the
22 trajectory of the labor because that is in Dr.
23 McNeive's and Sarah Anyan's hands, correct?

24 A. If she's properly counseled and has the
25 opportunity to be educated on what's going on with

1 the baby and her labor progress, certainly she has
2 the right to either consent or refuse.

3 But, as I said, do I think more likely
4 than not that had the nurses met their standard of
5 care as it applied and advocated and utilized chain
6 of command, I do think that is a process that worked,
7 and it would have worked to affect an earlier
8 delivery. When that would have happened, or if it
9 would have avoided injury, that I cannot say.

10 Q. All of your criticisms in this case of
11 Jessie and Maggie are based on retrospective review
12 of the records in this case and your training,
13 education, and experience, correct?

14 A. Review of the records, the deposition
15 materials, those types of things, and my education,
16 training, and background.

17 Q. And as we know from the literature we
18 talked about this morning, retrospective review of
19 specific fetal monitor tracings in this case are
20 unreliable when we know the outcome, correct?

21 A. It can be unreliable if you know the
22 outcome. It doesn't mean it has to be, but as I said
23 earlier both sides, defense experts, plaintiff
24 experts are getting records after the fact. Everyone
25 has to review after the time has already passed.

1 Q. Now, Nurse Shinn, you initially had
2 opinions against Alex Greenwald and Kelsey Blanton.
3 You no longer have those opinions?

4 A. Correct.

5 Q. You initially had opinions that
6 tachysystole was involved heavily in this case,
7 causing or contributed to cause damages.

8 You did not give that opinion to Ms. Gunn
9 yesterday, correct?

10 A. I did not use the term "tachysystole." We
11 talked slightly about uterine activity, contractions
12 strength, that type of thing. What the purpose of
13 Pitocin is. I said even if there's a normal amount
14 of contractions, the baby could still negatively be
15 affected with decels and those type of things.

16 So the standard of care doesn't change.
17 The interpretation doesn't change. And
18 interventions, as you can see from all of those
19 different protocols, policies, orders in the
20 patient's medical record, show that the nurse is
21 required to do the same thing: position changes,
22 fluid bolus, oxygen, a reduction or cessation of
23 Pitocin.

24 So regardless of if there was or wasn't
25 tachysystole, which I'm of the opinion was at various

1 points in time, it didn't make a difference because
2 the length of the labor, the failure to descend, the
3 malposition, and the fact that it was persistently
4 Category II tracings with decels that these nurses
5 identified, required them under the standard of care
6 to do those interventions and to advocate for a
7 change in plan.

8 Q. But you didn't offer the opinion about
9 tachysystole because you heard me say it in my
10 opening, and you'd have to admit that you disagree
11 with Dr. Warsof on more than one big point in this
12 case.

13 Is there anything else, before I sit down,
14 that you want to change in your opinions?

15 A. I haven't changed my opinion. I still
16 hold the opinion that there is tachysystole present,
17 and there's an exhibit from my deposition in which I
18 counted contractions, and so it's quite evident that
19 I still believe there was tachysystole.

20 Q. And you're the only one in this case that
21 says tachysystole.

22 Are you aware of that?

23 A. No.

24 Q. Thank you.

25 MS. KAMYKOWSKI: Nothing further, Your

Honor.

THE COURT: On behalf of Dr. McNeive, any questions?

MR. PERRON: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. PERRON:

Q. Nurse Shinn, bringing your attention back to the safety rounds at 10:45 a.m. on May 4th.

During direct yesterday, you mentioned that this was an opportunity for the nurses to speak to a captive audience. And that's what you believe that should have been done, is the nurses communicating to the providers on the safety round which included an OB anesthesia doctor and a maternal-fetal medicine doctor, correct?

A. Correct.

Q. Do you know one way or the other if that MFM or OB anesthesia had the history of Sarah Anyan during that safety round or the other pertinent knowledge independent of the nurses?

A. No.

Q. And you don't offer any criticisms of the other members of the safety round, correct?

A. Correct.

Q. Counsel was asking you about Category I

1 after 8:00 a.m. I'm going to shift your attention
2 instead to accelerations.

3 The jury has heard a little bit about
4 this. But I want to give you the opportunity to
5 define for the jury what an acceleration is.

6 A. Sure. An acceleration is an abrupt
7 increase from the fetal heart rate baseline, where it
8 goes from baseline, peak, and comes back to baseline.
9 For a full-term baby, such as Remy Anyan, it would be
10 peaking at least 15 beats above the baseline, and the
11 duration of that peak or that triangle would be at
12 least 15 seconds, so one and a half boxes.

13 Q. And I believe it was your testimony that
14 you did not see any accelerations after 2:00 p.m.

15 A. I believe that's correct.

16 Q. Okay. And, similarly, this isn't a
17 question about whether or not it's over a period of
18 time. An acceleration is peak, correct? It doesn't
19 have to be over a certain amount of time. It's any
20 peak that you described, correct?

21 A. As long as it's not attached to a
22 deceleration. So there is a physiologic effect if
23 the vein or the large blood vessel is delivering
24 oxygenated blood to the baby. When that is
25 compressed, it has, in some babies, you'll see a rise

1 of the heart rate and then a fall when the arteries
2 are compressed. And, inversely, you might see that
3 rise on the other side.

4 So those are not true accelerations if
5 they are immediately preceding or following a decel.
6 That's just a normal response of the cord being
7 compressed during that decel. If you have a
8 baseline, an accel, back to baseline, again, normal
9 baseline either side, again, that would be an
10 acceleration by definition.

11 Q. Okay. And you did not see any after
12 2:00 p.m. on May 4th?

13 A. I don't remember seeing any. Certainly I
14 don't recall if I was even asked to mark any during
15 my deposition.

16 Q. Okay. And do you know if Dr. Warsof saw
17 any accelerations after 2:00 p.m. on May 4?

18 A. I don't recall.

19 Q. The reason accelerations are important is
20 that accelerations, independent of moderate
21 variability, accelerations are also a sign that the
22 baby is receiving adequate oxygen in that moment?

23 A. Yes.

24 Q. Okay.

25 A. So it would equally show that the baby is

1 not acidotic. And oftentimes babies that are -- I
2 mean, I will qualify this -- but neurologically okay,
3 can still elicit an acceleration.

4 Q. You're not offering any opinions critical
5 of Dr. McNeive?

6 A. I am not.

7 Q. Do you assign Apgar scores as part of your
8 practice?

9 A. Yes.

10 Q. Okay. Apgar scores are pretty important
11 information for the providers.

12 would you agree?

13 A. Yes.

14 Q. Okay. It's important to get those Apgar
15 scores correct in the moment, right?

16 A. In the moment because that does help guide
17 future resuscitation or ongoing resuscitation or the
18 need for resuscitation. It also is part of the
19 criteria for determining whether or not a baby would
20 have hyperthermia or cooling therapy as a result of a
21 perceived brain injury.

22 Q. Right. And providers need that
23 information from whoever is calculating that Apgar
24 score. Providers need that information to be correct
25 so that they can make the best decisions going

1 forward, right?

2 A. Correct. It is a subjective analysis.

3 Although there is some literature that says if the
4 baby's being actively resuscitated, that the Apgar
5 score should be somewhat dismissed because it may not
6 be accurate.

7 Q. Okay. And you disagree with the specific
8 Apgar score in this case?

9 A. The 5-minute Apgar score appears to be
10 assisted or inflated during ongoing resuscitation,
11 yes.

12 Q. You can't -- let me back up.

13 Do you have an opinion whether or not Remi
14 Anyan was injured because of the inflated incorrect
15 Apgar score?

16 A. I certainly don't have opinions
17 specifically about this baby's injuries or the
18 causation or timing of this baby's injuries
19 specifically, meaning, the type of injury, the part
20 of the brain that's affected. Those things would be
21 outside of my expertise.

22 But whether or not a baby gets cooling
23 therapy could mean that a baby continues to have
24 injury. Again, that is somewhat out of my
25 wheelhouse. I have a general understanding of it.

1 So to answer your question, it might
2 affect the baby because the baby may not receive
3 ceratin therapies that it needs to moving forward.
4 But whether that applied in this case, I wouldn't
5 say.

6 Q. Regarding the use of Pitocin during your
7 deposition, you described the continuing use of
8 Pitocin in this case as saturating a wet sponge.

9 Does that ring a bell? Does that metaphor
10 make sense to you?

11 A. It does.

12 Q. Okay. So you understand the -- in this
13 metaphor, the receptors that the Pitocin is working
14 on, in the metaphor, that's the sponge, correct?

15 A. Yes.

16 Q. The -- the receptors can be saturated to
17 the extent that the Pitocin has less of the same
18 effect as it would if it were first starting the
19 Pitocin?

20 A. well, it's not that it has less effect, it
21 doesn't have much of a desirable effect. So you see
22 more dysfunctional labor patterns, irregular
23 contractions. Sometimes the thought is that -- or I
24 should say -- the old scientific thought was if we
25 give more Pitocin, it will increase the strength,

1 increase the frequency. That only works to a certain
2 extent.

3 Once the kitchen sponge is saturated, it
4 can't absorb any more water, so all you do is have
5 water spilling out. So, in essence, it's not that
6 you don't have some effect from more Pitocin or
7 continued Pitocin, it's just not going to be as
8 effective, meaning, the contractions get very
9 dysfunctional. They might get too close together or
10 roll or have a pattern called coupling or tripling.
11 So it's just more -- we have a cute little saying,
12 more Pit doesn't make it fit. And that's essentially
13 what this case is about.

14 Q. Switching gears again. And I apologize
15 I'm flipping around. But with respect to the jury's
16 time, I'm trying to make it through my outline --

17 A. I appreciate it.

18 Q. -- and I apologize.

19 I'm sure we all do.

20 It's your opinion that by 8:00 a.m., that
21 is your deadline, 8 a.m., in your opinion, is when

22 Remi Anyan needed to be delivered?

23 A. From a nursing perspective, yes.

24 Q. Okay.

25 A. Well, let me back up really quickly

1 because I don't want it to be confusing to the jury.

2 At 8:00 a.m. is when the nurses needed to advocate

3 for a delivery to happen by way of C-section. I'm

4 not making an opinion that if he had been delivered

5 by 8:00 a.m. certainly providers could have chosen

6 that or advocated for that sooner. But it's not my

7 opinion that he must have been delivered by 8:00.

8 That the nurses needed to start advocating for

9 delivery at 8:00 and moving forward.

10 Q. You used the language, by 8:00 a.m., they

11 should have been moving to C-section.

12 Do you recall using that language?

13 A. I probably did use that language. And

14 what I meant was moving towards, meaning advocate.

15 Obviously the nurses can't call the C-section. They

16 can't perform said C-section.

17 So when I say from a nursing standpoint

18 that they need to be moving toward C-section or

19 moving toward delivery, that means advocating,

20 talking to people, getting the patient ready.

21 Q. Despite all of the positioning changes,

22 the nurses were doing throughout May 4, it's your

23 opinion that after 9:30 a.m., from 9:30 a.m. onward,

24 there was never improved tracings?

25 A. Nope. I don't think that's what I said

1 exactly. what I said, the decels may have gotten
2 less or a little more subtle, but I don't think that
3 the tracing reverted back to a Category I tracing.

4 And I certainly qualified that a moment
5 ago for Ms. Kamykowski that there were periods of
6 time that, in isolation, might look better
7 variability, but, in my opinion, because of what
8 preceded it or followed it, I would still consider it
9 to be Category II.

10 Q. And I attempted to quote you directly. I
11 will direct you to a page in your deposition.

12 Do you still have that in front of you?

13 A. I do.

14 Q. To refresh your recollection, I'm looking
15 at page 97. of course this in the midst of a longer
16 answer. I'll let you review your answer, and I'll
17 re-ask that question.

18 And if I could focus your attention. It's
19 about a paragraph long sentence that starts on line
20 22 of 96 and goes to page 97.

21 A. Okay.

22 Q. After 9:30 a.m., despite all the
23 positioning changes, it's your opinion that it never
24 improved the tracing?

25 A. Correct.

Q. okay.

A. Do you want to read the actual answer?

Q. No. That was my question. Thank you.

A. okay.

Q. 33 to 40 percent of your income comes from your medical legal work -- correct? -- the expert work you're doing right now?

A. That's correct.

Q. Mostly for plaintiffs?

A. Correct.

Q. okay. I believe on direct yesterday, you made a comment that the duration itself of the second stage of labor, just the duration, without any other context, was outside ACOG guidelines.

Did I remember that? Did I hear that correctly?

A. well, we talked about as the minimally accepted. we did talk about the recommendations from ACOG for a first-time mother with an epidural versus someone who is subsequently delivering a baby with an epidural. And I said 4 hours, with allowing for the epidural, malpresentation, pushing.

It was clear from these records that the baby was not descending, remained malpositioned. we were beyond 4 hours, 4 hours and 10 minutes or so, at

1 8:00 a.m. And then we just kept ticking by hour
2 after hour.

3 So I've already said to Ms. Kamykowski
4 there is not a published upper limit, you are
5 correct. There are certain things that go into that.
6 Variables like patient refusal, maybe instability of
7 the mother, I don't know. But I don't think any of
8 those things would apply in this case. It just was
9 an abnormally, absurdly long stage of labor.

10 Q. Right. So the statements that the
11 duration of the labor itself was outside ACOG
12 guidelines is not accurate because there is no ACOG
13 recognized cap for the duration.

14 A. There is not a cap. There are
15 recommendations for first-time moms and subsequent
16 mothers of 3 hours and 4 hours with epidurals. There
17 is not an upper limit cap.

18 Q. The Clark algorithm article, and we call
19 it the Clark algorithm. This is Dr. Steven Clark?

20 A. Correct.

21 Q. You're familiar with that?

22 A. I am.

23 Q. Okay.

24 MR. PERRON: will you put up on the board
25 page 5 of I16, that same Clark algorithm. Just

1 highlight a little bit lower of the sentence that
2 starts "superb reliability."

3 Q. (By Mr. Perron) And I'll read this to
4 you, and I'll try to go slowly for the benefit of the
5 court reporter.

6 The superb reliability of accelerations
7 and moderate variability, excluding any degree of
8 hypoxia related central nervous system depression or
9 risk of ongoing hypoxic injury, would allow
10 observation of patterns with these features, an
11 adequate labor of progress regardless of the
12 deceleration pattern.

13 Did I read that correctly?

14 A. You did.

15 Q. Okay.

16 A. Focusing in on the adequate labor
17 progress, which wasn't happening here.

18 Q. Right. And I'm not drawing your attention
19 to that part of that. Of course you can talk about
20 that on redirect on that portion.

21 But in some of the questions and answers,
22 both yesterday and again today, you were making a
23 distinction between hypoxia and the anoxic condition
24 of the blood. So I just want to focus right back.

25 The injury that Remi suffered, was hypoxic ischemic

1 encephalopathy, correct?

2 A. Correct.

3 Q. And you have testified more than once over
4 the course that, yes, you might see moderate
5 variability, but he might be still suffering some
6 type of hypoxic injury, even before Category III.

7 A. No, that's incorrect. I did not say he
8 was suffering from hypoxic injury. What I said was,
9 if there is the presence of deceleration, even in the
10 presence of moderate variability, while we can
11 exclude metabolic acidemia, which we would diagnose
12 with a cord gas, which we don't have in this case,
13 there could be evidence of hypoxia, low oxygen in the
14 blood because the cord is being affected or the
15 placental flow is being affected. So that would
16 prompt decelerations, which could tax fetal reserve.

17 I never said he was suffering from hypoxic
18 injury. I know we've used a lot of terms sort of
19 interchangeably, but I was very specific that I did
20 not say he was suffering from injury. We were
21 talking about the exclusion of metabolic acidemia and
22 what might also be present at the same time on the
23 tracing which could represent hypoxia or low blood in
24 either the blood or the tissue.

25 Q. Well, let's go back. It's not just

1 hypoxic injury, it's hypoxia related central nervous
2 system depression. So even taking away hypoxic
3 injury, if we see moderate variability or things
4 acceleration, every time you see one of those things,
5 according to Dr. Clark, we can exclude hypoxia
6 related central nervous depression, correct?

7 A. If there -- well, he's talking about
8 accels and moderate variability, yes, so they're --

9 Q. One or the other, right?

10 A. One or the other, yes.

11 Q. Okay.

12 A. So there is not an injury. Again, that's
13 talking about depression or risk of ongoing injury,
14 not whether it is present, period.

15 Q. So moderate variability and accelerations
16 are both highly-predictive of a good outcome.

17 Generally speaking, that's what the literature says?

18 A. No, sir. It is not predictive of a good
19 outcome. It is predictive that if the baby were
20 delivered at that moment, the baby is likely not
21 acidotic, as evidenced on the cord blood gases.

22 Q. Okay. Well, we'll get to that language in
23 just a little bit.

24 Moderate variability can occur in Category
25 II, correct?

1 A. Yes.

2 Q. Accelerations can occur in Category II,
3 correct?

4 A. Yes.

5 Q. And Category II does not mean -- Category
6 II, just by itself -- does not mean fetal distress.

7 Those terms are not synonymous.

8 A. Correct.

9 Q. Okay. Ms. Kamykowski brought this out,
10 but I just want to highlight it for just one second.

11 In this case, every time we observe
12 moderate variability or accelerations, that is the
13 sign baby is not acidotic.

14 A. Correct.

15 Q. Okay. Just to refocus our attention on
16 Pitocin policy for just one moment. Without throwing
17 it up on the big board again, you are familiar with
18 ACOG Bulletin 116 from November of 2010?

19 A. Correct.

20 Q. Okay. I'm going to ask you this
21 specifically: In your opinion, would ACOG recommend
22 a response to Category II with regards to Pitocin
23 administration that fell below the standard of care?

24 A. For nurses, given that this is geared
25 towards physicians?

1 Q. Sure. If you're a nurse, I assume you can
2 only comment on nursing.

3 A. Sure.

4 Q. Would ACOG recommend a course of action to
5 respond to Category II with regards to administration
6 of Pitocin that fell below the nursing standard of
7 care? Would ACOG do that?

8 A. Well, it's a physician group putting out a
9 physician publication geared towards physicians, so I
10 don't think they would ever have that intention
11 certainly because nurses are familiar generally, and
12 some of this information is incorporated into AWHONN
13 materials, as well. So I don't think there would be
14 an intentional publication meant to make nurses fall
15 below the standard of care.

16 Q. And just to rephrase my question because
17 we -- yesterday we talked about Pitocin being such a
18 dangerous drug.

19 Would ACOG recommend a potential use of
20 Pitocin in a Category II study that was dangerous, in
21 your opinion?

22 A. I don't know that I can really answer
23 that. We talked about the potential for Pitocin to
24 be dangerous. How it's used, when it's used, the
25 rate at which it's used, or continued use, and some

1 of that is in realtime decisionmaking.

2 So is one publication going to tell you
3 every specific scenario without putting it in context
4 of that patient's clinical circumstances? I don't
5 think so. But, no, I don't -- I would not venture to
6 say that ACOG or AWHONN would ever put out a
7 publication that if the nurses followed it, its
8 intention was meant to cause harm.

9 Q. One of the other articles that you sent to
10 Ms. Lenivy, although it wasn't discussed at length in
11 your deposition, was something printed from
12 obgmanagement.com, an article titled "A Recent Plan to
13 Manage a Persistent Category II FHR Tracing" by a Dr.
14 David Miller.

15 Are you familiar with that article?

16 A. I believe I sent it to them, so generally,
17 yes.

18 Q. Okay. Yeah, it's -- I don't want to put
19 it on the big board yet, but Exhibit I14.

20 Are you -- again, just to back up one
21 second.

22 You're familiar with the article I'm
23 talking about by Dr. Miller?

24 A. Yes.

25 Q. And I believe you testified in your

1 deposition that all of these articles you sent to Ms.
2 Lenivy, you have saved on your personal computer
3 because you find them useful in these types of cases?

4 A. Correct.

5 Q. And just to back up one more time. This
6 article, in particular, you also believed to be
7 reliable in your field of work?

8 A. Generally speaking, yes. I don't think
9 there's any one particular text that maybe applies to
10 all comers, but, general speaking, yes.

11 Q. Okay.

12 MR. PERRON: Now, you want to put up I14,
13 the first page?

14 Q. (By Mr. Perron) That's the article we've
15 been talking about by Dr. Miller?

16 A. Correct.

17 Q. Okay.

18 MR. PERRON: And then, Justin, if you want
19 to go to page 5 -- oh, it might be page 6. My
20 numbers are off.

21 Q. (By Mr. Perron) So right under the
22 paradox of FHR monitoring.

23 Are you familiar with this portion of the
24 article?

25 A. Yes.

1 Q. okay.

2 MR. PERRON: So just highlight the first
3 sentence.

4 Q. (By Mr. Perron) And I'll read it. You
5 let me know if I'm reading this correctly: The
6 greatest strength of intrapartum FHR monitoring is
7 the ability of moderate variability or acceleration
8 or both to predict normal neurologic outcome with an
9 extremely high degree of reliability.

10 did I read that correctly?

11 A. You did read it correctly.

12 Q. Okay. I -- there's no equivocation in
13 that sentence, is there?

14 A. There's none. I don't know that I
15 completely agree with that. I mean, certainly that
16 would -- that means that the baby has moderate
17 variability, then certainly there's been no
18 neurologic injury preceding that.

19 So I think that there is some distinction
20 in Dr. Miller's article. Fetal monitoring, I think
21 everyone can agree across the profession, is not
22 meant to be a predictive tool. The only thing it can
23 predict is whether or not the pH will be normal in
24 the presence of accels and/or moderate variability at
25 that moment in time. But to say that there's not

1 going to be injury, or there hasn't been any
2 injuries, that never was the intention of fetal
3 monitoring.

4 Q. Sure. But a moment ago, you disagreed
5 with me whether or not moderate variability or
6 accelerations are predictive of a good outcome.

7 Dr. Miller does seem to agree with me that
8 moderate variability for accelerations are extremely
9 high degree of reliability in predicting a normal
10 neurologic outcome, correct?

11 A. That's what it says.

12 Q. Okay.

13 A. I still maintain that fetal monitoring is
14 not a predictive or diagnostic tool. It is used as a
15 screening tool in realtime.

16 Q. Okay. And the reason -- the next
17 sentence: One of the greatest weaknesses of fetal
18 heart monitoring is the inability of an abnormal
19 tracing to predict abnormal neurologic outcomes with
20 any clinical relevant degree of accuracy.

21 Did I read that correctly?

22 A. You did.

23 Q. Okay. And just to separate it out for the
24 jury. Moderate variability and accelerations, either
25 one or both, are highly reliable, correct?

1 A. That's what his article says.

2 Q. Okay. And abnormal tracings, not
3 reliable --

4 A. That's what his article says.

5 Q. -- fair?

6 Okay. Ms. Kamykowski read this next bit
7 before, but it was from a different publication: A
8 false positive rate of FHR monitoring predicting
9 cerebral palsy has been reported to be between 99
10 percent, yielding a positive predictive value of less
11 than 1 percent.

12 And just for the jury's edification, and I
13 certainly wouldn't presume that everybody knows this,
14 but what does false positive mean?

15 A. It means that if there was an abnormal
16 tracing predicting which of those would go on to
17 produce a baby with cerebral palsy, there -- if you
18 deliver those kids, 99 percent of them would likely
19 be fine, so similar to what Ms. Kamykowski said, one
20 in a thousand babies might have cerebral palsy.
21 That's essentially what that's references.

22 That fetal monitoring is not a great
23 predictor, hence why it's a screening tool only for
24 which of those kids are actually going to go on and
25 develop cerebral palsy, not accounting for human

1 elements, actual facts of each patient in the labor
2 process.

3 MR. PERRON: If you want to go to page
4 6 -- or page 7, Justin, if I had my initial page.
5 The numbers are wrong.

6 Q. (By Mr. Perron) Trying to use
7 intrapartum.

8 MR. PERRON: The last paragraph, maybe the
9 third sentence down beginning with "trying." If you
10 could highlight that.

11 Q. (By Mr. Perron) Trying to use intrapartum
12 FHR monitoring to diagnose neurologic injury is a
13 recipe for failure.

14 Did I read that correct?

15 A. You did.

16 Q. Okay. If any expert or any attorney says
17 that the deceleration itself is a red flag for
18 diagnosing neurologic injury, Dr. Miller is speaking
19 through this text to say that was a recipe for
20 failure, correct?

21 A. Which somewhat contradict his prior
22 statements that you highlighted and read into the
23 record, that you can predict, and then he's saying,
24 you can't predict because you can't diagnose. It is
25 only a screening tool in realtime putting into

1 context with the stage and the length and the
2 progress of labor, whatever stage of labor that
3 particular mother is in. But using fetal monitoring
4 to diagnose a neurologic injury to determine that a
5 baby is injured, is not injured, with certainty,
6 that's not what it is deemed to do.

7 Q. And in contrast, the last sentence. In
8 contrast, relying on the presence of moderate
9 variability or accelerations or both to confirm
10 adequate fetal oxygenation allows the clinician to
11 formulate and articulate a rational evidence-based
12 plan of management that reflects consensus in
13 literature.

14 Did I read that correctly?

15 A. That's what it says.

16 Q. Do you disagree with that statement?

17 A. I think, again, it doesn't take into
18 account the human element and the specific facts of a
19 patient's labor because it doesn't talk about length,
20 stage, progress, no progress. It is merely talking
21 about the fetal monitoring interpretation only.

22 MR. PERRON: No further questions. Thank
23 you, Judge.

24 THE COURT: Redirect?

25 REDIRECT EXAMINATION

1 BY MS. GUNN:

2 Q. what is the point of fetal monitoring
3 strips, then?

4 A. Fetal monitoring strips are really the
5 best screening tool we have in realtime. So, again,
6 there is always going to be outliers. There are
7 always going to be conditions that may impact whether
8 a baby does well, doesn't do well, antenatal risk
9 factors, those types of things.

10 But it is the most widely utilized test or
11 screening tool for women of child bearing age in the
12 United States. And it is really the best tool we
13 have to assess for fetal oxygenation and fetal well
14 being in realtime.

15 Q. Isn't it to do what you're saying, predict
16 how the baby is doing, and how the baby may do if he
17 or she continues in the second stage?

18 MS. KAMYKOWSKI: objection to form. Official Cou
19 Leading.

20 THE COURT: Sustain as to form.

21 Q. (By Ms. Gunn) So --

22 MS. KAMYKOWSKI: Your Honor?

23 MS. GUNN: I can rephrase.

24 MS. KAMYKOWSKI: I don't think she can --

25 MS. GUNN: I can rephrase.

1 Q. (By Ms. Gunn) None of -- does any of the
2 literature and the articles that we spent the last 4
3 hours going over, Nurse Shinn -- you're familiar with
4 this -- do any of those articles base their
5 conclusions or their thoughts on data or studies that
6 involve second stages of labor that have gone on for
7 6, 7, 8, 9, 10, 11, or 12?

8 A. None.

9 Q. Does -- do any of these articles, then,
10 tell you anything about what was going on with Remi
11 in those hours 6, 7, 8, 9, 10, 11, or 12?

12 A. No.

13 Q. What, though, did Nurse Maggie and Nurse
14 Jessie know about what was going on with Remi in
15 those hours?

16 A. They knew that there had been a
17 malposition from a report they received from Nurse
18 Greenwald. They knew that the baby had not been
19 descending. They knew how long this labor course had
20 gone, and historically, in their experience, what was
21 the longest they had ever seen or what was average.

22 They knew that the baby had continued to have
23 decelerations, despite the occasional position
24 changes that were still being pushed with most of the
25 time. And Pitocin was continuously being run. So

1 they knew all of those things.

2 Q. And what do you think they should have
3 done in light of the knowledge of all those things?

4 A. I'm still of the opinion that starting at
5 8:00 a.m., and thereafter, they should have
6 advocated, based on all of these factors, to Dr.
7 McNeive for a change in the plan of care, to counsel
8 Sarah Anyan to discuss moving forward with C-section,
9 to at least give her the option of this is a
10 reasonable option.

11 we've gotten this far. The baby is not
12 descending. There's been decelerations. We've done
13 the typical things. But it is incumbent on the
14 nurses to recognize what is typical progress because
15 they're there a hundred percent of the time. In this
16 case, there were two of them.

17 And they are checking the patient,
18 evaluating pushing, seeing if the head is moving,
19 rotating, descending. If there's more of that soft
20 tissue, indicating a possible fit issue, they're
21 documenting decelerations over and over and over
22 again.

23 They're not doing any other measures to
24 try to markedly improve the tracing. They're not
25 decreasing or discontinuing Pitocin to lessen the

1 strength or frequency of contractions to improve the
2 tracing and better perfuse the baby.

3 So I'm still of the opinion, as I was in
4 2022 and 2023, and yesterday and today, that their
5 job, under the standard of care, their duty, to this
6 mother and her unborn baby was to advocate to the
7 powers that be, Dr. McNeive and anyone else above
8 him, if he was unresponsive, to change the course of
9 action, to protect this mother and to protect this
10 baby.

11 Q. And they weren't looking in hindsight.

12 A. No.

13 Q. They were -- and I showed you the records
14 and the jury all the records yesterday. We've seen
15 none of Sarah's records today other than 2:48, in the
16 eleventh hour of her second stage of labor.

17 MS. KAMYKOWSKI: Your Honor, I'll object.
18 This is not a question. And if it is, it's leading.

19 MS. GUNN: I'm getting to my question.

20 THE COURT: Thank you. The Court is going
21 to overrule the objection.

22 Q. (By Ms. Gunn) We've seen none of the
23 records from Sarah, that's the ones I've showed you
24 yesterday.

25 A. Correct.

1 Q. The nurses were documenting in realtime or
2 shortly thereafter what they were seeing.

3 A. Correct.

4 Q. And tell us briefly what they were seeing
5 and documenting with respect to the status of Remi.

6 A. They were documenting late and variable
7 decels, predominantly late. And even though my
8 interpretation is slightly different, when we talked
9 about red and burnt sienna and magenta, it's shades
10 of red.

11 They were seeing abnormalities on the
12 tracing. Enough of their interpretation, I believe
13 was correct, that should have prompted different
14 actions, additional actions, to protect any potential
15 harm for this baby by turning off Pitocin.

16 Again, standard of care required it, even
17 if Mercy Health didn't have a policy or protocol
18 embedded into their medical records for the nurses to
19 follow: fluid bolus, position change, stop pushing,
20 turn Pitocin off.

21 Again, usually done in a bundle. The
22 position changes weren't working in this case. There
23 are other options a nurse has in her wheelhouse, her
24 tool box, if you will, that she can try to improve
25 the tracing, and those things were not done.

1 There was no independent advocacy,
2 conversation with Dr. McNeive, the doctor in charge
3 of this patient, to say, we are concerned. We're
4 worried.

5 This goes beyond anything we've seen in
6 terms of the length of a second stage of labor. Or
7 we're getting pretty close to the max we've seen,
8 what is our plan moving forward.

9 No advocacy from the nurses to Dr.
10 McNeive. The safety rounds, the huddle, the strip
11 reviews, didn't result in any change in the plan. It
12 was continue Pitocin, continue pushing, continue
13 moving toward vaginal delivery, until the baby was
14 wedged down there so tightly, that was the option,
15 was deliver vaginally.

16 Q. Thank you.

17 MS. GUNN: Nothing further.

18 THE COURT: Recross?

19 RECCROSS EXAMINATION

20 BY MS. KAMYKOWSKI:

21 Q. The nurses also documented the entire time
22 the presence of moderate variability and on occasion
23 accelerations in the heart rate, correct?

24 A. They did.

25 Q. Thank you.

MS. KAMYKOWSKI: Nothing further.

THE COURT: On behalf of Dr. McNeive?

MR. PERRON: No, Your Honor.

THE COURT: Anything further of this witness?

MS. GUNN: No, ma'am.

THE COURT: May this witness be excused?

MS. GUNN: Yes.

MS. KAMYKOWSKI: Yes.

THE COURT: Thank you very much. You may be excused.

THE WITNESS: Thank you.

THE COURT: All right, ladies and gentlemen, based on the timing, this is a good time for us to take our lunch recess.

(A break was taken at 12:49 p.m., and the jury was duly admonished. At 1:57 p.m., the following proceedings were held in open court, in the presence of the jury:)

THE COURT: Go ahead and be seated, everyone.

On behalf of the plaintiff, you may call your next witness.

MS. GUNN: Thank you, Your Honor, I call Dr. Steven warsof.

1 THE COURT: Step on up, please. Raise
2 your right hand.

3 STEVEN L. WARSOFF, M.D.,
4 having been duly sworn, was examined, and testified
5 as follows:

6 DIRECT EXAMINATION

7 BY MS. GUNN:

8 Q. Please state your name.

9 A. Yes. It's Steven warsof.

10 Q. what is your profession?

11 A. I'm a maternal-fetal medicine specialist
12 and obstetrician/gynecologist who has specialized
13 training in high risk obstetrics.

14 Q. where do you practice currently?

15 A. I practice in Norfolk, Virginia; Virginia
16 Beach, Virginia; and I'm an employee of the Eastern
17 Virginia Medical School in Norfolk.

18 Q. And can you tell us a little bit about
19 your clinical practice and any teaching work that you
20 do.

21 A. Uh-huh. So as a professor of obstetrics
22 and gynecology, I have several roles. One role is to
23 be a teacher. I teach medical students in
24 obstetrics. I teach residents in obstetrics. I
25 teach maternal-fetal medicine fellows in how to

1 practice high risk obstetrics. I teach OB nurse --
2 labor and delivery nurses -- on the practice of
3 obstetrics.

4 And I'm also a clinician, that is, I
5 provide care to patients who are mostly high risk
6 obstetric patients. There are various high risk
7 indications. There are sometimes low risk patients,
8 as well.

9 Q. How long have you been delivering babies?

10 A. Oh, golly. I think I delivered my first
11 baby in 1975. I finished my fellowship in 1984. So
12 I've been continuously employed delivering babies
13 from 1984, until pretty much 2022, at which point, I
14 stopped doing deliveries. But nothing has changed in
15 the last couple of years. It's -- deliveries is
16 still the same.

17 Q. Doctor, what is your role in this case?
18 why are you here?

19 A. My role is to try to educate the jury as
20 to what is standard of care in the management of a
21 case like this, and where the deviations in the
22 standard of care were.

23 Q. And what specifically were you asked to
24 do?

25 A. I was asked to review the records and

1 depositions and fetal monitoring tracings, and to
2 give my opinion about whether there was any negligent
3 acts on behalf of the doctors or nurses that were
4 involved in care.

5 Q. Can you agree, Doctor, that any opinions
6 or conclusions that you render today and provide to
7 the jury will be to a reasonable degree of medical
8 certainty?

9 A. Yes.

10 Q. And can we agree that the definition of
11 standard of care is the failure to use that degree of
12 skill and learning ordinarily used under the same or
13 similar circumstances by members of defendant's
14 profession?

15 A. Yes.

16 Q. Let's do some high level, and then we'll
17 dig in a little bit.

18 Do you have opinions that Dr. McNeive
19 and/or the nurses breached the standard of care in
20 this case?

21 A. I do.

22 Q. And can you provide that high level
23 opinion?

24 A. Sure. So the first failure deviation from
25 the standard of care occurs around 8:30 in the

1 morning, May 4th, 2020.

2 why? Because we're now 4 hours into the
3 second stage of labor. There's a highly-abnormal
4 fetal heart rate tracing, and the standard of care
5 would be to deliver the baby at that time, either by
6 operative vaginal delivery, forceps, vacuum, if
7 that's possible, or by cesarean section, if it was
8 felt not to be possible.

9 Now, over the next -- if it wasn't done at
10 that time, there's -- then over the next hour, there
11 are a series of further decelerations, such that by
12 9:30, even though I think he should have been
13 delivered by 8:30, but by 9:30, going past that time,
14 now we're 5 hours into the second stage of labor, now
15 we have this persistent abnormal tracing, that going
16 past that time, would clearly be a deviation from the
17 standard of care in not delivering the baby by that
18 point in time. That's the first deviation.

19 The second deviation in the standard of
20 care is that when there were all these abnormal fetal
21 heart rate tracings, these very significant
22 decelerations, is to not have stopped the Pitocin.
23 Again, Pitocin is the medicine that makes the uterus
24 contract, and these decelerations are in response to
25 the uterine contractions. The baby's not tolerating

1 these contractions.

2 I think Ms. Shinn used the analogy of
3 gasoline in your car and putting your foot on the gas
4 pedal. And that's a reasonable analogy. And so, you
5 know, if you're going too fast, what's the first
6 thing anybody does when they're driving? Is you take
7 your foot off the gas pedal. And so that's the
8 second fault with Dr. McNeive, is not stopping the
9 Pitocin at that juncture in time.

10 The third deviation in the standard of
11 care, is allowing the second stage of labor to go to
12 12 or 13 hours. I think everybody will agree that
13 the average second stage of labor -- by the second
14 stage of labor, I'm referring to when a woman gets
15 fully dilated, and some people call it the pushing
16 part -- when you're fully dilated until the delivery
17 of the baby.

18 The average second stage of labor is 2
19 hours. Now, we will allow it to go further than
20 that under certain circumstances and may go to three
21 or possibly 4 hours, if there's an epidural
22 first-time mom like Mrs. Anyan. But to go past 4
23 hours, to go way past 4 hours, which is what happened
24 in this case, is clearly the deviation of the
25 standard of care.

1 And I would add as to go past 2 hours and
2 3 hours and 4 hours, relies on a couple of very
3 important factors: One, is that the mother is well.
4 Two, that the baby is well. And, three, that you're
5 making progress in the way that the baby is
6 descending through the birth canal.

7 Those are the criteria that have to be met
8 in order to go past two, three, 4 hours. But there
9 is nothing, I've never -- I've been an obstetrician
10 for 40 years -- I've never seen a case going to 12
11 hours.

12 The fourth failure is when the baby was
13 born and was hypertonic, didn't cry, we had an
14 abnormal tracing, and then we didn't get any blood
15 gases. And although, and I think it's important, and
16 I heard some testimony earlier, that the blood gases
17 would help in terms of knowing how to best treat this
18 baby, and as you know, this baby apparently went to
19 the normal nursery, and then only several hours
20 later, was identified as having a significant injury.
21 And that could have been identified early on with the
22 blood gases. So those are the four deviations of the
23 standard of care.

24 Q. Okay. So just to understand, the first
25 deviation of standard of care is failing to deliver

1 Sarah Anyan at the 8:30 time frame based on the
2 highly-abnormal strips, and now we are at hour --
3 going past hour four of the second stage of labor.

4 And that follows in a 9:30 time frame, correct?

5 A. Right. So at 8:30, the standard of care
6 would be to deliver. But, you know, I understand
7 there's some difference of opinion and some
8 flexibility, and you may want to see a little bit
9 more. So -- so to watch it for a little bit longer,
10 I think you could -- I wouldn't have done it -- but
11 somebody else might have done it. I think that would
12 be okay.

13 But to go past 9:30, would be continuing
14 abnormal tracing during that hour of time that, going
15 past 9:30, it becomes unrealistic to anticipate a
16 safe vaginal delivery at that point.

17 Q. And the second one involved management of
18 Pitocin. You told us that it was never turned off?

19 A. Correct. In fact, it was turned up
20 towards the end.

21 Q. Okay. And then it sounds like you got a
22 different sort of refined issue in the time frame of
23 two o'clock, three o'clock in terms of failing to
24 deliver at that time?

25 A. Well, as we go throughout that whole day,

1 every minute, every hour that the baby stays in utero
2 non-delivered, it's a further deviation from the
3 standard of care.

4 Q. And then, finally, failing to order cord
5 gas?

6 A. Or failing to obtain cord gas.

7 Q. Let's go back a little bit. You told us a
8 little bit about your practice.

9 MS. GUNN: If we could see Exhibit 100-2.

10 Q. (By Ms. Gunn) Doctor, this is your
11 curriculum vitae, your CV.

12 You told us a little bit about where you
13 practice now. Can you tell us about your education
14 and training?

15 A. Sure. So I grew up in a small town in
16 Massachusetts. I wound up going to MIT,
17 Massachusetts Institute of Technology. Got my
18 undergraduate degree there, then went on to Yale
19 University School of Medicine, graduating from
20 medical school in 1977. Went on to residency in
21 OB/GYN at the George Washington University Medical
22 Center in Washington D.C., from 1977 to '81.

23 From '81 to '84, I pursued a further
24 combined fellowship between King's College Hospital
25 in London, England, an emphasis on prenatal

1 diagnoses, as well as a maternal-fetal medicine
2 fellowship at Georgetown University, which I
3 completed in 1984.

4 Since that time, I've been pretty much on
5 the faculty at the Eastern Virginia Medical School
6 since 1984, until the present day, starting as
7 assistance professor, associate professor, and full
8 professor in 2006.

9 There was an interlude in 1991/'92 and
10 through much of the '90s, in which at first I took a
11 different job in Chicago -- I would not recommend
12 anybody going to Chicago -- and then I wound up in
13 private practice in Virginia Beach, Virginia, for six
14 or seven years, until I rejoined the medical school
15 again in 1999.

16 Q. Are you fellowship trained? Did you say
17 that?

18 A. Yes, I did two fellowships: one in the
19 prenatal diagnoses, as well as in maternal-fetal
20 medicine.

21 Q. What does it mean to be fellowship
22 trained?

23 A. So that's additional training past your
24 residency. And you didn't ask, but I am board
25 certified in both OB/GYN in 1985, as well as in

1 maternal-fetal medicine in 1987.

2 Q. And what does it mean to be board
3 certified?

4 A. That means that you have -- you've done a
5 course of study and additional training past the
6 appropriate examinations, both written as well as
7 oral examinations, that you know your stuff.

8 Q. Throughout your career, you've mentioned
9 you've been teaching. So can you give us an idea of
10 how much you spend with patients, like a clinical
11 setting, versus your teaching, or other
12 administrative work you may do for --

13 A. So probably 90 percent of my work is in
14 clinical medicine. And the teaching is like, as we
15 say, bedside teaching, where, if you're on call, you
16 have residents, medical students, with you. When I
17 am in clinic, I had medical students, residents, or
18 MFM fellows with me, and we see a patient and discuss
19 the case: How would you treat it? This is the way I
20 would treat it. So it's an ongoing teaching process.

21 Q. And you also have publications? Your CV
22 is a number of pages, 30ish pages. Does it contain
23 all the articles that you've written or co-authored?

24 A. Yes.

25 Q. And can you give us a sense of what type

1 of things you studied and written on and reported on
2 over the years?

3 A. Well, most of my research has been in the
4 field of prenatal diagnoses, ultrasounds, also some
5 work on prenatal diagnoses of various problems,
6 chromosomal problems, things like Down syndrome, as
7 well as identification of fetal anomalies with
8 ultrasound.

9 Q. You also have a number of memberships in
10 various organizations, is that correct?

11 A. Yes.

12 Q. And you also have a number of fellowship
13 or fellows that you've trained.

14 Tell us about how that works.

15 A. So at Eastern Virginia's Medical School,
16 OB/GYN, we have had a fellowship program that dates
17 back to the late 1980s. It was, for a couple years,
18 it was -- it wasn't ongoing, but most of those years,
19 we hired fellows. A fellow would be somebody who's
20 completed their OB/GYN residency and wants to have
21 additional training. And so I know on my CV, I've
22 listed all of the different fellows that I've trained
23 successfully to be practicing maternal-fetal medicine
24 specialists.

25 Q. Now, Doctor, you told us a little bit ago

1 that you haven't -- you're no longer delivering
2 babies. And I want to be clear because it was
3 mentioned in one of the opening statements that they
4 made it a point to say you don't deliver babies
5 anymore. So I wanted to understand whether you think
6 that affects your ability to testify about the
7 standard of care for HIE.

8 A. No, I don't think that affects it at all.

9 Not much has changed in how babies have been
10 delivered in the last 40 years, and it certainly
11 hasn't changed in the last couple of years.

12 And even though I'm not taking night call,
13 like many maternal-fetal medicine trained
14 individuals, they limit their practice just to the
15 outpatient setting. And so in my current role, for
16 the last couple of years, I still have plenty of
17 opportunity to consult on patients in the labor and
18 delivery process.

19 Q. Now, regarding some of the other work that
20 you've done, I think you've written a book in the
21 last number of years?

22 A. Yes.

23 Q. Tell us about the book you've written.

24 A. So the book, it has a little bit difficult
25 title. I keep forgetting the exact name of the

1 title. But it's a book that I've written based on my
2 experience as a medical-legal expert. You know, we
3 have a problem, medicine has a problem, many times
4 not being willing to admit you're guilty, you know,
5 and a lot of times --

6 MS. KAMYKOWSKI: Your Honor, we need a
7 sidebar on this.

8 THE COURT: You may.

9 (The following proceedings were held at
10 sidebar, outside the hearing of the jury:)

11 MR. PERRON: Your Honor, in two parts.

12 Number one, it's not relevant. Number two, a much
13 bigger issue is that it was granted in a motion in
14 limine specifically on that not using the language of
15 guilty or not guilty. The witness just qualified his
16 understanding of the medical-legal process as doctors
17 having problems admitting guilt or guilty, and I
18 think, Your Honor, we have to move to strike and/or
19 direct our claim.

20 MS. KAMYKOWSKI: Your Honor, the only -- I
21 don't think that this witness talking about a book he
22 wrote about his experience as an expert has any
23 relevance as to any of the opinions here for what he
24 just gave in containing the burden of proof and the
25 definition of negligence in this case, and it's

1 overly prejudicial.

2 At a minimum, he needs to be -- what was
3 just discussed -- needs to be stricken from the
4 record, and he needs to be instructed not to
5 additionally talk about this book that he wrote that
6 I don't think he's ever relied on for an opinion in
7 this case. And there were motions in limine that he
8 would not use any literature.

9 And I don't know if it's literature in the
10 medical expert realm or literature in the fiction
11 realm that we're talking about here. But it has not
12 ever been produced to us. We did not know he was
13 going to be relying on it. And I think the fact that
14 he just said doctors have a hard time admitting when
15 they're guilty probably warrants a request for a
16 mistrial.

17 MR. PERRON: I'll join on that.

18 MS. GUNN: Your Honor, I have no intention
19 of soliciting any evidence or any discussion about
20 guilt or innocence. Quite frankly, I anticipated the
21 defendant would talk about his book because it
22 involves medical-legal work, and my effort would be
23 to get in front of it to explain why he wrote it.

24 There was no intent to talk about guilt or
25 innocence. I think the jury has been well instructed

1 on the burden of proof and will continue to be well
2 instructed on the burden of proof, and that there
3 shouldn't be any confusion as to what the burden of
4 proof is in this case.

5 MR. PERRON: well, Judge, we had another
6 motion in limine about taking responsibility, and
7 actually saying that, you know, part of the problem
8 in malpractice work is doctors not admitting they're
9 guilty.

10 MS. KAMYKOWSKI: And I was going to say
11 the same thing. what he's doing now is he's
12 essentially saying, well, here, I came here as an
13 expert, and I'm coming in here telling you that I'm
14 here because in my experience, doctors have a hard
15 time not admitting they are guilty, would be
16 essentially the same as saying that doctors are not
17 taking responsibility, and asking -- saying that, the
18 reason why I'm here is so that I can make sure to
19 tell other doctors you need to take responsibility.

20 That's the implication. No one from the
21 defense is indicating that Ms. Gunn was attempting to
22 elicit this. It's not her fault that her expert has
23 gone awry and done this. But now that he has
24 injected that improper information in this case, it
25 is severely prejudicial to the defense.

1 MS. GUNN: Your Honor, I think that the
2 jury can be instructed as to disregard the last
3 statement. I will move on from the book.

4 THE COURT: The Court is going to deny the
5 request for a mistrial, but will grant the request to
6 instruct the jury to disregard.

7 Please tell your witness before we start
8 back again to avoid getting anywhere near such words.

9 MS. KAMYKOWSKI: Thank you.

10 (The proceedings returned to open court.)

11 THE COURT: All right. At this point, I'm
12 going to instruct you to disregard the answer of the
13 witness.

14 Q. (By Ms. Gunn) Doctor, have you served as
15 an expert before?

16 A. Yes, I have.

17 Q. And how long have you served in the
18 capacity as an expert witness in medical-legal cases
19 like this?

20 A. Approximately 25 years.

21 Q. And in those 25 years, have you found
22 yourself in front of juries such as this one?

23 A. Yes, about 15 times over the 25 years,
24 I've been in front of a jury.

25 Q. Okay. And have you also given

depositions?

A. Yes.

Q. Can you estimate about how many depositions you've done over the last 25 years?

A. About 150.

Q. And with respect to the work that you do in these cases, do you have an estimate as to how often that you are asked to review records on behalf of a patient or an institution or a hospital?

A. So probably 80 to 90 percent of the time, it's on behalf of plaintiffs. 10 to 15 -- 10 to 20 percent of the time, it's on behalf of the doctor or a hospital.

Q. And do you -- do you advertise or solicit for any of the calls that you get from attorneys?

A. No.

Q. And if the phone rings, do you pick it up, whether it's from a patient's attorney or from a hospital's attorney or doctor?

A. Or from a patient. And even my wife.

Q. Okay. Do you charge for your time?

A. Yes.

Q. And what do you charge?

A. So since 2022, I've been charging \$400 an hour for review of records and reading depositions

1 and discussions.

2 Q. Do you charge differently for depositions
3 or trial testimony?

4 A. Yes. At a deposition, I usually charge
5 600 an hour. And for trial, if I have to close my
6 office and get coverage, and come out of town to a
7 different city, then I charge \$6,000 a day.

8 Q. And how much of your time is
9 professionally spent on medical-legal work versus the
10 work on your patients and your students?

11 A. So my medical-legal work is all, what I'd
12 say, after hours, either in the evenings or weekends,
13 of those kind of things.

14 Q. You have received materials from me, my
15 office?

16 A. Yes.

17 Q. And that's been over the last couple of
18 years, receiving materials?

19 A. Yes.

20 Q. I'm going to list the materials that you
21 received, just out of ease. And you can let me know
22 if this is what you reviewed over this time frame.

23 You received the medical records of Sarah
24 Anyan from Mercy Hospital, you also received her
25 labor and delivery chart, her prenatal records, and

1 the fetal monitoring strips?

2 A. Yes.

3 Q. You've also seen and reviewed Remi Anyan's
4 Mercy Hospital chart?

5 A. Yes.

6 Q. You've reviewed the depositions of Sarah
7 and Blake Anyan, Dr. McNeive, April Parker, Kelsey
8 Mckillip, Morgan Miller, Nurse Alex Greenwald, Nurse
9 Kelsey Blanton, Nurse Jessie Brown Wagner, Nurse
10 Margaret Hilt-McLeland, Dr. Mark Landon, Nurse
11 Practitioner Mary Younger Spencer, Dr. Joseph Cantey,
12 Dr. Brian Woodruff, and Dr. Aylin Tekes?

13 A. Yes.

14 Q. In addition to that, you reviewed ACOG
15 articles and guidelines and Mercy policies and
16 protocols?

17 A. Yes. Some. Some. Not all of their
18 policies and protocols, but limited, yes.

19 Q. Limited to what's relevant to this case?

20 A. Yes.

21 Q. Thank you.

22 Now, can you generally take the jury
23 through your process of what you do to review the
24 records so you can prepare yourself to come give your
25 conclusions?

1 A. I reviewed the prenatal records and then
2 labor and delivery records and the fetal heart
3 monitoring tracing. I try to put myself in the
4 position of the doctor. And, again, this is whether
5 I'm looking, reviewing for the defense or for the
6 plaintiff.

7 I put myself in the position of the
8 physician at that period of time in providing
9 prenatal records, in being the managing obstetrician,
10 or sometimes the maternal-fetal medicine specialist,
11 and to look at this kind of like what would I do --
12 what is the standard of care when, in this particular
13 clinical situation, as we move forward in time?

14 And then the -- after looking at the
15 clinical scenario, making an opinion based on that,
16 and the depositions are helpful kind of filling in
17 why did this happen? what was the doctor thinking?
18 what was the patient thinking? what was the nurse
19 thinking at that time?

20 Q. Thank you.

21 Now, I want to turn your attention now to
22 those records, to those prenatal records, of Sarah
23 Anyan.

24 You understood that Dr. McNeive was her
25 obstetrician?

1 A. Yes.

2 Q. All righty. so let's go to Exhibit 6,
3 page 36.

4 These are medical records that everyone
5 has. Everyone.

6 A. Can I get a copy?

7 Q. well, can you read it? we'll get it
8 closer.

9 MS. GUNN: Go down.

10 Q. (By Ms. Gunn) Now, these, you've seen
11 before, correct?

12 A. I have.

13 Q. okay. just to be clear. so let's look at
14 Exhibit 6, page 36. The date on this is September
15 19, 2029.

16 Do you see that, Doctor?

17 A. Yes, September 19, 2019, yes.

18 Q. yeah, sorry. 2029, not --
19 what does CC mean?

20 A. Chief complaint.

21 Q. And what does it say there?

22 A. A confirmation pregnancy. So I guess this
23 is her first prenatal pregnancy. So I guess this is
24 her first prenatal visit. She wants to know, am I or
25 am I not pregnant?

1 Q. And what's the answer?

2 A. Yes.

3 Q. Okay. And at that time, what did you
4 learn about Sarah?

5 A. Well, that she's a 30-year-old female, and
6 her last period was July 23rd. That makes her about
7 eight plus weeks gestation, and gives her a due date
8 of 4/28/20. She was having some symptoms of
9 pregnancy: nausea, breast tenderness, and she was
10 good.

11 Q. Okay. You see that she plans to see Dr.
12 McNeive?

13 A. Yes.

14 Q. All righty. And then in terms of let's go
15 to Exhibit 6, page 206.
16 Doctor, you told us a minute ago that
17 obviously you know about ultrasounds, so this is an
18 ultrasound. Do you see the date there? It looks
19 like September 24th, 2019?

20 A. Yes.

21 Q. Okay. Why do we do ultrasounds?

22 A. Well, at this point in the pregnancy,
23 early in the pregnancy, you do an ultrasound, one, to
24 confirm that there is a pregnancy. But I usually say
25 to try to answer three important questions: Are you

1 pregnant or not? And the answer is yes.

2 Then the next question is, where is the
3 pregnancy located? Is it in the uterus where it
4 belongs? Or is it outside the uterus in what's
5 called an ectopic pregnancy? In this case, it's in
6 the uterus where it belongs.

7 And then you want to know is the fetus
8 viable? That is, is there a fetus and a fetal
9 heartbeat? And the answer is yes.

10 And then you want to know, well, how far
11 along is this pregnancy? We had talked in the
12 previous exhibit that she was -- she had a due date
13 based on her last menstrual period.

14 We've learned over the years that dating a
15 pregnancy by early ultrasound is even more precise
16 than using the clinical parameters. So we measure
17 the crown-rump length, CRL, and you can see that's
18 1.58 centimeters, and that gives us a gestate -- a
19 due date of May 7th, 2020.

20 Q. So the EDC is -- what does that stand for?

21 A. Estimated date of confinement or otherwise
22 known as the due date. When is the baby due?

23 Q. Seems like an old term.

24 A. An old term.

25 Q. All right. Let's go to page 78 of

1 Exhibit 6.

2 So we're going to move forward into
3 December 17th, 2019. Doctor, at -- from your
4 recollection of the prenatal records, was everything
5 going well?

6 A. It was quite a smooth pregnancy, yes.

7 Q. All right. So this is a note, progress
8 note, on that date from Lindsey Foster, someone at
9 Dr. McNeive's office.

10 And what does that indicate?

11 A. That they were going to have a party
12 because it was a boy. I hope they'd have a party if
13 it was a girl, too.

14 Q. Well -- now, the -- obviously the
15 ultrasound revealed the gender at some point of the
16 baby?

17 A. Yes.

18 Q. Okay. Now, we'll go forward. There was a
19 note somewhere about a low-lying placenta.

20 was that of any concern ultimately?

21 A. Ultimately, it was not a concern.

22 what we're talking about is the location
23 of the placenta, the afterbirth. And in rare
24 situations, the afterbirth is in the area of the
25 cervix, the opening of the uterus, and that could

1 cause a problem that we refer to as placenta previa.

2 Fortunately, in this case, as in most
3 cases, when the low-lying placenta, meaning it's near
4 the cervix, as the uterus grows, it kind of pulls the
5 placenta away from the cervical area, so it was not a
6 problem in this pregnancy.

7 Q. All right. And you reviewed those
8 records. Were there any concerns about Sarah's
9 ability to have a healthy baby or whether the baby
10 would be healthy, at least during all this prenatal
11 time frame?

12 A. No. It was normal prenatal care. There
13 was no red flags. Everything looked good.

14 Q. And from what you could tell, she went to
15 all her appointments, took all of her vitamins, and
16 followed all the directions?

17 A. She was a compliant patient, yes.

18 Q. All right. We know that her water broke
19 around noon Sunday, May 3rd?

20 A. Yes.

21 Q. And she came right from Mercy?

22 A. Yes.

23 Q. She was admitted.

24 were there any concerns once she was
25 admitted?

1 A. well, you know, whenever you have ruptured
2 membranes before the onset of labor, that's a
3 situation that we call premature ruptured membranes.

4 That means that you ruptured membranes before the
5 labor starts.

6 It's not a major concern. It's important
7 to note that the fluid was clear at that time. So
8 that would imply that the baby was healthy. There
9 was no meconium, and meconium being the first bowel
10 movement of the baby in utero, is frequently a sign
11 of fetal stress. There was no evidence of that. So,
12 again, at twelve o'clock on that day, or two o'clock,
13 when she's admitted, everything looks fine.

14 Q. when she was asked upon admission whether
15 she had felt the baby, it was noted that she had good
16 fetal movement.

17 what does that mean?

18 A. so, again, a sign of a healthy baby at the
19 onset of labor.

20 Q. And then what happened once she admitted
21 to the hospital? what was -- generally what do you
22 do?

23 A. well, the -- you know, she was admitted at
24 the process: draw some labs, get an IV started, put
25 on a fetal heart monitor. Everything looked good on

1 the monitor. And the, you know, because she ruptured
2 her membranes, you want to start to get her into
3 labor, so the idea was that she would be augmented
4 with Pitocin.

5 Q. Is that pretty standard?

6 A. Yes. Because you don't want, once the
7 membranes have ruptured, the membranes is sort of a
8 seal that keeps the uterus sterile. And once the bag
9 of waters, the membranes, have ruptured, then there's
10 sort of a -- a little bit of a clock going on as to
11 they don't want to have an extended, a long extended,
12 period of time of an indefinite period of time with
13 ruptured membranes because of risk of ascending
14 infection from the vagina to reach the baby.

15 And this is unfortunately what did happen
16 finally at the end of this labor. And maybe I'm
17 getting ahead of myself.

18 Q. we'll get there.

19 A sterile vaginal exam was done of Sarah?

20 A. Yes.

21 Q. And the jury has heard from Nurse Shinn
22 what that was.

23 I want to ask you that at the time, the
24 first one that was done, she had, Sarah had, cervical
25 dilation of 1.5, effacement of 70 percent, and fetal

1 station at negative 2.

2 Can you tell us whether that is something
3 typical or normal to present --

4 A. It's pretty typical of a first pregnancy.

5 So her cervix is 1 and a half centimeters dilated,

6 and you have to get to 10 centimeters. Her cervix

7 was 70 percent effaced, so thinning out

8 appropriately. And the head was still high because

9 she hadn't been in labor yet. So all typical normal

10 first pregnancy kinds of things.

11 Q. You mentioned Pitocin. And she was --

12 there was an order for her to be augmented by

13 Pitocin.

14 And tell us about Pitocin.

15 A. Well, Pitocin is a hormone that's now

16 artificially made that is used to cause contractions.

17 There's a couple of different medications that we can

18 use that we call uterotonic that make the uterus

19 contract. Ms. Shinn used the analogy, I think, of

20 it's the gas in a car, and so it's what drives the

21 contractions.

22 Q. And does that -- does Pitocin make the

23 contractions -- how does it affect the contractions?

24 A. Well, it should make the contractions

25 stronger and more regular and help augment the labor

process.

Q. Now, you've reviewed the medical records --

MS. GUNN: And I want to have Exhibit 1, page 100, brought up.

Q. (By Ms. Gunn) And this is, again, directly from Sarah's chart, and the jury has already seen this, but let's walk through it again.

This is the hospital STLLD virginal -- virginal? -- vaginal birth protocol.

Do you see that, Doctor?

A. Yes.

Q. Now, this, again, this is part of Sarah's chart. This is embedded in her chart.

A. Yes.

Q. Is this a protocol that applies to Sarah Anyan?

A. Yes.

Q. Does it apply to physicians and nurses alike?

A. Yes.

Q. So the next page --

MS. GUNN: So two pages down, to intrauterine resuscitation. Let's keep it big for a minute.

1 Q. (By Ms. Gunn) Now, first this is nursing
2 communication orders.

3 what is that generally?

4 A. It's -- it sort of describes when a nurse
5 should contact the attending doctor/responsible
6 physician, whether it's a resident or an attending
7 doctor. It -- there's many places -- and these are
8 various obvious things, and you don't need --
9 necessarily need to have a protocol, everybody should
10 know this kind of stuff. But it's nice to just to
11 emphasize the importance of it in the chart.

12 Q. All right. And under the intrauterine
13 resuscitation, it says, if the fetal heart rate, FHR,
14 pattern is indeterminate, Category II, or abnormal,
15 Category III, the following measures will be
16 initiated based on maternal-fetal response.

17 And there's six things listed there,
18 correct?

19 A. Yes.

20 Q. And even though it's tabbed over, there is
21 a discontinuation of oxytocin if infusing, correct?

22 A. Yes. That's the gas on the pedal in
23 describing this. And so when you have an abnormal
24 heart rate -- or the first thing that you would do
25 is, you know, take your foot off the gas.

1 Q. All right. And that's what I want to
2 understand.

3 So there's a lot of discussion with Nurse
4 Shinn about policies and protocols, and if you do or
5 you don't use Pitocin, or whatever you do.

6 what is the main concern when you have a
7 Category II tracing?

8 A. That it will evolve into a Category III
9 tracing. And so it goes from indeterminate -- what
10 you worry about -- is it goes from indeterminate to
11 bad.

12 Q. And how do you prevent that?

13 A. They -- well, you try to prevent it by
14 these various steps of intrauterine resuscitation.

15 And the main one in my mind is stopping the Pit. You
16 can turn her on her side, give her some fluids.

17 we've heard that about intrauterine resuscitation,
18 but, you know, stop the Pit.

19 Q. And why does it matter -- why does it
20 matter that you stop the Pit?

21 A. Because that is what is driving the
22 contractions and most likely driving the abnormal
23 heart rate.

24 Q. And how does it drive the abnormal heart
25 rate?

1 A. Because, you know, when the Pitocin is
2 leading to contractions, and when there's a
3 contraction, it tightens the uterus and affects the
4 blood flow to the placenta, and from the placenta to
5 the baby. So you want to try to decrease the
6 contractions to give the baby a chance to recover.

7 Q. And what is wrong with an abnormal heart
8 rate?

9 A. Well, if left with, you know, and
10 continues, then you could cause the hypoxic injury to
11 the baby, deprive it of oxygen, and lead to
12 neurologic damage to the baby.

13 Q. So there's a direct line from Pitocin to
14 hypoxia in a baby?

15 A. Hopefully there's a few steps in the
16 middle --

17 Q. I understand.

18 A. But you have an opportunity to stop the
19 Pitocin and to prevent it from becoming a damaged
20 baby. I think that's the key. And that's what the
21 labor and delivery nurses, that's what the
22 obstetricians, all the safety and -- on labor and
23 delivery is all about: preventing it from going from
24 a bad tracing to an indeterminate tracing to damage
25 the baby.

1 Q. Okay. So it's not just unrelated or a
2 coincidence that you turn down Pitocin? There's a
3 real reason to do that in the fact of a Category II
4 tracing that deals directly with the health and
5 safety of the baby?

6 A. Yes. Now, sometimes you can do all these
7 things. You can stop the Pit, but the contractions
8 keep going. And so there was mention about using a
9 tocolytic of medicines that can try to slow down the
10 contractions even more if these steps don't work.

11 Q. But the idea is with Category II tracings,
12 you want to do what you can to prevent them or switch
13 them or do things to make them better?

14 A. And to relieve the abnormal tracing, yes.

15 Q. Okay. At any point in time, after Sarah
16 Anyan's Pitocin would titrate up to 18, which I think
17 was around a little bit after midnight, was it ever
18 turned off --

19 A. No.

20 Q. -- before Remi was born?

21 A. No.

22 Q. Was it ever turned down?

23 A. No.

24 Q. So the protocol that's in Sarah's chart,
25 that is a protocol of Mercy Hospital, at no point in

1 time, in the face of an indeterminate Category II
2 tracing, was the Pitocin discontinued?

3 A. That's correct. At no time was it
4 discontinued. In fact, towards the end, it was
5 increased.

6 Q. But with respect to the other intrauterine
7 resuscitation things that were listed: the lateral
8 positioning, the modifications, fluid bolus, all of
9 those things, if they had worked, would we still be
10 seeing recurrent Category II tracings?

11 A. If they had worked, then the idea would be
12 that you wouldn't see that, that it would have
13 resolved and been turned back to a normal tracing.

14 Q. So you understand, you've read the fetal
15 monitoring strips, correct?

16 A. Yes.

17 Q. Did Remi Anyan's heart rate continue in
18 Category II for most of the time frame between 7:00
19 a.m., unfortunately until it turned Category III at
20 about a little bit before four o'clock?

21 A. That is correct.

22 Q. So if there were other intrauterine
23 resuscitations going on in terms of turning mom over
24 and putting her on the ball, were they working?

25 A. No.

1 Q. And if they're not working, are there
2 other tools that should have been utilized?

3 A. Well, the stopping of Pitocin. And if
4 that didn't work, then the tocolytic medication. And
5 if that didn't work, then you need to deliver.

6 Q. Yes. All right. Now, fetal monitoring
7 strips. We talked about how -- I think the jury
8 knows now there are two parts to that. And what are
9 the two parts?

10 A. Well, usually in a fetal monitor, you have
11 the top part, which is related to the baby's heart,
12 fetal heart rate. And the bottom part is related to
13 the contractions.

14 Q. And we've heard quite a bit about the
15 heart rate, that first line, and the second line, the
16 contractions. We heard quite a bit about the heart
17 rate remaining at moderate variability?

18 A. Yes.

19 Q. And moderate variability is a good thing?

20 A. Yeah. We usually refer to it as
21 beat-to-beat variability. It's this little wiggle in
22 the tracing. It's over time.

23 Q. But the fetal monitoring strip has two
24 parts, right? It has the contractions and how the
25 heart rate reacts to the contractions?

1 A. Yes.

2 Q. In addition to just a heart rate?

3 A. Yes.

4 Q. So you have to read them together?

5 A. That would be the best thing to do, yes.

6 Q. So if you just look at the heart rate, and
7 it appears to be of moderate variability for a good
8 amount of time, are you safe?

9 A. Not necessarily. Because there could also
10 be, I guess, decelerations in response to
11 contractions. There could be bradycardia, slowing of
12 the heart rate. There could be rising heart rate,
13 tachycardia. So it's more than just beat-to-beat
14 variability.

15 Q. All right. So you can't just look at one
16 of the pieces of the puzzle and say everything's
17 fine?

18 A. That's correct.

19 Q. You have to look at the entire clinical
20 picture before you decide how to go forward?

21 A. Right.

22 So when we're looking at the fetal heart
23 rate, you know, we talked about beat-to-beat
24 variability, important. You also want to know what
25 the baseline is. You want to know whether there's

1 accelerations, increase in the heart rate, or
2 decelerations, the slowing of the heart rate and its
3 response to the contractions.

4 Q. So if somebody says, you know, there's
5 moderate variability throughout, does that mean
6 there's nothing to worry about?

7 A. No. I mean, that's good, but there's
8 other things to worry about.

9 Q. Like what?

10 A. Well, again, what the baseline is, whether
11 there's accelerations or decelerations. And, also,
12 whether the patient is making progress in labor.

13 Q. Let's talk about progress.
14 So when Remi -- or when Sarah was
15 complete, so that was the beginning of the second
16 stage --

17 A. Uh-huh.

18 Q. -- at 3:50 a.m.?

19 A. Yes.

20 Q. There was an exam done by the night nurse
21 at that time, Alex Greenwald.

22 Do you recall that, Doctor?

23 A. Yes.

24 Q. And that's how you see the 10 percent
25 dilate -- sorry -- 10 centimeters dilated, the

1 hundred percent effaced? And then you measure where
2 the baby is?

3 A. Right.

4 Q. And you can't just look and see where the
5 baby is?

6 A. That's correct. You have to do a vaginal
7 exam and to feel where the descending part is in
8 comparison to the ischial spines, that's the bony
9 prominence in the spine.

10 Q. All right. Everybody has seen this.

11 MS. GUNN: But let's go to 342.

12 Q. (By Ms. Gunn) So, Doctor, I'm putting up
13 an illustration here, a drawing, of a baby in --
14 in -- coming down the birth canal.

15 A. Yes.

16 Q. And you see the negative 3 to the plus 3,
17 right?

18 A. Right.

19 Q. And are those the stations?

20 A. That's typically how we refer to it as
21 station, yes.

22 Q. And then you talked about the spine. what
23 is the ischial spine -- spine?

24 A. It's a -- I mean, you can see the label,
25 and it's that little bony prominence that you can

1 feel when you do a vaginal exam. As an obstetrician,
2 anybody doing a vaginal exam, you want to know the
3 station, that is, how far is the baby's head in the
4 birth canal in relationship to the ischial spines.

5 Q. So that's how you feel? You feel for the
6 ischial spines? And then where the head is in
7 relation to it?

8 A. Yes.

9 Q. And you do that with your fingers?

10 A. Yes.

11 Q. Okay. So at 3:50 a.m., Remi's head was at
12 zero station?

13 A. Yes.

14 Q. So that would be -- I mean, that little
15 head is between 1 and 2, but that would mean his head
16 was higher, correct?

17 A. Higher than what is demonstrated in this
18 picture, just to zero station.

19 Q. Okay. All righty. And so let's -- my
20 handy-dandy tape measure.

21 So generally I understand, and you can
22 correct me if I'm wrong, that a woman's vagina is
23 about 10 centimeters typical?

24 A. Yes.

25 Q. Okay. You see this, sir? This is set

1 at -- the red number is 10 centimeters?

2 A. About 4 inches, yes.

3 Q. There's also inches on that, too. I don't
4 know. It would be better if we did inches, but here
5 we are.

6 So 10 centimeters is about that length
7 between negative 3 and plus 3, right?

8 A. Correct.

9 Q. So Remi then, at zero station, when you're
10 up there feeling, was at zero station, so about 5
11 centimeters?

12 A. Correct, yeah. He had 5 centimeters to
13 go.

14 Q. And this is the amount of length of space
15 that his head has to travel in order to get to plus 3
16 which is crowning?

17 A. Yes.

18 Q. 5 centimeters?

19 A. Yes.

20 Q. which is about 2 inches?

21 A. Yes.

22 Q. okay. And you told us that typically the
23 average for a baby to go into the second stage of
24 labor, whether they start at, I guess it's an
25 average, right? whether you start at plus 3 or

1 negative 3 or zero, 2 hours?

2 A. On average, it takes about 2 hours to
3 negotiate that last bit of vagina, yeah.

4 Q. And if you looked at -- we started this
5 discussion when you look at progress.

6 Is there a typical time frame of length of
7 space to traverse before you consider that progress
8 or not?

9 A. Well, again, the average is 2 hours. We
10 would let it go maybe 3 hours for the first-time
11 mother, maybe a fourth hour if they have an epidural
12 as she did. But, you know, the vast majority of
13 women who are going to safely deliver a baby
14 vaginally, will have done it in that time frame, 4
15 hours, and maybe a little bit more, maybe -- maybe 5
16 hours. But I've never heard of it taking 12 hours to
17 safely negotiate those last couple of centimeters.

18 Q. Never?

19 A. In 40 years, I have never seen that.

20 Q. You've never seen it yourself, or never
21 heard anybody talk about it?

22 A. That's correct. That's what was so
23 astounding about that case.

24 Q. So 5 centimeters, 2 inches to go,
25 3:50 a.m., right?

1 A. Yes.

2 Q. Okay. And then what we know, if you
3 recall from the records, is that Nurse Greenwald
4 pushed with Sarah for about an hour and a half?

5 A. Yes.

6 Q. And then she called for a pushing
7 evaluation.

8 what is that?

9 A. Well, I guess that's to have one of the
10 doctors to come in and to see how she's doing and
11 whether there's progress made and how's the pushing,
12 whether she's pushing adequately.

13 Q. So there was at least, from that, some
14 concern or a second set of eyes to see what's going
15 on here?

16 A. Right. And I think that was done in a --
17 at that time, it was still at zero station, although
18 there was caput, that is, swelling at the top of the
19 head, that came down at plus 1, plus 2 at that time.

20 Q. Can you count caput for progress?

21 A. No.

22 Q. Okay. Now, let's just take a quick look
23 at Dr. McKillip's note. And that is Exhibit 1, page
24 107. I think it maybe starts at 108.

25 sorry. 106 to 107. what did I say?

1 Let's go to 106.

2 All right. So we've got -- let's go to
3 the bottom. Yeah. So we've got Nurse Greenwald
4 documenting at 5:35 that Dr. Mckillip was at the
5 bedside for pushing evaluation and position. And
6 then directly under that, we have Dr. Mckillip. And
7 I think it goes to the next page, at 6:02, that she
8 has written a little note about what she's done.

9 So I know the jury's already seen this.
10 so let's walk through this, Doctor, I think it is
11 critically important.

12 Called per RN to evaluate maternal pushing
13 for the last hour and a half, correct?

14 A. Yes.

15 Q. So that's what it is?

16 A. Yes.

17 Q. Alex has been with her, not coming?

18 A. Yeah.

19 Q. Per RN, fetus zero station upon initially
20 pushing.

21 So that translates to Alex -- was at zero.

22 Alex noted with her actual --

23 A. vaginal exam, yeah.

24 Q. -- examination that baby was at zero. She
25 was using those ischial spines for her --

A. Yes.

Q. -- mark.

And patient had pushed on -- what's all those? -- bilateral sides with handlebars and towel pushing? what's all that?

A. These are different techniques that labor and delivery nurses use to help the patient push, especially when you have an epidural, you have the loss of feeling in the pelvic area, and so these are maneuvers that are done that are fine to do to assist in the pushing.

Q. Okay. And then patient denies excessive fatigue or pain.

So I guess somebody was asking her, how you doing, Sarah?

A. Yep.

Q. How you feeling?

A. She's good.

Q. Upon evaluation, fetus, 10 -- 100, zero station with caput present to plus 1, plus 2. You told us that.

So now this is Dr. Mckillip doing her separate vaginal examination, and she gets the exact same values as Alex Greenwald.

A. Right. So even Dr. Mckillip, TGY1. what

1 does that mean? That means she's one year out of
2 medical school, she's an intern. And even she knows
3 there's been no progress here.

4 Q. The fetus is ROP with rotation to ROA,
5 with maternal pushing effort and rotation back to ROP
6 upon cessation of pushing efforts.

7 So translate that for us, Doctor.

8 A. So typically the best way for a baby to
9 enter and exit the birth canal is what we call ROA or
10 LOA. That means right occiput anterior. That's
11 referring to how the head is coming down through the
12 birth canal. So usually it's this part of the head
13 here that is going down the birth canal.

14 And the OA is the preferable way, but
15 sometimes babies enter the birth canal kind of sunny
16 side up, as referred to with the face -- the eyes
17 facing up, and that would be occiput posterior. And
18 that's more difficult for a baby to be born in the
19 occiput posterior position.

20 Q. Okay. So it looks like Remi is, with
21 pushing, he's kind of going -- turning the right way,
22 turning facedown, but when pushing is over, he goes
23 right back to where he was?

24 A. Right.

25 Q. So Dr. Mckillip was there for how long?

1 A. 20 minutes.

2 Q. And she is pushing with Sarah for 20 more
3 minutes?

4 A. Right.

5 Q. And what did she note?

6 A. Minimal descent.

7 Q. What does that mean?

8 A. So it wasn't coming down. You know, and
9 so, again, even the intern will recognize that -- and
10 this is at seven o'clock in the morning --

11 Q. Six o'clock?

12 A. Six o'clock, sorry. Six o'clock in the
13 morning, that this was not headed in the right
14 direction.

15 Q. All right. And she documents all of that
16 in the chart?

17 A. Yes.

18 Q. For everybody to see?

19 A. Yes.

20 Q. And she calls Dr. Parker.

21 And who was Dr. Parker at the time?

22 A. Dr. Parker was the attending doctor, that
23 is the senior doctor, who is managing the labor.

24 Q. So at six o'clock in the morning, or
25 around that time, Dr. Mckillip has identified

malposition?

A. Yes.

Q. And failure to descend?

A. Yes.

Q. Are those good things?

A. No. But, again, it doesn't mean that the baby's injured at this time. It just means that this is not favorable for a successful vaginal delivery.

Q. So those are two things that, in the face of knowing, you got to be aware that this is something to watch?

A. Yes.

Q. Because could it go great?

A. Always a possibility, but it's looking not so good right now.

Q. So she was told to labor down.

Tell us about that.

A. So labor down is a technique that's used that, instead of actively pushing with every push, that's just what they refer to as passive pushing, that is, the uterine contraction is going to push the baby down, rather than the mother's expulsive efforts.

Q. Do you count that as part of the second stage of labor?

1 A. Yep.

2 Q. Can you push pause on the timer of that?

3 A. No, the clock is running.

4 Q. Okay. So take a break, labor down. And
5 now we get to close to eight o'clock, but let's look
6 at one more thing: FHT remains reassuring.

7 And what are the elements of that
8 reassuring fetal heart tracing?

9 A. So, again, when we talked about it
10 earlier, that, first, that baseline is normal. There
11 is moderate beat-to-beat variability. There are
12 accelerations, that is, speeding up of the heart
13 rate. And aware of variable decelerations, slowing
14 of the heart rate. So one would, from that
15 assessment, if the baby was born at that moment in
16 time, one would assume the baby would be perfectly
17 healthy.

18 Q. Okay. Is there any indication in anything
19 you've seen, the prenatal records or in the fetal
20 heart tones at this point or anything that we've seen
21 in these records, that Remi is anything other than
22 perfectly healthy?

23 A. No. Everything is pretty much
24 straightforward.

25 Q. Now, it does say that there are rare

1 variable decelerations, but you also have moderate
2 variability accelerations. So that's a puzzle that
3 you're pushing together, right?

4 A. Yes.

5 Q. You can't just look at the moderate
6 variables, just like you can't just look at the
7 variable decels, right?

8 A. Right. You have to put it all together.

9 Q. And putting that all together, the fetal
10 heart tones remained reassuring?

11 A. Yes.

12 Q. Okay.

13 A. That was Dr. Mckillip's impressions --
14 that's my impression, as well -- in looking at the
15 tracing at that time.

16 Q. Okay. So let's then go to what happens
17 next.

18 At seven o'clock, there's a shift change.
19 Did you understand that?

20 A. Yes.

21 Q. Okay. And at this shift change, who takes
22 over for Dr. Parker?

23 A. Dr. Mckillip.

24 Q. And who takes over for Alex Greenwald?

25 A. The two nurses. I think one is wagner,

1 and the other is Hilt.

2 Q. okay. So we've been, not disrespectfully,
3 but calling them Jessie and Maggie.

4 A. okay.

5 Q. okay. All righty. It indicates that
6 report was given to Jessie and Maggie. Generally
7 tell us what it means for a report to be given, if
8 you know.

9 A. well, that would be, you know, the night
10 nurse, I guess, Ms. Greenwald, would tell the day
11 nurses, what's the situation? where are we in this
12 labor?

13 she's fully dilated. She's been pushing
14 for 2 hours, lack of descent, the fetal monitor is
15 still good.

16 Q. okay. And then Dr. McNeive comes to the
17 bedside at eight o'clock. And now we're kind of
18 getting into the time frame to your opinions?

19 what did Dr. McNeive know from the records
20 about Sarah Anyan and Remi Anyan at eight o'clock.

21 A. well, at that point in time, he should
22 have known that, okay, so she started pushing at four
23 o'clock. So now we're 4 hours into the second stage
24 of labor.

25 The fetal heart rate tracing had been good

1 up until about this time, and I'm sure that we're
2 going to start looking at what happened to the fetal
3 heart rate tracing in a moment because the situation
4 is going to be changing.

5 Q. Okay. Is there any documentation that Dr.
6 McNeive checked -- got on his gloves and did the
7 sterile vaginal exam at that time?

8 A. Not that I saw.

9 Q. And is there any documentation of what
10 Remi's station was by eight o'clock a.m.?

11 A. I didn't see anything, so the assumption
12 is he's still at zero station.

13 Q. Because he wasn't delivered.

14 A. There was no baby yet, that's for sure.

15 Q. And what is the Pitocin set to?

16 A. The Pitocin is still at 18 milliunits per
17 minute.

18 Q. Okay. You want to talk about the fetal
19 monitoring strip specifically?

20 A. Sure.

21 Q. All right. So let's look at Exhibit 5.

22 And, Doctor, let's go to -- where would
23 you like to start, if this is in this time frame?

24 A. 7:00 or so.

25 Q. Okay. So let's go to page 119. Some of

1 the pages are off by 1, so we'll get there.

2 And, Doctor, you understood that Exhibit 5
3 was an exhibit -- this is the original -- that I took
4 to a number of depositions in this case, right?

5 A. Uh-huh.

6 Q. And I had the folks that I was deposing,
7 Dr. McNeive; the night nurse, Alex Greenwald, Maggie
8 and Jessie and April Parker, Dr. Parker, I had them,
9 on the same piece of paper, use different colored
10 inks to describe what they're seeing in these strips,
11 correct?

12 A. Yes.

13 Q. And they asked to go through them, and
14 they did that. And that's the markings here.
15 Everybody's got different initials, okay?

16 A. Uh-huh.

17 Q. So all of these people are identifying
18 what they're seeing?

19 A. Yes.

20 Q. And there's a lot of clusters of
21 identification.

22 Do you see that?

23 A. Yes.

24 Q. For example, on page 119 of Exhibit 5,
25 what are people saying they're seeing, all agreeing,

1 there?

2 A. Deceleration.

3 Q. And what time is that? Can you read that?

4 A. No.

5 Q. Okay. Well, the time on the sheet is
6 7:09.

7 A. Okay.

8 Q. And is it 8 minutes per page?

9 A. Right. And each kind of a darker vertical
10 line should represent a minute. The smaller vertical
11 lines is every 10 seconds.

12 Q. All right. So at seven o'clock, we've got
13 a -- let's talk first real quick about late decel.
14 You said that's a decel.

15 A. Yes.

16 Q. There are different types of decels.
17 Let's talk about late decels.

18 what is a late decel? what is it
19 indicative of?

20 A. Typically it's indicative of
21 uteroplacental insufficiency. That means that the
22 baby is not getting enough oxygen and nutrition as a
23 result of that contraction that led to that
24 deceleration.

25 Q. And that's significant? That's a

1 significant thing to recognize?

2 A. Yes.

3 Q. That puts the baby -- the strips into a
4 Category II in and of itself?

5 A. Yes. And, again, one deceleration doesn't
6 matter that much, or at least in most cases, but it's
7 the repetitiveness that's important. As we move
8 forward, we can just see how many decelerations there
9 are.

10 Q. okay. so let's do that. well, sorry,
11 let's finish out.

12 what is a variable deceleration?

13 A. So a variable deceleration is usually
14 related to cord compression. And it typically is not
15 dangerous in and of itself, but can evolve into a
16 pattern that has variable and late components to it
17 that makes it more worrisome?

18 Q. okay. Does it also indicate potential
19 oxygen deprivation to the baby?

20 A. Yes. But not as significantly as a late
21 deceleration.

22 Q. All right.

23 MS. GUNN: so let's go to the next page,
24 Zack. Let's go to page 120.

25 Q. (By Ms. Gunn) we've got -- looks like

1 everybody was pretty much on the same page here.

2 what am I-- what are we seeing, Doctor?

3 A. So it's starting from the left-hand side
4 of the page, first looks okay. The baseline is good.

5 It seems appropriate beat-to-beat variability. But
6 then I can see one, two, three, four pretty dramatic
7 decelerations. I don't know if everybody can see

8 them, where the heart rate drops from about 140 down
9 to 90. The nadir, that is the low point of the

10 deceleration, about to 90 on at least the three
11 decelerations on the left-hand side of the page.

12 Q. Okay. So you've got a page here where
13 people are identifying decelerations, correct?

14 A. Yes.

15 Q. And it looks like there might be some
16 people calling it variable, some people calling it
17 early, some people maybe saying late.

18 so here's the question: They're all
19 decelerations?

20 A. They're all decelerations, and they can't
21 be ignored.

22 Q. The next page, page 121. This is ending
23 at 7:25.

24 what are you seeing?

25 A. So in this page, we're seeing, I guess,

1 discontinuity of the tracing. You can see gaps in
2 the tracing. And that's always a difficult thing.
3 Most people would say that if you have significant
4 discontinuity, you should put a scalp electrode
5 there -- that's a lead on the baby's head -- so that
6 you won't have those kinds of discontinuity because
7 you really don't know what's going on when you're not
8 getting a reading. You don't know whether it's
9 normal or whether there's even worse decelerations
10 during that period of time.

11 Q. All right.

12 A. But it does look like where you do see it,
13 that it's -- the heart rate is low and trying to come
14 back up to its baseline.

15 Q. Okay. So if it's written noncontiguous,
16 you can't really assume that's good, can you?

17 A. That's correct.

18 Q. So next page, 122.
19 It looks like there's some non
20 contiguousness there, as well.

21 You don't get to assume that's fine, do
22 you?

23 A. That's right. I mean, it looks like
24 there's, towards the left-hand side, there are two
25 decelerations, I think you can see how it's trying to

1 get back up to the baseline.

2 Q. All right. Then we've got the next page,
3 123.

4 And there's a note, a late deceleration
5 noted there, by Dr. McNeive.

6 Do you see that?

7 A. Yes.

8 Q. Do you also see the late there?

9 A. Well, it's a subtle late. It's not a big,
10 severe late, but it does look to be a subtle late
11 deceleration.

12 Q. The next page is 124. It looks like
13 there's just a noncontiguous there, as well?

14 A. Right.

15 Q. All righty. And then let's go to page
16 125, and now we're at eight o'clock.

17 What are you seeing there?

18 A. So now it's becoming clearer that these
19 decelerations are almost on every contraction, and
20 they're deep, going down to 80 from -- I can eyeball
21 it from here, at least the one in the middle -- and
22 the duration is also of concern, that is, the length
23 of time that the heart rate is down.

24 Like for the one in the middle, the heart
25 rate looks like it takes about a minute and a half to

1 go back up to its baseline.

2 Q. All right. So at eight o'clock, this is
3 when Dr. McNeive's in the room?

4 A. He's in the room, and so now you have 4
5 hours of second stage, probably no descent. Now you
6 have an abnormal tracing, as well.

7 Q. In terms of these strips, are they right
8 there by the bedside, or are they in the room?

9 A. Typically the monitor is in the room so
10 that anybody in the room can see it. Many times they
11 have a distant monitor, either in the labor and
12 delivery nurses' station, or maybe in the doctors'
13 call room or the doctors' lounge where you can see
14 the tracing, as well.

15 Q. Let's go to the next page, 126.

16 So this takes up to 8:06, so possibly
17 while Dr. McNeive it still in the room.

18 what do you see there?

19 A. So it's the left-hand side, there's two
20 decelerations. And then on the right-hand side, it
21 looks like maybe she's not pushing, and the heart
22 rate is -- you don't see the decelerations there.

23 Q. Okay. So let's just -- I want to walk
24 through the next few pages.

25 127, do you see that?

1 A. Uh-huh.

2 Q. I don't see any markings on that page.

3 Do you agree with that?

4 A. No markings, yes.

5 Q. No. 128. This one ends at 8:24.
6 what do we see there?

7 A. So now it looks like she's beginning to
8 push again, and we're seeing decelerations. There's
9 a discontinuity on the left-hand side, so you don't
10 know what's going on. In the middle, you see a small
11 deceleration. But as we go to the right, you can see
12 the deceleration is becoming more prominent with each
13 push.

14 Q. Okay. So, I mean, we're still talking
15 about how these are evidence of issues with
16 oxygenation to the baby.

17 A. The baby isn't tolerating the contractions
18 and the pushing.

19 Q. This is not Category I.

20 A. That's correct.

21 Q. This is the indeterminate Category II.

22 A. Yes. But it's a worrisome Category II in
23 so much as we're already 4 and half hours -- because
24 you have to put it in context of the whole case.
25 Four and a half hours now in the second stage of

1 labor, Pitocin driving this, and no descent.

2 Q. Page 129. Looks like we've got a
3 variable, a noncontiguous.

4 A. So now the picture is she's pushing, and
5 the picture is looking worse. And when we get -- I
6 think this is about 8:30, and I think I said that the
7 onset, that this is the time Dr. McNeive is there,
8 the tracing is looking bad, it's time we get her to
9 delivery.

10 The average obstetrician would say, you
11 know, either an operative vaginal delivery, forceps,
12 vacuum, if you think you can, or this is a baby
13 that's not going to make it through the birth canal,
14 and move to a cesarean section.

15 Q. All right. Let's move on. Next page,
16 130. We've got variables, noncontiguous, and more
17 variables, correct?

18 A. So the pattern is continuing. And, you
19 know, again, my opinion is based on what would an
20 obstetrician be thinking at this time? I'm putting
21 myself right in this place, on this labor and
22 delivery, with this mother. You know, my experience
23 would be that nothing good is going to happen moving
24 forward. Either it's time to deliver by forceps or
25 vacuum, if you thought you can, or it is unrealistic

1 to anticipate this is going to be a safe, successful
2 vaginal delivery. And that if you're not able to get
3 it out from below, as we say, then you do a cesarean
4 section.

5 Q. And at this point, there's no question
6 that ACOG and anybody that weighs in on this, this is
7 a prolonged second stage of labor.

8 A. There's no question about it. This is
9 8:30, so now we're 4 and a half hours into the second
10 stage of labor.

11 Q. Okay. Page 131.

12 Okay. We've got how many decels on that
13 page?

14 A. One, two, three, four. Four is very
15 significant decelerations.

16 Q. Okay.

17 A. So, again, you know, eventually this has
18 to hit that nothing good is going to happen here if
19 the baby -- if you're not able to get the baby out
20 soon.

21 Q. The next page is 132.

22 How many on that page?

23 A. One, two, three.

24 Q. And this is, again, an 8-minute situation?

25 A. Yes.

1 Q. The next page, 133, where this is at

2 9:06 --

3 A. Uh-huh.

4 Q. -- we've got -- what are we seeing there?

5 A. So, again, you see one, two, three,
6 probably four decelerations with each push.

7 Q. All right. Let's go to page 134.

8 A. And, you know, continuing one, two, three
9 decelerations.

10 Q. Page 135. This ends at 9:23?
11 And what do you see there?

12 A. Did they advance the page?

13 Q. Yes, sorry. 135. And the time frame on
14 that ends at 9:23.

15 A. Again, you see more of the same. There's
16 one, two, three, four, at least four, decelerations
17 over the course of that 8-minute period of time.

18 Q. Then let's go to 9:31, which is the next
19 page, 136.

20 And what do you see there?

21 A. And so now, yeah, I mean, you're seeing
22 really a worsening of these decelerations. And you
23 can see that the amount of time that the fetal heart
24 rate is down, is longer. And then of course there's
25 discontinuity on the right-hand side.

1 so I think, you know, as I said before, at
2 8:30, there was information there to move to delivery
3 by 9:30. Again, to anticipate that going past this
4 time, you're going to have a successful vaginal
5 delivery, is inappropriate. It's not going to
6 happen.

7 And, you know, not in retrospect knowing
8 what happens at 4:00 in the afternoon, but in
9 prospect, knowing from plenty of experience, being in
10 that position many times, that the standard of care
11 would have required moving to delivery, if not
12 already, certainly by this time, she's proven that
13 this baby is not going to tolerate labor.

14 Q. Now -- now, hold on. We know that he
15 actually did deliver. He delivered vaginally, albeit
16 8 hours later, but how can you say that at this
17 point, you knew he wasn't going to deliver?

18 A. Well, because, yes, he delivered, but
19 unfortunately he is a damaged baby. And, as I said,
20 the idea is not to deliver a damaged baby. The idea
21 is to deliver a baby while it's still healthy. You
22 know, every mother wants -- what does she want? She
23 wants a healthy baby. And this is, you know, by
24 moving ahead and delivering at this point, if not
25 earlier, you're going to have a healthy baby.

1 Q. At 9:30, did Remi still have moderate
2 variability?

3 A. Well, on this particular page, you can't
4 really tell. But I think if we move forward, there
5 are periods where there are moderate beat-to-beat
6 variability so that, you know, one would think that
7 if you move to delivery, whether 8:30, 9:30, 10:30,
8 11:30, 12:30, anytime that there are periods of good
9 beat-to-beat variability, the baby would have been
10 healthy.

11 Q. Okay. So what you're saying, look, at
12 this time, all the evidence you need, all the
13 evidence you need, is right here in front of you?

14 A. Yes.

15 Q. To deliver this baby safely and healthy?

16 A. Yes.

17 Q. And it was below the standard of care for
18 Dr. McNeive not to do that?

19 A. That's correct.

20 Q. At this time and then going forward?

21 A. Yes. Whether it was Dr. McNeive there or
22 any physician, that...

23 Q. So -- but the defense is going to want to
24 ask you about the Cat I that you saw a few times as
25 you flip through the next 8 hours, 7 hours.

1 Did you see an occasional time frame,
2 short as it may be, where the fetal monitoring strips
3 technically came into a Cat 1 situation?

4 A. There were some periods of time, but,
5 again, that, I guess, shows you how strong that baby
6 was, that even -- and I think this was around two
7 o'clock in the afternoon -- that even at two o'clock
8 in the afternoon, and that would be 11 -- no, 10
9 hours of second stage, 10 hours that the baby was so
10 strong enough that if he had to be moved to delivery
11 at that point, I think the baby still would have been
12 okay.

13 Q. Okay. So if -- let's talk about that 2
14 hours -- or sorry, that two o'clock time frame.

15 we know that Dr. McNeive left Sarah's
16 room. That's the last time that was documented that
17 he was there until after he returned at -- after two
18 o'clock, correct?

19 A. Correct.

20 Q. And you've seen some deposition testimony
21 that he delivered, I think, three other babies by
22 C-section between 9:30 and 1:45 or two o'clock.

23 A. I'm not exactly sure how many, but he
24 certainly had time to do other deliveries.

25 Q. Okay. And there's a 10:45 safety rounds

1 that were conducted.

2 Do you remember reading about that,
3 Doctor?

4 A. Yes.

5 Q. And it was noted at that time, that there
6 were a number of other specialists, either Jessie or
7 Maggie or both, Dr. McNeive, the OB anesthesia
8 person, the MFM, the faculty nurse, certified nurse
9 midwife, and the chief resident.

10 And what did those folks --

11 MS. GUNN: Let's pull it up: Exhibit 1,
12 page 107.

13 Q. (By Ms. Gunn) So at the time, at 10:45,
14 it notes there were 15 minutes.

15 MS. GUNN: Next one. Sorry.

16 Oh, no, it's at the bottom. Yeah. It's
17 one of those split pages, yeah.

18 Q. (By Ms. Gunn) So do you see at the
19 bottom, Doctor, it says: safety rounds noted at
20 10:45?

21 A. Yes.

22 Q. 15 minutes of fetal heart tone and plan of
23 care reviews with all these folks, correct?

24 A. Yes.

25 Q. Okay. So that indicates to you what 15

1 minutes of strips reviewed?

2 A. Right.

3 Q. 15 minutes.

4 MS. GUNN: And then go back -- or sorry.

5 Go to the next page, please.

6 Q. (By Ms. Gunn) And it was determined that
7 it was Cat II.

8 And you would agree with that?

9 A. Yes.

10 Q. Can you look at that in a vacuum?

11 A. No. You have to look at that in the
12 setting of now she's 6 and a half hours or so in the
13 second stage. Nobody examined her. The assumption
14 is she's still at zero station. The baby hasn't been
15 born. And so even though, yeah, the tracing is Cat
16 II, yeah, she's in the second stage, but she hasn't
17 delivered.

18 And I don't know what the discussion was
19 or who said what to who or wherever. But clearly
20 they missed the boat here in terms of recognizing
21 this prolonged second stage of labor.

22 Q. And the names of these folks, are they
23 anywhere in her chart?

24 A. No. And I'm glad they're not.

25 Q. With respect to that, would -- well, we

1 know that Dr. McNeive was there, right?

2 A. Yes.

3 Q. He said he was there. And he would have
4 known at 10:45 a.m. a lot of stuff about Sarah Anyan?

5 A. He should have known everything I was just
6 telling the jury about.

7 Q. Including she was almost 7 hours in to her
8 second stage?

9 A. And hadn't delivered yet. And wasn't
10 close to delivering at that point.

11 Q. And that there had not been a documented
12 station of Remi's head position since about, what?
13 6:00 a.m., when Dr. Mckillip did it?

14 A. That's correct. And although there was no
15 documentation, clearly the baby wasn't born. There
16 was no sign of it crowning so that you could see the
17 head at the vulva, at the opening of the vagina. So
18 the assumption is it hadn't moved.

19 Q. And no one is looking or checking, or at
20 least no one's documenting that the baby -- that
21 Remi's head is anything other than OP?

22 A. Yeah. We don't know what the position
23 was, whether it was sunny side up or facedown. But
24 it doesn't matter because the baby is still not born.

25 Q. And we know that these folks looked at it,

1 and everybody agreed on Cat II, right?

2 A. Yeah. I agree it's Cat II.

3 Q. Yeah. No one says, this is Cat I. Keep
4 on going, no worries.

5 A. Right.

6 Q. And Cat II, we've already discussed,
7 indeterminate.

8 okay. So then the action was current --
9 continue current plan of care, right?

10 A. That's what's written there. And at least
11 to me, the only appropriate action is delivery. The
12 baby has to be born. Everybody has to be born.

13 Q. And there doesn't appear to be any
14 indication in here that McNeive or Jessie or Maggie
15 looked at this and decided, based on this meeting of
16 the minds, that there should be a turn down of the
17 Pit, right?

18 A. They didn't do that.

19 Q. Or turn off of the Pit?

20 A. They didn't turn off the Pit.

21 Q. And we know she didn't proceed to
22 delivery.

23 A. That's correct.

24 Q. Okay. So yesterday we spent a good deal
25 of time going through the flow sheets of the nurses

for the rest of the afternoon.

In an effort to not repeat the same thing, Doctor, let me just ask you if I can show you Exhibit 500, page 1.

okay. This is a lot, I know it is. But what I want to show is, ask you is, does this time line depict kind of what we talked about so far?

So Sarah is complete at 3:50.

A. That's correct. That's on the left-hand side. I don't know if the jury can see that.

Q. okay.

A. But it's --

Q. -- small.

okay. So at 3:50, Sarah is complete. We talked about that.

The next significant thing that I have added here, and I'm not saying this is everything that was ever significant ever, but I'm trying to illustrate what we have talked about.

So at 5:35, Dr. Mckillip is at the bedside for pushing evaluation, malpositioned, and OP and zero station, correct?

A. Correct.

Q. And then we'll go through it. We know it's about to go down between 6:15 and 6:45. And

1 then, Doctor, you've gone through all of the pages of
2 the strips between the 7:00 and 9:30 time frame. And
3 I know that's a lot. And I will tell you that I
4 documented, based on what was in the chart that the
5 nurses charted and what was on Exhibit 5, based on
6 what the defendants and a few other folks wrote down.

7 Can you -- can you accept that?

8 A. Yes.

9 Q. Okay. So this is just a visualization of
10 what was available and knowable and known to everyone
11 who cared to look at the chart, would you agree?

12 A. Yes.

13 Q. So then there's another laboring down
14 between 9:44 and 10:25 for 40 minutes.

15 How often are -- do you participate in
16 decisions about laboring down? Or is that generally
17 a nursing thing?

18 A. It's generally a doctor and nurse thing.

19 Q. Okay.

20 A. But frequently nurses will do it on their
21 own, depending -- different doctors are differently
22 involved. I know in my patients over the years, I
23 always want to know if it was the strategy that we
24 were going for.

25 Q. Okay. But, again, it counts. It's not

1 like you stop the clock?

2 A. Right.

3 Q. And so what I've done is, with those areas
4 going forward, is to document hours we're in the
5 second stage.

6 so by 11:00 a.m., we're at hour 7. And
7 this is beyond anything you've ever seen, right?

8 A. That's correct.

9 Q. Okay. And then I tried to capture from
10 Exhibit 5 and the nurses' notes and the chart, the
11 continuous late and variables that you see there,
12 correct?

13 A. Yes.

14 Q. And then I've added in that safety round
15 that determined it was Cat II, right?

16 A. I'm hesitant to call them safety rounds,
17 but...

18 Q. You may see my quotes there.

19 A. Okay. I didn't.

20 Q. All right. Then you've got -- let's go to
21 by eleven o'clock, this is what we know: There's a
22 C-section at 9:45 -- how long does it take to do a
23 C-section?

24 A. Well, it depends on the circumstance. It
25 depends on how you count the time. Sometimes, when

1 you talk about how long does it take to do a
2 C-section, you talk about from skin-to-skin, you
3 know, from making your incision until you sew it up,
4 and a half an hour, 45 minutes, is maybe a standard
5 time. But there are other times like leaving the
6 labor room until coming to the recovery room, of
7 course had longer periods of time. Maybe an hour,
8 hour and a half, those kind of typical times.

9 Q. So as the physician, as the delivering
10 physician, how long do you normally spend in a
11 C-section?

12 A. About an hour.

13 Q. Okay. So if the baby's delivered at 9:42,
14 how much before and after that are you involved?

15 A. So probably 15 minutes before and 40
16 minutes afterwards.

17 Q. Okay.

18 A. For an hour total time.

19 Q. Okay. So roughly that depends on the
20 circumstances, but that's roughly what you'd say
21 here.

22 A. Yep.

23 Q. Okay. So then we've got -- let's go to
24 the next page. And, again, I'm just trying to walk
25 through this.

1 we have another laboring down -- oh,
2 that's what I was going to ask you -- laboring down.
3 How -- I mean, three times during the second stage,
4 is that typical?

5 A. No. I mean, if you go back to the other
6 slide, and you see that dark vertical line, that's
7 the 4-hour mark, okay? And that is the -- let me see
8 that.

9 Q. Right in the middle, right?

10 A. Right in the middle.

11 That -- that's the 4-hour mark, okay? And
12 going past that, I think everybody agrees, is a
13 prolonged protracted second stage of labor.

14 Now, you know, if there are any final --
15 you know, does eight o'clock have any definitive, you
16 can't go back past time? No, they don't have any
17 rules like that. But to go past, and everyone agrees
18 it's a prolonged and protracted second stage of
19 labor, and to go past that, what do you need? You
20 need to have, as I said before, a healthy mother, a
21 healthy baby, and progress in labor, okay, and
22 progress in descent. And we see in this case it goes
23 on for hour after hour after hour without progress in
24 labor.

25 Q. okay. So let's just round up the last,

1 well, hours 8, 9, 10, 11, and 12. On the second page
2 of this time line, we have dates documented in the
3 noon hour, a couple in the one o'clock hour. We've
4 got two more sections for Dr. McNeive, coincides at
5 least partially with the laboring down. And then we
6 know that Dr. McNeive gets back at the bedside by a
7 little bit after 2:00, correct?

8 A. Correct.

9 Q. And then what happens at 2:21?

10 A. I think he turns up the Pit.

11 Q. From -- you see it's on the top there,
12 it's 20. And then turns it up again, when? Can you
13 read that?

14 A. I can't. But I know it's 15, 20 minutes
15 later.

16 Q. Yes.

17 A. And then 15, 20 minutes later after that.

18 Q. Yes. So he turns up the Pitocin four
19 times in this time frame, right?

20 A. Uh-huh.

21 Q. Now, let's talk about two o'clock.

22 Because that was one of your breaches of the
23 standard, is that, again, at two o'clock, he's back
24 there, right? He's back there, and he's looking at
25 everything.

1 And are you critical that he didn't
2 deliver Sarah at that time?

3 A. Yes.

4 Q. Why?

5 A. Well, for every reason that we've talked
6 about. And now we've got from 4 -- so now we've got
7 10 hours of the second stage of labor.

8 You know, this is so beyond the pale at
9 this point, and, you know, he didn't examine her, the
10 assumption is she's still at zero station, maybe with
11 caput. And he's just putting more Pitocin onto this
12 contraction. There was never a problem with the
13 strength of the contractions. She had contractions
14 strong enough to get the full dilation. It's just
15 that, you know, this baby was not going to safely
16 negotiate the birth canal.

17 Q. Have you seen, Dr. Warsof, any evidence of
18 any sort that Dr. McNeive ever offered a C-section to
19 Sarah?

20 A. I did not see that.

21 Q. That he ever ordered it or recommended it?

22 A. I did not see that.

23 Q. Did you see anything from any source that
24 Sarah Anyan ever refused a C-section?

25 A. No, I did not see any evidence that she

1 refused a C-section.

2 Q. Do you have any information that she would
3 have refused a C-section at all?

4 A. No. I think we all know she wanted to
5 have a safe, healthy baby. And if that required a
6 C-section, she would have been willing to do that.

7 MS. KAMYKOWSKI: Well, I'm going to
8 object, Your Honor. I think that calls for
9 speculation, lacks foundation. Move to strike.

10 THE COURT: Sustained.

11 The jury will disregard.

12 MS. GUNN: We'll ask Sarah.

13 THE WITNESS: Uh-huh.

14 Q. (By Ms. Gunn) Now, at two o'clock, we
15 know that instead of delivering Remi, Dr. McNeive
16 turns up the Pitocin four times. And we know that at
17 this 3:50ish time frame, Remi hit Category III
18 tracings.

19 So is there -- tell us about those for
20 Remi. Tell us about those for Remi.

21 A. So around this time, she also develops a
22 fever, which is not surprising because now we've
23 gone -- she ruptured her membranes at noon the day
24 before, so we're 24 -- we're 28 hours with ruptured
25 membranes. And as I said in the beginning, the

1 concern is for the potential of ascending infection.

2 So now she's had 28 hours of ruptured
3 membranes. She's developing an infection. It is --
4 now she has a fever. There's a fetal tachycardia.

5 The baby has a fever, as well, so the heart rate is
6 going up, and we see worsening of the heart rate and
7 Category III tracing.

8 Q. So we've heard a little bit about Category
9 III, and that's evidence of hypoxic injury to the
10 baby.

11 A. Right. So I think at this point is when
12 the baby really becomes damaged.

13 So as I said before, if he had delivered
14 her before this time, more likely than not, the baby
15 would have been fine. He may have needed some
16 resuscitation, but once we get to Category III, you
17 know, that's when a baby is being damaged. And as an
18 obstetrician, you know, the idea is not to get to
19 Category III and then to deliver, the idea is to
20 avoid Category III tracings and deliver the baby
21 before that happens.

22 Q. At this point where Remi goes Category III
23 around 3:50, and then tachycardic, is that
24 predictable in this case?

25 A. So I would say it is predictable. Now, I

1 couldn't tell you exactly what time this would
2 happen. But if you let it go long enough, that
3 eventually with ruptured membranes, for a prolonged
4 period of time, that eventually something bad is
5 going to happen like develop a fever, tachycardia,
6 Category III tracing, hypoxic damage to the baby.
7 And that's why these time lines, whether 2 hours, 3
8 hours, 4 hours is reasonable. Maybe 5 hours, maybe 6
9 hours if there's progress. But going beyond that, is
10 inexcusable.

11 Q. And we know Remi was born as 4:24. We
12 know he's diagnosed with hypoxic ischemic
13 encephalopathy.

14 was that entirely preventable?

15 A. Yes. By delivering him either by
16 operative vaginal delivery or a cesarean section at
17 the appropriate times from 8:30 in the morning on.

18 Q. Now, I want to go to page, in the Mercy
19 records, Exhibit 1, page 109.

20 The bottom half there is a vaginal
21 delivery note, Doctor. And this is authored by Dr.
22 McNeive. Is this the only thing and only note that
23 you found in Sarah's chart that Dr. McNeive authored?

24 A. Yes.

25 Q. And let's go to this next page.

And it's delivery --

MS. GUNN: Oh, I sorry, let's go back.
 sorry, Zack.

I want to go back to the -- I don't
 know -- like the time stamp, yeah. Yeah. Yeah.

Q. (By Ms. Gunn) Okay. You see it's filed,
 what time? Could you read that?

A. Yeah. May 7th. So three days after the
 baby was born.

Q. That's when this note was filed in the
 chart?

A. Yes.

Q. And what do we know about Remi's brain
 injury by May 7th?

A. well, the MRI unfortunately showed that
 the baby had hypoxic ischemic encephalopathy.

Q. So then let's go to the next page, which
 is the body of the note, delivery summary.

The first sentence: The second stage
 proceeded slowly but with steady progress.

Do you agree?

A. No.

Q. How do you disagree?

A. well, first of all, it took an inordinate
 amount of time, I think we decided 12 hours in the

1 second stage. So that is not normal. And to say it
2 makes steady progress, that didn't happen, at least
3 we don't know it happened, because, you know, the
4 only documentation was she was still at zero station
5 for much of that time, and finally the baby came out
6 later on. So certainly there was no documentation of
7 any steady progress.

8 Q. Next sentence: Fetal status remained
9 reassuring throughout, other than a brief stretch of
10 fetal tachycardia, with development of maternal fever
11 at the end of the second stage.

