

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.

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Appellate Trial Transcript

Volume 2 of 2

March 19-25, 2025

Posttrial Motions

May 5, 22, August 20, September 17, December 4, 2025

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GUNN | SLATER

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Wednesday, March 19, 2025

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(At 9:04 a.m., the following proceedings
were held in open court, in the presence of the
jury:)

THE COURT: Go ahead and be seated.

on behalf of the defendant?

MR. PERRON: Defense would call
Dr. Woodruff.

THE COURT: Sir, if you'd step on up and
be sworn.

BRIAN WOODRUFF, M.D.,
having been duly sworn, was examined, and testified
as follows:

DIRECT EXAMINATION

BY MR. PERRON:

Q. would you please introduce yourself to the
jury.

A. Good morning. My name is Brian Woodruff.

Q. Do you have a subspecialty in medicine?

A. Yes. So I'm a pediatric neurologist.

Q. So the jury has heard from a lot of
different specialties.

Could you help them understand the

1 differentiation between neurology versus
2 neonatologist or obstetric care?

3 A. Yeah. So obviously different specialties.
4 So pediatric neurology, we take care of a combination
5 of neurology and pediatrics. We take care of
6 children. Children, you know, being college age and
7 below and as it relates to anything neurological:
8 brain, brain stem, spinal cord, nerves, and muscles.

9 Neonatology, instead of having an organ
10 system that they focus on, they focus more on a time
11 frame. So they're taking care of babies after
12 they're born for a period of time that they're in the
13 neonatal intensive. So they're sort of like a
14 primary care physician for newborn babies or
15 premature babies. And then obstetrics is the
16 profession of delivering babies and taking care of
17 pregnant mothers.

18 Q. Did our office send you records and other
19 materials to review as part of this cases?

20 A. Yes. I received I think in excess of
21 10,000 pages of records.

22 Q. Did you arrive at opinions pertinent to
23 the likely timing of Remi's injury?

24 A. I did.

25 Q. Will you give all your opinions today to a

reasonable degree of medical certainty?

A. I will.

Q. what is your ultimate opinion on the timing of Remi's neurologic injury?

A. So Remi had a severe brain injury. And it did not happen within the last 30 minutes, just prior to the delivery.

Q. Doctor, do you have a CV or curriculum vitae that explains your background and education?

A. Yes. I gave that to you some time ago, yes.

MR. PERRON: Justin, if you want to go to the CV, F7-B.

Q. (By Mr. Perron) And just to take us through --

MR. PERRON: Justin, You might scroll down just a little bit and blow up the education.

(By Mr. Perron) Take us through a little bit of your educational background.

He's going to blow it up here. Probably the next page.

A. So you can see I'm a Big 10 guy. So I went to the University of Michigan for undergrad, graduated in 1995, and then travelled across state, and I went to medical school in Michigan State

1 university. So that was eight years after I
2 graduated high school.

3 Q. (By Mr. Perron) And then from there, did
4 you pursue a medical education?

5 A. I did. So following medical school, we do
6 residencies and fellowships, meaning we're not
7 capable of taking care of patients when you graduate
8 medical school. We've got the foundation of
9 knowledge, but we don't have the skills, kind of the
10 boots on the ground skills.

11 So I did another 5 years of training
12 following that. I did two years of general
13 pediatric. And I think if you'll pull that up, but
14 if not, I did two years of general pediatrics at the
15 University of Wisconsin.

16 And then I went back to the University of
17 Michigan and did three years of training in adult
18 neurology and pediatric neurology. And that all--
19 so from the end of high school until I was done, that
20 was 13 years, and that concluded in 2004.

21 Q. What is your current professional status?

22 A. So I'm a professor at the University of
23 Illinois.

24 Q. And describe your practice for the jury.
25 Sort of your everyday practice, the patients that you

1 see, and your role in their care.

2 A. Yeah. So they're kind of, in my mind,
3 there are two kinds of physicians out there often.

4 Little bit simplistic. But there are the researchers
5 that write all the papers, and there are a lot of us,
6 the boots on the ground, that take care of most of
7 the patients.

8 And, you know, and so I'm the latter. I
9 tend to focus my time on taking care of patients.

10 And so my practice now entails both inpatient and
11 outpatient. I take care of children and young
12 premature babies in the neonatal intensive care unit,
13 term babies, as well as kids on the pediatric floor,
14 the pediatric ICU, and then -- so that's what I do
15 part of the time, the inpatient work.

16 And then outpatient work, seeing kids in
17 clinics, taking care of kids with various neurologic

18 disorders. So a combination of both inpatient and
19 outpatient pediatric neurology. Along with my

20 teaching. I teach medical students and pediatric
21 residents neurology while we're rounding, kind of

22 like you see on shows, and you round, and everybody's
23 kind of going to bedside-to-bedside. And you're
24 teaching as you work.

25 Q. Are you board certified, Doctor?

1 A. I am. So for pediatric neurology, we're
2 board certified by the American Board of Psychiatry
3 and Neurology. There's kind of two sides to it.
4 They board certify the psychiatrists and
5 neurologists.

6 I'm board certified by them. And I'm a
7 diplomate of the American Board -- it's a long way of
8 saying board certified -- but I'm a diplomate of the
9 American Board of Psychiatry and Neurology, with
10 special qualification in child neurology. It's a
11 mouthful.

12 Q. As part of your education, training, and
13 experience, do you review literature in your field to
14 help build your knowledge and keep up to date about
15 the current stage of medicine?

16 A. Almost every day. It's important.

17 Q. From your knowledge of pediatric
18 neurologic literature, do you have an understanding
19 that you can explain to the jury how babies respond
20 to hypoxic insults to the brain, and how they appear
21 when they're born following a hypoxic injury?

22 A. Absolutely. Based on my training,
23 experience, education, and understanding of the
24 literature, I am certainly capable of explaining that
25 to the jury today.

1 Q. And, again, you mentioned it in part of
2 your answer. There's both the literature, but you
3 also have clinical hands-on experience seeing and
4 treating babies that have experienced some type of
5 hypoxic neurologic injury.

6 A. Absolutely. Almost every week that I am
7 on service, I'm on service 12 weeks a year, almost
8 every week that I'm on service, I will be asked to
9 come to the neonatologist intensive care unit and see
10 a newborn baby, whether they're premature or term,
11 that has a question of encephalopathy, whether it's
12 hypoxic ischemic encephalopathy or some other cause.

13 Q. So the jury has heard from several
14 experts: Dr. Kerzner, Dr. Warsof, Dr. Nelson. Their
15 opinion is that Remi suffered a global permanent
16 hypoxic injury in the last 30 or even last 14 minutes
17 of the labor and delivery.

18 So just to take a step back, do you have
19 an opinion or do you agree with those expert
20 opinions?

21 A. Well, no. I mean, it's not based on as
22 what I look at as a pediatric neurologist. That's
23 not possible that this happened, you know, if what
24 you're saying is an assumption that this must have
25 happened in the last 30 minutes prior to delivery

1 based on how Remi looked following the delivery,
2 that's just not possible.

3 Q. So from your understanding of the
4 literature and your clinical experience, how do
5 babies appear clinically when they're born if they've
6 experienced a -- this global permanent hypoxic injury
7 in the last 30, 40 minutes, how do they look?

8 A. They're severely abnormal. So there's the
9 combination, I'm sure you talked Apgar scores up to
10 this point. But Apgar scores are at 1 minute. And
11 then once you -- it first stops. So it -- that first
12 number between 0 and 10. There's 5 categories. And
13 once you get to a score of 8, generally you'd stop.

14 So you always get a 1-minute and a
15 5-minute. And then if it's less than 8, then you go
16 on. And it tells us about how the baby is doing. 8
17 is certainly normal, and that's what Remi had at the
18 5-minute mark as reported in the chart.

19 And so you would have -- you would have
20 significantly more abnormalities. More need for
21 resuscitation, more need for support in those few
22 minutes of life.

23 Q. Is there literature that you're aware of
24 that speaks directly to how babies appear when they
25 have suffered a hypo -- significant permanent hypoxic

1 injury in the last terminal stage of labor and
2 delivery?

3 MS. SLATER: Objection, Your Honor. May
4 we approach?

5 THE COURT: You may.

6 (The following proceedings were held at
7 sidebar, outside the hearing of the jury:)

8 MS. SLATER: Your Honor, this witness was
9 just asked about literature, his knowledge of
10 literature and if he's aware of literature that
11 supports his opinion. He produced absolutely no
12 literature in his deposition.

13 In his file there was one article that he
14 brought that was something about genetics that he had
15 sent the lawyers earlier, and he said it had nothing
16 to do with his opinions.

17 We have absolutely no literature that this
18 expert has produced to us or relied on to suggest
19 that he knows about all this literature that supports
20 his opinion at this point. It's completely unfair,
21 prejudicial, and a surprise for this witness's
22 opinion.

23 MR. PERRON: So, Your Honor, in two parts:
24 In his -- one of his answers, he mentions a
25 particular piece of literature written by Dr.

1 Pasternak, and he didn't produce it, but he said he
2 was aware of it. And that forms part of the basis of
3 his opinion.

4 I'm not going to put it up on the screen.

5 I'm only going to ask him about his knowledge of this
6 article that he mentioned specifically in his
7 deposition, this Pasternak article. And I'm not
8 going to put it up. We --

9 MS. SLATER: which one is it? There are
10 several Pasternak articles. I looked them up.
11 There's a lot of Pasternak articles where he has not
12 produced those.

13 MR. PERRON: I don't think he has to say a
14 particular one. He's aware of this literature by
15 this Dr. Pasternak.

16 THE COURT: Did he specify in the
17 deposition which article?

18 MS. GUNN: No.

19 MS. KAMYKOWSKI: He didn't pull it up in
20 the deposition, but he did talk about it and what his
21 knowledge was from that article in response to the
22 questions by Ms. Gunn. That's the only thing that
23 he's going to talk about. That's exactly what he
24 said in his deposition.

25 MR. PERRON: There's a study about 11

1 babies.

2 MS. SLATER: On 39, line 5, he says the
3 name Pasternak and says there are Pasternak articles.

4 He does not --

5 MR. PERRON: The classic Pasternak
6 article.

7 THE COURT: Was that article ever provided
8 to plaintiffs?

9 MR. PERRON: No, Your Honor. And, again,
10 he's just going to give the same answer, which is
11 what he said in this depo.

12 THE COURT: But it is unclear as to which
13 article he's speaking about. Even though he says the
14 classic one, I don't know what the classic one is.
15 And it's a very generalized statement as to the acute
16 injuries that it addresses.

17 They should have been provided a copy of
18 the article he was speaking about if -- so that they
19 could then review it and determine whether or not it
20 does in fact support his statements or not support
21 his statements.

22 To allow him to, in essence, support his
23 statements by this Dr. Pasternak without the ability
24 to cross examine on it seems inappropriate, so the
25 Court is going to sustain the objection.

1 MR. PERRON: And I understand the
2 objection about a particular name of a doctor. But
3 just as he said, he is aware of literature as part of
4 his regular competency. I'll raise it within the
5 context of his clinical experience without referring
6 to a specific article.

7 THE COURT: That's fine. That's fine.

8 MS. SLATER: Your Honor, I think any
9 reference to any literature that is not in the case
10 that he refers to bolster his opinion is unfair, and
11 I will have to continue to object.

12 THE COURT: I understand. The fact that
13 he says literature is something that he uses on a
14 regular basis, it's nebulous, and obviously on
15 cross-examination can be addressed with regards to
16 the fact that there's no specific articles that were
17 provided.

18 MS. SLATER: okay.

19 MS. KAMYKOWSKI: well, Your Honor, I think
20 if she asks that kind of question, then she would be
21 stuck with whatever his answer is.

22 THE COURT: Correct.

23 MS. KAMYKOWSKI: okay.

24 THE COURT: Did he provide any articles to
25 her?

1 MS. KAMYKOWSKI: No. But he mentioned
2 them. I mean, I can see him saying -- I don't want
3 us to be caught, me getting caught, because our
4 witness answers as to what he said in his deposition,
5 she didn't provide one, but he referenced one.

6 THE COURT: That's not providing.

7 MS. KAMYKOWSKI: Thank you.

8 (Proceedings returned to open court.)

9 Q. (By Mr. Perron) Doctor, in your
10 experience and your knowledge of the literature, how
11 do babies appear in the immediate minutes after
12 they've suffered a global permanent hypoxic injury?

13 A. So think very, very low Apgar scores. In
14 general, a 5-minute Apgar score is almost always 5 or
15 less. If there is as severe of an injury as Remi
16 had, in that time immediately before the delivery, so
17 zero, 1, 2, 3, 4, or 5. And that's based on my
18 experience as also supported in the literature.

19 Q. So there's been a suggestion that Remi's
20 true Apgar score might have been a 7 instead of an 8.
21 Even just taking it as a hypothetical, and
22 the Apgar score would have been 7, is that consistent
23 with a global permanent hypoxic injury in the last
24 few minutes of the labor and delivery?

25 A. No. 7, 8, 9, and 10 are all very

1 reassuring.

2 Q. They would have had to have been
3 significantly off on that Apgar score in order for it
4 to be consistent with your understanding of how
5 babies appear?

6 A. Yes. Because if you have that severe of a
7 brain injury, you're going to have injury that the
8 brain stem and the brain are going to be stunned and
9 have significant difficulty with those features,
10 appearance, grimace, the pulse, the respiratory rate,
11 the movement that babies have that make up the Apgar
12 score.

13 Q. Doctor, from a neurologic standpoint,
14 what's going on in a brain when they suffer a global
15 permanent hypoxic injury like the one we're talking
16 about? What happens in those first few minutes?

17 A. So obviously the brain lacks oxygen, and
18 it's -- and it's dysfunctioning. I mean, you need
19 oxygen to produce energy. You need oxygen to produce
20 ATP in order for your cells to work.

21 And when it's immediately following that,
22 it has spent all of its ATP, that is, the battery has
23 been drained, the energy has been lost in the brain.
24 And it takes time, once the oxygen has been delivered
25 back, some areas of the brain have died in those

1 minutes, and other areas have been stunned.

2 And so it takes time for, once the oxygen
3 has returned, for the battery to recharge, the ATP to
4 build back up, so that you can function even, even
5 function in a better state.

6 Q. within the brain, within the organic
7 brain, are there different parts of the brain that
8 control the different aspects of our thinking and our
9 movement and breathing and things like that?

10 A. Absolutely.

11 Q. So when the brain starts to sense that it
12 may not be getting enough oxygen, is there some sort
13 of reaction, or can the brain control, you know, what
14 to prioritize versus what can be sacrificed?

15 A. well, it certainly, it tries to not -- it
16 doesn't -- I mean, there are physiologic mechanisms
17 within the brain. The brain's not thinking about
18 this, but there are physiologic mechanisms in the
19 brain where it will shunt blood, if it has time, to
20 the more critical areas, the deep brain structures.

21 But in a more acute injury, you'll see
22 primarily the areas, because it's so fast and so
23 severe, you'll see those deep brain, sort of the
24 primitive areas of brain, be injured first.

25 Q. So the deep brain, is that also associated

1 with just the breathing and motor function that are
2 essential to continue living?

3 A. Right. The brain stem has our sort of all
4 the automatic functions that's deep down within the
5 base of the brain. And that does our breathing and
6 our heart rate and even a lot of our movement that we
7 don't even think about.

8 And babies work mostly from the deep part
9 of their brains. They're mostly working on a lot of
10 the primitive areas of their brain when they're born.

11 Q. So if there is a global injury, a global
12 permanent hypoxic injury that it is so significant
13 that it's striking even at those deeper parts of
14 breathing and motor function, your experience and
15 your knowledge, is that something that they can
16 bounce back from in just a few minutes?

17 A. They would not. They would not. It's,
18 you know, I don't want to discount. Remi has a very,
19 very severe brain injury. That is -- I am not here
20 to discount how severe Remi's brain injury is. It is
21 severe. And what I see when I examined Remi, and
22 what I see on his imaging, that brain injury that he
23 has is so severe, he would not have bounced back in a
24 matter of minutes. It is not possible.

25 Q. So Remi did need some resuscitation when

1 he was born?

2 A. That is correct.

3 Q. Okay. So we talked about Apgar scores for
4 just a little bit. What kind of resuscitation and
5 how long of a resuscitation do you typically -- would
6 you expect to see in a baby that just, minutes before
7 delivery, had this global hypoxic injury?

8 A. Well, we almost always see 10-minute Apgar
9 scores, meaning that the 5-minute Apgar score is not
10 normal. And then you have to go on, you're still
11 resuscitating. And you get a 10-minute Apgar. And,
12 in fact, the literature would support that the
13 5-minute Apgar score is almost always 5 and below.
14 And it's pretty rare for the 10-minute Apgar score to
15 be a 7 and above.

16 Q. So the fact that they -- well, let me go
17 back.

18 Do you have an understanding, looking back
19 here, was there a 10-minute Apgar score?

20 A. There wouldn't have been because the
21 5-minute was an 8, and you would stop. At that
22 point, you wouldn't need to go on and continue doing
23 Apgar scores once you've achieved that -- that high
24 of a score.

25 Q. In your understanding, what kind of a

1 score would they see that they would think this baby
2 still needs more resuscitation efforts?

3 A. Certainly a 7. But likely something less
4 than a 7.

5 Q. Okay. Doctor, Dr. Nelson testified a day
6 ago and told this jury his opinion that the closer
7 and more significant of a hypoxic injury to the time
8 of resuscitation, the higher the Apgar score would be
9 expected to be.

10 Do you agree with that statement?

11 A. Absolutely not. That makes no physiologic
12 sense. I saw that in his deposition when he -- and I
13 talked about it in my deposition.

14 If you sustained a severe injury, the
15 manifestations are going to be more severe. It
16 doesn't make any sense, from a medical standpoint.

17 Q. So from your understanding, would the
18 Apgar score even be any benefit to you as a
19 neurologist if a baby could be just minutes removed
20 from a focal permanent injury and get a 7 or an 8?

21 A. I guess I'm not understanding the
22 question. With -- can you rephrase it, or...

23 Q. Sure.

24 Do the providers, like yourself, rely on
25 the Apgar score to guide further care like potential

1 cooling?

2 A. well, it's one piece of it. Like cooling
3 is a -- is a decision generally made by the
4 neonatologist following the resuscitation. And
5 cooling, I assume you all have talked about cooling
6 with the jury. I mean, I don't need to go into that.

7 But cooling is a way to try to reduce the
8 potential for injury by providing a hypothermic
9 environment. And there are several components that
10 go into that. One is Apgar score.

11 Q. So in terms of even just as a piece of a
12 puzzle, would we even bother to do the Apgar score if
13 it can be so far off as to miss a global hypoxic
14 injury in the 5 minutes since he was born?

15 A. I mean, the Apgar score is done, and I
16 thought in the chart, so, I mean, Apgar scores are
17 done with every baby, so, I mean, I think...

18 Q. The NICU team was also present, at least
19 the nurse practitioner and a nurse from the NICU team
20 were present, when Remi was born.

21 Did they perform some type of, at least,
22 baseline assessments of Remi at the time he was born?

23 A. I did see sort of a page in the record,
24 there was a resuscitation. And then -- and then they
25 made a decision to leave at that point.

1 MR. PERRON: Justin, can we put up Exhibit
2 A3, page 1572. So, Justin, if you could highlight,
3 this neonatologist consultant. And then the time is
4 5:37.

5 Q. (By Mr. Perron) So this would have been,
6 if Remi was born at -- well, so May 4th, 2020, that's
7 the same day Remi's born?

8 A. Yes.

9 Q. Okay. All right.

10 MR. PERRON: All right. So if you want to
11 scroll down. All right.

12 Q. (By Mr. Perron) Infant with brief
13 spontaneous cry in between the 1-minute and the
14 5-minute Apgar score.

15 Is that significant to you, as a
16 neurologist to know whether or not it is likely that
17 he suffered a hypoxic global injury in just the last
18 30 minutes of labor and delivery?

19 A. It is. I mean, because both my experience
20 and the literature would support that when there is
21 this severe of an injury, just prior to the delivery,
22 almost 100 percent of the time babies are intubated,
23 they have such severe difficulty that they're
24 intubated with a breathing tube, and have to be
25 supported in their respiratory function.

1 so they're not crying in the delivery
2 room. They are -- they are being supported. From a
3 respiratory standpoint, usually what happens is
4 there's a bag and mask ventilation, or there's a mask
5 and bag, and they're being supported.

6 And when they don't perk up in that amount
7 of time, then a clinician will put a -- put a
8 breathing tube in through their vocal cords and down
9 in their lungs to support breathing. And that's the
10 case in -- when you have a severe injury just prior
11 to the delivery.

12 Q. (By Mr. Perron) Spontaneous respirations
13 established.

14 Is that significant to your opinion?

15 A. Goes back to exactly what I just said.

16 Q. In the end, did the NICU nurse decide to
17 send Remi to the NICU?

18 A. Not at that time.

19 Q. Okay. At this time, after the 5-minute
20 Apgar score, after her initial assessment, what was
21 the judgment of the nurse practitioner as to whether
22 Remi should go to the NICU or stay with his parents?

23 A. I think just up there, I can kind of, I
24 don't know. I think right here I see well appearing,
25 you know, and so I'm assuming that they -- I'm

1 assuming they felt -- felt that he was well enough
2 to -- to -- to continue to be.

3 Q. Okay. For infant to remain with parents.

4 A. Yeah. But I think when it's not subtle.

5 I think the important thing is it's not subtle. when
6 babies have this severe of a brain injury, it's not

7 subtle. It's not like, well, maybe they should go to

8 the NICU, maybe not. Maybe they're a little floppy,

9 maybe they're not. These babies are -- it's very

10 clear. They are in such severe state that almost

11 always they're intubated so they would obviously go

12 to the neonatal intensive care unit.

13 Q. Doctor, there was testimony yesterday from
14 one of the plaintiffs' experts, Dr. Sze. In his

15 opinion, at the moment that Remi was born, he had

16 moderate to severe HIE. The moment that he was born.

17 Doctor, we've been talking a little bit in

18 terms of global and hypoxic injury in the last 30

19 minutes.

20 Switch gears a little bit. A baby that is

21 born, and at that moment has already moderate to

22 severe HIE, what do those babies look like?

23 A. well, the severe babies are not moving.

24 They generally have very poor breathing and have

25 little to no movement and no reflexes, no roots, no

1 suck, no Moro, where they kind of come out and do
2 that Moro reflex. The severe babies are not really
3 doing anything. The moderate babies tend to have low
4 tone, feeding difficulties, and those sorts of
5 things.

6 MR. PERRON: Justin, if you want to go to
7 A3, page 239 -- page 2392.

8 Q. (By Mr. Perron) So this is May 4, 2020,
9 at military time 1738.

10 So this is about 5:38 p.m.?

11 A. Correct.

12 Q. And what are we looking at? what is a
13 nursing flow sheet?

14 A. So the nurses do assessments, and we're
15 looking at a system based, from what I can tell, this
16 is an Epic electronic health record -- I happen to
17 work in Epic. It's probably the most common one that
18 most hospitals have. But they'll -- the nurses will
19 do an assessment. And when I was looking at this,
20 originally I said, you know...

21 MR. PERRON: Justin, can you scroll down
22 from 1738 to 2394. Keep it in the same column.
23 Right here.

24 A. Yeah.

25 Q. (By Mr. Perron) So joins with full range

1 of motion. what does -- did that tell you anything
2 about whether or not this baby was encephalo --

3 A. Encephalopathic.

4 well, you know, it's more important right
5 after that movement's symmetric. Because if
6 sometimes if the question is is it range of motion,
7 that's not telling us if it's active or passive range
8 of motion. Like are they moving it, and it's a full
9 range of motion. But the more important part is that
10 the movement was symmetrical. That one side of the
11 body to the other was moving in symmetry.

12 MR. PERRON: And, Justin, if you want to
13 scroll down on the same page. This right here, I
14 want to, Justin, grab the Babinski at the very bottom
15 of the screen right now. Bring that up and hold it.

16 Q. (By Mr. Perron) Doctor, what is the
17 Babinski Moro?

18 A. So -- so, yes. The Babinski is a little
19 different. That would -- that can -- that's not
20 really anything to worry about. The Babinski is like
21 where you scrape the bottom of the foot. I think the
22 important things down here are Moro, root, and suck.
23 Those are primitive reflexes.

24 So a Moro reflex is if -- if there is
25 something that startles a baby, they will have that

1 sort of primitive reflex where their hands will come
2 out, and they'll do kind of a reaching movement. So
3 reflexes are things we don't have volitional control
4 over.

5 The second thing is a rooting reflex. If
6 you have a baby, and you rub on the corner of their
7 mouth, they'll, without even thinking about, they
8 will turn like there's a nipple there, they'll turn
9 in order to feed themselves. So that's a rooting
10 reflex. And then obviously a suck reflex is a reflex
11 in order to feed oneself.

12 Q. Is this documentation -- and this is still
13 in the column of 5:38 p.m., so maybe just an hour
14 after Remi was born -- so is this consistent with a
15 global permanent hypoxic injury in the last 30
16 minutes before delivery?

17 A. It would not be.

18 MR. PERRON: Justin, if you want to go to
19 A3, page 2395. Scroll down.

20 Q. (By Mr. Perron) At the bottom of this
21 page, N-I-P-S, Doctor, what does that stand for?

22 A. So it's a pain scale. So they're looking
23 at signs and symptoms of a baby potentially having
24 pain. Because obviously they can't talk to us, so
25 we're looking at physiologic signs that a baby could

1 be in pain.

2 Q. And is there a time stamp on this?

3 A. 1753.

4 MR. PERRON: Justin, you want to scroll
5 out. And you have to go back to see which column
6 this is in.

7 Q. (By Mr. Perron) So this is?

8 A. I think that's in a separate -- that's in
9 separate -- I think in an electronic health record,
10 that comes out separately. That's a separate
11 evaluation.

12 MR. PERRON: Go back two more pages,
13 Justin.

14 Q. (By Mr. Perron) okay. So this -- this
15 was in this far left column. So military time, 1735.
16 So what time is that?

17 A. 5:35. I always have to do the minus 12.

18 MR. PERRON: So back to 2395, Justin, and
19 it's the score.

20 Q. (By Mr. Perron) So this is at 5:35 p.m.,
21 The relaxed muscles maneuver, relaxed, relax
22 retrained, relaxed retrained.

23 what is this telling us about whether or
24 not Remi is encephalopathic at this moment?

25 A. It's more of pain, you know, looking at

1 signs and symptoms of pain. And based on that, you
2 know, clearly it does not look like he's in distress,
3 based on that evaluation.

4 MR. PERRON: Justin, switching to the
5 mother's medical record. It's A2, page 251.

6 MS. KAMYKOWSKI: 251.

7 MR. PERRON: Can you go back one page,
8 Justin?

9 Q. (By Mr. Perron) okay. So first we have
10 to establish the time.

11 MR. PERRON: So, Justin, if you could
12 scroll up so we know what time this column is in. We
13 have to go back.

14 Q. (By Mr. Perron) okay. So we're in this
15 column. I think 1945 military time.
16 what time is that?

17 A. That's 7:45.

18 MR. PERRON: And then, again, I apologize,
19 Justin for moving around. Back to page 251.

20 Q. (By Mr. Perron) okay. So this is from
21 the mother's medical records.

22 And what are they documenting here?

23 A. Cuddles infant, eye contact with infant,
24 feeds infant.

25 Q. Is this consistent with an encephalopathic

1 inconsolable infant at this time?

2 A. So not consistent with what I would expect
3 likely following a severe 15- to 30-minute brain
4 injury just prior to delivery. Absolutely not.

5 Q. Okay. Just getting to your ultimate
6 opinions on timing. To a reasonable degree of
7 medical certainty, more likely than not, did Remi
8 suffer a global hypoxic injury in the last 30 minutes
9 of labor?

10 A. He did not.

11 Q. How long would a baby need to recover from
12 a global hypoxic injury before they came out looking
13 like Remi did?

14 A. I would say you need to resuscitate for at
15 least 1 to 3 hours, meaning there would have to be an
16 intrauterine resuscitation for at least 1 to 3 hours
17 if he was to come out looking like this.

18 Q. Do you, as part of your practice, review
19 strips? Can you look at a strip and know whether or
20 not it's a good sign or a bad sign?

21 A. I do not review fetal heart monitoring
22 tracings.

23 Q. So you have, in your opinions, in your
24 practice and here, you have to rely on an OB to let
25 you know what the strips says?

1 A. That is correct.
2 Q. Okay. So I'm going to ask you to rely on
3 the opinion of plaintiffs' expert, Dr. warsof, that
4 between the time of presentation at the hospital on
5 the afternoon of May 3rd, and up to the last even 14
6 minutes of labor, that there was no sign in those
7 strips of a global permanent hypoxic injury. If Dr.
8 warsof is true, and it didn't happen in the last 30
9 minutes, do you have an opinion by default when this
10 injury could have occurred?

11 A. As a pediatric neurologist, I cannot tell
12 you when it, I mean, when it occurred. If you're
13 saying Dr. warsof said it could not have occurred
14 between when they hooked up the baby -- hooked up the
15 mom to monitor the baby, until the last 15 to
16 30 minutes.

17 Q. And so --

18 MS. SLATER: Your Honor, objection. May
19 we approach?

20 THE COURT: You may.
21 (Proceedings were held at sidebar, outside
22 the hearing of the jury.)

23 MS. SLATER: Your Honor, counsel is
24 misrepresenting Dr. warsof's testimony and to require
25 cross-examination on fighting about what Dr. warsof's

1 testimony was. I understand that the jury can recall
2 Dr. warsof's testimony, but at this point we object
3 to mischaracterization of the evidence and ask that
4 the jury disregard the last question or state to the
5 jury out loud that the objection to mischaracterizing
6 the evidence has been sustained, if so inclined.

7 MR. PERRON: Your Honor, he testified in
8 his depo, and consistent with just here, that he can
9 exclude the last 30 minutes. But beyond that, or I
10 guess the last hour, but beyond that, he doesn't know
11 the timing. I don't think he's changed at all about
12 what he said in his depo. And I think that he can
13 rely -- I can pose a hypothetical question that
14 another expert is correct. It's just another
15 hypothetical question.

16 MS. KAMYKOWSKI: And I would like to add
17 to that, Your Honor, it is appropriate for Ms. Slater
18 to cross examine him if she felt she needed it. Official Cou
19 Counsel has mischaracterized the evidence in this
20 case. And that would be what cross-examination, like
21 one of the main purposes of cross-examination, but
22 certainly asking a hypothetical question is an
23 appropriate way to elucidate evidence on direct.

24 MS. SLATER: Your Honor, what he just said
25 in front of the jury is that Dr. warsof said that

1 there was no evidence of hypoxic injury within a half
2 hour. And then this witness re characterized it and
3 said, if he says there's nothing on the strips until
4 the last 15 minutes.

5 And counsel just told you that --
6 represented to you that Dr. warsof's opinion was the
7 last hour. So now he has admitted to the Court that
8 he's mischaracterized the evidence and what was said
9 in front of the jury? It's mischaracterization. And
10 what he said to the Court at sidebar is the actual
11 evidence.

12 MR. PERRON: No. Dr. Woodruff said you
13 need at least 1 to 3 hours of recovery to look how
14 Remi did. And then I said, Dr. warsof, in his
15 interpretation, said no hypoxic injury the entire
16 time he was at the hospital, permanent. No permanent
17 hypoxic injury at the entire time he's at the
18 hospital until the last 14 minutes.

19 MS. KAMYKOWSKI: And that was Dr. warsof's
20 testimony.

21 THE COURT: I'm going --

22 MS. SLATER: It's an hour.

23 MR. PERRON: No. Dr. Woodruff said an
24 hour.

25 THE COURT: Dr. Woodruff said what in an

1 hour?

2 MS. KAMYKOWSKI: That it would take at
3 least an hour for a baby to have intrauterine
4 resuscitation if that injury was occurring. Then we
5 have Dr. warsof and the plaintiffs' whole theory that
6 there was no permanent hypoxic injury until the last
7 30 minutes. Well, one expert says 60 minutes, one
8 expert says 30 minutes, one expert says 14 minutes.

9 THE COURT: I'm going to overrule the
10 objection.

11 MS. KAMYKOWSKI: Thank you.
12 (Proceedings returned to open court.)

13 Q. (By Mr. Perron) Doctor, I'm going to back
14 up a little bit.

15 so how long, at the very least, how long
16 would a baby need to be resuscitated in utero to come
17 out looking like Remi did?

18 A. At least 1 to 3 hours.

19 Q. Okay. Now, when you said it is at least 1
20 to 3, does that mean, for the jury, you are intending
21 to tell that Remi was specifically injured 3 hours
22 before delivery?

23 A. No. I'm saying it's at least 1 to 3 hours
24 or sometime before that.

25 Q. Okay. That's beyond the scope of what you

1 can tell by looking at the Apgar score and the
2 medical records?

3 A. Yeah. As a pediatric neurologist, based
4 on the data that I have, I can't tell you with any
5 more detail beyond what I have already stated.

6 Q. Okay. Now, you used the term -- and I
7 apologize, I just realized this now -- "intrauterine
8 resuscitation." I only barely know what that means,
9 and I am questioning myself, as anybody in the
10 courtroom might, what is intrauterine resuscitation?
11 what do you mean by that? what are you trying to
12 describe?

13 A. Just like you could, you know, deliver
14 oxygen and resuscitate a baby outside, things can
15 happen to a baby in utero that then cease happening,
16 and then oxygen is then delivered, and so that is a
17 possibility that can happen.

18 Q. okay. So hypothetically, if this injury
19 occurred sometime prior to delivery, Remi would need
20 at least 1 to 3 hours of good blood flow in the womb
21 to come out looking like he did?

22 A. Yes.

23 Q. Can you put a time stamp and say, okay, he
24 needs at least 1 to 3 hours to recover, and,
25 therefore, I know, boom, this is when the injury

1 happened?

2 A. I do not know when the injury happened.

3 Q. Okay. Just like you said, you rely on OB
4 review of strips to know -- to make assumptions about
5 how the baby's doing in utero?

6 A. Certainly. And clinically, you know, I
7 will go back and look at what the OB -- you know,
8 when I'm rounding, I'll go back and look at what the
9 obstetrician has written or what may be in the
10 maternal records when -- as a clinician.

11 Q. Okay. So just, again, moving backwards in
12 time. Can you, to a reasonable degree of medical
13 certainty, more likely than not, exclude the
14 possibility that this hypoxic injury occurred in the
15 last hour before delivery?

16 A. Yes.

17 Q. Okay. So I'm going to ask you again.
18 I'll represent Dr. warsof has testified in this case,
19 and he, plaintiffs' expert, Dr. warsof, has
20 testified, in his review of the strips, that there
21 was no global injury, permanent injury, from the time
22 Ms. Anyan got to the hospital, up to the last 30 or
23 even 14 minutes, if Dr. -- I'm asking
24 hypothetically -- if Dr. warsof and his
25 interpretation of the strips is correct, if we take

1 his opinion and your opinion together, can you
2 express to the jury hypothetically when more likely
3 than not, to a reasonable degree of medical
4 certainty, Remi was injured?

5 A. well, I've stated that it couldn't have
6 happened in the hour before. And he stated -- if I'm
7 understanding you correctly -- he stated it didn't
8 happen at any time other than the hour before, then,
9 by logic, it had to happen sometime before she was on
10 the strips, on the fetal heart monitoring. I mean,
11 you know, I think that's just kind of putting the
12 logic together.

13 Q. If this injury occurred sometime before
14 Ms. Anyan got to the hospital, is there any way for
15 us, sitting here in 2025, to pinpoint the cause
16 impetus of that hypoxic injury?

17 A. As a pediatric neurologist, I do not know
18 the cause of Remi's brain injury.

19 Q. In your clinical experience and
20 understanding of literature, is it uncommon, after
21 you are made aware of the hypoxic injury, to just not
22 know the actual cause?

23 A. It certainly happens where, as a
24 clinician, when I looked back and tried to look and
25 see if people had been able to determine a reason,

1 it's pretty common that there's not a specific
2 reason.

3 Q. The jury heard late last week from
4 plaintiffs' expert, Dr. Kerzner, who asked a question
5 whether or not there was any genetic testing.

6 So, Doctor, is -- can you exclude the
7 possibility that there was a genetic cause to this
8 HIE?

9 A. I cannot.

10 Q. Okay.

11 MS. SLATER: Your Honor, can we approach,
12 please?

13 THE COURT: You can.

14 (The following proceedings were held at
15 sidebar, outside the hearing of the jury:)

16 MS. SLATER: Your Honor, now they've
17 elicited a new opinion. As I stated earlier, this
18 witness said that he had no opinion that this was a
19 genetic cause and that he had given an article to the
20 attorneys prior to -- in their review. And he
21 produced it because he had transferred it to them,
22 and that it had nothing to do with his opinions.

23 And there has been no evidence in this
24 case that there's a genetic cause. And now we have a
25 new opinion where he says, oh, now I just can't

1 exclude it, right after he testified that, we just
2 don't know sometimes. We just don't know.

3 So the implication to the jury has been,
4 Judge, some sort of genetic anomaly that nobody
5 talked about, and I ask that the Court strike the
6 last testimony and instruct the jury to disregard it.

7 MR. PERRON: Hold on. It's page 19. It's
8 exactly what...

9 THE COURT: Here's the problem that I
10 have: He testified that he cannot pinpoint the cause
11 of this. To then have him rope back in some
12 potential --

13 MS. SLATER: Judge, this is specifically
14 contemplated with the Lincoln case that's on the
15 defense side --

16 MS. KAMYKOWSKI: No.

17 MS. SLATER: Yes, it is.

18 MS. KAMYKOWSKI: May I finish my record?

19 MS. SLATER: Not without prior information
20 to us in disclosing this is an alternative cause.

21 MS. KAMYKOWSKI: Your Honor, he
22 specifically said: I cannot completely exclude the
23 possibility of some sort of genetic issue, although I
24 don't have any evidence.

25 This is exactly what the supreme court

said he could do in these cases.

THE COURT: But he didn't testify that he didn't have any evidence of that just now.

MR. PERRON: I can ask my next question.

MS. KAMYKOWSKI: We can offer alternative possible causations that don't have to be more likely than not.

THE COURT: But here's the thing: when he says he can't determine something, to then have him say that he thinks it might be this, or it could be that, it --

MS. KAMYKOWSKI: That's exactly what the supreme court said we are allowed to do.

THE COURT: I disagree with that.

MR. PERRON: The next question is: How -- the next question is just as it says here: How can you ever exclude genetic testing? Right. So you can't include it or exclude it without genetic testing.

MS. KAMYKOWSKI: And this is because Dr. kerzner brought this issue up. She brought it into the case because she asked their office in an email we showed the jury years after this injury occurred after she knew, she admitted, she knew that they had ruled it out, or she didn't think anyone was

1 questioning it, she still had a question in her mind,
2 and she admitted that on my cross-examination.
3 She still had a question whether this was.
4 She now thinks she's ruled it out. There has never
5 been testing done. And we should be allowed under
6 the Lincoln case to offer this as a possible
7 alternative cause.

8 THE COURT: The problem I still have is
9 that you're putting up a witness who says, I cannot
10 figure out how this happened, but if you don't
11 believe that I can't figure it out, it could be this.
12 You can't do it that way.

13 MS. SLATER: Right.

14 THE COURT: Evidence flows have to be that
15 you have a witness who testifies that they have
16 possibilities. He said flat out he didn't have any
17 capacity to pinpoint the cause.

18 MS. KAMYKOWSKI: He can lay the foundation
19 with other possible causes now.

20 THE COURT: No. Because once you say you
21 can't figure out the cause, you can't figure out the
22 cause. You need a different witness to say that.

23 MR. PERRON: Well, just, Your Honor, both
24 Dr. Kerzner and Dr. Woodruff, in their depositions
25 say, the only way -- the only way to test is to do

1 genetic testing. And without genetic testing, you
2 can't rule it out, and you can't rule it in.

3 THE COURT: Let me ask this question: Did
4 you request genetic testing be done?

5 MR. PERRON: No.

6 THE COURT: You could have.

7 MS. KAMYKOWSKI: We don't have the burden
8 of proof. We don't have to prove a cause --

9 THE COURT: I understand that.

10 MS. KAMYKOWSKI: We only have to offer
11 alternative causes.

12 THE COURT: But to be able to do that in
13 the absence of having requested discovery on that
14 issue seems a bit disingenuous.

15 MS. KAMYKOWSKI: They track the burden of
16 proof here, Judge, and that's the issue. We are
17 allowed to offer alternative causes, whether we
18 investigated them or not. We don't have a burden to
19 rule things out. I know the plaintiff would love for
20 us to have to rule things out, but the supreme court
21 has specifically contemplated we don't have to do
22 that.

23 THE COURT: But I'm not speaking about
24 whether or not -- the burden of proof is. I'm
25 talking about this witness who says specifically: I

1 cannot pinpoint the cause.

2 MR. PERRON: Right. And the reason he
3 can't --

4 MS. KAMYKOWSKI: I understand your ruling
5 that that's the ruling. We're making our record. I
6 think that the record is probably pretty clear. This
7 is going to a big issue, and I think that I
8 understand the Court simply because of what he has
9 said thus far, is it possible for us to lay further
10 foundation with him?

11 THE COURT: He's -- he's excluded himself
12 from being able to pinpoint the causation.

13 MS. KAMYKOWSKI: Well, he hasn't finished
14 testifying yet.

15 THE COURT: But then he shouldn't have
16 said, I cannot pinpoint.

17 MR. PERRON: Right.

18 MS. KAMYKOWSKI: And that sounds like a
19 really great point for cross-examination if we
20 backtrack now.

21 MR. PERRON: Your Honor, there's positive
22 evidence and negative evidence. So what I'm trying
23 to say is that there's no negative evidence with
24 which to exclude one of the possible things.

25 THE COURT: Here's the fun part: I think

1 the jury is -- this is all lost on them at this
2 point.

3 MR. PERRON: Oh, most certainly.

4 THE COURT: But once he says he cannot
5 pinpoint a cause, I'm not going to let him go back
6 and say he has potential causes. Once he says that,
7 he's excluded himself from being able to provide
8 other causes, in my opinion.

9 MR. PERRON: I disagree, but I think I've
10 explained my thoughts.

11 MS. SLATER: Your Honor, I ask that a
12 limiting statement be made about the last testimony,
13 that they are to exclude it -- or to disregard it.

14 MR. PERRON: That's fine.

15 MS. KAMYKOWSKI: It's not fine.

16 (Proceedings returned to open court.)

17 THE COURT: Ladies and gentlemen of the
18 jury, the Court is going to instruct you to disregard
19 the previous question and answer.

20 Q. (By Mr. Perron) Doctor, did you examine
21 Remi?

22 A. I did.

23 Q. As far as you know -- well, let me back
24 up.

25 Anything different about that exam that

would be different than your typical patient exam, except for the fact it involved litigation as opposed to Remi being one of your patients?

A. No.

Q. Did you create, not a written report, but some typed up notes about your exam and your findings?

A. I did. I initially had handwritten notes, and then I typed them up, given my penmanship.

Q. Okay.

MR. PERRON: Justin, if you want to bring up F7-I. And if you can just blow up the very top, the date.

Q. (By Mr. Perron) So this is January 15th, 2024.

Is that when you examined Remi?

A. Yes.

Q. In general, did you attempt to document some of your findings in your notes?

A. I did.

Q. Are you familiar with -- the jury has heard this name before -- are you familiar with Dr. Shavelle and his work on life expectancy?

A. I am.

Q. One of Dr. Shavelle's criteria for

1 examining life expectancy is walking, and in
2 particular, walking unassisted.

3 when you saw Remi in January 2024, was he
4 able to walk unassisted?

5 A. He was not.

6 MR. PERRON: Justin, if you want to go to
7 the second page of that, and I've kind of highlighted
8 it.

9 Q. (By Mr. Perron) Right here, when you're
10 talking about the gait trainer, the jury has seen
11 videos of Remi in the gait trainer.

12 Did you also observe him in the gait
13 trainer?

14 A. Yeah. He was in a gait trainer that day.

15 Q. Are you familiar with a gait trainer?

16 A. Yes. Yes.

17 Q. Your patients have similar gait trainers
18 and devices?

19 A. They do.

20 Q. Okay. Is walking with a gait trainer the
21 same or comparable as an injured person or an older
22 person walking with a walker?

23 A. No.

24 Q. How is it different?

25 A. well, a gait trainer supports much of your

1 weight so that you can use your feet to kind of --
2 kind of an analogy would be is if you were seated on
3 an elevated skateboard with your legs over the side,
4 and you could kind of use your feet, but you don't
5 have to support your weight.

6 So movement of feet, you can help navigate
7 yourself around. You can get some weight bearing
8 with it, and that's important for bone and for bone
9 health and to allow kids to have some ability to try
10 to move around.

11 Q. This next sentence here, being able to sit
12 independently.

13 was Remi able to sit up independently?

14 A. He was reported both, from what I recall,
15 not from a historical standpoint, not -- and then in
16 my exam, he was not able to sit independently.

17 Q. Okay.

18 A. And I think he was 3 -- I think he was
19 between age 3 and 4 at that time.

20 Q. would you explain to the jury how is being
21 able to sit up pertinent or relevant to a question
22 about weight bearing and ability to walk?

23 A. So there's been a lot of literature,
24 and -- that has been produced to try to project into
25 the future what children will actually be independent

1 walkers in the community.

2 And one of the key -- there are several
3 very good articles. One of the key things is can you
4 sit independently at age 2? Can you sit
5 independently at age 2?

6 If children cannot sit independently on
7 their second birthday, the chance of them walking
8 independently is very, very low in the future. And
9 so obviously you roll before we sit. We crawl before
10 we walk. And so -- so that's -- that's something
11 that is well established in medicine, the ability to
12 sit by age 2, and to walk independently in the
13 future.

14 MR. PERRON: Justin, if you could go back
15 to page 1 of this same document. Scroll down. This
16 line right here.

17 Q. (By Mr. Perron) Care is provided -- so
18 what was your note here? Care is provided only by
19 parents due to feedings being so difficult?

20 A. From what I recall, I think the parents
21 had described that it's -- at that time, this is a
22 little over a year ago, it was really tough to feed
23 Remi, and he was being fed by mouth.

24 And in order to meet his nutritional
25 needs, they had techniques and ways as parents that

1 they were able to do it, but felt other people, from
2 what I recall, other people, whether they were family
3 or friends, I can't remember, that was not something
4 they were -- other people were -- had the ability do.

5 Q. And, Doctor, having some functional
6 ability to sort of, you know, bring some food to your
7 mouth, just having that basic function, is that the
8 same as being ultimately able and responsible to
9 provide nutritional needs for yourself?

10 A. No. At age 3 and a half, we should be
11 able to feed independently, meaning even without
12 utensils, if we put food, a tray of food in front of
13 children, they should be able to grab enough food and
14 put it in their mouth to chew and swallow to get food
15 to meet their nutritional needs.

16 And so being independently fed doesn't
17 mean they have to cut up their own food, it doesn't
18 mean they need to get it out of the refrigerator. It
19 just means that developmentally -- what's
20 developmentally appropriate at that age? So putting
21 food in front of you, being able to pick it up and
22 put it in your mouth, that is what I would expect for
23 a 3 and a half year old to be an independent eater.

24 Q. And since this time, have we sent you
25 updated records and some videos that were

1 subsequently produced to us after the date of your
2 exam?

3 A. Yes. There were more records.

4 Q. Anything in your review of those that
5 changed your assessment, as you noted them, in your
6 notes from January 2024?

7 A. No.

8 Q. Okay. Just getting to your final ultimate
9 opinions one last time. To a reasonable degree of
10 medical certainty, more likely than not, did Remi
11 suffer a global permanent hypoxic injury in the last
12 30 minutes of labor and delivery?

13 A. He did not.

14 Q. Those are all my questions. Thank you.

15 A. You're welcome.

16 THE COURT: Examination on behalf of the
17 hospital?

18 MS. KAMYKOWSKI: Mr. Perron has adequately
19 covered everything that I was going to. No further
20 questions. Thank you.

21 THE COURT: Thank you.

22 Cross-examination?

23 MS. SLATER: Yes, Your Honor.

1 CROSS-EXAMINATION

2 BY MS. SLATER:

3 Q. Dr. Woodruff, good morning.

4 A. Good morning.

5 Q. How are you doing?

6 A. I'm doing well. I've got a little bit of
7 a cold. As you can see, I've had to use a Kleenex a
8 few times, but I'm doing okay.9 Q. Okay. So you're here to tell the jury
10 that you can't tell them when the injury happened,
11 correct?12 A. As far as when exactly, I can tell them
13 when it didn't happen, but I cannot tell them when it
14 did happen, you are correct.15 Q. All right. So you're here to tell them
16 that you don't know when it happened, but it's not
17 when the other guys say, right?18 A. What I'm saying is that it did not happen
19 in the 30 or even the 1 hour prior to delivery.20 Q. Okay. And you base that on the Apgar
21 score at 5 minutes, correct?22 A. I based that on not just the Apgar score,
23 but the Apgar score, the assessments following the
24 Apgar scores, and that he did not need to go to the
25 neonatal intensive care unit, as well as that he was

1 not intubated.

2 Q. Okay. And you didn't look at strips,
3 right?

4 A. I did not.

5 Q. Okay. And you said as a pediatric
6 neurologist, that's not something you look at?

7 A. Pediatric neurologists are not trained,
8 nor do they look at strips.

9 Q. So this has heart rate tracing on it,
10 correct?

11 A. What are you showing?

12 Q. These are the fetal monitoring strips that
13 the other experts have reviewed.

14 A. Okay.

15 Q. Heart rate tracings on these, right?

16 A. I don't have any opinions on -- I don't
17 look at fetal heart rate tracings. I assume what

18 they have, what I understand is, they have a fetal --
19 fetal heart rate, yes. And they have contractions on
20 there. But beyond that, I have no clinical training
21 in that.

22 Q. You've testified before in this -- in
23 these -- in the courtroom, right?

24 A. Yes, I have.

25 Q. Okay. And you represent both plaintiffs

1 and defendants from time to time?

2 A. Yes. I probably review more cases for
3 plaintiffs on your side than I do on defense side.

4 Q. And when you're testifying for a
5 plaintiff, you make comments on the fetal monitoring
6 strips, don't you?

7 A. If -- depending on the situation -- if
8 you're referencing something, I'd be happy to hear.

9 Q. Yeah. So do you remember -- let me find
10 the name here. You gave us a list of all the cases
11 that you looked at, and I -- over the past 15 years
12 or so.

13 A. Yes.

14 Q. You testified to that?

15 A. Yeah. I think I've got a list that goes
16 back to October of 2014.

17 Q. That's right. That's right. Okay. Do
18 you remember -- I looked up a couple of those, and I
19 found the same thing every time I looked at the
20 plaintiffs' cases.

21 Do you remember working for Stephen Cain
22 in Miami, Florida, and at Stewart, Tilghman, Fox,
23 Bianchi & Cain?

24 A. I mean, I don't specifically, but if you
25 bring up something to look at, I'd be happy to look

1 at it.

2 Q. well, in that case you had to file a
3 report, and you were testifying for the plaintiffs,
4 and you made comments about these, and you looked at
5 them in that case.

6 A. I don't know that I did or not, I mean
7 if --

8 Q. Yes. So we don't need these, right?

9 A. But -- but you're representing something
10 that I don't recall. And whether or not I actually
11 looked at this -- I do not look at strips. I may
12 make comments as it relates to what other people have
13 said about the strips, but I personally do not look
14 at the strips and never have --

15 Q. All right.

16 A. -- and I'm not trained to look at strips.

17 Q. Understood.

18 okay. And in this case, when you are
19 talking about those Apgar scores, you kept making a
20 comment to the jury: It's in the literature. It's
21 in the literature.

22 Do you remember that?

23 A. Correct.

24 Q. Okay.

25 I'm going to mark this as 150-14.

1 what is that?

2 A. That is a folder.

3 Q. Is there anything in the folder?

4 A. There is not.

5 Q. Did you bring us any literature in this
6 case?

7 A. I referenced it in my deposition.

8 Q. You know how this works when you testify,
9 right? We've seen, this jury, ad nauseam has seen,
10 literature from experts throughout this case, we're
11 on Day 7. We looked at literature again and again
12 and again.

13 You must bring that with you when you tell
14 us what your opinions are, if you're going to rely on
15 it, so we can show it to the jury, and we can have an
16 opportunity to look at it.

17 You understand that?

18 A. I have it. I have it with me. On my
19 computer, and my computer is right there.

20 Q. Did you give us -- this is empty. This is
21 the amount of literature I got from your deposition.

22 And you're not showing that to the jury, and you
23 didn't give it to us when you were supporting your
24 opinions?

25 A. So in my deposition, I specifically

1 referenced Dr. Pasternak's article, which was written
2 in 1998, and that article looked at 11 children with
3 an injury just prior to delivery, and the legal
4 stuff, I'm a physician, I'm not a lawyer.

5 Q. I understand.

6 A. I --

7 Q. Doctor --

8 A. Just a second, I haven't finished my
9 answer.

10 Q. Go ahead.

11 A. I'm not a lawyer. As far as, you know, I
12 come here and answer questions, but to know what I
13 need to bring and what -- that's for the lawyers to
14 understand, not for me.

15 Q. I understand. And this is what I do for a
16 living. And it's frustrating to me when there --
17 when you talk to a jury and say there's all this
18 literature out there --

19 MR. PERRON: Objection, Your Honor. We
20 need a sidebar.

21 THE COURT: I'm going to sustain the
22 objection to the form of the question.

23 MS. SLATER: Sure. Understood.

24 Q. (By Ms. Slater) when I don't have the
25 literature that you're talking about, I can't look at

1 it.

2 A. You do because I reference it in my
3 deposition --

4 Q. Okay.

5 A. -- very clearly, and it's not a surprise.
6 I brought it up at my deposition --

7 Q. Okay.

8 A. -- and you clearly -- you went back and
9 looked at past cases. You took the time. That was
10 more work than looking up the Pasternak article that
11 I clearly talked about in my deposition.

12 Q. So Remi, when he was born, he had
13 tachycardia, right?

14 A. when he was -- after he was born?

15 Q. Nope. when he was born.

16 A. So can you be specific?

17 Q. Sure.

18 A. when he was born?

19 Q. Sure, in the last, when that strip was
20 Category III at the end, he was tachycardic, correct?

21 A. That's outside of my expertise. I don't
22 know what the strip said at that point.

23 Q. Okay. So you don't know if he had an
24 increased heart rate immediately before he was born,
25 and the immediate time frame that you say this injury

1 couldn't have happened?

2 A. Correct. As a pediatric neurologist, I
3 look at what's happening at the time of delivery,
4 what's happening with resuscitation, with the
5 neurologic exam, and how the baby does at that point.
6 I do not take care of babies when they are in utero.

7 Q. Doctor, when he was born, so am I
8 informing you that he was -- he had tachycardia, high
9 heart rate, immediately before he was born?

10 A. I have seen that in the records.

11 Q. Okay. And did he ever -- is this a baby
12 who had a long period of bradycardia, or low heart
13 rate, before he was born?

14 A. Not from my knowledge.

15 Q. Okay. And so we heard from Dr. Nelson the
16 other day, and he talked to us about when a baby is
17 in distress, the heart rate goes up first because
18 they are trying to compensate and pump as much blood
19 to their brain and their heart as possible because
20 they're not getting enough oxygen.

21 That's -- that's medicine, right?

22 A. That's certainly possible.

23 Q. And if that progresses, then the baby's
24 heart rate drops to bradycardia. And then
25 unfortunately, we heard, if that prolongs, if that

1 continues, then the baby goes into asystole, which is
2 the baby passing, correct?

3 A. Well, it simply is the heart stopping,
4 yes.

5 Q. Okay. So it's a progression, it sounds
6 like. First, we see tachycardia and then
7 bradycardia, and then if that continues, we're in bad
8 shape, correct?

9 A. That is one scenario. Sometimes we see
10 just flat out bradycardia.

11 Q. And the -- and what you're talking about,
12 when you say that the baby must have been severely
13 depressed, is when the baby's already gotten into
14 that bradycardic position.

15 That's what the literature is based on,
16 isn't it?

17 A. Yes.

18 Q. It talks about bradycardic babies,
19 correct?

20 A. Bradycardic or severe distress.

21 Q. Okay. And we don't have bradycardia yet
22 here. The baby is tachycardic, high heart rate,
23 before it was born, right?

24 A. Yes.

25 Q. Now, as far as I believe what I heard you

1 say is, if he suffered an injury at that last point
 2 where you don't know what the strips are saying at
 3 that time, he would have had a severely abnormal
 4 Apgar score, correct?

5 A. Correct.

6 Q. Okay.

7 MS. SLATER: Zack, can you bring up
 8 Exhibit 420, please?

9 Q. (By Ms. Slater) okay. This is the ACOG
 10 committee opinion on Apgar scores. This is -- hold
 11 on a second -- this is not only obstetricians, but
 12 this is in conjunction with the American Academy of
 13 Pediatrics, correct?

14 A. Correct.

15 MS. SLATER: Let's come down here to the
 16 abstract. Yes.

17 Q. (By Ms. Slater) okay. This says the
 18 Apgar score alone cannot be considered to be evidence
 19 of or a consequence of asphyxia.

20 A. Correct. And you take it --

21 Q. And you agree with that, right?

22 A. I would take it as you look at the Apgar,
 23 you look at the resuscitation, you look at what
 24 happened after the resuscitation. You take those
 25 puzzle pieces, and you put them together.

1 Q. Okay. The Apgar score does not predict
2 individual neonatal mortality or neurological outcome
3 and should not be used for that purpose.

4 You agree with that, correct?

5 A. Correct.

6 Q. Okay.

7 A. If you just are looking at that and only
8 that, that would be inappropriate.

9 Q. Sarah Anyan experienced a profoundly
10 prolonged second stage of labor, correct?

11 A. That is outside of my expertise. I
12 have -- I do not have an opinion. I don't deliver
13 babies. I don't have an opinion about that. I'm a
14 pediatric neurologist.

15 Q. So that's a piece you didn't consider in
16 your opinions. That's not coming in?

17 A. It would not -- it would not play a role
18 in my opinion at all.

19 Q. Okay. But in other cases, you've given an
20 opinion that injury happened during labor, correct?

21 A. If they're a different set of facts in a
22 different case, certainly.

23 Q. Do you remember how long Sarah Anyan's
24 second stage of labor was?

25 A. I do not know.

Q. You don't know?

A. I do not know.

Q. Okay. What are the concerns -- do you know what the concerns for an infant are during a prolonged labor?

A. I do not deliver babies, I have no expertise, and I don't have any opinions on that.

Q. Well, as a pediatric neurologist, you told us you take care of babies immediately when they're born, correct?

A. I don't take care of them immediately when they're born. Following resuscitation, I will be called to the neonatal intensive care unit if there are neurologic concerns.

Q. So it would be important for you to understand the effects of oxygen and placental deficiency or insufficiency on an infant, correct?

A. From a high level broad endpoint, I do. I do understand that.

Q. Okay. So babies are at risk during a prolonged labor for asphyxia and acidemia, correct?

A. That is outside of my expertise because you said it relates to a prolonged second stage of labor. I do not manage deliveries, and I do not deliver babies.

1 Q. Then you would agree with me that when
2 you're giving a jury timing opinions about what did
3 or did not happen during labor, that's not part of
4 your expertise.

5 A. Yes, it is, as it relates to the specific
6 question that I was asked: How would a baby look
7 neurologically, as a pediatric neurologist, following
8 something as severe as what Remi had in the last --
9 something as severe as his brain injury that would
10 have happened in the last hour of his delivery.

11 That is fully within my expertise and my
12 ability to discuss that because that is a neurologic
13 opinion. And as a board certified pediatric
14 neurologist, I feel comfortable giving that opinion.

15 Q. Sir, in your deposition, you told me that
16 it wouldn't have happened in the last 30 minutes, but
17 it could have happened in the previous 1 to 3 hours.

18 Do you remember that?

19 A. I said -- and that's --

20 Q. So --

21 A. Just a second.

22 Q. To be fair, that --

23 A. No. You just interrupted me.

24 Q. Sir, I'm, you know --

25 MR. PERRON: Your Honor, objection. This

1 is improper impeachment, Your Honor.

2 THE COURT: If you don't understand her
3 question, let her know you don't understand her
4 question. She'll re-ask her question. If you
5 understand her question, answer her question.

6 THE WITNESS: Absolutely, Your Honor.

7 MS. KAMYKOWSKI: Your Honor, can we have a
8 sidebar?

9 THE COURT: You can.

10 THE WITNESS: But...
11 (Proceedings were held at sidebar, outside
12 the hearing of the jury.)

13 MS. KAMYKOWSKI: This is now the second or
14 third time that we have raised an objection on
15 improper impeachment.

16 Impeachment, as the Court knows, and I
17 believe everyone understands how this is supposed to
18 happen. If she thinks he has testified differently
19 in his deposition, she has to ask him a question, and
20 he has to give a different answer here today before
21 she can then reference his deposition and go through
22 it.

23 She can certainly read from his
24 deposition, if she gives him a copy so he can follow
25 along, and tell the rest of us where she's reading

1 from. otherwise: You told me in your deposition
2 "X," is not proper impeachment. So if we're going to
3 continue to go down this road, I think that
4 establishment of using the correct evidentiary
5 process in the courtroom needs to be happening.

6 And we'll give him a copy of his
7 deposition. She can tell counsel and the Court what
8 page and line number she's reading from so we can see
9 if it's done properly. And then we can lodge a
10 further objection.

11 So we continue to object to the use of his
12 deposition to try to -- and not letting him answer
13 his questions. So I understand the Court's
14 instruction to the witness if he doesn't understand
15 it. He wasn't saying that he didn't understand it.
16 She is not -- she was not actually letting him answer
17 the question she asked because she didn't like where
18 it was going.

19 THE COURT: I think there was a little bit
20 of both him wanting to answer a different question,
21 and her not liking the question -- the answer that he
22 was giving.

23 MS. SLATER: Your Honor, with regard to
24 the objection, I believe the Court will recall, and
25 the record will reflect, that we are following the

1 same procedure we saw from Ms. Kamykowski with almost
2 every witness.

3 MS. KAMYKOWSKI: without objection.

4 And it's not my fault that they didn't
5 object, Your Honor. And I don't know, this is not a
6 game we're playing when we're talking if they wanted
7 to object to it. We've also not objected to leading
8 questions, based on trial strategy. I don't know why
9 they haven't objected to it. We didn't object to it
10 with Ms. Gunn yesterday.

11 THE COURT: The Court is going to instruct
12 you to use proper impeachment.

13 MS. KAMYKOWSKI: Thank you.

14 (Proceedings returned to open court.)

15 Q. (By Ms. Slater) All right. Dr. Woodruff,
16 you don't believe it happened in the last 30 minutes
17 because you think the evidence showed that Remi came
18 out looking good, so he must have recovered in utero,
19 correct?

20 A. Correct. Or -- or at sometime in utero,
21 yes.

22 Q. Okay. And you think that that, you're not
23 using medical knowledge, but you've said common sense
24 tells me then, even though you're not an
25 obstetrician, that that's before she got on the

monitors, correct?

A. No. I'm using a hypothetical. What I was using as a hypothetical was, well, Dr. Woodruff, you say it didn't happen in the last hour. The plaintiff experts say between when she was hooked up, and that last hour there was no problem. If you take both of those things and put them together, it has to be sometime before that.

Q. Okay. Well, let's look at that period of time.

You've reviewed all of the records, right?

A. I did.

Q. Okay.

MS. SLATER: Let's bring up Exhibit 6, of page 163, please.

Q. (By Ms. Slater) Okay. This is Sarah Anyan's last prenatal visit before she goes to the hospital on April 29th, 2020.

That's 5 days before Remi's born, correct?

A. He was born on -- yeah.

Q. Okay. So this is --

MS. SLATER: Let's just go to that top portion. Thank you, Zack.

Q. (By Ms. Slater) And this is the note by the nurse practitioner at Dr. McNeive's office. And

1 the subjective, that's what we are, the practitioner
2 is learning from the patient, correct?

3 A. Correct.

4 Q. Okay. So Sarah McDonald Anyan is a
5 30-year-old female who presents for return OB care,
6 feeling pelvic pressure, irregular contractions,
7 denies vaginal bleeding.

8 That's a good sign, right?

9 A. Outside of my expertise.

10 Q. Okay. Or loss of fluid. Denies
11 headaches, dizziness, blurred vision, or shortness of
12 breath. Reports positive fetal movement.

13 That's a good sign in utero, right?

14 A. It can be.

15 Q. Okay. And no concerns today, correct?

16 A. That's what it states, yes.

17 Q. Okay.

18 MS. SLATER: Let's go down to assessment
19 plan, please, Zack.

20 Q. (By Ms. Slater) All right. So she's
21 being assessed at Dr. McNeive's office 5 days before.
22 And they're finding fetal status reassuring, correct?

23 A. That's what it states, yes.

24 Q. That's a good finding.

25 That's what we want to know, right?

1 A. I assume, but you're starting to get into
2 obstetrical opinions and things that are outside of
3 my expertise.

4 Q. Okay. Counseled on labor precautions,
5 vaginal bleeding, range of motion, and fetal
6 movement, correct?

7 A. That's what it states.

8 Q. Okay. And when an OB is talking to a mom
9 about fetal movements, is saying, watch it, right?
10 Let's make sure we keep feeling movement, right?

11 A. I have no idea. I'm not an obstetrician.

12 Q. Okay. Sarah Anyan didn't call the office
13 or anything until she showed up for delivery, a
14 couple of days, four days later, correct?

15 A. That is my understanding --

16 Q. Okay.

17 A. -- from the medical records.

18 Q. Okay.
19 MS. SLATER: Let's look at Exhibit 1, page
20 96, please. Let's zoom in.

21 Q. (By Ms. Slater) This is her history and
22 physical when she gets to the hospital after her
23 water broke, correct?

24 A. Yes.

25 Q. On May 3rd, 2020.

1 A. Correct.

2 Q. Okay. And the history that was taken, it
3 says in the middle there: she reports good fetal
4 movement, but denies vaginal bleeding, correct?

5 A. That is what it states, yes.

6 Q. That's a good sign, right?

7 A. Once again, starting to get into
8 obstetrical opinions outside of neurology opinions.

9 Q. Okay.

10 MS. SLATER: Let's go to page 97, please,
11 under the assessment and plan, the next page. Thank
12 you.

13 Q. (By Ms. Slater) So we're looking here,
14 she -- they assessed her and understood that her
15 water broke at about noon with clear fluid, correct?

16 A. Yes.

17 Q. Now, that's different from when Remi was
18 born, right? Because we talked about the meconium,
19 the baby's first poop, right?

20 A. He did have meconium in utero, yes.

21 Q. Okay. And that is associated with the
22 baby being stressed, correct?

23 A. It can be. That is a possibility, yes.

24 Q. Okay. And it's not clear when she gets to
25 the hospital, correct?

1 A. Correct.

2 Q. Okay. And then they looked at the baby's
3 heart rate on the tracing and said Category I.
4 That's a good finding, right?

5 A. From my understanding, my limited
6 knowledge of fetal heart tracing, that, you know,
7 that is the best.

8 Q. Okay. So you understand from the records
9 and reading all the depositions, that when she gets
10 to the hospital, mom and baby looked great, correct?

11 A. From what I understand, yes.

12 Q. Okay. And you said pediatric neurologists
13 don't even look at the strips, right?

14 A. In our clinical -- when I am in the
15 trenches working in the hospital, we do not look at
16 strips. We may read what other people have read or
17 said about the strips, but we don't independently
18 look at them like we would the neuroradiology or EEGs
19 or exams or other things.

20 Q. So I -- this is what I look at. Volpe's
21 Neurology, that's a normal textbook that you use.

22 A. Great -- great textbook.

23 Q. Okay. There's an entire section on fetal
24 assessment in here with strips.

25 A. There is.

1 Q. For pediatric neurologists.

2 A. Maybe for people to understand, but it's
3 certainly not something that we do clinically.

4 Q. Okay. But to represent that that's not
5 even anything you look at as a pediatric neurologist,
6 that -- I mean, you're being taught it in your
7 textbook.

8 A. There are lots of things in the textbook.
9 we are not clinically taught in the wards, on the
10 floors, to read fetal monitoring. It doesn't happen.
11 No pediatric neurologist reads fetal heart monitoring
12 anywhere that I know of anywhere in the country.

13 Q. Okay. But they rely on others and their
14 opinions about that.

15 A. Correct.

16 Q. Okay.

17 A. Absolutely.

18 Q. All right. So how about the ultrasound?
19 Did you look at that at all?

20 A. I looked at the ultrasound, yes.

21 Q. Okay. And you decided that this didn't
22 give you any information, correct?

23 A. It was normal, it did not -- from what --
24 I think -- can I take a peek?

25 Q. Sure, absolutely. You're looking at it

1 now.

2 A. Let me just take a peek.

3 Q. Sure.

4 A. Yes, there was two cysts, but, yes.

5 Q. Okay. And you deferred to Dr. Sze on his
6 reading of this head ultrasound, right? It's not
7 part of your opinion?

8 A. Well, I don't know that I deferred. I
9 just, when I looked at it, it didn't change my
10 opinions in this case.

11 Q. Okay. I'm going to hand you your
12 deposition --

13 A. I have a copy in front of me.

14 Q. Oh, great.

15 A. You can keep yours.

16 Q. Go ahead and go to page 50, 49 and 50.

17 A. All right. I'm there.

18 Q. If you could look at 49, line 10. The
19 question was: You're relying on the Apgar, the
20 resuscitation, and the MRI. What about the head
21 ultrasound? Did you look at that?

22 And you said, I did. The head ultrasound
23 was reported as normal. Dr. Sze, I would agree with
24 Dr. Sze. He said it can be normal for up to two
25 days, and that was done at 16 hours. But the timing

1 is -- you can have a normal head ultrasound and still
2 have a brain injury. It's not super sensitive,
3 correct?

4 A. Correct.

5 Q. okay. And then the next page on 50 --
6 5011, we're talking about the head ultrasound. You
7 say, I will defer to the neuroradiologist, correct?

8 A. Correct.

9 Q. okay. So that, again, is not part of
10 your -- what you look at?

11 A. It is. I look at it, but when it's
12 normal, it doesn't add to -- to my knowledge base in
13 a case like this.

14 Q. okay. So we just need to look at Dr. Sze
15 for that?

16 A. There may be -- there may be more than one
17 neuroradiologist. I -- I -- I -- I would -- maybe
18 there's two -- maybe each side has a
19 neuroradiologist, I don't know.

20 Q. well, in your deposition, you had
21 Dr. Sze's opinions, correct?

22 A. I had those at that point because Dr. Sze
23 had been deposed at that point. I don't think the
24 defense neuroradiologists had been deposed at that
25 point, from what I recall.

1 Q. okay. But do you agree with him in your
2 deposition?

3 A. In my deposition, yeah, I mean, he said it
4 was normal. I thought it looked normal. I didn't
5 have any disagreements with Dr. Sze.

6 Q. So what did you use to assess how he was
7 doing after birth?

8 A. So I used what we talked about earlier.

9 Q. okay.

10 A. The assessments from the nurses --

11 Q. Got it. Okay.

12 A. -- and the fact -- sorry -- I didn't want
13 to talk over the top of you.

14 And the fact that we talked about that he
15 wasn't intubated.

16 Q. okay. Did you look at the pictures that
17 the parents provided from the delivery room?

18 A. I did get those, yes.

19 Q. okay. And that's an important piece of
20 evidence when you're coming into court, and you're
21 representing that you've looked at all the
22 information?

23 A. Correct.

24 Q. okay. Let's look at Exhibit 63-1.

25 okay. This is one of the pictures of Remi

on the warmer in the delivery room. We have some data on the side that shows this is 13 minutes at 4:37 after he's born.

You took this into consideration, of course?

A. Absolutely.

Q. And you see that his feet are still blue.

Is he vigorously crying?

A. I can't tell from this because it's a still photo. I mean, I don't see any grimacing of his face.

Q. How about his flexion tone?

A. So he has decreased tone at that point.

Q. Okay. And you agree with Dr. Cantey, the defendants' neonatologist, that tone and reflex in the delivery room are subjective, and providers sometimes differ plus 1 or minus 1, correct?

A. That is possible.

Q. Okay.

A. I don't know that it's subjective --

Q. Can you --

A. Let me clarify. I don't know if it's subjective. But people can have different interpretations of what they are seeing.

Q. And he had an 8 at 5 minutes, right?

1 A. He did.

2 Q. And that's 8 minutes before we're looking
3 at this picture, correct?

4 A. Correct.

5 Q. And you said with a 7, he certainly needs
6 more resuscitation?

7 A. That is possible. Certainly less than 7.
8 7, 8, 9, and 10 is what I stated earlier is
9 reassuring.

10 Q. Well, I wrote down, and I wrote it down
11 because I wanted to talk to you about it.

12 It says: Certainly a 7 requires more
13 resuscitation.

14 A. Might have been misspoken. 7, 8, 9, and
15 10 is reassuring. I'm pretty sure I said 7, 8, 9,
16 and 10 is reassuring.

17 Less than 7, from my understanding --

18 would, you would continue to do more Apgars. You
19 would go on and do a 10-minute Apgar.

20 Q. At 5 and 10 minutes of life, both before
21 this picture was taken, Remi was still receiving
22 resuscitation, correct?

23 A. Before 5 minutes?

24 Q. No. At 5 minutes, he was receiving
25 resuscitation, and actually still at 10 minutes, he

1 was receiving resuscitation?

2 A. I think he might have been having some
3 respiratory support at that point, but I -- that's --
4 if you have something you can show me that you're
5 referring to, I'd be happy to look at it.

6 Q. Yeah. Sure. Sure.

7 MS. SLATER: Exhibit 3, page 3185, please.

8 And 31. We'll start with the 85. That's the
9 5-minute one.

10 okay. So, Zack, it's under resuscitation
11 measures at 5 minutes. Right down there. Yeah.
12 Let's bring up this section right here.

13 Q. (By Ms. Slater) Okay. And so
14 resuscitative measures at 5 minutes? Yes. Oxygen
15 use at 5 minutes? Yes. FIO₂ is at 50 percent.
16 Positive pressure ventilation, CPAP, at 5 minutes?
17 Yes.

18 So he's still getting respiratory
19 resuscitation, correct?

20 A. He is getting -- so resuscitation -- so
21 that can differ. I would -- I would speak -- I would
22 have a neonatologist speak more. CPAP, putting a
23 CPAP in the nose, is that -- specifically is that
24 resuscitation? Or is that support? I would defer
25 that specific question to a neonatologist.

1 Q. okay. So this is not part of your
2 assessment?

3 A. That is by the fact that he did not have
4 an endotracheal tube. He was not intubated at that
5 point.

6 Q. okay. So are you here to tell the jury
7 and me on record, in any other deposition that you
8 have, that if you don't have intubation, you weren't
9 damaged in utero?

10 A. Absolutely not.

11 Q. okay.

12 A. What I'm saying is based on the evidence
13 that we have here, based on the severity of Remi's
14 brain injury --

15 Q. okay.

16 A. -- which I'm not -- can I please finish my
17 answer?

18 Q. well, I mean, we've been here a long time.

19 A. okay.

20 Q. The attorneys that have hired you can give
21 you an opportunity to restate.

22 A. okay.

23 MS. SLATER: The next page, please, 3186.

24 Q. (By Ms. Slater) All right. This is a
25 10-minute resuscitation.

1 MS. SLATER: Can you blow that up, Zack,
2 please, at the top? At the top, yeah.

3 Q. (By Ms. Slater) So this is at 10 minutes.
4 This is the oxygen in use that is at 10 minutes. And
5 we're still using oxygen, correct?

6 A. Yes.

7 Q. Now, the FIO₂ is at 30 percent positive
8 pressure ventilation and CPAP, right?

9 A. Correct.

10 Q. He's still on those measures at 10
11 minutes, correct?

12 A. He is.

13 Q. Okay.

14 MS. SLATER: Let's look at --

15 Q. (By Ms. Slater) You're not suggesting to
16 the jury that an Apgar score during resuscitation is
17 the same as an Apgar score for normal babies that are
18 not receiving resuscitation, correct?

19 A. Can you be -- I guess I'm not
20 understanding the question.

21 Q. Yeah. What we have here is not an Apgar
22 score that you could apply to any kid, right?

23 A. Apgar scores are Apgar scores. You do
24 them at the time. I guess, I'm not understanding the
25 question.

1 Q. This is an assisted Apgar score. He's
2 being resuscitated. This is not a kid being
3 evaluated when he comes out and needs nothing.

4 A. Well, Apgar scores, you would assign them
5 whether you're being resuscitated or not. Apgar
6 scores are what's going on at 1 minute, 5 minutes.
7 It doesn't matter if you're -- you're resuscitating
8 them or not.

9 Q. Right. But the ACOG and the American
10 Academy of Pediatric bulletins that we've all looked
11 at says that this is an assisted Apgar score. And
12 you don't use this the same way when a kid's not
13 being resuscitated, right?

14 A. An Apgar score, in my mind, as a pediatric
15 neurologist, an Apgar score is an Apgar score.

16 Q. Okay. So that narrow window, you don't
17 participate in resuscitations, right?

18 A. Not any longer. I did back when I did
19 pediatric training and when I was moonlighting as a
20 hospitalist in the neonatal intensive care unit. But
21 it's been a long time. But I have done -- I've done
22 a lot of it in my past.

23 Q. Okay. But at least for your opinions in
24 this case, this specific period where he's being
25 resuscitated, the narrow -- that distinction is not

1 part of what you look at, right? whether an Apgar
2 score for a normal baby, who doesn't need
3 resuscitation is equal and equivalent to an Apgar
4 score of a baby needing resuscitation, an assisted
5 Apgar score?

6 A. An Apgar score is an Apgar score.

7 Q. Okay. Okay.

8 A. It's telling you what is going on at that
9 moment, whether they need resuscitation or not.

10 Q. okay. All right. And the literature that
11 the jury has been shown that may say otherwise,
12 that's not something you reviewed as part of the
13 case?

14 A. Correct.

15 Q. Okay.

16 A. As reviewed for here.

17 Q. Do you recall how he was doing when he was
18 handed to his parents up until the time he went to
19 the NICU? That's those first couple hours of life.

20 A. I do. I mean, we looked at the nursing
21 records.

22 Q. Uh-huh.

23 A. I've reviewed mom and dad's depositions.

24 Q. Okay. I have a question about that: Mr.
25 Perron asked you about the notation that said mom is

1 cuddling him, that they're making eye contact, and
2 that she's trying to feed him.

3 And you said that was an indication that
4 Remi wasn't encephalopathic, right?

5 A. well, I would say he wasn't -- he did not
6 look in distress. I think I specifically said he
7 didn't look in distress.

8 Q. okay. But those notations for nurses,
9 those are how the mom's reacting to the baby to make
10 sure that in those first moments of life, mom is
11 receiving a baby and cuddling it and looking into his
12 eyes and trying to feed him. Because if that's not
13 happening, the nurses have a different protocol that
14 they need to get involved, right?

15 A. Yeah.

16 Q. So that was about what mom was doing,
17 right?

18 A. But still it has data about the baby.

19 Q. okay. Let's look at that.

20 MS. SLATER: Exhibit 3, 2583, please.

21 Q. (By Ms. Slater) okay. And so this was
22 the column at 5:35 that we were looking at. And Mr.
23 Perron showed you the neonatal note from Younger at
24 5:37, correct?

25 A. Correct.

1 MS. SLATER: Let's go down to right down
2 here, if you don't mind. Right down here.

3 Q. (By Ms. Slater) So it says 68 with an
4 exclamation point. And in Epic, but in Epic that's
5 usually red -- right? -- if you're looking at it on
6 the screen?

7 A. I'm pretty sure, yes.

8 Q. And so that's at that same time?

9 A. Correct.

10 Q. What does that mean? Why do we have an
11 exclamation point there?

12 A. It's an elevated respiratory rate.

13 Q. Okay.

14 MS. SLATER: And, Zack, can you back out
15 of that? And then what's the time of this?

16 Q. (By Ms. Slater) Okay. And between 5:35
17 and what's this? 11:30? 10:30?

18 A. 10:30.

19 Q. There's no assessment, right?

20 we don't have a record of information for
21 what's going on during this time, right?

22 A. I don't know or not. Obviously there is a
23 column there.

24 Q. The respiratory rate at 10:30 --

25 MS. SLATER: Bring that up, Zack.

1 Q. (By Ms. Slater) It's 140.

2 A. Correct.

3 Q. what does that tell you?

4 A. He's in respiratory distress at that
5 point at 10:30 at night.

6 Q. Okay. And for that time period in
7 between, you didn't factor in Sarah and Blake's
8 information about what was going on, right?