12 I want to break that up.

13 Fetal status remained reassuring
14 throughout. And then he talks about the tachycardia,
15 which we know didn't happen till 3:50.

16 Do you agree that Remi's fetal status
17 remained reassuring throughout the entire second
18 stage until 3:50?

19 A. No, I don't agree with that. And I think
20 I've tried to explain to the jury all of the
21 decelerations that we saw that made it nonreassuring
22 through much of the second stage of labor. There was
23 some periods of time where it was okay around two
24 o'clock, I think. But for the vast majority of
25 times, it was nonreassuring.

1 Q. And I think we saw a note about -- from
2 Dr. Mckillip. When she defined reassuring, she gave
3 a whole list of things, correct?

4 A. Uh-huh, yes.

5 Q. Okay. Then, finally, this notion of brief
6 stretch of fetal tachycardia, I think we identified
7 that that was close to 30 minutes.

8 A. Yes.

9 Q. I mean, I guess we can argue about what
10 brief stretch.

11 Do you believe that that's a brief
12 stretch?

13 A. Well, I guess in the scheme of the whole
14 labor, I would say that 30 minutes out of 28 hours is
15 brief. But from the baby's situation, I think it was
16 what caused this baby's injury, that brief stretch.

17 Q. Okay. All right, Doctor. Now, one of the
18 opinions that you have critical of Dr. McNeive is
19 that he failed to obtain the cord gas.

20 Tell me about that.

21 A. Well, what we're referring to is after a
22 baby is born, you know, one way of assessing the baby
23 is with an Apgar score. There's another way, a more
24 subjective way, of determining the baby's status, is
25 with what we call cord gases.

1 Q. I'm just going to stop you. You said
2 "subjective." Is a cord gas subjective?

3 A. I'm sorry. Cord gas is objective --
4 okay? -- because it's facts, you know, it's
5 measurements. So the Apgars are sometimes subjective
6 in nature. But the cord gas would be the objective
7 nature, and you can determine the baby's acid base
8 status at the time of birth.

9 Q. And why wasn't it ordered, do you know?

10 A. At least from what I can see in the chart,
11 it was collected but discarded at Dr. McNeive's, I
12 don't want to say his order, but his involvement.

13 Q. Now, do you remember reading Jessie
14 Wagner's deposition where she called it a chaotic
15 delivery?

16 A. I don't recall.

17 Q. Okay. Sorry. Well, let's say she said it
18 was a chaotic delivery.

19 A. I imagine it was.

20 Q. I want to understand the circumstances
21 under which a cord blood gas was drawn or not drawn,
22 or obtained or not obtained.

23 what's standard?

24 A. Well, different hospitals have different
25 policies, and I think in my deposition, I mentioned

1 that in my hospital, we get it on -- we get blood
2 cord gasses on -- all deliveries. But certainly
3 there are some hospitals that don't do that, and
4 that's fine.

5 So when would you do it? You would do it
6 when you had a question about a baby's status at
7 birth. Now, in this case, the baby is documented as
8 hypotonic. That means was floppy, was not brisk, did
9 not cry at birth, had a fever and fetal -- an
10 abnormal fetal heart rate.

11 So if there ever was a case in which cord
12 gases would be helpful for the neonatologist in
13 determining the baby's situation, this would be that
14 kind of case.

15 Q. what difference does it make?

16 A. well, in this case, you know, if the
17 baby --

18 MR. PERRON: Your Honor, may we approach?

19 THE COURT: You may.

20 (The following proceedings were held at
21 sidebar, outside the hearing of the jury:)

22 MR. PERRON: I apologize that this is
23 preemptive. In his deposition, he's going to say he
24 could not say and would defer to a neonatologist
25 about whether or not it would have made any

1 difference to final outcome. I understand there's
2 two steps up to that. I just wanted to put my note
3 on the record with any new opinion that he's going to
4 opine on medical causation or any intervention that
5 occurred --

6 MS. GUNN: No. He's going to say, as he
7 said in his deposition, that he believes it would
8 have been abnormal.

9 MR. PERRON: The cord blood gas?

10 MS. GUNN: Yes.

11 MR. PERRON: Yes. Okay.

12 MS. GUNN: And that's what I'm asking --

13 MS. KAMYKOWSKI: No. I think the question
14 was, what difference does it make? And he said --
15 started to answer what difference it would make.

16 MR. PERRON: He did not.

17 MS. GUNN: well, he says this, on page 67:
18 I would have thought those gases would
19 have been highly abnormal and should have at least
20 put somebody on notice that this baby should be cared
21 for closely and looked at more closer and cared for
22 in a different way than what was actually done.

23 And that's what he's going to say.

24 MR. PERRON: Okay.

25 MS. KAMYKOWSKI: As long as he doesn't --

1 MS. GUNN: Well, and I --

2 MS. KAMYKOWSKI: Because I feel like the
3 question that is pending is different from what he
4 would have made in his --

5 THE COURT: Why don't you clarify that
6 question a little bit to direct it a little more in
7 that area.

8 MS. GUNN: You bet.

9 MS. KAMYKOWSKI: Thank you.

10 (The proceedings returned to open court.)

11 Q. (By Ms. Gunn) Dr. Warsof, regarding the
12 cord blood gases that we know were not obtained or
13 not sent to the lab, do you have an opinion whether
14 they would have been normal or abnormal?

15 A. I would think in this clinical setting, in
16 the way the baby was described at birth, it would be
17 abnormal.

18 Q. And if they had been abnormal, would
19 anything -- do you believe anything would have been
20 done at the time?

21 A. I'm not a neonatologist, I don't take care
22 of babies, newborn babies, but I would think that if
23 the gases were abnormal, the baby would have gone to
24 the NICU initially rather than to the normal nursery,
25 and that any treatments that might have been helpful,

1 would have been initiated earlier.

2 Q. Doctor, with respect -- I'm going to
3 wrap -- I'm going to wrap this up.

4 You've told us that you believed that Dr.
5 McNeive fell below the standard of care, was
6 negligent in the time frame of 8:30 to 9:30, when he
7 failed to deliver Sarah, correct?

8 A. Correct.

9 Q. And that was based on what he knew at the
10 time, which was what?

11 A. What he knew at the time was that at 8:30,
12 she was already 4 and a half hours into the second
13 stage of labor and had not descended. There was no
14 progress in labor. The baby was likely
15 malpositioned. We talked about the OP/OA business
16 and that she had been on Pitocin during that whole
17 period of time, and even with that, again, no
18 descent.

19 That the standard of care would have
20 required him to move -- to recognize these problems
21 and to move to delivery at that time, in which case,
22 this baby would have been fine.

23 Q. And you have opinions with respect to
24 Pitocin. It was never turned down on Dr. McNeive's
25 recommendation or order?

1 A. That's correct. And we saw all these
2 decelerations, that abnormal heart rate pattern, and
3 the first thing one should do in that setting is to
4 shut off the Pitocin.

5 Q. And then any further opinion with respect
6 to later on in the second stage in the two o'clock
7 hourish?

8 A. So, you know, continuing to persist in the
9 second stage of labor in 5, 6, 7, 8, 9, 10 hours, to
10 anticipate a safe vaginal delivery, was unrealistic.

11 Q. And do you -- and then you told us about
12 the cord gas breached the standard of care, as well?

13 A. Yes.

14 Q. Do you have an opinion within a reasonable
15 degree of medical certainty whether those failures,
16 as you described them, directly caused or directly
17 contributed to cause harm to Remi?

18 A. Yes, I do.

19 Q. And what is that opinion?

20 A. That these factors all led to the injuries
21 that occurred to this child.

22 Q. Okay. And we've talked mainly about Dr.
23 McNeive, but do you also have standard of care
24 opinions with respect to the nurses?

25 A. Yes, I do.

1 Q. And what are those?

2 A. That, you know, the nurses were in the
3 same situation. They should have recognized the
4 problems with the heart rate. They should have, as
5 part of their in utero resuscitation, turned down the
6 Pitocin. Turned off the Pitocin. And to have
7 recognized that this was an absurdly prolonged second
8 stage of labor, and advocated to this patient to be
9 delivered starting from 8:30 on.

10 Q. Thank you, Doctor.

11 THE COURT: All right. Ladies and
12 gentlemen, it seems like this is a good time for us
13 to take a very short recess and give you guys a
14 chance to just get up and move around and use the
15 restroom if you need to.

16 (At 3:43 p.m., the jury was duly
17 admonished, and the proceedings stood in recess. At
18 3:57 p.m., the following proceedings were held in
19 open court, in the presence of the jury:)

20 THE COURT: On behalf of the defendant,
21 cross-examination?

22 MR. PERRON: Yes, Your Honor.

23 CROSS-EXAMINATION

24 BY MR. PERRON:

25 Q. Dr. Warsof, in general do you agree with

1 the statement: In viewing fetal monitoring strips,
2 the observations of moderate variability and/or
3 accelerations is reassuring and an indication there
4 is no hypoxic injury?

5 A. As a general statement, yes.

6 Q. You testified in reference to Dr.
7 Mckillip's examination that she documented a failure
8 to descend.

9 Is that your testimony?

10 A. The head was still at zero station, yes.

11 Q. But specifically did she document failure
12 to descend?

13 A. I don't know if she used those particular
14 words, but it was zero before, and it's zero now.
15 That's the end. That it's no progress.

16 Q. Sure.

17 MS. PERRON: You want to put up, Justin,
18 A2 page 107, MDF108. I don't know which one your
19 numbers are aligned.

20 Q. (By Mr. Perron) And Dr. Mckillip's notes,
21 and she documents minimal descent.

22 Now, is it your testimony Dr. Mckillip's
23 note there minimal descent is indistinguishable from
24 the medical term of art failure to descend?

25 A. Yes.

1 Q. Okay. Between 8:00 a.m. and 9:30 a.m.,
 2 first of all, it was your testimony between 8:04 and
 3 8:16, there was a return to Category I tracing,
 4 correct?

5 A. I think I said that in my deposition, yes.

6 Q. Well, do you still believe that today?

7 A. Yes.

8 Q. Okay. Maintenance of good beat-to-beat
 9 variability during that stretch, correct?

10 A. Correct.

11 Q. Even if only for a short time, it's better
 12 to return to Category I than to remain in Category
 13 II, fair?

14 A. Correct. That's what I say, if he
 15 delivered at that time, we would expect the baby to
 16 be okay.

17 Q. Just like you mentioned, you've been
 18 deposed a great number of times, is that fair?

19 A. Yeah, 150 over 25 years.

20 Q. Every one of those depositions, you raise
 21 your hand under oath to swear to tell the truth,
 22 fair?

23 A. I think so, yes.

24 Q. For the most part, to the best of your
 25 recollection, you've always told the truth in all of

those depositions?

A. Yes.

Q. In the past, have you testified that you agreed ACOG puts out a series of practice bulletins on management of difficult problems in pregnancy?

A. Yes.

Q. And the jury's heard a lot about ACOG, but just to remind them all, you understand what ACOG is?

A. Yes.

Q. American College of Obstetrics and Gynecologists?

A. Yes. Although sometimes it's American Congress now --

Q. Okay.

A. -- instead of college.

Q. I knew I was going to mess that up.

For the benefit of the jury, what is the purpose of, in general, these types of organizations in the medical field?

A. Well, the hope is that, you know, it's kind of like the union, I suppose. You know, it's -- you have the educational arm, it has a social arm, it sets maybe legal policies. Sort of like, you know, when somebody tries to influence the government, what is -- what is that word?

1 Q. Doctor, you'd agree ACOG publishes
2 practice bulletins and consensus statements intended
3 to be read by obstetricians?

4 A. Yes.

5 The word I was looking for was like a
6 lobby. A lobby firm.

7 Q. Just like I mentioned, the consensus
8 statements, the bulletins, they put together, they
9 are published, and they are meant to be guidelines
10 for obstetricians.

11 A. Yes.

12 Q. And not guidelines in how to drive a car
13 or go about a business. Specifically guidelines for
14 how to practice within the field of obstetrics.

15 A. Yes.

16 Q. Okay. They show -- they demonstrate, in
17 their written guidelines, not the only way, but a way
18 to practice and meet the standard of care?

19 A. Yes.

20 Q. Okay. And if an obstetrician reviewed
21 ACOG guidelines and conducted their practice in
22 accordance with ACOG guidelines, for the most part,
23 that would be reasonable?

24 A. For the most part, yes.

25 Q. Okay. We've been talking about ACOG

1 bulletins in general, but you sat there in the back,
2 with Nurse Shinn, we were talking extensively about a
3 particular ACOG bulletin, the November 2010 ACOG
4 bulletin 116 on the Management of FHR Tracing.

5 A. Yes.

6 Q. You're very familiar with that bulletin?

7 A. Yes.

8 Q. Not just as a practitioner, but someone
9 that regularly testifies in this type of case, you
10 are very familiar with debating the finer points of
11 this document?

12 A. To a certain degree, yes.

13 Q. And just like you mentioned, this document
14 that we've been talking about is representative of
15 ACOG as a body publishing a guideline meant to
16 represent, maybe not the only, but a way to meet the
17 standard of care?

18 A. Okay.

19 Q. Okay. I'm asking you if you agree with
20 what I'm saying.

21 A. Yes.

22 Q. Okay.

23 MR. PERRON: Justin, if you want to put up
24 I1.

25 Q. (By Mr. Perron) This is the practice

1 bulletin we've been talking about. I can blow it up,
2 if you need it.

3 A. There you go.

4 Q. would it help if I hand you a copy?

5 A. That would be great. Thank you.

6 MR. PERRON: Justin, can you put up page
7 3?

8 Q. (By Mr. Perron) Doctor, there are
9 subheadings on this document, but, again, the
10 particular focus of this document is obstetricians
11 managing intrapartum fetal heart rate tracing.

12 For just a moment, what does intrapartum
13 mean in your field, Doctor?

14 A. During labor.

15 Q. Okay, during labor. And that's what we've
16 been talking about the last few days, the stage of
17 labor that Mrs. Anyan was in, correct?

18 A. So you kind of got that a little confused.

19 Q. Correct me.

20 A. So, I mean, I don't what you were talking
21 about before today, but when you talk about

22 intrapartum, that means during labor, so that's the
23 first stage, which is the onset of labor until full
24 dilation. And then there's the second stage. And
25 you differentiate between the two. The second stage

1 means from full dilation until the delivery of the
2 child.

3 Q. And the first subheading on this page --

4 MR. PERRON: Is this I? Exhibit I?

5 MS. KAMYKOWSKI: II.

6 MR. PERRON: My copy has highlights on it,
7 but that's all right.

8 Q. (By Mr. Perron) Given the diverse
9 spectrum of abnormal FHR patterns in Category II, the
10 presence of accelerations -- then it has a
11 parenthetical -- for moderate FHR variability, or
12 both, are highly predictive of normal fetal acid base
13 status, and thus may help guide clinical management.

14 Did I read that correctly?

15 A. I didn't see exactly where you read it
16 from, but...

17 MR. PERRON: May I approach, Your Honor?

18 I already did. I apologize. I should
19 have asked.

20 Q. (By Mr. Perron) Right here.

21 MR. PERRON: Oh, you know what? His copy
22 is covered with the highlighted --

23 Let me trade you.

24 THE WITNESS: I see it now. Thank you.

25 Q. (By Mr. Perron) Okay. Did I read that

1 correctly?

2 A. I think so.

3 Q. And, again, I apologize. I skipped a
4 little bit of a parenthetical, but the substance of
5 what I read out loud is that accelerations and
6 moderate variability are highly predictable, correct?
7 of a normal fetal acid based status?

8 A. Yes, you read it correctly.

9 Q. Okay. And explain for the jury normal
10 fetal acid base status, is what?

11 A. Usually a pH of above 7.2.

12 Q. Right. And how is it important to whether
13 or not a baby has or is experiencing a hypoxic
14 injury?

15 A. So usually with normal beat-to-beat
16 variability and with accelerations, which is Category
17 I, this would indicate that the baby was not damaged
18 at that time.

19 Q. And, like I said, bringing you back to
20 your testimony on direct, you testified that Category
21 II strips, in particular decelerations, are evidence
22 of something going wrong, evidence of issues that
23 might negatively affect the baby?

24 A. Correct.

25 Q. And if you skip down to paragraph 2 of

1 that same page, the subheading is "How are
2 Intermittent and Recurrent Variable Decelerations
3 Evaluated and Managed?"

4 And the question posed to obstetricians,
5 and what the ACOG guidelines purportedly do, is give
6 guidance to those OBs on how to manage in this
7 situation of recurrent variable decelerations,
8 correct?

9 A. Yes.

10 Q. And it says: In FHR tracings with
11 recurrent variable decelerations, the presence of
12 moderate variability or spontaneous for deceleration
13 suggests that the fetus is not currently acidemic,
14 correct?

15 A. Correct. That's what it says.

16 Q. Okay. Now, on direct testimony, you said
17 that moderate variability was just one piece of the
18 puzzle.

19 A. Yes.

20 Q. That you have to also look at
21 decelerations?

22 A. Yes.

23 Q. But what ACOG is saying, what ACOG is
24 advising OBs, that even in the space of a variable
25 deceleration, you can have moderate variability or

1 accelerations if the fetus is not currently acidemic?

2 A. And your question was what?

3 Q. I'm asking you if you agree with that's
4 what ACOG is saying?

5 A. Yes, that's what it says here.

6 Q. Okay. Even in the face of decelerations,
7 moderate variability is still a reassuring sign of
8 management of that Category II tracing.

9 A. So, again, this is in the setting of
10 intermittent variable decelerations, not all
11 decelerations. So if it was persistent variable
12 decelerations, or if it was late decelerations, then
13 this would not be applicable.

14 Q. Okay. Well, on the next page, page 4...

15 MR. PERRON: Justin, if you want to
16 highlight the other subheading.

17 Q. (By Mr. Perron) "How are Recurrent Late
18 Decelerations Evaluated and Managed?"

19 So, again, this specific subheading is not
20 just variable decelerations or a mixed bag. But
21 specifically this is ACOG guidance in the specific
22 issue of recurrent late decelerations: How are they
23 evaluated, and how are they managed?

24 I'm going to read a portion that I
25 attempted to underline. I don't know if I did, but

1 it is the second paragraph of that subpart:

2 Given the low predictive value of late
3 decelerations for acidemia and the known false
4 positive rates for fetal neurologic injury,
5 evaluation for the presence of accelerations or
6 moderate variability or both may be useful to assess
7 the risk of fetal acidemia.

8 Did I read that correctly?

9 A. Yes.

10 Q. Okay. So, again, ACOG's advice to
11 practicing OBs, even in the face of late
12 decelerations, moderate variability is a good
13 predictor of the absence of acidemia, correct?

14 A. Yes. That's what it says here.
15 of course this doesn't say anything about
16 in the setting of protracted second stage of labor at
17 6 hours or 8 hours, 10 hours of second stage of
18 labor.

19 Q. You're right. It doesn't put any --

20 A. Context.

21 Q. -- qualifications. There's no context,
22 there's no qualification, fair enough?

23 A. Right. So it's just isolated in that way.

24 Q. Right. And then it even has an algorithm.
25 And the algorithm is towards the top.

1 A. Yes.

2 Q. The algorithm purports to give specific
3 guidance. At the very top: Assessment of
4 intrapartum FHR tracing.

5 Now, we're in the middle of Category II,
6 right?

7 A. Yes.

8 Q. Okay. In evaluation and surveillance, the
9 first question is: Even within the context of
10 recurrent late decelerations, the option is whether
11 or not there is accelerations or moderate FHR
12 variability.

13 That's the first question you have to ask
14 in evaluating, correct?

15 A. I'm a little lost. You said even in the
16 setting of recurrent late decelerations?

17 where does it say that?

18 Q. Well, let me back up a bit.

19 In the subheading of "How to Manage
20 Recurrent Late Decelerations, Evaluating and
21 Managing": If despite intrauterine resuscitative
22 measures, late decelerations continue in the setting
23 of minimal FHR variability and absent accelerations,
24 the presence of fetal acidemia should be considered,
25 and the potential for expedited delivery should be

evaluated.

A. I agree with that.

Q. Right.

A. That's what was going on in some parts of this case, yes.

Q. Right. So the question is, is there minimal or absent variability, or is there instead moderate variability, right?

A. So there are periods of both.

Q. Right. So in this algorithm, if you see moderate variability, you continue surveillance, and you attempt intrauterine resuscitative measures, correct?

A. Correct.

Q. Okay.

A. And it should resolve with intrauterine resuscitative measures.

Q. Right.

MR. PERRON: Justin, if you go to page 5, options for intrauterine resuscitative measures are at the top of the page, and the potential interventions are listed.

Q. (By Mr. Perron) And it specifically says potential intervention, correct?

A. Yes.

1 Q. Okay. And one of the first options is
2 initiate lateral position in the left or right?

3 A. I think that was done.

4 Q. Okay. So if we go back to the algorithm.
5 So if you attempt intrauterine resuscitative
6 measures, would you agree with me once you get to
7 this second box, okay? You go back up to the top,
8 and you say -- you ask whether or not it's still
9 Category II, correct?

10 A. Okay.

11 Q. All right. And, again, if you follow it,
12 and you say the first question is, are there
13 accelerations or moderate FHR variability, is the
14 first question, right?

15 A. Okay.

16 Q. And if you see moderate variability,
17 again, you continue surveillance. And you continue
18 intrauterine resuscitative measures, which include
19 the lateral position.

20 A. They include lateral positioning and IV
21 fluids, shutting off the Pitocin --

22 Q. Well -- oh, wait. Wait. Let me go back.
23 Let me go back. Let's go back -- let's go back to 5.

24 MR. PERRON: Zoom in right here. Not just
25 the right column, all the way over. Right here.

1 Q. (By Mr. Perron) Associated Fetal Heart
2 Abnormality. Recurrent late decelerations, prolonged
3 decelerations or bradycardia, minimal or absent fetal
4 heart rate variability. These are the potential
5 interventions here: Initiate lateral positioning,
6 administer internal oxygen, administer intravenous
7 fluid bolus to reduce uterine contractions for
8 tachysystole as well as Category II or III tracing.

9 That is when you discontinued the
10 oxytocin.

11 A. I would not have interpreted that way. I
12 would have interpreted that all these would be
13 appropriate.

14 Q. Irregardless of the associated fetal heart
15 risk in the middle column, you read all of the column
16 on the right as potential intervention?

17 A. Uh-huh. Clearly, for recurrent late
18 decelerations, stopping the Pitocin is something that
19 we've always done for 40 years.

20 Q. Between 9:30 a.m. and 2:00 p.m., fetal
21 heart rate seems to get better after 9:30 a.m.,
22 correct?

23 A. At times. But there were other times
24 where there were recurrent decelerations.

25 Q. Right. You said: Surprisingly, even

1 unanticipatedly, after 9:30 a.m., fetal heart rate
2 tracings get much better?

3 A. There were times when it got better.
4 There were other times that it was still abnormal.

5 Q. But the providers who were attempting to
6 regain normal fetal tracings and get back to Category
7 I, they would not have been surprised or believe that
8 that was unanticipated, correct?

9 A. I think they would have been surprised
10 like I was surprised.

11 Q. Okay. And, again, regardless of whether
12 or not you, sitting here today, thought that it was
13 surprising, nonetheless, after 9:30 a.m., there is a
14 recovery in the fetal heart tracing?

15 A. Correct. And that would be the time to
16 deliver the baby while it is still healthy. Because
17 remember we have this protracted second stage of
18 labor second stage of labor that we have to consider,
19 as well.

20 So if we're 5, 6, 7 hours into the second
21 stage, yes, the heart rate recovered, good thing.

22 Now is the time to deliver the baby while it's still
23 healthy. Thank you for pointing that out.

24 Q. So Category II, more than 80 percent of
25 fetuses in labor demonstrate FHR patterns that fall

1 into Category II, correct?

2 A. Yes.

3 Q. It's very common?

4 A. Yes. what's not common is 8, 10-hour
5 second stage labors.

6 Q. In ACOG consensus, most intrapartum fetal
7 heart rate tracings fall into indeterminate Category
8 II.

9 A. Correct.

10 Q. And how prevalent is the use of Pitocin?

11 A. It's frequently used.

12 Q. Okay. So it's a frequently used drug.

13 And it's your testimony that in every single case,
14 standard of care is to turn off Pitocin for every
15 instance of Category II?

16 A. No.

17 Q. Okay.

18 A. In Category II that has worrisome features
19 because, as you correctly point out, Category II is a
20 wide spectrum. In some instances not so bad, and
21 some it's very concerning. So in the situations that
22 are very concerning, is when you need to shut off
23 Pitocin.

24 Q. Okay. So it is subjective whether or not
25 you need to turn off the Pitocin whether the Category

1 strips are concerning, or if they're reassuring,
2 correct?

3 A. I would think that what we were looking at
4 today, everybody agrees that they were abnormal. I
5 think when you put up the tracings that had every
6 doctors' markings on them, everybody agreed that they
7 were decelerations.

8 So I don't think that is subjective. I
9 think everybody was in agreement. And of course the
10 other factor that's truly objective is the amount of
11 time in the second stage of labor, which there is no
12 question about. And who -- everybody knows what a
13 clock is. And, you know, when we're way beyond the
14 normal limits of the second stage, you have to
15 consider that fact.

16 Q. It's your testimony, and I understand it,
17 you want to exclude the presence of moderate
18 variability and accelerations to focus only on the
19 decelerations, correct?

20 A. No. I'm considering all of it, as well as
21 the protracted second stage of labor. And that's why
22 I said that if you deliver at 9:30, 10:30, 11:30,
23 one o'clock, two o'clock, where there are still
24 periods of time where there is moderate beat-to-beat
25 variability, that the outcome would have been good

1 for the child.

2 Q. And, yet, ACOG says that the presence of
3 moderate variability is highly predictive of normal
4 fetal acid status and thus may help guide clinical
5 management.

6 A. Correct. And's why -- that's the time to
7 deliver the baby while it has -- is still healthy.

8 You don't wait until something bad happens, like what
9 happened here, the ascending infection, fetal
10 tachycardia, hypoxia.

11 Thank you for pointing that out.

12 Q. Right. So I had the algorithm up here.

13 The algorithm asked, is there moderate variability?

14 And you have testified over and over again not just

15 periods of moderate variability, you see a

16 maintenance -- that's your testimony -- that it

17 maintains moderate variability from 8:00 a.m. to

18 category III at 3:57 p.m.

19 A. I'm not sure I used those words, but you
20 want to show me?

21 Q. We'll get there.

22 A. Okay.

23 Q. Interpreting FHR fetal heart monitor
24 strips is an inexact science.

25 Do you agree with that statement?

1 A. Yes. But determining the length of the
2 second stage of labor, is not an exact science.
3 That's based on that clock that you see up there.

4 Q. we talked a little bit about this with
5 Nurse Shinn. But the use of fetal heart monitoring
6 has not led to a decrease in the number of babies
7 that are diagnosed with cerebral palsy.

8 You're familiar with that?

9 A. Yes, I agree with that. And why has that
10 happened? Because people ignored what is on the
11 fetal heart rate tracing. So people -- I mean,
12 unfortunately some doctors overlook what's going on
13 in the tracings, they let the labor continue, and the
14 ultimate outcome is a baby that's damaged with
15 hypoxic injury that leads to cerebral palsy.

16 And so, you know, a monitor cannot deliver
17 a baby. A monitor cannot do a cesarean section.
18 It's up to the physician to understand what's on the
19 monitor and act appropriately.

20 Q. You've testified on direct you heard us
21 talk to Nurse Shinn while we were talking to her this
22 morning. There is no maximum duration for the second
23 stage of labor, according to ACOG, correct?

24 A. That is correct. But what is in ACOG is
25 that the average length of the second stage is 2

1 hours. And that protracted or prolonged second stage
2 is either after 3 hours or 4 hours. Nowhere does it
3 say that the second stage can be 6, 8, 10, 12 hours.
4 why not? Because it is unthinkable that you would
5 let that happen.

6 Q. Even by your testimony, you agree there is
7 no rule that says 4 hours, and you have to get a
8 C-section?

9 A. That is correct. Although if you haven't
10 delivered in 4 hours, it's always said offer a
11 vaginal delivery. If at 4 hours, or at any time
12 between 8:30 and two o'clock, it's not always a
13 C-section. The first thing is can you deliver the
14 baby vaginally, either with forceps or a vacuum? And
15 if the judgment is that you can't, then that's when
16 you have to do a cesarean section.

17 Q. Just like you said on direct, you can go
18 longer. You can go beyond 4 hours, as long as you
19 see reassuring fetal heart tracing, and you're making
20 progress.

21 A. And if the mother is well, if the baby is
22 well, and you're making progress.

23 Now, in this case, you know, after 4
24 hours, it was zero, and if we start at zero station,
25 and it's still zero station, there's some caput,

1 that's just swelling of the head. And if nobody
2 examines her for an extended period of time, but we
3 know the baby didn't deliver, so, you know, there's
4 clearly no progress or limited progress.

5 Q. Are you familiar with the ACOG consensus
6 statement from March of 2014?

7 A. Which one?

8 MR. PERRON: Justin, if you put up just
9 the first page of F11G.

10 Q. (By Mr. Perron) Let me read you this
11 statement, and you just let me know if you agree with
12 it: In the era of electronic fetal heart monitoring
13 among neonates born to nulliparous women, adverse
14 neonatal outcomes generally have not been associated
15 with the duration of the second stage of labor.

16 A. So, you know, to put that into context, I
17 would probably agree with that, if we're talking
18 about 2, 3, 4 hours, maybe even 5 hours. There is
19 actually a paper that talks about how long is too
20 long. It talks about the difference between 1 hour,
21 2 hours, 3 hours, and -- and more than 4 hours.

22 And when you go more than 4 hours, then
23 there aren't more complications. But nowhere is
24 anybody talking about 6, 8, 10, 12 hours. That is
25 just -- nobody talks about it because it is unheard

1 of. It's unthinkable in modern obstetrics.

2 Q. So you don't believe there's been studies
3 about second stages of labor beyond 5 hours and
4 the -- and the outcomes?

5 A. I don't think there's any papers that say
6 beyond 10 hours. I don't know of any beyond 5 hours.
7 There may be. I haven't done a world search in the
8 literature. If you have one, I would like to see it.

9 Q. ACOG Consensus -- ACOG -- ACOG Care
10 Consensus No. 1, March of 2014.

11 MR. PERRON: Justin, you want to blow that
12 up?

13 Q. (By Mr. Perron) Are you familiar with
14 this?

15 A. No.

16 Q. Okay.

17 MR. PERRON: Justin, page 15. And then
18 highlight that language, the sentence "the era of
19 electronic fetal monitoring."

20 Justin, starting on the second sentence,
21 try to blow that up.

22 Q. (By Mr. Perron) In a secondary analysis
23 of a multicenter randomized study of fetal pulse
24 oximetry of 4,126 nulliparous women who reach the
25 second stage of labor, none of the thousand neonatal

1 outcomes are found to be related.

2 Duration of the second stage of labor, in
3 some cases, was 5 hours or more, colon.

4 So would you agree with me ACOG is
5 referencing a study that included extended second
6 stages of labor more than 5 hours. And they -- they
7 associated that it was not -- these outcomes were not
8 related, none of these outcomes were related, to the
9 duration.

10 5-minute Apgar scores of less than 4.

11 Umbilical arteries pH, less than 7. Intubation in
12 the delivery room, need for admission of neonatal
13 intensive care unit for neonatal sepsis, okay.

14 A. So to put it in the context of this case,
15 then I agree. If she had been born -- if this baby
16 had been born after 5 hours of the second stage, it
17 probably would have been okay. Even 6, maybe 7, but
18 not 12.

19 Q. And the next --

20 A. There is nothing there that talks about
21 the second stage of labor that extends to 10, 12
22 hours.

23 Q. But you'd agree with me, they were
24 specifically looking. Did -- this is what we're
25 talking about. The question that they sought to see

1 with this study is did the duration itself of the
2 second stage of labor increase the risk of these
3 outcomes? And the answer is no, correct?

4 A. Correct. In the context of, you know, 1,
5 2, 3, 4, in some cases 5 or more, but certainly
6 nowhere in the 8, 10, 12 did it talk about it.
7 Because I'm sure if there were cases that were in
8 that period of time, it would be in there.

9 Q. That's why it says later on, on the next
10 page, page 16: Thus, a specific absolute maximum
11 length of time spent in the second stage of labor has
12 not been established, correct?

13 A. Correct. But 10, 12 hours is not the
14 right answer.

15 Q. That's Dr. warsof sitting here under oath.
16 when we look just at the plain text of the
17 ACOG consensus, would you agree with me these
18 authors, if they thought there was an obvious limit,
19 they could have put that guidance into this consensus
20 statement, correct?

21 A. They could have, yes.

22 Q. And they chose not to?

23 A. well, it's not there.

24 Q. Right. They didn't qualify it, correct?

25 A. Correct. Because I don't think anybody

1 thought that anybody would be -- would extend the
2 second stage to that period of time.

3 Q. Right. That's you, Dr. Warsof, sitting
4 here putting your context that is not there in the
5 guideline, correct?

6 A. It's just so obvious that you wouldn't --
7 you wouldn't -- it's not necessary to put that into
8 these guidelines.

9 Q. Right. They had the ability to put that
10 cap in there or offer guidance on how long is too
11 long, and they did not, correct?

12 A. Correct. They -- they did not say you
13 shouldn't go to 12 hours because it is so obvious
14 that you shouldn't go to 12 hours. It's not
15 necessary to put it in there.

16 Q. In an earlier part of our questioning, I
17 asked you if you agreed with me if an obstetrician
18 read these guidelines, read the actual black and
19 white text with the guidelines, relied on their
20 guidance, that that physician would be within the
21 standard of care?

22 A. Yes. If they went to 5 hours, 6 hours, if
23 there was good progress, if the baby was well, and
24 the mother was well, that would be within the
25 guidelines. 10 hours, 12 hours is not within this

1 consensus panel.

2 Q. Right. That's you arguing not with me.
3 That's you arguing with the black and white text of
4 the ACOG consensus, correct?

5 A. No. I think that's just clinical
6 practice. I'm not arguing with anybody.

7 Q. Okay. During COVID, your delivery volume
8 dropped dramatically, correct?

9 A. Right. They didn't like old guys being in
10 the hospital.

11 Q. Okay. I think you testified you did 10
12 deliveries since 2020?

13 A. Probably that's about right, yes.

14 Q. And I think you testified earlier today
15 that you do no more, period. I'm sorry. What -- how
16 many deliveries do you do currently?

17 A. So as I said before, I haven't done any
18 since July 2022, when I cut back on my time. So like
19 a lot of maternal-fetal medicine specialists, we just
20 do outpatient consulting work now.

21 Q. Okay. Talk a little bit about the first
22 safety round at 10:05 a.m.

23 Your review of the strips leading up to
24 that 10:45 time stamp. At 10:05 a.m., you saw
25 reasonable beat-to-beat variability in the strips.

1 A. Yes.

2 Q. Okay. At 10:21, a change in baseline, but
3 still a good beat-to-beat variability?

4 A. Yes.

5 Q. At 10:30, good beat-to-beat variability,
6 correct?

7 A. Yes.

8 Q. And at 10:38, you saw some discontinuity,
9 but you couldn't characterize it?

10 A. I think so. I don't -- if you want to put
11 it back up on the -- on the screen, I'd be happy to
12 comment on it.

13 Q. Well, did you have a chance to review your
14 deposition prior to today?

15 A. Yes. But I didn't memorialize every page.

16 Q. Well, did you attempt to be honest in your
17 deposition the first time around?

18 A. Yes.

19 Q. Okay. So I'll take your word for it that
20 at the time of your depo, that you were describing
21 things accurately.

22 A. Okay.

23 Q. These -- when I'm describing 10:05 through
24 10:45, these are the strips that the 10:45 safety
25 round would have been looking at, more or less.

1 A. At a minimum, I would have hoped that they
2 would have looked at the strips for the last several
3 hours. But maybe at a minimum, that's what they did.

4 If they were really safety rounds, then they would
5 want to look more than just the last 15, 20 minutes.

6 They'd want to really look at this patient
7 in its entire context. And would have seen at that
8 time that -- let's see. 10:45, it's 6 and a half

9 hours in the second stage of labor. And the safest

10 thing to do in the safety rounds is to say, it's time

11 for Mrs. Anyan to get delivered either by operative

12 vaginal delivery or cesarean section. That's what

13 safety rounds should have said.

14 Q. Right. So there was a group of physicians

15 and other people, not just Dr. McNeive, not just the

16 nurses that were there, but a separate group of labor

17 and delivery professionals who came and rounded on

18 Mrs. Anyan at 10:45. They were there. They would

19 have had access to her history and to what had been

20 going on, her current status, and reviewing the

21 strips, correct?

22 A. Yes. Now, when you say "rounded," I don't

23 think they went in and saw her. And they didn't

24 examine her. They didn't do a vaginal exam. They

25 just kind of looked at the -- I guess the general

1 clinical scenario.

2 Q. And you -- it's your testimony, both now
3 and on direct, that all of those additional labor and
4 delivery professionals, including this OB anesthesia
5 doctor and maternal-fetal medicine doctor, they all
6 missed the boat?

7 A. So, again, I don't know what they said. I
8 would imagine -- I would hope that at least some of
9 these people said, hey, wait a second, what's going
10 on with this patient? We just can't let this go on
11 indefinitely. I mean, I wasn't there, I don't know.
12 All we know is that safety rounds came by and said
13 continue. I don't know if there was a dissenting
14 opinion. I don't really know.

15 Q. And you said, they're lucky that their
16 names aren't in there.

17 A. Yes.

18 Q. Okay. Because you would have named them
19 as negligent in this case, as well.

20 A. Well, I'm not a lawyer, I don't name
21 people. But I would have got -- I would have wanted
22 to know what their thinking was that would allow this
23 to continue.

24 Q. MFM, you, in your past history as a
25 plaintiff expert, you have testified against

1 maternal-fetal medicine physicians, correct?

2 A. If somebody is negligent, whether they're
3 an obstetrician or a maternal-fetal medicine person,
4 you know, the standard of care is the same for
5 whatever physician.

6 Q. So if this MFM, she is negligent, is she
7 negligent for not ringing the bell and stopping this
8 second stage of labor?

9 A. I would -- I would think she would be,
10 yes. I don't know who it is. You said it's a she.
11 Maybe it's a he. I don't know.

12 Q. The OB anesthesia doctor, he's negligent?

13 A. Well, he doesn't do deliveries. He's just
14 an anesthesiologist. So I don't think he would opine
15 on whether there was a delivery or not.

16 Q. All of these professionals, including the
17 MFM, they all got it wrong at 10:45?

18 A. I believe so.

19 Q. Okay.

20 A. Perhaps it wasn't mentioned that she was
21 complete at 3:00 or 4:00 in the morning. They just
22 looked at what was going on at that period of time.
23 Perhaps that's what he was doing. I don't know what
24 was said, or, you know, how much of a picture they
25 were given. But if they got the whole picture, the

1 management at that time would be, you know, is she 6
2 and a half hours in the second stage? Let's get her
3 delivered one way or another. That is the standard
4 of care.

5 Q. For the most part, maintenance of moderate
6 variability between 9:30 a.m. and 2:00 p.m., correct?

7 A. That is correct. And that's why as I've
8 said many times already, that delivery at anytime
9 during that period time, the outcome would have been
10 a normal baby, healthy baby, I should say.

11 Q. Accelerations between 9:30 a.m. and
12 2:00 p.m.?

13 A. Yes. There were a few, you know, during
14 that period of time. Most of the time, there wasn't.

15 Q. Periods of slipping back into Category I
16 between 9:30 and 2:00 p.m.?

17 A. There were short periods, yes.

18 Q. When Mrs. Anyan wasn't pushing, it's your
19 assessment that Remi seems to have had chances to
20 recover?

21 A. Right. And that's -- that's the time to
22 deliver the baby, while it's still okay.

23 Q. And if we use the ACOG algorithm, Exhibit
24 I1, page 4.

25 The algorithm had been up before, and

you've got a copy?

A. Uh-huh, yes.

Q. If there is -- if we're using the ACOG algorithm, and it's for a Category II, you just said there's maintenance of moderate variability between 9:30 and 2:00 p.m., correct?

A. Yes.

Q. Okay. And if we're following the ACOG algorithm, if you go to continuous surveillance, intrauterine resuscitative measures, which include lateral positioning, which is what they were doing throughout this process, correct?

A. Yes.

Q. Okay.

THE COURT: Is this a good time to break?

MR. PERRON: Yes, Your Honor.

THE COURT: All right, ladies and gentlemen, based on the time and the Court's circumstances, we're going to end for the evening.

(At 4:43 p.m., the hour of adjournment having arrived, the jury, being duly admonished by the court, by agreement, is allowed to separate for the evening, under the usual instructions of the Court, until Friday, March 14, 2025, at 9:00 a.m.)

o o o

Friday, March 14, 2025

(At 9:02 a.m., the following proceedings were held in open court, in the presence of the jury:)

THE COURT: Good morning, everyone. Go ahead and be seated.

Doctor, as you recall, you were previously placed under oath, and at this time, you remain under oath.

THE WITNESS: Thank you.

THE COURT: Thank you.

On behalf of defendant, you may resume.

CROSS-EXAMINATION (Resumed)

BY MR. PERRON:

Q. Doctor, during your direct testimony, your direct examination, you testified that it was your opinion Dr. McNeive could take between 30 and 45 minutes to complete a C-section, correct?

A. I think I said that that's on average what it takes from skin-to-skin.

Q. Right. And even up to an hour, to include time preparing for the C-section, correct?

A. Yes. Yes.

Q. During your deposition, you were

1 criticizing Dr. McNeive for how quickly he could get
2 Remi out. You testified that a guy like Dr. McNeive,
3 a board certified obstetrician, he could do a
4 C-section in 5, 10 minutes.

5 A. Well, I think what I was referring to is
6 an emergency situation, not how long it takes to
7 complete a C-section, but how long it takes to get
8 the baby out. So from like incision to delivery, in
9 an emergency situation, I would think he could do
10 that.

11 Q. Right.

12 A. That's different from the total time of
13 the C-section.

14 Q. Incision to delivery, that's skin-to-skin?

15 A. No. No. Skin-to-skin means the incision,
16 get the baby out, repair the uterus, repair the rest
17 of the mother, and then closing, closing the skin.

18 so skin-to-skin could take 45 minutes to an hour.

19 skin to delivering the baby, is 5 or 10 minutes.

20 Q. Doctor, progress isn't guaranteed, even
21 with continuous pushing, correct?

22 A. That is correct. That's the problem here,
23 that progress didn't happen with continuous pushing.

24 Q. All right. But Remi did progress from a
25 zero station to plus 3, correct?

1 A. Eventually, over 10 hours, 12 hours, yes.

2 Q. Right. Progressed to vaginal birth,
3 correct?

4 A. He did have a vaginal birth.

5 Q. Okay. Rotational of the fetal head is
6 included in the definition of progress.

7 A. I'm not sure that it's clear about that.

8 Q. Okay. There's at least some literature to
9 suggest that rotation of the head is included in the
10 definition of progress, correct?

11 A. Okay.

12 Q. Okay. You disagree that babies swivel
13 when they're engaged?

14 A. That's correct.

15 Q. Okay. The nurses described, though, this
16 rotation, even later into the afternoon, when Dr.

17 McNeive described Remi as engaged, correct? That was
18 their testimony?

19 A. I believe so, yes. It's hard to
20 understand how that can happen, but that was their
21 testimony.

22 Q. Certainly. Regarding Pitocin and the use
23 of Pitocin, when we were referring to the Mercy
24 Pitocin protocol that was embedded in the medical
25 records, that protocol is under the subheading for

1 the protocol dealing with responses to Category II.

2 That portion of the protocol is under the subheading
3 "Nursing Communication Orders," correct?

4 A. I'm not sure. But we can look at it
5 together.

6 Q. Sure.

7 MR. PERRON: Justin, if you want to put up
8 A2 103.

9 And I'm going to -- I'm going to highlight
10 right here.

11 Q. (By Mr. Perron) This is the protocol
12 we've been talking about: intrauterine
13 resuscitation. It's under the subheading of "Nursing
14 Communication Orders," correct?

15 A. Correct.

16 Q. Okay. And this protocol qualified by the
17 language based on maternal-fetal response, correct?

18 A. It says, yes, based on the maternal-fetal
19 response. So you shut off the Pit, and then you see
20 what the response is.

21 Q. Right. I understand that's your position,
22 but this is qualified by these measures will be
23 initiated with the qualifications based on
24 maternal-fetal response, correct?

25 A. That's what it says there, yes.

1 Q. And the nurses did take the initiative of
2 lateral positioning. We've discussed that at length,
3 correct?

4 A. Yes.

5 Q. Okay. And the response to the
6 repositioning continuously was returned to moderate
7 variability, accelerations, and at the time Category
8 I, correct?

9 A. No, I don't think that's correct. Over
10 12 hours, it was a short period of time that it might
11 have been Category I, but most of the time the
12 response was not like that. And then the
13 decelerations returned shortly after.

14 Q. Right. There were multiple periods of
15 Category I during this period of time, not just one
16 brief period. You testified between 8:00 and
17 9:30 a.m., there were periods of Category I, correct?

18 A. Short periods, yes.

19 Q. Between 9:30 and 2:00 p.m., periods of
20 Category I.

21 A. So over that 5 or 6 hours, there may have
22 been 10 minutes of Category I.

23 Q. And even setting aside Category I,
24 throughout this time period, there was a general
25 maintenance of moderate beat-to-beat variability?

1 A. Yes. But there were also numerous --

2 Q. Doctor --

3 A. -- decelerations throughout that period of
4 time.

5 Q. Sure. We talked yesterday afternoon about
6 the ACOG bulletin which has specific guidance on
7 intrauterine resuscitation, correct?

8 A. Yes. Yes.

9 Q. Right. Just hearing to some extent the
10 Mercy policy, but the ACOG guidance explicitly says
11 these are just potential options, not do all of
12 these, correct?

13 A. Yes. But it only makes sense that you go
14 to shut off the Pit when there's that abnormal
15 tracing, especially with recurrent decelerations.

16 Q. I understand. You're saying it only makes
17 sense. But the actual text of the ACOG bulletin does
18 not say initiate all of these things. It just lists
19 turn off Pitocin amidst several other options,
20 including lateral positioning, correct?

21 A. I believe so.

22 Q. Okay.

23 A. But it's the one that's most obvious.

24 Q. Again, you are saying it's the most
25 obvious, sitting here today under oath. But the ACOG

1 bulletin makes no such language, correct?

2 A. I don't think it specifically says that,
3 but an obstetrician, experienced obstetrician, would
4 know that that's what you do.

5 Q. And you've already testified yesterday,
6 and in previous cases, if an OB follows the practice
7 bulletins and guidelines published by ACOG, for the
8 most part, OBs are practicing within an acceptable
9 standard of care.

10 A. I said that, yes.

11 Q. Okay. Between 2:00 and 4:00 p.m., there
12 were still evidence of accelerations during that
13 period of time?

14 A. There were some -- a short period of time
15 that there were a few accelerations.

16 Q. Maintenance of beat-to-beat variability?

17 A. Yes. And, again, that's another
18 opportunity to deliver the baby, and it would have
19 been healthy.

20 Q. You're familiar with the Clark diagram and
21 the literature published by Dr. Clark explaining the
22 algorithm?

23 A. Yes.

24 Q. Okay. And in his paper, he says
25 explicitly: we have used moderate rather than

1 moderate or minimal variability as the defining,
2 reassuring feature of our algorithm, correct?

3 A. Correct.

4 Q. Okay. So what Dr. Clark is telling us in
5 his article that moderate variability is the
6 defining, reassuring feature of the algorithm?

7 A. Correct.

8 Q. Okay.

9 A. And if we use his algorithm, we would see
10 that the --

11 Q. You'll have an opportunity to go through
12 the algorithm on redirect.

13 A. Thank you.

14 Q. The specific accelerations that you saw
15 between 2:00 and 4:00 p.m., include accelerations at
16 1548 or 3:48 p.m.?

17 A. I think that's correct, yes.

18 Q. Let me put them up so that you can see
19 them.

20 MR. PERRON: Justin, Exhibit A1, page 182.

21 And then if you can bold the date and time
22 just briefly.

23 Q. (By Mr. Perron) So, again, 1548, that's
24 3:48 p.m. This is less than 10 minutes before the
25 Category III, correct?

1 A. Correct.

2 Q. And it's within 36 minutes of Remi
3 actually being delivered, correct?

4 A. Correct.

5 Q. Okay.

6 MR. PERRON: Let's put that back up.

7 THE WITNESS: Excuse me. Would you mind
8 standing on the other side of the podium, so that

9 I -- thank you.

10 Q. (By Mr. Perron) so in your deposition,
11 you said there were multiple accelerations on this
12 page, correct?

13 A. Correct.

14 Q. Okay. And during Nurse Shinn's
15 deposition, in which you sat through, and in parts
16 during yours, you reference, again, the language from
17 Dr. Clark's article about the superb reliability of
18 accelerations to exclude any degree of hypoxia-
19 related injury, regardless of the acceleration
20 pattern.

21 A. And the question was?

22 Q. I -- I -- you -- you don't disagree with
23 that clarification of what an acceleration means.

24 A. Right. So that if he -- if Remi had been
25 delivered at this time before the tachycardia, before

1 the fever, I think the baby would have been maybe not
2 perfectly okay but neurologically intact.

3 Q. Right. And when you say we're speaking
4 about a neurologic injury, correct?

5 A. Yes.

6 Q. Particularly a hypoxia-related neurologic
7 injury?

8 A. Yes.

9 Q. And what these accelerations tells us is
10 that we can exclude any degree as late as 3:48 p.m.,
11 exclude any degree of hypoxia related injury,
12 correct?

13 A. So if he had been delivered at anytime
14 prior to this time, now we're in that eleventh hour
15 of the second stage, then he would have been okay at
16 delivery.

17 Q. A consistent agreement: Category III at
18 1557 or 3:57 p.m.?

19 A. Yes.

20 Q. Okay. So Category III, and the response
21 to Category III, there is published ACOG guidelines
22 about how to respond in a situation of a Category
23 III, correct?

24 A. Yes.

25 Q. Okay. And, again, we put this up on the

1 board. You're familiar with ACOG Bulletin 116 from
2 2010?

3 A. Yes.

4 Q. okay.

5 MR. PERRON: Justin, put up I1, page 7,
6 the ACOG guidelines in response to Category III.

7 Q. (By Mr. Perron) I'm getting in your way
8 again.

9 A. Thank you.

10 Q. okay. so if I'm reading this correctly,
11 this is the subheading. Question posed: If a
12 Category III tracing continues, and intrauterine
13 resuscitative measures are unsuccessful, over what
14 time interval should delivery be accomplished?

15 Did I read that correctly?

16 A. Yes.

17 Q. And what the ACOG guidelines are
18 attempting to do in this next paragraph is give
19 guidance to OBS in response to this question.

20 A. Yes.

21 Q. okay. The first sentence is: The
22 acceptable time frame to accomplish delivery in the
23 setting of a Category III FHR tracing has not been
24 established.

25 Did I read that correctly?

1 A. Correct.

2 Q. Do you agree that that's ACOG's current --
3 at least in 2020 -- that was ACOG's guidance, or at
4 least the first part of it?

5 A. Yes.

6 Q. Okay. Because historically a 30-minute
7 rule from decision-to-incision time for emergent
8 cesarean deliveries in the setting of abnormal FHR
9 patterns has existed.

10 And I'm going to pause there, there's a
11 semicolon.

12 But what this is telling us, what this is
13 telling any OB reading it, is historically -- so
14 maybe leading up to 2010 -- historically it was
15 recognized that the OB had 30 minutes in the setting
16 of Category III to get that baby out?

17 A. I don't think that's exactly accurate.

18 what that 30-minute rule was what we call the JCAHO

19 regulation. JCAHO is the Joint Commission of

20 Hospitals that said that a hospital providing

21 obstetrical services has to be able to perform a

22 cesarean section -- has to have the facilities

23 available to perform a cesarean section within 30

24 minutes from the decision to do a cesarean section to

25 get the baby out.

1 And so that was the JCAHO regulation.

2 And, yes, it was kind of thought that that might be
3 an appropriate guideline for getting a baby out, but
4 in fact, in some Category III tracings, you need 5
5 minutes to get the baby out. In truly in an
6 emergency, 30 minutes may be too long.

7 Q. Right. And I don't disagree. I'm less
8 familiar with JCAHO. I don't disagree that JCAHO
9 might also have that rule. But when this guideline
10 was published, they were recognizing this historic
11 rule. They didn't -- they don't reference JCAHO at
12 all in here, do they?

13 A. No. But that's where this came from, this
14 30 minutes --

15 Q. Okay. Well, you see this footnote 7.

16 A. Yes.

17 Q. Footnote 7? Okay.

18 MR. PERRON: Justin, if you want to go to
19 the next page, page 8, and highlight what footnote 7
20 is referencing. Isolate and blow it up for us.

21 Q. (By Mr. Perron) Footnote 7: American
22 Academy of Pediatrics, American College of
23 Obstetricians and Gynecologists. That's ACOG, right?

24 A. Yes.

25 Q. Okay. Fetal heart rate monitoring

1 guidelines for perinatal care.

2 Did I read that correctly?

3 A. Yes.

4 Q. Okay. So ACOG is citing itself for that
5 rule. They're not citing to JCAHO, they're citing
6 ACOG, correct?

7 A. Right. In that guideline, is the JCAHO
8 regulations.

9 Q. Sure. And they don't -- it doesn't appear
10 that they disagree with JCAHO. If JCAHO and ACOG
11 agree, it's still ACOG referencing themselves in
12 2007, that there's a 30-minute rule between deciding
13 to get the baby out in a Category III, and actually
14 getting him out?

15 A. Historically, that is correct.

16 Q. Okay.

17 MR. PERRON: Go back to -- Justin, back to
18 page 7, that paragraph.

19 Q. (By Mr. Perron) I told you there was a
20 semicolon. I didn't get to the rest of that
21 sentence.

22 okay. So after the semicolon it says:
23 However, the scientific evidence to support this
24 threshold is lacking, right?

25 A. Correct. Yes.

1 Q. Okay. So after that, it says: A study of
2 2,808 women had cesarean deliveries for emergent
3 indications.

4 That's what you're talking about:
5 emergency indications. Emergencies, right?

6 A. Yes.

7 Q. Okay. Investigators found that more than
8 30 percent of cesarean deliveries began more than 30
9 minutes after the decision to operate, yet, adverse
10 neonatal outcomes were not increased among those
11 infants delivered after more than 30 minutes.

12 Did I read that correctly?

13 A. Yes.

14 Q. So what ACOG is telling an OB reading this
15 in 2010, is that -- the studies show that even beyond
16 30 minutes, there's no evidence of neo -- adverse
17 neonatal outcomes, and they were -- those adverse
18 neonatal outcomes were not increased, even among the
19 infants born later than 30 minutes, correct?

20 A. Right. There's an old obstetrical adage:
21 It's better to be lucky than good.

22 Q. Okay. And they don't put that adage, they
23 put what I read.

24 A. That's fine. Yes.

25 Q. Okay.

1 A. Same thing.

2 Q. Sure. Now, it says: Multiple other
3 studies affirm the lack of association of increased
4 adverse outcomes with this 30-minute decision-to-
5 incision time frame, right?

6 A. Yes.

7 Q. Okay. Now, it goes on to say if a woman
8 comes in to the hospital in Category III, and you
9 don't know when it started, even if you got the baby
10 out immediately, it might be too late, right?

11 A. It might be, yes.

12 Q. Okay. But that's not the case here. We
13 know exactly when the Category III started, right?

14 A. Correct. Like 12 hours after this -- the
15 beginning of the second stage.

16 Q. Right. Dr. McNeive got Remi out in 27
17 minutes, correct?

18 A. Yeah. I'm not critical of what he did
19 starting at that moment in time.

20 Q. Okay. You testified on direct examination
21 Pitocin itself is not a risk of danger to the baby.
22 The baby isn't injured by the Pitocin, right?

23 A. That's correct.

24 Q. The risk is that the Pitocin will initiate
25 Category III, which Category III can injure the baby?

1 A. Yes. Or sometimes a severe Category II
2 can injure a baby, as well.

3 Q. Now, we were just looking at the ACOG
4 guideline. The American college of obstetricians and
5 Gynecologists, they understand when they're writing
6 this guideline about Category III, the possibility
7 that there might be concerning Category IIs leading
8 up to that Category III.

9 A. Yes.

10 Q. And they don't put any qualification in
11 there. They say, Category III, historic 30-minute
12 rule, and even longer might be okay, correct?

13 A. Right. But they also say that even within
14 30 minutes, the baby could be damaged.

15 Q. They say -- they say, if you know when it
16 starts, even within 30 minutes, the baby could be
17 damaged?

18 A. Could be, yes.

19 Q. You read that in that paragraph?

20 A. Well, that's certainly clinical
21 experience.

22 Q. Okay. Clinical experience but not what
23 ACOG is telling --

24 A. ACOG doesn't talk about 12-hour, second
25 stages of labor.

1 Q. okay. They do talk about that there's no
2 maximum duration, correct?

3 A. Right. And I'm glad you brought that
4 up --

5 Q. And, Doctor, I understand. You are going
6 to have -- you are going to have an opportunity on
7 redirect to opine at length, but to respect the
8 jury's time, we've already been going for a long
9 time, and there might be a tornado later on. I'm
10 trying to, for the sake of brevity, keep us on track,
11 so I understand.

12 There was -- we discussed a little bit
13 yesterday the consensus statement from ACOG saying no
14 maximum duration for second stage of labor, that was
15 published in 2014.

16 Does that ring a bell?

17 A. Yes.

18 Q. okay. So remind me again when you started
19 your career?

20 A. 1984, is when I finished my fellowship.

21 Q. okay. So from '84 to 2014, 30 years?

22 A. Yes.

23 Q. okay. So 30 years of your career was
24 spent before that consensus statement changing the
25 rules on the maximum duration, correct?

A. Correct.

Q. Okay.

A. Before that time, it had been 2 hours, is the usual second stage of labor. But after that, they allowed it to be three or 4 hours, or maybe a little bit further, as long as the mother's healthy, the baby's healthy, and there's progress in the labor.

Q. Just like you said, you're not critical of Dr. McNeive's care at the point when Category III tracing comes into play?

A. That's correct.

Q. Okay. And you can't comment on Dr. McNeive's testimony that between 2:00 and 4:00 p.m., the baby became too far engaged to safely do a C-section?

A. I can't comment on that.

Q. You can't comment on whether or not that is true. You're relying on Dr. McNeive to report that accurately, that in his opinion, the baby was too far down to safely get out via C-section?

A. If that were the case, then he should be able to get the baby out with what we call operative vaginal delivery using either forceps or a vacuum, cutting an episiotomy, and bringing the baby out that

way.

Q. Okay.

A. Because if it was so far down in the pelvis that you couldn't do a C-section, then you can get it out the other way.

Q. And you testified, it's your opinion, you can't say that at 4:00 p.m., a C-section or an OVD, would have been faster or safer than vaginal delivery?

A. That's right.

Q. Okay. During a prolonged labor, it's possible for Pitocin receptors to become saturated, correct?

A. Yes.

Q. Weak contractions slow the course of labor, correct?

A. Yes.

Q. Increasing the Pitocin in the final hours of this case, helped lead to the vaginal birth of Remi within that 27-minute period when he was in Category III?

A. I'm sorry. I didn't understand.

Q. Dr. McNeive increasing the Pitocin helped, at least in part, lead to the end result of getting Remi out within 27 minutes of that Category III

1 starting?

2 A. I don't think so, but it's hard to know.

3 Q. Okay. It's at least possible?

4 A. Unlikely.

5 Q. Okay. After delivery, Dr. McNeive's role,
6 as the obstetrician, is to care for the mother,
7 correct?

8 A. Correct.

9 Q. Okay. You mentioned with regard to the
10 cord gas. If there's a question about the baby's
11 status, that's when you get the cord gas, correct?

12 A. Yes.

13 Q. Okay. You read the deposition of the NICU
14 nurse who examined Remi right after delivery?

15 A. Who is the NICU nurse?

16 Q. She with by Younger at the time. Her name
17 is Nurse Spencer.

18 A. I don't think I did.

19 Q. You don't know if you were provided her
20 deposition?

21 A. I don't think so.

22 Q. Okay. You mentioned in your direct exam
23 the purpose of getting that cord gas is to get more
24 eyes on the baby?

25 A. To get more information about the baby.

1 Q. Right. The NICU team was already there at
2 the time of delivery, correct?

3 A. Correct.

4 Q. Those were the eyes, and they were already
5 on Remi.

6 A. Yes.

7 Q. Okay. And the assessment of the NICU
8 team, the eyes at that time, they assessed Remi,
9 correct?

10 A. Yes.

11 Q. And it was their determination, after
12 their assessment, to send Remi to the regular
13 nursery, not the NICU, correct?

14 A. Correct.

15 Q. Okay. Just to talk about the Apgar scores
16 for a minute. Again, it's the NICU team, not Dr.
17 McNeive, it's the NICU team and Nurse Spencer that
18 made that assessment and calculation of the Apgar
19 score, correct?

20 A. Correct.

21 Q. With a 5-minute Apgar score of 8, in your
22 opinion, it sounds pretty good, and in that moment,
23 would have been reassuring?

24 A. Yes. But it would -- you cannot -- the
25 Apgar scores during a resuscitation of the baby,

1 is -- does not have the same implication as an Apgar
2 score based on the spontaneous respirations of the
3 baby.

4 Q. Right. Did you review -- you already said
5 you don't know Nurse Spencer's testimony.

6 A. Correct.

7 Q. Did you review the actual individual
8 scores of the Apgar score?

9 A. I did see that, yes.

10 Q. He was rated at 2 for respiratory,
11 correct?

12 A. Right. And during that time, he was
13 either having positive pressure ventilation or CPAP,
14 continuous positive airway pressure, as it states in
15 the resuscitation note. And so these are
16 artificial -- these are things that can artificially
17 elevate the Apgar scores.

18 Q. So in your -- do you have an opinion that
19 Nurse Spencer assessed and documented an incorrect
20 Apgar score?

21 A. Well, I believe it's the Apgar score that
22 she assessed, but it was based on respiratory support
23 of the child during that time. And it is well
24 recognized that the Apgar score during a
25 resuscitation is -- does not have the same

1 implication as the Apgar scores in a spontaneously
2 breathing baby.

3 Q. And I suppose you can cite me some
4 literature?

5 A. Yes.

6 Q. Okay. Go ahead.

7 A. The ACOG community opinion on Apgar
8 scores.

9 Q. The neonatal encephalopathy and neurologic
10 outcome is an ACOG guideline, correct?

11 A. Correct.

12 Q. And that states: If the Apgar score at 5
13 minutes is greater than or equal to 7 is unlikely
14 that peripartum hypoxia ischemia played a role in
15 causing the neonatal encephalopathy.

16 Did I read that correctly?

17 A. You read that correctly. But, again,
18 that's in the context of a baby that comes out
19 spontaneously breathing on its own without aggressive
20 resuscitation.

21 Q. So, again, you're basing that opinion on a
22 presumption that the NICU nurse miscalculated the
23 Apgar score?

24 A. No, I'm not. It might have been the
25 correct Apgar score, but it was based on

1 artificial -- well, not artificial -- but on
2 resuscitation that was ongoing, which should be
3 ongoing, I'm not critical of resuscitation, but, you
4 know, when a baby needs respiratory support, it's not
5 the same as when you have spontaneous respirations.

6 Q. well, what is the point of doing the
7 5-minute Apgar score if, in your opinion, it's not
8 reliable to tell you how the baby is doing?

9 A. It's one piece of information, along with
10 the blood gases, that will help to determine of the
11 baby's actual status.

12 Q. Do you know if the ACOG has
13 recommendations on when to order blood gases with
14 regards to 5-minute Apgar scores?

15 A. No.

16 Q. Okay. I think it's been testimony your
17 testimony, and we discussed just a minute -- well,
18 just a minute ago, that, in your opinion, there was
19 no permanent neurologic injury to Remi between the
20 time he gets to the hospital and 3:57 p.m.?

21 A. I think towards the end, I might have said
22 there's some -- possible some neurologic injury, but
23 hopefully not permanent injury.

24 Q. Right. And that's in the setting of
25 accelerations based on 10 minutes before Category

1 III, which excluded the possibility of ongoing
2 hypoxemia.

3 A. Makes it unlikely.

4 Q. Okay. Very unlikely.

5 A. Unlikely.

6 Q. Okay. The last half hour, in your
7 opinion, just the last half hour, that Remi suffered
8 an irreversible injury?

9 A. That's correct.

10 Q. Okay. And I think you even said, even by
11 4:10 p.m., there might have been time to get Remi out
12 to avoid the injury?

13 A. I'd have to look. If that's what I said
14 before, I stand by it. I'd want to look at the
15 tracing, if you want me to confirm that.

16 Q. Well, if you've got your deposition, I
17 think it's page 64. Page 64 going into 65. It's at
18 the end of -- sorry -- I'll give you the line.

19 A. So my answer was: I mean, I think that
20 every minute that the baby stayed in utero created
21 ongoing damage to the baby. Now, I defer to a
22 neonatologist and a pediatric neurologist as to
23 exactly how much damage.

24 But when you look at the heart rate
25 tracing starting at about 1610, that's really when we

1 have this tachycardia, and I think that's really when
2 most of the damage is done.

3 Q. So 1610 military time is 4:10 p.m.

4 A. Yes.

5 Q. Okay.

6 A. And so any delay in this really critical
7 period of time contributed to the ongoing damage.

8 Q. All right. In your opinion, the only time
9 that it's possible, looking at the strips, for Remi
10 to have suffered this injury, is just within this
11 window of the last 14 minutes, permanent irreversible
12 injury, just within the last 14 minutes?

13 A. If that's what I said before, if you want,
14 I --

15 Q. Right.

16 A. Yeah. I'd be happy to look at the tracing
17 again. But if that's what I said before, I stand by
18 it.

19 Q. Right. And so the -- the strips tell us
20 that from admission, to at least 14 minutes before
21 he's delivered, those strips are not consistent with
22 a permanent neurologic injury?

23 A. Correct.

24 Q. Okay. We referenced this yesterday. In
25 response to one of my questions, you offered the

1 opinion beat-to-beat variability was maintained, and
2 that is reassuring, and that is why you're saying
3 even at this point in time, if Remi had been
4 delivered, he could have avoided permanent injury.

5 That's your opinion, correct?

6 A. Correct. Any time during that extended
7 12-hour, second stage of labor, up until the time
8 that we're talking about, up until 1357, I would
9 think the baby would have been neurologically intact.

10 Q. So when we're talking about your opinions
11 on causation, you believe all of the tracings of
12 moderate variability are reliable, even those
13 tracings beyond 4 hours, beyond 5 hours, beyond 6
14 hours of the second stage of labor? And we're
15 talking about your opinions on causation. Those
16 strips are reliable to exclude the presence of
17 hypoxic-related ischemia, correct?

18 A. In general, yes.

19 Q. But Dr. McNeive, he can't rely on those
20 strips at the time to know there's no hypoxic-related
21 ischemia. Or can he?

22 A. I would think yes.

23 Q. Okay.

24 A. He can rely on it. And, again, it's all
25 about the length of the second stage of labor.

1 Q. All right. 20 to 30 percent of your total
2 personal income comes from your expert work?

3 A. Yes.

4 Q. And that's 80 to 90 percent for
5 plaintiffs?

6 A. Yes.

7 Q. And I've got a deposition all the way back
8 to 1998, so at least as far back as '98, is that
9 fair?

10 A. That must have been my first one as an
11 expert.

12 Q. Well, congratulations.

13 The accelerations we saw at 3:48 p.m., as
14 we've mentioned a couple of times, we know, based on
15 literature, the consensus in the literature, those
16 accelerations, even 36 minutes before he's born,
17 exclude the possibility of ongoing hypoxic neurologic
18 injury, correct?

19 A. Typically that would be correct, yes.

20 Q. Okay. And we know from ACOG, 30 minutes
21 of Category III is typically not enough to cause HIE.
22 That's what the ACOG guidelines tell us. If you get
23 it out within 30 minutes, you've got the best chance
24 of avoiding HIE. That's what ACOG tells us, right?

25 A. The faster you get the baby out in an

1 emergency situation, the less a chance of there being
2 a problem.

3 Q. And the 5-minute Apgar score traditionally
4 is consistent with a successful resuscitation,
5 correct?

6 A. A 5-minute Apgar in a spontaneously
7 breathing baby is consistent with a good outcome,
8 yes.

9 MR. PERRON: Those are all my questions.
10 Thank you.

11 THE COURT: On behalf of Mercy Hospitals?

12 MS. KAMYKOWSKI: Yes, Your Honor.

13 CROSS-EXAMINATION

14 BY MS. KAMYKOWSKI:

15 Q. Good morning, Dr. Warsof.

16 A. Good morning.

17 Q. How are you?

18 A. Terrific, thank you. And you?

19 Q. I am great, thank you.

20 A. You're not worried about a tornado?

21 Q. I grew up in Nebraska, so, no. I've seen
22 many and lived through many. So, no, they don't
23 bother me.

24 A. Okay.

25 Q. I don't want to be driving home in one

1 today, though, so -- and you probably don't want to
2 have to be flying through one, so we'll try to get
3 you out of here and get you on a plane before you're
4 worried about that.

5 A. I appreciate it.

6 Q. I want to go back to a couple of things
7 that you discussed with Ms. Gunn yesterday. And I
8 wrote them on the outside of my outline so I wouldn't
9 forget, and I put them in quotes.

10 So I think the question that was posed to
11 you at some point during direct exam was that if you
12 have a Category III fetal monitor strip, that that is
13 evidence of hypoxic injury, and you answered yes.

14 Do you remember that?

15 A. I don't remember it, but typically that's
16 true, yes.

17 Q. Okay. Well, that's not actually the
18 definition of Category III that ACOG and the National
19 Child Institutes for Health and AWHONN have
20 established.

21 Do you agree with that?

22 A. You lost me.

23 Q. So a Category III, by definition, does not
24 say that that is evidence of hypoxic injury, does it?

25 So let's look at it.

1 MS. KAMYKOWSKI: Justin, can you pull up
2 19, pages 2 and 4. It goes over a whole page of a
3 table.

4 Q. (By Ms. Kamykowski) So this ACOG Practice
5 Bulletin 106.

6 MS. KAMYKOWSKI: Go to the title for me,
7 the first page, Justin.

8 Q. (By Ms. Kamykowski) This is the
9 intrapartum fetal heart rate monitoring nomenclature
10 interpretation and general principle -- management
11 principle.

12 You've seen this before?

13 A. Yes.

14 Q. And this is -- we went through this with
15 Ms. Shinn. You were here when I cross examined Ms.
16 Shinn yesterday, correct?

17 A. Yes.

18 Q. All right. And the definitions on page
19 2 --

20 MS. KAMYKOWSKI: where it says Category
21 III on the right bottom, Justin. It starts with
22 that.

23 Q. (By Ms. Kamykowski) And this is providing
24 the definition that ACOG and AWHONN have adopted
25 after the Eunice Kennedy NICHD study came out, and

1 they said, let's make sure we're not just going to
2 say back in your day, reassuring or nonreassuring.
3 They wanted to help categorize fetal heart rate
4 patterns, correct?

5 A. Correct.

6 Q. All right. And it says: The definition
7 is Category III, FHR tracings are abnormal. And then
8 it goes through and it says: They are associated
9 with abnormal fetal acid base status at the time of
10 observation, right?

11 A. Yes.

12 Q. Category III FHR tracing requires -- or
13 tracings -- require prompt evaluation.

14 You see that?

15 A. Yes.

16 Q. Do you agree with that?

17 A. Yes. Yes.

18 Q. Okay. And then depending on the clinical
19 situation --

20 MS. KAMYKOWSKI: And this, Justin, we'll
21 have to go to page 4.

22 Q. (By Ms. Kamykowski) -- efforts to
23 expeditiously resolve. The abnormal fetal heart rate
24 patterns may include but are not limited to position
25 of maternal -- provision of maternal oxygen, change

1 in maternal position, discontinuation of labor
 2 stimulations, treatment of maternal hypotension, and
 3 treatment of tachysystole with FHR changes. And then
 4 if a Category III tracing does not resolve with these
 5 measures, delivery should be undertaken.

6 You agree with that?

7 A. Yes.

8 Q. And so nowhere in that definition of
 9 Category III did it say that they are evidence of
 10 hypoxic injury.

11 You would agree with that, correct?

12 A. Can you go back to the beginning of that?

13 Q. Sure.

14 A. I thought that was pretty close.

15 Q. It says: They are associated with
 16 abnormal fetal -- or acid base status. That is not
 17 evidence of an actual injury, correct?

18 A. Pretty close.

19 Q. Okay. So your testimony under oath here,
 20 as a maternal-fetal medicine expert, is that Category
 21 III tracings are evidence of an actual injury has
 22 already occurred?

23 A. No, not that has already occurred.

24 Q. Oh, okay.

25 A. But that the persistent of a Category III

1 tracing, if it doesn't resolve, could lead over
2 time -- exactly how much time is unclear -- to an
3 injury.

4 Q. Sure. And you just went over that with
5 Mr. Perron about for like 30 minutes. I'm not going
6 to rehash that.

7 All right. I want to talk about your work
8 as an expert and specifically in this case, okay?

9 A. Okay.

10 Q. I think you told us in your deposition
11 that you were contacted through an entity called the
12 Expert Institute.

13 Do you recall that?

14 A. Yes.

15 Q. And while that's not something that you
16 didn't pay to join it, somehow you became an expert
17 that this service that what they do is, they are a
18 liaison between lawyers looking for experts in the
19 medical field, right?

20 A. Yes. Defense and plaintiff lawyers.

21 Q. And in this case, somehow, through the
22 Expert Institute, Ms. Gunn or Ms. Lenivy was able to
23 contact you.

24 A. Yes.

25 Q. And you told us at your deposition, that

1 with respect to the information you were given at the
2 first contact about this case, you presumed that you
3 were told that this was a case that involved a
4 prolonged second stage, and that the baby was
5 damaged, correct?

6 A. If that's what I said in the deposition,
7 then that's correct, yes.

8 Q. Okay. Do you want to look at it?

9 A. No. I believe you.
10 So the deposition was September 21, 2023,
11 so a year and a half ago.

12 Q. Yes. And we did it by zoom, I believe.

13 A. I think so.

14 Q. I did not get to go to Virginia Beach, and
15 I wish I did.

16 A. You're always welcome.

17 Q. I would love to.

18 Going back to yesterday and in her
19 opening, Ms. Gunn showed you what's been marked as
20 Plaintiffs' Exhibit 500. And that's that two-page
21 document that was purple and red and green and yellow
22 and blue.

23 Do you remember that graph?

24 A. Yes.

25 Q. And we went through it at length with

1 Nurse Shinn. She went through it in some detail with
2 you and told you that that was her time line created
3 by her review of the medical records and correlating
4 it with Exhibit 5, which is the review of the fetal
5 monitor strips that the providers in this case
6 including Dr. McNeive, Dr. Parker, Dr. McKillip,
7 Kelsey Blanton, Alex Greenwald, and Nurse Maggie and
8 Nurse Jessie -- and I may have left some out -- had
9 reviewed when they were deposed in this lawsuit.

10 You understood that, correct?

11 A. Yes.

12 Q. That was not a prospective review of those
13 strips, was it?

14 A. That's correct.

15 Q. All of the writings on there that called
16 decelerations or noncontiguous strips, late
17 decelerations, early decelerations, that's all that
18 was marked on there, were decelerations of the heart
19 rate, right?

20 A. Correct. But presumably, although this
21 was done in the deposition and retrospectively, I
22 assume that they would have the same feelings about
23 it when they were the treating nurses or physicians.

24 Q. Well, we don't like to make assumptions,
25 do we? And if you're making an assumption about

1 them, you know what the old adage is about

2 assumptions, don't you?

3 A. No.

4 Q. I can't say it in court. But I think

5 everybody does.

6 so that's your assumption, and they'll be

7 able to tell the jury about that.

8 But my point is, that exhibit with all of

9 the colors was taken from the medical records, and it

10 included -- well, it excluded a couple of things, did

11 it not?

12 It excluded any documentation from the

13 flow sheets in real-time of variability, right?

14 There was nothing on there about variability.

15 A. I don't know.

16 Q. Do you remember? Okay.

17 A. No. I wasn't involved in making that flow

18 sheet.

19 Q. Well, I'm just asking you. You looked at

20 it, and you said it supported your opinions. And it

21 shows the things that needed to be -- it was so

22 obvious -- that needed to be changed in this case,

23 but it didn't talk about variability at all, did it?

24 A. I don't know.

25 Q. You don't know.

1 okay. And it didn't talk at all about any
2 documented accelerations of the heart rate, did it?

3 A. I don't know.

4 Q. You don't know.

5 okay. But you agree, and you told
6 Mr. Perron, that throughout this strip for the most
7 part, there was moderate beat-to-beat variability?

8 A. Yes.

9 Q. And we just talked about even if close to
10 12 minutes before four o'clock, there were
11 accelerations of the heart rate, correct?

12 A. Yes.

13 Q. All right. I want to talk to you about
14 the vaginal birth protocol, right? I just want to
15 make sure I understand your opinion. It seems pretty
16 similar to Nurse Shinn. And I went over it with her
17 a lot yesterday.

18 The Category II responses, you are
19 interpreting Mercy Hospital's protocol that Mr.
20 Perron showed you a little bit ago to require first
21 turn the Pitocin off, correct?

22 A. Yes.

23 Q. Okay. You used the words a couple of
24 times, and, again, I wrote this down. Make sure I've
25 got it right. In describing, I think trying to bring

1 this case to -- in line with your opinions, the
 2 strips in this case, you described worrisome features
 3 of a Category II?

4 Do you remember using that description?

5 A. Yes.

6 Q. And you said a severe Category II.

7 Do you remember that description?

8 A. Yes.

9 Q. And then we talked a little bit -- and I

10 think you said worrisome features, and then there are

11 some Category II's that have, quote, more reassuring

12 features, correct?

13 A. Or less worrisome, yes.

14 Q. Okay. And when we took your deposition,

15 you brought with you a copy of the Clark algorithm,

16 did you not?

17 A. Probably.

18 Q. Okay.

19 MS. KAMYKOWSKI: May I approach, Your

20 Honor?

21 THE COURT: You may.

22 Q. (By Ms. Kamykowski) I'm going to hand you
 23 what we've marked as Exhibit E6C.

24 A. Thank you.

25 Q. Do you recognize that as what -- the

1 single page that you brought to us for your
2 deposition?

3 A. Yes.

4 Q. And it actually has your markings on it?

5 A. Yes.

6 MS. KAMYKOWSKI: Can you pull that up for
7 us, Justin?

8 Q. (By Ms. Kamykowski) And although today or
9 yesterday you described Category II as having, quote,
10 worrisome features or severe Category II, really what
11 Clark and his colleagues did when they came up with
12 this algorithm, and we went through it yesterday.

13 And we went through the history and the paper, the
14 opinion that developed the ACOG guideline and the
15 AWHONN guidelines that adopted this algorithm.

16 The purpose of them starting this was so
17 that there would be some clarification for bedside
18 providers on how to manage Category II fetal heart
19 tracings, correct?

20 A. Correct.

21 Q. So we will know if it's a reassuring
22 Category II or a worrisome Category II because we can
23 follow this algorithm, right?

24 A. Yes.

25 Q. Okay. Now, at your deposition, you told

1 us that this was your application of the facts of
2 this case around the 9:30 time frame?

3 A. Yes.

4 Q. I think it says it requires an hour of
5 review: 8:30 to 9:30, right?

6 A. Yes.

7 Q. So your opinion is -- but first question:
8 Do we have moderate variability or accelerations?

9 And you say, yes?

10 A. Yes.

11 Q. All right. So we go to the left side,
12 right?

13 Now you say, significant decelerations
14 with greater than or equal to 50 percent of
15 contractions in one hour, right?

16 A. Yes.

17 Q. And you were here yesterday when I did my
18 exercise with Nurse Shinn, right? You saw me do this
19 with her? You don't remember when we went -- she and
20 I spent -- it was at the very end of my exam of her,
21 and you were sitting back there.

22 Do you remember that?

23 A. Yes, I think so.

24 Q. Okay. And it was 18 hours ago.

25 All right. So you say the second answer

1 is also yes, correct?

2 A. Correct.

3 Q. Okay. So you, in preparing for your
4 opinions in this case, applied this algorithm to the
5 strips, and you counted up that there were more than
6 50 percent of contractions, or there were -- the
7 number of significant decelerations was more than
8 50 percent of the contractions?

9 A. Yes.

10 Q. Okay. Over that hour?

11 A. Yes.

12 Q. All right. So because of that, in your
13 mind, when it says yes, you drop down, and you figure
14 out, okay, where are we in the labor? That's the
15 next step that Clark and his colleague say we do,
16 correct?

17 A. Correct.

18 Q. Because Sarah was in the second stage at
19 all times we're talking about in this case?

20 A. Correct.

21 Q. Normal progress, you say no?

22 A. Correct.

23 Q. And that's what supports your opinion that
24 by 9:30, a C-section should have been done?

25 A. Or operative vaginal delivery.

1 Q. Sure. Somehow Remi needed to be
2 delivered. That's your opinion?

3 A. Yes. Yes.

4 Q. Okay.

5 A. Thank you.

6 Q. Well, what do you think Nurse Shinn's
7 review of this case would result if we applied the
8 algorithm to the same time frame?

9 A. I don't recall.

10 Q. You don't know?

11 A. I assume the same, I mean...

12 Q. Well, actually not. I actually counted it
13 up. So I'm going to show you that, too, okay?

14 Let me get my marker. So I went over with
15 Nurse Shinn what would happen at the end of labor
16 after those safety -- or those strip rounds happened
17 at 2:48. But I also, since she -- her Exhibit E4B,
18 which you saw me talk to her about, she had reviewed
19 and counted contractions and identified decelerations
20 in -- throughout from 6:30 through the time frame.
21 So we have her information that she told us on that
22 exhibit.

23 MS. GUNN: Your Honor, may we approach?

24 THE COURT: You may.

25 (Proceedings were held at sidebar, outside

1 the hearing of the jury.)

2 MS. GUNN: Your Honor, I don't know that
3 it's appropriate for this witness to comment on the
4 thought process and opinions of a different witness
5 in this case. If Ms. Kamykowski wants him to walk
6 through his review of this case and what his opinions
7 are, that's one thing. But it is improper of a
8 witness, even on cross-examination, to go through
9 some other witness's thought process and comment on
10 it. I don't think it's proper.

11 MS. KAMYKOWSKI: I believe Exhibit 500 has
12 them doing the exact same thing with all of my
13 witnesses in Exhibit 5. So he's already done it with
14 another exhibit in this case, Exhibit E4B, Ms.
15 Shinn's, I think. And I'll read it in right now if I
16 have to, but it will be in evidence, and I can use it
17 for any purpose, Judge.

18 I don't think it's improper for me, when
19 she holds those opinions, for me to show that she
20 disagrees with him. I'm sorry that Ms. Gunn does not
21 like that her experts disagree, but it's
22 cross-examination, and there's nothing wrong with it.

23 MS. GUNN: I think that that would be left
24 for argument. But to have this witness comment on
25 another witness's thought process is improper.

1 MS. KAMYKOWSKI: I'm not asking him to
2 comment on it. I'm showing him exactly what she did.

3 MS. GUNN: I mean, you could have done
4 that with her.

5 MS. KAMYKOWSKI: I'm sure -- I don't
6 understand the legal objection, that she doesn't like
7 my comment, and I appreciate that, but I don't know
8 what the legal basis of that is.

9 MS. GUNN: The legal basis, as I indicated
10 before, is that it's improper to have a witness to
11 comment on someone else's credibility if he disagrees
12 with them.

13 MS. KAMYKOWSKI: I'm not asking him to
14 comment on her credibility. And I'm using the
15 evidence, and then I will then comment on his
16 credibility in closing.

17 THE COURT: The Court is going to overrule
18 the objection.

19 But be careful not to go into that road of
20 asking him to opine.

21 MS. KAMYKOWSKI: Yes. Yes. Thank you,
22 Judge.

23 (Proceedings returned to open court.)

24 Q. (By Ms. Kamykowski) Okay. Dr. Warsof, so
25 we will have Exhibit E4B, which is Nurse Shinn's

1 retrospective review of the strips, right?

2 And so if we do the algorithm, put a date
3 on this because I always do that when I'm in trial.

4 So just for the record, I dated this page and put
5 your name on it so we know we talked to you about it,
6 okay? When I talk about this later, I want to make
7 sure we remember.

8 So if we apply this algorithm for the hour
9 before you say the standard of care required a
10 C-section, that's the correct time frame, correct?

11 A. Uh-huh, yes.

12 Q. All right. So, again, we'll do the number
13 of contractions and then decelerations. And I did
14 those as late, variable, and prolonged, right?

15 And when I reviewed Exhibit E4B, I counted
16 29 contractions: 12 lates, zero prolonged, and 7
17 variables.

18 So if we start with that, that gets us to
19 19, right?

20 A. Okay.

21 Q. So you remember this algorithm, you see
22 it? It has those qualifications. Do you remember
23 the clarifications for its use that we talked about
24 with Ms. Shinn yesterday?

25 A. Please remind me.

1 Q. well, we talked specifically for
2 variables. And I don't want to go back through it.

3 MS. KAMYKOWSKI: But if you could pull up
4 I13, page 3, Justin.

5 Q. (By Ms. Kamykowski) And I'll just go
6 through this quickly. But specifically as it relates
7 to variable deceleration, as we talked with Nurse
8 Shinn yesterday, to be significant, right? Where we
9 talk significant decelerations.

10 (Pause in proceedings.)

11 Q. (By Ms. Kamykowski) All right. So if we
12 have significant decelerations, when we're talking
13 about a variable yesterday, what we told them, what
14 the jury saw, and what Nurse Shinn agreed what the
15 definition was, was anytime a variable deceleration
16 reaches a nadir of below 60 beats per minute.

17 A. Below 60 beats per minute from the
18 baseline.

19 Q. No. I'm doing them in reverse.
20 Did anyone -- yes, below 60 minutes per
21 minute from the baseline anytime?

22 A. I mean, that would be the time frame.

23 Q. And the other way they defined it was
24 anytime, regardless of the baseline, if it hit below
25 60 beats, so if you're talking bradycardia, okay?

1 A. That would be bad, yes.

2 Q. And I'll tell you again when I looked
3 through Exhibit E4B, none of these variables met that
4 definition.

5 So if we take those seven out, that leaves
6 us to 12. So if you have 29 contractions divided by
7 12, that is not more than 50 percent. And so we
8 would not follow your part, you know, pick -- choose
9 your own adventure on the algorithm because we don't
10 have significant decelerations with greater than 50
11 percent of contractions in an hour.

12 MS. KAMYKOWSKI: And so can you scroll
13 down, Justin?

14 Q. (By Ms. Kamykowski) And if you remember
15 from yesterday what that means --

16 MS. KAMYKOWSKI: No, I'm sorry.

17 Q. (By Ms. Kamykowski) -- is if you say no,
18 we have moderate variability and accelerations, say
19 yes. Then we evaluate what we just did with what
20 Nurse Shinn did in this case, her conclusion is, no,
21 you observe, right?

22 A. And then you go over to the next step
23 which is, is there normal progress? The answer is
24 no, so you go to cesarean section or operative
25 vaginal delivery.

1 Q. Actually, you don't. That would only --

2 A. Actually, you do.

3 Q. So, Doctor, I know you want to fight me on
4 this, but I can read it. The only time you drop down
5 here is if you get a yes. That's how the algorithm
6 works, right?

7 A. No.

8 Q. Okay. You disagree with that?

9 A. I disagree with you, yes.

10 Q. Okay.

11 A. So whether you go to the yes side or the
12 no side, they all -- once you get to the normal
13 progress, the answer is no. And it's either cesarean
14 section or operative vaginal delivery.

15 Q. I want to make sure I understand.

16 MS. KAMYKOWSKI: Can you draw on this for
17 me?

18 Q. (By Ms. Kamykowski) what you are telling
19 this jury, Doctor, is that if we get to the no, which
20 is what Nurse Shinn's interpretation of this hour
21 was, you still drop --

22 MS. KAMYKOWSKI: Take from the no, Justin,
23 and draw a red line to second stage.

24 Q. (By Ms. Kamykowski) You think that's how
25 we apply this algorithm?

1 A. No. If you go down to observe.

2 Q. Sure.

3 A. You'll have to follow that. And then
4 follow the arrow. There was a line from observe to
5 no or yes.

6 Q. It doesn't take you back up there, Doctor.
7 That's not how it works.

8 A. Yes, it does.

9 Q. Okay. So Nurse Shinn says observe. And
10 once you get to observe, you reapply it every 30
11 minutes unless you get to a Category I, and then it
12 no longer applies, correct?

13 A. First of all, I disagree with you. I
14 still think it goes to the yes. I think those
15 variables are significant. They may not meet the
16 exact criteria that you guys were talking about. But
17 from a clinical perspective, they certainly do. But
18 even if you went to no, you still have to achieve an
19 adequate progress. And if the answer for that is no,
20 and the solution to this algorithm is cesarean
21 section or operative vaginal delivery.

22 Q. Because your whole opinion in this case
23 is, and I quote -- and I wrote it down, and I
24 highlighted it, it's all about the length of the
25 second stage, regardless of moderate variability,

1 regardless of accelerations, regardless of what the
2 literature says, we know shows adequate oxygenation
3 less than 12 minutes before the first time there was
4 Category III, correct?

5 A. Correct.

6 Q. Thank you, Doctor. That's all I have. I
7 don't have anything else.

8 A. Of course that's the time to get the baby
9 out --

10 Q. Thank you.

11 A. -- while there's adequate oxygenation.

12 THE COURT: Redirect?

13 MS. GUNN: Yes, ma'am.

14 REDIRECT EXAMINATION

15 BY MS. GUNN:

16 Q. Dr. Warsof, this is going back a ways so
17 stay with me, but with respect to some of this

18 discussion yesterday, there was talk about Dr.
19 Mckillip, the pushing evaluation. The question was

20 whether there was any descent. And after she did
21 that, and you recognized that there wasn't, correct?

22 A. Correct.

23 Q. And Mr. Perron indicated, well, she said
24 minimum descent with pushing.

25 Is that the same thing? If you have

1 minimal descent with pushing, but we know that the
2 baby rotated back, does that count for descent?

3 A. No.

4 Q. Now, just real quick on what we were just
5 doing, the fetal monitoring strips.

6 Is there any evidence in Sarah Anyan's
7 chart, I know we saw them in the courtroom, and we
8 are going to go through these things and run an
9 algorithm that's on piece of paper that was written

10 10 years ago. Is there any evidence in Sarah Anyan's
11 chart that Dr. McNeive or any of the Mercy nurses,
12 Jessie or Maggie, ran that algorithm?

13 A. No. Because they didn't.

14 Q. The only time there's evidence -- and we
15 know it couldn't have been in the chart because at
16 2:48, the strip round folks apparently ran it,
17 correct?

18 A. Yes.

19 Q. Now, I mean, with respect to that, and the
20 medical record is very clear that the amount of time
21 that the fetal heart tracing were reviewed were 15
22 minutes.

23 You remember that?

24 A. Yes.

25 Q. And, yet, they were still able to run the

1 Clark algorithm?

2 A. Yes.

3 Q. Does that make sense you?

4 A. Not really.

5 Q. Now, about accelerations. The
6 accelerations in this case, weren't there just a few
7 accelerations?

8 A. Over this 12-hour period of time, there
9 were a few accelerations, yes.

10 Q. If you see an acceleration once every
11 three or 4 hours, is that reassuring?

12 A. Not really. Not really.

13 Q. And even in the face of moderate
14 variability, you get one acceleration, or a handful
15 of accelerations, over 8 hours, are you reassured?

16 A. You would have to put in the context of
17 the whole case, and so one acceleration doesn't --
18 that doesn't say that everything is great, you know.

19 Q. Is that true, if all you see are
20 accelerations, would that be reassuring?

21 A. If it's -- the more accelerations you
22 have, the more reassurance it is, yes.

23 Q. So if you only see an acceleration
24 occasionally, Doctor, in a 12-hour stage of labor, I
25 know that's unheard of, but here we are, is that

1 reassuring?

2 A. Not really, no.

3 Q. So if you're the one looking at the strips
4 over this 8-hour time period or 23-hour time period,

5 let's just go from eight o'clock forward, 8 hours-
6 plus time period. If you're reading those strips,
7 and you're really going to rely on the strips to say
8 that everything looks great because you saw Dr.

9 McNeive's vaginal delivery note -- right? -- remains
10 reassuring?

11 A. Uh-huh.

12 Q. If you're looking at those strips, and
13 you're seeing an occasional acceleration and multiple
14 and recurrent decelerations, are you reassured?

15 A. Not in the overall picture. You know,
16 overall it's a concerning picture. It hasn't been
17 that way for the whole tracing.

18 Q. And with respect to the end here in this
19 Category III, I know we focused on Category III,
20 wasn't Remi also tachycardic?

21 A. Yes.

22 Q. And that's not within -- that's not while
23 he was Category III, right?

24 A. That's correct. That's even worse than
25 Category III.

1 Q. So category III is bad.

2 A. Yes.

3 Q. But then you add tachycardia on top of it.

4 A. On top of a 12-hour second stage of labor
5 on top of maternal fever. And now Remi is
6 unfortunately quite sick.

7 Q. So you can't just look at, well, it's a
8 Cat III, and it looks like this document here from
9 ACOG, I can look at that and look back afterwards and
10 say, well, here's a little line that says there's a
11 30-minute rule, and I got it done in 27 minutes, no
12 problem?

13 MS. KAMYKOWSKI: Object to the form.
14 Leading.

15 Q. (By Ms. Gunn) Do you agree that's no
16 problem?

17 THE COURT: Overruled.

18 A. So in a Category III situation, it doesn't
19 resolve, you need to get the baby out as fast as you
20 can.

21 Q. (By Ms. Gunn) And then how many hours did
22 Dr. McNeive have before 4:00 p.m. to deliver Remi?

23 A. From 8:00 a.m. to 4:00 p.m., so 8 hours.
24 He had an 8-hour period of time to deliver Remi. And
25 more likely than not, the baby would have been fine

1 during that period of time, if he would have been
2 delivered at that time.

3 Again, the idea is to deliver the baby
4 before you get to Category III. And it was
5 inevitable, if we were going to continue this second
6 stage for -- for -- for whatever -- forever, I guess,
7 that eventually the baby is going to get sick.

8 Eventually the mother is going get sick, too.

9 Q. Mr. Perron asked you Apgar scores, and you
10 mentioned a committee opinion, Doctor.

11 MS. GUNN: Let's pull up Exhibit 420.

12 Q. (By Ms. Gunn) So, Doctor, let's just --

13 MS. GUNN: Zack, let's get the first half
14 of that page.

15 Q. (By Ms. Gunn) Is this the committee
16 opinion you were referring to?

17 A. Yes.

18 Q. It's most commonly known as the Apgar
19 score?

20 A. Yes.

21 Q. Okay.

22 MS. GUNN: And let's go to that abstract.

23 Q. (By Ms. Gunn) And the sentence that
24 starts "an Apgar score."

25 A. Yes.

Q. Can you read that to the jury, please?

A. I'll try.

Q. Okay.

MS. GUNN: Zack, can you make it bigger?

A. Can he make it a little bit bigger? I'm getting old, sorry.

Q. (By Ms. Gunn) would it be okay, I can hand it to you.

A. That's okay.

An Apgar score assigned during resuscitation is not equivalent to a score assigned to a spontaneous breathing infant --

Q. What does that mean?

A. -- and that's what I was trying to say during the earlier discussion.

Q. What does it mean?

A. It means that if we can actively be resuscitating a baby, in other words, you're oxygenating it, sometimes you're doing chest compressions.

In this case, that wasn't -- Remi didn't require chest compressions, but what -- needed significant oxygen support, both with what we call positive pressure ventilation, and then subsequently CPAP, continuous positive airway pressure, in order

1 to get the baby to breathe. Remember, it was
2 described as hypertonic, not breathing on its own,
3 when it was first born.

4 MS. GUNN: So let's go to Exhibit 3, page
5 3186.

6 A. I'm sorry. Just to be clear: I'm not
7 critical of the resuscitation, you know, it was
8 necessary. But, you know, did the Apgar scores --
9 are not being accurate, but they have to be put into
10 the context of, you know, what was going on with the
11 baby at that time.

12 Q. (By Ms. Gunn) So specifically to Remi's
13 respiratory rate or respirations, the breathing part
14 of it.

15 A. Yes.

16 Q. This indicates that you can't rely on
17 resuscitation to get your Apgar scores, right?

18 A. It doesn't have the same meaning, that's
19 right.

20 Q. And we know --

21 MS. GUNN: Let's go to -- it might be the
22 page before, Zack.

23 Q. (By Ms. Gunn) Yeah. So this a part of
24 Remi's chart.

25 You've seen this, correct?

1 A. Yes.

2 Q. And this is resuscitation. And this is
3 done -- these are the Apgar scores -- well, this is
4 the data behind it, I guess you would say.

5 It says resuscitation measures one minute.

6 A. Yes.

7 Q. So Remi was being resuscitated at one
8 minute.

9 A. Yes.

10 Q. We know that.

11 We know that he was getting oxygen and on
12 positive pressure ventilation, nasal CPAP, it looks
13 like 1 minute, maybe? Yes. Correct?

14 A. Yes.

15 Q. And let's go down. No endotracheal tube.
16 Thank goodness. Let's go down. And the next section
17 is 5 minutes, correct?

18 A. Yes.

19 Q. What does it show for oxygen in use at 5
20 minutes?

21 A. It -- Oxygen was in use. They were still
22 resuscitating the baby. That's above that. And the
23 FIO2 is 50 percent. So usually oxygen is 20 percent
24 in the atmosphere. And they needed to have it at 50
25 percent oxygen supplementation, as well as the

1 positive pressure ventilation, with nasal CPAP at 5
2 minutes.

3 Again, I'm not critical, but this is what
4 was needed to achieve those Apgar scores.

5 Q. So you cannot look at an Apgar score of --
6 regarding respirations outside of CPAP and
7 resuscitation, correct?

8 A. But we have to include that in
9 understanding of what that Apgar score means.

10 Q. Thank you, Doctor.

11 THE COURT: Recross?

12 MS. KAMYKOWSKI: Just one question.

13 RE CROSS EXAMINATION

14 BY MS. KAMYKOWSKI:

15 Q. So we just looked at the language of that
16 Apgar bulletin, Doctor?

17 A. Yes.

18 Q. Is it your testimony and your opinion in
19 this case, based on what you reviewed, that at 5
20 minutes of life, Remington Anyan wasn't a
21 spontaneously breathing infant?

22 A. I think by that time, he was spontaneously
23 breathing with the support of, as it says there, CPAP
24 and --

25 Q. CPAP isn't for spon -- you don't have

1 to -- if you're spontaneously breathing, CPAP is not
2 breathing for you, correct?

3 A. That's correct.

4 Q. Thank you, Doctor.

5 MS. KAMYKOWSKI: That's all I have, Judge.

6 THE COURT: Thank you.

7 May this witness be excused?

8 MS. KAMYKOWSKI: Yes, ma'am.

9 THE COURT: Thank you very much, Doctor,

10 you may be excused.

11 Is this a good time for us to take a short

12 morning recess?

13 MS. GUNN: I think that makes sense.

14 MR. PERRON: Sure.

15 (At 10:11 a.m., the Court duly admonished

16 the jury, and proceedings stood in recess. At

17 10:25 a.m., the following proceedings were held in

18 open court:)

19 THE COURT: Please be seated, everyone.

20 On behalf of plaintiff, you may call your

21 next witness.

22 MS. LENIVY: Thank you, Your Honor. We

23 call Dr. Leslie Kerzner.

24 THE COURT: Ma'am, if you'll step on up

25 and be sworn.

1 LESLIE KERZNER, M.D.,
2 having been duly sworn, was examined, and testified
3 as follows:

4 DIRECT EXAMINATION

5 BY MS. LENIVY:

6 Q. Good morning.

7 A. Good morning.

8 Q. Can you please -- can you please introduce
9 yourself to the jury.

10 A. Yes. I'm Dr. Leslie Kerzner. I'm a
11 neonatologist from Boston, Massachusetts.

12 Q. All right. And, Dr. Kerzner, are you here
13 today to testify as to your opinions as a
14 neonatologist regarding the cause and timing of Remi
15 Anyan's HIE and his damages?

16 A. Yes.

17 Q. As a starting principle, are all of the
18 opinions you hold, that you will express to the jury
19 today, held to a reasonable degree of medical
20 certainty?

21 A. Yes, they are.

22 Q. And as an initial proposition, what is
23 your opinion of the cause of Remi's brain damage?

24 A. The cause of Remi's brain injury, in my
25 opinion, is to a reasonable degree of medical

1 certainty, is the ongoing second stage of labor when
2 he was experiencing these squeezes. And I call them
3 kind of punches, one after the other, and some
4 recovery, and then another one, and then a recovery,
5 and then another one. Until the point when it was
6 hours long, and then he then suffered the final
7 knockout punch, in my opinion, that final blow with
8 that loss of oxygen where he suffered irreversible,
9 permanent brain damage.

10 Q. And you've described for the jury the
11 process of the second stage of labor, and we'll get
12 in to your opinions more specifically, but just sort
13 of as a starting point, is your opinion, to a
14 reasonable degree of medical certainty, that this
15 injury occurred intrapartum?

16 A. During the labor, yes.

17 Q. During the labor. Most severely at the
18 end?

19 A. Correct.

20 Q. Okay. And is it your opinion that the
21 nature of Remi's HIE -- well, let me ask you
22 generally, what is your opinion as to the nature or
23 the cause of Remi's HIE?

24 A. Lack of oxygen to the brain.

25 Q. Okay. And has that HIE that Remi

sustained caused, or directly contributed to cause, permanent and irreversible damage to his brain?

A. Yes.

Q. Thank you, Doctor.

I'd like the jury to get to know you and your background a little bit more.

MS. LENIVY: Zack, can you pull up Exhibit 115-12.

(By Ms. Lenivy) And, Doctor, I will try to step out of your way as much as possible.

All right. Doctor, I know that's pretty tiny, but from where you're sitting, can you identify what this document is?

A. This is what's called my resume or my CV.

Q. All right. And if we scroll down, there is a section called "Education." And I was hoping you could tell the jury about your educational background.

A. Yes. There was a lot of stickers on the back of my parents' car.

I started at University of Michigan, so I'm always going to be "Go, Blue."

I transferred and graduated with a bachelors in psychology at Boston University. And then I actually didn't take science. I wasn't really

1 thinking medical school at that point. So I went
2 back, after working for a couple of years in the
3 psych field, went back to do what's called a
4 post-bachelorette premedical program. I did that at
5 Tufts University.

6 Then I did a year of cardiovascular
7 surgical research, and then I attended the University
8 of Vermont College of Medicine.

9 MS. LENIVY: And, Zack, if we scroll down
10 further, there is a section called "Post-Doctoral
11 Training."

12 (By Ms. Lenivy) Can you explain for the
13 jury what this shows.

14 A. So after you graduate medical school, you
15 need to pick a specialty. And I initially chose
16 what's called a triple board program, which is
17 pediatric, adult, and child psychiatry. But I kind
18 of just fell in love with the babies so much that I
19 left the psychiatry team, and ended up graduating
20 with straight pediatrics and then going on to an
21 additional three years of a neonatal fellowship.

22 Q. All right. And if we scroll down, it kind
23 of cuts into page 1 and 2, "Faculty Academic
24 Appointments," and we see from August of 2001, up
25 until 2013, Harvard Medical School pediatrics.

MS. LENIVY: Zack, I don't know if you can scroll down a page. I think it's page 2.

(By Ms. Lenivy) It shows 2013, to present, Assistant Professor of Pediatrics at Harvard Medical School.

Explain this part of your -- your profession to the jury.

A. So because Mass General Hospital is a Harvard affiliate, we get appointments through the Harvard Medical School because they're constantly teaching next generations of pediatricians, neonatologists, nurse practitioners, physicians' assistants. Things like that. So we get this appointment.

Q. The next part of your CV list was appointments at hospitals, affiliated institutions, and there's quite a bit of information there, but for the sake of time, could you tell the jury where your clinical practice is now?

A. I work full-time at Mass General Hospital in the level 4 NICU, and also we do some time -- we have to provide some night and weekend coverage at a community hospital which has a level 2 nursery, which is called Salem Hospital.

MS. LENIVY: Zack, would you jump to page,

1 I believe it's 11. Great.

2 (By Ms. Lenivy) Dr. Kerzner, up at the
3 top, "Current Licensure and Certification."

4 Dr. Kerzner, where are you licensed to
5 practice medicine?

6 A. In Massachusetts, New Hampshire, and
7 Maine.

8 Q. All right. And are you also board
9 certified?

10 A. In both pediatrics and neonatal-perinatal
11 medicine, yes.

12 MS. LENIVY: Zack, we can take that
13 exhibit down at this time.

14 (By Ms. Lenivy) Dr. Kerzner, how much of
15 your professional time do you think you spend
16 actively caring for newborn babies?

17 A. So I do work full-time, so if I'm not on
18 service in a NICU or the delivery service, I run the
19 follow-up clinic, so I'm seeing babies there. So I
20 would say probably about 80 percent of my time is
21 actively taking care of babies. In addition, I
22 provide about 40 nights and weekends across the year,
23 I'm also sleeping over in the hospital for that same
24 reason.

25 Q. As part of your job duties as a

1 neonatologist, do you get to attend deliveries?

2 A. Many, many yes.

3 Q. If you had to estimate for this jury how
4 many deliveries you've attended over your career,
5 what number could you give us?

6 A. Probably in the thousands. My fellowship
7 for three years alone, we did 10,000 deliveries a
8 year at the hospital, and I started as an intern, so
9 six years of going to deliveries, it's a lot.

10 Q. So six years, 10,000 deliveries, just as
11 an intern?

12 A. Well, I'm saying over the six years that I
13 was there, I covered the delivery service a lot
14 during my residency and fellowship.

15 Q. Needless to say, you are familiar with the
16 delivery room?

17 A. Yes. And tomorrow I'll be there again,
18 hopefully I can get home with the tornado.

19 Q. I am going to try to get you out of here
20 as fast as possible.

21 Now, Dr. Kerzner, in addition to your very
22 busy clinical practice and the academic positions
23 that you hold, do you, on occasion, review cases that
24 may be in litigation?

25 A. Yes.

1 Q. And when did you first start doing that?

2 A. I had one case in 2019 and -- but mostly
3 from 2020.

4 Q. And in the last 5, six years that you've
5 been reviewing cases in litigation, have both
6 plaintiffs' attorneys and defense attorneys reached
7 out to you?

8 A. Yes. Both sides.

9 Q. Both sides.

10 Currently do you have any cases ongoing
11 where you are working with a defense attorney who has
12 retained you on behalf of a defendant health care
13 provider?

14 A. Yes, I do have some of those right now.

15 Q. Okay. Let me ask: Do you ever review
16 records, after an attorney has reached out to you,
17 and told the attorney that you can't support their
18 case?

19 A. I think I had one with you that I said
20 that, yes. I would say about 20, 25 percent of the
21 time, when I'm handed a case, I don't find merit in
22 the case. So whether they have filed or not, I don't
23 continue with that review.

24 Q. Okay. And for your work and the time
25 spent reviewing cases, do you charge an hourly fee?

A. Yes.

Q. All right. And, Dr. Kerzner, what -- what is your hourly fee?

A. I think for this case it was 600 an hour.

Q. Okay. Do you charge a fee for your deposition?

A. Yes.

Q. Do you recall what that is?

A. Because it was 2023, things have changed a little, I'm not sure what it was, sorry.

Q. Okay.

A. Somewhere around 675, I think, an hour.

Q. All right. Additionally, are you invoicing for the time spent testifying today?

A. Yes.

Q. Okay. And is that part of, or is part, because you have to leave your clinical practice, take time away from Boston, fly out to St. Louis to testify for this jury?

A. Yes.

Q. And in anticipation of testifying for this jury, did you spend additional time reviewing records and depositions to be as informed as you could be for your testimony?

A. Yes.

1 Q. So let's talk about the materials
2 reviewed.

3 And do you recall when I first reached out
4 to you for this case?

5 A. I think it was somewhere in the beginning
6 of 2023.

7 Q. Okay. And it sounds like you do remember
8 how it was that I found you?

9 A. Yes.

10 Q. Was I one of the 20 to 25 percent of
11 people that you had turned down on a previous case?

12 A. Yes. But you didn't file it so you
13 listened.

14 Q. Well, obviously I wasn't too hurt by that
15 experience, so I reached out to you on this one.

16 And do you recall what I asked you to do
17 regarding Remi Anyan's case?

18 A. You asked me to look to see why he was
19 brain injured.

20 Q. And did you receive and review several
21 medical records and other documents collected in this
22 litigation?

23 A. Yes, initially.

24 Q. And initially did you review Sarah Anyan's
25 medical records, Remi Anyan's medical records from

1 Mercy Hospital, as well as Remi Anyan's medical
2 records from Washington University Physicians and
3 Dr. Weisenberg, who I believe is a neurologist?

4 A. Yes.

5 Q. Did you also review the depositions of
6 Blake Anyan, Sarah Anyan, Dr. McNeive, Dr. April
7 Parker, Dr. McKillip, Dr. Morgan Miller,
8 Neonatologist Nurse Practitioner Mary Spencer
9 Younger, Nurse Alex Greenwald, as well as Dr. Warsof?

10 A. Yes, ma'am.

11 Q. And have you also had an opportunity to
12 review the defense neonatology expert, Dr. Canteley?

13 A. Yes.

14 Q. Did we also send you photographs of Remi?

15 A. Yes.

16 Q. And additionally --

17 MS. LENIVY: Amy, do you have Exhibit 5
18 handy dandy?

19 Q. (By Ms. Lenivy) Additionally, did we send
20 you what has been labeled and referred to throughout
21 this case as Exhibit 5, which is the "marked-up," so
22 to speak, version of the fetal heart monitor strips?

23 A. Yes.

24 Q. So there's a lot of materials that you've
25 been sent.

1 Can you walk the jury through your process
2 for reviewing the case?

3 A. So the most important thing in this case,
4 when I'm asked for causation, why did this happen?

5 I'm not looking for if anybody did anything wrong.

6 I'm only asked to see why this baby has this brain
7 injury.

8 So I look at all -- all the things. I
9 look at the mother's prenatal records. I look at the
10 labor and delivery summary. Then I look at the
11 baby's resuscitation, how he looked after birth, and
12 then how he was in the normal nursery.

13 And then in this case, he was admitted to
14 the NICU. I look at all the laboratories. I look at
15 all the imaging reports. I look if they have
16 placental pathology. If there are any cord gases. I
17 look at the results of the EEG, if the baby had any
18 seizures. And then I'm also looking at the report of
19 the MRI. And then looking at the developmental
20 outcome, as well, to see if that continues to match
21 what I've seen in the process of all those records
22 themselves.

23 Q. And were you able to complete that review
24 in this case?

25 A. Yes.

1 Q. All right. And is it based on your review
2 of the records and materials in this case, that you
3 based your conclusions that the cause of Remi Anyan's
4 HIE is due to hypoxia and ischemia that occurred
5 during the second stage of labor, most severely in
6 the last half hour range?

7 A. Yes. When he came in, or I should say
8 when mother came in, everything looked fine, and then
9 things deteriorated, so, yes, that ended up being my
10 conclusion after looking at all of the things
11 together.

12 Q. And, Dr. Kerzner, I know you weren't here
13 during opening statements on Wednesday morning, but
14 the jury was shown a PowerPoint slide by one of the
15 defendants that said something along the line of this
16 injury occurred days before Sarah and Remi got to the
17 hospital. And it listed four items: Apgar, NICU
18 assessment, MRI, and liver tests.

19 Dr. Kerzner, do you believe the evidence
20 in this case supports an opinion that Remi's HIE
21 occurred days before Sarah got to Mercy Hospital?

22 A. No, I do not.

23 Q. And is there evidence from the medical
24 records that instead supports your conclusion about
25 the timing of this injury?

A. Yes, I believe so.

Q. All right.

MS. LENIVY: Zack, can we pull up Exhibit 350.

Q. (By Ms. Lenivy) All right. And so, Dr. Kerzner, this is Exhibit 350. It's titled "Constellation of Markers." And it says: neonatal status, contributing events, developmental outcome --

MS. KAMYKOWSKI: May we approach?

MR. WILLMAN: May we approach?

THE COURT: Uh-huh.

(Proceedings were held at sidebar, outside the hearing of the jury.)

MS. KAMYKOWSKI: So we have not been provided a copy of this to look at it. Before she shows it, I think there has to be a foundation laid as to the demonstrative itself, who created it, what it is, what it will be proving. And I just wanted to object to that, whatever it is here, as hearsay.

And, I mean, I know I haven't given her the chace to lay the foundation. But she already showed part of it, and we didn't know it was coming.

And then are you going to -- what's the foundation?

MS. LENIVY: We can lay the foundation

1 from it. It's purely demonstrative. There's a
2 lot -- a lot in that question.

3 THE COURT: I understand. You need to lay
4 a foundation before you show it to the jury.

5 MS. KAMYKOWSKI: So I think you need a
6 copy.

7 Thank you, Judge.

8 (Proceedings returned to open court.)

9 Q. (By Ms. Lenivy) Dr. Kerzner, I just
10 dropped a document in front of you there. Can you --
11 do you recognize that document?

12 A. Yes.

13 Q. Okay. And flipping to or throughout the
14 document, it's only two pages, can you explain to the
15 jury what this document is.

16 A. Yes. So these are all of the different
17 things that I look at to make the puzzle, to see if
18 it's going to fit and where that injury happened.

19 So if I -- what I've determined is that
20 because it happened during labor, these are all the
21 supporting facts that have helped me come to that
22 conclusion.

23 Q. So these are the pieces of the puzzle that
24 you have collected in your review of the records, and
25 you're compiling them to sort of put the full picture

1 together, so to speak.

2 A. Yes.

3 Q. Okay. And what is contained in this
4 exhibit, is this opinion, or are these just facts
5 pulled from the medical records?

6 A. These are all the different facts from
7 documentation in the medical records.

8 Q. Okay. And because there are so many
9 pieces of this puzzle, have you and I created this
10 document as a way to sort of synthesize the pieces of
11 the puzzle, so to speak, for ease of the jury's
12 understanding?

13 A. Yes.

14 Q. Okay.

15 MS. LENIVY: Your Honor, I would ask for
16 permission to publish Exhibit 350 to the jury.

17 MS. KAMYKOWSKI: No objection, Your Honor.

18 MR. WILLMAN: No objection, Judge.

19 THE COURT: 350 will be published.

20 Q. (By Ms. Lenivy) All right. So it's that
21 constellation of markers. And I think you testified
22 earlier that you're looking at neonatologist status,
23 contributing events, developmental outcome as part of
24 your general review?

25 A. Yes.

1 MS. LENIVY: So let's flip to the next
2 page.

3 Q. (By Ms. Lenivy) And there we have, I know
4 it's tiny writing, there's a lot of information in
5 there, I apologize. It says "Constellation of
6 Markers" up at the top. And there's 27 different
7 items on here, and we're going to go through all of
8 these pieces of the puzzle.

9 But is this what you were referring to as
10 far as what you look for in the records to help you
11 to determine what caused Remi Anyan's injury and then
12 when it happened?

13 A. Yes.

14 Q. All right. Now, the jury -- there's a lot
15 to get through. Kind of start with the beginning.
16 And looks like this tried to move a little bit in
17 chronological order. The beginning is always a good
18 place to start.

19 MS. LENIVY: Zack, we can take this
20 exhibit down for now.

21 Q. (By Ms. Lenivy) And that's when Sarah
22 gets to the hospital.

23 Now, the jury has already heard a lot
24 about fetal monitoring strips from Dr. Warsof and
25 Nurse Shinn.

1 And let me ask, Dr. Kerzner, do you
2 personally interpret fetal monitoring strips?

3 A. So I am not an expert in interpreting
4 fetal monitoring strips. I understand them when
5 they've been interpreted, but I do not personally
6 interpret them.

7 Q. And do you have a general understanding of
8 what it means to a baby if they're in Cat I, Cat II,
9 Cat III?

10 A. Yes.

11 Q. And as far as your review in this case,
12 when looking at the fetal monitoring strips, did you
13 rely on Exhibit 5 that was provided to you where Dr.
14 McNeive, Nurse Maggie, Nurse Jessie, as well as some
15 other providers, marked up the fetal monitoring
16 strips to indicate where there were decels?

17 A. Yes. In addition to the documentation in
18 the nurses' L and D records.

19 Q. And so based on your review of the
20 records, which included Exhibit 5, how did Sarah and
21 Remi initially present when they arrived to Mercy
22 Hospital at 2:00 p.m. on May 3rd, 2020?

23 A. She had broken her water, and it was
24 clear. So there was no meconium at that time. She
25 came and had what I understand was a very reassuring

1 fetal monitoring strip with good fetal movement at
2 that time.

3 Q. Throughout the first stage of her labor,
4 which ended around 3:50 a.m., when she entered the
5 second stage, based on your review of the records,
6 how did it appear Remi was doing?

7 A. Continuing to be reassuring.

8 Q. So the jury has already heard that at
9 3:50 a.m., on the morning of May 4th, Sarah enters
10 the second stage of labor, and that's when she begins
11 actively pushing, right?

12 A. Yes.

13 Q. Okay. And understanding that you have
14 attended thousands of deliveries and treated
15 thousands of patients, what is your understanding
16 about how long the second stage of labor usually
17 lasts?

18 A. Having been on different committees where
19 we discuss these types of, you know, outcomes, and we
20 go back and look at things, I've learned over the
21 years that 4 hours seems to be the agreed upon, you
22 know, unless the strips are completely pristine and
23 no evidence of fetal stress.

24 Q. Now, Sarah Anyan hit the four-hour mark
25 around 8:00 p.m.

1 Dr. Kerzner, do you believe Remi sustained
2 any permanent neurologic injury by 8:00 a.m. on
3 May 4th?

4 A. No, I do not.

5 Q. Okay. The jury heard extensively from
6 Dr. Warsof already. And he talked about this 8:30 to
7 9:30 a.m. time frame. He talked about it a lot
8 yesterday.

9 And from your review of the records and
10 Exhibit 5, what is your opinion as to what was going
11 on with Remi during that 8:30 to 9:30 a.m. time
12 period?

13 A. You might have to refresh with some type
14 of charting. I don't want to misspeak.

15 Q. Okay. Do you believe from 8:30 to
16 9:30 a.m., his head was engaged?

17 A. Oh, yes. I -- somewhere around that time,
18 they documented that his head was in the pelvis.

19 Q. Okay. And so why is it significant that
20 the baby's head is in the pelvis?

21 A. Well, in this case, he had broken his
22 water, so there was no cushion around him at all. So
23 it was just his body, no fluid, and his head is now
24 in the canal waiting to be delivered and compressed
25 by the bones on each side.

1 Q. Okay. Based on your review of the
2 records, including Exhibit 5, in your opinion if Remi
3 had been delivered by 9:30 a.m. on May 4th, do you
4 believe he would have suffered -- he would have
5 suffered a permanent, irreversible brain injury by
6 that point?

7 A. No, I do not.

8 Q. Delivery by 9:30 a.m., would that have
9 been like a likely good outcome for him?

10 A. Yes.

11 Q. The jury is well aware he was not
12 delivered by 9:30 a.m. And I know we talked that you
13 have attended thousands of deliveries over your
14 career.

15 In your experience, Dr. Kerzner, have you
16 ever seen or heard of a newborn who remained in
17 second stage of labor for more than 12 hours?

18 A. No, I have not.

19 Q. Okay. Have you ever heard of a newborn
20 who has stayed in the second stage of labor for more
21 than 10 hours?

22 A. The only ones could be at a home, possibly
23 a home birth, and I don't know the exact number of
24 hours, but not in the hospital, no.

25 Q. So not -- not in a hospital setting. This

1 doesn't happen in a hospital setting.

2 A. That I've experienced, no.

3 Q. Okay. Are you able to recall what is the
4 longest second stage of labor for a patient you've
5 seen?

6 A. I remember one that was around 6 hours. I
7 remember because it wasn't a good outcome.

8 Q. The jury has already seen this exhibit,
9 and I would like to pull it up because it helps speed
10 things up.

11 MS. LENIVY: Zack, can you pull up
12 Exhibit 500.

13 Q. (By Ms. Lenivy) All right. And the jury
14 has seen this exhibit. This is something Ms. Gunn
15 put together to sort of, again, just take a lot of
16 information and synthesize it down for us.

17 But we can see from 3:50 a.m., when Sarah
18 enters the second stage of labor, and this one goes
19 all the way up to 11:00 a.m.

20 And I know you've testified now that by
21 9:30 a.m., delivery by 9:30 a.m., good outcome for
22 Remi, right?

23 A. Yes.

24 Q. Okay. I heard you earlier talking about
25 taking punches, knockouts. I'm hoping that looking

1 at this Exhibit 500, can you explain to the jury in a
2 little bit more in depth what you mean, what was
3 happening to Remi during this time period?

4 A. So the types of decelerations that were
5 happening was almost the baby's way of protecting
6 himself from low oxygen state. He kind of decreases
7 his cardiac output at times.

8 It's also indicative of some cord
9 compression. So, again, there's no cushion in there
10 because his water is broken, so there's some cord
11 compression.

12 And, in addition, some of those decels,
13 say that may be the placenta, the placental
14 circulation, wasn't adequately getting oxygen to him.

15 what we also know, which I believe was
16 pointed out earlier, is that there was some moderate
17 variability during this time. So that's the
18 recovery. So that's the punch, recovery, punch
19 recovery. He was still maintaining himself during
20 this time.

21 However, I don't believe there was
22 significant accelerations during the remaining part
23 of the right. And what an acceleration is is the
24 baby moving a bit, enough to make the shift in the
25 strip.

1 And so when the baby starts experiencing
2 low oxygen, they preserve, okay, I'm not going to
3 move too much right now because I've got to save as
4 much energy as I can. So that's why we don't -- we
5 might have some variability, but we don't have a
6 significant number of accelerations through the rest
7 of this labor.

8 Q. I want to make sure. There's been a lot
9 of sports analogies so far. I want to make sure I
10 understand this.

11 MS. KAMYKOWSKI: I love sports analogies.

12 MS. LENIVY: Me, too. Me, too.

13 Q. (By Ms. Lenivy) So what's happening here,
14 then? When you say Remi is taking punches, does this
15 mean he was experiencing the decelerations when we
16 talk about Category II, correct?

17 A. Yes.

18 Q. Okay. So he's in Cat II, late decels.
19 He's in there. His head is kind of taking punches,
20 but every now and then, we'll get some accelerations,
21 some, and he might slip back into Cat I, correct?

22 A. Yes.

23 Q. And what's that like for him? I mean,
24 he's in the ring, he's fighting in Cat II. And then
25 he slips back into Cat I. What's that mean?

1 A. Well, it's one thing if this is just
2 three, four hours. But this is going on for hours and
3 hours and hours. So he doesn't have the same reserve
4 by the time he gets to the end, and that's where that
5 knockout happened.

6 So, you know, I like to say this isn't
7 like the Tyson fight that happened a few months ago
8 where, you know, we weren't really throwing a lot of
9 punches. This was actually like getting compressed
10 and then recover. Getting compressed and then
11 recover. Until there wasn't that capability anymore.

12 Q. It's kind of like taking a water break,
13 Cat I?

14 A. Sure. Sure.

15 Q. Okay. So we see the red and the purple.
16 Remi is in the ring taking his punches. Might flip
17 back into Cat I and get a water break.

18 MS. LENIVY: Zack, can you go to the
19 next -- go to the next page.

20 Q. (By Ms. Lenivy) Okay. And then we see
21 from 12:00 to 4:00, that fight continues, correct?

22 A. Yes.

23 Q. And then just so I understand -- and let
24 me ask you this: I mean, we're using the analogy of
25 boxing. And I know we've seen a boxing match. Each

1 time the boxer gets back into the ring after a water
2 break, a little bit worse for the wear, right?

3 A. Yes.

4 Q. Okay. And is that something similar as to
5 what's going on with Remi?

6 A. Yes. And that's what I talk about, his
7 reserves are going down during this time.

8 Q. Okay. And so 3:57 p.m., what happens at
9 3:57 p.m.?

10 A. At 3:57, it becomes really concerning.
11 The strip does not look good. He's -- his -- when
12 you have enough hypoxia, low oxygen, the only way to
13 kind of get oxygen to your body is to speed up your
14 heart rate. You're increasing your cardiac output to
15 try to pump. Okay, I'm going to keep trying to get
16 oxygen to my body. And that's what's happening here,
17 in my opinion, as to why he starts becoming so
18 tachycardic or fast heart rate.

19 Q. All right. So when -- 3:57, Cat III and
20 tachycardia, and it starts a little bit before that,
21 that's Remi's heart beating faster to try to save
22 himself?

23 A. Yes.

24 Q. And 3:57 to 4:24, when Remi is finally
25 delivered, he remains in those Cat III strips, is

1 that correct?

2 A. Yes.

3 Q. And we'll stick with the boxing analogy,
4 what's happening from 3:57 to 4:24 at
5 delivery?

6 A. He progressively just is in a state of
7 lower and lower oxygen, to the point where his
8 brain -- so babies are actually really smart when
9 they're inside. They -- they shunt -- when they
10 start getting stressed out, they shunt blood away
11 from the vital organs -- the heart, the adrenals, and
12 the brain -- and they say, okay, kidney, liver,
13 you're not going to get as much right now because I
14 need everything upstairs.

15 And then after time, when the oxygen
16 continues to be low, the baby's actually smart enough
17 to sacrifice the interior part of the brain before
18 the deep, most metabolically-active part, which
19 controls even more of the brain and your function.

20 So -- but this is -- what's happening here
21 is, he's already, his kidneys and liver, he's already
22 kind of said, I'm diverting blood flow to you. Now
23 he's going to bring blood flow, and it's hitting the
24 deep gray matter in the inside of his brain.

25 Q. And you mentioned fetal reserves.

1 Just so I have an understanding, what do
2 you mean by "fetal reserves"?

3 A. The -- how long you can sustain the period
4 of hypoxia and low oxygen.

5 Q. It's kind of like a gas tank in a car?

6 A. Yes.

7 Q. All right. So a fetal reserve, like gas
8 in a car, eventually you might run out.

9 A. Yes. And, generally speaking, that
10 tachycardia, that fast heart rate, occurs before what
11 we call a terminal bradycardia. Or, at the end, you
12 finally just can't -- if you can't do it anymore, and
13 the heart goes really down. This did not happen
14 here. But this predates that in many deliveries of a
15 stressed fetus.

16 Q. The jury has heard about a potential
17 conversation that occurred around 2:00 p.m. when Dr.
18 McNeive came back to Sarah's bedside. And I
19 believe -- you weren't here for opening statement --
20 but I believe Dr. McNeive's counsel said something
21 along the lines of Dr. McNeive told Sarah Anyan, we
22 can do a C-section. I don't recommend it, but we
23 can.

24 So I want to talk to you about C-sections.
25 Understanding you're not an obstetrician, you're a

1 neonatologist, but in your career, Dr. Kerzner, have
2 you ever had an OB colleague ask you to talk to a
3 laboring patient about a C-section?

4 A. It usually comes up where the OB is
5 saying, Hey, I think we need to deliver, and the
6 mother is hesitant. So then I'll go in and kind of
7 say, gee, I'd rather have your baby out than in. I
8 can, you know, I understand that it's a real bummer
9 to have an operation, but in this case, we need to
10 keep your baby safe, and so those are the type of
11 conversations I might have about C-sections.

12 Q. Okay. And when you're having those
13 conversations about C-sections -- about a hesitant,
14 laboring patient, is part of the conversation, or at
15 least part of the reason for the conversation,
16 concern about the baby's oxygenation status?

17 A. Completely, yes.

18 Q. And I know we've talked about hesitation,
19 mother's hesitation.

20 Have you seen anything in the records that
21 Sarah Anyan was hesitant to have a C-section?

22 A. No, I do not.

23 Q. Do you see anything in the records that
24 Sarah Anyan outright refused a C-section?

25 A. No, I do not.

1 Q. Did you see any documentation in the
2 records that Sarah Anyan was ever offered or even
3 consulted on a C-section?

4 A. Not that I saw.

5 Q. Let's say, though, that around this
6 2:00 p.m. time frame, when Dr. McNeive says that, he
7 had a family -- he had a conversation with the
8 family. And we'll hear from all the parties involved
9 there.

10 But let's say that 2:00 p.m., Remi was
11 delivered via C-section or operative vaginal
12 delivery, whatever may have been available, do you
13 have an opinion as to what Remi's likely outcome
14 would have been with delivery around 2:00 p.m.?

15 A. Should have been -- should have been good.

16 Q. Okay. And is that because he hadn't
17 gotten to that final knockout punch stage yet?

18 A. Correct.

19 Q. And just so I'm clear -- and I apologize
20 if I'm making you repeat yourself -- but that time
21 frame, that 3:57 to 4:24 p.m., is that when Remi
22 sustained the permanent brain damage?

23 A. That is my opinion, yes.

24 Q. Okay. And that permanent brain damage in
25 a last approximately 27 minutes of labor, knowing

1 that we're focusing on that, do you have the opinion
2 whether the hours and hours and hours preceding that
3 still contributed to Remi's damage in this case?

4 A. Absolutely. It's like running a marathon.
5 You know, running and running and running, and then
6 you get to the end. He's using up all the glucose
7 and his oxygen stores during that time.

8 And as you do that, you decrease making
9 your ATP -- might be going back to high school
10 chem -- but you don't have energy and sugar going to
11 your brain. And that's what the brain needs for
12 energy. So repetitive times where you're getting
13 compressed, repetitive times where you're not getting
14 enough oxygen, that is going to lead to a baby who is
15 compromised, then, during that last part of labor.

16 I can't -- if it was everything fine, and
17 just this last part, I may be okay. But you're
18 taking me, I'm exhausted, you know, having been
19 compressed now for however many hours in a row, and
20 now we're getting to the end point, yeah.

21 Q. And at 2:00 p.m., when the -- Dr. McNeive
22 says he has a conversation with Sarah and Blake
23 about, I'm not recommending C-section, but we can do
24 it, did Dr. McNeive -- or did you see any evidence in
25 the records that would indicate to any provider that

1 this baby would come out in the next 2 hours or not?

2 A. Not that I recall.

3 Q. Okay. All right. We're getting into
4 Remi's delivery, and we're going to talk more about
5 the constellation of symptoms.

6 MS. LENIVY: And, Zack, can we pull up
7 Exhibit 3 page 1572 of Remi's records.

8 Q. (By Ms. Lenivy) All right. I know that's
9 tiny, and we can zoom in. But this is the nurse
10 practitioner's neonatology consult note from
11 5/4/2020.

12 And, Dr. Kerzner, why was the NICU team
13 called to the delivery room that day?

14 A. What they documented was due to a maternal
15 temperature prior to delivery.

16 Q. Okay. So Sarah spiked a fever. And NICU
17 was called to come in and take Remi?

18 A. Yes. I would imagine they would also have
19 been aware that the strips did not look well, and
20 they would have been there either for fetal
21 tachycardia, at least any delivery I go to, that's
22 included if a baby has had a nonreassuring strip
23 and/or a fetal tachycardia and a fever, as well.

24 Q. And at least with Nurse Practitioner
25 Younger Spencer -- Younger up here -- documents, and

1 I think it's that third sentence: Pregnancy
2 complicated by maternal temperature prior to delivery
3 and meconium stained amniotic fluid.

4 Can you explain for the jury what meconium
5 is.

6 A. Meconium is the first poop. It is -- it
7 is the poop, actually, as far as what the baby --
8 they're swallowing amniotic fluid that whole part of
9 their gestation, and it forms a kind of black, tarry
10 stool.

11 And most of the time, 90 percent of the
12 time, the babies don't poop inside before they're
13 born. And, in fact, we know when the water was first
14 broken, there was no sign of any poop.

15 But when a baby is getting stressed out,
16 about 10 percent of the time, one in ten babies will
17 poop inside. And that's what the meconium-stained
18 amniotic fluid is.

19 Q. Is the meconium-stained amniotic fluid
20 part of your constellation of markers?

21 A. Yes.

22 Q. Okay. Why is that?

23 A. It indicates some degree of fetal stress.

24 Q. Okay. Baby is stressed right now.

25 MS. LENIVY: Scroll down a little bit,

1 Zack, getting into the infant presented paragraph.

2 Thank you.

3 Q. (By Ms. Lenivy) So we don't -- the jury
4 has already seen this record. And I think they've
5 got an idea of what was happening at the time.

6 But can you explain from a neonatology
7 perspective how Remi was doing at the time of
8 delivery?

9 A. Yeah. So it sounds like he was rather
10 lifeless. And he had a lot of meconium that needed
11 to be suctioned because you don't want them to inhale
12 it to go into the lungs. That can be difficult for
13 breathing.

14 So they adequately suctioned him, and then
15 they realized he wasn't breathing. And they
16 appropriately gave him what's called positive
17 pressure ventilation, actually giving breaths because
18 he wasn't breathing.

19 And then during that time, they were also
20 giving oxygen to him to get his color better. And
21 that's how he looked initially. And because they
22 were giving the positive pressure, his heart rate was
23 able to come up.

24 Q. And were you here for, I believe,
25 Dr. Warsof's, on redirect examination, Amy showed him

1 the 1-minute, 5-minute, 10-minute oxygen for Remi.

2 Do you recall that?

3 A. Yes.

4 Q. And just so I'm -- I'm understanding, does
5 it appear from the records that Remi was still
6 getting some type of oxygen at 5 to 10 minutes?

7 A. In that part of record, it did state that,
8 yes.

9 Q. Okay. I want to, oh, the very first line
10 "infant presented with meconium-stained fluid," the
11 next part of the sentence reads: Decreased tone and
12 no cry. Infant brought directly to radiant warmer
13 where he was bulb suctioned, and copious secretions
14 remained and discarded. And then: Infant with
15 brief, spontaneous cry.

16 Dr. Kerzner, besides this note that says,
17 "brief, spontaneous cry," were you able to find any
18 other descriptions of Remi crying in the delivery
19 room?

20 A. No.

21 Q. And you read the depositions of Blake and
22 Sarah Anyan.

23 Do you recall what they testified as far
24 as what they can recall about Remi crying in the
25 delivery room?

1 A. I don't believe they heard him cry in the
2 delivery room.

3 Q. Okay. Now, maybe I'm over sharing. I
4 don't have kids yet.

5 But at least from what I've seen on TV and
6 in movies, in the delivery room, the baby is born,
7 and then you hear a nice, big cry.

8 And is that what typically happens in the
9 delivery room?

10 A. So when a baby, who hasn't been
11 compromised at all, with rubbing the back and
12 suctioning, they should have a nice, lusty cry.

13 They're heart rate should be over a hundred. They
14 should be moving around kind of fighting you,
15 pushing away the little bulb suction. And that would
16 be a baby who had no compromise at all.

17 Q. A strong, vigorous cry. That's a good
18 sign. That's what you want to see with a newborn.

19 A. Yes.

20 Q. Okay. The lack of documentation or
21 evidence, and the parents' description of no cry,
22 Remi not having a big, vigorous cry, is that
23 significant to you?

24 A. It goes along with that he didn't have as
25 much reserve, yes. And that he had low muscle tone.

1 And when you have low muscle tone, you can be
2 spontaneously breathing, but you may not be strongly
3 crying.

4 MS. LENIVY: I'd like to pull up, Zack, if
5 you could, 60-1.

6 Q. (By Ms. Lenivy) And while Zack is pulling
7 that up, we referenced earlier, you were provided
8 photographs prior to your deposition, correct?

9 A. Yes.

10 Q. Okay. And so, Dr. Kerzner, was this one
11 of the photographs you had as part of your deposition
12 in October of '23?

13 A. Yes.

14 Q. Okay. And just so the jury understands
15 what we're looking at here. This is the metadata
16 pulled off of the cell phone of the parents here --

17 MS. KAMYKOWSKI: Your Honor, can we
18 approach please?

19 THE COURT: You may.

20 (Proceedings were held at sidebar, outside
21 the hearing of the jury.)

22 MS. KAMYKOWSKI: Your Honor, I'm going to
23 object to this evidence as hearsay. She took a
24 photo, that's what the doctor sent initially before
25 the late production of the metadata with these.

1 There's no foundation to support that the metadata on
2 this phone is accurate, that it matches the time
3 clocks in the hospital.

4 I think that's what their representation
5 is going to be at that particular time. There has
6 been no foundation thus far for that that it's
7 accurate at the time. I don't think there's any
8 basis for that. I would object to the metadata as
9 hearsay.

10 MS. LENIVY: Your Honor, the metadata is
11 not related for discussion of discovery. They did
12 not ask for metadata in discovery. They asked for it
13 about two weeks before trial. They wanted additional
14 information, and we sent it to them. The metadata
15 was not a part of the photo discussion, it never has
16 been. And that was never something that has been
17 brought up.

18 So the fact that these are photos from a
19 cell phone, this is the first time we're hearing
20 there's any discrepancy or dispute about the time
21 that they were taken by the cell phone and how it
22 shows up here. We gave them an opportunity to ask to
23 have the phone examined, and they did not take it.
24 This has never been part of the photo discussion.

25 MS. KAMYKOWSKI: Your Honor, that is

1 absolutely inaccurate as far as our capability to
2 examine and do a forensics examination of this
3 information. Also it's not my burden to do so. If
4 they would like to put this in evidence, they have to
5 get around the hearsay.

6 These photos and the metadata, this doctor
7 did not see them until the time frame after this
8 court entered a sanction that allowed for additional
9 discovery, delaying the start of this trial. For us
10 to do the discovery without this information was
11 later and very close to the start time of this case.

12 This is part of the information that this
13 doctor was not allowed to rely upon. She saw the
14 photo itself before her deposition. She did not see
15 the metadata. And I still stand on the objection
16 that there is absolutely no foundation. And I don't
17 believe that Mr. Anyan, who is the owner of the
18 phone, I guess he could come in and talk about it.

19 But, still, with respect to a time line, no
20 foundation.

21 I don't think plaintiff will ever be able
22 to prove it as to the fact that the metadata on his
23 phone is synced to the hospital's time line. And
24 that's what the implication is going to be. They're
25 going to try to say this shows a certain time frame.

1 And the photo is fine. That's what we talked about
2 before, but the metadata is hearsay and has no
3 foundation.

4 THE COURT: I disagree that the metadata
5 is hearsay in that it is not provided by a human. It
6 is actually computer generated. Things that are
7 computer generated automatically are not hearsay
8 such as phone numbers, phone records, things like
9 that.

10 So I'm going to disagree that it's
11 hearsay. The Court is going to overrule the
12 objection, and you can cross examine with regards to
13 the timing if you believe that there's some sort of
14 disagreement as to the timing.

15 MS. KAMYKOWSKI: Just for the record, I
16 cannot argue with the Court's ruling, but as far as
17 if it's not a hearsay objection, then it's also not a
18 business record. There's not been -- this was not
19 filed as a business record. I still think it doesn't
20 come in, but I understand the Court's ruling.

21 THE COURT: Understood. Thank you.

22 MS. KAMYKOWSKI: Thank you, Judge.

23 (Proceedings returned to open court.)

24 MS. LENIVY: Zack, can you put up Exhibit
25 60-1.

1 Q. (By Ms. Lenivy) All right. So to get
2 myself squared away here. Just so the jury
3 understands, this photo, what we can see from the
4 metadata provided, is that it was taken on Monday,
5 May 4th, 2020, around 4:34 p.m.

6 So now that we've kind of got ourselves
7 situated in this time line --

8 MS. LENIVY: Zack, can you blow up the
9 actual photo itself?

10 Q. (By Ms. Lenivy) All right. There's Baby
11 Remi.

12 Dr. Kerzner, is there anything that
13 catches your attention as far as the photo? And I
14 think we were talking about decreased tone earlier.
15 So I kind of want to focus on that.

16 A. Yes. So when I look at this baby who is
17 approximately 10 minutes old, I see that he does have
18 significant moulding of his head, which is how long
19 you're engaged. Luckily it rounds out again after.
20 But that does show that he is sitting in that pelvic
21 area long enough to really mould him.

22 He's got floppy tone. His legs are off to
23 the side. And from what I can see, he doesn't have a
24 big cry going. Although this is a still photo, he is
25 not crying actively there.

1 Q. So not crying actively. You said he looks
2 low tone.

3 A. He looks floppy to me.

4 Q. Floppy.
5 And tone is muscle contraction, right?
6 The baby is fighting?

7 A. Correct. You want the baby to be flexing
8 arms, legs to whatever activity you're doing with
9 them.

10 Q. Okay.
11 MS. LENIVY: Zack, can you pull up
12 Exhibit 62-1.

13 Q. (By Ms. Lenivy) Again, similar metadata
14 over here. Just to get us on the time line: May
15 4th, 2020, 4:34 p.m.
16 We can go back to the photo. And this is
17 another photograph you had for your deposition,
18 correct?

19 A. Yes.

20 Q. Okay. And we see, there's Blake.
21 MS. LENIVY: And can we zoom in on the
22 picture there.

23 Q. (By Ms. Lenivy) Okay. So Dad is -- meets
24 baby.

25 Is there anything as far as tone that you

1 can identify from 62-1 here that strikes you?
2 A. Same idea: He looks floppy. And he isn't
3 grasping -- neonates have what's called a grasping
4 reflex if they're neurologically doing well. And
5 he's just not grasping the hand. He's just kind of
6 loosely over the father's finger, from what I can see
7 in this photo.

8 Q. Okay. There's one more photo from the
9 delivery room that I want to show you.

10 MS. LENIVY: It's 63-1, Zack.

11 Q. (By Ms. Lenivy) Again, metadata over
12 here, from May 4th, 2020, 4:37 p.m. So a couple of
13 minutes into life here, there's Baby Remi.

14 what do you -- do you think about his tone
15 here, Dr. Kerzner?

16 A. The same. In this one, he's actually
17 fully on extension where he just really looks like
18 his arms aren't flexing at all, his mouth's a little
19 open. Again, not in an active crying in that
20 picture.

21 Q. Okay. And, again, babies -- babies, in
22 the first couple minutes of their life, you want
23 crying, you want flexing, muscles moving, facial
24 movements?

25 A. That would connote a good, from in utero

1 to ex utero, transition, yes, that they were actively
2 crying, moving around, kicking, etcetera.

3 Q. Okay. And the jury has heard about Apgar
4 scores a lot.

5 Is tone one of the measurements for Apgar
6 scoring?

7 A. Yes, it is.

8 Q. Okay.

9 MS. LENIVY: Zack, can we pull up Exhibit
10 344.

11 The jury has already seen this one, as
12 well, the ACOG guidelines.

13 Q. (By Ms. Lenivy) Okay. So can you explain
14 to the jury what this is.

15 A. So the left top side is the Apgar score.
16 So I believe you've heard about it before,
17 but it's basically how the baby is responding to ex
18 uterine light.

19 They've been inside. Do they come out --
20 are they crying? Are they moving? Are they having
21 reflexes? And is their heart rate good?

22 Q. Okay. And at 1 minute of life -- the
23 jury's already heard -- Remi got a 3, correct?

24 A. Yes.

25 Q. Okay. And then resuscitative measures

1 were active and ongoing, correct?

2 A. Yes.

3 Q. And at 5 minutes of life, Remi was given a
4 score of 8 by the NICU nurses, correct? Or nurse
5 practitioners?

6 A. Correct.

7 Q. Okay. And the -- just sort of walking
8 through how Remi got that score.

9 we know he got a 2 for his heart rate,
10 above 100, correct?

11 A. Yes.

12 Q. And that's pretty objective. We can count
13 numbers, right?

14 A. Correct.

15 Q. He was also given a 2 for respiration.
16 And I think Dr. warsof just kind of already talked
17 about the respiration earlier.

18 He was given a 1 for color.

19 So acrocyanotic. It's -- well, what does
20 that mean?

21 A. So babies -- acrocyanosis means the hands
22 and the feet are still blue. And that usually takes,
23 you know, an hour or two to go away. So I would
24 expect not to get a 2 necessarily, unless he was in a
25 high amount of oxygen at that time.

1 Q. Okay. Reflex irritability. What -- what
2 does that mean?

3 A. So your reflexes and your tone kind of go
4 together. So if you're scrunching when they come to
5 suction you, kind of averting, that would be a 2. If
6 you're just kind of giving like a weak, you know,
7 don't bother me right now, that would be a 1. And if
8 you have no reaction, that's a zero.

9 Q. Okay. So Remi's reflex irritability score
10 by Ms. Younger was a 1.

11 So that's weak limits, kind of get away
12 from me, right?

13 A. Yes.

14 Q. Okay. And what does a reflex irritability
15 of 1 indicate to you a neonatologist?

16 A. Well, it's not normal because you should
17 have more robust reflexes by that point, so I would
18 want to be kind of really paying attention to what
19 else is going on neurologically at that time.

20 Q. Okay. So does the reflex irritability of
21 1 indicate to you that there may be some sort of
22 neurologic injury or neurologic impairment going on
23 in this child?

24 A. I don't want to say injury or impairment
25 when I'm just seeing that at 5 minutes. But I'd like

1 to kind of continue to watch the baby, continue to do
2 neurologic exams to see where we're going with that.

3 Q. It's a piece of the puzzle?

4 A. Correct.

5 Q. And then the muscle tone, Ms. Younger gave
6 Remi a 2. So we see zero is limp. Baby is just
7 laying there. 1, some flexion. And then 2 is active
8 motion. And Ms. Younger gave Remi a 2 for tone.

9 Do you, based on the evidence that you've
10 seen in this case, including the photographs, have
11 reason to disagree with Ms. Younger's assignment of 2
12 for the tone?

13 A. That is the one I would disagree with
14 because he did not look like he was actively moving
15 to me. So I would have taken off 1 for tone.

16 It also goes along with what -- off the
17 reflex because you can't really be moving all around
18 and not have like a grimace. So, to me, they also go
19 together.

20 Q. Do you believe that the Apgar score of 8
21 may have been too high for Remi?

22 A. Might have been 1 up, yes.

23 Q. Okay. And we've talked about. I'll stop
24 there.

25 Just so I remember, none of the photos

1 that we just looked at from the delivery room show
2 Remi crying, right?

3 A. Correct.

4 MS. LENIVY: Zack, we can take that
5 exhibit down. Thank you very much.

6 Q. (By Ms. Lenivy) Dr. Kerzner, is an Apgar
7 score of 8 alone sufficient evidence to rule out the
8 possible of an intrapartum HIE?

9 A. No. The Apgar score alone, just by
10 itself, cannot tell you that no injuries happened in
11 utero because there's so many pieces to the puzzle
12 you need to look at.

13 And, in fact, because some of the Apgar
14 score is subjective, meaning that you were standing
15 there, and sometimes, I know when I go to deliveries,
16 a lot of time I am not doing the Apgars in realtime.
17 I'm resuscitating in realtime.

18 So we go back later, hey, what do you
19 think? You know, it's not the most exact science.
20 That's why it's not meant to determine how you
21 resuscitate. We have a resuscitation program for
22 that. These are just scores given to kind of, you
23 know, how is the baby doing at that period of time?

24 Q. And when you say Apgar scores are
25 subjective, does that mean the reflex irritability

and tone?

A. Yes.

Q. Okay. Do clinicians like yourself use Apgars -- an Apgar score alone to diagnose an HIE?

A. Never just alone, no.

Q. Okay. And, for example, baby comes in with a really low Apgar score at 5 minutes and 10 minutes.

Does that mean the baby has an HIE?

A. No, it does not.

Q. Okay. And sort of the reverse of that. Baby is assessed or assigned a score of, let's say 7 or 8, does that mean the baby absolutely cannot have an HIE intrapartum?

A. No, it does not. The baby can compensate and probably had a good resuscitation at that point in order to have a better score for that moment in time.

Q. If Apgar scoring is not a diagnostic tool for HIE, what's an Apgar score then tell?

A. It's not meant to tell us about the outcome of the baby. It's meant to, again, mostly if things are looking good, then, you know, you wrap them up and hand them to the baby -- hand them to the parent. And it tells us how the baby is

1 transitioning from inside to outside. That's really
2 all it tells us.

3 Q. And I asked you to kind of reverse a
4 little bit where I said, you know, a baby can be
5 assigned a score of 7 or 8, and still have suffered
6 an intrapartum HIE, correct?

7 A. Yes.

8 Q. And, I mean, physiologically how is that
9 possible?

10 A. Well, I mean, it happened in this case,
11 right? So we have the hours of the low reserve, the
12 boxing match, the final punch. He comes out pretty
13 lifeless. They respond to resuscitation, and they
14 assign him an 8. Yet, all the other things in the
15 puzzle continue to show that he had suffered this
16 brain injury during this time.

17 Q. The jury I think just saw the testimony of
18 Dr. warsof.

19 MS. LENIVY: Zack, can you pull up
20 Exhibit 420.

21 Q. (By Ms. Lenivy) All right. This is a
22 committee October 2015, ACOG and American Academy of
23 Pediatrics, committee opinion on the Apgar score.

24 MS. LENIVY: And I want to actually scroll
25 to page 2, that second column, that first full

1 paragraph on the second column, where it says the
2 Apgar score alone.

3 Can you zoom in on that?

4 Q. (By Ms. Lenivy) okay. So this -- and,
5 Dr. Kerzner, you're familiar with this document,
6 correct?

7 A. Yes.

8 Q. This paragraph reads: The Apgar score
9 alone cannot be considered to be evidence of or a
10 consequence of asphyxia. Many other factors,
11 including nonreassuring fetal heart rate monitoring
12 patterns and abnormalities in umbilical arterial
13 blood gases, clinical cerebral functions,
14 neuroimaging studies, neonatal
15 electroencephalography?

16 A. Yep.

17 Q. okay. Placental pathology, hematologic
18 studies, and multisystem organ dysfunctions need to
19 be considered in diagnosing an intrapartum hypoxic
20 ischemic event.

21 Did I read that correctly besides the part
22 I screwed up on the EEG?

23 A. Yes.

24 Q. Okay. And, Doctor, can you -- can we take
25 this sentence and translate it for us non doctors?

1 A. Yes. So it's what I've been saying. That
2 in this case the Apgar score may have been greater --
3 assigned greater than it was. But all of the other
4 indicators that we have available to us, should --
5 still are consistent with the fact that Remi was
6 injured while his mother was in labor with him.

7 Q. Okay. And did you look at all of the
8 items listed her, the local arterial blood gases,
9 clinical cerebral function, all of that in making, or
10 I guess collecting, your constellation of markers?

11 A. We didn't have a blood gas. There was not
12 a blood gas drawn. And we don't have placental
13 pathology, what he sent to the lab. We only have the
14 essential culture. But the other things, yes.

15 Q. Okay. So no -- placental pathology was
16 never sent to the lab. So that's a piece of this
17 constellation that we can't include, correct?

18 A. Yeah. It surprised me, given the
19 prolonged labor and how the baby ended up after
20 birth, but, yes, it was not there.

21 Q. Okay. You mentioned cord blood gases.
22 The jury has already heard a little bit about that.

23 But can you explain, first of all, where
24 does the cord blood gas come from?

25 A. So after you deliver the baby, you clamp

1 the placenta by the umbilical cord, and all that
2 blood flow is still in the cord. So you take a
3 section of the cord not from the baby but after
4 they're born, at the maternal side, and then you
5 clamp two sections.

6 And then a nurse, or whoever is assigned
7 to do it, takes a syringe, and then draws out of the
8 artery and the vein, so we have a comparison. And
9 they send those to the lab. That tells how is the
10 fetus doing at the time of birth --

11 Q. Okay.

12 A. -- as far as -- sorry -- acid base status.

13 Q. You mentioned Apgar scoring. There's a
14 level of subjectivity. Because we have human beings
15 looking at the situation and assigning a number,
16 correct?

17 A. Yes.

18 Q. Is there subjectivity to a cord blood gas?

19 A. If it's done right, no. It's objective
20 data.

21 Q. Okay. It's objective, laboratory-based
22 evidence of what this baby's acidosis is like at the
23 time of birth?

24 A. Yes.

25 Q. There's been some discussion about whether

1 a cord blood gas was even needed at this time because
2 of the Apgar score.

3 Dr. Kerzner, do you have an opinion as to
4 whether a cord blood gas should have been ordered for
5 Remi Anyan on May 4th, regardless of the Apgar?

6 A. well, there's what the papers say, which
7 is, you know, if my Apgar score is less than 5 or 7,
8 that's when I get a cord gas.

9 But there's also like, well, I'm a
10 neonatologist looking at a baby with low muscle tone.
11 Is this a kid I need to do more -- like bring it to
12 the NICU and undergo cooling? So I need a gas to
13 determine that.

14 So -- and also the obstetricians, in my
15 institution, would be saying, Hey, want a gas? Yes,
16 I want a gas. And that would be drawn so that we
17 have objective data on top of those Apgar scores and
18 the neurologic exam.

19 Q. Okay. Let's say Remi did have his cord
20 blood gas taken and sent to the lab to determine what
21 his metabolic acidotic level was at the time of his
22 birth.

23 Do you have an opinion as to what that
24 testing more likely than not would have shown?

25 A. well, given the rest of his outcome and

1 course, and seeing the lactate, which was quite
2 elevated, which is lactic acid, which is what builds
3 up to cause you to have a high acid level at birth,
4 and that level was high on 2 days of life, is the
5 first time they drew it.

6 It didn't just get high out of the blue,
7 it probably on its way down from that significant
8 level he suffered from. So I would say that he would
9 have a moderate acidosis at the time of his delivery.

10 Q. And if Remi's cord blood gas had shown he
11 was acidotic, what would have happened next?

12 A. Well, if you're born with a concerning
13 tracing, particularly Cat III, as in this case, and
14 you have a baby who has low muscle tone and needed
15 some resuscitation, and you have a metabolic acidosis
16 on a cord gas, we admit you to the NICU and consider
17 you for something called cooling, which we know can
18 help diminish the potential to brain injury. That
19 means you might have started to suffer in utero.

20 Q. All right. Dr. Kerzner, I heard you say
21 head cooling. We're going to talk about head cooling
22 in a moment here.

23 And I think you also mentioned neuro exam.

24 A. Yes.

25 Q. Okay. Explain for the jury what you mean

1 by a neurologic examination. what's happening?

2 A. So you want to make sure, again, if the
3 baby isn't just breathing, has a good heart rate, but
4 that they're neurologically transitioning to a
5 healthy state.

6 so you look at their muscle tone. You
7 look at how they're sucking. You do something called
8 a startle reflex to see do they do the entire thing?

9 Does he have plantar and palmar grasps? Are his toes
10 grasping? Are his fingers grasping you? Does he
11 have regular breathing? Are his vital signs normal?
12 And you look at all those things to determine how he
13 is transitioning and if there's something maybe going
14 on neurologically that you need to know about.

15 Q. Did Remi have the full neurologic
16 examination before being sent to the nursery?

17 A. Not that I saw, no.

18 Q. okay. Have you seen any documents
19 indicating that Remi had normal reflexes before being
20 sent to nursery?

21 A. Not that I saw.

22 Q. okay. we know that he was sent to the
23 newborn nursery around 5:35 p.m.

24 MS. LENIVY: Sorry. Sorry, Zack. Can you
25 pull up Exhibit 3, page 2391. 2391. Okay. oh,

1 sorry. Exhibit 3, page 2391. Thank you, Zack.

2 Q. (By Ms. Lenivy) what am I trying to show
3 here?

4 I just wanted to indicate to the jury that
5 he got to the nursery at 5:35 p.m., so that's about
6 an hour 10 after delivery, correct?

7 A. Yes.

8 Q. And, Dr. Kerzner, from your review of the
9 records and from the parents' depositions, how was he
10 doing in the nursery?

11 A. I know at that time he was admitted, his
12 respiratory rate was already high. It was 68. And
13 the parents described that he wasn't feeding well,
14 and he was floppy at that time. But he was
15 spontaneously breathing and not in distress, so to
16 speak. And that's probably why he was sent to the
17 regular nursery.

18 MS. LENIVY: Zack, can you go to page
19 3397.

20 Q. (By Ms. Lenivy) This is the newborn NICU
21 infant iNO. That's intake/output. what was the baby
22 taking in? what was the baby putting out, right?

23 A. Correct.

24 Q. And we see at 8:00 p.m. on May 4th, so
25 about 2 and a half hours after he got to the nursery,

1 there's an oral intake feeding method: breastfeeding
2 attempted, and a feeding tolerance resistance,
3 refusing to suck, correct?

4 A. Yes.

5 Q. Okay. 8:30, so about half an hour later,
6 what's going on with Remi there?

7 A. Continue -- sorry. I definitely can't
8 read that.

9 Refuses to suck. And lack of interest in
10 breastfeeding.

11 Q. Okay. And then at 11:30 p.m., what's
12 happening here?

13 A. So I believe that's when the NICU was
14 called. And they said, this baby was irritable, not
15 feeding, and they came up and said, okay. Well, try
16 some formula, you know, put it in a bottle. Maybe
17 he's just not latching the breast. And they tried
18 that, as well, but he couldn't even take a teaspoon.

19 Q. 3 milliliters, that's not a whole lot?

20 A. A teaspoon is 5, and 3 mLs is almost half
21 a teaspoon.

22 Q. Okay.

23 MS. LENIVY: And then Exhibit 3, page
24 1507, Zack.

25 Q. (By Ms. Lenivy) And this is after the

1 start of the NICU admission notes, so the jury has
2 kind of an idea of where this record is coming from.

3 MS. LENIVY: If you could scroll to 1509
4 under history, nutritional support history.

5 Q. (By Ms. Lenivy) It says: Mom plans to
6 breastfeed. Baby was frantic at breast. Cried with
7 attempts at bottle feed. NPO on admission.

8 what does NPO mean?

9 A. Nothing by mouth.

10 Q. okay. so indicating he hadn't really
11 taken anything yet?

12 A. well, it's also because he was breathing
13 up to 140 times a minute. So in a baby, anything
14 over 60 is fast. You may still be comfortable and
15 able to eat at that point, but he was breathing up to
16 140 times a minute, so they didn't think it was safe
17 to even try feeding at this point where he's admitted
18 by mouth because he could aspirate.

19 Q. okay. so he refused to suck. Refused --
20 lack of interest in feeding. wasn't latching.

21 Does that fit the parents' description, as
22 well?

23 A. Yes.

24 Q. It notes that the baby was frantic at
25 mom's breast. Cried with attempts at bottle feed.

1 Is this one of those constellation of
2 markers, pieces of puzzle, for you, Dr. Kerzner?

3 A. Yeah. Particularly that he doesn't have a
4 good suck because now I have a low tone baby they
5 described as floppy. And an irritable, very
6 hyperirritable, baby who can't be consoled. So that
7 to me is some neural inflammation going, and we don't
8 have a suck. So those three things are all going on
9 that leads for me to be more concerned.

10 Q. And, Dr. Kerzner, you called my next move
11 there.

12 MS. LENIVY: Zack, can you go to page
13 1574.

14 Q. (By Ms. Lenivy) I want to look at this
15 note right here. That's 5/4/2020, Nurse Maureen
16 Phoebe at -- date of service: 5/4/2020, at 11:30
17 p.m.

18 Dr. Killian notified of baby's constant
19 crying even after interventions to calm him. would
20 not breastfeed even though he was alert and had good
21 latch initially. Respiration has fluctuated from 16
22 to 140 -- and we'll talk about those respirations in
23 a moment -- O2 sat 98. Other vital signs stable.
24 Baby's head is swollen, and baby seems to be in
25 distress possibly from pain.

1 mom pushed for 9 hours. Dr. Killian says,
2 try and give baby formula, try and calm him down, and
3 if continues to cry, call NICU if tachypnea
4 continues.

5 so he mentioned irritable.
6 okay. Is this one of the constellation of
7 markers?

8 A. Yes.

9 Q. And why is that?

10 A. So if you had any brain injury, one of the
11 things that happens over the first few hours is you
12 get -- you go from not having enough oxygen to then
13 what's called reperfusion. When that reperfusion
14 happens, which is now you're breathing oxygen, you
15 get some -- a lot of factors going on in your brain.
16 They're excitatory, they're inflammatory, and they
17 are causing swelling -- or inflammation alone causes
18 the baby often to be quite irritable.

19 Q. I think -- were there also descriptions
20 from Sarah and Blake about the baby being floppy in
21 the nursery?

22 A. They kept -- I believe the nurses were
23 saying he's tired. He's gone through a long labor,
24 and they were saying, yes, he was floppy.

25 Q. And why is that? Or is that significant?

1 A. Again, that goes back to me being
2 concerned that his muscle tone is low. And
3 hypotonia, or low muscle tone, is classic in babies
4 who have sustained metabolic acidosis. Their muscles
5 also have that lactic acid buildup, and they don't
6 move a lot.

7 So when I see a baby not moving well after
8 birth, that's another thing I would say, hey, let's
9 get a cord gas. Or if we don't have a cord gas
10 available, let me get a baby gas because something is
11 going on here enough that this baby is floppy.

12 MS. LENIVY: Zack, can you go to 2-5-8-3.
13 2583.

14 Q. (By Ms. Lenivy) Here we see the newborn
15 NICU vital signs. And I want to start with that
16 first row: temperature. At 5:35, he's got a
17 temperature of 98 degrees. But then the next one,
18 two, three, four reads, there's little exclamation
19 points next to them.

20 what does that indicate?

21 A. So the baby was cold, despite warming
22 methods. And that's another form of neural
23 irritability. I can't keep my temperature up. I
24 can't suck. I don't move as well. Like all of those
25 together, with a constellation of, something's going

on there neurologically with me.

Q. Okay. And it looks like if you read these across, Remi's getting progressively colder, correct?

A. It looks like that, yes.

Q. Okay. And that's described in the record as hypothermia, as well, correct?

A. Yeah, low temperature.

Q. If we scroll down, do you see there's a line that says "resp."

Is that respiratory rate?

A. Correct.

Q. Okay. And this is how fast, how many breaths Remi is breathing in 1 minute?

A. Yes.

Q. Okay. And we see, when he got to the nursery, this was the 5:35 column, when he initially got to the nursery, his respiratory rate was 68. And there is an exclamation point next to it.

why is that?

A. As I mentioned, the upper limit is 60. So if this is 68 for that minute, maybe he was a little more active or a little tachypneic for that minute. But clearly it went on to get much worse.

Q. Okay. Do you see this is the 10:30 column, so about 5 hours later. Now he's at 140

1 respirations per minute. And that's tachypneic,
2 correct?

3 A. Yeah. So when your respirations are more
4 than your heart rate, which is 120 here, we're really
5 concerned because something is going on to make you
6 so tachypneic.

7 Now, in this case, when you have a
8 metabolic acidosis, which, again, these babies are
9 very smart. They try to compensate on their own. If
10 I breathe really fast, I can breathe out my CO₂ and
11 try to normalize my acid base levels in my own body.
12 He was trying to help himself there.

13 Q. So the baby is acidotic. He's trying to
14 save himself by breathing so fast to clear it out?

15 A. He's trying to help his acid base status,
16 yes.

17 Q. Okay. And then by 12:51 a.m., before he
18 got to the NICU, now he's up to 160 respirations?

19 A. That's extreme, yes.

20 MS. LENIVY: Zack, can you pull up 1674?
21 Thank you.

22 Q. (By Ms. Lenivy) And I want to start with,
23 we talked about the Nurse Phoebe note. And now we've
24 got a Nurse Youngest. 5/5/2020 at 1:57 a.m. And it
25 says: NICU came to assess infant for tachypnea and

1 increase irritability. And infant transferred to
2 NICU. So I think it was around about -- do you
3 recall how old Remi was when he was transferred from
4 the nursery to the NICU?

5 A. I believe he was 9 hours of life when he
6 got to the NICU.

7 Q. Okay. Once he got into the NICU, was
8 there a blood and spinal fluid culture run?

9 A. Because the mother had had a fever, and he
10 was breathing, they wanted to make sure he didn't
11 have an infection. So they did draw blood culture at
12 that time and start antibiotics in case he had an
13 infection.

14 Q. Okay. And they took that blood culture,
15 they sent it out. What -- do you recall what the
16 results of that were?

17 A. Yeah. There was growth. There was no
18 infection that they found. And they added a spinal
19 tap the next day, which, again, was negative.

20 Q. Okay. And were the -- did you say the
21 antibiotics were stopped as a result?

22 A. Yes.

23 Q. Okay. So the negative blood culture and
24 negative spinal fluid culture, would that be
25 indicative of no infection for this baby?

1 A. No infection and no meningitis as a
2 possible cause as to why he was irritable and having
3 those neurologic symptoms.

4 Q. And, again, is that another -- the
5 negative infection, is that another constellation of
6 markers?

7 A. Yes. It helps me rule out that there was
8 an infection causing his symptoms.

9 Q. Okay.

10 MS. LENIVY: Zack, can you pull up that
11 same record we've been looking at before.

12 Q. (By Ms. Lenivy) So this is from Nurse
13 Rabe. Date of service: 5/5/2020 at 7:44 a.m. it
14 says: Infant arrives to NICU on room air. Remain on
15 room air remainder of shift. Infant's respiratory
16 rate mostly 100 to 200.

17 And so I think earlier you said 160 was
18 extreme, right?

19 A. Yes.

20 Q. And so now it's being documented that he's
21 even getting up to 200?

22 A. Yes.

23 Q. However, after 0600, 6:00 a.m., infant
24 began going apneic after crying spells and having
25 decaps.

1 what does "apneic after crying spells"
2 mean?

3 A. So at this point, he's gone from breathing
4 really fast to, in my opinion, this was probably the
5 beginning of seizure activity. Apnea means you stop
6 breathing altogether. So he went from breathing
7 really fast to, like my tank is out. Now I'm just
8 not going to breathe. And it's possible that this
9 was also when seizures, or at least that additional
10 neuro inflammation, was firing here.

11 Q. Okay. It says -- sticking around here.
12 Infant remains quite fussy and irritable, despite --

13 MS. LENIVY: Can you go to the next page
14 to finish up that sentence, Zack.

15 Q. (By Ms. Lenivy) So infant remains quite
16 fussy and irritable despite intervention. Infant
17 favoring not moving right arm as symmetrically as
18 left arm. Doctor aware.

19 what's going on with the right arm?

20 A. So we talked about that startle reflex as
21 one of the things that a normally transitioning baby
22 should have. And when you don't have both arms
23 coming back, that's asymmetry. That means one is not
24 as strong as the other. So that tells me something,
25 again, something is happening neurologically there

1 that we don't have symmetry of that startle or morrow
2 response.

3 Q. And then it says: PRN Tylenol suppository
4 given at 3:28, with no real improvement noted.

5 Is that to try to treat Remi's pain?

6 A. I think they were just trying to see is
7 this kid in pain from his head being in there for so
8 long. It wasn't the reason, but, you know, they were
9 trying to think of everything.

10 Q. okay.

11 MS. LENIVY: Zack, can you pull up 1586.

12 Q. (By Ms. Lenivy) All right. And I just
13 want the jury to understand that we're looking at a
14 note from a Dr. Heather Hall from 5/7/2020. And it
15 goes to 1589. She provides a history.

16 MS. LENIVY: Right there. And so that
17 first sentence I want to focus in on.

18 Q. (By Ms. Lenivy) Approximately 0700, so
19 7:00 a.m., on 5/5, had episodic desaturation with
20 staring, blinking, and lip smacking.

21 Doctor, what's going on with Remi at seven
22 o'clock in the morning on May 5th?

23 A. So that sounds like he's having a seizure.
24 That's how babies have seizures. They don't always
25 move and shake their arms. They have these kind of a

1 little bit different types with staring, rhythmic
2 blinking, and then lip smacking. Any of those
3 rhythmic type of things, those are seizures until
4 proven otherwise.

5 Q. At seven o'clock in the -- now, I know you
6 said at 6:00 a.m., the apneic was crying, that may
7 have been the start of seizures, correct?

8 A. Yes.

9 Q. But by at least 7:00 a.m., we've got
10 documentation of staring, blinking, lip smacking, the
11 classic signs of seizure.

12 How old was Remi at approximately
13 7:00 a.m.?

14 A. About 14 and a half hours old.

15 Q. All right. Is that, the fact that he was
16 having seizure activity at approximately the 14th
17 hour of life, is that one of your constellation
18 markers here?

19 A. Yes.

20 Q. And why is that?

21 A. So there's three phases of neurologic
22 injury after you've had a significant brain -- after
23 you have this injury that I feel Remi had around the
24 time of his birth, you go through a period where you
25 may recover for a period for 30 to 60 minutes.

1 That's probably why he ended up going to the regular
2 nursery. He wasn't in fetal distress. They didn't
3 notice that at that time.

4 And then you go on to have the reperfusion
5 start. And when that reperfusion starts, again, all
6 of those factors are starting to come into your
7 brain. They cause you to have a lot of inflammation.
8 They're cytotoxic. So cytotoxic, that takes 6 to 15
9 hours to develop after that injury. And that
10 cytotoxic, that's where the seizures happen. So very
11 common that 6 to 15 hours after the injury, you would
12 start to see seizures. And that is what helped me
13 time his injuries to at or around the time of his
14 birth.

15 Q. Okay. And you said 6 hours. So that
16 would be while Remi was already alive.

17 Is there any evidence in this case that
18 Remi's HIE occurred after delivery?

19 A. No, I don't think so.

20 Q. Is there any experts that you're aware of
21 in this case that's going to tell this jury that
22 Remi's injury did not occur prior to his delivery?

23 A. No.

24 Q. So you said 6 to 15 hours after an injury
25 is sustained, you will often see seizures, first sign

1 of seizure activity?

2 A. Correct.

3 Q. Okay. And Remi's documentation shows that
4 it may have started at 6:00 a.m., so 13 and a half
5 hours of life, correct?

6 A. Yes.

7 Q. But at least we have this, the very
8 classic signs of a seizure at 14 and a half hours of
9 life, correct?

10 A. Yes.

11 Q. And that fits right in that 6- to 15-hour
12 window that you, as a neonatologist, are trying to
13 figure out when this kid's injury occurred, fits
14 right in there?

15 A. Yes, it does.

16 Q. Okay. The fact that we could highlight
17 this sentence starting with received. It says:

18 Received phenobarbital load, fosphenytoin, Keppra
19 load, pyridoxine, and Ativan. I skipped a few words
20 around just to focus on the names of the medication.

21 But the number -- well, first of all, what
22 are all of these medications?

23 A. So what is happening is they've now put an
24 EEG on the baby's head to see what is happening
25 electrically in the brain. Are these actually

1 seizures?

2 And they were in fact seizures. And the
3 seizures were so significant, it took, I think, four
4 or 5 different medicines to try to control them.

5 Q. And why is that significant that there
6 were so many medications being used for Remi?

7 A. It just indicates the degree of
8 inflammation that's going on, and that cytotoxicity
9 is significant. So this is no longer like a mild.

10 This is more of a moderate type of injury when you
11 have this many seizures.

12 Q. Okay.

13 MS. LENIVY: Zack, can you pull up Exhibit
14 1594 -- I'm sorry -- Exhibit 3, page 1594.

15 Q. (By Ms. Lenivy) I want to scroll down to,
16 this is Dr. Thalakoti, and they're with neurology.

17 And it reads: EEG preliminary review from overnight.

18 Dr. Kerzner, is what Dr. Thalakoti put
19 into -- this is a woman -- Dr. Thalakoti's notes, is
20 that significant to you?

21 A. It's highly significant because what this
22 is showing in the background is that not only is the
23 baby having a seizure, but in the background, how my
24 electrical activity is significantly depressed. It's
25 really, really low, to the point where they

1 actually -- their impression is that this EEG is
2 abnormal and consistent with a moderate to severe
3 encephalopathy or abnormal neuro exam on the baby.

4 Q. And it says: Abnormal toxicity with
5 clinical event correlated with electrographic
6 abnormalities. The background is abnormal with
7 diffuse depressive amplitude, suggestive of moderate
8 to severe encephalopathy.

9 And that's what you just described for us,
10 correct?

11 A. Yes.

12 Q. And that's another one of your
13 constellation of markers?

14 A. Yes.

15 Q. Something that I can see on this exhibit
16 is oliguria and hyponitremia.

17 Can you explain to the jury what that is?

18 A. So when we talked before about when a baby
19 starts having low oxygen in utero, they divert blood
20 away from their kidney and their liver and their bone
21 marrow and anything else that isn't vital like the
22 heart, the adrenal, and the brain.

23 And what's happening here is that the baby
24 has shown now that he did divert blood flow away. He
25 was trying to save the brain. He diverted blood flow

1 away from his kidney, and now he's not peeing.
2 oliguria, low urine output; hyponitremia, low sodium.
3 Because when the baby isn't peeing, they then lose
4 their sodium. He also had elevation of a creatinine,
5 which is the kidney function they test.
6 significantly elevated.

7 All of those things together tell me that,
8 yeah, this got to the level of his kidneys. He was
9 trying to help his brain by letting his kidneys not
10 get the blood flow. The good news is those things
11 usually reverse, and the bad part is you end up with
12 a brain injury, but your kidneys recover.

13 Q. Let's talk about the creatine level.

14 MS. LENIVY: Zack, can we go to Exhibit 3,
15 page 1912.

16 Q. (By Ms. Lenivy) All right. And so the
17 jury can see it, this is collected. This is
18 creatinine. And that measures the patient's kidneys,
19 how the kidney functions?

20 A. Correct.

21 Q. Okay. And we see this was collected on
22 5/5 of '20 at 8:29 a.m. So Remi is about -- do my
23 math here -- 16 hours of life?

24 A. Right.

25 Q. Okay. And we see the creatine is 1.55,

1 and the reference range is .31 to .88, so this is a
2 high creatine level, correct?

3 A. Correct.

4 Q. Elevated. And you were describing the
5 baby is sending blood away from the organs to try to
6 preserve the brain.

7 A. Correct.

8 Q. Okay. So at 16 hours of life, Remi's
9 creatine is 1.55.

10 MS. LENIVY: Zack, can we go to the next
11 page, 1923.

12 Q. (By Ms. Lenivy) I believe there is a --
13 now we're on 5/6 of 2020, at 4:23 a.m., so a couple
14 hours later. The creatinine comes down a little bit.
15 It's 1.49, correct?

16 A. Yes.

17 Q. Okay. It's downtrended.

18 MS. LENIVY: And, Zack, if you'd go to
19 page 1937.

20 Q. (By Ms. Lenivy) 5/7/2020, 4:41 a.m., so
21 the next day this is collected. And now his creatine
22 is down to a .91, which is still elevated, but it's
23 getting pretty close to that reference range,
24 correct?

25 A. Yes.

1 Q. Okay. And so we've seen 5/5, 1.55; 5/6,
2 1.49; and then 5/7 of .91 downtrending.

3 Is that part of your constellation of
4 markers?

5 A. Yes. Exactly what I was saying, that the
6 kidney recovers. So as the baby gets treatment, he
7 gets IV fluids and his kidneys recover, and that
8 number starts to normalize.

9 Q. Something else I think I've heard you
10 mention earlier, and while we're talking about labs,
11 is lactate.

12 Can you explain what lactate is?

13 A. Well, lactate is a buildup of when you
14 have -- it's like running a marathon. By the end of
15 the marathon, you start to produce lactic acid
16 because you haven't been getting in as much oxygen in
17 the body.

18 As an adult, you can increase your
19 respiratory rate for that, but babies can't in utero
20 because they're not breathing air. So it builds up
21 over time when a baby has ongoing low oxygen state.

22 And when you have an ongoing low oxygen state, you're
23 born like Remi with that, you know, almost lifeless,
24 the low muscle tone. And then in his case, because
25 we don't have any labs until this lactate of 9, but

1 we see that he has this elevation in his lactic acid
2 which confirms that it was predated and going on
3 during that time.

4 MS. LENIVY: Zack, can you pull Exhibit 3,
5 page 1933.

6 Q. (By Ms. Lenivy) At the bottom there, we
7 see the lactic acid. And it's collected on 5/6/20,
8 at 12:59 p.m.

9 So this is what? 44 hours of life? 45
10 hours of life? Almost two days old?

11 A. Yes.

12 Q. And Remi's lactic acid level is at 9.0.

13 The reference range is .5 to 2.0, and his flag is HH.

14 what's HH?

15 A. Significantly high.

16 Q. Okay. High, high.

17 what -- is it significant to you, Dr.

18 kerzner, as far as your constellation of markers when
19 timing this baby's HIE, that at almost two days old,
20 his lactic acid is still significantly high at 9.0?

21 A. Yes. Particularly because, as like the
22 kidney function, the lactate starts to normalize over
23 the next couple of days, so they're in concert. The
24 kidney and the lactic acid, they're normalizing and
25 downtrending. And that would be consistent with a

1 baby who has had an injury and now things are getting
2 better rather than something else going on.

3 Q. Let's focus on the lactate then. See how
4 Remi did over the next couple of days.

5 MS. LENIVY: Zack, can you go to page
6 1935?

7 Q. (By Ms. Lenivy) All right. And so we see
8 5/6, 1652, so 4:52 p.m., just a couple hours later,
9 Remi's POC lactate, and is that the same as the
10 lactic?

11 A. Yes.

12 Q. Okay. Now, it's gone down from a 9 to a
13 5. It's still flagged as significantly high, but
14 he's -- it's downtrending?

15 A. Yes.

16 Q. Okay. And that's important, right?

17 A. Yes.

18 Q. Okay.

19 A. It takes awhile for them to wash out. It
20 doesn't go away right away.

21 Q. Okay.

22 MS. LENIVY: And then page 1940, Zack.

23 Q. (By Ms. Lenivy) 5/7/2020, so a couple of
24 hours later, the next day, now his lactate level is
25 at a 3.0. And that's almost close to being in the

1 normal reference range, right?

2 A. Yes.

3 Q. Okay. And, again, does the fact that he's
4 downtrending, indicate to you that now that Remi, he
5 suffers a major injury intrapartum, and now his body
6 is being able to try to normalize out that end organ
7 dysfunction?

8 A. Yes.

9 Q. Okay. I do want to talk about the liver
10 because that was specifically mentioned in that list
11 of four things that apparently are evidence that this
12 injury occurred days before Sarah got to the
13 hospital.

14 MS. LENIVY: Zack, can you pull up Exhibit
15 3, page 1929.

16 Q. (By Ms. Lenivy) And at the bottom,
17 there's an AST and ALT scale.

18 MS. KAMYKOWSKI: Your Honor, can we
19 approach?

20 THE COURT: You may.

21 (Proceedings were held at sidebar, outside
22 the hearing of the jury.)

23 MS. KAMYKOWSKI: So in her deposition, Dr.
24 kerzner talked about the lactate, and she actually
25 put it in her report. There was no other lab

1 evaluation to support the basis of her opinion as to
2 the timing of this injury at deposition.

3 I understand this morning when Ms. Lenivy
4 walked us through the information, including our
5 expert, Dr. Cantey, who, as we know, specifically
6 commented on the liver function when Mr. Willman
7 talked about them. He received correspondence from
8 Ms. Gunn sometime in the last month advising her that
9 Dr. Kerzner had seen Dr. Cantey's deposition, and
10 that her opinion had not changed. She never offered
11 an opinion about liver functioning at all in her
12 deposition.

13 And for her now to do so would be a brand
14 new opinion. I would object. We object to her
15 talking about the lactate. We object to her now
16 offering that opinion presumably to get ahead of Dr.
17 Cantey to conduct his opinion about liver
18 functioning.

19 MS. LENIVY: Judge, Dr. Kerzner talked in
20 her deposition, and it's in the record, about
21 transaminitis. It's a liver enzyme. She talked
22 about the liver enzymes. She talked about kidney.
23 She talked about liver, and how the lab results are
24 particular and important to her opinion about the
25 timing of the child's injury. She specifically said

1 the transaminitis and the liver in her deposition.

2 I'm going to --

3 Mandy, it's on page 57 of --

4 THE COURT: She still can't read it
5 without her glasses.

6 MS. KAMYKOWSKI: I can't see timestamps.

7 THE COURT: It's on pages 57 and -- 57 --

8 MS. LENIVY: It's 57. Transaminitis: 57,
9 4 and 64, 7.

10 MS. KAMYKOWSKI: Sure. She talks about
11 one time that he had it. She didn't present it --
12 associate that in her deposition. When we asked her
13 all of the evidence, she didn't say it trended
14 downward like she did with the last statement. This
15 is a new opinion.

16 MS. LENIVY: Judge, we've already
17 explained that. We've already talked about that we
18 don't have evidence of the downtrend, which is what
19 we're trying to say, but it's still important to her
20 opinion in showing that this is an elevated liver
21 enzyme.

22 So I -- and, also, additionally, even if
23 she hadn't testified to it, and she did, she
24 testified to it, she talked about the liver. She
25 talked about saying the transaminitis, why that AST

1 and ALT elevated scores were important to her
2 opinion. But Mr. Willman had opened the door to her
3 by making it a point that the liver enzymes somehow
4 proved the timing of this child's injury. He opened
5 the door, but also she testified to it.

6 MS. KAMYKOWSKI: You don't get to open the
7 door by pointing out inconsistencies between experts.
8 If we did that, we would open the door to brand new
9 opinions in trial all the time. And that's not the
10 way things work.

11 THE COURT: The Court is going to overrule
12 the objection. I believe it's previously been
13 testified to, and it's fair game.

14 MS. KAMYKOWSKI: Thank you, Judge.

15 (Proceedings returned to open court.)

16 THE COURT: All right. Ladies and
17 gentlemen, based on the timing, this is probably a
18 good time for us to take our lunch recess.

19 (A break was taken at 12:04 p.m., and the
20 jury was duly admonished. At 12:49 p.m., the
21 following proceedings were held in open court, in the
22 presence of the jury:)

23 THE COURT: Go ahead and be seated,
24 everyone.

25 Q. (By Ms. Lenivy) Dr. Kerzner, before we

1 get ourselves reoriented into the constellation of
2 markers we've been talking about, before the lunch
3 break, we talked about the lactate, how it was
4 significantly high, and then it was downtrending,
5 correct?

6 A. Yes.

7 Q. And then we talked about the creatine, the
8 kidney function, and how that was very high, and then
9 it started downtrending, correct?

10 A. Yes.

11 Q. Okay. So let's pick up where we left off
12 in the lab.

13 MS. LENIVY: And, Zack, can I have,
14 please, Exhibit 3, page 1929?

15 Q. (By Ms. Lenivy) All right. And so
16 5/6/2020, at 12:54 p.m., more labs were collected of
17 Remi, and the two that Zack has highlighted for me
18 are AST and ALT.

19 Before we talk about what those numbers
20 mean, can you explain for the jury what AST and ALT
21 signify.

22 A. So those are hepatic function enzymes. So
23 similar to when I said we divert blood flow away from
24 kidney and liver. This would be how you determine
25 how that blood flow was diverted away from the liver

1 because you get a bump in the enzyme. For kidney,
2 you get a bump in the creatine. For liver, you get a
3 bump in the enzyme.

4 Q. And so we see Remi's liver enzyme, his AST
5 and ALT, 186 respectively.

6 Is that elevated?

7 A. Those are both elevated, yes.

8 Q. Okay. Did you consider the elevated liver
9 enzymes as part of your constellation of markers?

10 A. Yes. I included that as one of the
11 markers.

12 Q. And, sorry, Doctor, but why is that?

13 A. So exactly what I just said. It's
14 evidence to me that there was a diverting away from
15 the kidney and the liver during that process while
16 Remi was in a low oxygen state, trying to preserve
17 his brain.

18 Q. Okay. And these liver enzymes were taken
19 at about 44 and 45 hours of life. And they're still
20 showing that they're elevated, correct?

21 A. Yes.

22 Q. And unlike the creatine and the lactate,
23 which we can track between 5/5 and 5/7, is this the
24 only AST, ASL liver enzyme lab we have for Remi
25 during this time period?

1 A. Yeah. It's too bad we don't have the one
2 with the creatine with it, the 1.55, to compare and
3 see how they downtrended together. This is the only
4 one we have.

5 Q. Okay.

6 A. Presuming it's downtrending because the
7 kidney downtrend is the baby never developed a liver
8 problem and otherwise as to why they would be high
9 and also the lactate downtrended.

10 Q. Okay. Dr. Kerzner, can we -- well, I'm
11 going to move on to a different topic.

12 You reviewed all of the medical records
13 for Remi from Mercy Hospital, correct?

14 A. Yes.

15 Q. And that includes head imaging reports?

16 A. Yes.

17 Q. And does that include the 16 hours of life
18 ultrasound?

19 A. Brain ultrasound, yes.

20 Q. Brain ultrasound. And was that -- was
21 that read as normal?

22 A. Yes.

23 Q. 16 hours of life, Remi has a normal head
24 ultrasound.

25 And in that ultrasound, did it mention any

1 edema?

2 A. No.

3 Q. what is edema?

4 A. Swelling.

5 Q. okay. 16 hours of life, a head
6 ultrasound, no swelling.

7 Does the head imaging in this case, do we
8 get more of it? And does it indicate something
9 different going on with Remi?

10 A. Yes. The brain ultrasound done at 16
11 hours of life is 16 plus 26 hours since he's been
12 under the monitors in the hospital. So I think it's
13 about 44 hours of life, they get that brain
14 ultrasound, which is normal. Two days later, we see
15 evidence of significant and severe injury on the
16 brain MRI, which is more sensitive and specific.

17 Q. okay. well, let's take a look at the
18 brain MRI report.

19 MS. LENIVY: Zack, can I have Exhibit 3,
20 page 1992, please?

21 Q. (By Ms. Lenivy) So we've got the MRI of
22 the brain performed on 5/6/2020, between 2:39 p.m.
23 and 4:23 p.m., so about 48 hours of life, correct?

24 A. Yes.

25 Q. And you see under the history, it reads:

Newborn born at 39 weeks, 4 days, with seizures and difficult delivery. Clinical concern for hypoxic ischemic encephalopathy, genetic or metabolic abnormalities, and infection.

I'm going to pause here for a second.

Is there anything significant to you, Dr. Kerzner, as far as the history and why Remi's getting this MRI?

A. well, they're acknowledging that there's been a difficult delivery and seizures. And they're also saying, you know, this could be HIE, but is there anything else also going on? So let's look and see.

Q. Okay. So I want to take a minute and talk about HIE in general, because they list hypoxic ischemic encephalopathy, genetic or metabolic abnormalities, and then infection.

Dr. Kerzner, it's my very broad understanding that hypoxic ischemic -- it's the idea of the encephalopathy, kind of a big umbrella term.

A. would you like me to explain HIE?

Q. I would love for you to do that, thank you.

A. All right. So hypoxia, low oxygen; ischemia, low blood flow; and encephalopathy, an

1 abnormal neurologic examination of the baby, all
2 three of those things together can cause permanent
3 brain injury or a recoverable brain injury. In this
4 case, permanent.

5 Q. Okay. The genetic metabolic abnormalities
6 and infections, can you explain what it is that we're
7 reading here with that?

8 A. Before you get the brain imaging, you're
9 not exactly sure why the baby is having seizures at
10 that point. They didn't have all the information
11 that we now have. So they're giving a broad category
12 to the neuroradiologist who's going to look at that
13 MRI and say, do I see anything? Is this consistent
14 with one of those things? And they determined it was
15 consistent with HIE, not one of those other things.

16 Q. Okay. And so through the records, do you
17 feel that you've been able to rule out a -- and I'll
18 start with the infection cause of Remi's brain
19 injury?

20 A. Yes. They ruled it out. They stopped
21 antibiotics after two days of not finding any
22 bacteria in the blood or the spinal fluid.

23 Q. Okay. Similarly, genetic or metabolic
24 abnormalities. Have there been any evidence of
25 genetic or metabolic abnormalities of the cause of

1 Remi's brain injury?

2 A. No, there has not.

3 Q. Okay. Are you aware of any expert in this
4 case who would testify this was something other than
5 hypoxia or ischemia?

6 A. No, I have not. I believe the defense's
7 neo actually also concurred that there was no
8 genetic, metabolic, or infections present.

9 Q. Okay.

10 MS. LENIVY: So let's look then, Zack.

11 Can I have the impression of the MRI towards the
12 bottom.

13 Q. (By Ms. Lenivy) All right. It says:

14 Abnormal MRI -- MRIs with findings that are most
15 consistent with acute hypoxic ischemic encephalopathy
16 in part appears to involve the white matter watershed
17 region, as well as the more metabolically active
18 areas, including cortex and bilateral thalami.

19 This is confounded by subarachnoid
20 hemorrhage, as well as small parenchymal hemorrhages
21 within the parietal lobe.

22 I'll stop there because I want to focus
23 more on the first part that I read of the white
24 matter watershed regions, and then the metabolically
25 active areas, including the cortex and bilateral

1 thalami.

2 Doctor, is what we see on the MRI, is that
3 part of your constellation markers?

4 A. Yes, it is.

5 Q. Okay. Tell us why.

6 A. So what this is saying in simple terms is
7 what I mentioned before about when the baby tries to
8 divert blood flow initially away from the anterior,
9 the watershed area.

10 when they're experiencing ongoing hypoxia,
11 they divert blood flow away from that, so they're not
12 getting blood flow or oxygen to that part of the
13 brain, that's the watershed.

14 By the time that is already affected, now,
15 when we continue to have ongoing problematic not
16 getting enough oxygen or blood flow, you now have
17 gotten into the deep part of the brain that controls
18 more things, particularly motor, in the brain, and
19 that's what's that showing up. It's symmetric,
20 bilateral, and consistent with an injury that
21 occurred at or around the time of his birth.

22 Q. All right. So I want to kind of put some
23 of these things together. As I understand it, the
24 baby, low perfusion or low oxygen to save the center
25 of the brain, and that's the -- the big important

1 part of our brain, right?

2 A. The basal ganglion, and thalami, yes.

3 Q. Okay. To -- to preserve that really
4 important part of the brain, the body -- because
5 baby's are amazing -- they will push blood away from
6 the white matter, the outside, and redirect it to
7 that really important critical -- the gray matter,
8 right?

9 A. Yes.

10 Q. Okay. And so it's kind of -- is that
11 similar to what you were talking about earlier, where
12 the baby is taking blood and oxygen away from maybe
13 some of the organs. They could sacrifice kidneys,
14 for example, to then send blood to the brain?

15 A. Yes. That's the next step. First you
16 divert away from those organs to preserve the brain.
17 And then when it's ongoing and ongoing, and you don't
18 have a choice, then they divert away from that outer
19 part, and then it gets to the inner part.

20 Q. Okay. So what we see, or the MRI tells
21 us, is that we see the injury to the white matter
22 from the diversion, correct?

23 A. Yes.

24 Q. But then eventually the diversion wasn't
25 enough, and is that where we get the injury to the

1 gray matter?

2 A. Yes.

3 Q. Okay. Doctor, I'm going to hand you what
4 I have marked as Exhibit 349.

5 I'll hand the defense a copy as well.

6 Doctor, is Exhibit 359 an illustration?

7 A. Yes.

8 Q. Okay. And -- and what is the purpose of
9 this illustration in Exhibit 349?

10 A. Are you putting it up there, or...

11 Q. Not yet.

12 A. Okay. Sorry. So this is explaining what
13 I've been talking about before with the three
14 different phases of injury after the initial insult.

15 Q. Okay. Is Exhibit 349 something you
16 believe will help tie your opinions together and
17 illustrate for the jury what is it we've been talking
18 about as far as timing?

19 A. Yes.

20 MS. LENIVY: Your Honor, I would like
21 permission to publish Exhibit 349.

22 MS. KAMYKOWSKI: Is it possible to
23 identify it, just so we know what publication it came
24 from?

25 MS. LENIVY: Oh.

1 Q. (By Ms. Lenivy) Dr. Kerzner, do you know
2 where this Exhibit 149 [sic.] -- this illustrative
3 figure came from?

4 A. It's posted in several places. The
5 article I believe it came from was "HIE for
6 Clinicians" by Escobar.

7 MS. KAMYKOWSKI: That's S-O-R?

8 THE WITNESS: Escobar, I think.

9 MS. KAMYKOWSKI: Thank you.

10 THE WITNESS: Yes. Or "Understanding HIE
11 for Clinicians," something like that.

12 MS. KAMYKOWSKI: Oh, no objection. Sorry.

13 THE COURT: You may.

14 MR. WILLMAN: No objection. Thank you.

15 MS. LENIVY: Exhibit 349, Zack.

16 Q. (By Ms. Lenivy) And we did talk about
17 this, so I wanted to make it clear for the jury.

18 Is this an illustration you came up with,
19 Doctor?

20 A. Definitely not.

21 Q. Is this an illustration I came up with?

22 A. No.

23 Q. Okay. Is this an illustration, though,
24 that you believe can help explain how you have taken
25 the constellation of markers that we slogged through

1 and placed it into the time of Remi Anyan's second
2 stage of labor, up until the diagnosis of HIE was
3 made and on?

4 A. Yes.

5 Q. All right. Explain to us how it is you're
6 taking all of the evidence and constellations and
7 putting it into a time line?

8 A. So this is specific to how we get the
9 brain injury. We've already diverted it away from
10 the kidneys and liver. We talked about that.

11 We've gotten, it says "insult" in the top
12 left. That's like when the injury happened. That's
13 a picture of the brain, and it says: decreased
14 glucose and oxygen delivery.

15 And then you get into in anaerobic
16 glycolysis, which again, not to be too, you know,
17 technical, but it's like when you're running a
18 marathon, and your body has to now produce extra
19 energy because you've run out of the initial energy.

20 So it's when we get to the point of
21 anaerobic, and that's when the lactate, the metabolic
22 acidosis, is rising at this point because we don't
23 have glucose for our energy, so we have to use other
24 mechanisms.

25 So that's times zero. So in my opinion,

1 that's at or around his time of birth. And that
2 lasts, you know, several minutes before he was born.
3 And then you can look okay for that, you know, first
4 30 minutes. You can resuscitate. Your Apgars might
5 not be terrible.

6 But what then happens is you have this
7 reperfusion. Now, presumably you're doing okay. And
8 so you get the blood flow back to your brain. You're
9 outside mom, so if there wasn't good perfusion, for
10 any reason, you now have it.

11 So what's happening in that first several
12 hours of life is called the latent. You don't
13 necessarily see anything. You might have a baby
14 who's not acting well. Like Remi was irritable and
15 couldn't control his temperature and was floppy. So
16 you might not see anything more specific at that
17 time.

18 However, as this injury goes on, it's
19 not -- it's that first injury. You don't get this
20 latent secondary tertiary unless you have that first
21 injury. But with that happening, you now get all
22 these cells that I've talked about before rushing
23 into the brain. They are mitochondrial failure. The
24 baby can't make its own energy, so you get these
25 cytotoxins, these inflammatory cells, something

1 called oxidative stress.

2 These are all just fancy terms for things
3 aren't going on well up there. And that then leads
4 to seizures in this 6- to 15-hour window. It says 6
5 to 12. Some people say 6 to 12. Some people say 6
6 to 15, but that's when the seizures are now
7 happening.

8 So the tertiary phase is actually far down
9 the road after the baby's home even. And we're
10 trying to rebuild some of that brain, but a lot of it
11 is now dead. It's not going to. That's why the
12 brain -- that's why the head doesn't grow bigger.

13 That's why they get microencephaly. Their brain
14 doesn't get bigger, and they're kind of stuck right
15 where they are. And they can get to remodeling, but
16 they can't get those brain cells back.

17 Q. Dr. Kerzner, we talked about head cooling
18 awhile back before our lunch break.

19 And just to remind the jury, what is head
20 cooling?

21 A. So head cooling or therapeutic
22 hypothermia, they studied it in adults first, and
23 they found that if somebody is going to maybe have a
24 brain injury, if we cool them down, we can decrease
25 the brain from utilizing extra energy. And so maybe

1 those brain cells don't die.

2 So we've now figured out, based on models
3 like this, that we can use this in babies. And so if
4 we start it by about 6 hours of life, which is before
5 this secondary phase is happening, we can mitigate or
6 diminish or decrease the amount of brain injury that
7 a baby has who's suffered from HIE.

8 Q. Where does head cooling fit within this
9 time line window of time?

10 A. The studies are -- currently we're
11 recommending to start within 6 hours of life, before
12 you get all that stuff coming into the brain that's
13 going to cause all that issue.

14 The babies are cooled for three days on a
15 blanket, a very cool blanket. They get to about
16 33.5, about 3 degrees lower, they're often shivering.
17 You have to give them a little pain medicine. You're
18 monitoring all kinds of different things at that
19 time. And then on the fourth day, you rewarm them,
20 and then you get the brain MRI.

21 Q. Once you're past that 6-hour window, is
22 head cooling helpful?

23 A. There are some sectors that will lead to
24 cooling, but it hasn't been studied to the point of
25 it being standardized.

1 Q. Okay. And do you have an opinion,
2 Dr. Kerzner, whether head cooling would have given
3 some help to Remi in this case, had he received it
4 within that 6-hour window?

5 A. I think because he was in that more
6 moderate state, it could have benefitted him, yes.

7 Q. Okay. And just to get a time line of the
8 order of operations correct, what triggers head
9 cooling?

10 A. So you have to meet certain criteria. You
11 have to come out and not transition well to ex utero
12 life. You have to have evidence of acidosis on
13 either a cord gas or a blood gas. You have to have a
14 abnormal neurologic exam. Those are the main ones.

15 Q. And I think you testified earlier that you
16 believe, more likely than not, had a cord blood gas
17 been taken of Remi, it would have shown he was
18 acidotic.

19 A. Yes.

20 Q. Okay. And similarly the neuro exam, we
21 know a neuro exam was not performed here, correct?

22 A. That was documented, yes, correct.

23 Q. Or at least not documented in the records,
24 correct?

25 A. Yes.

1 Q. And, similarly, we don't have cord blood
2 gases in this case either, correct?

3 A. Correct.

4 Q. Okay.

5 MS. LENIVY: Zack, can we pull back up
6 Exhibit 350.

7 Q. (By Ms. Lenivy) which the jury saw at the
8 beginning of your testimony, Doctor.

9 So we've spent a lot of time getting
10 through all of the things, all of the constellation
11 of markers, Doctor.

12 Does this appear to be a pretty full and
13 accurate list, as far as what Remi's medical records
14 show he was experiencing?

15 A. Yes, it does.

16 Q. Okay. Dr. Kerzner, considering the full
17 constellation of markers, do you believe to a
18 reasonable degree of medical certainty that Remi's
19 HIE was due to hypoxia, low oxygen, and ischemia, low
20 perfusion, low blood?

21 A. At or around the time he was born, yes.

22 Q. Okay. That was going to be my next
23 question. I just want to make sure it's clear.

24 Looking at the full constellation of
25 markers, do you believe that it is consistent with

the evidence in this case that Remi's HIE occurred during the intrapartum phase, most notably the last several minutes of Sarah's second stage of labor?

A. Yes.

Q. And specifically is it your opinion, Dr. Kerzner, that Remi took, or Remi's injuries, became permanent and irreversible during that last half hour when he became Category III and tachycardic?

A. Yes. I believe that's when his reserve just pretty much gave up.

Q. Was the knockout?

A. That was the knockout.

Q. Thank you, Dr. Kerzner.

THE COURT: Thank you.

On behalf of the defendants?

MS. KAMYKOWSKI: Sorry, Your Honor.

CROSS-EXAMINATION.

BY MS. KAMYKOWSKI:

Q. Good afternoon, Dr. Kerzner. How are you?

A. Good. Thanks. How are you?

Q. I promise we're going to get you out of here so you're not going to be flying through -- well, you might have to fly over some tornados to get back, but we'll get you there.

I just want to make sure, this morning we

1 went through your CV. My understanding is that you
2 have kind of a pretty cool -- I don't know if it's
3 research or just a clinical interest -- that isn't
4 HIE, but it is on substance use disorder and its
5 effect of the neonate, right?

6 A. Yes.

7 Q. And you actually have done a lot of
8 outreach in your community there in Boston to help
9 mothers who might have substance use disorder maybe
10 help them figure how to transition. And when they
11 have a baby, those babies are doing well even though
12 they have a mother who's got some issues, correct?

13 A. Essentially, yes.

14 Q. Okay. But you've never written or
15 published or spoken specifically about hypoxic
16 ischemic injuries, the timing of them or any of the
17 opinions you have given here today, correct?

18 A. Not in lecture study, but day-to-day, yes.

19 Q. Okay. And this morning, Ms. Lenivy asked
20 you, I think that we joked you turned her down on a
21 case, right?

22 when you turned folks away in this realm
23 as a medical legal expert, that would mean she asked
24 you to evaluate, I presume, the standard of care from
25 a neonatology standpoint of a case, correct?

1 A. No, not necessarily.

2 So I'm asked to review, you know, it can
3 be causation, standard of care, can be a combination.

4 But after I review it, I may say that I
5 don't find any merit to the fact that whatever injury
6 or issue came is meritorious for a legal suit that
7 I'm going to participate in.

8 Q. The one that you turned her down, though,
9 was on a standard of care question?

10 A. I have no recollection of the actual case.

11 Q. Well, I think it sounded like you both
12 knew what you were talking about because you said she
13 didn't file the lawsuit so I presume that, as the
14 jury just heard, in Missouri, they have to have
15 someone like you provide merits, which is also a word
16 you used. So she was asking you to look for the
17 merits of a case. You turned her down on the merits
18 of a case potentially.

19 A. Yeah, I did. I'm sorry. I don't recall
20 the exact case.

21 Q. Let's -- I want to talk about, just to
22 make sure I understand what you told us at the very
23 end of your direct examination.

24 That Exhibit 350, which I know you have a
25 copy in front of you. It's in the range of 27

1 separate paragraphs, I think.

2 Do you have that there?

3 A. Oh, yes.

4 Q. And just to make sure. This is something
5 that you, in conjunction with Ms. Lenivy, the lawyers
6 for Remi, put together to help the jury kind of
7 distinctly see in one place what your opinions are
8 and what you based those on, correct?

9 A. These are all my comments that were then
10 put together by counsel, yes.

11 Q. Okay. And so, again, they start with No.
12 1, and they go through No. 27. And to the best of
13 your efforts, this is accurate and up-to-date and
14 complete of all the opinions you have in this case?

15 A. Yes.

16 Q. Okay. And that included all of the
17 records that you reviewed, the depositions that you
18 reviewed. I think you had a couple of photographs
19 that you saw. we talked about a couple of those.

20 And then generally you get to rely upon your own
21 personal training, education, and experience as a
22 neonatologist, correct?

23 A. Yes.

24 Q. Okay. So we didn't leave anything out.
25 Everything's in here.

1 A. Right.

2 Q. I want to talk just a little bit about
3 what your understanding was of the -- of Remi's
4 condition right after birth.

5 I think you told us that you were relying
6 on testimony, I thought I heard you say, that you
7 told the nurses -- the nurses said that he was tired.

8 what -- what evidence do you have that a
9 nurse had said under oath in this case that Remi was
10 tired after birth?

11 A. I believe I said that as part of parental
12 depositions, their testimony that the nurse said that
13 the baby was tired.

14 Q. So the -- and then anything about what was
15 said about Remi's condition would come from the
16 depositions of the parents that were taken as they
17 were representative of Remi in this lawsuit, correct?
18 Like they didn't contemporaneously keep any notes or
19 write anything down, it's all in the depositions for
20 this lawsuit?

21 A. Correct.

22 Q. Okay. There's no documentation in the
23 record that shortly after birth, no one was able to
24 weigh him properly, correct? That was one of the
25 things you told us in your deposition that you were

1 relying upon that they were -- you interpreted the
2 tiredness as lethargy, which is a medical term,
3 correct?

4 A. Yes.

5 Q. He was lethargic. And I think you even
6 said in your deposition if he wasn't able to be
7 properly awakened or aroused, that would be from the
8 parents -- correct? -- that's not in the record?

9 A. I believe so. But what is in the record
10 is that he couldn't suck and couldn't feed, so those
11 go together for me.

12 Q. It says he wasn't sucking and that he
13 wasn't -- well, we'll talk about this -- said that he
14 wasn't sucking and that he wasn't interested in
15 feeding, correct?

16 A. Correct.

17 Q. And that was at 8:00 p.m. and 8:30 p.m.,
18 as we saw on the flow sheet that Ms. Lenivy put up in
19 her direct, correct?

20 A. Correct.

21 Q. Okay. And then after that 8:30 that said
22 not sucking and not interested in feeding, the next
23 note is at 11:30, after the pediatrician was
24 contacted, his personal pediatrician, correct?

25 A. And he had only taken 3 mLs since the time

1 he was born, yes.

2 Q. And that was -- the pediatrician's
3 recommendation was not immediately send him to the
4 NICU, let's see if we can get him to eat, correct?

5 A. Correct.

6 Q. Okay. You would agree, Dr. Kerzner, that
7 not all newborns in that immediate couple of hours
8 after birth are encephalopathic, right?

9 A. Correct.

10 Q. Not all tired babies have encephalopathy?

11 A. Correct.

12 Q. And, in fact, in the newborn period,
13 babies can be -- we talked about this I think in your
14 deposition -- they can be tired. They can be quiet.
15 They can be hyperalert. They can be extremely
16 active. It's kind of variable how babies in this
17 transition period appear right after birth, correct?

18 A. So when you're talking about the few hours
19 after birth, all babies still should transition to
20 that normal flexion crying place.

21 And so then if they go on to being alert
22 and have a feeding and then sleep, that's more of
23 normal. But, in my opinion, he didn't get to that
24 point.

25 Q. And that would be -- that would happen in

1 the first couple of hours after birth, then?

2 A. well, he didn't have any period where he
3 perked up in the first several hours of life,
4 including eating through 11:30 at night.

5 Q. write that down. He didn't have any
6 period of time where he perked up for the first
7 several hours after birth, is that your --

8 A. For eating.

9 Q. okay. But no -- what other things could
10 he -- you're saying just because he didn't eat, he
11 didn't perk up? I'm confused about what you said.

12 A. So in -- what I understood is, when he got
13 to the room, he remained floppy, he wasn't feeding
14 well. He acted tired. The parents stated that he
15 was tired due to his long labor, or the mother's long
16 labor, and that he continued not to feed well, and he
17 was tachypneic.

18 Q. okay. You say to the room. I want to
19 make sure we know what we're talking about.

20 I have had a couple of babies, so I've
21 been through this process. You stay in the labor and
22 delivery room depending on what may have to happen to
23 you, the mother -- right? -- there's some things that
24 have to happen, a third stage of labor and some other
25 things.

1 Baby can get assessed, get his bath,
2 maybe, maybe not, that can happen at a variable time,
3 sometimes depending on the parents' preference,
4 right?

5 And then at some point, mom gets moved to
6 labor and delivery to postpartum or mother-baby.

7 Is that how it works in your hospital?

8 A. Yes.

9 Q. Okay. So when you said -- and do we know
10 what time frame? I want to know what we're talking
11 about here. To the room, when do you understand --
12 what room are we talking about and when?

13 A. So he was logged into the nursery at 1535,
14 so that tells me he left postpartum and somehow was
15 in the regular nursery about 1535, at least that was
16 when the first vital signs were done.

17 Q. In your hospital, do the newborn nursery
18 nurses not come to labor and delivery to assess a
19 baby?

20 A. They have. The labor and delivery nurses
21 do it.

22 Q. Okay. Do you have any testimony in this
23 case that says whether Remi actually physically on
24 his own by himself went to the newborn nursery?

25 A. No. When I say "normal nursery," that's

1 where they are on paper, but they're with the mother.

2 Q. Okay. That's what I thought. The newborn
3 nurses do that. Sorry. Until I wanted to sleep and
4 then I sent my kid to the nursery and had the nurses
5 take care of him so I could sleep.

6 But what you mean is labor and delivery,
7 the three Anyans are together. Whatever time Sarah
8 got transferred out of labor and delivery, whatever
9 time Remi got admitted to the newborn nursery, he's
10 not by himself like back in the old days where we
11 could go peek through the window and look at the baby
12 in the isolette.

13 A. Correct.

14 Q. All three of them moved to this other
15 postpartum mother-baby unit, and he stayed with his
16 parents.

17 A. Correct.

18 Q. That's your understanding.

19 A. Yes.

20 Q. Okay. And we don't know what time
21 specifically, but we were looking at a document that
22 a nurse from the newborn nursery documented vital
23 signs that we went through at 1535, so 5:35 p.m.,
24 right?

25 A. Yes.

1 Q. And as we said, I think that's an hour and
2 10 minutes after he was born, okay.

3 Going back to the breastfeeding issue. So
4 if you would agree, would you not, Dr. Kerzner, that
5 it's not uncommon for it to take time, sometimes for
6 both a new mom, like Sarah was, this was her first
7 baby, and a newborn to figure out how to connect and
8 how breastfeeding works, correct?

9 A. Yes.

10 Q. Okay. And hospitals have things like
11 lactation consultants for that very purpose. Because
12 it can be real frustrating, in your immediate
13 postpartum period, when your baby is freaking out at
14 your breast, and you are tired, maybe, you are
15 hormonal, all of those things.

16 So there are the nurses that can help
17 that, and there are lactation consultants
18 specifically for that very reason, correct?

19 A. Yes.

20 Q. And simply because a baby doesn't seem to
21 want to latch, doesn't seem interested in
22 breastfeeding, doesn't mean that he has a
23 neurological problem, correct?

24 A. In this context, this baby was not
25 interested in or able to suck and was inconsolable.

1 And so I'm putting those things together. Not every
2 case of a baby who won't latch has a neurologic
3 problem, that's true.

4 Q. He wasn't documented as inconsolable until
5 the nurse called Dr. Killian at 11:30, correct?
6 That's the first time a record uses those words to
7 describe him?

8 A. That's true.

9 Q. The eight o'clock and 8:30 is when they
10 were trying to get this thing to work for the first
11 time with Sarah and Remi, right?

12 A. The not even being interested, the baby
13 should at least be feeding by 4 to 5 hours. Even if
14 they're not latching well, they should be interested,
15 which means they should be alert enough because
16 they're getting hungry.

17 Q. And as far as the not -- not sucking, do
18 you believe that was a further sign he was
19 encephalopathic or had a neurological issue at that
20 time?

21 A. I believe that.

22 Q. And your opinion is he couldn't suck?

23 A. Nobody documented that he could. And they
24 documented that they wouldn't, so yes.

25 Q. And, in fact, when the nurse made her

1 note, she -- and Ms. Lenivy went through this with
2 you -- prior to the first eight o'clock documentation
3 that he wouldn't suck or didn't want to suck or
4 however it read, that previously he was alert and had
5 good latch.

6 Do you remember seeing that?

7 A. It said a brief latch, yes.

8 Q. okay. On this topic of labs and labs that
9 Ms. Lenivy spent some time going through with you
10 that I think the creatine she showed was -- went from
11 a higher level to a lower level over this span of I
12 think of a day about, you could go longer than that.

13 And we know we only had one data point for the liver
14 function, correct?

15 A. Yes.

16 Q. And that lactate, same thing: It started
17 and it trended down.

18 typically would you agree, Doctor, that if
19 you have an acute hypoxic event at or near the time
20 of delivery, you're going to initially see a rise in
21 those levels over the course of days?

22 A. No. Actually many times we do not see a
23 rise. We see -- and we don't know what they were at
24 first. So we would get them at 12, 24 hours. The
25 24-hour creatine was pretty high at 1.5 and then

1 trended down. we do not necessarily see a rise.

2 Q. well, we can't say -- you can't say that
3 from 4:24 on May 4th, until the first chem panel and
4 then the last they were drawn on May 5th and 6th,
5 whether or not they were already trending down, or if
6 there was a trend up, correct?

7 No one can say that because you don't have
8 that data.

9 A. we do have that data for -- for the
10 creatine, as a matter of fact. It started at 24
11 hours at 1.55. They did not take liver function
12 tests at that time, and they did not take lactate.

13 So given that day when they did, they were
14 downtrending it. It all follows that theory.

15 Q. More than -- but the first test was more
16 than 24 hours, correct?

17 A. The creatine is tested about 24 hours of
18 life.

19 Q. Okay. The imaging studies that we talked
20 about, the head ultrasound and the MRI, you would
21 agree that all Ms. Lenivy showed the jury was the
22 find -- the impression on the head ultrasound where
23 the findings talk about some technical difficulties
24 of that study.

25 Do you recall reviewing that?

1 A. Yes.

2 Q. Okay. And both of those studies not only
3 were concerning, I mean, that they were ordered by
4 the NICU team, a neonatologist at Mercy Hospital,
5 correct?

6 A. Yes.

7 Q. And they were ordered on May 6th, so two
8 days of life, not just because they thought he had an
9 HII, which is what you think in this case, but
10 because they were still concerned at that point,
11 despite already having done some workups, that there
12 was a possible infection, or there could have been a
13 metabolic or genetic component to his problems,
14 correct?

15 A. Sorry to make you ask it again, but could
16 you ask that again?

17 Q. Sure. The -- the ultrasound and the MRI
18 that were ordered on -- or I'm sorry -- the MRI that
19 was ordered on May 6th, had three indications,
20 correct?

21 A. Yes.

22 Q. Infection was still on the differential,
23 but they'd already done a pretty substantial workup
24 for infection at that time, right?

25 A. Yes.

1 Q. And genetic or metabolic components were
2 also still on the differential, correct?

3 A. Correct.

4 Q. And then hypoxic ischemia encephalopathy,
5 as well, right?

6 A. Yes.

7 Q. And you told Ms. Lenivy on direct that
8 genetics was not at all a part, or any part, of this
9 patient's, this baby's, hypoxic ischemia
10 encephalopathy, correct?

11 A. Nobody considered it in the newborn
12 screening as normal.

13 Q. Right. So nobody considered it at Mercy
14 Hospital. They didn't -- they could have ordered
15 genetic testing in his -- while he was there for the
16 length of time he was in the NICU, correct?

17 A. Actually, the WES is usually not covered
18 by insurance if you're inpatient, so you have to be
19 an outpatient to have that. Now, luckily, it's
20 changed, but at the time...

21 Q. And you're talking about -- the WES is the
22 whole exome sequencing, correct?

23 A. Correct.

24 Q. And that's a test that's either from
25 saliva or blood that can extract DNA that then can be

1 analyzed against controls that scientists way smarter
2 than me have been able to isolate various things.
3 If you've got a missing allele on Remi's
4 blood, and it matches up with something they've
5 already isolated in a previous test, then we've got a
6 match, and we can say, oh, my gosh, that might have
7 caused this. That's what they would be looking for,
8 correct?

9 A. So when you have an HIE that does not
10 follow the rules, so to speak, of you can't figure
11 out how this happened, then we have to look at other
12 things. And that's where they would get the genetic
13 testing and say, okay, we have an HIE. It's not
14 following all the other trends, the rules, the
15 picture, the puzzles, and that's when they would do
16 the genetic. So, to my knowledge, nobody in his
17 lifetime has considered genetics as an issue,
18 therefore, nobody has ordered it, his follow-up
19 neurologist, etcetera.

20 Q. And you were aware of that, based on your
21 review of Remi's records, before I took your
22 deposition, correct?

23 A. As what? I'm sorry.

24 Q. You were aware of the fact that no one had
25 considered or had further investigated a possible

1 genetic component of Remi's HII or HIE, based on your
2 review of the records, in advance of me taking your
3 deposition in October of 2023, correct?

4 A. Yes.

5 Q. Yet despite the fact that you knew from
6 the records that no provider had thought that maybe
7 we should investigate genetics, a couple months
8 before your depo, you sent Ms. Lenivy and her office
9 an email that said, hey, has there been genetic
10 testing, correct?

11 A. Correct.

12 Q. And the response was no, right?

13 A. Yes.

14 Q. But you had a question, at least as you
15 were preparing for your deposition, as to, well, I
16 didn't see it in the records, but has it been done?
17 That was what you were still asking about, correct?

18 A. Yes.

19 Q. Despite the fact that you had concluded
20 that the only possible cause of his injury was
21 asphyxia or hypoxia at or near the time of birth,
22 correct?

23 A. Correct.

24 Q. When you were talking about your
25 assessment of Apgar, and what we've already gone

1 through that, and that you maybe think it was a
2 little bit inflated by one point from the neonatal
3 nurse practitioner who assessed Remi right after
4 birth, you would agree that the photos upon which you
5 base your opinions that he was floppy are just a
6 snapshot in time -- correct? -- a single snapshot?

7 A. Yes, multiple, but, yes, snapshots.

8 Q. We don't have any videos of Remi at that
9 time, do we?

10 A. Correct.

11 Q. And we have what the parents described,
12 correct?

13 A. Which I have no reason not to believe.

14 Q. And we have what's in the medical record,
15 correct?

16 A. Yes.

17 Q. And the medical record is the realtime
18 documentation of a trained neonatal nurse
19 practitioner who was at the bedside at 4:20 -- prior
20 to and at 4:24 p.m., on May 4th, correct?

21 A. Yes. But she didn't document this for 45
22 minutes, so as I mentioned earlier, when we're doing
23 Apgars, we don't do it necessarily right away. So if
24 the baby was moving more by that time, she may not
25 have a hundred percent thought what was he doing

1 exactly at 5 minutes.

2 Q. well, I think the jury is going to hear
3 from her, so I think we'll know. You just -- and you
4 just disagree with her documentation, and I
5 understand that.

6 The committee opinions that we talked
7 about, and this is No. 420 --

8 MS. KAMYKOWSKI: And, Zack, I'm going to
9 need you to pull that up for me because I don't have
10 it in my notes.

11 Q. (By Ms. Kamykowski) And I want to go back
12 to page 2 where Ms. Lenivy started reading the
13 paragraph, but she didn't quite finish it.

14 And before -- and while Zack is doing
15 that, you would agree, would you not, Dr. Kerzner,
16 that the provider at the bedside is in the best
17 position to evaluate and assess the newborn and
18 provide Apgar scores?

19 A. with the exception that we've determined
20 that a couple of the points are subjective. And so
21 even two people at the bedside at the same time,
22 which I've had happen hundreds of time, what did you
23 think? what did you think? when it's subjective,
24 even we may disagree, and we're both physically at
25 the bedside.

1 Q. And it's important for the people at the
2 bedside to try to get, even those subjective parts,
3 as accurate as possible, because it could have
4 serious implications for a baby if a baby has signs
5 of neonatal encephalopathy, and they don't get the
6 option to have someone like you evaluate them for
7 head cooling, correct?

8 A. Yes. Except it's only one piece of the
9 puzzle. So we wouldn't leave it at just the Apgar
10 score. We would leave it as many other things, as
11 well. So it's not going to make or break, and I've
12 had many babies admitted to the NICU who we end up
13 cooling who had normal, quote/unquote, Apgar scores.

14 Q. And you would agree -- well, let me go
15 back. The jury has heard this -- but the highest
16 score that someone could get is a 10?

17 A. Yes.

18 Q. And I think you told us at your deposition
19 you've never heard of anyone getting a 10 until you
20 had a baby, and someone said your baby got a 10,
21 right?