9 A. I did.

10 Q. well, what do you mean?

11 A. They are -- well, be more specific in your
12 question.

13 Q. well, so you have your deposition.

14 A. Right here.

15 Q. Okay. Let's go to page 16 and 17.

16 A. I am there.

17 Q. Okay. The question on line 10 and 16:

18 were you provided the depositions of Sarah
19 and Blake Anyan in this matter, sir?

20 "ANSWER: I was, yes."

21 Did you read those?

22 I did.

23 Do you recall their testimony regarding
24 how Remi was between his birth and before he was
25 transferred to the NICU?

1 I don't recall specifically that. If you
2 have something you want to pull up, fine, but I don't
3 specifically recall that.

4 A. Correct. At that time, I didn't
5 specifically recall anything that would have changed
6 my opinions, based on their testimony at deposition.

7 Q. Okay. But these aren't normal parents.
8 This is a nurse and a respiratory therapist, right?

9 A. Correct. To my understanding.

10 Q. And that's kind of uncommon in the cases
11 that you've looked at that you're usually looking at
12 people with no medical knowledge.

13 A. That is pretty true, I think for most
14 people who have babies.

15 Q. Okay. And what we learned, even from the
16 records, we learned that he was having trouble
17 feeding when he was first with mom, right?

18 A. Correct.

19 Q. Okay. And that he refused to suck?

20 A. At one point. There was one record that
21 said he was feeding. And then at another point that
22 said he was having feeding difficulty.

23 Q. Okay. And the nurses described him as
24 frantic at mom's chest.

25 Do you remember that?

1 A. I don't specifically remember, but I know
2 he was having feeding difficulty.

3 Q. Okay. But the nurses describe him as
4 frantic.

5 A. Okay.

6 Q. Those nurses, all they do all day every
7 day is help moms in that period bond with their baby,
8 get that first feeding underway. They're describing
9 him as frantic during this time.

10 Tell me what neuro irritability is.

11 A. Well, neuro irritability can be from a
12 brain injury where you have chemicals in your brain
13 that make you irritable.

14 Q. And that's going on in between when
15 there's no vitals, no assessment, no pain score,
16 right?

17 A. He had a brain injury at that point. I am
18 not discounting. He, prior to that point, he had a
19 brain injury. There is no doubt about it. I am not
20 here to say at that point, when those assessments
21 were taken, his -- he had his brain injury.

22 Q. Let's talk about what you charged in this
23 case.

24 Up until your record review and through
25 that exam, you charged about \$16,000, correct?

1 A. Correct.

2 Q. Okay. And for the deposition, you charged
3 \$2500?

4 A. I think 2400 or 2500, yes.

5 Q. Okay. And how many hours -- what's your
6 hourly rate?

7 A. \$500 per hour.

8 Q. Okay. Except for we don't have the
9 invoices for when you prepared for your deposition.

10 How many hours do you think it took you to
11 prepare for your deposition?

12 A. Usually it takes me 8 or 10 hours. I
13 mean, this is a -- there's a lot, as I said at the
14 beginning, there's 10,000 pages, in excess of 10,000
15 pages, of records, from what recall.

16 Q. Okay. So that's \$5000 to prepare for your
17 deposition, correct?

18 A. Correct.

19 Q. And how about how many hours it took you
20 to prepare for your trial testimony today?

21 A. Probably about the same amount. Because
22 it had been a long time, so I had to sort of re
23 prepare.

24 Q. So another \$5,000, correct?

25 A. Correct.

1 Q. Okay. And then you got here yesterday, I
2 assume?

3 A. Got here last night, yes.

4 Q. So you charge -- so you'll be here for two
5 days.

6 Do you charge your trial rate for each day
7 you're here?

8 A. No. I got into town last night. Had some
9 time with my daughter who lives here in town. I'll
10 be here today. And I'll be flying out sometime this
11 afternoon, probably.

12 Q. Okay. So you're charging one flat fee?

13 A. One day.

14 Q. And that's how much?

15 A. \$8,000 a day.

16 Q. Okay. All right. I have -- we'll add
17 that up later.

18 The damages. You gave the jury opinions
19 about what you think Remi's damages are, correct?

20 A. I gave damages opinions, correct.

21 Q. And you examined him in January '24?

22 A. I did.

23 Q. And in the last 14 months since you
24 examined him, can you -- what did -- you said that
25 you received records.

1 A. I did receive some follow-up like records
2 from, I can't recall, from treaters, yes.

3 Q. Okay. And have you looked into how Remi's
4 doing?

5 A. I -- I haven't.

6 Q. Okay.

7 A. I mean, as far as beyond I haven't had a
8 chance to do another examination or talk with the
9 family.

10 Q. Okay. That's fine.

11 Did you, when you examined Remi, you got a
12 chance -- did you kind of interview the family a
13 little bit?

14 A. I did. I can't remember who all was
15 there.

16 Q. Okay.

17 A. Somebody from your office was there. I
18 can't remember if you were. I think you were there.

19 MS. GUNN: I was there.

20 THE WITNESS: Oh, you were there. I'm
21 sorry, well -- I'm sorry. Sorry.

22 A. I just knew there was somebody from your
23 office that was there.

24 Q. (By Ms. Slater) Yeah. Yeah, absolutely.

25 A. Yeah.

1 Q. And all the attorneys are there, and the
2 parents are there?

3 A. Absolutely.

4 Q. Okay. So when you talked to Blake and
5 Sarah, did they tell you -- the jury heard the other
6 day about the first conversation they had with Dr
7 Thalakoti in the hospital when he diagnosed Remi with
8 HIE.

9 Did they tell you about that conversation?

10 MS. KAMYKOWSKI: I'm going to object, Your
11 Honor. It calls for hearsay.

12 A. I don't -- but I don't recall the
13 conversation.

14 THE COURT: He chose not to let me rule
15 before he answered.

16 Q. (By Ms. Slater) So --

17 THE WITNESS: Sorry, Your Honor.

18 Q. (By Ms. Slater) So let me share with
19 you -- and you read their depositions, right?

20 A. Which depositions?

21 Q. You read the parents' depositions.

22 A. Yes.

23 Q. I mean, we talked about these and remember
24 what they said about that time period.

25 But they shared with the jury that Remi's

1 come so much further than what Dr. Thalakoti

2 expressed to them at first.

3 Is that what they kind of told you when

4 they were talking about their son?

5 A. I think they had expressed to me that he
6 was making progress, yes.

7 Q. Okay. All right.

8 MS. SLATER: Zack, can you bring up

9 Exhibit 632. This was a video we wanted to show the
10 other day.

11 Q. (By Ms. Slater) Can you see this?

12 A. Yeah, yeah. If you're on that side of the
13 podium, that would be great.

14 Q. Yeah.

15 (A designated portion of the video was
16 played for the jury.)

17 MS. SLATER: Okay. Can you just pause
18 that real quick?

19 Q. (By Ms. Slater) Can you just orient the
20 jury to what are we -- we paused Sarah's arm in front
21 of it. That's okay.

22 what are we looking at here?

23 A. well, it looked like -- I don't know if
24 this is -- I don't know if it's an assistive
25 communication device or what exactly it is.

Q. So it's a Tobii device.

Are you familiar with that?

A. I have some familiarity with it.

Q. Okay. Okay. Let's go ahead and watch this through.

(A designated portion of the video was played for the jury.)

MS. SLATER: You can stop.

Q. (By Ms. Slater) And can you tell us what Remi's doing in this?

A. It looked like an eye assist speech augmented device.

Q. Okay. And tell us how it works.

A. Well, I'm not an expert when it comes to these -- these devices. But being able to look at something, it -- my understanding is it can recognize eye gaze and be able to use kind of -- that one would be a two-part switch, so a right and left, and it can recognize some -- your eye gaze in order to trigger one versus the other.

Q. Well, the -- the switch is different.

A. Well, I mean, like, it's not a mechanical switch, but like looking at it from an electronic standpoint, like choosing one versus another.

Q. Okay. So he's using his eye pattern to

1 learn how to use this and select which thought he
2 wants to choose, correct?

3 A. Correct.

4 Q. Okay. And do you prescribe those for your
5 patients?

6 A. So what I will do is, I will send people
7 off for speech and language pathology. And then
8 usually what happens is they will have an assessment,
9 and then it will come back, and they'll say
10 such-and-such a patient would be appropriate for
11 this.

12 And then they'll send back something, a
13 prescription, you can sign. And then you can -- you
14 can sign off on it, but I wouldn't be personally
15 making the choice of is it this or this? That's
16 usually speech and language pathology that has
17 expertise in that.

18 Q. Okay. So this is part of his therapy
19 regimen?

20 A. That is my understanding.

21 Q. Okay. And you have several patients who
22 use those type of devices, right?

23 A. Various augmented, speech augmented
24 devices, yes.

25 Q. Okay. And that improves their

1 communications?

2 A. It does.

3 Q. Okay.

4 MS. SLATER: And let's bring up 643,
5 please.

6 Q. (By Ms. Slater) I think this one is self
7 explanatory. But I want to let you watch it.

8 (The designated portion of the video was
9 played for the jury.)

10 MS. SLATER: Thank you, Zack.

11 Q. (By Ms. Slater) what are you seeing? So,
12 I mean, you've examined him. You've done an
13 assessment. what are you seeing as far as what he's
14 doing with his movements?

15 A. so he's kicking his legs in the water, and
16 he's being held up by kind of a flotation assist
17 device. His arms look somewhat held with spasticity,
18 and, yeah.

19 Q. And, I mean, for you as a neurologist, you
20 saw him 14 months ago. I mean, that's great, right?

21 A. I think, you know, anything you do is
22 wonderful. He is a cute little kid.

23 Q. well --

24 A. I mean, on top of all of that, he is.

25 Q. That's on the record. It's agreed to

1 that. That's not in dispute, sir. I appreciate your
2 comment.

3 But as far as his movements?

4 A. Yes. I mean, he is making some movement
5 kicking in the water.

6 Q. And making some progress.

7 A. Yes. Without a doubt, he's going to make
8 some progress.

9 Q. Yeah. Okay. Let's look at one more, and
10 this should be something you're familiar with, as
11 well.

12 THE COURT: Before we go to that, maybe we
13 should take a break. We've been going for about 2
14 hours or so.

15 MS. SLATER: Yeah. And I won't have much
16 when we come back, yeah.

17 (At 10:57 a.m., the Court duly admonished
18 the jury, and proceedings stood in recess. At 11:17
19 a.m., the following proceedings were held in open
20 court, outside the presence of the jury:)

21 THE COURT: We're back on the record
22 outside the presence of the jury. The Court has
23 indicated that it is going to disallow a designation
24 on behalf of Mercy Hospitals and Dr. McNeive relative
25 to page 72 of the deposition of Dr. Miller.

1 MS. KAMYKOWSKI: So the portion that the
2 Court has ruled will be excluded is page 72, line 7,
3 through page 72, line 18 at the -- excluding the
4 question at line 18: what about any late decels?

5 The designation can continue from there.

6 THE COURT: Correct.

7 MS. KAMYKOWSKI: And just briefly for the
8 record, Your Honor, this is actually a counter
9 designation. There were designations on both sides
10 to begin with. This was a counter designation by the
11 defendants dovetailed to yesterday we had a sidebar
12 about -- or did we have a sidebar?

13 At the end of the day a discussion about
14 an objection previously that also related to Dr.
15 Miller, an OB resident's review, or, as my words put
16 it in the deposition, skimming of the fetal heart
17 rate tracings prior to her deposition and her
18 opinions, thereon.

19 The Court excluded that question and
20 answer based on a lack of foundation. My
21 understanding is, because it's late to kind of
22 restate that objectionable question, the Court is
23 going to excluding it without further opinion.

24 THE COURT: Correct.

25 MS. KAMYKOWSKI: Thank you, Judge.

1 THE COURT: Okeydoke. Are we ready to
2 bring the jury back in?

3 MS. KAMYKOWSKI: Yes, Your Honor.

4 (At 11:22 a.m., the following proceedings
5 were held in open court, in the presence of the
6 jury:)

7 THE COURT: You may resume.

8 MS. SLATER: Thank you, Your Honor.

9 Zack, if you would pull up Exhibit 565,
10 please.

11 (A designated portion of the video was
12 shown to the jury.)

13 Q. (By Ms. Slater) All right. Can you tell
14 me what we're seeing in that video?

15 A. So that's a gait trainer type --

16 Q. I'm sorry. Let me interrupt you. This is
17 from August 2024.

18 A. 2024?

19 Q. Yeah.

20 A. Okay. So this was last fall, yeah.

21 Q. Yes. And so was, and to be fair, so this
22 is swimming. Swimming was last August. And then the
23 Tobii device was actually April of 2023. Just a
24 couple of months after you saw him.

25 A. April 2024. Because you said 2023.

1 Q. Oh, it is 2023, a couple of months before
2 you saw him.

3 A. Wait. I thought January 2024.

4 Q. Correct.

5 A. Okay. So it would have been -- okay.
6 Anyway, is there a question pending?

7 Q. Yeah. If you could go ahead and describe
8 to the jury what we're seeing in this picture.

9 A. Yeah. So it -- that is a device that is
10 sort of like a wheelchair. It has cantilevered
11 wheels. He's being supported, but he can use his
12 legs to propel himself.

13 Q. Okay. And what type of leg use did you
14 see him use?

15 A. Yeah. He had some flexion and extension
16 of the lower extremities.

17 Q. Okay.

18 A. To propel himself forward.

19 Q. And we also saw him push off and bounce a
20 little bit.

21 A. Yeah.

22 Q. Like kind of a little jump?

23 A. A little bit, yeah.

24 Q. And that's great when kids can put
25 pressure on their feet and push up, right?

1 A. Yes. I mean -- I mean, it's progress.

2 Q. Yeah. That's what we want to see, right?

3 A. Yeah.

4 Q. And you take care of kids just like Remi?

5 A. I do.

6 Q. Okay. And that's the type of thing you
7 would tell a family, let's keep going, right?

8 A. Correct.

9 Q. And that's improvement from when you saw
10 him, right?

11 A. It is.

12 Q. Okay. Assisted walking, right?

13 A. That is -- there's different types of
14 assisted walking, whether it's crutches or a walker
15 or -- that would not be -- that would not be
16 considered independent community like being
17 independent in the community. That wouldn't qualify
18 in my mind as a pediatric neurologist for that.

19 Q. Well, no one is saying that's him
20 independently walking.

21 A. Right.

22 Q. No. And no one is saying he's going to be
23 walking in the community and jumping on a train to go
24 to the next stop. That's not -- nobody is saying
25 that, right?

1 A. Correct.

2 Q. we know he has a severe brain injury,
3 correct?

4 A. Yep. And we -- exactly.

5 Q. But as far as working with kids like this
6 and families like Remi's, you would tell them, keep
7 doing this. This will cause improvement?

8 A. Correct.

9 Q. okay. Great.

10 In your exam at the bottom -- do you have
11 a copy of your exam in front of you?

12 A. I don't. I don't.

13 Q. I'm happy just to show this to you, our
14 exhibit --

15 A. Looks like he's going to bring it up
16 maybe, but that's okay.

17 Q. My question is this, just down here: You
18 were talking about possible surgeries, including VNS
19 placement. And then strabismus surgery and removal
20 of the hip surgery hardware.

21 A. Correct.

22 Q. we heard from Dr. Nelson yesterday a
23 little bit about VNS surgery. That's vasal nerve
24 stimulator?

25 A. vagal nerve stimulator.

1 Q. vagal -- sorry -- vagal nerve stimulator.

2 Tell me what that is.

3 A. So a vagal nerve stimulator is an
4 implantable device that then has a wire that goes up
5 to the vagus nerve that has some ability to decrease
6 the frequency and severity of seizures. It's an
7 epilepsy treatment when, in general, when somebody
8 has failed medications, and they're not a surgical
9 candidate, meaning there's not a spot they can go and
10 cut out to cure epilepsy. It's a -- it's a -- it's
11 another treatment to help try to reduce frequency of
12 seizures.

13 Q. okay. How long is that surgery been
14 around?

15 A. I would say it's probably been at least 15
16 or 20 years that it's available.

17 Q. okay. And that was developed after
18 medications weren't working for kids, correct?

19 A. Correct.

20 Q. what's a baclofen pump.

21 A. So a baclofen pump is something that's
22 also -- so baclofen is a medication to decrease
23 spasticity. And sometimes people will take it
24 orally, but there are more side effects if you get
25 into higher doses.

1 so a baclofen pump would be a device which
2 contains liquid baclofen that can be refilled. It is
3 surgically placed underneath the skin, and then there
4 is a tube that goes into the cerebral spinal fluid
5 that can then administer small doses of baclofen into
6 the CFS, and then it doesn't have to go through the
7 digestive tract. when kids --

8 Q. And how --

9 A. -- oh, I'm sorry -- for use for kids that
10 have spastic quadriplegic cerebral palsy.

11 Q. Okay. And that's a potential future
12 option for Remi, as well?

13 A. It potentially is, yes.

14 Q. And how long has that surgery been around?

15 A. You know, I don't know exactly. It's
16 certainly been around for 10 or 15. Since I've been
17 practicing. I've been practicing for 20 -- oh,
18 goodness -- 24 years. So it seemed to be around,
19 from what I recall, back at the beginning when I was
20 practicing.

21 Q. Okay. And we asked Dr. Nelson this, too.
22 I mean, you, in your practice, when you're taking
23 care of patients like Remi, you're using everything
24 that technology and medicine has developed to help
25 their patients, correct?

1 A. We certainly hope.

2 Q. Yeah. What else is on the horizon for
3 kids like Remi?

4 A. Well, there's probably some advances in
5 communicative assistive devices. And as far as
6 nothing repairs the brain at this point, but we
7 really don't know a lot about what's in the future,
8 but hopefully we'll continue to make some
9 advancements.

10 Q. Two important parts of Remi's future is
11 his ability to communicate and his mobility, correct?

12 A. Correct.

13 Q. Okay. And you've seen improvement in both
14 of those items since you met with him about 14 months
15 ago?

16 A. Yeah.

17 Q. Thank you.

18 A. You're very welcome.

19 THE COURT: Redirect?

20 MR. PERRON: Thank you, Your Honor.

21 REDIRECT EXAMINATION

22 BY MR. PERRON:

23 Q. Doctor, are you denying that Remi has
24 suffered a significant hypoxic injury?

25 A. Absolutely not. I'm not here to downplay

1 that Remi's had a severe hypoxic brain injury.

2 Q. Are you denying that that injury occurred
3 in utero?

4 A. I am not.

5 Q. What is the one aspect of plaintiffs' case
6 on timing that you disagree with? The top line
7 disagreement you have?

8 A. That it could not have happened in the
9 hour preceding his delivery.

10 Q. So evidence that Remi was later documented
11 as frantic, was later documented as being
12 inconsolable, was later documented as having
13 seizures, is that inconsistent with your opinions
14 about the timing and how he presented at the time of
15 his delivery?

16 A. Absolutely not.

17 Q. What period of window are -- is your focus
18 on when you're trying to decide whether or not this
19 was the injury that happened in the last 30 minutes
20 of delivery or some other time previously?

21 A. I'm focusing on, as a neurologist, the
22 resuscitation and the next few hours after that.

23 Q. Okay. You were asked a question about
24 tachycardia.

25 Is a hypoxic injury the only possible

1 cause of fetal tachycardia?

2 A. No. But that starts to get, like I said,
3 starts to get outside of my expertise. It probably
4 is more of an obstetrical opinion, it would be best.

5 Q. Can a maternal fever cause fetal
6 tachycardia?

7 A. Yes.

8 Q. The fact that Mrs. Anyan had a fever right
9 at the time of delivery --

10 MS. SLATER: Your Honor, objection. This
11 is outside of his expertise, and then we're
12 continuing to have questions about this time period.

13 THE COURT: He did indicate that he would
14 defer to the obstetrician.

15 MR. PERRON: I narrowed it down to
16 maternal fever. He did respond with qualification,
17 Your Honor.

18 THE COURT: I understand. But he's also
19 testified that it's not his expertise.

20 Q. (By Mr. Perron) Doctor, you were asked on
21 cross-examination about the Dr. Pasternak article.

22 At the time of your deposition, in
23 explaining your opinion, did you reference the Dr.
24 Pasternak article?

25 A. Yes. It's in my deposition.

1 Q. Okay. And did you characterize that it
2 was one particular article that--

3 MS. SLATER: Objection, Your Honor, this
4 is the same issue. Can we have a sidebar?

5 THE COURT: I'm going to overrule the
6 objection, based on the cross-examination.

7 MS. SLATER: Sure.

8 Q. (By Mr. Perron) Did you identify a
9 particular article written by Dr. Pasternak that
10 supported your opinion?

11 A. Yes.

12 Q. Now, you called it "the classic"
13 Dr. Pasternak article in your field.

14 Is there one classic Dr. Pasternak article
15 that's well known in your field?

16 A. Yes.

17 Q. Okay. And you even spell Pasternak for
18 counsel.

19 A. Correct, in the deposition.

20 Q. Did they ask any further questions of you
21 about any inability to track that down or any further
22 questions of you in your depo to specify with more
23 detail that Pasternak article?

24 A. I don't recall.

25 Q. Okay. In your mind, that Dr. Pasternak

1 article supports your opinions?

2 MS. SLATER: Objection, Your Honor. We
3 have not identified the article. He hasn't produced
4 one.

5 THE COURT: The Court is going to sustain
6 the objection.

7 MR. PERRON: Okay.
8 Do you have the file folder that you
9 marked?

10 MS. SLATER: I think it's -- I took it out
11 with the other stuff.

12 MR. PERRON: Did you mark it as an
13 exhibit? If not, can I have a --

14 MS. SLATER: Sure.
15 (Pause in proceedings.)

16 Q. (By Mr. Perron) So this empty file folder
17 was marked as an exhibit, and it was shown to you,
18 and you were asked whether or not you brought any
19 literature with you to your deposition.

20 A. Correct.

21 Q. Okay. Did you, in fact, bring an article
22 of medical literature with you to your deposition?

23 A. Yep.

24 Q. Okay. So there is something to put in
25 Plaintiffs' Exhibit 150-14?

1 A. Yes.

2 Q. Okay. So just so -- for demonstrative
3 purposes, this is not an empty folder. You did bring
4 an article with you to your deposition?

5 A. Yes.

6 Q. That you believe was pertinent to the case
7 and your opinions?

8 A. Correct.

9 Q. And what was the title of that article?

10 MS. SLATER: Objection, Your Honor, can we
11 approach?

12 THE COURT: You can.

13 (The following proceedings were held at
14 sidebar, outside the hearing of the jury:)

15 MS. SLATER: Your Honor, this is the
16 genetic article that he said has no bearing on his
17 opinions, and said that he turned it over because he
18 had emailed it to defense counsel, and it has no
19 bearing on the case. So, I mean, I'm not sure we can
20 call that his opinion.

21 MR. PERRON: Your Honor, there was a
22 dramatic demonstrative show that he showed up to his
23 deposition with no medical literature. I, again, the
24 foundational question that I'm going to ask is, did
25 you believe that this medical literature was a factor

1 for this genetic cause? Can you say one way or the
2 other, without genetic testing, whether or not there
3 could have been a genetic cause? No, I can't.

4 That's all.

5 MS. SLATER: Your Honor, that door has
6 been opened with that demonstrative that was done on
7 cross-examination. And I think this is pertinent to
8 the previous discussions we had on the record with
9 respect to his opinion, that he cannot rule out a
10 genetic cause of Remi's HIE in this case.

11 And we still believe that we are entitled
12 under the law to offer alternative possibilities,
13 even if they don't rise to the level of more likely
14 than not.

15 THE COURT: But there's a different issue
16 in being able to offer that and having a witness who
17 says very plainly that he cannot pinpoint the cause.
18 To then have him going into other issues once he says
19 that, it's really hard to reel it back. And then add
20 in, well, it also can't be this, or it can be this,
21 or it can be this.

22 I think we're spending a lot of time, and
23 you're gaining absolutely no ground on either side
24 with this jury. But that's your choice, not mine.

25 But I'm going to allow you to ask

1 questions relative to an article, but not the
2 specifics of the article.

3 MR. PERRON: Okay. That's fine. Just
4 title only?

5 THE COURT: Yep.

6 (Proceedings returned to open court.)

7 Q. (By Mr. Perron) Doctor, I'll hand you
8 what's been marked as Exhibit I17.

9 Doctor, I'm just going to ask you to read
10 the title of that article.

11 A. "Molecular Diagnostic Yield of Exome
12 Sequencing and Chromosomal Microarray in Cerebral
13 Palsy: A Systematic Review and Meta-analysis."

14 Q. Okay. And that was an article that you
15 brought with you to your deposition?

16 A. Correct.

17 Q. Okay. The duration of labor -- the
18 duration of the second stage of labor, when you come
19 in as a neurologist, that's something that is
20 specifically important to you when you're trying to
21 look at a baby that's already been delivered and
22 decide what kind of care that baby needs?

23 A. Yes.

24 Q. Okay. You were shown records about Mrs.
25 Anyan's last OB visit before presentation to the

hospital, and shown records describing her presentation at the hospital.

Do you treat kids with Remi's same condition?

A. Yes.

Q. Some of -- are some of those kids, have they suffered an HIE in utero?

A. Yes.

Q. Is it always the case that those in utero injuries have clinical symptoms that the mother can appreciate or that OB can see by just examining the mother?

MS. SLATER: Your Honor, objection. This is a new opinion and outside the scope, as he has told the jury.

THE COURT: I don't have an answer as to whether or not this is a new opinion, since I don't have the deposition. I'm assuming you'll provide me where in the deposition this exists?

MR. PERRON: Your Honor, if we may approach?

(Proceedings were held at sidebar, outside the hearing of the jury.)

MR. PERRON: The records of Mrs. Anyan leading up to and the last OB visit at the hospital

1 was not covered at all in his deposition. He was
2 asked to look at those records and imply that there
3 was no clinical sign of an HIE. And I believe that I
4 should be able to ask him if that is a way to exclude
5 that between the last visit and the presentation at
6 the hospital there could have been an in utero
7 injury.

8 THE COURT: But you're acknowledging that
9 this opinion was not shared in the deposition, is
10 that correct?

11 MR. PERRON: It was not solicited from
12 him.

13 THE COURT: Therefore, it would be a new
14 opinion.

15 MR. PERRON: I disagree.

16 MS. KAMYKOWSKI: And I don't think that's
17 even a topic of his deposition. It's now a topic
18 being explored at plaintiffs' counsels' request on
19 cross-examination. It now opens the door. They're
20 implying of showing these records, there was nothing
21 wrong prior to Mrs. Anyan coming to the hospital,
22 and, therefore, this must be no time or injury. And
23 I get that, that's great cross-examination.

24 But she opened the door for this witness
25 now to say he has personal experience with patients

1 who have the same presentation, that those records
2 that they showed, and they still have the same
3 injuries.

4 MS. SLATER: No, Your Honor, that's a new
5 opinion. It's outside the scope. I did not ask him
6 for an opinion. And this is asking him to opine
7 about what is just a clearly obstetric condition.
8 And he did not share that in his deposition. Had he
9 done so, he would be stricken from providing that
10 expertise.

11 THE COURT: I will allow you to ask
12 questions with regards to, specifically with regards
13 to, Ms. Anyan's records and whether or not that
14 indicates to him one way or another that the child
15 was injured at that time. That's it.

16 (The proceedings returned to open court.)

17 Q. (By Mr. Perron) Doctor, just as we were
18 talking about, you were shown a record of Mrs.
19 Anyan's last OB visit or presentation to the
20 hospital. And you were shown a record showing her
21 presentation to the hospital.

22 Looking at those records, one way or the
23 other, can you or any neurologist look at that and
24 say anything about that timing of the injury
25 intrapartum?

1 A. No.

2 Q. Doctor, you don't read fetal heart
3 monitoring strips?

4 A. Correct, I do not.

5 Q. The heart itself, can you, based on your
6 understanding of pediatric neurology, can a baby in
7 utero suffer a brain injury, but -- and then later
8 have normal looking heart signs?

9 A. That starts to get outside of my
10 expertise. I defer that to maternal-fetal medicine
11 or obstetrics.

12 Q. We were reading a little bit of your depo
13 concerning your review of the ultrasound and Dr. Sze.
14 And the question posed to you was on page 49 of your
15 depo starting at line 10.

16 I just want to be clear, in your
17 deposition and today, did you agree with Dr. Sze that
18 the ultrasound was normal?

19 A. I did.

20 Q. Did you agree with Dr. Sze, at least as
21 far as your understanding of his testimony, that an
22 ultrasound can be normal for up to two days after an
23 HIE injury?

24 A. That is possible, yes, I did agree with
25 that.

1 Q. Okay. Did you agree with Dr. Sze that
2 ultrasounds were not very sensitive about picking up
3 HIE?

4 A. Correct.

5 Q. Okay.

6 MR. PERRON: If you go to the next page,
7 page 50, starting at line 9.

8 Q. (By Mr. Perron) Doctor, either at the
9 time of your deposition or today, are you deferring
10 completely your opinions to Dr. Sze in particular?

11 A. I am not.

12 Q. Okay. What --

13 MS. SLATER: Your Honor, this impeaching
14 his own witness with that deposition.

15 MR. PERRON: I was -- I'm allowed to
16 refresh his recollection, which I believe I've done
17 based on...

18 THE COURT: I don't recall hearing whether
19 or not reviewing something would refresh his
20 recollection or giving him an opportunity to review
21 or showing him, which is how that is done.

22 MR. PERRON: I'll move on, Your Honor.

23 Q. (By Mr. Perron) Have you ever been
24 retained by me or Mr. Phil Willman?

25 A. I have not.

1 Q. Have you been consulted on behalf of a
2 defendant or a plaintiff where you have said, I'm
3 unable to render a helpful opinion on causation in
4 this case?

5 A. Absolutely.

6 Q. Have you turned down work because you
7 couldn't support a causation theory?

8 A. On both sides, absolutely.

9 Q. There's been a significant fight about the
10 Apgar score, both in previous testimony, and again on
11 cross-examination of yourself.

12 Looking at the total picture of that 30-
13 to 60-minute period when Remi was delivered, the 8
14 Apgar score consistent with the resuscitation
15 efforts, and the NICU decision to leave him with the
16 parents.

17 A. Yes.

18 Q. Okay. And, again, does the Apgar score
19 form the only foundation of your opinions on the
20 timing of the injury?

21 A. It does not.

22 Q. What else?

23 A. The Apgar scores and what happened
24 following that, a lack of intubation, and how he
25 looked over the next minutes and hours.

1 Q. The Moro test that we looked at, the pain
2 score that we looked at, are those consistent with
3 the 8 Apgar score and resuscitation efforts and the
4 decision to leave Remi with his parents within the
5 scope of the issues we are talking about?

6 A. Yes.

7 MR. PERRON: Those are all my questions.

8 MS. KAMYKOWSKI: Nothing further from
9 defense.

10 RECROSS EXAMINATION

11 BY MS. SLATER:

12 Q. Can you turn to page 26 of your
13 deposition, please?

14 A. Sure. I'm there.

15 Q. Okay. Can you read lines 4 through 6,
16 please?

17 MR. PERRON: Your Honor, I believe we
18 brought this up earlier. Improper impeachment.

19 Q. (By Ms. Slater) If you can read those to
20 yourself.

21 A. Okay.

22 Q. Okay. And does that -- are you relying on
23 this article that you gave us at your deposition to
24 support any of your opinions?

25 A. Not the opinions that I've given today,

1 because I don't think we had a chance to talk about
2 that article.

3 Q. In your deposition you were asked, are you
4 relying on this article in this matter to support
5 your opinions?

6 And what was your answer?

7 A. No.

8 Q. okay. Thank you.

9 MS. SLATER: Nothing further, Your Honor.

10 THE COURT: Anything further of this
11 witness?

12 MR. PERRON: No, Your Honor.

13 THE COURT: May this witness be excused?

14 MR. PERRON: Yes.

15 THE COURT: Thank you very much.

16 THE WITNESS: Thank you, Your Honor.

17 THE COURT: All right. Based on my
18 understanding, we have a video that's about an hour
19 and 5 minutes. We can play the video all the way
20 through if you think that is something you all are
21 prepared for, or we can do maybe half of it then take
22 a lunch break.

23 You all tell me what you prefer.

24 MS. KAMYKOWSKI: I say play it all the way
25 through.

1 THE COURT: All right. Play it all the
2 way through.

3 Anybody who doesn't like that, turn around
4 and look -- okay. No, I'm kidding.

5 MS. PFIRMAN: Thank you, Your Honor.

6 At this time, defense calls Dr. Morgan
7 Miller by way of video deposition.

8 This deposition was taken on March 28th,
9 2023. And the total runtime is one hour and 5
10 minutes.

11 (Designated portions of the videotaped
12 deposition of Dr. Morgan Miller were played for the
13 jury.)

14 MS. PFIRMAN: That concludes this video
15 deposition.

16 THE COURT: All right.

17 Ladies and gentlemen of the jury, now is a
18 good time to take our lunch break.

19 (A break recess was taken at 12:55 p.m.,
20 and the jury was duly admonished, and the following
21 proceedings were held in open court, outside the
22 presence of the jury:)

23 THE COURT: There are a couple of things
24 we need to address.

25 MS. SLATER: Yes, I do. We have a couple

1 of objections on Jessie Brown's deposition that the
2 defense is planning to play sometime this afternoon.

3 MS. PFIRMAN: That's correct. And I have
4 a copy of her -- and just as an initial matter, Your
5 Honor, the parties agreed to file deposition
6 designations and the objections prior to the pretrial
7 conference on February 17th. We filed ours, and the
8 plaintiffs did not file any objections to Jessie
9 Wagner's, which we intend to play this afternoon.

10 Last night we were told that, I mean, now
11 they do have objections. So I guess we can take
12 those up.

13 If Your Honor would like, I would just ask
14 if they have any additional objections, that we get
15 that sooner than later so we're not attempting to
16 recut these videos which have already been prepared
17 based on the designations and objections that were
18 filed timely.

19 So with regard to our one remaining
20 objection, 135, line 25 through 137, 15, this has
21 to --

22 MS. SLATER: Hang on. Do you have --

23 MS. PFIRMAN: We filed that with the
24 pleading.

25 MS. GUNN: When we exchanged emails last

1 night. So what page?

2 MS. PFIRMAN: Page 135, line 25, through
3 137, line 15.

4 MS. GUNN: okay.

5 MS. PFIRMAN: which changes the answer to
6 what the blood gas was and why there were no experts
7 that were critical of the nurses for not drawing
8 blood gases. So we would object that it's
9 irrelevant, misleading, and confusing to the jury.

10 THE COURT: How far is the designation on
11 here?

12 MS. GUNN: It goes from 15, 25, to 137,
13 15, and that is the designation we made in its
14 entirety.

15 MS. PFIRMAN: Yes. Our objection is to
16 the entire designation or object to the entire
17 designation.

18 THE COURT: what was the response for the
19 objection?

20 MS. GUNN: Your Honor, the nurse who was
21 in the delivery room at the time Remi was delivered.
22 I don't think it mentions anything about the standard
23 of care article or nurse standard of care. It's
24 certainly described under -- which cord gas was
25 obviously an issue in this case. It has been spoken

1 of by various witnesses throughout the course of the
2 trial.

3 MR. PERRON: Your Honor, if there wasn't a
4 proper foundation, then she can speak to these
5 issues. We're arguing that's not relevant and lacks
6 foundation.

7 MS. GUNN: She's the nurse in the delivery
8 room.

9 MR. PERRON: It's not her call or her
10 decision. I don't know that she has the foundation
11 to opine on that.

12 THE COURT: She's speaking specifically
13 with regards to Remi's situation, and a portion of
14 this response indicating that she doesn't recall: I
15 mean, if we didn't -- if we don't, we didn't send
16 one, so I don't know if we tried to draw one or not.
17 Or maybe in the moment, you know, I think it was a
18 very chaotic delivery, and so I think I was over, you
19 know, helping with the baby. And, sadly, I don't
20 think that crossed my mind, otherwise I would have
21 offered to put one on the field.

22 which indicates that she has the ability
23 to request one be done. So I'm going to overrule the
24 objection, and I'm going to allow the entirety of the
25 statement.

1 MS. GUNN: Thank you, Your Honor.
2 our objections start at -- or the
3 objection I have, you have to actually go backwards.

4 Do you have one now that's marked up?

5 THE COURT: I do.

6 MS. GUNN: It would be easier. So that
7 page 128 -- 128, line 1, through 130, line 15. So
8 it's about two and a half pages. This is, by the
9 way, Nurse Jessie, so she's not coming.

10 So when I took this deposition, I didn't
11 expect -- it happens. It happens. You know, I asked
12 her a whole bunch of questions -- I didn't expect one
13 of the nurses to not be here at trial -- so I asked a
14 whole bunch of questions, including, do you have an
15 opinion as to the cause of Remi's brain damage? And
16 she says, I don't.

17 And then she goes on to say, due to the
18 moderate variability over all the strips, that can
19 mean it's reassuring. And then she goes on to just
20 talk about everything that she saw and heard.

21 But ultimately she is not -- she is a
22 labor and delivery nurse. She is not qualified in
23 this context to give opinions about the cause of
24 Remi's brain damage. She disqualifies herself on top
25 of that when she says, I don't have an opinion.

1 she goes on and on for a few minutes, and
2 then I ask her again, are you planning on giving an
3 opinion? And she says, I don't -- I feel like I
4 don't have another reason or another potential cause.

5 And so then I say, well, the judge is
6 going to decide who's qualified. I'm just trying to
7 understand, you know, what you're saying. And she
8 goes on to say essentially, I don't know, line 13. I
9 say, you're telling me I just don't -- hold on.

10 And I need to understand the foundation
11 for that. Or if you're telling me you just don't
12 know, then we can leave it at that. She says, I feel
13 like I mentioned before overall strips. And so,
14 again, she's sort of pontificating and wondering out
15 loud what could have happened.

16 Because basically and initially she has no
17 foundation for that opinion and disqualifies herself
18 by saying, I don't have an opinion. So to allow her
19 to, you know, throw into the record various reasons
20 about her thought process, I think would be improper
21 and confusing.

22 MR. PERRON: Your Honor, if she can't form
23 an opinion as to ultimate causation, she does have
24 opinions about factors that are pertinent to
25 causation, that are within the scope of a nurse to

1 observe and to provide one.

2 Those are still responsive and relevant,
3 even though she can't put all of the pieces together.

4 If you say, does it add up to 4? And you say, I
5 can't add it all up, but I see 1, and I see 1, and I
6 see 1, that's pertinent and responsive to the
7 question, Your Honor.

8 MS. KAMYKOWSKI: In addition, Your Honor,
9 during this entire answer, what she's doing in her
10 mind, talking both about standard of care and
11 causation at the same time, and how it doesn't add up
12 in her mind.

13 And certainly, as a nurse whose care has
14 been called into significant question by the
15 plaintiffs' theory in this case, she should be
16 entitled to offer all of this testimony to support
17 her ultimate conclusions that she and Maggie,
18 throughout the course of their monitoring of this
19 patient on May 4th, met the standard of care, and
20 that's what is included in all of this discussion.

21 MS. GUNN: She -- there are standard of
22 care questions. They are covered elsewhere. I have
23 not objected to those. But this particular witness
24 is not qualified under the statute to give opinions
25 with respect to causation. She disqualifies herself,

1 and there's no foundation.

2 In addition, the part at the end of page
3 129, where she talks about seeing Dr. McNeive at
4 work, and he told her this, that is hearsay and
5 should also not -- that also is another reason why it
6 should not be played.

7 MS. KAMYKOWSKI: So Dr. McNeive is a
8 defendant, named defendant, in the lawsuit. That is
9 an exception to the hearsay rule.

10 MS. GUNN: Not if you're offering him.

11 MS. KAMYKOWSKI: He's not mine. He is not
12 my client.

13 MS. GUNN: This is not admission party
14 opponent.

15 MS. KAMYKOWSKI: It's a statement against
16 interest being -- or admission by a party opponent.

17 MS. GUNN: I'm not offering it; you're
18 offering it. And you can't offer that. You can't
19 bolster this other defendant with hearsay.

20 MS. KAMYKOWSKI: I could offer it, but
21 what if I'm not offering it?

22 THE COURT: So I think what would be
23 appropriate to remove from this is 128, 01, as to the
24 question: Do you have an opinion as to the cause of
25 the brain damage? And continue through 128, 03 to

1 the period. Due to the moderate variability overall
2 on the strip, that to me was reassuring. Allowing
3 the remainder of that in.

4 MS. GUNN: Sorry. I'm not following you.
5 Could you say that again?

6 THE COURT: I can.

7 So, in essence, I'm removing your question
8 and the first part of the answer which is, honestly,
9 I don't. And then allowing it to go on from where it
10 says, due to the moderate variability overall in this
11 strip, that to me was reassuring. And then he
12 continued to respond to intervention, and I know you
13 know she spiked a temperature, and then he had more
14 minimal variability with tachycardia at the end.

15 Continuing on: However with this child --
16 and then removing, starting at 128, 18. Starting
17 back at page 130, 07 -- I like, you know, flipped
18 back in my head. I was like, what did I miss? What
19 could I have done differently? Like did I miss any
20 cues? Like what happened? And I replay the entire
21 day in my head and could not think of anything. Like
22 it sounds bad to say because like I'm happy with the
23 nursing care that I provided, and it just sucks that
24 it's a bad outcome. Like this couldn't be expected.

25 MS. GUNN: Okay. It's between 128, 18,

1 and 130, halfway through 7 is out. And then 07 to 50
2 is in?

3 THE COURT: Yes.

4 MS. GUNN: okay. okay. The next one,
5 Your Honor, is page 137, 23, through 138, 7. There
6 is discussion, and it is designated about how she
7 feels about her standard of care. My concern with
8 this is the question: Do you have any opinions to
9 correct anyone else's standard of care? Like
10 concerns about other people in this case?

11 I said, yes. And she said, no, I think we
12 all did our best in the situation at that time we
13 were given. I think everyone treated her and baby
14 like the best we could, knowing what we knew.

15 My concern with that is, she's not
16 qualifying who she's speaking about, and that it
17 could and would include Dr. McNeive, for which she's
18 not qualified.

19 Now, if you go down through the end of
20 page 138, the same question is asked: So do you
21 believe you acted in the standard of care? You also
22 believe Maggie acted in the standard of care? So she
23 gets to say it in terms of herself and Maggie. And I
24 think that 137, 23, through 138, 7, is beyond her
25 qualifications.

1 MS. PFIRMAN: Judge, this goes directly
2 to standard of care for the nurses, including Jessie
3 Wagner. Plaintiff is alleging that the nurses didn't
4 invoke the chain of command to question Dr. McNeive's
5 actions. So this is going to that direct point,
6 showing that she doesn't think that Dr. McNeive was
7 doing anything wrong that required her to invoke the
8 chain of command, as plaintiff is alleging.

9 MS. GUNN: She also answers the question
10 no. Do you have any more? And she said, no. But I
11 think despite that, it is covered elsewhere. And,
12 here, she's talking about folks that are outside of
13 her ability and qualifications to render opinions on.

14 MR. PERRON: Your Honor, if it is
15 plaintiffs' case, then they should have understood
16 that Dr. McNeive was making decisions outside of
17 hospital policy and outside of norms. And they had
18 an obligation to go up the chain of command.

19 The implication is that these nurses have
20 an ability to appreciate a physician making some kind
21 of a mistake. So if you're -- I think the nurses --
22 I think the defense should be allowed to present
23 evidence that, in her opinion, limited though it is,
24 to just a nurse, and from her experience, there was
25 nothing to trigger her to go up the chain of command.

1 THE COURT: I'm going to overrule the
2 request to exclude it and will allow it in.

3 MS. GUNN: Your Honor, my last one is page
4 160. Starts -- so the question starts at line 7:

5 After Remington was born, did you observe
6 any other signs or make any other observations that
7 prompted you to say something to Mary Younger or to
8 anyone else in the NICU? And the answer was no.

9 And I propose that the rest of her answer
10 is nonresponsive. And it probably bolsters another
11 witness because she talked about how wonderful Mary
12 Younger is and how she would trust her with her own
13 children.

14 MR. PERRON: But isn't she wonderful, Your
15 Honor?

16 THE COURT: I haven't met her, so I don't
17 know. But we're -- there's no reason for that in
18 there. The answer is no.

19 MS. PFIRMAN: what about the paragraph
20 after where she talks about the postpartum nurses
21 doing an assessment and after the assessment,
22 everyone was in agreement that Remi could stay with
23 his parents? so it directly contradicts plaintiffs'
24 theory that Remi was not doing well after the
25 delivery.

1 MS. KAMYKOWSKI: Keep out to line 17,
2 then?

3 MS. PFIRMAN: Correct.

4 MS. GUNN: She also was --

5 MS. KAMYKOWSKI: That would be responsive
6 to the question, taking out the character stuff from
7 the nurse practitioner.

8 MS. GUNN: I agree with that.

9 So we'll take out 11 through 17, starting
10 after the "no."

11 THE COURT: Yep.

12 MS. GUNN: Thank you, Judge.

13 MS. PFIRMAN: Thank you, Judge.

14 (At 1:16 p.m., the jury was duly
15 admonished, and a break was taken. At 2:01 p.m., the
16 following proceedings were held in open court, in the
17 presence of the jury:)

18 THE COURT: Go ahead and be seated,
19 everyone.

20 On behalf of the defendant.

21 MR. PERRON: Yes, Your Honor. The defense
22 calls Dr. Dreyer.

23 GARY DREYER, M.D.,
24 having been duly sworn, was examined, and testified
25 as follows:

DIRECT EXAMINATION

BY MR. PERRON:

Q. Doctor, would you please introduce yourself to the jury.

A. Yes. My name is Dr. Gary Dreyer.

Q. And what is your current position?

A. I'm a neonatologist at Mercy St. Louis in the NICU.

Q. And the jury has heard a little bit about these different subspecialties in medicine.

Just give them a quick overview as if you were talking to a patient what neonatology is.

A. Sure.

Q. The scope of your practice.

A. So as a pediatric subspecialty, we train as pediatricians first, and then do more additional training, taking care of sick or premature babies.

Q. So the jury has heard your name a couple of times in reference to this case.

Were you involved, within your capacity as a neonatologist, in your care and treatment of Remi Anyan at Mercy Hospital?

A. Yes, I was.

Q. And this would have been in May of 2020?

A. Correct.

1 Q. within the course of your treatment, did
2 you ever have cause to be concerned or doubt the
3 accuracy or the reliability of the Apgar scores?

4 MS. GUNN: Your Honor, may we approach?

5 THE COURT: You may.

6 (Proceedings were held at sidebar, outside
7 the hearing of the jury.)

8 MS. GUNN: Your Honor, this witness has
9 been discussed previously on the record. We objected
10 to him coming to trial because he was not previously
11 disclosed as a witness that had specific opinions.
12 It was on his list, potential witness list, before
13 trial. He's a treating physician at Mercy. I
14 recalled the court's previous order that he could
15 stick to the facts as to the chart and talk about his
16 care and treatment of Remi, which did not include the
17 warming or being in the delivery room when Remi was
18 born. He has not established that at all.

19 And the first question, essentially the
20 first question that was asked, was that he asked this
21 physician whether he had cause to believe the Apgar
22 scores were right or wrong or good or bad, that would
23 be improper, a late disclosure and should be stricken
24 from the record.

25 MR. PERRON: Your Honor, plaintiff has,

1 over the course of this case over and over again,
2 attacked the reliability of the Apgar scores within
3 the content of the neonatal care and treatment. I am
4 not asking the witness, and I understand in the
5 Court's ruling I can talk about his care and
6 treatment. I need to talk about, in this care, the
7 timing opinion and the causation opinion. The
8 reliability of scores that were given at the hospital
9 is not a timing question. It is not a causation
10 question.

11 THE COURT: So your question to him was
12 what?

13 MR. PERRON: whether or not, over the
14 course of his treatment, he ever had cause to be
15 concerned or doubt the accuracy of the Apgar scores.

16 THE COURT: I don't believe that that's
17 something that he should be able to testify to. He
18 can testify to what he understood the Apgar score --
19 what he did based upon the Apgar score.

20 MR. PERRON: well, if his understanding of
21 the Apgar scores is the basis for any of his
22 treatment, he should be allowed to share them. He
23 took them as they were. If I ask, are you aware of
24 the Apgar scores? Did you accept those as accurate
25 as part of your care and treatment?

MS. GUNN: Your Honor, again, for a witness to come at the last minute and render testimony that none of us has ever heard of, that's not part of the record, and to pretend that this is a physician who has the foundation and the qualifications to render opinions about Apgar scores and how they play in this case, is a new opinion and a new witness that was not previously disclosed in any manner.

THE COURT: You can ask him what his understanding of what the Apgar was and what he did. Not the accuracy of it or the inaccuracy of it. I don't have any reason to believe that this witness has the foundation to be able to testify that he knows it was accurate or inaccurate. And at this point, he can testify to what he was told the Apgar score was or how ever he learned it and what he did as a result.

MS. KAMYKOWSKI: Just so we don't have to have another one of these when I might have some questions. As an attending neonatologist in the NICU, who works in conjunction with nurse practitioners, Missouri law requires a nurse practitioner to work under a collaborative practice with a nurse.

1 I presume that Dr. Dreyer, well, I don't
2 know this, but I'm going to ask him, I don't know,
3 I've never talked to the man, but that he has a
4 collaborative practice with Nurse Practitioner
5 Younger or Spencer, she was Younger at the time. And
6 I plan to ask him about that relationship and the
7 role that he would have as an attending overseeing,
8 working in collaboration with, the neonatal nurse
9 practitioners, and he would expect them to do their
10 job. And I don't think that that goes beyond, that
11 is well within his scope or practice, and as he was,
12 at the time, was collaborating with Mary and others.

13 MS. GUNN: Again, there's another improper
14 bolstering of this -- of Mary Younger. She has
15 testified. She has given her thoughts and her
16 opinions. And to bring in a new person now to talk
17 about, yes, that was a collaboration, she was great,
18 I just think it is improper, and it's a new opinion.

19 THE COURT: He can testify that he works
20 in collaboration with Ms. Younger and how that
21 collaboration works, but he's not allowed to give
22 statements with regards to how wonderful she is or
23 how fabulous she is or how horrible she is.

24 MS. KAMYKOWSKI: Agreed a hundred percent,
25 Your Honor. But I think he can certainly talk about

1 collaborations with nurse practitioners. He expects
2 them to do accurate assessments and accurately record
3 those in the chart.

4 MS. GUNN: Your Honor, again, we are 5
5 years -- four years into this litigation. And I know
6 that Dr. Dreyer is the treating physician, and he's
7 been on their list for a couple of years, but at this
8 late date, at this late date, to bring in a witness
9 for the first time revealing brand new things, that,
10 after a week of trial, they've now decided what our
11 theory is, and they're trying to poke holes in it by
12 bringing in a physician, without admitting anything,
13 without offering his deposition, without giving any
14 opinions about this, whatsoever, is a late disclosure
15 and wholly improper.

16 THE COURT: The doctor is not permitted to
17 testify as to the accuracy or inaccuracy of the Apgar
18 score. He's allowed to testify that he works in
19 collaboration with her. And that he relies upon the
20 information received from her, if that is what in
21 fact is true.

22 MS. KAMYKOWSKI: And I'd like the record
23 to reflect the timing of the disclosure of this
24 witness by both parties as nonretained, and neither
25 side tried to take his deposition.

1 THE COURT: Okay.

2 (Proceedings returned to open court.)

3 Q. (By Mr. Perron) Doctor, do you have an
4 understanding, from your care and treatment, what the
5 5-minute Apgar was?

6 A. Yes.

7 Q. What was it?

8 A. 8.

9 Q. Okay. And what did that mean to you
10 within your care and treatment?

11 A. I actually reviewed that Apgar score that
12 was in the chart. So I think there was 1 off for
13 color, and 1 off for reflexes, I believe. But the
14 rest of the scores were 2.

15 The Apgar score really is a guide for us.
16 Does the baby need to be resuscitated? And then what
17 is the response to the resuscitation?

18 So by the time I came on the next day,
19 it's useful information, but it doesn't really guide
20 therapy, you know, at some hours.

21 Q. Okay.

22 A. It's really -- I'm sorry -- it guides
23 therapy in the minutes in the delivery room.

24 Q. Okay. Switching gears for a minute.

25 Are you familiar with Dr. McNeive?

1 A. Yes.

2 Q. Have you worked with him within your
3 professional capacity as a neonatologist specialist?

4 A. Yes. His whole career.

5 Q. Through the time that you've known him
6 within a professional capacity, have you ever know
7 him to potentially harm --

8 MS. GUNN: Your Honor, may we approach?

9 THE COURT: You may.

10 (Proceedings were held at sidebar, outside
11 the hearing of the jury.)

12 MS. GUNN: I don't think Remi's medical
13 records mentioned Dr. Dreyer's personal opinion about
14 Dr. McNeive, whether he's a good doctor or a bad
15 doctor. I understand there are comparative damages
16 in this case. I understand why the defense wouldn't
17 want Dr. Dreyer, who's known McNeive for his entire
18 career, to come in and talk about what a wonderful
19 doctor he is and how he's never, ever understood that
20 Dr. McNeive would ever intentionally hurt anybody.

21 But the relevance of that is not proper.

22 It is extremely prejudicial, and it is not proper for
23 this witness, again, to have any comment about
24 anything other than what Your Honor has allowed,
25 which is to talk about Remi's -- the care and

1 treatment of Remi Anyan.

2 MR. PERRON: Your Honor, this was an issue
3 that was invited by plaintiffs' decision to proceed
4 with punitive damages. And specifically, under the
5 standards set by Missouri statute, that they have to
6 prove intent to cause harm or malicious misconduct.
7 We took this issue up, and we argued it extensively.

8 And it was my understanding of the Court's
9 ruling that evidence going to Dr. McNeive's past
10 history of causing harm to patients was relevant.

11 This is someone who has laid foundation who used to
12 work with Dr. McNeive in a professional capacity, and
13 if he has never seen Dr. McNeive act intentionally to
14 harm a baby, it is relevant to our defense on
15 punitive damages.

16 THE COURT: The issue with whether or not
17 this witness should be allowed to testify to that
18 fact, we've gone back and forth with regards to what
19 this witness can testify to. This issue has not been
20 raised before the Court previously, and the Court is
21 going to stick to its previous rulings with regards
22 to what this witness can testify to, which is the
23 care and treatment of Remi Anyan.

24 MS. GUNN: Thank you.

25 (Proceedings returned to open court.)

1 MR. PERRON: No further questions of this
2 witness.

3 THE COURT: Cross-examination?

4 Sorry. Direct examination?

5 MS. KAMYKOWSKI: whatever we're calling
6 it. Yes, Your Honor. Thank you.

7 DIRECT EXAMINATION

8 BY MS. KAMYKOWSKI:

9 Q. Hi, Dr. Dreyer.

10 A. Hi.

11 Q. I'm Mandy Kamykowski.

12 We've not met before today, have we?

13 A. Have not.

14 Q. And I think we just met briefly outside.

15 A. Correct.

16 Q. Are you here voluntarily today?

17 A. Yes.

18 Q. But did we issue a subpoena upon you?

19 A. Yes.

20 Q. Okay. So you got a subpoena to come and
21 testify, correct?

22 A. Correct.

23 Q. And you've never spoken to me before
24 today, correct?

25 A. No, ma'am.

1 Q. And have you ever spoken with Mr. Willman
2 or Mr. Perron before today?

3 A. No.

4 Q. And when you introduced yourself, you
5 indicated that you are a neonatologist at Mercy
6 Hospital, and I know that to be true.

7 I represent Mercy Hospital East
8 Communities.

9 That is not your employer, is it?

10 A. No.

11 Q. How about are you an employee of any Mercy
12 Clinic?

13 A. No.

14 Q. Who is your employer?

15 A. Pediatrics Medical Group of Missouri.

16 Q. Okay. And as a neonatologist for
17 Pediatrics Medical Group of Missouri -- I'll call it
18 Pediatrics -- when you are working at Mercy
19 Hospitals, do you work in collaboration with neonatal
20 nurse practitioners?

21 A. Yes.

22 Q. Tell the jury what it means, as a
23 neonatologist, to work in collaboration with neonatal
24 nurse practitioners.

25 Can you just explain that relationship

1 that you have and why it exists.

2 A. Certainly. So our nursery is a big and
3 busy nursery, and we use the practitioners as
4 assistants, really, and -- and work as a team. So we
5 have our access medical team, both doctors and the
6 nurse practitioners.

7 So that's the role we work. We have a
8 doctor and two practitioners on night call all the
9 time. We usually have four practitioners and four
10 doctors as our rounding teams during the day. So we
11 will collaborate on patients and attend deliveries
12 together or separately and round on those patients.

13 Q. And to prepare for coming here to testify,
14 were you able to access Remi's chart and do some
15 reviews to kind of familiarize yourself why in the
16 heck are they asking me to come in here?

17 A. Yes.

18 Q. Okay. What did you review?

19 A. I reviewed the delivery room note, the
20 sheet that had the Apgar scores assigned, and my
21 progress notes.

22 Q. Okay. And the delivery room note was
23 prepared by, at the time, her name was Mary Younger?

24 A. Yes.

25 Q. She now is Mary Spencer?

1 A. Correct.

2 Q. She still works in collaboration with you?

3 A. Yes.

4 Q. I don't know how it works there. But I
5 understand, from doing this type of work for a very
6 long time, there's a legal relationship that you have
7 to have an agreement, a collaboration --

8 A. A cybrary practice agreement, yes.

9 Q. What is that?

10 A. That may be a law question.

11 Q. Okay. So -- but in order for neonatal
12 nurse practitioners, who have their own license by
13 the state of Missouri, correct?

14 A. Correct.

15 Q. But they aren't able to fully practice
16 like a medical doctor.

17 Is that fair?

18 A. Correct.

19 Q. So the state requires the agreement, like
20 a signed contract?

21 Is that fair?

22 A. Yes.

23 Q. And do you have those signed contracts for
24 the neonatal nurse practitioners that you work with
25 at Mercy?

1 A. Yes.

2 Q. And would that include Mary Younger?

3 A. Yes.

4 Q. And we know that in this case, well, you
5 reviewed her delivery notes.

6 Is that fair?

7 A. Yes.

8 Q. And I wanted to make sure that was the
9 delivery note you're talking about, was this neonatal
10 nurse practitioner's delivery's note, not Dr.
11 McNeive's?

12 A. Correct.

13 Q. Okay. When you reviewed that note, you --
14 did you learn that she was present at Remi's birth?

15 A. Yes.

16 Q. And tell us how that comes about? How
17 does the neonatal nurse practitioner come to the --
18 to be present at a delivery?

19 A. Actually, Dr. McNeive invited the medical
20 team to come, and Mary went as a practitioner and
21 then had another practitioner, Ashley, join her.

22 Q. And how is it that Mary and Ashley --

23 A. Ashley.

24 Q. -- went instead of someone like you, the
25 attending neonatology doctor?

1 A. Correct. We would certainly go as needed.
 2 If the -- if it were an emergent delivery, we would
 3 go to that. So there are tiers, triage of
 4 deliveries, that we would attend.

5 Q. Okay.

6 A. So a premature baby or a known birth
 7 defect, those sorts of things.

8 Q. And you, in your practice, have triaged
 9 the things that require someone with your skill set
 10 as a specialized neonatologist --

11 A. Correct.

12 Q. -- versus the neonatal nurse practitioners
 13 who also are specialized, but in a different way?

14 A. Yes.

15 Q. Okay. And so if -- does pediatrics staff
 16 the NICU with neonatologists 24/7?

17 A. Yes.

18 Q. So although Mary Younger -- well, do you
 19 know who else from the NICU besides a nurse
 20 practitioner, if a doctor, like Dr. McNeive, calls
 21 for them to be present for delivery, who shows up?
 22 Do you know? Like is there a nurse from the NICU
 23 that also accompanies them?

24 A. If there's a -- a code white is an
 25 emergent delivery or a baby code blue would be things

1 that we would respond to. Then we would have
2 doctors, nurses, nurse practitioners, so a whole team
3 would respond.

4 In an attended delivery, we would use a
5 nurse practitioner, a respiratory therapist, not
6 necessarily one of our bedside nurses, because there
7 would be another nurse, a baby nurse we call them, so
8 a nurse to assist Remi outside of the delivery nurse
9 that was helping Dr. McNeive.

10 Q. Okay. And the jury -- I'm not going to
11 bore you with it because the jury has heard of some
12 of those nurses' names -- but the nursery team,
13 whether it included NICU folks or not, there's always
14 going to be a nursery nurse at the delivery?

15 A. Yes. A labor and delivery nurse assigned
16 to the baby.

17 Q. Okay.

18 A. Not -- not, I, you know, I need a
19 different tool. Yeah. So a nurse for the baby
20 specifically.

21 Q. Okay. And so how this attended delivery,
22 meaning the NICU --

23 A. Yes.

24 Q. -- Mary Younger, and her team attended
25 this delivery, that happens probably every single day

1 on labor and delivery, in your experience.

2 A. Multiple times.

3 Q. Okay. And if Nurse Younger was concerned
4 about Remi's condition at the time --

5 MS. GUNN: Your Honor, may we approach?

6 THE COURT: You may.

7 (Proceedings were held at sidebar, outside
8 the hearing of the jury.)

9 MS. KAMYKOWSKI: The rest of my question
10 was, if she was concerned, there would have been an
11 attending in the house that she could have called.
12 That's all I'm going to ask him.

13 MS. GUNN: So, again, care and treatment
14 of Remi Anyan by this provider, if what I understood
15 the Court's ruling to be. And not only that, in
16 addition to that, it sounds like it's calling for
17 speculation about what Nurse Younger would or would
18 not do. I object on both of those grounds.

19 THE COURT: I'm going to sustain the
20 objection.

21 If you want to ask what the doctor can do
22 relative to whatever circumstances are at play, you
23 can ask that question.

24 But for him to say that if Mary Spencer
25 was concerned, which how would he know one way or the

1 other what would be her options, I think is improper.

2 MS. KAMYKOWSKI: And I wasn't going to ask
3 him what her options were. I think he would know
4 this. He testified they have a neonatologist
5 in-house 24/7, so the only thing I was going to ask
6 was if she had a question for a neonatologist, there
7 would have been one available to her.

8 THE COURT: No.

9 MS. KAMYKOWSKI: That's all I'm going to
10 do. But if you're saying I can't do that, that's
11 fine.

12 Thank you, Your Honor.

13 Q. (By Ms. Kamykowski) Dr. Dreyer, when you
14 reviewed your involvement in this case, which
15 happened the following day, correct?

16 A. Yes.

17 Q. At that time, what was on the differential
18 diagnosis for you for Remi, do you remember?

19 A. Yes. So certainly from a neurologic
20 standpoint, hypoxic ischemic encephalopathy would be
21 on there. More complicated would be metabolic
22 diseases. And I think we screened for those sorts of
23 things. Infection could certainly cause Remi to be
24 sick. So those are probably the top three on the
25 differential.

1 Q. And in fact I think your name was part of
 2 the team -- I think you were the ordering provider
 3 for a head ultrasound on the 5th, an MRI on the 6th,
 4 and some other laboratory studies to work up
 5 potential infections, hypoxic ischemic injury, and
 6 other things, is that correct?

7 A. Correct.

8 Q. Okay. I think those are all the questions
 9 I have. Thank you, Dr. Dreyer.

10 A. You're welcome.

11 THE COURT: Cross-examination?

12 Q. Yes, Your Honor.

13 CROSS-EXAMINATION

14 BY MS. GUNN:

15 Q. Thank you, Dr. Dreyer, for being here.
 16 The -- the three things on the list that
 17 you mentioned, sir, with respect to Remi Anyan and
 18 the cause of his encephalopathy, you all did your
 19 full workup, correct?

20 A. Yes.

21 Q. And you looked at the EEG, the head
 22 ultrasound, the MRI, all the labs. And the -- did I
 23 say MRI? The MRI.

24 And what was your conclusion with respect
 25 to Remi's brain damage?

1 A. So the other thing we would have looked at
2 would be infectious. So we did a spinal tap and
3 looked at those studies and having him on
4 antibiotics.

5 Q. Okay. And did you -- did you determine it
6 was HIE or metabolic or infectious?

7 A. HIE.

8 Q. And that was based on what, sir?

9 A. On all those things.

10 Q. All those things?

11 A. Yes.

12 Q. Thank you. Do you remember Blake Anyan?

13 A. Yes.

14 Q. I know that you have spent some difficult
15 times with him. And I want to talk about the May 5th
16 time frame.

17 So Remi was born on May 4th. Do you
18 recall that?

19 A. (Nodding head.)

20 Q. You have to answer out loud.

21 A. Yes. I'm sorry.

22 Q. I don't mean to --

23 A. Head bobs don't work.

24 Q. Yes. Yes. And -- and you -- were you on
25 shift on May 5th? Is that how it happened?

1 A. You know, I'm not sure about that. So I
2 know Dr. Thakadiyil was the nighttime doctor when
3 Remi was born.

4 Q. Okay.

5 A. So I would have come in the next morning,
6 and I don't have those dates absolutely in my -- in
7 my brain.

8 Q. And I appreciate that.
9 Dr. Thakadiyil was another neonatologist?

10 A. Yes.

11 Q. And so do you recall having conversations
12 with Blake and his wife Sarah about their baby?

13 A. I think after reviewing the records, yes.
14 And I would not have recognized dad, not without
15 seeing him. I didn't have a picture of him in my
16 mind.

17 Q. Sure, I understand. And do you recall at
18 the time when you came on service, either from your
19 own recollection or through your review of the
20 records, the morning of May 5th, that Remi was
21 seizing?

22 A. From the records.

23 Q. Having seizures?

24 Okay. Do you remember going to the room
25 where Sarah and Blake were to tell them about those

1 seizures?

2 A. I do not remember that.

3 Q. Okay. Now, you mentioned there was a
4 lumbar puncture?

5 A. Yes.

6 Q. So did you perform the lumbar puncture?

7 A. I'm not certain of that.

8 Q. I can tell you you did.

9 A. Okay.

10 Q. So I could show you --

11 A. I was going to say I suspected I did.

12 Q. Okay. And can you describe what that is,
13 a lumbar puncture?

14 A. Yes. It's a test to obtain spinal fluid
15 so that we can evaluate babies for meningitis and
16 infection. So babies are placed on their side. They
17 get some numbing medicine in their back. Then we put
18 a small needle between the bones of the spine and
19 withdrawal some of that fluid.

20 Q. And this came back negative?

21 A. Yep.

22 Q. Which was good.

23 And then the head ultrasound was read as
24 normal.

25 Is that your recollection?

1 A. I think there was perhaps a small, of the
2 lowest grade, bleed on one side.

3 Q. Was that concerning to you at all?

4 A. No.

5 Q. And you saw no cause to repeat that
6 ultrasound. You -- it was read as normal. And that
7 was diagnostic for you.

8 A. Well, we did the MRI the next day.

9 Q. Sure.

10 A. Which was a better study. So there was no
11 reason to work -- we got the better study the next
12 day.

13 Q. And that's what I meant. The ultrasound,
14 for what it was, was normal and helpful --

15 A. Right.

16 Q. -- and told you you need to look for other
17 causes?

18 A. A screening bedside exam, but to meet them
19 very -- very promptly.

20 Q. Correct. And then with respect to the MRI
21 the next day, that was -- what did that show?

22 A. There -- there was some watershed
23 infarctions.

24 And I can explain that, if you'd like.

25 Q. Yes, please.

1 A. So the circulation in the brain, I use my
2 fingers for that. And so there's two blood vessels
3 that supply the brain. And then the watershed is the
4 area between my fingers. So big vessel and then
5 branching out to smaller vessels. And then, again,
6 the area between my fingers, where they don't touch,
7 are those watershed areas. That's the way I can
8 conceptualize that and explain it to parents.

9 Q. And that part was damaged?

10 A. Yes.

11 Q. Were there any other parts of his brain
12 that were damaged, as well?

13 A. Might have been some bleeding, but I
14 didn't memorize that. I certainly didn't.

15 Q. Would it be helpful for you if I brought
16 up the report?

17 A. Certainly. We can see what other
18 questions you have.

19 Q. Sure, of course.

20 MS. GUNN: Exhibit 3, page 1992.

21 Q. (By Ms. Gunn) And, Doctor, I'll let you
22 know that this is a copy of Remi Anyan's MRI from
23 May 6th, 2020.

24 And it was -- I want to start at the
25 history.

1 Now, what's the history usually with them?

2 what's the point of a history?

3 A. Just information for the radiologist.

4 Q. Okay. And the history here was newborn

5 born at 39 weeks, 4 days with seizures and difficult

6 delivery. Clinical concern for hypoxic ischemic

7 encephalopathy, genetic or metabolic abnormalities,

8 and infection.

9 Did I read that correctly?

10 A. Yes.

11 Q. So the history included difficult

12 delivery.

13 Did you know that at the time?

14 A. No.

15 Q. Okay. And then if we -- could you read

16 through that? And we go down to the impressions.

17 A. Yes.

18 Q. Does this indicate there was damage both

19 in the watershed and in the central area?

20 A. Yes.

21 Q. Okay. All right. Thank you.

22 Now, do you recall having a conversation

23 with Sarah and Blake upon receiving the results of

24 this MRI?

25 A. It's documented. We updated them about

1 those results. I don't recall that specific
2 conversation.

3 Q. All right. And so with respect to what
4 was said during that time, you're not going to be --
5 you don't have a recollection of that?

6 A. No.

7 Q. Okay. Doctor, I think that's all I have.
8 I appreciate your time.

9 A. You're welcome.

10 THE COURT: Any redirect?

11 MS. KAMYKOWSKI: No, Your Honor.

12 Thank you, Doctor.

13 THE COURT: May this witness be excused?

14 MS. KAMYKOWSKI: Yes, Your Honor.

15 THE COURT: Thank you very much, sir.

16 THE WITNESS: Thank you.

17 THE COURT: On behalf of the defendant,
18 you may call your next witness.

19 MS. PFIRMAN: Thank you, Your Honor.

20 At this time, the defense calls Jessie
21 wagner by way of video deposition. This was taken on
22 April 27th, 2023, and the total runtime is 2 hours
23 and 21 minutes.

24 THE COURT: So why don't we plan on taking
25 a break after an hour and 15 minutes.

1 MS. PFIRMANN: That sounds great.
2 (Designated portions of the videotaped
3 deposition of Nurse Jessica Wagner were played for
4 the jury.)

5 THE COURT: All right, ladies and
6 gentlemen, let's go ahead and take our afternoon
7 recess.

8 (At 3:33 p.m., the Court duly admonished
9 the jury, and proceedings stood in recess. At
10 3:49 p.m., the following proceedings were held in
11 open court, in the presence of the jury:)

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

14 (Designated portions of the videotaped
15 deposition of Nurse Jessica Wagner were resumed and
16 concluded for the jury.)

17 MS. PFIRMAN: This ends the deposition.

18 THE COURT: Okay. Ladies and gentlemen,
19 this is a good time to take our evening recess.

20 (At 5:11 p.m., the hour of adjournment
21 having arrived, the jury, being duly admonished by
22 the Court, by agreement, is allowed to separate for
23 the evening, under the usual instructions of the
24 Court, until Thursday, March 20, 2025, at 9:00 a.m.,
25 and the following proceedings were held in open

1 court, outside the presence of the jury:)

2 THE COURT: We are outside the presence of
3 the jury on the record. At this time, on behalf of
4 the defendant, Mercy Hospitals, there is an offer of
5 proof.

6 offer of Proof by Defendant Mercy Hospitals

7 MS. KAMYKOWSKI: Thank you, Your Honor.

8 This is an offer of proof of testimony
9 from defense neurology expert, Paul Woodruff. We had
10 a couple of sidebars during his testimony this
11 morning with respect to the following -- with respect
12 to him testifying at his deposition about whether
13 there was a possibility of another cause of his brain
14 injuries or his hypoxic ischemic encephalopathy.

15 And I wanted to just read in with respect
16 to his opinion that genetics was a possibility that
17 had not been ruled out, what his testimony would have
18 been had we been allowed to ask him about that
19 opinion.

20 It starts at page 18 of his February 14th,
21 2024, deposition, beginning at line 15.

22 He was asked by Ms. Gunn:

23 Do you have an opinion of the seven likely
24 causes that we discussed of encephalopathy? Do you
25 have an opinion as to Remi?

1 "ANSWER: Yes.

2 "QUESTION: And what is that?

3 "ANSWER: I think he had a hypoxic
4 ischemic encephalopathy.

5 "QUESTION: And do you know why?

6 "ANSWER: I do not.

7 "QUESTION: will you be giving the jury in
8 this matter any opinions as to the cause of Remi's
9 hypoxic ischemic encephalopathy?

10 "ANSWER: No.

11 "QUESTION: By the virtue of your opinion
12 that Remi had HIE, have you then ruled out the other
13 six; namely, toxic, metabolic, infectious, genetic,
14 congenital, and traumatic?

15 "ANSWER: I don't think any of those
16 causes are more likely than not. I cannot completely
17 exclude the possibility of some sort of genetic
18 issue, although I don't have any evidence of that.

19 we're finding out more and more that
20 genetics can play a role with HIE, but in studies
21 where they've actually done extensive -- but I don't
22 have any evidence in this case. So I would say it's
23 possible, but not to the level of more likely than
24 not.

25 "QUESTION: So you will not be telling the

1 jury that you have -- that you have an opinion within
2 a reasonable degree of medical certainty that Remi --
3 Remi -- the cause of Remi's encephalopathy is
4 anything other than hypoxic ischemic, correct?

5 "ANSWER: Correct. I could say that there
6 are a possibility of other things that contributed
7 but not more likely than not."

8 I think that's it, Judge, that would be
9 his testimony.

10 MR. PERRON: Judge, just for the record, I
11 think you said an offer of proof on behalf of Mercy
12 Hospitals, but just for the sake of clarity, on
13 behalf of Mercy Hospital, Mercy Clinic, and Dr.
14 McNeive.

15 THE COURT: I wasn't trying to exclude
16 you. I wasn't sure if you were in on it.

17 MS. KAMYKOWSKI: All defendants.

18 THE COURT: I'm getting confused as to who
19 on which.

20 MS. KAMYKOWSKI: Thank you, Judge.

21 THE COURT: The Court is not inclined to
22 change its previous ruling. As once he says that he
23 cannot do something, the Court believes he shouldn't
24 be allowed to then talk about other things that he
25 cannot do.

1 MS. KAMYKOWSKI: Thank you, Judge.

2 MS. SLATER: Your Honor, briefly for the
3 record.

4 As I think you were referencing part of
5 the testimony came up today with Dr. woodruff right
6 after he excluded himself from giving these types of
7 opinions. The thing I wanted to note for the record
8 is defense counsel cited the Linton case.

9 In that case, the defense, I think it was
10 an OB, testified that the injury either happened at
11 some point after delivery or before, long before
12 delivery, I believe. And said to a reasonable degree
13 of medical certainty that it was in that time frame.
14 And that that particular expert just couldn't say
15 which one it was. And that's the testimony that was
16 allowed.

17 And here, Dr. woodruff specifically says,
18 there's other possibilities, and, quote, so I would
19 say it's possible but not to the level of more likely
20 than not.

21 so he has specifically excluded himself in
22 a way that distinguishes these facts from Linton.

23 THE COURT: Thank you.

24 MS. KAMYKOWSKI: Thank you, Judge.

25 THE COURT: Anything else we need to put

on the record?

MS. SLATER: I don't believe so.

MS. KAMYKOWSKI: No.

THE COURT: Okay. Off the record.

(At 5:18 p.m., court stood in
adjournment.)

o o o

Thursday, March 20, 2025

o o o

(At 9:06 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.

All right. On behalf of the defendant?

MR. WILLMAN: May it please the Court? I
would like to call Dr. Daniel McNeive.

THE COURT: Sir, if you'll step on up and
be sworn.

DANIEL MCNEIVE, M.D.,
having been duly sworn, was examined, and testified
as follows:

DIRECT EXAMINATION

BY MR. WILLMAN:

Q. would you reintroduce yourself to the

1 jury, please?

2 A. My name is Dan McNeive.

3 Q. And you are an OB/GYN?

4 A. I am an OB/GYN at Mercy Medical Center-St.
5 Louis.

6 Q. And you provided care and treatment during
7 the labor of Sarah Anyan and the delivery of Remi
8 Anyan, correct?

9 A. I did.

10 Q. Do you have an opinion that you met the
11 standard of care in that labor and delivery?

12 A. Absolutely, I did.

13 Q. Now, I'll take you through your care and
14 treatment and your opinions about what happened.

15 Before I get there, though, let me ask you
16 questions about your education, your training, and
17 your experience.

18 First of all, take us through your
19 education. Where did you go to undergraduate?

20 A. I was an undergraduate at the University
21 of Notre Dame. I graduated in 1993. From there, I
22 went to St. Louis University Medical School and
23 graduated with an M.D. in 1997. From there, I did my
24 residency training at St. John's, at the time Mercy,
25 for four years and completed that in 2001.

1 Q. And tell us what you did in your
2 residency. what type of things were you taught?

3 A. So a general OB/GYN residency teaches you
4 a whole scope of OB/GYN care: care for women, both
5 prenatal care and delivery, also general wellness
6 care for women, taking care of women as far as some
7 of their gynecologic needs, minor and major
8 surgeries, menopausal health. The whole gamut of
9 care for women.

10 Q. After completing your residency, then you
11 stayed on at Mercy, is that correct?

12 A. I did. Initially I joined a private
13 practice with one other physician who was at Mercy
14 who was looking for a partner. So we were partners
15 from 2001 until 2005.

16 And then I had an opportunity to join a
17 new practice, which is my current practice. They
18 were looking for someone to fill their role. So
19 still within Mercy, still the same physical location
20 generally, but a new practice group there.

21 Q. And that was in 2005?

22 A. Yes.

23 Q. All right. And then did you have a dual
24 responsibility, then, when you joined that new
25 practice?

1 A. So my scope of practice changed at that
2 point or was added to. So I continued to do the full
3 scope of what we call private practice: managing my
4 patients and taking call, and co-managing with my
5 partners, like you would in a normal practice, but we
6 had the added role of what's called the OB
7 hospitalist.

8 Q. And what is that?

9 A. The OB hospitalist, I think it's been
10 referred to here before, but every labor and delivery
11 suite generally requires that there be a licensed
12 practicing OB/GYN physically present on labor and
13 delivery 24/7.

14 And that at Mercy, it's called the OB
15 hospitalist group. And so we served lots of roles.
16 when we were on for our shift, we physically were
17 there for that 24 hours. So as opposed to, let's
18 say, your obstetrician, if you're in labor, they
19 might be at home at 2:00 in the morning and get
20 called in.

21 when I was on call when I was on my shift,
22 I was physically, 95 percent of the time, on labor
23 and delivery, or we had a call rotation, where they
24 would let us go to the cafeteria a couple of times a
25 day. But I was there for that time, both managing

1 our own patients and serving in the hospitalist role.
2 Q. As a hospitalist, then, did you have an
3 occasion to help out other OBs with difficult labors
4 and deliveries?

5 A. We did. We served multiple roles as a
6 hospitalist. We oversaw the residents. We had a
7 resident clinic there. We did a lot of teaching. We
8 were often just the physical body there. So, again,
9 if you're about to deliver, and your doctor is stuck
10 in traffic, I would get called in.

11 Occasionally, I would say once a shift,
12 every other shift, we would have a more acute
13 emergency, so we were available to help other
14 attending physicians in the course of their
15 management of a patient if they needed it.

16 So a common phone call would be, can you
17 get to room 6210? They can't get the baby out.

18 And so we'd be brought in and not really
19 have an idea of what's going on. But oftentimes the
20 baby might be stuck halfway out. And then we would
21 affect the delivery. And we would sometimes be
22 called emergently to the operating room. That was
23 often a, we don't know what it is, but they need on
24 ORC. Run in. And sometimes they can't get the baby
25 out.

1 Sometimes they got the baby out, but the
2 uterus is torn, and they need help putting it back
3 together. The blood loss is too much. Can you help
4 me sew this up? So a whole host of different things
5 from the mundane to the urgent or emergent part of
6 that role.

7 Q. What was your success rate in terms of
8 delivering babies at -- when you were serving as a
9 hospitalist?

10 A. So the interesting thing as a hospitalist,
11 when they call you in, you're it. They don't have a
12 plan B. So the doctor calls you in and says, can you
13 help me get this baby out? There's not really a
14 viable plan B. So I always had. We got the baby
15 out. So it was a hundred percent. There was not a
16 time I was, in 15 years, called into to an urgent or
17 emergent situation that I was not able to do what
18 they needed me to do at that time.

19 Q. During your time as an OB, can you tell us
20 how many babies that you have brought into this
21 world?

22 A. I lost count before residency was
23 finished. So I want to say 3,000, give or take, 1500
24 or so.

25 Q. And out of those 3,000 or so, have you

1 ever been named as a defendant in this lawsuit, other
2 than this case?