22 A. Yeah. That was because she was breach,
23 her feet were straight up, and the pediatrician got
24 called at 3:00 a.m. in the middle of the night. It's
25 a 10. I'm like, it's not a 10. I can see her feet

1 from here. But, yes, technically the doctor, he gave
2 her a 10.

3 Q. which is why, when we look at this, even
4 though there's subjective components, 7 or greater is
5 considered normal and reassuring, right?

6 A. Depending on what the scores are for. And
7 when I say that, I mean if you still have a zero for
8 color, and that's why you have an 8 at 5 minutes.

9 You may still be just trying to perfuse. But if you
10 have low tone as part of your 7 or your 8, that's
11 something that we need to pay attention to until that
12 tone is normal.

13 Q. okay. so let's look at the time paragraph
14 here, the one that Ms. Lenivy had before that started
15 with the Apgar score --

16 MS. KAMYKOWSKI: Can you pull that out for
17 me, Zack? Thank you.

18 Q. (By Ms. Kamykowski) So we stopped at the
19 other factors -- right? -- that need to be considered
20 in diagnosing an intrapartum hypoxic event.

21 what we didn't read, though, is this next
22 one: when a Category I normal or a Category II

23 indeterminate fetal heart rate tracing is associated
24 with Apgar scores of 7 or higher at 5 minutes, a
25 normal umbilical arterial blood pH, plus or minus

1 standard deviation, or both, so it is -- that's
2 dysjunctive, correct?

3 A. Correct.

4 Q. That means you don't have to have a cord
5 blood gas. You can rely, based on this ACOG
6 committee bulletin, on an Apgar score of 7 or higher
7 at 5 minutes. It says: It is not consistent. It is
8 not consistent with an acute hypoxic ischemic event.

9 That's what it says, right?

10 A. So in this case --

11 Q. Hold on. Can you just answer my question
12 first?

13 A. That's what it is.

14 Q. That is what it says, right?

15 A. Yes.

16 Q. Okay. Thank you so much.

17 You would agree, would you not, Dr.

18 kerzner, that there's no test that anybody like you
19 or an MFM or an OB can use to diagnose an HIE or
20 cerebral palsy in utero, correct?

21 A. In utero?

22 Q. Yeah.

23 A. Correct.

24 Q. You can't do an ultrasound and say like
25 you can find, you know, other abnormalities of

1 somebody's heart or their stomach or their bowels or
2 their feet? There's nothing that anybody could do to
3 say the baby does or does not have cerebral palsy
4 before their birth, correct?

5 A. Cerebral palsy, it does not occur before
6 you're born, just so we're clear.

7 Q. Let me rephrase.

8 A. If you're talking the HIE.

9 Q. Yeah. So before -- before labor, or in
10 the early -- before second stage of labor, there's no
11 test that any provider can do that could rule in or
12 rule out that a baby has or does not have a hypoxic
13 ischemic injury, correct?

14 A. It depends on the type of injury. If it's
15 just a stroke, if it's global like that, the baby
16 will have signs on their fetal heart tracing of some
17 type of stress and will have signs after they're
18 born. They're not going to have an HIE and not have
19 any signs at some point.

20 Q. And most cases of cerebral palsy have no
21 known cause, correct?

22 A. True.

23 Q. And meaning that most cases of cerebral
24 palsy then can't be associated with labor and
25 delivery, correct?

1 A. True.

2 Q. And I wrote down -- and I just want to be
3 sure that we're not arguing about what you meant
4 later. Because this trial is going to go on for many
5 days after you're no longer here for us to consult,
6 okay?

7 You used the term "at or around the time
8 of birth." And then I think, as far as when Remi's
9 injury occurred in this case, and I want to make sure
10 at or around can be -- is it minutes? Is it hours?
11 Is it days?

12 And it sounds to me like, based on the
13 last two questions that Ms. Lenivy asked you, that
14 for Dr. Kerzner, at or around the time of birth, as
15 far as the timing of Remi's injury, was that his
16 injury occurred in the last several minutes of Sarah
17 Anyan's labor; is that true?

18 A. Yeah. And I think I testified after that
19 1557 time period.

20 Q. Thank you. That's all the questions that
21 I have.

22 THE COURT: Mr. Willman?

23 MR. WILLMAN: Yes. Thank you, Judge.

24 CROSS-EXAMINATION

25 BY MR. WILLMAN:

1 Q. Good afternoon, Doctor. My name is Phil
2 willman. You and I have not had the pleasure of
3 meeting before today, but I do have some follow-up
4 questions. And I'm here for Dr. McNeive.

5 A. Thank you.

6 Q. First of all, so it's clear for the jury,
7 you are not making any criticisms of Dr. McNeive's
8 decisionmaking, are you?

9 A. Correct.

10 Q. And specifically you're not making any
11 criticisms of his decisions with respect to the cord
12 gases, true?

13 A. Correct.

14 Q. And with respect to the cord gases, that's
15 something that any member of the NICU team could have
16 asked for, correct?

17 A. I believe I said in the most common case,
18 the obstetrician knows that this has been a tough
19 delivery and says, hey, do you want a gas? And
20 that's when I say yes or no. But it generally comes
21 from the obstetrician asking us if we would like a
22 gas.

23 Q. But that request, and that interest in
24 getting that gas, can come from any member of the
25 NICU team, fair?

A. Yes.

Q. Okay. Will you agree that the Apgar score needs to be correct?

A. Yes.

Q. And this case, you believe it was a 7, not an 8. But that -- otherwise, that's a correct number in your view is a 7, correct?

A. Yes.

Q. And you are aware of the ACOG guidelines with respect to the use of Apgar scores, right?

A. Yes.

Q. And those guidelines say that they only recommend, this college of OBs throughout the country, they only recommend obtaining cord gases with a 5-minute Apgar score of 5 or below, right?

A. Yeah. I believe I talked about that earlier, that that may be on the paper, but in real life, because if we have a baby who needed resuscitation with that type of history, we want to know if we do need to cool or not and what we have to do, so we don't only get a cord gas with less than 5.

Q. But this is the guidance that this community of obstetricians are giving to the members of their community, fair?

A. And that's why I'm not criticizing of his

1 not ordering it. But I'm stating that in realtime,
2 we would have asked for a cord gas in this case.

3 Q. And it was appropriate for Dr. McNeive and
4 other caregivers to rely on the Apgar score for
5 making decisions into the future, agreed?

6 A. I can't really speak to what obstetricians
7 might...

8 Q. All right. Let me then ask about the
9 NICU.

10 It's appropriate for them to rely on the
11 results of the Apgar scores in terms of
12 decisionmaking?

13 A. That is a piece of it, but as I said, it
14 depends on the actual score itself. And when we
15 still have low tone or abnormal reflexes on that
16 5-minute score, we need to keep monitoring it and
17 seeing what's going on with that baby. So the score
18 is one thing, how it's made up is actually very
19 critical.

20 Q. And you know that a Nurse Spencer Younger
21 is the one who scored that, the Apgar score?

22 A. Yes.

23 Q. And you have no reason to believe that she
24 was not competent to be doing that procedure; is that
25 right?

1 A. Correct.

2 Q. Okay. Are you familiar with the National
3 Resuscitation Program?

4 A. Yes.

5 Q. It's a reliable source of information in
6 your field?

7 A. Yes.

8 Q. Can you quantify the difference in the
9 outcome if cooling had occurred?

10 A. Quantify?

11 Q. Yes.

12 A. We know that there's something around the
13 20 to 30 percent reduction in the morbidity.

14 Q. All right. Now, you told us that you did
15 refuse a case that Ms. Lenivy sent to you, is that
16 right?

17 A. Say that again.

18 Q. I'm sorry.

19 A. No, I -- I didn't refuse it. I did a full
20 review --

21 Q. I apologize. Bad question.

22 A. -- and then determined that I didn't feel
23 it was viable.

24 Q. Right.

25 A. Sorry.

1 Q. So you looked at a case, you said, I can't
2 help you. There's no merit to what the claim is that
3 you think is going to be made, is that right?

4 A. Correct.

5 Q. Is there another case, though, besides
6 this one, where you have found merit?

7 A. With -- with --

8 Q. With respect to Ms. Lenivy?

9 A. No.

10 Q. This is the only one that you have with
11 her right now?

12 A. Yes.

13 Q. Okay. Thank you. That's all I have.

14 THE COURT: Thank you.

15 Any redirect?

16 MS. LENIVY: Very briefly, Your Honor.

17 REDIRECT EXAMINATION

18 BY MS. LENIVY:

19 Q. Dr. Kerzner, a couple of questions came up
20 on cross-examination.

21 First, you're not critical of Dr.

22 McNeive -- you're not an obstetrician, correct?

23 A. Correct.

24 Q. That's what this morning Dr. Warsof, who
25 is a member of the same profession as Dr. McNeive,

that's what he was here to testify about, correct?

A. True.

Q. All right. You're here to focus on causation.

A. Right. why it happened, yes.

Q. why and when it happened, right?

A. Yes.

Q. Ms. Kamykowski brought up the head ultrasound, and you read that head ultrasound at 16 hours of life. You read that report, correct?

A. Yes.

Q. Was there any indication in there that the head ultrasound was of such poor quality, it needed to be repeated?

A. No. They were able to state the ventricles looked normal. And when the ventricles look normal, and they're not called slit-like, there's usually not a lot of swelling there. That's how I read that.

Q. Okay. The head ultrasound, it didn't say that it was of such poor quality that it was undiagnostic, correct?

A. That I recall, no.

Q. Okay. In fact, I think it was Dr. Applewhite, who is a board certified radiologist with

1 Mercy, he's the one who read that head ultrasound,
2 correct?

3 MS. KAMYKOWSKI: I'm going to object to
4 the leading form of that question in that it
5 mischaracterizes -- it has no basis of fact, Your
6 Honor.

7 THE COURT: why don't you rephrase the
8 question.

9 Q. (By Ms. Lenivy) The Mercy radiologist --

10 MS. KAMYKOWSKI: No, Your Honor. May we
11 approach?

12 (The following proceedings were held at
13 sidebar, outside the hearing of the jury:)

14 MS. KAMYKOWSKI: If she would not imply
15 referencing Dr. Applewhite as a Mercy radiologist.
16 There is zero evidence in this case that Dr.
17 Applewhite is a Mercy radiologist. In fact, they
18 know, and we have told them, the radiologists, like
19 the neonatologist group, are contracted out. They
20 are not Mercy employees. And to imply to this jury
21 that there is someone out there that is mine that I
22 am responsible for, I would ask that the jury
23 disregard that question and that Ms. Lenivy ask the
24 question in a way that doesn't implicate Mercy.

25 MS. LENIVY: I can rephrase it.

1 THE COURT: Okay. I will order the jury
2 to disregard.

3 MS. KAMYKOWSKI: Thank you.

4 (Proceedings returned to open court.)

5 THE COURT: Ladies and gentlemen of the
6 jury, please disregard that previous question.

7 Q. (By Ms. Lenivy) Dr. Kerzner, the
8 radiologist, who read Remi's 6-hour head ultrasound,
9 did he indicate if the head ultrasound was normal?

10 A. He indicated that there was a small
11 resolving germinal matrix hemorrhage or subependymal
12 cyst.

13 Q. But no edema or swelling, correct?

14 A. Correct.

15 Q. Okay. You were asked about genetic
16 testing. And initially, when we were preparing for
17 this case, you did reach out to me just to inquire
18 about whether any had been done, correct?

19 A. Correct.

20 Q. Do you feel confident in your opinion
21 today that Remi's HIE is not from an underlying
22 genetic cause?

23 A. Yeah. An underlying genetic cause has a
24 very different look to it. It's usually progressive.
25 where this is kind of static. Once the injury has

1 occurred, it's occurred. After this latency phase
2 things kind of stabilized. But in a genetic
3 condition, if you have a rare deficiency, it's going
4 to continue to get worse and worse, and they often
5 die early on in childhood.

6 Q. I think you used a phrase in your
7 deposition, zebra in the medicine. Something like
8 that?

9 A. Yes.

10 Q. What does that mean?

11 A. Well, it just means what common things
12 occur commonly, and unusual things are called zebras.
13 So if you can't figure out what something is
14 commonly, then you try to go down the list of what
15 else could this be.

16 Q. Okay. And none of Remi's treating
17 providers have sent him out for genetic testing,
18 correct?

19 A. Correct.

20 Q. And has his condition remained relatively
21 static?

22 A. Yes.

23 Q. Okay. We talked about, and Ms. Kamykowski
24 brought back up, Exhibit 420.

25 MS. LENIVY: Zack, can I have that?

1 Q. (By Ms. Lenivy) This is that ACOG
2 committee opinion. And why don't we go back to this
3 paragraph.

4 MS. LENIVY: You knew where I was going,
5 Bud.

6 Q. (By Ms. Lenivy) And Ms. Kamykowski read
7 to you: when a Category I normal or Category II
8 indeterminate fetal heart rate tracing is associated
9 with Apgar scores of 7 or 8 higher at 5 minutes. I'm
10 going to stop there.

11 Okay. In Remi's case, did we have
12 Category III tracings?

13 A. Yes.

14 Q. So this -- does this paragraph at all
15 mention what happens when we have Category III
16 tracing?

17 A. No.

18 Q. Okay. It only says when we have Cat I,
19 normal; Cat II, indeterminate, associated with an
20 Apgar score of 7 or higher, it's my understanding you
21 think at most this was a 7, correct?

22 A. Correct.

23 Q. What if this jury thinks it's a 6 or
24 lower?

25 MS. KAMYKOWSKI: Objection, Your Honor.

1 May we approach?

2 THE COURT: You may.

3 (Proceedings were held at sidebar, outside
4 the hearing of the jury.)

5 MS. KAMYKOWSKI: This witness testified
6 clearly in her deposition that the only discrepancy
7 with the Apgar would be her opinion it was a 7. She
8 has never given the opinion that it was a 6. A
9 hypothetical asking her now is beginning to elicit a
10 new opinion at trial. That is improper and should be
11 excluded.

12 MS. LENIVY: Your Honor, I'm going to ask
13 if she thinks it was 6. I'm not asking her that.
14 But at most it should have been a 7. There is other
15 evidence in this case that going to, we believe,
16 provide the jury that at most this was a 6. There's
17 other evidence. And I'm not going to get into that
18 with Dr. Kerzner.

19 But Ms. Kamykowski has asked, she has made
20 this paragraph in Exhibit 420 seem like it is this
21 a -- is what the evidence is, and this is what must
22 be followed. This is it. So I am asking similarly
23 just as I just did Category I and Category II. We
24 have Category III. This seems to be disregarded.

25 similarly, if the jury does get to 6, the

1 lower, this can be disregarded, but I'm not going to
2 ask her if she thinks this is 6. This was opened on
3 cross-examination, and I was addressing it in
4 redirect.

5 THE COURT: The jury does not have the
6 ability to say -- to determine an Apgar score. That
7 is not within their power, their capabilities, their
8 education, their experience. So to ask what if the
9 jury thinks it's a 6, is to give them power they do
10 not have.

11 MS. SLATER: Your honor, may I please ask?

12 THE COURT: You may.

13 MS. SLATER: Nurse Shinn testified the
14 other day that it was her opinion that she gave one
15 off for respiration. Today Dr. Kerzner testified
16 that she gave one off for tone. That is 2 under the
17 8 Apgar score from which the Jury has evidence that
18 they could believe that both Shinn and Kerzner was a
19 6. There is evidence in front of this jury as we
20 stand here that it could be a 6 and --

21 THE COURT: I restate the fact that the
22 jury does not have the education, the capacity, and
23 the ability to determine the Apgar score. They have
24 the ability to determine the information of the
25 experts and whether or not they believe or disbelieve

the testimony of the experts.

MS. SLATER: So is my objection sustained, Your Honor?

THE COURT: Yes.

MS. SLATER: All right. And can you ask the jury to disregard the question?

THE COURT: Yes.

MS. SLATER: Thank you.

(Proceedings returned to open court.)

MS. KAMYKOWSKI: The jury will disregard that previous question.

MS. LENIVY: Zack, can you pull up 420 again.

Q. (By Ms. Lenivy) All right. Let's get to the sentence reflected here: Fetal heart rate tracings associated with Apgar scores of 7 or higher at 5 minutes, a normal umbilical cord arterial blood gauge or both, is not consistent with an acute hypoxic ischemic event.

You started an answer with Ms. Kamykowski when she asked you if she had read that correctly, and you said 7 or 8, and it sounded like you were getting ready to give an explanation, and then Ms. kamykowski moved on.

I was hoping, Dr. Kerzner, was there some

1 explanation you wanted to provide to put that
2 sentence into context in this case?

3 A. So, again, taking all of the puzzle pieces
4 together, an Apgar score of 7, does not rule out that
5 you cannot have HIE, based on all of other puzzle
6 pieces.

7 It's like if you were putting a puzzle
8 together of a dog, and you're missing one of the
9 paws, maybe that's the Apgar score in this case.

10 You can still see the puzzle of the dog,
11 you just don't have the paw. So if you didn't have
12 the paw, and you didn't have the nose, you didn't
13 have the tail, you didn't have the midsection, if you
14 didn't have anything else, then you couldn't say to a
15 reasonable degree of medical certainty that this
16 occurred during the labor process, but I think we
17 have enough. And that was what I was going to say
18 that the Apgar score alone, particularly because part
19 of it is subjective, should not be the reason that we
20 don't have our answer, which I feel we do.

21 Q. Okay. Thank you.

22 You talked about the Apgar score is
23 subjective.

24 Are there objective measurements that can
25 help diagnose an HIE that are listed in this

1 paragraph?

2 MS. KAMYKOWSKI: Your Honor, I would
3 object that this now repetitive, and I think we went
4 over this most of the day today already.

5 THE COURT: Overruled.

6 A. The cord gases we've talked about already.

7 Q. (By Ms. Lenivy) I'm going to wrap up
8 here, Dr. Kerzner.

9 Ms. Kamykowski asked you a question of
10 most cases of HIE, we don't know the cause.

11 That's fair, correct?

12 A. I think she said most cases of CP.

13 Q. Oh, CP. I'm sorry.

14 But, however, Dr. Kerzner, based on the
15 evidence in this case, that constellation of markers
16 that we have spent a lot of time reviewing, do you
17 feel confident to a reasonable degree of medical

18 certainty that we do in fact know the cause of Remi's
19 HIE which caused his CP?

20 A. Yes.

21 Q. And is that cause hypoxia and ischemia?

22 A. Yes.

23 Q. During the second stage of Sarah Anyan's
24 labor?

25 A. Yes.

Q. Thank you, Dr. Kerzner.

MS. KAMYKOWSKI: Nothing further, Your Honor.

MR. WILLMAN: Nothing.

Thank you, Judge.

MS. LENIVY: Safe travels, Doctor.

THE WITNESS: Thank you.

THE COURT: Thank you very much. You may be excused.

THE WITNESS: Thank you.

THE COURT: All right. Is this a good time for us to maybe take a short recess?

MS. GUNN: Yes, Your Honor.

(At 1:53 p.m., the Court duly admonished the jury, and proceedings stood in recess. At 2:06 p.m., the following proceedings were held in open court, in the presence of the jury:)

THE COURT: Go ahead and be seated, everyone.

On behalf of the plaintiff, you may call your next witness.

MS. SLATER: Yes, Your Honor, plaintiff calls Alex Greenwald, R.N., by video deposition. The video deposition was taken on May 2nd, 2023, and the runtime is 43 minutes.

1 THE COURT: Thank you.

2 (Designated portions of the videotaped
3 deposition of Alex Greenwald, R.N., were played for
4 the jury. During which time, at 2:22 p.m., the
5 following proceedings were held at sidebar:)

6 MS. KAMYKOWSKI: That Exhibit 525 had some
7 writing from somebody from Ms. Gunn's -- Ms. Lenivy's
8 office that we previously took the "yes" out. This
9 exhibit had been used, I think it was marked by
10 someone from their office at the very beginning, and
11 then unfortunately was what he used throughout these
12 depositions.

13 I didn't know before and I apologize
14 profusely. When we got to the break, I didn't
15 realize they were going to show the way this was
16 going to come out. This exhibit was getting very
17 close to the first page, at 9:30 someone from their
18 office has appeared to have written the word "bad" on
19 it, and it has not been redacted.

20 I don't -- we were trying to see if we
21 could work it out without having this word on it, but
22 I don't think that was something they could do on the
23 fly. At this point, I would object to continuing to
24 play this video. Either they play the video on its
25 own without the exhibit contemporaneously showing, or

1 they do the redaction to the court order to this
2 exhibit previously.

3 MS. GUNN: The best I can do, since the
4 objection came after the video was played, but I
5 think that that's the best we can do is maybe have
6 the audio player in the 15 seconds or whatever that
7 the exhibit is shown, but I don't think he can hold
8 it to a part in real-time, but I think he can maybe
9 have the audio playing.

10 MS. KAMYKOWSKI: And take that video down
11 altogether?

12 MS. GUNN: while the audio is playing.

13 MS. KAMYKOWSKI: If that's the workaround.

14 MS. GUNN: I mean, we can just hold the
15 paper over it on the video.

16 MS. KAMYKOWSKI: well, it's the first page
17 of 9:30, someone wrote "bad," and that obviously
18 can't come into the case. It's not being supported
19 by anybody who's under oath.

20 THE COURT: Understood.

21 MS. KAMYKOWSKI: I think if that can be
22 done --

23 MS. GUNN: I just need a second to talk to
24 them.

25 MS. KAMYKOWSKI: Thank you, Judge. I'm

1 sorry.

2 THE COURT: Okay.

3 MS. GUNN: Technology.

4 (Designated portions of the videotaped
5 deposition of Alex Greenwald, R.N., were resumed and
6 played for the jury.)

7 MS. SLATER: That concludes the deposition
8 of Alex Greenwald.

9 THE COURT: You may call your next
10 witness.

11 MS. SLATER: Yes, Your Honor. Plaintiff
12 calls again a video deposition of Mary Spencer, nurse
13 practitioner now, Mary Younger.

14 This video deposition was taken on April
15 28th of 2023. I believe the cut is going to be about
16 40 minutes.

17 Thank you, Your Honor.

18 THE COURT: Thank you.

19 (The designated portions of the videotaped
20 deposition of Mary Spencer Younger, R.N., were played
21 for the jury.)

22 MS. SLATER: That concludes the video for
23 today.

24 THE COURT: All right. Ladies and
25 gentlemen, it's my understanding that we are on

1 track, and based on the timing, I will go ahead and
2 give us our weekend recess.

3 (At 3:41 p.m., the jury, being duly
4 admonished by the Court, by agreement, is allowed to
5 separate for the evening, under the usual
6 instructions of the Court, until Monday, March 17th,
7 2025, at 9:00 a.m., and the following proceedings
8 were held in open court, outside the presence of the
9 jury:)

10 THE COURT: Are we ready?

11 MS. SLATER: These are all stipulation
12 copies that we provided to defense counsel.

13 THE COURT: Thank you.

14 MS. SLATER: And the intention is to enter
15 a joint stipulation with both amounts on it as to the
16 medical records and bills.

17 THE COURT: Okay. We are here on the
18 record outside the presence of the jury.

19 On behalf of the defendant, Mercy
20 Hospitals, there is an issue that you wanted to
21 address?

22 MS. PFIRMAN: Yes. Thank you, Your
23 Honor.

24 Prior to the pretrial conference in this
25 case, we had filed defendants' objections to

1 plaintiffs' medical billing records affidavits and
2 motions to exclude the same. That was related to
3 Exhibits 9, 10, and 24 that were filed by the
4 plaintiffs.

5 Specifically our objection relates to
6 Missouri Statute 490.525, which requires that an
7 affidavit -- that the amount a person is charged for
8 a service was reasonable at the time and place that
9 the service was provided, and that the service was
10 necessary as sufficient evidence to support a finding
11 of fact by the judge or jury that the amount charged
12 was reasonable or that that service was necessary.

13 I can hand you a copy of the statute if
14 you'd like.

15 But our issue with Exhibits 9, 10, and 24,
16 Your Honor, is that it doesn't contain that language
17 in the affidavit that the amounts -- it doesn't
18 contain that reasonable and necessary language that
19 the statute requires.

20 And then additionally we have an objection
21 to Exhibit 42 that was filed by the plaintiffs with
22 regards to billing records. And our issue with that
23 is that it was filed after the 30 days as required
24 under the same statute. If you look under No. 4, the
25 party offering that affidavit and the evidence for

1 the parties' attorneys shall file the affidavit with
2 the clerk of the court and serve a copy of the
3 affidavit at least 30 days before the day on which
4 evidence is first presented at the trial of this
5 case.

6 And with regard to Exhibit 42, that was
7 filed by the plaintiffs on --

8 MS. SLATER: February 26th.

9 MS. PFIRMAN: February 26th, which was
10 less than 30 days prior to the start of the file.

11 THE COURT: Can I look at a copy of the
12 affidavit?

13 MS. PFIRMAN: Sure.

14 MS. SLATER: The supplemental file?

15 THE COURT: No, the actual affidavit.

16 MS. PFIRMAN: For 42? would you also
17 like 9, 10, and 24?

18 THE COURT: whichever ones you're
19 objecting to.

20 MS. PFIRMAN: Sure.

21 THE COURT: Response?

22 MS. SLATER: Your Honor, there's three
23 reasons why these affidavits -- I'm going to take up
24 the affidavit issues.

25 The position is that the affidavit issues

1 on Exhibit 9, 10, and 24 first. These records are,
2 Exhibit 9 is, St. Louis Children's Hospital records.
3 Exhibit 10 is St. Louis Children's Hospital records.
4 And Exhibit 24 are records from First Steps.

5 when we request these records from the
6 providers, we send them an affidavit that is
7 compliant with the language of 490.525. And it
8 includes the reasonable and necessary language. We
9 get back a different affidavit that leaves out that
10 language.

11 As you know, the procedure in the statute
12 is there's a rebuttal presumption if the affidavit
13 says reasonable and necessary. If there is no -- and
14 then the procedure that we would usually do is bring
15 in the custodian of records to testify that these
16 bills were made in the course of business and were
17 reasonable and necessary and confirm the charges.

18 And then it would be on defendants to
19 provide affidavits to the contrary.

20 often parties agree to stipulate to these
21 amounts so we can forego deposing the custodian of
22 records from every provider who has charged and
23 billed this child. That's what we were led to
24 believe was the procedure we've been doing here.
25 otherwise, we of course would just subpoena the

1 custodian of records to testify in front of this jury
2 about the reasonable and necessary charges in these
3 three affidavits.

4 Going forward, they are -- there are
5 reasons these bills should be admitted as reasonable
6 and necessary. And there's a couple of respects for
7 that. First, I cite the Briggs v. Baker case, at
8 631 S.W.2d 948. And this stands for the proposition
9 that recognizing that there is substantial evidence
10 that charges of the services when they are charged
11 and paid for show that they were reasonable and
12 necessary at the time.

13 These charges involved payments on all of
14 the records that were produced with the affidavit and
15 adjustments by the insurance companies. So if we
16 read these records, and under Briggs v. Baker,
17 because these charges were accepted and paid by
18 multiple different sources, they are deemed
19 reasonable and necessary.

20 On top of that, we have heard substantial
21 evidence thus far, and will continue to hear
22 evidence, in plaintiffs' case, that Remi Anyan was
23 born with a global brain injury they affects every
24 part of his personhood.

25 So to say that these bills charged by St.

1 Louis Children's Hospital and First Steps, which are
2 required and connected with his HIE diagnosis are not
3 reasonable and necessary, would be against the weight
4 of the evidence.

5 with response to the -- I'd like to talk
6 about 42. I'm looking at you to see if you have any
7 questions for me on that.

8 THE COURT: No. No. Go ahead.

9 MS. SLATER: With regard to affidavit 42,
10 we filed a certificate of filing within the 30 days.
11 I can hand that to you. Plaintiffs filed their
12 original certificate of filing on February 7th and
13 listed all their medical records and bills affidavits
14 in that filing.

15 And then we supplemented, on
16 February 26th, that filing with the records from Wash
17 U in Exhibit 42. Those records, the affidavit, is
18 signed by Washington University on February 20th,
19 2025.

20 And they were provided to us, and we
21 received them, supplemented our affidavits
22 immediately with the Court. So it is very common
23 that once we file our initial filings, we may need to
24 supplement them, and of course these were records
25 that were received and promptly supplemented to the

1 Court. So we ask that those be admitted, as well,
2 over objection.

3 THE COURT: Response?

4 MS. PFIRMAN: Sure. Just briefly, Your
5 Honor.

6 This is a filing that was filed within the
7 30 days, did not include Exhibit 42. So we would
8 suggest that that was filed out of time.

9 with regard to coming to an agreement on a
10 stipulation so that custodians of records don't have
11 to be deposed, there was no request for any
12 stipulation prior to the 30 days. We just received
13 the stipulation as to the medical bills a couple of
14 days ago.

15 And then as far as evidence of payment --
16 well, strike that. Evidence of payment can be
17 evidence that the charges are reasonable, but what
18 they're asking is for you to also include in that
19 stipulation the charged amounts, which would be
20 improper when these affidavits don't comply with the
21 statute.

22 THE COURT: So with regards to the
23 Missouri affidavits that were filed prior to the time
24 pursuant to Section 490.525, the Court is going to
25 deny the motion. With regards to the Washington

1 University, Exhibit 42, I'm guessing you're going to
2 be sending a subpoena out, and we're going to be
3 having a custodian of records testifying at trial.

4 MS. SLATER: That would be our next
5 procedure, if they do not withdraw their objection on
6 that -- those ones being filed.

7 THE COURT: Yeah. I think that's what
8 we're going to have to do.

9 MS. KAMYKOWSKI: Your Honor, just so I
10 might object for the record.

11 THE COURT: Sure.

12 MS. KAMYKOWSKI: Because we have Brancati
13 out there, as you know.

14 THE COURT: I do.

15 MS. KAMYKOWSKI: I think how this came
16 about is that we have a new modified collateral
17 source rule that is 490.715 that relates to 490.525,
18 which is the affidavit statute that sets forth what
19 we just talked about.

20 And because we have those two in
21 conjunction, it's not for the rebuttal of presumption
22 anymore. That's what has changed under the law.

23 490.715 says that the evidence of what is paid, the
24 amount paid to satisfy, is what's a reasonable
25 amount. And the defense's position has been, since

1 that codification of the modified collateral source,
2 then that's the only amount that comes in.

3 Because we then have 490.525 at play, I
4 think those are the two issues that Brancati talked
5 about, and we would suggest that 490.715 control.

6 And the amount that only comes in, is the amount
7 paid. And we would stipulate to amounts paid for any
8 of the treatment.

9 what we're talking about is amounts
10 charged. And that's where the procedure and the time
11 line within 490.525 becomes important because the
12 plaintiff didn't do it timely.

13 That's the defense's position. But we are
14 not trying to eliminate the numbers altogether,
15 absent the Children's Hospital Exhibit 42, I believe,
16 but the other ones, we would stipulate to those
17 numbers coming in as the paid amounts. So that's the
18 distinction.

19 MS. SLATER: Your Honor, let me clarify
20 that.

21 on 42, their objection is not that the
22 affidavit is insufficient. It's only that it's late
23 in file. And if you read the statute, the
24 requirement for plaintiffs is to file the affidavit
25 30 days before. And then that, you know, that we've

1 met our burden under that statute.

2 As I showed you, these were received by
3 our office, and we continually are requesting updated
4 records. These ones came in after the 30 days, which
5 is why we supplemented with that affidavit.

6 A party that's looking to controvert a
7 claim in an affidavit -- and I'm reading from the
8 statute -- shall file a counteraffidavit with the
9 clerk of the court and serve a copy of the
10 counteraffidavit on the parties. And that says no
11 later than 30 days after the day they receive a copy
12 of the affidavit, and at least 14 days before trial,
13 or with leave of court at any time before the
14 commencement of evidence at trial.

15 So my understanding of the objection is
16 that these, by necessity, were supplemented and filed
17 late. They don't have time to file counter
18 affidavits unless the Court gives them leave or
19 shortens time.

20 So bringing in a custodian of records
21 would be saying the same thing that's on the
22 affidavit. And we are happy to do it that way if we
23 need to put evidence and not -- and plaintiff not
24 rely on this procedure in the statute.

25 MS. KAMYKOWSKI: And just to respond to

1 that.

2 If they correlate that affidavit to the
3 bills that were produced, it is for care that was
4 well before the 30-day deadline.

5 so, again, it's not that it happened to be
6 that he went to the doctor on day 29, and they
7 weren't able to get a charged amount, a paid amount,
8 of bills. This is just something that could --
9 should have been done for plaintiff to meet their
10 burden of proof on this stuff well in advance of
11 trial, and it wasn't done.

12 THE COURT: I believe, based on the timing
13 of it being filed, the appropriate workaround is to
14 bring in the custodian of records and have them
15 testify with regards to the issue of paid versus
16 charged.

17 MS. SLATER: Thank you, Your Honor.

18 MS. PFIRMAN: Thank you, Judge.

19 MS. KAMYKOWSKI: Thank you, Judge. Have a
20 great weekend.

21 THE COURT: You, too.

22 (At 3:57 p.m., Court stood in
23 adjournment.)

24 o o o

25 Monday, March 17, 2025

1 o o o

2 (At 8:58 a.m., the following proceedings
3 were held in open court, outside the presence of the
4 jury:)

5 THE COURT: I understand we have a couple
6 of things to put on the record.

7 MR. PERRON: Yes, Your Honor.

8 In terms of timing, it's our understanding
9 that they're going to play Dr. Liles today, so we've
10 got a couple of things pertinent to that. I know
11 we're short on time, but I'll defer to the Court.
12 There's one thing that I apologize. We wrote it over
13 the weekend, but through the filings, they didn't get
14 onto Case.net until this morning.

15 But it's pertinent to Mr. and Mrs. Anyan's
16 testimony, just soliciting the testimony of
17 noneconomic damages beyond the noneconomic damages
18 pertinent to the actual named plaintiff. So we can
19 take up all of them or just the ones pertinent to
20 Mr. Anyan, just to stay on track with timing, but...

21 THE COURT: well, I think that the one
22 depo still needs to be finished they've cut. So why
23 don't we address that -- the issue.

24 MR. PERRON: Okay. Your Honor, sort of
25 taking one bite at a time. Last Sunday night or

1 Monday morning, we filed a motion for sanctions
2 regarding Dr. Liles' trial testimony. Just to give
3 the background facts, we deposed Dr. Liles in 2023.

4 At that time, I asked Dr. Liles, who had
5 examined Remi and spoken with the parents, if he
6 intended to do any simple mental exam before his
7 trial testimony, and he said, No, I don't have any
8 such intention unless the attorneys ask me to, in
9 which case I certainly will.

10 In preparing our cross, we relied, at
11 least in part, on that representation in his
12 deposition that when, you know, we were reviewing the
13 pertinent medical records and preparing our
14 questions, that he wasn't going to have any more
15 updated information than what we had in 2023.

16 we've learned that around 4:00 p.m., on
17 Sunday, just 2 hours before, it could have been -- it
18 could have been a little bit more than 2 hours, but
19 not more than 2 hours before Dr. Liles was scheduled
20 to start his deposition, we learned that he had, the
21 previous afternoon and evening, a new video
22 conference with the parents, and also, in that same
23 email, it included several pages of notes that
24 Dr. Liles had produced.

25 To just take it in two parts. Number one,

1 we had a previously filed motion in limine to exclude
2 any undisclosed new opinions or new bases for
3 opinions. And the reason that we always add "or new
4 bases for opinions" is of course so you don't have to
5 change your opinion to have some new undisclosed
6 support for that opinion.

7 And just to use sort of a metaphor, if I
8 depose an expert, and he says, well, I've got this
9 opinion out, but the foundation of that opinion is,
10 you know -- you know, a line of straw, and I prepare
11 my cross-examination to attack that straw. And then
12 2 hours before his deposition he says, well, I've
13 still got the same opinion, but now I've got these
14 steel girdles all underneath as a foundation for my
15 opinion.

16 And that necessarily changes the way that
17 I have to prepare for that cross-examination for two
18 reasons, Your Honor. Number one, undisclosed new
19 bases for opinions is similarly improper and should
20 be excluded. And I will represent to the Court it's
21 not as clear to me as I was sitting through the
22 deposition, but going back and looking at the
23 designations, it does not appear as though
24 plaintiffs, in their designations, highlighted Dr.
25 Liles', you know, representations about this most

1 recent conversation.

2 However, it is still, in our opinion,
3 sanctionable that in our preparing for the cross, our
4 opportunity to prepare a cross for what he said in
5 his deposition was inhibited because with only 2
6 hours to work with, now we've pages of potential new
7 opinions that I have to go back and prepare
8 potentially new cross-examination techniques, go back
9 and look at the most recent medical records to see,
10 you know, what I can use to cross examine Dr. Liles
11 with if he does represent that he's got, you know,
12 this supplemental information that supports his
13 earlier opinions.

14 And that's the key, Your Honor, is not
15 that his opinions are different, but he's got more
16 up-to-date information that supports his opinions,
17 more up-to-date than he had in 2023, and more
18 up-to-date than the most recent medical records we
19 have, which are still, in some cases, back in July of
20 2024.

21 So, again, with just 2 hours, I've got to
22 prepare potential -- and, again, I don't know that
23 they're going to, you know, self limit their
24 testimony to not make that a central part of
25 Dr. Liles' testimony. I still have to prepare

1 instead of spending that time shoring up my questions
2 as if he's only going to testify in his 2023
3 opinions, and not reference this new conversation
4 that he had. I have to spend the 2 hours that I have
5 instead to make sure that if he does talk about this
6 new conference in 2024 about, you know, his
7 understanding in 2025, about Remi's current
8 condition, that I can, you know, successfully mount
9 any kind of cross-examination.

10 so for those reasons because, and, again,
11 you know, I'm sure when the Court was practicing that
12 there was instances where the State attorney came in
13 and said, you know, oh, we just discovered, just
14 before we put this witness on, that we've got all
15 these, you know, you know, new things that we want to
16 testify with, and I'm sure the State's attorney
17 always represented to the Court, well, Your Honor, we
18 just got this information, we didn't know this was
19 out here.

20 But in this case here, plaintiff invited
21 Dr. Liles to have this supplemental conversation.
22 They knew that that supplemental conversation
23 occurred Saturday evening, and then they waited until
24 Sunday, 2 hours before his deposition, to even let us
25 know that this occurred.

1 For those reasons, Your Honor, we believe
2 that it's inhibiting our ability to successfully
3 prepare our cross-examination throwing this curve
4 ball to us so soon before he was due to give his
5 trial testimony, that Dr. Liles' testimony should be
6 stricken.

7 THE COURT: All of it. Not just the stuff
8 that's new, all of it.

9 MR. PERRON: Right. Right. And that's
10 what I was explaining.

11 THE COURT: So unfortunately for the
12 defense, the child is going to continue to have
13 changes. Were the child not still be alive, maybe it
14 would be an easier case to deal with, but the child
15 is still alive, and there's going to be consistent
16 changes, and nobody can predict what those changes
17 are going to be.

18 I don't see them having a conversation
19 with Dr. Liles the day before as being something
20 worthy of such a drastic sanction. In your own
21 statements, you've indicated that plaintiff does not
22 highlight any opinions or new bases for the opinions
23 in their disclosures. And the Court would ask that
24 they remain consistent with that. I also received
25 the motion to exclude Dr. Liles' life care plan based

1 on the life expectancy of the age of 75, which I know
2 we've talked about to some extent previously --

3 MR. PERRON: Your Honor, that's not the
4 entire life care plan. That's just a separate life
5 care plan that contemplates the expected care beyond
6 the age of 60.

7 THE COURT: I understand.

8 And based upon what the defense says,
9 they're saying that there's no reasonable degree of
10 medical certainty that the child would live to the
11 age of 75, correct, based on this witness's
12 testimony?

13 MR. PERRON: Yes, Your Honor.

14 So we understand, in previous cases, that
15 the mortality tables themselves are admissible. But
16 this is a slightly separate issue. It is not just a
17 mortality table, it is Dr. Liles who both has the
18 opinion that his care beyond age 60 is not reasonably
19 likely, but also that he'll -- he'll get his care,
20 specific care, beyond age 60, is put into this life
21 care plan, and those specific numbers can be put in
22 front of the jury.

23 So I think fairly, as consistent with
24 previous opinions, the mortality table can be
25 referenced. But in terms of Dr. Liles' specific

1 numbers for the expenses beyond age 60, we don't
2 think are admissible for those reasons.

3 THE COURT: But here's the problem: were
4 Remi to live to the age of 65, he would not have been
5 able to have been compensated, and he would not be
6 able to come back to court at that time. The jury is
7 free to disregard that information and believe your
8 life care planner, which I think puts him at death in
9 his 20s.

10 Is that right?

11 MS. KAMYKOWSKI: 32.

12 THE COURT: 32, sorry.

13 They're free to believe that and only
14 award such money that would be that. None of us know
15 when this child is not going to still be with us. I
16 think most of us hope that he will be with us until
17 he is in his 70s. I won't be here to see that. I
18 imagine most of us won't. But I don't believe that
19 it's appropriate to exclude that testimony. The
20 Court believes that the appropriate way of handling
21 that is through cross-examination and through the
22 contradictory testimony of your experts.

23 MS. KAMYKOWSKI: Your Honor, may I just be
24 heard for the record?

25 THE COURT: You may.

1 MS. KAMYKOWSKI: I just want to address a
2 couple of the cases that were cited in plaintiffs'
3 opposition. And I think Mr. Perron hit correctly.
4 we are not claiming at all that the evidence of the
5 normal life expectancy through the vital statistics
6 life tables would not be admissible. That is not the
7 argument with Dr. Liles.

8 We are not seeking to limit the plaintiff
9 from arguing what the Court just concluded or talked
10 about as the potential for the jury to believe what
11 happens if he lives beyond what Dr. Liles has
12 concluded as his more likely than not life
13 expectancy.

14 So our position is that -- that is
15 certainly evidence of the total life expectancy will
16 come in, and the plaintiff can argue that the jury
17 should make sure that in case he lives longer than
18 what their expert concludes, with a preponderance of
19 the evidence, which is the probability that is
20 required under the burden of proof, that can
21 certainly be argued.

22 But for it to come in particularly with
23 the -- with numbers of Dr. Liles, is what is being
24 objected to, the cases that were cited in response to
25 defendant's motion, Swartz v. Gale Webb

1 Transportation, 215 S.W.3d 127, and Wiley v. Homfeld,
2 307 S.W.3d 145, those discussed -- they didn't have
3 anything to do with life expectancy or what the
4 probability of somebody's life, how that had been
5 impacted by the injuries. Those dealt with
6 discussions where providers, treating providers or
7 expert witnesses, were discussing and talking about
8 increased risk of future harm and the length of time
9 for ongoing care.

10 No one here is disputing what care this
11 child will need throughout his life. You're going to
12 hear that in the defense case. There's no dispute
13 that we agree with Dr. Liles and the care he needs to
14 have. The issue is life expectancy not his present.
15 And what they concluded was, going beyond a
16 probability. You know, the preponderance of the
17 evidence in those cases was allowed for an element of
18 damage not economic. They go to the potential of his
19 present risk for future injury and the nature and
20 extent of his injury.

21 The cases cited there were general
22 personal injury cases. This medical malpractice case
23 will have a separate jury instruction that will
24 require categorization of the past and future
25 damages, both economic and noneconomic. So what we

1 believe the cases even plaintiff cites support the
2 proposition that evidence that Remi may live to be --
3 that it's not reasonably probable, based on Dr.
4 Liles, his number is 60.

5 our life expectancy expert puts it at
6 something less than that, but that there is a
7 possibility he could live up to his normal life
8 expectancy. That goes to the nature and extent of
9 his injuries, which is a noneconomic damage.

10 The jury can hear that and can hear it for
11 that purpose only. And that Dr. Liles' numbers from
12 age 60 to age 75, are irrelevant to that analysis.

13 And they talk about the cost numbers in the cases and
14 say that it wasn't -- it was proper to exclude the
15 cost numbers, but not the fact that it was possible
16 they might have speculative future surgeries and
17 speculative future care.

18 If you corollate that through speculative
19 life expectancy, I think that we're on the same page.
20 But that's the defense's position that Dr. Liles
21 should not be allowed to offer the numbers toward his
22 life care plan beyond his more probably than not life
23 expectancy number of 60.

24 THE COURT: And the Court is going to
25 overrule that objection.

MS. KAMYKOWSKI: Thank you, Judge.

THE COURT: Anything else before we bring the jury in?

MS. LENIVY: There are, I think, a very few number of objections just from his deposition itself, and we'll just need to get the Court's ruling on that so that Zack can make the final edits, and we'll be ready to roll and play it.

Do you all want to start with your --

MS. PFIRMAN: I think we're just going to into 75, but you can just withdraw those objections.

THE COURT: No. No. It will be -- overruled.

MS. PFIRMAN: Oh, overruled. Excuse me.

MS. KAMYKOWSKI: We're not withdrawing them.

MS. LENIVY: I think the only -- and I apologize, I don't have a highlighted copy, so I don't know exactly -- it might be better to hand this over to --

Judge, I will hand you those two. The highlighted copies there are what have been designated by the defendant, and I had objections to basically starting 91, 22, starting at 91, 22, through 92, 20. There were questions posed to

1 Dr. Liles basically regarding, you know, what
2 difference head cooling could have made, if that
3 would have then changed his outcome, and how that
4 would have affected his life care plan.

5 This expert, he's a physiatrist, a
6 pediatric PMR -- I'm sorry -- just a physiatrist PMR
7 doctor, and he's not qualified, and he's never
8 offered any opinions about what difference head
9 cooling would have made. I don't think it's
10 relevant. It's outside the scope. It would be
11 confusing and misleading to the jury to have an
12 expert, a doctor, testify that he doesn't know what
13 difference head cooling would have made, when he is
14 not qualified to have opinions on head cooling.

15 so 91, 22, is the start of that, through
16 92, 20, and I think those were, I believe, those were
17 Mr. Perron's questions.

18 MR. PERRON: Yes, Your Honor, if I may
19 respond.

20 so the reason this is important, is going
21 all the way back to our pretrial conference. One of
22 my motions in limine was talking about the separate
23 allegation about not getting cord gas, which
24 plaintiffs' experts had testified may have or would
25 have likely led to this subsequent intervention

1 called cooling.

2 And what I was trying to highlight to the
3 Court back at the pretrial conference is that it was
4 this impending danger of setting up, you know, two
5 buckets of possible damages. You've got Dr. Liles
6 who says if he doesn't have HIE at all, he would not
7 need these medical expenses. That's what he can --
8 that's what they say. If he doesn't have HIE at all,
9 he doesn't need any of these expenses. He needs
10 these expenses because he's got severe, or moderate
11 to severe, HIE.

12 When Dr. Kerzner testified, she said
13 cooling would not have reversed the HIE. Cooling
14 might have lessened the effects of the HIE. So
15 that's why I have to ask Dr. Liles, can you say,
16 Dr. Liles, that -- that Remi would still need all or
17 just some of these future medical care, if instead of
18 moderate to severe HIE, he only had mild HIE? I'm
19 going to ask him in a slightly different way if he
20 had been cooled.

21 So it's vitally important that I ask those
22 questions, and that it be in evidence, Your Honor,
23 is, number one, it's going to be an issue that we
24 have to take up at potentially the jury instructions
25 conference that the -- the separate allegation of

1 failing to get the cord blood gas so that he might
2 have been cooled, that would have only lessened the
3 HIE, not reversed it.

4 And so that particular allegation, if
5 there's one or several jurors that only believe that
6 the cord gas and failure to get Remi cooled was
7 negligent, then that allegation by itself does not
8 support Dr. Liles' life care plan.

9 THE COURT: The question that you asked at
10 91, line 22: You are not going to opine, in fact,
11 you cannot opine, what neurological deficits Remi
12 might have had if he was delivered at 3:30 p.m. on
13 May 4th, 2020.

14 That's outside of his expertise -- I'm
15 sorry -- the objection is that it's outside of his
16 expertise.

17 No, sir. I have no opinion on that.

18 Right. And that's the same if I had
19 changed the time to 12:30 or 10:30 or 4:30 p.m. on
20 May 4th?

21 Same objection.

22 Again, my answer would be no opinion
23 because --

24 Right.

25 -- I have -- I don't have -- I don't have

1 an idea.

2 You cannot say when in the time line of
3 Ms. Anyan's labor the delivery injury, the
4 neurological injury, became completely irreversible,
5 correct?

6 No. That is outside my scope.

7 MR. PERRON: Right. Just -- just like
8 when I asked the other experts, you know, you don't
9 have a criticism of Dr. McNeive. No, I'm not an OB.
10 I mean, I think I -- we have the ability to highlight
11 for the jury the limits of the scope. I think this
12 is a foundational question for my next series of
13 questions.

14 THE COURT: I don't know that it's
15 necessary because I think the jury can, on their own,
16 understand that if the child does not have this
17 profound injury, they would not require a life care
18 plan and wouldn't be here in court.

19 I don't think that's something that is
20 lost on them. And were the child to be lesser
21 injured, I don't know that that's necessarily, I
22 mean, you're saying that the child -- well, we only
23 did a little bit of damage, and how much of that
24 damage it really our fault, is what you're trying to
25 parse it out at?

1 MR. PERRON: No, not quite. I'm trying
2 to -- I'm trying to highlight the distinction between
3 a point at which it was reversible, and a point at
4 which it might only be lessened, which -- which
5 separates the category of -- categories of damages.

6 THE COURT: But there's been no admission
7 that there was any wrongdoing to cause any injury,
8 whatsoever, nor do I expect there to be any. And
9 there's no question that this is not reversible. Do
10 you believe it's reversible?

11 MR. PERRON: No. But that's --

12 THE COURT: There's not going to be any
13 testimony or evidence that it's reversible?

14 MR. PERRON: No.

15 THE COURT: And there's -- I mean, I guess
16 the question is, is the doctor going to blame the
17 nurses for not recommending doing the cooling, and
18 therefore, they should be responsible for anything
19 that happened when the baby wasn't cooled?

20 MR. PERRON: No. I -- I -- what I'm
21 trying to highlight is on the plaintiffs' side
22 they're saying there's negligence before he was born
23 and negligence after he was born. Negligence after
24 he was born has a completely different set of damages
25 than the negligence before he was born.

1 THE COURT: Dr. Liles can't testify to
2 that. And he says he can't testify to that.

3 MR. PERRON: Right.

4 THE COURT: And you want him to testify to
5 the fact that he can't testify to that so that the
6 jury understands it better?

7 MR. PERRON: I think --

8 THE COURT: Because your experts are going
9 to testify to that, right?

10 MR. PERRON: well, to just start one piece
11 at a time. This medicine is incredibly complex, and
12 the difference between what might have been
13 completely prevented versus what might have only been
14 partially prevented, I think that is an incredibly
15 complex issue within the scope of this medicine.

16 And for me to be able to solicit from
17 Dr. Liles, you, Dr. Liles, cannot make this
18 distinction, it's outside of the scope of your
19 knowledge. And then proceed from there. I think
20 that's a fair question to pose from me so the jury
21 understands this expert, Dr. Liles, can only speak
22 within this bubble, and then my next questions
23 proceed from that point.

24 MS. LENIVY: Judge, if I may.

25 Dr. Liles is coming in and saying, I'm

1 looking at the child as he presents right now. we're
2 not talking about what Remi Anyan could of, would of,
3 should of been. we're talking about what he is right
4 now and what his care is going to be in the future.

5 That is the entire purpose of a life care
6 planner. To have him testify, when he is entirely
7 and wholly unqualified, and he says he's unqualified
8 to testify to what could have or would have been
9 different at the point of delivery, and in those
10 first 6 hours, when cooling was available.

11 That is confusing. That is misleading for
12 the jury. It is -- it's giving them an op -- it's
13 basically trying to undermine Dr. Kerzner, who is
14 qualified, and that is her area of expertise, by
15 throwing it up and mucking it up by saying, well, we
16 don't know if this child has been qualified. what if
17 we had a different child?

18 That is -- it's an incomplete -- it's a
19 wrong hypothetical. That's completely outside the
20 scope of what Dr. Liles' purpose is, and it has --
21 has no relevance. There is no probative value to him
22 confirming that he, as a physiatrist, a
23 rehabilitation doctor, can't testify to what should
24 have been done in a NICU setting.

25 And so there's no probative value, but

1 it's highly-prejudicial because of how misleading and
2 confusing it is. And I agree with Mr. Perron, this
3 is confusing medicine, which is why we should have
4 our physicians, as they are testifying, frankly, stay
5 in their own lane. And that's what Dr. Liles is
6 doing, he's staying in his own lane.

7 MR. PERRON: And, Your Honor, if it's --
8 if it's your position that the foundational questions
9 91, 22 to 92, 20 are less helpful to the jury, you
10 know, I'm willing to concede that point. But the
11 next layer of objections go right to what I was
12 trying to talk about highlighting for the jury the,
13 you know, the allegations on cooling is not relevant
14 to his life care plan.

15 MS. LENIVY: Your Honor, he never made it
16 a point. He never said, well, if this child is in a
17 mild HIE, and got cooling, if he could have done
18 these things, this would have changed my plan.

19 Again, Dr. Liles is a prospective looking expert.

20 He says, let's take the child as we know
21 him today, as he is today, and talk about what is the
22 future care he is going to need because of these
23 injuries that he has. How it could have been
24 different, should have been different, he cannot
25 testify to that. Again, it's misleading. It's

1 confusing. No probative value. And it's

2 highly-prejudicial.

3 THE COURT: I'm going to sustain the
4 objection. I don't believe that it provides the jury
5 with any information that would be useful or
6 appropriate for them to determine what, if any,
7 damages would be appropriate were the baby to have
8 been cooled or not cooled.

9 MS. LENIVY: And, Judge, just to make it
10 clear, because I kind of split them up, but they're
11 really the same issue. 92, 25 through 94, 16, again,
12 there's more questions about what if Remi had a mild
13 HIE. And Dr. Liles says, you're asking me to
14 speculate on a hypothetical about what this child
15 could have been? Similarly, we ask that that be
16 taken out. So basically 91, 22 through 94, 16.

17 MS. KAMYKOWSKI: Well, Your Honor, if I
18 can be heard on that. We're going to get tomorrow
19 two other causation and damages experts, Dr. Zse, the
20 neuroradiologist, and Dr. Nelson, who is a
21 neurologist. And you won't be surprised because I
22 said it in my openings. They're not on the same page
23 as to what type of injuries he had at the time of his
24 birth. One of them says mild. One of them says
25 moderate. Dr. Liles says severe.

1 so that is a fact of dispute in this case
2 that the jury is going to have to resolve. And
3 whether or not Dr. Liles' life care plan took into
4 account if he had -- if they believe one of their
5 experts, who says it was mild, is not contemplated.

6 And that is certainly something the jury
7 should hear, that the life care plan of up to
8 \$20-some million, if we're going out to age 75, is
9 only if they believe he had a severe encephalopathy
10 at the time he was born. It's a disputed fact, and
11 this stuff should be coming before the jury so they
12 can see the truth.

13 MS. LENIVY: And I want to clarify. Dr.
14 Liles is not saying he had a severe encephalopathy at
15 the time he was born. He knows he has a severe
16 encephalopathy at the time that he's examining him.
17 And he's pulling moderate to severe HIE from Remi's
18 medical records. So it's not a diagnosis he himself
19 is making. He's saying his doctors have already, his
20 treating doctors have already, diagnosed him with
21 that. I'm going to look at the child as he is today
22 and determine what his future care is.

23 And I'd also dispute the -- Ms.
24 kamykowski's representation about mild versus severe.
25 I -- we can hear that from Dr. Zse and Dr. Nelson

1 tomorrow who will be testifying to what was going on
2 throughout the labor and delivery in those first few
3 hours of Remi's life.

4 But Dr. -- Dr. Liles has nothing to do.
5 He has no testimony, he has no foundation for what
6 happened in the delivery room, what happened in the
7 NICU. He's looking at the child in the moment and
8 prospectively determining what his future care needs
9 are. So the level of his encephalopathy, that's not
10 for him to determine. He's pulling the records and
11 making his opinions.

12 THE COURT: I agree with you it's not for
13 him to determine the level of injury. But it is
14 appropriate for him to be allowed to testify as to
15 had the child had a lesser injury, what the life care
16 plan would have been, which ultimately he's not going
17 to be able to give much information on, right.

18 MS. LENIVY: It would be speculative
19 because that's not the child we have.

20 THE COURT: I'm going to allow just that
21 portion of it in.

22 MS. LENIVY: All right. Thank you, Judge.

23 THE COURT: Are we ready to bring the jury
24 in?

25 MS. KAMYKOWSKI: Yes.

1 MR. PERRON: The defense moves in limine
2 to limit, not exclude, because there would be no way
3 to do it, but to limit questions soliciting any
4 testimony about noneconomic damages to parties that
5 are not the plaintiff. So specifically, in any case
6 like this, there's a typical question to the witness,
7 how has this affected you emotionally? You know,
8 pain and suffering, distress, hardship, those
9 questions are all relevant and pertinent to the
10 plaintiff.

11 Mr. and Mrs. Anyan are not the plaintiffs
12 in this case. Of course, of course within the scope
13 of describing their care they provide to Remi and how
14 this has changed their life, that is going to come
15 in. But what we're asking the Court is some modest
16 limit to questions soliciting a narrative testimony
17 as to the emotional -- and emotional effects that
18 would fall into noneconomic damages and hardships on
19 themselves.

20 THE COURT: I'm not sure I even know where
21 to start with that. In essence, I mean, I guess just
22 exclude them from testifying and let Remi testify?

23 MR. PERRON: No. Just direct an
24 open-ended question --

25 THE COURT: Don't be emotional.

1 MR. ANYAN: I'll try my best.

2 THE COURT: That's, I mean, I don't know
3 what else I can do.

4 MR. PERRON: Like I said, typically there
5 would be a question, how has this affected you, to
6 almost any plaintiff. And I think -- I think there
7 are many other ways to solicit the -- the
8 information.

9 THE COURT: How? Who's going to testify
10 to that? Somebody else? Not these two? How it
11 affected them? Because they are the next friends.
12 And I don't know how to exclude that. I just -- if
13 you hear a question that you think is objectionable
14 object.

15 MR. PERRON: All right.

16 THE COURT: But I don't know of any way of
17 deciphering that.

18 MR. PERRON: I just don't.

19 MS. KAMYKOWSKI: And then one last thing,
20 Judge. We talked in our pretrial about Ms. Anyan had
21 some testimony about -- or Mr. Anyan had some
22 testimony in his deposition that what he was told by
23 his wife about Dr. Weinsenberg, their neurologist.
24 They're talking about she can come in and talk about
25 what Dr. Weinsenberg had told her about Remi's

1 condition, but can't relate that causally to the
2 birth because she didn't have the foundation to do
3 so.

4 Similarly, there was testimony from
5 Mr. Anyan that a neurologist in the NICU, or after
6 the fact, was talking to him and attributed a
7 statement to Dr. Thalakoti that the HIE that was his
8 diagnosis, so that's not hearsay, but that his
9 diagnosis was caused by a prolonged labor,
10 specifically by head compression. And I don't think
11 there's any foundation -- first, it's hearsay for Mr.
12 Anyan to come in here and testify to that
13 conversation.

14 And it's not subject to the medical
15 treatment or diagnosis exception because it's not in
16 any medical records. So it's an out-of-court
17 statement by Dr. Thalakoti that is not supported by
18 his business records that are in issue in this case.
19 And so we would ask the court to limit and exclude
20 any of that hearsay statements attributed to the
21 neurologist.

22 MS. GUNN: Your Honor, I believe that if
23 that issue does come up, it is an exception to
24 hearsay. It is the reaction of the listener -- I
25 don't know if that's exactly the right phrase. But

1 basically whether this is something the family was
2 hearing when they were searching for answers with
3 respect to their child's diagnosis. And the
4 pediatric neurologist is expressing to him what he
5 believes happened. And that is an exception to
6 hearsay with respect to the reaction on the listener,
7 is what that is.

8 MS. KAMYKOWSKI: Well, I -- go ahead.

9 MR. WILLMAN: Well, I assume she's talking
10 about the excited utterance exception, Your Honor?

11 THE COURT: No. I think she's actually
12 speaking about the present sense impression.

13 MR. WILLMAN: Yeah, okay. Which it
14 doesn't qualify of that, as well. I mean, it's a
15 medical opinion. It's not a, you know, not an
16 impression. She's supposed to have given a medical
17 opinion for which we have no basis to cross examine
18 her on here in court. It's an out-of-court statement
19 that we can't challenge.

20 THE COURT: He can testify if the doctor
21 told him there was an injury, not how the injury
22 occurred or when the injury occurred. And that's
23 what he then did in response to that.

24 MS. KAMYKOWSKI: Thank you, Judge.

25 Nothing further from the defense.

1 THE COURT: Anything further on behalf of
2 the plaintiff?

3 MS. GUNN: No, ma'am. We're ready.

4 (At 9:35 a.m., the following proceedings
5 were held in open court, in the presence of the
6 jury:)

7 THE COURT: Good morning, everyone. I'm
8 very grateful to see all of you this morning and see
9 that you're all here safely. I hope that means that
10 nobody had too much damage or problems over the
11 weekend and that everybody's got everything back on
12 and running if they didn't have power over the
13 weekend.

14 Go ahead and be seated.
15 on behalf of the plaintiff.

16 MS. GUNN: May it please the Court. We
17 call Blake Anyan.

18 THE COURT: Sir, if you'll step on up and
19 be sworn.

20 BLAKE ANYAN,
21 having been duly sworn, was examined, and testified
22 as follows:

23 DIRECT EXAMINATION

24 BY MS. GUNN:

25 Q. Good morning.

1 A. Good morning, everybody.

2 Q. Can you tell everyone your name?

3 A. My name is Blake Anyan.

4 Q. And where do you live?

5 A. I live in Pacific, Missouri.

6 Q. Who lives with you there?

7 A. Sarah McDonald Anyan, who's my wife; Remi
8 Anyan, which we've been talking about; my 4-month-old
9 daughter, Rory Anyan; and our dog, Hattie.

10 Q. I was hoping that you wouldn't leave
11 Hattie out.

12 A. She's part of the family.

13 Q. Now, what is -- how old of a gentleman are
14 you, sir?

15 A. I am 36 years old, I believe?

16 Q. I know, but I started easy, man.

17 A. I thought there's no math, ma'am. Sorry.

18 Q. Can you tell us a little bit about your
19 background? Where did you grow up?

20 A. Yeah. My wife and I both grew up in St.
21 Louis County, particularly in the Fenton area. And
22 we moved out to Pacific, Missouri, after we were
23 married in 2012.

24 Q. What about your educational background?

25 A. High school or?

1 Q. yeah. start there.

2 A. So we both went to Rockwood Summit High
3 School. I was a year ahead of Sarah, and that's of
4 course where we met, in high school.

5 Q. so I told the jury in opening statements
6 that you all were high school sweethearts.

7 Are you proving me correct on that?

8 A. That is correct.

9 Q. okay. Did you attend college?

10 A. I did.

11 Q. And where was that?

12 A. A lot of places. My initial respiratory
13 training -- I'm a registered respiratory therapist --
14 that was at St. Louis Community College at the Forest
15 Park campus.

16 After receiving my credentials and state
17 licensure, I continued to go to school for really
18 another decade, and I attended University of
19 Missouri-Columbia, University of Missouri-St. Louis,
20 and ultimately Missouri Southern State University.

21 Q. why all the different places?

22 A. I didn't know what I wanted to do when I
23 grew up.

24 Q. And you landed on?

25 A. Education has always been something that

1 I've been drawn to. And I was already in health
2 care, and I did that, and I didn't plan on leaving
3 that. I just didn't know what other type of capacity
4 I really wanted to stay in health care in regards to.
5 And desiring to really move toward education, it does
6 require a little bit more training than just the
7 regular medical training.

8 So I initially lived in Columbia,
9 Missouri, after school. And the reason I went to
10 University of Missouri-Columbia was I was affiliated
11 with that hospital there, and they paid for my
12 tuition.

13 And then a lot of my other options in
14 going to UMSL, it was trying to take classes in
15 person, getting some of my general education
16 requirements out of the way. And then ultimately
17 that became a little bit too much of a struggle
18 making the commute to Pacific, Missouri, to UMSL
19 every day, and Missouri Southern had opportunities to
20 kind of do distance and hybrid learning.

21 Q. So what is your current occupation?

22 A. There's several things that I do
23 technically. I am a registered respiratory
24 therapist. That's a national credential I hold. The
25 license in the State of Missouri is a respiratory

1 care practitioner. Although I'm always still a
2 respiratory therapist, my current title is Assistant
3 Professor of Respiratory Care and Director of
4 Clinical Education for St. Louis Community College.

5 Q. And how long have you held that position?

6 A. I believe I'm completing my seventh year
7 as faculty at St. Louis Community College.

8 Q. Now, Blake, you've told us a little bit
9 about your education and some of it in the medical
10 field.

11 when you were in school, in any of those
12 capacities, did you spend any time learning about
13 labor and delivery?

14 A. Not labor and delivery specifically, no.

15 Q. what about obstetrics in general?

16 A. No.

17 Q. Okay. I know that you have had some
18 training in respiratory therapy as it relates to
19 children?

20 A. Correct.

21 Q. Was that ever your focus: children?

22 A. Part of being a registered respiratory
23 therapist is being able to provide care for patients
24 of all size and ages.

25 That being said, a lot of our curriculum

1 in the programs is adult facing, however, you know,
2 our clinical training, we do internships with
3 neonatal.

4 As far as my clinical practice goes, I've
5 taken care of a hundred-year-old grandfather in the
6 same day as seeing a tiny baby come through the
7 emergency room. But I would say that my primary
8 level of expertise does kind of stick more with the
9 adult care side of things.

10 Q. Okay. was there a time, Blake, that you
11 and Sarah -- you got married in 2012?

12 A. Correct.

13 Q. Was there a time in -- and she'll be here
14 this afternoon to talk about her journey, as well --
15 was there a time that you all decided that you wanted
16 to have children?

17 A. Yes. We were both busy working on our
18 careers and trying to rehabilitate the home that we
19 had moved into right before getting married, and it
20 did not take us a long time to get pregnant with
21 Remi. We were trying for maybe several months, kind
22 of before then.

23 It was something that we had thrown around
24 for some years, you know, prior to making that
25 decision, and, you know, you start to forget how

1 quickly time passes.

2 Q. I want to move a little bit forward,
3 Blake, and I might go a little bit back and forth.

4 But let's go, if you don't mind to --

5 MS. GUNN: Zack, Exhibit 615.

6 Q. (By Ms. Gunn) Okay. So we're going to
7 walk through a little bit, Blake, some pictures and
8 photographs.

9 You understand that part of what you're
10 here to do today is to tell this jury a little bit
11 about your son, right?

12 A. Correct.

13 Q. And -- and we've talked about this. We
14 think that one of the ways to do that is to maybe
15 show some pictures and videos.

16 A. Okay.

17 Q. So Exhibit 615, I'll tell you that this
18 was from 2021.

19 A. Okay.

20 Q. And we all know Remi was born or May 4th,
21 2020. This is about a year or so later.

22 So I want to know about this. Tell us --
23 tell us -- tell us why a chef's hat.

24 A. So I have an extreme passion for cooking.
25 I do prepare all the meals. And, you know, for Remi,

1 eating early on, as we moved into purees, was a
2 challenge. So I kind of took it upon myself to try
3 and make the tastiest food to trying to entice him to
4 eat.

5 You know, running a kitchen is just a lot
6 of work. And, Remi, not being able to do a lot of
7 the things that most normal typical children do, he
8 likes to observe, and he sees me always working away
9 in the kitchen.

10 And he's just been interested. So with
11 the height of -- so you can't see it in this picture,
12 but the kitchen island is just off to the side of
13 there, he can kind of see what I'm doing as I'm
14 preparing food, and he's always been interested. So
15 trying to get him involved in as much of the stuff
16 that we possibly can on a daily basis, he ended up in
17 the kitchen. He's my little sous-chef.

18 So that -- the device that he's in is
19 something that allows him to bear weight and kind of
20 build up that leg muscle strength and prevent him
21 from getting cramps. It's called a stander.

22 So we've got him -- he's actually
23 standing. And we can strap him in. It gives him a
24 little bit more trunk support. And, you know,
25 started out doing some basic kind of kitchen skills.

1 He likes to whisk things a lot. So I don't know if
2 we have anything in that bowl just yet, but that's
3 probably us getting ready to start making some stuff.

4 Our family, Sarah's parents, live close to
5 us, but my mom lives out of town, lives in Florida,
6 and my dad, he lives a little over a hundred miles
7 away from us. So we try and take as many pictures as
8 we possibly can, just to kind of keep the family
9 updated. And the chef's hat ended up initially just
10 for making -- trying to make a cute picture, but he
11 seems to like it, so we still put that on quite a bit
12 when we're making things in the kitchen.

13 Q. Now, Blake, I see little devices on Remi's
14 hands.

15 what are those?

16 A. Yeah. So part of having cerebral palsy is
17 the inability to have normal muscle function and
18 control. Some muscles of his are floppy, and he
19 struggles to use them. Other ones are the opposite,
20 they're extremely tight. His hands being something
21 that he gets, especially if he gets excited, he
22 clenches his hands quite a bit.

23 So what you're seeing on his right and
24 left hands, we refer to them as orthotics or braces.
25 It allows him to kind of keep his hands open a little

1 bit, and it's meant to kind of add onto his
2 functionality.

3 Q. Now, he's got that whisk in his hand. I
4 kind of see him kind of grasp it with two fingers.

5 Did -- did you put that there? or how did
6 he get ahold of that?

7 A. Sometimes he struggles with being able to
8 lift up his arm. So you'll see a lot of times if
9 we're interacting with him, whether it's in pictures
10 or in person or videos, sometimes he does require a
11 little bit of assistance just getting his arms up to
12 that level. But he does like to grasp. He doesn't
13 have a problem with clenching. Sometimes it's a
14 problem with relaxing the hand.

15 Q. Is he able to help? How does he help you?

16 A. So he's my moral support when things get a
17 little chaotic. Once again, I refer to him as my
18 sous-chef. I'm not letting him control, you know,
19 the heat on the skillet or anything like that
20 obviously. But he helps me in a lot of the prep. He
21 finds that very fascinating.

22 So, for instance, my wife was in the
23 hospital with our daughter after being delivered
24 right before Thanksgiving, it was the week of, he
25 wanted -- he knew Thanksgiving was coming up, he's a

1 big fan of the holidays, especially Christmas. But
2 Thanksgiving is my favorite holiday, and he gets
3 excited about all that. He actually kind of helped
4 me kind of prepare everything to take, you know, my
5 wife and his mom, Sarah, a Thanksgiving dinner.

6 so we had him helping me cut up cornbread
7 and mixing in sausage for my famous cornbread
8 stuffing recipe, so he really helps me more from the
9 preparation side of things. But of course the taste
10 testing, as well.

11 Q. You mentioned he's excited about holidays
12 and things.

13 Blake, how -- how do you know that? Is he
14 verbal?

15 A. Remi it not verbal in the traditional
16 sense. Having spent the last four and a half years
17 getting to know Remi and all of his quirks and his,
18 you know, his normals and things like that, whenever
19 he's excited, he's got some very specific mannerisms.
20 And one of them is he likes to vocalize. So he can't
21 tell us he's excited, but he (indicating). He
22 starts, I don't want to say screaming because it
23 sounds bad, but it's kind of screaming with joy and
24 excitement.

25 Q. And how do you tell the difference in his

1 screaming?

2 A. So that has been part of the challenge of,
3 you know, being able to be Remi's dad.

4 Communication, you think about all the things you can
5 say, you know, convey what you need and things like
6 that. It's challenging. And it's taken some time in
7 trial and error.

8 Fortunately, with modern times and some

9 assistance with some assistive devices, we do have

10 ability to communicate with Remi, aside from the
11 nonverbals that we heavily rely on. But we can use a
12 two-button switch, a simple yes/no command to

13 questions like that. And he also -- it's been a work
14 in progress -- but we've been using like an eye gaze
15 computer device.

16 So he can kind of look at different

17 options on a screen and kind of communicate with us.

18 So really we use those alternative assistive devices

19 to kind of narrow in our focus and try and figure

20 what some of these different noises he's making

21 means.

22 You know, early on, you can hear a child

23 kind of vocalize, and you just assume that

24 something's wrong. He wants to do something. He's

25 not happy. And that's something that, you know, the

1 reason why Remi is probably cooking more with me now
2 than even, you know, early on. He makes some of
3 these noises, and with these different communication
4 devices, instead of just assuming that he wants out
5 of his stander, you ask him, do you need something?
6 No. Are you just excited? Yes.

7 So that's allowed us to really pinpoint
8 his vocalization. But some of the other nonverbal
9 stuff, it's just getting to know your kid. I mean,
10 you spend so many hours with him, and it gets
11 frustrating when he's trying to tell you something,
12 and we're not getting it. And it's just been an art
13 of getting to know my son.

14 Q. And that's something that's obviously
15 taken a lot of time.

16 A. An immense amount of time.

17 Q. Are you a patient person?

18 A. If I wasn't a patient person, I probably
19 wouldn't be in education. I am a very patient
20 person. You know, being a parent with any kid, I'm
21 sure, can test your patience. But the communications
22 side of things, he's frustrated, and it's frustrating
23 to not be able to know what your kid wants. So it's
24 tested my patience, but I'm a very patient person.

25 Q. When you said it a minute ago about the

1 yes and no, does he say yes or no?

2 A. with his button, yes. There's some other
3 communication that we can -- it's not just yes/no.

4 where I can record my voice, and there's really three
5 different settings.

6 Another one we did early on was "more" and
7 "all done." Mainly for food and drink and things

8 like that. He can say what we feel is fairly

9 legible, not as clear as me speaking or anything like

10 that. He can say all on. And so his vocalizations

11 have become slowly but steadily refined over time,

12 but it's still not the same as, you know, what most

13 parents have had with their children.

14 Q. Now, you obviously know about Remi's

15 injury, and the jury has heard HIE, hypoxic ischemic

16 encephalopathy. They've heard different areas of the

17 brain that have been damaged.

18 And I want know if you could tell us sort

19 of just generally what does it mean for Remi? You

20 said a minute ago that he's challenged physically.

21 How do you know he's understanding you?

22 A. So when you first look at Remi, you know,

23 he does have the significant physical limitation and

24 disability. You would assume that, you know,

25 cognitively there wasn't much going on. And we

1 weren't really sure early on. And getting to know
2 him and getting him through therapy and especially
3 with the communication devices, we've been able to
4 realize he's in there. He knows what's going on.

5 He's been able to kind of show us that and
6 reiterate that. And, you know, it was -- something
7 was mentioned about being trapped in your body.

8 That's what Remi deals with. He's in there. He
9 knows what he wants to do, he just can't.

10 Q. How do you know?

11 A. You can see the frustration. We can ask
12 him why he's upset sometimes, and we can tell.

13 MS. GUNN: I want to go to Exhibit 620.

14 Q. (By Ms. Gunn) Okay. Now, you know why
15 I'm asking you this one, right? Okay. We're going
16 to stay in the food theme.

17 A. Yeah.

18 Q. Because I want to talk about the hair.
19 Okay. So what is going on with this
20 child's hair? What have you done?

21 A. So mohawk was not our first -- our first
22 go-to as far as hairstyle. I believe Dr. Kerzner
23 maybe mentioned something called microcephaly. I
24 know in her deposition -- or her testimony on Friday,
25 I know it was made mention on, I believe on Friday,

1 as well, about the molding of the skull, you know,
2 postdelivery.

3 Now, because of Remi's injury, whenever
4 you have tissue that doesn't receive the oxygen and
5 the nutrients it needs, in his case due to his HIE,
6 that part of the tissue doesn't grow. It doesn't
7 expand like a growing child's brain normally would.

8 So because of that, it is hard to tell
9 with my great styling of his hair, he -- his head
10 didn't really grow to its normal size, and he has --
11 so microcephaly is just a small circumference of the
12 head.

13 If we -- and, well, Sarah cuts his hair,
14 and sometimes if something goes wrong, and we end up
15 taking a little bit off, he does still kind of have a
16 little bit of a cone head type shape.

17 So, first, it started out just to try and
18 kind of normalize that appearance. But that's become
19 his iconic style. When we go to therapy, everybody
20 really digs his hair. And, you know, you can see I
21 don't really style my hair. So it's been a little
22 bit of an art, but I am the main -- main person
23 behind that mohawk there.

24 Q. I know. I've seen it.

25 A. Yeah.

Q. You take time.

MS. GUNN: And, again, let's look at -- I want to go to --

Q. (By Ms. Gunn) By the way, this 620, the date on that is from July 2022. So he was about 2 years old at that point?

A. Okay.

Q. And let's -- I want to go back to a time frame prior to Remi's birth, Blake.

A. Okay.

Q. And ask -- and ask you about ya'll's decision to -- ya'll's decision to deliver Remi at Mercy.

So why did you choose Mercy?

A. So although, you know, Sarah and I are married, we still are on our own respective health insurance plans. I did work at Mercy, but at the time when we started trying to conceive Remi, I was working at St. Louis Community College. Sarah continued to work at Mercy.

Part of that health insurance plan is you do need to, at least the tier Sarah had, you do need to try and receive your care at Mercy St. Louis.

Having -- or Mercy network, not just Mercy St. Louis.

us both having worked there in the past,

1 we were familiar with the facility, their

2 capabilities, and we thought it was a good decision.

3 Q. And you chose McNeive, Dr. McNeive?

4 A. Sarah chose, you know. Not being my
5 doctor, Sarah had more to say in that. But it was
6 something we had discussed, yes.

7 Q. And Sarah was -- is no longer employed.

8 She's working -- she's working at home with Remi?

9 A. That is correct.

10 Q. Do you recall going to any of the prenatal
11 visits with Sarah and Dr. McNeive or people from Dr.
12 McNeive's office?

13 A. Yes, I do.

14 Q. Blake, there was a statement made on the
15 first day of this trial in opening statement that
16 Sarah wanted a vaginal delivery, and she thanked Dr.
17 McNeive for giving her the vaginal delivery she
18 wanted.

19 was that true?

20 A. That is not true.

21 Q. Can you -- how do you know that? Were you
22 there.

23 A. Sarah and I, both being in health care, we
24 know to -- when to stay in our lane. We chose Dr.
25 McNeive, we chose Mercy because we thought we were in

1 good hands. We were completely trusting, and, you
 2 know, the ability for them to do whatever was
 3 necessary in order to have a safe and healthy baby.
 4 Safety was our birth plan. We were happy with
 5 whatever route we had to take to get there.

6 Q. Do you recall ever having any discussions
 7 with Sarah specifically about wanting a vaginal birth
 8 and nothing else?

9 A. No.

10 Q. Do you remember being in any visits with
 11 Dr. McNeive or anyone else in his office with Sarah
 12 where that was discussed at all?

13 A. No.

14 Q. Was there ever any notion that Sarah did
 15 not want a C-section?

16 A. No.

17 Q. And during the entire time that you all
 18 were in the hospital laboring with Remi, did -- and
 19 you were there the whole time?

20 A. The entire time.

21 Q. -- was there any discussion with Dr.
 22 McNeive or Nurse Jessie or Nurse Maggie about a
 23 C-section?

24 A. No.

25 Q. Was there ever any time that, during that

1 entire time frame, before or after, that you or Sarah
2 indicated you don't want a C-section?

3 A. No.

4 Q. Or that you specifically wanted only a
5 vaginal birth?

6 A. No.

7 Q. So any testimony in this case otherwise
8 would not be true?

9 A. That's correct.

10 Q. Now, you all got to the hospital. It was
11 May 3rd, 2020, and the jury has heard and seen some
12 medical records, Sarah's water broke around noon?

13 A. That's correct.

14 Q. And you remember that?

15 A. I do.

16 Q. So tell us about that.

17 A. I was in the kitchen, and I told you I was
18 whipping up food and things like that. Sarah was
19 taking a nap. There was a little bit of a storm
20 front coming through. It was a sleepy day. She was
21 laying on our bed, which is like an upper loft type
22 situation in our home.

23 And she thought that she had peed the bed,
24 and she told me that. I came up, and I'm like, what?
25 No, I think that your water broke. And that seemed

1 to be the more likely solution. We called Mercy
2 Hospital, and -- and there was some questions
3 assuming, and we then packed up ready to go, grabbed
4 our stuff, and headed to Mercy.

5 Q. The records show that you all arrived a
6 little bit after two o'clock. And describe kind of
7 what happened at first.

8 A. So I haven't worked at Mercy for
9 approximately 5 years. I was well aware kind of
10 where everything was at. Mercy St. Louis has the
11 main entrance, something they referred to as OB
12 triage.

13 So instead of sending a pregnant mother to
14 the emergency room or something like that, I'm
15 guessing unless something terrible is going on, they
16 just have you come into a separate little check-in
17 point right off to the side of that main entrance.

18 we pulled up. And there's a little
19 parking spot for you and everything. I dropped Sarah
20 off, parked the car, we went in. We got Sarah hooked
21 up on some monitoring. They did assessments and
22 probably started an IV, and sat down there for a
23 little while.

24 Q. This was the first child for either one of
25 you?

A. Correct.

Q. When before -- before getting settled in, did you have any notion, because of your health care background, any notion of what Pitocin was?

A. Not really.

Q. Did you have an understanding that Pitocin strengthens contractions?

A. Prior to going?

Q. Yes, sir. Prior to this.

A. No.

Q. And before all -- before going to the hospital to have Remi, were you familiar with fetal monitoring strips?

A. I know that they monitor a baby's heart rate and things like that in utero when you're in the delivery process because I have cared for pregnant women in the intensive care units and things like that. As far as being able to read those things, no.

Q. Were you familiar with the different categories? Category I, Category II, Category III, we've been talking about here?

A. No.

Q. Before arriving at the hospital and going through labor and delivery with Sarah and Remi, were you aware of the various stages of labor. The ones

1 we've just talked about: first stage, second stage,
2 third stage?

3 A. No.

4 Q. Did you have any notion of how long any
5 particular stage was supposed to last or likely to
6 last?

7 A. Going into that, no.

8 Q. Okay. Now, when you got to Mercy, and you
9 got hooked up on all the monitors, including that
10 fetal monitor, was there any indication that there
11 was anything wrong?

12 A. No.

13 Q. Did anyone indicate that Remi's heart rate
14 didn't look good when you got there?

15 A. No.

16 Q. Any indication at all that there were any
17 concerns about how healthy and safe Remi was when he
18 first got there and got set up on the monitors?

19 A. None.

20 Q. Now, the time frame, I think we understand
21 that there was an epidural maybe around midnight?

22 A. I'd have to look at the medical records.
23 There was an epidural -- Sarah eventually did start
24 to feel those contractions and was ready.

25 Q. And when you all got -- I know you know

1 now from all of this and -- that she was complete.

2 Did you -- tell us about that: who was in
3 there and what was happening.

4 A. So once we moved out of the OB triage,
5 they move you to a room. I want to say we were up on
6 the sixth floor: labor and delivery. And we had our
7 nightshift nurse, which we heard from on Friday,
8 Alex, I believe. And she kind of explained a lot of
9 things that where she was going, what she was doing.

10 And did some vaginal exams, and she did explain at
11 the point of which we can finally start pushing.

12 Q. And were you there for that?

13 A. I never left.

14 Q. You never left.

15 A. I -- I wasn't going to leave Sarah, no.

16 Q. The -- that first hour and a half or so,
17 do you recall Sarah pushing?

18 A. Yes.

19 Q. And did it appear that she was giving it
20 her all?

21 A. Sarah is the toughest woman I know, yes,
22 she gave it her all.

23 Q. And at some point, did another
24 physician -- or did a physician come in to check on
25 the status of her pushing?

1 A. Yes. I believe she was a resident
2 physician, came in, did an assessment, and made sure
3 Sarah was pushing effectively. And there was some
4 brief conversation.

5 Q. And what was the sense after that
6 resident -- I think the jury's heard from Dr.
7 Mckillip -- what was the sense after that assessment?

8 A. So he just said he was comfortable.
9 Nothing was alarming or anything like --

10 Q. "He" being Remi?

11 A. Remi, yes. I'm sorry. Nothing was wrong
12 with Remi. Wasn't progressing. Now it was coming up
13 close to the shift change. She was going to speak
14 with her attending physician, and we were going to
15 kind of go from there and see how things went, and we
16 were told to take a brief break.

17 Q. And were you -- did you speak to that
18 physician -- speak to that physician again or any
19 other physician? And this is going to be the time
20 frame before Dr. McNeive came on shift.

21 A. That was really everything regarding our
22 conversation with that resident. The attending
23 physician, who I believe is one of Dr. McNeive's
24 partners, Dr. Parker, she came in, and it was getting
25 close to shift change, and she was the one that

1 informed us that Dr. McNeive was the covering doctor
 2 that day. And he was going to be on within the hour,
 3 and we were going to kind of wait and have Dr.
 4 McNeive come and see us.

5 Q. How did you feel about that?

6 A. Overjoyed.

7 Q. Why?

8 A. I liked Dr. McNeive. I felt very
 9 comfortable. Dr. McNeive, I only got to know him in
 10 a couple of visits, but I was happy that he was going
 11 to be our doctor for the day.

12 Q. And so Dr. Parker basically indicated Dr.
 13 McNeive is coming on, everything looked fine. We're
 14 going to let him take over?

15 A. Correct.

16 Q. Now, was there any note -- any discussion
 17 at all what was expected to happen prior to Dr.
 18 McNeive coming on?

19 A. No conversation with the physicians.
 20 Alex, our bedside nurse, had just told us, you know,
 21 if things didn't, you know, if Remi didn't begin to
 22 make some movement, that we might be looking at a
 23 C-section.

24 Q. And at that point, was there any pushback?
 25 Any concern from you or Sarah that that's not what

1 you wanted?

2 A. No.

3 Q. What was your thought after that?

4 A. We were just going to kind of follow
5 orders. We were on a pushing break. And we were
6 going to keep pushing until Dr. McNeive got there.

7 Q. So it was your understanding that whatever
8 the physicians were telling you all to do, that's
9 what you were going to do?

10 A. Absolutely.

11 Q. Okay. And then at any point after that,
12 when Dr. McNeive came on, was there any discussion of
13 C-section?

14 A. Not in regard to Sarah's care, no.

15 Q. Okay. Now, let's go to that eight o'clock
16 time frame.

17 Dr. McNeive did come into the room?

18 A. Correct.

19 Q. And what do you recall about that?

20 A. Being happy to see him. Came in and
21 started doing his assessment on Sarah, looking over
22 everything, and having some discussion with us.

23 Q. Do you remember anything specific about
24 the discussion?

25 A. He said everything looked good. Asked

1 Sarah how she was doing. And Sarah was still very
2 good -- a good patient. She was doing everything
3 they were telling her to. And that was about it. He
4 still wasn't really, you know, coming down. He
5 wasn't -- they kept saying he was too comfortable.
6 Everything looked good.

7 Q. And at that point, did anyone say to you,
8 McNeive, or now we also have Nurse Maggie and Nurse
9 Jessie on the shift, correct?

10 A. Correct.

11 Q. Did any of those folks, Nurse Maggie,
12 Nurse Jessie, Dr. McNeive ever mention either at that
13 point, or frankly at any point during the rest of the
14 day, that Sarah's second stage of labor pushing was
15 prolonged?

16 A. No.

17 Q. Or longer than usual?

18 A. No.

19 Q. Or the longest they'd ever seen?

20 A. No.

21 Q. Blake, you keep telling us at no point
22 between the hours of 8:00 a.m., and when Remi was
23 born, Maggie, Jessie -- Nurse Maggie, Nurse Jessie,
24 and Dr. McNeive, no one explained to you or Sarah how
25 long this was going on and how unusual it was?

1 A. We had no idea that this was an outlier.

2 Q. No one ever said to you the average second
3 stage of labor is 2 hours?

4 A. No.

5 Q. Did anyone in that time frame that you can
6 remember ever express concern over the fetal
7 monitoring strips?

8 A. No.

9 Q. What was your sense?

10 A. Everything was going great.

11 Q. Now, with respect to that time frame we've
12 talked about, I guess between the 8:00 and the 2:00,
13 you mentioned something about C-section. It wasn't
14 in relation to Sarah.

15 But what was your understanding?

16 A. The -- when C-section was mentioned in our
17 room?

18 Q. Yes.

19 A. It was for other patients on the unit.
20 So we'd be generally aware Dr. McNeive was having to
21 go do a C-section on another patient, or if he was in
22 a C-section, and we were told to labor down and take
23 a break, that would have been the only mention.

24 Q. All right. Now, did -- there was a time,
25 then, between these laboring downs that -- that Dr.

1 McNeive, or after the laboring downs, there were
2 three of them, that you can recall?

3 A. I can't recall the -- this was a long
4 stretch.

5 Q. Dr. McNeive did return to the room?

6 A. Correct.

7 Q. At some time -- what time?

8 A. I couldn't attest to what times he popped
9 in after that eight o'clock hour. The eight o'clock
10 and the two o'clock would have been the longest in
11 duration, the two o'clock one. He'd pop in maybe
12 every hour or two, something like that. But I don't
13 recall the exact times.

14 Q. And in those pop-ins, do you recall what
15 he would do or how long he would be in?

16 A. Yeah. I mean, they were, aside from the
17 eight o'clock and the two o'clock, they -- they were
18 brief. Pop in, get a feel of what's going on. He'd
19 review some, I guess Remi's fetal heart rate
20 tracings, ask Sarah how she's doing. Sometimes he'd
21 do some sort of an assessment on Sarah. And that was
22 the nature of it. Said everything looks good, kind
23 of reassure us, and that was that.

24 Q. Then after the two o'clock hour, he came
25 in and stayed.

1 A. Correct.

2 Q. Now, at that two o'clock hour, did he say
3 anything along the lines of, we're now 10 hours into
4 the second stage of labor. This is extremely
5 prolonged. This is the longest I've ever seen.
6 Anything like that?

7 A. No. Just said, let's deliver this baby.

8 Q. Was there any discussion at that point of,
9 you know, let's do the C-section, or I'm going to
10 decide to do the C-section, or any mention at all?

11 A. No.

12 Q. So in that -- in that nearly, I guess it
13 would be, 2 hours between sometime after 2:00 and
14 when Remi was born as 4:24, what was happening?

15 A. Dr. McNeive was in there with us the
16 entire time. You know, obviously a lot of review of
17 fetal heart tracings. Those papers come out of the
18 machine like crazy. Dr. McNeive was trying to get in
19 sync with Sarah's contractions, I suppose, so he
20 would have a glove on and kind of tell her when to
21 push and when to stop.

22 Q. And how was Sarah?

23 A. She's the trooper. She was still giving
24 everything her all. I believe doing well with
25 everything.

1 Q. And at any point, did anyone mention to
2 you that Remi had -- his strips had gone from a
3 Category II to a Category III?

4 A. No.

5 Q. And I guess you wouldn't have known what
6 that meant anyway?

7 A. No.

8 Q. Was there any sense -- what about
9 tachycardia? Did anybody tell you your baby's heart
10 rate was above 160 beats a minute?

11 A. I would have been aware of the term
12 "tachycardia" and what that means, but nothing
13 explicitly was ever told to us of any concern.

14 Q. And then at 4:24, we know Remi was born.
15 Do you recall what had happened just in
16 that moment?

17 A. The moment of delivery?

18 Q. Yeah.

19 A. Yes. So as it was getting to the point
20 where Remi was about to come out, I suppose, Dr.
21 McNeive gave Sarah some very specific instructions,
22 to push when he said, and to be sure to stop when he
23 said. There was some sort of a maneuver that had to
24 be done. And I remember when Remi came out, I saw
25 meconium, which was referred to in some of the

1 previous testimony, it was fecal matter that had
2 splattered on his gown.

3 Dr. McNeive knew that I was a respiratory
4 therapist and knows about that, and he assured me
5 that that had just happened at that moment in time.
6 Dr. McNeive was holding Remi. The NICU team had
7 arrived, and they brought like a little radiant
8 warmer or baby basin, something like that, and they
9 were kind of off in the corner of the room ready and
10 waiting.

11 I knew enough, having been to other, you
12 know, babies' post deliveries, that Remi did not look
13 good, and Dr. McNeive hand clamped the cord, I
14 suppose, and handed Remi over to the NICU delivery
15 team, and that's when they started resuscitating
16 Remi.

17 Q. So how far away did the NICU team take
18 Remi from where you were?

19 A. Probably the distance of me to the front
20 row here.

21 Q. And what -- what were you doing at that
22 moment when they took Remi?

23 A. It was an intense moment. You know, we
24 had been through this long time and just waiting, and
25 seeing Remi come out, I knew he was doing bad. But

1 Dr. McNeive had to make some cuts on Sarah, as well,
2 and I knew she was bleeding pretty well. And it was
3 one of those tough situations, do I stay here with my
4 wife? or do I step over with my kid? And I stood
5 there with Sarah for a little while, and then Dr.
6 McNeive recommended that I should go over and see
7 Remi, and I did.

8 Q. Okay. So was that within a minute or so,
9 or how long do you think that took?

10 A. I don't recall a lot. I was with Sarah
11 for another minute or so at least.

12 Q. Okay. So then you walk over to where Remi
13 was?

14 A. Correct.

15 Q. And what did you see?

16 A. I knew he was doing poorly. He didn't cry
17 when he first came out. He was very blue, which
18 sometimes it takes a little bit for these kids to
19 pink up. He wasn't moving. They didn't have to do
20 chest compressions, but they did have to provide, you
21 know, the term PPV was thrown out. That is just
22 holding a mask and providing ventilation, pushing air
23 into Remi's lungs. And there was some suctioning
24 efforts and trying to stimulate him and things like
25 that. And that continued for a few minutes.

1 Q. okay. And with respect to the respiration
2 support --

3 A. Uh-huh.

4 Q. -- how long did that go on?

5 A. within, you know, the time I was there,
6 they were able to stop delivering the breaths and
7 just holding a mask on Remi's face. They'd
8 occasionally take the mask off and suction him out.

9 So with meconium, you're worried about that stuff
10 getting in their mouth and getting down into the
11 lungs.

12 So intermittently they would pop that mask
13 off, suction him out, and put the mask back on and
14 give him that support. And I remember not being
15 concerned, from a respiratory perspective, because he
16 was not really coughing or gagging or fighting or
17 anything like that.

18 Q. And if the medical records, Blake,
19 indicate that Remi was still on PPV or oxygen or CPAP
20 at the 5-minute mark, would you have any reason to
21 disagree with that?

22 A. No. Being there as dad and not
23 respiratory therapist, I wasn't paying attention to
24 the time. I'd have to defer back to whatever is in
25 the record, yes.

1 Q. okay.

2 MS. GUNN: Let's to Exhibit 601.

3 Q. (By Ms. Gunn) I know you're trying to see
4 past me.

5 A. You're fine.

6 Q. So this picture was taken at 4:34.

7 Can you show us what we're seeing?

8 A. So that's Remi in the infant warmer. And
9 at this point, you can see the green piece of plastic
10 in the bottom hand part of the screen was the
11 resuscitator, the CPAP bag, the PPV bag we were kind
12 of referring to.

13 I don't know if I cut the cord. You can't
14 see it. I can't tell if that's before or after. It
15 looks like there's some bloody scissors there. And I
16 finally was kind of able to settle in and try to come
17 up and kind of see my son. And he wasn't moving
18 around, and I was just trying to kind of hold his
19 hand.

20 Q. And was he gripping your finger?

21 A. No.

22 MS. GUNN: Let's go to Exhibit 603. This
23 one is also at 10 minutes of life, 4:34 p.m.

24 Q. (By Ms. Gunn) what are we seeing here?

25 A. So you can see that I'm holding some

1 bloody scissors, so I was able to cut the cord. It
2 was already clamped. I believe that is the nurse
3 practitioner we heard from on Friday, at the head of
4 the bed, Mary Younger Spencer. She's holding a
5 suction device.

6 So at this point in time, you can see the
7 resuscitator bag is there and also for Remi, she is
8 either just getting ready to suction, or just
9 finished with that little bulb suction there, and
10 just kind of laying there.

11 Q. And now, as I indicated, this was at 10
12 minutes.

13 At any time that you saw Remi between the
14 time he was born and this 10 minutes, did he look
15 substantially different?

16 A. No.

17 Q. So not really moving?

18 A. No.

19 Q. Not crying?

20 A. No.

21 Q. Had he opened his eyes?

22 A. No.

23 Q. The -- are those -- those are your hands
24 in that picture?

25 A. Correct.

1 Q. You did get to cut the cord?

2 A. I did.

3 MS. GUNN: Let's look at Exhibit 603 --
4 sorry -- 600.

5 Q. (By Ms. Gunn) So, Blake, this one was
6 taken at 4:37 p.m., so this is 13 minutes of life.

7 Are we seeing basically the same
8 situation?

9 A. Correct.

10 Q. Not moving? Not crying?

11 A. No.

12 Q. He was breathing now?

13 A. Correct.

14 Q. I want to talk to you about -- his feet
15 are still a little blue there. I want to talk to you
16 about tone.

17 A. Okay.

18 Q. You -- is that a term that you are
19 familiar with before Remi was born?

20 A. As a registered respiratory therapist,
21 it's something we learn about as we go through the
22 Apgar, the algorithm, and things like that. So I was
23 aware of tone for my previous training, as well as
24 something we look at in a variety of clinical
25 situations. So I was aware of the term "tone," yes.

1 MS. KAMYKOWSKI: Your Honor, can we
2 approach?

3 THE COURT: You may.

4 (Proceedings were held at sidebar, outside
5 the hearing of the jury.)

6 MS. KAMYKOWSKI: As the Court knows, the
7 defense has a motion in limine with respect to these
8 parents who also are licensed health care providers
9 giving opinions as experts, or even, I guess,
10 nonretained or retained experts in this case.

11 As far as where it's going now, it appears
12 that they may be seeking to elicit the testimony from
13 Mr. Anyan to maybe back into essentially his
14 observations about the Apgar score is different than
15 what was given in this case.

16 That was not something that he offered as
17 an opinion in his deposition. It was not discussed.

18 we did not discuss his knowledge of use of the
19 Apgars. In fact, he actually said he didn't know
20 anything about them or that he knew about what tone
21 was. So we would object to this lay witness, which
22 is what he's here for today, as a parent and next
23 friend of this child, offering opinions as a medical
24 professional with respect to retrospective
25 reapplication based on his prognosis at the time of

giving new Apgar numbers, and so that's the objection that I have now, Judge.

THE COURT: Are you going to be asking him to provide an Apgar score?

MS. GUNN: No.

THE COURT: Are you going to be asking him to provide a determination as to what Remi's tone was at the time of birth?

MS. GUNN: He spoke specifically of that, his understanding of what tone is. And he has said specifically that he would -- not in terms of scoring him, but describing what he saw, which was this picture that he was floppy and that he stayed that way. And that's the point of the questions.

MS. KAMYKOWSKI: And I didn't fully explore -- I agree that that fits his description as to what they did and what they saw at the time and what mom said about when the baby was given to her. And that was discussed at length in the motion in limine, that they can say he was floppy and tired and all of those things.

To then specifically get into more of the medical terms as far as his tone and what they thought that meant, I think that goes beyond him as a layperson, and they're seeking an expert opinion.

1 THE COURT: So long as he's not going to
2 provide a score, he can speak to his knowledge of
3 what tone is and what he believed that he saw with
4 regards to the baby.

5 MS. KAMYKOWSKI: Thank you, Judge.

6 (Proceedings returned to open court.)

7 MS. GUNN: Okay. Let's have that picture
8 back.

9 Q. (By Ms. Gunn) Blake, what -- what is your
10 understanding, whatever means, of -- of tone?

11 A. Well, tone is really if those muscles,
12 even if you're not using something, you can see
13 there's sort of referred to as basal tone. I can be
14 sitting here, but I don't look floppy.

15 So when we're talking tone, is the baby
16 moving? Are they tensing muscles? Things like that.
17 So that's what I refer to when I'm looking at -- at
18 muscle tone.

19 Q. Okay. And with respect to your son Remi,
20 this was at 10 or 13 minutes of life, how would you
21 describe his tone?

22 A. Lack of. We use the term medically
23 flaccid, floppy, things like that.

24 Q. And did that -- did that improve? Did he
25 become within, you know, in between these pictures

1 that were taken, did we miss a picture where he was
2 active and full of vigor?

3 A. No.

4 Q. Was there ever a time that you saw your
5 son, in this first, let's say, half an hour, where he
6 looked anything other than what we're seeing in
7 Exhibit 600?

8 MR. WILLMAN: 600.

9 MS. GUNN: Thank you.

10 A. No. Even -- the only changes that took
11 place was we eventually did get to hold him, and he
12 got to go on top of Mom, but he still maintained the
13 same tone.

14 Q. (By Ms. Gunn) In that 30-minute time
15 frame, was he ever actively crying?

16 A. No.

17 Q. I think Nurse Practitioner Younger
18 described a brief, spontaneous cry.

19 Do you even remember that?

20 A. I don't recall.

21 Q. So there was a time obviously that Dr.
22 McNeive was finishing up with Sarah, right?

23 A. Correct.

24 Q. And they, the NICU team, was able to wrap
25 Remi up. You've told us that.

A. Correct.

Q. And so what happens after that?

A. What happens after?

Q. When they wrap Remi up and bring him over to you and Sarah -- or what happens next?

A. Yeah. So once the decision was made by the nurse practitioner that he was not going to go to the NICU, they wrapped him up, and wrapped Remi up, and he was able to go on Mom's chest for the first time.

Q. And how did you feel about that?

A. Happy.

Q. Relieved?

A. Yes.

Q. Were you still concerned?

A. Yes. I had concern about his, from what I would assume at that point, kind of atypical presentation. They said he was tired. But nobody shared any other sort of concerns with us at that time. And trusting the system that we were at, I believed that.

Q. So if Remi got to stay -- we've heard something about, you know, he went to the regular nursery.

Tell us exactly what we're talking about.

1 was he in the room with you and Sarah?

2 A. Yes. So we all stayed in this labor and
3 delivery room for a brief period of time. I want to
4 say maybe until close to their shift change at Mercy,
5 which is around the seven o'clock hour, 1900 military
6 time. We then get moved to -- I don't know what the
7 proper term is -- but Mercy unfortunately, whether
8 it's mother-baby or postpartum.

9 Then we moved to another room. Remi still
10 stayed with us the entire time. But as we moved over
11 to mother-baby, I suppose they do have like a nursery
12 that maybe it's not the same as looking through a
13 glass window type thing that we all kind of think
14 about. But an area where the parents can get rest,
15 and you have nurses back there that they can take
16 care of your baby. But Remi stayed with us, even
17 when we moved into our new room.

18 Q. So you think the moving to a new room was
19 around seven o'clock or so?

20 A. I'd have to look at the records.
21 Somewhere in that vicinity of time, yes.

22 Q. So I want to ask you to share what you
23 recall about Remi in that time frame.

24 So in the time where you all are still in
25 the labor and delivery room, but then also got moved

1 to postpartum, can you help us understand how Remi
2 was doing?

3 A. So Remi was still looking the same. He
4 eventually did open his eyes briefly while we were
5 still in the labor and delivery room. Became, you
6 know, slightly more lively as we moved over into our
7 new room over in mother-baby.

8 You know, having been several hours trying
9 to, you know, recognize he's no longer getting
10 nourishment from Mom now that he's been delivered,
11 Sarah was working with a nurse to try to do some
12 attempts at breastfeeding. Remi, in the new room
13 over on mother and baby, started -- that's the first
14 time we really started to hear him kind of cry and
15 become a little bit agitated.

16 Q. Describe that. What do you mean?

17 A. So baby's hungry. Trying to go and latch
18 on Mom's breast and was having some difficulty doing
19 so. Our nurse out there, on this particular area,
20 was trying to help Remi. We weren't sure if he was
21 in pain or what was going on. He was breathing very,
22 very quickly, is one of main things that sticks out
23 in my mind. And that's really -- we tried to do what
24 we could to see if we could console him, and we were
25 not able to.

1 Q. Did he ever fully latch on and start
2 drinking?

3 A. No. He tried.

4 Q. And, I mean, you all were endeavoring to
5 make that go, make that work?

6 A. Yes.

7 Q. And receiving assistance from what? Like
8 the lactate specialist to try do that or a nurse?

9 A. It was our assigned nurse.

10 Q. Was he -- did he appear to just be
11 agitated, fussy?

12 A. Yes.

13 Q. Was he consolable?

14 A. No.

15 Q. What did you all try to do to console him?

16 A. Everything we could. We were new parents.
17 were open for suggestions. Just assumed that it
18 was -- he was hungry or the head was hurting. We
19 weren't sure, and our nurse wasn't really sure
20 either.

21 Q. You mentioned he was fast breathing, and I
22 know this is your area.

23 So describe that for us.

24 A. So being the respiratory guy, yeah, I am
25 always watching people and things like that,

1 especially family members, much less my newborn son.

2 Sometimes when babies are mad, frustrated, they're
3 going to breathe fast.

4 You know, still not really being sure if
5 anything happened with the meconium, I didn't know if
6 he had some lower airway type stuff, and that was
7 causing him to breathe fast. But he wasn't working
8 hard. He wasn't using a lot of musculature. Just
9 breathing really fast. And not really with a normal
10 pattern like we would usually see.

11 So you think about watching somebody
12 breathe up and down with rhythm. We had periods
13 where he was like panting like a dog, so to speak.
14 And very, very quick, and I noticed our nurse -- I'm
15 bad on names, maybe Reeni or Renee, something like
16 that -- she -- I know all the tricks of how we're
17 trying to watch people breathe and get vital signs.

18 And I saw her trying to obtain that respiratory rate.

19 And I just remember telling her, that's pretty fast,
20 right? He's breathing about a hundred. And she
21 agreed.

22 Q. What -- what is normal?

23 A. As Dr. Kerzner mentioned, as we start
24 getting up above 60, sustained 60 breaths per minute,
25 I start worrying about that. But, once again, his

1 worker breathing wasn't -- he wasn't struggling to
2 breathe. He was just breathing very, very quickly.

3 Q. Did you -- was there anything that was
4 done for Remi at that time regarding the fast
5 breathing?

6 A. No. I don't know if the thought was the
7 pain, and it was his head hurting after the delivery,
8 or if it was frustration and hunger or what was going
9 on, so the decision was made to try and take Remi
10 back to the nursery or back under the nurse's care,
11 let us try and get a little bit of rest, and I
12 believe they were maybe going to try to feed him a
13 bottle or something like that.

14 Q. But do you have a sense about what time
15 that was?

16 A. I'd say probably somewhere between the
17 hours of eight o'clock and 10:00 p.m., 2000 to 2200.

18 Q. So was there, I mean, what you've
19 described from basically at the time he was given to
20 you guys, and up until the time he went to the
21 nursery, would that have been pretty consistent with
22 what you told us, the breathing, the not feeding, the
23 fussiness, the inconsolable, he was consistent
24 throughout that entire time?

25 A. Correct.

1 Q. were you aware of any temperature
2 fluctuations?

3 A. I know whenever the delivery team arrived,
4 you know, over in the L & D unit for Remi, what
5 prompted that was Sarah did spike a temperature in
6 that last hour or so, and that's why they were there.
7 So there was an initial worry about the possibility
8 of infection. And they were able to -- I guess his
9 temperature was normal right before we left, and that
10 was part of their rationale behind why they decided
11 to let him kind of stay with us.

12 So as far as I recall, there wasn't any
13 issue with an increased temperature over on
14 mother-baby or the postpartum area.

15 Q. Okay. Now, was there a time after the
16 nursery, after Remi went to the regular nursery, that
17 you got him back, or what happened next?

18 A. So Sarah and I finally got a little bit of
19 some broken sleep, and, you know, generally shift
20 change, we were 12-hour shifts in health care,
21 typically 7:00 to 7:00.

22 Our particular nurse, I don't know if she
23 was working a mid shift or what was going on, but we
24 had another shift change that happened roughly maybe
25 the eleven o'clock hour. So we worked those kind of

1 mid 11:00 to 11:00 shifts. It could have been the
2 2300 hour. Her name was Kat.
3 And they both came in, and in addition to
4 introducing herself, just kind of told us what was
5 going on back there, and they were still having some
6 trouble with the feedings. He was still really
7 irritable. And I believe somebody had called
8 Dr. Killian, who was going to be our pediatrician.

9 Q. And any understanding of what they were
10 doing for Remi in that time frame?

11 A. Not really, no.

12 Q. Okay. So she just came in and sort of
13 gave you an update.

14 And then what's the next thing you
15 remember happening?

16 A. Trying to go back to sleep a little bit.
17 And then somewhere maybe an hour or so afterwards,
18 whatever measures I'm guessing they were trying back
19 there, I don't think it led to any improvement with
20 Remi, and somebody made the decision to call the NICU
21 again. And that was the conversation I remember them
22 coming and waking us up, and that was Remi was going
23 to be going to the NICU, and having a conversation
24 with another nurse practitioner.

25 Q. What did you learn after that about Remi?

1 A. They were going to go down, take him to
2 the NICU, and we were walking and talking, so I'm
3 laying eyes on Remi again, and we were going to roll
4 down to the NICU. Pretty much I think at that time
5 they were still concerned about the same things we've
6 already addressed. worried about the fast breathing,
7 the inability to feed, the irritability. And I
8 believe the main emphasis was to do a workup for a
9 possible infectious etiology or cause.