3 A. I have not.

4 Q. So have you described for us, then, the
5 range of your practice currently?

6 A. It is. So -- so we stopped -- we fazed
7 out of the hospitalist role in late 2000 -- or 2020/
8 early 2021. The hospital reconfigured, and they
9 decided they didn't want to stay with the hybrid
10 model they had at the time. So they just hired a
11 purely hospitalist group. That's all they did was a
12 hospitalist. They don't take care of their own
13 patients or anything else. And they just did that
14 for administrative reasons.

15 So then we returned back to just purely
16 practice oriented. So we take care of patients in
17 the office. We take care of prenatal patients, do
18 deliveries, do surgeries. Answer lots of phone calls
19 and messages and things like that.

20 Q. At do you have responsibilities for
21 patients' safety?

22 A. Well, always. As hospitalists, we had
23 lots of patient roles, safety roles. But just
24 day-to-day in practice, we have safety protocols and
25 all sorts of other things that we have to answer to.

Q. Are you board certified?

A. I am.

Q. And in what certification do you have?

A. I'm board certified in general OB/GYN.

Q. And are you a member of an organization called the American College of Obstetrics and Gynecology?

A. Yes. I'm a member of ACOG.

Q. What is that?

A. American College is a governing body for OB/GYNs. It provides a lot of educational opportunities, provides a lot of leadership. It gives us a lot of guidance on areas, different areas, within OB/GYN. To a certain extent, there's some dos and don'ts. It's some guidance. It's generally that guidance is considered our standard of care.

In most cases, there are certain situations where there's some gray. But, in general, those are the principles we try to follow. And as they update in different areas, then we continue to update some of our practice guidelines.

Q. Did you follow those guidelines in the labor and delivery that we're talking about in this case?

A. I did.

1 Q. And those guidelines are published and
2 written?

3 A. ACOG releases bulletins. They'll update
4 them periodically, sometimes every couple of years.

5 Sometimes there are certain publications that have
6 been in place for some more years that are still
7 considered the leading, guiding document on a certain
8 topic.

9 Q. And we've already seen some snippets of
10 those guidelines already, is that true?

11 A. Yes, we have.

12 Q. Okay. All right. I'm going to turn your
13 attention, then, to labor, stages of labor. Before I
14 get in to that, let me ask just generally, when I ask
15 you to give an opinion, can you do so within a
16 reasonable degree of medical certainty?

17 A. I can.

18 Q. And if I use the phrase "standard of
19 care," you understand that to mean using that degree
20 of skill or learning that is ordinarily used in the
21 same or similar circumstance by members of your
22 profession?

23 A. Yes, I can.

24 Q. All right. Stages of labor, let's talk
25 about that.

1 what are the stages of labor, and how are
2 they defined?

3 A. So I know there's been a lot of talk about
4 this in the last week or two. Stages of labor
5 generally are broken into the first and second stage
6 of labor. There's a third stage which is after the
7 placenta is delivered. But the first stage is when a
8 woman begins to actively dilate and then becomes
9 completely dilated, the first stage of labor.

10 The second stage of labor is once she
11 becomes completely dilated until she delivers her
12 baby, the second stage. And the first stage is
13 broken up into a couple of subcategories. But the
14 second stage, which has been discussed a lot this
15 week and last week, is complete dilation to full
16 delivery of the baby, I'll say.

17 Q. Is there a defined limit as to how long a
18 mother should be in stage 2?

19 A. That's kind of a tricky way of putting it.

20 Q. Let me ask you a different way. We've
21 heard testimony about 3 hours, 4 hours. And there's
22 a -- there's an OB ACOG consensus guideline that
23 talks about this, is that right?

24 A. There is.

25 Q. All right. And what is that that they're

1 talking about with respect to that 3 hours and 4
2 hours where you have, for example, a first-time mom
3 who's been given an epidural?

4 A. So this is a really -- it's been talked
5 about a lot in this trial, and I think it's a really
6 important concept to understand. It's understand to
7 understand where it came from and why it was put into
8 use.

9 where it came from is basically over time
10 they were starting to see a rise in the number of
11 C-sections, and specifically across the country. The
12 number of C-sections that were being done for, quote/
13 unquote, "failing labor."

14 In other words, she's pushed, baby's not
15 coming down, it's time to be done. And in an effort
16 to try to somewhat curtail the C-section rate, the
17 American College and some of the leading people in
18 the field tried to really define, well, what is
19 normal? How long would typically somebody push --
20 right? -- so what is the pushing at that stage?

21 And they looked at a lot of data, and they
22 looked at statistics, and said, okay, they broke it
23 down into groups, if this is your first baby, or it's
24 not your first baby. So it's nullip. You heard the
25 term "nullip," if this is her first baby. Or

1 multipara for your second or third.

2 And what they basically found was that a
3 normal second stage of labor was 2 hours of pushing,
4 if it was your -- not your first child, 3 hours of
5 pushing if it was your first child. And add the
6 caveat on there you tend to push a bit longer if you
7 have an epidural, so you basically add an hour for an
8 epidural.

9 So if it's your first baby, and you've
10 pushed for 4 hours, you've now met the definition of
11 a prolonged second stage of labor, one hour less for
12 multiple children. And that's what the definition of
13 a prolonged second stage is. Where I think it gets
14 confused is it was all set up not to say necessarily
15 once you've reached this point -- okay? -- well,
16 now you failed, you have to be delivered.

17 It was set up initially to say to the
18 obstetricians, let's be careful about throwing in the
19 towel before we've gotten to that point, meaning, you
20 know, if you're going -- if she's been pushing for an
21 hour, and you decided it's a failed second stage,
22 maybe she hasn't pushed long enough.

23 Now, you could go earlier than those times
24 for other reasons, right? If bleeding or if mom
25 couldn't push hard enough, or there's other reasons

1 to go. But it was never initially set up as I think
2 it is sometimes understood to be, well, this is the
3 time limit, you can't go past this.

4 And ACOG gives guidance to us. And what
5 they say is these are the typical times by which most
6 women will have delivered completed. And not all of
7 those are vaginal. Some women would have gone to
8 C-section.

9 But what they'll say is, okay, if you've
10 reached this time, the general guidance is, let's
11 watch. why? why is it taking so long? Is there
12 something going on? Do we need to take a closer
13 look? Now is maybe the time to have a discussion
14 about an alternate plan.

15 But they don't say you to have a -- you
16 have to deliver now at this point. That's not said
17 anywhere. And it gives guidance, it says longer
18 duration may be appropriate in certain clinical
19 situations based on how is the baby looking? How is
20 the mom doing? How reasonable do I clinically think
21 this has a chance, based on exam, based on how the
22 baby's positioned?

23 we know there was discussion about Remi's
24 position in the birth canal, looking this way,
25 looking that way. we know that can prolong pushing.

1 So basically what that -- that definition of stage
2 is, what it was intended to do, is say, give her a
3 chance. Give her -- try to give her at least this
4 much time, and if you've reached that point, that
5 is -- okay, now that is -- you've reached the point,
6 at which most women, if they're going to deliver,
7 will have delivered. So what's the game plan for
8 that?

9 And evaluate. Is there a reason why it's
10 taking this long? Is there an obvious reason that
11 maybe we need to consider a C-section at this point?
12 But sit down and look again at your game plan.

13 Q. There is an ACOG OB care consensus that's
14 been discussed during the last week, week and a half.

15 Does that bulletin, that document, address
16 whether there is a maximum length of time spent in
17 the second stage?

18 A. It does.

19 MR. WILLMAN: Can we put on the screen
20 Exhibit I9, page 2, please.

21 THE WITNESS: That's not the right one.

22 MR. WILLMAN: okay. All right. Let's go
23 back to Exhibit I9, page 11. That document, first
24 page of it is I9.

25 Q. (By Mr. willman) All right. Is this the

1 bulletin that discusses whether there is a maximum
2 time limit?

3 A. So this is not the right bulletin, but I
4 can tell you what the right bulletin says based on --

5 Q. which one is it?

6 A. I believe it's under the OB Care
7 Consensus, I believe. But basically what it says is
8 to this point, there has not been a time limit set on
9 the length of the second stage. There's no magic
10 number that says, at this point in the second stage,
11 you can no longer push. You can no longer move
12 towards a vaginal birth.

13 Now, that doesn't mean in all situations,
14 right? You constantly have to be looking at multiple
15 factors that we have to evaluate to decide can we go
16 forward, right? You've, you know, heard lots of
17 phrases thrown around this week about ludicrous
18 second stage, absolutely ridiculous length of second
19 stage, I think was one.

20 And, well, every patient is different. I
21 approach every labor the same, but every patient is
22 different. Every condition is different. And so you
23 can have guidance on how you approach the labor, but
24 then you have to be driven by what's happening,
25 happening in front of you.

1 And so when they say there is no absolute
2 limit -- okay? -- you can take that out forever and,
3 yes, that maybe gets ridiculous, but what it's trying
4 to say is, even when you've reached what we call
5 prolonged second stage, it doesn't mean you have to
6 be done, and you want to look at multiple factors.

7 And that's when I, you know, I went in and
8 first talked to Sarah that morning, and when I
9 evaluate any patient, I'm going to look at factors.
10 I'm going to look at, number one, how is mom doing?
11 How is she feeling? Is she able to push well? Is
12 she too numb? Can she feel? Does she have the
13 energy to go on? Does she have the willpower to go
14 on? That's a lot of pushing.

15 I'm going to look at the baby. I'm going
16 to look back at the heart rate tracing. How have we
17 looked? How do we look now? What have the
18 categories been? I know we're going to talk more
19 about these heart tones that you have been clubbed
20 over the head with for a week.

21 But I'm going to give maybe a little more
22 of my perspective of -- of how we evaluate that. But
23 we're going to look at -- and that's the only way
24 really I have to know Remi's status. I can't talk to
25 him. I can't touch him. I can't -- I can feel the

1 top of his head, but that's about it. And so, you
2 know, that's why obstetrics gets tricky.

3 Two patients: One that I can see, touch,
4 talk to, and one I can't. So we rely on these
5 monitor strips, which is not perfect and has certain
6 conflicting data in them. But I'm going to look at
7 how do I think Remi's doing? Is he looking great?
8 Is he looking okay but recovering well? Where is he
9 on that spectrum? Again, we'll get more into it.

10 I'm going to assess Sarah's pelvis. Do I
11 think this baby is going to fit? And that's why my
12 first exam is so important. Even if a nurse -- and
13 I'll talk to the nurse, and she says, yep, I just
14 checked her -- I'll be coming on in the morning. She
15 said, oh, I just checked her. She's at whatever.
16 And I say, great. Let's go back in. I'm going to
17 check her. I want my check.

18 Not that I don't trust -- Jessie is an
19 amazing nurse. I would trust her exam, but I want
20 mine, you know. There's other nurses that are newer,
21 that -- okay? -- I'm not going to trust them. So I'm
22 going to do it.

23 But that's one of the boxes that I need to
24 check of where are we right now in this second stage?
25 I've come on, I know she's been pushing -- she's been

1 complete at that point for about 4 hours pushing, I
2 think, or a little under 3 because she rested for a
3 bit.

4 But definitely we're bumping up toward
5 that prolonged stage, so I need -- I've seen the
6 heart tones. I've gotten at that checkout point. At
7 that point I need to see where are we. What's going
8 on? Is there something obvious that's going to tell
9 me this isn't going to happen? That actually
10 happened with another patient later in the day.

11 Or do I feel like I can check these boxes
12 and say, this has been long. You're pushing great.

13 If we want to continue, I think we can. I think Remi
14 is going to allow us to do that. And I feel, based
15 on where you are and what you're doing, that you have
16 a good likelihood, not guaranteed, but a good
17 likelihood to be able to make that progress.

18 I knew Sarah from her whole pregnancy. I
19 knew she was a fighter. She remained a fighter
20 through that whole, I mean, listen, I'm on record,
21 she pushed longer than any patient I've ever had.

22 And she was pushing almost as hard at the end as she
23 was at the beginning. I mean, she was a rock star.

24 And so I knew she probably was going to
25 have what it took. Would Remi have what it took?

1 would the pelvis give us the room? And all those
2 things. I mean, and with the progress and all those
3 things. But that's how I addressed her second stage,
4 and where we were as far as -- there's not an exact
5 limit. It is minute-to-minute, how is everything
6 varying? And show me in this case, tell me
7 something, tell me it's time to go the other way.

8 That's what obstetricians are kind of always doing.
9 Show me at some point you can't keep going this way,
10 and then it's time to go another way.

11 Q. well, we have up on this screen, which now
12 I think is the right consensus document, is that
13 right?

14 A. I believe it is.

15 MR. WILLMAN: Can you go to page 11,
16 please?

17 THE WITNESS: I believe that was page 11.
18 Boy, yeah, you're going to have to zoom in on that
19 one.

20 Q. (By Mr. willman) All right. So take us
21 through what --

22 A. It's basically what I just said. So this
23 is an OB/GYN Care Consensus which was from 2014. So
24 this was in effect at the time: A specific absolute
25 maximum length of time spent in the second stage of

1 labor beyond which all women should undergo operative
2 delivery has not been identified.

3 Before diagnosing arrestive labor in the
4 second stage, if the maternal and fetal conditions
5 permit, allow for the following: at least 2 hours of
6 pushing in multiparous, and at least 3 hours in
7 nulliparous, first baby.

8 And finally it says: Longer durations
9 maybe appropriate on an individualized basis;
10 example, with the use of epidural analgesia or with
11 fetal malposition, as long as process is being
12 documented.

13 Q. All right.

14 MR. WILLMAN: Than can you go to page 15
15 of that document, please? And bring out the
16 highlighted.

17 A. So this is from the same document. And
18 one of the things we looked at when we looked at the
19 length of the second stage, we're not really looking
20 at what is there, whether it's a long stage or
21 whatever is going on.

22 obviously her safety, her baby's safety,
23 those are two of the biggest considerations we have
24 to look at. And you've heard a lot of discussion in
25 the past week about, again, what does that long

1 pushing process -- what does it do to a baby?

2 And there's a lot of data out there. Some
3 of it's conflicting, but they basically, the OB
4 consensus that is agreed on by the governing bodies,
5 at the time it's basically saying: In the era of
6 electronic fetal monitoring among neonates born to
7 nullip birth women, first-time mom, adverse neonatal
8 outcomes generally have not been associated with the
9 duration of the second stage of labor.

10 In a secondary analysis: Women who reach
11 the second stage of labor, none of the following
12 neonatal outcomes were found to be related to the
13 duration of the second stage, which, in some cases,
14 was 5 hours or more, 5-minute Apgar score of less
15 than 4, umbilical artery pH less than 7, intubation
16 in the delivery room, need for admission to NICU, or
17 neonatal sepsis.

18 So, again, what this is addressing is one
19 of lots of puzzle pieces that we have to figure out
20 when we're on labor and delivery in trying to decide
21 is, you know, okay, Sarah could have pushed forever.
22 She probably could have pushed for 24 hours. But is
23 there a point at which we need to say we can't,
24 right? And that's what she's relying on. She's
25 relying on me.

1 But like I set up with all my prenatal
2 patients, I set up usually in their first prenatal
3 visit. I sit down with them and I say, the era of
4 doctors saying do this, and patients saying okay is
5 gone. This is an era, rightly so, of we want to do
6 sort of a team approach, right?

7 My goal for a woman's labor is I'm going
8 to set up railways -- railings of what's safe and
9 reasonable. My goal is to keep you somewhere within
10 the safe and reasonable. There's several lanes in
11 there. Some women, they want to drive in that lane
12 of get this kid out of me as soon as possible. If
13 I'm not delivered by "X," I want a C-section.

14 Other women are, if I can keep going, let
15 me keep going. And my goal is just to keep you in
16 one of those lanes. And then if we start straying
17 outside of what is safe and reasonable, then we start
18 having discussions. And, again, sometimes those
19 railings are flexible, sometimes they have to be
20 rigid.

21 But when we look at how long are we going
22 to let somebody go --

23 MS. GUNN: Your Honor, may we approach?

24 THE COURT: You may.

25 (Proceedings were held at sidebar, outside

the hearing of the jury.)

MS. GUNN: Your Honor, I apologize. I'm just concerned with the narrative answer at this time. I know this is testimony, but the answer has been nonresponsive to the question. And I would just ask this witness be directed a little bit more as opposed to being allowed to narrate ad nauseam.

MR. WILLMAN: He's just explaining his answers. I think he's entitled to kind of give that amplification. I'll do what I can to direct more. I can certainly do that.

THE COURT: Okay.

(Proceedings returned to open court.)

Q. (By Mr. willman) All right. Doctor, finally, on page 17 of this document, does this give us guidance on what the second stage of labor entails in the highlighted portions, please?

A. okay. Yeah. This is sort of toward the tail end of that discussion, which is: Longer durations may be appropriate on an individualized basis. The example would be epidural anesthesia or fetal malposition, as long as progress is being documented.

And I know documenting has been something that's been discussed a lot.

1 Q. And that gives you further guidance on
2 what is the length of the second stage of labor,
3 correct.

4 A. Well, it gives us guidance. What they're
5 truly saying is there's not a length of second stage.
6 There are criteria that should continue to be met if
7 you're going to allow the second stage to continue.
8 But you don't know when those criteria are going to
9 be met. So there's not -- that's why they say there
10 is not an absolute limit. What you need to be doing
11 is constantly evaluating multiple different factors,
12 and if you reach a point where those factors say, we
13 have to go to a cesarean delivery, then that's the
14 discussion you have. If you're going to discuss the
15 possible options go down -- but if you finally reach
16 a point where all the factors align that say, we're
17 done here, then you should be done there.

18 Q. All right. Let's switch gears here.
19 Let's talk about how labor is monitored. First of
20 all, who are the personnel involved typically when a
21 woman is in labor at Mercy Hospital?

22 A. So the most immediate boots on the ground
23 are the nurses. We heard from Jessie yesterday, and
24 Maggie was her partner, or orientee that day while I
25 was on. So you'll have the nurses assign the

1 patient. There are typically several residences
2 floating around labor and delivery that have
3 different roles that periodically may be asked to
4 intervene with your patient or observe or evaluate.

5 And then charge nurses, other people
6 around, other layers. Ultimately myself. The
7 attending is the one in charge. And, you know, it's
8 nice when I can be there physically all the time like
9 that type of day that I had.

10 Q. So just so it's clear, in this particular
11 case, Sarah Anyan had two RNs that were by her beside
12 minute-to-minute?

13 A. She did.

14 Q. And they were able to communicate with you
15 if they needed you?

16 A. Always.

17 Q. And you were always within minutes of that
18 room if you were not there, is that correct?

19 A. When I was a hospitalist, I was often
20 within earshot. I mean, Jessie talked yesterday
21 about -- a little bit about how we communicate. I am
22 kind of in constant motion when I'm on. When I'm on,
23 my patients that are active on labor and delivery are
24 the primary focus. They have something wrong.

25 we'll have a number of women who gave

1 birth over the last couple of days or are routinely
2 discharged. But always our primary goal of those
3 patients is currently high acuity that are active on
4 labor and delivery. And so oftentimes -- and then
5 I'm also a hospitalist so I'm there doing those
6 things.

7 So I'm in, out, next to 6203, was the room
8 they were in -- that's team 1 at the nurses'
9 station -- constantly. And so the way -- the way we
10 communicate typically was going to be face-to-face or
11 maybe by cell phone or by calling the cell phone, if
12 I'm upstairs and she wasn't able to reach me. But
13 constant communication with multiple rooms, so just
14 basically moving from room-to-room most of that day.

15 Q. And in addition to that, you said that
16 there were residents who would come in from time to
17 time, is that right?

18 A. There are residents that are assigned to
19 generally the low risk pool of patients on labor and
20 delivery. I think we've heard from one of them. And
21 so they basically are aware of all the patients that
22 are there. They may be called in periodically maybe
23 to break water or to evaluate, so how's one pushing?
24 Or do some other things.

25 But, yes, they are available. A nurse may

1 call them if they're closer or they're right there,
2 or they don't feel it's a level that I need to know
3 about, call them first.

4 Q. And in addition to that, and we've heard
5 some discussion of this already, there are processes
6 called safety rounds and strip rounds, is that right?

7 A. There are.

8 Q. Okay. And we'll talk more about what
9 those were in this particular case. And then Sarah
10 Anyan's goal, what -- you said she is a member of the
11 team, is that right?

12 A. She is. I mean, she's the patient.

13 Q. And what is her -- what is her --

14 A. She's the patient. And I think most
15 providers nowadays, at least most that I know, try to
16 really incorporate, again, it's not the old days
17 where the doctor says and the patient does. We try
18 to really have a very, and I generally tend to be
19 known as, over talking my patients sometimes, meaning
20 I'll -- a lot of communication.

21 And, again, Sarah, I felt throughout this
22 whole labor, I thought Blake and Sarah and I were on
23 the same page. I felt like we were very team
24 oriented. I always felt that we were communicative.
25 And my ultimate goal was to try to give Sarah the

1 experience she wanted, as long as we could keep it
2 safe and reasonable.

3 Q. Okay. Let's turn to fetal heart rate
4 monitoring. Just very quickly tell us what that is.

5 A. So I think it's been explained several
6 times. That's how we evalv -- our main way of
7 evaluating a fetal status on labor and delivery. It
8 tells us from moment-to-moment what their heart rate
9 is. And so in addition to knowing what their pulse
10 is at that point, which basically is what it's
11 telling us, it also prints out a pattern.

12 And over time we've come to recognize the
13 significance of these patterns. They are broken up
14 into categories. And each category has a certain
15 caveat to it. But it's -- and it's an imperfect
16 system because it can give you -- certain patterns, I
17 think, are relied on too much. Certain are relied on
18 not enough.

19 So how we interpret -- the system works
20 fine. And then how do you interpret that? And there
21 are guidelines put out on how to interpret that. But
22 we can probably get into some of the categories get
23 muddy.

24 Q. Let's talk about those categories.
25 Because I don't think the jury really heard a

1 definition of them.

2 First of all, accelerations. Let's talk,
3 if you can tell us what those are. I think we have a
4 sample that's used to help explain what it is. This
5 is from C2.

6 A. I think we have just the general picture.

7 Q. Well, we actually have a sample.

8 A. Okay.

9 MR. WILLMAN: If you can blow that up some
10 just back where you were, yeah.

11 THE WITNESS: Yeah, if you can blow that
12 up a bit.

13 Q. (By Mr. willman) So we're moving on to
14 baseline variability. Tell us what that is.

15 A. Well, so when we evaluate a heart strip,
16 the first thing you really look at is what is the
17 baseline, right? So the baseline is basically where
18 that baby's pulse is hanging out the majority of the
19 time. And so that's their baseline. You typically
20 round it to the nearest 5, so 140, 145, 150. Because
21 it's going to vary a little bit above and below. You
22 know --

23 THE WITNESS: Zoom that in there. There's
24 no way I'm going to be able to tell exactly what that
25 is.

1 MR. WILLMAN: Could you blow up that --

2 THE WITNESS: The green area, yeah.

3 Yeah, you don't even need that word. Just

4 blow up that part. Yeah, a little bit bigger. Okay.

5 That's fine. I think I keep taking over your

6 clicker, sorry. Do that one more time. I took your

7 clicker over, Justin.

8 A. So the first thing we have to establish is

9 what is baseline? So basically we say what is the

10 baby's heart rate, essentially. And that's again

11 listed as, round to the nearest 5, so 140, 145, 150.

12 So all right, okay.

13 So we would look up here, and, again, it's

14 not quite big enough for me to see, but I'm guessing

15 that's going to say around, yeah, okay, there's 120.

16 So the baseline is going to be about 120, about 125.

17 So about 125. So that's where that heart rate is

18 hanging out most of the time.

19 So that's going to be our established

20 baseline. And that baseline can shift and move over

21 time. We want, at full term, 110 to 160, as the

22 baseline, is what we would consider normal. And so

23 that's the first thing we're going to establish. We

24 have a low baseline. Do we have a high baseline?

25 And then the next thing we're going to

1 look at, which is really important, and it's
2 important to really understand, is what's called
3 variability. So we don't want that baseline to be
4 flat -- right? -- we don't want it to be a flat line.

5 Nope. We don't want it to be a flat line
6 right here. This segment right here, a baseline, we
7 don't want it to be 125, 125, 125, 125. We want it
8 to be 125, 127, 129. We want it to move a little
9 bit, right? Just like all of us sitting here, our
10 pulse is not exactly the same all the time, it's
11 going to vary. And that gives us what's called
12 baseline variability. That has categories: absent,
13 none. It does not move at all.

14 And then you have minimal, basically 1 to
15 5. And so basically what you do is --

16 THE WITNESS: Can you blow that up any
17 more, Justin? Yeah. Keep blowing as much as you can
18 blow that up.

19 A. So in these segments here, again, and it's
20 important to be able to see the box. The boxes are
21 really important because a box here from the top of
22 the box to the bottom of a box, right there, that's
23 10 beats per minute.

24 And so when you're looking at variability,
25 and you see how it sort of bumps up and down, it's

1 jaggedly. what you're going to do is you're going to
2 find your stretch of variability. You're going to
3 find where it is at its lowest and where it's at at
4 its highest, and that's going to give you a multi
5 image. That's going to give you common.

6 so if it goes -- it doesn't stray more
7 than 4 or 5, it's going to be an area of minimal
8 variability. If you have segments where it's
9 straying more above 5, it's straying 6 or 8 or 9,
10 that's going to be moderate variability. why do we
11 care about the tiny hair splitting of a 5 or a 4 or a
12 6?

13 It's because what studies and data has
14 come to show us, is you can reliably look at several
15 things in the heart rate tracing that are reliably
16 more reassuring, and then there are things you can
17 look in the tracings that are not, like you heard
18 several times throughout late decels, variable
19 decels, things like that, early decels.

20 so there are things that we look at to try
21 to look at the other side. what's in there that
22 makes us think that Remi's doing well, right? And so
23 that's variability and accelerations. so when it
24 jumps above that baseline, like up here, right? so
25 those are accelerations.

1 Now, in a full-term baby, for it to meet
2 the definition of a true acceleration, it has to go
3 up by at least 15 beats above baseline, and it has to
4 stay up for at least 15 seconds. I know we're
5 getting really into the weeds here. But, again, the
6 baseline is here. This one is going to be close to
7 15, and it has to last -- each box is 10 seconds
8 wide. So it has to last from beginning to end for at
9 least 15 seconds, and it has to go up.

10 So accelerations are reassuring.
11 Accelerations give us a sign of good oxygenation and
12 a good acid base status. So that's a reassuring
13 sign. It's a spontaneous sign. We're not doing
14 anything, and the baby just goes up. They respond to
15 sound. They respond to movement. Just like if you
16 were startled a little bit, your heart rate would go
17 up a little bit and then come back down.

18 We can try to test for this while
19 they're -- what's called scalp stimulation. You just
20 tickle on the baby's head during the vaginal exam.
21 If you can get a spontaneous acceleration, that's
22 reassuring. You don't always -- even if it's a good
23 pain, oh, they might be sleeping. So scalp
24 stimulation doesn't -- isn't always a given. But if
25 you do scalp stimulation, and you get a good

1 acceleration, that's a reassuring sign.

2 And why all this minutia is important is
3 we're constantly, again, this is the only way I have
4 to see how Remi is doing. And you've heard about
5 categories, and we'll talk about them. But the
6 majority of babies spend some time in Category II,
7 and lots of labors spend the majority of their time
8 in Category II.

9 The other thing they do is they can just
10 jump from Category I to II, I to II, at a moment's
11 notice, jump in and out of categories. They have
12 different policies, how long you watch a Category II
13 or a Category I. A true category, they jump in and
14 out of. So most of these babies are in Category II
15 for much of their labor. So what -- official
16 designation of Category II is indeterminate.

17 Think of Category I like your report card
18 of A through F. Category III is like an F. Category
19 II is everything in between. It can be an A minus,
20 could be a D, right? So if a kid's going through
21 school getting all A minuses, yeah, okay, you can
22 kind of look at that. Getting all Ds, you need to
23 fix something, right?

24 So when we look at Category II, we have to
25 look at the presence and absence of things that make

1 it shift more toward that A minus/B plus, or more
2 toward that D. And so we have to look at things like
3 the presence of accelerations. we have to look at
4 what's our baseline variability. we have to look at
5 how frequent are decelerations? How deep are they?
6 we have to look at, you know, what does
7 repositioning do? How frequent are the contractions?
8 So when we're looking at a strip, we're constantly
9 trying to put all of these pieces together.

10 There was discussion, I know, over the
11 last couple of days about, okay, if we're in Category
12 II what do you do, right? There's different
13 policies. what do you do to get a baby out of
14 Category II? well, in reality, you don't necessarily
15 get a baby out of Category II. Category II is not
16 ominous. It's listed as indeterminate.

17 Q. Does ACOG tell us about whether Category
18 II tracings are predictive of brain injury?

19 A. They tell us they are not predictive of
20 brain injury.

21 MR. WILLMAN: Can you put up on the screen
22 Exhibit I9, page 2? And if you could highlight the
23 paragraph in the lower right-hand corner, please.
24 Bring that up.

25 THE WITNESS: The one above that,

1 actually.

2 MR. WILLMAN: Above that, excuse me.

3 Q. (By Mr. willman) All right. So tell us
4 what ACOG is describing to you with respect to --

5 A. Again, Category II heart rate tracings are
6 indeterminate. They are not predictable of abnormal
7 fetal acid base status. Yet, presently there is not
8 adequate evidence to classify them as I or III. Sort
9 of that wastebasket in between classes.

10 Category II tracings require evaluation
11 and continued surveillance and re-evaluation, taking
12 into account the entire associated clinical
13 circumstance. In some circumstances, either
14 ancillary tests to ensure fetal well-being, or
15 intrauterine resuscitation may be used with Category
16 II tracings.

17 Q. So let me get you to an overarching
18 statement here.

19 In looking at the strips from 8:00 a.m. to
20 4:00 p.m., what in your opinion were those strips
21 showing with respect to Category I and Category II?

22 A. It was showing a combination of Category I
23 and II, often jumping in and out frequently from one
24 to the other.

25 In general, when she would rest, they

1 would be more Category I, which we know that just in
2 general not pushing and things like that just tends
3 to allow babies to rest more.

4 But even within pushing within the active
5 phase, jumping from Category I to Category II, so
6 jumping from excellent or normal Category I to not
7 perfect. But, again, most babies live much of their
8 labors in Category II.

9 Q. And that was the case with Remi Anyan?

10 A. It was. Absolutely.

11 Q. Okay. All right. So we've defined the
12 different fetal heart rate categories, and we've
13 defined categories I, II, and III --

14 A. Yes.

15 Q. -- have you not?
16 All right. Let's talk about your
17 involvement with Sarah Anyan.

18 You were actually her obstetrician before
19 labor and delivery, is that right?

20 A. I took care of her prenatal care. She had
21 seen, I believe, a nurse practitioner for a visit or
22 two before she got pregnant. And then I started
23 taking care of her during her pregnancy.

24 Q. I think the first office visit -- we don't
25 need to put up on the screen -- but October 18th,

1 2019.

2 Does that sound right to you?

3 A. That sounds right.

4 Q. And during the course of her prenatal
5 care, any problems, any complications?

6 A. No. She was a great -- a great patient.

7 She was a nurse. I mean, so they always have an

8 expert fund of knowledge, which is nice. They kind

9 of get it, and it was great. I thought we hit it off

10 pretty well. Blake came to a few, and I got to know

11 him.

12 Q. She was -- she was scheduled for

13 induction, is that right?

14 A. She was. A couple of days, I think, after

15 her water broke, she was scheduled for one.

16 Q. But as it happened, her water broke,

17 right?

18 A. Right.

19 Q. So let's move ahead of time, then, to

20 May 4, 2020.

21 Tell us when did you start your shift?

22 A. So I would come on at 7:00. I would do a

23 7:00 to 7:00 shift.

24 Q. Did you learn, then, that your patient,

25 Sarah Anyan, was actually in labor at the time?

1 A. I did. So I would get physical handoff.
2 My partner, April Parker, was the in-house for the 24
3 hours before, so usually I'd get there about 10 or 15
4 minutes before 7:00 so she could give me handoff and
5 give me a list of all of our patients in the
6 hospital, including Sarah and the other patients on
7 labor and delivery and postpartum patients, and she
8 would give me a rundown of them.

9 MR. WILLMAN: Exhibit 8 to page 107.
10 Highlight the note from Dr. Parker. Scroll down,
11 please. There you go.

12 Q. (By Mr. Willman) So this is the note that
13 Dr. Parker entered into the charts, is that correct?

14 A. Yes.

15 Q. And this is the information that you would
16 have received from her on the handoff, is that right?

17 A. That's part of the information. We
18 would -- she would give me basically -- I didn't need
19 a lot of background because she was my patient. She
20 was basically giving me information of when she got
21 here, when Pitocin was started, how she's progressed.
22 She had an epidural. She's been pushing for an
23 amount of time. She told me about discussions she
24 had with the resident about a pushing evaluation.

25 Q. So the resident was Dr. Mckillip, is that

1 right?

2 A. Correct.

3 Q. And her note, is that Exhibit A2, pages
4 96, 97? Just real quickly. 96, 97?

5 So this is the resident's note, is that
6 right?

7 A. This is the H&P from the day before when
8 she was --

9 MR. WILLMAN: Scroll down, please. You
10 probably have to go up a page or down, I would guess.

11 Q. (By Mr. willman) All right. Well,
12 anyway, you reviewed the note from Dr. Mckillip?

13 A. I did.

14 Q. And you talked to Dr. Parker?

15 A. I did.

16 Q. And you went in to see Sarah Anyan, did
17 you not?

18 A. I did. Not right at 7:00. I know I had
19 seen a couple other -- we had several patients on
20 labor and delivery, but I went right around eight
21 o'clock, I went to see Sarah and Blake.

22 Q. What did you do when you saw her?

23 A. So, again, I said before, I approach every
24 labor the same, but they all end up different. But
25 when I went in to see her, I knew a couple of things.

1 I knew she had been pushing for several hours. I
2 knew she had an epidural.
3 I knew what the resident had documented as
4 her station and sort of what was happening. I knew
5 that the resident had said minimal descent with
6 pushing. I knew the resident had documented that
7 there was some shifting, some rotating of the fetal
8 head, I think was during her exam. I had reviewed
9 the heart rate tracings at that point. So I knew
10 that information going on.

11 And I knew she was on Pitocin. I knew
12 that she had gone through the first stage of labor
13 pretty quickly once the Pitocin started going, and
14 she had gotten to complete very quickly, which is
15 always a reassuring sign with the baby dropping into
16 the pelvis.

17 So I had that information in hand. And
18 then when I went in to see her, I do -- what I do is
19 sort of a snapshot like, I'll do with a lot of my
20 laboring patients.

21 First thing I see is Sarah. Is she awake?
22 Does she look energized? How is she feeling? How is
23 she sounding? Because I want to get a sense of where
24 she is mentally and physically.

25 she's been awake all night. She's been

1 pushing already for several hours. And so I want to
2 get an initial sense of how does she look? How does
3 seem? She and Blake were both there. They were
4 energized and looked good.

5 And then I wanted to -- I already reviewed
6 her heart strip, but I might have reviewed it a
7 little more in the room there sort of in realtime.

8 And then --

9 Q. Anything else you did?

10 A. Yes.

11 Q. What else?

12 A. Well, and then I would examine her.

13 Q. And what examination would you do?

14 A. This would have been a digital vaginal
15 exam.

16 And, again, I've been there long enough to
17 know I want to know, especially if she's been pushing
18 for a while, I want to know what she seems like
19 myself. Just a variety among exams, different
20 examiners. And so I, especially if I know I'm going
21 to have to make a decision where is this going, I
22 want to examine her myself.

23 And when I'm examining her, I know she's
24 already completely dilated, so I'm not having to deal
25 with the cervix or anything. The cervix is gone, and

1 now the head is replacing it.

2 what I want to try to figure out is
3 where -- how low is the head? If -- how molded is
4 it, all right? so they start as a round head, and
5 those plates overlap, and they turn into a bit of a
6 cone head. Most first-time babies, almost all of
7 them, do it, and it gets into a better shape. How
8 molded is it, right? That can give you an indication
9 of how hard has he already been working to get in.

10 Can I figure out how he's positioned? Is
11 he looking at the floor? Is he looking at the
12 ceiling? Is he looking sideways. I want to feel how
13 much room do I think there is? so I feel behind his
14 head, in front of his head. Is there space around
15 the bone?

16 So I'm just trying to get an assessment
17 of, okay, we've been pushing a long time. It's her
18 first baby. She has an epidural. Sometimes those
19 early pushes aren't strong, and they go back to
20 baseline.

21 I wasn't there for early on, so sometimes
22 that first might not be anything, I don't know, I
23 wasn't there. So are we bumping up against a
24 situation where this is just not going to happen? or
25 do I have some level of confidence that this can

1 happen? I mean, I knew, again, she was very fit. I
2 heard she was pushing well. So all of those things
3 I'm trying to do is assess where do I think we are?
4 And where do I think we can go from here?

5 Q. Based on all of what you did at
6 approximately 8:00 a.m. on that morning, what was
7 your plan?

8 A. My plan, I said, listen, I'm sure you're
9 tired. You've been pushing a long time. We -- I
10 think you have room to deliver, I think. The baby
11 seems, based on his exam, that he is trying to fit.
12 I don't think he's quite in the position yet that's
13 going to be optimal. They don't always get into that
14 position. We would like them to be able to spin to get
15 to pointing looking at the floor and not the ceiling.
16 And I said, you know, listen, Remi's doing
17 okay. He's in Category II, which a lot of them are.
18 They will have dips here and there, and then he'll
19 have good spaces of time. So I'm seeing reassuring
20 signs that tells me Remi can go on. I think your
21 labor looks like it is willing to give me, give us,
22 space to progress. And she said, yeah. I mean, she
23 was...

24 Q. Let's take the jury through quickly those
25 strips that you would have examined at approximately

1 8:00 a.m. on May 4.

2 A. Okay.

3 MR. WILLMAN: Can you put on the screen
4 page 122?

5 Q. (By Mr. willman) All right. So this was
6 taken from Sarah Anyan's chart, the fetal strips.

7 MR. WILLMAN: Can you go to page 122?

8 THE WITNESS: I think this looks like it's
9 about 7:35.

10 Q. (By Mr. willman) I think it's 7:30 to
11 7:33.

12 A. Okay. I think you passed it. Yeah,
13 that's basically it. That's about 7:28.

14 Q. All right.

15 A. So this is right before I would have come
16 in to see her.

17 Q. All right. And these are strips that you
18 would have seen when you examined her at
19 approximately 8:00 a.m., correct?

20 A. Correct.

21 Q. Take us -- just generally describe for us
22 what you see there, what you were seeing when you saw
23 her on that day?

24 THE WITNESS: Yeah. Can we maybe enlarge
25 that upper part of the strip, maybe the -- yeah, and

1 maybe a little bit to the right. Right there. And

2 enlarge it a little bit more. Okay. Yeah.

3 Q. (By Mr. Willman) Take us through what
4 you're seeing here.

5 A. So what we are seeing here is, again,
6 we're looking at, first of all, what's her baseline,
7 which is just this line basically running along here.

8 which, again, like I see here, it's just about

9 1:45 -- to 1:40 to 1:50, so it's shifting a little
10 bit.

11 But that's her baseline. She had several
12 decelerations. So she had a deceleration here. It

13 looks like a very old deceleration probably. She had
14 a small variable deceleration here. And then I'm
15 going to look at her variability.

16 So I'm going to look at that's that
17 fluctuation right around the baseline, where it goes
18 up and where it goes down. You can't -- you'd really
19 have to zoom in here to see.

20 But you're clearly getting 8, 10, 12 in
21 different sections. And, again, that's moderate
22 variability. And what you have to remember is, when
23 you look at heart tones, they're going to change
24 potentially second-to-second, minute-to-minute.

25 There's areas that you try to categorize

1 based on, okay, this strip of this length of time,
2 how much of it is in moderate variability? How much
3 of it is in minimal?

4 But what you're looking at is, you're
5 trying to get a general sense of how healthy does
6 this baby look? He's having the decelerations that I
7 will see in almost every actively pushing patient.
8 So I'm not surprised by those.

9 But am I seeing minimal variability? Am I
10 seeing absent variability? Am I seeing moderate
11 variability? Do I see accelerations? I want to try
12 to weigh the less reassuring against the more
13 reassuring.

14 That's going to be one piece of the puzzle
15 that I want to look at that's going to go along how
16 is the exam? How does the baby's head feel? How is
17 Sarah doing? To try to come up with, like I talked
18 about, can we keep going? Or is it time to bail out?

19 Q. So these strips were reassuring to you at
20 that time?

21 A. Yeah, they are, yeah. These are typical
22 strips that you're going to see throughout a pushing
23 patient.

24 Q. All right. So then you describe what your
25 plan was at that time, is that right?

1 A. Yeah. Yes, it was.

2 Q. I'm going to jump ahead just for a minute.
3 Between 8:00 a.m. and 2:00 p.m., did you see Sarah
4 Anyan on several different occasions?

5 A. I did. I typically would try to get into
6 my active patients' rooms every -- sometimes every 30
7 minutes, sometimes every hour and a half. That would
8 be in addition to discussing things with her nurse or
9 communications with her nurse.

10 Q. Did you write down every time that you
11 were visiting her between 8:00 a.m. --

12 A. No.

13 Q. -- and 2:00 p.m.?

14 why not?

15 A. Because I'm a little like Jessie Brown in
16 that documentation has changed for the last 4 years.

17 For me, usually when I'm jumping from
18 patient to patient, I'm not good at writing things
19 down, right? So our documentation on labor and
20 delivery tends to be -- firstly, in the office, in
21 labor and delivery, our documentation tends to be
22 verbal, back and forth.

23 where are we now? what are the
24 contractions doing now? Up until now, it's never
25 bitten me, but now that lack of documentation is

1 obviously front and center. Same with Jessie. And
2 similar kind of things. Sometimes we're just moving
3 and running, and so things don't necessarily get
4 written down that may happen.

5 Q. Well, we know from Mr. Anyan's testimony,
6 that he knows you were there maybe three or four
7 times.

8 Does that sound about right?

9 A. Probably. I know there were other cases
10 that I had to get in and out of, so typically I would
11 try to check in before or after those to see how
12 we're doing.

13 Q. All right. And each time when you would
14 visit her, would you do the same kind of examination
15 and assessment that you described for us earlier?

16 A. Typically I would because I want to know
17 what she's doing, right?

18 Q. Overall, with, again, with respect to
19 those tracings, between 8:00 a.m. and 2:00 p.m., what
20 did you observe with respect to the fetal heart rate
21 tracings?

22 A. What I observed is, what I observed during
23 that time period, is that she would fluctuate between
24 Category II and Category I. She spent probably the
25 majority of the time in Category II, which would not

1 surprise me.

2 But within Category II, I would be looking
3 for evidence of more are we more in that B plus
4 Category II range? Or are we more in that C minus/D
5 category? So that's part of what I'm evaluating when
6 I look at how we're doing.

7 Q. And what was the conclusion that you
8 reached from your evaluation of those strips between
9 8:00 and 2:00 p.m.?

10 A. There was not a time there that I felt
11 concerned that we need to now be moving forward to an
12 expedited immediate delivery.

13 Q. 9:30 a.m., have you had a chance to look
14 at those fetal heart strips that proceeded at that
15 time, 9:30 a.m.? Page 130.

16 A. Yeah. She was still -- she is pushing at
17 that time. She was having repetitive, looks like
18 some late, some variables.

19 MR. WILLMAN: Can you put up on the screen
20 page 130, please?

21 Q. (By Mr. willman) So this is timed at
22 8:35, is that right? Or 8:38?

23 A. Okay.

24 Q. Are you with me?

25 A. Yeah. Mine are 8:35, 8:38, okay.

1 Q. Page 130?

2 A. Yeah.

3 Q. Okay. Just take us through then, again,
4 what the strips are showing at this time before 9:30
5 in the morning.

6 A. Sure. So I'm trying to match it up.
7 So she's pushing, it looks like she pushed
8 about maybe four times on this strip. Looks like
9 she's having variable -- somewhere -- oh, so she's
10 got a variable here, decel here. It's hard to say.

11 So she's having several decels. And then
12 this is her recovery time in between, all right?

13 This is where she's returning to her baseline.

14 MR. WILLMAN: All right, Justin, if you
15 could move ahead in time to 8:45.

16 A. And one last thing on this --

17 Q. (By Mr. willman) oh.

18 A. You can see if you can blow it up. She is
19 having moderate variability here. She's having
20 moderate variability here. She's having in
21 contiguously -- I can't see there -- but she's,
22 again, having moderate variability here, as she's
23 recovering between her contractions.

24 Q. Moderate variability is a good thing?

25 A. That's the good thing.

1 Q. Okay. And so was there anything that you
2 see in these strips that indicate that you should
3 have done a C-section at 9:30 in the morning on
4 May 4th?

5 A. Not based on these strips, no.

6 Q. Was she making progress during that time?

7 A. She was.

8 Q. Okay. And you, when you examined, you
9 would examine to see whether there was progress being
10 made with respect to the fetus?

11 A. That's definitely one of the things we're
12 looking -- progress is -- progress has been discussed
13 a lot here. Progress is tricky. I think it's trying
14 to be painted here as a linear, almost like an
15 elevator shaft, right?

16 You start here, and then on some sort of a
17 regular basis you'll take, down, down, down until
18 you're all the way to the bottom. That ideally is
19 how progress works on a patient.

20 And often if it's their second or third
21 baby of normal size, they'll just (indicating) come
22 straight down very predictably, very straightforward.

23 Sometimes that's not how it happens.
24 There's different things we describe as progress,
25 right? I talked a little bit about a baby molding

1 their head, going from round to cone head. That's
2 progress because that often has to happen before they
3 can start navigating the birth canal.

4 A baby that is malpositioned, so maybe
5 looking down and trying to get itself to looking in a
6 more favorable way to come through the birth canal,
7 that's progress. That's -- sometimes we'll go back
8 and forth, and I'll often explain it to patients.

9 Like if you have an old lock, a key, and a backdoor
10 lock or something. You have to jiggle and jiggle it,
11 and finally it will catch and turn.

12 That's what babies that are malpositioned
13 are often trying to do. They're trying to navigate.
14 And if they're starting to try to turn in that right
15 position, that's progress.

16 The pelvic floor muscles, that sheet of
17 muscle that has to get out of the way, it wraps
18 itself around the vagina and rectum. It has to
19 spread it out of the way. That separates under the
20 force. That's progress.

21 so all of these things are going to affect
22 our progress. So it's not just a numerical negative
23 3, 2, 1, 0, 1, 2, 3, out. Sometimes it does work
24 that way, and that's how we measure station. That's
25 not how I measure progress.

1 you have to measure progress based using
2 that exam. Sometimes we'll see, during a lot of
3 times, especially at the end, during a push, what do
4 I feel? But also periodically, through exams, that's
5 why I look to do it myself. That's why Jessie was
6 saying she knew how I liked to do this. Because I do
7 like to be there and do that exam. Are we in a
8 better place than we were before?

9 Q. Do we have an animation that will help you
10 explain to the jury how babies rotate in utero?

11 A. I believe we do.

12 MR. WILLMAN: would you play C3, which is
13 the animation?

14 Q. (By Mr. willman) Anytime you want Justin
15 to stop, please let him know.

16 A. Okay. So this is a baby in the uterus,
17 the head above a closed cervix. And this is the
18 occiput posterior position. The occiput is the crown
19 of the head is toward the back. Now it's rotating.

20 THE WITNESS: Pause right there.

21 A. So you see the head is rotated, and now
22 it's looking at one of mom's hips. So now we're in
23 what's called an occiput transverse, or OT position.
24 That's really the hardest one to deliver. It's
25 rarely that way, although I had one deliver that way.

1 Ideally they want to ultimately swing all
2 the way around.

3 THE WITNESS: I think you can keep going.

4 A. And throughout the course of labor,
5 they're trying to get to that -- okay.

6 THE WITNESS: So you stop right there.

7 A. So that's what's called LOA. So the far
8 side of mom's body is to the left of the occiput,
9 this would be to the mom's left hip. And the baby is
10 looking toward the top, sky. That would be left
11 occiput anterior.

12 Lots of times babies will finish their
13 laboring crowning process either LOA or ROA.
14 Sometimes straight OA. But this is a baby that has
15 progressed through that change and gotten into more
16 of an ideal delivering position, and this is how we
17 would like it to be.

18 Now, babies navigate that differently, and
19 they can navigate that differently based on a lot of
20 things. But one of those is the shape of mom's
21 pelvis, the size of the baby, the size of the baby's
22 head, how strong the contractions are, how much room
23 there is.

24 But that process for some babies, some
25 babies will do that in one push. And the nurse and I

1 will watch, and she's crowning, and you will watch
2 that head, as she's pushing, turn 180 degrees as it
3 comes out and completely flip around as it's crowning
4 and coming out.

5 So sometimes you'll see that immediately
6 in realtime. But I know Dr. Mckillip was feeling it
7 at 6:00 a.m., I believe, 6:30, she was feeling that
8 OP, trying to make that move. And that, to a certain
9 extent, explains why was this taking so long. The
10 baby was trying to make that shift --

11 Q. (By Mr. willman) So Remi started out in a
12 malposition?

13 A. He did.

14 Q. And that's when -- one of the things you
15 were trying to resolve during the course of labor,
16 was his positioning in the uterus, correct?

17 A. That's what we were hoping for. There are
18 ways that you can actually try to manually resolve --

19 Q. And did you try those?

20 A. I tried to a certain extent, but I didn't
21 have a whole lot of room to do it. To truly do a
22 manual, where you basically put your hand in and try
23 to turn a baby, you want to try to -- you really need
24 to do that before they get too deeply engaged, okay?

25 And so because they're just -- once that

1 get locked in, they're either going to do it on their
2 own, or it's not. Oftentimes it's more of you truly
3 trying to do it, you just get your hand on it and
4 just try to tease it a little bit and see if it will
5 shift under that pressure.

6 But that's part of where, you know, part
7 of his journey was trying to get aligned. And he
8 ultimately did. He delivered OA, I think, or maybe
9 LOA or ROA. But he did finally get turned. But part
10 of the problem, then, the further you go along, the
11 head -- to figure out how a baby is facing. I don't
12 know -- it probably won't help.

13 The soft spot's here. The main soft spots
14 are here and here. And then one's a triangle, and
15 one's a diamond. So we can feel the scalp. You can
16 feel the diamond or triangle, and that can help you
17 figure out which way the baby's looking.

18 As they get into a cone shape towards the
19 end, a really cone shape and swollen, those are
20 getting distorted. So toward the end, it can be
21 really hard necessarily to determine how exactly a
22 baby is facing. But earlier on, you can get that.

23 Q. So earlier you mentioned that pelvic shape
24 and size also affects how a baby will progress, true?

25 A. Yes.

1 Q. All right. Do you have some example here
2 of the different pelvic shapes and sizes? And
3 describe for us how --

4 A. I do.

5 Q. -- those affect -- and, in particular,
6 Sarah Anyan's case.

7 MR. WILLMAN: Can you put up on the screen
8 C9, please?

9 Q. (By Mr. Willman) Anything else that we
10 need to see on this animation?

11 A. No.

12 Q. So generally describe for us what are the
13 different shapes and sizes and then what specifically
14 were you dealing with in Sarah Anyan's case.

15 A. Yeah. Right. And I don't -- And I'll say
16 right out of the bat, I don't know exactly what
17 Sarah's shape is. I have some suspicions. You know,
18 I could do some x-ray imaging and maybe see, but that
19 won't necessarily show you since she's already
20 delivered.

21 But what's important to know is there are
22 different shapes of a female pelvis, and there are
23 variations throughout, right? So it's not all
24 exactly one or the other, but the top line is what's
25 called gynecoid, which is the typically normal female

1 pelvic shape.

2 So when you look at the top here, this is
3 from looking at it above. So the right hip, spinal
4 column, left hip, pubic bone, and you can see the
5 overall shape.

6 And then you go down to an android, which
7 is a little less round, a little more kind of
8 misshapen here, and a little less space from front to
9 back. An anthropoid, which is a more elongated
10 display. And then you have a platypelloid, which is
11 sort of a heart shape.

12 And then these pictures right here show
13 you how does that affect, then, their outlet. So
14 really this is all mainly what you can see in a
15 laboring patient. When you go to check them, you can
16 feel what their pubic arch feels like, normal. And
17 then you'll see some get a bit sharper and narrower,
18 more rounded, sharper. Some get really broad.

19 But you see down here at the bottom, the
20 pelvis is -- that arch it really wide, but the actual
21 height of the pelvis itself is a lot shorter. So a
22 lot of it is just variation.

23 But where this really becomes important in
24 labor is sort of the inner part of the pelvic bone.

25 And the way I'll often describe it is if you think of

1 a pelvis like a salad bowl with the bottom's cut out.
2 You've got this wider space up top, and
3 that pelvic inlet between the hipbones, and you've
4 got the narrow space down at the bottom. Then you've
5 got the sides of the bowl. So you can have the
6 really wide sort of pasta bowl, where it's really
7 wide and not very deep, or you might have a much
8 narrower bowl.

9 And so as a baby tries to come down and
10 navigate it, part of what he has to navigate is how
11 do I get my body and my head and my shoulders and my
12 body through the shape?

13 And at the very end of when she was
14 crowning, and I think I described it in my
15 deposition, but I can describe it again. How she
16 starts to come out and present was very different
17 than typical, and --

18 Q. How was it different?

19 A. It was different in that he got really
20 crowned up. And crowned up basically means he's come
21 almost past the pubic bone essentially. And so they
22 spend a lot of time here, they spend a lot of time
23 here.

24 And then kind of get to here, and that
25 typically is the point where they just release,

1 right? So for most babies, getting under and past
2 that pubic bone is their speed bump. That's really
3 their hardest place to get past there, typically,
4 unless you have what's called a shoulder dystocia,
5 where the shoulder gets stuck, usually then you just
6 pull the baby out.

7 well, Remi got to that point, and it was
8 clear that the pubic bone was not obstructing his
9 head from getting out, and I could feel where
10 typically where a shoulder would be, and where a
11 shoulder might get stuck, and I felt there was space
12 there.

13 But even with numerous pushing of certain
14 areas and her pushing, it was kind of wedged, almost
15 like think about Winnie the Pooh when he's trying to
16 get through that hole in the tree. It just kind of
17 gets wedged. And so that's what led me from not
18 really real-time, because it doesn't matter then, it's
19 just getting him out.

20 But when I looked back later, and trying
21 to think, okay, why did that end just want to take
22 long? why would -- part of why because normally
23 the -- basically the head was almost out and cleared
24 the pubic bone, and there was no shoulder dystocia.
25 It was able to clear easily the shoulder.

1 Q. So shoulder dystocia means the shoulder
2 gets stuck?

3 A. The shoulder dystocia means the head has
4 come out, physically fully out, and then the anterior
5 shoulder gets stuck behind the pubic bone.

6 Q. That didn't happen?

7 A. That did not happen. I could easily clear
8 the shoulder. It was really basically more the trunk
9 and hips. That's where I -- and I think Jessie kind
10 of talked about it, where I just had to get in there
11 and just basically physically unwedge him from the
12 pelvis.

13 And so that's part of what made it just an
14 usual way coming. It just was kind of here for a
15 while. And the head had cleared. And then once
16 the -- at the very end, he got a temperature, and the
17 heart rate started going up, started going up, had to
18 physically get in there and pull him out at that
19 point.

20 That in retrospect made me think, you
21 know, she dropped so easily into the pelvis, and at
22 the end of her first stage, when she got complete, I
23 mean, she kind of flew through that at the end. And
24 so typically when you have that, so then Sarah's
25 really tall. She's about 5'6", 5'7", so definitely a

1 little taller than average for a woman, and it
2 took -- typically if you get a quick in, a lot of
3 these abnormal pelvises have a wide upper bowl, and
4 then just narrows and tightens here.

5 Q. Okay. So, again, dealing with the time
6 period 8:00 a.m. to 2:00 p.m., you were wearing two
7 hats at that time, correct? You were wearing the hat
8 as the attending for Sarah Anyan, true?

9 A. I was.

10 Q. But you were also there as a hospitalist?

11 A. I was.

12 Q. And so you had some responsibilities that
13 took you away from Sarah Anyan at various times
14 during that time period, 8:00 a.m. to 2:00 p.m.?

15 A. They did.

16 Q. All right. We've heard some about it. I
17 think the first one was at 9:42 a.m.

18 what happened? what were you called to
19 do?

20 A. So as a hospitalist, again, part of our
21 role is kind of have to be available for any
22 emergency that rolls in. whether they don't have a
23 doctor, or if the doctor's not there, or it's
24 something acute that's going on, we're the ones that
25 have to sort of oversee that.

1 In order to keep that safe for us because
2 if we're in a situation where something's going on
3 with your patient, and then somebody rolls in, you
4 can't split.

5 So as hospitalists, we always would have a
6 backup. We had a backup calendar. There was always
7 physically someone on the calendar that was on campus
8 that was one of our partners, was our backup.

9 So if I had to call and say, hey, I've got
10 a patient that's about to deliver, but I've got to do
11 this, and then they would be there, we would have a
12 built-in backup, one of our partners.

13 But what came in was a patient of another
14 Mercy -- not one of my partners -- but another Mercy
15 patient. She came in, and I had -- basically I got a
16 call on the phone, we got a patient, and she's 38
17 weeks, and she's hemorrhaging, and baby currently
18 looks good.

19 So we basically brought her up in what's
20 called code white, which is they brought her up
21 emergently from triage, and we just did a very rapid
22 emergency C-section on her right around the 9:30
23 hour.

24 Q. During this time, what was Sarah Anyan
25 asked to do?

1 A. So at that time, I said -- and she had
2 been pushing for several hours at that point, again,
3 she had a brief break around change of shift. So I
4 said, let's have her rest for a little bit, labor
5 down for two reasons: Number one, I knew she had
6 been pushing for a long time. I wanted to let her
7 get a little bit of a break.

8 often when babies, when you're not
9 pushing, their decelerations aren't as frequent, so
10 we could give Remi a little more time to rest and
11 rebound. But, also, I was going in that C-section
12 briefly because code white is really fast, there's
13 less chance that something, you know, was going to go
14 on with Remi, maybe something may be acutely more
15 concerning that I would have to -- want to be
16 available for. So I had her rest while I did that.

17 Q. And how long were you involved in that
18 particular delivery?

19 A. I think that baby came out at 9:42. I was
20 probably out of that OR a couple of minutes after
21 10:00.

22 Q. Okay. The next one that called you into a
23 different situation was at 12:41 p.m.

24 Tell us what that was about.

25 A. So when I came on service that morning, I

1 got a checkup from Dr. Parker. She gave me
2 information about one of our other partners who had a
3 patient in labor.

4 And so right when I came on, she was 9
5 centimeters and complete and started pushing that
6 morning. And I had been, sort of like with Sarah's
7 case, I had been seeing her, met her. I hadn't met
8 her before, so I was in there talking with her.

9 And she got to complete, and she started
10 pushing, and her nurse at the time was also a really
11 good, veteran seasoned nurse you can rely on. She
12 wanted me to come evaluate her pushing.

13 And I think it was maybe the eleven
14 o'clock hour, closer to 12:00. So I was in there for
15 a while and evaluated her pushing. And she was not
16 going to make it. So she had gotten to complete, but
17 her pushes were not moving the baby at all. She had
18 been pushing for over an hour, an hour and a half,
19 but had made zero progress.

20 I had been dealing with her pushes in an
21 hour and a half, maybe, and she was also physically
22 done, so we discussed at that point, I said, you're
23 not making progress. We can watch it a little
24 longer. Because I typically examine them, and I had
25 a nurse who was very reliable, and she had been

1 pushing with her and said, the baby is not moving at
2 all. So she was tired at that point. And she wanted
3 a C-section. So we did a C-section.

4 Q. And how long did that take you?

5 A. A little quicker because she already had
6 her epidural. We take a little bit of time when
7 we're getting set up. So we roll out of the room,
8 and I can have that C-section done in 25 minutes.

9 Q. All right. And, again, what was Sarah
10 Anyan asked to do while this was going on?

11 A. So she pushed again for a couple of hours
12 after that 9:30, and then that's when we labored her
13 down, I think it was around 12:20ish, so maybe to the
14 one o'clock hour.

15 Q. Laboring down means taking a break.

16 A. Resting.

17 Q. All right. And then finally at 1:44 p.m.,
18 1344 military time --

19 A. Uh-huh.

20 Q. -- are you again involved in another
21 procedure?

22 A. That was another hospitalist case. That
23 was a -- so as a hospitalist, we oversee the JFK
24 clinic. They had a scheduled C-section for one of
25 their patients, and so we are their staff attending.

1 So when we do a C-section on a patient, we
2 would be in the room staffing them. So the nice
3 thing about those is that those can take -- the
4 standard is that I don't gown and glove, I'll stand
5 at the bedside, and the chief resident and the second
6 and third years will do the case, and I'll be
7 standing there observing.

8 Sometimes if they run into a situation
9 where they need me, I'll scrub in and be available.
10 But you can kind of walk in right when they're about
11 ready to make the incision and then walk out when
12 they're closing the skin. So that tends to be pretty
13 quick. But that was my third C-section that morning.

14 Q. And was Sarah --

15 A. Afternoon.

16 Q. Was Sarah Anyan asked to again labor down?

17 A. Yeah. I had talked to Jessie, and said,
18 these are some things I have, and we had talked about
19 them. And, again, Jessie always said -- she's
20 amazing, so she said, well, let her rest a little bit
21 because we were getting to that -- this stage at that
22 point. Okay. We're going to let her rest a little
23 bit, and then we'll go ahead and try to work toward
24 delivery after that.

25 Q. During any of these times that you were

1 involved in another procedure, were you available if
2 something had happened to Sarah Anyan if --

3 A. I or my -- my backup partner, which I
4 would be connected to the hospital. we're always
5 available immediately, within a minute or within a
6 couple of minutes immediately, as an attending to
7 either Sarah or a patient in the OR or wherever
8 needed to assist.

9 Q. Gotcha.

10 MR. WILLMAN: Judge, if you'd like, is
11 this a good time to take a morning break?

12 THE COURT: Very good. All right. Ladies
13 and gentlemen.

14 (At 10:30 a.m., the court duly admonished
15 the jury, and proceedings stood in recess. At
16 10:48 a.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 You may presume.

21 MR. WILLMAN: Thank you, Judge.

22 Q. (By Mr. willman) Doctor, I'd like to go
23 back in time for a moment.

24 The jury's heard some about safety rounds.
25 A safety round did happen during that morning,

1 May 4th, did it not?

2 A. Yes.

3 Q. I think it was at 10:45 p.m.

4 Does that sound right to you?

5 A. It's possible they may have waited for me
6 to get out of that emergency delivery.

7 MR. WILLMAN: So if you would put up on
8 the screen Exhibit A2, page 107. If you can
9 highlight it for me.

10 Q. (By Mr. willman) All right. That's a
11 strip review. All right. There we go. Okay. All
12 right.

13 A progress note from a Tamsin Lewis at
14 10:46 a.m., safety round.

15 Tell us, what is a safety round?

16 A. A safety round is one of four -- there are
17 four scheduled rounds by the team throughout the
18 24-hour period. They set the safety rounds, and then
19 there are two strip rounds.

20 Safety rounds are meant to be an
21 evaluation of each patient on labor and delivery, a
22 brief evaluation. It occurs at the physical nursing
23 team, where a patient is. There's 5 teams on labor
24 and delivery, not all are open at all times.

25 But the team would go to each nursing

1 station. So that team would include typically an OB
2 hospitalist, nurse wife, when they were still
3 there, a chief resident, maternal-fetal medicine
4 specialist, the charge nurse, the OB
5 anesthesiologist, and the pro hoc charge nurse. And
6 then all of the -- that would be for the core team.

7 And then when they would go to a team, the
8 nurses that were on that team stationed assigned to
9 patients would individually present their patient.

10 Q. So this tells us that other sets of eyes
11 looked at the fetal heart tracings for Sarah Anyan
12 who were not involved in the labor and delivery of
13 Sarah, correct?

14 A. Correct.

15 Q. And you just listed for us the different
16 specialties that were involved?

17 A. Correct.

18 Q. And you said they review 15 minutes of
19 FHTs, which means fetal heart tracings?

20 A. Yes.

21 Q. All right. And do they make any
22 recommendations as to making a change in the plan in
23 any way?

24 A. On this, they do not. On some, they will,
25 if they feel that maybe the doctor needs to be

1 notified, or they feel like a change of something
2 needs to be addressed.

3 Q. So the safety round really gives an
4 additional layer of safety to the patient and the
5 team.

6 A. Yes.

7 Q. Is that correct?

8 A. Yes.

9 Q. By giving them an independent set of eyes
10 looking at the strips?

11 A. Correct.

12 Q. So let's move ahead in time then to 2:07
13 p.m.

14 That was when you are actually at her
15 bedside?

16 A. Yes.

17 Q. And what brought you to her bedside?

18 A. Well, a variety of factors. This had been
19 a long day for her, a long second stage. That was
20 not lost on me. She had, again, started getting to
21 this point where, in talking to Jessie, saying, boy,
22 curious why this baby has not sort of released at
23 this point. He should have. We think he would have,
24 based on what we're seeing.

25 So we think it's time. Let's just really

1 actively try and see if we're going to be able to
2 make that happen. So I decided at this point I was
3 just going to stay at the bedside with her and push.

4 Q. And were you there minute-by-minute until
5 delivery at 4:24?

6 A. I did not leave the room. I don't even
7 know if I took off gown and gloves during that to
8 when I was done repairing her.

9 Q. And during this time, are you helping,
10 guiding her with her contractions, telling her when
11 to push?

12 A. So I'm typically sitting at the foot of
13 the bed, so she'll have her feet usually up in the
14 stirrups, and either the nurse or Blake might be
15 helping holding the legs. And I'm often either
16 visually or manually feeling what's going on.

17 At the same time, the heart rate tracing
18 is there, so I'm evaluating what that's doing. I'm
19 watching Sarah. I'm trying to assess how effectively
20 is she pushing. She was doing great, but, I mean,
21 she had been pushing for a long time. I mean, I
22 would have quit long before. She was doing amazing.

23 But I'm watching her saying, okay, is
24 she -- so I'm evaluating her, evaluating the strength
25 of her contractions. And then I'll feel, while she's

1 not pushing, I'll feel, okay, how firm are her
2 contractions? I'll palpate on her belly and feel
3 vaginally. I feel the pressure, and I can tell --
4 I'll look at the strip, are they starting to space
5 out?

6 Can't tell with the external monitor how
7 strong they are, but just how frequent they are. You
8 can tell by palpation how strong they are. Is there
9 a change? Are they weakened?

10 So those are all the things, and then I'm
11 still feeling for the room, right? And literally
12 with Sarah and with some patients, the progress is a
13 fetal hair comes further out with a push, right? I
14 mean, it can be that much, right? That can be her
15 progress.

16 Some patients push, and one push, they
17 push the entire baby out. Some patients, it's the
18 whole scalp. But you're looking at is it coming out
19 to stay, or is it retracting? In other words, if it
20 goes out and comes back, and if that's all that ever
21 happens, you're not making any progress when the head
22 pushes down while she's pushing.

23 So, you know, that can happen sometimes
24 when they're trying to find their alignment, right?
25 I think Dr. Mckillip said that earlier. But once

1 she's aligned, at this point, I think she was most
2 likely to OA or in the right line up. So is she
3 coming, and is she staying? So that's what I'm
4 evaluating. And how does she look? How is she
5 pushing? And how does she feel?

6 Q. And how often are you doing this
7 evaluation between 2:00, until the delivery?

8 A. Constantly. Again, typically what I'll
9 do, because, again, she looked ready to deliver.
10 where that head was, she seemed ready to deliver.
11 And I still sat for 2 hours, and that's what led into
12 the whole something upstream seemed to be holding us
13 up.

14 So I was gowned and gloved sitting at the
15 foot of her bed the whole time. I wasn't necessarily
16 physically examining her every time. I was trying to
17 assess the strength of the contractions. I would --
18 I would just gently put a fingernail against Remi's
19 head, and I can feel that pressure build up there.
20 You can tell. Sometimes you can feel, and you can
21 tell her to push, but you can feel there's not much
22 pressure, that they're getting weaker and spreading
23 out.

24 Q. During this time, was Remi making
25 progress?

1 A. Yes.

2 Q. And were you doing those scalp
3 stimulations that you told us about earlier?

4 A. Well, anytime you're doing an exam and
5 evaluating for -- trying to feel how he's feeling or
6 feel the room, you're technically stimulating the
7 scalp. So, yes, I mean, you're not typically doing
8 it to stimulate the scalp, but those are all the
9 scalp stimulations.

10 Q. All right. Let's talk about two other
11 subjects: C-sections and then what's been described
12 as operational vaginal delivery.

13 A. Uh-huh.

14 Q. You're familiar with that?

15 A. I am.

16 Q. First of all, a C-section, what is it?

17 A. So a C-section is a -- the other way to
18 deliver, where you take the patient to the operating
19 room, and you give them an extra level of anesthesia
20 and make an incision in the lower abdomen and then an
21 incision in the lower uterus, and then you go to pull
22 the baby out that way and then sew everything. And
23 you bypass the vaginal route.

24 Q. Are there risks and complications
25 associated with doing a C-section?

1 A. There are.

2 Q. And does ACOG recognize that there are
3 risks of doing that?

4 A. It does.

5 MR. WILLMAN: Can you put up on the screen
6 I2, page 4?

7 Q. (By Mr. willman) All right. So what does
8 this tell us?

9 A. You're looking at risks of both vaginal
10 births and C-sections, which there's always a risk,
11 and there's a balance. And that balance can then
12 shift throughout the course of labor one way or the
13 other.

14 childbirth, by its very nature, carries a
15 potential risk of losing the baby, regardless of the
16 route of delivery. That's the reason you examine the
17 risks and benefits to a cesarean and vaginal
18 delivery.

19 Q. All right. And the last sentence says:
20 However...

21 A. However, for most pregnancies which are
22 low risk, cesarean delivery appears to cause greater
23 risk of maternal morbidity and mortality than vaginal
24 deliveries do.

25 So, in general, in general, we basically

1 say that C-sections, in general, tend to be riskier
2 for the mom. Vaginal deliveries, in general, tend to
3 be riskier for the baby. But that can flip. And
4 eventually that flipped in this case. But -- so the
5 mother has increased risk of infection, higher blood
6 loss, increased risk of -- for future pregnancies,
7 scarring, uterus scarring. A C-section always
8 carries a risk. It's a major surgery.

9 Q. what is your C-section rate?

10 A. It will fluctuate. I think it is around
11 the typical Mercy Hospital rate, which is around
12 25 percent of deliveries.

13 Q. And we know you know how to do that
14 because you did several that day, correct?

15 A. I did two and oversaw a third.

16 Q. Did you ever have a discussion with Sarah
17 Anyan about the possibility of doing a C-section?

18 A. Yes.

19 Q. what was your discussion?

20 A. well, so we had multiple discussions.
21 Those discussions were sort of in the context of how
22 are we doing? All right. You know, right at 8,
23 anytime a patient has been pushing for a while, I'd
24 say, listen, here's where we are. You're pushing
25 great. You've been pushing for a while, but we're

1 bumping up toward the end of typically when a second
2 stage would be.

3 And so I usually will lay it out in a way
4 of options. At any point where I feel we are not at
5 an option where we can go forward, I'm not advising
6 for it -- or I'm not discussing -- I'm telling the
7 patient, I think you need a C-section for reason X,
8 Y, Z.

9 That's -- below that is, okay, a C-section
10 may be a possible route that we're going to need to
11 go. And that's really all day the way it was in
12 Sarah's case. You're making progress, you're pushing
13 strong. Your baby is resilient. Your progress is
14 slow, however. There may be a point where it stops.

15 And, you know, so a C-section is always
16 going to be an option in vaginal -- in labor,
17 emergent labor or planned. But in those
18 discussions -- discussions kind of ended around 3:00,
19 when the situation had changed. But up until then,
20 those -- part of those how are you doing
21 discussions -- Do you feel like you can go on? Do we
22 need to consider other options? -- those are the
23 discussions I'm having probably a couple of times.

24 Q. You've never reached the point where you
25 said, Sarah, I'm recommending to you that you have a

1 C-section, did it?

2 A. No. No. No.

3 Q. She never -- she never refused a
4 C-section?

5 A. No. And I feel like there's some of that,
6 I don't know, sense. But I'm on record, and I still
7 agree, Sarah never would have refused a C-section if
8 I said, you need one. I'm on record of saying that,
9 and I truly believe that.

10 I never said, you need a C-section. And I
11 don't think she would have refused if I said that.
12 She was very reasonable. She never said to me, I
13 will only accept a vaginal birth. And I've never
14 claimed that.

15 It was very clear to me, like a lot of my
16 patients, a majority, if she could have a vaginal
17 birth, she would like one. It's hard to push that
18 long and not want to do a vaginal birth. Most of my
19 patients would be just tapped out by this point.

20 But I think we were always on the same
21 page. I don't think there was any sort of animosity
22 or confrontation in that room of, I think you should
23 do this, and I don't ever think it go to that point.
24 I never said she had to have one. I had no reason
25 she would have refused it. And she was able to

1 proceed.

2 Q. Earlier you said at 3:00 p.m., things
3 changed where even if you thought a C-section was
4 warranted or necessary, it wasn't feasible, correct?

5 A. So we're always looking at what are our
6 alternate ways out. So for when you have a patient
7 who's trying for a vaginal birth, your alternate ways
8 out are either an operative vaginal birth, which is
9 forceps and a vacuum and try to help pull the baby
10 out vaginally, or do a C-section.

11 I don't know exactly when, because, again,
12 the progress was slow and steady, but she reached a
13 point where, in my physical evaluation, I said, and
14 this is where I was talking about, and I can show you
15 if need --

16 Q. Let me just stop you. We have an
17 animation, C4, if that might help you explain to the
18 jury what this situation was.

19 A. Uh-huh.

20 Q. Okay.

21 MR. WILLMAN: If you could start that,
22 please?

23 A. So this is an animation that looks at --
24 it's basically a brief of how a C-section is done.

25 so here's the baby in the uterus. And

1 what we'll do is we'll make an incision in the skin,
2 which they'll show you. Try to make what we call a
3 bikini cut, where we'll do an incision right down
4 around the hairline.

5 And we do it usually not all in one cut,
6 multiple layers. And we go through the fatty tissues
7 that separate the muscle. And then we'll get down to
8 the level of the lower uterus, which is right here.

9 Typically we're going to make an incision
10 by the bladder down here. And this baby --

11 THE WITNESS: Do you want to pause that
12 right there?

13 A. This baby is in a good position for a
14 C-section. And what we're talking about is where is
15 the baby's head in relation to how far down the birth
16 canal? And so I'll show why --

17 THE WITNESS: You can go ahead and
18 continue.

19 A. So we make an incision in the uterus. And
20 then if the water is not broken, we'll break the
21 water and separate the uterine muscle. And then the
22 operator will reach in by hand, so we're opening the
23 incision wider, and the operator will reach in a
24 hand.

25 THE WITNESS: And pause it for just a

1 second.

2 A. And right now it's showing the baby is OP,
3 staring at the sky. This really doesn't change
4 regardless of what position that head is in, whether
5 they're look at the ceiling or sky. You can do it
6 pretty much either way in the situation.

7 THE WITNESS: Okay. Go ahead and keep
8 going.

9 A. So you can feel the parts. You feel
10 what's where. Sometimes you need to lift the baby up
11 a little bit, but you don't necessarily. The goal
12 ultimately gives you both the head. And you have to
13 lift the head up to the level of the incision. And
14 then the baby is delivered that way.

15 Now, if you go back --

16 THE WITNESS: Can you go to the very end
17 of that? Oh, wait. I'm sorry. Could you go to the
18 very end of that? Oh, wait. Keep going.

19 A. So this shows what's different in this
20 situation.

21 THE WITNESS: So you can keep going right
22 to where he's about to bring the head out.

23 A. Now, in some situations, you can do this
24 in a different way. And sometimes if the head it too
25 low, what you can do is either reach up to where the

1 baby's feet are in the uterus.

2 And sometimes to do that, you might have
3 to extend the uterine incision upward, but you can do
4 what's called a reverse breech, where you reach up,
5 and you grab the baby's feet. If you can't get down
6 below the head and pull the baby out --

7 THE WITNESS: You can just pause right
8 there.

9 A. Pull the baby out feet first. So you get
10 the feet to come to the incision and then bring the
11 baby up that way. Oftentimes in a situation like
12 that, you'll have the operator below an assistant
13 that will have their hand in the patient's vagina,
14 and actually physically be pushing up on the baby's
15 head to try to get it a little bit disengaged from
16 the birth canal to put less traction on the baby's
17 head.

18 So that is a different way you can do it
19 if the baby's too low. But Sarah's situation was
20 different.

21 THE WITNESS: So if you want to show the,
22 I guess, the second half of this.

23 A. So, really, the main difference here is
24 you run into this in patients who are pushing, and do
25 what's called a complete and pushing C-section.

1 so labor has brought the head much more
2 significantly down the birth canal.

3 THE WITNESS: So if you can pause right
4 there.

5 A. So in the first one -- but here's the top
6 of the baby's head. And here's the bladder, and
7 here's the feet. So in the first one, the top of the
8 baby's head is about where the baby's ear is now. So
9 it's not nearly as low in the birth canal. You have
10 to remember, as you get further down, everything is
11 narrow and tighter.

12 At this point, you're essentially reaching
13 your hand down into the vagina past where the cervix
14 was to get to the top of the baby's head.

15 And so they can be much lower down, and it
16 can be -- these are often the ones I would get called
17 into as a hospitalist because the attending has made
18 the incision, gotten in, and they or the resident
19 couldn't get down and couldn't get the head up.

20 So now Remi was significantly past this,
21 but this will show you some of the difficulties in
22 trying to do that.

23 THE WITNESS: Keep playing, please.

24 A. Well, it doesn't -- I can just demonstrate
25 where we were with Remi, if you want me to.

1 MR. WILLMAN: Okay. So may I have him --

2 Q. (By Mr. Willman) You want to use the
3 model over here?

4 A. I was going to.

5 Q. Yeah. You may stand up and use the model.
6 And we had those marked as exhibits. Go ahead. If
7 you would, Doctor.

8 THE COURT: Make sure you keep your voice
9 up nice and loud.

10 THE WITNESS: I can walk back here.

11 A. Okay. So this is again a general model of
12 a pelvis: pubic bone, tailbone, and the hips.

13 So, again, what we typically will do in a
14 C-section, the baby might be somewhere around here.

15 So when I make my incision, go in, and you reach with
16 your hand, and you get below the head and very

17 carefully support it well and bring the head up to
18 below the incision.

19 The one they were showing was the baby

20 more down here. And it just gets a lot narrower. So
21 now you're trying to get in here, and you can't. And

22 that's sometimes the situation where they would make
23 the incision and try to bring the feet out.

24 Even then, you have to be careful if the
25 head is really lodged in there. As you try to pull

1 up, you could put a lot of strain on the neck and
2 cause issues.

3 I described Remi's labor and how unusual
4 his final levels of it were. Remi was essentially
5 doing this at this point. And that's how I knew his
6 head was past the pubic bone. So I knew forceps and
7 a vacuum were no longer going to be an option.

8 And, again, having been a hospitalist for
9 15 years, and being called into these a lot, and
10 never having failed to do these successfully, at the
11 bedside, I was of the opinion that I was not going to
12 be able to get all the way down there and get below,
13 even with pushing up, because of how tightly wedged
14 that felt, that I felt a C-section at that point was
15 not an option.

16 I can't tell you when that time happened.
17 It wasn't -- the process was slow. So I can't tell
18 you when we finally reached that point. But I want
19 to say around three o'clock, it became evident to me
20 that the least traumatic way was going to be
21 vaginally. What you also have to remember is that
22 once you do a C-section, and you've made the incision
23 in the uterus, now you're out of time.

24 That is why I will often get those
25 emergency calls because you have opened up the

1 uterus, and now they're starting to bleed. You cut
2 through the uterus. And if the placenta is in front,
3 it's starting to bleed a lot. And so now that clock
4 is ticking. And if you can't get that baby out, then
5 you have no other option.

6 And so it was around three o'clock when we
7 talked about that things had changed, where this is
8 we're going forward, and that's where we started to
9 make plans about how are we going to try to get that
10 moving.

11 Q. You mentioned vacuum and forceps. And
12 there's been some discussion that you should have
13 considered possibly operation -- vaginal delivery --
14 operational vaginal delivery.

15 A. Uh-huh.

16 Q. That would be using either a vacuum and
17 forceps, is that right?

18 A. Yeah.

19 Q. Did you bring those with you today?

20 A. I did.

21 Q. And could you show us?

22 A. Sure.

23 Q. Did you think that was ever an option for
24 you in delivering Remi?

25 A. Well, I didn't think it was an option in

1 that the problems that we were running into with Remi
2 were not typically the options that this is going to
3 fix.

4 So these are forceps.

5 Q. And that's Exhibit C10.

6 A. So these are the more old fashioned way.
7 The vacuum's newer. But typically what this is going
8 to be for is when you have -- it ultimately depends
9 where this baby is.

10 So when you have the baby, and you feel
11 you need to clear under the pubic bone, in other
12 words, you feel like we're here, and we need to be
13 here, you would either apply the forceps, and I do
14 use forceps, but they have to be very carefully
15 applied because of these ridged edges, and it's very
16 easy to get a tear.

17 I think Jessie had mentioned that was not
18 the reason that I didn't use them. The vacuum --

19 Q. That's Exhibit C11.

20 A. -- is a similar process. The vacuum can
21 be affixed to the top of the baby's head like this,
22 and then suction is applied. And then this, you use
23 a downward traction, and you do that. And, again,
24 the goal of that is to clear the baby under the pubic
25 bone.

1 And, again, Remi's problem was not that he
2 didn't clear the pubic bone. That was one of the
3 more unusual things. The head itself was already, by
4 that time, which, again, is why a C-section, I knew
5 at that point, was not going to be possible.

6 The head had already cleared under the
7 pubic bone. So that's what the role of the vacuum
8 and forceps would be. If I feel that there is what
9 we call soft tissue wedging or dystocia further up
10 the pelvis, me pulling on the head that had already
11 gotten out from under the pubic bone, is not going to
12 resolve this that might be wedged into that pelvis
13 shape, it's just going to do this. And that's --
14 that's not going to be productive to what we need to
15 achieve to get him to release from the pelvis.

16 Q. All right. Let's move ahead in time. At
17 2:48 p.m., it's documented that there were strip
18 rounds, is that right?

19 A. Okay.

20 Q. And Exhibit A2, page 108. I think we saw
21 this earlier.

22 A. Yeah. And I don't believe I was at these
23 because this is when I was already in the room, so
24 sometimes I think this was probably the midwife. So
25 sometimes if one of the members of the safety rounds

1 is not available, they're in surgery, or, in this
2 case, I was gowned and gloved in Sarah's room.
3 They'll continue to do the strip rounds as sort of a
4 skeleton crew if they need to.

5 Q. At 2:48 p.m., who was involved in the
6 strip rounds?

7 A. So that was the charge nurse, the nurse
8 midwife, which was Tamsin Lewis, and the chief
9 resident.

10 Q. And are they different -- are strips round
11 different from safety rounds?

12 A. Strip rounds are different in that they
13 don't involve the MFM, they don't involve anesthesia.
14 Sort of a skeleton crew. And it's not going
15 room-to-room seeing all the patients. It's usually
16 that -- that core group sitting at computer terminal
17 and just going through all of the strips on labor and
18 delivery, so it's sort of an abbreviated version. It
19 doesn't involve the nurses or the patients.

20 Q. And so they tell us that they did examine
21 25 minutes of the FHT, the fetal heart tracings?

22 A. Uh-huh.

23 Q. Is that right?

24 A. It does.

25 Q. All right. Have you looked at those to

1 see what those strips show?

2 A. I have. I can look again.

3 Q. Page 168.

4 A. Okay. Basically leading right up to.

5 Q. So what I have is at 1:59 through 2:30 --
6 2:40, pages 168 and 169 and 173, through 168 and 169.

7 A. Okay.

8 Q. That was what we see here, these strip
9 rounds that would be available to the strip round
10 team who are -- it doesn't involve you?

11 A. Correct.

12 Q. It's other people.

13 A. Right.

14 Q. What were they looking at?

15 A. So we're likely at a different spot there.
16 So they're seeing, well, this one is hard
17 to say for sure. If you back up a little bit a
18 couple of minutes, just a couple of minutes, they're
19 seeing several decelerations here.

20 Q. Decelerations?

21 A. Decelerations.

22 They would be seeing up here at the
23 baseline with variability. They would be seeing
24 here. The baseline with variability. They would be
25 seeing here. They would see another decel.

1 THE WITNESS: If you go to the next page.

2 Yeah.

3 A. Right there where it drops down, I can't
4 tell what this is. That's what we call again a
5 noncontiguous strip there, if you go a little
6 further.

7 Q. (By Mr. Willman) just so it's clear,
8 we're in the time period of 4 --

9 A. Yeah.

10 THE WITNESS: So you can stop right there.

11 A. So basically what we see here is we have a
12 baseline that's -- I'd have to look over 30 minutes
13 to see exactly what the average is. So somewhere
14 around 1:45 to 1:50, is our baseline. What we do
15 actually have here is we have a prolonged accel. So
16 we see this go up there, and it lasts for up till
17 about there, so several minutes of a prolonged accel.

18 Q. That's a good thing.

19 A. That's a good thing.

20 And then we have like probably a variable
21 here, although it's -- I don't know -- sometimes that
22 can be artifact if it jumps down and up like a
23 bicycle. Sometimes it does that and picks back up.
24 But that could be a variable decel there. So that's
25 what they were seeing over that period of time.

1 Q. In your opinion, what they were looking
2 at, was that reassuring?

3 A. It's the reassuring Category II tracing at
4 that time.

5 Q. All right. Pitocin.

6 A. Yes.

7 Q. You're familiar with Pitocin. The jury
8 has heard what that is, correct?

9 A. I am.

10 Q. And you used it during this labor, is that
11 right?

12 A. Yes.

13 Q. All right. Can you help the jury
14 understand how Pitocin works.

15 And I think we've got an animation that
16 might be helpful, as well, C5.

17 So take us through how Pitocin works
18 during labor.

19 A. So, again, it has been explained, I think,
20 multiple times this week. But the uterus is one big
21 muscle. And when it's working correctly, it
22 contracts sort of in concert all around the baby.

23 And the natural substance in the body that does it is
24 called oxytocin. And they have created a synthetic
25 form of that called Pitocin that they can administer

1 through the IV.

2 And so this can add to stimulation of the
3 uterine muscles. We will sometimes use this to
4 induce labor. So get labor started in someone who is
5 not able to for medical reasons. Or sometimes we use
6 this to augment labor. If he have a labor that's --
7 the contractions are noneffective, they're not
8 frequent enough, then we can add Pitocin to make
9 those contractions stronger or more frequent.

10 Q. So the nurses were administering Pitocin.
11 And then you were also personally making decisions
12 about Pitocin, is that right?

13 A. So when I had come on service, she was on
14 18, I believe. So when she showed up, her water had
15 broken and not a whole lot was happening. And they
16 started Pitocin to help get her labor going. And she
17 had gotten up to 18 milliunits per minute. And
18 typically 15 to 20 is oftentimes where augmented
19 usually ends up.

20 20 is typically where we'll go, but you
21 can go to 30 in certain situations. So she was up to
22 18, and that was adequate to get her to the labor
23 that got her completely dilated. That seemed to be a
24 good dose for her. She was having tachysystole where
25 the contractions were piling on top of each other,

1 so -- but they were giving her strong enough and
2 frequent contractions that she could get dilated.
3 when I came on service, she was on 18. And most of
4 my time with her, she was on 18 until that final
5 couple hours.

6 Q. And why did you increase the Pitocin? You
7 did increase the Pitocin in the final hours, is that
8 right?

9 A. I did.

10 Q. why did you do that?

11 A. So, again, the goal of it is to make
12 contractions either stronger, more frequent, or both.
13 And over the course of a long labor, the receptors on
14 the uterus, the receptor is where the oxytocin and
15 Pitocin binds to create an effect.

16 They had been just getting Pitocin topical
17 all day. They do what's called down regulate labor,
18 for lack of a better word. They're tired. They're
19 oversaturated. And so you can reach a point where
20 you just don't get the same effect that you were
21 getting, okay?

22 And so when I was at the bedside with
23 Sarah, again, the way we can look at the
24 contractions, she did not have an IUPC. Because the
25 way we're able to evaluate it is feeling her tummy,

1 how tight it gets, the uterus.

2 I can feel the top of the baby's head,
3 right? And so I use the back of a finger or a
4 fingernail. As that pressure builds up, you can feel
5 it. And you can feel the changes. You can feel it
6 earlier in the day, the strength of it.

7 And then some contractions get weaker and
8 just a little wisp of pressure. So between that and
9 we were starting to see that her contractions looked
10 like they were spacing out a bit, I said, let's
11 increase the Pitocin because typically then you can
12 use that to get those receptors to give you the same
13 effect that you were getting before.

14 So basically I know that I think somebody
15 last week had talked about that they wouldn't put the
16 gas -- pedal on the gas if you were already going,
17 whatever.

18 well, in a situation like this, we put the
19 pedal on the gas, and the speed drops down to like 10
20 miles. In other words, the contractions are weaker,
21 and they're less frequent. So we're putting our foot
22 on the gas to get us back to the speed we need to be
23 going because we had dropped below that. And that's
24 what helps get us a little over the finish line and
25 being able to get him out.

1 Q. And in your opinion, was it appropriate
2 for you to increase the Pitocin at the times you did
3 at 2:21, 2:44 and 3:10 and 3:56?

4 A. Yes.

5 Q. And you looked at the fetal heart tracings
6 for that time period?

7 A. Uh-huh.

8 Q. And were they reassuring, as well?

9 A. Yeah. They were much like they had been
10 throughout in that she would fluctuate. She would
11 have periods of Category I. She would have lots of
12 periods in Category II. She would have
13 accelerations. She would resolve those. There were
14 times in there where she would have some
15 accelerations.
16 She had some moderate variability
17 throughout there. So, again, she had the balance.
18 we were looking at the balance of what it was showing
19 us. And that was allowing us to continue. And the
20 weakness and the spacing of the contractions is what
21 the indication for more Pitocin is.

22 Q. We've heard about the Mercy policy with
23 respect to intrauterine resuscitation. Is stopping
24 or decreasing Pitocin one of the options that is
25 available to do that resuscitation?

1 A. It is.

2 Q. Are there other options?

3 A. There are.

4 Q. And what are the other options?

5 A. There's fetal repositioning. There's IV
6 bolusing. There's amnioinfusion for variable
7 decelerations. oxygen level, we do that bending of
8 that now.

9 Q. were the nurses doing the repositioning as
10 a way of resuscitating the baby?

11 A. They were doing a lot of repositions, both
12 a dual role of resuscitating, but they were also
13 helping with position changes and for push.

14 Q. In your opinion, was Pitocin given within
15 the Mercy policy and guidelines?

16 A. Yes.

17 Q. And why is that?

18 A. well, because, you know, you have to look
19 at what's our big picture and what's our end goal?

20 And ultimately, you know, we were not dealing with a
21 situation where we had too many or too strong

22 contractions, all right? we were looking at the

23 opposite. we were having too few and too weak

24 towards the end. And so clearly Pitocin was not a

25 problem, as far causing issues, Pitocin was going to

1 be an answer to resolve issues.

2 Now, if you want to look at, well, if the
3 policy says Category II, you should try these things.

4 Again, you have to understand that the policy allows
5 for modification based on what the baby is doing and
6 what the mom's doing, okay?

7 And so, again, looking at the big picture
8 of, yeah, we're having, yeah, she's pushing. We're
9 in Category II. We're having decelerations. Of

10 course we are. That's -- I would be shocked if we
11 weren't.

12 But overall we're seeing episodes of
13 moderate variability. In that three o'clock hour, we
14 were seeing several episodes of accelerations, so the
15 balance of good versus bad, telling me we can move
16 forward.

17 Once we reached about the three o'clock
18 hour, I know that the only way I can reasonably get
19 that baby out is vaginally. And so stronger rather
20 than weaker contractions. It's going to be that and
21 the maneuver is going to be the only things that are
22 going to allow me to there.

23 Policies are important. Policies, they
24 do -- they're important. They're guidelines, but,
25 you know, there's a time where you have to sit back

1 also and rely on decades of experience, where you say
2 where are we? And where do we need to get?

3 Policies are important, and they're good
4 general guidelines. But they do allow areas where
5 you can look at a specific clinical situation and
6 say, okay, what do we need here?

7 Q. Is that true about the Mercy policy? That
8 is one of several options that you and the nurses can
9 use?

10 A. It is.

11 Q. All right. Let's move ahead in time to
12 3:57 p.m.

13 Have you reviewed the fetal heart rate
14 tracings that occurred before 3:57 p.m.?

15 A. I have.

16 MR. WILLMAN: And let's put up on the
17 screen page 175.

18 Q. (By Mr. willman) All right. Okay. So
19 this was at -- should be at 2:50, going up through
20 page 180, which is 3:34 or 3:40.

21 Is that right, Doctor, looking at the
22 fetal strips?

23 A. Again, mine are just a little bit off from
24 yours.

25 MR. WILLMAN: well, could you highlight,

1 Justin, the page?

2 THE WITNESS: what does the time say there
3 at that top of the strip? There. Yeah. what does
4 that say?

5 MR. PERRON: 1459.

6 THE WITNESS: 1459, oh, okay. Okay.

7 Q. (By Mr. willman) So starting at 1450, you
8 looked at these tracings from 1450 through 3:40 p.m.,
9 is that right?

10 A. Yes.

11 Q. And tell us what those strips show with
12 respect to how Remi is doing in this labor.

13 A. Okay. So you would, again, right here,
14 what we're seeing is Remi's baseline, which is about
15 155, okay? And then what we see here is an
16 acceleration.

17 Q. A good thing?

18 A. A good thing.

19 we drop back down to baseline. And then
20 possibly a variable here, we lose the strip, we're
21 back to baseline. And then but what you also see in
22 here, the baseline, is the moderate variability, all
23 right? where the fluctuations and these undulations
24 here are surpassing 5 beats per minute. The top to
25 the bottom is greater than half a box. And it's

1 probably hard to see there. So we're here getting a
2 mix of moderate variability and accelerations
3 interspersed with decelerations.

4 Q. Is that all reassuring?

5 A. It's all reassuring and expected.

6 Q. And that continued up through 3:40, is
7 that right?

8 A. Yeah. We continued to have a mix all the
9 way through. At 3:30, we have basically about as
10 good a strip as we have on Remi the entire labor.

11 Q. What do you mean "as good of a strip"?

12 A. Well, so ending at 1531, so it's going to
13 be about 1524 to 1531.

14 THE WITNESS: I don't know if you can go
15 there. So don't move.

16 Q. (By Mr. Perron) Take all the time you
17 need.

18 A. So basically what we're seeing here --
19 we're seeing here the baseline. We're seeing
20 acceleration. We're seeing baseline. Again, we're
21 seeing acceleration. And then back here, again,
22 we're not perfectly lined up.

23 THE WITNESS: Go back just a little bit to
24 the left. Well, this is not going to help.

25 A. You can see the contractions.

1 THE WITNESS: So if you stop right there.

2 A. So this is actually an early deceleration.

3 It's lined up with contractions, but -- so -- but

4 basically we're getting multiple accelerations in

5 that stretch. We're having moderate variability, and

6 we're having multiple accelerations.

7 Q. (By Mr. Perron) Reassuring?

8 A. Reassuring.

9 Q. Category I?

10 A. Category I.

11 Q. And this is right before 3:57 p.m.?

12 A. This is at 1531. And even to the next

13 page, again, we have, if you go a little further, we

14 have a prolonged acceleration from about 1534 to

15 1538, which is starting right about here. Right.

16 we're coming up several minutes.

17 THE WITNESS: Stop there.

18 A. Now, you probably want to change the

19 baseline if it's -- you call it prolonged

20 acceleration, but there's that baseline change. And

21 so right there, we're at 170, basically. So if it

22 stays up there at that point, we would call that a

23 tachycardic baseline change. But he comes back down

24 within about 4 minutes back down here. His baseline

25 is back in that 150 range.

1 Again, acceleration, acceleration. So
2 these again are more of those reassuring signs. And
3 then, again, if you go to the page, we get more of
4 that.

5 So basically this is while I'm at the
6 bedside doing a physical evaluation. At this point,
7 I've determined that a C-section is not an option for
8 him. I have determined that operative vaginal
9 delivery is not going to help because the head is
10 already at least past the pubic bone.

11 And then so at this point, I'm surmising
12 either a shoulder, which I can't feel, and he didn't
13 show the typical signs of the shoulder.

14 THE WITNESS: You can stop right there.

15 A. where he would track both maternal
16 findings -- not showing that. And what I can feel
17 internally where the shoulder was, it didn't feel
18 like it was there. So that's leading me to believe
19 that, again, his torso must be something. And those
20 heart tones there in that late three o'clock hour
21 were all very reassuring for oxygen status and
22 therefore for acidemia.

23 Q. (By Mr. Perron) Did things change?

24 A. They did.

25 Q. Did he go into Category III?

1 A. He went for a short time in Category III,
2 yes, he did.

3 Q. And what time was that after?

4 A. well, so a couple of things happened.
5 First of all, sarah developed a fever. I think the
6 time -- the first documented fever, I believe, was at
7 1613, I believe.

8 But prior to that, she really truly became
9 tachycardic, not related to acceleration, about just
10 before 4:00, so I want to say maybe about 3:58.
11 That's where she basically had -- was in around 180
12 at that point.

13 Q. So let's talk about Category III.
14 what do the ACOG guidelines tell you about
15 how to manage a baby when that baby is in Category
16 III?

17 A. Right.

18 MR. WILLMAN: And how about if you put up
19 on the screen Exhibit I1, page 7.

20 Q. (By Mr. willman) Okay. So take us
21 through what ACOG says.

22 How do you respond when you get a Category
23 III tracing?

24 A. well, first of all, we know Category III
25 is bad. we know Category III is abnormal. You can't

1 just observe a Category III.

2 Now, what you do in the time and how you
3 do it, there's some pretty stringent guidelines. But
4 ultimately it is either Category III needs to be
5 resolved, or you need to deliver.

6 so it's unlike Category II, in which there
7 are shades of gray there where, hey, Category II is
8 not -- if you hit Category III, you have to make a
9 plan where you're either making it go away, which you
10 can. You can have a baby, for certain reasons, the
11 blood pressure is down. And you can have a Category
12 III that you can get to resolve and go back to
13 Category II. So it's not an absolute II delivery or
14 not resolving.

15 But what ACOG says is you immediately take
16 steps to either try to resolve Category III, or you
17 move immediately towards delivery.

18 Now, the timing on how that delivery
19 occurs, they talk a lot about the 30-minute rule.

20 The 30-minute rule is a little -- has been discussed
21 here before. It's a little ambiguous, meaning they
22 call it the decision to incision. Once you've
23 decided the baby has to come out, you've got to be
24 making your decision to get the baby out within 30
25 minutes.

1 Q. In this case, you weren't making an
2 incision, were you?

3 A. No.

4 Q. But you were able to deliver --

5 A. That's just what they call it, and so,
6 therefore, that 30-minute window is called the
7 decision to incision. More properly called decision
8 to delivery time. But baby out within 30 minutes.

9 Now, that's not a hard and fast rule.
10 Most people try to get it out sooner --

11 Q. We read that rule, didn't we?

12 A. We did.

13 Q. You delivered this baby less than 30
14 minutes from the time the Category III began,
15 correct?

16 A. We did.

17 Q. All right.

18 A. And when trying to determine where
19 Category III started, it's a little tricky because
20 she also became tachycardic.

21 Q. Tell the jury what tachycardia means.

22 A. So tachycardia is just when the heart rate
23 becomes sustained above 180. So not where it goes up
24 for a bit during acceleration and comes back down.
25 But where it stays -- I'm sorry -- above 160. And

1 stays up there.

2 Q. And you believe that was associated with a
3 fever that --

4 A. well, so when you look at what causes
5 tachycardia, several things can: one is hypoxic.
6 One is maternal fever. We see this all the time.

7 Mom gets a fever, mom's heart rate starts to go up,
8 baby's heart rate starts to go up.

9 Now tachycardia in and of itself does not
10 qualify you for category III. what you require for a
11 category III tracing is absent variability with
12 deceleration or what's called sinusoidal patterns,
13 which you rarely see, and we did not see them in this
14 case.

15 so just because she became tachycardic,
16 that's still an abnormal fetal heart rate -- fetal
17 heart rate tracing finding just like decelerations

18 are. But that didn't actually qualify her for
19 category III. She qualified for category III when
20 she developed absent variability, okay?

21 so she started becoming tachycardic in
22 the, just before four o'clock, but she did not
23 develop absent variability -- you can look at the
24 tracing -- she still had minimal, and in some places,
25 moderate variability past 1605, past -- so really

1 1607, is when you see the end of variability. There
2 is about a minute break in the strip.
3 And then beyond that, you really don't see
4 variability. So technically speaking, absent
5 variability, which is what is required to qualify as
6 a Category III tracing, started at approximately 1607
7 and continued until delivery at 1624.

8 Q. Have you, in your experience, successfully
9 delivered vaginally babies who have gone into this
10 Category III?

11 A. Yes.

12 Q. And successfully delivered without any
13 hypoxia or any kind of complications?

14 A. Yes.

15 Q. How often has that occurred?

16 A. Well, I've -- it's hard to put a number on
17 it. I've delivered, you know, more than a handful.
18 I would say probably a couple of dozen over, you
19 know, 25 years that have ended their delivery time in
20 Category III.

21 Q. All right. So you're in a situation of
22 Category III. You now know that you need to deliver
23 the baby.

24 what do you do to get that baby out at
25 4:24 p.m.?

1 A. So, again, I've assessed that forceps
2 aren't going to help, the vacuum is not going to
3 help, and a C-section is not an option. And so what
4 we did at that point is -- I -- she was very swollen,
5 and I had been doing exams, but I felt I needed to
6 fully get my hands in the birth canal to get Remi out
7 because, again, even when I cut the episiotomy out so
8 it's cut to see -- now we can see Remi's nose with
9 this, the traction didn't immediately want to come

10 Now sometimes it could be the shoulder.
11 But I could feel his shoulder was already out, and so
12 I basically had to put my hand in and start pulling
13 him and his torso, just basically unwedging him
14 from -- that includes pulling the whole shoulder, but
15 basically the whole chest and torso area, pulling him
16 out of the birth canal.

17 Q. And you were able to do that successfully?

18 A. Yeah.

19 Q. And you had a vaginal delivery?

20 A. We did.

21 Q. All right. And you say you had to cut an
22 episiotomy.

23 That's an incision in the skin?

24 A. Cut an episiotomy and then extend it into
25 what's called a laceration. So an episiotomy is the

1 tissue you specifically cut. As the baby delivers,
2 the pressure of the delivery can extend that cut
3 further, and that's called a laceration.

4 Q. And the jury heard that there was meconium
5 stain.

6 what is that?

7 A. Yeah. So she had -- I heard Sarah
8 reference this, too. She had what's called terminal
9 meconium which comes out looking almost like -- it
10 doesn't look like human feces, but it looks almost
11 like goose poop you'd see in the park, really dark
12 and tarry-looking fecal matter. And that's
13 meconium. And she saw it kind of on my gown, and
14 that's when she started to worry he had a bowel
15 movement.

16 Sometimes as the baby and the butt comes
17 out, there will be some meconium that comes at that
18 point.

19 Q. Was that an unusual occurrence?

20 A. It's not.

21 Q. All right. Is that an indication that the
22 baby is experiencing hypoxia during delivery?

23 A. Not necessarily a baby is experiencing
24 hypoxia. We see it all the time in normal newborns.
25 We can see meconium earlier. Sometimes you'll have a

1 baby that has a bowel movement much earlier in labor,
2 and you see a lot of meconium stained fluid coming
3 out. When it's right at the end, usually it's just,
4 they pass it at the very end, so maybe they pass it
5 on the table or whatever. His came out at the very
6 end, kind of on my gown, and so it's --

7 Q. What did you do next?

8 A. So we had the NICU team there.

9 Q. Had you asked for the NICU team to be
10 there?

11 A. I had.

12 Q. And the reason for it was for the fever?

13 A. Right. Right.

14 Q. Okay. Go ahead.

15 A. Just the fever, and I just knew he was
16 wedged in there, and he was kind of fighting hard, so
17 I knew we wanted to have the NICU team there. So we
18 called them soon enough, they like a couple minutes'
19 warning so they can get their gear ready.

20 So as soon as we saw the fever, I said,
21 let's get them here now because I think we're going
22 to deliver now. And then between when we called them
23 and they got up there, it was at the end of Category
24 III. But luckily I wanted to have them there so they
25 were set up and had everything they needed and were

1 ready.

2 And as soon as he delivered, I cut the
3 cord and hand him off to the NICU team. They took
4 over for him from there.

5 Q. And you attended to Sarah, is that right?

6 A. And I attended to Sarah.

7 Q. All right. You did write a vaginal
8 delivery note, is that right?

9 A. I did.

10 MR. WILLMAN: Exhibit A2, page 109.

11 Q. (By Mr. willman) Okay. So we're seeing
12 the note here.

13 Now, it says it was filed 5/7/2020.

14 why was it dated on that date and why not
15 5/4?

16 A. Because I wrote it on 5/7. I had no --
17 so --

18 Q. At that time, did you know what -- what
19 the condition of Remi was?

20 A. When I found out I had not written a
21 vag -- I was called and told that the vag -- that
22 Remi was in the NICU -- no, I wasn't called. I asked
23 my partner why was Remi still here. I delivered
24 Remi, and then the next day another partner takes
25 over. So they round, I'm in the office, so I don't

1 necessarily know when my patients are going home and
2 where they are, things like that.

3 But he had delivered on the 4th and
4 typically would go home on the 6th. And I think I
5 pulled up the assessment on the 7th, and saw that --
6 then I saw that Remi was in the NICU, and I had not
7 heard that, and I didn't know he was in there.

8 So I called down to the NICU and talked to
9 the NICU doctor, and I said actually that, Remi Anyan
10 is in there. Can you tell me what's going on?
11 Because I hadn't heard he had been transferred there.

12 Q. And what did you understand was his
13 condition when you --

14 A. I talked to -- I can't remember which
15 pediatrician I talked to, it was one of the females.
16 But she basically said that he had been brought down
17 there for seizures, and he was in the middle of a
18 neurological evaluation. They didn't give me a lot
19 of information at that point. And I said I was going
20 to go down and see him.

21 Q. Did you go down and see him immediately?

22 A. I did. But then she informed, she said,
23 hey, we were wanting to see what's going on
24 clinically, but there's not a delivery note. I said,
25 oh, okay. That's not good. So, you know, then I

1 said, well, then, let me put a delivery note in
2 again.

3 Q. Had you ordered blood gases at the end of
4 delivery?

5 A. No, I did not.

6 Q. Why not?

7 A. well, I think a couple of reasons. I
8 mean, I think Jessie described it as a chaotic or
9 kind of a crazy day, which it was. I was
10 physically -- I think we were all a little
11 discombobulated. Sarah was the most. I was very
12 relieved he was out. And, you know, I don't -- I
13 know they were not sent -- typically we would not
14 send them if they have an Apgar of 7 or above.

15 Q. Did you learn what the Apgar score was
16 with his care?

17 A. I did.

18 Q. And what was it?

19 A. It was 8.

20 Q. So, with that, according to the hospital
21 policy that was in place, it wasn't necessary to get
22 a cord blood gas, correct?

23 A. The routine at that point would be either
24 not to draw them or to discard them, is what most
25 would do in that situation, once a 5-minute Apgar

1 score of 8 has been documented.

2 Q. Okay. So you go up to the NICU and visit
3 with Mr. and Mrs. Anyan, is that right?

4 A. Down to the NICU, yeah.

5 Q. And what was your discussion with them at
6 that time?

7 A. It was a bit tearful. Sarah saw me. She
8 turned around and saw me. She was tearful, but gave
9 me a hug. Said, I'm glad you came down. Said, we
10 were worried about you. And so she had, you know,
11 she's a nurse, Blake's a therapist, I mean, they've
12 been in these situations.

13 They said, we're so glad you came down.
14 We were worried about you. Worried that you may be
15 beating yourself up. And, you know, I had the
16 delivery that I wanted. I want to thank you for your
17 care, basically is what it was.

18 People asked me, different people asked
19 me, why would you go there? And when I start telling
20 that story immediately, I'm like, the Anyans restored
21 my faith in humanity. They were at a dark place, a
22 dark moment.

23 Q. Did you tell them you were sorry?

24 A. I did.

25 Q. Sorry for what?

1 A. Sorry you're here. Sorry you're here.
2 I'm so sorry that Remi's suffering. You guys are now
3 suffering. I said, I don't know what's going on.
4 This is surprising to me. I will see what I can find
5 out. I didn't really want to tell them much,
6 because, A, I didn't know much. And, B, I don't want
7 to start adding in uneducated information to them
8 to, you know, cloud educated information they're
9 going to get from the NICU team.

10 Q. Did you offer your help? Extend to them
11 your help?

12 A. I said to them, I'm going to be checking
13 in on you. If there's anything I can do to help, let
14 me know. I don't know what I could do at that point.

15 Q. Did you continue to see them while Remi
16 was in the --

17 A. I did. I saw them often. There's some
18 days where I'm not in the hospital, I'm off campus.
19 I really tried to communicate when I was on shift
20 because I would have an opportunity to go down there
21 in the NICU. So usually once or twice a week while
22 they were in, I would pop in, and one or both,
23 typically they'd be in there.

24 Q. All right. Final series of questions --
25 opinions. Standard of care. Did it require you, in

your opinion, to deliver Remi at 9:30 a.m., on May 4?

A. No.

Q. why not?

A. Because we still had a reassuring fetal status, we had evidence, in my opinion, that her labor was still effective and producing progress to bring Remi down, and we had a patient who was still motivated to continue laboring.

Q. How about at 3:06 p.m.? could you have done a C-section or an operative vaginal delivery at 3:06 p.m., under the standard of care?

A. No.

Q. why not? Same reasons?

A. Same reasons.

Q. How about that you should have delivered Remi before the Category III change occurred?

A. No.

Q. why not?

A. Because he was not yet in Category III.

Q. And that you should have decreased or discontinued Pitocin.

Did the standard of care require you to do that?

A. No.

Q. Did the standard of care require you to

1 order blood gases?

2 A. No.

3 Q. Dr. McNeive, do you have an opinion,
4 within a reasonable of medical certainty, whether you
5 used that degree of skill and learning that's
6 ordinarily used in the same or similar circumstances
7 by members of your specialty and profession?

8 A. Absolutely.

9 Q. Thank you. That's all I have.

10 THE COURT: Thank you.

11 why don't we go ahead and start

12 cross-examination --

13 Again, I'm so sorry. I'm skipping you

14 again. I apologize. Do you want to go ahead and go

15 now?

16 MS. KAMYKOWSKI: Sure. Thank you.

17 DIRECT EXAMINATION

18 BY MS. KAMYKOWSKI:

19 Q. Good morning, Dr. McNeive.

20 A. Good morning.

21 Q. I want to ask you just a couple of

22 follow-ups about what you told us this morning to

23 make sure we all understand.

24 First, I'm hoping that you might be able

25 to help orient this jury to this team area on labor

1 and delivery where Ms. Anyan was laboring on May 4th,
2 for your shift and for Jessie and Maggie's shift.

3 You said her room number was what number?

4 A. 603.

5 Q. And then you talked about --

6 A. I'm sorry. 6203.

7 Q. And then you talked about a nurses'
8 station.

9 where was her room in relation to the
10 nursing station?

11 A. So she was on the 6th floor, team 1.

12 So she was essentially, her room was just
13 across the hall facing the nursing station about ten
14 doors to the left.

15 Q. And this was in May of 2020, as we know.

16 Today, do you still practice on that same
17 floor?

18 A. I do.

19 Q. It hasn't changed? That room is still
20 there?

21 A. It's still there.

22 Q. You probably see patients there on a
23 regular basis still?

24 A. I do.

25 Q. Okay. The nurses' station, what is the

nurses' station? What's there?

A. So it's a cluster of several long desks that will have lots of computer terminals, with both Epic computer access, but also usually a dual monitor with fetal heart rate strips on it that you can adjust. So usually 5 or six clusters of those scattered around that. And then there will be a central computer monitor strip terminal above that lists all the rooms -- shows the heart tracings of all the rooms assigned.

Q. And how many rooms are assigned to each team?

A. Each team has six, so 5 teams, so a total of 30 labor rooms.

Q. But on --

A. 5: six per team.

Q. Okay. So team 1, where Jessie and Maggie were, though, two on one nurses with Ms. Anyan on May 4th, that team had no more than six patients?

A. Correct.

Q. Okay. And if other patients on that team at that time were not pushing in the second stage, there could be a nurse having two patients, but no more than that at one time?

A. Correct.

1 Q. Okay. So if we had Jessie and Maggie, are
2 two nurses, right? And then that if -- that's one
3 room. We have 5 other rooms to cover. Let's just
4 assume none of them were -- the biggest to smallest,
5 none of them had a pushing patient, that means two
6 nurses for the other -- or three nurses -- two
7 patients, two patients, and one, right?

8 A. Right.

9 Q. Okay. But if each of those six rooms had
10 a complete and pushing patient, you'd have 5 nurses
11 or six nurses, and they'd all be in those rooms,
12 right?

13 A. Right.

14 Q. Okay. But then you're there as a
15 hospitalist that day, on May 4th?

16 A. I was.

17 Q. So you're not only on team 1, but you're
18 covering all --

19 A. I'm all around labor and delivery.

20 Q. Okay. So you said that there are monitors
21 for them to put in their electronic medical records,
22 right?

23 A. Correct.

24 Q. At their nurses' station. And also they
25 can use a strip for an individual room or all six

1 teams at the same time?

2 A. They can adjust it to however many screens
3 they want.

4 Q. And then on the wall, kind of like if
5 you're in a sports bar, there's bigger monitors that
6 are at that station that will show every laboring
7 patient at that time?

8 A. On that team.

9 Q. On that team for up to six patients.

10 A. Right.

11 Q. So Sarah Anyan's strips were available at
12 that nurses' station for any nurse, any resident, any
13 other providers who happened to be there, correct?

14 A. Yes.

15 Q. Okay. And what, since you worked there
16 how many years now, have you been working at Mercy as
17 an obstetrician?

18 A. This will be 24 years.

19 Q. Okay. So in those 24 years, tell me just
20 kind of how does this work? what's going on in the
21 day? Let's talk about specifically in your
22 hospitalist role. I know you don't have that role
23 anymore.

24 But in your hospitalist role, what are
25 people doing? what are the nurses doing at the time

1 of Sarah's delivery? we know we had a midwife on
2 staff. You had some residents that were first years
3 like Dr. Miller, who we heard from yesterday, intern
4 first year, second-year residents, third-year
5 residents, fourth-year residents.

6 Tell me what's going on. what's going on
7 with the staffing of the labor and delivery
8 department?

9 A. So basically what's going on, as you start
10 7:00 a.m., you'll have a host of typically scheduled
11 C-sections. So the 7th floor will have a pre and
12 postop area. And then it will have 5 delivery --
13 operating rooms for C-sections, and then there's one
14 up on the sixth for emergency responses --

15 Q. I'm sorry. I don't want to interrupt you,
16 but let's just stick with on the 6th floor labor and
17 delivery.

18 who's around?

19 A. Right. So there will be -- there's three
20 teams on 6. So one or all of them may be partially
21 or fully occupied. So you could have a total of 18
22 patients on the sixth, and they would have the same
23 type of nursing accompaniment.

24 And then you're going to have a mixture of
25 different charge nurses that are basically traveling

1 from team to team, evaluating staffing, evaluating
2 room needs and usage, maybe spelling a nurse so she
3 can go on break or go to the restroom or something
4 like that. we'll have some of the nursing management
5 and administrative staff percolating through.

6 we'll have housekeeping coming through.
7 we'll have techs, we'll have techs getting rooms
8 ready or doing other things on the floor.

9 you'll have the residents floating around
10 doing lots of different roles on 6 and 7 and other
11 places. And then you'll have lots of attendings.
12 Attendings are there to deliver their patients or
13 getting ready to do a C-section on their patients, or
14 there will be different OB attendings scattered among
15 the teams, as well.

16 Q. Do people hang out at the nurses'
17 stations?

18 A. well, I mean, there are people at the
19 nursing stations. so people, you know, if your
20 patient is pushing, you're there holding a leg or in
21 the room, if you're very active with your patient.

22 If your patient is recovering. If they've
23 had their baby, and they're going to go out in the
24 next couple of hours, or if you're in the first stage
25 of labor and not much happening, the nurses will be

1 at the bedsides for some time, and then they'll come
2 out charting. And then they'll catch up this order.
3 So I don't know if that's what you call "hanging
4 out," but there will be groupings of people there
5 coming and going throughout the day.

6 Q. It's a space where nurses who aren't at
7 the bedside who are on labor and delivery to do their
8 work, right?

9 A. Right.

10 Q. Okay. And then we heard from Dr. Miller
11 yesterday about her as the role of the intern.

12 where does she fit when she's managing?
13 she kept talking about the handoff and what her role
14 is to kind of monitor all of these patients who are
15 labor and delivery. where is she?

16 A. well, so she could be in a variety of
17 places. She could be on one of the teams working
18 there. The residents have their own work area, which
19 is right across the sky bridge from labor and
20 delivery, which is where they have their call rooms,
21 and they have a large work area where they can
22 collect and do work there. But it's about 50 feet
23 over the sky bridge from labor and delivery --

24 Q. And in there, are there monitors that have
25 fetal monitor tracings for the women who are in

1 labor?

2 A. They are, yeah.

3 Q. And they can watch them from there?

4 A. They will often watch them and call that
5 team and tell that nurse, hey, what's going on in
6 Room 2 with those contractions? So there's a lot of
7 interaction.

8 Q. Okay. And we talked about the safety
9 rounds and the strip reviews. I want to talk just
10 specifically.

11 Do you remember the safety round on May
12 4th, 2020?

13 A. No.

14 Q. That's something that you as an OB
15 hospitalist at that time participated every time you
16 were on the shift?

17 A. Four times a shift for 15 years, so I'd
18 say Sarah's -- my interactions with Sarah, obviously
19 gets sort of burned in your brain for the rest of the
20 day. I didn't even remember who those three other
21 deliveries were that I had done until I looked it up.

22 Q. And the safety rounds, the information
23 that is imparted at those that goes to that team that
24 goes around, it would include things like if they're
25 a first-time mom? If they have an epidural?

A. Uh-huh, yes.

Q. Where they are in their labor?

A. A brief summary of their labor, yeah.

Q. And so is it fair to say that on May 4th, 2020, when you participated in those safety rounds, the discussion of how long Sarah had been in that second stage would have been part of that team?

MS. GUNN: Objection, Your Honor. That question is speculative. He's indicated he doesn't have a recollection.

THE COURT: Sustained as to speculation.

Q. (By Ms. Kamykowski) Typically, in your experience, over 15 years working as a hospitalist at Mercy in labor and delivery, participating in strip rounds -- safety rounds -- I'm sorry -- safety rounds, what would be the level of detail as far as the individual patient that you're reviewing at any given time?

A. Anything that stood out from the norm about the patient or about the labor typically was discussed.

Q. Length of the second stage, would that have met the norm?

A. Frequently. Boy, she had been pushing a long time. You know, things like that.

1 Q. And it's not something that would be
2 whispered. It would be discussed amongst that team,
3 correct?

4 A. Correct. Because you're typically
5 discussing what's -- what is in our journey to hear
6 and what's the plan of care, and then the change of
7 plan of care needs to be addressed.

8 Q. Prior to May 4th of 2020, had you worked
9 with Jessie -- she was Brown then and Wagner by the
10 time she was deposed -- before?

11 A. I had.

12 Q. How many times?

13 A. She had been there 3 years at this point.
14 I mean, I might go a week or two without working with
15 her. And then on a shift over the course of a week,
16 I might see her two or three deliveries. I knew her
17 well. I knew her well enough to know I felt she was
18 a very keen nurse, very skilled. And nurses are
19 different. Some have been there for a long time, and
20 they don't ever get it. And some, they're there for
21 a short time, and they get it. And she definitely,
22 she was keen, and she was sharp.

23 Q. And she that day, as we heard already, was
24 recepting or orienting with Maggie.

25 Had you ever worked with Maggie before,

1 that you're aware of?

2 A. I had because I worked with Jessie, so she
3 would have been basically her orientee. So every
4 time I worked with Jessie, I worked with Maggie.

5 Q. And I heard you talk just a little bit the
6 communications that you would have. And I think we
7 heard yesterday from Jessie. She doesn't believe
8 that Maggie had any direct communications with you
9 about Sarah. They were mostly from Jessie at the
10 nurses' station throughout the day because she was
11 trying to make sure Maggie was getting -- she was in
12 the last month of her orientation or her fellowship
13 period, her training period, letting her kind of
14 manage Sarah on her own in speaking with you.

15 Do you have any specific recall, as you
16 sit here today, about how many times that you
17 communicated with Jessie, outside of the room about
18 Sarah Anyan?

19 A. With Jessie?

20 Q. Yeah.

21 A. In a typical situation, it would be
22 obviously every time I was in the room. And then I
23 was, again, around those calls, I would be
24 interacting with her on safety rounds. And then I'm
25 around basically those several teams all day.

1 so anytime that she was at the nursing
2 station, there would just be a brief comment of how
3 is she feeling? Observe her for second. When was
4 the last time you checked her? what kind of progress
5 are we making? You know, she didn't, you know, she
6 would check her in different ways. we do checks, you
7 can just kind of watch. So she can watch her while
8 she's pushing. She could see the pelvis kind of
9 bulge up and start with the next one. She can see
10 the signs of when the baby is getting low. So I
11 would ask her, are you starting to see that sign?
12 And all that. So I can't give you an exact number.

13 Q. And I do want to ask you of the watching
14 of the progress, right?

15 You were here last week when Nurse Shinn
16 testified, were you not? You've been here every day.

17 A. Yes.

18 Q. And do you recall, she said, there's no
19 way you can just visualize progress, you have to put
20 your hands in the vagina, and you have to feel
21 progress.

22 Is that accurate, based on your experience
23 as an obstetrician?

24 A. Yeah, I recall her saying that. There are
25 ways to visualize. Now, in some situations, if --

1 you don't have to have the crowning, but if there's
2 enough separation that the labia are separated, you
3 can see the head moving.

4 But even if the labia are not separated,
5 and the baby is not low enough yet to kind of force
6 that pressure open, typically, as she's pushing, you
7 can see the perineal body, so the head is coming down
8 here. And as she's pushing, externally you can see
9 that perineal body, that area around the anus and
10 sphincter start to flare. And you can see that kind
11 of bulge start to develop as the baby is getting
12 lower. It's something you can clearly evaluate.

13 Q. And that's something that you would expect
14 a labor and delivery nurse, like Maggie and Jessie,
15 to also understand as a way to visualize progress?

16 A. I don't know about Maggie at that point as
17 an orientee. But Jessie definitely.

18 Q. And then we heard Jessie yesterday also
19 talk about her recall that Sarah, as she related to
20 lots of her experience for first-time moms, as two
21 steps forward, one step back when she was pushing.

22 Do you remember hearing that?

23 A. Uh-huh.

24 Q. Does that sound familiar to you as part of
25 this process?

1 A. It is. Especially for a first-time mom.
2 Especially for a baby that ultimately is a tight fit.
3 You know, her progress was gradual. It was slow.
4 And it was, again, just this trying to find a good
5 way. We ultimately did. But it's not unusual where
6 you see where it comes down, and it goes back a
7 little bit. But eventually it comes down and pulls
8 back a little bit less. So that sort of
9 back-and-forth progress is very typical.

10 Q. And Mr. Willman showed you the ACOG
11 guideline that talks about progress, right? How you
12 were asked, I think, with Sarah, anything defining
13 the maximum limit of the second stage.

14 And then you walked us through with
15 highlights with I think some stars on it.

16 A. Uh-huh.

17 Q. Where it said as long as, you know, in
18 some circumstances, for example, and it used the
19 fetal malposition, which we had in this case,
20 correct?

21 A. Correct.

22 Q. You can push longer. And it says, as long
23 as there's documented progress, right?

24 A. Correct.

25 Q. I suspect we're going to hear that

1 documented means you had to put it in the medical
2 record.

3 Is that how you interpret that ACOG
4 guideline?

5 MS. GUNN: I'm going to object, Your
6 Honor, this is a new opinion. There's been no
7 discussion of this up to this point. It's a new
8 opinion.

9 MS. KAMYKOWSKI: But, Your Honor, I'm
10 asking him about how he interprets the literature
11 that has been in this case without objection
12 throughout this trial.

13 THE COURT: The court is going to overrule
14 the objection.

15 You may answer the question.

16 A. So documentation in realtime on labor and
17 delivery, I don't know, maybe some people are
18 hypervigilant about writing it.

19 But documentation is, we document in
20 realtime about conversations. I document with my
21 eyes. I document with him fingertips. You know,
22 writing it down doesn't help me. I'm documenting in
23 that I'm seeing it, I'm noting it, and I'm logging it
24 away.

25 And so in our conversations, all of those

1 things, in my opinion, constitute documentation
2 without actually physically entering a note in a
3 computer.

4 Q. (By Ms. Kamykowski) And it's your
5 testimony here today that your recall of the second
6 stage of labor for Sarah Anyan, so the number of
7 times that you were in there evaluating her checking
8 her progress, that she did make slow progress?

9 Is that your testimony?

10 A. Absolutely.

11 Q. And we know that because she delivered a
12 baby vaginally at 4:24, correct?

13 A. Yeah, ultimately, yes.

14 Q. And whether or not -- and I know the last
15 documented station in the chart was from Dr. McKillip
16 at zero station around 6:00 or 6:30, correct? And
17 there's nothing documented about her station after
18 that, correct?

19 A. Right.

20 Q. But is station the only way to document
21 progress?

22 A. No. And I discussed it before. There's
23 lots of things that qualify as progress. Progress is
24 anything that is improving our picture of the baby
25 making its way towards delivery. That can be

1 rotational. It can be stretching of the tissues. It
2 can be the head getting into a more crowned shaped.
3 It can be vertical progress down the birth canal.

4 So there are a whole host of things that
5 constitute progress. And, you know, that's part of
6 the benefit for doing it for a long time, is you can
7 see that. Progress, everyone has certain types of
8 progress they want to see. Every time I see a mom in
9 her final month, she wants to be dilated 36 weeks, 37
10 weeks, 38 weeks. Oh, I'm not dilated. No, but
11 you're making progress. It starting spinning, the
12 baby is getting low, your lower uterine segment is
13 starting to soften and develop. Who cares if you're
14 not dilated yet. So progress is not just linear.
15 It's in lots of different ways.

16 And when you look at how we're progressing
17 on labor and delivery, is this baby getting in a
18 better situation to continue that journey through
19 birth?

20 Q. And we've seen Ms. Gunn's tape measure.

21 A. Yes.

22 Q. 10 centimeters is, I think, from minus 3
23 to plus 3, and 5 centimeters is from zero to 10.
24 That's a linear measurement that she's showing to try
25 to talk about progress in this case?

1 A. Yes. Yes.

2 Q. Is that a fair analogy for, in your
3 experience, as a labor and delivery -- an
4 obstetrician for 25 years almost?

5 A. Well, it's not -- it's not -- it's not a
6 way in people that manage pregnant patients would
7 rigidly look at what constitutes progress. If you
8 look at a diagram, it says negative 3 to plus 3. And
9 that helps people, I guess, visualize better where we
10 need to start and where we need to get to.

11 But how you make your way from high up to
12 down low, is not a, again, it's not like an elevator
13 coming down, you know, 5 floors at a particular time.
14 It is lots of different things. And that's why a lot
15 of, you know, labors get managed maybe by people who
16 don't necessarily understand what true progress is
17 and what it isn't.

18 MS. KAMYKOWSKI: Justin, can you pull --

19 Q. (By Ms. Kamykowski) well, let me ask you.
20 I want to talk about Pitocin for just a second.

21 A. Okay.

22 Q. Again, you were here when Nurse Shinn
23 testified, and I wrote down that she said, most
24 patients don't need more than 6 microunits of Pitocin
25 for an induction of labor to have it assist them with

1 a vaginal birth.

2 Do you remember that testimony?

3 A. I do.

4 Q. And do you -- have you ever seen any
5 literature that would support her statement that most
6 patients are, the average amount of Pitocin used to
7 augment or to induce the labor, is 6 milliunits of
8 the drug or less?

9 A. I've not seen the literature. I mean, the
10 problem is in that statement is you're comparing lots
11 of apples and oranges, right? If you've had three
12 kids, and you're coming in, and your water's broke,
13 and you're starting to contract some, you might take
14 1 milliunit of Pitocin, and that's all you need.

15 So augmenting, inducing, is this your
16 first kid? Your eighth kid? That's such an apples
17 and oranges comparison. I mean, I have lots of
18 patients come in. They break their water, they never
19 need a drop of Pitocin. I have patients that have
20 sat on Pitocin, 20 milliunits of Pitocin, for
21 36 hours. It depends on what their body needs and
22 what is indicative at that time.

23 So it's such a wide variety. I don't know
24 where the number 6 comes from, I have not seen that
25 in literature. Maybe they're -- maybe someone did a

1 study, but you have to really be comparing a
2 particular subset of the same type of patients.

3 Q. Completely variable patient to patient,
4 right?

5 A. It is.

6 Q. I want to walk through something quickly.

7 MS. KAMYKOWSKI: Can you pull up E6-C,
8 please.

9 Q. (By Ms. Kamykowski) Do you remember this
10 algorithm that we had with Dr. warsof?

11 A. I do.

12 Q. Okay. And do you remember Dr. warsof --

13 MS. GUNN: Your Honor, may we approach?

14 THE COURT: You may.

15 (Proceedings were held at sidebar, outside
16 the hearing of the jury.)

17 MS. GUNN: Your Honor, I just -- this is a
18 new opinion from this witness. I know he's been
19 sitting in this courtroom, and this is his
20 opportunity to plug in his skill set. But for
21 counsel to think or indicate, that he never, in this
22 case, this witness never worked the Clark algorithm
23 during his deposition.

24 He brought an article that was a Clark
25 article. But he never worked the Clark algorithm in

1 his deposition. He hasn't worked it up to this
2 point. And I object to the extent that it is a new
3 opinion, and it's a specific comment on Dr. warsof's
4 opinion, which is also improper.

5 MS. KAMYKOWSKI: So I'm not going to have
6 him comment on Dr. warsof's opinion. He did
7 absolutely bring us a whole article, that we talked
8 about with Dr. warsof, to his deposition. The fact
9 that she chose not to ask about it, does not preclude
10 him from talking about literature that he brought
11 with him at the time. That's what discovery is for.

12 Since then, however, he also is a
13 disclosed nonexpert witness in this case. He has sat
14 in this trial and listened to additional information.
15 All I am going to ask him to do is how to work an
16 algorithm.

17 And I'm using this example because, as the
18 court recalls, Dr. warsof made up the huge choose
19 your own adventure with this algorithm on the stand.

20 Dr. McNeive has testified on direct
21 examination already that at no time does he believe
22 that the strips, the contraction pattern or anything
23 else, the fetal heart rate monitoring, fetal heart
24 rate tracings, requires any action sooner. So he has
25 in effect worked this algorithm, just not the way

1 that Ms. Gunn thinks he should have.

2 MR. WILLMAN: And I would just note for
3 the record that I identified Dr. McNeive as a
4 nonretained opinions expert before his deposition.

5 So there was certainly notification that he'd be
6 giving opinions. And I think as a codefendant, she
7 is limited to opinions that were voiced in his
8 deposition.

9 MS. KAMYKOWSKI: Yeah. Thank you. I
10 agree with that.

11 MS. GUNN: Your Honor, I specifically
12 asked every witness, including this one, have you
13 given me all your opinions, and have you had every
14 opportunity to discuss every opinion and the basis of
15 your opinion?

16 Yes.

17 He brought the Clark algorithm article,
18 the entire article. He never worked it. He didn't
19 discuss it. Ms. Kamykowski or someone from her
20 office was there. If she wanted to ask questions of
21 this witness to get it on the record so it's not a
22 new opinion at trial, she also certainly had an
23 opportunity to do that. I'm simply objecting that it
24 is a new opinion at this late time.

25 MS. KAMYKOWSKI: I would actually think

1 it's not actually a new opinion. His opinion is his
2 opinion. That at no time does the fetal monitoring
3 tracing or anything about this labor pattern require
4 him to do anything different than they did, which was
5 proceed to a vaginal delivery.

6 This would just be an expansion of that
7 opinion, if the court's considering that to be an
8 opinion at all, to then now say, yes, and this
9 article supports my opinion. It's just a reasonable
10 expansion of his prior opinion. It's not a new
11 opinion.

12 THE COURT: I think we are beating a dead
13 horse. And I think the jury is very tired of beating
14 the dead horse. But I'm going to allow you to beat
15 the dead horse because that's what you guys like to
16 do.

17 So I'm going to overrule the objection.

18 MS. GUNN: Thank you, Judge.

19 (Proceedings returned to open court.)

20 MS. KAMYKOWSKI: Justin, you can put that
21 exhibit down.

22 Q. (By Ms. Kamykowski) Doctor, your opinion
23 in this case is that, based on the totality of the
24 circumstances throughout the time that you were
25 caring for Sarah after you came on your shift at 8:00

1 a.m. -- 7:00 a.m., on May 4th, that taking everything
2 into the clinical context, it's not just the fetal
3 heart strips. It's not just the contraction
4 patterns. But everything that was happening in that
5 room, that it was okay, as long as there was a safety
6 for the baby, safety for the mom, and everybody was
7 on the same page to go forward.

8 That's your opinion, correct?

9 A. Correct.

10 Q. Okay. And when we look at this algorithm,
11 you saw -- we talked about Nurse Shinn, and we talked
12 about Mr. -- or Dr. Warsof.

13 Is it your opinion that moderate
14 variability existed throughout this strip until the
15 time frame after four o'clock that we talked about on
16 direct?

17 A. Yes. Yes, ma'am. It was not continuous
18 moderate. There were episodes of moderate
19 variability throughout the day.

20 Q. Okay. And I think you told us lots of
21 position changes are happening from my nurses,
22 correct?

23 A. Correct.

24 Q. And those position changes, based on your
25 review of the strips, at the time, and in retrospect

1 in the context of this lawsuit, did they have an
2 impact on the fetal heart rate tracings that we've
3 seen here?

4 A. They did.

5 Q. Positive or negative?

6 A. Generally positive. I mean, not every
7 positioning change is going to affect the same thing.
8 But, in general, Remi would always return to a more
9 favorable situation.

10 Q. Taken outside of the context of the facts
11 in this case, the algorithm, if you have moderate
12 variability, and you go to the next step of whether
13 you have significant decelerations with greater than
14 or equal to 50 percent of contractions for an hour,
15 if the answer is no, what does the algorithm tell us
16 to do?

17 A. It tells us to observe.

18 Q. Okay. Does it then, if you have -- does
19 it in any way, shape, or form allow you to backwards
20 go from observe, yes, to normal progress, second
21 stage, or observe to yes to no, to the circled part
22 of cesarean or operative vaginal delivery?

23 Is that how algorithms work?

24 A. No.

25 Q. What is the significance, Dr. McNeive, of

1 the fact that over -- until the last half an hour
2 before Remi was born, his fetal heart rate patterns
3 had always had moderate beat-to-beat variability?

4 what's the significance of that?

5 A. Moderate variability is one of the
6 findings that gives you an extremely high level of
7 confidence that there is no hypoxia, and that there
8 is no acidemia.

9 Q. And how about fetal heart rate
10 accelerations?

11 The jury also heard, and Dr. warsof
12 agreed, that in the minutes leading up to, I think it
13 was, 1348, at the end of that strip, he pointed out a
14 single page of four accelerations.

15 what is that telling us at that time if
16 that strip is ending at 3:48 -- sorry -- at 1548 --
17 at 3:48 p.m.?

18 A. Again, accelerations, like moderate
19 variability, are in that category of reassuring
20 findings that have a very high correlation with
21 normal oxygen levels.

22 Q. Thank you, Dr. McNeive. That's all I
23 have.

24 A. Thank you.

25 THE COURT: All right. Ladies and

1 gentlemen, this is a good time for us to take our
2 lunch recess.

3 (A break was taken at 12:19 p.m., and the
4 jury was duly admonished. At 1:31 p.m., the
5 following proceedings were held in open court, in the
6 presence of the jury:)

7 THE COURT: Go ahead and be seated,
8 everyone.

9 Cross-examination?

10 MS. GUNN: Yes, Your Honor.

11 May it please the Court?

12 CROSS-EXAMINATION

13 BY MS. GUNN:

14 Q. Good afternoon, Dr. McNeive.

15 A. Good afternoon.

16 Q. You made it a point to tell this jury on
17 your direct exam that you've never been sued before.

18 But let's be clear, you also have never allowed a
19 woman to go 12 hours in the second stage of labor, is
20 that correct?

21 A. That's correct.

22 Q. Now, you talked about ACOG guidelines.
23 And I think I heard you say that ACOG's guidelines
24 had set the standard of care.

25 But you're familiar of course with the

1 disclaimer that's all over the ACOG guidelines where
2 they say specifically this isn't the legal standard
3 of care, correct?

4 A. well, they state there is -- it is a set
5 of guidance, but does not necessarily always -- I
6 don't know -- I didn't read anything about legal
7 standard of care, but where it doesn't necessarily
8 set all guidance for all situations.

9 Q. Right. And we know that in this court,
10 the judge is going to tell us what the standard of
11 care is. And we've all heard it over the last couple
12 of weeks: that degree of skill and learning
13 ordinarily used in the same or similar circumstances
14 as defendants in your profession, correct?

15 A. Correct.

16 Q. You accept that as the standard of care
17 that applies in this courtroom?

18 A. Yes.

19 Q. So let's talk about the circumstances.

20 You have never had a woman go 12 hours in
21 the second stage of labor, correct?

22 A. Correct.

23 Q. And that is after 3,000 deliveries, give
24 or take?

25 A. Approximately.

1 Q. And I think you told me in your deposition
2 that you had one other patient who had gone somewhere
3 between 6 and 8 hours, correct?

4 A. She pushed for approximately 7 hours.

5 Q. Okay. So 7 hours. And other than another
6 case where a woman had been pushing at home with a
7 doula, those were the only two cases that you could
8 give me that you'd ever had any, any of the 3,000 or
9 so deliveries of a woman go over 7 hours, correct?

10 A. Correct.

11 Q. So Sarah is not just an outlier, but she's
12 over your record, correct?

13 A. She was the longest patient I had had in
14 the second stage of labor.

15 Q. And with respect to the other gal, other
16 lady with the 7 hours, she never got to Category III
17 strips, correct?

18 A. I don't recall if she ever had, no.

19 Q. If you told me at deposition that she
20 didn't get to that Category III, does that help?

21 A. Then that's correct, yes.

22 Q. Okay. Now, we know that late decels are a
23 potential sign for acidosis in the baby, correct?

24 A. Correct.

25 Q. And we know that variable decels can also

1 receive blood flow to the baby and be a sign of
2 hypoxia or acidemia, correct?

3 A. Theoretically, correct, yes.

4 Q. All right. So let's talk about prolonged
5 second stage of labor.

6 we've seen this --

7 MS. GUNN: Let's pull up Exhibit 145-8.

8 And that would be page 11.

9 Q. (By Ms. Gunn) And, Doctor, Mr. Willman
10 showed you this. It's part of the Obstetric Care
11 Consensus No. 1, from March of 2014.

12 And you brought this to your deposition,
13 didn't you?

14 A. I did.

15 Q. And let's go to the star.
16 That's your star, correct?

17 A. That is my star.

18 Q. So what I have done -- there's lots of
19 copies of this floating around -- but what I've done
20 and marked as Exhibit 145-8, is what you brought to
21 the deposition, and you marked.

22 Can you accept that?

23 A. Okay.

24 Q. Do you remember that?

25 A. I do remember that, yes.

1 Q. Okay. So second stage of labor, and we
2 talked about before diagnosing arrest of labor in the
3 second stage, as the maternal and fetal condition
4 permit, allow for the following.

5 And we'll to the second one because that's
6 Sarah, first-time mom. At least 3 hours of pushing
7 in -- I can't say it -- nulliparous?

8 A. Nulliparous.

9 Q. -- nulliparous -- thank you -- women.
10 Okay. So we know that's her.

11 A. Yes.

12 Q. And then longer durations may be
13 appropriate on an individualized basis such as the
14 use of epidural analgesia or a fetal malposition --
15 which is what Remi had, right?

16 A. Correct.

17 Q. -- as long as progress is being
18 documented.

19 Do you agree with that?

20 A. I do.

21 Q. This is an ACOG document, correct?

22 A. I do.

23 Q. So I know you told us, when you were
24 talking to Ms. Kamykowski, that you don't have to
25 actually write things down to document with your eyes

1 or your fingers, right?

2 A. Uh-huh.

3 Q. But I just want to be clear, when we're
4 talking about a patient's medical record, the
5 official medical record of Sarah Anyan, despite what
6 you may have seen with your eyes or felt with your
7 fingers does not include any documentation after
8 6:00 a.m., when Dr. Mckillip did it, with respect to
9 Remi's station or position, correct?

10 A. You're asking me if her medical record
11 shows that documentation?

12 Q. Correct.

13 A. No, it does not.

14 Q. All right. So just so we're clear,
15 there's nothing anybody could go back and look at
16 when they were treating Sarah, perhaps if you weren't
17 available, or going back now to treat Sarah, to
18 determine anything that you were talking about with
19 respect to going in, talking to Jessie or Maggie,
20 checking Sarah, none of that exists, and none of that
21 is documented, correct?

22 A. Other than talking to me, no, there would
23 not be any evidence.

24 Q. So progress was not being documented,
25 correct?

1 A. I was documenting it. It was not being
2 written down.

3 Q. That's -- well, let's say documentation is
4 being written down.

5 Progress was not being documented in her
6 chart, correct?

7 A. It was not being written in her chart,
8 correct.

9 Q. Now, so from what I can understand from
10 your testimony and what I've done, progress is the
11 key, right?

12 A. That's definitely one of the keys,
13 absolutely.

14 Q. So when you're in a prolonged second stage
15 of labor, which -- which is defined, as we all know
16 at this point, prolonged means anything after the
17 4-hour mark -- well, let's come back to that for a
18 second.

19 MS. GUNN: Let's go to page, I believe
20 we're on page 8 of 147 -- sorry -- 145-8. So same
21 document, Zack, page 7.

22 Q. (By Ms. Gunn) So, again, this is your
23 copy, Doctor. And I want to talk about arrest of
24 labor.

25 And what is arrest of labor?

1 A. Arrest of labor is a labor that is no
2 longer making progress.

3 Q. Okay. Arrest of labor and progress are
4 used pretty much together, correct?

5 A. Very frequently, yes.

6 Q. Okay. So this ACOG consensus indicates
7 that: Arrest of labor, an abnormal or indeterminate
8 fetal heart rate tracings account for more than half
9 of all primary cesarean deliveries in the studied
10 population, correct?

11 A. Yes.

12 Q. So what does this tell, then? ACOG is
13 telling us they've done all this literature, and what
14 they've determined is that half of the reasons why
15 women have C-sections is based on arrest of labor for
16 failure to make progress, correct?

17 A. That's only part of that statement,
18 though.

19 Q. Well, with the abnormal or indeterminate
20 fetal heart tracings, correct?

21 A. Yeah. But they've underlined more than
22 that, there's context.

23 Q. We'll get there, I promise.

24 So I'm just asking you that ACOG indicates
25 that half of the C-sections that get done are because

of arrest of labor or failure to make progress with
Cat II or Cat III tracings, correct?

A. It doesn't say Cat II or III. It says
abnormal fetal heart tracings.

Q. Well, wouldn't abnormal be Cat III?

A. Abnormal would be Cat III.

Q. And indeterminate is Cat II?

A. Indeterminate is Cat II, yeah. You could
have Cat I and have a tachycardia, though, or --

Q. Understood.

A. Yes.

Q. I understand.

A. Okay. I -- yes, that's correct.

Q. All right. So, now if we go to
Exhibit 145-16, it's another document that you
brought to your deposition. And, Doctor, 145-16 is
from UpToDate.

And what is UpToDate?

A. UpToDate's a data aggregate for medicine.
So it's almost kind of like a wikipedia for medicine.

Q. And you rely on this, correct?

A. I don't rely on it. It's a quick place to
go to find links to different topics and subjects.

Q. And this particular document, you brought
to the deposition, correct?

1 A. Yes.

2 Q. And it's called "Labor: Diagnosis and
3 Management of a Prolonged Second Stage."

4 MS. GUNN: And let's go to page 4 of 16.

5 Q. (By Ms. Gunn) So, Doctor, let's go to the
6 bottom. And this red marking, that is your -- that's
7 your ink, correct? So you studied this before you
8 came to your deposition, and then you brought it,
9 correct?

10 A. Correct.

11 Q. So this incidence and prognosis -- and,
12 again, let me just back up.

13 This is the diagnosis and management of
14 prolonged second stage -- so we're talking about
15 Sarah Anyan. She is prolonged second stage starting
16 at eight o'clock, correct?

17 A. Correct.

18 Q. All right. So this is Sarah Anyan. Official Cou
19 In a retrospective study, including over
20 15,000 first-time moms, cephalic singleton births
21 from 1976 to 2001, in which 56 percent of the entire
22 cohort had epidural anesthesia, the frequency of
23 patients giving birth during each hour of the second
24 stage of labor was as follows.

25 So this is a study explaining how often

1 women give birth within the normal or standard time
2 frame. And it tells us that 76 -- excuse me -- 46
3 percent of women give birth, first-time moms, give
4 birth between zero and 1 hour, correct?

5 A. Correct.

6 Q. And then another 23 percent give birth
7 between hours 1 and 2, correct?

8 A. Correct.

9 Q. So we're now at 69 percent of women give
10 birth in the first 2 hours of the second stage of
11 labor?

12 A. Right.

13 Q. And then it goes on to say another
14 14 percent deliver by third hour.

15 So now we're up to 83?

16 A. Uh-huh.

17 Q. And by the fourth hour, we're at
18 93 percent of women give birth within 4 hours,
19 correct?

20 A. Absolutely.

21 Q. So that is something that you knew, as of
22 May 4th, 2020, that 93 percent of first-time moms
23 give birth before 4 hours, correct?

24 A. That's why it's prolonged, absolutely.

25 Q. So then what we have, in addition -- oh,

1 by the way, you define progress as fetal descent with
2 maternal contraction and pushing, correct?

3 A. That's one aspect of progress.

4 Q. when I asked you to define progress in
5 your deposition, that's what you told me: fetal
6 descent with maternal contraction and pushing.

7 Do you remember that?

8 A. If you say that's what I said, yes.

9 Q. okay. well, it is. It's on page 61.

10 A. I'll believe you.

11 Q. Thank you. All right. So, again,
12 progress is the key.

13 A. uh-huh.

14 Q. so talking about arrest of descent and
15 progress.

16 MS. GUNN: Let's look at Exhibit 145-16.

17 Q. (By Ms. Gunn) Oh, same one. So we're --
18 this is the diagnosis and management of prolonged
19 second stage.

20 MS. GUNN: Now, let's go to page 5 under
21 "management."

22 Q. (By Ms. Gunn) Patient with adequate
23 descent and/or rotation. So this is the second
24 stage. If descent is adequate -- so let's define
25 descent.

1 According to this document, descent is --
2 or adequate descent is greater than 1 centimeter over
3 60 to 90 minutes.

4 Do you see that?

5 A. I see that.

6 Q. Greater than 1 centimeter over an hour,
7 that would be considered descent, correct?

8 A. That's one of two things that would be
9 considered adequate.

10 Q. I know you want to talk about rotation,
11 and we're going to get there, I promise.

12 A. Thank you.

13 Q. So we've got Dr. Landon, who everybody
14 will hear from tomorrow, the OB who testified on your
15 behalf defined descent, adequate descent, as 1
16 centimeter an hour.

17 This document is between an hour and an
18 hour and a half, but, nevertheless, there is a way to
19 document descent, correct?

20 A. There are several ways to document
21 descent.

22 Q. Right. And one is the elevator shaft that
23 we talked about.

24 That is one way to document descent,
25 correct?

1 A. That's not necessarily how I would explain
2 it. I mean, ultimately how you get to that, down
3 that elevator shaft, is part of progress and part of
4 descent. That's what I was trying to explain this
5 morning.

6 Q. And I think that this paragraph goes on
7 with that, right? So if descent is adequate, greater
8 than a centimeter an hour to an hour and a half,
9 and/or rotation from a non occiput anterior position
10 to OA occurs or is occurring --

11 A. Uh-huh.

12 Q. -- then we continue supportive care as
13 long as the fetal heart rate pattern does not
14 necessitate expeditious delivery.

15 so let's figure that out, right? So if
16 you have a baby that is coming down adequately
17 defined as greater than 1 centimeter an hour, an hour
18 and a half, and/or the rotation from a non-OA to an
19 OA is happening --

20 A. Correct.

21 Q. -- then you're good.

22 A. Yes.

23 Q. Okay. Now, let's talk about patients with
24 inadequate descent.

25 If descent is minimal, less than a

centimeter an hour, less than a centimeter an hour
and a half, then the probable cause should be
ascertain and treatment initiated.

Do you agree with that statement?

A. Patients with inadequate descent or
rotation, is that what you're -- I see two things are
blown up there.

Q. If descent is minimal, less than a
centimeter, less than a centimeter an hour, or an
hour and a half.

A. Actually, are you talking about inadequate
vertical descent?

Q. Then the probable cause should be
ascertained and treatment initiated.

Possible causes include hypo
contractibility, that would be inadequate
contractions, right?

A. Right.

Q. Or physical issues, right? Is that what
that says?

A. It is.

Q. Okay. So those are ways that we need to
figure out why we're having minimal descent.
Because, again, progress is the key to continuing in
the second stage of labor.

1 MS. GUNN: So let's go to page 6 of 16.

2 Q. (By Ms. Gunn) Let's see. Where are we?

3 If -- under access to likelihood of
4 physical issues -- sorry. Wrong page -- 7 of 16.

5 Okay, again, these are some of your
6 underlines, right, Doctor?

7 A. Okay.

8 Q. Are they?

9 A. Yes.

10 Q. Okay. So if -- risks of prolonging the
11 second stage. So there's no question that there are
12 risks to prolonging the second stage of labor,
13 correct?

14 A. There -- there are questions as to what
15 those risks may be.

16 Q. Sure. But there's no question that there
17 are risks of letting a woman progress in the second
18 stage of labor, correct?

19 A. Are you saying risks to the mother or the
20 baby?

21 Q. Well, are there risks, Doctor?

22 A. Yes, there are risks.

23 Q. Well, we're going to talk about those
24 risks.

25 A. Okay.

1 Q. But we can agree that as of May 4, 2020,
2 you fully understood that there were risks involved
3 in allowing a woman to labor prolonged in her second
4 stage, correct?

5 A. Well, it depends on what you look at
6 because it's --

7 Q. Are you saying that you were not aware, as
8 of May 4th, 2020, that there were any risks involved
9 in allowing a woman to labor prolonged in her second
10 stage?

11 A. No, that's not what I'm saying.

12 Q. Okay. So you agree that as of, May 4,
13 2020, you were fully aware that there was risks, both
14 to the mother and to the baby, to go prolonged in the
15 second stage of labor?

16 A. No. But if you --

17 Q. You didn't understand the risks?

18 A. No. There is documentation from the
19 consensus statement that says that the risks to
20 the -- that there does not seem to be risks
21 associated with elongation of the second stage, which
22 we demonstrated this morning. And that was from the
23 care and consensus from 2014. And that was changed
24 in 2024, but that document was not available in 2020.

25 Q. Are you telling us that, as a practicing

1 obstetrician for 25 years, you didn't think there
2 were risks for allowing a woman to go 4 hours in a
3 second stage of labor?

4 A. Risks versus those risks that weren't
5 related to a prolonged labor?

6 Q. I don't understand how I'm -- let me do
7 this: Do you agree, Dr. McNeive, that there are
8 risks to allowing a woman to proceed past 4 hours in
9 the second stage of labor?

10 A. There are potential risks, depending on
11 the data that you review.

12 Q. Perfect. Potential risks, so risks.

13 A. Uh-huh.

14 Q. So page 7 of 16 of the document that you
15 brought to your deposition, risks of prolonging the
16 second stage: whether it's to allow the duration of
17 a second stage to extend beyond the time, diagnostic
18 of a prolonged second stage -- less than 4 hours,
19 right?

20 A. Correct.

21 Q. -- before operative intervention is
22 controversial.

23 A. Uh-huh.

24 Q. It's controversial --

25 A. Correct.

1 Q. -- whether to proceed, correct?

2 A. whether to allow -- yes, it's
3 controversial.

4 Q. It's controversial whether to go past 4
5 hours at all, correct?

6 A. Correct.

7 Q. As a prolonged second stage has potential
8 clinical challenges and consequences, correct?

9 A. Can I ask you again, is this from the
10 UpToDate document?

11 Q. Yeah.

12 A. This is not from the consensus?

13 Q. We're going to get there.

14 A. Well, that's what I'm -- I'm just asking
15 where you're reading from, just reminding myself.

16 Q. Yeah.

17 A. This is not from the ACOG consensus, this
18 is from the UpToDate.

19 Q. Yeah.

20 A. I'm just asking to clarify. I forgot --

21 Q. Correct. So if a cesarean birth becomes
22 necessary, a prolonged second stage -- this is your
23 underline, correct?

24 A. Correct.

25 Q. If a cesarean birth becomes necessary, a

1 prolonged second stage may result in the fetal head
2 being trapped deep in the pelvis, and further
3 thinning the lower uterine segment, both of which
4 increase the chances of extension of a hysterotomy
5 into the uterine vessels and surrounding tissues at
6 cesarean, correct?

7 A. So you're talking about maternal risk?

8 Q. This is a maternal risk that you
9 understood as of May 4th, 2020, correct?

10 A. I just asked about risk before for the
11 fetal and maternal. So you're referring to a
12 maternal risk here, yes, I would agree that any --
13 any C-section after a pushing gives you maternal risk
14 at C-section. I would a hundred percent agree with
15 that statement.

16 Q. Because the fetal head can be trapped deep
17 in the pelvis, correct?

18 A. Yeah. So it can lead to an increased risk
19 for damage to the mother during C-section. That's
20 what that is saying.

21 Q. There's also a prolonging the second --
22 prolonging the second stage increases the risk for
23 occurrence of postpartum hemorrhage and maternal
24 infection, correct?

25 A. Right.

1 Q. So there's risk to mom, and in fact this
2 case includes Sarah getting a fever, which is a
3 symptom of an infection, correct?

4 A. She did have a fever, yes.

5 Q. And then not only is there risk to mom,
6 but there's risk to baby. Prolonging -- it goes on
7 to say -- prolonging the second stage worsens
8 neonatal outcomes such as increased neonatal
9 intensive care unit admissions and neonatal sepsis,
10 correct?

11 A. I don't agree with their citation in there
12 because that's not what the ACOG document in 2020
13 says. So I don't know where they pulled that from.
14 Again, this is an aggregate source. This is not
15 ACOG's.

16 Q. Okay. So you underlined that, but you
17 disagree.

18 A. Yes, that's true.

19 Q. So you don't think there's any risk to the
20 baby in a prolonged second stage of labor?

21 A. I think that the ACOG guidelines from
22 2020, documents that there does not appear to be a
23 risk, which we showed this morning, understanding the
24 second stage increases fetal risks.

25 Q. Is there a risk for Category III?

1 A. Extending the second stage?

2 Q. Yeah.

3 A. There's always risks for Category III.

4 Q. Right. And the longer you're in the
5 second stage of labor, the more likelihood
6 availability is for a Cat III strip, correct? It's
7 just time, right?

8 A. Right. There's more time for every
9 category, sure.

10 Q. Right. So Category III tracings, we've
11 already talked about. So let's go back to the
12 consensus. The Obstetric Care and Consensus, 145-8.
13 I'm sorry. You know what? I've got one more thing
14 to talk about from your UpToDate.

15 MS. GUNN: Zack, I'm sorry. Can you go
16 back to 145-16, page 8?

17 Q. (By Ms. Gunn) Just to finish out that
18 section.

19 Now, again, we've got these check marks,
20 and I just want to make sure I understand.
21 These are your check marks, correct?

22 A. Yes.

23 Q. Okay.

24 MS. GUNN: So sorry, Zack. We're going to
25 have to go back to the first one, the previous page.

1 Q. (By Ms. Gunn) So see the little -- bottom
2 ultimately, the obstetrician's clinical experience
3 and judgment -- that's you.

4 A. Correct.

5 Q. -- in concert with the patient's value and
6 preferences -- that's Sarah and Blake -- should guide
7 maintenance, right?

8 A. Management.

9 Q. Together -- excuse me -- together you all
10 talk about these things and make decisions, correct?

11 A. Absolutely.

12 Q. There's an informed discussion about going
13 forward. That's what this dictates, correct?

14 A. Absolutely.

15 Q. And you agree with that, whether it came
16 from UpToDate or the consensus, correct?

17 A. 100 percent.

18 Q. Clinical factors associated with increased
19 chances of safe vaginal delivery.

20 So these are things that would tell you
21 that it would be safe to go forward, correct?

22 A. A safe vaginal delivery, which she had a
23 safe vaginal delivery, so, yes, I would agree with
24 all of those.

25 Q. All right.

1 MS. GUNN: Let's go to the next page.

2 Q. (By Ms. Gunn) So these are the things
3 that dictate increased chances of safe vaginal
4 delivery. Descent is occurring.

5 Now, you checked that because that's what
6 you thought was happening with Sarah, right?

7 A. Descent was occurring, yeah.

8 Q. And, again, this is something you pulled
9 out, and you checked, and you brought to your
10 deposition, correct? This is not something you were
11 doing in the moment, right?

12 A. In the moment of her delivery?

13 Q. Right?

14 A. No, I was not doing that at the moment.

15 Q. So you, after the fact, kind of sat down
16 and thought through it all and decided these things
17 were worth checking, correct?

18 A. Prior to my deposition, yes, is when I
19 pulled this.

20 Q. Okay. So then we've got previous vaginal
21 birth not checked because that hasn't happened.

22 A. Correct.

23 Q. Absence of comorbidities that are likely
24 to impact labor, you checked that because Sarah
25 didn't have any comorbidities, correct?

1 A. Correct.

2 Q. And then you checked that pelvis is being
3 adequate for vaginal birth. You checked that,
4 correct?

5 A. Correct.

6 Q. We had a little bit I think of a
7 discussion today about pelvis.

8 That this is something that at the time
9 you thought was fine?

10 A. What you can check in the office for that
11 was yes.

12 Q. And the next one that is checked is
13 patient is not short or obese. Again, good for
14 Sarah, correct?

15 A. Correct.

16 Q. And then the next one is fetus is OA, with
17 minimal caput and molding. And that's not checked,
18 correct?

19 A. Because fetus did not begin OA, correct.

20 Q. Correct. So this was not Remi, fetus was
21 not OA?

22 A. Correct.

23 Q. So this is not something that you can
24 check and say this is potential for it to be safe,
25 correct?

A. Initially it was not OA.

Q. Right. I mean, he wasn't even OA when you got there after two o'clock, correct?

A. He was OA at delivery.

Q. Right. At 4:24.

A. Correct.

Q. 12 hours later, correct?

A. Correct.

Q. So the next thing is station is at least plus 2.

That was not Remi, correct?

A. Well, I don't know what that entry means as far as Sarah. I mean, at some point, he was plus 2 because he went all the way to delivery. So I don't know what that -- I'm not sure why they included that in there.

Q. Okay.

A. I don't know when they're referring to it being plus 2.

Q. Okay. Nevertheless, you didn't check that at the time.

A. Absence of maternal fever, which is presumptive or chorioamniotic. That wasn't checked because we know Sarah had that, correct?

A. She had a maternal fever, yes.

1 Q. All right. You did check that the
2 estimated fetal weight is appropriate for gestational
3 age.

4 Now, I think you indicated -- I mean, Remi
5 was 8 pounds, 13 ounces, that's on the bigger side,
6 isn't it?

7 A. He's above average, yes, ma'am.

8 Q. All right. So should that have been
9 checked?

10 A. I think we're still below the 95th
11 percentile.

12 Q. Do you know what the 95th percentile is?

13 A. I believe it was just at or near below
14 that. I had the data somewhere of the birth
15 percentile, but I believe it was below the 95th
16 percentile.

17 Q. 40/20 was the grams.

18 A. Yeah. So that would be just below. I'd
19 have to look at on a table.

20 Q. I thought 4,000 was macrosomic.

21 A. I'd have to look on the table what the
22 95th percentile is.

23 Q. Anyway, it's pretty darn close.

24 A. It's close, uh-huh.

25 Q. All right. And then Category I, fetal

1 heart rate tracing, that's not checked, correct?