10 Q. And did you stay with him -- are you
11 allowed to stay with your baby in the NICU?

12 A. So I did want to go to -- even though I
13 had worked at Mercy for several years, I knew my way
14 around the NICU, you know, we had just been through
15 this long process, we were tired, and I wanted to go
16 down, at least go to his room, make sure I could find
17 my way back pretty easily. And I wanted to see him
18 kind of get settled in, and wasn't sure if I would
19 have a chance to speak with the admitting physician
20 down there or not.

21 I stayed around long enough to see them
22 try and put an IV in Remi. They kind of did explain
23 some of the things that they were doing. And, once
24 again, it seemed like the general workup that they
25 were looking at was infectious in nature at that

1 point. They were drawing blood cultures, looking at
2 bacterias and things like that. They did get a chest
3 x-ray, due to his fast breathing, as well, and I kind
4 of stayed for that to take place.

5 Q. I mean, at this point, how worried are
6 you?

7 A. Being very comfortable with Mercy and
8 knowing their NICU and the people I worked with, I
9 was still pretty comfortable knowing that, you know,
10 I thought he was in good hands. And working with a
11 good group of people, I just assumed that they were
12 going to get us some answers and going to get to the
13 bottom of everything.

14 Q. And based on that, did you feel
15 comfortable going back to the room?

16 A. Felt comfortable enough going back to the
17 room at that time, yes.

18 Q. And, again, to update Sarah?

19 A. Correct.

20 Q. Blake, when did that change?

21 A. So the next morning, I had already been
22 down to see Remi, I think, in the early morning
23 hours, and that would have been May 5th, then, I
24 suppose. Didn't really have a lot to say at that
25 point. And then we're back in the room. Sarah's

1 running a little bit slower than me obviously.

2 We were getting ready to go down to the
3 NICU and visit Remi, and we had a knock on our door,
4 and that was the neonatologist that was coming on for
5 the next day's shift, Dr. Dreyer. And he kind of
6 blind sided us with something we were not expecting
7 to hear about what he thought was leading to Remi's
8 irritability and all of his symptoms.

9 Q. what did you learn?

10 A. He thought he had a head injury.
11 Particularly I think they were working him up for a
12 possibility of a head bleed at that point. And they
13 told us that they thought he was maybe having some
14 seizures. And that shifted the workup from an
15 infectious etiology, it was kind of taking a change.

16 Q. Did ya'll go down to the NICU at that
17 point?

18 A. Took a little while for Sarah to get ready
19 to make that trek, but, yeah, we did go down to the
20 NICU.

21 Q. And what did you see?

22 A. We saw Remi appearing to have seizures.

23 Q. And what did that look like?

24 A. Not pleasant.

25 Q. Help us understand it, Blake. I know it's

1 hard.

2 A. So he was doing some things where he kind
3 of stared off in space, lip smacking, and just didn't
4 look good.

5 Q. Were you aware of additional tests and
6 things that were being done to try to help understand
7 what was going on?

8 A. Yes. Dr. Dreyer, before we went to the
9 NICU, told us that the first order of business was to
10 get a bedside diagnostic imaging, a cranial
11 ultrasound, so to speak. And that was the plan
12 there. Said ultimately we would need an MRI to see
13 kind of what's going on.

14 But with him having the seizures, don't
15 want to take the kid down while he's having seizures
16 and try and get him to lay on a table still and
17 things like that. So I believe at that point, they
18 were giving him a bunch of medications to try to
19 suppress those seizures.

20 Q. The -- the cranial with the brain
21 ultrasound?

22 A. Correct.

23 Q. Were you aware of the results of that?

24 A. I wasn't aware of the results because
25 they told us that it didn't really show what the

1 source was, and he needed an MRI.

2 Q. Did -- were you ever aware that that head
3 ultrasound was somehow of poor quality or needed to
4 be repeated?

5 A. No.

6 Q. And you understood they were doing that to
7 try to figure out what was going on with your child
8 to make him have seizures?

9 A. Correct.

10 Q. What about was there an EEG?

11 A. Prolonged EEGs.

12 Q. And what is that?

13 A. So whenever somebody's having a seizure,
14 you know, you can see these distinct physical
15 manifestations we think about when we hear the term
16 "seizure."

17 But that's not good enough, right? You've
18 got to try and really get some solid diagnostics. So
19 it's kind of like if you think about getting an
20 electronic tracing to your heart, an EKG, it's kind
21 of the same idea.

22 With me not being a radiologist,
23 explaining of course, they put a bunch of electrodes
24 on Remi's head, wrap him gauze, hook up to a monitor
25 in the room, and you're able to kind of confirm are

1 these seizures, and also kind of take a look at the
2 underlying activity of the brain?

3 Q. So let's look at Exhibit 604.

4 what -- I believe this was taken on

5 May 5th, so the next day.

6 what are we seeing?

7 A. So that's the EEG I was talking about.

8 That's Remi in his NICU room. And me, I believe

9 that's my hand -- that looks like my hand instead of

10 Sarah's -- me trying to hold his little hands, and

11 when he would have seizures, they didn't stop, so

12 trying to console your child.

13 Q. You would try to hold his hands?

14 A. Yes.

15 Q. You mentioned the MRI.

16 when did that happen?

17 A. I can't recall the exact date. I know

18 that they wouldn't -- they wanted to get it quickly

19 because they couldn't suppress his seizures, despite

20 all of the medications that they were giving him.

21 And I believe we had that probably late in the

22 afternoon/evening of possibly May 6th.

23 Q. Okay. So about two days old?

24 A. Sounds correct.

25 Q. What was your understanding of the results

1 of that Blake?

2 A. Dr. Thalakoti was Mercy's pediatric
3 neurologist, and, you know, neurologists have to talk
4 about all this high level stuff to parents all the
5 time, and he was particularly obviously concerned
6 about the situation, but he was happy that we were
7 health care providers.

8 So he pulled up the imaging and tried to
9 explain things to us there at the bedside that
10 evening as soon as the results came back and was able
11 to confirm what his suspicions were based on the EEG,
12 that Remi suffered a pretty significant injury.

13 Q. Okay. Did he -- did you understand the
14 term "HIE"?

15 A. The term "HIE" was actually never shared
16 with us for -- for quite awhile until later on in our
17 stay.

18 Q. So what was the diagnosis that was shared?

19 A. That he had a hypoxic brain injury, but I
20 had never heard of the actual term "HIE."

21 Q. Let's go -- I want to walk through --
22 first of all, let me go back.

23 Do you recall any further discussions with
24 Dr. McNeive while Remi was in the NICU?

25 A. I do.

1 Q. Can you tell us about those?

2 A. I think Dr. McNeive had a couple of days
3 off, and we're going through this, and I don't think
4 he was aware that we were in the NICU. And I suppose
5 that we're still on the list for certain decisions
6 and things like that, and we would have otherwise
7 been going home. And I couldn't tell you the exact
8 morning, but Dr. McNeive came down once he realized
9 that Remi was in the NICU.

10 Q. And do you recall any conversations with
11 him?

12 A. Yes. He told us he was sorry and didn't
13 know what happened. And, let us know if you need
14 anything.

15 Q. Do you remember anything that you would
16 have said to him?

17 A. You know, we all liked each other, it felt
18 like, and, you know, we were just there for each
19 other, really.

20 Q. Okay. Going through your time at the
21 NICU, how long was Remi in the NICU?

22 A. Seemed like an eternity, but in the grand
23 scheme of things, there's people that are in the NICU
24 for far longer. Some more. I want to say 40-
25 something days, we were able to go home.

1 Q. And I believe that the homecoming date was
2 June 18th.

3 Does that sound familiar?

4 A. I'll take your word for it.

5 Q. You all would have celebrated your
6 birthday in the NICU in May?

7 A. Celebrated -- so Remi was born on the 4th.

8 Sarah -- I think Mother's Day was maybe the 10th.

9 Sarah's birthday is the 14th, and mine is the 16th.

10 So we celebrated Mother's Day, we celebrated Sarah's

11 birthday -- we're the same age for a day -- and

12 celebrated my birthday.

13 Q. And I bet you point that out to her all

14 the time.

15 A. Yeah.

16 MS. GUNN: So let's go to Exhibit 607.

17 Q. (By Ms. Gunn) And, Blake, this was taken

18 on May 27th, 2020.

19 what's -- what's in -- what's that tape to

20 Remi's face?

21 A. That's referred to as an NG tube or

22 nasogastric tube. One of the struggles with Remi's

23 injury continually affects the ability to use your

24 muscles.

25 And one of those first set of muscles that

1 a baby used, one of the few things they can do is
2 take to a bottle or breast, and he severely struggled
3 with being able to take breast milk. So even though
4 we were trying to work with speech therapy and some
5 of these other specialists to try and get him to take
6 food via bottle, a lot of times he wasn't able to
7 complete a feeding in teeny-tiny little amounts. And
8 we'd have to continue to give him his nourishment
9 through that tube, so we take the breast milk and put
10 it in a big syringe and give it to him in that
11 manner.

12 Q. What was being -- what was the goal of
13 being in the NICU that long?

14 A. So our goal was to make sure that his
15 seizures were suppressed. So even when that was --
16 you can see he's not wearing the EEG cap in this
17 particular picture. Was trying to avoid putting
18 what's called a PEG tube or a feeding -- a permanent
19 feeding tube in through the stomach.

20 And, you know, we weren't ready to give up
21 hope that we could get Remi to the point where he
22 could take nourishment by mouth. And even though it
23 was discussed that, you know, if we got this PEG tube
24 earlier, we could go home a little bit earlier, we
25 were encouraged to not just give up just yet.

1 we were trying to give Remi any degree of
2 freedom as we could and try to subject him to as
3 little as possible. And I am glad that we listened
4 to those providers because getting your baby home
5 does sound very nice, but in hindsight, I'm very
6 grateful that were we able to get him to continue to
7 eat by mouth and eventually get that out.

8 Q. And now you mentioned the seizures.
9 Did they continue while they were in the
10 NICU?

11 A. Intermittently. But not near as bad as
12 they were for those first several days.

13 Q. And he was on a number of medications?

14 A. Correct.

15 Q. The -- they were all antiseizure
16 medications?

17 A. Anticonvulsants or antiseizure medicine,
18 yes.

19 Q. And did he go home on those, as well?

20 A. Yes.

21 Q. You're still avoiding any kind of PEG or
22 feeding tube?

23 A. One thing that Remi does very well is he
24 likes to eat. You all will meet him, I believe, here
25 later this morning, and he is quite large. You know,

1 it's obviously difficult to process all this stuff
2 happening to your kid, but, you know, knowing that
3 he's going to struggle with, you know, maybe not a
4 lot of the normal things, I try to think, okay, well,
5 if you could try to get up and move, or you could sit
6 and eat good food all day, not as terrible, right?
7 And I told you, I cook a lot of good food. So we are
8 able to get him to do well, and he continues to
9 thrive with eating.

10 Q. Now, Blake, if the jury sees fit to find
11 in Remi's favor and award him some money in this
12 matter, what is your understanding of where it goes?

13 A. That money is Remi's, not ours, right? It
14 gives him a lot of security. Obviously, you know,
15 right now I can take care of him and what he needs to
16 the best of my abilities. But there's never any
17 guarantees, okay? And that scares us.

18 So we would hope that it would be managed
19 in a way that Remi continues to get anything he
20 needs -- pardon me -- even after I can't take care of
21 him anymore, and, you know, even though -- pardon
22 me -- even though that -- you know, Remi's injuries
23 are irreversible, the damage is done, there's a lot
24 of things that can help him have normalcy.

25 Q. A lot of things that can help --

1 A. I'm sorry.

2 Q. -- Remi be the best that he can be.

3 A. It can give him qualities of life and an
4 ability to -- ability to partake in things that every
5 kid should be able to.

6 Q. Now, Blake, I want to walk you through --
7 you okay?

8 MR. WILLMAN: I'm sorry, Judge. May we
9 approach and get something informal out of the way?

10 THE COURT: You may.

11 (Proceedings were held at sidebar, off the
12 record, outside the hearing of the jury, and the
13 proceedings returned to open court.)

14 THE COURT: This seems like a good time
15 for us to take our morning recess.

16 (At 10:52 a.m., the Court duly admonished
17 the jury, and proceedings stood in recess. At

18 11:13 a.m., the following proceedings were held in
19 open court:)

20 THE COURT: Go ahead and be seated,
21 everyone.

22 MS. GUNN, you may resume.

23 MS. GUNN: Thank you, Your Honor.

24 May I have Exhibit 613?

25 Q. (By Ms. Gunn) All right. Blake, what are

1 we looking at here? And I'll direct your attention
2 to the number on Remi's hat.

3 A. Thank you for clarifying that one. Yes.
4 This is a big day, his first birthday. And a
5 ginormous cake.

6 Q. And what?

7 A. And a ginormous cake.

8 Q. And did you make that?

9 A. No.

10 Q. You're the cook.

11 A. I can cook but not bake well.

12 Q. Okay. How were you all feeling that day?

13 A. Happy, excited. Excited that he got to
14 enjoy a little bit of that cake.

15 Q. Yeah. It was a long process during that
16 first year. And I am going to ask Sarah some
17 questions about that.

18 But in terms of how you were feeling, and
19 how Remi was doing, can you help us understand a
20 little bit about that first year.

21 A. The first year was a challenging one.

22 with his injury, continued to have a lot of
23 irritability. So there's a lot of times of screaming
24 during the daytime hours, trying to continue to get
25 him to take his medications, you know.

1 Like with my daughter, if she doesn't want
2 a bottle, it's okay. But when you're mixing
3 medications, you know, he has to take them.

4 Sometimes getting him to take that last little bit of
5 medicine, was a challenge. And, you know,
6 fortunately Remi was born, you know, in the warmer
7 months. A lot of times the only thing that would
8 really sooth him would be walking on our trail in the
9 woods while trying to feed him a bottle. So we would
10 be wearing headphones, sometimes because of the
11 screaming. A neuro scream is very loud and
12 continuous, and it's tough to try to console him and
13 trying to get him to take the medication. So it was
14 a challenging one.

15 And anytime we had a good day, you know,
16 was a big win for everybody. And by the time he was
17 reaching his first birthday, you know, we started to
18 have a lot more good days, and this is a particularly
19 good one.

20 Q. What meds was he on in that first year?

21 A. A lot of medications. Some of them for
22 the seizure control. Some of them to -- I kind of
23 alluded to some of the struggles of cerebral palsy,
24 some muscles can't use at all. Other ones, they're
25 too tight. So giving him different medications to

1 try and ease that kind of muscle tone and make them
2 functional.

3 And, you know, the other thing, some of
4 these kids that have cerebral palsy, they can feel
5 things going through their GI tract more than you or
6 I can. That's called visceral hyperalgesia. So part
7 of the struggle is to get him to take his medicine.

8 But, by trying to get him to drink medicine, it hurts
9 his stomach, and he can feel all the things coursing
10 through, so that was another big medication. We have
11 to give him something to kind of suppress some of
12 that sensitivity in his stomach.

13 Q. And did that take some tweaking to kind of
14 get right?

15 A. It's a never ending battle, yes.

16 Q. Even now?

17 A. We're in a good place right now.

18 Different medications and things like that. But the
19 steady states are very brief.

20 Q. You said neuro scream. What do you mean?
21 what is a neuro scream?

22 A. So I realize that every child has temper
23 tantrums sometimes where they're going to cry,
24 although our daughter has been sweet. So a lot of it
25 is just difficulty processing the environment around

1 you. With the nature of Remi's injuries, we begin to
2 find out more and more. Another complicated thing
3 that he suffered, due to the part of his brain injury
4 or brain injured, is something called CVI: cortical
5 visual impairment. Nothing's wrong with his eyes,
6 but the part of his brain that takes that input from
7 his eyes so he can process it, he struggles with
8 that.

9 So imagine a world where you feel
10 everything going through your stomach, and it hurts,
11 and your brain is going to take a long time to heal.
12 And he had just a lot of continued fussy and
13 irritability, feeling everything going on in his
14 stomach, and then really not know what's doing on in
15 the world around you. Think about all the visual
16 input you get at every moment of your day. It kind
17 of makes sense in the context of what's happening
18 around you, and he didn't have it. And it took us a
19 little while before we realized that was part of the
20 problem.

21 MS. GUNN: Exhibit 616.

22 Q. (By Ms. Gunn) Okay. So I call this the
23 victory pose picture. It looks like this was in
24 January of 2022, so he's a year, over a year, and a
25 half.

1 what's -- what's going on here?

2 A. well, just like any kid, I mean, once
3 again, Remi is, we believe, really cognitively aware
4 of anything like any other kid, right? He just has
5 trouble kind of with motor control, and he likes to
6 wrestle. He likes to kind of roughhouse just like
7 any other kid. But he struggles a little bit. So,
8 you know, from time to time, we'll go at it a little.
9 He's getting a little bit better. And this

10 particular case is one of the days that he happened
11 to maybe get me vested there, and he was victorious.
12 Yeah. Yeah.

13 Q. Is it also helpful with his -- with the
14 tone, to work with him on these things?

15 A. Yeah. So with Remi, so we have a very
16 extensive therapy schedule, right? So early on, you
17 meet with a lot of these therapists. But it's not
18 enough, it's not constant. So the whole idea is
19 these therapists work with your kid at that moment in
20 time that week, and they're showing you what to do
21 with him at home, right?

22 Doing something once a week, is not
23 enough. So a lot of our play that we do with Remi is
24 also therapy. You're kind of blurring those things,
25 so to speak. So, yeah, anything we can do with

1 dynamic movement, getting Remi moving, gives him that
2 kind of feedback to his muscles. These big movements
3 that kind of make him be able to kind of go along and
4 do some of those normal type things.

5 so, yeah, we're kind of stretching it -- I
6 mean, this right here is really me going, he's the
7 winner. So it's not therapy, but we do stretch his
8 limbs and do therapy every day of his life.

9 Q. And do you find that the therapy is
10 helpful?

11 A. Yes.

12 Q. And how so?

13 A. So, once again, it's not about reversing
14 Remi's injuries. That's -- that's irreversible. But
15 the functionality, your ability to approach things
16 that we all take for granted, you know, with some
17 degree of independence, some degree of normally.

18 Therapy can help him do those type of
19 things, trying to make sure that, you know, we put
20 him in the best position and best situation every day
21 to be able to use his hands, even if it requires
22 assistance. Be able to walk, even it requires him to
23 be in like a walker type setup. So it helps.

24 MS. GUNN: Let's go to Exhibit 633.

25 Q. (By Ms. Gunn) Again, a birthday photo.

1 which birthday?

2 A. Number 3.

3 Q. So now we are 2023, May 2023. And you
4 mentioned the gait and helping to walk.

5 what do we see here?

6 A. So aside from his birthday crown, that is
7 what I was referring to as his walker. So the proper
8 term is a gait trainer. So Remi can use his limbs --
9 right? -- so I know early on he wasn't moving and
10 things like that. He can use his limbs, but he
11 struggles with that kind of gross motor function.
12 One of those things that he struggles --

13 Q. Let me just stop here.

14 A. Yeah.

15 Q. The gross motor function --

16 A. Being able to use your arms, your legs,
17 your head, all these different things that we do
18 without even thinking about it, Remi struggles,
19 right?

20 so he might know that he wants to take
21 some steps. It might take him a little while to
22 figure that out. And he doesn't have the core
23 strength, he doesn't have the abs and the trunk
24 support, to be able to do those things without some
25 sort of assistance.

1 his legs are very, very strong. He just
2 lacks the core to kind of be able to stand in an
3 upright position unassisted. So this gait trainer is
4 like, if you want to think about it as a standing
5 wheelchair. He kind of sits on a little stool. He
6 can bear weight on his legs to help his bones and
7 muscles develop and things like that. But he doesn't
8 have to worry about falling over and hitting his head
9 or anything like that. He's strapped in. And then
10 he can kind of move his legs and try to self propel.
11 He loves that thing.

12 Q. And is he, I mean, he's strapped in?

13 A. Correct.

14 Q. Does he have like any other core help
15 there?

16 A. Yes. Something that is part of Remi's
17 every day, any time we are trying to get him to
18 ambulate or move or bear weight in his stander, he
19 needs all the support we can give. So even though
20 he's got mechanical support in this thing, we wear
21 what's called a Benik vest, so it's kind of like a
22 compression vest, kind of squeezes that torso and
23 kind of gives him a little bit more functional
24 strength.

25 MS. GUNN: Let's go to Exhibit 634.

1 Q. (By Ms. Gunn) okay. So this is the first
2 day of school?

3 A. Correct.

4 Q. August 2023?

5 A. Yes.

6 Q. You made that one simple.

7 A. Yeah.

8 Q. So let's talk briefly -- I'm going to ask
9 Sarah some questions about it, too -- but let's talk
10 briefly about his school?

11 A. Okay.

12 Q. Tell me about the school.

13 A. Yeah. So it's pre-K. So Remi qualifies
14 for an early intervention program. So he started,
15 after turning 3 that May, and ultimately he gets his
16 therapy services there. It's not like a full day of
17 school. We drop him off. And he sees the speech
18 therapist, the occupational therapist, the vision
19 therapist. He gets a lot of therapy services there.
20 It's more for socialization, and, you know, he gets
21 that in town by our home.

22 Q. And how does he get there?

23 A. So we do have to provide his
24 transportation. You know, so Remi, not being able to
25 get up and jump in the vehicle, I usually carry him

1 and put him in the vehicle and kind of drop him off.

2 Because we made the decision to leave St. Louis

3 County, and we kind of live out in the woods a little

4 bit, the bus won't come down our, a wheelchair

5 accessible bus, won't come down our road because we

6 have to have so much pavement, and I do live at the

7 end of a gravel road, so we are responsible for his

8 transportation.

9 MS. GUNN: Let's go to Exhibit 639.

10 Q. (By Ms. Gunn) All right. Dad, that's a

11 classic. So I don't know, I mean, who's winning that

12 fight?

13 A. I feel like you've chosen all photos in

14 which I have not been victorious. But --

15 Q. I've got one more, don't worry.

16 A. I'm sure.

17 Q. I'll help you out. I'll help you out.

18 A. So Remi likes to get in what we call his

19 wheels, his gait trainer. And, you know, I mentioned

20 that even us playing, it's therapy, right? So even

21 though it doesn't seem like much, we use his orthotic

22 braces to get him to kind of open his hands up and

23 help him to kind of be able to hold things.

24 And we gave him these life sabers or

25 swords as a gift, but he really, really enjoys it.

1 with the cortical visual impairment, a high contrast
2 of light makes it helpful. So as soon as he started
3 playing with these, he loves them. And we'll get him
4 in the gait trainer, and he will kind of chase me
5 around a little bit. And then he struggles with
6 doing a full swing. So sometimes he'll hold it kind
7 of like a jousting stick and run at me and try to get
8 me. And he was getting the better of me this
9 particular day.

10 Q. (By Ms. Gunn) All right.

11 MS. GUNN: Let's go to Exhibit 642.

12 Q. (By Ms. Gunn) I told you I'd give you
13 one.

14 A. Yeah.

15 Q. All right. So I understand that you like
16 to fish?

17 A. Correct.

18 Q. And you want your son to fish with you.
19 That's something you would enjoy and that he enjoys?

20 A. So there was a lot of work in the making
21 getting up to this point. We talked to Remi about
22 fishing. This was something he was interested in
23 trying to go and do.

24 Q. And how did you know that?

25 A. So he's used to me making a lot of fish,

1 and I cook them up and things like that. And he
2 hears us talking all the time processing things. And
3 that's something that I try to meet with my dad and
4 do. My dad lives about a hundred miles west of St.
5 Louis these days. So we try and meet up at a place
6 called Meramec Springs, which is a trout park, and go
7 fishing. And he's -- he was all vocal and excited,
8 and we didn't know what was going on, and asked him,
9 and he told us he wanted to go fishing, and so we
10 made that happen.

11 Q. How did he tell you that?

12 A. With his button: yes/no.

13 Q. Okay.

14 A. And once he told us, you know, I wanted
15 him to be actually able to fish. I mean, most kids
16 aren't going to want to just sit there and watch Dad
17 land all these lunker trout.

18 There's a lot of work getting him to this
19 point. Some of those fish are actually, like the
20 ones he's holding, are actually the fish he caught.
21 So part of, you know, trying to set therapy and play
22 kind of merge, found a really cool toy, just a little
23 motorized fish that swims around in the water, and
24 he's got a magnet on its mouth and a little fishing
25 pole, and it's got little lures.

1 so we started out getting him, strapping
2 that little fishing pole in his hands, a little toy
3 set, we get him fishing in a little kiddie pool, and
4 I do put up a little pool for us in the summertime,
5 and then we got him on his little float, and that
6 fish swims around, and it latches on, and he knew
7 that whenever that fish latches on, he could feel it.
8 He started setting the hook. And took him out to
9 Meramec Springs. And I believe this is probably his
10 first or second trip there, and he's a natural.

11 Q. And he's your boy.

12 A. Oh, yeah, you know.

13 Q. Now, you strap the pole to him. And do
14 you cast it for him?

15 A. So while they make assisted fishing
16 equipment, things like that, but we don't -- we don't
17 have any of that. We just have a regular little
18 kid's fishing pole. Sarah repurposed his old vest
19 that I was telling you about, the compression vest.
20 You know, he's a big kid, he outgrows a lot, so we
21 have all this very high-strength velcro.

22 Sarah is a -- a pretty big innovator. She
23 makes this special little brace where we can strap
24 this fishing pole to his hand. And then I kind of
25 got to do a hand-over-hand to help him cast. And you

1 can't fish lures where you've got to reel it in very,
2 very quickly.

3 so I'll take his hook and roll on a little
4 bit of bait, and we'll kind of -- I'll have him try
5 and point which area he wants to try and cast, and
6 I'll try to help him cast it out there. And then he
7 can kind of sit there with his little pole, but
8 sometimes he pulls a little bit too hard when he
9 thinks he feels something, and it scares them away.

10 But we've had a lot of very experienced fishermen
11 move along after them not catching anything, and
12 he'll start catching trout.

13 Q. And how easy is it to get him to where we
14 are in this picture in terms of -- what do you call
15 this device?

16 A. That is a -- that is a regular jogging
17 stroller that I retrofitted with a lunch tray mounted
18 to a platform to keep his legs stationary. And then,
19 yeah, that allows me to kind of push him down
20 alongside the stream to get him to the good fishing
21 holes and things like that.

22 so, yeah, I'm also very crafty, I suppose,
23 when it comes to making things that can help Remi
24 kind of enjoy the stuff we want him to and he wants
25 to. But, yeah, it's a little bit of a challenge.

1 Going anywhere is a challenge. There's a lot of
2 equipment and medications and all those things, but
3 we make it happen.

4 Q. Now, Blake, you told us a little bit ago
5 about some of your concerns. I -- can you share with
6 us what your concerns are for Remi now and in the
7 future?

8 A. So right now, you know, being able to
9 do -- look at things like transportation. I can pick
10 him up and take him down a set of stairs and load him
11 in a vehicle, you know. Mom, after having our
12 daughter, is back to the point where she can, too,
13 but that's not necessarily sustainable.

14 Q. What does he weigh right now?

15 A. He's just shy of 50 pounds right now. So
16 unfortunately this house we live in and been working
17 on since we moved there, you know -- what? -- 13
18 years ago, is not the most accessible. There's a lot
19 of stairs involved, but we can kind of move him and
20 all of his equipment. It takes several trips.

21 So things like the logistics there, being
22 able to continue to give him the therapy services
23 that gives him a good -- a good attempt of being able
24 to do those things we take for granted, whether
25 that's eating or walking. We're continuing to work

1 with him to maybe walk with minimal assistance. You
2 know, so that's more of the short-term type stuff.

3 The equipment side of things that he
4 needs, he keeps gaining and growing, and those
5 pieces of equipment don't last forever, so, you know.
6 And in the big picture of things, once again, I work
7 as hard as I can to kind of provide for everything
8 Remi needs right now.

9 But, you know, there's concerns about what
10 happens if something happens to one of us. You know,
11 being able to move Remi up and down, we didn't even
12 think about, you know, when Sarah was pregnant and
13 not being able to lift 50 pounds anymore, you know,
14 post, you know, delivery.

15 And me having to be able to step away from
16 work and me trying to be that caregiver for him. We
17 don't, even though we have family that live nearby,
18 our in-laws, they're a little bit elderly and frail,
19 they can't lift Remi up.

20 My father-in-law, you know, he's got some
21 unfortunate medical stuff. He can't even hold our
22 daughter who's only like 12 or 13 pounds right now.

23 We don't really have anybody that we can be assured
24 and count on to step in and help Remi out, should
25 something happen to us.

1 we don't ever want Remi to end up in a
2 home or something years down the way. We want him to
3 be able to continue to have some degree of
4 independence and live in his home, be able to do
5 things he likes doing, rather than just sitting
6 there. And we want him to be able to ensure that he
7 can get the care that he needs and the equipment that
8 he needs and never be lacking.

9 MS. GUNN: Can I have Exhibit 641?

10 Q. (By Ms. Gunn) I just thought that was
11 timely.

12 A. Very appropriate for today.

13 Q. This was last year.

14 A. Yes.

15 Q. But I thought we might as well celebrate.

16 A. Yes. Sarah's family is Irish, and, yeah,
17 they provided us with this flag. And Remi likes to
18 hold things in his hand and kind of wave it and stuff
19 like that. He did try and use it as a weapon later
20 that morning.

21 Q. He's a boy.

22 A. Yeah. But he got a kick out of that one.

23 Q. Thank you, Blake. I appreciate that.

24 A. Thank you.

25 THE COURT: On behalf of the defendants?

MR. WILLMAN: Thank you, Judge.

CROSS-EXAMINATION

BY MR. WILLMAN:

Q. Morning, Blake.

A. Morning, Mr. willman.

Q. You and I have talked before and met before?

A. Yes.

Q. And I've shared with you our sorrow about what has happened to Remi.

A. I appreciate that.

Q. Yeah. I do have some questions. Let me start with how you got to see Dr. McNeive.

It was your wife Sarah who had asked around about recommendations for obstetric care, is that right?

A. Yes, I believe so.

Q. And he came well recommended to the both of you?

A. Yes.

Q. And you wanted somebody who was personable?

A. Yes.

Q. And you met him once or twice before regarding labor and delivery?

1 A. Correct.

2 Q. And you liked his bedside manner?

3 A. Yep, I did. I really liked Dr. McNeive.
4 I think he liked us, too. Good sense of humor, very
5 knowledgeable and capable, is what my impression was
6 of him, and I liked him.

7 Q. And it was a good relationship?

8 A. I'd say so, yes.

9 Q. Okay. And he seemed confident with what
10 he was capable of doing?

11 A. Yes.

12 Q. And you learned at some point that he had
13 done a number, a lot of deliveries, right, before
14 being involved with Remi?

15 A. I did not know the number of deliveries,
16 but from what I heard, he had been at Mercy for a
17 decently long period of time, yeah.

18 Q. All right. C-sections. You told us about
19 what conversations happened about that or didn't
20 happen?

21 A. Correct.

22 Q. You understood, though, what -- that Dr.
23 McNeive knew that you understood what a C-section
24 is -- didn't you? -- as a health care provider?

25 A. Yes. Dr. McNeive did a good job of not

1 trying to maybe do the same spiel he does with every
2 family or anything like that. He didn't -- he never
3 had to explain anything like that, really.

4 Q. Because he knew that you had more
5 knowledge than a lot of folks would have about that?

6 A. I'm sure he assumed that we knew what a
7 cesarean or C-section was, yes.

8 Q. Okay. All right. So let's move up in
9 time to May 4th about 8:00 a.m., I think is what you
10 said, when Dr. McNeive first came in?

11 A. Correct.

12 Q. Just to make sure we take the jury through
13 all of what he did, when he came in, he first talked
14 to your wife Sarah Anyan, is that right?

15 A. Correct.

16 Q. About how she was doing?

17 A. Correct.

18 Q. She had been pushing?

19 A. Correct.

20 Q. And he looked at the strips, the
21 monitoring strips, that you talked about earlier?

22 A. Correct.

23 Q. And he examined her, didn't he?

24 A. Yes.

25 Q. He actually examined her physically to see

1 where Remi was in terms of position, right?

2 A. Yeah. He even did some sort of digital --
3 I refer to it as a digital exam -- and, you know, I
4 don't know if it's reflected in the record, but I
5 thought he did a straight catheterization to relieve
6 the bladder of urine at 8:00 a.m.

7 Q. And by saying "digital," you mean by using
8 his fingers?

9 A. Correct.

10 Q. And he told you that everything looked
11 good?

12 A. Yes.

13 Q. And he encouraged Sarah to continue
14 pushing?

15 A. He said Sarah was doing great, the baby
16 looked great, everything looked great.

17 Q. And between 8:00 and 2:00 p.m., when he
18 came, and he was there minute-to-minute with Sarah,
19 he did come in periodically and see her, I think you
20 said, every one to 2 hours or so?

21 A. I'd say probably between -- before two
22 o'clock, probably some three to four times, somewhere
23 along those lines.

24 Q. Every time that he would come in, he would
25 do the same thing: Look at the strips, talk to Sarah

1 to see how she was doing, do an examination to see
2 where Remi was positioned, fair?

3 A. That could be. I don't recall every
4 single visit. But it was always, how are you doing?
5 Looking at the rhythm strips, making sure everything
6 was good, and kind of reassuring us, yeah.

7 Q. And then you told us about laboring down.
8 You thought laboring down means just take a break,
9 right?

10 A. Correct.

11 Q. And at each time that he was called to do
12 a C-section, Sarah was told to take a break, and she
13 did?

14 A. Correct.

15 Q. And so there was no pushing going on
16 during those times?

17 A. Correct.

18 Q. All right. Now, at two o'clock, he
19 arrives there and then stayed there, as we've said,
20 up until the time of the delivery?

21 A. That's correct.

22 Q. And during that time, he was constantly
23 examining Sarah, wasn't he?

24 A. Yes.

25 Q. He was helping her with her pushing and

1 telling her when to push and when to stop?

2 A. I think between the hours of 1400 or two
3 o'clock, and when Remi came out, I don't think he
4 really moved away from his position there with Sarah.

5 Q. And during that entire time, he was
6 checking to see where Remi was in position by doing a
7 digital examination that you talked about?

8 A. I believe he had a finger in most of the
9 time, and he was trying to coordinate with the
10 contractions and telling her when to push and making
11 sure everything was okay.

12 Q. And you believed or understood that Remi
13 was making progress?

14 A. That wasn't explicitly stated, but we
15 figured everything was okay.

16 Q. All right. Then when it was said that
17 your wife had a temperature, that's when this NICU
18 team came in, is that right?

19 A. Correct. I --

20 Q. I'm sorry. Go ahead.

21 A. Yeah. As she's -- her temperature began
22 to go up, Dr. McNeive had asked the bedside nurses to
23 call the NICU due to her temperature.

24 Q. And you understand that that NICU team was
25 a nurse practitioner, a register nurse, and a

1 respiratory therapist?

2 A. That would usually be the case. Having
3 worked there at Mercy, I knew that respiratory
4 generally goes to any of these deliveries. And, you
5 know, having been through this long process, I was
6 kind of -- not that I want a former colleague to see
7 my wife in delivery and everything -- but I was kind
8 of wondering who the respiratory therapist was going
9 to be to see if it was somebody I knew. And they
10 told me that the respiratory therapist generally
11 doesn't show up for a maternal temperature.

12 Q. All right. But it was a team of doctors
13 and nurses who came in as part of the NICU.

14 A. No doctors. It would have been a nurse
15 practitioner and maybe bedside nurse.

16 Q. And something else Dr. McNeive talked to
17 you about right before delivery is that he told you
18 that he may need to make an incision on her? On
19 Sarah?

20 A. The -- are you referring to the
21 episiotomy?

22 Q. Yes.

23 A. Correct.

24 Q. And an episiotomy is a incision to help
25 the baby come out, is that right?

1 A. Yeah. And that wasn't discussed until the
2 very final stretch, and he anticipated some problems,
3 I suppose.

4 Q. Right before delivery?

5 A. Correct.

6 Q. And he told you that he had to do some
7 maneuver to help get Remi finalized out of the womb,
8 is that right?

9 A. That'd be correct.

10 Q. All right. And you saw him doing that
11 maneuvering?

12 A. Not from his perspective, but yes.

13 Q. And then Remi came out, is that right?

14 A. That is correct.

15 Q. And after Dr. McNeive had done this
16 maneuvering, got Remi out, clamped the cord, and then
17 the NICU team took over, is that kind of a fair
18 summary of that that -- that time frame?

19 A. Yes, that would be correct.

20 Q. All right. Then afterwards, the nurse
21 practitioner, Mary Spencer-Younger, was talking to
22 you while she was working on Remi, right?

23 A. Correct.

24 Q. And she was explaining to you what she and
25 the team were doing?

1 A. Yes.

2 Q. And she talked to you that there were some
3 Apgar scores, but you don't know what that meant?

4 A. She -- I did not know Mary Younger from a
5 professional level. So she just explained to me some
6 of the resuscitative measures they were doing and
7 what she was doing. She never told me what his Apgar
8 scores were or anything of that sort.

9 Q. Sure. And they did the resuscitation?

10 A. Yes.

11 Q. And you understood and saw that he
12 responded -- "he" meaning Remi -- that he responded
13 well to that resuscitation, didn't he?

14 A. His breathing did improve with
15 resuscitative measures.

16 Q. To the point where he was able to breathe
17 on his own?

18 A. Eventually, yes.

19 Q. And you understood that his numbers looked
20 good. And good enough that he could stay with you
21 and Sarah?

22 A. I had assumed that he was just going to go
23 to the NICU because of some of my concerns, and I was
24 told that they weren't sure just yet -- and when I
25 say "they," I'm referring to the NICU and delivery

1 team -- they weren't really sure. They had to plug
2 something into the computer and see if he would go --
3 stay with us or go down to the nursery. They didn't
4 really explain what exactly they meant by plugging
5 that in, but they said he was tired, but otherwise
6 looked like he responded to the resuscitation.

7 Q. And he responded well enough that he did
8 not need to go to the NICU. Is that your
9 understanding?

10 A. That was their impressions, yes.

11 Q. Okay. And after that, he got to the point
12 where he was breathing strong enough on his own,
13 fair?

14 A. Correct.

15 Q. All right. His heart rate was okay?

16 A. Yes.

17 Q. And you were able to cut his cord?

18 A. Yes.

19 Q. which is a great father thing to do, isn't
20 it?

21 A. Absolutely.

22 Q. Yeah. So in the meantime, Dr. McNeive is
23 tending to Sarah, is that right?

24 A. That is correct.

25 Q. And he was closing up the incision that he

1 had made?

2 A. There was quite a bit of bleeding, and,
3 yeah, he was taking care of Sarah.

4 Q. He was paying attention to her?

5 A. That would be correct.

6 Q. All right. So then the next time that you
7 see Dr. McNeive is May 5th or May 6th -- you're not
8 sure what the date is -- but sometime after Remi was
9 taken to the NICU?

10 A. Yes. After Dr. McNeive finished with
11 Sarah, and he's leaving the room, I mean, he was able
12 to see Remi smile, and go on and taking care of other
13 patients, and, yeah, he didn't see him until the
14 NICU.

15 Q. And when he came in, he did not know what
16 had happened to Remi, did he?

17 A. He knew he was in the NICU, and I don't
18 know if he knew exactly why or what prompted that at
19 that point, so he came to check on us and check on
20 Remi.

21 Q. And he told you he didn't know what had
22 happened to Remi, and he wanted to find out for you?

23 A. That sounds accurate, yes.

24 Q. So he did some things to try to find out
25 what had happened, true?

1 A. He told us he wasn't sure what happened
2 and was looking over everything, and came down to
3 really check on us and console us.

4 Q. So, for example, one of the things he did,
5 and this was during the time of the pandemic, he
6 said, let's look at --

7 MS. GUNN: Your Honor, may we approach?

8 THE COURT: You may.

9 (The following proceedings were held at
10 sidebar, outside the hearing of the jury:)

11 MS. GUNN: I understand that -- or if I
12 had to guess -- the next line of questions are going
13 to be about COVID and the antibodies. And I believe
14 we've gone the whole trial without talking about
15 COVID. I think that opening up a box about COVID
16 since May of 2020, could be very prejudicial. The
17 answer is going to be that Dr. McNeive had Sarah take
18 a COVID antibody test, which was negative.

19 And because he had had the conversation
20 with a neonatologist about what was going on with all
21 these babies with HIE in the NICU, my concern is that
22 I think it's opening the door that is going to be
23 misleading to this jury about how -- the things that
24 COVID could or could not have done, and I think it's
25 improper and prejudicial.

1 MR. WILLMAN: All that I am establishing
2 is that Dr. McNeive did investigate -- he was doing
3 things to investigate what had happened, and that's
4 the point.

5 THE COURT: Why mention COVID?

6 MR. WILLMAN: Pardon me?

7 THE COURT: Why mention COVID?

8 MR. WILLMAN: Because it's one of the
9 things he looked into as an example. I'm going to
10 leave it at that. And I can follow up and say it
11 turned out that it was negative, though, if that
12 would help ease the Court's concerns.

13 THE COURT: There's so many conspiracies
14 about whether or not COVID did or didn't exist and
15 how it impacted people. And I don't think that that
16 fact that it came back negative is going to be
17 sufficient to assuage the jury's concerns with regard
18 to do you recall we've had a year of litigating over
19 whether or not everyone should be wearing masks or
20 not?

21 MR. WILLMAN: Right.

22 THE COURT: And people very voraciously
23 disagreed on a lot of these issues.

24 MR. WILLMAN: Sure.

25 THE COURT: I don't see the need to do the

1 COVID stuff. There's other stuff he did that you can
2 talk about, but I don't see the need to do the COVID
3 stuff.

4 MR. WILLMAN: All right.

5 (Proceedings returned to open court.)

6 Q. (By Mr. willman) So picking up on the
7 conversation, you know, Dr. McNeive was in disbelief
8 about what had happened, true? Is that what your
9 impression was?

10 A. Yes, I would say so.

11 Q. All right. And from then on, he would
12 come in periodically to visit with Sarah Anyan and
13 Remi and yourself when you were there, is that right?

14 A. Whenever he was on service, he did tend to
15 continue to pop in sometimes. Whether it was the
16 beginning of his shift, in the middle, or the end, it
17 kind of varied, but we continued to see him for a
18 while.

19 Q. And when he would come in, he would show
20 his support, is that right?

21 A. Yeah. See how -- see how we're doing, see
22 how Remi's doing.

23 Q. offered his help?

24 A. Talk to us, you know.

25 Q. Did he offer to help?

1 A. There wasn't a lot of things he could do
2 to help, but just come there to support us, yes.

3 Q. And it wasn't uncommon for him to come in
4 when he was in the hospital to visit with you all?

5 A. I would agree with that.

6 Q. And he was very compassionate, wasn't he?

7 A. He seemed genuine, yes.

8 Q. Thank you. That's all I have.

9 THE COURT: Cross-examination?

10 MS. KAMYKOWSKI: Thank you.

11 CROSS-EXAMINATION

12 BY MS. KAMYKOWSKI:

13 Q. Blake, I only have a couple of questions
14 for you. And, again, I'm sorry that we're all here.

15 A. Thank you.

16 Q. Going back to your time with my clients,
17 Nurse Jessie and Nurse Maggie --

18 A. Okay.

19 Q. -- you remember them, correct?

20 A. I do.

21 Q. And I think you told us at your deposition
22 that between seven o'clock, when their shift started
23 after they took report from Alex, until two o'clock,
24 when Dr. McNeive was with them in the room at the
25 bedside, both nurses were always in the room with you

1 and Sarah, correct?

2 A. There would be times where maybe Jessie
3 would step out to talk to somebody or something like
4 that, but we had a nurse the entire time.

5 Q. Okay. And when you had the nurses in the
6 room with you, they were attentive to Sarah, were
7 they not?

8 A. Seemed to be.

9 Q. And they were watching the monitor?

10 A. Yes.

11 Q. And they were checking her progress at
12 various times, correct?

13 A. I don't recall them doing the same digital
14 examinations we had talked about, but they continued
15 to check on Sarah, yeah.

16 Q. And they were -- I think you told us in
17 your deposition -- that they were aware that Remi may
18 have been a little malpositioned in there, correct?

19 A. Correct.

20 Q. And that throughout that time, they were
21 using different pushing positions with Sarah to
22 attempt to get him lined up, correct?

23 A. There was a lot of different positioning
24 things and her on exercise balls and all sorts of
25 different maneuvers, I would agree with that.

1 Q. And then I think you just told Mr. Willman
2 that throughout that time, and you told us that in
3 your deposition, that before four o'clock, so that
4 whole day, Remi was making progress? Slow, but
5 progress, correct?

6 A. I mean, nobody explicitly told us, you
7 know, slow and steady progress or anything like that,
8 but we assumed that things were going the route that
9 they should.

10 Q. And I think you -- and I can't remember if
11 it was Ms. Gunn or Mr. Willman -- but when we were
12 talking a little bit about what was going on while
13 you were at the isolette with Nurse Practitioner
14 Younger after Remi was born, you said your memory may
15 not be the greatest, obviously there was a lot going
16 on that day, and it has been almost 5 years, so you
17 would defer to the medical records for details of the
18 resuscitation, is that fair?

19 A. You're saying in regard to whether he was
20 on the CPAP and the timing and his Apgars and things
21 like that?

22 Q. Yeah. I think you said you'd defer to the
23 record on those things.

24 A. I believe what I said was, yeah, as far as
25 the timing and what measures are taking place at

1 different times, we'd just have to defer to the
2 records on that, correct.

3 Q. And as a health care provider yourself,
4 you have been taught about how to make medical
5 records, correct?

6 A. Yes.

7 Q. And the importance of making sure that
8 medical records are accurate and that they reflect
9 the care that was actually provided?

10 A. Yes.

11 Q. Okay. You don't have any reason to
12 dispute that the medical records in this case don't
13 accurately reflect the care that was provided by
14 whomever put those notes in the record, correct?

15 A. I wouldn't refute the timing of whatever
16 they're saying was being providing at that given
17 time. Once again, I was there kind of as dad and not
18 respiratory therapist that day, so I wasn't being as
19 diligent on watching the clock as I otherwise would
20 be. So in that context, yes.

21 Q. And the -- I call it an isolette. I think
22 that might be the medical term. But kind of the
23 little bassinet bed that they put Remi in for the
24 resuscitation -- we saw him in those photos -- you
25 had seen those types of setups for the babies before,

1 correct?

2 A. Correct.

3 Q. And you know that he had -- I know we
4 heard this from Nurse Younger on Friday afternoon --
5 he had a heart rate monitor, that was that little
6 heart rate on his belly, right?

7 A. Correct.

8 Q. And that is actually connected to that
9 bed, and it has a monitor you can see, right?

10 A. Yes.

11 Q. And same for, I think she told us that he
12 had an oxygen saturation, like a wristlet, around his
13 right wrist. Do you remember that?

14 A. Yeah. Right hand, pulse oximetry, yes.

15 Q. And, again, that's connected to the bed
16 somehow, and it has a monitor that would show that,
17 right?

18 A. Yes.

19 Q. And so that monitor was showing his O₂
20 saturation, so how much oxygen was perfusing in his
21 blood, correct?

22 A. Not exact physiologic in context, but I
23 understand where you're coming from, yes.

24 Q. You know a lot more about that than I do,
25 I'm sure. Okay. But it's measuring how much the

1 percentage of oxygen in his blood, in a very broad
2 lawyer, non-respiratory therapy standpoint?

3 A. I could agree with that.

4 Q. Okay. And that would have been available
5 on that bed. His heart rate would have been
6 available on that bed. His temperature -- I believe
7 they had a temperature probe on him, as well?

8 A. Right.

9 Q. And would it also be monitoring his
10 respiration rates?

11 A. We have the ability to measure respiratory
12 rates non-evasively. It picks up on tiny, little
13 motions and artifacts and things like that.
14 Generally, in those types of situations, we are
15 relying on a manual measurement. So I don't know if
16 they actually had respiratory leads and
17 electronically obtaining that versus manual
18 assessment.

19 Q. And the manual assessment is with a
20 teeny tiny stethoscope? Is that what they're doing?
21 Or just watching his chest rise and fall?

22 A. Stethoscope is listening to the heart.
23 For respiratory, you couldn't listen to breath
24 sounds, but you generally watch.

25 Q. Okay. And I think you told us that around

1 60 is what you're looking for for neonates, of 60 and
2 under, for a normal heart rate?

3 A. Looking at the --

4 Q. Sorry. For a normal respiratory rate.

5 A. -- for a respiratory rate, yeah. As it
6 starts getting up above generally 60, you can start
7 kind of looking a little bit more, things like that.

8 Q. And I think you said maybe later, when you
9 were watching him after, and I think you called her

10 Remi. There is a name in the record, her name is
11 Maureen Phoebe. Would maybe somebody who goes by the
12 name Maureen have a nickname Remi, or...

13 A. Very well could be, yes.

14 Q. Okay. She seems to be the mother-baby
15 nurse after Sarah was transferred -- after your
16 family was transferred -- to that area. Does that
17 sound -- kind of ring a bell to you?

18 A. I would agree, yes.

19 Q. And that the two of you, at that point
20 after transfer from labor and delivery to

21 mother-baby, you had seen -- you, because of your

22 training, were like, oh, okay, you were maybe

23 counting his respirations with her trying to come up

24 to where she was at that time. Is that what you told

25 us before?

1 A. Yes. And I didn't notice any
2 abnormalities in regards to his respiratory rate in
3 labor and delivery. And then he was on mom for a
4 little bit and not really worried about that. And
5 then just, like you said, part of doing what I've
6 done for the amount of time I've done it, is the
7 qualities of watching somebody breathe. So finally I
8 could kind of see him, and I saw her -- I recognized
9 what she was doing, looking at her watch and trying
10 to count him breathing. That's when I'm kind of
11 counting, as well, and realized he's breathing a
12 little fast at that time, yeah.

13 Q. And he had been moving -- it's something
14 that I think previously last week we saw one record
15 that sometime in the first hour or so after he was
16 born, he had a heart rate that was at 68. Is that
17 something that caused you concern?

18 A. As a health care provider, a heart rate of
19 68, yes.

20 Q. Okay. And 60 would be within the upper
21 limit of normal for a neonate, correct?

22 A. You're talking respiratory rate or heart
23 rate?

24 Q. Oh, sorry, you're right. Let me start
25 that over.

1 talking about his breathing. If 60 is the
2 upper limit of normal-- I think you may have alluded
3 to this on your direct -- something in the 68 range,
4 if the baby's active, if the baby's moving, that
5 maybe -- you're kind of taking it into the clinical
6 context to see if, are we worried about a high
7 respiration rate? or is this just kind of an active
8 baby, and let's keep watching, is that fair?

9 A. In the kids I've worked with, you do have
10 to consider the context in which you're obtaining
11 that number. It could be 68 when they're mad and
12 you're trying to do something, and kind of resume
13 back to normal. It's not just the number. we're
14 really looking for quality. So if it's fast, is it
15 regular, or is it working hard? Things like that.

16 Q. And I think what you told us, though, is
17 based on your observations of Remi from the time he
18 was born, and the resuscitation efforts began, until,
19 you know, he was taken to the newborn nursery for the
20 feeding help, he pretty much had the same appearance
21 to you, is that fair?

22 A. From the time going from the labor and
23 delivery room till we got to the mother-baby, or
24 whatever you're referring to?

25 Q. So, I mean, I think I thought you told us

1 that essentially he was -- you used the word flaccid,
2 floppy, not -- he was breathing on his own, correct?

3 A. Yes.

4 Q. But he was not crying, he was not moving.
5 That that condition persisted from when he was
6 delivered until you let him go to the newborn nursery
7 for feeding?

8 A. His muscle tone, things like that, stayed
9 pretty much the same. He did start to cry, and
10 inconsolably, by the time we were over there in
11 mother-baby. He continued to breathe. I didn't have
12 any concerns about his respiratory rate at the time
13 of delivery to the extent that I did whenever he was
14 over at mother-baby and breathing very fast.

15 Q. And the inconsolable crying, that
16 happened when -- you've seen a couple of the records
17 with the difficulties with breastfeeding, that's when
18 that began, is that fair?

19 A. Somewhere in that time frame probably,
20 yes.

21 Q. Okay. Talking just about Remi currently,
22 because I know we've looked at some photos now -- and
23 it sounds like we're going to get to meet him today,
24 which I will look forward to because I have not had
25 that pleasure -- is he able to eat on his own right

1 now?

2 A. what do you mean by "on his own"?

3 Q. If you put him in his stander or in a
4 highchair, and put some cutup food in front of him,
5 is he able to pick it up and feed himself?

6 A. It looked that one picture that Ms. Gunn
7 showed with a mess everywhere. So he has the desire
8 to try and get food to his mouth, but generally we
9 got to support him at the elbow level, and, you know,
10 he can make some efforts with some assistance. If we
11 allowed him to just do that, it would take him
12 forever in one meal, yeah.

13 Q. And then I think it sounds like we might
14 get to see him in his gait trainer. It looks like a
15 really cool --

16 A. We'll see how he's doing today.

17 Q. -- contraption. But without the gait
18 trainer, he can't stand and walk on his own, is that
19 true?

20 A. No. That's not entirely true.

21 Q. Okay. Tell me about that.

22 A. So he can bear weight as long as he's
23 wearing his Benik vest that I kind of talked about,
24 whether that's just of static standing at a couch,
25 sometimes standing up against us, taking a seat

1 somewhere, he can bear a little bit of weight.
2 whenever we're trying to ambulate with him, getting
3 him walking and things like that, generally we'll use
4 the gait trainer. It is a little bit of a logistical
5 challenge to take that thing everywhere we go.

6 So one of our frequent outings is over to
7 Sarah's parents. They live about 10 or 12 minutes
8 away from us. And it's where his third birthday
9 picture was taken. Usually we'll take his wheels
10 with us, but sometimes we don't, and sometimes we
11 need to decide what piece of equipment goes with us.
12 He can actually, with support from us, and in lieu of
13 the gait trainer, he can take some kind of
14 independent steps, as long as we just keep him from
15 falling and things like that.

16 Q. Thank you so much. That's all I have.

17 A. You're welcome. Thank you.

18 THE COURT: Any redirect?

19 MS. GUNN: No, Your Honor.

20 THE COURT: Thank you very much, sir. You
21 may step down.

22 THE WITNESS: Thank you.

23 THE COURT: All right. Based on the
24 timing, this is probably an appropriate time for us
25 to take our lunch recess.

1 (A break recess was taken at 11:58 a.m.,
2 and the jury was duly admonished. At 1:04 p.m., the
3 following proceedings were held in open court, in the
4 presence of the jury:)

5 THE COURT: Go ahead and be seated,
6 everyone.

7 On behalf of the plaintiff.

8 MS. GUNN: Thank you, Your Honor. I call
9 Sarah Anyan. And Remi Anyan.

10 So, Your Honor, with your permission,
11 we're just going to -- I'm going to have Sarah sit
12 down.

13 You want to say hi. So you can say hi.

14 REMINGTON ANYAN: Hello.

15 MS. GUNN: I know you're excited. I know.
16 So hello. Real excited. You want to say
17 hello? Yeah, you can calm down and say hello.

18 Excited.

19 REMINGTON ANYAN: Hello. Hello. Hello.

20 MS. GUNN: I'm going to stay right here.
21 I'm going to stay right here with you. Mama's going
22 to go. I am going to stay right here. And daddy's
23 coming. Got it?

24 THE COURT: Okay. Ma'am, if you'll raise
25 your right hand.

1 SARAH ANYAN,
2 having been duly sworn, was examined, and testified
3 as follows:

4 DIRECT EXAMINATION

5 BY MS. GUNN:

6 Q. Please state your name.

7 A. My name is Sarah McDonald Anyan.

8 Q. And, Sarah, who are we looking at here in
9 front of the jury?

10 A. That's Remi.

11 Q. And how old is Remi right now?

12 A. He's 4 and a half.

13 Q. I just -- before the record began, we
14 brought Remi in, and he has a little device here.

15 Can you tell us what this is?

16 A. So that's his button. We use that when
17 we're out and about. When we're like up in our gait
18 trainer, and we're wild, we use that when we're out
19 in the world. It's got yes, no, we're all done,
20 hello, good-bye. Just so he can talk to people and
21 kind of communicate. He does use a Tobii at home,
22 but the Tobii is big and expensive, and the other
23 kids tend to think it's a tablet, so...

24 Q. So Remi is talking to us in Remi's way.

25 A. Uh-huh.

1 Q. How would you describe him right now?

2 A. He is really excited. We have been
3 talking about court. He's excited. He wants to see
4 you hit the gavel, just so you know. But, yeah,
5 he's -- he's really excited. And he's probably going
6 to, when he leaves here, go run around in the hallway
7 with dad in his gait trainer.

8 Q. Thank you, Sarah.

9 MS. GUNN: All right, Daddy. You're up.
10 Good bye, Remi. Good-bye. Good show.
11 You had your show.

12 (Remington Anyan exits the courtroom.)

13 Q. (By Ms. Gunn) Okay. Thank you, Sarah.
14 Okay. We started with your name. Tell us
15 where you live.

16 A. We live in Pacific, Missouri.

17 Q. And who lives with you there?

18 A. It is Blake, me, Remi, his new baby sister
19 Rory, and our dog Hattie.

20 Q. Well, it was fun. That was kind of a test
21 because Blake mentioned Hattie. I wasn't sure if you
22 were going to.

23 A. Oh, yeah. Hattie is part of the family.

24 Q. Where did you grow up?

25 A. We both grew up in Fenton, Missouri.

1 Q. And Blake told us that you all met in high
2 school.

3 A. We did.

4 Q. And started dating in high school, but
5 then went different places for college.

6 A. Yeah.

7 Q. Where did you go to college?

8 A. I went to Maryville University.

9 Q. And what did you study there?

10 A. Nursing.

11 Q. What years would that have been?

12 A. I graduated in 2011.

13 Q. And when -- what did you -- what was your
14 degree in in college?

15 A. So a bachelor's of science in nursing.

16 Q. So in 2011, were you ready to start
17 nursing?

18 A. Yeah. I got out. I got an internship at
19 MoBap, and then I started my job there.

20 Q. What kind of things did you do at MoBap?

21 A. I started out with an internship on a,
22 like, postsurgical unit. So I started out in that,
23 like, post open heart surgery. And then after that,
24 I got my first real nursing job on the telemetry
25 floor. So it was adult cardiac nursing, and it was

1 like acute care, so acute cardiac issues.

2 Q. And when did you and Blake get married?

3 A. Oh, gosh. 2012, yeah.

4 Q. How long were you at MoBap?

5 A. I think like 5 years.

6 Q. And then did you switch jobs?

7 A. I did. I left that job to go work at St.

8 Clare in Fenton because I wanted to do cardiac cath

9 lab, but you're on-call with that job for people who

10 are having heart attacks, so you have to be within 30

11 minutes of that hospital. So I couldn't do that at

12 MoBap, so I had to go to someplace closer.

13 Q. Because St. Clare is closer to where y'all

14 are?

15 A. Yeah.

16 Q. Okay. I mean Pacific.

17 A. Yeah.

18 Q. And how long were you there?

19 A. Two years.

20 Q. Where did you go after that?

21 A. Then I worked at Mercy.

22 Q. What year would that have been?

23 A. Oh, I -- let's see. I had Remi in 2020,

24 so like 2018. Because I was at Mercy for two years

25 before I had him.

Q. what did you do at Mercy?

A. So I worked in the clinical decision unit, and it is a -- kind of an area above the emergency room. They take low acuity patients. A lot of times it is cardiac patients. That's kind of where I fit in there. So a lot of times people waiting for their stress tests, kind of having to stay overnight, mainly low risk patients.

Q. Did you enjoy that job?

A. I did, yeah.

Q. We know that you started seeing Dr. McNeive or the Mercy Clinic practice for your OB/GYN care; is that right?

A. Yes. Yes.

Q. And you saw them even before you got pregnant?

A. Yes. Because, you know, we wanted to make sure we were doing everything right while we were trying.

Q. Now, when you were in the previous position, whether at MoBap or St. Clare or even at Mercy, did you ever work on a labor and delivery floor?

A. No. In nursing school, you go through a rotation because that's how you figure what specialty

1 you want to be. So in nursing school I did a
2 rotation in like a labor and delivery unit, but it
3 was also postpartum. It was also the nursery. And
4 it's very brief, and you're more like an observer.

5 Q. And in that rotation in nursing school,
6 did you ever learn anything about how to read fetal
7 monitoring strips?

8 A. No.

9 Q. Or what, you know, I guess administration
10 of Pitocin or anything like that?

11 A. No.

12 Q. Did you learn anything about the stages of
13 labor and how long each stage is typically?

14 A. No.

15 Q. Okay. Now, when you started with the
16 Mercy Clinics practice, you indicated that you were
17 trying to do everything right.

18 so tell us about your decision to start a
19 family.

20 A. Yeah. So we've been talking about it for
21 a while. One of the reasons that I actually really
22 liked my Mercy job was that it had really flexible
23 hours. You could work 4-hour shifts, 8-hour shifts,
24 whatever you wanted. So I was kind of ready with
25 that. But we met a nurse practitioner who I had been

1 seeing, just kind of mentioned that, you know, we
 2 wanted to start trying. And she was like, you know,
 3 take prenatal vitamins three months before, and then,
 4 you know, kind of told us like how to come off birth
 5 control. We were extra cautious. I gave myself lots
 6 of time, just because I wanted to make sure
 7 everything went well. Quit drinking diet soda.

8 Q. I know you told us about nursing and never
 9 doing any labor and delivery. This was -- Remi was
 10 your first child?

11 A. Yeah.

12 Q. And do you have siblings?

13 A. I do.

14 Q. And had you been involved in any of the
 15 labor and delivery, specifically of any of your
 16 siblings?

17 A. No. I was the first of my sisters to have
 18 a baby.

19 Q. What about best friends or super good
 20 friends? Anything like that?

21 A. No.

22 Q. I saw in the record, you know, a lot of
 23 times people take the prenatal classes or courses.

24 Did you all do that?

25 A. We did not. We asked Dr. McNeive, and,

1 you know, he kind of felt like with our backgrounds
2 we probably were okay. Blake and I were kind of like
3 with our schedules, 12-hour shifts, couldn't really
4 find one that was going to work for us, you know, and
5 I know he kind of just said like, your health care
6 team will kind of like guide you.

7 Q. So that's something that you discussed
8 with Dr. McNeive, and he said, you're fine?

9 A. Yeah. And I had read like four books, you
10 know, what to Expect when You're Expecting. Birth
11 Partner. I can't remember the other two.

12 Q. And in either of those books, do you
13 recall learning specifically about how long a second
14 stage of labor should be or how to read fetal
15 monitoring strips? Or anything specific like that?

16 A. No.

17 Q. Okay. Do you recall any concerns being
18 expressed to you throughout the course of your
19 pregnancy with Remi?

20 A. No. I know towards the end, when I was
21 really big, Dr. McNeive was like, lay off the salt.
22 Lay off the popcorn. But that was -- that was about
23 it.

24 Q. There had been some evidence or a note
25 about a low-lying placenta in an ultrasound.

1 Do you remember that being -- coming to
2 your attention?

3 A. Yeah. But it moved, so then it wasn't a
4 concern anymore.

5 Q. And you understood -- what was your
6 estimated delivery date when they thought Remi would
7 come?

8 A. I can't remember. I want to say it was
9 May 5th. And then I know if he didn't get there in
10 time, they were going to plan like an induction like
11 on the 7th or something. But I kind of went into
12 labor, like my water broke on the 3rd.

13 Q. Now, do you remember any -- filling out
14 any papers or any forms or being asked to
15 specifically state what your birthing plan was?

16 A. No. But I didn't have an elaborate
17 birthing plan.

18 Q. What do you mean?

19 A. I think being a nurse, you kind of realize
20 that a birthing plan isn't really realistic. You're
21 going to show up, and you're going to do what they
22 tell you. And the baby is going to come out the way
23 they want it to, basically. Like I didn't have an
24 elaborate birthing plan. My birthing plan was just
25 safety.

1 Q. was there ever a time in your prenatal
2 care, Sarah, or while you were in labor with Remi,
3 that you refused a C-section?

4 A. No.

5 Q. was there ever a time that anybody offered
6 you a C-section or recommended a C-section?

7 A. No.

8 Q. Is there any possibility that you said, I
9 want a vaginal delivery?

10 A. No, I never said that.

11 Q. So if it was stated in opening statements
12 that you thanked Dr. McNeive for giving you the
13 vaginal delivery that you wanted, is that true?

14 A. No. I would not throw around the word
15 "vaginal." That's just not something I would say.

16 Q. Okay. Now, we know that your water
17 broke -- let me ask you this: You tried to watch
18 your weight with Remi?

19 A. Yeah.

20 Q. You felt like you were kind of big?

21 A. Yeah.

22 Q. We all -- we all do.

23 A. Yeah.

24 Q. And were you told that you had gained too
25 much weight or any concern with your health during

1 the pregnancy?

2 A. No. No. I mean, I did feel very big. At
3 one of my last appointments with one of nurse
4 practitioners, I, you know, kind of mentioned, like
5 I'm really big. Are we still thinking that this is
6 going to be a vaginal delivery? And she was like,
7 yeah, it should be fine. Everything's good. okay.

8 Q. okay. And that last visit was not with
9 Dr. McNeive?

10 A. No. It was one of their nurse
11 practitioners.

12 Q. All right. So it's true, then, that even
13 in that last visit, you've never had a conversation
14 with Dr. McNeive about, I want this, or, I don't want
15 that, with respect to delivery?

16 A. No. I had no preference.

17 Q. okay. So we get to -- we get to May 3rd.

18 A. uh-huh.

19 Q. so tell us about that day.

20 A. Yeah, I like took a shower or like a
21 lukewarm bath and got out and laid down for a nap.

22 And I woke up, and it must have been the storm that
23 rolled through that caused my water to break. But I
24 kind of yelled at Blake from upstairs. I was like,
25 hey, I think I peed. And he was like, no, you didn't

1 pee in your sleep, your water broke. I was like, oh,
2 okay. So he was like, we've got to get your bags in
3 the car. And I think he ate like a quick sandwich,
4 and then we got on the road.

5 Q. I apologize. But I want to back up. I
6 promise I'll pick up with the --

7 MS. GUNN: Zack, can we do Exhibit 6, page
8 110.

9 Q. (By Ms. Gunn) This is a note from your
10 prenatal care with Dr. McNeive, and it's dated
11 March 13th, 2020, so not quite two months before you
12 delivered.

13 And it indicates: Baby active, patient
14 doing well, no complaints, found a ped, labs normal.
15 And I don't know that you have a specific
16 recollection of this visit, Sarah. But what I'll ask
17 you is baby active.

18 was Remi an active baby?

19 A. Yeah.

20 Q. I mean, how so?

21 A. He was always kicking me.

22 Q. I mean, he still kind of wants to?

23 A. Yeah. It kind of makes sense, considering
24 how much he loves soccer now. I'm sorry.

25 Q. You okay?

1 A. Uh-huh.

2 Q. would you like a glass of water? Are you
3 sure? Listen, there's a kleenex there.

4 A. Yeah, I found them.

5 Q. And, Sarah?

6 A. Yeah.

7 Q. If you want to take a break, let me know,
8 okay?

9 A. No, I'm okay.

10 Q. I know.

11 A. I'm okay. It was just a lot easier for
12 him to move in the belly, you know. He was very
13 active.

14 Q. okay. was there -- was there
15 any discussion, concern, expressed to you about
16 Remi's health at any time before you got to the
17 hospital on May 3rd, 2020?

18 A. No.

19 Q. was there ever a time that Remi wasn't
20 active and kicking?

21 A. No.

22 Q. okay. so let's go back to May 3rd.

23 And you are now getting yourselves to the
24 hospital.

25 A. Uh-huh.

1 Q. And you -- you check in --

2 A. Uh-huh.

3 Q. -- to was it OB triage?

4 A. Yeah. It's that -- it's like where you go
5 to deliver. You're going to the right, there's a
6 whole center there.

7 Q. Okay. Any -- did you feel okay? were you
8 even feeling your contractions?

9 A. No. No. I, you know, I was surprised at
10 how much water comes out, so I had like a towel, you
11 know, kind of wedged down there as we're like walking
12 in, which is embarrassing, but, no, I mean, I felt
13 fine.

14 Q. what happened next?

15 A. They came in, kind of examined things.
16 They weren't sure if my water had completely broken
17 or partially broken. But they were like, yeah, your
18 water broke, it's not pee.

19 Q. Confirmed.

20 A. Confirmed, yeah.

21 Q. Did you get to a room?

22 A. Yeah.

23 Q. And what did they do, once you got to the
24 room?

25 A. So once we got up to like the labor and

1 delivery unit, they gave me an IV, started Pitocin,
2 and then, you know, I was kind of sitting on an
3 exercise ball for a while.

4 Q. when you were hooked up to the IV and got
5 Pitocin, did you know prior to that what Pitocin was
6 for generally?

7 A. I mean, I know from nursing school that,
8 you know, it helps with the contractions, but
9 that's -- that's about it.

10 Q. Did you know anything specifically about
11 what the dosing should be? I may have already just
12 asked you that, but anything specific about the
13 dosing or turning it up and down or under what
14 circumstances that should be done?

15 A. No.

16 Q. And was the fetal monitoring on?

17 A. Yeah.

18 Q. In the room, is that something that you --
19 is sort of in your line of sight? Or where is that?

20 A. No. So that's like behind me. And like
21 even when I was laboring, like I -- it's not like
22 anywhere that I can see. I also -- I wouldn't know
23 how to read that.

24 Q. And was it literally like spitting out
25 pieces of paper? Or was it all just digital?

1 A. I don't know honestly. I don't really
2 remember.

3 Q. Do you remember it making any noises?

4 A. I don't remember.

5 Q. It's all right. Needless to say, when you
6 talk about -- when we talked about fetal monitoring
7 strips, and I know you haven't been here. You're
8 relying on Blake to update you at the end of the day.

9 But were there any -- did you have any previous

10 knowledge of categories in the fetal monitoring
11 strips, I, II, III, decels? Anything like that?

12 A. No.

13 Q. Okay. Now, when you first got hooked up
14 to the monitors, did anyone express to you any
15 concerns about you and how you were doing, or Remi
16 and how Remi was doing?

17 A. No.

18 Q. As far as you can tell, everything looked
19 like it was going smoothly?

20 A. Yeah.

21 Q. And no one expressed any worries or
22 concerns?

23 A. No.

24 Q. So, now, at some point, there was a nurse,
25 Alex.

1 Do you remember Alex?

2 A. I do, yeah.

3 Q. Was she your night nurse?

4 A. Yes.

5 Q. Were there a couple of hours that you
6 pushed with her?

7 A. Yeah.

8 Q. So tell us about that.

9 Did you understand what it meant to be
10 complete?

11 A. I did understand that. I know that that's
12 when you're like fully dilated, you know. That's
13 about it.

14 Q. And were you told, ready? It's time?

15 A. Yeah.

16 Q. Were you up for it?

17 A. I was.

18 Q. Were you still feeling pretty good?

19 A. Yeah, I was at that time.

20 Q. And you had an epidural?

21 A. I did.

22 Q. And did that help with the pain, and --

23 A. Yeah. Because I really didn't have pain
24 until about two 2 hours like before I was dilated,
25 and that's kind of like when I had the epidural

1 placed.

2 Q. Okay. And anybody express any concerns
3 about the epidural?

4 A. No.

5 Q. All right. So now you're with Nurse Alex,
6 and Blake was there, as well?

7 A. Yeah.

8 Q. Any doctor in the room during that first
9 couple of hours of pushing?

10 A. I don't think so. When we got towards the
11 morning, Dr. Parker was on, and she just came in and
12 kind of touched based and said, you know, hey, you
13 know, just letting you know everything is looking
14 good. You know, you might have to go for a
15 C-section. We'll see. Your doctor is coming on
16 soon.

17 Q. Okay. There's been some evidence in the
18 case about Dr. Mckillip, who was a resident, who was
19 asked to do a pushing evaluation.

20 Do you remember that?

21 A. I don't remember that, but I mainly just
22 remember Alex.

23 Q. Okay. Did you have any notion of why Dr.
24 Parker may have mentioned that you may need a
25 C-section?

1 A. She had said that like, you know, I was
2 making progress but slow progress, but that was all
3 that we knew.

4 Q. And did you know that Dr. McNeive was
5 coming on in the next shift?

6 A. Yeah. She told us that.

7 Q. And how did you feel about that?

8 A. We were excited about it because we were
9 happy to have a doctor that we had spent all this
10 time with. You know, we were comfortable with him.

11 Q. And after Dr. Parker got off shift, and
12 Nurse Alex got off shift, there were two other nurses
13 with you?

14 A. Yeah.

15 Q. One was Nurse Jessie and then Nurse
16 Maggie?

17 A. Yes.

18 Q. And what was your understanding of Nurse
19 Maggie's role?

20 A. So Maggie was on orientation, and she was
21 working with Jessie.

22 Q. Okay. Now, at any point after Nurse
23 Maggie and Nurse Jessie came on service, and they
24 were your 1:1 or 2:1, right?

25 A. Yeah.

1 Q. was there any mention by either of those
2 nurses about C-section at all?

3 A. No.

4 Q. At no point throughout the rest of the
5 day?

6 A. No.

7 Q. Were you reassured by that?

8 A. I mean, yeah. I mean, I guess. We didn't
9 really -- they just said everything was okay. And so
10 we thought that we were good.

11 Q. Prior to that time, well, so in this time
12 frame, let's go like from 7:00 a.m. to the 2:00 p.m.
13 we'll talk about that.

14 So this 7 hours, did anyone, either Nurse
15 Jessie or Nurse Maggie or even Dr. McNeive, mention
16 to you anything about your -- how long this pushing
17 stage had been going on for you?

18 A. No.

19 Q. Or that it was the longest any of them had
20 ever seen?

21 A. No.

22 Q. Were there different position changes
23 going on?

24 A. Yeah, a lot.

25 Q. Okay. was there a time when you would do

1 a position change, and everything would be fine and
2 great. And then several hours go by, and there was
3 another position change? Or what was the timing of
4 those?

5 A. I feel like they were pretty frequent
6 position changes. I know we did a lot of, I think in
7 the early morning hours, they had me do this move
8 where I kind of arched back, tried to grab my ankles
9 to get Remi to move or something, and they had me on
10 all fours, on top of that ball, on my side, on my
11 other side, on my back.

12 Q. Okay. So did you feel like you were
13 frequently making or moving around?

14 A. Yeah.

15 Q. I know you had that epidural. It's not
16 always that easy.

17 A. No, it's not.

18 Q. So was there any discussion, or were you
19 told anything about Remi's position where his head
20 was positioned?

21 A. They told me that he was like sideways,
22 and so that's why they needed me to keep changing
23 positions.

24 Q. Any discussion from Maggie or Jessie or
25 Dr. McNeive about how much more Remi needed to go to

1 descend before he was going to be born?

2 A. No.

3 Q. Or how much he had come in the hours that
4 had -- how much he had come down in the hours that
5 had gone by?

6 A. No.

7 Q. Okay. So let's talk about eight o'clock
8 when Dr. McNeive did come in. At that time, what,
9 if anything, do you remember him talking about?

10 A. We just kind of came in to say hi and let
11 us know he was on shift. And just wanted to, you
12 know, check in and say, you know, how are you doing?
13 And then just kind of popped in and then, you know...

14 Q. Okay. Did he sit with you and push with
15 you at that 8:00 a.m. time frame?

16 A. I don't think so.

17 Q. Okay. Did he -- did he -- do you have a
18 recollection of whether he checked you, like, did the
19 exam?

20 A. I don't remember.

21 Q. Okay. Do you have a recollection of Dr.
22 McNeive coming into your room between 8:00 a.m. and
23 sometime after two o'clock?

24 A. I don't remember. I just know -- I know
25 he came at 8:00, when his shift was on. And then at

1 two o'clock is when he came in and said, let's have
2 this baby. Let's get this baby out.

3 Q. Okay. So he may or may not have been in
4 the room. That's just not something that you have a
5 good recollection of?

6 A. No. I just -- I just really remember all
7 of the position changes.

8 Q. Do you recall ever being informed about
9 the -- about Remi's heart tones and whether they were
10 good, strong, bad, any of that?

11 A. No.

12 Q. What were you -- did you assume?

13 A. I assumed everything was okay.

14 Q. And did you assume that because that's the
15 impression you were getting?

16 A. Yeah. Nobody told us anything about his
17 heart tones. They just -- I assumed that everything
18 was fine.

19 Q. Now, do you remember -- well, I'm going
20 to -- so let's get to the two o'clock. So now we're
21 at two o'clock, and he comes in. And still no one
22 had ever said anything to you, that is the longest
23 pushing we've ever had a patient do, right?

24 A. No. We didn't know that that was unusual.

25 Q. So when Dr. McNeive came in, you told us a

1 little bit about what he said.

2 Tell us what you remember him saying.

3 A. I mean, that was pretty much it. He was
4 just kind of like, okay, let's get this baby out and
5 have this baby. So he came in, and he stayed with us
6 and pushed until Remi was born. I think Remi was
7 born at like 4:24 or something. So he stayed with us
8 while we pushed.

9 Q. And in that time frame, when he came in
10 after two o'clock, was there any discussion at that
11 time from Dr. McNeive or Nurse Maggie or Nurse Jessie
12 saying, hey, this has been going on a long time, we
13 think we need to go ahead and do a C-section?
14 Anything like that?

15 A. No.

16 Q. Or even, hey, do you want one?

17 A. No.

18 Q. Okay. All right. So then 2 more hours
19 goes by. And we know that Remi was born at 4:24 p.m.

20 Do you remember -- let me just say this:
21 what do you remember about that time frame?

22 A. About like the time that he actually was
23 delivered?

24 Q. Correct. Or the time just leading up to
25 it or -- and the time of delivery.

1 A. I remember right before I delivered, Dr.
2 McNeive said, you know, I'm going to do a maneuver,
3 and it's critical that you follow my instructions.

4 You know, he said, when I tell you not to push, I'm
5 going to need you to not push. And I said, that's
6 fine.

7 So, you know, I pushed for a while, and
8 then he said, okay, now stop. And he had to do some
9 sort of maneuver for Remi. And then he said, okay,
10 now go ahead and push again. And then I know that
11 there was some ligaments that had to be cut. I
12 remember that. I had an episiotomy. I had a tear,
13 yeah.

14 Q. In that last 30 minutes or so, do you
15 remember being told that Remi was tachycardic?

16 A. No.

17 Q. And you know what tachycardic is?

18 A. I know what that means.

19 Q. Or were you told that he had a really high
20 heart rate?

21 A. No, no one told me that.

22 Q. Any notion that the strips were looking
23 abnormal or bad in any way?

24 A. No.

25 Q. Now, this maneuver, was it something that

1 Dr. McNeive, you had a sense was his hand involved,
2 or what do you remember?

3 A. I think so. I know there was another
4 maneuver a little bit before that a couple of times.

5 I don't know if it's the same maneuver or not. But I
6 know there was some, you know, he had put his hand up
7 there and kind of twisted me. Because I remember
8 that part. That part was painful.

9 Q. Did you follow his directions about the
10 stopping and then pushing when he told you to?

11 A. Yeah. Because I didn't really know, but I
12 knew that he made it sound like it was important, so
13 I did that.

14 Q. Okay. All right. You did that,
15 episiotomy, tear, Remi is born?

16 A. Uh-huh.

17 Q. How did you feel?

18 A. I was a little nervous because when I
19 looked down, McNeive, Dr. McNeive, was covered in
20 meconium. And that's basically like fecal matter
21 from the baby. I wasn't sure, first of all, I wasn't
22 sure if I had done it. That was alarming. But he
23 said it was meconium. And I was kind of worried
24 because I know that's a sign of stress for a baby.
25 And so I said, when did that happen? And he said,

1 just now. And I said, okay. And then I was a little
2 worried because it was kind of quiet, and the NICU
3 team was there, and I didn't really hear any crying.

4 Q. Okay. This meconium, was that something
5 that you knew before you had a baby, you knew what
6 meconium was?

7 A. I knew it, and I knew it was not usually a
8 good sign, but that's all I really knew.

9 Q. Okay. So no -- no crying?

10 A. No. I didn't really hear anything. It
11 was pretty quiet. And the NICU was over there.
12 Blake left, went to go check on Remi.

13 Q. He told us you gave him permission.

14 A. I did. I did. I wanted somebody to check
15 on Remi because I couldn't get up and go over there.
16 I was getting stitched up, and McNeive was stitching
17 me up.

18 Q. Okay. So you're -- you're there. You
19 can't really go anywhere, you can't really do
20 anything, and you don't hear anything from your baby?

21 A. Yeah.

22 Q. Were there -- do you remember hearing
23 anybody talking? I mean, this isn't a huge room. Do
24 you remember hearing anybody talking about Remi or
25 what they were saying?

1 A. No. I think I was kind of like further
2 away from everything. I know, I think Jessie came
3 over and like took my temperature and my vitals and
4 that kind of thing, and Dr. McNeive was kind of, you
5 know, helping me still like pass the placenta, and he
6 was doing a lot of stitching.

7 Q. Okay. When was it, Sarah, that you got to
8 see Remi?

9 A. When the NICU team left, they had, I guess
10 it was like a tech in the room who had been cleaning
11 Remi up. And she brought him over and put him on my
12 chest. So like everybody was out of the room at that
13 point.

14 And Blake went downstairs. Like he stayed
15 with me for a while and got a couple of pictures.
16 And I -- you know, we'd asked everybody, you know, he
17 was really quiet. And they just kept telling us that
18 he was tired. He was just -- he wasn't really doing
19 a whole lot, he was just tired. And they said, you
20 know, it was a long labor, he probably is just really
21 tired.

22 And we said, okay. So Blake went
23 downstairs, and I think he finally got food, and I
24 was kind of alone in the room with Maggie, and I was
25 like, you know, it's weird. He won't open one of his

1 eyes. I was like, wow, that's kind of weird. I even
2 made a joke about it because at the time we had a dog
3 that had only one eye.

4 You know, but I just -- she kind of was
5 like, yeah, that is weird. Didn't really say
6 anything. Went back to charting. You know, but then
7 he did open it, and I just thought that maybe it was
8 because his face was puffy and swollen because he had
9 had a long labor.

10 Q. Okay.

11 MS. GUNN: Zack, can we have Exhibit 602?

12 Q. (By Ms. Gunn) Sarah, the picture is going
13 to come up on this screen.

14 A. Okay.

15 Q. I'm going to get out of your way.

16 Are you okay?

17 A. Yeah.

18 Q. Okay. And ask you if you can tell us what
19 we're seeing here.

20 A. That's Remi. That's like the first time
21 he got to be on my chest.

22 Q. Okay. And so it was your sense that this
23 was, you know, 20, 30 minutes later, something like
24 that?

25 A. Yeah.

1 Q. And this is -- is this generally how he
2 looked in that time frame?

3 A. Yeah. Until we went up to the labor and
4 delivery unit, and that's when he started to be
5 really irritable.

6 Q. Okay. So how long do you think you were
7 in that room, the labor and delivery room, before you
8 moved to the different room?

9 A. We stayed there until about 7:00. And
10 then after shift change, we went up to a new room
11 because our nurse, Alex, from the night before, she
12 even popped in to say hi. And then we went up to
13 labor and delivery -- not labor and delivery --
14 postpartum unit.

15 Q. And did you have Remi with you that whole
16 time?

17 A. Yeah.

18 Q. Okay. So you get upstairs.
19 what did you say? That was about shift
20 change, maybe seven o'clockish?

21 A. Yeah.

22 Q. So can you tell us about the next, you
23 know, two or 3 hours how Remi was acting or how he
24 was acting to you, to your recollection?

25 A. So we got him settled in. We were up on

1 the postpartum unit. We had this nurse, Maureen,
2 because I remember, she said she went by Reeni. And
3 so I kind of asked her, I was like, you know, I still
4 haven't gotten him to breastfeed.

5 And at one point, you know, he was just
6 really irritable. He was really screaming, and it
7 wasn't like a normal scream, it was like really loud.
8 And he just was kind of inconsolable. Nothing I was
9 doing was helping him.

10 And I remember I took his hat off, and I
11 was just holding his head. And I asked the nurse,
12 you think his head hurts? And I didn't know. I just
13 said, you think we can give him some Tylenol or
14 something because his head is really misshapen? And
15 she didn't really -- she just kind of blew me off.

16 Q. And Blake was with you all during those
17 times, as well?

18 A. Yeah. Uh-huh.

19 Q. Was he ever able to feed? To eat?

20 A. No.

21 Q. Okay. Do you remember anything about his
22 breath?

23 A. He started breathing faster. And that was
24 what was concerning to Blake. And then Maureen, her
25 shift ended at 11:00, and then we had another nurse

1 come on at 11:00. Her name was Kat. And she finally
2 listened to us. Because she came in, and I kind of
3 said the same thing all over again. And I said,
4 look, I can't get him to stop crying. I can't get
5 him to eat. And I just wasn't sure if this was
6 something like a new first mom thing. But I said,
7 you know, I think he's in pain.

8 And she took a look at him, and Blake was
9 concerned because he was breathing a little faster.
10 And she said, well, I'm going to go ahead and take
11 him back to the nursery. We'll call your
12 pediatrician, and I'll come back and talk to you guys
13 in a little bit.

14 Q. And did she do that?

15 A. Yeah.

16 Q. And what did you learn?

17 A. She had talked to our pediatrician. They
18 tried to give him some formula. And she was going to
19 have the NICU team come up and re-evaluate him.

20 Q. What did you -- did they bring Remi back
21 to your room in this 11:00/12:00 time frame?

22 A. No. He was still in the nursery.

23 Q. What did you next learn about Remi?

24 A. Somebody from the NICU team came by to
25 tell us they were going to take him back down to the

1 NICU. And so when we heard that, Blake was like,
2 well, you know, I'll go with him. And so Blake went
3 downstairs with him to the NICU.

4 Q. And in this time frame, Sarah, you weren't
5 seeing this for yourself. You were not able to also
6 go.

7 A. Yeah.

8 Q. When you got -- when Blake came back up,
9 what did you learn?

10 A. He said that he was kind of settled in,
11 and that they were kind of, you know, they were
12 watching him. They were concerned about how fast he
13 was breathing. You know, I think he got to look at
14 the chest x-ray. And then he came up, and it was
15 like, I don't know, 2:00 or 3:00 in the morning, so
16 we both decided to get a little rest.

17 Q. At that point, what -- what -- did you
18 have any notion of what was going on with Remi?

19 A. No. We thought that because he was in the
20 NICU, we thought he was safe. We thought he was
21 being watched. We thought he was being monitored.
22 And that was why we, you know, finally felt like we
23 could rest.

24 Q. Okay. What did you learn next about Remi?

25 A. So that morning, Dr. Dreyer came up --

1 sorry. Excuse me.

2 Q. Do you know what kind of doctor Dr. Dreyer
3 is?

4 A. Yes. Dr. Dreyer is their neonatologist.

5 So he's from the NICU. But he came up and sat down
6 in a chair across from us, and he said, you know, I
7 have to have a conversation with you guys. You know,
8 we think Remi is seizing.

9 Q. Sarah, I know this is a hard part for you.

10 A. That's okay. At that time, I didn't quite
11 understand. I kind of thought it was just something
12 temporary from his birth. I didn't quite understand
13 that this was going to be a big thing for him.

14 Q. Did you get to go see him?

15 A. I did. And I quickly got cleaned up.
16 Because I was like really sweaty and gross. And then
17 once I got kind of cleaned up, I got down to the NICU
18 to go see him.

19 Q. What did you see?

20 A. I'm sorry. I'm sorry. I'm sorry.

21 Q. That's okay. Take your time.

22 A. There was -- there was a nurse in there,
23 and she was with Remi, and I knew he was seizing just
24 by looking at him. And there was one seizure where
25 he quit breathing. And I said, I'm sorry, I'll get

1 out of your way. And she started bagging him.

2 And -- and the doctor was there, and I just kind of
3 got out of the way and just -- just watched.

4 Q. were they doing things to try to
5 understand what was wrong with Remi?

6 A. Yeah. It started with just a doctor and
7 nurse. And then, you know, a whole team of people
8 came in. And I just kind of took a few steps back,
9 and I just couldn't even process what was happening.

10 Q. Blake was here of course, and he told us
11 about the EEG.

12 A. Yeah.

13 Q. That they did for Remi.

14 A. Yeah.

15 Q. Did you learn the results of that?

16 A. He was on an EEG for a long time.

17 Dr. Thalakoti was the neurologist who came in and
18 hooked him up to the EEG. And he was the one that
19 kind of had the first devastating conversation with
20 us about why he was seizing. And he explained to us
21 that it was from the mechanical force --

22 MS. KAMYKOWSKI: Your Honor, we object.
23 May we approach?

24 THE COURT: You may.

25 (Proceedings were held at sidebar, outside

1 the hearing of the jury.)

2 MS. KAMYKOWSKI: This was a subject of our
3 motion in limine from this morning. I know Ms. Gunn
4 specifically instructed Mr. Remi -- Mr. Anyan,
5 because he was here, not to get into the hearsay
6 testimony Dr. Thalakoti. It appears that maybe this
7 witness was not also given that same instruction.

8 But I move to strike her answer with
9 respect to Dr. Thalakoti. That's hearsay, subject to
10 the Court's prior motion in limine.

11 MS. GUNN: We understand that the ruling
12 was to the exception to hearsay. Since then, this
13 has become what she's learning about the condition of
14 her son in the moment that she's hearing it, I don't
15 think -- it's an exception to hearsay.

16 MS. KAMYKOWSKI: No. What she's saying he
17 told us, which is absolutely hearsay and not her
18 present impression.

19 And this morning the discussion was that
20 Dr. Thalakoti, there was nothing in any record that
21 would be an exception to the hearsay that Dr.

22 Thalakoti has confirmed what Mrs. Anyan testified to
23 and what Mr. Anyan testified to in their depositions.
24 And, therefore, it's still an out-of-court statement
25 by him that is not subject to the exception. This is

1 not her present impression, that's -- she's
2 attributing that statement to another speaker.

3 MR. WILLMAN: I'll join in the objection.

4 THE COURT: My recollection of the
5 discussion this morning was that she was not going to
6 testify to the fact that -- when the child was
7 injured or how the child was injured.

8 MR. WILLMAN: Right.

9 THE COURT: Because I don't think she has
10 the ability to testify to those facts. And that
11 includes what she was told by this doctor.

12 MS. KAMYKOWSKI: So I would ask the Court
13 to strike her answer to the question and tell the
14 jury to disregard it.

15 THE COURT: Okay.

16 MS. KAMYKOWSKI: Thank you.

17 (Proceedings returned to open court.)

18 THE COURT: Ladies and gentlemen of the
19 jury, just disregard that previous question and
20 answer.

21 Q. (By Ms. Gunn) what did you learn was
22 Remi's diagnosis?

23 A. He had had -- Dr. Thalakoti said that he
24 had had a hypoxic event.

25 Q. Did you understand that there was a head

ultrasound, a brain ultrasound done of Remi?

A. Yes.

Q. And would that have been on May 5th, that next day?

A. Yeah. I believe Dr. Dreyer had told us about that, and he also did like a spinal tap on Remi.

Q. Okay. And did anyone, with respect to that ultrasound, did you understand what the result of that was?

A. Dr. Dreyer said everything looked good.

Q. Did Dr. -- did anyone tell you that there was anything of poor quality, anything wrong with that ultrasound?

A. No.

Q. That it couldn't be read because it was of poor quality or of poor technique?

A. No.

Q. You understood that they were performing that test to find out why your child was seizing?

A. Yeah.

Q. Now, there was an MRI done?

A. A couple days later, they had to wait because Remi was seizing so much. He wasn't stable enough to leave the floor for the MRI. So we had to

1 wait a couple of days.

2 Q. The records indicate that the MRI was done
3 on May 6th, so about two days later.

4 Does that sound about right?

5 A. Yeah. Uh-huh.

6 Q. And were you aware of the results of that?

7 A. Yeah.

8 Q. And what was -- what was your
9 understanding of that?

10 A. That was a tough conversation with
11 Dr. Thalakoti. He came in and basically explained
12 the brain damage. And then we kind of asked him, you
13 know, what does this mean? what does this mean for
14 his future?

15 And he kind of was very honest, but he
16 said, you know, he may never walk. He may never
17 talk. He may not be very aware. Probably will have
18 a feeding tube. He probably will be in a wheelchair.
19 And that conversation was tough, and Remi's already
20 done a lot more than Thalakoti predicted.

21 Q. Let's take a look at Remi.

22 MS. GUNN: Let's look at 609.

23 Q. (By Ms. Gunn) Okay.

24 MS. GUNN: 609, yep.

25 Q. (By Ms. Gunn) So Blake had told us a

1 little bit about the tube.

2 A. Yeah.

3 Q. What was that for?

4 A. So Remi was having, you know, a tough time
5 with eating, so he had to learn to eat. We spent
6 basically our two months in the NICU, was spending
7 every minute we could with learning how to
8 successfully feed him. Speech therapy came in every
9 day. Occupational therapy came in every day. PT
10 came in, but we had to figure out if he was going to
11 be able to successfully eat by month, or if he was
12 going to end up with a feeding tube in his belly.

13 Q. Sarah, I have a couple of little -- some
14 of the things I'm going to show you are little
15 videos.

16 MS. GUNN: And so can we look at
17 Exhibit 606?

18 These have all been provided, Judge.

19 Q. (By Ms. Gunn) I know it's cute. I wanted
20 to ask you about it. The reason I wanted to ask you
21 about that, the date I have on that is May 18th?

22 A. Uh-huh.

23 Q. I know we had some big days in your family
24 of May 10th, May 14th, May 16th?

25 A. Yeah.

1 Q. Birthdays and Mother's Day?

2 A. Birthdays, Mother's Day.

3 Q. What was, I mean, the crying? Because we
4 talked about the inconsolable crying.

5 A. Yeah.

6 Q. And this little cry, how were you
7 measuring that?

8 A. That was -- that's a tame crime. So even
9 when we were in the NICU, we had one nurse that was
10 really great, and she told us before we left the
11 NICU, she said, listen, because of his brain injury,
12 he's going to cry. And I'm not talking a little cry.
13 He's going to scream a lot.

14 And we weren't even quite prepared for how
15 much he would scream, but that is very much part of a
16 brain injury. So like when we went home from the
17 NICU, Remi was a very irritable baby. You know, at
18 first, they said, oh, it's colic. But then it's also
19 the neural irritability. And that can go on for
20 years after a brain injury.

21 So when Remi -- we were home from the
22 NICU, and Remi was a baby, he would scream sometimes
23 for like 10 hours a day. So Blake and I actually
24 invested in noise cancelling headphones because I
25 said it was cheaper than therapy. And we would just

1 walk around -- Remi needed to be held constantly.

2 And looking back, that was because of his cortical
3 visual impairment injury to his brain. He couldn't
4 see very well. And so he needed constant touch to
5 know where he was in space.

6 And so literally for sometimes 8 hours a
7 day, he was in the baby carrier. I remember Blake
8 would come home from work, and I would be walking
9 around in the garden with Bluetooth headphones on,
10 and he'd say how long have you been walking for? And
11 I'd say 8 hours.

12 And that was between pumping and, you
13 know, because I had to pump and then feed him. He
14 couldn't do the breast. That was too complicated for
15 him. Too much effort with the mouth muscles. So I
16 had to pump and then feed him and then try to get him
17 to take seizure meds. And then any moment that he
18 was calm, try and do some physical therapy, some
19 occupational therapy.

20 Q. we know that you didn't return to work.

21 A. No.

22 Q. That was a decision you made to stay home
23 with Remi and take care of him?

24 A. Yeah. when we met with Dr. Thalakoti, and
25 he told us about his injury, it was very clear that

1 the first three years of their life, because the
2 brain is still developing, that the most -- you want
3 to do the most therapy you can because you're going
4 to get the most out of it.

5 And so Blake and I had talked about it,
6 and Blake made more money than me, I stayed home.

7 Q. And is that what you did? You did a lot
8 of lawn therapy?

9 A. Still a lot of therapy, yeah. Yeah. when
10 you have to make it fun. You have to make it through
11 life. But any moment he was calm, we were doing
12 therapy.

13 MS. GUNN: Let's look at Exhibit 610.

14 Q. (By Ms. Gunn) Okay. So I'm reading the
15 note here on his shirt. What's it say?

16 A. 2020 NICU graduate, yeah.

17 Q. So is it fair to say that this was on his
18 first day -- or first day out?

19 A. Yeah, we got to go home. We got the NG
20 tube out, and he was eating by mouth. It was still a
21 struggle, but we really wanted him to be able to eat
22 by mouth because Blake's a huge foodie.

23 Q. Sarah, the jury this afternoon is going to
24 hear from Dr. Richard Liles. And you understand that
25 he has put together what's known as a life care plan

1 for Remi.

2 A. Yeah.

3 Q. Are you familiar generally with what he
4 recommends for Remi for his future care?

5 A. Yeah.

6 Q. And there are things in there regarding,
7 you know, the care he's going to need.

8 A. Yeah.

9 Q. The therapies --

10 A. Yeah.

11 Q. -- the equipment --

12 A. Yeah.

13 Q. -- the medical visits, the medication, and
14 all those things.

15 And is that part of what you think is
16 essential for Remi to be the best Remi he can be?

17 A. Yeah.

18 Q. And there's specific issues or questions
19 in there about home care and facility care.

20 Do you have opinions on that?

21 A. We will never want him to be in a
22 facility. We believe that Remi should be able to be
23 at home. You know, right now, we take care of him,
24 but there is going to come a point in our lives where
25 we won't -- probably we'll need somebody to help.

1 Remi is probably going to be a very big man, from the
2 way he is growing.

3 So also, you know, Remi is very, very
4 smart, and he is not always going to want, you know,
5 me to wipe his butt for him. At some point, he's
6 going to want somebody else to do that. And I do
7 think that at some point, he's going to want some
8 more freedom.

9 You know, he's not going to want to live
10 with us. He might want to live near or, you know,
11 right next to us or in the basement. But he's, you
12 know, so far he is cognitively on track, and he's
13 just going to want his own freedom.

14 Q. And you don't know, you can't predict,
15 when he might -- when you all might not be available
16 for him?

17 A. No. We don't really have a whole lot of
18 family that can take care of him. The people that we
19 currently would leave him with now are older, and so
20 they physically would not be able to take care of
21 him. The way that we would have to keep him at home
22 would be like an in-home nurse, if something were to
23 happen to Blake and I, yeah.

24 Q. I -- I think that I want to ask you this,
25 but I know it's upsetting.

1 A. It's okay.

2 Q. So I have to say, Sarah, I know this is
3 hard.

4 A. It's okay.

5 Q. I want to know what your fear is for Remi.

6 A. My -- my biggest fear is what will happen
7 to him when Blake and I are gone. I do not want him
8 to be in a nursing home. I don't think that's fair.
9 He didn't do anything wrong, and he doesn't deserve

10 that. I don't want him to be with -- in a situation
11 where somebody just lets him sit, because he is
12 capable. He is capable of getting up, and he wants
13 to be up. And he wants to do things himself, he just
14 needs some help. And he should have that ability.
15 He should have that.

16 Q. When you say, you know, he wants to be up,
17 how do you know those things?

18 A. He tells us. He is very opinionated.
19 Sometimes we use the button. Sometimes we use the
20 Tobii. It depends on how he wants to communicate
21 that day and how his tone is affecting his body.

22 Sometimes when he gets really excited,
23 like he was earlier with his tone, he has a tough
24 time, you know, using his hands. But he is very
25 much -- he is not a kid that wants to sit. He's

1 never been a kid that wants to sit. And that is a
2 huge blessing. He wants to be up. He wants to go.
3 It's a little bit physically harder on us
4 because I have to do a lot of transfers, and I have
5 to lug a lot of equipment when we go to the Magic
6 House. But he wants to be up, and I'm always going
7 to promote that.

8 Q. Let's go to -- I want to walk the jury
9 through a little bit more of his life --

10 A. Yeah.

11 Q. -- and what you all have done with him.

12 well, let me ask you this: In terms of
13 the way getting him on a feeding schedule, doing all
14 those things, Blake told us a little bit about how
15 tough that is, how tough that was, because of the
16 digestive issues.

17 A. Oh, yeah.

18 Q. were you able to kind of get that figured
19 out?

20 A. Yeah. I mean, he's doing really well with
21 his eating. I mean, we do have to keep him on a
22 schedule. Just, I mean, the main thing is that when
23 he eats, he has to be in like a well-supported chair.

24 so like the chair we brought with him
25 today, like we can't go to a restaurant, and like sit

1 him in like a regular chair. He needs some support
2 with that. But we kind of plan our outings around
3 his feeding schedule just because it's a little
4 easier. But we do take him out and go places and
5 eat. He's done really well with feeding therapy, and
6 he loves to eat.

7 Q. There's a note in -- in Remi's chart, I
8 think you made a call to Dr. Thalakoti's office, and
9 at one point you were -- he was still having
10 seizures?

11 A. Uh-huh.

12 Q. At home?

13 A. Uh-huh.

14 Q. And you indicated you just had a question
15 about that for Dr. Thalakoti. I think you were
16 worried about whether they were continuing to hurt
17 his brain.

18 Do you remember that?

19 A. Yeah, I think so. Yeah. Remi, when we
20 first came home from the NICU, we weren't sure --
21 there were a couple of movements that he did, we
22 weren't sure if they were seizures or not. And we
23 had him on antiseizure medication.

24 And we did stick with Thalakoti for a
25 little bit, but then we switched our care down to

1 Children's. And Dr. Weisenberg was still his
2 neurologist, and she was better at identifying what
3 was actually a seizure versus just some dystonia
4 spastic movements related to his CP.

5 Q. Okay. So I want to go to -- just to give
6 the jury a better understanding.

7 MS. GUNN: Let's go to Exhibit 612.

8 Q. (By Ms. Gunn) And this is a video that
9 you took April of 2021?

10 A. Uh-huh.

11 Q. So he's not quite a year?

12 A. No.

13 (The video was played for the jury.)

14 Q. (By Ms. Gunn) Okay. So we saw a little
15 bit at the beginning of that.

16 what would you have called that?

17 A. That looks like it was probably the start
18 of when his funny -- we call it funny business
19 because we don't know what else to call it.

20 And Dr. Weisenberg doesn't know really
21 what it is. So we call it funny business. That's
22 like the start of when he started having some
23 movements, and they are -- they're kind of -- they're
24 strange. They look like seizures sometimes, but
25 they're, on EEG, they're not seizures. And, yeah,

1 so...

2 Q. And I noticed you were talking to him.

3 A. Uh-huh.

4 Q. First of all, why did you video that?

5 A. So we have to take a lot -- anytime he has
6 a seizure, or something that looks like a seizure,
7 the neurologist always wants to see the video.

8 And the other thing that I'm doing in that
9 video is that I'm holding his arms because if you
10 can -- the neurologist has told us that if you can
11 stop it, it's not a seizure. If it keeps going, then
12 it is. So I'm always checking when we see a new
13 movement.

14 Q. And you were also talking to him?

15 A. Uh-huh.

16 Q. Why do you do that?

17 A. Just to comfort him.

18 Q. Was there a time when his seizures got
19 better?

20 A. Yeah. He actually -- and that's pretty
21 typical. Weisenberg has told us that, with a brain
22 injury, he may go through some quiet periods where
23 you don't see seizures for a while, and they could
24 come back.

25 And so he, when he was 1 and a half, he

1 came off of his seizure medication. So he came off
2 of phenobarb, and that was when we really started to
3 see him being less sedated. And we started to
4 realize that he knew a lot more than what we thought.

5 I remember one time we were playing with
6 these little like toy vegetables, and you can, you
7 know, sorting them by color, and we always presented
8 things to him, even though we were told not to expect
9 much. And Blake came home from work, and I said,
10 Blake, I think he knows colors. And he said, what do
11 you mean? I think he knows colors. And he thrived
12 when he came off of the phenobarb.

13 Q. How are his seizures now?

14 A. He still has them. They're not every day.
15 But they are, you know, they are frequent. They're
16 short usually. We're lucky that they're focal. But
17 one of the bad things about them being focal is that
18 when you have seizures, you're aware of them.

19 So he's aware of them. He gets very
20 scared. He's told us he's scared. He really doesn't
21 like it when they happen when he's alone, and that
22 has happened. I know one time I went downstairs to
23 switch over the laundry, and I came back up, and I
24 was just gone for a second, and he was seizing, and
25 then he threw up. And I felt terrible.

1 And so we've had lots of conversations
2 about epilepsy and why he has epilepsy and what that
3 means. And I try to remind him that, you know, it's
4 just an electrical impulse to the brain making your
5 body feel yucky.

6 And recently he's been a little more
7 scared because he had one at about 3:30 in the
8 morning, and so he's been putting up a fight at
9 bedtime because he says he doesn't want to be alone
10 because he's afraid he's going to have a seizure.

11 So we've been co-sleeping with him a lot,
12 and I educated him a lot. Showed him the baby
13 monitor, so he knows we're watching him. I showed
14 him Diastat which is a rescue medication. And I
15 showed him his Klonopin, and I told him -- and I told
16 him, I said, look, I know you can't get out of bed
17 and come get us. If you feel a seizure coming,
18 because sometimes he does, you get loud, get really
19 loud, and we'll hear you, and we'll help you.

20 And actually he has gotten really good in
21 the last, like, month about -- he has a new
22 vocalization that he does before he has a big one.

23 And we'll ask him, like, when he gets really vocal,
24 we'll ask him, are you just excited? Do you need to
25 pee? Are you hungry or thirsty? Or do you feel a

1 seizure coming? And a couple -- about three times,
2 he said, yes, I feel a seizure coming. And I said,
3 okay. Then we'll sit. we'll just sit and take a
4 break, and we'll wait. And he was right, they came.

5 Q. And so I know you said he said, I feel a
6 seizure coming. How does that actually -- how do you
7 actually know that?

8 A. We use the Tobii to talk about it.

9 Q. Let's talk about the Tobii.

10 A. Yeah.

11 Q. I mean, we talked about it, but not what
12 it is. what is the Tobii?

13 A. Oh, yeah. The Tobii is an eye gaze
14 device. So for people that don't know, it's kind of
15 like the thing that Stephen Hawking had. It's
16 basically like a computer. And his computer goes in
17 front of him, and it picks up his eyeball. We do
18 have to hold his eyeballs up a little bit because
19 Remi has very hooded eyeballs. And his eyelids
20 really have a lot of puffiness.

21 we have to kind of hold his eyelids up a
22 little bit. But -- and we have to position his head
23 a little bit. But it picks up his eyeballs, and he
24 can look left and right to tell us what he wants.
25 And there's anywhere between two and four, sometimes

1 more options, but usually we keep things between two
2 and four, so he can tell us what's going on.

3 Q. So you input the little screen --

4 A. Uh-huh.

5 Q. -- and then he gazes at the answer?

6 A. Yeah. We show him a lot of times. So if
7 it's a new page that I've created, I'll say, okay.

8 Here's yes, here's no. Now I'm going to ask you a
9 question. You know, do you feel a seizure coming?

10 Yes. Okay. Are you nauseated? Yes. Okay.

11 MS. GUNN: So let's go to Exhibit 632.

12 And this was a little bit of a lengthy
13 one.

14 So, Zack, if you don't mind playing
15 about -- I'll let you know how long to play it.

16 Do you have any videos -- anything that
17 says Tobii? It's okay. It's not really --

18 Q. (By Ms. Gunn) All right. So let's
19 just -- you've already described it, but it's a video
20 that I was intending -- that I obviously failed to
21 put in the right spot.

22 Had you sitting on the ground, and Remi is
23 sort of sitting in front of you. So this was
24 probably a couple of years ago. And then you have
25 the device here.

1 so how do you decide what to input? Are
2 you always the one putting in information, or are
3 there like programs and stuff?

4 A. There are programs, but there aren't many
5 that are CVI friendly.

6 So when Remi was diagnosed with CVI --

7 Q. Let's just stop there.

8 A. Yeah.

9 Q. we've heard cortical vision impairment.

10 A. Cortical vision impairment.

11 Q. But can you tell us a little bit more
12 specifically about what that is and how it affects
13 him?

14 A. The cortical visual impairment is pretty
15 rare. It happens when there is damage to the back of
16 the brain, the occipital lobe.

17 The occipital lobes are what take the
18 visual information in and then make sense of it
19 basically.

20 so because it is kind of more rare,
21 there's not a whole lot of teachers of the visually
22 impaired that specialize in that. Because First

23 steps came and told us that he needed that. And I
24 read the same textbook as his CVI because she said
25 the best way that you can help him is to learn how he

1 sees. And if you can figure out how he sees, you can
2 teach him.

3 Q. So how does he see?

4 A. So Remi's CVI -- CVIs vary from kid to
5 kid, and it's not even something that a lot of
6 pediatric doctors really are very understanding of,
7 but it varies kid to kid. Every kid is a little bit
8 different. Remi's is unusual because he's actually
9 pretty functional with CVI. Most kids with CVI like
10 a black background. He likes a white background.

11 At first, you know, he could only see
12 things that were really high contrast. And I had to
13 make sure that when we were working on our vision, we
14 weren't doing anything else physically demanding
15 because Remi's brain, the best way to describe, his
16 brain works like a generator.

17 You could turn on something in the house,
18 but not everything all at once. So with him, you can
19 get his vision to work, but you need his motor
20 function to stop at that time. Because he can't do
21 both at the same time because his brain takes so much
22 for him to focus and to use his vision, that you
23 can't have him, like, running around in a gait
24 trainer and using Tobii at the same time.

25 Sometimes we'll have him stand and use it.

1 But there's also things that have to be very visually
2 simple for him. Like you can't put a bunch of things
3 in front of him, like, you know, and have him pick
4 from ten different items. It has to be visually
5 simple. It has to be white background.