2 A. well, because she did not solely have a
3 Category I fetal heart rate tracing.

4 Q. okay. And then you did check patient
5 desires to proceed with labor vertical. we're going
6 to talk about that.

7 And what I wanted to get to on this page
8 is down there is ineffective management
9 interventions. So these have been determined to be
10 ineffective management interventions for the
11 prolonged second stage of labor.

12 And the first one is turning down an
13 epidural, which we didn't have, didn't do, didn't
14 need to be done.

15 It appears to be ineffective, correct?

16 A. Correct.

17 Q. And then the second one was changing
18 maternal position.

19 MS. GUNN: so let's go to that one, Zack.

20 Q. (By Ms. Gunn) There is no strong evidence
21 that a change in maternal position, such as upright
22 posture, lateral, or hands and knees position instead
23 of supine, that's --

24 A. Right. supine is laying down.

25 Q. Oh, I'm sorry.

A. Supine is laying, uh-huh.

Q. Laying down, okay.

A. Uh-huh.

Q. Okay. So there's no strong evidence that a change in maternal position is useful for treatment in the prolonged second stage?

A. I completely disagree with that.

Q. Patient should be encouraged to labor, push, and start in a position they find most comfortable.

You disagree with that statement?

A. A hundred percent.

Q. Okay. Got it. All right. Let's talk about Cat III tracings.

A. Okay.

Q. 145-8 is back to the Obstetric Care Consensus.

MS. GUNN: Let's go to page 20, top of the page.

Q. (By Ms. Gunn) I know we talked about Cat II, but I want to talk about Cat III since we know Remi was Cat III for about 30 minutes prior to his birth.

A. I disagree with that, though.

Q. Okay. Well, Dr. Landon agrees with it, so

we can talk to him tomorrow.

A. Okay.

Q. All right. A Cat III, the first line, fetal heart rate tracings are abnormal and require intervention.

This is your consensus. You'd agree with that?

A. I do.

Q. The elements of Cat III patterns, which include either absent fetal heart rate variability with recurrent late decelerations and current variable decelerations or bradycardia, or a sinusoidal rhythm, have been associated with abnormal neonatal arterial umbilical cord pH, encephalopathy, and cerebral palsy.

Do you agree with that?

A. I do.

Q. So you agree that Category III tracings have been associated with encephalopathy?

A. They have been, yes.

Q. And cerebral palsy?

A. Yes.

Q. And we know that Cat III increases the risk for fetal acidemia, correct?

A. It does.

1 Q. Also, the ACOG 116, that is Exhibit 145-4.

2 I think we talked about this a little bit earlier in
3 your direct examination. This is a practice
4 bulletin, ACOG Practice Bulletin, "Management of
5 Intrapartum Fetal Heart Rate Tracings," okay?

6 MS. GUNN: And let's go to page 6.

7 Q. (By Ms. Gunn) How is a Category III EMF
8 tracing evaluated and managed?

9 A Category III fetal heart rate tracing is
10 abnormal and conveys an increased risk for fetal
11 acidemia at the time of observation. Category III
12 tracings have been associated with an increased risk
13 for neonatal encephalopathy, cerebral palsy, and
14 neonatal acidosis, correct?

15 A. Correct.

16 Q. So you agree with all of those things?

17 A. I agree with all of those things.

18 Q. And you knew all that before May 4th,
19 2020, correct?

20 A. Yes.

21 Q. All right. We know that Pitocin is a high
22 risk medication or high alert medication, you're
23 aware of that.

24 And it's been explained to the jury that
25 it strengthens contractions --

1 A. Correct.

2 Q. -- and thereby increases the force on the
3 baby during contractions, correct?

4 A. Yep.

5 Q. Okay. So I just want to be clear. With
6 respect to discussion of C-section, I mean, I've
7 heard a number of things. And I appreciate that you
8 said at no point in time did Sarah, you know, refuse
9 a C-section or anything close to that, correct?

10 A. Correct.

11 Q. And, instead -- and you never said, you
12 need a C-section, correct?

13 A. Correct.

14 Q. Now, you, in your deposition, you
15 indicated that at the 8:00 a.m. time frame, you would
16 not have had the discussion with Sarah and Blake
17 regarding a C-section.

18 Do you recall that?

19 A. Well, I know I wouldn't have recommended
20 one at that time. I don't remember if I said that
21 there was no -- there was a discussion of the plan of
22 care. I don't remember what -- if you can show me
23 the page, I can look at it.

24 Q. We can do that.

25 A. I would not have recommended a C-section

1 at 8:00 a.m., correct.

2 Q. Right. Yeah. And I'm just talking about
3 not discussing it at all. I'm going to hand you --
4 oh, you have one.

5 A. I have my deposition. If you just tell me
6 what page. what page, please?

7 Q. Page 121. And if you recall, we were
8 talking about 8:00 a.m. And we'll start at page 120.
9 we were talking about how there's no note.

10 Do remember that?

11 A. we're talking about --

12 Q. You didn't make a note. There's a nursing
13 note that we've seen. But you see on page 121, this
14 is what I asked you.

15 A. 121, okay.

16 Q. But this is not the time, you don't think,
17 that you would have discussed putting a C-section on
18 the table. And your answer: I do not believe I
19 would have discussed it at that point, no.

20 so the plan of care, I think we already
21 talked about this, at 8:00 a.m. was to continue?

22 Yes.

23 Did I read that correctly?

24 A. Yeah. I don't think I would have
25 discussed putting a C-section on the table, as far as

1 a recommendation.

2 Q. Right.

3 A. A C-section for every laboring patient is
4 always on the table.

5 Q. Right.

6 A. But I would not have put it forward as, I
7 think you need a C-section.

8 Q. Okay. I do not believe I would have
9 discussed it at that point, no.

10 So no C-section discussion at 8:00 a.m?

11 A. No. Are you reading it at line 3? Is
12 that -- or am I missing something else?

13 Q. Your answer on line 5, I do not believe I
14 would have discussed it at that point, no?

15 A. Right. Putting a C-section on the table.

16 Q. Right. Okay. So let's talk about
17 8:00 a.m. You go into their room.

18 A. Yeah.

19 Q. And there's no, I mean, we've talked about
20 this ad nauseam. There's no documentation other than
21 the nurse indicating that you're at the bedside, and
22 the plan was to continue.

23 So we were talking a little bit I think on
24 direct about the fetal heart monitoring strip at that
25 time, and I think Mr. willman was asking you about

1 the eight o'clock time frame, and you, I think,
2 identified some decels and things like that. But it
3 didn't appear that you were terribly worried about
4 anything.

5 Here's what --

6 MS. GUNN: Let's just go to Exhibit 5,
7 Zack, page 125.

8 Q. (By Ms. Gunn) I just -- I wrote down that
9 we didn't look at this page, which was -- ended at
10 7:59, so when you would have been there --

11 A. Yes.

12 Q. -- at eight o'clock, you would have looked
13 back at what had just happened.

14 So, again, the jury's heard this, but all
15 of the markings on there is when I asked, when I took
16 the depositions of folks, you and some of the nurses
17 and some of the doctors that were involved in Sarah's
18 care, everyone kind of went through and put their
19 notes on what they were seeing, correct?

20 A. Correct.

21 Q. And did you see them on page 125?

22 A. I do.

23 Q. Now, I know some of these pages end in
24 different numbers, but we've got -- this one ends at
25 759?

1 A. That's mine, as well, yes.

2 Q. So -- okay. So this would have been what
3 was on this 10 minutes before, 5 to 10 minutes
4 before, you go there, correct?

5 A. Yes.

6 Q. If you were there at eight o'clock?

7 A. I probably would have looked at more than
8 that, but, yes, that would have been -- you want to
9 know 5 or 10 minutes before I got there, this would
10 have been the strip.

11 Q. Right. So we've got lates, correct? Late
12 decels?

13 A. We have a late, yep.

14 Q. And then the next page, going into the
15 eight o'clock hour, we've got another late. You've
16 got two lates?

17 A. Yes.

18 Q. I think those are both -- two lates, and
19 that's starting at eight o'clock. And then it looks
20 like the next page may have looked all right. But
21 then the next page after that, that's the 8/24, we've
22 got two more. There's a late and then an early,
23 correct?

24 A. Correct.

25 Q. Okay. But that's what you would have seen

1 when you got in there at eight o'clock. But we also
2 know at eight o'clock, you would have reviewed, from
3 talking to as many people you talked to -- you talked
4 to Dr. Parker, right?

5 A. A little before 7:00.

6 Q. Yeah. And you were aware of Sarah. And
7 you were aware that at eight o'clock, when you went
8 into her room, that Dr. Mckillip had done a pushing
9 evaluation at about six o'clock, 5:30. And you also
10 were aware that Sarah had been complete by 3:50, and
11 had been pushing with Nurse Alex, correct?

12 A. Correct.

13 Q. And they pushed for an hour and a half,
14 correct?

15 A. Yeah. I believe that's about it.

16 Q. And then Nurse Alex wanted a pushing
17 evaluation, so Dr. Mckillip, a first-year resident,
18 went in, and pushed with Sarah for 20 minutes.

19 Do you recall that?

20 A. I do.

21 Q. And this is -- you would have known all of
22 this when you went to see Sarah and Blake at
23 8:00 a.m.?

24 A. Yes.

25 Q. And you would have known that Remi was

1 malpositioned in the OP, occiput posterior, at

2 6:00 a.m., correct?

3 A. Correct.

4 Q. And then over that course of 2 hours, he
5 had not descended, correct?

6 A. Over the course of 2 hours --

7 Q. 3:50 to six o'clock?

8 A. Again, yes, per all their notion, yes.

9 None of that was based on my exam, but, yes, that's
10 what their documentation says.

11 Q. But that's what you walk in the door, and
12 you are now knowledgeable. In addition to everything
13 else you know about what's happening, you know that
14 she is, at eight o'clock, now prolonged second stage,
15 right?

16 A. Right around that, yeah.

17 Q. Right. So she's entering -- she's past --
18 she's full -- I mean, technically, and we both know,
19 you know -- we don't both know -- we've agreed that
20 laboring down does not cause a second stage, correct?

21 A. It does not.

22 Q. All right. So at eight o'clock, she's 4
23 hours and 10 minutes into the second stage.

24 A. Uh-huh.

25 Q. She's been pushing. She's got good

1 energy.

2 A. Yes.

3 Q. There has been a note about

4 malpositioning.

5 A. Yes.

6 Q. There's been a note about no descent,
7 correct?

8 A. By the resident, yes.

9 Q. Right. And you knew at eight o'clock,
10 that the vast majority of women, 93 percent of
11 women --

12 A. Uh-huh.

13 Q. -- first-time moms, have delivered by now,
14 correct?

15 A. Yeah.

16 Q. Did you tell Sarah and Blake that?

17 A. I don't know if I told them that
18 statistic. I don't know. But I told them this has
19 been a long -- a long session of pushing at this
20 point. I don't know if I told them what percentage.

21 Q. At 8:00 a.m., we've been -- there's been a
22 long time pushing?

23 A. Yeah. It had been a long time pushing.

24 Q. Did you tell them at 8:00 a.m., that she
25 was already an outlier in terms of statistics and how

1 many women have delivered by now?

2 A. I told her that she was at the -- it was a
3 long pushing session. This is definitely a long
4 session for the second stage of labor. I don't know
5 if I told her percentiles, I probably didn't. But
6 definitely she was aware -- she was aware that I was
7 aware that she had been pushing for a long time,
8 absolutely.

9 Q. And did you tell Sarah and Blake at eight
10 o'clock that there had been no descent?

11 A. Well, then I checked her at eight o'clock.

12 Q. Did you?

13 A. Yeah.

14 Q. Because in your deposition, you couldn't
15 recall whether you checked her or not.

16 Do you remember that?

17 A. I don't remember what my deposition said,
18 but I recall checking her.

19 Q. Okay. Well, we know it's not documented,
20 correct?

21 A. Correct.

22 Q. And I'll find it here in a second.

23 Okay. Page 72. You want to look at that?

24 A. Of?

25 Q. Of your deposition. I ask at line 13:

1 You were there in the morning at eight o'clock, what
2 was his station?

3 I don't recall.

4 Do you remember being there in the
5 morning?

6 Yes.

7 Do you remember -- you don't remember and
8 you didn't write down what his station was, correct?

9 I don't recall if I had checked her at
10 that point in time.

11 Do you remember that?

12 A. I do remember saying that, yes.

13 Q. Okay. So you can't say at eight o'clock,
14 even if you did check her, correct?

15 A. I thought my recollection was, but from
16 that, it wasn't because I know I had checked her
17 several times throughout the morning, so I can't
18 recall when the first one was that it was.

19 Q. So at eight o'clock, you knew that she was
20 in the prolonged second stage of labor, that
21 93 percent of women had already delivered by then.

22 And that she was failing to descend, and the baby,
23 Remi, was malpositioned, correct?

24 A. Correct.

25 Q. You knew all those things?

1 A. Yes. Yes.

2 Q. And your decision was to continue?

3 A. We had discussion about where to go. And
4 our decision was to continue.

5 Q. And let's just be clear, Doctor.

6 A. Okay.

7 Q. The discussion about where to go.

8 A. Yes.

9 Q. You told me in your deposition that you
10 said you would ask Sarah, how are you feeling, right?

11 A. I would ask her, yes, several things. One
12 would be, how are you feeling?

13 Q. And at eight o'clock, she said, I feel
14 good. I can do this, right?

15 A. Right.

16 Q. And at eight o'clock, you said, let's
17 continue, correct?

18 A. Correct.

19 Q. Let's continue pushing, correct?

20 A. Correct.

21 Q. And then what was your plan at eight
22 o'clock?

23 A. My plan was to see how the baby would
24 tolerate her continuing to push.

25 Q. How?

1 A. By reading the fetal heart rate tracings.

2 Q. When?

3 A. Continuously over the -- intermittently
4 over the course of the entire day.

5 Q. And how do we know that?

6 A. How would you know that? or how would I
7 know that?

8 Q. How would I know that?

9 A. I don't know how you would know that.

10 Q. Because it's not in the record.

11 A. Right.

12 Q. There's nothing in the record that
13 indicates, you know what? Let's give this an hour
14 and see where you are. Because by that point, you're
15 going to be 5 hours in.

16 That's not in the record, correct?

17 A. Correct.

18 Q. And you didn't tell Sarah and Blake
19 anything about, let's go an hour, let's go an hour
20 and a half, let's even go 2 hours. I'll be checking,
21 but at this point, you're prolonged, and the baby's
22 not moving, correct?

23 A. You asked me several questions in there.

24 Q. That's right. That discussion at eight
25 o'clock didn't include any of that, correct?

1 A. The discussion at eight o'clock said, I
2 asked her, how are you feeling? Do you feel like you
3 could go on? And she answered, yes. And then I
4 said, well, then, let's continue to push.

5 Q. Okay.

6 A. That was the discussion.

7 Q. So at eight o'clock, despite knowing she
8 was prolonged definitionally, you did not have a time
9 frame for her delivery or the next steps, correct?

10 A. Well, it was -- I did not delineate an
11 exact time when I would recheck her. I said, we will
12 continue to check throughout the day.

13 Q. Do you remember on page 123 of your
14 deposition, Doctor, I asked you: At eight o'clock,
15 in your mind, did you have a time frame within which
16 you wanted to know how she was doing?

17 A. Sorry. What page is that?

18 Q. Page 123, line 12:

19 "ANSWER: I did not have a time frame."

20 A. I think that's what I just said. Yeah, I
21 did not have a specific time frame that I was going
22 to say where you would need to be checked or we would
23 have that be a discussion.

24 Q. Well, let's go to Exhibit 500. This is my
25 demonstrative, Doctor. It's been a few days since

1 the jury's seen it.

2 Now, I want to ask you -- now, I have
3 taken this from Exhibit 5 for anybody's who writing
4 down their strips and also from the nursing flow
5 sheets. we've talked about that.

6 So you knew -- also, I forgot -- you knew
7 also that she's labored down for already -- for 30
8 minutes by the time you saw her at eight o'clock,
9 right?

10 A. Correct.

11 Q. So in this time frame, I think we've shown
12 the jury the eight o'clock time frame. There's
13 variable and late decels going up through -- well,
14 just continuously, correct?

15 A. Intermittently, correct.

16 Q. Right. And then at 9:42, you told us that
17 you delivered another baby by C-section.

18 I think you told us about that, right?

19 A. Correct.

20 Q. And then are you familiar with an audit
21 trail?

22 A. A chart audit trail?

23 Q. Yes.

24 A. Yes.

25 Q. Okay. So what's an audit trail?

1 A. An audit trail is going into an electronic
2 record to see when people log in and where they log
3 in and things like that.

4 Q. Okay. So you know we have Sarah's
5 audit -- the audit trails from Sarah Anyan's chart --
6 correct? -- have been produced in this case?

7 A. I'm sure.

8 Q. And we know from the audit trail every
9 time that you were in Sarah's chart when she was an
10 inpatient there.

11 A. Okay.

12 Q. And we know that, based on that audit
13 trail -- by the way, there are 8,047 lines in that
14 audit trail. Does that surprise you? Anytime that
15 anybody accesses it for any reason, it produces
16 metadata.

17 A. Okay.

18 Q. And there's 8,047 lines of metadata. And
19 would it surprise you that there were 25 out of that
20 8,000, were you checking on her chart?

21 A. No.

22 Q. Okay. So, well, what that metadata tells
23 us is that one of the times that you did that was at
24 10:27 a.m., and you checked an in-basket message
25 about Sarah. And no one can tell me what the

1 in-basket message was.

2 But do you dispute that that's on her
3 metadata?

4 A. No. That in-basket probably was from her
5 previous to her coming in, I would imagine. That's
6 what in-basket means. Probably I was trying to clean
7 up her in-basket prior to her coming in for her to
8 deliver.

9 Q. So you would have checked something in
10 sarah's chart at 10:27 a.m., correct?

11 A. Yeah.

12 Q. And then you would have checked something
13 in sarah's chart at 11:33 a.m., correct?

14 A. If that's what it's saying, then, yes.

15 Q. So I just want to ask you, I mean, at
16 10:27, we are in the 6th hour of the second stage of
17 labor, correct? And there's no documentation that
18 you were recommending anything in particular to
19 sarah, correct?

20 A. Correct.

21 Q. And at 10:45, we've got these safety
22 rounds that you were a part of, right?

23 A. Uh-huh.

24 Q. And there was all these sets of eyes
25 looking at the fetal monitoring strips, correct? For

1 15 minutes of the fetal monitoring strips?

2 A. Right.

3 Q. At that point, she was 6 hours into her
4 second stage of labor. And this is getting close to
5 your previous record of 7 hours, right?

6 A. Now, 7 hours of pushing was the previous
7 record, so...

8 Q. Well, second stage, am I not saying it
9 right? Second stage pushing.

10 A. Yeah.

11 Q. It's the same thing.

12 A. Yeah. Well, no, she pushed -- you don't
13 push your entire second stage.

14 Q. Okay.

15 A. She had pushed for 7 hours, I'm not sure
16 exactly how long her second stage.

17 Q. The other woman?

18 A. Yeah.

19 Q. Got you. Okay. So what we have as we
20 continue through the day is more accelerations and
21 decelerations -- I'm sorry -- decelerations, both
22 variable and late, you had Sarah labor down between
23 9:44 and 10:44 a.m., correct?

24 A. I had her rest, correct.

25 Q. And that was for 40 minutes. That was the

1 second time that she was asked to labor down.

2 And, by the way, the Pitocin was set at
3 18, and at no point did you ever recommend or order
4 that it be turned down or discontinued, correct?

5 A. Correct.

6 Q. And you were fully aware on May 4th, 2020,
7 what Pitocin does? It strengthens the contractions
8 and increases the force on the baby. We talked about
9 that.

10 A. Or maintains, correct.

11 MS. GUNN: And then going into the next
12 page, Zack, of this.

13 Q. (By Ms. Gunn) We've got another laboring
14 down between 12:12 and 1:32 that you recommended or
15 ordered, correct?

16 A. Correct.

17 Q. So another hour and 20 minutes. And this
18 is in the 8th and 9th hour of her second stage of
19 labor, correct?

20 A. Correct.

21 Q. And in the face of additional late decels,
22 correct?

23 A. Correct.

24 Q. And instead of recommending that Sarah
25 have a C-section, and in instead of documenting

1 Remi's station at any point during this time, you
2 delivered another baby by C-section, correct?

3 A. Without checking or documenting her
4 station? You said I had not been documenting --

5 Q. Documenting her station, right.

6 A. -- station. Correct.

7 Q. And then, again, you have -- and at 1:44,
8 you have a scheduled C-section with another woman,
9 correct? Am I understanding that?

10 A. That was the clinic C-section, yes. So
11 that was the one I had been staffing.

12 Q. I wasn't aware of the details until today,
13 but we can agree that there were three C-sections
14 between 9:40 and 1:40 roughly, correct?

15 A. Correct.

16 Q. Okay. So then we get to two o'clock. And
17 I just want to be clear. At two o'clock or after two
18 o'clock, when you get to Sarah's room, a C-section
19 could have been performed, right?

20 A. At two o'clock?

21 Q. Yes.

22 A. I believe it could have been.

23 Q. It was before Remi was too low and too
24 engaged, correct?

25 A. Correct. It might have been difficult,

1 but I think it still would.

2 Q. Right.

3 A. He was trying to crown at that point.

4 Q. And, instead, you turned up Pitocin at
5 2:21, at 2:44, at 3:10, and at 3:56, correct?

6 A. Yes.

7 Q. And at the same time of that last dose,
8 the Pitocin was cranked up, turned up, Remi was going
9 into tachycardia and Cat III tracings, correct?

10 A. What's the timing of the last increase?

11 Q. 3:56 p.m.

12 A. Yeah. I just want to double check on the
13 timing.

14 Q. You bet.

15 A. Yeah. So at 3:55, I believe is when
16 she -- 3:55 to 3:56, is when she was first becoming
17 tachycardic.

18 Q. Yeah. Same time as the last increase of
19 Pitocin, right?

20 A. Right before, yes.

21 Q. So we've got -- and then we know that Remi
22 is finally born at 4:24, correct?

23 A. Correct.

24 Q. Oh, before that, Sarah spiked a fever --

25 A. Yes.

1 Q. -- because at noon, she was officially

2 24 hours post rupture of membranes, correct?

3 A. Yes.

4 Q. And you know that 24 hours after rupture
5 of membranes substantially increases likelihood of
6 maternal fever and chorioamnionitis.

7 A. well, anytime that's ruptured, that
8 definitely increases the risk.

9 Q. But 24 hours is sort of a -- is a time
10 frame that supports it, correct?

11 A. Some people look at that. It's not
12 routine to treat it, so it's a marker, but it doesn't
13 change the management.

14 Q. okay. So baby is delivered. we heard
15 Jessie say it was chaotic.
16 we know that you did not order cord gas,
17 correct?

18 A. Correct.

19 Q. And you have no idea what the cord gases
20 would have shown, correct?

21 A. Correct.

22 Q. And you told me in your deposition, I
23 asked you why, and you first said it must have
24 slipped your mind, correct?

25 A. That's what I first said, yes.

1 Q. yeah. And then you thought maybe you were
2 relieved by the Apgar score of 8, correct?

3 A. Correct.

4 Q. But you didn't know which one of those two
5 things caused you --

6 A. There was a lot going on, so, yeah.

7 Q. Right. You don't know which one of those
8 two things --

9 A. I don't know.

10 Q. -- caused you not to order cord blood gas
11 on a baby who had been tachycardic for close to 30
12 minutes in a Cat III tracing, correct?

13 A. Correct.

14 Q. Now, I want to bring up your delivery
15 summary. We've seen it briefly. I just want to go
16 through one little piece of it. well, maybe not.
17 Exhibit 109 -- excuse me -- Exhibit 1, page 109.

18 okay. This was established, you drafted
19 this, or you wrote this three days later after Remi
20 was in the NICU, and after you knew he had been
21 diagnosed with hypoxic ischemic encephalopathy,
22 correct?

23 A. Correct.

24 Q. So this is what you wrote. And this is
25 after someone mentioned you didn't write one, right?

1 A. Correct.

2 Q. Okay. So we know it was filed at about
3 eleven o'clock on the 7th, so 3 days later.

4 And you get called by the neonatal team
5 because of the fever, right?

6 A. Yeah.

7 Q. Not because of Remi. But because of the
8 fever, correct?

9 A. Well, because of Remi because of the
10 fever. We weren't calling for mom.

11 Q. Sure. All right. Let's keep going.

12 MS. GUNN: And then I want to go down,
13 down, down.

14 Q. (By Ms. Gunn) Okay. A second stage
15 proceeded slowly but with steady progression.

16 That's what you wrote?

17 A. Correct.

18 Q. And we know, though, that the definition
19 of arrest in descent is not going more than -- or a
20 centimeter an hour or so. And we know that it took
21 Sarah 12 hours to go about 2 inches, correct?

22 A. Yes.

23 Q. 5 centimeters, correct?

24 A. She had a lot of work to get there.

25 Q. And she did it.

1 A. She did. Champ.

2 Q. So this means that if you're counting this
3 as a centimeter an hour, this should have been done 5
4 hours max, correct?

5 A. Well, the vertical 5 percent, she had to
6 go through a lot of twists and turns to get there.
7 Sort of like going down a mountain path --

8 Q. Right.

9 A. -- from top to bottom --

10 Q. Right.

11 A. -- instead of going back and forth.
12 That's part of what gets you there, yeah.

13 Q. Right. And you knew that at eight
14 o'clock.

15 A. Right.

16 Q. You knew that that was the problem at
17 eight o'clock, that that could potentially prolong
18 her labor even longer, correct?

19 A. I knew it could prolong it. I knew it
20 would not negate the possibility she could have it.

21 Q. But you knew it could prolong it. And
22 every minute that that second stage of labor goes on,
23 those risks we've discussed for mom and baby went up,
24 correct?

25 A. Every minute that it goes on, the risks

for mom and baby go up?

Q. That's right.

A. No. Again, it depends on the sources that you use as far as the risks.

Q. Okay.

A. The overriding consensus at that point decided that there is no -- there is no -- there is no -- the risk to the fetus is not associated with the duration of the second stage.

Q. It's a possibility, Doctor, right?

A. Going into labor is a possibility --

Q. You knew that --

A. -- you can have a problem with the fetus.

Q. You knew that the longer the second stage of labor went on, the risks would be increasing?

A. No. I disagree with that statement.

Q. Okay.

A. As does the OB consensus.

Q. Okay. Fetal status remained reassuring throughout, other than a brief stretch of fetal tachycardia.

Now, you define a brief stretch of fetal tachycardia as 30 minutes?

A. Out of 12 to 12-plus hours, 18 hours, yeah.

1 Q. okay. So comparatively --

2 A. Right.

3 Q. okay. So then you've got --

4 MS. GUNN: Let's go to complications.

5 Q. (By Ms. Gunn) Late chorioamnionitis,
6 that's the only complication that you saw fit to put
7 in Sarah Anyan's medical record, correct?

8 A. I didn't include terminal meconium.
9 That's another one that would have been in there, as
10 well.

11 Q. So let's talk about that real quick
12 because I heard you say it was like goose poop?

13 A. That's what terminal meconium looks like,
14 yes.

15 Q. well, we know that the delivery or the
16 NICU record indicated meconium-stained fluid,
17 correct?

18 A. Yeah. I mean, it doesn't mean it happens
19 the moment it comes out. It could happen in a few.
20 But the fact that it's still formed, it's recent,
21 versus meconium, you know, long in the past.

22 Q. okay. But -- but the NICU note indicates
23 meconium-stained fluid?

24 A. Right.

25 Q. That's what Nurse Younger was suctioning

1 out of Remi's mouth and nose, correct?

2 A. Right.

3 Q. Meconium-stained fluid?

4 A. Right.

5 Q. Copious amounts.

6 Do you remember that?

7 A. It was copious amounts of fluid. I don't
8 know how much of it was meconium, but, yes.

9 Q. Okay.

10 MS. GUNN: Let's go to Exhibit 3, page
11 2040.

12 Q. (By Ms. Gunn) Now, this is --

13 MS. GUNN: No, scratch that. Exhibit 3,
14 page 1992. That's actually not what I want. Exhibit
15 3, page 1528.

16 Q. (By Ms. Gunn) Now, this is the discharge
17 summary from Remi's NICU visit. And I just want to
18 point out --

19 MS. GUNN: Let's go down to the bottom of
20 page 1528.

21 Q. (By Ms. Gunn) Okay. Do you see that last
22 line, Doctor, complications during pregnancy, labor,
23 and delivery? See that? It says yes.

24 A. Yes.

25 Q. This is -- this is Remi's chart, and now

1 his neonatologist and the folks that are working on
2 him have gone through the records, and this is what
3 they've indicated.

4 MS. GUNN: Let's go to the next page.

5 Q. (By Ms. Gunn) The complications that the
6 NICU folks added or found and documented were late
7 fetal heart rate decelerations, correct?

8 A. That's a finding. It's not a
9 complication. I mean, if they're considering a
10 complication, that's a finding in labor.

11 Q. Okay. It's under maternal -- it's under
12 complications during pregnancy, labor, and delivery,
13 correct?

14 A. That's what the NICU -- this is a NICU
15 note. This is not an obstetrician note.

16 Q. Okay. Maternal fever. That one's --
17 that's the same thing as what you wrote, late
18 chorioamnionitis?

19 A. It was the sign of chorioamnionitis, yes.

20 Q. Right. Mechanic staining, correct?
21 They -- that's a complication that the NICU cared
22 about that you didn't put on your delivery note,
23 correct?

24 A. Right. Correct.

25 Q. Prolonged rupture of membranes. That's

over 24 hours of having ruptured membranes, which is what created that fever to begin with, correct?

A. I don't know if it created the fever, but it's definitely what she had.

Q. And then prolonged labor?

A. Prolonged labor, yes, she did have that.

Q. Okay. So this on-call physician that I think you mentioned in your direct testimony, like, I'm sorry, the backup physician, was that somebody --

I didn't realize that -- somebody in your office, like if you got caught up, and since you were the only OB hospitalist on the floor that day, there was somebody you could have called for backup?

A. Yeah.

Q. Did you ever call that person for Sarah?

A. No.

Q. Or for anybody?

A. No.

Q. Okay. Now, so I just want to go through this. Everything you did on May 4th was intentional, correct?

A. Correct.

Q. You -- and you came in with knowledge, 25-plus years of knowledge, about prolonged second stage of labor, Pitocin, late decels, Category III

1 tracings, failure to descend, chorioamnionitis, all
2 those things, is what you knew as of May 4th, 2020,
3 correct?

4 A. I knew all of those things, yes.

5 Q. And when you didn't deliver Remi at eight
6 o'clock, despite prolonged second stage of labor,
7 arrest of descent, all the things, you did that on
8 purpose, correct?

9 A. Well, she never had arrest of descent.
10 She had slow descent.

11 Q. Okay. Well, we can --

12 A. She delivered vaginally. You can't have
13 arrest of descent if you deliver vaginally, it's
14 impossible.

15 Q. Right. Right. The definition -- we've
16 seen the definition, Doctor. But you purposely and
17 with full knowledge did not deliver Remi at eight
18 o'clock, correct?

19 A. Correct.

20 Q. Didn't deliver him at nine o'clock?

21 A. I delivered him at 4:24.

22 Q. And at no time between eight o'clock, when
23 you first saw that family, and 4:24, did you
24 purposely and intentionally deliver Remi, correct?

25 A. Correct.

1 Q. You were purposely -- you were fully aware
2 that Sarah's Pitocin was at an 18 when you arrived,
3 correct?

4 A. Correct.

5 Q. And you knew that she had been complete by
6 3:50, and had been pushing, correct?

7 A. Uh-huh, yes.

8 Q. And you knew that when you got to Sarah's
9 room, you knew all the things about her, correct?

10 A. I did.

11 Q. You left Sarah's room intentionally and
12 with full knowledge of all the circumstances of what
13 was going on with her at eight o'clock without a plan
14 other than to continue pushing, correct?

15 A. The plan was to continue pushing and
16 observe her, yes.

17 Q. And you went and delivered another baby at
18 9:42.

19 You did that intentionally, correct?

20 A. I did.

21 Q. And another one at 12:41, correct?

22 A. Correct.

23 Q. Didn't deliver Remi, but you delivered the
24 other baby, correct?

25 A. Correct.

1 Q. You delivered another baby at 1:44,
2 correct?

3 A. Correct.

4 Q. And at one o'clock, Sarah is now in the
5 9th hour of her second stage of labor, correct?

6 A. Correct.

7 Q. You never documented Remi's station,
8 correct?

9 A. Correct.

10 Q. And at two o'clock, at this point she's
11 10 hours in her second stage of labor, longer than
12 anybody you'd ever seen before, with late decels and
13 current decels -- or excuse me -- late and variable
14 decels, and you did not deliver Remi, correct?

15 A. At two o'clock, I did not deliver Remi,
16 correct.

17 Q. And you knew that, at some point, Remi was
18 going to be too low and too engaged to do a
19 C-section, correct?

20 A. All babies will be too low at some point
21 for a C-section, yes.

22 Q. At two o'clock, you knew that, correct?

23 A. Correct.

24 Q. Doctor, that's all I have. Thank you.

25 A. Thank you.

1 THE COURT: Redirect?

2 MR. WILLMAN: Yes, Your Honor.

3 May it please the Court?

4 REDIRECT EXAMINATION

5 BY MR. WILLMAN:

6 Q. A couple follow-up questions, Dr. McNeive.

7 And, again, you were asked whether you put

8 C-section on the table at 8:00 a.m. That was a

9 question that you were asked.

10 what did you mean by your answer that you

11 did not put it on the table?

12 A. Well, I did not put it on the table in the

13 meaning of, it's time to do a C-section versus

14 discussions about possible plans.

15 Q. Now, you've been in the courtroom for the

16 last week and a half or so, is that right?

17 A. Yes.

18 Q. And you heard Mr. Anyan and Mrs. Anyan

19 both testify.

20 A. I did.

21 Q. And did you hear Mr. Anyan say that you

22 were in that room every hour or so checking Sarah

23 Anyan and checking the fetal heart rate strips?

24 Do you remember that testimony?

25 A. I do.

Q. Do you agree with that?

A. I do.

Q. And you had heard Sarah Anyan say virtually the same thing, that you were in her room examining her and looking at the fetal heart strips, is that true?

A. I do.

Q. Now, when you do these checks of the fetal heart strips, does that require you to access the medical record?

A. It does not.

Q. Why not?

A. Because there are independent heart rate tracing monitors throughout labor and delivery that are showing all the heart tones. And you can just see them on any of those. You don't have to be in their charts.

Q. Now, you said that he was starting to crown at 2:07.

A. Uh-huh.

Q. What do you mean by crowning?

A. I mean that the upper part of his head is already coming out of the vaginal opening.

Q. Is that progression?

A. Significant progression.

1 Q. And why is it significant?

2 A. Because when we were there initially in
3 the morning, you couldn't see the head. So this is
4 the progression that Jessie Brown was talking about
5 that was developing throughout that time.

6 Q. You were asked whether you needed to call
7 a backup at any time.

8 Did you need to do that?

9 A. Absolutely not.

10 Q. Why not?

11 A. Because there was nothing going on that
12 required two people to be there at the same time.

13 Q. The final questions. You were asked about
14 what you intended to do.

15 Did you intend to cause harm to Remington
16 Anyan?

17 A. Absolutely not.

18 Q. Did you do anything that was malicious
19 conduct towards him or towards his parents during
20 that entire time?

21 A. Absolutely not.

22 Q. Thank you.

23 THE COURT: Cross?

24 MS. KAMYKOWSKI: No further questions,

25 Your Honor.

1 THE COURT: Recross?

2 MS. GUNN: I have nothing further.

3 THE COURT: May this witness be excused?

4 MR. WILLMAN: Yes.

5 THE COURT: Thank you very much.

6 All right, ladies and gentlemen, this
7 seems like a good time for us to take our afternoon
8 recess.

9 (At 2:40 p.m., the Court duly admonished
10 the jury, and proceedings stood in recess. At
11 3:02 p.m., the following proceedings were held in
12 open court, in the presence of the jury:)

13 THE COURT: on behalf of the defendants.

14 MS. KAMYKOWSKI: Thank you, Your Honor.
15 we would call Dr. Joseph Cantey to the stand.

16 JOSEPH CANTEY, M.D.,
17 having been duly sworn, was examined, and testified
18 as follows:

19 DIRECT EXAMINATION

20 BY MS. KAMYKOWSKI:

21 Q. Good afternoon, Dr. Cantey. would you
22 please introduce yourself to the jury.

23 A. Hi. Good afternoon. My name is Joseph
24 Cantey. I'm a neonatologist from the University of
25 Texas in San Antonio.

1 Q. And, Dr. Cantey, because we're all being
2 cognizant of time, and that you are now -- and we're
3 almost at the end of our second week of this trial,
4 and the jury has heard lots of the concepts that
5 you're going to tell them about, but I'm going to try
6 to keep us pretty straight and narrow, okay?

7 A. Yes, ma'am.

8 Q. I don't want to cut you off, but we've got
9 a lot to talk about, and we've got a lot to get
10 through.

11 I want to just talk briefly so the jury
12 knows why you're here. Are you here -- you're not
13 here to offer standard of care opinions, are you?

14 A. No, ma'am.

15 Q. And you're not here to offer any
16 interpretations of fetal heart monitoring strips, are
17 you?

18 A. No.

19 Q. You are not here to talk about Remi's
20 current condition or his damages, are you?

21 A. No, ma'am.

22 Q. So are you here to offer opinions to this
23 jury about the cause of Remi's brain injury and the
24 timing thereof?

25 A. Yes.

1 Q. Okay. Before we get into that, why don't
2 you tell the jury what a neonatologist -- tell us
3 about your practice as a neonatologist at the
4 University of Texas in San Antonio.

5 A. Yes, ma'am. So a neonatologist is a type
6 of pediatrician who specializes in the care of either
7 preterm babies or babies who have perinatal
8 complications. We do pediatric res -- we do medical
9 school. We then do pediatric residency for three
10 years to become a pediatrician in general, and then
11 we do three additional years of training just in
12 babies and perinatal medicine to become a
13 neonatologist.

14 Q. So how long have you been practicing as a
15 perinatologist since completing that fellowship?

16 A. I finished the fellowship in 2015, so this
17 is my tenth year.

18 Q. Congratulations.

19 I have -- just because I'm walking in
20 heels, I'm going to try to stay back here as much as
21 I can.

22 I left for you a copy of what we have
23 marked Exhibit F2-B in front of you.

24 Do you recognize that document?

25 A. Yes, ma'am. This is my CV. It's my

1 curriculum, uh-huh.

2 Q. And it has a date from November of last
3 year, and I've got it at 39 pages.

4 what does this pile of papers contain?
5 what does it tell us?

6 A. This is a very cumbersome way for me just
7 to summarize my -- my training and education, the
8 research that I do, the courses that I teach, and my
9 clinical responsibilities for other people. So if I
10 go to speak somewhere, or if I go give a lecture, or
11 if I go out for a promotion, this is the document
12 that sort of summarizes my career.

13 MS. KAMYKOWSKI: And, Justin, could you
14 just pull up F2-P while we're talking about this to
15 scroll through.

16 Q. (By Ms. Kamykowski) We're not -- we're
17 definitely not going to go through all of this. But
18 you broke this down and said you have a clinical
19 practice as a peri -- or a neonatologist, is that
20 true?

21 A. Yes, ma'am.

22 Q. Tell us about that practice. What do you
23 do as a perinatologist and neonatologist currently?

24 A. So a -- briefly, we staff the
25 neonatologist intensive care unit. So we take care

1 of babies who are admitted to the NICU, either from
2 our own delivery service or from outside hospitals.
3 We cover deliveries, even for babies who might not
4 necessarily wind up in the NICU, but if they need
5 help at delivery, we go to those.

6 we do consults for mothers or families who
7 are expecting that might go to the NICU, either for a
8 congenital anomaly or for prematurity. And we do
9 some, although I don't personally, we do some
10 outpatient follow-up of premature babies who are now
11 1 or 2 or 3 years old that we specialize in care.

12 Q. But your current practice is essentially
13 hospital; is that fair?

14 A. Yes, ma'am.

15 Q. And how much of your time is spent as a
16 clinician neonatologist versus an academic or a
17 researcher -- and we'll talk about that -- or a
18 teacher?

19 A. Yes, ma'am. If you break it up into sort
20 of hours served, which I do about 25 percent time
21 clinically between daytime coverage and then
22 nighttime calls. That may be going up as the NIH
23 grants are changing under current policies, so I
24 might do more clinical time, but my practice right
25 now is about 25, 30 percent.

1 Q. okay.

2 MS. KAMYKOWSKI: And, Justin, just stop
3 that scrolling for one second. Just go right back to
4 page 1.

5 Q. (By Ms. Kamykowski) This doesn't look
6 like a normal like resume like I'm used to. It says
7 "curriculum vitae," and then it has this self
8 description.

9 what's the purpose you had this 39-page
10 document in this very cumbersome format?

11 A. This is the format that the University of
12 Texas requires. I'm assuming it is to punish us.

13 Q. And in this self description, can you just
14 tell us the clinical aspects of your work. Tell us
15 about your academic aspects, and then we'll talk
16 about your research, okay?

17 A. So I -- I work for the University of Texas
18 as a clinician's scholar, which is sort of a
19 semiformal description of someone who takes care of
20 patients, but also is expected to, as part of their
21 job, to do clinical research. Or I guess it could be
22 any kind of research, but for me it's clinical. So
23 in addition to taking care of patients, I also do
24 investigational studies, clinical trials, both
25 locally and sort of multicenter NIH supported trials,

1 and trained and evidence-based medicine.

2 Q. And when we get to the later pages of your
3 CV, and, again, I'm not going to go through it, there
4 are pages and pages of books and journal articles,
5 lectures.

6 Do you have a clinical or a research
7 interest in neonatology that you have been kind of
8 prolifically researching and writing about?

9 A. I do. I'm going to try hard not to miss
10 my flight by talking too long. I study -- I'm also
11 boarded in infectious diseases. We have infectious
12 diseases, so my primary interest is kind of
13 everywhere where newborns and infection overlap, so I
14 do antimicrobial stewardship, how to safely use less
15 medicine in babies: perinatal infections, infections
16 that babies can get, either while they're born or in
17 the womb.

18 Q. Fair to say we're not going to find
19 anything on your CV that will deal with specifically
20 neonatal hypoxic ischemic encephalopathy?

21 A. Not from a research standpoint, no, ma'am.

22 Q. What about from any other standpoint?
23 Anything relevant on this CV?

24 A. Other than clinically I take care of them
25 with unfortunate frequency, but not from a research

1 or a teaching lens, no.

2 Q. And so you understand that you're here to
3 offer some opinions that relate to the cause of
4 Remi's brain injury, correct?

5 A. Yes, ma'am.

6 Q. And in order to do that, did you review
7 some materials that we sent you?

8 A. Yes.

9 Q. What did you review?

10 A. Over the course of the case, I've reviewed
11 medical records for mother and for Remi. Reviewed
12 the depositions that have been taken in the case,
13 both for the defense side and the plaintiffs' side
14 and a lot of the exhibits that were attached to that,
15 and the materials and photographs and strips and
16 things like that that have been provided.

17 Q. And after reviewing those materials,
18 utilizing that review specific to Remi Anyan, and
19 your education, training, and experience as a
20 neonatologist, did you reach opinions in this case
21 regarding the cause of Remi's brain injuries and the
22 timing of those?

23 A. Yes, ma'am.

24 Q. All right. And before we tell the jury
25 what those are -- what those are, would you agree

1 that the opinions that you hold in this case, any
2 opinions that you give, be based upon a reasonable
3 degree of medical certainty?

4 A. Yes, ma'am.

5 Q. And if you are offering an opinion to a
6 reasonable degree of medical certainty, can you also
7 agree that that opinion will be more likely true than
8 not true?

9 A. Yes, ma'am.

10 Q. So just to get to the point and start out,
11 can you just give us the overarching opinions that
12 you hold here with respect to the cause and timing of
13 Remi's injuries?

14 A. Yes, ma'am. Certainly unquestionably Remi
15 suffered a hypoxic ischemic encephalopathic injury
16 based on his MRI findings and his clinical course in
17 the NICU. Without going too deep into it right off
18 the bat, the injury for Remi on the MRI affects both
19 what we call the watershed areas, the areas of the
20 cortex and the subcortical white matter that are fed
21 by the big blood vessels that feed the brain, but
22 also the basal ganglia.

23 So as a neonatologist, that generally
24 means there was at least at some point an acute
25 profound where his brain was deprived of oxygen.

1 based on his clinical appearance in that
2 period after delivery, based on some of the initial
3 laboratory findings, the assessments that were done
4 on him, it seems unlikely that that was right
5 immediately around the time of delivery, which we
6 generally assume, and I think in this case in
7 particular, there doesn't seem to be any evidence
8 that there was hypoxia after he was born, which
9 generally makes us look back, you know, hours to days
10 before delivery to kind of see where that injury
11 might have happened.

12 Q. And if someone were to ask me is it
13 possible he had this global hypoxic ischemic injury
14 from -- in the last hour before he was born, based on
15 the data you reviewed in this case and your training,
16 education, and experience as a neonatologist, what
17 would your response be?

18 A. Is it possible? Yes, it's possible,
19 uh-huh.

20 Q. Is it more likely than not, though, Dr.
21 Cantey?

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

23 Q. Okay. Let's talk about that. Before we
24 get there, sitting in that chair, have you done this
25 before, testified as a medical legal expert?

1 A. I have testified at a trial once before.

2 Q. okay. well, welcome to the courtroom.

3 How many -- have you given depositions in cases
4 before?

5 A. Yes, ma'am.

6 Q. And how many times?

7 A. I think ten or eleven, at this point.

8 Q. And how long have you been doing this type
9 of work?

10 A. Right around the beginning of the
11 pandemic. So 5 -- seems like longer -- in pandemic
12 years, but about 5, six years.

13 Q. And is there a breakdown -- the jury has
14 heard this from every expert -- is there a breakdown
15 of how many cases you've testified for for the
16 plaintiff versus the defendant, that you're aware of?

17 A. In terms of testifying in court, I'm one
18 on each side at this point as of this case. One's
19 for the plaintiffs, and one's for the defense.
20 overall, it's probably two-thirds/one-third defense
21 versus plaintiff. I don't intend it to happen that
22 way, it just sort of went whatever people asked me
23 for.

24 Q. Do you remember -- I'm not going to pin
25 you down on dates, I can tell you it's sometime in

1 2023 -- when my office first contacted you, what
2 information you were provided about this case?

3 A. I think I was aware which -- that -- that
4 it was the defense counsel rather than plaintiffs'
5 counsel, and I was given mom and baby's unredacted
6 charts to kind of go through.

7 Q. And when we first contacted you, do you
8 recall if we asked you to offer -- to look for a
9 standard of care criticism or support in this case or
10 just to look at causation?

11 A. I believe initially it was just, hey, what
12 do you think about causation?

13 Q. Okay. And everybody's heard this, too,
14 you're being paid to be here, correct?

15 A. Yes, ma'am.

16 Q. Unfortunately, you can't do this for free,
17 right?

18 A. No.

19 Q. Can you tell us what you charge --

20 A. well --

21 Q. -- to be here today?

22 You could do it out of the goodness of
23 your heart, but I won't make you.

24 A. So the -- for review, it's \$450 an hour,
25 and then for a trial itself, it's just a one flat fee

1 for a trial of \$8,000.

2 Q. And you came in last night?

3 A. Yes, ma'am.

4 Q. And you're going home tonight, right?

5 A. Hopefully.

6 Q. All right. So let's just get into it,

7 then, Dr. Cantey. I don't think there's any dispute

8 in this case that everyone agrees Remi has a diffuse

9 global hypoxic ischemia injury, okay?

10 So we can -- that's your opinion, that's

11 everyone else's opinion. What's at dispute in this

12 case is the timing of that injury, okay?

13 So you told us at the outset that you

14 don't think it happened -- that based on what you've

15 reviewed in this case, your opinion is that this

16 injury did not happen within the hour before his

17 delivery.

18 Can you give us a window of time where

19 it's more likely than not your opinion, based on a

20 reasonable degree of medical certainty, when this

21 injury occurred?

22 A. Yes, ma'am. So just to broadly sort of

23 set the window, the mechanism for babies with hypoxic

24 ischemic encephalopathy, including Remi, is there's

25 an initial injury to the brain at some point. That

1 that primary injury happens, is very -- there's
2 nothing that we can do about it. The horse is kind
3 of out of the barn for that particular injury.

4 once the baby is reperfused, once the baby
5 is delivered, and here comes blood and oxygen and all
6 the good stuff rushing back to the brain, the -- the
7 injured area, as the blood sweeps across it, it picks
8 up all of the neurotransmitters and the salts and
9 proteins and sort of noxious chemicals that should be
10 inside the neurons, but have now spilled out from
11 those brain cells that have died in the primary
12 injury, and it washes them across a bigger section of
13 brain.

14 And that bigger section of brain then gets
15 what we call cytotoxicity, where it gets
16 overstimulated by all the products that it's getting
17 exposed to during that reperfusion period. That
18 secondary injury then gets presented clinically.

19 That secondary injury starts between about
20 6 and 12 hours and lasts for 48 to 72 hours, kind of
21 depending on which source you look at. So we know
22 for Remi to present as he's being transferred to the
23 NICU, and certainly as he's having the seizures, that
24 he is in that secondary injury window.

25 so that's all just somewhere between 6 to

1 12 hours before, up to 48 to 72 hours before, he has
2 primary imaging. After that, we're sort of stuck
3 trying to narrow the window of when it happened based
4 on his head imaging, so the MRI, and, again, I would
5 generally defer to the neuroradiologist.

6 But as a neo, we kind of look at the MRI,
7 try to get a sense of -- the injury evolves the same
8 way a bruise does. So when we get whacked on the
9 arm, we've got a big, red spot. And then it turns
10 into this blue-black spot. And then it turns yellow
11 and green and looks really yucky as it goes away.

12 And the neuroradiologists are able to look
13 at the MRI findings and interpret it the same way I
14 might. The neuroradiologists can sort of help us out
15 sometimes.

16 We generally try to get that MRI somewhere
17 between 3 to 5 to 7 days just to kind of give them
18 the best chance to time it. We can also do head
19 ultrasounds and sonograms of the head, just like we
20 would do when women are pregnant. And a sonogram can
21 look for brain swelling or significant injury of the
22 white matter that may show up as apropos findings.

23 We know that the head ultrasound takes
24 about 24 hours, maybe up to 48 hours, to start to
25 become abnormal. So if it's already abnormal when we

1 scan the baby on day of life 1, we know that the
2 injury happened a day or two beforehand.

3 If it's normal, either it's always normal,
4 and just we missed it, or it's a relatively more
5 recent injury, and then we have to look at the MRI to
6 time it.

7 So, in this particular case, the window is
8 hard to narrow with the degree of certainty that I
9 think everybody in this room probably wants, but it's
10 somewhere between, you know, 6 to 12 hours back, to
11 48 to 72 hours back.

12 Clinically, what we generally know for
13 babies who are born with an acute assault right at
14 the time of delivery, where the uterus ruptures, or
15 mom has a complete placental abruption, and the
16 placenta detaches, and the baby is suffocating in the
17 womb because the placenta is not connected anymore,
18 those babies when they're born, are generally very,
19 very depressed.

20 They come out, look terrible, and they are
21 very hard to resuscitate and kind of drag back to a
22 place of physiologic stability. Unfortunately we --
23 we, you know, care for those babies. Actually, it's
24 not unfortunate that we care for them, unfortunately
25 how often I have to do that. And those babies,

1 generally you can tell, like, wow, this baby was
2 super depressed, super stunned. It took a lot of
3 resuscitation to get them back.

4 Remi's case doesn't really fit that
5 pattern super well. He definitely comes out
6 depressed or what we would call nonvigorous where
7 he's not breathing, and he's floppy, and he's blue.

8 But then with -- with bag mask ventilation, he perks
9 up. His 5-minute Apgar score, 5-minute appearance is
10 pretty good, which is less consistent with an injury
11 that happens right around the time of delivery.

12 Q. Okay. Let's look at Exhibit A3-V 1571.

13 This is Nurse Practitioner Younger's resuscitation
14 note. You've seen this note, correct?

15 A. Yes, ma'am.

16 Q. And it says neonatal consult or
17 neonatologist consult. Tell us the circumstances
18 that you've been in or what your experience is
19 similarly as neonatal -- Nurse Practitioner Younger
20 was on May 4th.

21 A. Right. So this is essentially a delivery
22 note. We write these -- our format is slightly
23 different -- but we write these whenever we do a
24 delivery, whether we do anything or not. We say we
25 attended for X, Y, Z reasons, and here's how the baby

1 looked, and here's what we did. And here's what we
2 decided to do with the baby before we left and went
3 back to our home in the NICU.

4 Q. Okay. And we haven't talked about a
5 little bit of this.

6 MS. KAMYKOWSKI: Stay right there, Justin.

7 Q. (By Ms. Kamykowski) But do you use the
8 Epic electronic medical records system?

9 A. Yes, ma'am.

10 Q. All right. So at the top where it says
11 "data service, 5/4/23, 5:14 p.m.," and next on the
12 left of that is says "filed 5/4/2020, at 5:37 p.m."

13 Do you know what those two time stamps
14 mean?

15 A. I'm fairly sure it is the date of
16 service's time for when you start the note, unless
17 you go back and manually retime it. So I'm assuming
18 in this case that Ms. Younger started the note at
19 5:14, signed it at 5:37, and then it was cosigned by
20 the neonatology physician at 6:16 p.m. So all three
21 of those stamps are on there, uh-huh.

22 Q. And since she's a nurse practitioner, I
23 don't know if it's the same in Texas, but Missouri
24 has classic requirements that she has to have an
25 actual M.D. sign the note?

1 A. Yes, ma'am, we're the same.

2 Q. And you look at this note, you have looked
3 at it in this case, I'm not going to belabor it, but
4 can you tell us what, from a neonatology standpoint,
5 when you read this note is important for you to think
6 about in the constellation of markers or
7 constellation of data to help you with your timing
8 opinion?

9 A. So specifically in terms of timing, I
10 think our question is, you know, retrospectively, if
11 we're worried about HIE, how did this baby do in the
12 delivery room? And that's what the Apgar scores are
13 intended to do, is sort of give a quick summary to
14 someone in the hallway of, you know, how did this
15 baby transition.

16 So the baby comes out, you can see it down
17 there at the bottom, you know, decreased tone, no
18 cry, heart rate is less than a hundred when they
19 listen. We can't see that, but when they listened or
20 palpated the pulse, that's a nonvigorous baby.

21 And then they start PPV, is positive
22 pressure ventilation, where they put a mask on the
23 baby and (indicating), blow air into the lungs.

24 Babies are different from -- different from adults.

25 Babies will respond and start breathing on their own,

1 and their heart rate will pick up if we bag their
2 lungs. As adults, we don't do that. we find an
3 adult down on the street, we start chest
4 compressions, and call for help. Babies, we breathe
5 for them.

6 And so they started positive pressure
7 ventilation, and then the heart rate responds. It
8 comes up over a hundred. He starts to breathe.
9 Spontaneous respirations are established, and by, you
10 know, the 5-minute mark, he's looking pretty good.
11 So in terms of timing, that tells me, okay, he wasn't
12 so, so depressed because of an acute perinatal event
13 that he wasn't able to be resuscitated, he perked
14 right up.

15 Q. So going back to what you started with,
16 the MRI in this case showed, you would agree, a
17 diffused global hypoxic injury.

18 A. That's how I would describe it, yes,
19 ma'am.

20 Q. And you didn't look at the images, you
21 just looked at the reports?

22 A. Correct.

23 Q. And that's your typical practice?

24 A. Yes, ma'am.

25 Q. And that MRI, is that the gold standard

1 for trying to time HIE?

2 A. Yes, it's the...

3 MS. LENIVY: Your Honor, may we approach?

4 THE COURT: You may.

5 (The following proceedings were held at
6 sidebar, outside the hearing of the jury:)

7 MS. LENIVY: Your Honor, I don't recall
8 Dr. Cantey saying that, testifying about the gold
9 standard for the MRI.

10 MS. KAMYKOWSKI: I'll repeat the question,
11 Your Honor. He didn't say gold standard, but he
12 talked about MRI being the better study. I'll
13 withdraw it. If you want to strike it, you do it.
14 I'll rephrase it.

15 THE COURT: Okay. Okay.

16 MS. KAMYKOWSKI: I'm sorry. You can
17 strike it.

18 THE COURT: Okay.

19 MS. KAMYKOWSKI: That's fine.

20 (Proceedings returned to open court.)

21 MS. KAMYKOWSKI: May I proceed, Your
22 Honor?

23 THE COURT: You may.

24 MS. KAMYKOWSKI: Thank you.

25 Q. (By Ms. Kamykowski) Dr. Cantey, in your

1 experience and your clinical reliance on imaging to
2 help with evaluating children with respect to HIE, is
3 MRI the preferred modality to evaluate that?

4 A. Yes, ma'am.

5 Q. Okay. Looking at this note, one of the
6 things that we haven't talked about yet in this case,
7 and I was hoping you might be able to help us is
8 where it says: the temperature probe on abdomen and
9 oxygen saturation with probe placed on right wrist,
10 and needing up to 50 percent FIO₂ for appropriate
11 saturation.

12 The jury heard from Nurse Practitioner
13 Younger about -- a little bit about that, but what --
14 resuscitation or right ox delivery at this time, what
15 are they doing with this quote?

16 A. So if a baby does not need any
17 resuscitation, if we warm them, dry them, stimulate
18 them, and they perk right up, we won't put the
19 monitor on. But once any resuscitation is needed, so
20 in this case, the positive pressure ventilation, the
21 neonatal resuscitation program, which is our
22 overarching program, recommends that we put a probe
23 on the right wrist to, one, to electronically capture
24 the heart rate, and, two, to watch the oxygen
25 saturation. So that was done because PPV was

1 started, I'm assuming, uh-huh.

2 Q. And let's talk about watch the oxygenation
3 saturation. I think there may be -- there was some
4 discussion in here about you saw the resuscitation
5 note that shows that Remi continues to receive some
6 sort of oxygen at 5 minutes and 10 minutes of life,
7 correct?

8 A. Yes, ma'am.

9 Q. So let's -- just to cut to the chase
10 there, too, if the evidence is that Remi had -- do
11 you understand what kind of oxygen requirements he
12 was having at 5 minutes?

13 A. Sort of, yes, ma'am.

14 Q. Okay. Tell us what that is.

15 A. So he, at some point, and there was some
16 debate about the timing, but I think -- with Ms.
17 Younger's deposition that once he established his
18 spontaneous respirations, he was still needing more
19 oxygen. His oxygen sats were lower than the target
20 that they wanted for that moment, that minute of
21 life.

22 And just to back up briefly. We're all
23 cyanotic in utero. We are --

24 Q. What is cyanotic?

25 A. Oh, I'm sorry. We all have relative

1 hypoxia in utero. We're getting our oxygen from our
2 moms through the placenta. And when we're born,
3 we're usually, about 60 to 65 percent of our red
4 blood cells are saturated with oxygen.

5 so if anyone's ever had a pulse oximeter
6 on their finger, and it's blinking 99 on the monitor,
7 babies don't do that. They're 60, 65. And over the
8 first 5 to 10 minutes after they're born, they'll
9 sort of gradually transition their way up to 80, 85,
10 90.

11 And it's not until a couple of hours go by
12 that they get to what we would consider adult norms.

13 And so in the -- I don't want to wander too far. In
14 the old days, we used to, the baby was getting
15 resuscitated, we'd turn them up to a hundred percent
16 oxygen and blast them to make them pink.

17 And what we've learned is that's not
18 always the best thing because they want to
19 transition. So we use the monitors now to make sure
20 we're hitting the targets and not over or
21 undershooting on the oxygen.

22 Q. And so oxygen requirements at 5 or 10
23 minutes, if the baby is spontaneously breathing, able
24 to breathe on their own, is the oxygen requirement
25 more for perfusion of tissue, or what is the point?

1 A. Yeah. It's -- exactly. So administering
2 oxygen or administering pressure like CPAP without
3 getting breaths is not resuscitation, per se, it's
4 meant to make sure the oxygen targets are where
5 they're supposed to be so that, like you said, so
6 that the tissue is getting the oxygen that it needs.

7 Q. And Nurse Younger included this in the
8 note when she said that oxygen saturation probe was
9 placed and that Remi was needing up to 50 percent
10 of -- what is FIO₂?

11 A. FIO₂ stands for fraction of inspired
12 oxygen. A minor pet peeve, the O is a capital O and
13 not number a zero, but we do that a lot.

14 Q. And that was for appropriate saturation.
15 So they're trying to make sure that the red blood
16 cells that carry oxygen all over his body, to his
17 organs, his brain, his fingers, his toes are coming
18 up to where that transition period you want to see
19 him?

20 A. Yes, ma'am.

21 Q. Okay. So what we have talked about, you
22 agree that based on Nurse Younger's note, that Remi
23 wasn't able, in this resuscitative period, to
24 establish spontaneous breathing?

25 A. Yes, ma'am. That's what she documented,

1 spontaneous respirations, meaning he's breathing on
2 his own. He's not needing additional support -- he
3 doesn't need additional resuscitation in order to
4 start breathing.

5 Q. And if a baby is spontaneously breathing
6 but still needs to be CPAPed, what does that mean as
7 far as the Apgar assessment?

8 A. It does not count against Apgar. So once
9 the baby is neurologically breathing on their own,
10 that's when they get the full credit for that
11 particular domain, which is 2 points.

12 Q. Okay. And in the very last line of this
13 paragraph, she documents: observed infant with
14 comfortable respirations and continued improving
15 perfusion.

16 what does that mean as a neonatologist
17 when you read this?

18 A. So just reading it, comfortable
19 respirations to me talks about worker breathing and
20 rate. So when someone tells me comfortable
21 respirations, I am assuming that they mean the worker
22 breathing is normal, meaning they're not using extra
23 muscles. They're not using their neck or their chest
24 muscles to expand the lungs. They're just using
25 their diaphragm, and that the rate of breathing is

1 normal for the age that we're talking about, uh-huh.

2 Q. Okay.

3 MS. KAMYKOWSKI: Scroll down just a little
4 bit for us, Justin, for me.

5 Q. (By Ms. Kamykowski) She talked about:

6 okay for infant to remain with parents. Asked the RN
7 to call if any concerns arise. And at the very end,
8 she says: to FTN, does that mean full-term nursery?

9 A. I'm assuming it does, yes, ma'am.

10 Q. And no distress at this time, correct?

11 A. Correct.

12 Q. And then also what she's noting is:

13 significant head molding on assessment. Remaining
14 assessments unremarkable.

15 what does the term "assessment" mean to
16 you in this context?

17 A. So, again, this is an assumption on my
18 part, but the assessment of the baby in the delivery
19 room, and then shortly after delivery, if the baby is
20 getting tucked in to whatever nursery they're going
21 to, is a combination of visual and whatever hands-on
22 has been done.

23 The, you know, in this note, they're
24 talking about breathing. They're talking about
25 perfusion. They're talking about the condition of

1 the head. So clearly they're at least looking at the
2 baby and also saving some things.

3 In the -- zooming out a little bit, there
4 has to be -- and it's documented a little bit right
5 there. That okay for infant to remain with parents.

6 When we go -- when we, as the NICU, go to
7 a delivery, if we're about to leave, we're like, bye,
8 good luck, there has to be a handoff, even if it's
9 super informal, to the labor and delivery staff, to
10 the nurses, who are going to be caring for that baby
11 after we leave, after we retreat back to our ivory
12 tower.

13 We say, hey, we're going to go. The baby
14 looks good. Are you guys good? And if the labor and
15 delivery nurses are like, whoa, whoa, time out, the
16 baby is still doing like x, y, or z, then we have to
17 have more discussion.

18 Q. Okay.

19 A. If the assessment is okay for infant to
20 remain with parents, no distress, we're leaving, and
21 the L&D nurses say, okay. Thank you. Then we're all
22 in agreement that that baby is okay to stay. So
23 that's implied here. That's obviously not
24 documented. But that's the way I would read that,
25 uh-huh.

1 Q. And that is what happened in this case.
2 Nurse Younger and her team finished their assessment
3 of her, went back to the NICU. And you understand
4 that Remi stayed with his parents for many hours,
5 correct?

6 A. Yes, that's my understanding.

7 Q. Okay. Let's talk about Apgar. We've
8 heard about it a lot. And I'm going to try to get
9 through it, like I said, quickly.

10 There's been some discussion in this
11 courtroom about whether or not it's subjective.
12 How -- if I asked you if the Apgar score is
13 subjective, how would you answer that?

14 A. My answer is a little bit.
15 So the Apgar is named after Virginia
16 Apgar, a 20th century neonatologist, who was
17 wonderful. I didn't meet her. My -- well -- it's 5
18 domains.

19 Q. Your slide is too cute.

20 A. I know, I'm sorry.
21 It's 5 domains: It's heart rates, it's
22 spontaneous respirations or lack, thereof, it's
23 reflex irritability or grimace, some people call it.
24 It's color, and it's tone. And it's -- you can get
25 zero or up to 2 points in every domain. And it's

1 just a quick sort of shorthand way for us to
2 communicate how does the baby look when they were
3 born? How did they respond to resuscitation?

4 Q. we've heard that, so I want to move on.

5 A. Yes.

6 Q. That's okay. Again, I'm trying to be
7 mindful of time for everybody.

8 There's also been some discussion about
9 whether Remi's 5-minute Apgar was a, quote,
10 "resuscitative Apgar" or "assisted Apgar."

11 Is that a thing in neonatology?

12 A. I mean, I've seen that term before in,
13 like, ACOG bulletins. It's not something we use
14 clinically. I think what people are getting at that
15 with that -- so obviously if a baby needs
16 resuscitation, we're going to give it to them.

17 we're not going to sit there and be like,
18 no, we're going to withhold resuscitation and see
19 what his true Apgar is. The point is that if the
20 baby is being -- if any of those domains are being
21 artificially elevated, and usually it's in terms of
22 the respirations, if we put a breathing tube into the
23 baby, put the baby on a ventilator, and the baby is
24 doing nothing, no respiratory effort, no output,
25 whatsoever, if the ventilator is breathing for the

1 baby, the baby does not get a 2 for respirations
2 because it's the ventilator doing the work.
3 If the baby is doing their own
4 respirations, and we're providing oxygen or CPAP,
5 then the baby still gets credit for the work they are
6 doing. So I think that's maybe what people are
7 talking about when they talk about assisted Apgars.

8 Q. And how about is there subjectivity in a
9 baby's tone or reflexes?

10 A. So in the sense that -- so that the
11 interrater reliability of the Apgars are pretty good,
12 meaning --

13 Q. Let's -- yeah. So dumb that down for us.

14 A. Right. So meaning if I have a baby, and I
15 examine them, and then we bring in another
16 neonatologist, and they examine them, and then we
17 bring in a third-year medical student, and they
18 examine them, we'll all be pretty close to each
19 other's answer. We'll either have the same number,
20 or we might be off -- heart rates, color, breathing,
21 the interrater agreement is excellent.

22 Tone and reflex can be a little bit
23 subjective, and so you might see a point shift here
24 or there between different providers. But in terms
25 of globally, the Apgar is pretty easy, and it's

1 pretty easy to be assessed similarly between equally
2 trained people.

3 Q. And so in -- for a neonatologist, what is
4 the significance, if any, if you hear that a
5 5-minute -- a baby receives a 5-minute Apgar of 8?

6 A. So depending on what the first Apgar is,
7 so if the first Apgar was also a 7 or 8, then we're
8 looking at this baby transitioned well. You know, it
9 was delivered well, and it looks good.

10 If the initial Apgar was really low, and
11 the 5-minute Apgar is 7 or 8 or 9 or whatever it is,
12 that tells me that they responded well to the
13 resuscitation efforts that the team provided, whether
14 that was PPV or whether that was more intensive.

15 Q. would you expect a child, a newborn, who
16 has suffered a global hypoxic ischemic injury in the
17 last hour before he was born, to respond well to
18 resuscitative efforts to -- enough to receive an 8
19 Apgar score at 5 minutes?

20 A. So in general, no. Usually those babies
21 are quite challenging to resuscitate, and they might
22 have low Apgars for 5 or 10 or something -- 15
23 minutes or longer.

24 Q. Just so we cover it, last week the jury
25 heard from Dr. Kerzner, who's your counterpart from

1 the plaintiffs' side of this case. She talked about
2 some photographs that were taken of Remi in the
3 delivery room.

4 You've seen some of those photograph,
5 correct?

6 A. Yes, ma'am.

7 Q. And she was utilizing the photographs, as
8 well as her review of the parents' descriptions of
9 Remi around the time of delivery, to talk about her
10 beliefs that there might be tone that maybe wasn't
11 appreciated by Nurse Younger.

12 Tell us, what's the -- from your
13 perspective, outside of coming here in the courtroom
14 to talk about it, would you rely on a still photo of
15 a baby to assess tone?

16 A. I'd rather touch the baby. But if a
17 photograph is all I have, I'd would use it, uh-huh.

18 Q. Okay. And what can you get from that, as
19 far as assessing the tone at a 5-minute score for an
20 Apgar?

21 A. From the photograph, or from touching?

22 Q. Yeah.

23 A. From the photograph?

24 Q. The photograph.

25 A. So the normal term newborn is in the fetal

1 position, right? That's why we call it that, where
2 their arms and legs are flexed.

3 Tone is a really a dynamic sort of
4 resistance. If I move the baby's arm, how tough is
5 it to move? Is it wracked all the way? Is it tight?
6 Or is it normal?

7 If all I have is a picture, what we're
8 looking for for what we would assume would be normal
9 tone, is that the arms would be flexed, and the legs
10 would be flexed. You know, frog legs, if you hold
11 out like this, as opposed to fully extended like
12 this.

13 So in the, you know, collection of
14 pictures that were made available to me, for the most
15 part, Remi is tucked up. So I would, again, I
16 wouldn't want to rely on it, but if all I have is the
17 picture, I would assume the tone is normal, or near
18 normal, because the arms and legs are flexed
19 appropriately.

20 Q. And, again, those are just snapshots in
21 time, like a millisecond, right?

22 A. Right.

23 Q. Let's talk, then, about Remi's condition
24 after Nurse Younger -- she does her assessment, they
25 do their resuscitation, and they decide -- they got

1 the thumb's up, they're going to leave him mom and
2 dad and the other nursery nurses and the labor and
3 delivery nurses, but there's still a team in their
4 with mom and Remi, correct?

5 A. Correct. At least for the initial period,
6 uh-huh.

7 Q. Okay. So we've heard from the -- Mr. and
8 Mrs. Anyan, and Dr. Kerzner relied on that, and we
9 saw in their depositions that -- is their assessment
10 of Remi in the first hour or so, or maybe even all
11 the way until he got to the NICU, they perceived him
12 to be floppy. I think Dr. Kerzner interpreted that
13 to be flaccid. They also thought he was very tired.
14 The nurses said, yes, he went through a long
15 delivery, he's probably tired. Dr. Kerzner
16 translated that to lethargic.

17 Based on the totality of the records of
18 Remi that you've reviewed in this case, does that
19 perception from the parents track what the objective
20 evidence in the record is?

21 A. No. And I don't mean to say that the
22 parents were mistaken. I do, you know, certainly the
23 initial assessment when the nurses are getting him
24 and kind of doing their first head-to-head
25 assessment, is pretty reassuring.

1 He certainly could have been tired, and I
2 read their assessments awhile ago. But, you know,
3 that is a long labor process, and you have the soft
4 tissue swelling of being a big baby coming out, so
5 certainly that part might fit that he's more sleepy
6 or more wiped out.

7 Lethargic is a big word, it's a scary
8 word, from a medical standpoint, I would be surprised
9 if the labor and delivery nurses or the labor and
10 delivery team were seeing that and not, in my
11 personal experience, labor and delivery does not put
12 up with much in the way of abnormality. They're
13 calling NICU, and say, hey, get your butt back down
14 here. You need to come see this baby, uh-huh.

15 Q. And did you see that some nursery nurses
16 were in the room before -- in the delivery room --
17 before Sarah, Blake, and Remi were transferred to
18 postpartum to do a head-to-toe assessment of Remi?

19 A. Yes, ma'am.

20 Q. Okay. Let's look at that.

21 MS. KAMYKOWSKI: If we could start at
22 Exhibit Number 3, page 2390. 2390. And I want to be
23 at the bottom of the page under general information.

24 Q. (By Ms. Kamykowski) And do you see that
25 at the top there, and, again, the jury has seen these

1 flow sheets, so I'll try to orient us and just get us
2 quickly through this. They're working columns on
3 this printed sheet. So we're going to start with the
4 May 4, 2020, at 1735. If Remi was born at 4:24,
5 we're about an hour and 11 minutes after birth in
6 this document, correct?

7 A. Yes, ma'am.

8 Q. Okay. And the first general information I
9 think they're probably putting an alarm on him so
10 nobody can steal him from the floor and those types
11 of things.

12 MS. KAMYKOWSKI: Go to the next page,
13 Justin.

14 Q. (By Ms. Kamykowski) we've got the flow
15 sheet that continues the newborn, WDL2017 flow sheet.
16 Initially we have -- so we have documentation at
17 1735, and right next to it, documentation at 1738.

18 Do you see the that?

19 A. Yes, ma'am.

20 Q. And the documentation in the column for
21 1738 that says "initial assessment," what is this in
22 your experience?

23 A. So the initial assessment, at least the
24 way we do it, I think the way most way people did it,
25 is at some point after the baby is born, they need a

1 full head-to-toe look. Sonograms are great, but
2 they're not perfect, especially for the small stuff.
3 And so we just get the baby naked, or as
4 close as naked as possible, and go -- kind of look
5 for everything. Is the hard palate intact? Is the
6 soft palate intact? Are the testicles where they're
7 supposed to be? Does everything -- ten fingers, ten
8 toes on each side? Is the anus patent, or does it
9 have a covering?

10 So little stuff like that that is
11 important to know but maybe isn't known
12 obstetrically, uh-huh.

13 Q. And this goes through, and I'm not going
14 to go through all of them, but it starts at the head.
15 This is basically a nursing head-to-toe assessment of
16 Remi happening as documented at 5:38 p.m.?

17 A. Yes, ma'am.

18 Q. Okay. And you talked a little bit about
19 it. There are, at the top, you see the little, it
20 looks like a little note typed in there. How -- is
21 this your understanding of a, quote -- what are the
22 differences between where it starts and says
23 fontanelle stops, and then we have a little note and
24 some smaller typing?

25 A. I'm assuming, again, this format, when it

1 gets printed, is a little bit different from what we
2 see clinically, but I'm assuming that this is a check
3 box or a drop-down for things they do all the time.

4 And then there's an option for free texting, as well.

5 So when it has that paper document with a
6 right corner folded, and then there's text, that's
7 usually something that people have free texted and
8 they've typed in.

9 Q. Okay. So on this first page, when we go
10 from head to neck to face to eyes to nose and then
11 part of the mouth -- I think it goes to the next
12 page -- when you reviewed that, did you see anything
13 significantly abnormal in the assessment that this
14 nurse did at 5:38?

15 A. In terms of HIE, no. In terms of the soft
16 tissue swelling and injury, you know, that's
17 certainly there. And we would expect that with a big
18 baby that had a prolonged labor, uh-huh.

19 MS. KAMYKOWSKI: Okay. Let's go to the
20 next page, please, Justin.

21 Q. (By Ms. Kamykowski) So it finishes with
22 the mouth. We're going to keep going up ahead. So
23 the ears are next, and then the chest. I want to
24 talk about that.

25 when it says "symmetrical movement on the

1 chest," what does that mean?

2 A. So the way I would interpret that is as
3 the baby's breathing, the chest is expanding and
4 contracting symmetrically. In rare cases, if we have
5 a nerve injury or a diaphragmatic injury, you might
6 see just one side of the chest moving and the other
7 side being still, and they're documenting the absence
8 of that, uh-huh.

9 Q. And the cardiac exam was normal at that
10 time?

11 A. Yes, ma'am. Well, at least what's
12 documented there is normal.

13 Q. So the rhythm was appropriate, the rate,
14 being how fast it was, and they did not hear a
15 murmur, which obviously is a big thing to be
16 evaluated in a newborn?

17 A. Yes, ma'am.

18 Q. Respiratory. What did they find on his
19 respiratory?

20 A. So they documented no retractions,
21 respiratory movements easy, and unlabored.

22 Q. All right. And then we go through the
23 abdomen, the umbilical cord, the back.

24 when we talk about backs, are these
25 nurses, is this nurse having her hand on Remi at the

1 time?

2 A. Yes, ma'am. So at this point, I'm
3 assuming, again, what we do in normal practice is, we
4 would flip the baby over, maybe have our hand on the
5 belly and kind of holding them up and pulling the
6 diaper down and looking at the spine and the back,
7 uh-huh.

8 Q. Okay. Then let's talk about the upper
9 extremities. What are the findings on the upper
10 extremities?

11 So when you are doing an assessment like
12 this of a newborn, how are you evaluating upper
13 extremities?

14 A. So basically just pulling each hand out of
15 the onesie and counting fingers, making sure their
16 range of movements and the tone is normal on each
17 side.

18 Q. And did they find ten fingers without
19 webbing, right?

20 A. Yes, ma'am.

21 Q. Fixed position maintained -- sorry --
22 flexed position maintained.

23 What does that mean?

24 A. So that gets back to the tone. So we want
25 to see full-term babies be in that flexed position,

1 and if they're not doing that, if their arms are out
2 or floppy, then we worry that something had happened.

3 Q. And then fullness of range of motion,
4 movement symmetrical, palmar creases, and then
5 present tone, symmetrical tone, and then we have this
6 note.

7 what does the note actually say about the
8 tone being asymmetrical?

9 A. Right. It says right arm with slight
10 increase in tone.

11 Q. And can you, after the fact, without
12 having examined this child, understand what that
13 means?

14 A. So after the fact, my assumption would be
15 based on what subsequently happens is that's likely a
16 nerve strain.

17 So Remi is -- so there's a couple
18 possibilities. Is he hypotonic everywhere for some
19 reason, HIE, or some other -- you know, Down Syndrome
20 babies can be hypoxic, things like that.

21 That generally is everywhere. We don't
22 see those causes present with hypotonia in one
23 particular extremity. So if it's just the right arm,
24 or if it's just the left arm, did something happen to
25 that arm or the nerves that supply that arm?

1 And the two big ones would be did the
2 clav-- did the collarbone break? Did this humerus,
3 the arm and the proximal arm, break? Or did the
4 nerves that run down the neck that supply the arm get
5 stretched?

6 And given that on subsequent imaging, he
7 doesn't have any fractures, the assumption would be
8 that he had a stretched nerve, what we call an
9 Erb-Duchenne palsy. And we see that with big, you
10 know, macrosomic babies who are delivered vaginally.
11 we see that periodically, and it generally will
12 resolve on its own, uh-huh.

13 Q. This nurse also documented at 5:38 on the
14 lower extremity, so his legs, that his movements were
15 symmetrical. He still had flexed position
16 maintained. His tone was symmetrical. And then it
17 talks about his hip click.

18 what's that?

19 A. So and when we're doing this assessment,
20 we're also checking for hip dysplasia. If the
21 femur -- sorry -- this big thigh bone, goes into the
22 hip socket like a ball into a -- it's like a ball
23 joint, if that's not right when we raise the knees up
24 and (indicating) dislocate the femur, and it is
25 horrible to feel when that happens. And we've all --

Q. Just to shortcut this --

A. Yeah. Sorry.

Q. Does the fact that the hip clicks were present, or bilateral hip clicks were present, have anything to do with whether he's showing signs of encephalopathy or anything to do with HIE?

A. No. I'm sorry. So clicks are normal. Clunks are very much not. And bilateral hip clicks are not related to HIE and are not pathologic, uh-huh.

Q. Okay. And so we know from this assessment that upper extremities and his lower extremities are all remaining in the flexed position, and he has some decreased tone in his right arm.

Is that the picture of a baby who has decreased tone as a result of hypoxic ischemia?

A. No.

Q. Okay. Then keep going through this assessment, the only other thing I wanted to talk about is at the bottom where it says "reflexes."

Tell us what is documented there and maybe explain what those are. We've heard a little bit about them.

A. So once they document a Babinski, grasp, Moro, rooting, and suck, those are 5 of the

1 primordial reflexes that all babies should have.

2 Q. And why would a newborn nursery nurse be
3 assessing these reflexes an hour and 10 minutes after
4 birth?

5 A. Two views: One, they're a global maker of
6 encephalopathy, so we want to make sure that they're
7 there. And the second one is, especially for rooting
8 and suck, they're going to be important in feeding,
9 as the baby starts to feed over the next couple of
10 hours. So we need to know that mechanically they can
11 do the work.