6 Q. How has he progressed on this?

7 A. He has done phenomenal. I mean, and that
8 is because of all of the work that we have done and
9 because of his amazing therapist at First Steps that
10 has taught me how to teach him how to see.

11 We never thought that he would be able to
12 do the things that he's doing. Me and his speech
13 therapist right now are teaching him to read and to
14 spell, and he loves it. We get into really intense
15 spelling bees with Dad, and Remi usually wins.

16 Q. It's a thing.

17 A. It's a thing, yeah. Remi usually wins,
18 yeah.

19 Q. I'm going to direct your attention to --
20 let's see.

21 MS. GUNN: what about, yeah, 642, Zack,
22 you have that? 642? we don't have that? 642. Oh.
23 I think 642. No.

24 Q. (By Ms. Gunn) Okay. I want to ask you,
25 you have a new baby --

1 A. Uh-huh.

2 Q. --named Rory. Is she still with us?

3 A. No. She had to leave the room.

4 Q. Tell us how you decided that you wanted to
5 expand your family.

6 A. Yeah. So I always take Remi out in the
7 world because he's like any other kid. He wants to
8 go do everything. So we go to the Magic House, we go
9 to the zoo, go to the science center, go to the
10 playground.

11 And we did, you know, kind of have an
12 experience on the playground where, you know, I
13 always try to get him to be social. There was this
14 little girl, and we were out on the playground. And
15 all of the kids are really excited. There was this
16 little girl, and she was holding up this turtle. And
17 I was like, Okay, Rem, you're going in your gait
18 trainer, go look at the turtle. And there's like ten
19 kids, and the little girl said, what's wrong with
20 him? And I was just like, oh, my gosh.

21 And so I told her, well, no. That's not a
22 very nice way to say that, and nothing is wrong with
23 him. Remi has cerebral palsy. He's just like you.
24 He understands everything just like you. He probably
25 likes a lot of the same things that you like, except

1 he uses his gait trainer to help him walk to get
2 around.

3 I said, you know, he can't talk. He uses
4 his buttons to communicate because the muscles in his
5 mouth are affected, and he can't move his muscles to
6 speak. But he understands everything just like you
7 do.

8 And so we kind of went and played. The
9 mom of the girl was like totally mortified and came
10 up to me and apologized. And that was a tough day,
11 but that day was kind of a day where I kind of
12 realized that the social part of his life was always
13 going to be really hard. And no matter how many play
14 dates I take him on, and no matter how much I get him
15 out in the world, the social part of his life is
16 always going to be hard unless he has a sibling.

17 Q. How is that going?

18 A. They love each other. And he is like --
19 he's such a good big brother, and she is fascinated
20 with him. And he is just so happy because he's not
21 just this disabled kid at home with his parents
22 anymore. He's got like another kid that can go
23 along. And he knows, I've told him, you know, I said
24 she's going to get bigger. She's going to play with
25 you more.

1 And when she does, she's going to go
2 everywhere with you. She's going to be able to
3 understand you. She's going to be able to know what
4 you want. She's going to know how you use your
5 Tobii, and you guys are going to be best friends.
6 You're going to go everywhere.

7 Q. Do you, I mean, there's some -- I don't
8 know if we have them. Any more of those.

9 MS. GUNN: But what about page -- or
10 Exhibit 650. Okay. Got one.

11 A. Yeah. Yeah.

12 Q. (By Ms. Gunn) Okay. So what are we
13 looking at here?

14 A. That was Rem, when I think it was
15 Thanksgiving, he came up and brought me food because
16 I was in the hospital for Thanksgiving with Rory.
17 And he was so happy to hold her. And I just think
18 his smile says it all.

19 Q. And now I know she's only 4 months old.
20 How is Rory with Remi?

21 A. She loves him. She's oddly comforted with
22 how loud he is. And he just -- we get them on the
23 floor together, and he just plays and kicks his legs,
24 and he tries really hard to talk to her, and she just
25 grabs onto his little arm and falls asleep. And she

1 smiles at him. They love each other. They have a
2 really special bond.

3 Q. Sarah, I wonder if --

4 MS. GUNN: Do we have 648? Did I ask that
5 one already? Or 645? Or 642?

6 Q. (By Ms. Gunn) Okay. Well, I had a few
7 more videos, one of which was Remi. That's still a
8 good one. We know all about that. One of which was
9 Remi swimming.

10 A. Uh-huh.

11 Q. So I wanted to ask you about swimming.
12 How does he do? And where does he get to
13 swim?

14 A. So we do some therapy at Rankin Jordan
15 particularly, but we also just have like a little
16 tiny like above ground pool we put out every year.
17 But swimming is like fantastic therapy, and he loves
18 it.

19 Q. And how does he -- how does he do it?

20 A. So he has to have some sort of flotation
21 device. We use this like baby Bobo to kind of put
22 him in. At some point, he might be outgrowing that.
23 He's probably over the weight limit for that one,
24 but, you know, even if we just hang onto him in the
25 water, he can still swim. We just kind of have to

1 get something that is going to help support his head
2 and keep his head out of the water.

3 Q. What is -- what is your hope for Remi in
4 the future?

5 A. I hope that -- I just hope that he
6 continues to thrive, like, I hope that he just
7 continues to stay mobile and get more independent on,
8 you know, some of the things that he wants to do. I
9 hope he never loses his bossiness, sassiness,
10 whatever you want to call it because he's super
11 funny.

12 But I hope that, you know, I hope that
13 he'll be able to communicate independently. That's
14 why we're working on reading and spelling. Because
15 of his cortical visual impairment, he's never going
16 to be able to look at, like, 50 buttons on his Tobii.

17 But if we teach him the alphabet, and he can spell
18 that word, he can tell us exactly what he wants to
19 say, we won't have to put words in his mouth, you
20 know.

21 Q. Thank you, Sarah. I appreciate it.

22 A. No problem.

23 THE COURT: On behalf of the defendants?

24 MR. WILLMAN: Yes, Your Honor. Thank you.

25 CROSS-EXAMINATION

1 BY MR. WILLMAN:

2 Q. Good afternoon, Mrs. Anyan. I feel a need
3 to start by saying how sorry I am about what has
4 happened to Remi, and I appreciate your being here
5 under very difficult circumstances.

6 I'm here for Dr. McNeive. You had a good
7 relationship with him?

8 A. Uh-huh.

9 Q. And you visited him a number of times
10 before going to Mercy for labor and delivery?

11 A. Yes.

12 Q. You had checked ahead of time and asked
13 around about his reputation, is that right?

14 A. Yes.

15 Q. And he came highly recommended to you, did
16 he not?

17 A. Yeah. I think I checked with a couple of
18 people that I worked with. He had some good Google
19 reviews, yeah.

20 Q. All right. So let me -- just a couple of
21 questions about that -- that time between 8:00 a.m.,
22 when you said you were complete, you told us about
23 that --

24 A. Uh-huh.

25 Q. -- and then 2:00 p.m., when Dr. McNeive

1 was at your bedside minute-by-minute.

2 During that time, you were able to
3 continually push?

4 A. Yes.

5 Q. Never got fatigued or tired?

6 A. No. They had me take some breaks.

7 Q. Right. And those breaks, you were told,
8 was when Dr. McNeive had to leave to go do a
9 C-section?

10 A. Yes.

11 Q. And so of course you complied with that,
12 you stopped pushing during those time periods?

13 A. Yes.

14 Q. And you were told that if you got tired or
15 fatigued, to let them know, and you could stop
16 pushing at that time?

17 A. Uh-huh.

18 Q. Then at 2:00 p.m. -- well, let me go back.
19 Do you know when he came to visit you
20 during that 8:00 a.m. to 2:00 p.m., he did an
21 examination of you at that time? or do you remember?

22 A. I don't remember.

23 Q. Okay.

24 A. I'm sorry.

25 Q. Yeah. No. That's fine. That's fine.

1 But at 2:00 p.m., when he was at -- by
 2 your bedside, he was there for 2 hours and a half
 3 approximately?

4 A. Yeah.

5 Q. The whole time.

6 A. Yes.

7 Q. He was talking to you the whole time?

8 A. Yes.

9 Q. He was asking about your contractions?

10 A. Telling me kind of like when to push, you
 11 know.

12 Q. When to push.

13 A. Yes.

14 Q. Okay. So he was help guiding you when to
 15 push and when to stop?

16 A. Yes. Yes.

17 Q. And he was examining you at that time,
 18 physically examining you?

19 A. Yeah.

20 Q. And do you remember at times that he would
 21 do maneuvers to rotate Remi's head, is that correct?

22 A. Yes.

23 Q. And you had been told that his heart rate
 24 was good, is that right?

25 A. Yes, uh-huh.

1 Q. And that things would be fine, so long as
2 you kept pushing?

3 A. Yes.

4 Q. Now, move ahead in time.

5 we heard from your husband Mr. Anyan --

6 A. Yeah.

7 Q. -- that Dr. McNeive did come to see you in
8 the NICU after the delivery.

9 A. Uh-huh.

10 Q. And he offered to help, is that right?

11 A. Uh-huh. Uh-huh.

12 THE COURT: You're going to have to
13 actually use words.

14 THE WITNESS: Oh, I'm sorry.

15 THE COURT: It's okay.

16 THE WITNESS: I'm sorry.

17 Q. (By Mr. Willman) You're fine. You're
18 fine.

19 He came to check on you and Remi?

20 A. Yes.

21 Q. He was sympathetic?

22 A. Yes.

23 Q. He asked if there was anything he could
24 do?

25 A. Yes.

1 Q. He was always very respectful to you and
2 to Remi?

3 A. Yes.

4 Q. You don't think he's a bad guy, do you?

5 A. No.

6 Q. Thank you. That's all I have.

7 THE COURT: On behalf of Mercy Hospital?

8 MS. KAMYKOWSKI: Your Honor, I don't have
9 any questions for this witness.

10 THE COURT: Thank you.

11 Any redirect?

12 MS. GUNN: No, Your Honor.

13 THE COURT: May this witness be excused?

14 MR. WILLMAN: Yes.

15 THE COURT: Very good. You can go ahead
16 and step down. Thank you very much, ma'am.

17 I think, based on the timing, this is
18 probably a good time for us to take our afternoon
19 recess.

20 (At 2:27 p.m., the jury was duly
21 admonished, and a break was taken, and the following
22 proceedings were held in open court, outside the
23 presence of the jury:)

24 MS. KAMYKOWSKI: I have something very
25 briefly, Your Honor. For about the past 15 minutes,

1 Juror No. 8 had his phone out on his notepad
2 scrolling through it, and then making notes. This
3 morning, he was scrolling through his iPhone. And as
4 the court, I'm sure, is aware, he also makes verbal
5 signs and ticks during testimony.

6 I don't know, obviously none of us know,
7 what he was doing, but his phone is in a red-pink
8 case, and it was sitting on his notes, and he was
9 scrolling through it and making notes in his notebook
10 while the testimony was going.

11 THE COURT: This is Juror No. 8 as seated
12 in the box?

13 MS. KAMYKOWSKI: Yes, as seated in the
14 box.

15 MS. GUNN: So he's the one -- the
16 85-year-old?

17 MS. KAMYKOWSKI: Yes, ma'am.

18 THE COURT: Okay. And we think he's
19 taking notes on an iPhone?

20 MS. KAMYKOWSKI: He has his phone out, he
21 was scrolling through it, and then making notes in
22 his juror notepad at the same time.

23 THE COURT: Okay.

24 MS. KAMYKOWSKI: And this morning he was
25 on his watch not paying attention. He wasn't taking

1 notes that I could see at that point. But just now,
2 while Ms. Anyan was testifying, he was scrolling
3 through his phone and contemporaneously making notes
4 in his juror notepad.

5 THE COURT: And what is it you propose we
6 do?

7 MS. KAMYKOWSKI: well, I've never had this
8 happen. I, you know, you very clearly have
9 instructed him about paying attention and listening.
10 He clearly is not regarding that instruction, at
11 least as I saw, and I pointed it out to Ms. Pfirrman
12 and my co-defense counsel, so we all saw it. I don't
13 really know what to do, Judge, really. I mean, do I
14 voir dire him on what he was doing? I don't know.

15 THE COURT: Unfortunately I think there's
16 been also other people at counsel table that have
17 been on phones. He may not be understanding that
18 that's not permissible when people involved in the
19 litigation have been on phones.

20 I'm certainly open to bringing him in and
21 asking him questions with regards to what he was
22 doing. I didn't know notice it at any given point.

23 MS. KAMYKOWSKI: well, let me talk with
24 Mr. Willman and Mr. Perron --

25 THE COURT: Okay.

1 MS. KAMYKOWSKI: -- and maybe right before
2 we bring them back in, we can decide if we'll finish
3 the record on that.

4 THE COURT: Okay.

5 MS. KAMYKOWSKI: But I don't, I mean, Your
6 Honor, I don't believe any counsel have been on their
7 phones --

8 THE COURT: It's not counsel.

9 MS. KAMYKOWSKI: Thank you.

10 THE COURT: Okeydoke.

11 (At 2:31 p.m., proceedings stood in
12 recess. At 2:48 p.m., the following proceedings were
13 held in open court:)

14 THE COURT: Go ahead and be seated,
15 everyone.

16 Just a quick reminder not to use your cell
17 phones for any purposes during the course of
18 testimony. I understand some of you may have hearing
19 aids, and they may be Bluetooth enabled.

20 If you just want to raise your hand and
21 let us know that you're using it for that purpose,
22 then we can all know what's happening, and it will
23 all be fine.

24 on behalf of the plaintiffs?

25 MS. GUNN: Yes, Your Honor.

1 THE COURT: You may call your next
2 witness.

3 MS. SLATER: Thank you, Your Honor.
4 Plaintiffs call Dr. Liles, a physiatrist. He will be
5 called by video deposition.

6 This video deposition was taken on Monday,
7 March 10th, 2025, and the runtime is 2 hours.

8 THE COURT: okay.

9 (Designated portions of the videotaped
10 deposition of Dr. Richard Liles were played for the
11 jury.)

12 THE COURT: It looks like we need a
13 recess.

14 (At 4:42 p.m., the Court duly admonished
15 the jury, and proceedings stood in recess. At
16 4:53 p.m., the following proceedings were held in
17 open court, in the presence of the jury:)

18 THE COURT: Go ahead and be seated,
19 everyone.

20 (Designated portions of the videotaped
21 deposition of Dr. Richard Liles were resumed for the
22 jury and concluded.)

23 MS. SLATER: Your Honor, that concludes
24 the testimony of Dr. Liles.

25 THE COURT: All right.

1 Ladies and gentlemen of the jury, we'll go
2 ahead and adjourn for the evening.

3 (At 5:01 p.m., the hour of adjournment
4 having arrived, the jury, being duly admonished by
5 the Court, by agreement, is allowed to separate for
6 the evening, under the usual instructions of the
7 Court, until Tuesday, March 18, 2025, at 9:00 a.m.)

8 o o o

9 Tuesday, March 18, 2025

10 o o o

11 (At 8:31 a.m., the following proceedings
12 were held in open court, outside the presence of the
13 jury:)

14 THE COURT: We are outside the presence of
15 the jury. At this time, on behalf of the plaintiffs,
16 there has been a request on make an offer of proof.

17 You may proceed.

18 MS. LENIVY: Thank you, Judge.

19 I'd like to hand the Court a few exhibits
20 that have been marked.

21 First, Plaintiffs' Exhibit 141, which is a
22 copy of the trial deposition transcript of Jean-Paul
23 Pascal Gringas, taken on March 7th, 2025.

24 Exhibit 141-2 which is Mr. Gringas's CV.

25 Exhibit 141-24, which is his report in this initial

1 Excel format printed out for, frankly, the sake of
2 being able to have a physical copy of it.

3 And, additionally, attached to that, are
4 several -- 11 different demonstratives that are
5 marked as Demonstratives 1 through 11 that
6 Mr. Gringas utilized in his deposition to quickly
7 explain an otherwise very lengthy record.

8 So at this time, I will hand that to the
9 Court.

10 THE COURT: Thank you.

11 MS. LENIVY: And prior to going on the
12 record, I believe the Court confirmed that there was
13 no objection to plaintiffs handing the exhibits over
14 to the Court.

15 The offer of proof itself, though,
16 consists of Mr. Gringas's testimony and his economic,
17 expert economic opinions, as contained in that trial
18 deposition.

19 By way of background, and for the record,
20 Mr. Gringas was named as a rebuttal expert economist
21 by plaintiff in May of 2024, less than 30 days after
22 defendants produced their expert economist, Matthew
23 Bishop, for deposition, and almost 9 months before
24 the trial.

25 Defendants deferred taking his deposition

1 pending a motion to strike, which was denied. Mr.
2 Gringas then sat for his deposition in September of
3 2024. Defendants filed a motion to strike Mr.
4 Gringas in January of 2025.

5 On February 18th, the Court entered an
6 order stating that the Court would grant the motion
7 to strike if the defense elected to not present
8 Mr. Bishop as an expert witness.

9 At the pretrial held on February 27th,
10 defendants indicated that they would be withdrawing
11 Mr. Bishop as an expert. Plaintiff requested orally
12 for the courts to reconsider its prior ruling on
13 striking Mr. Gringas, which was denied.

14 On February 28th, defendant filed a notice
15 of withdraw of Mr. Bishop. Subsequently, plaintiff
16 filed a formal written motion for reconsideration,
17 or, in the alternative, motion for leave to
18 supplement expert disclosures. Oral argument was
19 heard on March 6th, and the Court denied the motion,
20 but did permit the trial deposition of Mr. Gringas to
21 go forward over defendants' motion to quash because
22 of the offer of proof issue here.

23 As part of the plaintiffs' offer of proof,
24 we have submitted Mr. Gringas's trial deposition
25 transcript, his CV, which shows that he is a

1 highly-qualified, licensed CPA and forensic

2 accountant, has been for the past 25 years.

3 I don't believe there's ever been a

4 challenge to Mr. Gringas's expertise and competency

5 to testify to economic losses. Additionally, his

6 Excel spreadsheet report printed out and the eleven

7 demonstrative slides used during his deposition.

8 Had Mr. Gringas been permitted to testify

9 for the jury, the jury would have heard his expert

10 opinions regarding his calculation of Plaintiff

11 Remington Anyan's economic damages or economic

12 losses, including the present value of plaintiff's

13 lost earnings, which includes lost future wages and

14 lost benefits, assuming plaintiff had achieved a high

15 school diploma, a bachelor's degree, or a

16 professional degree.

17 Present value of plaintiff's future cost

18 medical care based on plaintiffs' life care expert,

19 Dr. Liles's life care plan, and the value of

20 plaintiff's loss of future household services.

21 Mr. Gringas testified in his trial

22 deposition that in determining these numbers, he

23 utilized his discounted cash flow model as reasonable

24 and appropriate for an economist to do.

25 Mr. Gringas goes into great detail in his

1 deposition in what his sources are and how he applies
2 those sources to his methodology in calculating these
3 numbers out, just because the numbers on the record
4 as evidence of plaintiff's economic losses that the
5 jury did not get to hear.

6 Mr. Gringas's opinion Remi Anyan's loss of
7 earning valuations are \$4,191,692, had he been able
8 to receive a high school diploma. \$6,927,448, had he
9 been able to receive a bachelor's degree. And
10 \$11,151,427 for a professional degree. And yesterday
11 in -- sorry -- Dr. Liles's video deposition, the jury
12 has heard evidence that because of the severity of
13 plaintiff's injury, he will not be able to go to a
14 normal school, receive a normal degree, and will not
15 be able to work, even with a benevolent employer.

16 Regarding Mr. Gringas's loss of household
17 services, he testified that with a 5 percent
18 limitation based on a 24-hour day, plaintiff's lost
19 future household services value is 784,501. At a 25
20 percent limitation, it would have been \$3,922,507.

21 And then regarding Mr. Gringas's present
22 value expression of plaintiff's future medical costs
23 based on Dr. Liles's life care plan, he provides a
24 very detailed chart basically listing from year 1 to
25 year 90. And he's not offering life expectancy

1 opinions. He made that very clear. That life
2 expectancy is merely an assumption, that he must have
3 and include in his chart in order to render opinions.
4 And he utilizes the CDC life tables as reasonable and
5 appropriate.

6 For year 1 to year 90, Mr. Gringas offers
7 numbers that would cover Remi, should he live in a
8 facility or if he lives in a home with his family or
9 independently at a home, as follows, Dr. Liles's life
10 care plans, which offered numbers for both facility
11 and home care.

12 what Mr. Gringas's report would allow the
13 jury to do is determine which year of life expectancy
14 they want to apply under either scenario and
15 determine with a number for plaintiff's future
16 medical costs and present value thereof.

17 The lowest year 1 facility care is
18 \$170,982. And the highest, included in the report
19 year 90, home care is \$62,692,344. And his plan
20 included the calculated cost at each year between 1
21 and 90 for both the facility care option and the home
22 care option. And all of those numbers are listed
23 again in the very detailed Excel spreadsheet plan,
24 just to present it for the Court.

25 And if the jury had gotten to hear Mr.

1 Gringas's testimony, and be presented with his
2 report, and chosen to utilize, for example,
3 Dr. Liles's life expectancy opinion of 60 years old
4 living at home, which the jury has now heard that --
5 from both of plaintiff's parents, the goal is to keep
6 him at home. They don't want him living in a
7 facility. They don't think that's the best option
8 for him.

9 For home care, up to 60 years old, Mr.
10 Gringas explains that the present value of
11 plaintiff's future medical costs is \$27,986,165.
12 Again, Mr. Gringas's full chart is contained in his
13 full, Exhibit 141-24, and he testified to it
14 extensively.

15 Mr. Gringas testified that all of his
16 opinions offered in this case were held to a
17 reasonable degree of economic certainty and based on
18 sound economic principles.

19 And regarding the admissibility, the Court
20 is aware of all arguments previously, but just to get
21 it on to the record, this was a witness disclosed to
22 the defendants almost nine months before trial. They
23 had ample opportunity to depose him, which they did,
24 learn his opinions, and even get surrebuttal opinions
25 by their economist several weeks before trial.

1 Mr. Gringas provided highly-relevant
2 testimony that is important for the jury to hear and
3 be able to consider when determining the true value
4 of plaintiff's future medical costs.

5 RSMo 538.215.2 states: All future damages
6 which are itemized as required by subsection 1 of
7 this section shall be expressed by the trier of fact
8 at present value. And I just want to add emphasis on
9 "expressed." He does not say reduced present value.

10 Defendants offered a, during pretrial, a
11 non MAI jury instruction to that effect, although I
12 know we haven't had a jury instruction conference.

13 It would be to determine -- it will determine
14 whether it will provided to the jury. But this MAI
15 basically cites 538.215, and we believe if this MAI
16 were to go in front of the jury, it would trigger
17 this testimony.

18 Plaintiff also anticipates that the
19 defendant will open the door to the issue by
20 presenting argument to the jury about the value of
21 money or present value or a discount rate. Without
22 Mr. Gringas's economic calculations, the jury will
23 only hear Dr. Liles's cumulative total of around 14
24 to 21 million, depending if they want to use 60 years
25 of life expectancy or the normal life expectancy for

1 an average American man of 75.

2 And not being able to present Mr.
3 Gringas's testimony and report, plaintiff is
4 prejudiced by this because he will not be able to
5 present true value of economic damages in the amount
6 of several millions of dollars.

7 Plaintiff is further prejudiced because
8 under RSMo 538.210, his noneconomic damages for pain
9 and suffering are already capped. And given the
10 severity of damages, there is only a relatively small
11 amount of noneconomic compensatory damages accessible
12 that balances any errors to calculations that require
13 future costs or that cushion the reality of future
14 medical costs.

15 Mr. Gringas's evidence proves that the
16 present value of plaintiff's future costs is more
17 than the dollar amount in the life care plan. By
18 excluding this evidence, and should the jury find in
19 favor of the plaintiff and award him future medical
20 costs, plaintiff will not fully and justly be
21 compensated under the law for future damages, and the
22 verdict rendered will be rendered for an amount
23 insufficient to meet the future medical needs, which
24 is both a safety and quality of life concern for this
25 particular individual.

1 plaintiff is prejudiced from a quality of
2 life perspective, should the jury agree that the
3 defendants are responsible for causing severe,
4 lifelong permanent brain injuries of this global
5 hypoxic ischemic encephalopathy. And that's all.

6 Thank you, Judge.

7 THE COURT: Thank you.

8 Any response on behalf of either
9 defendant?

10 MS. KAMYKOWSKI: Just briefly, Your Honor.
11 And I know we took this issue up with the plaintiffs'
12 motion to reconsider Dr. Gringas back at the
13 beginning of this month, prior to the start of this
14 trial.

15 I think it bears knowing that this might
16 be a conundrum that the plaintiffs put themselves in
17 because under Wickham v. Hummel, Klotz v. St.

18 Anthony's, and then the Anglum case that's cited,
19 therein, it is true that although the plaintiff has
20 the burden of proving the elements of this medical
21 malpractice case that include damages, our supreme
22 court thus far has not decided that the plaintiff
23 actually requires that burden when it comes to
24 present value, despite there being a statutory
25 mandate that the itemized damages allowed under the

1 jury instruction in medical malpractice cases require
2 a present value expression by the jury.

3 In this case, strategically, presumably
4 plaintiffs chose not to offer an economist in their
5 case-in-chief. That has been the practice of the
6 plaintiff bar for many, many years. As we said
7 before, the defense sees that, and what the case law
8 currently is on this issue is a burden shift to
9 either the defense having to put on an economist or
10 follow what Klotz, Wickham v. Hummel, and Anglum say,
11 and just arguing an expression of present value based
12 on this jury's lay knowledge of the dollar -- the
13 value of a dollar today being different than the
14 value of a dollar in a year or in 60 years.

15 so in this case plaintiffs had deadlines
16 for disclosing the experts they wanted to offer to
17 support all of the elements that they have to prove
18 in this case. They chose not to produce an
19 economist.

20 The defense then chose to disclose an
21 economist or an economic damages expert, Mr. Bishop,
22 to do what the statute mandates and reduce Dr. Liles'
23 life care plan and the various options to present
24 value.

25 In response, the plaintiffs then

1 disclosed, as a rebuttal expert only, Mr. Gringas,
2 that comes at the risk of there not being evidence to
3 rebut when it comes to time for trial. That's where
4 we are today. That's where we have been for the past
5 month. To address the "no harm, no foul" because he
6 was disclosed 9 months before this trial, that, to
7 me, is somewhat of a red herring because it is not in
8 any party's control necessarily when a court may, for
9 various reasons, require a trial continuance. And so
10 to allow the plaintiff to argue, well, we had 9
11 months, and really we probably should have put this
12 in our case-in-chief. For whatever reason, we chose
13 not to.

14 The case was set for trial in April of
15 2024, but we continued it. And then there was more
16 time. You should have just let us put him in our
17 case-in-chief. Then that would be a strategy
18 employed every single time there was a continuance in
19 a case where plaintiffs could retool their claims
20 with any expert, not just an economist expert.

21 So we think that the Court's ruling is
22 appropriate. It is -- the reason why Mr. Gringas is
23 not allowed to testify in rebuttal is because, since
24 we believe there has been burden shifting to the
25 defense on this present value mandate, we chose not

1 to do that with an expert in the evidence in this
2 case.

3 The issue also has been raised with
4 respect to whether the Court might entertain, or I
5 guess maybe even just simply the tender of an
6 instruction that is not an MAI that would track
7 538.215's mandates that itemized damages for future
8 economics in the medical malpractice cases must be
9 expressed at present value would somehow open the
10 door to this testimony.

11 Or even further, and I think pretty
12 incredulous, after evidence has closed, is when both
13 the jury instructions are given to the jury, and
14 argument is made.

15 And it is specifically contemplated by the
16 Missouri Supreme Court in the Anglum case that if
17 there is no evidence, neither party has the burden
18 apparently right now. Nobody has to put on evidence
19 in the case of present value. So -- and that's
20 what's going to happen in this case, based on the
21 Court's ruling.

22 Therefore, we still have the right and the
23 obligation for our clients to tender an instruction
24 that may or may not be given by the Court and
25 certainly to argue it to the jury. And that in no

1 way, an argument of this case, after all sides have
2 rested, would that open the door to reopen evidence
3 for Mr. Gringas. So we agree with the Court's
4 decision, and that's all I have.

5 THE COURT: Thank you.

6 MR. PERRON: Your Honor, we'll stand and
7 endorse the Court's previously ruling of course.

8 THE COURT: Thank you.

9 MS. SLATER: Your Honor, to respond to the
10 argument about the case law on present value. The
11 same court cases: Anglum, Kotz, and Wickham, the
12 supreme court has stated for 40 years that this is --
13 that present value is something that juries can
14 understand the value of money, and that's why -- the
15 value of a dollar today versus the future. And
16 that's why traditionally expert evidence is not
17 required to meet plaintiffs' burden of proof.

18 So under that framework, there is no
19 burden shifting of defendants' claim.

20 In this particular case, since we are
21 dealing money and damages of medical costs today
22 going forward, for a child who is severely brain
23 damaged, and there is no dispute that the care that
24 he would require are based on his actual injury of
25 HIE causing brain damage.

1 There is testimony in the case that
2 there's a dispute among economists about whether that
3 means more today to provide for future medical costs,
4 or if that dollar amount is less today than the cost
5 of Dr. Liles' life care plan.

6 And so from that perspective, we do not
7 agree that there has been any burden shifting in the
8 way the information has come in this case, and we
9 appropriately rebutted Mr. Bishop's opinions that
10 they have now strategically decided to withdraw,
11 while still tendering this instruction as we have
12 discussed, the non MAI instruction.

13 We also know that in a case that we tried
14 against the same defendants last year, where this
15 instruction, the present value instruction, was
16 tendered and denied by the Court, that's the issue on
17 appeal in front of the Eastern District of Missouri
18 right now, the fact that the instruction was not
19 given.

20 So all we can anticipate is that whether
21 the Court decides to give the instruction or not, it
22 will become an appellate issue parallel to the other
23 cases that are on appeal.

24 Thank you.

25 THE COURT: Thank you.

1 The Court will take the issues under
 2 submission and will incorporate in the record
 3 exhibits provided to the Court relative to the offer
 4 of proof.

5 The Court's expectation is that it will
 6 review these records this morning when we're on
 7 break, and will enter an official ruling before the
 8 close of plaintiffs' case.

9 MS. LENIVY: Thank you, Your Honor.

10 MS. KAMYKOWSKI: Thank you, Your Honor.

11 THE COURT: Thank you.

12 Anything else we need to put on the record
 13 before we get started?

14 MS. KAMYKOWSKI: Not from the defendants.

15 MR. WILLMAN: No. No, Your Honor. Thank
 16 you.

17 MS. SLATER: One moment, Your Honor.

18 MS. GUNN: Judge, it's my understanding
 19 that the defense intends to call Dr. Dreyer live
 20 tomorrow.

21 MS. KAMYKOWSKI: Dreyer?

22 MS. GUNN: Yes, Dreyer live tomorrow.

23 You may remember that this was the subject
 24 of a pretrial motion. There were three sets of
 25 witnesses. The first really was that certified nurse

1 midwife, Tamsin Lewis, who was set for trial -- or
2 set for the trial deposition that we were going to
3 pay. And then it was withdrawn.

4 The second set, were the MFM OB
5 anesthesia, the title of those folks that we doing
6 the safety rounds and stip rounds. And Your Honor
7 ruled that with that late disclosure, they came up
8 with a couple of names late disclosure.

9 The third grouping was some treating
10 physicians who had been part of Remi's chart, along
11 with, you know, hundreds of other people. And your
12 ruling at that point was that they, you know, we
13 basically take it with the case.

14 If they showed up, they would be limited
15 to what's in the records, like the fact issues in the
16 records. Because if they were intending to offer
17 opinions that they had not been expressed or
18 specifically identified by the defendants, then that
19 would not be allowed.

20 So I learned yesterday that Dr. Dreyer was
21 coming, and so I wanted to address that issue before
22 it was too late.

23 MR. PERRON: Your Honor, briefly on
24 background.

25 At the pretrial conference, there were

1 several motions to quash noticed up for a hearing at
2 that time, at that particular time, and that I happen
3 to include, as counsel mentioned in the motion to
4 quash, a number of depositions, trial depositions, of
5 this certified midwife, Tamsin Lewis, and the noted
6 but unnamed MFM and OB of Dr. Fathian and Dr. Wong.

7 That was both noticed up. Those were properly taken.

8 We had also disclosed a potential witness
9 list that included several providers that we had
10 both, plaintiff and defense, identified in our
11 disclosures as nonretained expert witnesses.

12 Though it wasn't noticed up, counsel
13 brought it to the Court's attention that our notice
14 included providers who we attempted to depose.

15 We made oral arguments, and both sides had
16 named Dr. Dreyer and the two radiologists as
17 nonretained expert witnesses. And even though they
18 weren't deposed, we should be allowed to solicit from
19 them expert opinions.

20 It's my understanding the Court's ruling
21 was that their testimony would be limited to the care
22 and treatment they provided. I understand that
23 differently than the tables just read out loud in the
24 black and white text of the records.

25 I understand the Court's ruling

1 respectfully. I believe they were properly disclosed
2 as nondisclosed experts, disclosed as nonretained
3 experts. But I understand that the Court's ruling at
4 the pretrial conference was that we would be able to
5 talk about care and treatment they provided, which I
6 think includes more than just the black and white
7 text and being able to just read out loud what those
8 documents mean.

9 THE COURT: I don't disagree that they
10 don't just have to read what's in their records. Are
11 there -- is there an expectation that they're going
12 to opine on how the injury was caused?

13 MR. PERRON: Not the cause of the injury.

14 MS. KAMYKOWSKI: No.

15 THE COURT: When the injury was caused?

16 MS. KAMYKOWSKI: No. We won't be asking
17 those questions.

18 MR. PERRON: I don't think so. I mean,
19 I'm not going to ask that question. I'm going to --
20 I think it would be fair to ask them to explain, in
21 layman's terms, the portions of documentation from
22 their notes.

23 MS. GUNN: Your Honor, we've had numerous
24 experts that have been disclosed and have been
25 deposed and have been on the stand and will continue

1 to be on the stand, that have interpreted those
2 records.

3 If Dr. Dreyer were going to be able -- if
4 he were someone that they can pull from their stable,
5 no disrespect, but their stable that they control,
6 that they have access to, that we don't have the same
7 access to, they can go through everybody and then, at
8 the last minute, pull someone in and ask them really
9 critical questions about causation.

10 we think that is unfair. We think that is
11 prejudicial. I don't know what he's going to say. I
12 understand what his records say. Our experts have
13 all relied on those records to a certain extent. But
14 to allow him to come in now without having any kind
15 of formal disclosure, other than putting a name on a
16 witness list, it is unfairly prejudicial and a late
17 disclosure.

18 MS. KAMYKOWSKI: So just to -- for the
19 record to be clear. Dr. Dreyer is not a Mercy
20 Clinics or a Mercy Hospital employee. Dr. Dreyer is
21 a partner in pediatrics, an independent, neonatology
22 group that provides neonatology services at Mercy
23 Hospital who was, in fact, a defendant in this
24 lawsuit at the very beginning. So we don't have
25 control over him.

1 MS. GUNN: He wasn't.

2 MS. KAMYKOWSKI: We don't have -- he
3 wasn't -- but pediatrics was, as was Mary Spencer.
4 we don't have control over him if we have not spoken
5 to him. we have thoughts about what we want to ask
6 him, based on what may be placed in the record, then
7 that's the intent of having Dr. Dreyer here.

8 It is disingenuous to say that we
9 disclosed him as a nonretained expert exactly as the
10 rule requires, in the exact same manner that the
11 plaintiff did. so I don't think there's any unfair
12 advantage. There's no surprise. And there's not
13 late disclosure.

14 THE COURT: So the Court is going to allow
15 Dr. Dreyer to testify, but will not allow him to
16 opine as to the cause of the injury, when the injury
17 occurred, or issues related to the causation. But to
18 allow him to testify as to the treatment that he
19 provided and information contained in the records,
20 which has been discussed at length in the trial.

21 MS. GUNN: Thank you, Judge.

22 MS. KAMYKOWSKI: Thank you, Judge.

23 THE COURT: Anything else?

24 MS. GUNN: No, ma'am.

25 THE COURT: All right.

1 (At 9:05 a.m., the following proceedings
2 were held in open court, in the presence of the
3 jury:)

4 THE COURT: Good morning, everyone.
5 Go ahead and be seated.
6 On behalf of the plaintiff.

7 MS. SLATER: Your Honor, may it please the
8 Court? Plaintiff calls Dr. Stephen Nelson.

9 THE COURT: Sir, if you'll step on up and
10 be sworn.

11 STEPHEN NELSON, M.D.,
12 having been duly sworn, was examined, and testified
13 as follows:

14 DIRECT EXAMINATION

15 BY MS. SLATER:

16 Q. Good morning.

17 A. Good morning.

18 Q. will you please introduce yourself to the
19 jury.

20 A. I am Dr. Stephen Nelson.

21 Q. And what is your profession, sir?

22 A. I'm a pediatric neurologist and an
23 epileptologist, meaning I specialize in epilepsy.

24 Q. And where are you currently employed?

25 where are you coming to us from?

1 A. From New Orleans. I work at Tulane
2 Ochsner and LSU Health Systems.

3 Q. All right. And can you generally explain
4 to the jury what the role that you play in this case
5 is.

6 A. So as a pediatric neurologist, we often
7 are consulted in any case where there's a concern for
8 a neurological injury or a neurological symptom or
9 sign, to help determine causation, meaning what's the
10 cause of the injury or the neurological symptoms, as
11 well as potentially treatment or prognosis or other
12 types of issues. But that could be anything from a
13 brain injury, spinal cord injury, seizures, or
14 epilepsy, developmental delay, or autism.

15 Again, patients are referred to us either
16 in clinic or we retained as a consult, and our -- the
17 question to us is why is the patient the way they
18 are? And what can we do to make them better?

19 Q. And in this case, I want to allow the jury
20 to get a high level of your opinions we're going to
21 be talking about today.

22 But you have reviewed medical records from
23 Sarah Anyan's delivery at Mercy, correct?

24 A. Yes.

25 Q. As well as Remi's birth and NICU records,

1 correct?

2 A. Yes.

3 Q. All the way -- Remi's records all the way
4 up to the recent past.

5 A. Yes.

6 Q. Radiology studies and then also
7 depositions that we've been discussing in this case,
8 correct?

9 A. Yes.

10 Q. Okay. And based on that review, did you
11 formulate an opinion to share with the jury?

12 A. Yes.

13 Q. And you're ready to share that?

14 A. Yes.

15 Q. And will you agree with me that all the
16 opinions and testimony you give today will be based
17 on a reasonable degree of medical certainty?

18 A. Yes.

19 Q. Okay. You hold opinions regarding what
20 type of brain injury Remi has, correct?

21 A. Yes.

22 Q. And what is that opinion?

23 A. That he suffered severe and global hypoxic
24 ischemic brain injuries.

25 Q. And you hold opinions regarding what

caused those injuries, correct?

A. Yes.

Q. And what are those opinions?

A. Placental insufficiency, or, in other words, inadequate oxygenation during the end of the labor and delivery process.

Q. And you hold opinion regarding when those injuries occurred, correct?

A. Yes.

Q. And what is that opinion?

A. Again, close to the time of when Remi was born, so approximately within the last 30 to 60 minutes.

Q. All right. And you hold opinions regarding when those injuries could have been avoided, correct?

A. Yes.

Q. And what is that opinion?

A. That if he had been delivered prior to suffering fetal hypoxia, then we would have avoided all of those injuries.

So if he'd been delivered prior to that, roughly 30- to 60-minute window, then he would be completely normal and not have suffered any brain injury.

1 Q. And that was my next question. You have
2 opinions regarding how his life would have been
3 different if he had been delivered even 30 minutes
4 earlier, correct?

5 A. Yes.

6 Q. And you hold opinions about how those
7 injuries affected Remi and will affect him in the
8 future, correct?

9 A. Yes.

10 Q. Can you give us a general overview of
11 those opinions?

12 A. Yes. So unfortunately because of the
13 injuries that Remi suffered, although cognitively he
14 has a lot of intactness, like he's able to think and
15 understand things that are going on around him, he's
16 not able to express his needs or wants without
17 assistive devices.

18 He's not able to care for himself without
19 assistance, and that's because of the parts of his
20 brain that were injured made it so all of the things
21 that he thinks in his head that he knows or wants to
22 say or he wants to do, he can't get those to his body
23 to make it actually happen.

24 The analogy I use is like knocking out the
25 bridge. So all the cars are coming to the bridge,

but the bridge is out, and so the signals can't get to his body, and so you have an intact brain, an intact person, trapped in a body that they're not able to control.

Q. All right. Thank you.

Let's start with your qualifications.

You have a CV or a resume that is on your case, correct?

A. Yes.

MS. SLATER: Zack, can we bring up Exhibit 120-2.

Q. (By Ms. Slater) You probably don't need your resume to tell us where you went to college, huh?

A. No.

Q. All right. Let's start with that while they're bringing these up.

Tell us about your education and training. And if you could start with your college degree.

A. Sure. So I did my undergraduate degree at California State Polytechnic University of Pomona. I graduated with a bachelor of science in biology. I then worked for a year doing validations engineering for a pharmaceutical company. And then did a PhD through University of California-Riverside in

1 biomedical sciences, looking at the effects of
2 radiation on any human cells and on humans.
3 I then did a medical degree through the
4 University of California-San Diego. Following
5 medical school, I then did my internship at Lackland
6 Air Force Base Wilford Hall Medical Center, San
7 Antonio, Texas. That's a three-year pediatric
8 residency.

9 I then practiced for a year as a general
10 pediatrician at Los Angeles Air Force Base. And then
11 I went and did my child neurology fellowship at
12 Stanford.

13 And I can give you my experience, if you'd
14 like, too.

15 Q. Yes, please.

16 A. So following my fellowship completion at
17 Stanford, that was 2007, I then went to Keesler Air
18 Force Base, Biloxi, Mississippi, where I was the
19 chief of pediatric neurology. I was the special
20 needs coordinator for the Department of Defense,
21 meaning that if you are an active duty member, and
22 you had a dependent who had a medical issue, whatever
23 service you were in, I was the person who cleared you
24 as to where you could move, or if you needed to be
25 moved compassionately, things like that.

1 I also did outreach clinics to a Navy
2 Hospital-Pensacola and Eglin Air Force Base. And
3 then I led a humanitarian mission to Ecuador. Then
4 2010, I moved to the -- Bethesda, Maryland. I was at
5 Walter Reed National Military Medical Center.

6 I was also the director of child neurology
7 education, and the deputy director of neurology
8 education through the Uniformed Services University
9 of the Health Sciences. That's the medical school
10 that the Department of Defense has for training
11 doctors in the military.

12 Then -- or actually also during that time,
13 I was the program director for the child neurology
14 fellowship through the National Capital Consortium.

15 At the end of 2013, I left active duty,
16 moved down to New Orleans, where I'm currently a
17 professor of pediatrics, neurology, neurosurgery, and
18 psychiatry through Tulane University School of
19 Medicine. I'm also a professor of neurology through
20 LSU School of Medicine. I'm a medical director for
21 the Tulane Center for Autism and Related Disorders,
22 and I work with the pediatric neurologists and
23 epilepsy specialists through Tulane Ochsner and LSU
24 Health Systems.

25 Q. And tell us about -- are you board

1 certified, Doctor?

2 A. Yes.

3 Q. Can you tell us about your board
4 certifications.

5 A. So I'm board certified in general
6 pediatrics by the American Board of Pediatrics. And
7 I'm board certified in epilepsy by the American Board
8 of Psychiatry and Neurology. And I'm board certified
9 in neurology with special qualification in child
10 neurology by the American Board of Psychiatry and
11 Neurology.

12 Q. You've mentioned a lot of specialization
13 and orthopedists and child care.

14 Do you also, in your current practice and
15 throughout your career, have you also treated adults
16 who seek you out for epilepsy and neurology related
17 issues?

18 A. Yes.

19 Q. Do you belong to any professional
20 societies that are related to your field?

21 A. Yes.

22 Q. And we have your resume up here. I see MD
23 and PhD, and the other qualifications.

24 Are those your professional associations,
25 also?

1 A. Yes. Those are some of the -- so the
2 alphabet soup after my name, once you get past MD,
3 PhD, are various societies that I'm a member of.

4 And then the highest status that you can
5 have in a society is to be a fellow. So I'm a fellow
6 of the American Academy of Cerebral Palsy and
7 Developmental Medicine, a fellow of the American
8 Academy of Neurology, a fellow of the American
9 Neurological Association, and then the American
10 Academy of Pediatrics.

11 Q. In particular, to become a fellow of the
12 American Association of Neurology, what process did
13 you go through?

14 A. For the ANA, it was -- so you had to be
15 board certified, and you had to be out in practice
16 for a certain number of years, and then you had to
17 apply for it. Probably the one that was the most
18 difficult was the American Academy of Neurology.

19 You have to finish your training, you have
20 to be board certified, you have to practice at least
21 seven years, you have to attend 5 annual meetings,
22 and then you have to submit this like multipage
23 application where you have to show excellence in
24 clinical practice, excellence in teaching, and
25 excellence in research.

1 Then you have to get three letters from
2 other people who are fellows endorsing you. And then
3 those are before the committee, and they vote. And
4 about 25 percent of people who apply, get it. And I
5 would say less than 10 percent of people in the
6 society never even can achieve it. So it's a lot of
7 work to get this distinction.

8 Q. And how long have you held that
9 distinction?

10 A. About seven years.

11 Q. Okay. And you explained your current
12 practice being both children and adult patients.

13 Can you tell the jury about how you spend
14 your clinical time?

15 A. Sure. So pediatric neurology is mostly an
16 outpatient practice. So the majority of my time
17 would be seeing patients in clinics. But at the same
18 time, we also cover an inpatient practice, and so
19 there's consults in the NICU and the PICU, the ward,
20 the ER, etc. And those patients are needed to be
21 seen and evaluated and staffed.

22 My time is divided among the various
23 institutions, so I cover hospitals through the
24 Ochsner system in New Orleans, through the Tulane
25 system in New Orleans, and Ochsner LSU in Shreveport,

1 Louisiana.

2 Q. And can you tell me about -- you do
3 research as a fellow professor -- I'm sorry -- a
4 professor through those institutions.

5 A. Yes. Yes.

6 Q. Do you have a particular research focus?

7 A. Yeah. I've always been interested in
8 autism and genetics of epilepsy and autism and
9 developmental delays and how to manage complex
10 epilepsy patients. Those are probably the things
11 I've done the most work in.

12 Q. And in your clinical practice now, and
13 throughout your 25 years of practicing medicine, do
14 you see patients and treat patients like Remi Anyan?

15 A. Yes.

16 Q. All right. Can you tell us about your
17 teaching experience, please.

18 A. Sure. So, I mean, I guess I'd have to go
19 back to the very beginning when I was in graduate
20 school. Obviously you do a lot of teaching in
21 graduate school. And, in fact, I won the award for
22 outstanding graduate student teacher of the year when
23 I was doing my PhD.

24 And then in medical school, of course we
25 teach our younger class of medical students. And

1 then once I went into the military system as a
2 pediatric intern and resident, then I got an
3 appointment to the Uniformed Services University of
4 the Health Sciences as an instructor.

5 Once I finished my training in child
6 neurology, then I became an assistant professor in
7 Tulane. And then from that, you sort of work your
8 way up to that, and I became an associate professor
9 and a full professor.

10 And part of how you make that -- advances
11 in the rank in an academic system, is by doing
12 research and publishing, and you have to publish
13 quite a lot to get those promotions. But also
14 teaching is a big part of it.

15 So I teach medical students. I teach
16 residents. And have taught a variety of different
17 residencies, including neurology, pediatrics,
18 neurosurgery, psychiatry, child psychiatry. And they
19 look very closely at your feedback you get because
20 they want to promote people who teach well, you know,
21 they don't want to keep people who students and
22 residents don't like because, you know, if you're
23 mean or whatever.

24 And so I've always had a passion for
25 teaching, I mean, honestly that's why I went and did

1 my PhD. I thought I was going to follow a research
2 track and just teach at an institution. But when I
3 did my PhD, I thought about -- I got more and more
4 involved in thinking about medicine and the effects
5 of radiation on -- on people and populations.

6 Then I went to medical school and did my
7 pediatric residency, and that was only from -- like,
8 as soon as I did pediatrics, I'm like why would you
9 do anything else other than pediatrics? A great
10 career.

11 Q. As far as giving testimony or your
12 professional opinion in this setting, when did you
13 first start doing that?

14 A. So the very first case that I reviewed was
15 2004, for the Department of Defense. That was when I
16 was at Los Angeles Air Force Base.

17 Throughout my career in the military, I
18 continued to review cases for the Department of
19 Defense, and I continued to do work for them since
20 leaving the military. I also do work for the
21 Department of Justice. And then 2007, would have
22 been the first case that I reviewed outside of the
23 military. And that was for the attorney general's
24 office in Louisiana.

25 Q. Okay. So the federal government and state

1 governments had asked you to do this type of work,
2 and that's how you got started?

3 A. Yes.

4 Q. Okay. And this is a civil case obviously,
5 but you also do consulting in this format in criminal
6 cases, as well, correct?

7 A. Yes.

8 Q. Okay. How many depositions do you give
9 per year in this setting?

10 A. I think it's gone up a little bit
11 post-COVID. There's -- we always start with the
12 post-COVID bounce. Everything sort of shut down and
13 slowed, and then everything is downloading like light
14 speed. So I would say on average now, probably three
15 or four per month.

16 Q. And have you worked with Amy or I or Liz
17 before?

18 A. Yes.

19 Q. And how many times, if you recall?

20 A. At least one trial, and there's been at
21 least a couple of depositions.

22 Q. Okay. And we've asked a lot of experts
23 this: As far as plaintiff versus defendant, do you
24 have a breakdown that you recognize in your work?

25 A. Yeah. Initially, I mean, I was almost a

1 hundred percent defense. Over time it shifted a
2 little bit. Now it's probably 60/40, plaintiff
3 versus defense.

4 Q. Okay. And what do you charge per hour?

5 A. \$600 an hour.

6 Q. Okay. And you came here from Louisiana
7 yesterday, correct?

8 A. I did.

9 Q. And that takes away from your clinical
10 teaching and administrative work when you do that,
11 correct?

12 A. Yes.

13 Q. Okay. And you charge for your time to do
14 that here?

15 A. I do.

16 Q. Okay. You were retained by our office in
17 this case in February of '23, correct?

18 A. Yes.

19 Q. And what did we ask you to do?

20 A. To look at medical records and to provide
21 opinions on the cause of Remi's injuries, as well as
22 the timing and the impact that those injuries would
23 have on his future care needs or on his ability to do
24 things in the future.

25 Q. I wanted to lay out the list of all of the

1 records that you've reviewed. So let me go through
2 these, and you can confirm that that's what you
3 looked at.

4 I have down that you looked at Sarah and
5 Remi's Mercy records, correct?

6 A. Yes.

7 Q. Records from Dr. McNeive?

8 A. Yes.

9 Q. Records from the NICU stay, as we talked
10 about, correct?

11 A. Yes.

12 Q. Records from St. Louis Children's
13 Hospital?

14 A. Yes.

15 Q. Wash U physicians records?

16 A. Yes.

17 Q. Rankin Jordan records?

18 A. Yes.

19 Q. Okay. And then Remi's pediatrician, Dr.

20 Pruitt; his pediatric neurologists, Dr. Viehoveer and

21 Dr. Weisenberg; his orthopedic surgeon who's operated

22 on his hips twice and his femur after a fracture,

23 Dr. Gordon; a plastic surgeon who evaluated his

24 microcephaly, Dr. Gage; the optometrist who's

25 following his cortical visual impairment, Dr. Rallo;

1 his pediatric neurosurgeon, Dr. Smith; and then
2 various occupational physical therapists from Rankin
3 Jordan, Missouri First Steps, and others, correct?

4 A. Yes.

5 Q. And then as far as depositions you've
6 reviewed in this case, you've looked at the Mercy
7 provider depositions, Dr. McNeive, Dr. Parker, Nurse
8 Practitioner Spencer, who was Younger at the time,
9 Nurse Maggie, Nurse Jessie, and than any other nurses
10 and residents who were deposed about the care and
11 treatment, correct?

12 A. Yes.

13 Q. All right. And then you also read Remi's
14 parents' depositions, Blake and Sarah, correct?

15 A. Yes.

16 Q. And then you reviewed some of the expert
17 depositions: Dr. Liles, Dr. Kerzner, Nurse --
18 Dr. Shinn, Dr. Warsof, and Dr. Sze, who we'll hear
19 from later, correct?

20 A. Yes.

21 Q. You also reviewed Dr. Woodruff's
22 deposition, that was defendants' pediatric neurology
23 expert.

24 A. Yes.

25 Q. And then Dr. Tekes, defendants'

1 neuroradiologist, correct?

2 A. Yes.

3 Q. All right. Did that give you a full
4 picture of Remi's medical care and treatment?

5 A. Yes.

6 Q. All right. Did it also give you a full
7 picture of the facts and the other opinions in this
8 case?

9 A. Yes.

10 Q. All right. And tell us how you went about
11 your review.

12 A. Well, I review the information in a case
13 the same way I would if I was evaluating a patient in
14 clinic or in the hospital. I look through all the
15 information that I have to determine, you know, what
16 happened and when it happened and generate a
17 differential diagnosis like you would in any patient
18 that you're evaluating clinically.

19 A differential diagnosis is, you know
20 what -- what did the patient have happen to them,
21 right?

22 In other words, we start with a broad
23 category like encephalopathy, being altered mental
24 status, and then you work through, well, what are the
25 various causes of that? And then eliminating those.

1 Then there's no evidence to support, and looking to
2 see what cause the evidence does support. And,
3 again, that's based on reviewing all of the available
4 information.

5 Q. And let's talk about Remi's brain injury.
6 we haven't talked about HIE yet this week in detail.

7 MS. SLATER: If we can bring up
8 Exhibit 355, please.

9 Q. (By Ms. Slater) Just to refresh. when
10 we're talking about hypoxic ischemic encephalopathy,
11 we're talking about a shortage of oxygen in the
12 blood.

13 That's hypoxic, correct?

14 A. Yes.

15 Q. And a shortage of blood flow to the brain,
16 that's the ischemic part?

17 A. Yes.

18 Q. And that results in brain damage, correct?

19 A. Yes.

20 Q. Okay. And that -- this process, this
21 mechanism, is what you believe caused Remi's brain
22 injury?

23 A. Yes. And it's in his medical record, I
24 don't know, thousands of times.

25 Q. Yeah.

1 A. It seems what all of his medical providers
2 have agreed is his diagnosis.

3 Q. Okay. There's no real dispute to that by
4 anyone?

5 A. No.

6 MS. SLATER: Let's bring up Exhibit 354,
7 please.

8 Q. (By Ms. Slater) I want to talk, if you
9 can explain to the jury, we've talked -- we've heard
10 about partial prolonged and acute profound injury.

11 I brought up that -- will this help you
12 describe what we're looking at a little bit here?

13 A. Sure. So maybe just to -- sorry -- maybe
14 just to orient slightly. The outer part of the brain
15 is what we refer to as the brain matter. So that's
16 where the neurons are that make you think all of the
17 things that you think.

18 And the neurons are the cell body of the
19 nerve. And then from the cell body, then you get
20 what's referred to as an axon, and that's like the
21 road that runs from the gray matter down through your
22 brain, and it can go a couple of different places.

23 One of the places it goes to is deep gray
24 matter structures, which we'll talk to you about on
25 the right picture. And then it can run down through

1 your brain stem into your spine. And that's -- Not an Official Court Document
2 that's the white matter. Not an Official Court Document
3 So the white matter are all the tracks
4 that are running from the gray matter. And so on the
5 left side, if you damage the gray matter, then you
6 lose the capability to generate the electrical
7 impulses, to think, or to generate the actions that
8 you want to do, right? Not an Official Court Document

9 So if you have a stroke that damages the
10 motor cortex, meaning the gray matter that's for
11 motor movement, which is like moving your arm, then
12 that's why you have paralysis like in your face or
13 your arm or your leg, or things like that. Not an Official Court Document

14 And then if you damage on the right side,
15 the basal ganglia, the deep gray matter structures,
16 or the thalami, they process information. And so
17 people who have damage there, the impulse paralysis
18 is on the bridge. All the white matter runs down to
19 the basal ganglia to try to get the signal
20 interpreted into something that then makes sense to
21 the muscles. And if that's damaged, then the signal
22 can't get down. So that -- that's sort of helps to
23 understand the mechanism a little bit. Not an Official Court Document

24 And then acute profound versus partial
25 profound, I like to use the lawn analogy. So meaning

1 that, I don't know if any of you have sprinklers
2 that, like, are in your lawn, and they pop, and they
3 water your lawn.

4 And you know how normally you want your
5 water to overlap a little bit when it's coming out of
6 the sprinklers? But let's imagine that your water
7 pressure drops a little bit so that you don't get
8 overlap between your sprinklers. Then the grasses
9 between your sprinklers will -- will die off because
10 it's not getting water. And that's a partial
11 prolonged injury. It's referred to as a watershed
12 injury. And it's where parts of the brain that are
13 between vascular territories don't get adequate
14 oxygen.

15 versus if I just turn your water off
16 completely, then your lawn can survive for a while,
17 but your, you know, precious flower beds, they die
18 fairly quickly, that they need -- they're very water
19 sensitive.

20 And that is like that acute profound
21 injury. So if you have a complete loss of blood flow
22 or oxygen, then you get the injury to the right. And
23 that's to that basal ganglia, those deep gray matter
24 structures, and to the brain stem.

25 And the brain stem is sort of what

1 connects your brain to your spinal cord. And so
2 that's why -- how it manifests and how it occurs is,
3 you know, based on whether it's a partial reduction
4 on oxygenation or a complete reduction on
5 oxygenation.

6 Q. When a baby is in utero during labor and
7 delivery, how are they getting that -- how are they
8 getting oxygen to their brain?

9 A. From the placenta. So the babies -- the
10 babies do breathe, actually, when they're inside of
11 mom, but they're not breathing anything to generate
12 oxygenation. They're just breathing to help their
13 lung development. The lungs are full of amniotic
14 fluid. So the only way they can get any type of
15 oxygen to them is it has to cross from the mother to
16 the baby through the placenta.

17 Q. And you understand the facts of this case
18 involve a 12-hour pushing labor.

19 Have you ever seen or learned of that in
20 your clinical practice?

21 A. No.

22 Q. You've reviewed the imaging, correct?

23 A. Yes.

24 Q. Anything to share about the imaging that
25 you reviewed?

1 A. Just it -- sorry -- it did demonstrate
2 global severe hypoxic ischemic injuries. I agreed
3 with the interpretation that was in the medical
4 records. I didn't have any disagreement with the
5 interpretations by the treating neuroradiologists.

6 Q. Okay. And you read Dr. Sze's opinions, as
7 well?

8 A. Yeah.

9 Q. And was that consistent with what you saw
10 on those records?

11 A. Yeah. Dr. Sze actually agreed with the
12 treating providers, also.

13 Q. Okay. And when we talk about the
14 radiology imaging, did that include both the head
15 ultrasound and the MRI?

16 A. Yes.

17 Q. So you talked about having a differential
18 diagnosis.

19 Tell me of the things that you ruled out.

20 A. Sure. So, again, I went back to
21 encephalopathy, is sort of where we start with a baby
22 that has altered mental status. And causes of
23 encephalopathies can be things like congenital
24 infection, congenital brain malformation, a postnatal
25 infection, trauma, intracranial hemorrhage,

1 periarterial ischemic stroke, which means like a
2 stroke in the baby before birth, hypoxic ischemic
3 encephalopathy, or HIE, metabolic derangements like
4 hypoglycemia, hyper or hyponatremia, metabolic
5 disorders like genetic type processes.

6 All of these can manifest in a child that
7 is encephalopathic, and all of the -- and also
8 genetic as a potential cause. But the only
9 explainable cause, based on the information in this
10 case, was hypoxic ischemic brain injuries during the
11 latter portion of the labor and delivery process, as
12 I mentioned earlier.

13 Q. Okay. And all those things that you
14 mentioned, it's not just that you ruled them out,
15 they were all ruled out by Remi's doctors, correct?

16 A. Yes.

17 Q. Okay. And there's -- you saw no
18 disagreement about that?

19 A. Yep.

20 Q. Okay. Let's talk about your opinion
21 regarding the timing of when this lack of blood flow
22 and oxygen happened.

23 Based on a reasonable degree of medical
24 certainty, can you tell us again when did this occur?

25 A. Sure. So we know that Remi has both

1 patterns of the -- that picture that we showed of the
2 partial prolonged and acute profound, that he has
3 both patterns of injury on his brain. And we know
4 that acute profound injuries occur over somewhere
5 between a 5- and 20- to 25-minute window.

6 The reason we know it doesn't occur over a
7 longer period of 25 minutes, is that eventually you
8 just get fetal demise if you continue to deprive a
9 baby of oxygen to that level, to where you're
10 damaging the deep gray matter structures in the brain
11 stem.

12 And then we know that a partial prolonged,
13 which is the other pattern that he has, occurs over
14 approximately 30 to 60 minutes. So that gives us a
15 window, then, of roughly the last hour.

16 But the other thing also that tells us
17 that Remi's injuries occurred close to the time of
18 birth, is in babies who have had a much more extended
19 period of time -- of period of time of hypoxia during
20 the intrauterine period, we see a lot of evidence of
21 multiorgan injury, which we didn't see here.

22 Or we see a baby who's born profoundly
23 depressed, meaning not depressed like sad, but
24 depressed where you have to resuscitate them
25 extensively. And so they're born no heart beat, no

1 respiratory effort, blue, floppy, and you resuscitate
2 them, and their Apgars, you know, are zero, zero,
3 zero, 1, 2, right? And that's because the longer a
4 baby is hypoxic, the longer it takes to get them back
5 to resuscitation after they're born.

6 Q. That's kind of an uncomfortable thing to
7 think about. But you said that with the acute
8 profound injury, that if left in that environment, it
9 eventually causes the infant to pass away, correct?

10 A. Yes.

11 Q. Tell me what you see on the heart rate
12 when that is going on?

13 A. Sure. So one of the first changes in
14 heart rate with fetal hypoxia is tachycardia, meaning
15 increased heart rate. And, again, that's an attempt.
16 Babies have what are called autoregulation. You
17 know, we have a thing called an autonomic nervous
18 system, and it tries to compensate for things that it
19 identifies are a problem.

20 So if you're not getting adequate oxygen
21 to the brain, the first response is the heart rate
22 goes up to try to get more blood to the brain. If
23 you allow that to continue, then the next response is
24 you actually get bradycardia, meaning that the heart
25 rate actually starts to drop.

1 And then if you continue to allow that to
2 go on, then you get asystole, which is the heart rate
3 stops. And that's when a baby is born with an Apgar
4 of zero. So, again, the goal is to never allow, you
5 know, a labor to progress to where you're -- you're
6 compromised to the fetus, such that you're getting
7 brain injury.

8 Q. And as far as you talked about to us, you
9 know, about how you came to the conclusion that HIE
10 caused Remi's brain damage by ruling out other
11 possible explanations, did you do the same thing with
12 considering the window of timing? Did you look at
13 the whole picture and see if there was evidence of
14 something else that correlated with the injury?

15 A. Yes.

16 Q. And can you tell me about that process and
17 what you learned?

18 A. Sure. Well, there's no evidence of
19 anything that occurred prior to the mother coming to
20 the hospital. The fetal monitoring on presentation
21 was documented as reassuring. And then there is a
22 progression in the fetal monitoring from reassuring
23 to nonreassuring, such that, towards the end, it was
24 referred to as Category III.

25 Again, I'm not the one that interprets the

strips, but that's my understanding as a neurologist is, is that it was the worse strip that you can have, which is Category III.

Number two, the head ultrasound did not demonstrate any abnormalities. And if you have a more remote injury, meaning that it occurred before mom came to the hospital, then you would expect that to be seen on the head ultrasound.

And so, again, based on the information we have, this occurred during the -- most likely occurred during that time period when the fetal monitoring was abnormal.

Q. Okay. And did you also rule out the time after the -- when Remi was born going forward?

A. Yes. After Remi was born, other than his seizures, his neonatal course was otherwise relatively uncomplicated. But his seizures were a direct cause -- or were directly caused -- by the brain injury.

So, in other words, even if there was additional injury to the brain that occurred from the seizures, he wouldn't have had the seizures if he hadn't suffered the hypoxic ischemic brain injuries.

The reason that there's a delay after birth when the seizures start, is that it has to do

1 with reperfusion. So when you don't get adequate
2 oxygen to the brain, you do what's called anaerobic
3 metabolism. And that's what causes acidosis in the
4 baby.

5 And it also causes free radicals to build
6 up in the brain, and then when you reperfuse it with
7 blood and oxygen, all that -- all that free radical
8 buildup gets spread out into the brain tissue, so
9 then it causes additional injury to the brain, and
10 that's why it's very common with HIE to see seizures
11 within the first 24 hours. We eventually see that
12 cortical irritability, that cortical, meaning the
13 gray matter is irritated because it was injured, and
14 then we cause further injury to it with reperfusion.

15 Q. Okay. So similar to your conclusion that
16 HIE caused the injury, did you -- did you take
17 everything into consideration to arrive at your
18 opinions regarding timing?

19 A. I did.

20 Q. Okay. Tell me when Sarah and Blake
21 arrived at the hospital to have Remi, what did all of
22 the available information indicate?

23 A. That it was an uncomplicated pregnancy,
24 and that everything was reassuring when mom was
25 admitted to the hospital.

1 Q. Okay. And what amount of time accounts
2 for the majority of Remi's injuries, his brain
3 damage?

4 A. Well, the acute profound would have
5 occurred in that last up to 20 minutes. Honestly,
6 it's probably even a shorter period of time, so
7 certainly within, I would say, vast majority would be
8 within the last 30 minutes.

9 Q. And you talked about that he -- his brain
10 damage could have been avoided if he was delivered
11 earlier.

12 what do you base that on?

13 A. Based on the mechanism of how the injury
14 occurs and also based on how he looked when he was
15 born.

16 Again, the fact that he was able to be
17 resuscitated relatively quickly, and although he was
18 mildly encephalopathic, he didn't really demonstrate
19 the extent of the injury until he started having
20 seizures. So, again, that's more consistent with an
21 injury that was very close to the time of birth.

22 Q. And had he been delivered earlier, how
23 would Remi's life have been different than what he
24 experienced?

25 A. Well, number one, had he been delivered

1 prior to any of the brain injuries, then he'd be
2 completely normal. But, number two, every minute
3 that he had been delivered earlier would have reduced
4 the brain injury that he suffered.

5 Once you're in that hostile intrauterine
6 environment, meaning that you're not getting adequate
7 oxygen or blood flow to the baby, then every minute
8 counts. And every minute you deliver earlier, can
9 affect the outcome.

10 Q. We've heard a lot about cord gases last
11 week.

12 What do neurologists like you use cord
13 blood gases to determine?

14 A. So cord blood gases, there's two types.
15 There's arterial and venous. The venous reflects the
16 mother's status, and the arterial reflects the baby's
17 status. And it helps us look at what level of
18 hypoxia there was during the labor and delivery
19 process.

20 What we are really looking for is
21 metabolic acidosis. And why you get metabolic
22 acidosis in the setting of hypoxia is if you don't
23 have oxygen, then your metabolism is done
24 anaerobically, and you make lactic acid. And that
25 accumulation of lactic acid, is what causes metabolic

1 acidosis.

2 It's actually what causes muscle pain.

3 You know, you go out, and you're not that -- you're

4 not really in shape, and you decide, I'm going to run

5 like 5 miles a day. And you go run, and then the

6 next day you can't even get out of bed because your

7 legs are burning and hurting. That's actually lactic

8 acid in your muscles because you -- because you

9 weren't deconditioned, you did anaerobic metabolism

10 in your muscles.

11 Q. Okay. And do you have blood gases here to
12 evaluate?

13 A. No.

14 Q. All right. And if they were taken, what
15 do you believe they would have shown?

16 A. Possibly they would have shown metabolic
17 acidosis.

18 Q. And why does that matter to Remi?

19 A. Well, it's one of the criteria or one of
20 the components that's used for determining if a child
21 qualifies for cooling therapy, which is a treatment
22 for HIE.

23 But, number two, it's just a helpful data
24 point for, again, better timing when the injury
25 occurred. So that's why cord gases, you know, like

1 my experience is, any child where there is abnormal
2 fetal monitoring, the need for resuscitation, any
3 complications during the labor and delivery, cord
4 gases are an automatic.

5 You want them because you want to know --
6 it helps you understand what happened.

7 Q. All right. Thank you.

8 I want to talk to you about Remi and
9 patients that you treat like Remi and kind of get
10 some information about what their future looks like
11 from today.

12 First of all, you talked about you
13 currently see both pediatric and adult patients,
14 correct?

15 A. Yes.

16 Q. And have you followed with children into
17 their adult years where you may have referred them to
18 their next physician or their neurologist?

19 A. Yes.

20 Q. Okay. And have you personally seen
21 patients that have the same condition as Remi get
22 into their later years?

23 A. Yes.

24 Q. 50s? 60s? 70s?

25 A. Yes.

1 Q. You read Dr. Liles' life care plan and
2 testimony, correct?

3 A. Yes.

4 Q. Okay. And do you have an understanding of
5 what type of doctor he is?

6 A. Yes. He's a physiatrist, physical
7 medicine and rehabilitation.

8 Q. And in your own practice, do you work with
9 those types of doctors?

10 A. Yes.

11 Q. And tell us about that.

12 A. So PMR doctors are, if we take a step
13 back, so all of us, when we pick our specialty, we
14 sort of determine we're going to specialize in a
15 certain thing.

16 Neurology, we kind of do everything to
17 relate to the brain, the spinal cord, the muscles,
18 the nerves, and everything in between. Physiatrists
19 really kind of focus on people who have motor
20 disability. That's a huge part of their practice.
21 Meaning pediatric or adult patients who suffer a
22 brain injury, whether it's a stroke or a traumatic
23 brain injury or other things, they -- they're really
24 involved in managing them.

25 And so they're incredibly useful to me

1 because they're the ones that often determine like,
2 should we do Botox? Like give the Botox? They help
3 work with the orthotist on what braces are needed.
4 They work with orthopedics on what wheelchair is
5 needed. work with the family on accommodations for
6 the home, like home modifications. So really they're
7 the lynchpin to take care of children with cerebral
8 palsy.

9 Q. And the jury after -- they heard
10 Dr. Liles' deposition testimony yesterday. We've
11 heard about a lot of providers and a lot of
12 therapists and a lot of different specialties that
13 Remi requires.

14 Tell me how in practice the medical field
15 is able to coordinate that care.

16 A. Well, in theory, if coordinated well, it's
17 not always as coordinated as we would like, but
18 that's why a case manager, for example, is very
19 important for helping to coordinate all of the visits
20 and try to make sure we get patients in.

21 But I think a big part of it, also, is
22 trying to be proactive rather than reactive when it
23 comes to medical care. So, for example, patients
24 that I see, I'm not adverse to putting in referrals.
25 Some specialists don't like to.

1 Like if I'm seeing a patient for epilepsy,
2 and they have terrible constipation, or they have
3 recurrent abdominal pain, I'm going to send them to
4 the GI doctor. Or they have chest pain, I'm going to
5 send them to the cardiologist.

6 And so how we best can coordinate that
7 comprehensive care is for all of us to be
8 communicating with each other. I frequently send
9 messages to the providers of the patients that I

10 follow. You saw my patient for this, what's the
11 plan? What's going on?

12 That's what should happen. I think that's
13 why also a case manager is essential to coordinate
14 all of that medical care and keep it cohesive.

15 Q. And when you -- so anyone who works with
16 kids like Remi and into adulthood, that's not unique
17 to Remi that he requires these different specialties.

18 That's something that you're used to managing,
19 correct?

20 A. Oh, yeah. I mean, a lot -- a lot of
21 children and adults, like Remi, they see 10 or 12
22 different specialties.

23 Again, they have a lot of complex medical
24 needs. And what I always tell people is, you know,
25 I'm a brain doctor. I don't know what to do about

1 your kidney. You know, I studied that back in
2 medical school in residency, but I don't know all of
3 the up-to-date stuff on it. So you've got a kidney
4 problem, you need to see the kidney specialist. Or
5 if you have an eye problem, you need to see the
6 ophthalmologist.

7 Q. And what is the goal of all this
8 co-managing and coordination of care for someone who
9 has suffered a permanent brain damage?

10 A. To give that person the best quality and
11 quantity of life. So that's really the goal of
12 medicine, to improve the lives of our patients and to
13 give you the best quality of life and the best
14 quantity of life with a good quality of life. So
15 that's why we go into medicine, is we want to help
16 people improve their lives.

17 Q. And as far as your review of the care and
18 things provided for Remi for the future in the plans,
19 can you comment on that, please?

20 A. Sorry. Can you say the question one more
21 time, please?

22 Q. Yeah. You reviewed Dr. Liles' plan?

23 A. I did.

24 Q. Can you comment on what you saw provided
25 in that plan for going forward?

1 A. Oh, sure. I mean, the plan accounted for
2 a number of different specialties, as we talked
3 about. Again, he follows an extensive number of
4 specialists, as was sort of mentioned earlier. I
5 think the parents probably talked about it yesterday.

6 It also accounts for his ongoing therapy
7 needs. It accounts for his supervision that he'll
8 require over his lifetime, given that Remi will never
9 be able to live independently, never be gainfully
10 employed, never graduate high school, never get
11 married, never do the things he would have done in
12 the absence of his brain injuries. And he'll always
13 need somebody to care for him and to assist him over
14 his lifetime.

15 But also accounts for all of his equipment
16 needs, whether it's wheelchairs, walkers, standers,
17 gait trainers, again, everything that he'll require
18 due to the extensive injuries that he suffered.

19 Q. When you have a patient referred to you,
20 regardless of, I assume that's at different points in
21 their care sometimes, correct?

22 A. Yes.

23 Q. All right. And have you seen patients who
24 have received what you deemed to be substandard care
25 versus those who have received the best care that you

1 would prescribe?

2 A. Yes. Unfortunately.

3 Q. And what's the difference?

4 A. Well, obviously if the quality of care is
5 better, then the outcome is better. You know,
6 depending on where you live sometimes, it's going to
7 be difficult to access care, either because there are
8 no health care systems, or health care systems are
9 not responsive to the patient, or your insurance
10 doesn't, you know, cover anything, or denies
11 everything.

12 I mean, I think what I see unfortunately
13 with a lot of children and adults with disabilities
14 is they have a lot of needs that don't get met
15 because lack of staffing, lack of funding, insurance
16 denials. You know, I do insurance utilization also
17 as part of my job, meaning that when things get
18 denied by the insurance company, it gets sent to me
19 for appeal.

20 And I see people all the time getting like
21 a lifesaving medication they're on, it gets denied.
22 Or their epilepsy medication gets denied. Or a
23 patient who can't walk, and they're denied a
24 wheelchair. They're denied a home modification.
25 It's like, well, what do you expect these people to

1 do, right? I mean, that's why they have insurance,
2 right? They need the care items that are requested.

3 Q. Dr. Nelson, as far as access to care in
4 this area, we have a lot of specialties in the St.
5 Louis area to provide for what Remi needs, correct?

6 A. Yes.

7 Q. Okay. Let's talk about Remi specifically.
8 The jury heard from Sarah and Blake
9 yesterday about how they interact with Remi, and, you
10 know, what things he's able to do.

11 Tell me, from a neurologist's perspective,
12 how does Remi, and children with this type of brain
13 damage, experience this course?

14 A. So, as I said, Remi has his cognition.
15 His ability to think is much more intact than you
16 would think just by looking at him.

17 So if you'd just look at him, you'd think,
18 oh, he doesn't know what's going on. But that's
19 actually not true. He just has difficulty expressing
20 what's going on because of the problems he has with
21 speaking and moving.

22 And so patients that are in that state,
23 the best thing you can do honestly is talk to them
24 all the time, explain to them what's going on,
25 involve them in the decisions and in the process of

1 their daily life because you're making them feel like
2 they have control and input into what's going on and
3 also working on helping them to communicate, so using
4 augmentative communication devices.

5 I have patients who are completely unable
6 to move anything at all, and you would think that
7 they're completely no brain activity, and they talk
8 to me by tapping on a keyboard with one finger in
9 complete sentences. And they are able to communicate
10 back and forth with me. And so, again, if they
11 didn't have that technology, you would just think,
12 oh, I don't know, they don't know anything, and
13 they're not thinking.

14 Q. So when Remi visited yesterday, and the
15 jury, they noticed Sarah seems to narrate, and Blake,
16 too, that we've seen as we've gotten to know them.
17 They seem to narrate to Remi -- all -- everything
18 that they're doing.

19 Is that what you're talking about?

20 A. Yeah.

21 Q. Is that part of the recommendation?

22 A. Yeah, that -- that's wonderful. That's
23 exactly what you should do. I mean, because, again
24 Remi knows that things, like, he's in a different
25 place, and he's around different people. But he

1 doesn't understand necessarily how or why unless you
2 explain it to him. And so, again, the more you
3 explain to him, then you help him feel safe and
4 secure and -- and involved in the process.

5 Q. Does that also help him developmentally?
6 I mean, he's almost 5. I mean, is that -- he's still
7 developing, correct?

8 A. Yes. And I think probably there's a lot
9 of literature that says the best things you can do to
10 help your child develop, read to them and talk to
11 them, right?

12 The more you talk to your child, the more
13 you're reading to your child, the more they grow and
14 learn in the way that we want them to.

15 Q. So you mentioned people who can use one
16 finger, so minimal movement, to communicate.

17 what other avenues have you seen people
18 use to break those communication barriers?

19 A. Eye gaze technology. So the eye gaze
20 technology is that by looking at the screen, kind of
21 like I don't know if you've gone to the airport
22 lately. They have those facial recognition things,
23 or they have the retinal scanners for like for clear,
24 where they like scan your eyes.

25 The same thing: The device can actually

1 tell where you're looking on the screen, and you can
2 use that, then, to look at pictures. Like you're
3 hungry, you looked at the picture of food, and then
4 it opens up a submenu, and it even will you show you
5 different types of food. And if you look at that, it
6 opens up a submenu. And they can then communicate in
7 that way to their wants and needs.

8 Q. Based on your experience working with
9 these types of patients, does Remi experience that
10 he's different from the rest of us walking around?

11 A. Yes.

12 Q. In what ways?

13 A. Well, he's aware there are other children.
14 And so the more that he interacts with other children
15 who are not developmentally delayed the way he is,
16 the more he'll start seeing that difference.

17 Now, that being said, I think that in the
18 early childhood years, it's noticed less, right?

19 children tend to notice differences less, when it
20 will become much more obvious, when he gets into his
21 teenage years.

22 And that's why children that have
23 developmental disabilities, the time when we see
24 depression and anxiety and really severe emotional
25 issues become more obvious as we get into the teenage

1 years, and they really recognize that they can't do
2 the things that their peers are doing.

3 Q. All right. Most people from the outside
4 when they see Remi probably think that he's not very
5 capable.

6 Tell me is that something that your
7 patients struggle with?

8 A. Oh, yes. I mean, it's interesting. I
9 think that before augmented communication devices, we
10 often thought these patients -- just, we didn't know
11 actually, right? But we didn't know one way or the
12 other. People just assumed that they didn't have
13 anything going on in their brain.

14 Even autistic children. There are
15 autistic nonverbal children that had been labeled as
16 mentally retarded, and, you know, just sort like left
17 in a room, and nobody interacted with them. And they
18 -- they allowed them to get augmentative
19 communication devices, and they were writing complete
20 sentences, or they were communicating completely.

21 So, again, it's essential that with Remi,
22 that, you know, you put a lot of time and effort into
23 helping him learn to communicate because that's going
24 to be a big part of him having the best quality of
25 life, is feeling like he's involved with people and

1 decisions and society and being able to tell people
2 what he wants or needs.

3 Even things like, my foot itches. Can you
4 scratch it? Right? I mean, that's terrible to say.

5 But, like, if you have a terrible itch, and you can't
6 tell anybody, you know, so helping him communicate
7 things that are even that simple.

8 Q. And how do we -- how do we take a kid like
9 Remi from not being able to efficiently communicate
10 because of the brain damage, to someone who is able
11 to interact with a parent or maybe someone he just
12 meets?

13 A. Lots and lots of therapy. So that's why
14 you do a lot of physical and occupational and speech
15 therapy, including a lot of time training with the
16 augmentative communication device.

17 And I think probably therapy really is not
18 a one -- like an hour a day type thing, therapy is
19 like a lifestyle. Like it's literally what parents
20 and children with disabilities say it is: Everything
21 is therapy. Everything you do with Remi is therapy.
22 whatever you're doing, you're always doing therapy
23 because you're always trying to work on improvements.

24 Q. What can Remi's family expect as Remi gets
25 into his teen years and into adulthood?

1 A. well, I mean, he'll make continued
2 progress with his ability to communicate. But at the
3 same time, that's going to put him -- there is high
4 probability that there also will be some depression
5 and anxiety and mood disorder type stuff that won't
6 become evident until he's a teenager.

7 The other thing is mobility. So although
8 he is doing some ambulation with assistance, right
9 now, he's a fairly small child. Like he's, you know,
10 he's 18, and he's 5'11," and he weighs 200 pounds,
11 then mobility issues become much more of a problem.
12 Meaning, that if you have to lift him from the bottom
13 floor to the top floor on the stairs, you can do with
14 a child who's 5. You can't do that with a child
15 who's 18.

16 Or even getting them in and out a bathtub
17 or in and out of a bed or in and out of a car. So as
18 he gets larger, it does cause a lot more challenges.
19 Even changing a diaper on a 200-pound, 18-year-old is
20 much more difficult than a small child.

21 Q. Okay. And from your perspective, what is
22 the main goal of providing for Remi going forward?

23 A. The main goal is to give him the best
24 quality and quantity of life. In other words, he
25 unfortunately, because of his brain injuries, lost

1 out on a lot of things that he could do.

2 But -- but what I always tell my medical
3 students and residents is that we can always do
4 something at every visit with every patient to try to
5 make things better, right? Like we don't give up, we
6 find other ways. So we want -- the goal is to make
7 him have the best life possible.

8 Q. And in your 25 years of practice, have you
9 seen advances in your field?

10 A. Yes.

11 Q. And in providing for kids like Remi?

12 A. Yes.

13 Q. What kind of advances?

14 A. I mean, if we're talking just about
15 cerebral palsy, for example, now we have things like
16 Botox. We have Baclofen pumps, which are implanted
17 that help with spasticity.

18 Robotics is starting to be used where it
19 actually can be used to help people get up into an
20 upright position. And there's trials using it to
21 actually have them ambulate. Of course we have
22 assistive communication devices, right? Computers
23 that sort of revolutionized a lot of things.

24 Epilepsy, you know, 20 years ago, we had
25 half the drugs we have now. We have devices to

1 treatment epilepsy that we didn't have before. we
2 have devices to treat spasticity that we didn't have
3 before. So I think, you know, I am curious to see
4 how AI takes things, right? But, yeah, they're
5 already talking about the next generation of iPhones
6 will be, you don't carry it, right? -- it's going to
7 be in your glasses, and you'll be doing eye gaze
8 technology to make phones and do things.

9 I mean, they already have cameras in your
10 glasses. It's amazing. As Ben Franklin said, I wish
11 somebody could wake me up every hundred years to see
12 the advances in technology.

13 Q. And are those things that you've
14 mentioned, we know those things are on the horizon
15 right now.

16 A. Oh, yeah.

17 Q. Okay. You've spent all this time
18 reviewing this case, and you flew here to talk to the
19 jury this morning.

20 what's your big takeaway from what you see
21 in Remi's case?

22 A. That this child was left in a hostile
23 intrauterine environment with inadequate oxygenation
24 and perfusion during that end portion of the labor
25 and delivery that resulted in permanent, severe brain

1 injuries, and in him being permanently disabled for
2 the rest of his life.

3 Q. Thank you, Dr. Nelson.

4 THE COURT: On behalf of the defendant?

5 MS. KAMYKOWSKI: Your Honor, before we do
6 that, can we have a quick sidebar?

7 THE COURT: You can.

8 On the record?

9 MS. KAMYKOWSKI: Yes.

10 (Proceedings were held at sidebar, outside
11 the hearing of the jury.)

12 MS. KAMYKOWSKI: Your Honor, Mr. Willman

13 is going to take up the first round of

14 cross-examination of this witness, and then I plan to

15 take it up. I don't know if he'll cover it, I won't.

16 But because this has been a motion in limine

17 previously, I think we needed to address this before

18 our cross starts.

19 And it is my position that this witness

20 has opened the door to collateral source information

21 coming into this lawsuit because he talked

22 extensively about patients who have insurance, what

23 he does for patients with insurance. That he helps

24 them get -- that he helps them with denials of

25 claims.

1 He talked -- he went on and on about how
2 he assists patients like Remi who may have insurance
3 to make sure that they can get their needs covered.

4 And so I think he opens that door, and that we should
5 be allowed to walk through on our cross-examination
6 of him, as well as throughout the case from now on.

7 MR. WILLMAN: In addition to that,

8 Mr. Anyan did state during his examination, he had
9 talked about insurance coverage, some of what
10 benefits -- benefit this child has. So the door has
11 been opened by his testimony, as well as this expert.

12 MS. SLATER: Your Honor, Dr. Nelson's
13 testimony was a side comment about some of the things
14 that he's involved in when new devices come out that
15 aren't provided for a child.

16 As far as opening the door to collateral
17 sources, we know that the defendant is responsible
18 and does not get a credit on any collateral sources
19 that the plaintiffs or their family have.

20 And to allow them to suggest -- take what
21 he says, this was not based on Remi, to allow them to
22 then go a step further and apply it to Remi, would
23 violate the law of the defendants' responsibility to
24 pay for any damages that are caused, and they would
25 be seeking discounts by doing that on

1 cross-examination of Dr. Nelson.

2 In addition, we will be offering an
3 instruction to the jury to disregard any idea of
4 insurance, insurance instruction, in this case, and
5 so the jury will be instructed to disregard any
6 mention of insurance for -- which benefits either
7 side. And that would be as far as liability
8 insurance as far as any medical benefits that Remi
9 may need to be able to access.

10 So as far as that goes, we do not believe
11 the door has been opened. He has said that on an
12 offhand comment. I moved on immediately and did not
13 emphasize it.

14 THE COURT: If the Court were to allow
15 inquiry into this issue, it would have to allow them
16 to then inquire as to the defendants, how they're
17 paying for this, and whether or not they're covered
18 by insurance. And I don't think we want to go down
19 that road for either side. So the Court is going to
20 overrule the objection.

21 MS. KAMYKOWSKI: And just for the record,
22 I actually disagree that collateral source, as far as
23 the plaintiffs go, there is -- that that is not -- we
24 have not done anything on the defense side to open
25 the door to any potential discussion of professional

1 liability insurance in this case.

2 And how the defense would cross examine
3 this witness, or potentially utilize the door being
4 opened with our life care planning -- I'm sorry --
5 our neurology expert, would be simply to talk about
6 the fact that Dr. Liles' costing in this case does
7 not take into account whether or not a patient has
8 insurance, and, therefore, those numbers, if there is
9 insurance, would be inflated. They would not be
10 given credit. We didn't do this. They opened the
11 door. And that's just for the record, Your Honor.

12 THE COURT: I appreciate that, and I
13 understand what you're saying, but once insurance
14 becomes part of the case, everybody believes that it
15 applies, and they will then want to know whether or
16 not insurance is paying for any verdict in this case.
17 I guarantee that question would come out with the
18 jury deliberations, as it does in most every case I
19 do these days.

20 So the Court is going to sustain the
21 objection and not allow -- the Court does not believe
22 that the door has been opened, and therefore the
23 Court is not going to allow inquiry into the
24 insurance issue.

25 MS. KAMYKOWSKI: So, Judge --

MS. SLATER: Judge --

THE COURT: I know. That's why I went on to indicate.

MS. KAMYKOWSKI: So my objection has been overruled?

THE COURT: Correct.

MS. KAMYKOWSKI: Thank you, Judge.

MS. SLATER: Thank you, Your Honor.

(Proceedings returned to open court.)

THE COURT: On behalf of the defendant?

MR. WILLMAN: Yes. Thank you, Judge.

CROSS-EXAMINATION

BY MR. WILLMAN:

Q. Good morning.

A. Good morning.

Q. What I understand your telling us is that you believe there were two different patterns of injury, true?

A. Well, it was a global ischemic injury, but the two components of that pattern are acute profound and partial prolonged.

Q. So there are two components, then, to the global injury.

That's your testimony, correct?

A. Yes.

1 Q. And one component is what you call an
2 acute profound injury, true?

3 A. Yes.

4 Q. As well as a partial prolonged injury?

5 A. Yes.

6 Q. All right. And it's your testimony -- is
7 it not? -- that that partial prolonged injury took 45
8 minutes or even longer to develop before the delivery
9 of this child?

10 A. Yeah. 30 minutes is typically the minimum
11 for a partial prolonged, but it can be a longer
12 period.

13 Q. So you believe that if the delivery had
14 occurred within 30 minutes, for example, Remi might
15 still have some neurologic deficits, true?

16 A. Yeah. He would have avoided all of the
17 acute profound, which is the major injury that causes
18 his neurological disability. And he would have
19 avoided at least a portion of the partial prolonged.
20 But he may have still had some disability.

21 Q. And in your experience, acute and profound
22 injuries tend to be less responsive to this cooling
23 technique that I think you alluded to earlier, true?

24 A. Yeah. There's less -- there's less data
25 to it in this because they don't always look as

encephalopathic when they're born, and so they often don't get cooled. Or if they do get cooled, they don't respond as well.

Q. So you cannot say, to a reasonable degree of medical certainty, more likely than not, that cooling therapy would have reversed the acute profound injury, right?

A. I -- yes. I don't have an opinion that whether cooling would or would not have affected outcome.

Q. Let's talk about medical decisionmaking. There are different tools that you and other physicians use to make decisions, true?

A. Yes.

Q. That includes the training of the physician?

A. Yes.

Q. Their experience?

A. Yes.

Q. Their expertise?

A. Yes.

Q. Their knowledge?

A. Yes.

Q. And medical literature as a whole?

A. Yes.

1 Q. And physicians look at medical literature
2 as part of their ongoing maintenance of their
3 competency, fair?

4 A. Yes.

5 Q. You are aware of what are called the ACOG
6 guidelines, are you not?

7 A. Yes.

8 Q. That's the American College of obstetrics
9 and Gynecology.

10 A. Yes.

11 Q. And you're not a member of that
12 organization, true?

13 A. True.

14 Q. That's just because it's simply outside
15 your area of expertise?

16 A. Yes. I'm not an obstetrician.

17 Q. But you are aware of them --

18 A. Yes.

19 Q. -- the guidelines. And you haven't read
20 all of them?

21 A. No. I read the ones that related to a
22 neurological issue, but I don't read about other
23 stuff related to...

24 Q. And in this particular case, you don't
25 have an opinion one way or the other as to whether

1 the Apgar score of 8 was accurate, true?

2 A. I don't have an independent opinion. My
3 understanding is there may -- maybe others would give
4 that opinion, but I don't -- I'm not giving that
5 opinion.

6 Q. That's not your opinion, true?

7 A. Yes.

8 Q. All right. And the information that
9 physicians and health care providers gather from
10 Apgar scores, tells you, number one, that the baby
11 was resuscitated?

12 A. Yes.

13 Q. And it tells you how the baby is going to
14 do after resuscitation, true?

15 A. No. The purpose of an Apgar score is to
16 tell you the quality of the resuscitation.

17 So it actually comes from Virginia Apgar,
18 who created the Apgar scores. She came up with the
19 scoring system, and it was designed to tell providers
20 the quality of the resuscitation. And so the Apgar
21 score should come up, and if it's not coming, that
22 tells you that you're not doing something right
23 during resuscitation, and that was why it was
24 designed.

25 Q. Okay. You believe that this, in this

1 particular case, that normal Apgar score of 8, you
2 agree it's normal at 5 minutes, true?

3 A. It was a normal assisted Apgar score,
4 meaning that he was still getting CPAP.

5 Q. well, Apgar score: normal. 10 or above
6 true, true?

7 A. Yes. But with the caveat that it's
8 assisted. And, again, an assisted Apgar score is not
9 the same as an unassisted Apgar score.

10 Q. You believe that a normal Apgar score at 5
11 minutes is evidence that an acute profound injury
12 occurred later in the labor process, true?

13 A. It can be, yeah. I mean, it could be 1
14 point evidence.

15 Q. And if it had been over a longer period of
16 time, we would have seen organ failure, that is,
17 injury to other organs in Remi's body, true?

18 A. That's one of the things that might have
19 been seen, yes.

20 Q. You do believe that he was resuscitated
21 appropriately?

22 A. Yes.

23 Q. And have you testified in the past that
24 the higher the Apgar score is, the less likely it is
25 something that occurred in the terminal stages of

1 labor?

2 under a different scenario, but haven't
3 you given that testimony before?

4 A. well, I think it was in the context of
5 other things. So I think I might have been listing
6 all the things that would help you determine if HIE
7 had or had not occurred.

8 So a higher Apgar score, it doesn't mean
9 that HIE didn't occur, but it means at least that it
10 wasn't a severe or clinical HIE at birth, right?
11 Like you weren't born with an Apgar score of zero.
12 When we add up our score at zero, it's pretty obvious
13 that's a severe presentation at birth.

14 If you have an Apgar score of 8, sure,
15 that could be a baby that did not have HIE, or that
16 could be a baby that had HIE over a shorter period of
17 time. And then you look at the other information in
18 the case to help determine when the event occurred.

19 Q. So I asked you earlier about ACOG
20 guidelines. Here's what ACOG says: If the Apgar
21 score at 5 minutes is greater than or equal to 7, it
22 is unlikely that peripartum hypoxic ischemia played a
23 major role in causing neonatal encephalopathy.

24 You disagree with that statement from
25 ACOG, don't you?

1 A. well, I disagree with it for two reasons.

2 Because, number one --

3 Q. First of all, if you could answer my
4 question.

5 You disagree with it, true?

6 A. Yes.

7 Q. And you believe that his presentation at
8 the time he was delivered was more consistent than
9 mild HIE, true?

10 A. Clinically, yes.

11 Q. All right. Let's talk about your
12 involvement in this case.

13 You weren't asked to examine Remi, is that
14 true?

15 A. True.

16 Q. You have a website where you advertise
17 your services as a medical legal consultant in the
18 way that you're here today testifying as a witness,
19 true?

20 A. Yes.

21 Q. And you told us earlier the percentage of
22 time that you are retained by a family or a patient
23 to testify against a health care provider.

24 Didn't you tell us in your deposition that
25 it was 70 percent? 70 percent of the time that you

1 are involved in cases on behalf of a patient or a
2 patient's family?

3 A. Well, I think, if you're talking only
4 about medical malpractice, it's probably 70/30
5 plaintiff versus defense.

6 Q. And that's what we are here today is a
7 medical malpractice claim, true?

8 A. Yeah. But, I mean, I also do personal
9 injury in criminal cases, and I do a lot of defense.
10 But even for medical malpractice, I do a fair number
11 of defense cases.

12 Q. On average, you earn a hundred thousand
13 dollars or more every year from doing what you're
14 doing here today, and reviewing a case, giving a
15 deposition, and testifying live at trial?

16 A. Yes.

17 Q. And, in fact, that number has gone up from
18 a hundred thousand dollars since COVID occurred,
19 true?

20 A. Yeah. Like I said, it's been busier since
21 COVID.

22 Q. And you do get medical legal cases through
23 some expert witness sources?

24 A. Yeah, there's a few.

25 Q. Expert Institute, you've had cases

1 referred to you from there?

2 A. Yeah, periodically.

3 Q. Thomson Reuters, also known as Roundtable?

4 A. Yeah, I've had a few.

5 Q. ExpertPages, you get cases from them, as
6 well?

7 A. ExpertPages was way in the past, and I
8 don't think I've gotten something from them for
9 10 years.

10 Q. And then you told us that you have worked
11 for the Simon Law Firm before?

12 A. Yes.

13 Q. And, in fact, you testified live in a
14 trial here in St. Louis County?

15 A. Yes.

16 Q. For that -- for that law firm, true?

17 A. Yes.

18 Q. Okay. You don't have any standard of care
19 opinions, is that right?

20 A. Yeah, that's right.

21 Q. So just so it's clear, it's your testimony
22 that the acute profound injury is the bulk of what
23 caused Remi's unfortunate disability, right?

24 A. Yes.

25 Q. And that is less likely to respond to

1 cooling, that kind of injury?

2 A. Yes.

3 Q. Thank you.

4 THE COURT: On behalf of the hospitals?

5 MS. KAMYKOWSKI: Yes, Your Honor.

6 Briefly.

7 CROSS-EXAMINATION

8 BY MS. KAMYKOWSKI:

9 Q. Good morning, Dr. Nelson. How are you?

10 A. Good.

11 Q. Good to see you again.

12 Just since I'm the third one to go, I'll

13 jump around just a little bit. And I don't have very

14 much for you, but I want to dovetail off what

15 Mr. Willman was just asking you.

16 At the end of your direct examination, you

17 were asked by Ms. Slater, and I wrote it down, to

18 give kind of your big takeaway.

19 Do you remember that question?

20 A. Yes.

21 Q. And part of that was what you stated that,

22 in your opinion, based on what you reviewed in this

23 case, that Remi was, and I wrote it down, left in a

24 hostile intrauterine environment.

25 Do you remember that?

1 A. Yes.

2 Q. Okay. But you're not here offering
3 standard of care opinions on any provider, correct?

4 A. That's correct.

5 Q. And you are not here offering any opinions
6 about interpretation of the fetal heart monitor
7 tracings, correct?

8 A. Correct.

9 Q. So your conclusion, your big takeaway,
10 that Remi was left in a hostile intrauterine
11 environment, that came from Nurse Shinn and Nurse --
12 Dr. Warsof and their depositions that you read?

13 A. So my -- yeah, any opinion that I give and
14 what the fetal monitoring showed, is based on the
15 medical records and depositions. I have not reviewed
16 the fetal monitoring. I don't review it.

17 Q. And the only witnesses this jury is going
18 to hear from, that Remi was potentially in this
19 hostile environment, were the paid experts hired by
20 the plaintiffs: Nurse Shinn and Dr. Warsof.

21 You understand that, correct?

22 A. I don't know what anyone's going to say at
23 trial.

24 Q. Regarding the imaging, fair to say that
25 you relied on the ultrasound as a basis for part of

1 your timing opinion in this case?

2 A. Yes.

3 Q. Okay. You agree that the MRI that was
4 done on May 6th, around 4:30 p.m., shows a diffused
5 hypoxic ischemic injury?

6 A. Yes. It was a global injury, so it
7 affected all parts of the brain.

8 Q. Yeah. And I think in your deposition, you
9 described it the same way: global or a large event,
10 correct?

11 A. Yes.

12 Q. And the MRI can't show the order in which
13 the injuries that you think occurred happened,
14 whether acute profound happened and then partial
15 prolonged. It can't tell us that. That's a snapshot
16 in time, correct?

17 A. Yeah, that's true.

18 Q. And it's possible that the MRI is actually
19 exhibiting a single global injury, correct?

20 A. Well, I mean, it is a single global injury
21 in the sense that, from start to finish, you know,
22 some of what is seen as the partial prolonged injury
23 on the MRI, also may be postictal changes which can
24 occur from seizures. But, again, it all occurred in
25 that same time period.

1 Q. And that time period, according to you, is
2 less than 60 minutes before he was born?

3 A. Yes.

4 Q. You have no more than that, right? I
5 mean, you said generally partial prolonged about 30
6 minutes, but I think you gave that window up to 60
7 minutes, right?

8 A. Yeah, exactly.

9 And, again, some of what looks like
10 partial prolonged injury on the MRI, may also be
11 postictal changes, which Dr. Sze may talk about. So
12 I think that what clinically Remi shows is that the
13 acute profound injury to his basal ganglia is
14 a significant portion of his injury.

15 Q. Going back to that Apgar. You were
16 deposed in this case back in December of 2023.
17 Remember that?

18 A. I don't remember the date, but I won't
19 dispute it, if that's the date.

20 Q. You've probably given quite a few
21 depositions since then, but I know we did it by Zoom.
22 I think Mr. Perron and I were there on the Zoom. And
23 I think it was -- I'm not sure -- Ms. Lenivy from --
24 on behalf of Remi.

25 And I think at that time what you told us

1 was that with respect to the 5-minute Apgar of 8,
2 that supports your opinion on the timing of this
3 injury happening in the last, you know, half an hour,
4 hour, of delivery, right before delivery. Because he
5 was not born profoundly depressed.

6 You still hold that opinion?

7 A. Yes.

8 Q. Okay. And you told us typically in
9 children where there's hours and hours of fetal
10 distress, we have much lower Apgar scores and a much
11 greater need for resuscitation.

12 Do you remember giving that testimony?

13 A. Yeah. That's true.

14 Q. And you still stand by that testimony?

15 A. Oh, yeah. I mean, that's what I've seen
16 many times. I've seen children who have had very
17 extended periods of fetal hypoxia, and then they're
18 born profoundly depressed and have extensive
19 multiorgan injury.

20 Q. And you told us also at your deposition
21 that because -- because if there had been hours and
22 hours and hours of injury to Remi, you would have
23 expected the Apgar scores to be much lower and for
24 him to be much more encephalopathic at the time he
25 was born.

1 Do you still hold that opinion?

2 A. I do. That's why my opinion is if he had
3 been delivered even an hour earlier, he would have
4 avoided all or most of the injuries.

5 Q. And your opinion, based on your review of
6 the NICU notes for Remi, is that his clinical
7 presentation at the time of birth was clinically more
8 consistent with a mild HIE than a moderate HIE, and
9 that is reflected in that 5-minute Apgar of 8,
10 correct?

11 A. Initially clinically he was mild HIE, and
12 then once he had seizures, that, by definition, then,
13 changes the category to moderate HIE.

14 Q. And I was just going to say that same
15 thing. You also told me at your deposition that it
16 was your understanding, based on your review, that he
17 had seizures at 6 hours of life that changed the
18 diagnostic category from mild HIE to moderate HIE.

19 Do you remember that?

20 A. Yes.

21 Q. But actually his seizures didn't happen at
22 6 hours of life, did they? They happened at 14 and a
23 half hours, right?

24 A. Yes.

25 Q. And you described this phenomenon of how

1 he clinically appeared at first for which he received
2 an 8, 15-minute Apgar, then resulting in these
3 seizures 14 and a half hours later as progressive
4 encephalopathy.

5 Do you remember that testimony?

6 A. Yes.

7 Q. You weren't here last week, but this jury
8 heard from Dr. Kerzner that Remi was, despite the
9 Apgar score in her review of this case, that he had
10 significant clinical signs that he was
11 encephalopathic at birth.

12 You disagree with her, correct?

13 A. I don't know, without reading her
14 testimony. I mean, I know that -- so there's what's
15 referred to as SARNAT scoring. A Code 1 is
16 considered mild --

17 Q. I'm sorry, Doctor. You answered my
18 question. And you didn't talk about SARNAT in your
19 deposition, and I'm not asking you about that now.

20 I was just -- you agree that he had a
21 progressive encephalopathy, correct?

22 A. Yeah, I do. I mean, he had irritability
23 and fussiness, and was consistent with mild HIE. And
24 once he had seizures, then that's moderate HIE.

25 Q. And that's what you told me at your

1 deposition.

2 You're not changing your testimony, right?

3 A. No.

4 Q. Oh, good.

5 I want to go back to the discussion about
6 Dr. Liles.

7 And Ms. Slater asked you what type of
8 physician he is. And you said that he was a physical
9 medicine and rehab doctor.

10 In this case, though, he's a physician
11 life care planner, correct?

12 A. Well, he's still a PMR doctor.

13 Q. Sure. But his role in this case was not
14 as a treating provider for Remi. His role was, in
15 this context of this litigation, to come up with a
16 life care plan for the needs for Remi, correct?

17 A. Well, that's true, but none of the
18 retained experts are treating clinical providers, so
19 that doesn't mean that we ignore the specialty that
20 we are.

21 Q. And you know that Dr. Liles -- you've read
22 Dr. Liles' deposition, correct?

23 A. Yes.

24 Q. Did you read -- he was deposed for his
25 trial testimony that this jury heard yesterday.

1 Did you read that deposition before you
2 came here today?

3 A. No.

4 Q. Okay. It didn't -- it didn't change his
5 opinion. He gave the same opinions that he has in
6 the deposition you've reviewed, so no tricks, I
7 promise.

8 A. Okay.

9 Q. But you saw in his original deposition
10 where he agreed that he prepares thousands of life
11 care plans. He has done so in his career, correct?

12 A. I don't recall what the number is, but
13 I'll defer to him. He would know more than me.

14 Q. But he doesn't, nor does any life care
15 planner, it's not part of their methodology. He
16 doesn't follow those kids to see if the things he
17 includes in his plans are actually utilized over the
18 either short or very long life expectancy that he
19 offers for those children.

20 Do you remember reading that in his
21 deposition?

22 A. I don't know. I would defer to whatever
23 he says. I mean, I'm not him. I would direct those
24 questions to him.

25 Q. And I know Mr. Willman asked you this, but

1 you haven't examined Remi, correct?

2 A. That's correct.

3 Q. But based on everything that you've seen,
4 everything in the records, everything that you
5 reviewed in the deposition, his parents are taking
6 really good care of him, aren't they?

7 A. Yeah. I mean, I think they've done an
8 amazing job with him. Obviously we want to make sure
9 that we continue to provide Remi everything that he
10 needs so he can have the best quality and quantity of
11 life.

12 Q. And I think everybody wants that for every
13 child that has a disability like Remi, correct?

14 A. Yeah.

15 Q. And in your case, the patients that you
16 talked about with Ms. Slater, who haven't been in
17 litigation, they don't have a life care plan, do
18 they?

19 A. Unfortunately many patients with
20 disability don't get adequate medical care,
21 supervision, and physical therapy --

22 Q. And you said that. But my question is
23 they don't have life care plans because life care
24 plans are tools for litigation, correct?

25 A. Well, that's true. I mean, the value of a

1 life care plan is to try to come up with a plan on
2 how to care for the child. Outside of litigation,
3 the reason you don't have a life care plan is
4 insurance companies couldn't care less what you want
5 for the patient in a year. They want to know only
6 about today because, you know, you might change
7 plans, you might move, you might change jobs.

8 Q. Let's talk just really quickly. I think
9 the only other thing that I have on my outline is
10 your medical legal work.

11 And Mr. Willman covered this a little bit.
12 But you and I met on another case. You may not
13 remember that, but it was a case that you testified
14 for Ms. Lenivy in a not a hypoxic ischemia injury.

15 Do you remember that?

16 A. I think you mentioned it at my deposition.

17 Q. But you don't remember the name of that
18 case, what was the injury that was involved, anything
19 like that?

20 A. No.

21 Q. Okay. And you told me at your deposition
22 back in December of 2023, that you, at that time, had
23 already given depositions in the two cases, so this
24 case and the other one that I depose you in, and a
25 couple of others, and had already testified once at

1 trial for them.

2 But you also, besides your sworn
3 testimony, had other cases on your plate that you
4 were reviewing for them.

5 Do you remember that?

6 A. Yeah, I believe so. There might be one or
7 two of those.

8 Q. Since December of 2023, do you know if
9 you've given any other deposition or testified live
10 at trial on behalf of the Simon Law Firm?

11 A. I don't believe so.

12 Q. Have you reviewed more cases for them,
13 since I talked to you last?

14 A. I don't believe so.

15 Q. And just so we're clear, all of the cases
16 you would review for the Simon Law Firm, which is the
17 firm that all of the lawyers here worked at at the
18 time I took your deposition, would be on behalf of
19 patients or plaintiffs, correct?

20 A. Yes.

21 Q. And you've given at least, as of a year
22 and a half ago, yeah, December of 2023, you've given
23 testimony under oath, that means depositions or like
24 you are here today at trial, 200 or 250 times,
25 correct?

A. Yes.

Q. And I think you told us at that deposition that you testified somewhere in the range of 30 to 50 times. So of that 200 to 250, 30 to 50 times have been on behalf of plaintiffs in medical legal matters involving what's in this case, an alleged hypoxic ischemic injury that occurred at or near the time of delivery, correct?

A. Yeah. Or -- or more. I mean, I think birth injuries are a common topic that litigation occurs over.

Q. And your testimony has always been in those cases on birth injuries with alleged hypoxic ischemic injuries, happening at or near the time of delivery, on behalf of plaintiffs?

A. No.

Q. You've testified on behalf of defendants?

A. Yeah. Many times.

Q. And in HIE cases?

A. Yes.

Q. How many times?

A. 20, 25. I don't know.

Q. So 20 to 25 times on behalf of defendants, but 30 to 50 times on behalf of plaintiffs?

A. I mean, if I testified that 30 to 50, that

1 might be a little low. I don't know. Maybe it's 50,
2 maybe it's 20 on behalf of defendants. I know I've
3 testified at trial, I think maybe at least twice, for
4 the defense for -- on a birth injury case: once in
5 Florida and once in Missouri. And I've testified
6 deposition at least 10, 12 times.

7 Q. Thank you, Dr. Nelson. I don't have
8 anything further.

9 THE COURT: Any redirect?

10 MS. SLATER: Yes, Your Honor.

11 REDIRECT EXAMINATION

12 BY MS. SLATER:

13 Q. Dr. Nelson, you were asked by Ms.
14 Kamykowski, Mercy Hospital's attorney, if you agree
15 that Remi's parents were taking good care of them.

16 A. Yes.

17 Q. What if they're not here?

18 A. Well, exactly. So the reason that a life
19 care plan is so important is knowing the care needs
20 of Remi. That, you know, God forbid if the parents
21 are unable to care for Remi, we want to make sure
22 that there's a plan in place so that he gets the care
23 that he needs over his lifetime.

24 And I think this is a constant worry of
25 parents who have children with disabilities. Is, you

1 know, what's going to happen to me -- what's going to
2 happen to my child when I'm gone.

3 Q. You were asked by Mr. Willman about the
4 ACOG bulletin.

5 Do you recall that?

6 A. Yes.

7 MS. SLATER: And, Zack, could you bring up
8 Exhibit 420, please. And let's go to the last
9 sentence of the conclusion, which is on page 3.

10 Q. (By Ms. Slater) Now, did you even know
11 what bulletin he was pulling this out of? He didn't
12 hand it to you.

13 A. Yeah, I did. It was from the neonatal
14 encephalopathy, the ACOG bulletin.

15 Q. The bigger book?

16 A. Yep.

17 Q. Got it. Okay. So you were read --

18 MS. SLATER: Can you zoom out real quick,
19 Zack?

20 Q. (By Ms. Slater) Okay. This is the
21 conclusion?

22 MS. SLATER: Zack, if you could go to the
23 last page -- or the last sentence again.

24 Q. (By Ms. Slater) Mr. Willman read you
25 this: If the Apgar score at 5 minutes is 7 or

greater, it is unlikely that it is peripartum hypoxia
ischemia encephalopathy.

Is that what you were asked?

A. Yes.

Q. Okay. Let's go to where that information
comes from.

MS. SLATER: Zack, if you can go to page
2.

Q. (By Ms. Slater) where this is discussed.
This is the body of the article.

MS. SLATER: Zack, can you bring up
exactly where the discussing of this topic, this
paragraph here. And it's the last sentence.

Q. (By Ms. Slater) All right. So this is
where this comes from, that conclusion that he has
only showed you that conclusion. Here's where it
comes from: when a Category I, normal, or Category
II, indeterminate, a fetal heart rate tracing is
associated, an Apgar score of 7 or higher after 5
minutes and a normal umbilical cord arterial blood
pH.

we don't have that, right?

A. Correct.

Q. So we can't confirm whether that existed
in this case, right?

1 A. Correct.

2 Q. Okay. Or both, is not consistent with an
3 acute hypoxic ischemic event.

4 Did you see Category I tracing here?

5 A. On presentation.

6 Q. And then Category II, correct?

7 A. Yeah.

8 Q. What's missing from this paragraph? What
9 happens after Category II?

10 A. Category III.

11 Q. Did that occur in this case?

12 A. Yes.

13 Q. Okay. And the conclusion he showed you is
14 based on that?

15 A. Yes.

16 Q. Okay.

17 MS. SLATER: Thanks, Zack.

18 Q. (By Ms. Slater) You were asked, it sounds
19 like a clip of one of your depositions was taken
20 about the Apgar score.

21 Can you look at the Apgar score and tell
22 anything about a child on paper?

23 A. Well, no. Because an Apgar score, again,
24 is not meant to tell you whether there was HIE or
25 not. Number one, you have to know whether the Apgar

1 score is even accurate.

2 But, number two, you have to use all the
3 other information other than the Apgar score. And
4 then you have to keep in mind that the Apgar score is
5 meant to be a measure of the quality of the
6 resuscitation.

7 And then, number four, you have to know
8 what was the resuscitation that was ongoing at the
9 time of the Apgar score. The other thing that also
10 is in that neonatal encephalopathy guideline is it
11 says that if the child is receiving supplemental
12 oxygen or resuscitation at the time of the Apgar
13 score, then that Apgar score may not be accurate.

14 So that's another thing. It may be
15 falsely elevated because you're assisting the child.

16 Q. And you can't take certain parts of the
17 facts and just disregard them in your conclusions,
18 correct?

19 A. Correct.

20 Q. And you considered this Apgar in your
21 conclusions, correct?

22 A. Yes. Again, to do it right, to do it in a
23 way that's not partial to who retains or what opinion
24 they want, you look at all of the information you
25 have. You don't discard information because it

1 doesn't fit your narrative.

2 Q. And I think early on you were asked about
3 there being two components to the injury.

4 The evidence that you reviewed, there's
5 one time of reduced blood flow and oxygen that you
6 see evidence of, correct?

7 A. Yes.

8 Q. Okay. And that's when?

9 A. At -- at the end of labor when there was
10 Category III tracing.

11 Q. Okay. And you were asked by Mr. Willman
12 if the injury takes 30 minutes.

13 A. Yes.

14 Q. When you talked -- when you talked about
15 this depletion of fetal reserves, do you remember
16 that?

17 A. Yes.

18 Q. Tell me about how that concept works when
19 you are in 12 hours of pushing?

20 A. Sure.

21 MS. KAMYKOWSKI: well, Your Honor, I'm
22 going to object. This goes beyond the scope of
23 direct examination. Fetal reserves were never talked
24 about, nor are they -- were the doors opened up on
25 cross-examination.

1 MR. WILLMAN: Yeah. And I'll add an
2 objection as lack of foundation --

3 MS. SLATER: Can we talk at sidebar,
4 please, Your Honor?

5 THE COURT: We can.
6 (Proceedings were held at sidebar, outside
7 the hearing of the jury.)

8 MR. WILLMAN: I was going to add my
9 objection to lack of foundation. He has already said
10 he doesn't read strips. He doesn't -- and he hasn't
11 read these particular strips. And now he's being
12 asked questions about categories when he does not
13 have any knowledge, either firsthand or in his own
14 training and in his own experience, while reading
15 fetal heart rate strips.

16 MS. KAMYKOWSKI: In this concept of the
17 depletion of fetal reserves, is an objectionable
18 concept, which is outside the scope of his expertise.

19 MS. SLATER: No, it's not, Your Honor.
20 Depletion of fetal reserves is something that we
21 talked about on direct without objection, and
22 something that has been spoken throughout this
23 deposition -- sorry, I didn't bring it, but I'm happy
24 to get it for you -- the concept of depletion of
25 fetal reserves is not an obstetric issue, even though

1 it occurs in utero. It's the effect on the baby, is
2 what he talked about.

3 And what Mr. Willman suggested to the jury
4 is that the injury would have to -- it wouldn't occur
5 until 30 minutes, so I am responding to that, a door
6 which has been opened by cross-examination. My
7 points have been directly angled at
8 cross-examination.

9 THE COURT: The Court's going to overrule
10 the objection.

11 (Proceedings returned to open court.)

12 Q. (By Ms. Slater) Okay. Dr. Nelson, let's
13 get back to what we were talking about.

14 You talked about the depletion of fetal
15 reserves during this labor process. And Mr. Willman
16 suggested that it would have to take 30 minutes to
17 incur this injury.

18 when you have a 12-hour pushing stage,
19 like this case, how does the baby -- how is the baby
20 affected once that flow of oxygen and blood is
21 stopped?

22 A. Sure. So a fetal reserve, first of all,
23 the concept that is if there is a reduction of oxygen
24 to the baby, that there's a period of time that they
25 can tolerate that. Again, with sort of compensation

1 mechanisms. It's kind of like when we hold our
2 breath. You know, we can tolerate for a certain
3 amount of time. And then once you exhaust your
4 reserves, you know, you have to breathe. Or if you
5 can't breathe, then you start to get a brain injury.

6 And so the same concept is if you have a
7 reduction of oxygenation to the fetus, when those
8 reserves run out, then you start to get that partial
9 prolonged type injury because you're getting some
10 reduction of oxygenation to the brain that's now
11 causing permanent injury.

12 And then if you continue to allow that to
13 occur, then you start to damage more of the acute
14 profound portion. Again, the acute profound portion
15 occurs 5 to 20 minutes. But if you've exhausted the
16 fetal reserves, it could even occur over a shorter
17 period of time. And then partial prolonged occurs
18 sort of leading up to that acute profound.

19 If I go back to my lawn analogy. If you
20 drop your water pressure -- right? -- and you're not
21 getting adequate water coming out of your sprinklers,
22 remember you damage the grass between the sprinklers.

23 But if you continue to have a low water pressure,
24 then even your flower beds will eventually start to
25 be damaged because they're also not getting water.

1 Q. At the end of 12 hours of pushing, was
2 Remi able to sustain the lack of oxygen and blood
3 flow?

4 A. No.

5 Q. Thank you.

6 MR. WILLMAN: I have no further questions.
7 Thank you.

8 RECROSS EXAMINATION

9 BY MS. KAMYKOWSKI:

10 Q. I just want to make sure we all
11 understand, Dr. Nelson. You told us in your direct,
12 your cross by Mr. Willman, and your cross by me, that
13 the hypoxic partial prolonged injury did not occur in
14 this case until 60 minutes before the delivery,
15 correct?

16 A. Yeah. I believe that all of the injury
17 occurred within the last 60 minutes.

18 Q. Thank you. That's all I have.

19 MS. SLATER: Nothing further, Your Honor.

20 THE COURT: Thank you.
21 May this witness be excused?

22 MR. WILLMAN: Yes.

23 MS. SLATER: Yes, Your Honor.

24 THE COURT: Thank you very much, sir.

25 THE WITNESS: Thank you.

1 THE COURT: All right. Ladies and
2 gentlemen, this is a good time for us to take our
3 morning recess.

4 (At 10:41 a.m., the court duly admonished
5 the jury, and proceedings stood in recess. At
6 10:58 a.m., the following proceedings were held in
7 open court:)

8 THE COURT: Go ahead and be seated,
9 everyone.

10 on behalf of the plaintiff?

11 MS. LENIVY: Thank you, Your Honor.

12 on behalf of the plaintiff, we call Dr.
13 Gordon Sze.

14 THE COURT: Sir, if you'll step on up and
15 be sworn. Please raise your right hand.

16 GORDON SZE, M.D.,
17 having been duly sworn, was examined, and testified
18 as follows:

19 DIRECT EXAMINATION

20 BY MS. LENIVY:

21 Q. All right. Good morning, sir.

22 A. Good morning.

23 Q. Could you please introduce yourself to the
24 jury.

25 A. Sure. My name is Gordon Sze.

1 Q. And, Dr. Sze, what do you do for a living?

2 A. I'm a neuroradiologist.

3 Q. And, Dr. Sze, are you a currently
4 practicing radiologist, or are you retired?

5 A. No. I'm currently practicing.

6 Q. Okay. So when was the last time you read
7 any films?

8 A. Friday.

9 Q. Okay. So just last week.

10 A. Yep. well, that's not including consults.
11 I had consults yesterday, but I was in the hospital
12 reading on Friday.

13 Q. Fair enough. Thank you.
14 where are you practicing, sir?

15 A. I'm at Yale.

16 Q. And can you explain to the jury what it
17 means to be a neuroradiologist.

18 A. Sure. So everybody in the jury has had
19 radiology studies at some point in your life.

20 Probably most of you have had chest x-rays, and some
21 of you probably had ultrasounds. And nowadays CAT
22 scans and MR scans are so common that probably some
23 of you have had those, as well.

24 so radiology is using these imaging
25 studies to diagnose diseases of the body. And

1 neuroradiology is using these imaging studies to
2 specifically to diagnose diseases of the brain,
3 spine, and neck.

4 Q. And as a general introduction for the
5 jury, are you here today to testify about your
6 conclusions regarding the nature and timing of Remi
7 Anyan's hypoxic ischemic encephalopathy based on the
8 imaging studies of his brain?

9 A. Yes.

10 Q. And very generally, what is the conclusion
11 you have reached about the nature of Remi's HIE?

12 A. He shows a significant HIE injury.

13 Q. And what is your conclusion as far as when
14 that significant HIE injury occurred?

15 A. Looking at just at the imaging, it's
16 certainly within approximately a day of his birth and
17 probably much less. It's probably nearer to the time
18 of his birth, or just before his birth.

19 Q. And do you hold all of the opinions
20 offered in this case to a reasonable degree of
21 medical certainty?

22 A. Yes.

23 Q. Okay. Let's introduce the jury a little
24 bit to your background more.

25 MS. LENIVY: Zack, would you pull up

Exhibit 130-2.

Q. (By Ms. Lenivy) All right. And, sir, we have a copy of your CV up there right now. And if we scroll down a little bit, we see your education.

Can you tell the jury about your education?

A. Sure. I went to Harvard College. I graduated in 1976. And then I did a fellowship to study health care delivery in developing countries. So I spent a year in Central Africa, Nepal, and New Guinea.

After that, I came back to Boston, and I went to Harvard Medical School. I graduated in 1981. And following my graduation from medical school, I then did my internship, residency, and fellowship in neuroradiology at University of California in San Francisco, which was a very fortuitous position for me because, at the time, University of California in San Francisco, had the first clinical MRI scanner in the world. So I was able to get into this very important developing area of medicine at a very early stage.

MS. LENIVY: Zack, can you scroll down past the postdoctoral training. And zoom in on positions and appointments.

1 Q. (By Ms. Lenivy) It looks like this is
2 where your career picks up after your fellowship at
3 the University of California-San Francisco.

4 Can you tell the jury about that?

5 A. Sure. After I finished training, I came
6 back east, and I was an attending at Sloan Kettering
7 Cancer Center for three years until 1989, when I went
8 to Yale. And I've been at Yale ever since.

9 Q. And what's your professional
10 responsibilities at Yale since you've returned in
11 1997?

12 A. Well, basically I served as chief of
13 neuroradiology for 30 years. My responsibilities are
14 to make sure that the imaging is done well and also
15 to make sure that I -- that everybody has
16 responsibilities in terms of teaching, and
17 particularly in pediatric neuroradiology.

18 Because up until, well, basically we used
19 to have three people who were very interested in
20 pediatric neuroradiology, and then one left a year
21 ago, and one just left, so at the moment, a lot of
22 the burden falls on me. So it's -- really it's a lot
23 of time that I spend doing neuroradiology.

24 And basically my duties are to make sure
25 that the people who come after us, that is our

1 trainees, are educated in all facets of
2 neuroradiology. But my sort of little -- designated
3 role is particularly, among other things, pediatric
4 neurology.

5 And I enjoy teaching how these little
6 babies show injuries or what little babies can
7 undergo. And also to make sure that the best imaging
8 reports are put out. And I'm constantly being asked,
9 almost on an every day basis, to look at scans that
10 may have been looked at by other radiologists.

11 And then also to do research. Because one
12 of the important things that we do in academic
13 centers is to make sure that we help in developing
14 techniques that will better develop -- or will better
15 diagnose diseases of the brain and spine in our
16 patients. And so I have grant funded research from
17 places like the National Institutes of Health.

18 Q. Scrolling down towards the bottom of page
19 2 of your CV, it lists your board certifications.

20 Can you tell the jury, Dr. Sze, what are
21 you board certified in?

22 A. I'm board certified in both radiology and
23 neuroradiology.

24 Q. And then scrolling over to the next page,
25 page 3, we see scientific societies.

1 And can you explain to the jury, I mean,
2 there's a number of organizations listed up there.
3 But are there any in particular that, I guess, you're
4 particularly -- that you find distinctive or
5 important?

6 A. Well, the American Society of
7 Neuroradiology is the largest scientific society of
8 neuroradiology in the world. And its mission again
9 is to both educate neuroradiologists, neurologists,
10 and neurosurgeons, both in this country and around
11 the world, in the latest techniques in
12 neuroradiology, also to train people who are younger
13 than us and to encourage research. So that's the
14 American Society of Neuroradiology.

15 It has several sub-branches, such as the
16 American Society of Spine Radiology, the American
17 Society of Head and Neck Radiology, and the American
18 Society of Pediatric Neuroradiology. So the American
19 Society of Neuroradiology is sort of like the
20 overarching federal government, and then the other
21 subspecialty societies are sort of like states.

22 Q. And one of those states that you mentioned
23 is the American Society of Pediatric Neuroradiology,
24 which you also belong to?

25 A. Yes.

1 Q. Going down to honors and awards, there's
2 quite a few on here. But there is one that I wanted
3 to ask you about in particular.

4 In 2023, you got the gold medal in the
5 American Society of Neuroradiology.

6 Can you tell us about that.

7 A. Sure. So basically I was very fortunate
8 to be awarded the gold medal from the American
9 Society of Neuroradiology. And basically it's,
10 because you don't know what the gold medal is, in our
11 field, it's sort of like getting the award for
12 lifetime achievement.

13 Q. Scrolling to the bottom of page 3, it
14 talks about scientific society activities. And I
15 will represent to the jury that this goes on for
16 several pages.

17 We're not going to look at it all. But I
18 do want to jump to page 10.

19 MS. LENIVY: If we could, Zack.

20 Q. (By Ms. Lenivy) Because at the bottom
21 there that Zack has highlighted, it says the
22 editorial board of the International Journal of
23 Pediatric Neuroradiology from 2010 to 2014.

24 Can you tell the jury what your
25 responsibilities were in that role?

1 A. Sure. So what an editorial board is is
2 it's a group of experts who come up with different
3 topics that are worthy for scientific pursuit. And
4 also we review manuscripts so that if you, for
5 example, came up with an idea that you thought would
6 better help other radiologists and neuroradiologists
7 diagnose diseases of the brain, you could write up a
8 little manuscript about it. But just because you
9 write it up, doesn't mean it's going to be accepted.

10 It has to go through a process called peer
11 review. And basically what happens is your
12 manuscript would be sent to other experts in the
13 field who would then decide whether or not it was
14 worthy of publication.

15 And this is all done in a blinded fashion
16 so, as the writer of the manuscript, I would not know
17 who is reviewing it. And the people obviously
18 reviewing that would not know who wrote the
19 manuscript. And that's also part of what an
20 editorial board does.

21 MS. LENIVY: Zack, can we go to page 13?

22 Q. (By Ms. Lenivy) All right. There is a
23 section here called bibliography, and it starts on
24 page 13. I'll represent to the jury it goes all the
25 way to page 28.

1 And is this part of the articles and the
2 research that is I think incumbent on you as a member
3 of the Yale staff?

4 A. Yes. Exactly.

5 Q. Okay. We're not going through all of the
6 peer-reviewed articles you worked on over your many,
7 many years, but I do want to point out a few.

8 MS. LENIVY: Page 21, Zack, No. 104.

9 Q. (By Ms. Lenivy) This is an article titled
10 "Stroke in a Neonate Heterozygous for Factor V
11 Leiden" in Pediatric Neurology.

12 Did I read that correctly?

13 A. Yes, you did.

14 Q. No. 23 -- oh, I'm sorry -- page 23, No.
15 126 and 128. We'll zoom in on both.

16 well, starting with 126: "Intracranial
17 Infantile" -- I'm not going to be able to pronounce
18 that word --

19 A. It's a tumor.

20 Q. It's a tumor. Okay.

21 A. Yeah. Infantile tumor.

22 Q. In the Journal of Neurosurgery for
23 Pediatrics.

24 And 128, again, talking about fetal MRI
25 results, correct?

A. Yes.

Q. All right. Page 24, No. 134.

Do you see there, it talks about "Does Prenatal Stress Alter the Developing Connectome?" Published in Pediatric Research.

And then No. 141 is "A Fetal fMRI Specific Motion Correction Algorithm Using 2nd Order Edge Features."

I have no idea what these articles are about, but do they concern pediatric and infant patients?

A. Yes, that's exactly what they're about. A lot of the papers are about pediatric neuroradiology.

Q. Okay.

MS. LENIVY: And then page 28, Zack.

Q. (By Ms. Lenivy) There's a section called chapters and edited books and journals.

And then if we scroll, then, to the next page, the two side-by-side book chapters or books that you've helped with, there's one called Pediatric Magnetic Resonance Imaging, it looks like two versions of that book?

A. Yes.

Q. Okay. And so you helped coauthor this book on Pediatrics Magnetic Resonance Imaging or MRI?

1 A. Yes.

2 Q. Okay. We're almost done with your CV, but
3 if you could go to page 30.

4 There's a section call "Presentations."

5 This goes on for a while, as well. But if
6 you could go to page 36, there's a couple highlighted
7 in there. And it looks like, from what we see here,
8 you have been invited by pediatric academic societies
9 or different professional societies to lecture or
10 present on pediatric neuroradiology.

11 Is that fair?

12 A. Yes, that is correct.

13 Q. Okay. And I'll say we don't have to go
14 through the entire thing, but is it safe to say, Dr.
15 Sze, that you do have experience in reading films of
16 pediatric patients, including neonates?

17 A. Well, as I said, I'm sort of at the moment
18 the designated point person at Yale. And so this is
19 a lot of what I'm asked to do. And I'm asked, as I
20 said, to look at scans that other people have read
21 basically on an almost every day basis, so, yes.

22 Q. Thank you.

23 MS. LENIVY: Zack, we can take that
24 exhibit down. Thank you so much.

25 Q. (By Ms. Lenivy) Now, in addition to your

1 clinical work and your academic work and your
2 research work at Yale, do you, on occasion, also
3 testify in litigation matters?

4 A. Yes.

5 Q. Okay. In injury cases, like we have here
6 today, do you have an idea as far as how often you
7 are retained by plaintiffs' attorneys versus defense
8 attorneys?

9 A. It's about 50/50. Basically the films are
10 the films, and the films will be there forever.

11 So basically I interpret the films as I
12 see them. And whether or not it is for one side or
13 the other, basically it's up for them to decide what
14 I have -- or what I review in seeing in the films is
15 useful.

16 Q. Okay. And in this particular case, the
17 defense lawyers who are behind me here, have you had
18 an opportunity to, I guess, review cases on their
19 behalf, on behalf of the clients they represent?

20 A. Yes, I have.

21 Q. Including pediatric neuroradiology cases?

22 A. Yes.

23 Q. Okay. Sir, do you charge for your time
24 spent working on matters in litigation?

25 A. Yes.

1 Q. And what is your fee for review?

2 A. The hourly fee is 660.

3 Q. Do you also charge for time spent giving a
4 deposition?

5 A. Yes.

6 Q. And you gave a deposition in this case?

7 A. Yes, I did.

8 Q. Now, you mentioned that you were reading
9 films last Friday, and you were doing some consulting
10 yesterday.

11 A. Right.

12 Q. Does travelling to testify in these types
13 of matters take away from your active clinical
14 practice?

15 A. Yes.

16 Q. All right. And so do you spend -- or do
17 you charge for your time spent travelling?

18 A. well, for the exact travel time, I bill at
19 half rate.

20 Q. Okay. Now, if I represent to you that my
21 office reached out to you in November of 2021, does
22 that sound about right?

23 A. Yes.

24 Q. And do you recall what we asked you to do?

25 A. I don't at this point. It's four years

1 ago or 5 years ago.

2 But basically, when it comes down to these
3 little baby cases, the questions that would be
4 interest -- people would be interested in is, is it a
5 hypoxic ischemic injury? And generally by the time
6 it's reached this point, it is.

7 Every so often it's something else like
8 infection or congenital malformation, but usually
9 it's a hypoxic ischemic injury. And if it is a
10 hypoxic ischemic injury, when did it occur?

11 Q. Okay. And we -- so in November of 2021,
12 we would have provided you with some materials to
13 review.

14 A. Yes.

15 Q. And just to get that in front of the jury,
16 I think we sent you Sarah Anyan's prenatal records,
17 labor and delivery records, as well as Remi Anyan's
18 Mercy Hospital records, correct?

19 A. Yes.

20 Q. But most important, for your review, we
21 sent you head imaging for Remi, and I think
22 specifically the head ultrasound taken on 5/5/2020,
23 the brain MRI taken on 5/6/2020. There was also a
24 brain MRI.

25 A. That is correct.

1 Q. Okay. Can you walk the jury how you
2 perform a records review?

3 A. Sure. So when I get the materials, first
4 of all, it's usually sent as a CD or as a USB. First
5 of all, I have to figure out if the films are
6 actually working because I would say at least a third
7 of the time, there's a problem. They're not copied
8 onto the CD or the USB correctly, or it's missing a
9 part or something like that.

10 And as I'm sure the jury doesn't know,
11 every so often it takes a really long time to load
12 them. So once I load the films, I then read them.

13 As a neuroradiologist, this is my primary
14 goal, to look at the films and to judge what's going
15 on in the films. After that, I then look at the
16 records, just to make sure everything seems to make
17 sense. In other words, basically if you have a baby
18 where you see a lot of injury, the records should
19 be -- correlate -- should correlate with that.

20 Q. Okay. And based on your review of the
21 records here, you subsequently prepared a brief
22 report containing your, not only your qualifications
23 and regarding your review of the records, but the
24 opinions you held in this case?

25 A. Yes.

1 Q. Okay. And, Doctor, I will hand you what
2 has been marked Exhibit 130-8.

3 A. Thank you.

4 Q. I believe that I already provided defense
5 a copy. Okay.

6 But is what I've just handed you, 130-8, a
7 copy of the draft you would have prepared in 2021?

8 A. Yes.

9 Q. Okay. We're going to put that report up
10 in a moment here. But before -- or I guess after you
11 drafted that report, you were also provided some
12 other materials in this case, some depositions
13 received throughout the litigation.

14 And I'll just read those so the jury knows
15 what you reviewed: Blake Anyan's deposition, Sarah
16 Anyan, Dr. McNeive, Nurse Maggie McLeland, Nurse
17 Jessie Brown, Nurse Practitioner Mary Younger
18 Spencer, Dr. Parker, Dr. Mckillip, Dr. Miller, Nurse
19 Alex Greenwald, Dr. Warsof, Dr. Kerzner, Dr. Nelson,
20 Dr. Peek, Dr. Landon, Dr. Woodruff, Dr. Cantey.

21 Does that sound about right --

22 A. That's it, yes.

23 Q. -- as far as your materials?

24 A. Right, uh-huh.

25 Q. Is it fair to say that reading those

1 depositions has not changed your opinions in this
2 case?

3 A. That is correct because my opinions are
4 basically based on the films.

5 Q. All right.

6 MS. LENIVY: All right. Zack, can we put
7 up Exhibit 130-8.

8 Q. (By Ms. Lenivy) And so this is a draft
9 report you sent my office on December 4th of 2021.

10 A. Yes.

11 Q. And the first page kind of goes through
12 your -- your background and your qualifications.

13 MS. LENIVY: If we could go to the next
14 page, Zack, that there. You're there. That's
15 imaging examinations.

16 Q. (By Ms. Lenivy) Can you -- it looks like
17 this summarizes what you saw on the head ultrasound
18 and the MRI.

19 Does that look correct?

20 A. Yes.

21 Q. Okay. Can you describe to the jury what
22 your initial thoughts are as far as what you saw on
23 the ultrasound and the MRI?

24 A. Sure. I thought the ultrasound, which was
25 done at 16 hours of age, was normal, and I thought

1 that the MRI, done at 47 hours of age, showed
2 significant hypoxic ischemic injury.

3 Q. All right. And if we go to the next page,
4 obviously that's a very detailed description, but on
5 the next page, the section called "Types of
6 Abnormalities."

7 In that first paragraph, the jury's heard
8 some of these terms already: This series of imaging
9 examinations demonstrates an appearance consistent
10 with hypoxic ischemic injury of the mixed type, with
11 elements of both the acute profound pattern and the
12 partial prolonged pattern.

13 I want to focus in on that mixed type with
14 the acute profound and partial prolonged pattern.

15 Can you explain from the neuroradiology
16 perspective what that means?

17 A. Sure. So there are different ways of
18 categorizing hypoxic ischemic injury. But one method
19 which is very widely accepted and very widely used is
20 to differentiate into acute profound and partial
21 prolonged. And I think you've heard those terms
22 referred to already.

23 Partial prolonged is when the fetus is
24 getting some oxygenated blood, but not quite enough.
25 And that tends to affect the periphery of the brain

1 and the generality.

2 Acute profound is when there's been a high
3 grade lack of oxygenated blood reaching the brain,
4 and this can be something of a catastrophe. And that
5 tends to affect the central portion of the brain.

6 For partial prolonged, it often takes
7 awhile, because the baby is getting some oxygenated
8 blood, to cause a problem, in often a half an hour or
9 more.

10 For acute profound, because the baby's
11 brain is getting almost no oxygenated blood, again,
12 this is something of a catastrophe. And it typically
13 can last for 10 to 25 or 30 minutes at most, because
14 if it lasts longer, the fetus often dies.

15 So because of that, when you have an acute
16 profound situation, you need to do something to
17 relieve that, or the fetus will die. And often that
18 solution is birth.

19 Q. And when we talk about the partial
20 prolonged injury, again, it kind of covers it in your
21 report here, but are you focusing on the white
22 matters, or the periphery of the brain?

23 A. The white and the gray matter. Because
24 you can think of the brain like an orange with a
25 peach pit in the middle. So the rind of the orange

1 is gray matter, the pulp of the orange is white
2 matter, and then the peach pit in the middle is gray
3 matter. So it goes gray, white, gray.

4 Q. All right. And with partial prolonged
5 injuries -- or I'm sorry -- with acute profound
6 injuries, that's when there is a hit, so to speak, to
7 the -- or injury to that deep gray matter, correct?

8 A. Acute profound, yes.

9 Q. Acute profound.

10 And that hit to the deep gray matter, what
11 you have up in your report here, that last sentence
12 in paragraph 2: This distribution of abnormality,
13 this generally occurs when there's been a high grade
14 loss of oxygenated blood reaching the fetus for a
15 relatively short amount of time, typically 10 to
16 25 minutes.

17 A. Right.

18 Q. Okay. And then similarly, the last
19 paragraph of that next para -- or that last sentence
20 of that next paragraph talks about the partial
21 prolonged, or injury to the watershed regions.

22 You wrote: The time period of the injury
23 is more variable but takes at least 30 minutes.

24 A. Yes.

25 Q. Okay. And this was your opinion in 2020?

1 A. Yes.

2 Q. And so medicine hasn't changed now in
3 2025, right?

4 A. That's correct, yes.

5 Q. Okay. And, Doctor, I know the jury has
6 heard this, but in your review of the records, you
7 are -- are you aware that in the last approximately
8 half hour of Remi Anyan's delivery, he was in
9 Category III tachycardic?

10 A. Yes.

11 Q. Okay. And, additionally, you are aware
12 that over the stage, second stage of Sarah Anyan's
13 labor with Remi, it took approximately 12 and a half
14 hours, correct?

15 A. Yes.

16 Q. And did those timing, those different
17 times, I guess, does that fit in with the narrative
18 that you put in about the types of abnormalities
19 here, about how long it takes an acute profound
20 injury to occur, as well as a partial prolonged
21 injury?

22 A. Yes, it fits.

23 Q. Okay. When you have an HIE with the acute
24 profound pattern or characteristic, is it common for
25 you to also see partial prolonged?

1 A. Yes, very common.

2 Q. And why is that?

3 A. Well, often what we think is that the
4 fetus is running into some problem but still getting
5 some oxygenated blood, so that's a partial prolonged.
6 And if that is not corrected, then often it continues
7 to deteriorate, and there's a catastrophe at the end,
8 which is the acute profound.

9 Q. Okay. So are these two separate injuries
10 happening? Or are these two components of one
11 greater injury?

12 A. It's usually two components of one
13 process.

14 MS. LENIVY: Zack, if we could go back to
15 Exhibit 130-8.

16 Q. (By Ms. Lenivy) The next section of your
17 report talks about the timing of the abnormalities,
18 and I want to focus in on that first sentence.

19 It says: Multiple aspects of an imaging
20 examination are useful in timing an injury. The
21 timing of the appearance of the finding is crucial.

22 Is this sort of just a general summary of
23 how neuroradiologists like yourself go about trying
24 to time an injury?

25 A. Yes.

1 Q. okay. You're looking at multiple -- all
2 the evidence in front of you -- and trying to piece
3 together the puzzle?

4 A. Right.

5 Q. okay. And determining the timing of when
6 an HIE injury occurs, is that something that you try
7 to help teach your students at Yale to do, as well?

8 A. Yes. Actually, that's one of the things
9 that I'm tasked with to do at Yale to -- I'm the one
10 who teaches them about neonatal imaging and fetal
11 imaging and problems that little babies could have
12 when they're born.

13 Q. okay. Let's go to the next page, then,
14 and talk about some of the pieces of the puzzle that
15 you looked at.

16 First section says the ultrasound. So
17 when we're describing Remi having a head ultrasound,
18 I'm sure the jury is familiar with ultrasounds, but,
19 just generally, what's going on?

20 A. well, I think a lot of you have had an
21 ultrasound. But basically what happens, of course,
22 is that the transducer, or the probe, is put on the
23 baby's soft spot because sound waves don't go through
24 bone very well, and so it's put on the baby's soft
25 spot, and then it shines sound waves back. And those

1 sound waves are bounced back to the computer, which
2 then translates them into structures of the brain, so
3 we can get an idea of what's going on in the brain.

4 Q. Okay. And there's been discussions about
5 ultrasound versus MRI.

6 You would agree ultrasounds are not as
7 sensitive as MRI, correct?

8 A. That's correct.

9 Q. Would you agree that ultrasounds are still
10 an important diagnostic tool for neuroradiologists?

11 A. Yes. They're very easy to do.

12 A lot of these little babies are very,
13 very sick. And it's very difficult to bring them
14 down into the scanner. Actually, at Yale, we have
15 one of the very few dedicated NICU scanners that the
16 MRI scanner is right in the NICU.

17 But, in any case, it's difficult, in most
18 places, to bring them down to the scanner because
19 you're removing them from where they're really being
20 very carefully watched. And with ultrasound you can
21 just -- and those of you who have had ultrasounds
22 know this -- you can just wheel the machine up to the
23 patient, and there's a scan.

24 Q. Okay. And so what you've concluded in
25 your report here is an explanation that you saw the

1 ultrasound taken on 5/5/2020, at 8:40 a.m., at
2 approximately 16 hours of life, and I think you told
3 us earlier, you read it as normal.

4 A. I did.

5 Q. Okay. So what is the significance of a
6 normal head ultrasound taken at 16 hours of life?

7 A. Well, what I think of it is what the jury
8 can probably relate to is, when you burn yourself,
9 you may not see anything for a day or so, and then it
10 starts to swell up. And then the swelling lasts a
11 few days, and then after that, the swelling goes
12 down.

13 And the brain is very similar. When you
14 have an injury to the brain on ultrasound, you may
15 not see anything the first day or so, and then it
16 begins to swell, and you'll start to see something on
17 ultrasound. And then after awhile, the swelling will
18 go down.

19 So if the ultrasound is normal, that
20 suggests that the injury happened roughly within a
21 day or so of the ultrasound.

22 Q. And so given the severity of Remi's brain
23 injury, if the injury had been greater than 24 hours
24 old, greater than one day old, would you have
25 expected it to have been picked up by the ultrasound?

1 A. I would. Because this is a significant
2 injury that he's had. An ultrasound, while it may
3 not be as good as MR, isn't that bad at looking for
4 hypoxic injury. And for a significant case like
5 this, I would have expected to see something.

6 Q. Okay.

7 MS. LENIVY: Zack, could we pull up
8 Exhibit 3, page 1983?

9 Q. (By Ms. Lenivy) okay. This is the actual
10 read report from the ultrasound. And I know there's
11 a timestamp that says 10:07 a.m., but the imaging
12 records themselves, that shows 8:40, correct?

13 A. Yes.

14 Q. Okay. It says it was read by a Dr. --
15 results are by Dr. Thomas Applewhite, and he's a
16 radiologist like yourself, correct?

17 A. Yes.

18 Q. Okay. Can you translate into easier to
19 understand terms, Dr. Sze, what Dr. Applewhite has
20 put into his report here?

21 A. Sure. Basically what he's saying is that
22 there are some small cysts which are not very
23 relevant to what we're discussing, and that the rest
24 of the study is normal.

25 He does mention that there is some

1 parenchymal echogenicity that is a little bit
2 inconsistent, but he -- that's all he says about
3 that, and then he does read the scan as normal.

4 Q. Okay. And so what does it mean
5 "echogenicity"?

6 A. So basically when we have an ultrasound,
7 and I think you guys have all seen ultrasound
8 commercials on TV, so you know that you can see the
9 baby and all that.

10 And so when we have areas that are
11 injured, they look a little brighter usually. And
12 basically, in this particular case, the left side of
13 the brain looked a little whiter than the right side,
14 but we know, from later on, that Remi had hypoxemic
15 injury, which affected both sides of the brain.

16 So we know that this inconsistency in the
17 echos was basically just what we would call artifact.

18 And this is something that we, as radiologists, see
19 every day, and we know how to interpret through it.

20 So I very much agree with what Dr. Applewhite said,
21 that we can interpret this scan, and my findings were
22 exactly the same as his.

23 Q. The fact that Dr. Applewhite took the time
24 to include the echogenicity, does that indicate
25 anything to you about how, I guess, careful or

1 deliberate or diligent he was?

2 A. Oh, yeah. This is a very good report.

3 Q. And the report otherwise says "normal head
4 ultrasound"?

5 A. Yes.

6 Q. All right. And then if we --

7 MS. LENIVY: Oh, you're already there.

8 Q. (By Ms. Lenivy) Clinical history, it says
9 suspected seizures.

10 So when you were receiving imaging to
11 review, do you get the clinical history or the reason
12 why the provider is sending that imaging out to you?

13 A. Yes. Not only do we get that, but we also
14 have access to the entire electronic medical record.
15 So if we want to, and I always do because I'm very
16 interested in this topic, I always go to the
17 electronic medical records to see how the mom did
18 during birth and if there were any problems and
19 things like that.

20 Q. Okay. And at the very least, we know that
21 Dr. Applewhite would have been aware that the reason
22 this baby's imaging was being sent to him was because
23 of suspected seizure, correct?

24 A. Yes.

25 Q. All right. And an infant who is

1 potentially suffering seizures, that's a serious
2 situation.

3 would you agree?

4 A. Yes. Very -- very serious, yes, uh-huh.

5 Q. And it's serious for you as a radiologist
6 because, well, is it because you understand that the
7 providers for this child may be relying on what you
8 report seeing on the inside?

9 A. Oh, sure. I mean, otherwise there
10 wouldn't be any imaging. There would be no point in
11 doing any imaging, sure.

12 Q. Okay. And if you, Dr. Sze, get sent bad
13 imaging, imaging that has bad technique or poor
14 quality, do you have the power to suggest or request
15 additional or better imaging being taken?

16 A. Oh, yeah, certainly. It's very common for
17 us to say, the scan is un diagnostic -- un diagnostic
18 and suggest repeat scan or something like that.
19 That's something we do routinely.

20 Q. Okay. And would you include that in your
21 report, that the ultrasound was of such poor quality
22 or such bad technique, that it should be rendered
23 nondiagnostic?

24 A. Sure. Again, if the scan is not up to a
25 certain quality, and we can't read it, we have to say

1 so in the report. And then that would go to the
2 clinicians, and they would decide whether or not to
3 repeat the scan.

4 Q. Okay. And in reading Dr. Applewhite's
5 report here, does he make any indication that the
6 ultrasound was of such poor quality or such bad
7 technique, that it should be rendered nondiagnostic
8 for this child who may be suffering seizures?

9 A. No, he doesn't say that.

10 Q. And Dr. Sze, we're going to take a look at
11 that ultrasound in a moment, but do you believe the
12 ultrasound was of such poor quality that it should be
13 disregarded or rendered nondiagnostic?

14 A. Well, as I said, one of the things that we
15 are trained to do is to read through artifacts and
16 also studies that aren't perfect quality.

17 we'd like to think that every study you
18 get is perfect quality, but it isn't. So often we
19 have studies where there are artifacts or other
20 problems, and we're trained to read through them.

21 Q. Okay.

22 MS. LENIVY: Zack, can we go back to
23 Exhibit 130-8, the -- Dr. Sze's report?

24 Q. (By Ms. Lenivy) So, Dr. Sze, my brain --
25 there's a lot of times and a lot of dates here. I

1 want to keep your opinions straight.

2 All right. You're aware that the delivery
3 of Remi occurred on 5/4, at approximately 4:24 p.m.,
4 correct?

5 A. Yes.

6 Q. Delivery.

7 And then the ultrasound we just took a
8 look at was taken at 8:40 a.m. on 5/5?

9 A. Yes.

10 Q. I'm going to write "head ultrasound."

11 And was your opinion -- well, maybe
12 explain it to me one more time. Based on the head
13 ultrasound that was read normal at 16 hours of life,
14 how does that impact your opinion as far as dating
15 this injury back?

16 A. Well, basically, as I said earlier, it's a
17 little bit like when you burn yourself. When you
18 burn yourself, you may not see anything for a day,
19 and then it starts to swell. And the same thing goes
20 on in the brain.

21 So in ultrasound, we frequently do not see
22 anything for the first day or so. Some, you know, I
23 mean, that's rough, I mean it could be, you know,
24 plus or minus hours, but often we don't see anything
25 for the first day or so. And so then in a

1 significant case like this, after about a day, we
2 would expect to see something.

3 And so the fact that we don't see
4 anything, suggests that the injury happened within
5 24 hours of the ultrasound, approximately.

6 Q. Okay. So that would put us at 5/4, at
7 8:40 a.m. That's 24 hours before the ultrasound,
8 correct?

9 A. Yes.

10 Q. Okay. All right.

11 MS. LENIVY: Zack, and I'm going to move
12 this out of the way. Could we go to Dr. Sze's
13 report. We're talking about the MR now.

14 Q. (By Ms. Lenivy) All right. Now,
15 obviously the ultrasound is not the only thing we
16 have.

17 And you also took a look at the MRI,
18 correct?

19 A. Yes.

20 Q. And can you explain to the jury what it
21 was that you saw on the MRI?

22 A. Oh, sure. So there are several sequences
23 that we use in MR, and you can think of them as
24 filters. They bring out different things. One is
25 called diffusion, another is called T2, and another

1 is called T1.

2 Diffusion is the most sensitive way we
3 have of looking for hypoxemic injury in a newborn.

4 And, in this case, the diffusion scan was very
5 positive, as I'll show you later.

6 Q. Okay. And so if we were to set aside the
7 ultrasound, pretend it never happened, pretend it
8 never happened, but based on the MRI alone, were you
9 able to reach an opinion as far as the earliest
10 Remi's HIE could have occurred?

11 A. Yes. I mean, for several reasons. Based
12 on the way the diffusion looked, based on the T1, and
13 also based on the pattern of injury, I thought this
14 probably did occur close to the time of delivery.

15 Q. Okay. At least within a three-day window?

16 A. Yes. But I think that, as we'll discuss
17 later, I think you can actually make it even a little
18 tighter than that. But, yes --

19 Q. Okay.

20 A. -- certainly within three days.

21 Q. Within three days.

22 A. Yes.

23 Q. And the MRI was taken 5/6 at 3:07 p.m.

24 Does that sound right, Doctor?

25 A. Yes, right. When it was started.

1 Q. okay.

2 MS. LENIVY: And, Zack, if we could go
3 back in to Exhibit 3, page 1992.

4 Q. (By Ms. Lenivy) while I've got you here,
5 Doctor, the MRI report that was generated by
6 Dr. Niebruegge, you had an opportunity to look at
7 this MRI yourself, correct?

8 A. Yes.

9 Q. And did you generally agree with what Dr.
10 Niebruegge put in his report for the MRI?

11 A. Yes, I did.

12 Q. There was one where I just wanted to make
13 sure --

14 MS. LENIVY: If we could scroll down.

15 Q. (By Ms. Lenivy) It talks about confounded
16 by subarachnoid hemorrhage.

17 Doctor, do you remember reading about this
18 being confounded by subarachnoid hemorrhage?

19 A. Yes. It's at the top under "Findings."

20 Q. Oh, okay. And I just want to know, does
21 that mean anything important or significant in the
22 timing of Remi's head injury?

23 A. Yes. What Dr. Nie -- what the doctor is
24 saying is that there is a little brightness on the
25 surface of the brain, not in the brain, but a little

1 brightness on the surface of the brain on the
2 so-called T1 weighted imaging which is due to a
3 little bleeding.

4 Q. Okay. And so looking at the time line
5 that I have written up here, based on the head
6 ultrasound you took a look at and the MRI, were you
7 able to, I guess, provide an opinion as to the window
8 of time for Remi's injury?

9 A. Yes. Let me just mention that he says not
10 only subarachnoid hemorrhage, he also says -- for the
11 people who can read it -- T1 lateralization. So
12 that -- that's just vessels on the surface of the
13 brain. But he was not saying there was anything
14 bright on the T1 in the brain itself.

15 And as far as timing goes, yes, my timing
16 on the MR, as we'll show later, is very similar to
17 the timing on the ultrasound. They correlate.

18 Q. Okay. And what is that window of time, as
19 far when, based on the imaging, Remi's brain injury
20 occurred?

21 A. Well, in general terms, I think you can go
22 back approximately three days from the MR, but I
23 think you can refine it. As I said earlier, there's
24 certain things which I'll go into later, which really
25 narrow it a little more than that.

1 Q. Okay. And so if that window of time,
2 because that started, as we talked about earlier, on
3 5/4 at 8:40 a.m.?

4 A. Yes, roughly.

5 Q. Okay. And then do you believe that this
6 injury -- you said that you believe this injury was
7 sustained at or around the time of delivery, correct?

8 A. I think there's certain things that make
9 you think that, yes, from the imaging itself.

10 Q. Okay. So then is this the window of time
11 of injury?

12 A. Yes.

13 Q. Okay. Thank you, Doctor.

14 Now, as far as getting more specific
15 within that about 8 -- about an 8-hour window of time
16 here, is that something you rely on other experts
17 like obstetricians, neonatologists, pediatric
18 neurologists to rely on?

19 A. No. It's my duty, as a neuroradiologist,
20 in my area of expertise, to hopefully be the one that
21 they would rely on. They would rely on what I
22 thought.

23 Q. Okay. Are you of the opinion, Doctor,
24 that had Remi been, at least based on the window of
25 time we talked about here, had Remi been delivered

1 before 8:40 a.m., he likely would not have sustained
2 the HIE that we've been talking about?

3 A. Yes. That makes sense to me.

4 Q. Okay. Dr. Sze, I'm going to hand you what
5 has been marked as Exhibit 357.

6 A. Okay.

7 Q. And can you identify for the jury --

8 A. Sure.

9 Q. -- what that exhibit is?

10 A. Sure. So every ultrasound and MR scan
11 comes with hundreds and sometimes thousands of
12 images. And you, as a jury, don't want to sit here
13 while I flip through thousands of images.

14 So in radiology, it's very, very standard
15 to make what we call a PowerPoint, where we pick out
16 the best images so that you can get a synopsis. We
17 do this not only for you as a jury, we do this at our
18 meetings, and we do this in the hospital, as well.
19 This is something we do all the time.

20 Q. Okay.

21 MS. LENIVY: And, Judge, I handed
22 Exhibit 357 to defense before we got started with Dr.
23 Sze, but I ask permission to publish the PowerPoint
24 to the jury.

25 THE COURT: Any objection?

1 MS. KAMYKOWSKI: As long as she lays the
2 right foundation while she's going through it, I have
3 no objection, Judge. I think she will.

4 THE COURT: Very good.
5 On behalf of the doctor?

6 MR. PERRON: Yes, Your Honor.

7 THE COURT: Any objection?

8 MR. PERRON: No, Your Honor.

9 THE COURT: Thank you.

10 Q. (By Ms. Lenivy) Dr. Sze, am I in your
11 way?

12 A. Well, I know what it shows.

13 Q. Okay. Fair enough. All right.

14 So Remi Anyan, these were 5/4/20. What do
15 his scans show us?

16 A. Yes. I don't think this is actually --

17 Q. Is that not working?

18 A. Well, I think it's working, but I think
19 it's so far away, it's not really...

20 Q. It's not picking up on the screen, I
21 apologize.

22 A. Yeah.

23 Q. Can you click to the next line? Are you
24 able to do that?

25 A. Yes, sure.

1 So maybe what I can do --

2 THE WITNESS: Is it okay, may I approach
3 the screen?

4 THE COURT: So long as you keep your voice
5 up nice and loud.

6 THE WITNESS: Okay. I'm pretty good at
7 that.

8 And do you have a pointer?

9 MS. LENIVY: I don't have, but I do have
10 like a pen.

11 THE WITNESS: Oh, okay. Thank you very
12 much.

13 MS. LENIVY: Okay. I'll actually put that
14 down.

15 MS. KAMYKOWSKI: No problem.

16 Q. (By Ms. Lenivy) Okay. So, Doctor, this
17 is your first slide here.

18 what are we looking at?

19 A. This is a side view of Remi's MR scan. I
20 think you can all figure that out.

21 Here is his nose and his mouth, his chin.

22 This is the back of his head, and this is his brain.

23 Q. What's that sort of thing at the top
24 there?

25 A. That's fluid that is outside his skull,

1 but it has something to due with his delivery.

2 Q. Okay. And so if we flip to -- do you have
3 your little --

4 A. I do.

5 Q. And I think the next page, what are you
6 trying to show the jury with the next page?

7 A. Oh, you know. Basically what we do in --

8 what we do in ultrasound, what we do in CAT scans,

9 which I'm sure some of you have had, and what we do

10 in MR, is that we take thin, little imaging slices of

11 the brain.

12 so basically all of you, as I've said,

13 have probably had chest x-rays, and there you just

14 get one projection from the front or maybe from the

15 side, and that's it.

16 In ultrasound, CAT scans, and MR, we take

17 thin, little imaging slices of the brain, so we end

18 up with something like a stack of CDs. And if you

19 want to see what's going on on the top of the brain,

20 you can pull a CD from the top of the stack and look

21 at that. If want to see what's going in the middle

22 of the brain, you can pull out a CT from the middle

23 of the stack and look at that.

24 And this is a very, very sensitive way to

25 see exactly what's going on inside of a living

1 person. It is the best way we have of seeing what's
2 going on inside a living brain.

3 This technique, by the way, is called a
4 cross-sectional imaging, and it was a major event,
5 not just in imaging, but in medicine. So much so,
6 that the people who developed CAT scans went on to
7 win the Nobel Prize. And then years later, the
8 people who developed MR scans, different people of
9 course, went on to win the Nobel Prize.

10 And so what we're going to show you today
11 are these thin, little imaging slices of the brain.
12 These are very, very thin. They're usually about 3
13 millimeters. And just to refresh the jury's memory
14 as to what 3 millimeters is, there are about 25
15 millimeters in an inch. So each of these imaging
16 little slices we're going to be looking at, is an
17 eighth of an inch thick.

18 Q. Okay. I think your next page talks about
19 what does a normal brain look like.

20 So the next couple of slides you're going
21 to show us, these are not Remi Anyan, correct?

22 A. Right.

23 Q. So?

24 A. So basically this is a normal ultrasound,
25 and I'm going to flip through these quickly. They're

1 just to show you and give you a general idea. So
2 later I will compare Remi's to these.
3 So this is a normal ultrasound. This is a
4 diffusion image. And on a diffusion image, in a
5 normal scan, basically looks sort of homogenously
6 gray like this. And this is another diffusion scan
7 normally looking homogenously gray.

8 And, again, this is just background. I'll
9 show you what Remi's looked like in a moment. Then
10 we'll compare them side-by-side.

11 This a so-called T1 weighted image, and
12 remember what I said, it's gray, white, gray, sort of
13 like the orange with the peach pit in the middle?

14 So this brighter stuff on the outside is
15 gray matter. The white matter is a little darker,
16 despite the name, and the gray matter in the center
17 is bright, and -- or a little brighter -- and this is
18 a normal T1 weighted scan.

19 Q. So the next slide says, what does Remi's
20 brain look like?

21 A. Right.

22 Q. This is the head ultrasound and the MRI.
23 Tell us what Remi's brain looks like.

24 A. Sure. So this is his ultrasound, and I
25 will compare it side-by-side with the normal in just

1 a moment. But this is just to give you a flavor.

2 This is diffusion. So we can see that
3 there is a lot of brightness in this frame, unlike
4 what the normal looked like. Here's his T1, showing
5 that there is a little brightness.

6 But remember what I said, a lot of this
7 brightness, particularly in this central portion, is
8 normal. And then here he is a side-by-side. So
9 here's the normal, and here's Remi's. And if we look
10 at this area, for example, you can see how much it
11 looks like the normal. It's sort of a homogenous
12 gray, and we don't see anything that's particularly
13 bright in it.

14 And I'll show you other examples where
15 there is something wrong in just a moment.

16 Q. And, Doctor, could I stop you here.

17 A. Uh-huh.

18 Q. The normal one, that's what we're looking
19 for as far as diagnostics, right? Diagnosing
20 something?

21 A. Right.

22 Q. And so comparing Remi's ultrasound to the
23 normal ultrasound, do you feel that Remi's head
24 ultrasound at 16 hours of life was of good quality to
25 render a reliable diagnosis?

1 A. I do.

2 Q. okay.

3 A. okay. And so this is Remi here at 2 days
4 of age. And you can see now again the normal should
5 be sort of homogenously gray, and then the abnormal
6 ones, we see all this white area here around and in
7 the center of the brain?

8 THE WITNESS: You guys can all see it,
9 right? So -- because you're sort of far away.

10 A. And the same thing here, this is another
11 normal, just to compare.

12 You'll also see that Remi's -- basically
13 these are what we call ventricles. They're fluid
14 spaces inside the brain, and we all have them. And
15 you'll see that Remi's are actually, in the MR scans,
16 not big, which is somewhat important in terms of
17 timing, as well.

18 And then this is his T1. So his T1
19 normally should show a little brightness of the gray
20 matter. And in Remi's case, we don't see any
21 abnormal brightness.

22 Q. okay. And we're going to talk about why
23 that's important in a moment here.

24 But I think the next slide you've got,
25 talks about why this hypoxic ischemic -- or what does

1 hypoxic ischemic injury look like?

2 A. Right.

3 Q. And your next slide talks about the
4 Barkovich book, and I borrowed that copy from Ms.
5 Slater, but that's -- that's the -- is that sort of
6 the most reliable textbook on -- on imaging?

7 A. It's probably the most highly-respected
8 textbook of pediatric neuroimaging in the world.

9 Q. Okay.

10 A. Okay. So here I'm going to show you what
11 acute profound looks like. And remember what I said.
12 It's when you have a high grade lack of oxygenated
13 blood reaching the brain, it can only last a short
14 amount of time, or the fetus will die. And it tends
15 to involve the central portion of the brain. And you
16 can often see these white patches.

17 And on MR, on diffusion, you also see a
18 little brightness in the central portion of the
19 brain. Here's one example, and here's another
20 example.

21 Q. And just so we're clear, we are looking at
22 examples -- are these taken from the Barkovich
23 textbook?

24 A. Yes.

25 Q. Okay.

1 A. So here is Remi's ultrasound on the left.
2 Here's the abnormal from the textbook. And you can
3 see that instead of having the normal sort of
4 homogeneous grayness in the center, the abnormal
5 shows these patches of brightness.

6 Q. I'm sorry. So if I can go back. Please
7 go back.

8 A. Sure.

9 Q. Does the difference between an abnormal
10 brain ultrasound -- or I'm sorry -- head ultrasound,
11 and what we see on Remi's, is that supportive of your
12 opinion that this injury did not occur 24 hours prior
13 to the ultrasound at 16 hours of life?

14 A. Yes.

15 Q. Okay. Thank you.

16 A. Okay. And this is the diffusion showing
17 this brightness in the central portion of the brain.

18 And here we see -- I'm sorry -- here we see Remi's,
19 and then we see the abnormal one from the textbook.

20 And you can this brightness here, looks
21 very much like this brightness here from the
22 textbook. And so that was acute profound.

23 And now we're going to partial prolonged
24 where the brain is getting some oxygenated blood, but
25 not quite enough, and that tends to affect the

1 periphery of the brain. And these are generalities,
2 but, you know, but put into terms that you, as the
3 jury, can understand.

4 so here is an example from the literature
5 where we show this brightness around the periphery of
6 the brain. There's some here. For those of you who
7 are sitting far back, you may not see it, but there's
8 also some right there.

9 And then here we compare Remi with a
10 partial prolonged from the textbook, and you'll see
11 that there's brightness along the periphery of the
12 brain. And you'll see that here in Remi's, there's
13 brightness along the periphery of the brain all the
14 way around. So Remi's is actually worse than the
15 example from the literature.

16 Q. All right. So this slide reads: when did
17 the injury occur?

18 And it looks like you've got ultrasound
19 highlighted?

20 A. Yes.

21 Q. All right. Explain -- can you explain
22 this to us?

23 A. Sure. So, again, this is all that we've
24 been talking about. The ultrasound scans take
25 roughly 24 hours, give or take, to show an

1 abnormality. And in Remi's case, the ultrasound is
2 normal, so we can suggest that this significant
3 injury probably happened within 24 hours of the
4 ultrasound.

5 Q. So sometime after 5/4 at 8:40 a.m.?

6 A. Yes, approximately.

7 So here we have Remi's compared to the
8 normal, and here we have Remi's compared to the
9 abnormal, and you can see the difference.

10 Q. All right.

11 Your next slide.

12 A. Remi also has an acute profound type
13 pattern injuring the central portion of his brain,
14 which we call the basal ganglia and thalami.

15 And as I've discussed before, acute
16 profound is a catastrophe, so something needs to be
17 done to reverse it, and that is often birth. Because
18 if it goes on for too long, the fetus will die. So
19 acute profound often occurs just prior to birth.

20 Q. And you've got some imaging for us on
21 acute profound. So we see Remi on the left, and then
22 we see the textbook example on the right, correct?

23 A. Exactly.

24 Q. And I think your testimony was Remi was
25 actually worse?

1 A. Yes. Both in acute profound and partial
2 prolonged.

3 Q. Okay. The next slide talks about
4 diffusion.

5 A. So on the diffusion, first of all, we tend
6 to see the positive findings for up to 5 to seven
7 days. These events, as you all know, when you burn
8 yourself, the swelling goes up, and then it goes
9 down. And the swelling tends to maximize in a
10 hypoxemic injury in around three days.

11 So, in any case, here's Remi on the left,
12 and here's the normal. And you can see clearly he
13 has hypoxemic indicators, which I think everybody
14 agrees with.

15 But, in addition, there are some other
16 things I'd like to point out. Do you see that the
17 border between the periphery and the white matter is
18 quite sharp? This is something we see early on. As
19 time goes on, it tends to bleed into the white matter
20 here.

21 So when we look at that, we know this
22 happened recently. This did not happen a week ago.

23 The other thing we can look at is the size of the
24 ventricles. The ventricles are quite small. In
25 Remi's case, I don't think that they're big at all.

1 But of course, keep in mind that the
2 swelling, as you know, when you have -- when you burn
3 yourself, it takes a few days for the swelling to
4 reach its greatest point, and the same thing is true
5 in the brain.

6 So in this case what I think is that the
7 injury happened probably near the time of birth, and
8 then the swelling is increasing. It hasn't reached a
9 peak yet, and it's not -- it hasn't gone down either
10 yet.

11 Q. What's the next slide, Doctor?

12 A. T1.

13 Q. All right. First of all, what is T1 when
14 we talk about MRI?

15 A. Well, just to make it simple for the jury
16 to understand, think of it as a filter.

17 Q. Okay. So let's talk about what you saw
18 and what was significant about the T1.

19 A. It's often said that findings on T1 start
20 at about three days, although some people say two to
21 three days.

22 And basically I thought that Remi's scans
23 on T1 for the brain were normal. I thought that
24 there was a little brightness overlying the brain
25 which I agree with Dr. Nie -- or whatever that is.

1 Q. Niebruegge.

2 A. Niebruegge. That it could be either a
3 little subarachnoid hemorrhage or maybe some vessels
4 on the surface of the brain. But I thought the brain
5 itself did not show abnormal brightness. And,
6 therefore, since this tends to start at about three
7 days, although this is a little variable, I thought
8 that the injury probably occurred within three days
9 of the MR, which was done at 47 hours.

10 Q. Okay. And so what are we looking at?

11 A. So, again, this is just what I showed
12 before with the T1 comparing it to the normal T1.

13 Q. All right. So because you did not see
14 abnormal brightness on the T1?

15 A. In the brain.

16 Q. In the brain.

17 A. Just abnormal brightness in the, what we
18 call, well, in the crevices of the brain.

19 Q. Ah, okay.

20 A. So that's what Dr. Niebruegge said, also.

21 Q. Okay. And so based on this, this helps
22 your timing opinion, as well?

23 A. Yes, it does.

24 Q. Correct, Doctor?

25 All right. So I think the next slide, you

1 said that there was maybe some debate.

2 A. well, I would say this: I usually say
3 about three days. And it is a little variable. The
4 Barkovich textbook has this chart, and it says two to
5 three days right there.

6 Q. So the Barkovich textbook -- we've got a
7 copy over there -- it says T1 hyperintensity timing
8 two to three days.

9 A. Right.

10 Q. Okay. And, Doctor, I think the last slide
11 might be your conclusion.

12 A. I thought that based on what I saw from an
13 imaging point of view, that this was the most
14 consistent for the reasons I've just stated, that
15 probably the injury occurred near the time of birth.

16 Q. All right. Thank you very much, Dr. Sze.
17 If I could just ask you a couple of
18 questions to close up.

19 A. Sure.

20 Q. All right. Dr. Sze, after completing your
21 review of the records in this case, most notably the
22 imaging, and relying on your own years of experience
23 as a neuroradiologist, is it your conclusion that
24 Remi's HIE is a mixed type, with elements of both the
25 acute profound pattern and the partial prolonged

1 pattern?

2 A. Yes.

3 Q. Is it your conclusion that Remi suffered
4 his HIE at or near the time of his birth?

5 A. Yes.

6 Q. And is it your conclusion that Remi, more
7 likely than not, did not suffer his HIE prior to 8:40
8 a.m. or 8:00 a.m. on 5/4/2020?

9 A. Yes.

10 Q. And do you hold all of these opinions to a
11 reasonable degree of medical certainty?

12 A. Yes.

13 Q. All right. Thank you, Dr. Sze.

14 A. Thank you.

15 THE COURT: Cross-examination?

16 CROSS-EXAMINATION

17 BY MR. PERRON:

18 A. Good morning.

19 Q. Good morning, Doctor.

20 Just for the sake of clarity, you've been
21 talking to the jury for a little bit about your
22 opinions on causation.

23 But, again, you are not offering any
24 standard of care opinions, correct?

25 A. Correct.

1 Q. You have no opinion on Dr. McNeive or any
2 other provider as to the standard of care?

3 A. Correct.

4 Q. You have no opinions about the actual
5 cause of Remi's injury, correct?

6 A. Right. Other than that the brain did not
7 get enough oxygenated blood.

8 Q. Or his future care needs?

9 A. Correct.

10 Q. This type of mixed hypoxic ischemic injury
11 is something you see on MR commonly.

12 A. Yes.

13 Q. It's your testimony radiology can only
14 give you a window of time, correct?

15 A. Yes.

16 Q. Okay. Just relying on the MRI, it's your
17 testimony, at least, when you wrote your report and
18 when we took your deposition, that based on the MRI,
19 you believe the injury is within a three-day window
20 of time from the date of the MRI?

21 A. Yes, approximately.

22 Q. Okay.

23 A. And then you can use a little bit of
24 clinical to narrow it down a little bit. As I -- and
25 also, based on the sharp border that I showed before,

1 I think you can narrow it down a little bit more than
2 that, but, yes.

3 Q. Well, all of the clinical indications and
4 other things that you're using to narrow that
5 three-day window, you would have had access to that
6 information from your personal experience at the time
7 that you wrote your report.

8 Is that fair?

9 A. Yes.

10 Q. But when you wrote your report, when you
11 sat down and wrote your report, you had all the
12 information available to you to render your
13 conclusions, correct?

14 A. Yes. I did elaborate a little more of it
15 in my deposition, where I went into quite great
16 detail about the sharp border between the white
17 matter and the gray matter, which is usually
18 something that is an early thing, uh-huh.

19 Q. Sure. But just to be clear, when you sat
20 down and wrote your report containing your
21 conclusion, your conclusion just limiting yourself to
22 the MRI, was a three-day window?

23 A. Yes.

24 Q. The MRI was taken on May 6th.

25 A. Right.

1 Q. That gets you to May 3, correct?

2 A. Yes.

3 Q. Okay. The three-day window is not meant
4 to be exact minute or the hour.

5 A. Correct.

6 Q. Typically you gave about a plus or minus
7 an 8-hour margin of error on -- on that window.

8 A. Sure. There's a margin of error, yes.

9 Q. And I think you even said you're typically
10 pretty liberal about the margin of error you give on
11 your windows of time.

12 A. Yes.

13 Q. The MRI, as you said, I hate to belabor
14 the point, but I've got my outline of questions, and,
15 by golly, I've got to stick with them.

16 The MRI is a more precise tool in terms of
17 identifying the details of the injury to form an
18 opinion on timing, fair?

19 A. As a rule, MR is better, but it also
20 depends when the MR is done.

21 So, for example, if we have an ultrasound
22 that's done on the first day, and an MR just, you
23 know, for purposes of example, done a year later,
24 that MR is useless in terms of timing. So it depends
25 when they're done.

1 Q. Sure. But in comparing apples to apples,
2 you've got an MRI on May 6th, that's not a year
3 later, correct?

4 A. Right. That's 47 hours after birth.

5 Q. Okay. So comparing apples to apples in
6 this case, MRI is a more precise tool than an
7 ultrasound in terms of identifying the details of the
8 injury that you need to form an opinion on timing,
9 fair?

10 A. I think that it's better to say that we
11 use everything that we have. If we have an
12 ultrasound, even if it's not as good as the MR, we
13 use it. If we have an MR, of course we use it, as
14 well. So we put everything together.

15 Q. Sure. I'm not -- I'm not saying you don't
16 put things together. That's your testimony. I'm
17 sure you're going to stick to it, but I'm comparing
18 MRI to ultrasound.

19 A. Yes.

20 Q. You have to agree with me, based on all of
21 your precious testimony, not just in this case, but
22 your years of testimony in cases like this, MRI is a
23 more precise tool than the ultrasound, correct?

24 A. In general, that is correct, yes.

25 Q. Okay. In this case, the testimony you

1 provide to the jury is that MRI, which is generally
2 more precise, gives you a three-day window, but when
3 you look at the ultrasound, which is less precise,
4 you can give a more narrow window of timing of this
5 injury.

6 Is that a fair understanding?

7 A. Not really. Because I did go into the
8 details about the sharp border, which I think is
9 actually very convincing in this case. And I went
10 into that at length in my deposition, also.

11 Q. You believe, to a reasonable degree of
12 medical certainty, that when Remi was born, he had
13 moderate HIE, based on your review of the imaging?

14 A. Well, we did discuss this, and what I see
15 is moderate to severe. He either had moderate severe
16 when he was born, or maybe it got a little worse. It
17 can progress.

18 Q. Okay. And, again, I wasn't meaning to
19 trap you on one versus the other, but moderate or
20 moderate to severe at the time that he was born.

21 A. Yes.

22 Q. Okay. You testified in your direct that
23 you had been retained by counsel at the table
24 previously.

25 I just want to be clear. Have you

1 specifically worked with Mr. Willman in the past?

2 A. Mr. Willman? Not to my memory, no.

3 Q. Okay. How about me? I'll reintroduce
4 myself. David Perron. Nice to meet you again.

5 A. I know your name, yes. No.

6 Q. Have you ever worked for me?

7 A. No.

8 Q. Okay. Okay. You have no opinion whether
9 an infant born with moderate to severe HIE could ever
10 be scored with an Apgar score of 8 or higher?

11 A. I -- we discussed this in my depo, and I
12 will defer to the clinical people, whom I'm sure have
13 discussed this at great length already.

14 Q. Okay. Are you aware -- you talked, I
15 believe I may have missed it, but I believe you
16 testified on direct about an increased risk for the
17 infant with a prolonged second stage of labor.

18 Is that your testimony as a
19 neuroradiologist?

20 A. No. No. I am not going to comment on the
21 length of the second stage of labor. That's a
22 clinical thing.

23 Q. Okay.

24 A. I will just say what I see is consistent
25 with a partial prolonged and acute profound.

1 Q. okay. So you're not -- you're not trying
2 to impress upon the jury a neuroradiology opinion
3 that a prolonged second stage of labor increases any
4 kind of risk?

5 A. Right. That's not my area of expertise.

6 Q. Okay. Doctor, are you presently an active
7 professor at Yale?

8 A. Yes.

9 Q. Okay. What is an emeritus professor?

10 A. At Yale, when we reach a certain stage, we
11 can request emeritus positions. Now, the emeritus
12 actually has many advantages which you carry on for
13 the rest of your life, which is why it is something
14 that is sought after. And it is a little bit of an
15 honor.

16 The vast majority of emeritus professors
17 do not work anymore, but I continue to work. But I
18 also enjoy these privileges now for the rest of my
19 life, such as keeping my email address for the rest
20 of my life.

21 Q. Okay. So typically emeritus professor is
22 an honorary title given to someone who's retired?

23 A. Usually, yeah.

24 Q. And you are an emeritus professor at Yale?

25 A. Yes, uh-huh.

1 Q. Okay. But your situation at Yale is
2 unique, different from a typical type of emeritus
3 professor?

4 A. Yes. Most people get it when -- and they
5 quit, yes.

6 Q. Okay. How many depositions do you think you've
7 given in medical malpractice cases over the years?

8 A. Oh, over 30-something years, probably over
9 250.

10 Q. Okay. About how many times have you
11 testified live at trial?

12 A. That's very uncommon. So I would say over
13 30-something years, it's probably 50, 60. Maybe a
14 little more at this point.

15 Q. Just like we talked about, not just in
16 this case, but in every one of those depositions, you
17 raised your hand to swear to tell the truth, correct?

18 A. Oh, sure.

19 Q. And you always endeavored to do that, to
20 the best of your ability?

21 A. Absolutely.

22 Q. Okay. Have you testified in a past
23 deposition that reviewing ultrasounds was just a
24 small percentage of your time compared to reviewing
25 magnetic resonance?

1 A. Yes, that is true. It's a larger part of
2 my time in research, but, yes, uh-huh.

3 Q. Available literature suggests that
4 hypoxic -- well, let me back up.

5 You have testified in the past that
6 available literature suggests that hypoxic ischemic
7 cerebral imaging at 24 to 48 hours can appear on
8 ultrasound.

9 A. Yes.

10 Q. Okay. Now, in your direct, you were
11 emphasizing the 24-hour limit?

12 A. Right.

13 Q. But in the past, you've broadened that to
14 24 to 48 because that's consistent with the
15 literature.

16 A. Well, we have to look at what the
17 literature shows. So there are many things that the
18 literature does show.

19 For example, the Barkovich textbook says
20 that imaging can become positive in about 16 hours.
21 And there are a number of other papers. For example,
22 the ACOG bulletin, I think that that's probably been
23 raised to the jury. Says that findings may not be
24 visible until after 24 hours.

25 So 24 is what I use as usually what I say.

1 But there are cases where you may not see it for 48.

2 And if it's mild on ultrasound, you may never see it.

3 So the window, in my opinion, goes from 24, plus or
4 minus, hours, to infinity.

5 Q. All right. Going back to the Barkovich
6 text, what I've got here, and I don't know if I've
7 got a version I can put up. But you flashed this on
8 the screen. I don't know if I can tell which slide
9 it is. I don't know if that's possible to put that
10 back up.

11 A. Are you looking for the chart?

12 Q. This table --

13 A. Yeah, uh-huh. That's at the very end.

14 Q. Right. So it describes the different
15 types of techniques -- you've got it now, yeah -- it
16 describes the different types of techniques in the
17 left-hand column, correct?

18 A. Yes.

19 Q. And then in the middle column, it says
20 "findings." For ultrasound, it says "increased
21 echogenicity."

22 A. Right.

23 Q. And echogenicity -- please don't try to
24 explain the science to me because I won't get it even
25 if you did a really great job -- that's the -- that's

1 what shows up on the ultrasound so you can

2 potentially see an injury. Document Not an Official Court Document

3 A. Yes. Not an Official Court Document Not an Official Court Document

4 Q. In a very simple type of way? Document Not an Official Court Document Not an Official Court Document

5 A. Yes. al Court Document Not an Official Court Document Not an Official Court Document Not an

6 Q. So technique ultrasound findings increased
7 echogenicity, and it says for timing, two to ten
8 days, correct? Not an Official Court Document Not an Official Court Document Not an Official Court Document

9 A. Yes. Not an Official Court Document Not an Official Court Document Not an Official Court Document

10 Q. And you said Barkovich is "the" textbook,
11 right? Not an Official Court Document Not an Official Court Document Not an Official Court Document Not an Official Court Document

12 A. Yes. Not an Official Court Document Not an Official Court Document Not an Official Court Document

13 Q. So it doesn't say 24 hours, it says two to
14 ten days, correct? Not an Official Court Document Not an Official Court Document Not an Official Court Document

15 A. Right. But you have to look at the
16 heading for the table. So what it says is findings
17 and effective times for imaging. Not an Official Court Document Not an Official Court Document Not an Official Court Document

18 Q. okay. Not an Official Court Document Not an Official Court Document Not an Official Court Document

19 A. Because it's easier to see things at 48,
20 so that's an effective time. Not an Official Court Document Not an Official Court Document Not an Official Court Document

21 Q. You have agreed with the statements that
22 ACOG and AAP have written that the ability to
23 precisely time the occurrence of a hypoxic ischemic
24 event is limited. Not an Official Court Document Not an Official Court Document Not an Official Court Document

25 Do you agree with that statement?

1 At least that's what's in the literature
2 from ACOG.

3 A. That is what ACOG says. As I said, I
4 think that the ability to time is not that -- not
5 that limited. We cannot time it to the hour or
6 certainly not the minute, not even the hour. But we
7 can give you a range.

8 And as I said in my deposition, I think of
9 12-hour blocks, roughly. Approximately.

10 Q. Right. You try to put it in 12-hour
11 blocks, but ACOG and AAP say that it's limited and
12 that it's estimated in days, not hours or minutes.

13 A. Right.

14 Q. That's at least what ACOG says, right?

15 A. Right. We -- we all agree not hours or
16 minutes, everyone agrees on that. But as I said in
17 my deposition, I would shorten it a little bit. I
18 think that saying 12-hour blocks is reasonable.

19 Q. You have testified in the past that a head
20 ultrasound is a crude tool in identifying hypoxic
21 ischemic insults.

22 A. Yes. It's not as sensitive as MR for
23 picking it up, that is true.

24 Q. All right. And you have testified that
25 there can be technical problems with an ultrasound,

1 such that you can't get an ideal angle to see that
2 hypoxic injury.

3 A. Well, that's not exactly what I said.
4 But, yes, you can certainly have technical problems
5 in ultrasound, just as you can have technical
6 problems in MR.

7 Q. And if the operator of the ultrasound
8 can't obtain the ideal or optimal angle, that can
9 inhibit the viewer's ability to see a hypoxic injury
10 on an ultrasound?

11 A. Yes. Theoretically, that is absolutely
12 true.

13 Q. Within the past 5 years, within the normal
14 scope of your work as a clinician, do you yourself
15 write up ultrasound reports?

16 A. No. I used to years ago, but not anymore.

17 Q. Okay. In your CV --

18 A. However, I do look at ultrasounds
19 constantly for research purposes.

20 Q. As you've mentioned. Fair.

21 In your CV, which was up for just a little
22 bit, pages long, correct?

23 A. Yes.

24 Q. Many, many, publications, correct?

25 A. Yes.

1 Q. Any publications directly on-point to
2 hypoxic injury in pediatric patients?

3 A. No. There is a reason for that.

4 Q. And one-third of your income comes from
5 this medical legal work, correct?

6 A. Yes, approximately.

7 Q. Those are all my questions.

8 A. On average, yes. Thank you.

9 THE COURT: on behalf of Mercy Hospitals?

10 MS. KAMYKOWSKI: Yes, Your Honor, just
11 briefly, I believe.

12 CROSS-EXAMINATION

13 BY MS. KAMYKOWSKI:

14 Q. Hi, Dr. Sze.

15 A. Hi.

16 Q. How are you?

17 A. Good. Thank you.

18 Q. I'm Mandy Kamykowski. Good to see you
19 again.

20 And I think there's been some hints that
21 maybe you and I have worked before in the past.

22 A. Yes.

23 Q. Is that true?

24 A. Yes.

25 Q. My recall, Doctor, is that I have

1 consulted you on adult stroke cases when I have
2 represented emergency medicine physicians accused of
3 malpractice for not timely diagnosing a stroke in an
4 adult, correct?

5 A. There's been more than one case. I didn't
6 go back and research what the cases were, to be
7 honest with you.

8 Q. okay. I just wanted to make sure because
9 I thought the question from Ms. Lenivy was that you
10 had worked with somebody over here on a pediatric
11 case.

12 I don't have that recall, and you haven't
13 gone back to --

14 A. I didn't research that, that's correct.

15 Q. okay.

16 A. But I know with the Brown & James firm, I
17 have for little infants.

18 Q. okay. So -- and I've consulted you
19 because you do, I think this came out in your direct,
20 you do deal in adult neuroradiology, correct?

21 A. Yes.

22 Q. okay. And it sounds like since we talked
23 to you in this case for your deposition, maybe things
24 have changed a little bit in your clinical practice
25 where you now have maybe increased some of your

1 pediatric reads from what we talked about earlier
2 when you were deposed, correct?

3 A. Yes. Again, because two of my colleagues
4 left, yes, uh-huh.

5 Q. Okay. But you will agree your -- you are
6 not subspecialty trained or certified as a pediatric
7 neuroradiologist, correct?

8 A. Well, let's be very clear. There is --

9 Q. Let's do.

10 A. -- no certification for pediatric
11 neuroradiology, number one. And, number two, the
12 people who wrote the textbooks, like Barkovich, are
13 actually in my generation. So when I was in
14 training, there were no fellowships in pediatric
15 neuroradiology.

16 Q. You do not hold yourself out as a
17 subspeciality pediatric neuroradiologist. You see
18 neuroradiology for all comers, correct?

19 A. Yes.

20 Q. Okay. And at least, and, again, this may
21 have changed, but when we took your deposition, you
22 told us that less than 10 percent of the pediatric
23 films that you look at would be of newborns about as
24 old as Remi. So less than whatever number of
25 pediatric films you're doing, a small, small

1 percentage of those, less than 10 percent, would be
2 of neonates in the two to three years, correct?

3 A. Yes. However, this is over years and
4 years and years.

5 Q. Yeah. You get the benefit of longevity
6 here, right?

7 A. Yeah.

8 Q. And the -- when Ms. Lenivy was going
9 through the publications, the book chapters, the
10 presentations that you have on your CV that use the
11 words either "neonate" or "neonatal," I didn't see
12 anything more recent than like 2017.

13 Does that sound right?

14 A. I think there are things that are more
15 recent, but they may not use those words "neonatal."

16 Q. So that may touch on -- they may not
17 describe it as neonatal, but based on you being the
18 person who was involved in that research, you know
19 they may touch on those issues?

20 A. Yes.

21 Q. Okay. So what I thought from the neonatal
22 was some dealing with stroke. And then quite a bit
23 dealing with preterm babies, correct?

24 A. Yes.

25 Q. Okay. Not -- neither of those issues are

1 what we're talking about here with Remi, right?

2 A. True.

3 Q. Okay. And you would agree that you've not
4 published any literature that would support your
5 timing opinions here, correct?

6 A. That is true because generally what we do
7 nowadays, since the timing has sort of been worked
8 out, are things, to be honest with you, much more
9 sort of esoteric and academic.

10 Q. And I don't like either of those words,
11 but I think what you told us in your deposition is
12 because you've now considered these kind of timing
13 opinions in these HIE cases, based on neuroimaging to
14 be what you called "bread and butter."

15 Do you remember that?

16 A. Yes.

17 Q. Less esoteric.

18 A. Right, uh-huh.

19 Q. Okay. And at the time of your deposition,
20 you told us that doing medical legal work makes up
21 about 30 percent of your annual income.

22 Is that still true?

23 A. On average, about a third, yes.

24 Q. That's always good when I can cross things
25 out and get through them quickly.

1 I do want to talk just a little bit
2 about -- and Ms. Lenivy did a good job going through
3 a lot of what I was going to talk about -- your
4 contact by their firm in this.

5 we're going to start -- I'm going to hand
6 you --

7 MS. KAMYKOWSKI: If I may approach, Your
8 Honor?

9 THE COURT: You may.

10 Q. (By Ms. Kamykowski) So, Dr. Sze, I'll
11 just represent to you for the record, the bottom of
12 this first page, this is labeled Defense Exhibit
13 E5-E.

14 And I double-sided it because I like to
15 try to save trees if I can. But its total -- I think
16 40 pages? -- 40 pages of correspondence that were
17 emailed back and forth between Ms. Lenivy's office
18 and you throughout the course of your involvement in
19 this case.

20 40 sounds like a lot, but everybody knows
21 how emails work. You tag on them, and then every
22 time you print them, so it's not really that much.

23 But you would agree, then, if we start
24 with page...

25 A. we only have odd pages.

1 Q. Oh, no.

2 well, you know what? I have it -- or do
3 you want to look through this one really quickly, and
4 I can -- well, we'll pull it up. I apologize.

5 Apparently I don't know how to use my printer at 6:00
6 in the morning.

7 MS. KAMYKOWSKI: Unless you have an
8 objection, Ms. Lenivy, is it okay if I publish a few
9 pages of this?

10 MS. LENIVY: No, no objection.

11 MS. KAMYKOWSKI: Okay.

12 So, Justin if you could pull up Exhibit
13 E5-E.

14 Q. (By Ms. Kamykowski) And go to page 2 to
15 start with.

16 well, I'll keep going. Do you have page 2
17 in front of you, or do you only have pages 1 and 3?

18 A. No. I only have the odd pages. I don't
19 have the even pages.

20 Q. well, you remember when Ms. Lenivy was
21 asking you questions, that you were first contacted
22 in November of 2021.

23 Do you remember that?

24 A. Yes.

25 Q. Okay. And at that time --

1 MS. KAMYKOWSKI: Justin, do we have it or
2 no?

3 (Pause in proceedings.)

4 Q. (By Ms. Kamykowski) Okay. At that time,
5 you were asked, I believe, by --

6 (Pause in proceedings.)

7 Q. (By Ms. Kamykowski) You get half the
8 pages.

9 MS. KAMYKOWSKI: I'm sorry, Ms. Lenivy.

10 Q. (By Ms. Kamykowski) So if you look at
11 pages -- start at page 2, and then it goes on to page
12 3: First contacted November 15th.

13 Do you see that?

14 A. Yes, I do.

15 Q. Okay. And it was just a quick request:
16 would you have time to look at a case?

17 Is that right?

18 A. Yes.

19 Q. All right. And then if you look back at
20 page 1, you responded that same day, November 15th,
21 with a bunch of details for Ms. Lenivy. It sounds
22 like you have a pretty standard, as you said, process
23 for how you like to get materials, what to get things
24 started, correct?

25 A. Yes.

1 Q. Okay. And that included, because, as you
2 told the jury, that we're taking 3 millimeter slices,
3 these MRS have a lot of data that oftentimes can't be
4 shared on a DropBox or something like that. You have
5 to put them on a USB or a flash drive, get them
6 mailed physically to you, for you to then put them on
7 your computer, and read through them, correct?

8 A. Yes.

9 Q. So gave them some instructions --

10 MS. KAMYKOWSKI: Perfect. There you go.

11 If you could go to page 8, Justin.

12 Q. (By Ms. Kamykowski) First contacted by
13 email on November 15th. Then on November 16th, they
14 sent you a USB device.

15 See that?

16 A. Yes.

17 Q. With medical records and films for your
18 review?

19 A. Yes.

20 Q. From the very beginning, they sent you
21 some medical records that we talked about and films?

22 A. Yes.

23 Q. Okay. But you told us when you get that,
24 you'll have them all, but you would start with the
25 imaging.

1 A. Yes.

2 Q. Okay.

3 MS. KAMYKOWSKI: Can you go to page 11,
4 Justin?

5 Q. (By Ms. Kamykowski) And then Ms. Jenkins,
6 who's a paralegal at the time -- she still is a
7 paralegal for Ms. Gunn -- but she was at Simon Law
8 Firm. They asked if you could set up a time a couple
9 of weeks later just to talk about what you reviewed.

10 Do you see that?

11 A. Yes.

12 Q. All right. And then that's on December --
13 oh, sorry -- November 3rd, asking for dates on
14 Thursday, December 2nd, or Friday, December 3rd.

15 MS. KAMYKOWSKI: And scroll up to the top,
16 Justin.

17 Q. (By Ms. Kamykowski) And how is noon
18 Thursday?

19 So you were setting up a call with Ms.
20 Gunn, it appears, on December 2nd.

21 A. Okay.

22 Q. And then we get to your draft report,
23 which Ms. Lenivy spoke to you about.

24 MS. KAMYKOWSKI: If you could go to page
25 13. Next page, page 4.

1 Q. (By Ms. Kamykowski) That was on
2 December 4th. So you got the information in mid
3 November, reviewed some information, talked to
4 Ms. Gunn, and then prepared this multipage report,
5 correct?

6 A. Right.

7 Q. Okay. And we're going to go through that
8 in just a little bit.

9 Do you mind if I take my copy back?

10 A. Oh, sure, of course.

11 Q. The report is long, and I've highlighted
12 what I want to talk about, so we don't have to talk
13 about all of it --

14 A. Yep.

15 Q. -- okay?
16 Okay. So we start here with this report
17 on December 4th.

18 MS. KAMYKOWSKI: You go to the next page,
19 Justin, where it's a paragraph that begins with, "I
20 have reviewed."

21 Q. (By Ms. Kamykowski) So you tell Ms. Gunn
22 in your draft report that you knew you were preparing
23 because it was likely going to be utilized to be sent
24 to us as defense counsel to learn your opinions in
25 this case, correct?

A. Yes.

Q. So your statement is here, I have reviewed medical records from Mercy Health of Sarah Anyan, and medical records from Mercy Health and the imaging examination of Remington Anyan?

Do you see that?

A. Yes.

Q. Okay. So what went into the conclusion in this report, is not just your review of the imaging, but also your review of the medical records, correct?

A. Yes.

Q. Okay. And then if we go down further on this page, and we talked about this a little bit, the imaging exams. The first paragraph is the ultrasound.

Do you see that?

A. Yes.

Q. The initial imaging studies.

And you have: This study demonstrates echogenicity within normal limits, correct?

A. Yes.

Q. That's not quite accurate with what Dr. Applewhite said, is it? He noted that there was inconsistency in the echogenicities?

Do you remember that?

1 A. I think it actually is the same. My
2 interpretation as a radiologist of what he said is
3 that it is the same.

4 Q. okay.

5 A. what he is pointing out is that there's
6 some artifact, but he does not say that there is an
7 abnormality. so I think what he says, from my
8 interpretation as a radiologist, is the same.

9 Q. okay. I'm going to pull it up again real
10 quick.

11 A. okay.

12 Q. If you could look at page -- Exhibit A3,
13 page 1982, please?

14 And in the findings in that second
15 paragraph, and you went over this with Ms. Lenivy,
16 it says: Parenchymal echogenicity is a little
17 inconsistent attributed to technique and contact at
18 the fontanelle.

19 And the fontanelle is the soft spot,
20 right?

21 A. Right.

22 Q. And that would mean the ultrasound
23 technician, who was performing this, this doctor is
24 commenting on the fact that he's seeing inconsistent
25 gray/white, you know, contrast, the echogenicity, is

1 likely from how the technique and the way the probe
2 was put on Remi's head, right?

3 A. well, that's not exactly what he means,
4 but that is the general idea.

5 Q. okay. All right.

6 A. Uh-huh.

7 Q. Let's go back, then, to your report.

8 MS. KAMYKOWSKI: That same exhibit,
9 Justin, E5-E, at page 15. Thank you.

10 Q. (By Ms. Kamykowski) And then you go
11 through, and you walk through the MR.

12 I just wanted to make sure I understand.

13 These two paragraphs are your, Dr. Sze, I'm looking
14 at this, kind of like if you were in the darkroom
15 dictating a report, you're not comparing
16 Dr. Applewhite or Dr. Niebrugge, these are your
17 findings, right?

18 A. Yes.

19 Q. okay. And that's kind of what you showed
20 up in that PowerPoint, were your findings?

21 A. Yes.

22 Q. So if we look at close to the bottom of
23 your imaging examination report, the second to the
24 last sentence says: The ventricles are normal in
25 size, shape, and position for an infant of this age,

1 correct?

2 A. Right.

3 Q. So at the time that you reviewed this MR,
4 the ventricles were normal size?

5 A. Yes.

6 Q. Keep going through this quickly, if we
7 can, on to the next page, page 16.

8 Let me ask you about this report because
9 you've testified many times about the timing of HII,
10 hypoxic ischemic injuries, based on your specialty,
11 neuroradiology, correct?

12 A. Yes.

13 Q. But you've given lots of testimony about
14 the use of either ultrasounds or MRIs and how those
15 can correlate to the timing of an injury, right?

16 A. Yes.

17 Q. So are some of the parts of this report,
18 kind of template, or that you use repeated, but then
19 you narrow it to the facts of each case you review?

20 A. Sure.

21 Q. All right.

22 A. I mean, basically my report discussing the
23 acute profound and partial prolonged patterns are
24 general, but then I also, as you can see, have a
25 paragraph specifically about Remi.

1 Q. And that's because a lot of the time you
2 have found in your review, as an expert witness, the
3 mixed pattern of injury that includes partial
4 prolonged and acute profound, correct?

5 A. Yes. When it comes to these sorts of
6 cases where the damage is significant, that's a
7 common factor.

8 Q. All right. So looking at this paragraph
9 at the bottom, the timing of the abnormalities, you
10 include in here: Multiple aspects of an imaging exam
11 are useful in timing an injury. The timing of the
12 appearance of the finding is crucial.

13 And you agree with that. That's in your
14 report, and that, you stand by that?

15 A. Yes.

16 Q. Okay. Abnormalities are generally first
17 detected at certain time intervals.

18 And it sounds like we've talked about your
19 opinions on that, correct?

20 A. Right, uh-huh.

21 Q. And generally. I've heard you use
22 generally, approximately, in general --

23 A. Right.

24 Q. -- that we're talking about what your
25 opinions are, right?

1 A. Yes.

2 Q. Okay. And then it says: Other findings
3 disappear after the passage of a certain amount of
4 time. And you used the analogy -- I did actually
5 have a very bad burn on my finger when I was a baby.
6 I was thinking about that on my hand, but -- of a
7 burn, where you might have a little bit of redness on
8 your skin, but it's going to take awhile for that
9 blister to develop, and then longer for it to
10 subside.

11 A. Right.

12 Q. I like the analogy.

13 But that's kind of what you're talking
14 about here, right?

15 A. Right.

16 Q. And right. And then it says: when all of
17 the different components of the imaging examinations
18 are considered, the period in which all of the
19 criteria overlaps, is the most likely time of the
20 injury, right?

21 A. Yes.

22 Q. And this timing of abnormality portion in
23 your report, it says, when all of the different
24 components of the imaging examination. It doesn't
25 include clinical, additional clinical, data. You are

1 talking about timing based on images?

2 A. That is correct.

3 Q. All right. I think I might be done with
4 that.

5 Based solely on the MRI -- and I think
6 Mr. Perron asked you this -- your opinion on the
7 timing of the global injuries is that they occurred,
8 I think you said, within three days, right?

9 A. Approximately, yes.

10 Q. Of the time that the MR was taken.

11 And that's what gets you. If the MR is
12 taken 3:07 p.m. on 5/6 -- that actually isn't on
13 here. Let me make sure we get this accurate for
14 later. Hold on. Dueling easels is not fun, fun,
15 fun.

16 okay.

17 (Pause in proceedings.)

18 Q. (By Ms. Kamykowski) okay. So just
19 because I like to make sure we know what we're
20 talking about, I'm going to -- today is the 18th.

21 So if we talk about the MR being a window
22 of three days, we start at 5/6, that takes us back to
23 3:07 p.m. on 5/3, right?

24 A. Yes.

25 Q. I like Ms. Lenivy's drawings, so I'm going

1 to try to use it.

2 All right. And then I think you told Mr.
3 Perron, because we're not talking minutes to hours,
4 we're talking about days, is what ACOG says, and you
5 agree with that.

6 You said initially plus or minus 8 hours,
7 but that you work in 12-hour blocks.

8 A. Approximately, yes, uh-huh.

9 Q. Okay. So three days, plus or minus 12
10 hours.

11 Is that fair?

12 A. Yes.

13 Q. Okay. So that could take us as far back
14 as 3:00 a.m. -- oh, I'm going to have to rewrite
15 this -- so that would take us to 3:00 a.m. on 5/3.

16 A. Yes.

17 Q. And could take us forward, I understand
18 that, but I'm just looking at the range.

19 A. Sure.

20 Q. And those are the opinions that you hold
21 more likely than not in this case?

22 A. Yes. Plus the other opinions that I
23 voiced, yes.

24 Q. Okay. As far as the timing, right?

25 A. Yes.

1 Q. Regarding the 5-minute Apgar of 8.

2 In your deposition, you told us that in
3 your experience, based on the imaging findings that
4 you saw in this case, it would be very uncommon for a
5 baby to clinically receive a 5-minute Apgar of 8.

6 And, in fact, you believed it would be
7 more common to see something like an Apgar of 2.

8 Do you remember that?

9 A. Yes. As a generality, that is correct.

10 However, this is not my area of expertise. As I said
11 in my deposition, so I would defer to the other
12 people who I'm sure have discussed this at length.

13 Q. Okay. And so just to recap, Dr. Sze, and
14 I'll be done.

15 Your timing opinion relies heavily on the
16 normal head ultrasound, as you interpret it, being
17 done at 16 hours of life, right?

18 A. Right. But not solely.

19 Q. Oh, no. No, I didn't say solely.

20 A. Yeah.

21 Q. But it relies on that to help -- well,
22 we'll start -- we start with the MR says three days
23 plus or minus 12 hours, right?

24 A. Right. But I did refine it, as you
25 recall, both in deposition and earlier today.

1 Q. And then you said -- but then you said, if
2 the head ultrasound is accurate, or we can rely on it
3 to be considered in the calculation of timing, then
4 that's how you can narrow it to within that three-day
5 window, correct?

6 A. I'm sorry. Can you repeat the question?

7 Q. Sure. So we have -- we know that we've
8 got potentially as far as back as 3:07 a.m. on
9 May 3rd, based on the MRI.

10 But when you, then, take into your account
11 as a neuroradiologist in this case the head
12 ultrasound of normal at 16 hours, you say that helps
13 refine your window.

14 A. Oh, yes.

15 Q. Okay. I have no further questions.

16 A. Thank you so much.

17 THE COURT: Any redirect?

18 MS. LENIVY: Very briefly, Judge.

19 REDIRECT EXAMINATION

20 BY MS. LENIVY:

21 Q. Dr. Sze, I just want to make sure it's
22 clear for the jury. You utilized all the information
23 that was given to you in forming your opinions today,
24 correct?

25 A. Yes.

1 Q. And that's the MRI, as well as the head
2 ultrasound?

3 A. Right.

4 Q. Okay. And based on the puzzle pieces that
5 you were given, you were able to come up with that
6 approximate window of time, 8:40 a.m., to the point
7 of delivery, as to when the injury occurred, correct?

8 A. Yes.

9 Q. And I think I also heard you talk with Mr.
10 Perron about the fact that on the MRI, there was
11 sharpness?

12 A. Right.

13 Q. And that helped inform your opinion based
14 solely on the MRI as to the timing of this injury?

15 A. Yes. Because it usually gets a little
16 blurry as time goes on, yes.

17 Q. So the sharpness between the white matter
18 and the gray matter junction, that -- I guess how
19 clear it is to you, helped inform you that this
20 injury occurred closer to the time of delivery?

21 A. Yes.

22 Q. Thank you, Doctor.

23 MS. KAMYKOWSKI: Nothing further, Your
24 Honor.

25 THE COURT: May this witness be excused?

1 MS. LENIVY: Yes.

2 THE COURT: Thank you very much, Doctor.

3 THE WITNESS: Thank you very much.

4 THE COURT: All right, ladies and
5 gentlemen, based on the time, this is probably a good
6 time for us to take our lunch recess.

7 (A break was taken at 12:35 p.m., and the
8 jury was duly admonished. At 1:29 p.m., the
9 following proceedings were held in open court,
10 outside the presence of the jury:)

11 THE COURT: We are here outside the
12 presence of the jury. We've had a brief discussion
13 off the record with regards to scheduling, and I
14 think we're all in agreement that at this time, we
15 will formally allow the plaintiff to rest in front of
16 the jury, subject to the admission of exhibits, as
17 well as the Court issuing the rulings with regards to
18 the offer of proof.

19 We will then turn and allow the defense to
20 call their first live witness, and we'll hold off on
21 their motion for directed verdict until the break to
22 keep continuity with the jury. The Court knows that
23 neither party is waiving any rights with regards to
24 doing things in such fashion.

25 MS. SLATER: Let me add that we need to

1 read our joint stipulation, Judge, before we rest.

2 THE COURT: Got it.

3 MS. SLATER: So we won't just open and
4 rest.

5 THE COURT: Got it.

6 MS. SLATER: If we could have 90 seconds
7 for that.

8 MS. KAMYKOWSKI: Thank you, Judge.

9 THE COURT: Thank you.

10 MR. WILLMAN: Thank you.

11 (The proceedings stood in recess from
12 1:35 p.m. to 1:37 p.m., and the following proceedings
13 were held in open court, outside the presence of the
14 jury:)

15 THE COURT: So the Court is reviewing Dr.
16 Morgan Miller's deposition with regards to an
17 objection made on page 70, line 12, with regards to
18 objection to the lack of foundation as to the form of
19 the questions. The questions that were posed
20 previously were:

21 And Ms. Gunn did ask you, and you talked a
22 little bit about essentially the entirety of the
23 fetal heart strip tracing in this case, right?

24 Yes.

25 And you skipped through those?

yes.

Did you, at any point, as you sit here today, when you reviewed those strips -- I'm sorry -- those, have any concerns about what you saw in those strips?

That's when the objection came.

And the answer was no.

I am going to sustain the objection because I don't believe that her statement is sufficient to lay foundation, and the fact that she even acknowledged she only skimmed through those strips, which I don't know that she ever gives a definition of what that means in this context.

MS. KAMYKOWSKI: And for the record, Your Honor, she was handed a copy of what has been marked in this case as Plaintiffs' Exhibit 5 and asked to look through it from midnight to delivery and mark her decelerations. So it's the same strip that was marked, and she actually handwrote on during this deposition, is what was being referenced at page 70, lines 3 through the objection through lines --

MS. GUNN: Yes. But she didn't actually write on them and look at them until I asked her to do it after that question was asked, and she identifies late decels and other abnormalities,

including Cat II tracings. So...

THE COURT: I am going to sustain the objection.

MS. KAMYKOWSKI: Thank you, Judge. Thank you.

MS. GUNN: Thank you, Judge.

(At 1:41 p.m., the following proceedings were held in open court, in the presence of the jury:)

THE COURT: Go ahead and be seated, everyone.

On behalf of the plaintiffs?

MS. SLATER: Thank you, Your Honor.

Plaintiffs wish to read a joint stipulation. This is an agreement about the cost of Remi's medical care from today and in the past.

The stipulation regarding Remington Anyan's medical records and bills. This is Exhibit 700. The parties stipulate to the dollar amount of \$593,849.51 as the amount of medical charges incurred by Remi for the medical treatment rendered on and after May 4th, 2020.

The parties stipulate to the dollar amount of 360,644.91 as the amount paid or owed to Remi's medical care providers to satisfy the financial

obligation for the medical treatment rendered on or
after May 4th, 2020.

And with that, Your Honor, and on behalf
of the Anyans, plaintiffs rest, subject to entry of
exhibits on the record, please.

(Plaintiffs rest.)

THE COURT: Thank you.

On behalf of the defendants?

MS. KAMYKOWSKI: Just subject to, Judge,
what we had on the record before the jury came in,
some administrative matters, we're ready to proceed.

THE COURT: Very good. And I guess I'm
not sure which one is going first.

Mr. Perron, you may call your first
witness.

MR. PERRON: The defense calls Dr. Tekes.

THE COURT: Doctor, if you'll wheel on up.
Raise your right hand.

AYLIN TEKES, M.D.,
having been duly sworn, was examined, and testified
as follows:

DIRECT EXAMINATION

BY MR. PERRON:

Q. would you please state your name for the
record?

A. Aylin Tekes.

Q. Do you have a subspecialty in medicine?

A. I do.

Q. what?

A. Pediatric radiology and pediatric neuroradiology.

Q. And where do you work?

A. At the Johns Hopkins Hospital.

Q. Did my office send you images to review?

A. I was contacted back in 2023.

Q. Did you form opinions, after reviewing that imaging, about the timing of Remi's injury being a hypoxic injury?

A. I did.

Q. will you give those opinions to us to a reasonable degree of medical certainty?

A. I can.

Q. what are your ultimate opinions considering the totality of the imaging you reviewed?

A. My opinion is that the injury took place three to four days prior to MRI.

Q. Do you have a curriculum vitae or a CV that explains your background, education, training, and experience?

A. Yes.

1 MR. PERRON: If you want to put up F6-B.

2 Q. (By Mr. Perron) And just starting with
3 your education and training. From 1990 to 1996,
4 where did you go to medical school?

5 A. I went to medical school in Istanbul, in
6 University of Istanbul, Medical Faculty of Istanbul.

7 Q. And where did you go to pursue your
8 medical training and education?

9 A. Following my medical degree, I went to
10 Haydarpasa Training and Research Hospital and did my
11 radiology residency which finished in 2000. Then in
12 2001, I came to the Johns Hopkins Hospital to pursue
13 a research career initially. And I did a few years
14 of research, as you can see. Then later on, I
15 continued a clinical fellow because my desire to do
16 direct patient care became very clear to me.

17 So in 2005 to 2006, I did clinical
18 fellowship in pediatric radiology, followed by
19 clinical fellowship in neuroradiology in the same
20 institution.

21 Q. So if the jury is looking at this, they'll
22 see both a research fellowship, as well as a clinical
23 fellowship. And I think you just breezed through it.
24 And, again, for the benefit of the court reporter but
25 also for the jury, if you could attempt to speak

slowly --

A. Yes.

Q. -- so we can try to follow because this is all going to be relatively technical things, I assume?

A. Yes.

Q. So research versus a clinical fellowship.

A. Yes. I'll be happy to explain it.

And, first of all, let me ask if my English is clear to you guys and you understand me clearly.

Thank you.

Research fellowship focuses on doing research. And because I'm a radiologist, it was through imaging modalities. Initially I did research in MRI, focusing on the applications of MRI to the human body.

And then I switched my research focus to applications of MRI and other advanced neuroimaging techniques to the brain. So I did research fellowship in the adult and children's brains. And at this time, I studied functional MRI, in addition to cancer imaging and other MRI sequences, which came out with multiple publications, which can also be seen in my CV.

1 so I don't know if you want me to explain?

2 Q. Certainly. But research involves looking
3 at studies and reviews and things of that nature
4 that's not direct patient care?

5 A. Absolutely. There is absolutely no
6 patient care, and it's one of the emphasis. At the
7 time, I did not take state license or any board
8 certifications in the United States, so there was
9 absolutely no patient care.

10 And it does try to answer a particular
11 question to a particular disease. It doesn't give
12 you a broader overview, but it helps you give more
13 specific opinions about an entity or an imaging
14 sequence.

15 Q. But then you did pursue the clinical
16 fellowship, and that does involve direct patient
17 care?

18 A. Yes. Direct patient care under
19 supervision of physicians. And I did it at the Johns
20 Hopkins Hospital. There were multiple faculties and
21 programs that I was involved.

22 So the way it would work is that
23 throughout the day, I would be part of the patient
24 care, from telling the patient, you know, get on the
25 scanner, come off the scanner, generate a preliminary

1 report to be reviewed by my faculty, and then
2 discussing the imaging findings. And other faculty
3 members will finalize the exams.

4 I also do consultations or participate in
5 multidisciplinary conferences, again, under
6 supervision, which is the requirement of the training
7 program.

8 Q. okay. And just to help explain some of
9 the terms we're going to be talking about, within the
10 study of radiology, what -- what does that entail?

11 we'll start broad and go down --

12 A. Right.

13 Q. -- smaller.

14 what does the study of radiology entail?

15 A. So radiology is a specialty where imaging
16 techniques are used primarily to diagnose disease. I
17 don't directly see my patients, but I do see the
18 details of their body. In my case, it is, you know,
19 the central nervous system, the brain, head and neck,
20 and the spine.

21 Q. That -- that was my next question.

22 So neuroradiology is a subspecialty within
23 radiology focusing on, just as you said, the head,
24 the brain, the neck, and the spine?

25 A. Yes.

1 Q. Okay. Is pediatric neuroradiology
2 different than neuroradiology for adults?

3 A. Yes. Every aspect of pediatric imaging is
4 different. And the way it's typically put is that
5 children are not small adults. It's not just looking
6 at the smaller size of the brain. It's a
7 fundamentally different state of brain.

8 It's immature yet. It has not fully
9 developed yet. It didn't hit all the milestones that
10 people like to see in the brain yet. And one should
11 be familiar with all those stages just so they don't
12 make overcalls or under calls in their reporting.

13 Q. And even within pediatric neuroradiology,
14 is the study of a newborn brain or a neonatal brain a
15 little bit different than maybe an 8-year-old or a
16 15-year-old's brain.

17 A. Very much so. Very much so. It is
18 distinctively different. The newborn is the time
19 period where all those maturation stages and other
20 developmental stages has not yet been completed. And
21 after school age, things become a little bit more
22 similar to the adult brain, yet, still different.

23 Just to briefly summarize how different
24 they are. You know, one aspect is how different they
25 are developmentally. But also the disease processes,

1 how they evolve, are quite different. Differential
2 diagnoses are quite different.

3 Now, you see, just to, you know, give you
4 a general example. A brain tumor in a 4-year-old,
5 differential diagnoses you are going to generate are
6 significantly different than a 40-year-old.

7 Q. So at Johns Hopkins, within the Department
8 of Neuroradiology, is a subpart of pediatric
9 neuroradiology.

10 what's your role there?

11 A. I am the section chief of pediatric
12 neuroradiology.

13 Q. So within that subdepartment at St.
14 John's -- or at Johns Hopkins, you are sort of at the
15 top of the pyramid, is that fair?

16 A. Yes.

17 Q. Okay. Do you also work in the NICU,
18 within your capacity as a neuroradiologist?

19 A. Yes. One of my roles is that I am the
20 codirector of our neonatal care intensive care unit,
21 specializing in neuroimaging programs. So on a
22 regular basis, I do review babies' brain MRIs. There
23 I am the primary radiologist generating the report or
24 in the consultation basis or as a teaching basis. So
25 these are different conferences that I hold with my

1 colleagues to discuss whichever baby is in the NICU
2 with a brain problem.

3 Q. Now, beyond your clinical work, do you
4 also teach at Johns Hopkins?

5 A. I do.

6 Q. And in what department do you teach in?

7 A. I do primarily teach the radiology

8 residency program which hosts over 40 residents

9 annually, in different, you know, levels.

10 we also have a neuroradiology fellowship

11 program which hosts more than ten. Ten fellows a

12 year. I also provide teaching to neurology

13 department and the neonatology department, if

14 requested, as well as the pediatric intensive care

15 unit.

16 Q. Your position as the director of pediatric

17 neurology, how long have you had that position?

18 A. Director of pediatric neuroradiology,

19 since 2022.

20 Q. And before that, what was your position

21 within Johns Hopkins?

22 A. Prior to this, I was the division director

23 of pediatric radiology, including body and

24 neuroimaging. So I was running both of them

25 simultaneously since 2018. So 2018 to 2022, I was

1 doing all pediatric imaging, '22, current pediatric
2 neuroradiologist.

3 Q. What imaging did you review to form your
4 opinions in this case?

5 A. It offered sound and brain MRI.

6 Q. These are the same imaging we've been
7 talking about just early today with Dr. Sze?

8 A. Yes.

9 Q. Similar to Dr. Sze, did you also prepare a
10 PowerPoint to explain some your opinions?

11 A. I did.

12 MR. PERRON: Justin, you want to put up
13 F6-H.

14 Q. (By Mr. Perron) Do you have a clicker
15 there?

16 A. I do. Oh, yeah, it works.

17 Q. You and Dr. Sze must have gone to the same
18 school of PowerPoint.

19 So we've got a title page here, and then
20 the next page, Doctor.

21 I think if you skip ahead, though, to
22 slide 5, do you have some pictures of general anatomy
23 and landmarks. Okay.

24 A. This one?

25 Q. Yes. So, Doctor, take us through why did

1 you include this in your slide? why are these
2 important? what are we looking at?

3 A. I just wanted to give a general
4 orientation to the brain anatomy. Dr. Sze did a
5 great job to describe different parts of the brain,
6 so I'm not going to elaborate too much about them.
7 But in the context of type of hypoxic ischemic
8 encephalopathy or hypoxic ischemic injury, we look at
9 the entire brain.

10 And we like to see the area of the basal
11 ganglia and thalamus particularly, as well as the
12 entirety of the external part, the cortex, and the
13 more internal areas, the white matter.

14 In this particular slide, the top two
15 slides, these are from the diffusion made image.
16 These are the diffusion tracer images. I am
17 highlighting the high signal of the DWI, pointing out
18 the area of the cortical spinal tract, which is a
19 very important nerve bundle relevant to the motor
20 function in the human body.

21 And also pointing out the areas of the
22 basal ganglia and thalamus distinctively which are
23 also injured and the entirety of the external cortex
24 and the white matter.

25 The bottom two slide is images that

1 demonstrate to us the T2 weighted images. As Dr. Sze
2 puts, you know, different sequences are sort of
3 different, you know, filters, and they give different
4 things to highlight.