12 Q. Okay. Is she documenting here that these
13 reflexes are normal?

14 A. I assume so. There's no verb in that one.
15 So the next one in the NICU assessment, it says
16 "present."

17 I am assuming that they're also present
18 here. It would be exceptionally unusual to be
19 missing all 5 of those. But it says reflexes,
20 Babinski, grasp, rooting, suck, but then it doesn't
21 say the word "present." But it also doesn't say the
22 word "absent." So I'm assuming they're all there and
23 normal.

24 Q. And you mentioned Moro?

25 A. And Moro is right there, too.

1 Q. Okay. And Moro is that startle movement,
2 kind of you pretend that you're going to drop the
3 baby, and they go like this (indicating).

4 A. It's impressive, yes.

5 Q. So at that time the nurse is documenting,
6 the only tone decrease is in the right arm, correct?

7 A. Correct.

8 Q. Any other, as far as encephalopathy or
9 hypoxic ischemic injury, any other -- is there
10 anything about this exam that would lead you to
11 believe anything encephalopathically?

12 A. No.

13 Q. Is this considered a neurological exam?

14 A. Yes.

15 Q. Okay.

16 A. Yes.

17 Q. Let's see. And I do want to talk about,
18 and we know, as you pointed out --

19 MS. KAMYKOWSKI: If we go back up to page
20 291, Justin, just go through this side-by-side.

21 Q. (By Ms. Kamykowski) There is another
22 identical assessment, this head-to-toe assessment,
23 Exhibit 391. That is at 1:45, at that time?

24 A. Yes, ma'am.

25 Q. And that would be the assessment that a

1 nurse is doing when they have a transfer to the NICU.

2 Have you reviewed that head-to-toe
3 assessment in preparing for coming here today?

4 A. Yes, ma'am.

5 Q. Do you remember what, if any, differences
6 they found on his examination in the NICU on his
7 admission, in this flow sheet?

8 A. I think -- I can't remember if it's on
9 this flow sheet. I know at this point he's having
10 more respiratory distress. He's more tachypneic.

11 MS. KAMYKOWSKI: Go to the next page,
12 please, Justin. Under respiratory. Highlight both.
13 The one from 1538 -- sorry -- 1738, and now the one
14 from 1:45.

15 Q. (By Ms. Kamykowski) Is there a change in
16 his respiratory condition?

17 A. So now they're describing retractions,
18 subcostal retractions, and tachypnea. So tachypnea,
19 meaning he's breathing fast. And subcostal
20 retractions meaning he's using his chest muscles to
21 pull, and so you're seeing his belly kind of cave in
22 under the ribs because he's working harder.

23 Q. And I want to go back to the one on the
24 left, the initial respiratory assessment done at
25 5:38.

1 we know, and the jury has seen, at 5:35,
2 initial vital signs were also documented for Remi.
3 And they've seen that his initial respiratory rate
4 was 68 with an exclamation point.

5 How do you reconcile a 68 exclamation
6 point vital recorded in the chart with what this
7 nurse says about his respiratory rate 3 minutes
8 later?

9 A. 68 is abnormal, and that's why it got the
10 exclamation point. Normally we cap term babies at 60
11 at the upper limit of normal. I'm guessing what
12 happened based on this description being pretty
13 reassuring, babies have what's called periodic
14 breathing where they will slow down, and then they'll
15 speed up. And they don't breathe regularly the way
16 adults do.

17 So if you're watching a baby, and the 20
18 seconds you're counting the respirations happens to
19 be when they're going (indicating). You happen to
20 catch them during one of those quicker periods, and
21 that's what you documented, then that might be a
22 reason for 68.

23 If that happened to me, I would go back to
24 the nurse and be like, can we watch him for a minute
25 longer? Because you just put -- which would be 68,

1 and then a few minutes later you describe that way,
2 isn't really consistent, so I'm guessing they caught
3 him during a faster period.

4 Q. Considering now the NICU assessment, when
5 we look at the upper extremities at the bottom of
6 this page, and then going on to the next page with
7 the lower extremities, did they find any decreased
8 tone in Remi at the time they assessed him at 1:45?

9 A. I think they're still describing him as in
10 flexion, yeah, here. It's still normal tone from
11 that standpoint. Although they do have the
12 asymmetric Moro, which, again, we see with either
13 nerve injury or -- or clavicular or humerus injury,
14 where when you do the Moro, they'll throw the normal
15 hand out, but they don't want to move this one or
16 can't move this one, uh-huh.

17 Q. And if, again, if you were looking for
18 signs of either progressing encephalopathy or some
19 sort of global hypoxic event that happened at all,
20 would you expect to find an asymmetrical Moro in a
21 baby like this?

22 A. No, ma'am. So HIE by definition is going
23 to be bilateral. It should be both arms, both legs
24 affected. For something like neonatal stroke, where
25 it can be on one side or the other, maybe we'll see

1 some asymmetry. But for HIE, it should be bilateral.
2 Q. Okay. And at the end, you kind of showed
3 this before, the very last where the reflexes are, in
4 the NICU, he had all of his reflexes present, as
5 well, correct?

6 A. Yes, ma'am.

7 Q. There's been some talk about
8 breastfeeding, and I talked about it with Dr.
9 Kerzner. You saw that there were some difficulties
10 noted in the breastfeeding records for Remi, correct?

11 A. Yes, ma'am.

12 Q. And tell me from a neonatology standpoint
13 what is the significance of the baby at -- the notes
14 were from -- eight o'clock and 8:30 p.m., that he
15 was -- mom was attempting, but he was refusing to
16 suck. And then at 8:30, he was not interested.

17 what, in a vacuum, does that provide you,
18 as far as a neonatology assessment?

19 A. I mean, I think our differential diagnosis
20 would be how much has he eaten already? Has he ever
21 fed? And if he's not feeding, is it because he's
22 trying to latch -- is he interested, and he's trying
23 to latch, and he can't, or because mom doesn't have
24 milk supply? Or is he just not interested at all,
25 and then sort of just troubleshooting from there.

1 Q. okay.

2 MS. KAMYKOWSKI: Can you pull up
3 Exhibit 82, page 250?

4 Q. (By Ms. Kamykowski) This is an assessment
5 done around the same time that they get to mother and
6 baby, of Sarah, where the nurses are checking her
7 fundus or her uterus to see how it's going, and
8 probably checking her pain.

9 And there's a part of this flow sheet that
10 starts to talk about -- because it's very important
11 to think about mom's mental health at this time, her
12 spiritual and cultural, and then her coping.

13 Do you see that part of the flow sheet
14 here?

15 A. Yes.

16 Q. Okay. And at this time it says:
17 "maternal-infant attachment."

18 Is that an important thing from a
19 neonatology standpoint?

20 A. It is. We do a better job focussing on it
21 now than we did when I was a trainee. But, yes,
22 making sure mom and infant can bond, dads, too.
23 Skin-to-skin care, breastfeeding, we're a lot more
24 supportive than we used to be back in the dark ages,
25 uh-huh.

1 MS. KAMYKOWSKI: Go back to page 250,
2 please.

3 Q. (By Ms. Kamykowski) At that time under
4 the coping flow sheet, what is it saying of the
5 nurses observing of Sarah and her interaction and her
6 attachment with Remi?

7 A. So it looks like what's documented is
8 cuddles -- cuddles infant, eye contact with infant,
9 feeds infant.

10 Q. This is before eight o'clock, and we've
11 seen --

12 MS. KAMYKOWSKI: If we go to Remi's chart,
13 please, Justin, at --

14 Q. (By Ms. Kamykowski) well, actually, we
15 know -- you remember, do you not, at 83, page 2396.
16 It shows that timing stamp here at 2000. That's
17 eight o'clock, right? And at 8:30, and that's where
18 there's this breastfeeding issue happening, and then
19 we know --

20 MS. KAMYKOWSKI: If we go, Justin, to page
21 1573, please. Next page.

22 Q. (By Ms. Kamykowski) A nurse, with Remi --
23 and we heard this from Mr. Anyan -- at 11:30 was
24 contacting the pediatrician.

25 You've seen this note, correct?

1 A. Yes, ma'am.

2 Q. And in response, it looks like they
3 attempted to give Remi some formula in the nursery,
4 correct?

5 A. Correct.

6 Q. And then sometime after this note, we know
7 he's admitted to the NICU at 1:19. So this is a time
8 frame where he's developing the tachypnea and other
9 issues --

10 A. Yes.

11 Q. -- is that right? That's your
12 understanding? Okay.

13 Let's look at Dr. Thakadiyil's admission.
14 We talked about this a little bit for Remi for the
15 NICU. This is the one, if you look at 1506, timed at
16 1:35 a.m.

17 And is that a note that you, as an
18 attending in the NICU, would be preparing if you had
19 a baby transferred from the newborn nursery to you?

20 A. Yes. We are required to do a history and
21 physical admission on every baby.

22 Q. And you've seen these notes before,
23 correct?

24 A. Yes. This, again, this format's a little
25 different when it's printed. But this looks like one

1 we'd do.

2 Q. And you looked through this note, correct,
3 Dr. Cantey?

4 A. Yes.

5 Q. And when Remi is admitted, and Dr.
6 Thakadiyil does her initial H&P, does she have signs
7 and symptoms of encephalopathy from a neurological
8 standpoint from your perspective at that time?

9 A. So I think the one that comes up because
10 of the reason for transfer is the fussiness, so the
11 irritability. And I can't remember whether that's
12 documented in this.

13 Q. It is. This is the one that says the baby
14 was frantic at the breast.

15 A. So if you give Remi, you know, points,
16 credit, for being irritable for one of those six
17 domains that we would look for encephalopathy in the
18 traditional sarnat neurologic examination, that is
19 the main one that I remember that's down there.

20 Pupils being responsive, the heart rate
21 and the respiratory rate are okay at that point.

22 Moving all of his extremities, decreased Moro on the
23 right arm, but otherwise no abnormalities noted. And
24 then neuro is down just below that, yeah. Yeah, very
25 difficult to console, which is that irritability,

1 uh-huh.

2 Q. Okay. So in thinking about the
3 plaintiffs' theory in this case that the severe --
4 would you agree that Remi's brain, as seen on MRI, is
5 severe?

6 A. So there's a couple of different ways to
7 categorize it. We refer to mild, moderate, severe
8 based on that Sarnat examination in the neonatal
9 period.

10 Then there's how bad does it look on MRI?
11 And then there's obviously the long-term. Like how
12 is Remi doing long-term, which -- so in the sense of
13 the MRI, yes, it's very severe.

14 Q. And as far as if Remi's severe hypoxic
15 ischemic injury that was global was in the deep gray
16 matter and in his white matter happened in the last
17 hour before he was born, how does that track with
18 what was seen for the hours of assessments that are
19 done all the way until he gets to the NICU?

20 A. So generally if a baby is going to have a
21 severe injury perinatal, so right around the time of
22 delivery, they're going to come out with significant
23 encephalopathy. They're going to have low Apgar
24 scores. They're going to have a very abnormal
25 neurologic exam.

1 Q. okay.

2 A. I want to make sure this is true before I
3 say it. I cannot recall a time I've ever had to go
4 get a baby for cooling because of Sarnat
5 abnormalities from the nursery. Usually they're
6 coming straight to us because either they had to
7 really struggle to get going in the delivery room, or
8 they're clearly encephalopathic, and we're taking
9 them right away.

10 Q. And as far as the fact we know that the
11 jury's heard at 14 and a half hours of life, Remi had
12 seizures, how does that play into your timing
13 opinion, if at all?

14 A. So this -- it's consistent with kind of
15 what the assumption is based on how he looks
16 perinatally. The seizures are a clear sign that he's
17 into that secondary reperfusion injury, which, again,
18 is somewhere between 6 to 12 hours, up to 48 to 72
19 hours. I know that's a big window.

20 But regardless of what his neurologic exam
21 is going into it, once he has a seizure, that is, by
22 definition, encephalopathy all by itself. It is
23 sufficient to make the diagnosis. So at 14 and a
24 half hours, that's his HIE manifesting regardless of
25 what you gave credit for earlier.

1 Q. So this has always been a puzzle for me.
2 we know, as we sit here today, that Remi suffered a
3 hypoxic ischemic injury, a full injury to his brain,
4 at sometime before he was born, correct?

5 A. Correct.

6 Q. And we know he had seizures that are
7 evidence of that injury at 14 and a half hours of
8 life, correct?

9 A. Correct.

10 Q. So what -- how can you tell this jury the
11 timing of this is more likely than not, not within
12 that last hour, based on everything that you've seen?

13 A. So it's a combination of the fact that he
14 looks pretty good after delivery. He's born, he's
15 resuscitated, and he has an Apgar score of 8. It is
16 not consistent for us, based on all the babies that
17 we take care of with us, that are profoundly HIE,
18 profoundly depressed, baby responds that beautifully
19 to resuscitation.

20 I wish they all did, they don't. They are
21 really hard to resuscitate. And then his neurologic
22 exam is normal, or at least normal enough, where's
23 able to be assessed by different people, go to the
24 newborn nursery, spend time with mom and dad, and
25 then start to manifest as he gets farther into that

1 secondary reperfusion injury period.

2 Q. And one last bit of data that you talked
3 about in this case that supports your opinion, or the
4 bases of your opinion, is Exhibit F2-J.

5 And you've seen this document before.
6 I've put this together. You and I put it together
7 from the medical records, is that right?

8 A. Yes, ma'am.

9 Q. And can you just walk us through this
10 document and how it also provides support for the
11 timing opinion that you have.

12 A. Sure. So -- and I realize this is
13 complicated. But basically when there is a hypoxic
14 ischemic hit to the body, it's not just the brain,
15 it's all of our tissues get impacted. And the body
16 has a way to prioritize which organs are going to get
17 the blood flow and which organs are going to get the
18 oxygen. You know, it's a wartime decision by the
19 body. It's you, you, you. You organs are on your
20 own.

21 The organ that generally is sacrificed
22 first by the body is the liver. The liver can
23 regenerate. The liver is remarkably resilient. So
24 if the body goes, okay, liver, no blood for you,
25 we're going to prioritize, the heart and the brain,

1 and the adrenal glands which secrete our -- our
2 stress hormone to help keep us alive when we're
3 struggling.

4 So when babies have hypoxic ischemic
5 encephalopathy, we often will see elevated liver
6 function tests. So this isn't essentially hepatitis.
7 This is enzymes that should be inside the liver that
8 have now spilled out into the bloodstream because the
9 liver is irritated.

10 Kidney function. How well are the kidneys
11 filtering the blood, clearing out laced product? In
12 some cases, cardiac muscle. The babies essentially
13 can suffer heart attacks, just like people my age
14 would when their cardiac enzymes can be elevated. We
15 don't have those here.

16 And so in this particular case, as they're
17 checking these labs on Remi, what we see is the
18 creatine is at -- very abnormal for a baby. So this
19 baby has had decreased oxygen, decreased blood flow,
20 to the kidneys.

21 The liver function tests aren't abnormal.
22 They're not wildly abnormal. But they are mildly
23 elevated, so the liver has taken a hit. Generally if
24 the injury is right around the time of delivery, what
25 we see is all these things get worse for a day or two

1 or three, kind of peak, and then gradually normalize
2 over time.

3 In this particular case, from the initial
4 labs that are drawn, looks like the morning of May
5 5th for the kidneys, and the morning or May 6th, or
6 lunchtime on May 6th, for the liver. Those organ
7 functions are already normalizing, which suggests
8 that the injury is a little bit farther back, because
9 the baby, Remi, has already had a chance to peak and
10 start his recovery process.

11 So this is a little bit more -- it's hard
12 because these are very small data points. This is
13 one sheet to work with. But if you force me to
14 guess, based on these labs, it looks like the injury,
15 the injury, is a little bit farther back, uh-huh.

16 MS. KAMYKOWSKI: All right. Can you pull
17 up for me, Justin, Plaintiffs' Exhibit 350 and page

18 2.
19 Q. (By Ms. Kamykowski) Dr. Cantey, the jury
20 saw this with Dr. Kerzner. And I just want to go
21 through based on what you just told us what you can
22 agree or disagree with Dr. Kerzner, okay?

23 I'm going to go into the -- starting on
24 the left-hand column, and you've seen this before.

25 A. Yes, ma'am.

1 Q. But most of this is his clinical data,
2 like it's just observable within the chart.
3 Is there anything in the first side that
4 you disagree with?

5 A. So I don't know that I would use the term
6 "lifeless" because that means something different to
7 me, but he's definitely more depressed for No. 5, so
8 I agree with those numbers. I agree with the Apgar
9 scores.

10 8 is really -- 8 is challenging because,
11 again, it doesn't look like from the photos that I've
12 seen, or from the exams that are documented that he
13 does have persistently low tone. His tone looks
14 normal from the assessments just on the pictures.

15 I do agree, at least from the pictures
16 that I saw, that he's not crying. Lots of babies do
17 that. You know, as long as he's awake, alert, and
18 snuggling with mom, that is itself -- I don't know
19 that I would put that as a marker of HIE on this
20 report.

21 Q. Can we say that 8 is a yes and no injury?

22 A. Yes. He's not actively crying in the
23 photos, yes, I agree with that.

24 Q. And I think we're all going to agree that
25 No. 9 is a yes, right?

A. Correct.

Q. what about 10?

A. So 10, he has his -- his neurologic examination is reflected, as documented in that initial head-to-toe assessment.

Q. well, let's go through this.

So 10 would be a no.

A. 10 would be a no.

Q. okay.

what about 11?

A. He definitely has a neurologic assessment as part of that head-to-toe.

Q. How about irritable in the nursery?

A. Initially no, based on the assessments. He certainly becomes fussy or irritable as he's being transferred to the NICU. So depending on the timing there, I would say no in the initial period, and then it becomes yes later on.

Q. we didn't talk about 12. Force feeding in the nursery. How do you feel about that?

A. It's hard to say. Because if he fed once and then passed out, or fell asleep, I should say, that would be pretty normal term newborn behavior. Certainly, at some point, he's not feeding well, and they offer him formula, and he won't take it, and

1 they move him to the NICU. So at some point it
2 becomes a yes, but initially it may have been normal,
3 uh-huh.

4 Q. Can we say yes and no on that one, too?

5 A. Yes.

6 Q. Okay. I'm going to write all over myself.

7 All right. And then we talked about
8 irritability. That's a no, right?

9 A. Correct.

10 Q. Tired and floppy in the nursery?

11 A. Yeah. I would disagree with floppy,
12 again, just based on what's documented in those
13 pictures. Tired is certainly possible, so that's
14 another yes and no.

15 Q. Okay. The rest of that, it kind of talks
16 about most of it. Is there anything else that we
17 talked about? She has elevated lactate and kidney
18 and liver labs.

19 As a constellation of a marker for
20 encephalopathy, what's your opinion about what we
21 just went over with the jury?

22 A. Right. So for No. 23, I agree. The
23 lactate creatine, which is the surrogate for how well
24 the kidneys are filtering and the liver enzymes, they
25 are elevated.

1 I do think based on the fact that they're
2 decreasing rather than increasing, that injury is
3 probably a little more remote than right around the
4 time of delivery, but they are definitely elevated.

5 Q. Okay. And so the jury has seen a bunch of
6 these. Our neuroradiologist had timed it. Dr. Sze
7 had some different timing. But Dr. Tekes, based on
8 the MR, said at least three days before, up to four
9 days before. So her window of injury is May 2nd,
10 from 3:07, to May 3rd, at 3:07.

11 Understanding your opinion, you can't
12 narrow it -- can you narrow it that far?

13 A. I don't know that I can narrow it that far
14 without specific MRI findings, but I have no reason
15 to disagree with that, based on when we know the
16 second injury tends to present.

17 Q. If I were to ask you -- well, you've
18 already told us, is it more likely than not that this
19 injury occurred in the last hour before Remi was
20 born, to a reasonable degree of medical certainty?

21 A. No.

22 Q. What is the window of time you, Dr.
23 Cantey, can narrow it?

24 A. So based on the -- if the seizure was the
25 last presenting finding of secondary reperfusion

1 injury, you would go back as far as two or three
2 days. So that's 5/5 in the afternoon. So you're
3 going back to maybe 5/2 in the afternoon.

4 Q. Okay.

5 A. If you use 48 hours, you might be going
6 back to 5:30 in the afternoon.

7 Q. So still sometime...

8 A. In that window.

9 Q. And I'm going to put a different color for
10 you.

11 A. Yeah. The -- sorry, I'll pause.

12 Q. That's okay. Go ahead. I'll write while
13 you talk.

14 A. The latest the injury could have
15 presumably have happened would be 6 to 12 hours
16 before the reperfusion started. So, again, the
17 irritability and the poor feeding and ultimately the
18 seizures, then that does put you closer to delivery,
19 but then I just -- I cannot reconcile that with how
20 he responded to the resuscitation in the delivery
21 room and how he looked initially. That would be
22 inconsistent with all the babies I've treated.

23 Q. Possible but not more likely than not?

24 A. Exactly.

25 Q. But your window, Dr. Cantey, is sometime

1 in the afternoon on 5/3, based on the timing of the
2 seizures. It could be maybe pushed back further onto
3 5/2 at sometime?

4 A. Yes, that's consistent.

5 Q. And have all the opinions you've given
6 here today been to a reasonable degree of medical
7 certainty?

8 A. Yes, ma'am.

9 Q. Thank you, Dr. Cantey. I have nothing
10 else.

11 THE COURT: On behalf of the doctor?

12 MR. PERRON: Yes, Your Honor.

13 DIRECT EXAMINATION

14 BY MR. PERRON:

15 Q. Doctor, who is in a better position to
16 judge tone of the options that we have: Nurse
17 Spencer, who's there physically at the time with her
18 hands on the baby, or someone sitting here in court
19 looking at one or two photos?

20 A. Both.

21 MS. LENIVY: Your Honor, may we approach?

22 THE COURT: You may.

23 (The following proceedings were held at
24 sidebar, outside the hearing of the jury:)

25 MS. LENIVY: I would object to this

1 question. I think there was a specific motion in
2 limine that all parties agreed to not have one expert
3 comment on the credibility of another expert, to ask
4 him to discredit Dr. Kerzner and her opinion in this
5 manner.

6 Again, the Court has ruled on that motion
7 in limine. And I believe it is an inappropriate
8 question, and it's not relevant.

9 MR. PERRON: Your Honor, I'm not touching
10 on credibility at all. I'm asking him to weigh the
11 accuracy of assessment, the hands-on trained nurse
12 practitioner versus what you can tell from a photo.

13 And I believe that's -- he's already testified to
14 that more or less on direct. I'm just asking him in
15 a concise way if he agrees with that.

16 MS. LENIVY: Who is in a better position
17 goes directly to the credibility. That's one expert
18 attacking the credibility of our expert, and I would
19 object.

20 THE COURT: I'm going to overrule that
21 objection. And I highly doubt we're getting this guy
22 out at 5:00.

23 MR. PERRON: I've got six questions.

24 MS. KAMYKOWSKI: There is
25 cross-examination, unless you're going to say we

1 can't do it.

2 (The proceedings returned to open court.)

3 Q. (By Mr. Perron) Doctor, is part of your
4 practice ordering blood gas?

5 A. Yes, sir.

6 Q. Okay. Is the duration of the second stage
7 of labor itself ever a consideration for you to order
8 blood gas?

9 A. Not in a vacuum, no.

10 Q. What clinically would make you, as a
11 neonatologist, think I need to order a blood gas on
12 this patient?

13 A. Generally we are going to get blood gases
14 if there's been a change in the respiratory
15 situation. So if the baby starts having increased
16 worker breathing or shallow breathing or no
17 breathing, we'll check the blood gas. That's my most
18 common reason.

19 Q. Okay. And that sort of respiratory
20 distress, does that match how Remi is documented to
21 have appeared after that initial resuscitation and
22 delivery?

23 A. No. After resuscitation, his breathing
24 looks reassuring.

25 Q. The cooling protocol. Do you have an

1 opinion -- do you have an opinion of whether cooling
2 protocol would have been initiated on Remi, even with
3 a cord gas ordered, considering the totality of
4 evidence you looked at?

5 A. So I think with the --

6 MS. LENIVY: I'm sorry, Judge, can we
7 approach?

8 THE COURT: You can.

9 (Proceedings were held at sidebar, outside
10 the hearing of the jury.)

11 MS. LENIVY: Judge, I don't --

12 MR. PERRON: It's page 129.

13 MS. LENIVY: You're asking him about cord
14 blood gas. I asked him: Do you have any opinion
15 versus Remi's blood cord gas would have been had they
16 been taken, and he's said no, he does not have an
17 opinion.

18 MR. PERRON: My question was whether he
19 would qualify for cooling protocol which was -- my
20 question begins on 128. It goes on to 129. It
21 finishes on 130. And it says: Most places will not
22 offer cooling to him at that point.

23 MS. LENIVY: You asking about regardless
24 of the cord blood gas. And he says he doesn't know
25 what the cord blood gas is. The question is --

1 MR. PERRON: I'll rephrase. I'll
2 rephrase.

3 THE COURT: Okay.
4 (Proceedings returned to open court.)

5 Q. (By Mr. Perron) Doctor, do you have an
6 opinion whether cooling -- do you have an opinion
7 whether Remi would have been a candidate for cooling
8 therapy, considering all of the evidence that you
9 reviewed in this case?

10 A. So based on what's available, I would say
11 more likely than not, no.

12 To qualify for cooling, there has to be,
13 first, evidence of acidosis. And, assuming that's
14 present, then we move to the neurologic examination.
15 And the neuro exam has to be abnormal to a -- there's
16 six domains. We score them normal, mild, moderate,
17 severe.

18 If three or more of those domains are
19 moderate or worse, then they would be cooled. So
20 based on the assessments that are documented, I think
21 it is unlikely that he would have been assessed as
22 having moderate or severe encephalopathy and then
23 starting on hypothermia.

24 Q. Do you have an opinion in this case
25 whether cooling would have made a difference in

1 Remi's final outcome, more likely than not?

2 A. Yeah. This is more speculative, but to
3 the standard of more likely than not, I don't think
4 so because I do think, based on the labs and his
5 initial presentation, the injury is somewhat remote,
6 and unfortunately the more remote the injury is, the
7 less good cooling is going to do.

8 Q. And the opinions that I've solicited from
9 you, do you hold those to a reasonable degree of
10 medical certainty?

11 A. Yes.

12 Q. Those are all my questions.

13 THE COURT: Cross-examination?

14 MS. LENIVY: Yes, Your Honor. If I could
15 just have one moment to sort of situate myself?

16 THE COURT: You may.

17 CROSS-EXAMINATION

18 BY MS. LENIVY:

19 Q. I apologize, Dr. Cantey --

20 A. No worries.

21 Q. -- I've got a little bit going on.

22 Dr. Cantey, it's good to see you again,
23 and welcome to St. Louis.

24 A. Thank you. You, too.

25 Q. I am going to do my very best to ask you

1 questions efficiently, but I do have some questions

2 for you because this is an important case.

3 You'd agree with me, right?

4 A. Yes, ma'am.

5 Q. All right. Dr. Cantey, you timed this
6 injury, and your window of time for this injury was
7 that it occurred as early as May 3rd at 4:30 a.m., up
8 until the time of delivery, correct?

9 A. Yeah. That would be -- that would be
10 consistent with the window.

11 Q. Correct. In your deposition I asked you
12 what is the earliest and the latest time this injury
13 could have occurred, and you told me the earliest was
14 May 3rd, at 4:30 a.m., approximately 36 hours before
15 birth, right? Correct?

16 A. Yes, ma'am.

17 MS. KAMYKOWSKI: Your Honor, can we talk
18 about the page and line numbers?

19 MS. LENIVY: Absolutely.

20 Q. (By Ms. Lenivy) If you want to look at
21 page 138, line 7 through 17. And, Doctor, it looks
22 like you've got a copy of your depo up there.

23 A. I do, yes, ma'am.

24 Q. Please feel free to reference it.

25 In your deposition, I asked you: Just to

1 make sure I'm clear, as far as your window of time,
2 you timed the injury happening as early as May 3rd --
3 I apologize. Are you there?

4 A. No, ma'am. Sorry.

5 Q. Oh, I'm sorry. I apologize.

6 A. 138?

7 Q. 138, yes, sir.

8 A. Sorry. My numbers might be different.

9 Q. I have a stapled copy, if that would be
10 helpful for you.

11 A. Is that okay?

12 Q. I printed it for you.

13 A. I appreciate it.

14 Q. And I'll just keep writing.

15 A. Yes, ma'am.

16 Q. So in your deposition, I asked you: And
17 when you took that deposition you swore your hand --
18 raised your hand and swore to tell the truth, just
19 like you did today, right?

20 A. Yes, ma'am.

21 Q. Okay. And so when you took your
22 deposition under oath, and I asked you: Just to make
23 sure I'm clear, as far as your window of time, you
24 timed the injury happening as early as May 3rd at
25 4:30 a.m., up until the time of delivery, and you

1 answered yes, correct?

2 A. Correct.

3 Q. And then you continued your answer: Yes,
4 ma'am. I think based on the initial clinical
5 appearance, the timing of the seizures, and the MRI,
6 I think that's a window that's pretty reasonable.

7 was that your answer, sir?

8 A. Yes, ma'am.

9 Q. Okay. So I'm going to just make sure I
10 get this up here now.

11 we know that delivery was what? 5/4, at
12 4:24 p.m., right?

13 A. Yes, ma'am.

14 Q. Okay. So this is Dr. Cantey's reasonable
15 window of time -- right? -- for your deposition?

16 A. Yes, ma'am.

17 Q. Okay. Great. I know you were asked a
18 little bit about your background, and I just want to
19 make sure that I'm clear. At the time of your
20 deposition, and it sounds like it's still that way
21 today, 25 percent of your time is clinical, quote,
22 "boots on the ground" -- we've heard that phrase --
23 and then 75 percent is research and academics,
24 correct?

25 A. Correct.

1 Q. And the vast majority of your research and
2 academic work focuses on infection and use of
3 antibiotics?

4 A. Of my personal research, that's where it
5 tends to specialize. I do a lot of clin -- because I
6 am the trialist, I do a lot of clinical trials for
7 things that aren't industrial related, like neonatal
8 congenital heart disease or things like that, but...

9 Q. Okay. But you agree, infection did not
10 cause Remi's hypoxic ischemic injury -- correct? --
11 his encephalopathy?

12 A. I do. I would slightly qualify and say
13 Remi had no evidence of infection. Ms. Anyan's
14 chorioamnionitis does not help the -- the raised
15 metabolism. Babies don't like being hot and hypoxic
16 ischemic at the same time, so that didn't help, but
17 that was not a primary cause of anything.

18 Q. Okay. And that's maybe a better way of
19 phrasing it. There's no evidence of infection and
20 similarly no evidence of a kinetic or metabolic
21 abnormality for Remi's HIE, right?

22 A. Yes, ma'am.

23 Q. And I think I heard you say on direct,
24 that you agree that this is a hypoxic ischemic event.
25 It's starved of oxygen basically?

A. Yes, ma'am.

Q. I asked you about Dr. Sze, who's my neuroradiologist, during your deposition, and I think you told me you recognized his name because he writes a lot about neonates, and you've seen some of his literature.

A. Yes, ma'am.

Q. Okay. Talked a little bit about your litigation history. And prior to your involvement in this case, you had actually worked with the Brown & James law firm before, correct?

A. I believe that's true. I didn't remember at the time of deposition, but that's right, uh-huh.

Q. Right. I think that's the Livingston matter. Does that sound correct?

A. It may well be, uh-huh.

Q. Okay. And I'm familiar with that case, and I believe that case did involve infection, right?

A. I do not remember. I'm sorry.

Q. Okay. That's okay.

A. Uh-huh.

Q. Either way, you'd agree the vast majority of the time when you've testified has been on behalf of defendants, correct?

A. The majority, yes, ma'am.

1 Q. Okay. And I know Ms. Kamykowski covered
2 how much you've been paid, or the fact you've been
3 paid, I just want to get this, and we'll add up the
4 numbers later.

5 But as of August 23, I believe you had an
6 invoice of \$2,250, correct?

7 A. Yes, ma'am.

8 Q. And then you told me in your deposition,
9 you've probably done about another 8 hours of work at
10 \$450, so the math is about 3600, correct?

11 A. Yes, ma'am.

12 Q. And then your depo was \$4,000 for a flat
13 rate, right?

14 A. Correct.

15 Q. And then you charge \$8,000 for a half day
16 of trial testimony, correct?

17 A. Full.

18 Q. Or full--

19 A. Might be a full day, yes, ma'am.

20 Q. And at least in your fee schedule, it says
21 you bill for travel.

22 Are you billing for your travel in this
23 case?

24 A. In this particular case, they got my
25 ticket and hotel, uh-huh.

1 Q. Okay. I assume you've done more work to
2 prepare for your deposition today -- I'm sorry -- to
3 appear for your testimony today?

4 A. Yes, ma'am.

5 Q. How many more hours do you think you've
6 worked since I last saw you for your depo?

7 A. Probably maybe 8ish. I don't want to
8 overly specify things. I don't want to perjur
9 myself, but maybe about 8, uh-huh, yeah.

10 Q. Okay. They'll read the transcript when
11 you send that invoice.

12 A. Okay.

13 Q. And that's at the \$450 rate?

14 A. Yes, ma'am.

15 Q. Thank you, sir.
16 Okay. Let's talk about Sarah and Remi
17 Anyan.

18 Dr. Cantey, do you know how long Sarah's
19 second stage of labor lasted with Remi?

20 A. Yes, ma'am, I believe so. It's about
21 12 hours.

22 Q. Okay. And you have an understanding that
23 the average second stage of labor for patients in the
24 hospital setting like Sarah, is around 3 to 4,
25 correct?

1 A. Yes. On average. But I would defer to
2 the OBS for the specifics, huh-huh.

3 Q. Okay. And we've had OBS talk about it.
4 But at least, from your perspective as a
5 neonatologist, average second stage of labor is 3 to
6 4, from your experience?

7 A. Yes, ma'am.

8 Q. And when you're getting called in as a
9 neonatologist into the delivery room, that's
10 typically because something may be going wrong with
11 mom or baby, right?

12 A. We get called for any baby that they think
13 might need resuscitation, and that's a pretty wide --
14 so, yes, any of prematurity, meconium, chorio,
15 nonreassuring fetal heart tones. Any of those will
16 get the team in, just because we'd always rather be
17 there and not be needed than vice versa, uh-huh.

18 Q. Okay. And one of the concerns with labor
19 in general is the possibility of decreasing or
20 worsening perfusion for the baby, right?

21 A. Yes, ma'am.

22 Q. And that's blood flow to the brain. And
23 the blood carries the oxygen to the brain, right?

24 A. Yeah. I would say blood flow to the
25 entire baby, but we tend to see it reflected on

1 strips based on the brain, uh-huh.

2 Q. Okay. And I think an example of -- that
3 you gave me of, at least in your deposition, as far
4 as, you know, this concern of perfusion, is you
5 talked about when the water breaks, and the baby
6 loses that fluid, kind of a cushion, right?

7 A. Uh-huh, yes. Yes, ma'am.

8 Q. Okay. And that's because once that
9 cushion is gone, now baby's head might be starting to
10 hit the pelvic region, and now it's bone-on-bone,
11 right?

12 A. Potentially, yes, ma'am.

13 Q. And you're aware that Sarah -- well, do
14 you know what time Sarah Anyan's water broke?

15 A. I -- I had it in my notes. It was -- it
16 was about 24 hours before delivery, so it would have
17 been about 4:30 p.m., on the -- give or take.

18 Q. Pretty close. Pretty close. It's about
19 28 hours?

20 A. 38 hours.

21 Q. At 12:00 p.m. on the 3rd. And she got to
22 the hospital -- and it was clear fluid. When her
23 water broke, it was clear. And do you have an
24 understanding if that's a good sign, when your water
25 breaks, it's clear?

1 A. We'd rather it be clear, than any other

2 color, yes, ma'am.

3 Q. Right. That's -- that's -- that's what we

4 want. That's a sign of a good, healthy pregnancy,

5 right?

6 A. It is reassur -- I would say it's

7 reassuring, uh-huh.

8 Q. Reassuring, that's a good word.

9 And then within about 2 hours after her

10 water broke, she's at Mercy Hospital, right?

11 A. I believe that's right, yes.

12 Q. And shortly after arriving, they hook her

13 and Remi up to the monitors, right?

14 A. Yes.

15 Q. Correct?

16 And those fetal heart monitors, from 2:00

17 p.m., through the rest of May 3rd and to the early

18 morning of May 4th, were Category I, and that's

19 reassuring, correct?

20 A. Correct.

21 Q. Okay. You also saw Sarah's records when

22 she got to the hospital that not only clear fluid

23 when her water broke, but also good fetal movement,

24 right?

25 A. Yes.

1 Q. Did you see that record?

2 A. Yes.

3 Q. Okay. And I think you testified in your
4 deposition that based on the fact that when Sarah got
5 to Mercy Hospital and was hooked up to the monitors,
6 and they were Category I for the rest of 5/3, that
7 could have reassured you that this injury didn't
8 occur from the time she got to the hospital all the
9 way through those Cat I readings, right?

10 A. Yeah. I think it's -- yes. I think
11 that's a reasonable statement. It's very unlikely
12 that Remi had hypoxia during the time where he was
13 Category I.

14 Q. Okay. After Category I, those are
15 reassuring, right?

16 A. Right.

17 Q. Okay. And we'll talk about fetal heart
18 rate tracings in a moment here. I want to shift
19 gears a little bit and talk about Apgars, which we've
20 talked about extensively before your testimony.

21 But you agree that Apgars are subjective,
22 primarily tones and reflex irritability.

23 A. To the sense they are subjective, and all
24 of those are the two categories where we usually see
25 some variance, uh-huh.

1 Q. Okay. And the jury already knows Nurse
2 Practitioner Younger gave Remi a 2 for tone at the
3 5-minute mark, right?

4 A. That's right.

5 Q. And just so we're clear on background
6 here, Nurse Practitioner Younger, she's a nurse
7 practitioner. She's not a neonatologist like
8 yourself, correct?

9 A. True.

10 Q. Or Dr. Kerzner or Dr. Dreyer. She's --
11 it's -- I don't mean to demean her, but it is less
12 training and less education than an M.D., correct?

13 A. The -- the -- the -- the credentialing
14 itself is less. That being said, I work with some
15 neonatal nurse practitioners who are a year out of
16 being a bedside nurse that have just gone through LNP
17 school. And I work for some who are 40-year vets.
18 so I don't -- it's not categorically that they have
19 less experience, but the specific credentialing is a
20 little bit less, yes.

21 Q. Right. And I think Ms. Kamykowski covered
22 this on direct. Nurse practitioners can only
23 practice under an M.D. for super beginner overview,
24 right?

25 A. Right. Sometimes that is very indirect.

1 Supervision is they have to have some over signer

2 signoff, uh-huh.

3 Q. Okay. And so Nurse Practitioner Younger,

4 and we saw Dr. Thakadiyil signed off on her note.

5 But to be clear, there was no actual neonatology M.D.

6 in the delivery room with Remi when those

7 resuscitation efforts were happening and when the

8 Apgar score was given, correct?

9 A. Correct.

10 Q. And I know you mentioned, you now have

11 seen pictures of Remi, correct?

12 A. Correct.

13 Q. You didn't have those pictures at the time

14 of your deposition, correct?

15 A. No, ma'am.

16 Q. Okay. So between the time of your

17 deposition and today, you've now gotten some photos.

18 I know you weren't here yesterday.

19 MS. LENIVY: And, Zack, maybe we could

20 pull up 63-1.

21 Q. (By Ms. Lenivy) And, Dr. Cantey, I'll

22 move this so you can see it here.

23 The jury has seen this photo before, just

24 to reorient ourselves. This was at 4:37 p.m. to

25 about 13 minutes of life.

1 Did you see this photo?

2 A. Yes, ma'am.

3 Q. Okay. You weren't here yesterday for
4 Dr. Woodruff's deposition -- or Dr. Woodruff's
5 testimony, and he's the pediatric neurologist the
6 defense hired.

7 You read his deposition, right?

8 A. I believe so, yes.

9 Q. Dr. Woodruff, when my colleague,
10 Ms. Slater, showed him this picture, he indicated
11 that he saw some decreased tone.

12 Do you see decreased tone?

13 A. So, again, the same caveat that it's a
14 picture, and I can't manipulate beyond it. This is
15 the one out of that whole sequence where his arms are
16 somewhat in extension, his wrists are flexed, which
17 is somewhat reassuring, and it looks like his right
18 arm is a little bit bent, but that left arm is
19 certainly an extension in that picture.

20 Q. So what you're saying is where Dr.
21 Woodruff sees decreased tone, you may not necessarily
22 see that?

23 A. I would say while sworn in, I would never
24 want to state that I could tell tone from a picture
25 because you can't. But based on position, if that

1 was the only picture I had seen, the assumption is
2 the baby's got lower tone because his arm is out in
3 extension.

4 Q. I'm sorry. You said the assumption is
5 he's got lower tone?

6 A. The assumption would be the baby's tone
7 would be lower because the arm is in extension. It's
8 also -- well, yes, uh-huh.

9 Q. Okay. Either way, there's some
10 subjectivity to Apgar scores.

11 A. A little bit. I wouldn't -- I just don't
12 want to categorize that it's subjective because
13 they're pretty good. But tone and reflex, when we
14 see people disagree, it's usually those two domains,
15 and it's usually by 1 point.

16 Q. Well, when I asked you if there is a level
17 of subjectivity in giving Apgar scores, you did
18 answer -- you did tell me a little bit, but primarily
19 in tone and reflex.

20 A. Yes, ma'am.

21 Q. Okay. Apgar scores don't tell us whether
22 a baby has HIE. They tell us whether a baby needs
23 resuscitation and different resuscitations work, is
24 that fair?

25 A. That's fair.

1 Q. Okay. And the jury has seen these records
2 already, but at least at 5 minutes of life, Remi was
3 still receiving some resuscitative efforts, correct?
4 He was still on the CPAP.

5 A. So, again, I wouldn't categorize CPAP as
6 resuscitation. It is meant -- and literally it's not
7 resuscitation because if that's all we do, we cannot
8 bill for resuscitation, that's fraud. It is meant
9 only to expand the lungs and support the baby's own
10 breathing.

11 MS. LENIVY: Zack, could you pull up
12 Exhibit 3, page 3185.

13 Q. (By Ms. Lenivy) while Zack is pulling
14 that up, giving the computer a minute to wake up.

15 But you do also recognize, Dr. Cantey,
16 that at 10 minutes of life, Remi was still receiving
17 CPAP, correct?

18 A. I think so, yes, ma'am.

19 Q. Okay.

20 MS. LENIVY: Hey, Zack, don't worry about
21 Exhibit 3. Let's actually go to Exhibit 420. These
22 are all exhibits the jury has seen before.

23 Q. (By Ms. Lenivy) All right. So while
24 we're working through some technical difficulties, I
25 will represent to you, Dr. Cantey, that

1 Exhibit 420 -- it's now up -- I think I heard you say
2 on direct that this is an ACOG thing about Apgar
3 scoring, and whether resuscitation -- Apgar is the
4 same as a regular Apgar. You called it an ACOG
5 thing.

6 A. Yeah. ACOG is the one who presented at
7 AAP.

8 Q. Okay. And just so we can zoom in. The
9 American Academy of Pediatrics, this is not just an
10 ACOG thing, it's the American Academy of Pediatrics,
11 their stamp is also on this, as well, too.

12 A. Yeah. A committee opinion was issued by
13 both. It was conceptualized by ACOG, uh-huh.

14 Q. And this is an organization you yourself
15 belong to, correct?

16 A. Yes, ma'am.

17 MS. LENIVY: And if we scroll down, Zack,
18 to Apgar, just to reorient ourselves a little bit.

19 Q. (By Ms. Lenivy) From here on, it says:

20 An Apgar score assigned during a resuscitation is not
21 equivalent to a score assigned to a spontaneously
22 breathing infant.

23 Did I read that correctly, Doctor?

24 A. Yes, ma'am.

25 MS. LENIVY: All right. Can we go to page

2 of this document.

Q. (By Ms. Lenivy) And while Zack is pulling that up, I think you're familiar with this particular statement.

MS. LENIVY: It's that paragraph above prediction of outcomes on the right-hand column, Zack.

Q. (By Ms. Lenivy) okay. This paragraph reads: The Apgar score alone, cannot be considered to be evidence of or a consequence of asphyxia.

And you agree with that sentence?

A. Yes.

Q. Many other factors, including non reassuring fetal heart rate monitoring patterns and abnormalities and umbilical arterial blood gases, clinical cerebral function, neuroimaging studies, neonatal -- we'll call it EEG -- placental pathology, hematologic studies, and multisystem organ dysfunction, needs to be considered in diagnosing an intrapartum hypoxic ischemic event.

Did I read that correctly?

A. Yes, ma'am.

Q. Okay. So let's --

MS. LENIVY: We can take it down.

Q. (By Ms. Lenivy) we're going to take these

1 piece-by-piece.

2 First one on that list says nonreassuring
3 fetal heart rate monitoring patterns.

4 Dr. Cantey, do you have an understanding
5 that Sarah Anyan's fetal heart tones -- I'm sorry --
6 Remi Anyan's fetal heart tones were in Category III
7 at the end stage of his delivery?

8 A. Yes, ma'am.

9 Q. Okay. And that's -- even though I know
10 you don't read necessarily and interpret fetal
11 monitoring strips, but you know what they mean,
12 right?

13 A. Right. So we -- we owe it to the OBS to
14 have an understanding so that they can communicate
15 with us, but I always refer to the OB/GYN, uh-huh.

16 Q. Right. And you agree that Category III
17 strips, that's nonreassuring. That's not a good
18 sign, right?

19 A. Yes. That means this baby's life, you
20 know, is at an increased risk for hypoxia, and
21 delivery needs to be soon.

22 Q. Okay. You called my next question.

23 Category III strips indicate an increased
24 risk for hypoxia, and developing severe acidosis in
25 the baby, correct?

A. Correct.

Q. And acidosis, that's when the baby is not getting enough oxygen. It's another way of saying that, right?

A. Right. Yes, in the absence of oxygen, we burn glucose and turn it into lactic acid, and that lactic acid is built up.

Q. Okay. So at least on that first of things that's in that ACOG and AAP guidelines, non-reassuring fetal heart tones, we have those here, correct?

A. Yes.

Q. Okay. The next one was abnormalities in umbilical arterial blood gases, and those are just cord blood gases, right?

A. Cord or early postnatal.

Q. Okay. We don't have those here, correct?

A. Correct.

Q. They were never ordered, or they were discarded. Either way, we don't have those results, correct?

A. Correct.

Q. You were sitting in the back of the courtroom when Dr. McNeive was testifying, correct?

A. Yes, ma'am.

1 Q. And did you hear him when he testified
2 that it was a chaotic delivery room, and ordering the
3 cord blood gases may have slipped his mind.

4 Did you hear that?

5 A. Yes, ma'am.

6 Q. Okay. Well, you have no opinion as to
7 what those cord blood gases would have been, had they
8 been ordered, correct?

9 A. No.

10 Q. Let's see. Following through the list of
11 this, the bulletin, clinical cerebral function, I
12 heard you talk a lot about neuro exams and neurologic
13 exams. You and Ms. Kamykowski talked about, and you
14 used the phrase "neuro exam" multiple times, correct?

15 A. Yes, ma'am.

16 Q. Okay. Remi Anyan did not have any
17 documented neurological examination until he went to
18 the NICU on the morning of May 5th, correct?

19 A. So he had the head-to-toe assessment by
20 labor and delivery, which includes, aspects of that
21 include, neurologic findings.

22 Q. Dr. Cantey, I'm going to read -- I'm going
23 to ask you this question again: Remi Anyan did not
24 have any documented neurological examination until he
25 went to the NICU on the morning of May 5th, correct?

1 A. No. I would disagree with that.

2 Q. Okay. Turn to page 115 of your
3 deposition, please, line 4.

4 A. Yes, ma'am.

5 Q. Okay.

6 "QUESTION: And I think we talked about
7 this earlier, there is no documented neuro exam until
8 the time that Remi entered the NICU, correct?

9 "ANSWER: That's right."

10 Did I read that correctly, Dr. Cantey?

11 A. Yes, ma'am. But when we talked about it
12 earlier, I think you had specifically asked about
13 neonatology assessment. So answering in that
14 context, the NICU had not seen him until he went to
15 the NICU.

16 Q. So there's no documented neuro exam until
17 Remi entered the NICU, correct?

18 A. Yes, ma'am. But I have to remember
19 where -- when you're referencing where we had talked
20 about it earlier, I think the initial question had
21 been there's no neonatal -- neonatology neuro exam.

22 Q. Okay. Well, how about you go to page 73
23 of your deposition. You have to flip back to that
24 earlier. I asked you --

25 A. Okay. Here it is.

1 Q. Page 5 or -- I'm sorry -- page 73, line 5:
2 kind of getting back to my initial question. Until
3 Remi had been sent to the NICU, he had not gotten a
4 neurological exam.

5 Is that your recollection of your
6 reviewing of the records?

7 A. Right.

8 Q. "ANSWER: I think I would qualify it as he
9 hasn't had a documented neuro exam. Certainly if
10 NICU is present at delivery, they're going to, per
11 NRP group team, they would give an assessment of the
12 baby and make a triage decision, and every baby, I
13 mean, really, every baby, but certainly every baby
14 who's undergone delivery room resuscitation. For the
15 PPV and the CPAP, there needs to be an exam and a
16 decision about, okay, where's the baby going?
17 Nursery? NICU to watch? NICU for good because
18 something's wrong?

19 And so my assumption is that they would
20 have given this baby a once over and then decided on
21 nursery, but that's not documented.

22 "QUESTION: whether or not a neuro exam
23 was done, you can't definitively say?

24 "ANSWER: No."

25 Did I read that correctly, Dr. Cantey?

1 A. You did. And I don't mean to be
2 confrontational, but when you say, getting back to my
3 initial question, the initial question was: Did you
4 see any neurologic exam performed by neonatology?

5 So I -- I think I was still answering in
6 that vein of did NICU see him -- did neonatology see
7 him.

8 Q. Well, my question was: Did you see any
9 documents of neurological examination?

10 And you agree, there's no documented
11 neurological examination, correct?

12 A. Right. Not by anyone in the NICU, no.

13 Q. And in fact your answer is, your
14 assumption is, that the baby would have been given a
15 once over and then decided on the nursery, but that's
16 not documented, correct?

17 A. But that was my mistake. Because it is in
18 the -- it is in the resuscitation note by the nurse
19 practitioner.

20 Q. Okay. But at least at the time that you
21 gave your deposition, and you had all of the records
22 to review before your deposition, right?

23 A. Except for the photos. I think those were
24 disclosed later.

25 Q. Except for the photos.

1 The medical records, you had all of those
2 in anticipation of your deposition, correct?

3 A. Yes, ma'am.

4 Q. And at that time, you told me it was your
5 assumption that they had given the baby a once over
6 before sending him to the nursery, right?

7 A. Yeah.

8 Q. Okay. I got to ask, Doctor, because this
9 was asked of one of my experts.

10 You know what they say about assumptions,
11 right? You've never heard of why you shouldn't make
12 assumptions?

13 A. Huh-uh.

14 Q. All right. well, I'll tell you when we're
15 off the record.

16 A. Okay. Oh, when you assume? Yeah, okay.
17 That one I have heard, sorry. Saying I've never
18 heard of assumptions before, the joke doesn't work
19 that way.

20 Q. Dr. Cantey, do you agree that
21 documentation of the neurological exam for a baby who
22 has undergone a very complicated difficult delivery
23 like Remi Anyan, that was important, right?

24 A. Yes, ma'am.

25 Q. Okay. Now, I want to talk about what you

1 reviewed in the records and your opinions based on
2 how Remi was doing in the nursery.
3 You and Ms. Kamykowski talked about how
4 he -- he seemed to be doing when he first got to the
5 nursery, and then how he was doing by the time he got
6 to the NICU, right?

7 A. Yes, ma'am. Yes, ma'am.

8 Q. Okay. And as far as how Remi was doing in
9 the nursery, I think you told me in your deposition,
10 you relied on the NICU team's assessment, which did
11 not contain a documented neuro exam, as we just spoke
12 about, correct?

13 A. Well, it did. I had not seen it at the
14 time of deposition.

15 Q. Okay. Well, now you've seen it now.
16 But at least at the time of your
17 deposition, we agreed there was no documented neuro
18 exam. That was your testimony at the time.

19 I think you told me you also relied on the
20 nursery, correct?

21 A. Yes, ma'am.

22 Q. All right. But you agree with me that
23 those nursery notes are pretty empty up in the first
24 few hours of life.

25 Do you agree?

1 A. Yes. In a sense that generally, for
2 babies who are doing well, not a lot tends to get
3 documented in public care, but, yes.

4 Q. Right. But the records are empty.
5 They're not telling us how Remi is really doing in
6 the first few hours of life, correct?

7 A. Yes.

8 Q. Okay. And I think you used this word a
9 couple of times during your direct examination, but
10 you assumed, you were guessing, you were speculating.
11 You were assuming that within those empty hours and
12 hours and hours of records, that Remi was fine,
13 right?

14 A. I wouldn't describe the records as
15 completely empty. But I think what -- what's there,
16 although it's limited, suggests that he was doing
17 well initially.

18 Q. Suggested that -- there's nothing in
19 there, though, Doctor, right?

20 A. Well, there's the -- there's maternal-
21 infant bonding. There's the initial attempt at
22 breastfeeding. There's the delivery room assessment.
23 There's the head-to-toe assessment. So I don't want
24 to characterize them as empty. But compared to the
25 neonatology documentation in the ICU setting, it's

1 certainly less, yes.

2 Q. Okay. The jury has seen those records,
3 and they know what was documented in the first couple
4 of hours of life, but at least at your deposition, to
5 try to help fill in the gaps, I asked you -- well,
6 did you see what the parents, Blake and his wife
7 Sarah, said about how Remi was doing during this
8 time?

9 Do you remember me asking you that
10 question?

11 A. Yes, ma'am.

12 Q. And you understand, too, that Blake and
13 Sarah, that they're not normal parents. Blake is a
14 respiratory therapist, Sarah's a nurse. They have
15 medical backgrounds, right?

16 A. Yes, ma'am.

17 Q. Kind of a unique set of parents for a
18 newborn.

19 would you agree?

20 A. Certainly most American adults are not
21 health care professionals. So less common than
22 normal, yes.

23 Q. Okay. So they've got certain education
24 and training, and I asked you in your deposition if
25 you relied on, or at least counted at all, what Sarah

1 and Blake said in their depositions about how their
2 baby was doing.

3 Do you remember that question?

4 A. Yes.

5 Q. And do you recall telling me that you
6 couldn't even remember what Sarah and Blake said in
7 their depositions.

8 A. At the time of the deposition, no.
9 Because it had been awhile since I reviewed their
10 deposition.

11 Q. Right. So you came to your deposition
12 understanding that you needed to tell me all of the
13 opinions you held in this case, including all of the
14 bases for those opinions, correct?

15 A. Yes.

16 Q. And so in anticipation of a deposition
17 where you were going to give testimony in a very
18 important case, I asked you, did you rely on the
19 materials and the depositions of these parents?

20 And you told them you couldn't even
21 remember what they said, right?

22 A. Yes.

23 Q. Okay. Let's talk about latching.

24 I know Ms. Kamykowski showed you Sarah
25 Anyan's medical records about she seemed to try to be

1 bonding with her baby.

2 And that's good. Sarah seemed like a good
3 patient, right?

4 A. Yes, ma'am.

5 Q. But as far as whether or not Remi was able
6 to latch or feed, the records indicate he never did
7 feed, really, correct?

8 A. There's that one comment during the
9 initial bonding, but it's not clear whether he did or
10 didn't feed at that point.

11 Q. Okay. Well, at least the records -- and
12 the jury has seen this -- show that at 8:00 p.m., he
13 refused to suck. At 8:30, he refused to suck. Lack
14 of interest in feedings. And then there was also
15 that additional note about him being frantic at
16 Sarah's chest.

17 Do you recall that?

18 A. Yes.

19 Q. And when I asked you in your deposition
20 whether it would be clinically significant
21 information to you to know whether Remi was able to
22 latch in those first few hours of life, you told me
23 it would be important for you to know, right?

24 A. In the sense that we would be assessing
25 tone and suck as part of the exam, yes.

1 Q. Right. Because if Remi is refusing to
2 latch, refusing to suck, that could be a sign of
3 hypertonia, right?

4 A. As part of the differential, yes, ma'am.

5 Q. Right. And so knowing when he first
6 started showing those signs of potential hypertonia,
7 that's important for you, as a neonatologist, to
8 know, correct?

9 A. Yes. Although -- yes.

10 Q. And at least at the time of your
11 deposition, you didn't know when that problem
12 started, correct?

13 A. No.

14 Q. Okay. Let's talk about inconsolability or
15 neuro irritability. There's been a couple of terms
16 thrown around.

17 You agreed with me at your deposition that
18 that was another clinically significant piece of
19 information for you, whether Remi was inconsolable,
20 right?

21 A. Yes.

22 Q. And you explained to me that
23 inconsolability in a baby, that's not just a baby
24 crying. It's a baby's crying so hard and for so long
25 and cannot be consoled. And that's a sign that

1 they're in pain. They're neural, right?

2 A. It can be consistent with it, yes.

3 Q. Right. And it would fit along the lines
4 of encephalopathy, correct?

5 A. Yeah, consistent. Not specific for, but
6 can be consistent with.

7 Q. Okay. You don't know, at least what you
8 told me in your deposition, you don't know when Remi
9 became inconsolable, correct?

10 A. I don't know the exact moment in time. I
11 know the documentation from nursery starts around
12 11:00, 11:30, where they were trying to feed him
13 formula and then ultimately move him, but as far as
14 when it happened before that, no.

15 Q. Okay. And I think in your deposition, you
16 told me you were assuming it was happening close to
17 the time of the NICU transfer. And you called it --
18 your assumption was based on something called a
19 priority bias bleeding through the chart.

20 Do you remember saying that to me?

21 A. That sounds like me.

22 Q. Okay. And I'll be honest, I don't know
23 what an a priority bias is. When I mean that, I
24 Googled it. It's -- Google will tell that me it
25 means that when you have experience doing something,

1 you kind of make the biased assumption that someone
2 else must have done something similarly.

3 A. Yeah. I would believe that. An end bias
4 like in terms of like babies -- and so a lot, you
5 know, I know I use the word assume a lot. What I
6 would say from a practical standpoint that there's 4
7 million babies born annually in the U.S.

8 And we've increasingly, in this country,
9 moved towards you're either in the NICU, or you're in
10 public care with your parents. And that's different
11 from, you know, back in the days of the nursery in
12 the window and the family gathering around.

13 In general, and, again, this is a blanket
14 statement, and I grant that, but in general, the
15 threshold for public care or for what we would now
16 call full-term nursery, to tolerate any abnormalities
17 has really gone down a lot since I was a medical
18 student and a trainee.

19 So I would find it really -- I would find
20 it hard to believe that a baby would be allowed to be
21 abnormal for a prolonged period, because usually, as
22 soon as something changes, they're knocking on our
23 door in the NICU saying, hey, you need to come see
24 this baby. You remember this kid from earlier. And
25 then we come and reassess.

1 Q. okay.

2 A. And obviously that's an assumption, and I
3 fully grant that. But that's my practical
4 experience, is that babies generally soothe. And as
5 soon as there's abnormalities, the NICU is getting
6 summoned.

7 Q. It's an assumption because the records are
8 pretty empty, right, they're blank, as far as when
9 Remi's irritability actually started, right?

10 A. Right.

11 Q. And you didn't bother to take into stock
12 what Blake and Sarah Anyan had to say about when Remi
13 started becoming fussy and irritable and
14 inconsolable, right?

15 A. well, it's not that I didn't buy it. I
16 certainly read the transcripts, and obviously, as in
17 all of these cases, I'm really sorry about what
18 happened.

19 But it is, even for trained health care
20 professionals, I generally am going to rely on -- and
21 this is true, and my wife and I are both
22 pediatricians, and we're really, really bad when it
23 comes to our own kids -- I would defer to the people
24 who are in the room laying hands on Remi as the
25 primary source of information.

1 Q. Right. So the way that you are
2 approaching this case is to automatically give the
3 people that have hired you, the defendant hospital
4 and defendant doctors, you're going to give them the
5 benefit of the doubt when the record's blank, right?

6 A. That's not how I'd characterize it, no.

7 Q. Okay. Let's talk about tachypnea.

8 I'm going to try to move through this.

9 But tachypnea, again, in your deposition, you told me
10 you assumed Remi became tachypneic right before the
11 NICU transfer, which was at 1:30 a.m., correct?

12 A. Correct.

13 Q. And I think this record may have already
14 been shown to the jury, but he was, by definition,
15 tachypneic at 5:35 p.m., when he got to the nursery,
16 with a respiration rate of 68, correct?

17 A. That is tachypneic, yeah.

18 Q. At 10:30, his respiration rate was 140.
19 Were you aware of that, Doctor?

20 A. Yes.

21 Q. And that's, what? 3 hours before he got
22 to the NICU?

23 A. That's about 45 minutes before the nursery
24 is calling NICU saying, hey, we've got a baby that
25 they're concerned about.

1 Q. Right. So it was a couple of hours
2 between the time of his transfer to the NICU, which
3 is when you thought his tachypnea started, and when
4 the first documented, very extreme tachypnea actually
5 happened, is that fair?

6 A. From when the HP started, yes.

7 Q. And at least as far as what Remi's
8 respiration rates were between 5:35 p.m. and 10:30,
9 the record doesn't tell us. The nurses didn't
10 document it, right?

11 A. Other than when they do their head-to-toe
12 assessment, they do not document increased worker
13 breathing and tachypnea.

14 Q. And, again, what Blake Anyan, who's a
15 licensed respiratory therapist, had to say about his
16 own son's tachypnea, you don't -- you didn't remember
17 that at the time of your deposition?

18 A. At the time of the deposition, no.

19 Q. Okay. Kind of going back to that ACOG
20 bulletin.

21 The next thing talks about neonatal EEG.
22 And at least in your depo, you told me EEG has no
23 effect on your opinion, as far as the timing of
24 Remi's HIE, correct?

25 A. Yes.

1 Q. And then the next one on that list was
2 placental pathology.

3 Again, we don't have one of those. One
4 wasn't ordered here, correct?

5 A. That's correct.

6 Q. Okay. Let's talk about some of these lab
7 studies.

8 Lactate -- to sort of get myself back in
9 chemistry years -- lactate is a chemical our cells
10 make when they burn glucose in the absence of oxygen,
11 right?

12 A. Correct.

13 Q. Okay. So when lactate is very high, that
14 indicates that our bodies don't have oxygen. Our
15 bodies are making more lactate, right?

16 A. That's correct.

17 Q. And you're aware that at 46 hours of life,
18 Remi's lactate was very high at 9?

19 A. I wouldn't describe that as very high.
20 But it was certainly elevated, yes.

21 Q. Well, the jury has seen it, and at least
22 in a reference range that was talked about in Mercy's
23 lab, it has an H and an H.

24 A. Yes. Double explanation point, yes,
25 ma'am.

1 Q. Double exclamation point. I mean, that
2 went high, high. That's very high elevated. Very
3 elevated, correct?

4 A. Yeah. Again, I guess it's relative. But,
5 yeah, certainly it's going to light up as a critical
6 value on labs.

7 Q. And then afterwards, it started to
8 downtrend, correct? correct?

9 A. Correct, yes.

10 Q. And then the creatinine, you told me in
11 your deposition that when the kidneys are involved,
12 you know the injury is probably deeper because the
13 kidneys are a little more resistant to hypoxia
14 compared to the liver, correct?

15 A. Compared to the liver, yes.

16 Q. You agree that Remi's creatine of 1.55,
17 that that was certainly high, correct?

18 A. Correct.

19 Q. And you acknowledge that after this
20 initial creatine level, Remi's labs started to
21 downtrend. He started to normalize, correct?

22 A. Correct.

23 Q. All right. And that's a good sign that
24 Remi started to normalize, his body did, right?

25 A. Right. Certainly. He's still trying to,

yes, uh-huh.

Q. Okay. Let's talk about those liver enzymes, then.

we only have one data point for liver enzymes, correct?

A. Correct.

Q. Correct. Unlike the lactate and creatine that we talked about, the liver enzymes, which you missed opening statement, but it was listed as one of the four reasons to support the defense's theory in this case.

You hold the liver as the canary in the coal mine, right? Right?

A. Correct.

Q. And you said the first thing to go, but it also regenerates quickly, right?

A. That's right.

Q. In your opinion, to help with your timing, is the fact that Remi's liver enzymes were only mildly elevated, correct?

A. Correct.

Q. And the jury has seen those. I know we just saw them in the exhibit that was posted.

But you told me that the line between mildly elevated, moderately elevated, and severely

1 elevated regarding liver functioning testing is very
2 subjective.

3 A. Correct.

4 Q. Okay. So what you consider mildly
5 elevated, moderately elevated, another person can say
6 severely elevated, it's subjective?

7 A. Yeah. And I would describe them also as
8 logarithmic. Even -- so usually we're not talking
9 about, you know, 120 versus 150. We're talking about
10 is it double digits? Triple digits? Quadruple
11 digits? Or higher?

12 Q. Either way, when I asked you to define
13 mildly elevated for me, you told me it was subjective
14 between mild, moderate, and severe, right?

15 A. That's true, yes.

16 Q. And you understand that those liver
17 enzymes that were only mildly elevated, those were
18 taken at 46 hours of life, correct?

19 A. Yes, ma'am.

20 Q. The head ultrasound, I think you said this
21 on direct, and I know you said it in your deposition,
22 but it's possible that the reason Remi's head
23 ultrasound at 16 hours of life was normal, was
24 because his injury was less than 24 hours old,
25 correct?

1 A. That's possible, yes, ma'am.

2 Q. Okay. And as far as the MRI, you haven't
3 looked at the imaging, but you've seen the report,
4 correct?

5 A. Correct.

6 Q. And I think you called, at least the
7 report description of it, a classic HIE, right?

8 A. Yes, ma'am.

9 Q. Classic.

10 And you believe, in support of your timing
11 opinions, that Remi's HIE must have happened before
12 Sarah went on the monitor because in the absence of
13 nonreassuring fetal heart tones, it would be
14 surprising to see an MRI like this?

15 Do you remember saying that?

16 A. Yeah. I think within the context, yes.

17 Q. Okay. Yeah, you told me --

18 A. You actually -- we -- we had talked
19 earlier in the deposition about him having Cat IIs
20 and Cat IIIs toward the end.

21 Q. Well, in your deposition, when I asked you
22 about MRI affected your opinion, and you told me you
23 think, well, you said you would assume clearly
24 something happened, but we didn't capture it on the
25 strip. It happened before the mom was on monitoring.

1 Because in the absence of nonreassuring heart tones,
2 it would be surprising to see an MRI like this,
3 correct?

4 A. Right. Meaning that based on his clinical
5 exam and his labs, it just seemed very inconsistent
6 that it would have been during that period of
7 Category III at the end.

8 And then we talked about the long -- as we
9 did earlier in this examination, that Category I
10 can't be the time -- Category I is reassuring. So if
11 it's not here, and it's not here, that leaves an
12 injury prior to monitoring.

13 Q. Right. Because when you see nonreassuring
14 nonfetal heart tones in an MRI like this, it's
15 something you might expect, right?

16 A. If the rest of the clinical course is
17 consistent, yes.

18 Q. And we know that there were in fact
19 nonreassuring fetal heart tones for about the last
20 half hour of labor, correct?

21 A. Correct.

22 Q. Okay. And during your deposition, also
23 when we started talking about the MRI, and this being
24 a classic HIE, you described and explained to me this
25 idea of a partial prolonged pattern and an acute

1 profound pattern.

2 Do you remember that?

3 A. Yes, ma'am.

4 Q. And when you see the watershed injury,
5 that's a part of the white matter that kind of gets
6 sacrificed first when a baby has had a hypoxia,
7 right?

8 A. Yes, ma'am. It's the very first thing,
9 yes.

10 Q. Right. And if a baby -- babies are really
11 smart, and they are shunting blood away from the
12 white matter to protect the really important gray
13 matter, the center of the brain that really controls
14 breathing and everything we need it to, right?

15 A. Yes. It's not -- yes, yes. In the
16 moment, it's not that in the moment they're
17 constricting or dilating the way we protect the other
18 organs, it's that we're just -- we evolved, all
19 mammals evolved, to have redundant blood supply in
20 certain areas.

21 The areas that don't have redundant blood
22 supply where the tips of the vessels are, they're the
23 ones that get hit first. That's what we mean by the
24 watershed areas, and that's the white matter.

25 Q. Okay.

1 A. So we've just evolved. It's not that --
2 it's not that any one baby makes an adjustment in the
3 moment, it's just that at that time, we've evolved.

4 Sorry. That's a minor point.

5 Q. I just like to say that babies are smart.

6 A. They are. Babies are awesome.

7 Q. Babies are awesome. Not in dispute.

8 But when we talk about watershed injuries,
9 so the injury to the white matter of the brain, you
10 said generally you were taught that partial prolonged
11 injuries occur when there are repetitive or chronic
12 hypoxic ischemia hits, right?

13 A. Correct.

14 Q. Okay. So what happens with repeated acute
15 injuries, you get dinged multiple times, and the
16 injury to the cells builds up over a prolonged period
17 of time, right?

18 A. Correct.

19 Q. Okay. And so when we see watershed
20 injuries and acute profound injuries, you called it a
21 mixed pattern, like a mixed picture?

22 A. Yes, ma'am.

23 Q. And you agreed with me that recurrent
24 dings, hypoxia can lead to an injury to the basal
25 ganglia, the gray matter, right?

1 A. That's more -- usually the basal ganglia,
2 the deep gray matter, is more associated with acute
3 profound because they -- those are relatively well
4 supplied.

5 Q. Okay. A partial prolonged injury can
6 eventually lead up to or cause an acute profound
7 injury, correct?

8 A. I guess what I would say is they tend to
9 overlap a lot clinically, as it probably does in this
10 case, uh-huh.

11 Q. Okay. So what probably happened here was
12 that Remi sustained repeated hits to the brain,
13 hypoxia, injuring the white matter, that eventually
14 led in to the injury to the gray matter. So a big
15 acute profound hit? Am I getting that pattern right?

16 A. It's possible, yes, ma'am.

17 Q. Okay. During your deposition, you also
18 talked about this idea of reperfusion. I know the
19 jury has heard that word a couple of times. And you
20 agree that there are cases of HIE, if a baby suffers
21 an injury, then they reperfuse themselves, and then
22 they look okay in the short-term, correct?

23 A. Correct.

24 Q. And then either a second reperfusion
25 injury happens, and they start to have seizures from

1 their injured brain, correct?

2 A. Correct. Sorry. I thought that was an
3 overstatement, but, yes.

4 Q. No, no, no. So baby has an HIE, comes out
5 looking pretty good in the short-term, and then
6 reperfusion injury happens, secondary reperfusion
7 injury happens, and they start having seizures,
8 right?

9 A. Yeah. If, in that context, if the initial
10 injury is somewhat remote, and they've had a chance
11 to recover from it, and they're born, and they look
12 good. And then they get the reperfusion injury
13 because they've been delivered, so now everything
14 is -- now everything is flooding back to the brain,
15 and they get that second injury.

16 Q. Right. And you said that you -- you based
17 it on the seizures. Because seizures around 6 to 12
18 hours of life -- right? -- or 24 to 48. You kind of
19 gave us that.

20 A. In general or for Remi?

21 Q. In general.

22 A. In general. So I would usually describe
23 secondary injuries starting at 6 to 12 hours, up to
24 about 48 hours. That's usually what I teach. I know
25 that my counterpart said up to 72 hours on her

1 diagram. But, yeah, usually the classic window is 6
2 to 12 hours -- at least 6 to 12 hours -- and then up
3 to 2 or 3 days later.

4 Q. And I think in your deposition, you were
5 talking about seizures and how that affected the
6 timing. You testified that a seizure would
7 indicate -- means it's either before she's on the
8 monitors or it's right at the end of delivery.

9 Do you remember giving that testimony, Dr.
10 Cantey?

11 A. Those times would be consistent if you
12 just -- the seizures are in isolation, yes, ma'am.

13 Q. And, again, I just want to make sure we're
14 perfectly clear. The earliest you think this injury
15 could have happened, 5/3 at 4:30 a.m., 36 hours
16 before delivery, correct?

17 A. Yeah. That's what I would say clinically,
18 and that's what we talked about in deposition. I
19 know the neuroradiologist felt like that the window
20 was a little bit wider, based on things they see, but
21 that's not -- that's not my specialty.

22 Q. All right. And in your opinion, the
23 absolute latest time this injury could have occurred
24 is up to and including the time right at delivery,
25 correct?

1 A. Right. Because after delivery, there's no
2 period where we see hypoxic ischemia, correct.

3 Q. Thank you, Dr. Cantey.

4 THE COURT: Any redirect?

5 MS. KAMYKOWSKI: Just very briefly, Your
6 Honor.

7 REDIRECT EXAMINATION

8 BY MS. KAMYKOWSKI:

9 Q. Dr. Cantey, Ms. Lenivy wrote that your
10 testimony in your deposition, you didn't give this as
11 a reasonable window of time, did you?

12 A. I can't remember the exact word I used,
13 but the theoretical -- the possible window, uh-huh.

14 Q. Yes. That's what you said. You told me,
15 and what you said consistent with your deposition
16 was, the window -- and I'm going to change it just
17 because I want to make sure that we got it correct on
18 here when we look at this in a couple -- in a week --
19 that the time frame goes -- well, first you said,
20 maybe 5/2 -- I know now we're going to say 5/3, the
21 latest, furthest back in time, would be 5/3 at 4:30
22 a.m.

23 All right. You told me before that the
24 reasonable window, though, is now 5/3 at 4:30, to
25 sometime in the p.m., based on the entire clinical

1 context and everything you were reviewing in this
2 case, correct?

3 A. Right. So based on the seizures
4 themselves, 6 to 12, up to 24 to 48 to 72 hours
5 later, based on the laboratory findings, the MRIs, I
6 think that tightens the window a little bit. I know
7 it doesn't tighten it as much as everyone probably
8 prefers that it does. But it looks more likely like
9 it was somewhat remote from delivery, just based on
10 how he looked after delivery.

11 Q. And that's what you told me on direct, and
12 you're sticking with that testimony. This time at or
13 near the time of delivery, you said it's possible,
14 but definitely not more likely than not, to a
15 reasonable degree of medical certainty?

16 A. Yes, ma'am.

17 Q. So it's not -- this is not a reasonable
18 window of time, is it?

19 A. Oh, I see what you're saying.

20 Q. For Dr. Canteley. This is not -- this is a
21 misrepresentation of your timing opinion?

22 A. Yes. I mean, I would describe that as a
23 possible window. If you force me to pick a narrower
24 window based on his Apgar scores, his labs, and his
25 presentation, I think it's probably a little bit

1 earlier.

2 Q. The one that we have here, 4:30 a.m. on
3 the 3rd to sometime in the afternoon on the 3rd,
4 that's the more likely than not to a reasonable
5 degree of medical certainty timing opinion you hold
6 in this case?

7 A. Yes, ma'am.

8 Q. And did any of the other questions that
9 Ms. Lenivy asked you, taking you through your
10 deposition, all of the things, we all saw the neuro
11 exam, anything that she asked you change that opinion
12 in any way?

13 A. No, ma'am.

14 Q. No further questions, Your Honor.

15 MR. PERRON: Nothing, Your Honor.

16 MS. LENIVY: Judge, incredibly briefly.

17 THE COURT: I don't think I have a choice.

18 I'm just trying to make sure he makes his plane.

19 THE WITNESS: Appreciate it, Your Honor.

20 MS. LENIVY: He will.

21 RECROSS EXAMINATION

22 BY MS. LENIVY:

23 Q. Doctor, we will get you back to Texas.

24 But Ms. Kamykowski just accused me of

25 misrepresenting your testimony, and I take that

1 accusation seriously, Doctor, so I want to be
2 perfectly clear.

3 It was your testimony in your deposition
4 where you swore under oath, page 138, 7 through 138,
5 17, when I asked you: As far as your window of time,
6 the time that the injury is happening as early as May
7 3rd, at approximately 4:30 a.m., up until the time of
8 delivery.

9 And you answered, yes. Yes, ma'am. I
10 think based on the initial clinical appearance, the
11 timing of the seizures, and the MRI, I think that's a
12 window that's pretty reasonable.

13 Was that your testimony, Doctor?

14 A. Yes, ma'am. That's my testimony. I'm
15 from South Carolina, so I tend to be folksy.

16 Q. Well, what I'm going to do, Doctor, so
17 there's no confusion, I'm going to put where it was
18 in your deposition, you said these lines. Did I
19 write that correctly? 138, 7 through 138, 17?

20 A. Yes, ma'am.

21 Q. Thank you, Dr. Cantey.

22 MS. LENIVY: Nothing further, Your Honor.

23 THE COURT: May this witness be excused?

24 MS. KAMYKOWSKI: He sure may.

25 THE COURT: All right. Ladies and

1 gentlemen, based on the time, this is a good time for
2 us to take our evening recess.

3 (At 5:09 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 Friday, March 21st, 2025, at 9:00 a.m.,
8 and the following proceedings were held in open
9 court, on the record, outside the presence of the
10 jury:)

11 THE COURT: Let's go ahead and go back on
12 the record. I've had an opportunity to review the
13 motion to strike, as well as the other information in
14 the record. I'm going to deny the motion to strike.

15 MS. SLATER: Thank you, Your Honor.

16 MS. KAMYKOWSKI: Okay. Your Honor. Thank
17 you.

18 MR. PERRON: Your Honor, counsel for
19 plaintiffs served this document on us yesterday, and
20 it -- our concern, number one, is that not
21 representing Dr. Shavelle, we don't think it's
22 properly served on him and will compel him to do
23 anything, especially with two days' notice to bring
24 data that we're not even sure exists or is in his
25 possession.

1 And our concern is that, A, we don't
2 believe that it could be enforced, at least under
3 this process. But also that we're concerned that Dr.
4 Shavelle might be asked on cross-examination, well,
5 weren't you subpoenaed to bring these documents? And
6 not -- and be in a position where he is going to look
7 to the jury as he's disobeying a court order.

8 MS. SLATER: Your Honor, the problem with
9 Dr. Shavelle's testimony is that it relies on data
10 that's like 25 years old. And we asked him obviously
11 on the rider to his deposition to provide all
12 materials that he was relying on.

13 He testified based on his own articles and
14 publications that summarized the data, and apparently
15 he won't produce it, and he doesn't without a court
16 order. And when he's ordered to do so, he often
17 withdraws from the case.

18 And so from the extent that we think that
19 them producing the data as part of their reliance
20 materials is important for this expert, we filed this
21 to solidify our request of the data before he
22 testifies. We also saw a subpoena filed for Dr.
23 Dreyer the day before he arrived, as well.

24 THE COURT: You would agree with me that
25 this is not service upon Dr. Shavelle.

1 MS. SLATER: Well, unless they agree to
2 it, which they are not. But it is their expert. And
3 regardless of a subpoena or not, they owe us all
4 reliance materials. And he has -- basically what
5 he's given us is a summary in an article of that
6 data. And that is not in our possession, and we
7 think we should be able to have and analyze it before
8 he testifies.

9 THE COURT: I would assume that out of an
10 abundance of caution, you informed the doctor that
11 this was going to be requested of him?

12 MR. PERRON: How -- I'm sorry. Go ahead.

13 MS. KAMYKOWSKI: No. We have not been
14 able to touch base with him on this since it was
15 served yesterday.

16 THE COURT: Didn't send him an email last
17 night saying, this is probably going to become an
18 issue?

19 MS. KAMYKOWSKI: No. Because we wanted to
20 take it up with the Court. We didn't think it was
21 proper service.

22 THE COURT: Proper service or not, the
23 issue is whether or not he's provided data that he's
24 been told to provide. And if that was done in the
25 course of the deposition, the fact that he may or may

1 not show up with it tomorrow, may turn into a very
2 big issue. So I'm going to suggest that you tell him
3 that's going to be a very big issue.

4 MR. PERRON: well, Your Honor, the data
5 that we're talking about is used to prepare an
6 article in 2014. He didn't base his opinions on the
7 original data. He based opinions on his article that
8 was written in 2014. And it's important, Your Honor,
9 Dr. Liles himself based his opinions on that same
10 2014 article and --

11 THE COURT: It's even more important that
12 we actually have the underlying data that was used in
13 creating the article.

14 MR. PERRON: But if Dr. Liles can form his
15 opinions without that data, then if you -- if the
16 argument is that that article can't stand without
17 that data, then -- the Dr. Liles' opinion also falls
18 by that same lack of foundation.

19 THE COURT: That wasn't an argument that
20 was raised with me, and it wasn't involved in claims
21 that he didn't provide that data. I assumed that I
22 should probably then consider that as a motion to
23 strike Dr. Liles' testimony, and I think at this
24 point, honestly, I should probably strike both of
25 them.

1 Because I do believe that what he relied
2 upon to create that article is relevant, and it is
3 something that they're entitled to, and they've asked
4 for it.

5 I mean, you do what you want to do, but
6 tomorrow morning, I'm assuming he's going to be here,
7 and we're going to have a conversation on the record
8 about whether or not he fulfilled his obligation as
9 an expert with regards to providing the underlying
10 data.

11 If you don't want to tell him that, that's
12 fine because I'm assuming you're concerned that he
13 may not show up if he's told that, but we're going to
14 have to deal with it on the record before we start.

15 MR. PERRON: We'll take a look at the
16 rider and get his interpretation at the time of the
17 depo what would be the questions. We'll let him know
18 that this is going to be an issue.

19 THE COURT: Okay.

20 Anything else?

21 MS. SLATER: No, Your Honor.

22 MS. GUNN: No, Your Honor.

23 THE COURT: Thank you.

24 (At 5:24 p.m., Court stood in
25 adjournment.)

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2 Official Court Document Not an Official Court Document Friday, March 21, 2025 Official Court Document

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4 Document Not an Official Court Document (At 9:07 a.m., the following proceedings

5 were held in open court, in the presence of the

6 jury:)

7 THE COURT: Good morning, everyone. Go

8 ahead and be seated.

9 on behalf of the defendants?

10 MR. PERRON: Defense calls Dr. Landon.

11 THE COURT: Sir, if you'll step on up and

12 be sworn.

13 MARK LANDON, M.D.,

14 having been duly sworn, was examined, and testified

15 as follows:

16 THE COURT: You may inquire.

17 DIRECT EXAMINATION

18 BY MR. PERRON:

19 Q. Doctor, would you introduce yourself to

20 the Court -- to the jury.

21 A. My name is Mark Landon.

22 Q. And what is your profession?

23 A. I'm an obstetrician/gynecologist and a

24 maternal-fetal medicine specialist.

25 Q. Did our office send you documents, medical

records, and other things to review pertinent to this case?

A. Yes.

Q. Did you review those documents?

A. I did.

Q. Did you form opinions regarding to your review of those documents and issues pending before the court in this matter?

A. I did.

Q. Will you give those opinions to a reasonable degree of medical certainty?

A. Yes.

Q. With regards to your ultimate opinion, did Dr. McNeive meet the standard of care in his care and treatment of Ms. Anyan and Remi?

A. I believe he did.

Q. To a reasonable degree of medical certainty, more likely than not, did Remi Anyan suffer a permanent hypoxic injury in the last 30 minutes of labor?

A. I don't believe she [sic.] did.

Q. To a reasonable degree of medical certainty, more likely than not, did Remi Anyan suffer a permanent hypoxic injury while under the care of Dr. McNeive and Mercy Hospitals?

1 A. I don't believe so.

2 Q. Do you have a CV that documents and
3 reflects your training and experience in the
4 profession?

5 A. Yes.

6 MR. PERRON: Justin, if you would put up
7 F3-B.

8 Q. (By Mr. Perron) Doctor, the screen is
9 over here.

10 Is this a copy of your curriculum vitae?

11 A. Yes.

12 Q. And, Doctor, if you want to just take the
13 jury through your education.

14 A. Sure. I attended college at the
15 University of Pennsylvania in Philadelphia. Medical
16 School then at Cornell University Medical College in
17 New York City. I then did a residency in obstetrics
18 and gynecology back in Philadelphia at the hospital
19 at the University of Pennsylvania, followed by a
20 fellowship in maternal-fetal medicine, also at the
21 University of Pennsylvania, which I completed in
22 1986.

23 Q. Are you board certified?

24 A. I'm board certified in obstetrics and
25 gynecology, as well as maternal-fetal medicine.

Q. what is your present position?

A. I am professor and chair -- chairman of the Department of Obstetrics and Gynecology at Ohio State University College of Medicine in Columbus, Ohio.

Q. Are you still active in that profession?

A. I am.

Q. When was the last time you were involved in labor and delivery?

A. Approximately two weeks ago, I attended labor and delivery.

Q. When's the last time you delivered a baby?

A. Same: approximately two weeks ago.

Q. How do you become board certified as an OB/GYN?

A. To become eligible to take the board exam, one has to complete a four-year residency in obstetrics and gynecology. You then take a written test at that time. If you pass the written test, you can submit a case list summarizing your practice to the board. And if they approve that, they will let you sit for an oral examination, which is the final stage of the board certification process.

Q. Are you one of those examiners for board certification?

1 A. I was a board examiner for the American

2 Board of Obstetrics and Gynecology for 25 years.

3 Q. How many individuals are -- become oral
4 board examiners per year?

5 A. Approximately a hundred doctors give the
6 oral exam in obstetrics every year.

7 Q. And that's out of how many board certified
8 board OBS in the U.S.?

9 A. About 40,000 board certified OBS in the
10 U.S.

11 Q. when you're doing your oral questioning
12 for board certification, do you ask questions on
13 duration of second stage?

14 A. Yes.

15 Q. About management of FHR, fetal heart rate,
16 and fetal heart monitoring?

17 A. All the time.

18 Q. Management of labor?

19 A. All the time.

20 Q. what is Gabby's text?

21 A. Gabby's text is a textbook of obstetrics
22 that I've been part of since its inception. so it's
23 now in its ninth edition.

24 Q. How long have you been doing expert work
25 like what you're doing here?

1 A. Over 35 years, I've looked at medical

2 legal cases.

3 Q. What's the breakdown between plaintiff
4 work versus defense?

5 A. In the last decade, I'd say about
6 three-quarters of the time, I'm retained by the
7 plaintiff. And about 25 percent of the time, I'm
8 retained by the defense.

9 Q. Have you ever worked for me or Mr. Phil
10 willman at counsel table for Dr. McNeive?

11 A. No.

12 Q. Have you ever worked for the Simon Law
13 Firm, retained as an expert for them?

14 A. Yes.

15 Q. Did -- Dr. McNeive came on shift at 8:00
16 a.m. on May 4. The jury has heard Dr. warsof
17 characterize the fetal heart monitoring strip between
18 8:00 a.m. and 8:16 as Category I.

19 Do you agree with that assessment?

20 A. I do.

21 MR. PERRON: Justin, if you want to put up
22 FG-3, PDF page 12.

23 Q. (By Mr. Perron) Doctor, you let me know
24 if you can see that or if we need to blow that up.

25 A. No.

1 Q. Am I in your way?

2 A. Yeah. Now I definitely see it.

3 Q. Okay. As we go through these pages,
4 just -- I thought this would be 8:07 a.m.

5 MR. PERRON: All right. I'm sorry. PDF
6 page 1 -- I must have left off a number.

7 MS. GUNN: 126.

8 MR. PERRON: 126.

9 And one more down, Justin. Yeah.

10 Q. (By Mr. Perron) So starting at where
11 someone has made a line right here, if you move
12 forward and on.

13 Looking at that strip --

14 MR. PERRON: And then going onto the next
15 page, Justin.

16 Q. (By Mr. Perron) -- does that strip
17 comport with what you would expect to see for
18 category I?

19 A. That strip does, yes.

20 Q. And explain to the jury again what the
21 significance of Category I is.

22 A. Category I, by virtue of the features of a
23 normal baseline, normal variability, and absence of
24 any significant decelerations, indicates that the
25 fetus or the baby in utero is well oxygenated.

1 That's what it tells you.

2 MR. PERRON: So, Justin, if you want to
3 skip to PDF, page 132.

4 Q. (By Mr. Perron) So on this page, some
5 providers have marked what they see as decelerations.

6 Doctor, are decelerations the only thing
7 apparent on this strip during this period of time?

8 A. No.

9 Q. What else do you see in between those
10 decelerations?

11 A. You see moderate variability about the
12 baseline. So when -- when the deceleration ends, and
13 the baby returns to baseline, the variability is
14 preserved as normal or moderate variability.

15 MR. PERRON: Justin, if you want to go to
16 the next page.

17 Q. (By Mr. Perron) Again, there's marked
18 decelerations because you see return to moderate
19 variability in this strip?

20 A. I do.

21 Q. What's the significance of moderate
22 variability?

23 A. Moderate variability --

24 (A discussion was held off the record.)

25 A. Moderate variability basically means that

1 you can be reassured that the fetus is non acidotic
2 and also unlikely to be significantly hypoxic.

3 MR. PERRON: So, Justin, if you want to
4 switch to the player, C2, and go to the first tab,
5 which I think is 8:46.

6 Q. (By Mr. Perron) All right.

7 Doctor, the jury has heard that Dr. Warsof
8 saw moderate variability between 8:00 a.m. and 9:30
9 a.m. on May 4th.

10 Do you agree with his assessment of the
11 strips over this period of time?

12 A. Yes.

13 Q. Dr. Warsof testified he saw some
14 accelerations between 8:00 a.m. and 9:30 a.m.

15 Do you agree?

16 A. I do.

17 Q. So even what -- let me back up.

18 what is the significance of your and Dr.
19 Warsof's opinion that there was moderate variability
20 and accelerations between 8:00 a.m. and 9:30 a.m.?

21 A. That the fetus, at that point in time, was
22 well oxygenated and unlikely to be sustaining any
23 injury at that point in time.

24 Q. I'm going to ask our tech guy, Justin, to
25 run this strip forward for just a little bit.

1 And, Doctor, if you want to describe to
2 the jury, number one, does this mimic how the
3 providers would be looking at the strip in realtime,
4 to some extent?

5 A. Yes, I mean, it's obviously moving at a
6 faster speed than it would in realtime, but it is
7 moving along, yes.

8 Q. Right. So in realtime, you don't get
9 someone's retrospective notes about, you know, making
10 notations and what they're seeing with the benefit of
11 retrospect, is that fair?

12 A. You know what's come before. You
13 obviously don't know what's coming after. And that's
14 basically what you can say.

15 Q. Okay. As we're running forward through
16 this strip, do you see moderate variability?

17 A. Yes.

18 Q. You saw a little bit before the notations
19 of the providers marking where they see
20 decelerations, including variable decelerations.

21 In your experience, when are -- in your
22 experience, how common are variable decelerations on
23 a fetal heart monitor?

24 A. Very common. They're seen in the majority
25 of labors.

Q. when do variable decelerations become a problem?

A. They become a problem if they become very deep, 60 beats per minute or lower, and accompanied by either minimal or absent variability. So as long as there is moderate variability present, again, you can be reassured that the fetus is not acidotic, and more likely than not, well oxygenated with a return to baseline.

Q. In your experience, is there reliable literature published by ACOG, in particular, that guides obstetrics and physicians who practice in that field of management of FHR strips, in particular with decelerations?

A. Yes. There is reliable literature, I believe.

Q. The jury has heard this quote before, but just for the benefit of your opinions and your testimony going forward: we accept the accuracy of data, including the FHR availability must be absent to reliably reflect a high degree of correlation and severe fetal acidemia.

Doctor, if I have read that correctly from the literature, do you agree with that statement?

A. I do.

1 Q. And what is that -- again, similar to what
2 you've just said, what does the literature tell you?
3 And does that conform with the opinions you're
4 expressing today?

5 A. Once again, the literature strongly
6 suggests and states, in fact, that if you have
7 moderate variability present, there's a very low
8 likelihood that there is any accompanying fetal
9 acidosis or any significant hypoxia in the fetus. So
10 despite the presence of decelerations, it allows you,
11 if you choose, to continue the labor process.

12 MR. PERRON: Justin, if you'll put up I1
13 and go to page -- well, I1 first.

14 Q. (By Mr. Perron) Doctor, the jury has seen
15 this a few times before. This is an ACOG practice
16 bulletin.

17 MR. PERRON: Justin, if you want to go to
18 page 3. And then highlight this box and then this
19 quote right here.

20 Q. (By Mr. Perron) Given the diverse
21 spectrum of abnormal FHR patterns in Category II, the
22 presence of accelerations for moderate variability or
23 both are highly predictive of normal fetal acid base
24 status and thus may help guide clinical management.

25 Did I read that correctly, Doctor?

A. You did.

Q. Do you agree with that statement?

A. I do.

Q. Just as you said, was there moderate variability, evidence throughout the strip between 8:00 a.m. and 9:30 a.m.?

A. Yes.

Q. If Dr. McNeive relied on that guidance from literature and seen moderate variability, would that have been a reasonable thing to do?

A. Yes.

Q. Did the standard of care mandate a C-section at 9:30 a.m.?

A. The standard of care did not mandate a C-section at 9:30 a.m.

Q. Why not?

A. Because the fetal heart rate tracing to begin with didn't mandate a cesarean section. So the only consideration is, at that point, is the progress in labor and, I mean, one could, if one wanted to do a cesarean section, I suppose they could. But that's different than saying the standard of care required you to stop the labor at that point in time. It's pretty much as simple as that, actually.

Q. The jury has heard this repeatedly over

1 and over again. But just to establish the basis of
2 your opinions, does ACOG set a maximum limit for the
3 duration of the second stage of labor?

4 A. No.

5 MR. PERRON: Justin, if you want to put up
6 I2.

7 Q. (By Mr. Perron) And, again, the jury has
8 seen this numerous times. But just to reorient
9 ourselves, obstetric care and consent for the
10 March 2014 ACOG clinical.

11 MR. PERRON: And, Justin, if you could
12 skip to page 15 just to highlighting that one line
13 again. No, the next one. The "thus."

14 I'm sorry. It's on page 16 of my copy,
15 Justin.

16 Q. (By Mr. Perron) And it starts right here:
17 Thus, a specific absolute maximum length of time
18 spent in the second stage of labor beyond which all
19 women should undergo operative delivery have not been
20 identified.

21 Did I read that correctly?

22 A. Yes.

23 Q. Do you agree with that statement?

24 A. I do.

25 Q. In your experience, does ACOG make these

1 determinations casually?

2 A. No. I mean, for something like this, and
3 for the practice bulletins, it's a group of experts,
4 a group of most the time people I know, frankly, but
5 colleagues that get together, discuss it, look at the
6 literature, and come up with a reasonable conclusion.
7 It's not one person's opinion, in other words.

8 Q. If Dr. McNeive relied on this statement to
9 guide his decisionmaking, was that reasonable and
10 within the standard of care?

11 A. It is.

12 Q. Again, last couple questions about this
13 period of time we've been talking about between 8:00
14 and 9:30 a.m.

15 The jury has heard Dr. Warsof does not
16 believe the strips indicate a permanent hypoxic
17 injury between 8:00 and 9:30 a.m.

18 Do you agree with Dr. Warsof?

19 A. I do.

20 Q. How do you -- how -- what is the basis of
21 your opinion that there's no evidence of hypoxic
22 injury between 8:00 a.m. and 9:30 a.m.?

23 A. There's preserved variability. So it
24 fairly reliably excludes acidosis. And, therefore,
25 makes it highly unlikely that the fetus would be

sustaining injury during that period of monitoring.

Q. This ability of yourself and Dr. warsof in retrospect to look back and exclude the likelihood of a permanent hypoxic injury during this period of time, would Dr. McNeive, in realtime, have been able to look at that same information and come to the same conclusion there was no hypoxic ongoing injury?

A. I believe so.

Q. From 9:30 a.m. to 2:00 p.m., the jury has heard testimony from Mr. Anyan that every hour Dr. McNeive was coming into the room, reviewing strips, and doing a digital examination of Ms. Anyan.

If Dr. McNeive was the on-staff attending OB, would that be usual for him to come back into the room with that regularity?

A. No.

Q. Again, the jury has heard from Dr. warsof, plaintiffs' expert, that in his opinion, between 9:30 a.m. and 2:00 p.m., the strips at that time were returning to Category I tracings.

Do you agree with Dr. warsof?

A. I do. I think that's true.

Q. Dr. warsof accepted that there were accelerations between 9:30 a.m. and 2:00 p.m.

Do you also see those accelerations over

1 that period of time?

2 A. I do.

3 Q. Dr. warsof testified that there was
4 moderate variability between 9:30 a.m. and 2:00 p.m.

5 Do you agree?

6 A. I do.

7 Q. Dr. warsof told this jury that he did not
8 see any evidence in the strips of a permanent hypoxic
9 injury between 9:30 a.m. and 2:00 p.m.

10 Do you agree with that assessment, as
11 well?

12 A. If you use the strips to make a judgment
13 as to whether there's injury or not, the strips did
14 not reflect injury during that time period.

15 Q. Okay.

16 MR. PERRON: Justin, if you want to go to
17 F3-G, PDF page 142.

18 Q. (By Mr. Perron) so this is looking at the
19 strips again. This is at 10:21 a.m.

20 Doctor, do you see -- first of all,
21 describe for the jury what kind of strips we're
22 looking at here. what do you see in those tracings?

23 A. I see a normal fetal heart rate based on
24 approximately 140 beats per minute. About two or 3
25 minutes into it, I think I see a deceleration. It's

1 probably a variable deceleration, where the heart
2 rate goes down about 15, 20 beats from the baseline.
3 But it quickly returns. And then for the last 5
4 minutes of the tracing, after that, I see clearly
5 moderate variability, no decelerations.

6 Q. And then going on to the next page, do you
7 see a continuation of that moderate variability?

8 A. Yes. Moderate variability or normal
9 variability.

10 Q. If you include the 5 minutes from the last
11 page, and then into this page, is this approaching
12 what can be called, if you're an OB in realtime, a
13 Category I strip?

14 A. That is correct.

15 Q. And, again, for the jury's benefit,
16 what -- what is the category strip telling to the
17 provider at this time?

18 A. High, high likelihood that the fetus is in
19 fact well oxygenated and very unlikely that the fetus
20 is acidotic or suffering from hypoxia.

21 Q. Is this a hostile uterine environment,
22 Doctor?

23 A. No.

24 Q. Does this strip mandate a C-section?

25 A. No.

Q. Is this baby in fetal distress?

A. No.

Q. Again, the jury has seen this article a number of times, but just to help establish the basis for your opinions, I16 page 3.

MR. PERRON: Justin, the bottom of the page.

Right here. Keep scrolling down. And then the last paragraph, and then going to the top.

Q. (By Mr. Perron) However, since any algorithm for the management of Category II patterns will apply to the majority of fetuses during labor, algorithm must also avoid unnecessary intervention and encourage vaginal delivery in women whose FHR pattern suggests minimal risk of significant deterioration prior to delivery.

Did I read that correctly?

A. You did.

Q. And, then, Doctor, if -- well, let me -- let me start over.

Do you agree with that statement?

A. I do.

Q. Okay.

MR. PERRON: Justin, if you want to go to C2 at 12:20.

1 Q. (By Mr. Perron) Okay. So, again, looking
2 at this strip, without any of the markings running
3 through it, what do you see on the strips here
4 running forward?

5 A. I see a normal baseline heart rate,
6 moderate variability, no decelerations.

7 Q. Okay.

8 MR. PERRON: Justin, if you want to stop
9 there, and...

10 Q. (By Mr. Perron) Doctor, switch gears a
11 little bit. The jury has heard a lot about the drug
12 Pitocin.

13 Do you use Pitocin as a part of your
14 practice?

15 A. Yes.

16 Q. Did you, in reviewing the medical records,
17 you would have seen the Pitocin protocol the jury has
18 seen a number of times embedded in the medical
19 records.

20 A. Yes.

21 MR. PERRON: Justin, if you would put up
22 A2, PDF 103. Scroll down. And up. Down. Down.
23 Keeping going down. Sorry. Keep going. A2, page
24 103.

25 (Pause in proceedings.)

1 Q. (By Mr. Perron) Intrauterine
2 resuscitation. Doctor, it's been represented to the
3 jury that from plaintiffs' expert that what this
4 policy is saying is that if there's any Category II
5 tracings, all of these actions at once, including
6 discontinuing oxytocin, have to go into effect.

7 Is that how you read this policy?

8 A. No.

9 Q. Doctor, is this language right here, does
10 this qualify your understanding of the policy based
11 on maternal-fetal response?

12 A. That is correct.

13 Q. Did Mercy -- did the nurse -- let me back
14 up.

15 In your review, did the nursing document
16 lateral positioning?

17 A. Yes.

18 Q. What was the maternal response to that
19 positioning? Did you see returns to moderate
20 variability?

21 A. Well, I saw reduction in variable
22 decelerations, so I would say that's a good response.

23 Q. In your review of the policy, if they are
24 seeing maternal-fetal response with lateral
25 positioning, do they then have to go all the way down

1 and do all of those next things, including

2 discontinuing Pitocin?

3 A. No. Particularly -- particularly if
4 moderate variability is preserved and present.

5 Q. Did the Mercy policy mandate discontinuing
6 Pitocin in this case, according to what you see here?

7 A. Not the way I interpret it. And it
8 wouldn't be the way to practice, frankly.

9 Q. At your facility where you work?

10 MS. GUNN: Your Honor, may we approach?

11 THE COURT: You may.

12 (Proceedings were held at sidebar, outside
13 the hearing of the jury.)

14 MS. GUNN: So Dr. Landon had those -- I
15 assume he's going to ask about his own policies at
16 Ohio State University. And in his deposition, he did
17 not know what the policies were. He didn't know the
18 Pitocin, so I think this is -- this would be a new
19 opinion on that basis with respect to that.

20 MR. PERRON: He said he did not know the
21 specific verbiage of the policy, but that it allowed
22 for critical judgment. And that's what I'm expecting
23 him to say.

24 MS. GUNN: I don't think -- he didn't say
25 that he had those. He didn't know what they were --

1 MR. PERRON: He said he didn't know the
2 verbiage, but that they allowed for clinical
3 judgment. And that's -- he's going to answer just
4 exactly the way he did in his depo.

5 MS. GUNN: what page is that? what page
6 is that?

7 MR. PERRON: If you use the key index with
8 the case.

9 MS. GUNN: Ohio --

10 MR. PERRON: He --

11 MS. GUNN: He didn't have --

12 MR. PERRON: Look for the word "verbiage."

13 MS. GUNN: Let's find it.

14 (Pause in proceedings.)

15 MR. PERRON: All right. Page 22 he says:

16 I don't know the verbiage. And to get to the

17 specifics of your question about oxytocin in the face

18 of Category II tracing, I'm not sure of the verbiage.

19 I've told you again twice before what to do in

20 Category II when oxytocin is running.

21 So the question and answer goes on and on

22 because he says that they allow running oxytocin

23 beginning with Category II tracings. I'm just going

24 to ask him if -- how he would think of the

25 institution turning it off in the face or Category

1 II.

2 MS. GUNN: Yeah, right. And he didn't
3 provide them. He says he doesn't have them. He
4 doesn't have them in front of him. And I don't have
5 them to know what they actually say. That's
6 argumentative.

7 MR. PERRON: I mean, you confronted him
8 with the Pitocin policy at Ohio State University
9 generally with respect to Pit administration,
10 indicates that if there are category strips,
11 determining what to do with the Pit is
12 individualized. I think it allows for that.

13 MS. GUNN: That was my question, was to
14 him.

15 MR. PERRON: Right. And he says, I think
16 it allows for that.

17 THE COURT: I'm going to overrule the
18 objection.

19 (Proceedings returned to open court.)

20 Q. (By Mr. Perron) At your facility, does
21 the hospital where you practice mandate that Pitocin
22 be turned off or discontinued or turned down in the
23 face of any kind of Category II tracing?

24 A. No.

25 MR. PERRON: Justin, if you want to put C2

1 back up and go to the tab toward the 1:00 p.m.

2 stretch.

3 All right. Justin, if you could slowly,

4 slowly play from there.

5 Q. (By Mr. Perron) And, Doctor, if you want
6 to just get our bearings. So this is 1:00 p.m., and
7 we're going forward in time, what do you see in the
8 strips here?

9 A. Looks like a Category I tracing. Normal
10 baseline heart rate, variability, and there even is
11 an acceleration there right under p.m., or so under
12 "m" of p.m.

13 Q. All right. Doctor, again, is this a
14 hostile uterine environment?

15 A. No.

16 Q. Are there many hypoxic injuries happening
17 all throughout this strip?

18 A. No.

19 Q. How do you know?

20 A. Well, I mean, I think it's highly
21 unlikely. I don't know any other way to express it
22 when you have essentially a normal baseline, a normal
23 heart rate variability, no recurrent significant
24 decelerations that you would come to a conclusion
25 that the fetus is hypoxic or be being injured or in a

1 hostile intrauterine environment. That doesn't ring
2 true to me.

3 Q. (By Mr. Perron) So up to 2:00 p.m., the
4 jury has heard Dr. warsof testify he does not see any
5 evidence in the strips of permanent hypoxic injury.

6 Do you agree with that assessment of the
7 strips, up to this point?

8 A. Yes.

9 Q. What do you base that opinion on?

10 A. The fact that we have not seen the strips
11 deteriorate in any way, that would suggest the
12 potential for injury. So when you have moderate
13 variability preserved like this, the chance of there
14 being an ongoing injury at that time is extremely
15 small.

16 Q. So you and Dr. warsof, using moderate
17 variability, and in 2025 and look back and say,
18 there's no injury during this time period.

19 Did McNeive in realtime use that same
20 information to make an assessment about the health of
21 Remi Anyan based on these strips?

22 A. He can, sure.

23 Q. And what would that realtime assessment
24 be?

25 A. That fetus is well oxygenated and is not

1 being injured or at risk for being injured.

2 Q. without the benefit of knowing the final
3 result, is there anything in these strips up to
4 2:00 p.m. that would make you or any OB believe that
5 Remi would have been injured if delivered at this
6 time?

7 A. Based on the fetal monitoring, no.

8 Q. If, again, it's Mr. Anyan's testimony that
9 between 8:00 p.m. and 2:00 p.m., Dr. McNeive was
10 checking in every hour, reviewing the strips,
11 performing the digital examination, is Dr. McNeive
12 missing dire alarm ringing strips during this period
13 of time?

14 A. I don't believe so.

15 Q. Let's -- 2:00 p.m. to 3:57, switching to
16 that period of time. Testimony -- and I think this
17 is not in controversy -- testimony was that Dr.

18 McNeive was at Ms. Anyan's bedside from 2:00 p.m.,
19 all the way up to delivery.

20 So the jury has heard from Dr. warsof
21 himself, that even between 2:00 p.m. and 3:57 p.m.,
22 he sees some return to Category II strips -- Dr.
23 warsof testified that even between 2:00 p.m. and 3:57
24 p.m., he saw a return of Category I tracings, do you
25 agree with that assessment?

1 A. I do.

2 Q. And, again, what would that tell a
3 provider who's reviewing the strips if they see
4 category I during this period of time?

5 A. Well oxygenated fetus, it's highly
6 unlikely to be acidotic, not at risk for injury at
7 that point in time.

8 Q. So if Dr. warsof testified that he saw
9 moderate variability between 2:00 and 3:57 p.m., do
10 you agree with that assessment?

11 A. I do.

12 Q. Dr. warsof testified he even saw some
13 accelerations. Now, he also said not that many, but
14 he saw some accelerations between 2:00 and 3:57 p.m.

15 Do you agree with that assessment of the
16 tracings?

17 A. I saw them, too.

18 Q. Okay. Dr. warsof testified that the
19 strips between 2:00 and 3:57 p.m., do not show
20 evidence of a permanent hypoxic injury during that
21 period of time.

22 Do you agree with Dr. warsof in that
23 assessment?

24 A. I agree.

25 Q. What is the basis for that opinion,

1 standing here today in retrospect, the tracings
2 between 2:00 and 3:57 p.m., are not consistent with a
3 permanent hypoxic injury?

4 A. Preservation of variability, namely,
5 moderate variability far and above anything else.
6 And you don't have a series of significant repetitive
7 decelerations with either minimal or absent
8 variability that would reflect a potential for
9 injury. So you don't have that. That's the basis.

10 Q. And, again, if that's our basis for
11 knowing to a reasonable degree of medical certainty,
12 in 2025, that there's no hypoxic injury between 2:00
13 and 3:57 p.m., would it have been fair for Dr.
14 McNeive in realtime, not knowing what the future was
15 going to be, to rely on that moderate variability and
16 make medical decisionmaking based on that observation
17 ever?

18 A. Yes.

19 MR. PERRON: Justin, if you could go to
20 C2, 2:20 p.m. It's tabbed, as well. Maybe not.
21 Yeah C2, and I guess 1420.

22 Q. (By Mr. Perron) All right. Doctor, do
23 you see moderate variability in this section?

24 A. I do.

25 Q. And, again, what is that telling you

1 sitting here today in 2025, that would have been also
2 what Dr. McNeive saw?

3 what do you see?

4 A. No, or virtually no chance, that the fetus
5 is acidotic at this point. And that the fetus
6 obviously with that is not at risk for injury at this
7 point. That's what it tells you.

8 Q. Out of all the things that you can observe
9 on fetal heart monitoring strips, what is the
10 loadstone, the key finding, when you're looking at a
11 strip? What is your sort of most reliable key
12 finding that you can look for?

13 A. It's variability.

14 Q. Any kind of -- right. And we've exchanged
15 around terms. If I say moderate variability, is that
16 the same things as when you say variability?

17 A. Well, no. I would describe it. In other
18 words, I'm saying variability tells me a lot. If
19 it's moderate, and it's present, it excludes
20 acidosis, and, to a large extent, excludes any
21 significant hypoxia, as well.

22 So that's where you start from, and then
23 you describe everything else. Because that has to be
24 the fork in the road. Is there normal variability,
25 or is there not normal variability, and then go from

there.

MR. PERRON: Justin, if you want to put up 1-4, page 4.

Q. (By Mr. Perron) The jury has seen this before, but ACOG --

MR. PERRON: Well, the subheading.

Q. (By Mr. Perron) How are the current late decelerations evaluated?

And I'll read this quote right here:
Given the low predictive value of late decelerations, decelerations for acidemia, and their known false positive rate for fetal neurologic injury, evaluation for the presence of accelerations or moderate FHR variability or both, may be useful to assess the risk of fetal acidemia.

Did I read that correctly?

A. You did.

Q. Do you agree with that statement?

A. I do.

Q. So just to start off, going back to the first part of that sentence: The low predictive value of late decelerations for acidemia and their known false positive rate for fetal neurologic injury.

So, Doctor, take me through that just a

1 little bit. what does false positive mean?

2 A. False positive means you have a finding,
3 but as it relates to neurologic injury, say it's
4 decelerations, say its even lack of variability, that
5 there is -- that if you have that finding, then, in
6 fact, the fetus is not injured or never becomes
7 injured.

8 Q. okay.

9 A. So there -- that -- that -- that's the
10 false positive. The low predictive value relates to
11 the fact that, in this sentence at least, there's
12 late decelerations that most of the time, the vast
13 majority of the time, the fetus is not acidotic.

14 Q. In realtime, can you or anyone else or any
15 OB, look at a deceleration and say, oh, that's a
16 hypoxic event happening right there?

17 A. The only time you can do that is with late
18 decelerations because the only way late decelerations
19 occur, is by way of hypoxia. But variable
20 decelerations may or may not be associated with
21 hypoxia.

22 Q. This says low predictive value of late
23 decelerations for acidemia.

24 so there's -- is there a low predictive
25 value of late decelerations for acidemia?

1 A. Right. To backtrack, late decelerations
2 reflect temporary hypoxia in the fetus. They don't
3 mean the fetus is acidotic. That's where you go to
4 the variability. Because if the variability is
5 moderate, that virtually excludes acidosis.

6 Q. So what is -- what is ACOG telling you to
7 do? Even if you see late decelerations, what is this
8 telling you to do?

9 A. It's telling you to look at the associated
10 variability and whether there are accelerations or
11 not, because that's going to tell you whether this
12 fetus is really at risk for acidemia. That's what it
13 says.

14 Q. To anyone who claims -- so, again, if late
15 decels are not predictive, what is predictive? What
16 is the guiding information that OBs should be looking
17 for?

18 A. If they're looking at associated
19 variability, if you have repetitive decelerations of
20 either kind. And if you have that, then you may be
21 at risk for associated acidosis in injury.

22 Fortunately the majority of time is when you have
23 that fetus, is not acidotic, or it becomes injured,
24 hence the false positive of fetal monitoring.

25 Fetal monitoring is a screening test.

1 It's not a diagnostic test. It just identifies and
2 stratifies is this a fetus that is well oxygenated or
3 not? Is this a fetus that is acidotic or not? And
4 therefore risk of injury? It's a screening test with
5 very high false positives, meaning most of the
6 abnormal fetal heart tracings will be associated with
7 a normal outcome.

8 MR. PERRON: Justin, if you want to go to
9 Exhibit A1, page 182. It should be the strip again
10 at 1548.

11 Q. (By Mr. Perron) The jury heard Dr. Warsof
12 look at the same strip. At 1548, this is just 36
13 minutes before delivery. Dr. Warsof said that he saw
14 accelerations here.

15 Do you agree with that assessment?

16 A. Yes.

17 Q. Okay. From what we just read, what can
18 you tell about the health of Remi Anyan, according to
19 these strips, in relation to a hypoxic acidotic
20 injury?

21 A. If you look at these strips in isolation,
22 the fetus is not injured. It would be remarkable
23 that the fetus is being injured at this time or is
24 acidotic at this time or even hypoxic at this time,
25 looking at those strips, because the fetus looks

1 great, frankly, at this point in time on the strips.

2 Q. So if ACOG tells us that accelerations in
3 particular are highly predictive that there is no
4 neurologic injury going on, can Dr. McNeive rely on
5 that literature when he's looking at this strip at
6 this time?

7 A. Yes.

8 Q. The jury heard that Dr. Warsof was not
9 critical of Dr. McNeive's management of the events
10 from 3:57 through delivery.

11 Do you agree with that assessment?

12 A. Yes.

13 Q. Did the standard of care mandate a
14 C-section before 2:00 p.m., on May 4th?

15 A. No.

16 Q. Did the standard of care mandate a
17 C-section before 4:00 p.m.?

18 A. No.

19 Q. Moving to causation.

20 Doctor, do you have an opinion to a
21 reasonable degree of medical certainty, more likely
22 than not, whether Remi Anyan suffered an acute
23 hypoxic injury in the last 27 minutes of labor?

24 A. I don't believe so.

25 Q. Based on what?

1 A. Based on the fact that we have a 5-minute
2 Apgar score of 8, we have no evidence in the fetus of
3 acidosis at any time, and if one were to accept that
4 there was an acute injury in the last 30 minutes of
5 entry into life, those babies don't go to the regular
6 nursery. They're invariably depressed enough that
7 they don't have a 5-minute Apgar score of 8, and they
8 go to the neonatal intensive care nursery.

9 Q. Do you have an opinion, to a reasonable
10 degree of medical certainty, more likely than not,
11 whether Remi Anyan suffered an acute hypoxic injury
12 between presentation to the hospital and delivery?

13 A. I don't see any evidence of that from the
14 medical record and the facts in this case.

15 Q. Do you, from the standpoint of OB MFM,
16 have an opinion about what the cord gas would have
17 shown if it had been ordered on May 4?

18 A. I think the cord gas would have been
19 normal. In other words, I don't think this fetus
20 would have shown acidosis consistent with an injury
21 in the last 30 minutes and then have an Apgar score
22 of 8 and then go to the regular nursery.

23 Q. Do you know the exact timing of Remi
24 Anyan's intrauterine hypoxic injury?

25 A. No.

1 Q. Even if you can't pinpoint the time, to a
2 reasonable degree of medical certainty, more likely
3 than not, can you exclude that there was a hypoxic
4 permanent global injury between presentation at the
5 hospital and delivery?

6 A. There's no evidence of that in this case.

7 Q. Can a brain suffer a hypoxic injury prior
8 to labor, but still later show a normal fetal heart
9 rate such that the tracings appear normal at the time
10 of admission to the hospital?

11 A. Yes.

12 Q. And how does that happen?

13 A. Well, it really depends upon the extent of
14 the injury and what areas of the brain are involved.
15 But fetuses that sustain hypoxic brain injury prior
16 to labor resulting in devastating neurologic
17 outcomes, including cerebral palsy. And the majority
18 of those cases in term fetuses are actually events
19 that occur before the labor itself in the majority of
20 the cases.

21 Q. Doctor, did Dr. McNeive meet the standard
22 of care with regard to management of the fetal heart
23 monitor strip?

24 A. I believe he did.

25 Q. Did Dr. McNeive meet the standard of care

in terms of labor and delivery management?

A. Yes.

Q. Did Dr. McNeive meet the standard of care with regard to his treatment of Remi?

A. He did.

Q. Did anything Dr. McNeive do or did not do cause or contribute to cause injury to Remi Anyan to a reasonable degree of medical certainty, more likely than not?

A. I don't believe so.

Q. Have all of your opinions stated today been to a reasonable degree of medical certainty?

A. Yes.

Q. Those are all my questions.

THE COURT: On behalf of Mercy Hospital.

MS. KAMYKOWSKI: Very briefly, Your Honor.

Justin, can you pull up exhibit A16, the algorithm, please.

DIRECT EXAMINATION

BY MS. KAMYKOWSKI:

Q. Morning, Doctor.

A. Morning.

Q. And, Doctor, the jury has heard a lot about the Clark algorithm.

You are aware of what that is, are you

1 not?

2 I am.

3 MS. GUNN: Your Honor, may we approach?

4 THE COURT: You may.

5 (Proceedings were held at sidebar, outside
6 the hearing of the jury.)

7 MS. GUNN: Your Honor, this doctor did not
8 work the Clark algorithm. I asked him on page 71:

9 Have you worked the Clark algorithm in this matter?

10 On page 72: Have I looked at it in this
11 matter?

12 Right. Have you worked it?

13 No, I didn't go through that exercise.

14 MS. KAMYKOWSKI: And I'm not going to have
15 him go through this. I've already made that point.

16 Just ask him to just to the extent to talk about the
17 provider's assessment to the fetal heart rate, the

18 moderate variability. And it starts with that and

19 ends with that. And that's it. And I'm not going to
20 work it with him.

21 MS. GUNN: Your Honor, he didn't bring the
22 Clark algorithm to his deposition. He didn't rely on

23 it. He didn't work it. And it's not appropriate to
24 my questions to this witness the first time.

25 MR. PERRON: And, Your Honor, he

1 obviously is familiar with the Clark algorithm. It's
2 a difference in explaining his interpretation of how
3 to do the Clark algorithm and the timing of the facts
4 to the Clark algorithm.

5 MS. GUNN: He didn't use them. He
6 didn't --

7 MR. PERRON: Dr. Warsof didn't suggest how
8 an OB runs an algorithm. The jury saw it up on the
9 board that Dr. Warsof said you get to observe, and
10 then you have to go back up to the normal
11 progression. But if not, an application backs the
12 algorithm.

13 That's Dr. Warsof testifying about how the
14 decision came to run the algorithm. Dr. Landon's
15 familiar in his depo with the Clark algorithm. If he
16 doesn't apply the facts, he shouldn't be allowed to
17 testify as to his understanding about how this
18 decision is to run the algorithm.

19 MS. KAMYKOWSKI: And I wasn't even going
20 to get into that with him, Judge. I'm only making
21 the point that the guidance of the American College
22 of Obstetrics and Gynecology gives these providers,
23 both doctors and nurses, that if you start an
24 assessment as to whether or not there is moderate
25 variability and/or accelerations, and then you go to

1 the discussion about theses decelerations of the
2 heart rate.

3 It is an exemplar, it is a demonstrative,
4 and it supports what he has already talked about here
5 today and what the jury has already heard about this
6 week and a half.

7 THE COURT: I'm going to sustain the
8 objection.

9 (Proceedings returned to open court.)

10 MS. KAMYKOWSKI: Take that down, please.

11 Q. (By Ms. Kamykowski) Dr. Landon, I think
12 what you told Mr. Perron on direct is that I think he
13 used the word "lodestar." That's a lawyer word. The
14 key finding when using electronic fetal monitoring as
15 a surveillance tool or during labor is the
16 presence -- you have to evaluate the variability of
17 the heart rate, correct?

18 A. Yes.

19 Q. And a provider can be reasonably assured
20 that a baby is doing well, has good oxygen status,
21 acid base status, in the presence of moderate
22 variability, correct?

23 A. I think by and large, that's true.

24 Q. Okay. And so if you have moderate
25 variability, you can be assured, but then you also

1 should be surveilling, evaluating, and if necessary,
2 performing intrauterine resuscitation if you see
3 decelerations of the heart rate, correct?

4 A. True.

5 Q. So you start with the knowledge of
6 variability. If you see baby's reaction, a
7 deceleration of the heart rate, whether it be
8 variable or late, because earlies are okay, right?
9 we're not talking about earlies when we're assessing
10 acid base status, right?

11 A. It's true.

12 Q. Okay. So variables or late decelerations
13 those, if you have moderate variability, you're not
14 ignoring them, but the standard requires you, the
15 providers, both the doctors and the nurses, to try to
16 figure out what might be causing them and if you can
17 resolve them, correct?

18 A. I think that's true.

19 Q. Okay. And the number, counting the number
20 of variables in any period of time, is that the
21 practice? Or is it really the quality of the
22 deceleration of the heart rates?

23 A. Yeah. I don't think you count them. I
24 mean, I haven't seen anyone count them ever in
25 practice, per se. But it is, you know, when it comes

1 to variable decelerations, I do think that depth is
2 important and the duration of the decelerations. But
3 what is obviously, again, very important is, is there
4 associated moderate variability or not.

5 Q. And in this case, you used the words
6 "significant decelerations" when you were describing
7 what might be considered or evaluated in Category II.

8 Did you see, in your review of the strips,
9 at any time there were heart rate decelerations,
10 significant decelerations, that required anything
11 more than the position changes that were being done
12 here?

13 A. No.

14 Q. And I think you told Mr. Perron in your
15 review of the entirety of the strips from the time --
16 from the shift change at 7:00 a.m., on May 4th,
17 through delivery, through -- until the last 3:57,
18 there was also moderate variability within the
19 baseline?

20 A. I would say predominantly over 90 percent
21 of the time.

22 Q. Okay. And in that time, there was also
23 not significant decelerations that required -- that
24 did not respond to intrauterine resuscitation?

25 A. They did respond. So we saw the tracing

1 improve. we saw the decelerations reappear. But
2 variability was preserved and didn't become an issue
3 until after approximately 4:00 p.m.

4 Q. okay. we know that there was vaginal
5 delivery in this case, correct?

6 A. Correct.

7 Q. And by definition, the end result of a
8 vaginal delivery, does that mean that even if it was
9 slow, that there was progress in the second stage of
10 labor?

11 A. There had to be progress ultimately for
12 delivery to take place.

13 Q. Thank you. That's all I have, Doctor.

14 THE COURT: Cross-examination?

15 MS. GUNN: Yes, ma'am.

16 CROSS-EXAMINATION

17 BY MS. GUNN:

18 Q. Good morning, Dr. Landon.

19 A. Good morning.

20 Q. So I was struck, Doctor, by your testimony
21 because you failed to mention at any point that Remi
22 Anyan -- who's a boy, by the way, I think you said
23 "she" earlier. So let's be clear, Remi is a boy --
24 but you failed to mention at any point, in the last
25 hour or so, that Remi went into Cat III tracings at

3:50.

Do you remember that?

A. I wasn't asked.

Q. Okay. I know why. Like I get it. But, I mean --

A. So is there a question?

Q. Yes, sir. I'll get there.

Your job is to take a look at all of the materials in this case, right?

A. True.

Q. To render opinions, in an important case like this, based on all of the evidence that you've been presented, correct?

A. Of course.

Q. And you saw all of strips in this case, right?

A. Of course.

Q. And we went over them together in your deposition, right?

A. True.

Q. And at 3:50, it's your opinion that Remi Anyan was not only in Category III strip, but was tachycardic, right?

A. 3:57.

Q. Well, okay. Let's go with 3:57.

1 3:57 p.m. --

2 A. Right.

3 Q. Remi Anyan was tachycardic.

4 what does that mean?

5 A. That the baseline heart rate was elevated.

6 Q. That's not good, is it?

7 A. I mean, it could be bad, it could be not
8 so bad. I mean, it's an abnormal finding.

9 Q. Right. It's a concern, right?

10 A. True. True.

11 Q. And can Category III, minimum variability.
12 we talked about moderate variability. Moderate
13 variability, I think the last thing you said was that
14 predominantly he had moderate variability throughout
15 the course of his labor. But by the time he got to
16 3:50, he had minimal variability, right?

17 A. (No audible response.)

18 Q. Do you remember that, Doctor?

19 A. I'm answering the question. Give me a
20 second.

21 Q. Okay.

22 A. well, leading up to 3:50, we have
23 accelerations, and we have moderate variability. So
24 I'm not sure what you're talking about.

25 Q. well, I asked you whether minimum

1 variability started at 3:50 -- minimal variability.

2 A. Okay.

3 Q. And you told me in your deposition that
4 minimal variability started at the same time as this
5 Cat III, approximately at 3:50, 3:55, 3:57, is that
6 right?

7 A. What page of my dep, please?

8 Q. Page 50.

9 A. Thank you.

10 I don't see this on page 50 of my dep.

11 Q. All right. Let's move on to 3:50 -- I'm
12 sorry -- go from -- I'm sorry -- page 50 at the
13 bottom, move onto 51. So let's just be clear.

14 MS. GUNN: Let's look at page 182, Zack,
15 of Exhibit 5.

16 Q. (By Ms. Gunn) Dr. Landon, this is --

17 A. I'm just looking for a reference to
18 minimal variability on page 50 that you proffered
19 your question with, and I don't see it.

20 Q. Okay. Do you remember saying that
21 variability is pretty much gone? Is that different
22 than minimal? Is that absent variability?

23 A. At 3:57, I testified to that.

24 Q. Right.

25 A. But I never testified that at 3:50 there

was minimal variability, as you've asked me the question today.

Q. Okay. Page 182 of the strip.

A. Yes.

Q. That page is between 3:50 p.m. and 3:57 p.m., roughly.

A. Right.

Q. Can we agree to that?

A. Right.

Q. And you told me -- we're looking at page 182 of the strip, that's when Category III starts.

And you said, I think that's fair.

On page 51, are you with me?

A. I'm listening, sure.

Q. Okay. So Category III starts on this page 182, which covers 3:50 to 3:57?

A. Hold on a second. Category III starts at 3:57. That was my testimony then; that's my

testimony today. It doesn't start at the beginning of the strip. It starts at the end of the strip at 3:57.

Q. Page 50 of your deposition, line 24, Doctor.

Looking at page 182, which is the time frame between roughly 1550 and 1557 or 1549 or 1557,

1 is that when the Category III starts roughly?

2 "ANSWER: I think that's fair."

3 Can we agree that Category III starts on
4 page 182 of Remi Anyan's strips?

5 A. If you look at page 51 --

6 Q. Doctor, here's what --

7 A. -- of my deposition --

8 Q. Doctor, here's what I want --

9 A. -- it's clear that when I --

10 Q. Doctor, I want to be clear --

11 A. -- testified when Category III begins.

12 Q. Doctor, if I may? If you could please --

13 A. Sure.

14 Q. -- look at that deposition, and I'm going
15 to read it again. And all I'm going to ask you to do
16 is answer if I've read it correctly, okay?

17 MR. PERRON: Your Honor, may we approach?

18 THE COURT: You may.

19 (Proceedings were held at sidebar, outside
20 the hearing of the jury.)

21 MR. PERRON: Your Honor, it's improper

22 impeachment. We were going to ask --

23 MS. KAMYKOWSKI: Show her the whole page.

24 It starts at the bottom and goes all the way through
25 the discussion.

1 THE COURT: I don't know that it's
 2 improper impeachment. It just hasn't gotten to that
 3 secondary place. She's read the pages as they're
 4 written. If you believe there's more to it that
 5 needs to be gotten to, I assume your doctor will
 6 actually answer the question, then that can be
 7 addressed on redirect.

8 MS. GUNN: Okay.

9 (Proceedings returned to open court.)

10 Q. (By Ms. Gunn) Doctor, on page 50, line
 11 24, looking at page 182, which is the time frame
 12 between, roughly, 1550 and 1555 and 1549 and 1557, is
 13 that when the Category III starts, roughly?

14 "ANSWER: I think that's fair."

15 Did I read that correctly?

16 A. Yes.

17 Q. And then I go on to ask: And what about
 18 it makes it a Category III?

19 And your answer is: well, now the
 20 variability is pretty much gone. So that's what does
 21 it.

22 So Category III starts on page 182, and so
 23 does tachycardia, correct?

24 A. True.

25 Q. So now --

1 A. At the end of page --

2 Q. --after --

3 A. Excuse me. At the end of page 182, is
4 when the Category III starts.

5 Q. Sure. We can agree it starts, right?

6 A. Well, we were just arguing about that for
7 about 10 minutes, so --

8 Q. I don't -- I don't consider it arguing,
9 Doctor, I consider it asking questions and getting
10 answers. So why don't we keep going with that.

11 We've got a child who has been in a second
12 stage of labor now for how long?

13 A. Since, I believe, approximately three
14 o'clock.

15 Q. In the morning?

16 A. Yes.

17 Q. So how many hours is that?

18 A. Over 12 hours.

19 Q. Yeah. And I wonder, that's also something
20 I didn't hear you talk about on direct.

21 You mentioned nothing about the fact that
22 this was a prolonged second stage of labor, correct?

23 A. There is a prolonged second stage of
24 labor, correct.

25 Q. Right. So here's where I'm going: We

1 have a woman, Ms. Sarah Anyan, who was complete at
2 3:50 a.m., to be precise, and she starts pushing with
3 her night nurse.

4 Do you remember that testimony?

5 A. I do.

6 Q. Okay. And then after an hour and a half,
7 what happens?

8 A. I'm not sure what you're -- what you're
9 getting at, "what happens"?

10 Q. Do you recall what happens after an hour
11 and a half of pushing?

12 A. In terms of a significant event?

13 Q. Yeah.

14 A. No.

15 Q. Okay. Well, the jury has seen that this
16 night nurse, Alex Greenwald, decides that she needs
17 to ask for a physician to do a pushing evaluation.

18 Does that refresh your recollection?

19 A. Fair enough.

20 Q. And why are pushing evaluations -- do the
21 residents at your hospital ask for pushing
22 evaluations from time to time, or the nurses?

23 A. Sure.

24 Q. And why?

25 A. If there's any concern about, you know,

1 pushing efforts, they may.

2 Q. And that happened here about 5:30 a.m.

3 Do you remember that?

4 A. Not precisely, but I don't have everything
5 memorized.

6 Q. Okay. Then we've got Dr. Mckillip came to
7 the bedside, and she's a first-year resident.

8 And do you recall what she identified
9 after pushing for an additional 20 minutes with
10 Sarah?

11 A. I think some caput.

12 Q. How much?

13 A. I don't remember the descriptor offhand.

14 Q. And caput, can you count caput as descent?

15 A. No.

16 Q. So caput is just the swelling on the
17 baby's head, correct?

18 A. Agreed.

19 Q. What was Remi's station at about
20 6:00 p.m.?

21 A. Zero.

22 Q. And what had it been when they started
23 pushing at 3:50 a.m.?

24 A. Zero.

25 Q. So no descent?

1 A. Essentially, right.

2 Q. And you can't count caput, correct?

3 A. Yes. Right.

4 Q. So after now 2 hours in the second stage
5 of labor pushing, Remi has not descended down the
6 birth canal, correct?

7 A. I think that's fair.

8 Q. What else happened that was identified --
9 or what else did Dr. Mckillip identify, other than
10 failure to descend?

11 A. I'm not sure. I'm not sure. Go ahead,
12 please.

13 Q. Do you recall that Dr. Mckillip identified
14 that Remi was malpositioned?

15 A. At some point. I don't remember if it was
16 precisely then, but malposition was identified, yes.

17 Q. And that malposition was OP?

18 A. Correct.

19 Q. And the optimal delivery position for a
20 head is what?

21 A. Occiput anterior, OA.

22 Q. So the difference between face-up and
23 facedown?

24 A. That's what we're talking about, true.

25 Q. So we've got a child whose mother has been

1 pushing well on Pitocin.

2 Do you recall that? That she was --

3 A. well, she's been pushing.

4 Q. And I switched my question in between
5 there.

6 was Sarah also on Pitocin?

7 A. Yes.

8 Q. Do you remember the rate by 3:50 a.m.?

9 A. My memory, I think it was -- I don't
10 know -- 18 or something like that.

11 Q. Yes, it was.

12 A. Thank you.

13 Q. And it stayed at 18 for how long?

14 A. I don't have that precisely memorized.
15 For a good period of time.

16 Q. It was never turned down?

17 A. True.

18 Q. It was never discontinued until after Remi
19 was born?

20 A. That is correct.

21 Q. And I know the jury saw the Pit policy,
22 and you think that the Pit policy at Mercy Hospital
23 was followed to the "T" by both the nurses and Dr.
24 McNeive?

25 A. I think it was, the way I interpret it.

1 Q. Sure. So at 3:50 -- or excuse me -- at
2 six o'clock, Dr. McKillip called the attending, which
3 at the time, was Dr. April Parker.

4 Do you recall that?

5 A. Yes.

6 Q. And do you recall what the recommendation
7 was?

8 A. Not specifically from Dr. Parker. I don't
9 recall at that early time.

10 Q. Do you recall or remember reading anything
11 about laboring down?

12 A. Yes.

13 Q. So there's 30 minutes of laboring down.
14 And that was reasonable at the time,
15 right?

16 A. I think it was.

17 Q. Okay. And then Dr. McNeive actually gets
18 on call at 7:00 a.m., right --

19 A. Correct.

20 Q. -- as far as you know?

21 He gets on call at 7:00 a.m., and then he
22 comes into Sarah's room at 8:00 a.m., right?

23 A. Yes.

24 Q. And the jury heard from Dr. McNeive
25 yesterday. And we heard that he doesn't remember

whether he checked Sarah at that time.

Can you accept that?

A. I have no reason to dispute, no.

Q. Okay. So he comes into the room. He may or may not have checked Sarah.

We can agree -- because you've read the records -- that he didn't document anything about that time into the room, correct?

A. That he didn't document at that time?

Q. Yes, sir.

A. I think that's true.

Q. The nurse documented that he was there.

Do you remember reading that?

A. Yes, ma'am.

Q. But Dr. McNeive didn't document his thoughts on Remi's station, correct?

A. There's no documentation at that time.

Q. He didn't document what the position of Remi's head was, correct?

A. There's no documentation at that time.

Q. So we don't know. At least not from the documents, right?

A. That's true.

Q. And at 8:00 a.m., we are now at 4 hours of the second stage of labor.

1 Does that -- the clock work out for that?

2 A. I believe so.

3 Q. And it's your opinion that prolonged
4 second stage of labor is actually 3 hours for a
5 first-time mom with anesthesia, right?

6 A. That's the classic definition.

7 Q. Right. And so according to your
8 definition of a prolonged second stage of labor, by
9 the time Dr. McNeive gets to Sarah, he was -- or she
10 was already an hour past that, right?

11 A. If you use the classic definition, that is
12 correct.

13 Q. And so at that time, it would have been
14 acceptable under the standard of care to perform the
15 C-section based on that prolonged second stage of
16 labor, would you agree?

17 A. I think I told you in my deposition, you
18 could do a C-section then and be within the standard
19 of care, but it's not required --

20 Q. Right. I understand --

21 A. -- to be -- excuse me -- to be within the
22 standard of care.

23 Q. Right. I understand that that standard of
24 care didn't mandate, there's no mandate by ACOG, to
25 do the -- standard of care in your opinion to do a

1 C-section.

2 But what I'm asking, and what I want the
3 jury to understand is, that it's your opinion, based
4 on a reasonable degree of medical certainty, that had
5 Dr. McNeive delivered Remi at this point, that would
6 have been perfectly acceptable under the standard of
7 care?

8 A. I wouldn't criticize it and tell you this
9 is a deviation from the standard of care. I would
10 just put it to you that way.

11 Q. All right. And we know, based on the
12 fetal heart monitoring strips that you talked about
13 earlier today, at that time frame, 8:00 a.m., Remi
14 looked good, right?

15 A. That's true.

16 Q. He had good variability. There were no
17 significant decels, according to you. And there
18 were, in fact, accelerations, right? It's Category I
19 before 8 a.m., right?

20 A. That's why they continued to labor.
21 True -- excuse me -- true.

22 Q. So based on everything that you told us in
23 your direct examination, based on those strips alone
24 in isolation, which is what we've been talking about,
25 based on those strips alone in isolation, Remi's was

perfectly healthy, according to those strips, right?

A. According to those strips, in isolation, that is correct.

Q. At 8:00 a.m.?

A. According to those strips, in isolation, again, that's correct.

Q. And had he been delivered, that's what you would have expected? A perfectly healthy baby boy?

A. Well, not knowing anything else, that's what you would have expected, agreed.

Q. Now, the duration of this second stage of labor, Sarah Anyan's second stage of labor, would suggest that, because we know how long it was, that malpositioning of Remi was a reasonable explanation for it, right?

A. It definitely played a role in the second stage duration, no doubt in my mind.

Q. For Sarah?

A. Beg your pardon?

Q. For Sarah? Not just generally, but actually for Sarah?

A. Right.

Q. Yes.

A. Right.

Q. So that was something that Dr. McKillip

1 identified at 5:30, six o'clock in the morning,
2 correct?

3 A. Right.

4 Q. And so that is something a reasonable
5 physician would know, that if there's a
6 malpositioning of a baby, after 2 hours of pushing
7 with no descent, a reasonable obstetrician would
8 understand that that could prolong a second stage of
9 labor indefinitely, correct?

10 A. It definitely would be associated with a
11 prolonged second stage. You can't say at that point
12 how long the second stage is going to last, but it
13 would be associated with a prolonged second stage, I
14 agree with that.

15 Q. And that's something that was known, not
16 just knowable, but known to Dr. McNeive at 8:00 a.m.,
17 correct?

18 A. True.

19 Q. So let's talk about failing to descend.

20 It's your definition -- well, first of
21 all, it's not coming down the birth canal. The baby
22 is not progressing down the birth canal, correct?

23 A. Right.

24 Q. And it's your definition that a failure to
25 descend is less than a centimeter an hour, correct?

1 A. Yes.

2 Q. That would be protracted descent if the
3 baby comes down less than a centimeter an hour,
4 right?

5 A. That's true.

6 Q. And you agree that, according to Dr.
7 Mckillip's note, that Sarah had failure to descend at
8 8:00 a.m. -- excuse me -- at 6:00 a.m.?

9 A. I'm sorry?

10 Q. I know I just asked you that already, but
11 could you please confirm that again?

12 A. I think that's true.

13 Q. Thank you.

14 Now, we also know that at 8:00 a.m.,
15 there's no evidence of whether that malpositioning
16 had fixed itself, right?

17 A. Agreed.

18 Q. And we don't know if at ten o'clock, the
19 malpositioning had fixed itself, correct?

20 A. Agreed.

21 Q. Because there's no evidence of any
22 documented sterile vaginal exams, correct?

23 A. At that point, agreed.

24 Q. At any point, really. I mean, the last
25 one was before Dr. McNeive came on service, right?

1 A. I think that's true.

2 Q. So we don't know -- well, I guess what we
3 do know is when Dr. McNeive came back to Sarah's room
4 after two o'clock, Remi was still malpositioned,
5 correct?

6 A. Presumably.

7 Q. Well, isn't that what he said in his
8 deposition?

9 A. I think so.

10 Q. Okay. So still malpositioned.
11 And now at two o'clock, how many hours are
12 we into the 10 -- I blew it -- into the second stage
13 of labor? I gave you my --

14 A. 10 hours.

15 Q. I blew it.

16 A. How'd I do?

17 Q. You passed.

18 A. Thank you.

19 Q. Now, we talked a little bit about the
20 times that Dr. McNeive kind of popped into the room.
21 And I think Mr. Perron indicated he came in every
22 hour.

23 That's not the case, is it?

24 A. I don't know. There's testimony on it, so
25 I'm not going to tell you I know for sure whether he

1 was there or not. There's testimony on it, and
2 others can decide what to do with that testimony.

3 Q. Thank you.

4 And with respect to that testimony, Sarah
5 and Blake Anyan gave depositions in this case before
6 you were deposed, right?

7 A. Right.

8 Q. And you were provided those --

9 A. Right. Sorry, right.

10 Q. That's okay.

11 And you didn't really read those, did you?

12 A. Didn't really read those? I don't think I
13 read them perhaps like I read McNeive's depo or
14 Warsof's depo, I would admit that to you. But I
15 looked at them. I don't think I read them or focused
16 on them like I did on McNeive or Dr. Warsof, for
17 example.

18 Q. Okay. But, nevertheless, when Dr. McNeive
19 popped into the room whenever, between 8:00 a.m. and
20 2:00 p.m., there's no documentation of the progress
21 that Remi was making, or the lack of the progress,
22 correct?

23 A. I think that's true.

24 Q. Now, I can't help myself, although I
25 probably won't be able to find it.

1 The jury has seen the record -- or the
2 article or whatever the guidelines about fetal --
3 about second stage of labor, prolonged second stage
4 of labor. And it discusses what needs to be done
5 when encountered with the second stage of labor.

6 Do you remember being shown that?

7 A. I think so.

8 Q. Well, and it indicates that if you're
9 going to go past the 3 hours or the 4 hours, progress
10 needs to be documented, correct?

11 A. It may say that. I mean, I don't have it
12 memorized.

13 Q. That's all right. Okay. Let me find it,
14 I'm sorry. That's one too many pieces of paper,
15 Doctor.

16 So there it is: 145-8, page 11.

17 This is the consensus, Doctor. This is
18 the obstetric care consensus No. 1, March 2014.

19 Are you familiar with that?

20 A. I'm familiar with the document.

21 Q. Okay. So this is called "Safe Prevention
22 of a Primary Cesarean Delivery." And so this was
23 just sort of a compilation of information when, I
24 guess, the United States medical community decided
25 that there were too many C-sections.

1 And so they kind of put together some
2 guidelines about -- and I'm generalizing. I can tell
3 what you're thinking -- and part of that was putting
4 this document together, fair enough?

5 A. I'm aware of what led to this document.
6 That, I am.

7 Q. Good. So we can talk about this part:
8 second stage of labor.

9 A. Sure.

10 Q. Where, again, here's the -- at least 3
11 hours of pushing for a first-time mom, correct?

12 A. Right.

13 Q. So before diagnosing arrest of labor, so
14 before saying arrest of labor equals C-section, we
15 need to give women at least 3 hours of pushing.
16 First-time moms and other mothers more than 3 --
17 excuse me -- at least 2 hours?

18 A. That's what it says.

19 Q. All right. So then it says: Longer
20 durations may be appropriate. It doesn't say they
21 are, but it says: Longer durations may be
22 appropriate -- sorry. Longer durations may be
23 appropriate on an individualized basis; i.e., with
24 the use of epidural anesthesia or with fetal
25 malposition --

1 we've got that, right? we've got fetal

2 malposition? Not an Official Court Document Not an Official Court Document

3 A. Right. Sorry. Not an Official Court Document Not an Official Court Document

4 Q. -- as long as progress is being

5 documented, correct? Not an Official Court Document Not an Official Court Document Not an Official Court Document

6 A. That's what it says.

7 Q. So it's okay to go past 3 hours. we're

8 going to say it's okay to do that on an

9 individualized basis, as long as progress is being

10 documented, correct? Not an Official Court Document Not an Official Court Document Not an Official Court Document

11 A. That's what it reads.

12 Q. It wasn't documented here, was it?

13 A. I don't think there's documentation of it.

14 Agree with that. Not an Official Court Document Not an Official Court Document Not an Official Court Document

15 Q. So, no, it was not being documented,

16 correct? Not an Official Court Document Not an Official Court Document Not an Official Court Document

17 A. Again, for the second time, I agree there

18 was no -- there was no documentation of it. Not an Official Court Document Not an Official Court Document

19 Q. So this rule wasn't met, was it? Not an Official Court Document Not an Official Court Document

20 A. I don't know if it's a rule, first of all.

21 Q. Okay. Not an Official Court Document Not an Official Court Document Not an Official Court Document

22 A. To be fair, this guideline in terms of

23 that, was not met in terms of documentation, yes.

24 Q. why is it important to document progress

25 in a prolonged second stage of labor?

1 A. well, I would say this: It's more
2 important to consider progress than it probably is to
3 actually document progress. But documentation is
4 never a bad thing in general, I would say.

5 Q. Okay. You told us that Dr. McNeive acted
6 within the standard of care, and that part of that
7 was based on the fact that he was aware of what was
8 going on.

9 Do you agree?

10 A. I believe that's true.

11 Q. So as long as Dr. McNeive was aware of
12 what was going on with Sarah Anyan, he was meeting
13 the standard of care?

14 A. As a general statement, that's true.

15 Q. So it doesn't matter -- it doesn't matter,
16 per se, what McNeive was doing between 8:00 a.m. and
17 2:00 p.m. As long as he was aware of what was going
18 on with Sarah, he was acting within the standard of
19 care, agreed?

20 A. well, I don't know that I would just say
21 it doesn't matter what he was doing. I think it does
22 matter, but I don't have any reason to believe he was
23 doing something he shouldn't have been doing, so I'm
24 not sure what you're asking about.

25 Q. well, I'm just trying to recall -- I'm

1 just trying to ask you what your opinions are in this
2 matter.

3 And you remember telling me in your
4 deposition what your opinions were, correct?

5 A. Sure.

6 Q. And we were talking about this time frame
7 between 8:00 and two o'clock, and what he was doing.

8 And you just told me he was aware of what was going
9 on. It didn't matter, per se, what else he was doing
10 as long as he was aware of what was going on with
11 Sarah?

12 A. As a general statement, I think that's
13 true. I mean, you know, assuming he's not outside
14 the hospital, you know, having a beer or something.

15 Q. Yeah. You indicated one of the basis of
16 your opinions that he was acting within the standard
17 of care was that he was at the hospital, and he was
18 attentive, correct?

19 A. I think that's true.

20 Q. And that you think he correctly
21 interpreted the fetal monitoring strips, correct?

22 A. That was my testimony, yes.

23 Q. Now, we've got, you know, you did your own
24 writings, not on Exhibit 5, but in your deposition
25 you did your own writings interpreting the fetal

1 monitoring strips, correct?

2 A. Yes.

3 Q. Okay. Well, I just want to go over a few
4 because we kind of skipped a few going forward.

5 MS. GUNN: And, Your Honor, I'm cognizant
6 of the time.

7 THE COURT: why don't we go ahead and take
8 our morning recess.

9 MS. GUNN: okay.

10 (At 10:39 a.m., the court duly admonished
11 the jury, and proceedings stood in recess. At
12 10:58 a.m., the following proceedings were held in
13 open court, in the presence of the jury:)

14 THE COURT: Go ahead and be seated,
15 everyone.

16 Ms. Gunn?

17 MS. GUNN: Thank you, Your Honor.

18 zack, if you don't mind, I'd like
19 Exhibit 5, page 125.

20 Q. (By Ms. Gunn) And, Dr. Landon, these are
21 the fetal monitoring strips that we've been
22 discussing.

23 And this particular exhibit that I think
24 was used in Mr. Perron's direct, includes the
25 markings by some of the providers in this case,

1 including Dr. McNeive. I think you probably were
2 provided those prior to your deposition.

3 So this one, page 125, is -- I know that's
4 kind of far away -- but it is at 7:59 a.m. I don't
5 know if you also have a copy there. Anyway, it ends
6 at 7:59 p.m.

7 Do you see that? And...

8 A. a.m.

9 Q. whoops. Thank you. All right. That
10 would make it different. Let me start that again.

11 Page 125 of Exhibit 5 is a copy of the
12 fetal monitoring strip for Remi Anyan that ends at
13 7:59 a.m.

14 Can you agree with me?

15 A. Sure.

16 Q. And the page -- let's just scroll through
17 the pages -- 125 shows decels, according to the folks
18 that read it, correct?

19 A. Right.

20 Q. And then the next page, 126, that ends at
21 8:07, that shows decels, correct?

22 A. I think it shows the end of a decel from a
23 previous page and another decel, yes.

24 Q. Okay. And just so we're clear, late and
25 DM, that's Dr. McNeive's writing. The green pen is

1 Dr. McNeive for DM.

2 Can you accept that, sir?

3 A. Sure.

4 Q. All right. So Dr. McNeive, on this strip
5 that ends at 8:07, is identifying late decels,
6 correct?

7 A. A late decel.

8 Q. Okay. Well, he writes late twice.

9 Is that just the same one or a longer one,
10 or...

11 A. I don't know. You'd have to ask him.

12 Q. Okay. Well I did, and he wrote twice.

13 A. Okay. Well, I'm not sure I agree that the
14 second one is late, but go ahead, please.

15 Q. Okay. That's fair.

16 I mean, there's a lot of intraobserver
17 variability in these strips, right?

18 A. Intra?

19 Q. I don't know. Is that the right word?

20 A. I think you meant inter.

21 Q. Inter?

22 A. Yeah.

23 Q. Different people can read them and see --

24 A. That's inter.

25 Q. Okay. Different people can read them and

1 see different things, right?

2 A. That possibility exists, sure.

3 Q. All right. So page 127, we've got nothing
4 there. That's pretty good, right?

5 A. Indeed.

6 Q. So one page with no markings. Go to page
7 128. we've got decels there: a late, an early,
8 correct?

9 And the next --

10 Is that correct?

11 A. I can't -- I can't read it from here. I
12 mean, I don't have any reason to dispute you.

13 Q. Thank you.

14 A. I think there are decelerations there, and
15 I think I marked the strips for you --

16 Q. You did.

17 A. -- at the time --

18 Q. You did.

19 A. -- of my deposition --

20 Q. And you saw --

21 A. -- if I'm not mistaken.

22 Q. Pardon me. And you saw a lot of variable
23 decels, correct? Or do you remember?

24 A. Predominantly, yes.

25 Q. So let's just go 129, 130, and go to 131.

And this ends at 8:49 a.m.

And that's got a whole bunch of coloring on it, right?

A. Yes.

Q. And multiple lates, by everyone's account, correct?

A. Boy, I think most of those are variable decelerations.

Q. Okay. Nevertheless, decelerations up to 8:49.

Let's go to page 132. Dr. McNeive sees a late, a couple of earlyies.

Page 133: Two more lates, ending at 9:06.

We go to 134: This is a lot of noncontiguous.

Can you make any determination about decels if the doc -- if the strips are noncontiguous?

A. It becomes more difficult.

Q. You can't really say one way or the other?

A. Oh, I think there are some decelerations on that page.

Q. Okay. Decels on page 134. That takes us to 9:14.

The next page, page 135: noncontiguous.

Do you see decels on that page, too?

1 A. This becomes more difficult to interpret
2 this page.

3 Q. Okay. So you don't know either way?

4 A. That's true.

5 Q. And then we go to 136. And, again, we've
6 got a lot of noncontiguous.

7 Can you see decels on that page?

8 A. Perhaps, is the best I can answer.

9 Q. Gotcha. So that's on page -- so that ends
10 at 9:31. So we've gone through an hour and a half
11 between 8:00 a.m. and 9:31, and it's about 10 or so
12 pages, and there's one page with no decels, correct?

13 A. Correct.

14 Q. All right. And you've testified that when
15 you reviewed these strips that almost all, as a
16 whole, starting at that maybe seven, eight o'clock
17 time frame, all the way until it turns Cat III,
18 Remi's strips were almost all Cat IIs.

19 would you agree?

20 A. I think that's true.

21 Q. Because any decel puts the strip into Cat
22 II, correct?

23 A. That's right.

24 Q. All right. So almost continuous Cat II,
25 all the way from 8:00 a.m., until it turns Cat III at

1 3:50. 3:50?

2 Official Court Document 3:57, ma'am.

3 Q. Oh, 3:57. I'll give you that, 3:57.

4 And you also agree that a late decel is
5 proof of a pathologic hypoxia, correct?

6 A. I didn't say pathologic hypoxia. That's
7 your descriptor. I --

8 Q. Well --

9 A. Excuse me. I testified that lates
10 indicate that there is hypoxia during that
11 deceleration.

12 Q. Well, you testified in other cases,
13 correct?

14 A. True.

15 Q. And in other cases, you've testified under
16 oath that a late decel is pathologic.

17 You indicated that de --

18 A. I'm listening.

19 Q. I'll read it together.

20 A. Go ahead.

21 Q. That it's enough to cause repetitive late
22 decels in most labors. So if you would ask me do

23 I -- that oxygen tension decreases in the fetus with
24 a normal contraction during labor, is it transient
25 manner? It does but it's not pathologic --

1 MS. KAMYKOWSKI: Your Honor --

2 MR. PERRON: Can we approach?

3 MS. KAMYKOWSKI: -- I object. This is
4 improper impeachment.

5 MS. GUNN: I'm asking -- I'll withdraw.

6 Q. (By Ms. Gunn) Okay. Here's my question:
7 Hypoxia becomes pathologic on a late decel.

8 You don't think it does?

9 A. These are descriptors. I -- I -- I will
10 just simply say this, and I think I've been
11 consistent over the years: To produce a late
12 deceleration, you have to have temporary hypoxia.

13 Now, whether you want to call it
14 pathologic or not, I'm not sure what that means, you
15 know, in a broader context. But that's -- that's --
16 that's a given. A late deceleration doesn't occur
17 unless there's temporary hypoxia.

18 Q. Okay. And that's what I'm trying to
19 understand. I thought I heard you say that you can
20 have these late decels, but it didn't affect Remi at
21 all?

22 A. What I said was, to be perfectly clear,
23 this tracing shows predominantly variable
24 decelerations, not late decelerations, preserve
25 variability, and, therefore, is not consistent with

1 an intrapartum hypoxic injury. And that doesn't even
2 become a possibility until roughly four o'clock.

3 Q. Right.

4 A. And then we can talk about four o'clock, I
5 suppose.

6 Q. Okay. But you'd agree that I just showed
7 you page after page where Dr. McNeive, in particular
8 was listing late decelerations, not variable, but
9 late, correct?

10 A. He marked what he marked. I mean, I
11 didn't, you know, add up how many he marked as late
12 versus variable. I've given you my interpretation of
13 the strip and what it means.

14 Q. In a late --

15 A. But let me just be clear --

16 Q. Sure.

17 A. -- even if you were to accept that these
18 are late decelerations, which I will not, that these
19 are all late decelerations, this preserved
20 variability. So I don't think there's injury to the
21 fetus. But go ahead, please.

22 Q. I understand.

23 But we can agree that if Dr. McNeive saw
24 late, then he would also have the knowledge base to
25 know that every late decel is evidence of hypoxia.

1 A. well, it's temporary hypoxia with a late
2 deceleration. Again, I think I've said it two times.
3 These are almost all variable decelerations, but I'll
4 leave it at that.

5 Q. Okay. But I know you think they're
6 variable decels, and you read the strips years later.
7 And Dr. McNeive was the one reading them at the time,
8 and he's identified lates.

9 So at the time he's identifying these
10 strips for Remi Anyan, he's noting lates, which is,
11 in an obstetrician's mind who knows about the
12 medicine, means that the baby is hypoxic when he
13 identifies a late decel, correct?

14 A. I said it. If you have late
15 decelerations, that indicates temporary hypoxia.

16 Q. So, now, you have published on the
17 correlation between Category III, at the end of a
18 labor, and hypoxic ischemic encephalopathy, correct?

19 A. To say -- yes. Okay. Sure.

20 Q. You remember the article you wrote?

21 A. Do I remember it? I think I know the
22 article you have.

23 Q. well, let's look at Exhibit 353. And you
24 mentioned this article not by name, but you mention
25 it in your deposition.

1 Do you recall? Is this it, sir?

2 A. I'm aware of the article, sure.

3 Q. It's called "An Evaluation of Fetal Heart
4 Rate Characteristics Associated with Neonatal
5 Encephalopathy: A Case Control Study," correct?

6 A. Right.

7 Q. And it's published in 2018. And you did
8 it in conjunction with, I think you had a visiting
9 physician from China, is that correct?

10 A. I did it with Chinese doctors, yes.

11 Q. Okay. And you ran this study. And you
12 published on the correlation between Category III
13 strips, at the end of a labor, and hypoxic ischemic
14 encephalopathy, correct?

15 A. No. Neonatal encephalopathy.

16 Q. Pardon me. Okay. Neonatal
17 encephalopathy. Okay. I appreciate that. You're
18 right.

19 So you published on the correlation
20 between Category III, at the end of labor, and
21 neonatal encephalopathy, correct?

22 A. That's one of the things in there, yes.

23 Q. And in that study, you found that -- and
24 you write: However -- this is on page 1485, which is
25 the second page under interpretation.

1 MS. GUNN: Zack, I'm not doing a very good
2 job on this. But let's go right here: however.

3 Q. (By Ms. Gunn) However, it should be noted
4 that 42.2 percent of women in the NE group -- and
5 let's be clear, the NE group is the neonatal
6 encephalopathy group -- presented with a Cat I
7 tracing.

8 It is within this group that we would
9 hypothesize that obstetrical interventions might have
10 the greatest chance of modifying the risk of neonatal
11 encephalopathy, correct?

12 A. Correct.

13 Q. And so what that means, Doctor, is that
14 when you come in with a Category III tracing, like
15 Remi Anyan did, the best hypothesis that you have
16 from this is that obstetrical intervention, a
17 C-section, had the greatest chance of modifying that
18 risk, correct?

19 A. For the record, you said Category III when
20 you began the question. Your co-counsel is shaking
21 her head yes.

22 Do you want to ask the question again?

23 MS. GUNN: Category?

24 MS. SLATER: Category I.

25 Q. (By Ms. Gunn) Okay. You believe,

1 according to your research, that you did in this
2 study, that women who came in in Category I -- now
3 I'm seeing it -- Category I, like Remi Anyan did,
4 that then proceeded to Category III, like Remi Anyan
5 did, it's that group that you hypothesized
6 obstetrical interventions, such as C-section, would
7 have had the greatest chance of modifying that risk,
8 correct?

9 A. I would say as opposed to someone who
10 presents with an abnormal tracing, that this might
11 present an opportunity, that's correct.

12 Q. Okay. And we also know that it's your
13 opinion that if a mom comes in in Category I, it's
14 very unlikely that a baby was injured at that time,
15 correct?

16 A. As I told you in my deposition, no one
17 knows the breakdown in terms of all of the kids
18 who've sustained preexisting injury. That is an
19 injury prior to labor that causes permanent brain
20 injury. No one knows what percent of those kids show
21 up with an abnormal tracing to start with versus a
22 normal tracing. It is simply unknown.

23 Q. Yeah.

24 A. So the answer to your question is no.

25 Q. Okay. If you go through the strips, and

1 Mr. Perron showed you a few, particularly one I think
2 at about the 1:20 time frame. Just -- I want to
3 be -- it seems important that -- do you recall that
4 Sarah Anyan was laboring down between 12:12 and 1:32?

5 A. I accept that.

6 Q. So the strips that Mr. Perron was showing
7 you encompass the time frame that Sarah was laboring
8 down.

9 A. Well, he showed me a lot of strips. I
10 mean, he may have shown me that time period. I don't
11 remember.

12 Q. All right. But you know that the laboring
13 down is an increased opportunity, I guess, for
14 Sarah -- for the baby to rest because the contract --
15 mom's not pushing, correct?

16 A. Mom is not pushing, correct.

17 Q. Now, we've got increases of Pitocin at 20
18 at 2:21, 22 at 2:44, 24 at 3:10, and 26 at 3:56.

19 Can you accept that, Doctor?

20 A. If it's fact, I have no reason to dispute
21 it.

22 Q. And each and every one of those times that
23 Dr. McNeive turned up the Pitocin, in your opinion,
24 was perfectly acceptable under the standard of care,
25 correct?

1 A. Yes.

2 Q. No complaints, whatsoever, with respect to
3 that, true?

4 A. That's true.

5 Q. Now, we know that Sarah, at two o'clock,
6 let's focus on two o'clock, she is now in her tenth
7 hour of the second stage of labor. There has been no
8 documentation that Remi has progressed down the birth
9 canal, correct?

10 A. Up until the exam shortly, thereafter,
11 that is correct.

12 Q. There has been no evidence that Remi is
13 anything other than malpositioned, which, in your
14 mind, makes it -- can explain why he hasn't come
15 down, correct?

16 A. It's part of the explanation.

17 Q. And we know that throughout that time,
18 there were late decels continuously, page after page,
19 maybe not every page, but page after page, and each
20 one of those late decels, as identified by Dr.
21 McNeive, is evidence of hypoxia at that time,
22 correct?

23 A. Once, again, I don't want to belabor the
24 point. I don't think there are those repetitive
25 delayed decels. I think they're variable decels with

1 all the previous testimony about what late
2 decelerations signify, yes.