5 On T2 weighted imaging, what you see as
6 bright is the fluid. So it's the central portion of
7 the brain beside the areas of the ventricles, and I
8 did a little drawing here to highlight the areas of
9 the ventricles on the higher slide.

10 The internal content of the ventricles are
11 bright on T2 because that's the water, they give that
12 signal. And as you can see, the entirety of the
13 brain is very bright on T2. This is because the
14 cerebral edema.

15 And if you look at the distinction between
16 gray matter and white matter, the cortical T2 signal
17 is also increased. And the gray/white matter
18 differentiation is blurred. This is typically seen
19 in the context of acute edema.

20 Q. To sort of start small and take baby steps
21 back up to the heart of your opinions, are you
22 familiar with hypoxic injuries to newborns and how
23 they appear on imaging?

24 A. I am.

25 Q. Have you researched HIE in newborns, even

1 outside of your clinical practice?

2 A. I have.

3 MR. PERRON: Justin, if you want to go to
4 XXV, page 15. Page 15. And, Justin, if you want to
5 highlight this box here and blow it up for me.

6 Q. (By Mr. Perron) Doctor, do you have a
7 part of your CV where you discuss your research
8 activities?

9 A. Yes.

10 Q. Okay. What do you describe as the focus
11 of your research?

12 A. Advanced neonatal neuroimaging applied to
13 numerous pathologies, particularly hypoxic ischemia
14 encephalopathy of the newborn. And this can be found
15 in public search. If you put my last name and HIE,
16 you will find multiple articles demonstrating
17 publications.

18 Also, optimizing advanced neuroimaging
19 protocols in pediatric neuroradiology and developing
20 fast brain MR protocols. This is important because
21 access to medical care is a problem in general,
22 particularly problematic for children.

23 In adults, especially a person who is able
24 to walk, talk, get on and get off the table
25 independently, and who can take themselves to the

1 hospital is challenging enough. But if you're a baby
2 or a child, somebody needs to help you and advocate
3 for your imaging.

4 so children usually need to hold still,
5 which is a harder task for them to do, even if they
6 are baby, a toddler, or a preschool age, you know,
7 child. So we try to optimize the imaging protocols
8 to run them faster so we don't keep them in the
9 scanner too long.

10 Q. All right. Just to highlight the number
11 one thing you put on here is advanced neonatal
12 neuroimaging, specifically applied to HIE, which is
13 what we've been talking about for a week and a half
14 here in trial, but also this morning with Dr. Sze and
15 yourself, correct?

16 A. Yes.

17 Q. So the number one focus of your research
18 is these specific topics we're talking about today.

19 A. Yes.

20 Q. Okay. What's grant funding? What kind
21 of -- what does that mean in the field of research
22 when you get grants or funding for research?

23 A. So for researchers, whether they are, you
24 know, physicians, those people with Ph.Ds, or any
25 other degree, focused around research, there needs to

1 be money to support their research.

2 And there are numerous government agencies
3 or private agencies who can provide this monetary
4 support, granted that you have a reasonable, you
5 know, case that they want to support your cause, etc.

6 So in my CV, you will see --

7 Q. Let me pause right there.

8 MR. PERRON: Justin, if you want to put up
9 on page 11. And then first blow up -- yep. This
10 right here, "Precision Medicine for Neonatal HIE."

11 Q. (By Mr. Perron) Okay. So the topic of
12 this, and I'm going to shorten it a little bit,

13 "Precision Medicine for Neonatal HIE: Combined
14 Neuroimaging Clinical Approach." And then some other
15 science bits that I'm not going to be able to
16 understand.

17 So, Doctor, this is funding that you, as
18 part of a group, received from the government to do
19 research on HIE, but specifically neuroimaging to
20 study HIE?

21 A. Correct.

22 Q. Okay.

23 MR. PERRON: And, then, Justin, if you
24 want to scan out, and then just below this, this next
25 one went from -- if you want to blow this one up and

expand that.

Q. (By Mr. Perron) From 2011 to 2012, was this another study that you participated that was funded by the government?

A. Yes.

Q. Okay. And what was this focusing on?

A. So the funding in that area is this item by the Thomas Wilson Sanitarium Foundation for Children's Research. So I just want to specify that that's the origin of the grant support. So in those babies, we looked at the brain MRI and other measures to see how we could identify injuries early enough or what else could be done in addition to the cooling protocols during their care.

Q. Doctor, to step back for a minute. Are you able to review MRI and other imaging of a neonatal newborn and determine the age of a hypoxic injury, at least within a window of time?

A. I can.

MR. PERRON: If you want to put back up the PowerPoint F6-H.

Q. (By Mr. Perron) And, Doctor, slide 3, I think, is the beginning of describing some of your opinions?

A. Yes. So in the earlier slide, we looked

1 at the diffusion weighted imaging and the T2 weighted
2 imaging.

3 On this one, what we're looking at is a
4 series of diffusion weighted imaging starting from
5 the top. And it is axial slices, think of the brain
6 cut as the bread. So we're starting from the upper
7 level, and I'm going lower and lower. So took
8 representative areas to cover the entire range of
9 these four images.

10 In this higher one, you do see the area of
11 the central gyrus. And in the lower one, you do see
12 the area of the cortical spinal track. Coming down,
13 you do see the area of the basal ganglia and
14 thalamus. And then lower down, you come to the area
15 of the brain stem and the cerebellum.

16 what you see on the diffusion weighted
17 imaging as bright, should lose signal on the ADC as
18 dark. So we can call this area restricted diffusion.

19 And what restricted diffusion means is
20 that the brain has acute ischemic injury. And in
21 this brain, as the other, you know, testimonies
22 highlighted, there is global injury.

23 This affected the entirety of the
24 supratentorial brain. I intentionally didn't go down
25 into the cerebellum, but in this patient, the

1 cerebellum is spared, which is very typical for any
2 HIE patient. The lower brain, the smaller brain, as
3 it's named usually below the tentorial level. So
4 that part is uninjured, but the supratentorial brain,
5 in entirety, has been injured in this case.

6 Q. What would you -- when you look at these
7 images, are you able to tell the age of the injury,
8 at least within a window of time, using these images?

9 A. Yes. And my impression is that this is
10 about three to four days in this window. And the
11 reason being is in a patient with global hypoxic
12 ischemic brain injury, the entirety of the brain has
13 the injury.

14 But at about three to four days from the
15 insult, you do see the diffusion restriction hugging
16 over the cortex, primarily going over the cortex
17 immediately, but the subcortical white matter areas
18 is immediately hugging the cortex. This is a typical
19 thing that we see about three to four days.

20 And also the ventricular systems is not
21 fully effaced, so when the brain is edematous and
22 swollen, the ventricular system, which is in the
23 central part of the brain, gets pushed in by the
24 brain parenchyma.

25 In this case, the ventricular system is

1 not fully effaced. There is reasonable cerebral
2 spinal fluid within the ventricular system, which
3 supports the idea that the edema is probably about
4 three to four days.

5 Q. So are there specific things that you see
6 on here that help you age the injury to three to four
7 days?

8 A. This and also the other T2 weighted images
9 that I have I think on the next slide.

10 Q. Right. So there are, just looking at this
11 slide, there are things that you see here that
12 typically do not tend to show up on MRI until that
13 hypoxic injury has aged three to four days.

14 A. Yes.

15 Q. Okay. We took a look at your research.
16 And have you also published specifically on HIE and
17 neuroradiology looking at HIE?

18 A. Yes.

19 MR. PERRON: Justin, if you want to pull
20 up FX-B. And I had a bunch of them listed, and we're
21 not going to go over all of them. FX-B, Page 3, line
22 23. What do I keep saying? That's weird. F6-B,
23 page 3, line 23. And, Justin, could you just blow up
24 that line?

25 Q. (By Mr. Perron) Doctor, what is -- what

1 is this study?

2 A. So this was one of the studies that came
3 off of this grant work that we just reviewed, what
4 we looked at here was the correlation between brain
5 autoregulation and imaging and to see how
6 autoregulation of the brain corresponds with our
7 imaging findings.

8 MR. PERRON: And, Justin, if you want to
9 go to line 31 of that same page. Blow that up, as
10 well. Is there any way to raise that up on the
11 screen?

12 Q. (By Mr. Perron) So, yeah, the name of
13 this if I'm reading it correctly...

14 A. Yeah.

15 Q. Does this also look at signs of neonates
16 with perinatal HIE?

17 A. Correct.

18 Q. And perinatal means what?

19 A. Around birth.

20 Q. Okay. So you've written specifically
21 about HIE that occurs right around birth and what
22 that looks like on imaging?

23 A. Yes.

24 Q. Okay.

25 MR. PERRON: You can take that down.

1 Q. (By Mr. Perron) Going back to your
2 PowerPoint, you've got one more slide that you show
3 some of the signs of the age of the injury.

4 So what, looking at these slides, if you
5 can explain to the jury first what we're looking at
6 and how this helps you age the injury.

7 A. So this is the T2 weighted image. And the
8 purpose of this particular sequence is highlight
9 whatever has water in it. And cerebral spinal fluid
10 is the fluid that, you know, travels in the central
11 and peripheral portions of the brain.

12 And you can see that this area is bright.
13 This is normal for fluid to adhere. What this shows
14 is how bright the rest of the brain parenchyma looks.

15 And in a normal infant, the external part,
16 the cortex, should be a darker gray. And the
17 internal part, the white matter, it should look less
18 bright than this, meaning a greater gray/white matter
19 distinction. In this one, the distinction is
20 blurred, due to the generalized cytotoxic brain
21 edema.

22 Q. So what would it look like instead if this
23 were just a one- or two-day-old injury?

24 A. In this infant, if the infant had an MRI,
25 on this MRI, probably the entire ventricular system

1 would be completely effaced.

2 Q. Okay. And so instead of being just two or
3 one days, again, you've said it a number of times,
4 what does this tell you specifically about the age of
5 this injury relative to the date of the MRI?

6 A. So in regards to the injury assessments,
7 you know, with age, we incorporate diffusion and T2
8 and T1 simultaneously.

9 In the light of what I had shown on
10 diffusion, with restricted diffusion globally in the
11 brain, at this time hugging to the subcortical white
12 matter, plus this generalized, you know, brain edema,
13 goes for three to four days.

14 Q. Okay. So this matches the time period
15 when you looked at the other signs from the previous
16 slide?

17 A. Yes.

18 Q. They're in concert with what they're
19 telling you in terms of the age?

20 A. Yes.

21 Q. They're sort of in agreement with each
22 other?

23 A. Yes.

24 Q. Okay. So just to put a date on it again.
25 If the MRI was on May 6th, if three days prior to

1 May 6th, three to four days prior to May 6th, that
2 would put the timing of the injury, if you are
3 correct, somewhere between May 2 and May 3?

4 A. Yes.

5 Q. In your -- we talked extensively about
6 your research. And, again, for the sake of the jury
7 and maybe even for myself, I won't go through every
8 single one, but about how many articles, if you could
9 estimate, have you personally been listed as one of
10 the authors about a text that dealt directly with
11 pediatric HIE and neuroimaging?

12 A. When you do a public search, put my last
13 name and word "HIE," it pulls at least 13 articles.
14 It doesn't mean it's limited to 13 only. If you do
15 the search with the key words used in the articles,
16 when the article was published, there are more
17 articles that talk about HIE. But to give a very
18 short answer to it, 13.

19 Q. Okay. We talked about your publication
20 and your research and your clinical practice.

21 Are you also called upon sometimes to
22 review neuroradiology of neonates or newborns?

23 A. Yes.

24 Q. Just to start general and get more
25 specific. If you can give even a rough estimate,

1 over the course of your career, how many imaging
2 studies of just neonatal newborns, do you think
3 you've probably reviewed?

4 A. Hundreds and hundreds.

5 Q. Now, if you limited it to just neonatal
6 imaging studies of suspected HIE.

7 A. It will still be in the over hundreds.

8 Q. What is your role as a neuro -- pediatric
9 neuroradiologist in cases where there's a suspected
10 HIE?

11 A. My role is to generate reports of both
12 imaging, either it's a head ultrasound or a brain
13 MRI. My role is also provide consultations if
14 another colleague read, but they're seeking my
15 opinions. Also do multidisciplinary conferences and
16 discuss the patient in a multidisciplinary format
17 with a neonatal intensive care unit specialist,
18 neurologist, and developmental care specialists down
19 the road if, you know, if future care needs to be
20 established.

21 Q. Do you have an opinion, more likely than
22 not, to a reasonable degree of medical certainty,
23 whether the hypoxic injury you observed there, was
24 one injury causing both partial prolonged and acute
25 types of damage, or whether it is more likely that

1 there were two injuries at distinct moments in time?

2 A. One injury.

3 Q. And why do you believe that to be the
4 case?

5 A. The injury evolves over time. So what you
6 find on imaging has to do with what the injury is,
7 but also it has to do with when you perform imaging. If
8 you perform imaging within 6 hours of a severe
9 insult, you may be able to see the level of basal
10 ganglia and thalamus, the more central portion of the
11 brain.

12 If you perform it later in a day or two
13 days benchmark, you may be able to see more globally.
14 It doesn't mean to say that two different, you know,
15 things happened at two different times. It just
16 takes time for different parts of the brain to show
17 up on the, you know, brain MRI.

18 Q. You heard Dr. Sze talk about the sharpness
19 that he sees on the T2 imaging, and that's how he
20 believes he can narrow it even further than the
21 three-day window that he gave in his report.

22 Do you see sharpness on the T2 imaging,
23 such that you can narrow the window down even further
24 than three days from the MRI?

25 A. On the T2 weighted images like what is

1 displayed here, it is the opposite. It's blurry. It
2 is not sharp. It is the opposite. The gray and
3 white matter distinction is blurry in this child,
4 which is what puts the injury to the three to four
5 days. If he meant the sharpness at the level of the
6 subcortical white matter on diffusion weighted
7 imaging rather than T2, this, again, puts it in the
8 three to four day window.

9 Q. Over the course of your education and
10 training, research, and clinical practice in the
11 field of pediatric neuroradiology, have you become
12 familiar with the methods of identifying the age and
13 timing of a neonatal hypoxic injury on the imaging?

14 A. Yes.

15 Q. Have you applied that method to your
16 review of the imaging in this case?

17 A. Yes, ma'am.

18 Q. Have you formed an opinion about the
19 timing of the hypoxic injury, more likely than not,
20 but to a reasonable degree of medical certainty?

21 A. Yes.

22 Q. Based on the totality of the MRI imaging
23 first, how many days old, from the date of MRI, is
24 this hypoxic injury?

25 A. Three to four days.

1 Q. Dr. Sze testified that he can use a normal
2 ultrasound to narrow that window of time to just a
3 24-hour period.

4 Do you agree with his opinion specific to
5 that matter?

6 A. I don't.

7 Q. Generally, in your experience from both
8 clinical practice, your research, and your published
9 work, what is the value of an abnormal ultrasound to
10 tell us about the timing of a hypoxic injury?

11 And I'll -- I'll, for the benefit of the
12 jury, abnormal means you do see something on the
13 ultrasound. If you do see something on the
14 ultrasound, what kind of value does that give you as
15 the clinician?

16 A. So as it has been previously mentioned,
17 ultrasound can be performed at the bedside. That's
18 why it is so precious for the neonatal intensive care
19 unit. These babies are unstable. You go to the
20 bedside and do it right there, you know, for the
21 baby. The baby doesn't have to travel outside of the
22 unit.

23 If you see an abnormal finding, the
24 positive predictive value of that is high. It is
25 still not considered to be as good as MRI, but an

1 abnormal head ultrasound finding can be predictive of
2 injury or more injuries to be found on MRI.

3 Q. Okay. Let's take the reverse of that. So
4 if you do see something, it has a high predictive
5 value. Let's take the reverse. What if you don't
6 see anything? What kind of predictive value does
7 that have in your clinical experience, training, and
8 understanding of the research and publications?

9 A. It doesn't have much value at that point.
10 It can still -- the brain can still be injured.
11 Ultrasound is not as sensitive or specific as MRI to
12 pick up injuries. It's just the nature of it. But
13 the predictive value is not to be considered.

14 MR. PERRON: Just for a moment, if we
15 could put up Plaintiffs' Exhibit 357, slide 42, which
16 is Dr. Sze's PowerPoint, if I've got my numbers
17 right.

18 Justin, if you want to first blow up this
19 heading. Dr. Sze wanted to make sure, when I was
20 cross examining him on this, he wanted to make sure
21 that I had that heading right.

22 Q. (By Mr. Perron) Doctor, if you could just
23 focus on this for a minute.

24 So what this is trying to tell us is what?
25 This is what the textbook that Dr. Sze, believes

1 supports his opinions that the finding and effective
2 times for imaging technique, perinatal HII.

3 So, again, we're talking about imaging
4 studies of hypoxic injuries in newborns, right?

5 A. Uh-huh.

6 Q. Okay. So the first line is about
7 ultrasounds. An increased echogenicity. What are
8 they talking about with that? That's what we're
9 talking about, is the findings that you can actually
10 see something, an abnormal ultrasound?

11 A. Uh-uh.

12 Q. You have to say yes or no for the benefit
13 of the court reporter.

14 A. Yes.

15 Q. Okay. And what does it say? Does it say
16 24 hours or less?

17 A. It doesn't.

18 Q. Okay. What does it say instead?

19 A. It says two to ten days.

20 Q. Okay. Is there a -- is there a comment
21 where the textbook provides additional information to
22 the clinician or the lowly attorney who might be
23 trying to decipher this about the value of these
24 ultrasounds?

25 A. Yes.

Q. what does it say?

A. It says: Poor assessment of deep structures and cerebral complexities which are highly critical for HIE assessment.

Q. okay. when it says "poor assessment of deep structures," what is that trying to convey to the clinician when they're trying to determine the value of this ultrasound?

A. Deep structures are the basal ganglia and thalamus, as we looked at earlier. So what this says is on the head ultrasound, the gray matter, the deep gray matter areas, and the cerebral complexities are poorly evaluated on the head ultrasound.

Q. okay.

A. Far more limited to MRIs, basically.

Q. so I think it's relatively clear, but for my benefit just in case I'm wrong, this textbook that Dr. Sze presented as the foundation for his opinion, does this textbook assessment of when HIE shows up on ultrasound, does that support Dr. Sze's opinion that a normal ultrasound means it's got to be a 24-hour injury?

A. It contradicts.

MR. PERRON: You can take that down.

Q. (By Mr. Perron) Beside this textbook,

1 have you, Dr. Tekes, published articles about using
2 ultrasounds to examine and look into suspected HIE?

3 A. I have.

4 Q. (By Mr. Perron) okay. All right.

5 MR. PERRON: If you would put up F6-I,
6 Justin. And then blow up the headline for us first.

7 Q. (By Mr. Perron) So if I'm reading this
8 correctly: "Head Ultrasound in Neonatal HII and Its
9 Mimickers for Clinicians: A Review of the Patterns
10 of Injury and the Evolution of Findings Over Time."

11 Doctor, were you endeavoring to describe
12 in this publication, the use of ultrasounds in
13 diagnosing or attempting to time or age hypoxic
14 injuries?

15 A. Yes.

16 MR. PERRON: And on that same first page,
17 Justin, the line from abstract. Starting right here.

18 Q. (By Mr. Perron) Right here. "US" is
19 ultrasound?

20 A. Yes.

21 Q. okay. Ultrasound has become increasingly
22 effective in determining the pattern of timing and
23 extent of injury in HII, as well as differentiating
24 findings from a host of diagnoses.

25 You -- you agree with that, that's

1 correct?

2 A. I do.

3 Q. Okay. Later, on page 8, there's a
4 subsection of your publication that you highlighted:

5 "Reliability and Predictive values of Ultrasound
6 Findings." Again, is this addressing the specific
7 question we're talking about this afternoon, the
8 reliability of ultrasounds, when you're trying to
9 make diagnostic opinions and timing opinions?

10 A. Yes.

11 Q. Is this what this paragraph is getting at?

12 A. Yes.

13 Q. Okay. So you and your coauthors write:
14 ultrasound has value as a screening tool in infants'
15 HIE as outlined above. However, it's not uncommon
16 that significant abnormalities are not detected until
17 24 to 96 hours after birth. Okay.

18 Does that time line match more or less
19 what Dr. Sze's textbook was trying to describe about
20 when these echogenicity signs begin to show up?

21 A. It doesn't. He thinks that 24 -- I mean,
22 the way he put it, the way I heard it, 24 hours is
23 sort of the benchmark. Like if the head ultrasound
24 was normal within 24 hours, then the brain is
25 presumed to have injury.

1 Q. Okay. From your own studies, how long can
2 it take for an HIE to show up on an ultrasound?

3 A. It can take up to 96 hours.

4 Q. Even an HIE, like the one we've been
5 talking about that you see on Remi's imaging, that
6 can take more than just 24 hours to show up on an
7 ultrasound?

8 A. It can.

9 Q. The next sentence: Thus, HII may not be
10 immediately apparent when the predictive value of a
11 normal head ultrasound in this early phase is low.

12 And, again, I think that's relatively
13 clear, but what are you trying to say here about how
14 significant a normal ultrasound is if you're trying
15 to retrospectively judge the age or the timing of an
16 injury?

17 A. It goes to say if you see a normal head
18 ultrasound for the first day, second day, or a third
19 day, it doesn't rule out HIE injury in an infant.

20 Q. Okay. So you could have a normal
21 ultrasound on Day 1, day 2, or day 3, and it just
22 might be missing that HIE?

23 A. Correct.

24 Q. Okay. What you wrote here, I'm going to
25 look and see what this date is.

1 This was published -- well, maybe we'll go
2 back. I don't want you guys to take my word for it.

3 MR. PERRON: Justin, can you go back to
4 page 1 and zoom in on the date at the very top.

5 Q. (By Mr. Perron) Okay. When was this
6 published?

7 A. In 2018.

8 Q. 2018, okay. This article that you wrote
9 two years before any event occurred in this lawsuit,
10 and several years before you were ever contacted by
11 us, what you published in 2018, is that consistent
12 with your opinions here about the value of the normal
13 ultrasound in judging the age and timing?

14 A. Yes.

15 Q. Okay. Does the ultrasound here at
16 16 hours of life have a high predictive value for
17 timing an age of the HIE?

18 A. Can you ask again?

19 Q. Does the ultrasound here at 16 hours of
20 life have a high predictive value?

21 A. No, it doesn't.

22 Q. Okay. Does technique matter whether the
23 ultrasound provides an optimal view of the brain to
24 detect HIE?

25 A. It does.

1 MR. PERRON: Justin, if you want to go to
2 page 2 of that same publication. Highlight -- blow
3 up and highlight this right here.

4 Q. (By Mr. Perron) with optimal technique
5 and view, ultrasounds can delineate multiple focal
6 intracranial technology.

7 A. Uh-huh.

8 Q. So if the technique is less than optimal,
9 can that further inhibit an ultrasound from giving
10 you the best view of a potential hypoxic injury?

11 A. Yes.

12 Q. And is that the same thing that you said
13 in your publication in 2018?

14 A. Yes.

15 MR. PERRON: Justin, I think if we flip
16 back, and the jury has seen this already. Maybe we
17 don't have to put it up again.

18 Q. (By Mr. Perron) But when you were sitting
19 back there watching Dr. Sze's testimony, they put the
20 ultrasound report up.

21 MR. PERRON: Justin, that's A3, page 1984.

22 Q. (By Mr. Perron) The findings in the
23 report, how did they describe the technique? Does
24 the reading radiologist report in his finding any
25 observations pertinent to technique and optimal view?

1 THE WITNESS: If you could enlarge --

2 MR. PERRON: The next page down, I'm
3 sorry, Justin.

4 THE WITNESS: okay. That's good. If you
5 could come down a little bit. Thank you.

6 A. So in his -- it is in the description, in
7 the second paragraph, in the body of the report,
8 parenchymal echogenicity is a little bit inconsistent
9 attributed to technique and contact in the
10 fontanelle.

11 So when Dr. Sze was describing ultrasound
12 to be performed at the opening of the head, because
13 the ultrasound waves cannot transmit through the
14 bone.

15 The other limitation, in addition to the
16 bone, is inadequate contact. And what this means is
17 ultrasound also does not travel through air. You
18 need to eliminate the air between the probe and the
19 head. so these days usually gels are used. It
20 depends on if you get an ultrasound, you would know.
21 It feels kind of, you know, cold, but, you know, they
22 got to do this to avoid the air between the probe and
23 the contact point in your body.

24 So the contact in this patient had already
25 been described as inadequate by the reading

1 radiologist. They refer to their technique and
2 contact at the fontanelle. And the inconsistency of
3 the parenchymal echogenicity is attributable to the
4 poor technique they've been utilizing.

5 Q. (By Mr. Perron) Now, sitting here today,
6 the question we're asking is the age and timing of
7 the injury.

8 So in terms of that question --

9 A. Uh-huh.

10 Q. -- does this describe technique issue,
11 inhibit or undermine the reliability of this
12 ultrasound, for the purposes of what we're asking the
13 question today?

14 A. Absolutely, yes.

15 Q. Okay. Now, setting aside the question
16 we're asking today, that's not the same question you
17 were asking on May 5, when they took the ultrasound.

18 Is that correct?

19 MS. GUNN: Your Honor, I'll object. Calls
20 for speculation.

21 Q. (By Mr. Perron) Doctor, are you familiar
22 with the reasons for why these ultrasounds get
23 ordered around this time period for suspected HIE and
24 then other issues?

25 A. In the report, it says suspected seizure.

1 Q. okay. So do you have an understanding,
2 based on your training and experience and review of
3 the medical records, why they ordered this
4 ultrasound?

5 A. Yes.

6 Q. Okay. Even though this might not have
7 direct bearing on the question we're asking today
8 about the age and timing, does this ultrasound still
9 provide the clinicians some information that they
10 felt was valuable?

11 A. Absolutely.

12 Q. Would they or anyone just throw it away
13 because it didn't help us in the jury box 5 years
14 later to decide the age of the injury?

15 A. It does help some other things, which the
16 reading radiologist got into explaining. Because
17 there are no definite focal parenchymal lesions or no
18 evidence of midline anomalies.

19 So he says there is nothing in the midline
20 of the brain that could cause a shift in the brain.
21 It doesn't look like there is a large hemorrhage or
22 anything. But the assessment also doesn't refer to
23 anything to do with HIE. In fact, at the end of
24 their conclusion, they talk about subependymal cyst,
25 which may be secondary to resolving germinal matrix

hemorrhage.

But, at the end of the day, they don't also call it a so-called "normal" head ultrasound either.

Q. In retrospect, knowing how long it could take for HIE to appear on ultrasound, does this normal study tell us anything about the timing of the injury?

A. Unfortunately, it doesn't help.

Q. What is the gold standard for assessing the age of an HIE?

A. Brain MRI.

Q. Do all cases of HIE have a known cause, where you can put your finger and point and say, this is what caused this HIE?

A. No.

Q. In your role as director of pediatric neuroradiology, do providers or neonatologists or pediatricians rely on your review to help guide their decisionmaking?

A. Yes.

Q. You have published on HIE?

A. I have.

Q. You've reviewed a number of MRI in newborns?

1 A. I have.

2 Q. Do you yourself, when you review an
3 ultrasound for a neonatal or a newborn, do you write
4 the ultrasound report yourself?

5 A. I do.

6 Q. And what difference does that make if you
7 just review it versus like if you are the radiologist
8 that actually writes the report?

9 A. I think that's where the expertise really
10 kicks in. We can claim expertise on things that we
11 directly performed as part of our practice. I do
12 review a lot of things as part of my medical
13 practice, but I can't claim expertise on them. Just
14 because I'm reviewing the medical records, doesn't
15 make me an IC specialist or a neurologist.

16 But I do generate these reports one-on-one
17 by myself. I do a little bit of ultrasound teaching
18 in my institutions, as well as some brain MRI
19 teaching. So doing something hands-on provides the
20 direct experience which is necessary for expertise.

21 Q. Do you believe you can say, to a
22 reasonable degree of medical certainty, more likely
23 than not, when Remi experienced the insult that
24 caused his HIE?

25 A. Three to four days prior to MRI.

1 Q. And if the MRI was on May 6, that would
2 put the insult somewhere between May 2 and May 3.

3 A. Yes.

4 Q. Have all of your opinions that you've
5 expressed this afternoon been to a reasonable degree
6 of medical certainty?

7 A. Yes.

8 Q. No further questions.

9 A. Thank you.

10 THE COURT: On behalf of the plaintiff?
11 I don't know which order we should go
12 with.

13 MS. KAMYKOWSKI: I don't know how you've
14 done it, Your Honor, I've done it both ways. Your
15 preference.

16 THE COURT: Well, because you would be
17 technically crossing, so I feel like we should get
18 back to that. Why don't you go ahead.

19 MS. KAMYKOWSKI: Thank you, Your Honor.

20 CROSS-EXAMINATION

21 BY MS. KAMYKOWSKI:

22 Q. Hi, Dr. Tekes.

23 A. Hello.

24 Q. I want to follow up on a couple of things
25 that Mr. Perron just asked you about.

1 First and foremost, we heard this morning
2 Dr. Size kind of correct me that there maybe isn't
3 some subspecialty of pediatric neuroradiology.

4 Do you agree with that?

5 A. Historically speaking, it is something
6 that evolved over time, so based on the years that he
7 had his training, it is accurate currently there are
8 fellowship programs. And as far as practicing
9 pediatric neuroradiologists go, there are some people
10 who do specific neuro training, or just peds or
11 neuro. Or some people like me, who do both, you
12 know, peds and neuro. So there's bit of a mix in
13 there, but what he said is true to the time period
14 that he trained.

15 Q. But you don't have any part of your
16 practice -- do you have any part of your practice
17 that deals with adult neuroradiology?

18 A. Not at all.

19 Q. Okay. Have you ever had part of your
20 practice that dealt with adult neuroradiology?

21 A. During my training times only. It
22 finished at the end of my fellowship.

23 Q. Let's talk just a little bit about medical
24 legal work. Every expert that's been in here has
25 been asked about their experience. And I want to ask

1 you about yours, okay?

2 when did you start reviewing cases like
3 this in this context?

4 A. My overall experience is very limited.

5 The first time ever I reviewed for a law firm was
6 back in 2016. And then there was a long gap of none.

7 And then around 2020, I started responding to the
8 attorneys' requests here and there, but still very

9 limited and few. Like I can confidently say less
10 than 10.

11 Q. Is there a reason why you don't do it more
12 often?

13 A. Yes. Because of my clinical, academic,
14 and leadership duties, I cannot spare the time,

15 especially for specific deposition on trial dates.

16 It's a major challenge for my schedule. I cannot do
17 it for this matter.

18 Q. Your deposition was taken in this case in
19 September of 2024.

20 Before that deposition, had you ever
21 testified under oath in a medical legal matter?

22 A. I have.

23 Q. How many times?

24 A. Once.

25 Q. And did that case involve similar matters

1 as this one?

2 A. No.

3 Q. So this is the first case that you've
4 taken, that you've reviewed, testified at deposition,
5 and testified at trial, regarding neonatal hypoxic
6 ischemic encephalopathy?

7 A. Correct.

8 Q. Are you typically -- well, let me ask you
9 this: we know now you have limited swear-your-hand-
10 and-tell-the-truth testimony in these cases.

11 How about review the cases? How many
12 cases have you reviewed, if you know?

13 A. I'm going to say a few. I'm having a hard
14 time putting a number to it. I guess a more
15 organized person would have -- keep an Excel sheet,
16 and put the name of the law firms, and the case, and
17 the entity, and the correspondence, etc.

18 Unfortunately, I don't have a record of it.

19 HIE is usually what people contact me for.

20 I have a hard time putting a number to it. Like the
21 whole -- the whole entirety of it all, what I have

22 done around medical legal work is less than ten for

23 sure. Probably seven or eight. Probably 5 or six is

24 around HIE or birth-related injury, but I have a hard

25 time like being so specific about it because I really

1 don't know.

2 Q. Do you pay attention to whether or not an
3 attorney like myself, who represents health care
4 providers, that are reaching out, or whether
5 attorneys like Ms. Gunn and her team who represents
6 patients, are reaching out to you?

7 A. I don't. I don't pay attention whether
8 it's a defense or plaintiff case.

9 Q. Why not?

10 A. To me it doesn't matter because my opinion
11 on the imaging is my opinion on the imaging. And the
12 way I see my role is to provide expertise. So
13 whether I represent a plaintiff or the defense, my
14 imaging opinion is the same.

15 Q. Okay. Let's talk specifically about your
16 review of this case.

17 MS. KAMYKOWSKI: Justin, could you pull up
18 Exhibit E6-F, please?

19 Q. (By Ms. Kamykowski) And this is a
20 document that -- well, I'm sorry, maybe it's not.
21 E6-F. There we go.

22 This was a document that my office put
23 together to detail kind of an index of materials that
24 we sent you with respect to your review in this case.
25 I know you didn't prepare it. We did it prior to

1 your deposition to make sure everyone was on the same
2 page.

3 I think we see initially, because we're
4 talking about private health information, we ask all
5 of our experts to sign confidentiality agreements.
6 And then because we're going to pay you for your
7 time, we ask you for a W-9. And that went by email
8 on August 7th -- do you see that? -- 2023?

9 A. Yes.

10 Q. All right. And then I presume, because my
11 staff is pretty good, that we got your signed
12 confidentiality agreement back and were then able to
13 properly send you protected health information from
14 Remington Anyan on August 10th.

15 Do you see that?

16 A. I do.

17 Q. And what did we initially send you?

18 A. Imaging only, including head ultrasound
19 and brain MRI.

20 Q. Did I ever send you medical records in
21 this cases?

22 A. No.

23 Q. Okay. And the fact that I asked you just
24 to review head ultrasounds, that's typically how you
25 get imaging in your clinical practice, correct?

A. Correct.

Q. It would have potentially, I guess, the imaging that you were sent for Remi would have his date of birth?

A. Yes.

Q. Would it have the specific time he was born?

A. No.

Q. Would it have any other details, other than what we've seen in the reports? For example, the head ultrasound says "suspected seizures." would you have any other clinical data?

A. No.

Q. Okay. Do you remember what the clinical indication was for the head MRI from May 6th?

A. On those images, there was no indication, nothing. There was no clinical information. And the other things that you mentioned are standards on any imaging exam. It is always identified by date of birth and name of the person.

Q. And we saw some of those images in Dr. Sze's PowerPoint. I think you may have taken the clinical data off, but --

A. I did.

Q. -- Remi's name and date of birth was

1 really all you had?

2 A. Yes.

3 Q. But you were able to know that at the time
4 those images were taken on May 5th and May 6th of
5 2020, you could have backdated and said, well, he was
6 born May 4th, so he's one day and two days of life.
7 That would be the sum and substance of the
8 information you had clinically when you reviewed
9 these images?

10 A. Yes.

11 Q. Okay. And after August 10th of 2023, you
12 didn't take any notes. We didn't have any notes from
13 you, correct?

14 A. No.

15 Q. Did you have a call with myself and Mr.
16 Perron about your review in this case?

17 A. I did.

18 Q. And did the opinions that -- had you
19 reached opinions on the timing of the injuries in
20 this case, based on review of just those radiology
21 studies --

22 A. I did.

23 Q. -- at the time we had our first call?

24 A. Yes.

25 Q. And are those the same opinions that you

1 have given here today?

2 A. Yes.

3 Q. And those are that the injuries occurred
4 three to four days before the MRI was taken?

5 A. Yes.

6 Q. We saw this this morning. I wanted to
7 make sure we get this time line out so we can talk
8 about this later, too.

9 okay. We'll do this for you, Dr. Tekes,
10 to make sure we're all on the same page. And, again,
11 I'm going to Ms. Lenivy's line for a time line here.
12 Start with the furthest away. This is
13 going to be the MRI I'm going to do. okay. So if we
14 have the MR. I think based on Ms. Lenivy's, I'll
15 make sure they all have the same time here. 5/6 at
16 3:07, right?

17 And so based on your review of the MRI,
18 you said, no earlier than three days before --
19 right? -- and then it goes up to four days, more
20 likely than not.

21 A. Correct.

22 Q. So your window would be from 5/2 at
23 3:07 p.m. to 5/3 at 3:07 p.m., correct?

24 A. Yes.

25 Q. Okay. Is it possible it's even beyond

earlier than 5/2?

A. Could be, but less likely.

Q. What you can tell us, more likely than not, to a reasonable degree of medical certainty, is this window?

A. Yes.

Q. Not likely between this window?

A. Yes.

Q. And anything before 3:07 p.m. at -- on May 3rd?

A. Yes.

Q. That's your opinion you've held since the beginning of this case?

A. Yes.

Q. There is something discussed, I think in your deposition, I want to make sure I understand it, but did one of those images -- I'm going to see -- did one of the imaging studies we sent you back in August of 2023, have something called an MR spectroscopy.

What is that?

A. MR spectroscopy is another advanced MRI technique. Any further questions?

Q. Well, yeah. And what significance does it have, if any, on the opinions you have in this

1 courtroom about the timing of Remi's injury?

2 A. I did not opine on the MR spectroscopy. I
3 hypothetically got training on it, but I never
4 practiced it. My hospital is in the state of
5 Maryland, and insurance companies do not cover for MR
6 spectroscopy in the state of Maryland.

7 So if it is ever done usually it becomes
8 an out-of-pocket charge for our patients, therefore,
9 it is not routine or a standard part of our

10 protocols. And I don't have a day-to-day practice or
11 experience on it, therefore, I personally did not
12 opine on the MR spectroscopy.

13 However, it can be helpful in cases with
14 hypoxic ischemic injury, not necessarily to time or
15 to provide further information, but change in the
16 level of the metabolites can be suggestive of hypoxic
17 ischemic injury.

18 Q. I think, in your deposition, you said MR
19 spectroscopy. And that showed in this case. Do you
20 remember what the lactate peak was on the MR
21 spectroscopy?

22 A. I don't remember.

23 Q. It was 1.3 parts per million.

24 Does that help you tell me whether or not
25 that can assist with or give any information on the

1 timing of the injuries here?

2 A. I do not have the expertise to utilize

3 MRIS.

4 Q. Okay. And you told us in your deposition
5 that that would respond generally speaking --

6 MS. GUNN: Your Honor, I'm going to object
7 to the leading nature of the question.

8 Q. (By Ms. Kamykowski) I'll let you answer
9 it on cross if she asks about it.

10 Dr. Sze, you sat in and listened to his
11 testimony this morning, right?

12 A. Right.

13 Q. And in talking about this diffuse global
14 injury, do you have an opinion as to what parts of
15 the brain were injured first in this case?

16 A. No.

17 Q. Can anybody state, to a reasonable degree
18 of medical certainty, in your opinion, which parts of
19 his brain were injured first?

20 A. No.

21 Q. Why not?

22 A. What we are seeing is the, you know, areas
23 of involvement like we do -- we did talk about the
24 central portion of the brain, the basal ganglia, the
25 cerebral cortex, subcortical white matter. We're

1 seeing all of them as injured, but one before the
2 other, or one after the other, cannot be particularly
3 assessed.

4 I mean, there's also the temporal
5 evolution of a particular injury. It is not
6 necessarily one insult after the second, you know.

7 Q. And when you say the "temporal evolution,"
8 just for those of us that may not understand that,
9 can you -- can you tell it to us in layman's terms?
10 what does that mean?

11 A. I'm going to, you know, just to use the
12 same analogy Dr. Sze talked about an injury today.
13 Like, you know, in the beginning, for 24 hours, you
14 won't see anything, and then a swelling, you know,
15 will show up. And then discoloration will show up.
16 And then purple will turn green to yellow to, you
17 know, nothing, and everything will look, you know,
18 healed.

19 So it is only one insult, but in, you
20 know, 24 to 48 hours, it presented itself as a
21 swelling and a blister. In, you know, four to seven
22 days, it became like a greenish discoloration. And,
23 you know, eight to nine days, it became yellow. Just
24 because the colors changed or the swelling, yes or
25 no, you know, happens, it doesn't make it different

1 injuries happening, you know, one after the other.
2 It's just one insult presenting itself a little bit
3 differently over time.

4 Q. And that timing is what you know from your
5 research, your education, your experience in
6 pediatric neuroradiology, specifically neonatal
7 hypoxic ischemic encephalopathy, the time course of
8 how things change and look on imaging, that's what
9 you're here to tell us today.

10 A. Yes.

11 Q. Okay. When we were talking about Dr. Sze
12 and his T2 images, I want to make sure we understand
13 it.

14 when you look at an MRI, you look at all
15 of the sequences. So the diffusion weighted images
16 correlated with the ADT, the T1 images, and the T2.
17 You look at them in conjunction with each other, is
18 that right?

19 A. Yes.

20 Q. Okay. When Dr. Sze's PowerPoint had the
21 T2 weighted images, and he said there was sharp
22 brightness, you told us the exact opposite, I heard,
23 right? That there was blurry gray/white matter.

24 You explained to Mr. Perron, I want to
25 make sure that we understand, that was due to

1 generalized cytotoxic brain edema.

2 Can you tell us what you meant by that?

3 A. So edema in the brain is usually described
4 under two categories: one, cytotoxic, which happens
5 in the setting of acute ischemic insult.

6 And the second type is vasogenic, which is
7 not associated with acute ischemic injury. What
8 could they be? One example is if there is a mass
9 lesion in the brain, like a brain tumor, it can cause
10 swelling in the surrounding tissue. It would be like
11 a vasogenic edema from the mesogenic of the tumor
12 itself. So cytotoxic edema in the acute stage of the
13 brain injury, causes a blurriness between gray matter
14 and white matter.

15 Q. And how does the cytotoxic edema correlate
16 to your timing opinions?

17 A. Cytotoxic edema persists from the insult
18 usually around six to seven days in general.

19 Sometimes it can even prolong longer, but majority of
20 the time, it does continue to be visible in the brain
21 in restrictive diffusion up to six to seven days.

22 Q. How long does it take to begin developing
23 if it lasts for six to seven? Is there, like -- is
24 it kind of a -- is it a peak and a valley? Or how
25 does it work?

1 A. It also can take a little bit of time,
2 too. It's usually more difficult to specify because
3 insult, you know, the presumed insult, and when the
4 insult happens to when the patients come to imaging,
5 they take a little while. So it can take a little
6 while, but usually it is studied in the context of a
7 stroke, not necessarily HIE.

8 Q. And, Dr. Tekes, have all of the opinions
9 you've given today with respect to the timing, your
10 window of time that the injuries occurred based on
11 both your analysis of the ultrasound and its
12 limitation, and your knowledge and analysis of the
13 MRI, have been to a reasonable degree of medical
14 certainty?

15 A. Yes.

16 Q. And this window that we have on this
17 exhibit or on this easel here that has "Dr. Tekes"
18 and today's date of March 18th, is that opinion
19 given -- that's your more likely than not opinion as
20 to when the injury occurred in this case?

21 A. Yes.

22 Q. Thank you, Doctor.

23 THE COURT: why don't we take a short
24 recess.

25 (At 2:54 p.m., the Court duly admonished

1 the jury, and proceedings stood in recess. At
2 3:21 p.m., the following proceedings were held in
3 open court, in the presence of the jury:)

4 THE COURT: Go ahead and be seated,
5 everyone.

6 Cross-examination?

7 MS. GUNN: Thank you, Your Honor.

8 May it please the Court.

9 CROSS-EXAMINATION

10 BY MS. GUNN:

11 Q. Dr. Tekes, good afternoon.

12 A. Good afternoon.

13 Q. We can all agree that Remi Anyan suffered
14 hypoxic ischemic encephalopathy, correct?

15 A. Yes.

16 Q. I'm going to call it HIE.

17 And you told us about that, and we've
18 heard about that.

19 But just to refresh, hypoxia is what?

20 A. Reduced oxygen delivery.

21 Q. And what is ischemia?

22 A. Reduced blood supply.

23 Q. So a hypoxic ischemic injury is a
24 combination of reduced oxygen and reduced blood flow,
25 correct?

1 A. Involves entities that may be limited to
2 reduced blood supply, such as placental abruptions.

3 Q. Okay. There's no placental abruption
4 here, right?

5 A. All I'm saying is a hypoxic ischemic
6 injury encompasses both of them, but there are some
7 entities that are, you know, targeting more to the
8 blood supply.

9 Q. Sure. And just to be clear, there's no
10 placental abruption here, right?

11 A. Right.

12 Q. You've seen that --

13 A. A placental abruption, yes or no, I cannot
14 see it off of imaging.

15 Q. Okay. But in Remi Anyan's case, can you
16 say whether his injury is more toxic or more
17 ischemic?

18 A. I can't make a comment. All I can say is
19 HIE.

20 Q. Okay. So we know that he has -- and how
21 would you rate it? Mild? Moderate? Severe?

22 A. I would say it's moderate. Moderate to
23 severe.

24 Q. Okay. And how long does it take, knowing
25 from reviewing Remi's MRI, how long does it take to

sustain moderate to severe HIE?

A. It can take up to two days for the edema to build up, but it can be quicker, too.

Q. Are you -- in this case, do you know?

A. I am trying to understand your question.

Q. Do you know, in this case, whether it took two days or -- or a couple of minutes for Remi?

A. I think what I know of what the imaging studies that I reviewed, is that the insult probably happened three to four days prior.

Q. Right. I understand that. We've heard that. And I'm asking a more specific question.

We know the insult -- that's what I'm asking about -- what was the insult? How long did the insult take?

A. I don't know.

Q. Okay. Do you have any opinion at all, based on all the research you've done into HIE, as to how long the insult took to cause Remi's moderate to severe HIE?

A. Particularly for Remi's, I don't.

Q. Okay. We can also agree that there were two components to Remi's HIE: acute profound and prolonged partial, correct?

A. I did not agree to it during my depo, and

1 I still do not use those terminologies to describe
2 the brain injury. This is a global brain insult, and
3 it doesn't need to be defined as, you know, partial
4 prolonged and more, you know, acute profound injury.
5 An insult happened that globally affected the entire
6 brain, is what I'm saying.

7 Q. That's right. And I don't think we're
8 disagreeing -- I don't think we're disagreeing. We
9 all agree it's a global insult.

10 A. Global brain injury, yes.

11 Q. Do you not see any partial profound on the
12 watershed? You don't see that? Or excuse me.
13 Partial prolonged on the watershed? You don't see
14 that injury?

15 A. That the brain is globally affected and
16 severely or moderate to severely insulted, including
17 the entire brain, you will see the injuries in the
18 central portion of the brain, basal ganglia, and
19 thalamus, and also in the peripheral parts of the
20 brain, in the white matter and the cortex. And in
21 this case, we are seeing it everywhere in the brain.

22 Q. Okay. So it's on the peripheral, and it's
23 in the middle?

24 A. It's in the entire brain.

25 Q. Okay. What you're, I guess, not -- or

1 seeming to point out, is that you're not willing to
2 call it partial prolonged or acute profound?

3 A. Those words signify a particular
4 causation. All I'm saying is in his testimony, and
5 he talked about it in his depo, too, I am not talking
6 about the causation of it, the brain injuries.

7 All I can say is the injured parts of the
8 brain, in this case, it is a global brain injury,
9 affecting the entire supratentorial brain.

10 Q. Okay.

11 A. And off of the imaging, I am getting an
12 estimate of the damages that might have happened,
13 which I'm estimating, three or four days.

14 Q. Right. Okay. So estimating three or four
15 days for a global insult. We don't know how long
16 that global insult took. And you're not willing to
17 indicate whether it was partial prolonged or acute
18 profound, correct?

19 A. Correct.

20 Q. Okay. Now, you were hired by both Mercy
21 Hospital and Mercy Clinic to be involved in this
22 case, right?

23 A. Yes.

24 Q. You were originally hired by Ms.
25 Kamykowski's office.

1 Do you recall that? Do you recall when
2 you were first hired?

3 A. Yes.

4 Q. And I believe that was in May of 2023?

5 MS. GUNN: Can we have Exhibit 190-3,
6 please, Zack?

7 Q. (By Ms. Gunn) This is a -- from your file
8 that you produced, and I want to go down to the
9 bottom -- I'm sorry -- page 24.

10 MS. GUNN: That would be helpful if we
11 have that. Go all the way down to the bottom.

12 Q. (By Ms. Gunn) So there was --

13 MS. GUNN: No. 109-3 you had, the emails.
14 Just like the last one.

15 Q. (By Ms. Gunn) Well, here's one I wanted
16 to ask you about, Dr. Tekes.

17 we've got -- you remember getting an email
18 from Ms. Pfirrmann and Ms. Kamykowski's office in May
19 of 2023?

20 A. To be honest with you, I don't have
21 specific months and dates in my mind. 2023, is what
22 I recall.

23 Q. Of course.

24 A. And that's the best I can confirm.

25 Q. I understand.

1 Now, if we can find it, great, otherwise
2 I'll just read the paragraph from Ms. Pfirrmann to
3 you.

4 Dr. Tekes, our office represents the
5 hospital in a labor and delivery lawsuit pending in
6 St. Louis County, Missouri.

7 We are looking for a physician with your
8 expertise to perform a review of the records and
9 discuss your findings.

10 Please let me know if you would be
11 interested. If you are interested, please forward me
12 a copy of your fee schedule and your most up-to-date
13 cv for consideration by our clients.

14 Do you remember receiving an email? That
15 email?

16 A. Sounds like it, yeah.

17 Q. So you were told, the first communications
18 that you were -- that you were looking to be hired by
19 the hospital in a labor and delivery lawsuit,
20 correct?

21 A. Yeah. Seems like so.

22 Q. So you knew, before you even looked at a
23 single record or a single image, that the folks that
24 were hiring you for the hospital involved in a
25 lawsuit with labor and delivery, correct?

1 A. Yes.

2 Q. Okay. And we know that you've been
3 involved in cases like this before and hired to time
4 injuries, correct?

5 A. Yes.

6 Q. And you've been hired by -- I think you
7 said you don't really keep track of it -- but you
8 told me in the deposition a few months ago, that
9 you -- all the depositions you've been given, you had
10 given up to date, have been for the hospital or a
11 doctor or whoever had been sued, correct?

12 A. So in the deposition, I told you that I
13 didn't, you know, keep track, you know, there were
14 both, you know, plaintiffs and defense attorneys, and
15 I recalled one case where it was the plaintiff.

16 Q. And that -- I'm asking about depositions.

17 A. Depositions, I have never done a
18 deposition other than this for an HIE case.

19 Q. And the other HIE case is also for a
20 doctor or defendant, correct?

21 A. Okay. So there are two depositions I have
22 ever done in my life.

23 Q. Right.

24 A. The first one was for a case in my own
25 hospital, and this had nothing to do with an HIE.

1 The first time ever deposition that I'm doing for an
2 HIE, is this one. But I had communicated with other
3 attorneys for HIE patients.

4 Q. And, Doctor, let -- the only question -- I
5 don't mean to make it broad -- you've given
6 deposition testimony before, and it has been on
7 behalf of the defendant.

8 And prior to the deposition in this case,
9 that's the only other one you've had, correct?

10 A. Correct.

11 Q. Okay. And this is the first time you've
12 come to trial?

13 A. Correct.

14 Q. Okay. Now, you get paid for your time,
15 correct?

16 A. Correct.

17 Q. And I believe I wrote down \$750 for your
18 review. A thousand dollars an hour for trial.

19 And up to when I took your deposition a
20 few months ago, you had charged about 6- or \$7,000.

21 Does that sound right?

22 A. And that will be -- it would be itemized
23 in there.

24 Q. Okay.

25 A. What the charges are.

1 Q. And then how many hours have you spent
2 getting ready and coming here today since then?

3 A. I did not keep track of my hours to get
4 ready. For the trial day, in my fee schedule, it
5 talks about \$3500 for the day of the trial and also
6 for the day of my travel.

7 Q. Okay.

8 A. And beyond that, I did didn't keep track
9 of my hours because I don't plan on charging for the
10 hours that I got ready for it.

11 Q. You're going to charge that 3500, is it
12 for two days?

13 A. 3500 per day. Yesterday was my travel day
14 and today.

15 Q. Now, you didn't -- we saw Dr. Sze wrote a
16 report.

17 You've never written a report in this
18 case?

19 A. I haven't.

20 Q. You've never written down any notes about
21 your interpretation of the MRI, correct?

22 A. I have not.

23 Q. I know we have the PowerPoint that I got
24 this morning.

25 Did you put that together like yesterday,

1 or?

2 A. No. It has been maybe this week. Maybe
3 the attorneys can confirm the day that I sent the
4 email to them. I don't remember it exactly, but it's
5 the PowerPoint that I also have on my flash drive.

6 Q. Okay. Now, in your clinical practice, I
7 think you've told us about kind of how you practice.

8 And in the majority of the cases that you
9 encounter in your everyday job at the hospital, the
10 clinical story and the patient's presentation and the
11 MRI findings usually have a consistent time line,
12 wouldn't you agree?

13 A. Usually.

14 Q. And because of that, you're not asked very
15 often in your practice to time injuries, correct?

16 A. When asked, we do time. But primarily it
17 just goes around the global -- the areas of the
18 involvement in the brain, what parts of the brain are
19 injured, etc.

20 So I would say around 30 to 40 percent of
21 the times maybe conversation evolves around timing.

22 Q. Right.

23 A. And then, you know, in every single case,
24 we talk about the areas of involvement in the brain.

25 Q. And there's usually a clinically described

1 incident, right? When you are asked to review an MRI
2 or do an interpretation of an MRI, there's usually a
3 clinically described incident.

4 And the baby's delivered, or immediately
5 after the baby, there are issues, and then an MRI is
6 ordered.

7 Is that the typical way things go?

8 A. As being a radiologist, primarily what I
9 know is there's suspicion. Whether or not there is a
10 documented incident or not is not in my, you know,
11 primary radar.

12 I am not digging into the records or
13 talking to the ordering providers to see if there was
14 an incident that's really happened or not because the
15 baby is sick, and they're requiring imaging. So it's
16 usually the current state of the baby that dictates
17 the imaging and my interest, and you know, my
18 interest in, you know, reading their imaging.

19 Q. Right. And what I'm trying to understand
20 really, Doctor, is in your everyday practice, you're
21 not often asked, when did this injury happen? You
22 are asked to interpret that imaging, to give that
23 information to the clinician, so he or she can do her
24 job for this patient, correct?

25 A. Oftentimes, meeting, as I say 30 to

1 40 percent of the times, we talk about timing.

2 Q. Right. And in those 30 to 40 percent of
3 the time, do you engage in analysis of the clinical
4 situations?

5 A. I give my opinion based off of the
6 imaging.

7 Q. And is there an analysis by the other
8 clinicians as to what's happening on the ground with
9 the patient?

10 A. They would be, if the conditions, whatever
11 they're responsible for, they would be analyzing what
12 they're supposed to analyze. And my job is to give
13 my opinion of the imaging.

14 Q. Right. And so the imaging is one piece of
15 the puzzle that the doctors and the hospital
16 professionals use to diagnose what's happening with
17 the baby, correct?

18 A. Correct.

19 Q. And in this case, you weren't even sent
20 any medical records, is that correct?

21 A. At the time that I received imaging, yes,
22 I was sent the medical records.

23 Q. And you've never seen any of the medical
24 records, and you don't know what was going on
25 clinically at any point in time with Sarah Anyan's

1 labor and delivery with Remi, is that correct?

2 A. At some point, I think I got some medical
3 records, but I don't recall exactly when or how much.

4 I think I got some depositions, Dr. Sze's
5 depositions, a couple other physicians' depositions.

6 Regarding their medical records, I can't quite recall
7 at any point in time, but at least initially I
8 didn't.

9 Q. Yeah. And I remember Ms. Kamykowski put
10 up the records review or materials relied on, I
11 didn't see any medical records on there, did you?

12 A. So here is where my struggle is: I guess
13 maybe most of you don't even remember what they ate
14 last night. Trying to recall the details and the
15 time line of these events and whether or not I
16 received specific things.

17 But I can tell you this: I reviewed
18 imaging without the medical records. I gave my
19 opinion. I had a conversation with, you know, the
20 attorneys. Other than this later, during the time
21 that I got the, you know, deposition records, if I
22 received anything pertinent to their clinical
23 records, I might have. I don't recall.

24 Q. Okay. That was it. That's all I wanted
25 to know.

1 Do you remember receiving any medical
2 records?

3 A. I don't recall.

4 Q. And did you, whether you received them or
5 not, which I don't think you did, but whether you
6 received them or not, did you rely on them in any
7 way --

8 A. I did not.

9 Q. -- to render your opinions to the jury
10 here today?

11 A. I didn't.

12 Q. So with respect to clinically what's going
13 on with Remi and with Sarah, that was of no concern
14 to you when you rendered your opinions here, correct?

15 A. No concern or --

16 Q. No consideration.

17 A. Thank you.

18 Q. So when you have -- you've told us already
19 you have no causation opinions. Meaning, while we
20 all agree that Remi had HIE, you're not here to talk
21 about why he has HIE?

22 A. Correct.

23 Q. Other than we know what HIE is, is
24 generally how you can have hypoxia and ischemia. But
25 you're not here to elaborate on that, correct?

1 A. Correct.

2 Q. And you of course have no opinions with
3 respect to standard of care or anything like that,
4 correct?

5 A. I don't.

6 Q. Now, the ultrasound. So, you know, I took
7 your deposition, you remember that. And we know that
8 you have not considered the ultrasound in your
9 opinion, correct?

10 A. Ultrasound quality and technique is not
11 appropriate for evaluation of HIE.

12 Q. Right. So, in this case -- now that's not
13 overall, right?

14 A. Correct. Not overall for this case. It
15 is not inappropriate.

16 Q. Right. So you -- you agree, and I think
17 we have your article that I found --

18 A. Uh-huh.

19 Q. -- and I talked about it at your
20 deposition, and we saw it earlier today, and we'll
21 talk about that in a second -- well, we can talk
22 about it now.

23 Let's go to Exhibit 358. This is the same
24 one that Mr. Perron showed you. His numbering system
25 I find difficult, so I'm going to go with my 358. If

1 that's okay.

2 All right. So this is your article, "Head
3 ultrasound in Neonatal Hypoxic-Ischemia Injury and
4 Its Mimickers for Clinicians" -- and a few other
5 words.

6 And you're a coauthor, correct?

7 A. Correct.

8 Q. Okay. So let's go to a few pages in, page
9 192, at the bottom number.

10 So Mr. Perron was asking you about this,
11 and just again to recap real quickly: This article
12 stands for the proposition that ultrasound has
13 emerged as a powerful screening tool for evaluation
14 of a neonate with suspected HII.

15 Correct?

16 A. Correct.

17 Q. That was in your abstract. That's kind of
18 your high level conclusion?

19 A. Correct.

20 Q. So you're not here to say ultrasounds
21 can't help time and injury?

22 A. Correct.

23 Q. You're here, in fact, to say they can,
24 correct?

25 A. Could, yeah.

1 Q. yeah. And so we've got: ultrasound has
2 become increasingly effective at determining the
3 pattern and timing and extent of injury in HII, as
4 well as differentiating these findings from a host of
5 diagnoses that can result in similar appearing
6 clinical pictures.

7 That's your -- that's your article?

8 A. Correct.

9 Q. That's your conclusion?

10 A. Correct.

11 Q. And that's what you're telling us today?

12 A. Correct.

13 Q. So then on page 192, on the bottom
14 right-hand corner: Reliability and predictive value
15 of U.S. findings, Mr. Perron and you went through
16 that first part, and I want to read that last part.

17 The last part of that sentence of, it
18 says: HII -- thus, HII might not be immediately
19 apparent, and the predictive value of a normal head
20 ultrasound in an early phase is low.

21 But then it goes on to say: If there is
22 significant abnormality already present at this
23 stage, less than 24 hours after birth, it is highly
24 predictive of a poor outcome due to a particularly
25 severe insult or because the injury occurred prior to

the onset of labor.

Did I read that correctly?

A. Very correctly.

Q. And that is -- very correctly. I appreciate that.

Then we can agree then if an ultrasound is abnormal, less than 24 hours after birth, then its highly predictive of a poor outcome, either because of a particular insult or because it happened prior to the onset of labor, correct?

A. Yes.

Q. So we can agree that an ultrasound, if it is positive at 24 hours, is instructive to tell us that the injury is older than 24 hours?

A. Very much so. And there is a very nice figure in the article that displays this.

Q. So we can agree that in this case, if it were abnormal -- did I say that right? -- if it were abnormal, if Remi's -- if Remi's ultrasound were abnormal, it would be highly predictive of an earlier injury prior to the --

A. It would be highly predictive of HIE. This ultrasound as a screening tool would already have demonstrated HIE.

Q. Right. And if that's the case, it would

1 have happened earlier?

2 A. Earlier, like earlier at the time of
3 delivery --

4 Q. Prior?

5 A. -- or earlier prior to the initiation
6 of --

7 Q. 24.

8 A. -- of the labor? You know, goes earlier.

9 Q. Right. So we know, in Remi's case, you
10 are not considering the ultrasound. You told us
11 that. It's not part of your opinion here.

12 A. It's not I'm not considering. I looked at
13 it very carefully because it's really part of my area
14 of my expertise. It really is a poorly executed
15 ultrasound.

16 Q. I know you -- I know you believe that. So
17 here's what I'm trying to understand: I think I
18 heard you say on direct, well, it's still kind of
19 diagnostic. And you didn't say it exactly like that.
20 It's -- it's -- people can look at it and understand
21 it. But I want to make sure that you and I are on
22 the same page as to what you told me in your
23 deposition.

24 Because in your deposition you told me:
25 It was a very poor technique. I wouldn't regard this

1 ultrasound as part of my interpretation. I would
2 regard this ultrasound as nondiagnostic. It was a
3 poorly performed ultrasound.

4 You said that it was -- it was a highly
5 limited exam. I wouldn't opine on it on that
6 ultrasound if it were to come to me to my reading
7 queue.

8 So -- so what you were saying is that if
9 you got this ultrasound on a patient at Johns
10 Hopkins, you would not even read it, correct?

11 A. If you continue on the deposition, it goes
12 to say there are certain things --

13 Q. I'm just going to -- you're going to be
14 able to --

15 MS. KAMYKOWSKI: well, Your Honor, I'm
16 going to object as improper impeachment, then. If
17 she wants to read the question and answer, show
18 her -- tell her the line and page --

19 MS. GUNN: I understand how to impeach.

20 MS. KAMYKOWSKI: well, I'm going to object
21 to improper impeachment.

22 THE COURT: The Court is going to overrule
23 the objection.

24 Q. (By Ms. Gunn) My question is that if this
25 ultrasound had come into your queue at John Hopkins,

1 you wouldn't have even considered it, correct?

2 A. I wouldn't read for HIE. I would have
3 said "why?" I mean, the context that you're talking
4 about is HIE. And this is probably HIE, as agreed
5 upon every single person pretty much that I heard
6 today. So it's in the context of HIE, it is a
7 nondiagnostic study.

8 Q. Doctor, I'm going to hand you your
9 deposition. It has been previously marked as
10 Exhibit 190.

11 I'm going to ask you, you might already
12 have it in front of you, but I'll give you a
13 different -- that one's a little bit easier.

14 I'm going to draw your attention to page
15 29, line 3.

16 And I'm just going to read it and ask you
17 to follow along.

18 you have an opinion that it's poor
19 technique. So are you discounting it, throwing it
20 out, with respect to giving your opinions in this
21 manner?

22 And your answer was: It should not be
23 part of the medical evaluation in this case.

24 A. Correct.

25 Q. It's a close to nondiagnostic, very poor

1 quality examination. It does not participate, in my
2 opinion, especially when there is an MRI performed,
3 it does not really serve any help. And in my
4 everyday practice, I do read head ultrasounds.

5 Did I read that correctly?

6 A. Correct.

7 Q. Thank you.

8 So with respect to Remi's ultrasound --
9 and I'll take that. Do you want to keep that?

10 A. No.

11 Q. Okay.

12 A. I think I have another copy.

13 Q. Okay. With respect to Remi's ultrasound,
14 we know, from the record, that it was ordered by, I
15 believe, Dr. Gary Dreyer. It was ordered at
16 8:20 a.m. on 5/5, on May 5th, so this is the next
17 day. Remi was born on May 4th at 4:24 p.m., so this
18 was ordered the next morning, 16 hours of life,
19 right? Well, trust me on the math.

20 A. Okay.

21 Q. Okay. It was ordered by a neonatologist,
22 Dr. Gary Dreyer, who was helping take care of Remi,
23 and it was performed at 10:07, at the bedside.
24 Because that's how these ultrasounds are performed,
25 right?

1 A. Correct.

2 Q. They're right -- they bring it to the
3 baby.

4 And that ultrasound was being performed
5 because the clinicians there suspected seizures.
6 Remi was seizing. Did you know that?

7 A. (No audible response.)

8 Q. Okay. Well, the clinical history on the
9 form here that I guess gives a radiologist like
10 yourself some idea of what they're looking for, is
11 suspected seizure.

12 Now, HIE can cause seizures, can't it?

13 A. Correct.

14 Q. Okay. So at this point it was certainly
15 on the table of potential things that could be
16 causing Remi's seizures, correct?

17 A. Correct.

18 Q. So I know you don't know Dr. Thomas
19 Applewhite, but he is, I mean, he's a 40-year
20 pediatric radiologist in the Mercy system. And he's
21 the one that read this ultrasound.

22 Did you know that?

23 A. I didn't know his years of practice. I
24 didn't know him.

25 Q. Okay. And Dr. Applewhite, you know, he

1 read it. His impression was two left subependymal
2 cysts thought to be due to a resolving left
3 subependymal hemorrhage.

4 Let me ask you first, did that have
5 anything to do with Remi's HIE diagnosis?

6 A. Very unlikely.

7 Q. Okay. So we kind of go back through the
8 findings.

9 MS. GUNN: And let's just get up -- this
10 is Exhibit 3, page 1983. So we can follow along.

11 We've got -- okay -- let's go down. Down.

12 Yep.

13 Q. (By Ms. Gunn) So as you can see on the
14 top right-hand corner final results. I mean, these
15 go through preliminary process, that the final
16 result, right, right there?

17 A. Uh-huh.

18 Q. And Dr. Dreyer is the ordering provider.
19 Dr. Thomas Applewhite is the resulting physician.
20 That's the guy or gal who reads it, right?

21 A. Uh-huh.

22 Q. Interprets it? Puts it into a patient's
23 medical record for all to see, correct?

24 A. Yeah.

25 Q. And to rely on, right? That's why they do

1 these things so other --

2 A. It's a part of the medical record, yeah.

3 Q. Okay. So we've got the findings. We've
4 talked a little bit about the cysts. But it says:

5 The parenchymal echogenicity is a little
6 inconsistent, attributed to technique and contact at
7 the fontanelle.

8 okay. We've talked about that. Dr. Sze
9 talked about that. That's the person doing the
10 ultrasound is putting it there and looking into
11 Remi's brain, correct?

12 A. (Nodding head.)

13 Q. And there is no definite focal parenchymal
14 lesions are seen, correct?

15 A. Uh-huh.

16 Q. So Dr. Applewhite doesn't say, I can't see
17 anything. He doesn't say, this is too hard for me to

18 see. He says, there are no definite focal
19 parenchymal lesions seen, correct?

20 A. May I comment on it?

21 Q. Well, is that what it says?

22 A. Clearly.

23 Q. Okay. And so what happens is, I mean,
24 parenchymal means tissue?

25 A. Uh-huh.

1 Q. That's what you're looking at to try to
2 figure out what's going on in the brain, correct?

3 A. Uh-huh. Not an Official Court Document

4 Q. Is that correct?

5 A. Correct.

6 Q. And he sees no focal lesions. That's what
7 you'd be looking for, correct?

8 A. Absolutely not. As you have seen on the
9 brain MRI, the injury is bilateral, symmetric, and
10 diffused. So what he's saying is there is no focal
11 injury such as which would be in the form of focal
12 intraparenchymal hemorrhage.

13 So he in fact acknowledges his
14 limitations, a diffused parenchymal injury, but goes
15 in to say that, okay, I cannot really see the
16 diffused parenchymal situation because his ultrasound
17 if limited by this sentence that is preceding the
18 sentence. It already says it's a little inconsistent
19 attributed to technique and contact at the
20 fontanelle. But I can talk about focal parenchymal
21 injury which doesn't exist, which we all agree.

22 But he already acknowledges his
23 limitation, but goes on to say the things that
24 confidently he can rule out: focal parenchymal
25 injuries nonexistent, agree, check.

1 He then goes on to say, there is no
2 evidence of midline anomalies because he can't see
3 the midline comfortably, too. There is no midline
4 shift. He doesn't go into the detail, but there is
5 no midline anomaly.

6 so he's giving explanation to the things
7 that he feels confident about that he can rule out,
8 but he's not ruling HIE in or out because of the
9 technical limitation of the exam.

10 Q. Doctor, does he say any of that? Does he
11 say, I'm ruling in, I'm not ruling in? I'm ruling
12 in, I'm not ruling out? Does he say any of that?

13 A. All I'm saying is no definite focal
14 parenchymal lesions are seen has nothing to do with
15 HIE. Like he's talking about something that doesn't
16 exist in the report, that doesn't even belong to the
17 category of injury for HIE.

18 Q. Is there any question that this provider
19 was looking for a reason for Remi's suspected
20 seizures?

21 A. Ask me one more time, please.

22 Q. Is there any question, based on the
23 medical record, that Dr. Applewhite was unclear that
24 he was looking for a reason for Remi's suspected
25 seizures?

1 A. I cannot tell.

2 Q. You can't tell?

3 A. I cannot tell what was going on in his
4 mind at the time that he was reading, what was going
5 on in his head, you know.

6 Q. Well, what -- so what we know, though, is
7 that this was not repeated, correct?

8 A. Correct. I don't see any other
9 ultrasound.

10 Q. And when you do see, in your practice, I
11 know you wouldn't have read this for your patients,
12 but when you see this in your practice, you ask for a
13 repeat image, correct?

14 A. I would. I would ask for a repeat image.
15 But repeat how I would do it, to answer your
16 question.

17 Q. I just want to kind of move forward, and
18 if there's some clarification, then we'll do that.

19 A. I don't feel comfortable, though, like if
20 this is really a situation of me, you know,
21 advocating of what I would do in my clinical
22 practice, I just want to explain what I would do.

23 Q. I understand. And my question was, you've
24 already told me in your deposition that you wouldn't
25 read this, correct?

1 A. So I'm so sorry. When an imaging exam
2 comes to my queue, and if it's an executed and
3 completed exam, there is no opportunity for a
4 radiologist to say, decline, I'm not generating a
5 report. I have to generate a report, but I would put
6 in all the limitations of the exam technically. And
7 I will say what the exam is good enough to talk about
8 and what the exam is not good enough to talk about.

9 Q. So you would add what the limitations
10 were?

11 A. I would.

12 Q. You would add all the problems that you
13 saw with respect to not being able to see very well,
14 believing that it was poor quality, poor technique,
15 all those things? You would have put that in your
16 interpretation if you saw that, correct?

17 A. I would have concluded that technically
18 they needed exam for assessment of HIE.

19 Q. And we don't that in Dr. Applewhite's
20 interpretation, correct?

21 A. Correct.

22 Q. So presumably that if he couldn't actually
23 see it or read it or understand what he was looking
24 at, he could have made those changes or added those
25 to the interpretation, correct?

1 A. I wouldn't be able to --

2 MR. PERRON: Objection, calls for
3 speculation.

4 THE COURT: Overruled.

5 Q. (By Ms. Gunn) You don't know if that's
6 going to happen?

7 A. I don't know how to presume on his behalf,
8 honestly.

9 Q. Fine. What's what you would do. Would
10 you expect radiologists, if they can't -- couldn't
11 read or weren't able to interpret an image, to make a
12 point of saying that in their report?

13 A. Correct. Technical limitations should be
14 addressed.

15 Q. And that's because it goes back to the
16 clinician, and the clinician has to use it to make
17 decisions, potentially life-or-death decisions, of
18 the patient?

19 A. Correct. Or they're just, you know,
20 incorrect medical records, like something being
21 presumed as normal when they're not.

22 Q. So if this interpretation was not able to
23 do -- Dr. Applewhite wasn't able to do the
24 interpretation, or didn't know what he was looking
25 at, or it was too -- too poor, then he could have

1 said that, and the folks taking care of Remi could
2 have asked for a repeat order, correct?

3 A. Probably.

4 Q. So we know that this happened at ten
5 o'clock on May 5th, correct?

6 MS. GUNN: We'll just go down to the
7 bottom there. And it -- and if we just go to page
8 1983.

9 Q. (By Ms. Gunn) It was performed at 10:07,
10 and Dr. Applewhite dictated it, and at 10:35 a.m., so
11 that's a pretty good turnaround, right? That's about
12 30 minutes, correct?

13 A. Very good.

14 Q. And was then seen by --

15 MS. GUNN: 1985? Sorry. 1985. Okay.
16 Right here.

17 Q. (By Ms. Gunn) So if at 10:35, he read it,
18 it's signed at 11:12, so if it was something that he
19 wasn't confident was going to be diagnostic and
20 wasn't going to help treat a seizing newborn, he
21 could have said that, and it was turned around in
22 pretty good time, and it could have been repeated,
23 correct?

24 A. I don't know how to make an assumption on
25 his behalf or his practice.

1 Q. If ultrasounds -- ultrasounds can be
2 repeated?

3 A. Ultrasounds can be repeated.

4 Q. Okay.

5 A. Whether he would have done it or not, is
6 something that I cannot make a judgment call on.

7 Q. I understand.

8 Now, about the MRI --

9 MS. GUNN: Let's go to Exhibit 3, page
10 1992.

11 Sorry. Yeah, 1992. Yes.

12 Q. (By Ms. Gunn) So back to the newborn --
13 well, newborn, born, at 39 weeks, 4 days, with
14 seizures and difficult delivery. Clinical concern
15 for hypoxic ischemic encephalopathy, genetic or
16 metabolic abnormalities, and infection. And, again,
17 the clinical picture includes a difficult delivery
18 and concern for HIE.

19 And this -- so you are ruling out these
20 other things -- right? -- the genetic, the metabolic
21 abnormalities, and the infection because you believe
22 that MRI confirms HIE, correct?

23 A. In my own opinion, it's more consistent
24 with HIE.

25 Q. Okay. Now, Dr. Tekes, we've done a little

1 time line over here. And Ms. Kamykowski asked you
2 whether the time frame for injuries could have been
3 earlier, and I think you said could be.

4 Could it also -- this three-day, three- to
5 four-day time line, could it also be later?

6 A. So three to four days is the most likely
7 time frame this would have happened.

8 Q. Correct.

9 A. I'm trying to make sure I understood the
10 question right.

11 Q. I'll do it better.

12 Ms. Kamykowski asked you, you know, could
13 it -- if you think it could have been the May 2nd to
14 May 3rd window, she asked you if it could be earlier,
15 and I think I heard you say yes.

16 well, we've got to be fair, it could also
17 be later if you're going to give wiggle room, right?

18 A. My wiggle room is within three and four
19 days, more likely than not, with, you know, a certain
20 level of certainty. The odds of, you know, later or
21 before, is much less likely.

22 Q. Okay. Thank you, Doctor.

23 A. Just for the, you know, you don't have any
24 questions, I'm probably not supposed to -- not to
25 talk anymore.

1 Q. yeah. You may have seen that on TV, yeah.

2 If there are questions --

3 A. There is -- there is --

4 Q. If there are questions --

5 A. Be quiet.

6 Q. -- your lawyer can ask you.

7 A. Okay. Thank you.

8 THE COURT: Any redirect?

9 MR. PERRON: Yeah, briefly.

10 REDIRECT EXAMINATION

11 BY MR. PERRON:

12 Q. Dr. Tekes, just to give you an opportunity
13 to respond with your supplemental part of your answer
14 at the end.

15 A. Thank you.
16 So since, you know, ultrasound has become
17 such a point of discussion for this case, and thank
18 you for asking if ultrasound would ever detect
19 anything before 24 hours, and the answer is yes. I
20 did an article that you referenced numerous times.
21 It was published by me and my colleagues.

22 There is a case that demonstrates injury
23 before 24 hours, and if you ever see this, you can
24 pretty much be sure that the case is going to be
25 lethal. Like those are cases that are really the

1 most severe injury, and they displayed imaging with
2 an ultrasound at Day 1, 2, and 3 in that article.

3 But in Day 1, when you see the injury in
4 the brain stem, you can predict that the outcome of
5 that baby will be really poor, and the patient that
6 we displayed in that figure is expired in day of life
7 3 or 4.

8 So, yes, in very severe injury early on,
9 you can see. So the positive predictive value is a
10 really high value, you know, see abnormality on the
11 ultrasound. But if the ultrasound is normal, the
12 window really goes much higher, out to, you know, 4
13 days of life, where it can still remain normal,
14 although there is an abnormality.

15 Q. So the cases that you've seen that are so
16 bad, they do show up in 24 hours on ultrasound?

17 A. They can. Really bad ones.

18 Q. What is the typical final outcome for
19 those babies?

20 A. They die. They usually die in a short
21 period of time.

22 Q. If it's something less big, something
23 smaller and less lethal, about how long do those take
24 to show up on ultrasound?

25 A. Usually, you know, it doesn't show up

1 within the first the 24 hours, can take up to 48
2 hours. And we have seen cases where it took up to 96
3 hours.

4 Q. And that's consistent with what you
5 wrote --

6 A. Correct.

7 Q. -- all the way back in 2018?

8 A. Correct.

9 Q. And just to put a final note on it.

10 setting technique aside, setting technique aside,
11 consistent with your published literature, consistent
12 with the textbook that Dr. Sze referenced for us, can
13 a normal ultrasound help us or anyone predict the
14 timing of an HIE insult?

15 A. Aside from the really severe cases like
16 the milder form, like mild to moderate, moderate to
17 severe, those forms will not be helpful for
18 prediction in a standalone technique. That's why the
19 wording in the article says it's a powerful screening
20 tool. It doesn't say, you know, it's a gold standard
21 of imaging or prognostication. It says screening for
22 this matter.

23 Q. No further questions.

24 MS. KAMYKOWSKI: Justin, can you pull up
25 that 6I, and just the top of the title again. I just

1 want to make sure we understand this article that was
2 brought up again. At the very top, even before the
3 title.

4 RE CROSS EXAMINATION

5 BY MS. KAMYKOWSKI:

6 Q. what journal was this published in?

7 A. Journal of Neonatology.

8 Q. And so who would your audience be that
9 this article was published for?

10 A. Primarily neonatologists, the specialists
11 caring for children in the neonatal intensive care
12 unit.

13 Q. And on the far right over here when it
14 has, received June 6th, 2017, accepted after
15 revision, February 28th of 2018, published online
16 June 22nd, 2018, what does that mean?

17 A. So for the final appearances of a
18 scientific article available for the readers, there
19 is a process that happens before. It's such that,
20 you know, we write the article as a team. And then,
21 you know, revisions are made, and then submit it to
22 the journal, which says that we submitted our work
23 back on June 6th, 2017.

24 At that time, the reviewers of the article
25 or the journal provide their reviews and ask us some

1 questions and some areas where there may be
2 disagreements. They may need clarification for or
3 require more imaging exams to make our point.

4 So we get those usually from two or three
5 reviewers, depending on the journal, and then we
6 address them, revise them, and then send it back to
7 the journal again. And then the journal takes the
8 revised article through a review process, and they
9 agreed to that final version of the article back in
10 February 2018.

11 And then from that date on, journal takes
12 its time to make it available online for the readers.
13 And this happens a few months after.

14 Q. Is this is what's called a peer-reviewed
15 publication?

16 A. This is a peer-reviewed publication.

17 Q. And it took them nine months after you
18 initially sent it to them to decide whatever
19 questions they had, to accept your final version?

20 A. They probably gave their questions and
21 comments earlier, but then took some time for us to
22 respond to them, and then for them to review again.

23 So this nine months includes them responding to us
24 and us responding to them, and them reviewing again
25 and then telling us its accepted.

1 Q. I want to make sure that we all understand
2 before we, like, go home, Dr. Tekes. The ultrasound
3 in this case, and Ms. Gunn read -- had you read part
4 of your deposition, is your opinion that ultrasound
5 is not diagnostic at all for Remi?

6 A. No. I wouldn't say that. For the
7 particular question of HIE, it isn't.

8 Q. So when you were, and there was a lot of
9 discussion in your deposition about whether you
10 disregarded or discounted or didn't rely on, is it
11 fair that -- well, what is the reason why for the
12 question that you are here today to answer, the
13 timing of Remi's injuries, that you don't believe the
14 ultrasound is reliable?

15 A. If the technique it poorly executed, the
16 evaluation of the brain tissue and, in fact, the
17 term, we referred to it as brain parenchymal, the
18 brain tissue evaluation is very limited in that
19 technique. And the primary thing that they should be
20 evaluating for HIE. On HIE, we need to be able to
21 see the gray matter and the white matter. In a very
22 nicely executed, you know, patient, this is an
23 ultrasound that is limited. The slide for HIE
24 evaluation is not unfortunately reliable, but --

25 Q. So with your deposition answer that it

1 should not be part of the medical evaluation in this
 2 case, you were talking about the question that we
 3 asked you to answer for us in the context of this
 4 litigation --

5 A. Correct.

6 MS. GUNN: Objection. Leading.

7 MR. PERRON: No further questions.

8 MS. GUNN: It also misrepresents.

9 THE COURT: The Court will sustain the
 10 objection.

11 Any further --

12 MS. GUNN: I have nothing further.

13 THE COURT: Anything further of this
 14 witness?

15 MR. PERRON: No, Your Honor.

16 THE COURT: May this witness be excused?

17 MS. KAMYKOWSKI: She may.

18 THE COURT: Thank you very much, ma'am.

19 THE WITNESS: Thank you.

20 THE COURT: All right. Ladies and
 21 gentlemen of the jury, you're getting your evening
 22 recess now, they're not.

23 (At 4:10 p.m., the jury was duly
 24 admonished and dismissed for the evening, and the
 25 following proceedings were held in open court,

1 outside the presence of the jury:)

2 THE COURT: Okay. We are outside the
3 presence of the jury, have we had a chance, and I
4 know I didn't give you much time, to review maybe
5 exhibits?

6 MS. SLATER: We have, Your Honor.

7 THE COURT: Very good.

8 Do we have a list of the ones we're all in
9 agreement on?

10 MS. SLATER: Yes. And I can provide, if
11 you want me to.

12 Your Honor, before we do that, there is
13 one administrative issue that I need to take up with
14 plaintiffs' case, which is to ask you to take
15 judicial notice of the life table that Dr. Liles
16 referenced. And we're going to mark that as
17 Exhibit 701. It's from the National Vital Statistics
18 Report. It's Table 17, the life table for white,
19 non-Hispanic males, which reflected the -- Remi's
20 expected normal life expectancy of age 75.

21 And I know that we have rested our case.
22 I believe defendants have no objection to you taking
23 judicial notice of that on the record, and we don't
24 need to reread it in front of the jury.

25 MS. KAMYKOWSKI: So, yeah, we have no

1 objection to that.

2 MR. WILLMAN: That is correct.

3 THE COURT: The Court will take judicial
4 notice of Exhibit 701, the life care table -- the
5 life table, No. 17.

6 MS. SLATER: And, Your Honor, what I
7 propose is I will go through and just for the record
8 put our exhibits on. And then to the extent we need
9 to talk through anything that we go through, or we'll
10 reserve any issues they want to bring up at the end.

11 THE COURT: Okay.

12 MS. KAMYKOWSKI: Your Honor, I can just
13 say, as far as we know, there are no objections to
14 any of their exhibits. It would just be discussions
15 about what may or may not be acceptable as a
16 demonstrative to go back to the jury. So with that
17 caveat, I don't think that we have any real
18 objections to admission.

19 THE COURT: Demonstratives never go back
20 to the jury.

21 MS. KAMYKOWSKI: I've had fights about
22 that before.

23 THE COURT: Tom Stewart taught me very
24 well. And he continues to teach me very well.

25 So demonstratives do not go back to the

1 jury. That's just a general proposition. But I will
2 go ahead and list out so we know which ones are
3 admitted, and we can discuss which ones are being
4 deemed demonstrative versus real evidence.

5 MS. KAMYKOWSKI: Thank you, Judge.

6 MS. SLATER: And I can indicate that. As
7 well.

8 So, Your Honor, starting with Day 2 of
9 trial, which was Wednesday, March 12th, 2025, which
10 witness Shinn, we used 135-2, which is Shinn's CV;
11 346, which is a demonstrative of stage one of stages
12 of labor; 347, which is a demonstrative of stage 2
13 and stage 3 of labor.

14 From Exhibit 1, which Exhibit 1 is
15 plaintiffs' group exhibit, which is Sarah Anyan's
16 chart from Mercy, we went through pages 96 through
17 97 -- excuse me -- 100 through 102, 105 through 107,
18 193 through 195, 215 through 216, 226 through 227,
19 230 through 233.

20 We used Exhibit 342, which is the plus 5
21 to negative 5 stations demonstrative. We used
22 Exhibit 135-11, which was an exemplar of fetal
23 monitoring strips from the AWHONN publication;
24 Exhibit 5, which was the fetal monitoring strips with
25 all the notations on them, we used pages 14 and 121.

1 And then we --

2 THE COURT: Slow down for me one second.

3 I lost you after the 135-11, fetal monitor.

4 what was the next one?

5 MS. SLATER: The next one is Exhibit 5,
6 and that particular Exhibit 5 had all of the, if you
7 remember, the notations from the prior deponent. And
8 we used page 14 and 121. And then we used 343, a
9 demonstrative showing the fetal presentation
10 positions of AO, OT, and OP.

11 On Day 3, Wednesday, March 13th, 2025, we
12 started with Dr. Warsof. We used Exhibit No. 100-2,
13 his CV. We used Exhibit 6, which are Dr. McNeive's
14 prenatal records, pages 36, 78, and 206. Again,
15 Exhibit 1, we added pages 109 and 110. From
16 Exhibit 5, we added pages 119 through 135. We used
17 Exhibit 500, which was a time line chart
18 demonstrative, and I believe we used two pages of
19 that, as well.

20 Day 4, Friday March 14th, 2025, in
21 Warsof's redirect, we used Exhibit 420, which is the
22 ACOG OB Care Committees's Consensus No. 1, we used
23 page 1; Exhibit 3 of -- which is the group,
24 Plaintiffs' Group Exhibit, which is Remi Anyan's
25 Mercy chart, we used page 316.

1 In Dr. Kerzner's direct that day, we used
2 Exhibit 115-12, her CV; Exhibit 350, which was her
3 constellation of markers demonstrative, which was two
4 pages; Exhibit 3, we used pages -- added pages from
5 Remi's chart 1572, 2397, 1507, 1509, 1574, 2583,
6 1574, 1586, 1594, 1933, 1935, 1940, 1912, 1923, 1937,
7 1929, and 1992.

8 We used Exhibit 60-1, which is a NICU
9 photo from 4:34 with metadata. We used Exhibit 62-1,
10 which is a NICU photo at 4:34 with metadata.
11 Exhibit 63-1, which is a -- I'm sorry. I'm calling
12 these NICU photos -- they were photos in the delivery
13 room, I'm sorry.

14 So Exhibit 63-1, which was a photo in the
15 delivery room at 4:57 with metadata. Exhibit 344,
16 which was an ACOG guidelines publication.
17 Exhibit 349, which was an illustration from an
18 article by Escobar, titled "Overview of
19 Pathophysiological Features of HIE."

20 Alex Greenwald testified by video
21 deposition, and in her deposition, which we will make
22 the highlighted transcript and admit Exhibit 210.

23 And then we used -- added from Exhibit 1 Sarah
24 Anyan's Mercy chart, pages 210 to 213.

25 And then Exhibit 210-3 was the fetal

1 monitoring strips that Greenwald marked in her
2 deposition. And from that exhibit, we used pages 72
3 to 74, 91, 103, 107, 116, 118 to 123, 126 to 127, 129
4 to 137, 145 to 147, 149 to 150, 152 to 153, 155 to
5 156, 159 to 161, 169, 171 to 173, 176 to 178, 183 to
6 187.

7 we also played the video of Nurse
8 Practitioner Spencer formerly Younger. We marked the
9 highlighted transcript of her deposition as played as
10 Exhibit 205. We used Exhibit 205-4, her delivery
11 note; 205-5, which is Remi Anyan's Apgars in the
12 chart; 205-7, which is the NICU daily note authored
13 by Younger. And from that exhibit, we used pages 1,
14 2, 5, and 5.

15 Day 5, Monday, March 17th, 2025, with
16 Blake Anyan, we used Exhibit 615, which is a picture
17 of Remi with a chef's hat; and Exhibit 620, which was
18 a picture of Remi with a mohawk; Exhibit 601, is the
19 picture of Blake at the warmer in the delivery room
20 at 3:40 -- I'm sorry -- at 3:34.

21 Exhibit 603, another one of Blake at the
22 warmer at 4:34. Exhibit 600, which was a picture of
23 Remi on the warmer at 4:37. Exhibit 604, was a
24 picture from May 5th, 2020, of Remi in the NICU with
25 the EEG connected.

Exhibit 607 is Blake holding Remi in the NICU on May 27th, 2020. Exhibit 613, was Remi's first birthday. Exhibit 616 was a picture of Remi and Blake doing the victory arms. Exhibit 633 is a picture of Remi's third birthday.

Exhibit 641 was a picture of Remi on St. Patrick's Day. Exhibit 642 was a picture of Remi and Blake fishing. And Exhibit 654 was a picture of Remi and his sister, Rory, on a blanket.

In Sarah Anyan's direct exam, we used Exhibits 6-110, which is a note from her prenatal care from Dr. McNeive from March 13th, 2020. We used Exhibit 602, which is a picture of the first time Remi was on her chest in the delivery room. Exhibit 609, which is a picture of Remi in the NICU. Exhibit 606, which was a video of Remi crying on May 18th, 2020.

Exhibit 610, which was a picture of Remi in his 2020 NICU graduate onesie. Exhibit 612, which was a video from April 2021, which Sarah described as him doing his funny business on the diaper pad, which was a video of seizures or that type of activity.

Exhibit 650 is Remi and Rory, a picture of them together.

we also played Dr. Liles' video

1 deposition. Exhibit 125 is the highlighted
2 transcript of Dr. Liles' March 10th, 2025, deposition
3 that was played for the jury.

4 Exhibit 125-8 is a narrative report.

5 Exhibit 125-34 is the printout of cerebral palsy from
6 lifeexpectancy.org. Exhibit 125-13 is the costing
7 research he produced. Exhibit 125-9 is his life care
8 plan that was a facility care option to age 60
9 exhibit.

10 Exhibit 125-10 was the home care option to
11 age 60. Exhibit 125-14 was the facility care option
12 life care plan to age 75. Exhibit 125-15 was the
13 home care option to age 75, of which we showed page
14 1, 4, 7 through 15 and 17 through 43. Exhibit 125-11
15 was a cost spreadsheet with the facility care option
16 to age 60. Exhibit 125-12, was a cost spreadsheet
17 with home care options to age 60.

18 Exhibit 125-16 was the cost spreadsheet
19 with facility care options to age 75. Exhibit 125-17
20 was the cost spreadsheet with the home care options
21 to age 75. Exhibit 125-31 was the demonstrative of
22 all of the life care plan totals from each of the
23 four options.

24 Day 6, today, Tuesday, March 18th, 2025,
25 with Dr. Nelson, we used Exhibit 120-2, which was his

CV. Exhibit 355 was a demonstrative of HIE.

Exhibit 354 was a demonstrative showing the parts of the brain affected by partial prolonged and acute profound injury.

with Dr. Sze, we used Exhibit 130-2, his CV. We used Exhibit 130-8, his narrative report. We used Exhibit 357, which was the PowerPoint that he produced and used to explain his opinions to the jury, of which we used all slides to that PowerPoint.

we also used Exhibit 3 from Remi Anyan's Mercy chart, page 1983.

we read the medical bill stipulation to the jury. I believe we read paragraph 2 and 3 as filed. we marked that as Exhibit 700.

And we have asked the Court to take judicial notice of Table 17 of the National vital statistics 2021 report for white, non-Hispanic male life expectancy, and we have marked that as Exhibit 701.

THE COURT: Thank you. Those will be admitted.

Rather than going through what's demonstrative, what's not, it doesn't really become an issue unless the jury asks for it, so let's not borrow extra trouble.

1 The Court has had an opportunity to review
2 the submissions of Plaintiffs' Exhibit 141 with
3 regards to 141-2 and 141-24 relative to John Paul --
4 John Gringas, which was provided to the Court as an
5 offer of prior, to which the Court had reviewed all
6 of the information, and at this time, it's going to
7 deny the plaintiffs' request to allow that witness to
8 testify.

9 MS. SLATER: Thank you, Your Honor.

10 THE COURT: I think the next matter we
11 need to address is probably yours.

12 MS. KAMYKOWSKI: I believe I think Mr.
13 Perron is going to start with his.

14 (A discussion was held off the record.)

15 MS. KAMYKOWSKI: Judge, on behalf of Mercy
16 Hospitals East Communities, I would move at the close
17 of plaintiffs' evidence for a directed verdict in
18 their favor. I would seek leave from the Court to file
19 a written supplemental motion in support of this, but
20 the basis would be that the plaintiff, after having
21 an opportunity through Nurse Shinn and Dr. Warsof to
22 causally tie any alleged negligence to the damages in
23 the case, we believe that they have not met that
24 burden, and, therefore, the verdict should be in
25 favor of Mercy Hospital.

1 THE COURT: Thank you.

2 on behalf of Mercy Clinic and Dr. McNeive?

3 MR. PERRON: Yes, Your Honor.

4 (A discussion was held off the record.)

5 MR. PERRON: Your Honor, first with regard
6 to punitive damages against Mercy Clinic, the Court
7 is aware of the procedural history, but just to
8 highlight, I've got a courtesy copy of that, if that
9 would be helpful for Your Honor.

10 THE COURT: Sure.

11 MR. PERRON: The plaintiff initially filed
12 their petition alleging punitive damages against all
13 parties. Among all of the defendants, Dr. McNeive
14 and Mercy Clinic, moved to dismiss those punitive
15 damages claims.

16 It was the Court's later order
17 acknowledging that plaintiff would consent to dismiss
18 punitive damages claims with the idea that they would
19 be allowed under section 538.210 to timely seek to
20 amend. They later did seek to amend the punitive
21 damages against Mercy Clinic, Dr. McNeive, and the
22 hospital.

23 At the time the Court made its order, the
24 order only clearly referenced granting leave to file
25 punitive damages against Dr. McNeive but did not

1 address Mercy Clinic, whatsoever. Plaintiff later
2 brought a -- later amended their petition, and,
3 again, conforming to the order of the Court, brought
4 punitive damages and claims against Dr. McNeive but
5 did not so allege against Mercy Clinic.

6 when that was noted at the pretrial
7 conference, plaintiff filed a motion for leave to
8 amend by interlineation. Prayer for relief was to
9 both amend the previous order granting leave. It
10 also grants them leave to amend to add punitive
11 damages against Mercy Clinic.

12 And this, Your Honor, gets to the heart of
13 the issue now before the Court. Section 538.210,
14 which, in the Court's order and in all the pleadings,
15 everyone has acknowledged Section 510.261, which
16 everyone, including the Court's order, acknowledge is
17 controlling, sets out clear criteria for punitive
18 damages against an employer.

19 And the plaintiffs' pleading burden and
20 substantive burden is once you bring a punitive
21 damages claim against an employer, it's not just that
22 they have to prove that the defendant employed, who
23 they're seeking to get punitive damages against, but
24 also one of those four factors. And the motion for
25 leave to amend by interlineation did not include any

1 specific language they wanted to add in between the
2 lines.

3 There was no exhibit attached to the
4 motion to amend by interlineation, and there was no
5 later filed third amended petition pleading their
6 necessary facts to make a submissible case against an
7 employer the actions of an employee. So this -- this
8 is the heart of the matter, Your Honor. We're now at
9 the close of plaintiffs' case.

10 Missouri statute, controlling Missouri
11 statute, explicitly says if you want to get punitive
12 damages against an employee for the -- for the
13 actions of an employee, you have to allege further
14 facts beyond just an employer/employee relationship.
15 Those facts have not ever been pled let alone
16 submitted evidence to support them during the
17 plaintiffs' case-in-chief.

18 So for those reasons, Your Honor, just a
19 simple reading of the statute, it failed to plead the
20 necessary facts. They have failed to make a
21 submissible case against Mercy Clinic for punitive
22 damages for the conduct of their employee, Dr.
23 McNeive.

24 THE COURT: Response?

25 MS. SLATER: Your Honor, if I may respond

1 in total for the motion for directed verdict?

2 In regards to the sufficiency of our
3 evidence, I'd like to remind the Court on Day 2 we
4 presented testimony of Dr. Shinn. She is a PhD and
5 RN. Talked about the nursing standard of care and
6 discussed how the nurses, specifically Nurse Jessie
7 and Nurse Maggie, who participated in Sarah Anyan's
8 care, fell below the standard of care by failing to
9 act and advocate for a C-section after 8:00 a.m., and
10 then onward to delivery. Failed to meet hospital
11 protocols for Pitocin administration. Failed to
12 manage Pitocin in the setting of failure to progress
13 prolonged, extremely prolonged, labor in calculating
14 a Category III tracing. Failure to invoke the chain
15 of command regarding care plan, changing the care
16 plan for Sarah Anyan.

17 We presented the records and strips and
18 facts of the case initially through Dr. Shinn. We
19 then heard from Dr. Warsof. He talked about the --
20 he's a maternal-fetal medicine doctor, and he talked
21 about how Dr. McNeive fell below the obstetric
22 standard of care. He should have delivered and
23 caused for Ms. Anyan to be delivered after 8:30, 9:30
24 and onward on May 4th.

25 The standard of care required him to

1 change the care plan to deliver by operative vaginal
2 delivery or C-section based on the abnormal fetal
3 monitoring strips, no progress, and the extremely
4 prolonged second stage of labor.

5 Dr. warsof discussed that he did not stop
6 Pitocin in the face of the abnormal fetal monitoring
7 strips, and he had discussed in allowing the second
8 stage of labor to go for over 12 hours was extremely
9 rare, extremely outside of the bounds of what
10 obstetric care is required for safe and foreseeably
11 safe delivery for the patient and the baby.

12 He discussed how it's only acceptable to
13 take the mom beyond three to 4 hours if mom and baby
14 are doing well and making progress. Dr. warsof also
15 discussed how Remi was born depressed, and the fact
16 that Dr. McNeive did not order blood gases was
17 further -- that may have showed evidence to allow
18 Remi to access care that would improve the severity
19 of his injury or alleviate and avoid further injury
20 was below the standard of care and particularly
21 egregious.

22 He -- Dr. warsof also gave evidence about
23 the nursing standard of care, and that the nurses in
24 the same day were required to turn down the Pitocin
25 allowed, without advocating for Sarah Anyan, to go

1 through an absurdly-prolonged labor and discussed how
2 they should have advocated for a C-section after the
3 8:30, 9:30 time frame. He discussed how the failures
4 in the standard of care for both the -- Dr. McNeive
5 and the nurses, caused or contributed to cause,
6 injuries to Remi.

7 We next heard from Dr. Kerzner, she's a
8 neonatologist, regarding causation and damages. She
9 had discussed how the cause of the injury was the
10 ongoing second stage of labor. The depletion of
11 fetal reserves caused permanent brain damage to Remi
12 that was caused by HIE or a loss of oxygen and blood
13 flow. We presented photos from the delivery room.

14 And she discussed how the nature of the injury had to
15 do with of course the HIE but also reperfusion, and
16 that it did not happen days before she arrived at the
17 hospital or went into labor.

18 Dr. Kerzner discussed the constellation of
19 markers that supported her opinion. She had 27 line
20 items that she shared with the jury that supported
21 her causation opinions. She also called into
22 question the Apgar scores and believed that a lower
23 Apgar score was more appropriate, given the facts of
24 the case and cross-referencing the medical records.
25 She said that if he had been delivered by 2:00 p.m.,

1 he would have been -- Remi would have avoided most of
2 the injury.

3 we played the video deposition of Alex
4 Greenwald. She was a treating nurse on the shift
5 before our experts are critical of the standard of
6 care for those providers. She explained the strips
7 and the fact that there were no concerns up to the
8 shift change as far as Remi's status.

9 we presented testimony by video of Nurse
10 Practitioner Spencer, who was Younger at the time.
11 She discussed how Remi had presented at delivery and
12 her records and also what would call into question
13 the Apgar scores, as well.

14 On Day 5, we heard from Blake Anyan. He
15 discussed the McNeive's, the Dr. McNeive's actions,
16 as well as the actions of the nurses, and reported
17 what he experienced and saw as when he was present
18 for the entire labor and delivery of Sarah Anyan and
19 the birth of his son and subsequent NICU stay. He
20 discussed Remi's condition, as well as his -- he gave
21 evidence of what Remi's damages have been.

22 Then we heard from Sarah Anyan, and she
23 introduced Remi to the jury. She also discussed Dr.
24 McNeive's actions, the nurses' actions, and described
25 Remi's condition. Both Blake and Sarah discussed

1 exactly what was told, and more specifically, what
2 they were not told during the labor and delivery.

3 They had no idea that there was concern
4 for their baby or that they were in the midst of
5 undergoing the longest second stage pushing labor
6 that any of the providers had ever experienced.

7 Dr. Liles testified next. He is a
8 physical medicine and rehab physician and a certified
9 life care planner. He agreed that the cause of
10 Remi's injuries are from hypoxic ischemic
11 encephalopathy. He testified regarding the life care
12 tables that would show Remi's normal life expectancy
13 to age 75. And he testified that there -- that
14 Remi's HIE would cause a decrease in his life
15 expectancy reasonably to age 60.

16 He provided a life care plan that he
17 prepared in October 2023. It had four options,
18 ranging from a -- starting from the premises that
19 Remi needs 24/7 care for the rest of his life, and
20 provided four options, with home care option and
21 facility care option, each to age 60 and 75. The
22 cost for that care ranged from 14 million to \$21
23 million. He opined that Remi would never be able to
24 be gainfully employed or lived independently and that
25 he requires 24/7 care.

1 This morning we provided an offer of proof
2 to this Court, which I understand has been denied,
3 but that would have provided further evidence of
4 Remi's damages. We presented testimony from Dr.
5 Nelson. He is a pediatric neurologist. He discussed
6 that the cause of Remi's injuries are from HIE. That
7 the last 30 to 45 minutes to an hour could account
8 for all of his injuries. And if he was delivered
9 before that time period, Remi would be normal or near
10 normal. He discussed that a cord blood gas, if it
11 had been drawn, would have likely shown acidemia, and
12 discussed Remi's damages as a child with a severe,
13 profound brain damage.

14 Dr. Zse was offered next. He is a
15 neuroradiologist. He reviewed Remi's imaging and
16 records. He gave opinions regarding the timing of
17 when you can tell that injury occurred, which it
18 was -- that the injury occurred at or near the time
19 of birth, and that it was caused by HIE.

20 Plaintiffs provided and read the joint
21 medical bill stipulation to the jury which provided
22 evidence of Remi's past medical bills which totaled
23 \$593,000 charged in the past. The testimony,
24 evidence, records, pictures, experts' opinions that
25 were all based on a reasonable degree of each of

1 those experts' professional certainties were
2 sufficient evidence that McNeive, the Mercy Hospital
3 nurse -- and the Mercy Hospital nurses breached the
4 standard of care, and that Remi's damages are caused
5 by the HIE that could have been prevented had Dr.
6 McNeive and the Mercy Hospital nurses acted
7 differently under this scenario.

8 As far as the punitive damages, McNeive,
9 as an employee of Mercy Clinic, never informed Remi's
10 parents of the dangers to -- of the danger both Sarah
11 and Remi were in as she labored for an absurdly long
12 labor, over 12 hours. And purposefully, over that
13 length of labor, never changed her plan of care.
14 And, instead, chose and intentionally gave care and
15 treatment to other patients in the form of
16 emergency -- excuse me -- in the form of C-sections,
17 which was exactly the type of care that she required
18 at that time.

19 In his clinical decisionmaking, if he
20 would have prioritized other patients over Sarah
21 Anyan as she continued to labor through the longest
22 labor he and any of the other providers had ever
23 experienced. His training and experience would have
24 told him the extremely dangerous position that she
25 was in, and the foreseeable nature of a 12-hour

1 pushing stage leading to not only what plaintiffs
2 have presented evidence happened, which was a
3 catastrophic brain injury, but also the zone of
4 danger of other causes and complications that would
5 arise from a 12-hour pushing stage.

6 As far as Dr. McNeive's conduct under that
7 scenario, understanding that the baby was born
8 depressed in a very black and white violation of the
9 standard of care in bringing her through a 12-hour
10 labor, he intentionally failed to order cord blood
11 gases, which may have allowed Remi to access care and
12 treatment that would have alleviated his injury or
13 halted the severity of that developing injury.

14 Those actions directly causing or
15 contributed to cause damage to Remi. And regarding
16 the clinic argument that Mr. Perron made, the clinic
17 has obviously endorsed his actions. There's case law
18 that supports that the way in which a defendant
19 defends a lawsuit can be evidence of punitive
20 damages, as well as far as how they endorse the
21 conduct.

22 It is -- I can't go by without stating
23 that we have attorneys that represent both the clinic
24 and the doctor who are arguing for one client over
25 the other regarding the punitive damage issue, and I

1 believe that is a conflict for them and Dr. McNeive
2 is that you're to be present for this part of the
3 court proceedings, and we have not had any entry of
4 personal counsel for Dr. McNeive.

5 In regard to the procedural posture that
6 was mentioned by Mr. Perron, we believe that our
7 arguments at that time led the Court to take the
8 correct actions, and we'll stand on that briefing.

9 THE COURT: Thank you.

10 The Court is going to deny the motions on
11 behalf of Mercy Hospitals and the nurses. With
12 regards to Mercy Clinic and Dr. McNeive, the Court is
13 going to deny the motion for a directed verdict at
14 this time.

15 MS. SLATER: Thank you, Your Honor.

16 MR. WILLMAN: We have a separate motion
17 for Dr. McNeive.

18 Adding onto the procedural history that
19 Mr. Perron, my partner, gave, the context of this
20 should be what the statute says. And as the Court is
21 well aware, the statute explicitly says that:

22 Evidence of negligence, including but not limited to,
23 indifference to or conscious disregard for the safety
24 of others, shall not, shall not, constitute
25 intentional conduct or malicious conduct, which is

1 what the proof should be.

2 Ms. Slater gave a very comprehensive
3 summary of their negligence claim without any
4 evidence of intentional conduct or malicious
5 misconduct on the part of Dr. McNeive.

6 And Dr. Warsof established a number of
7 points that work against any kind of intentional or
8 malicious misconduct. And, in addition, the
9 testimony of Mr. and Mrs. Anyan, there's no evidence
10 that Dr. McNeive did anything or said anything to
11 them or to anyone else that even comes close to the
12 clear and convincing evidence, which is the burden of
13 proof that the Court must apply to allow the
14 submission for punitive damages.

15 The Court has a power, as the gatekeeper
16 under that statute, to review this evidence and make
17 a decision, and should do so because the Court needs
18 to determine whether the conduct was so egregious
19 that it was tantamount to the intentional wrongdoing.

20 So I can go through the point of Dr.
21 Warsof's testimony, but there's been no evidence, no
22 documents, no testimony that Dr. McNeive did anything
23 that rises to that clear and convincing burden of
24 proof that he intended to cause harm to this baby,
25 that he intended to cause harm to anyone, that he

1 made any statements that were malicious in nature.

2 In fact, all the evidence about his
3 conduct, that he was caring, and he was
4 compassionate, he was concerned, nothing that was
5 presented in plaintiffs' case rises to that level of
6 clear and convincing evidence or that is --
7 approaches malicious misconduct or intentional
8 conduct that caused harm to this baby.

9 THE COURT: I appreciate the argument. I
10 believe the statute has created some challenges for
11 us that have yet to be resolved at the higher level
12 with regards to the definitions of those terms and
13 whether or not there's any daylight between them
14 because we have yet to figure out an example that
15 actually would show any daylight between them.

16 There's a reason why they use them both,
17 or at least we have to presume there's a reason they
18 use them both, with what's involved in the statute.

19 So the Court is going to deny the motion
20 for a directed verdict on behalf of Dr. McNeive.

21 MR. WILLMAN: All right. Thank you,
22 Judge.

23 THE COURT: Anything else that we need to
24 discuss this afternoon?

25 MS. SLATER: Not from plaintiffs, Your

Honor.

MS. KAMYKOWSKI: No, Your Honor. Thank
you.

(The court stood in adjournment at
4:52 p.m.)

o o o

*** End of Volume 1 of 2 ***

REPORTER'S CERTIFICATE

I, Melissa A. Schardan, a Certified Court Reporter, hereby certify that I was the official court reporter for Division 18 of the Circuit Court of the County of St. Louis, State of Missouri; that on the 11th day through the 25th day of March, the 5th day of May, the 20th and 22nd day of May, the 20th day of August, the 17th day of September, and the 4th day of December of 2025, I was present and reported all the proceedings had in the case of R.A., a minor, by and through His Next Friends and Natural Parents, Sarah Anyan and Blake Anyan, Respondents, vs. Mercy Hospitals East Communities d/b/a Mercy Hospital St. Louis, Mercy Clinic East Communities d/b/a Mercy Clinic OB/GYN and Dr. Daniel McNeive, Appellants, Appeal No. ED113824/Cause No.

21SL-CC03944; and I further certify that the foregoing pages contain a true and accurate reproduction of the proceedings had on those dates.

/s/ Melissa A. Schardan

Melissa A. Schardan, CCR #0743
Official Court Reporter
Twenty-First Judicial Circuit
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