3 Q. Okay. And at 3:50, Remi becomes
4 tachycardic and has minimum or absent variability,
5 correct?

6 A. I disagree. That's not my testimony.

7 Q. 3:57, pardon me. I'm sorry. I'm obsessed
8 with 3:50. You want 3:57. It's fine.

9 A. It's not what I want, it's what's there.

10 Q. okay. so let's just do it. 3:57 --

11 A. Yes.

12 Q. -- Category II and tachycardic?

13 A. At 3:57, the fetus is now tachycardic.
14 And that is when Category III commences or begins,
15 yes.

16 Q. And so Remi, the fetus, remained
17 tachycardic and in Category III until he was born at
18 4:24 p.m., correct?

19 A. That is true.

20 Q. And it is in that time frame that we know
21 we're no longer at moderate variability, correct?

22 A. Correct.

23 Q. we're minimum variability or absent
24 variability?

25 A. Correct.

Q. Tachycardic?

A. Correct.

Q. And you agree, under those circumstances, he has an increased risk of neonatal encephalopathy?

A. If you just looked at the tracing alone and don't know anything else in the case, you could come to that conclusion, with just the tracing alone.

Q. Right.

Now, Doctor, we know that Dr. McNeive, we've talked about the things he knew. One of the things that was available at two o'clock, and actually frankly had been available at eight o'clock and nine o'clock and ten o'clock and eleven o'clock and twelve o'clock and one o'clock and two o'clock, was a C-section, correct?

A. It's always available, agreed.

Q. And you would never have been critical of Dr. McNeive for performing a C-section on Sarah Anyan at any of those times, correct?

A. As I told you earlier, it wouldn't be a deviation from the standard of care to do that if you wanted to.

Q. And according to you, the fetal heart monitoring strips at every point in that time frame, according to you, Remi was perfectly healthy,

1 correct?

2 A. I agree with Dr. warsof on that, correct.

3 Q. So if he had been -- if a C-section had
4 been performed at any of that time by Dr. McNeive
5 during that prolonged second stage of labor, it's
6 your opinion, Doctor, that Remi Anyan would have been
7 born healthy, correct?

8 A. No. I think I've told you in my
9 deposition that I believe that there was a
10 preexisting injury, but if we just use the strips
11 alone and say do we think there would be an injury
12 here? In isolation, I wouldn't expect an injury.

13 Q. Okay. And Dr. McNeive stood by hour after
14 hour, and did not deliver Remi, correct?

15 A. That's true.

16 Q. He did nothing to stop this progression of
17 this prolonged second stage of labor, correct?

18 A. He continued the labor process, that's
19 true.

20 Q. That's all I have, Doctor. Thank you.

21 THE COURT: Redirect?

22 MS. KAMYKOWSKI: Do you have a copy of
23 Exhibit 353 that we can look at?

24 MS. GUNN: You bet.

25 REDIRECT EXAMINATION

1 BY MR. PERRON:

2 Q. Doctor, is rotation from OP to OA included
3 in the definition of progress we've been talking
4 about?

5 A. I think it is, in the umbrella of
6 progress, yes.

7 Q. If Dr. McNeive is relying on the ACOG
8 consensus about the duration of the second stage of
9 labor, and he sees rotation and descent, and the
10 nurses see rotation and descent, and they also
11 explain that to Mr. and Mrs. Anyan, and Mr. and
12 Mrs. Anyan have testified to this Court they were
13 being told throughout that the baby looked good on
14 the strip, and they were making progress towards a
15 vaginal delivery, if the jury has heard all of that
16 testimony, and we agree on the definition of
17 progress, is Dr. McNeive meeting the standard of
18 care, even if he isn't taking off his gloves and
19 going and documenting, "I see progress"?

20 A. Yes.

21 Q. In your practice, have you observed things
22 or done things in the midst of labor and delivery but
23 have not gone back and immediately, contemporaneously
24 documented it?

25 A. Many times.

Q. Does that mean it didn't happen?

A. No.

Q. The exams performed by Dr. McNeive between 8:00 a.m., and the delivery, if Mr. Anyan himself has testified to his memory of those exams, do we need to rely on the medical records to know whether or not they happened?

A. I mean, I don't personally think so, but other folks can decide whether you need the medical record, given that testimony.

Q. All right. You were asked a question, and again, we went back and forth on this, but I'll be very brief.

Your attention was directed to page 50 and 51 and of your deposition about your testimony regarding the start in time of Category III.

Directing your attention, would it refresh your recollection as to your deposition testimony if you reviewed your actual questions and answers?

A. I have it in front of me. What's your question, sir?

Q. So starting with the question page 51, line 19. Was there a direct question about when you believed the Category III tracing started?

A. There was a question at line 19.

1 Q. And what was your answer on the date of
2 your deposition, March 14th, 2024?

3 A. The answer, line 22, I would say, starting
4 at 1557.

5 Q. Okay. So is your testimony today any
6 different than the testimony at the time of your
7 deposition?

8 A. No.

9 Q. Okay. We talked a little bit on direct
10 exam about the time that Category III tracing starts
11 up to the point of delivery.

12 Again, if the jury has heard that Dr.
13 warsof himself, plaintiffs' expert, is not critical
14 of Dr. McNeive's care and treatment from 3:57 p.m.,
15 through delivery, do you have any reason to disagree
16 with him?

17 A. No.

18 Q. Okay. If Dr. warsof -- the jury heard
19 Dr. warsof testify that he cannot have any basis to
20 disagree with Dr. McNeive's assessment that if his
21 opinion when the Category III tracing started,
22 vaginal delivery was the safest and fastest way to
23 get Remi out, would you disagree with Dr. warsof?

24 A. I do not.

25 MR. PERRON: Justin, if you want to put up

1 A1 PDF page 185.

2 Q. (By Mr. Perron) Doctor, does this tracing
3 right here describe moderate variability?

4 A. On the left side, the very beginning of it
5 is moderate variability.

6 Q. Okay.

7 MR. PERRON: Justin, if you want to back
8 out so that we can see the time on this.

9 Q. (By Mr. Perron) This is May 4th at 4:13.

10 So to have that stretch of moderate variability if
11 you are in Dr. McNeive's shoes, you don't know what's
12 going to happen in the future, 1357 is what we now
13 know in retrospect is the beginning of Category III.

14 If you're Dr. McNeive, in his shoes,
15 looking at this strip, and you see moderate
16 variability, even if it's just a little bit, and you
17 can't predict what the next 5, 10 minutes are going
18 to show, does this, even at this point, this moderate
19 variability, had been reassuring to him, that he
20 could still deliver this baby in time safely?

21 A. I think it tells him he has a little more
22 time, and it certainly allows him to go to vaginal
23 delivery at that point, given -- given where they are
24 in the labor and so forth.

25 Q. Is there any test for -- is there any test

1 anyone can do to see whether or not there is a
2 hypoxic injury on a baby in the womb still? A
3 diagnostic test?

4 A. Not -- not really. I mean, you know, I
5 would say in most cases that doesn't exist. And the
6 only exceptions, you know, would be things that
7 aren't relevant to this case that involve
8 malformations in the fetus, in the brain, and things
9 like this. But assuming a normal brain, no.

10 Q. In your experience, if you leave a
11 patient's room in labor and delivery, can you still
12 remotely monitor that tracing from a different part
13 of the labor and delivery department?

14 A. In most labor and delivery units, that is
15 the case, yes.

16 Q. Okay. So even if Dr. McNeive wasn't in
17 the room, would he still have had the ability to
18 remotely review those tracings, even if he was
19 outside of the room?

20 A. I believe so.

21 Q. Counsel took you through pages and pages
22 of other providers marking, at least what they
23 believed at the time, was late decelerations.

24 But, again, Doctor, on any of those pages,
25 did you detect an absence of moderate variability?

1 A. No. I told you by and large they
2 contained moderate variability.

3 Q. So even on those pages, with all of those
4 colorful checkmarks and everything like that, even on
5 those pages, you still detect moderate variability?

6 A. I did. And so did Steve warsof.

7 Q. And, again, what does that tell us about
8 whether Remi is experiencing acidosis to the extent
9 he would have a hypoxic injury?

10 A. Highly unlikely.

11 Q. Highly unlikely.

12 And if we know that today in 2025, would
13 it have been fair to Dr. McNeive to rely on that
14 information for his medical management?

15 A. I think so.

16 Q. If Dr. McNeive is seeing moderate
17 variability and observing progress of both descent
18 and rotation, does the standard of care mandate a
19 c-section?

20 A. No. Simply no.

21 Q. Those are my questions.

22 MS. KAMYKOWSKI: Very briefly, Your Honor.

23 REDIRECT EXAMINATION

24 BY MS. KAMYKOWSKI:

25 Q. Doctor, do you remember this British

1 Journal of Obstetrics and Gynecology article that you
2 referenced?

3 A. I remember the study. Remember conceiving
4 the study and doing the study, sure.

5 Q. And that's what I wanted to ask you. It
6 says "A Case Control Study."

7 Tell us what that is.

8 A. So, you know, where did the study come
9 from? I was interested in the relationship between
10 fetal heart rate characteristics on monitoring and
11 the chance or the association of them with
12 encephalopathy. And we say neonatal encephalopathy

13 here in the title as opposed to hypoxic ischemic
14 encephalopathy because hypoxic ischemic
15 encephalopathy is just one category of all neonatal
16 encephalopathy.

17 You then have abnormal brain function when
18 it's not on the basis of hypoxic ischemia. And we
19 knew that we couldn't prove that these kids have
20 hypoxic ischemic encephalopathy unless we have
21 imaging, and we didn't have the imaging to begin
22 with.

23 So we also wanted a lot of cases because
24 these are rare, these cases, relatively rare, or
25 uncommon, I should say. And that's why I went to my

1 colleagues in China, in Shanghai, who have a hospital
2 that does 25,000 births per year, and I asked them, I
3 said how many -- how many years back can you go and
4 get me all the fetal tracings from the last 2 hours
5 of labor?

6 And then I said, well, what I want to do
7 is I want all of the cases of encephalopathy, and I
8 want the tracings from the last 2 hours of labor, and
9 then we will compare them with a control where we
10 know the kids did not have encephalopathy and get
11 their tracings from the last 2 hours of labor and see
12 the differences in those two groups in terms of what
13 the tracings looked like in the last 2 hours of
14 labor, and then we web blinded it to my colleagues.

15 They looked at the strips, they
16 categorized the strips, they described the strips,
17 but they didn't know when they did it, they were
18 blinded, whether this was a strip from a kid that
19 developed encephalopathy versus not. And that's the
20 study design.

21 So it shows associations. It doesn't show
22 cause and effect, but it does have some valuable, I
23 think, observations. That's -- that's how I
24 conceived the study.

25 Q. And one of the words that was used was you

1 hypothesized.

2 what does that mean in a scientific realm?

3 A. It means you're posing a scientific
4 question basically that you want to answer. In this
5 case, the scientific question is, is such-and-such's
6 fetal heart rate abnormality on a tracing associated
7 with encephalopathy or not?

8 So if you have it, you have a higher
9 chance that the baby will end up with encephalopathy
10 versus not.

11 Q. And the portion that Ms. Gunn read to you
12 was I think part of the statistical analysis, the
13 interpretation of the cohort data that you had.

14 MS. KAMYKOWSKI: And if you want to pull
15 that back up, Zack, it's at page 1485. And in the
16 very bottom of the first interpretation paragraph.

17 Q. (By Ms. Kamykowski) And, however, that's
18 a qualifier when you use that word, is it not, when
19 you're writing, Doctor?

20 A. Certainly is.

21 Q. We read this. Read this again, and tell
22 us what that meant as far as your hypothesis in this
23 case.

24 A. It says: It should be noted that 42
25 percent of women in the encephalopathy group

1 presented with a Category I tracing. So that means
2 that 58 percent presented with either a Category II
3 or a Category III tracing when they first came to
4 labor and delivery.

5 And so if you first show up with an
6 abnormal tracing, it follows that if you believe that
7 there are intrapartum events that can cause brain
8 injury to a fetus, your chance of being able to do
9 something about it is going to be greater if the baby
10 shows up with a Category I total normal tracing as
11 opposed to an abnormal tracing where the baby may
12 have already been injured.

13 Q. And in 42 percent of the patients in that
14 study where you knew their child was born with a
15 neonatal encephalopathy appeared with Category I?

16 A. On admission.

17 Q. On admission, right?

18 A. Yes.

19 Q. Okay. And then was there discussion in
20 the -- in your analysis of how many of the patients
21 had had neonatal encephalopathy had an Apgar of 7 or
22 greater at birth?

23 A. I think it's in there. I don't have it --
24 I don't have it in my memory.

25 Q. Let's see if we can find it.

1 A. I'm pretty sure it's in there.

2 MS. KAMYKOWSKI: Can you go to page 1483,
3 please.

4 Q. (By Ms. Kamykowski) And on the bottom
5 left there it says: As expected, infants who were
6 diagnosed with neonatal encephalopathy experienced
7 greater morbidity and higher rates of mortality.

8 Approximately 70 percent of infants in the
9 neonatal encephalopathy group had a 5-minute Apgar
10 less than 7 versus none in the control group.

11 Do you see that?

12 A. That's right.

13 Q. Okay. What was the Apgar that Remi was
14 assigned at birth in this case?

15 A. 5-minute at 8.

16 Q. And is the fact that you did this study
17 play into your opinion that you gave here today that
18 when you look not in isolation at the fetal monitor
19 tracings, but the totality of the clinical
20 circumstances at, near, and after Remi's birth, that
21 his injury more likely than not occurred before he
22 was placed on the monitors?

23 A. Right. It's one of the factors that you
24 have to consider, and, you know, it just supports the
25 fact and what I told the jury this morning, that most

1 babies that have an acute injury at the end of labor
 2 do not have a 5-minute Apgar score. They -- I'm not
 3 saying it's not possible, but most of them do not.

4 Q. Thank you, Dr. Landon. That's all I have.

5 THE COURT: Re-cross?

6 MS. GUNN: Briefly.

7 RE-CROSS EXAMINATION

8 BY MS. GUNN:

9 Q. Doctor, you agree that prolonged second
 10 stage of labor, anything beyond 3 hours, there's a
 11 concern of whether -- the concern is whether there is
 12 increased morbidity to the mother and the baby,
 13 correct?

14 A. Agreed.

15 Q. And there are increased risks
 16 statistically to both the mother and the baby for
 17 every hour of the prolonged second stage, correct?

18 A. There are increased risks.

19 Q. And --

20 A. I mean -- hold on. I do believe that.
 21 while there is some literature that maybe doubts it a
 22 little bit, I am of the belief that there is a
 23 relationship between the second stage of labor and
 24 risk to the fetus, I do believe that.

25 Q. Thank you. And the increased risk to the

1 baby is hypoxia?

2 A. There is an increased risk, sure, that's
3 among them, yes.

4 Q. And those are important and dangerous
5 risks, correct?

6 A. They are important risks.

7 Q. Now, I don't know. There was something at
8 4:13 p.m. and whether Dr. McNeive did everything
9 right at 4:13 p.m. we know -- right? -- Doctor, that
10 by 4:13 p.m., Remi was too low and too engaged to
11 have a C-section, correct?

12 A. I think that's true.

13 Q. That's what had happened throughout that
14 time, the 2 hours that Dr. McNeive was with Sarah, is
15 by that point, when he became tachycardic and in
16 Category III with minimum or no variability, you went
17 from being able to have a C-section at two o'clock,
18 to not being able to have a C-section by four
19 o'clock, correct?

20 A. That's true.

21 Q. Now, you talked about documentation.

22 MS. GUNN: If I could have Exhibit 3. No,
23 yes, 1. 1. 1. Page 78.

24 Q. (By Ms. Gunn) Now, you know that Dr.
25 McNeive, he told us yesterday -- I don't know if you

1 know this -- but he told us yesterday that he didn't
 2 write a delivery note until someone in the NICU
 3 reminded him that he didn't write a delivery note.

4 Did you know that?

5 A. No.

6 Q. So after someone in the NICU who was
 7 caring for Remi, or knew about Remi's status,
 8 mentioned to Dr. McNeive that he needed to write a
 9 delivery note, he did. And that occurred on May 7th,
 10 so three days after Remi was born, and one day after
 11 Remi's MRI showed HIE.

12 Does that sound right to you?

13 A. I don't have any reason to dispute the
 14 facts.

15 Q. All right. So the fact is that after Dr.
 16 McNeive found out about Remi's hypoxic ischemic
 17 encephalopathy, he wrote the delivery note, and the
 18 jury has seen that.

19 But in addition to that, which was the
 20 only thing that he documented himself in the record
 21 about the labor and delivery, the after-the-fact
 22 delivery note. But he actually did document
 23 something else in Sarah's chart. And this was on May
 24 7th.

25 Have you seen this, Doctor? It's part of

1 Sarah's chart.

2 A. At some time I did, not recently.

3 Q. So on May 7th, at 1:31 p.m., a couple of
4 hours after he wrote his delivery note, he writes
5 about going to see Sarah and Blake in the NICU, and
6 he writes this in Sarah's chart after he knows what's
7 happened and what's been diagnosed, and what Remi's
8 been diagnosed with, he writes: Met with patient and
9 her husband at their baby's side at the NICU.

10 So they're there with Remi. She
11 immediately expressed gratitude that I had come, and
12 they were worried that I was, quote, beating myself
13 up over their son's neurologic status -- this is what
14 he's writing in her chart -- they both expressed how
15 happy they were with my care. That they didn't feel
16 anything was done wrong.

17 I expressed my thanks over their sentiment
18 during their stressful time. We spent several
19 minutes discussing her son's condition, as well as
20 how they were holding up as a couple. Offered any
21 assistance they might need at this time.

22 Doctor, do you remember reading that as
23 part of Sarah's chart?

24 A. At some time, I did read that.

25 Q. Have you ever seen anything like that

1 before in a patient's chart?

2 A. I don't know. I honestly --

3 Q. Thank you.

4 A. -- don't know that I have.

5 Q. Thank you.

6 THE COURT: Anything further of this

7 witness?

8 MR. PERRON: No, Your Honor.

9 THE COURT: May this witness be excused?

10 MS. KAMYKOWSKI: Yes, Your Honor.

11 MR. PERRON: Yes, Your Honor.

12 THE COURT: Thank you very much, sir.

13 THE WITNESS: Thank you.

14 THE COURT: How long do we anticipate the
15 next witness will take?

16 MS. KAMYKOWSKI: Maybe an hour, hour and a
17 half. Depending on cross, too.

18 THE COURT: why don't we go ahead and do
19 direct and take our lunch break at that time.

20 MS. PFIRMAN: The defense calls
21 Dr. Robert Shavelle.

22 THE COURT: sir, if you'll step on up and
23 be sworn.

24 ROBERT SHAVELLE, M.D.,
25 having been duly sworn, was examined, and testified

as follows:

MS. PFIRMAN: May I inquire?

THE COURT: You may.

DIRECT EXAMINATION

BY MS. PFIRMAN:

Q. Good morning.

A. Good morning.

Q. Can you please introduce yourself to the jury?

A. Hi. Good morning. I'm Robert Michael Shavelle.

Q. And, Dr. Shavelle, what is your profession?

A. I do medical research and consulting on life expectancy.

Q. In this case, you were retained by the defendants, is that right?

A. Yes.

Q. What were you asked to?

A. To review the materials and to give an opinion of Remi's life expectancy based on the materials and the evidence.

Q. And I know that talking about life expectancy and our own mortality, specifically with regards to a young 4-year-old may be uncomfortable

1 for a lot of us.

2 But have you reached opinions based on
3 your review of the materials in this case?

4 A. Yes.

5 Q. And what are those opinions?

6 A. Briefly, based on all the materials I've
7 reviewed and looking at the medical literature and my
8 lifetime of work of life expectancy, I believe that
9 Remi's life expectancy is approximately 30, 3-0, 30
10 additional years. 30 years from now, not from birth.

11 Q. Okay. So he's 4 years old right now. So
12 30 additional years would put him to live to age 34,
13 is that right?

14 A. On average. Yes, of course he could live
15 longer or shorter.

16 Q. Just to be clear, you do not have any
17 standard of care opinions in this case, do you?

18 A. Correct, I do not.

19 Q. Okay. And you are not offering any
20 causation opinions in this case?

21 A. Correct, I am not.

22 Q. I want to talk about your CV.

23 MS. PFIRMAN: Justin, if you wouldn't
24 mind pulling up Exhibit F5-B, please.

25 Q. (By Ms. Pfirman) Do you recognize this

1 as your CV, Dr. Shavelle?

2 A. Yes.

3 Q. Can you start by walking the jury through
4 your education?

5 MS. PFIRMAN: And, Justin, I want to pull
6 that up, please.

7 A. Sure. Very briefly I earned an
8 undergraduate degree in mathematics from Cal State
9 University-Long Beach. I was the outstanding
10 mathematics graduate that year. And I was a high
11 school math teacher after I earned a single subject
12 teaching credential, and that was for two years.

13 Then I went back to school. My plan was
14 to become a life actuary. But I was, at that time,
15 earning a master's degree in statistics. I was
16 enjoying my studies.

17 I bumped into a group called the Life
18 Expectancy Project during this, and so I decided to
19 stay for a PhD in applied statistics. My
20 dissertation was on a method to calculate life
21 expectancy. with particular application with people
22 with disabilities. And then some time later, I
23 earned an MBA. But that was mostly for personal
24 interest, not professional.

25 Q. And what year did you earn your MBA?

1 A. 2000.

2 Q. I want to talk about the professional
3 memberships that are listed on your CV.

4 MS. PFIRRMAN: Justin, if you have an
5 opportunity to pull that out, please.

6 Q. (By Ms. Pfirrmann) Can you tell the jury
7 about your roles in these organizations, please?

8 A. So I'm a member of both. The second one,
9 the American Congress of Rehabilitation Medicine,
10 that is mostly physiatrists or physical medicine
11 doctors. I'm merely a member of that.

12 The first one, the American Academy for
13 Cerebral Palsy and Developmental Medicine, that's
14 another medical society. Most of the members are
15 medical doctors or therapists or others who have a
16 PhD. I'm a fellow of that organization. And, at
17 that time to be fellow, it required that I be
18 nominated by a peer and voted on by a committee based
19 on my life's work.

20 Q. And so you were in fact nominated and
21 voted to become a fellow of that organization, is
22 that right?

23 A. Yes.

24 Q. Let's talk about your professional
25 activities in your CV.

1 your CV indicates that you were an
2 assistant professor of statistics at the University
3 of California-Riverside.

4 A. Right. That's where I earned my master's
5 degree and my PhD. And I stayed there, was a
6 researcher, and I was a visiting assistant professor
7 for one academic year.

8 Q. Can you explain to the jury what
9 statistics is generally.

10 A. Generally it's a collection of scientific
11 methods that we use to analyze data and then to draw
12 the proper conclusions from that analysis. The
13 simple example of course is your basic average or
14 your so-called arithmetic mean, where you have a
15 bunch of numbers, you add them up, and then you
16 divide by how many numbers in order to get that
17 average.

18 Q. Did you also work as a postdoctoral
19 research fellow at the University of California?

20 A. Yes. Under the grant, the National
21 Institutes of Health grant, at that time.

22 Q. And what did you do research in?

23 A. Life expectancy. Mostly of children with
24 disabilities.

25 Q. Your CV says that you are currently the

1 technical director of the Life Expectancy Project.

2 Can you tell the jury what the Life
3 Expectancy Project is.

4 A. So it's a research project. It was funded
5 by NIH, the National Institutes of Health, or --
6 let's see. It was almost 20 years, from the early
7 1980s through the year 2000. We do research on life
8 expectancy and related topics. Most of our original
9 work was on children with disabilities, children with
10 autism or cerebral palsy or Down syndrome, spina
11 bifida, mental retardation, epilepsy.

12 Q. Has your group at the Life Expectancy
13 Project published any scientific research articles?

14 A. Yes. Since the 1960s, the group has been
15 in existence. And I think it's more than 150
16 articles. Since I've been involved in the mid 1990s,
17 I have been involved in more than 100 studies on life
18 expectancy or survival or something related to that.

19 Q. So more than a hundred that you have
20 personally been involved in?

21 A. Yes. And they should be listed on my
22 resume.

23 Q. What percent of your work is life
24 expectancy related?

25 A. Nearly all of my professional time is life

1 expectancy related, whether it's research or
2 consulting or other things.

3 Q. And you also do work in the litigation
4 context like you are here, correct?

5 A. Yes. It's about half my time.

6 Q. About 50 percent?

7 A. Yes.

8 Q. How many times have you been retained in a
9 lawsuit as an expert or consultant on life
10 expectancy?

11 A. At least 1,000 times over the past 20-some
12 years. Not all of them go to deposition or trial of
13 course.

14 Q. Sure. And of your litigation cases, what
15 percentage are on behalf of the plaintiff versus on
16 behalf of the defendant?

17 A. Well, to be clear, I'm sorry to be picky.

18 I would not regard myself as on behalf of or for or
19 against either side. My opinions would be the same
20 regardless of which side retained me, but I think
21 it's roughly 95 percent defense retentions and 5
22 percent plaintiff, at least over the past 10 years or
23 so.

24 Q. Does that make any difference with regards
25 to your opinions?

1 A. No. No. The facts of the case are
2 usually pretty clear. The evidence is clear. And so
3 the numbers are what they are, so to speak.

4 Q. Now, I understand that you are not a
5 medical doctor, is that correct?

6 A. Correct. I am not a medical doctor, as I
7 said, I'm a medical researcher and consultant.

8 Q. And can you explain to the jury a little
9 bit more about what specifically you research?

10 A. Well, for example, we did a study on life
11 expectancy, several studies on life expectancy,
12 children with cerebral palsy, which is to say we
13 looked at the patient data, the original patient
14 data, collected by doctors and therapists and others.

15 And we identified groups of children, and
16 then followed them over time, keeping track of how
17 long they lived. And then we also analyzed that data
18 to see what factors or features or characteristics
19 are related to survival.

20 So we looked at whether being male or
21 female mattered. Whether needing a feeding tube or
22 having the ability to self feed mattered. We looked
23 at vision and cognitive impairment and importantly
24 motor function, fine motor function, gross motor
25 function. Can they walk? That's just an example.

1 we've done many such studies.

2 Q. And your CV lists a number of
3 publications; is that right?

4 A. Yes, more than 100.

5 Q. Have you ever published any literature
6 that you believe to be relevant in this case?

7 A. Yes. Many recent relevant studies.

8 Q. Okay. I want to just kind of quickly go
9 through some of those publications.

10 MS. PFIRRMAN: Justin, if you could pull
11 up No. 15.

12 Q. (By Ms. Pfirrmann) And this is an article
13 of which you were an author entitled "Life Expectancy
14 of Children with Cerebral Palsy"?

15 A. Yes.

16 MS. PFIRRMAN: Justin, can you pull up No.
17 21, please?

18 Q. (By Ms. Pfirrmann) Is this another article
19 for which you were --

20 A. Yes.

21 Q. Is this another article that you were an
22 author of entitled "Comparative Mortality in Cerebral
23 Palsy Patients in California"?

24 A. Yes.

25 MS. PFIRRMAN: Justin, let's pull up No.

1 had 41, please.

2 Q. (By Ms. Pfirrmann) And here it looks like
3 you were an author of a publication entitled
4 "Comparison of Survival of Cerebral Palsy Between
5 Countries," is that right?

6 A. Yes.

7 MS. PFIRRMANN: No. 43, please, Justin?

8 Q. (By Ms. Pfirrmann) Were you one of the
9 authors of a 2001, letter entitled "Life Expectancy
10 and Cerebral Palsy"?

11 A. Yes.

12 MS. PFIRRMANN: No. 51, please.

13 Q. (By Ms. Pfirrmann) And here it looks like
14 you were an author of "Decline in Function in Life
15 Expectancy of Older Persons with Cerebral Palsy," is
16 that right?

17 A. Yes.

18 MS. PFIRRMANN: No. 74, please.

19 Q. (By Ms. Pfirrmann) Were you an author of
20 "Life Expectancy of Cerebral Palsy: An Update"?

21 A. Yes.

22 MS. PFIRRMANN: No. 85, please.

23 Q. (By Ms. Pfirrmann) Were you the author of
24 a 2011 publication "Low weight Morbidity and
25 Mortality in Children with Cerebral Palsy: New

1 Clinical Growth Chart"?

2 A. Yes.

3 MS. PFIRMAN: No. 94, please.

4 Q. (By Ms. Pfirman) were you an author of
5 the 2014 publication "Recent Trends in Cerebral Palsy
6 Survival Part I"?

7 A. Yes.

8 MS. PFIRMAN: 95, please?

9 Q. (By Ms. Pfirman) were you then the
10 author of a 2014 publication "Recent Trends of
11 Cerebral Palsy Survival Part II"?

12 A. Yes.

13 Q. And then lastly --

14 MS. PFIRMAN: No. 120, please.

15 Q. (By Ms. Pfirman) were you also an author
16 of the recent 2023 article "Severe cerebral Palsy
17 Survival is Similar in California, U.S.A., and
18 Victoria, Australia"?

19 A. Yes. And that is the most recent
20 publication on cerebral palsy.

21 Q. okay. so let's just start with life
22 expectancy in general terms.

23 Can you describe for the jury how you
24 compute life expectancy.

25 A. well, as I said in general for our

1 research, we identify a group and follow them forward
2 in time. The methods are a little bit more complex
3 than that. But essentially it boils down to the same
4 methods that the U.S. government uses every year when
5 they come up with a U.S. government life table for
6 the general population.

7 which means you look at age and sex, and
8 there's a table for males and a separate table for
9 females, and you know how many people are alive at
10 each age and how many people pass away at each age.
11 And using some fairly straightforward arithmetic, one
12 can calculate the average survival, which is the life
13 expectancy.

14 Q. And have you prepared a demonstrative to
15 explain to the jury the U.S. life expectancy table
16 that you're talking about?

17 A. Yes.

18 Q. I've already provided a copy to counsel.
19 Hand you a copy.

20 MS. PFIRMAN: The judge would like a
21 copy.

22 Q. (By Ms. Pfirman) Dr. Shavelle, can you
23 tell us what is depicted here in Exhibit F5-L.

24 A. It's a summary of the United States
25 Government Life Table from 2020. I know that's a

1 couple of years ago, but things have not changed much
2 in the interim. I think the numbers are all the
3 same, and we round to the nearest integer.

4 Q. And is this something that you prepared to
5 explain life expectancy tables to the jury?

6 A. Yes.

7 MS. PFIRMAN: Permission to publish
8 Exhibit F5-L to the jury?

9 THE COURT: Any objection?

10 MS. SLATER: No, Your Honor.

11 THE COURT: You may.

12 MS. PFIRMAN: Justin, can you pull up
13 F5-L, please?

14 Q. (By Ms. Pfirman) All right, Dr.
15 Shavelle, I will get out of your way.

16 Can you just give the jury a little
17 synopsis about what this slide is intending to show?

18 A. So these are numbers from the U.S.
19 government life table. The full life table would
20 have every year of age from zero to 109. This is
21 just every tenth year of age, and so it's
22 abbreviated. And then the full life table has much
23 other information.

24 Here, it's just the life expectancies.

25 And these are actually remaining life expectancies,

1 so for each age, it shows the average number of years
2 that an average person would live.

3 If we look at the row for age 50, the
4 number for males is 28. which means your average
5 50-year-old male would live, on average, 28 more
6 years. so of course you could live longer or
7 shorter, but 28 is the average, the fair number. And
8 similarly for a female, it's 33. Women live, on
9 average, longer than men, for a variety of reasons.

10 And the other thing you can see here
11 obviously is that the numbers decrease with age. so
12 a younger person would live longer on average
13 compared with an older person.

14 Q. So is it fair to say that life expectancy
15 varies by age and sex?

16 A. Yes, in general of course here, and then
17 in almost every medical condition or disability, it's
18 also true.

19 Q. And that was going to be my next question:
20 Does life expectancy vary by anything else?

21 A. It does. I think that's well known. And
22 we know that smokers don't live as long as
23 nonsmokers. And we know that people who have heart
24 disease or cancer or stroke or diabetes or who abuse
25 drugs or alcohol don't live as long as the people who

1 don't have those things or don't do those things.

2 And it can vary obviously, but from a very large
3 number to a very small number. Someone with, say,
4 metastatic brain cancer, who's in hospice care, we
5 don't expect them to live very long, whereas a
6 perfectly healthy newborn, but those are the numbers.

7 Q. What is the difference between the life
8 tables that you construct in your research and the
9 life tables of the U.S. government?

10 A. Briefly it's just the population that's
11 considered. That the U.S. government looks at the
12 whole population, and then we're looking at smaller
13 groups, mostly people with disabilities or a
14 particular medical condition.

15 Q. Has the medical community ever sought your
16 help in educating its physicians on life expectancy?

17 A. Yes, extensively.

18 Q. And how so?

19 A. Well, for one, one of the articles you
20 showed there a moment ago was on growth charts and
21 various medical facilities and electronic medical
22 record companies, like Epic, all around the globe
23 have asked us for the underlying information
24 underlying the graphs in the growth charts.

25 we've also spoken at medical conferences,

1 I have. Some of our articles that have been
2 published in the medical journals have been used for
3 CME, continuing medical education. The lectures that
4 I've given, some have been used for CME, continuing
5 medical education. And of course our articles
6 themselves, most of them, nearly all of them, have
7 been published in major peer-reviewed medical
8 journals, especially journals. Journals that the
9 medical community regularly reads and uses.

10 Q. Let's talk a little bit more about this
11 case specifically.

12 Can you tell us how much time
13 approximately you have spent working on this case?

14 A. About 25 hours, prior to today.

15 Q. And obviously you don't work for free,
16 unfortunately for us, right?

17 A. Right.

18 Q. Okay. Can you tell the jury how much you
19 charge per hour for your work as a life expectancy
20 expert.

21 A. The company bills my time for everything
22 at \$650 an hour.

23 Q. And what about when you're asked to come
24 testify at trial like you are today?

25 Is your fee any different?

1 A. It would be either \$6500 a day or \$650 an
2 hour, whichever is less.

3 Q. And in your work on this case, did you
4 review a number of different materials?

5 A. Yes, quite a few.

6 Q. And to keep it brief, I'll try to walk
7 through those with you. It looks like you reviewed
8 medical records for Remi from Rankin Jordan, is that
9 right?

10 A. Yes.

11 Q. Did you review medical records for Remi
12 from Washington University?

13 A. Yes.

14 Q. Did you review depositions of Blake and
15 Sarah Anyan?

16 A. Yes.

17 Q. Did you review several videos of Remi?

18 A. Yes.

19 Q. Did you review the deposition of
20 plaintiffs' life expectancy expert, Dr. Liles, and
21 his life care plans?

22 A. Yes, both depositions.

23 Q. Did you review the deposition of expert,
24 Dr. Woodruff, and his examination of Remi?

25 A. Yes.

1 Q. Did you review the deposition of Dr.
2 Matthews?

3 A. Yes.

4 Q. Is there anything else that you reviewed
5 that I didn't cover?

6 A. No.

7 Q. Did you ever examine Remi, or were you
8 ever present for any medical examination of Remi?

9 A. No.

10 Q. Was that necessary in reaching your
11 opinions in this case?

12 A. No, it was not.

13 Q. Why not?

14 A. Because many others have examined him
15 extensively over the years. And recently the
16 depositions of the parents, the therapists,
17 Dr. Liles, Dr. Woodruff, Dr. Matthews, they all did
18 examine him and wrote down their findings, and those
19 findings are in good agreement, to my understanding.

20 Q. Can you tell the jury generally what the
21 biggest -- what factors have the biggest effects on
22 life expectancy?

23 A. Well, in general, age and sex are
24 standard, and that's why the U.S. government life
25 table has age and sex. And we know lifestyle factors

1 matter like drinking and smoking and drug abuse and
2 medical conditions like heart disease, cancer, and
3 stroke, to a lesser extent, exercise and height and
4 weight.

5 But that's mostly about the general
6 population. If we're looking at a child or adult
7 with cerebral palsy, what really matters is the
8 severity of disability. And I realize that's a broad
9 and vague phrase. But the severity of disability,
10 especially with respect to motor function and feeding
11 ability. Those are the two big things: function and
12 feeding ability.

13 Q. And why does motor function affect life
14 expectancy, based on your research?

15 A. well, firstly, it's unambiguous. It's
16 absolutely clear from all of the literature, not just
17 cerebral palsy, but traumatic brain injury, spinal
18 cord injury, everything else, that motor function
19 matters, and particularly the ability to walk on
20 one's own.

21 It matters because the evidence shows it
22 matters. There of course are reasons, biological,
23 medical reasons that it matters. It reflects the
24 severity of brain damage. It is associated with all
25 sorts of problems. For example, even healthy people

1 who are so-called "couch potatoes" or who don't
2 exercise, have increased mortality risks or reduced
3 life expectancy.

4 Q. And based on your review of everything
5 that you've been provided in this case -- the medical
6 records, the exams, and the depositions -- what is
7 your understanding of Remi's motor function?

8 A. Well, he has some limited head control.
9 It's referred to as poor head control. He needs to
10 be strapped in in the wheelchair or supported. I
11 understand that he can't roll over front to back and
12 back to front on his own. He has to have a little
13 bit of rolling ability side-to-side, but not
14 completely over either way.

15 He can't crawl across the room
16 unfortunately or an equivalent distance. Can't
17 cruise the way a, say, a 6 or 9 -- or 1 year old, 6-
18 or 9-month or a 1 year old would cruise on furniture.
19 Can't walk with a cane or crutch. He can use a gait
20 trainer, so-called a "posterior walker," or a
21 kidwalk, or something equivalent.

22 Q. And --

23 A. So he can walk with quite a bit of
24 support, but not -- not on his own.

25 Q. Okay. So the walking with the gait

1 trainer, is that consistent with someone who's able
2 to have some walking ability, as you've -- as
3 reflected in your research?

4 A. well, no, because typically in the
5 research, there's at least a 4 point scale. And this
6 is a developmental scale that is used to evaluate
7 children. Initially of course children have no head
8 control at all and have to be supported as an infant.

9 And then at some point, they have head control. And
10 they learn to roll and then maybe to crawl and to sit
11 on their own and to stand -- to pull to a stand on
12 their own, and then to cruise. And unfortunately
13 Remi doesn't have any of those abilities.

14 But once we're talking about walking, the
15 scale would be does not walk on their own at all.
16 walks with some very minimal support, say, a cane or
17 a crutch. walks on their own, but unsteadily, so
18 they're wobbly, I think we're all familiar with
19 toddlers who are a little wobbly.

20 And then the best level would be level 4
21 on a 4 point scale. which is walks alone or
22 independently and balances well. And it's, as I
23 said, a developmental sequence. And typically the
24 kids who are here at the top or even here in the
25 middle, these are kids who have good head control,

1 they can roll over. They can crawl. They can sit.
2 They can get to a sitting position on their own, and
3 stay there on their own. They can cruise. They can
4 feed themselves. They can talk. But not so much
5 here at the bottom level where they can't walk
6 without support.

7 Q. And based on the materials that you
8 reviewed in those cases, which of those categories
9 does Remi fall in?

10 A. Well, unfortunately he's here. He
11 can't -- he can't walk on his own. Like he can't
12 walk with limited support. He requires extensive
13 support. And, further, this scale is meant to
14 indicate or describe how the child or adult typically
15 moves around in the community, is what they normally
16 do. So the people here can walk with a cane or a
17 crutch in the community. They can walk around.
18 That's how they get around. Here, they would walk
19 unsteadily, but they can still get around. They
20 wouldn't require a wheelchair.

21 Q. Does feeding ability impact a person's
22 life expectancy?

23 A. Right. That's the other of two main
24 factors in that.

25 Q. And based on everything that you reviewed

1 in this case, what is your understanding of Remi's
2 feeding ability?

3 A. well, fortunately I understand he does not
4 require a feeding tube, which would just describe the
5 most severely disabled of children. They need a
6 feeding tube for their nourishment with a tube into
7 the stomach. But he also unfortunately cannot feed
8 himself. He's fed by others. He's fed by mom and
9 dad. I understand there are some concerns about
10 that, such that others don't feed him. But he's fed
11 most of his nutrition by mom and dad.

12 Q. Doctor, I want to hand you what's been
13 marked as Exhibit 5V-0.

14 Do you recognize this, Doctor?

15 A. Yes.

16 Q. And is it something that you prepared in
17 developing your opinions in this case?

18 A. Yes. That's a summary of my opinions.

19 Q. Okay.

20 A. In some ways.

21 Q. Okay. And is this -- is this intended to
22 help the jury understand your opinions in this case?

23 A. Yes.

24 Q. Okay.

25 MS. PFIRMAN: Permission to publish

1 Exhibit F5-0?

2 THE COURT: Any objections?

3 MS. SLATER: No, Your Honor.

4 MS. PFIRRMAN: Justin, can you pull that
5 up for us?

6 Q. (By Ms. Pfirrmann) All right. Dr.
7 Shavelle, so we've already established that lawyers
8 are no good with numbers, and there's a lot on this
9 page.

10 So can you tell us what all of this means?

11 A. Yes. If you remember a moment ago, when
12 we were talking about the general population life
13 table, and the first exhibit had had just a summary
14 of the numbers. So this is a full life table, in
15 that it has all of the columns, most of which people
16 are not interested in.

17 Obviously, the first column is age, and
18 the right most column, where we see that lowercase
19 "e," the lowercase "e" is the scientific notation for
20 expectancy. So that's the remaining life expectancy
21 at each age. And we can see in the top right corner,
22 the number is 30 because that's my opinion, and this
23 is the table I constructed to summarize my opinions.

24 Q. Okay. And so we know that Remi is 4 years
25 old right now, right?

1 A. Yes.

2 Q. okay. So if you look at the first line,
3 age 4, that's his current age, right?

4 A. Yes.

5 Q. And then 30 is the 30 additional years.
6 That is your opinion in his life expectancy?

7 A. Yes.

8 Q. okay.

9 MS. PFIRMAN: You can take that down.

10 Q. (By Ms. Pfirman) Doctor, I'm going to
11 hand you what is marked Exhibit F5-P.

12 And do you recognize this, Doctor?

13 A. Yes, of course.

14 Q. what is it?

15 A. It's an excerpt from one of the four
16 principle studies I relied on to form my opinion of
17 30 years.

18 Q. okay. So this is an excerpt from a study
19 that you considered in reaching your opinions in this
20 case?

21 A. Yes. One of the four studies that I found
22 most recent and relevant.

23 Q. Okay. And you prepared this exhibit to
24 help explain that study to the jury, is that right?

25 A. Yes.

Q. okay.

MS. PFIRMAN: Permission to publish Exhibit F5-P.

THE COURT: Any objection?

MS. SLATER: No, Your Honor.

THE COURT: You may.

Q. (By Ms. Pfirman) All right, Dr. Shavelle. Can you walk us through what the purpose of -- or what this study was?

A. Sure. So Drs. Hutton and Farro are colleagues. They're in England. They did this study on a survival of kids with cerebral palsy. They studied several thousand kids for more than 30 years. They looked to see how long those kids lived.

And this is a summary graph from their study, published in a major peer-reviewed medical journal, a specialty journal, and, well, it's a complicated graph.

There are nine curves there. Those are called survival curves. They tell you how long a group survived. And at the very beginning, on the left there, we see the number 1.0. That's everyone, 1.0. It would have been a little clearer, I think, if had written 100 percent because most of us think in terms of percentages.

1 so at the beginning of the study, age 2,
2 everyone's alive, 100 percent. And then you can see,
3 no matter which curve you're looking at, that over
4 time or with age, the passage of time, the curves
5 drop, which means not everyone is still alive.

6 Now, these authors, like every other set
7 of authors on survival of children with cerebral
8 palsy, they weren't content to look at the whole
9 group, they looked to see within that group what --
10 what mattered for survival, and they found all sorts
11 of things.

12 But briefly here, they divided into nine
13 groups, according to the severity of disability. And
14 the group most like Remi is the one that's third from
15 the bottom. So if we start at the bottom, and we go
16 up, we see the line that says "severe motor and
17 cognitive disabilities." It's really severe learning
18 disability. Normal birth weight. And these authors
19 define normal birth weight as anything 5 and a half
20 pounds or more, which Remi was because he was 8
21 pounds.

22 So that curve there, that third from the
23 bottom curve, tells us the survival of a group of
24 kids like Remi's age. And it's not easy to see here,
25 but obviously it starts at 100 percent, and at the

1 end there, by age 30, you can see that the survivor
2 is somewhere between 40 percent and 60 percent.

3 It turns out that it's close to 50
4 percent. So 50 percent survive from age 2 to age 30.

5 That's 28 more years for 50 percent. So so-called
6 median survival time, 50 percent margin, is 28 years.

7 And the associated life expectancy, it turns out, is
8 about 31. So if we can continue that curve all the

9 way at the end, then on average, the kids would live
10 31 more years.

11 Q. And the third category from the top, that
12 you believe Remi would fall into, that's based on
13 your review of the depositions, the medical records,
14 and the examinations that have been conducted on
15 Remi?

16 A. The third -- the third group from the
17 bottom, yes.

18 Q. I'm sorry. Third group from the bottom,
19 thank you.

20 That group, you believe Remi would fall
21 into based on your review of everything, all the
22 materials that you've reviewed in this case?

23 A. Yes. That's pretty clear.

24 Q. Okay. Okay. I'm going to move on and
25 hand you Exhibit F5-R.

1 Doctor, can you identify this exhibit for
2 us, please?

3 A. Yes. It's an excerpt. It's Table 2 from
4 a study we, at the Life Expectancy Project, did. It
5 was a study of 16,000 children aged 4 with cerebral
6 palsy, followed for 28 years, up to 28 years.

7 Q. So this is an excerpt from an article that
8 you were one of the authors for?

9 A. Yes.

10 Q. And this is one of the articles that you
11 relied on in reaching your opinions in this case?

12 A. Yes. One of the many articles, but in
13 particular, one of four specific articles that I
14 found most recent and relevant.

15 MS. PFIRMAN: Permission to publish
16 Exhibit F5-R to the jury?

17 THE COURT: Any objections?

18 MS. SLATER: No, Your Honor.

19 THE COURT: You may.

20 MS. PFIRMAN: Justin, can you pull that
21 up for us, please?

22 Q. (By Ms. Pfirman) Okay, Dr. Shavelle.
23 Can you walk us through what this study was looking
24 into, please?

25 A. Sure. So this is published in

1 Developmental Medicine and Child Neurology, which is
2 a major peer-reviewed medical journal, a specialty
3 journal for neurologists, pediatric neurologists,
4 pediatric physiatrists, and others who are interested
5 in survival of children and adults. There's an adult
6 section of people with cerebral palsy.

7 And this a not a very convenient form to
8 look. It has the same information that we looked at
9 previously when we looked at survival curves, but
10 these are numbers rather than curves. But if we go
11 down to the fifth row of the table, it's the row that
12 is titled "Fed Orally by Others," it's under the
13 heading, "Lifts Head But Not Chest in the Prone
14 Position."

15 THE WITNESS: Scroll down.

16 MS. PFIRMAN: A little bit above that,
17 Justin.

18 Q. (By Ms. Pfirman) Is that the category
19 you're looking for?

20 A. Yes. But that's a generous or
21 conservative group, if we're looking to compare Remi.
22 Because my understanding is that he has poor head
23 control. He cannot lift his head in prone
24 independently and consistently and purposely. So he
25 needs a head strap, needs some support.

1 But if we look at that group, the "Lifts
2 Head but Not Chest in the Prone Position," there
3 are -- there are three subgroups there. Those that
4 are tube fed -- and of course that's not Remi. He
5 doesn't require a feeding tube, to my knowledge --
6 fed orally by others, and feeds self orally.

7 Now, that final subgroup there, feeds self
8 orally, those are people who feed themselves, finger
9 feed or utensils, for most of their nutrition, that's
10 how they would eat all of their meals. They might
11 need a little help with setup, maybe cutting their
12 food, but they would feed themselves. Put the -- put
13 the food into their mouth at the pace they may
14 desire. And I don't believe that's applicable here.

15 Q. Okay. So based on the materials that
16 you've reviewed in this case, you believe that Remi
17 falls into the category "Fed Orally by Others"?

18 A. Yes.

19 Q. Okay.

20 A. Certainly.

21 Q. Okay. And based on this table here, what
22 does that tell us about his potential life
23 expectancy?

24 A. Okay. So going across that row, and I
25 apologize, it's difficult to see, but there were 795

1 such children. They were all evaluated at age 4. By
2 age 10, 89 percent were still alive. Moving over.
3 By age 15, it was 80 percent. Age 20, it was
4 67 percent. Age 25, it was 54 percent. Age 30, it
5 was 48 percent.

6 And so we crossed that 50 percent mark
7 somewhere between ages 25 and 30. It's about age 28.

8 So we would say the median survival time is age 28
9 minus 4 is 24 more years, which leads to a life
10 expectancy of roughly 28.

11 I'm sorry. I obviously misspoke.

12 Q. Go ahead.

13 A. Yes. It's a life expectancy of 28.

14 Q. 28 more years?

15 A. 28 additional years, yes. And that's for
16 the generous group, as I say.

17 Q. And specifically this study was looking at
18 4-year-old children with cerebral palsy, is that
19 right?

20 A. Yes.

21 Q. And Remi is 4 years old, and he's been
22 diagnosed with cerebral palsy.

23 Is that your understanding?

24 A. Yes.

25 Q. You've mentioned a couple of times the

1 median survival time.

2 Can you just explain a little bit more
3 about what that means?

4 A. The median is the 50 percent mark, so for
5 example, the median strip on the highway is in the
6 middle of the highway with half the lanes on one side
7 and half the lanes on the other.

8 So the median survival time is also in the
9 middle: half of the people live longer, half live
10 shorter. It's one measure of -- it's one summary
11 measure of survival or summary measure of any set of
12 numbers. Whereas, the life expectancy is a different
13 summary measure. The two are usually pretty similar.
14 But in cases like this, the life expectancy is
15 usually a couple of years longer. So I think I said
16 24 as the median; 28 is the life expectancy. Close
17 but not identical.

18 Q. Okay. I'm going to hand you what's been
19 marked Exhibit F5-S.

20 Can you identify this exhibit for the
21 jury?

22 A. Yes. It's a study that I did with my
23 colleagues at the Life Expectancy Project where he
24 compared survival in California with survival in
25 Sweden. And, again, it's children with cerebral

1 palsy. Here was age 3. And this was, again,
2 published in a major peer-reviewed medical journal.

3 Q. And is this another article that you
4 relied on in reaching your opinions in this case?

5 A. Yes.

6 MS. PFIRRMAN: Permission to publish
7 Exhibit F5-S?

8 THE COURT: Any objection?

9 MS. SLATER: No, Your Honor.

10 THE COURT: You may.

11 Q. (By Ms. Pfirrmann) Okay, Dr. Shavelle, can
12 you walk us through what this study shows.

13 A. Yes. So we're back to a graph with
14 survival curves. And we can see there are four such
15 curves. And if we just concentrate on the two in the
16 middle there, where it says "California," and in
17 parentheses it says all. And a little guy that says
18 Sweden. And these are all kids with so-called severe
19 motor impairment with cerebral palsy.

20 So it's not everyone in the California
21 group, it's this severe motor impairment group. And
22 you can see that the California kids do a little bit
23 better than those in Sweden.

24 And then, you know, we broke that group
25 into two subgroups. The kids who are orally fed,

1 like Remi, that's the best group there. And the kids
2 who are on a feeding tube, the lowest group for the
3 survival group.

4 And this study gives a life expectancy of
5 roughly 32 additional years.

6 Q. So Remi would fall into that top category
7 there?

8 A. Right. In this study, it would be the
9 best group. That's the fair comparison group for
10 him.

11 Q. And you said 32 additional years, based on
12 this study?

13 A. Yes.

14 Q. I'm going to hand you what's been marked
15 Exhibit F5-T.

16 Can you identify this exhibit for us,
17 please?

18 A. This is the fourth and final of the four
19 that I found most recent and relevant. Again,
20 peer-reviewed, again, in a major medical journal.
21 Again, survival curves. And this one indicates a
22 life expectancy of roughly 20 -- 29 additional years.

23 Q. And this is an exhibit that you prepared
24 to help explain your opinions to the jury?

25 A. Yes.

Q. Okay.

MS. PFIRMAN: Permission to publish Exhibit F5-T.

THE COURT: Any objection?

MS. SLATER: No, Your Honor.

THE COURT: You may.

Q. (By Ms. Pfirman) Okay, Dr. Shavelle. Briefly walk us through this study and what is depicted here.

A. Again, survival curves, children with cerebral palsy. This is the severe group, which would mean who cannot walk on their own. It would include those who can use a wheelchair in some way.

But it's the severe group out of the three. These authors divide kids into three groups: mild, moderate, and severe. And so these are the severe and further stratify. And as I said, the appropriate curve there indicates a life expectancy of about 29 more years.

Q. And which curve would be where Remi falls into?

A. Either the third from the top or the fourth from the top. Or you can say the bottom one or the one above the bottom one.

Q. And tell us again how many additional

years, based on this study?

A. well, 29 is the average of those two.

Q. The jury has already heard from plaintiffs' life expectancy expert, Dr. Liles.

Are you aware of that?

A. Yes, I am now.

Q. Okay. Are you aware that he expressed an opinion that Remi's life expectancy is to age 60?

A. Yes. I read that in the trial deposition.

Q. Based on your decades of life expectancy research, do you agree with that?

A. No, I do not agree.

Q. Okay.

A. I think 30 is the fair number.

Q. Okay. And tell us specifically why you disagree with Dr. Liles' opinion of a life expectancy to age 60.

A. well, in fairness, could I just start by saying that, where I agree with Dr. Liles?

Q. Sure.

A. Because I agreed with him on a number of really important things.

Q. Sure. Let's start there.

A. Okay. well, I read Dr. Liles' report. And I read his first deposition, and I read his

1 second deposition, and I don't see any major
2 disagreement between what Dr. Liles says about the
3 child's condition now and what everyone else said.

4 So as I said earlier, I think there is
5 major agreement, so unfortunately we're talking about
6 a very severely disabled 4-year-old boy with cerebral
7 palsy. So I agree with him there.

8 Secondly, Dr. Liles said uniformly that
9 because of Remi's unfortunate severe disabilities, he
10 does not have a normal life expectancy. So it's not
11 71 more years, like you see in the general
12 population. Dr. Liles is saying to age 60, which
13 would be 56 more years. So he's saying 56 instead of
14 71. That's obviously a reduction. And so I agree
15 with Dr. Liles there. That's important.

16 Thirdly, Dr. Liles looked to the medical
17 literature to determine a life expectancy, so he went
18 to our website, my website, the
19 lifeexpectancyproject.org, and he looked at the
20 literature on cerebral palsy, I think, and then also
21 looked at literature on traumatic brain injury.

22 And so I appreciate he was looking at what
23 I think are good sources. I hope it doesn't sound
24 immodest to say the stuff we do is good. But those
25 things are published in major peer-reviewed medical

1 journals, and I think it's important to look at the
2 major peer-reviewed medical journals for evidence on
3 the survival of kids like Remi. So the three big
4 things I agree with him.

5 Q. Okay. So a number of agreements.
6 where is it that you may disagree with Dr.
7 Liles in this case?

8 A. Oh, I think in fairness, that if you're
9 asking about Remi's life expectancy, you have to
10 compare him with similarly-situated young boys, and
11 that's what I've done when I looked at those four
12 studies, and I won't belabor the point by talking
13 about them again.

14 But we have to compare apples to apples.
15 And I think Dr. Liles did not do that correctly --
16 I'm sorry to say that -- when he made the
17 comparisons. He was not comparing Remi with
18 similarly-situated boys who are like him now, he was
19 making assumptions about the future.

20 And I suppose I should say I'm not making
21 any assumptions about the future with respect to
22 Remi's abilities. I'm not assuming that he'll never
23 walk. I'm not assuming that he will walk. I'm not
24 assuming that he will one day feed himself or will
25 not one day feed himself. I'm looking at kids who

1 are like him now. Some of those kids improve, some
2 stayed the same, some don't.

3 Q. So when making a determination as to life
4 expectancy, you're looking at the child as they are
5 now, is that right?

6 A. Right.

7 Q. Okay. And Dr. Liles, is it your
8 understanding that he was looking at what Remi may be
9 like in the future?

10 A. That was part of it, yes. But there were
11 some other issues that I can address.

12 Q. Sure. Yes, tell us about that.

13 A. So if we could bring up that one principle
14 study he relied on, I think it would be helpful to
15 explain.

16 Q. Yeah.

17 MS. PFIRRMAN: Justin, can you bring up
18 Exhibit E2-S.

19 Q. (By Ms. Pfirrmann) And what is on this
20 screen, Dr. Shavelle, is this from your website
21 lifeexpectancy.org?

22 A. Yes.

23 Q. And is this one of the articles that you
24 understand Dr. Liles is relying on for his opinion?

25 A. What's on the screen now is not an

1 article. It's a web page.

2 Q. Oh, I'm sorry.

3 A. But it refers to an article.

4 Q. Okay. Let's look down onto the next page.

5 Did you see in Dr. Liles' testimony that
6 he was looking at this Table 17-3 in reaching his
7 opinion?

8 A. Yes.

9 Q. Okay.

10 A. And that's an excerpt from our article
11 from a book chapter where I was the first author, and
12 it was a book about traumatic brain injury.

13 Q. And in your opinion, is this article on
14 traumatic brain injury applicable in this case?

15 A. Yes and no. I -- because Remi has
16 cerebral palsy, it's more natural to look at the
17 cerebral palsy literature, and that's what I did in
18 those four studies. And we have a summary slide for
19 those four studies.

20 I suppose you could look at the traumatic
21 brain injury literature. Typically traumatic brain
22 injury is an acquired injury, acquired at an older
23 age, it's not a birth injury. But I think if we --
24 we gloss over that, and if we look at this table
25 fairly, I think, we get the same number, we get 30,

1 roughly.

2 Q. So tell us how we would get 30 from this
3 table.

4 A. Well, firstly, we would be looking at the
5 table for males, as highlighted here. Secondly, the
6 closest age in that table is 10, so we would be
7 looking at the first row of the table at age 10.

8 And then we have to find the group most
9 like Remi. So the first group, age 10, that says
10 PVS, that's permanent vegetative state. That's not
11 his condition. Most of those people have no
12 awareness. They are bent down. They need a feeding
13 tube. Not in this case.

14 The next group over says "Cannot walk, Fed
15 by Others." That's the group most like Remi. And
16 the number there coincidentally is 27, pretty close
17 to my 30, or the 30 I think is from the scientific
18 literature on cerebral palsy.

19 Now, I think Dr. Liles looked two columns
20 over. He jumped over two columns to had some walking
21 ability, and that's where his 50 more years comes
22 from. I think he took age 10, added 50, and got age
23 60, and then subtracted, or maybe didn't subtract the
24 4, but the 50 more years is not appropriate for
25 reasons I could explain.

1 Q. Yes. Please do.

2 A. All right. So there are several major
3 problems here. Firstly, he's jumped over the
4 self-feed groups -- the self-feeds group. We know
5 Remi cannot self-feed, so it's already unusual to be
6 there.

7 Secondly, Remi meets the criteria for
8 cannot walk on his own, and he's fed by others. He
9 does not meet the criteria for some walking ability.
10 It's difficult to see, from this exhibit, but there's
11 a footnote on some walking ability. I think it's
12 footnote "D" as in dog.

13 MS. PFIRMAN: Justin, can you pull up a
14 little bit more of the footnote there?

15 A. Okay. So this was a study I did. I was
16 the first author, again, traumatic brain injury. And
17 that group there that says, quote, walks well alone,
18 close quote, that's actually a composite. And that's
19 actually levels 2 and 3 on that 4 point walking scale
20 I was talking about earlier.

21 So it's "walks with support," and that
22 would be typically cane or crutch because in a TBI
23 context, this is rehab. These are people who have
24 suffered a brain injury, typically from a motor
25 vehicle or other accident. Initially they can't

1 walk, then they walk with a cane or a crutch, then
2 they can be unsteady.

3 So it's a composite there. It's "walks
4 with support," or it's level 3: "Unsteadily Alone at
5 At Least 10 Feet." So it's not just the people who
6 walk with cane or crutches, the two groups combined.

7 And that leads to my next important point,
8 is that these people in this group here, these are
9 people who nearly take control. They can roll over.
10 They can sit. They can roll to a stand. And they
11 can cruise. And they can feed themselves and take
12 care of themselves. And unfortunately that's a group
13 that is not very similar to Remi.

14 Q. (By Ms. Pfirrmann) So if we look at this
15 table, Table 17-3, which Dr. Liles relied on to reach
16 his life expectancy opinion, we would be -- your
17 opinion would be how many years for life expectancy?

18 A. 27.

19 Q. And in your opinion, can you tell us the
20 chance that someone like Remi will live to age 60, as
21 Dr. Liles opined?

22 A. Yes.

23 Q. What would that be?

24 A. I'm looking at Exhibit F5-0.

25 Q. Okay.

1 A. That's the life table.

2 And according to that table and all the
3 medical literature on similar kids, the chance that
4 Remi, or someone like him, would live to age 60 is
5 about 15 percent, which means one out of seven kids.

6 Q. In reviewing these things, did you review
7 the life care plan prepared by Dr. Liles?

8 A. Yep.

9 Q. And did you take that into account in your
10 analysis?

11 A. Essentially, yes.

12 Q. Would more care or better care increase
13 Remi's life expectancy more than the numbers that
14 you've given us here today?

15 A. No. Because the 30 is based on the
16 assumption or my understanding that he is now, or
17 will in the future, receive reasonable and necessary
18 medical care.

19 Q. You've told us that Remi's life expectancy
20 is 30 additional years.

21 Does that mean we can expect him to live
22 exactly 30 years?

23 A. No. The 30 years is average. He could
24 live longer or shorter. Even quite a bit longer or
25 quite a bit shorter.

1 Q. Just to be clear, is it possible for
2 anyone to predict with absolute certainty what Remi's
3 actual survival time would be?

4 A. Not with any sort of accuracy, no. Except
5 in the most unusual of circumstances that I don't
6 think apply here.

7 Q. I want to hand you what's been marked
8 Exhibit F5-Q.

9 Can you identify this exhibit for us,
10 please?

11 A. It's a summary sheet. It summarizes the
12 key facts related to survival and some other factors
13 that I was aware of.

14 Q. And did you prepare this exhibit in
15 anticipation of explaining your opinions to the jury
16 in this case?

17 A. Yes.

18 MS. PFIRMAN: Permission to publish
19 Exhibit F5-G, please?

20 THE COURT: Any objection?

21 MS. SLATER: No, Your Honor.

22 THE COURT: You may.

23 Q. (By Ms. Pfirman) Okay, Dr. Shavelle,
24 walk us through what this slide is intending to
25 explain to the jury.

1 A. If this is the key facts that are related
2 to survival, and then some so-called "other factors"
3 at the bottom, I think we've talked about most of
4 this already. He is a severely disabled young boy
5 with cerebral palsy unfortunately. He's better than
6 some. He doesn't require a feeding tube. He has
7 some head control. But he -- he can't move around on
8 his own. He needs considerable assistance.

9 Q. And these are all the key facts and
10 factors that you considered in reaching your opinions
11 in this case?

12 A. Yes.

13 Q. I have one last exhibit, and you're almost
14 done.

15 All right. I'm handing you what's been
16 marked Exhibit F5-V.

17 Can you identify what this is, please.

18 A. It's a summary slide I prepared that lists
19 the four studies, the four resulting life
20 expectancies, and then my summary opinion.

21 Q. Okay. And this is something that you
22 prepared to illustrate your opinions in this case?

23 A. Yes.

24 MS. PFIRMAN: Permission to publish
25 Exhibit F5-V.

1 THE COURT: Any objections?

2 MS. SLATER: No, Your Honor.

3 THE COURT: You may.

4 Q. (By Ms. Pfirrmann) And you said that this
5 was a summary.

6 Is this a summary of the four articles
7 that we've already discussed here today?

8 A. Yes. Though I have to point out that the
9 third article there, it says 33, it should say 31.

10 Q. Okay.

11 A. Sorry.

12 Q. That's okay. So we have 27, 32 -- that
13 should be 31 -- and then 29?

14 A. Yes.

15 Q. And how do those articles inform your
16 ultimate opinions in this case?

17 A. Well, it's how I arrived at my opinion. I
18 looked at the facts about him, and I looked to the
19 medical literature on the survival of similar kids.

20 Those are the four studies I think are the most
21 recent and relevant. I think I used them fairly.

22 Those are the four numbers that result, and I think
23 30 is a fair summary of those four numbers.

24 Q. And that's 30 additional years, correct?

25 A. Right.

1 Q. okay. Dr. Shavelle, have all of your
2 opinions here today been to a reasonable degree of
3 scientific certainty?

4 A. Yes.

5 Q. okay. Those are all the questions I have.
6 Thank you.

7 THE COURT: Thank you.

8 All right. All right. Ladies and
9 gentlemen, this is a good time for us to take our
10 lunch recess.

11 (A break was taken at 12:38 p.m., and the
12 jury was duly admonished. At 1:42 p.m., the
13 following proceedings were held in open court, in the
14 presence of the jury:)

15 THE COURT: Go ahead and be seated,
16 everyone.

17 You may proceed.

18 MR. PERRON: Thank you, Your Honor.

19 DIRECT EXAMINATION

20 BY MR. PERRON:

21 Q. Dr. Shavelle, in your final report, you
22 had two ultimate numbers: a median number and a
23 mean.

24 If you could just explain those
25 differences to the Court.

1 A. Right. The median survival time was 27
2 additional years, and the mean, or the average, or
3 the life expectancy, was 30.

4 Q. So for those of us who don't have the same
5 kind of background as you, what's the definition?
6 How do we understand the median number in this
7 context?

8 A. Well, as I said earlier, it's the
9 50 percent mark. So it's the middle number in that
10 sense.

11 Q. And in terms of 50 percent, we're still
12 talking about a probability of likelihood of
13 occurring, is that fair?

14 A. Yes.

15 Q. Okay. So, you know, leading up to 27
16 additional years, if the question is surviving 10
17 additional years using the median, you'd have to say
18 more likely than not, right?

19 A. Yes. It's more likely than not that he or
20 someone like him would survive at least 10 years.

21 Q. Okay. And then using the median again, an
22 additional 20 years is still more likely than not?

23 A. Yes, it is.

24 Q. But when we get right at 27, the median,
25 that's what?

1 A. It's equally likely to live longer or
2 shorter.

3 Q. And as we go further away from 27 years,
4 an additional 28, an additional 29, is it more likely
5 or less likely than not?

6 A. Less likely than not.

7 Q. Based on your statistical models and
8 calculations?

9 A. I would say based on the scientific and
10 medical literature, yes.

11 Q. Okay. Dr. Liles, you reviewed both of his
12 depositions?

13 A. Yes.

14 Q. Did he rely on your statistical research
15 to formulate his life expectancy opinions?

16 A. I would say he relied on our medical
17 research, including in particular that traumatic
18 brain injury book chapter table.

19 Q. Okay. Dr. Liles stated that the term
20 "fully ambulating" in your article on terrible
21 quality life expectancy was ambiguous.

22 Is that true that in your article, the
23 term "fully ambulating" is ambiguous?

24 A. I don't think so. I think he's talking
25 about level 4?

1 Q. Right.

2 A. People who walk alone or independently, no
3 support, they balance well, at least 20 feet. I
4 think that's what he's referring to.

5 Q. Okay. So if we're talking about your
6 article on life expectancy with cerebral palsy, the
7 term "fully ambulating," means being able to walk
8 unassisted?

9 A. Yes.

10 Q. Okay.

11 A. As far as I know. I think I'd have to see
12 what was quoted and see it in context.

13 Q. Okay. And then I think this question was
14 asked of you, but just to make sure: All the
15 opinions you've shared with us this morning and early
16 afternoon, have they been to a reasonable degree of
17 professional certainty?

18 A. Yes.

19 Q. Those are all my questions.

20 THE COURT: Cross-examination?

21 MS. SLATER: Yes. Thank you, Your Honor.

22 CROSS-EXAMINATION

23 BY MS. SLATER:

24 Q. Good afternoon, Dr Shavelle.

25 A. Good afternoon.

MS. SLATER: Good afternoon, everyone.

Q. (By Ms. Slater) All right. Let's see here.

Dr. Shavelle, you were hired by Mercy Hospital, Mercy Clinic, and Dr. McNeive, correct?

A. I would say retained not hired, but yes.

Q. Okay. So when the jury considers the information that you are here to share with them, they will have already gotten to the point where they have decided that these defendants are responsible for all of Remi's harms and losses due to his severe brain injury, correct?

MS. KAMYKOWSKI: I'm going to object to the form of the question. We need to approach, please.

THE COURT: You can.

(Proceedings were held at sidebar, outside the hearing of the jury.)

MS. KAMYKOWSKI: I'm going to object to that question as far as evidence as far as her determination to talk about instructions to the jury who have not seen them. We have no idea how you're going to instruct them. I believe this is confusing to them at this point in time. It invades the province of the jury, too.

1 MS. SLATER: Nothing about the
2 instructions that is -- my question isn't the facts
3 of the matter. It's when this witness's testimony is
4 relevant.

5 MS. KAMYKOWSKI: He has no idea when the
6 jury is going to consider damages, without looking at
7 the instructions, without looking to see what the
8 outcome is. He has no idea. That assumes facts that
9 is not proper at this point.

10 THE COURT: why don't you rephrase the
11 question.

12 MS. SLATER: Sure.

13 (Proceedings returned to open court.)

14 Q. (By Ms. Slater) Dr. Shavelle, the
15 information that you have shared with the jury is
16 relevant to Remi's damages in regard to his future
17 care and his life care plan, correct?

18 A. That's my understanding, yes.

19 Q. Okay. And in the event the jury is
20 looking at Remi's damages in the life care plan,
21 Mercy Hospital, Mercy Clinic, and Dr. McNeive have
22 offered your testimony for them to consider in
23 regards to the life care plan, correct?

24 A. Again, that's my understanding.

25 Q. And the fewer years expected for the rest

1 of Remi's life means the less burden on the
2 defendants to pay for that future care, correct?

3 A. Yes.

4 Q. Okay. And Mercy Hospital, Mercy Clinic,
5 and Dr. McNeive brought you here to tell Blake Anyan
6 and Sarah Anyan that information, correct?

7 A. Well, I would convey it to the Court, the
8 judge, the jury, and whoever else is interested, and
9 I also convey this information to the medical and
10 other communities.

11 Q. You know, that's interesting. You were
12 asked if you were ever consulted by the medical
13 community, and you responded that they've asked for
14 your data behind your growth charts before. That's
15 how you responded to that question. They can check
16 the information with your data, right?

17 A. They didn't ask for the underlying patient
18 data, they asked for the exact coordinates of the
19 plot on the graph. Like on the survival curves,
20 there are exact numbers there.

21 Q. Let me ask you about your articles.

22 So you have referenced your own articles
23 to give your opinion today, correct?

24 A. In part, yes.

25 Q. And importantly there is an article from

1 2012, that you referenced that table to, that only
2 gives an age up to 30 to consider, correct?

3 A. I believe it's 2014, but...

4 Q. 2012, the part 2 article?

5 A. Part 2 was 2014, but that's fine.

6 Q. Well, I'm not going to argue with you on
7 that. You're not going to get that wrong.

8 okay. 2014. Part 1 was May of 2012?

9 A. They were both 2014.

10 Q. Got it. All right.

11 A. But the second post article was 2012,
12 you're right about that.

13 Q. Tell me what data the -- that Table 2 was
14 based on.

15 A. It was more than 16,000 children with
16 cerebral palsy age 4, and many more were older. That
17 was people, children followed from 1983, through the
18 year 2010.

19 Q. Okay. But there's two sets of data. It's
20 not one set from 1980 to 2010, right? You had two
21 sets of data.

22 A. Well, there were more than two. I just
23 told you about the kids age 4. There's also a subset
24 age 15, 30, 45, and I think 60.

25 Q. Okay. Sir, have you ever been ordered by

1 a court to produce certain information, whether it's
2 related to your income from litigation or the data
3 from the studies that you've authored?

4 MS. KAMYKOWSKI: Your Honor, can we
5 approach?

6 THE COURT: You can.

7 (Proceedings were held at sidebar, outside
8 the hearing of the jury.)

9 MS. KAMYKOWSKI: Your Honor, what other
10 cases have stricken on this data is not relevant,
11 supposing the subpoena issued was improperly served
12 on him. She's just trying to get into that. It
13 would be improper.

14 THE COURT: She hasn't said anything about
15 the subpoena that was issued in this case, and I
16 don't expect she will.

17 with regards to the other information, the
18 court does find that it is relevant to
19 cross-examination.

20 MS. KAMYKOWSKI: For the record, I would
21 say that what another court has ruled about a
22 subpoena, first of all, any order striking him on
23 that basis, there's no challenge to this witness that
24 was made before, I guess, a day and a half ago.

25 with respect to his qualifications, his

1 methodology, there has not been a motion to compel
2 against the defendant that he failed to comply in
3 any way or for any orders that have been entered in
4 other jurisdictions outside of Missouri against this
5 witness, so anything relating to any orders would be
6 hearsay to begin with. She's going to try to get it
7 in the order. But there is also no relevance to this
8 witness.

9 THE COURT: The underpinning data with
10 regards to these studies is relevant, and this is
11 where we're at, so I'm going to overrule the
12 objection.

13 (Proceedings returned to open court.)

14 Q. (By Ms. Slater) All right. Dr. Shavelle,
15 has a court ever ordered you to produce certain
16 information, whether it was the underlying data from
17 your studies or the financial information regarding
18 how much you make from litigation consulting?

19 A. Yes.

20 Q. On how much occasions?

21 A. I think three, maybe four.

22 Q. Okay. And in those three or four cases,
23 were they all -- in all of those cases, were you
24 ordered to produce the underlying data of that Table
25 2 that we saw?

1 A. I don't think I've ever been asked about
2 the data underlying Table 2 --

3 Q. okay.

4 A. -- of the 2014 study, no.

5 Q. Have you been ordered by a court to
6 produce your underlying data for any of your studies?

7 A. Yes.

8 Q. okay. And how many times?

9 A. I think twice. I could be mistaken.

10 Q. okay. And in those two cases where you
11 were ordered to produce your data, tell me about the
12 outcome of those situations.

13 A. There was a case in Alaska where the Court
14 ordered that I had to produce the entire California
15 database of 400,000 people. There were some
16 misunderstandings there, and then I -- the Court
17 later changed its mind.

18 And then there was a case -- that case was
19 called stackhouse in Alaska. And then there was a
20 case in Chicago called Gallegos or Ramirez. In that
21 case, the Court ordered me -- ordered that I had to
22 produce the data underlying our two cerebral palsy
23 studies from 1998.

24 Now, I -- like here, I didn't rely on that
25 data, and I didn't have that data, so I couldn't

1 produce the data that's underlying those two studies.
2 So the defense had to withdraw me in that case. And
3 then the Court later, I was told, vacated its ruling.

4 Q. And so the data, though, that was ordered
5 to be produced, that was held by you and your partner
6 at the Life Expectancy Project, correct?

7 A. At one point, it was. When we did the
8 studies, certainly it was.

9 Q. Okay. What -- what happened to it?

10 A. I'm sorry. I talked about multiple
11 datasets there. I'm not sure which one you're still
12 on.

13 Q. So I want to talk about the dataset from
14 1980 through 1995, that courts have ordered you to
15 produce that underlie your articles and research that
16 you published in 1998, that your 2014, articles also
17 cite to.

18 what happened to that data?

19 A. Well, those were datasets that were
20 produced for the purposes of those two 1998 studies.
21 And they were not retained after the studies were
22 published.

23 Q. Okay. So --

24 A. But that was 1998. That's a long time
25 ago.

1 Q. You've been doing this for a long time,
2 haven't you?

3 A. Research and consulting, yes, I have.
4 More than 20 years.

5 Q. Okay. How many states have your opinions
6 been limited or excluded in court cases?

7 A. I think there were 5 very unusual
8 occasions where I was precluded, if that answers the
9 question.

10 Q. Okay. And as far as your opinions in this
11 case, you charge \$650 an hour?

12 A. The company bills my time for that, yes.
13 All the money goes to the company.

14 Q. Well, you and your two partners are the
15 company -- right? -- and you're a 50 percent owner in
16 that company, correct?

17 A. They're employees, but yes.

18 Q. Your partners are employees?

19 A. All three of us are employees, plus there
20 are other employees.

21 Q. All right. So you make \$650 an hour doing
22 legal litigation consulting, correct?

23 A. That's what my time is billed at for all
24 of my consulting, whether litigation or outside.

25 Q. Okay. And you told Ms. Pfirrmann that you

1 had billed 25 hours in this case, correct?

2 A. Roughly, yes.

3 Q. Okay. And is that before you charged the
4 6500 for trial?

5 A. Yes.

6 Q. Are you charging one, \$6500 fee, for
7 today, and one from yesterday when you flew in?

8 A. Yes. It would be two days.

9 Q. Okay.

10 A. At 6500 a day or 650 an hour, whichever's
11 less.

12 Q. Well, what are you planning to charge?

13 A. I haven't totaled it, but it's probably
14 about a 10-hour day both days all told.

15 Q. Okay. So if we put all that together, the
16 25 hours is 16,250. And then if we had 6500, that's
17 22,000. Then we got to add another 6500 on top of
18 that.

19 So we got 29,250 for your charges in this
20 case, correct?

21 A. What will be likely, yes.

22 Q. Okay. And you charged them to review all
23 the medical records?

24 A. All the materials I was provided, yes.

25 Q. And the results of that was the chart that

1 popped up with -- it was this chart, right?

2 A. That's a summary, but I have 10 pages of
3 typewritten notes.

4 Q. Okay. But all of the summary, all of this
5 information, that's in Dr. Woodruff's page and a half
6 exam, correct?

7 A. I'm not sure. I received that later.

8 Q. Okay. Whose exams did you rely on?

9 A. Dr. Woodruff, Dr. Liles principally, the
10 depositions of the parents, the medical records from
11 Rankin Jordan.

12 Q. You mention Dr. Matthews' exam.

13 Did you rely on that?

14 A. His deposition, yes.

15 Q. Okay. Okay. As far as -- have -- have
16 parents in this litigation setting -- you were asked
17 if you did your own exam. And you seemed like that
18 wasn't required. Have parents in a litigation
19 setting ever allowed you to examine, a statistician,
20 examine their child?

21 You've never done that, right?

22 A. Well, I'm a medical researcher and
23 consultant on life expectancy. Life expectancy is my
24 life's work, I think that's pretty clear, so I'm not
25 a statistician in this context.

1 Q. well, you --

2 A. But, no, I have not done a physical
3 examination. I'm not qualified to.

4 Q. Right.

5 A. I'm not a treating medical professional of
6 any kind. I've been present for physical
7 examinations.

8 Q. All right. So your life's work on the
9 Life Expectancy Project. That's a project that
10 started in the 1960s. It had NIH funding, and you
11 got involved in the '80s, is that right?

12 A. I believe it started somewhere in the
13 1960s. It was NIH funded through the year 2000, and
14 I became involved during my time in graduate school.
15 I think it was the mid -- early to mid 1990s. It was
16 before I earned my PhD.

17 Q. Okay. And so NIH funding stopped in 2000.
18 And since then, you and your two business partners,
19 Dr. Strauss, not a medical doctor, correct?

20 A. Correct.

21 Q. Okay. And Brooks, also not a medical
22 doctor, correct?

23 A. Correct.

24 Q. Okay. The three of you formed Strauss,
25 Brooks & Shavelle in 1999, correct?

1 A. well, it was just Dr. Strauss and myself
2 in 1999. But otherwise correct, yes.

3 Q. Okay. And you guys were publishing from
4 the Life Expectancy Project. And you were publishing
5 the articles about when certain people with
6 disabilities were going to pass away, right?

7 A. well, it was how long they were going to
8 live and the factors related to survival, and we've
9 done that since the early 1990s.

10 Q. okay. And '90 -- and you formed the
11 company so that you could capture the income that the
12 two of you were making from testifying in litigation
13 context on the research that you were putting out,
14 correct?

15 A. Not quite. But we did incorporate in
16 1999, in order to more formally account for the
17 consulting fees. But Dr. Strauss and I were getting
18 either paid individually or collectively.

19 Q. How many times has Dr. Strauss been
20 excluded in courts across the country?

21 A. I can only remember one strange occasion
22 in New Mexico.

23 Q. So not as many times. Just one for him; 5
24 for you, correct?

25 A. Correct.

1 Q. Okay. And 95 percent of the revenue from
2 the company, is from litigation consulting, correct?

3 A. Yes, whether by Dr. Strauss, Dr. Brooks,
4 or myself.

5 Q. Okay. And 95 percent of your litigation
6 consulting is for defendants in this type of personal
7 injury setting, correct?

8 A. Well, I'm sorry to quibble. I wouldn't
9 say I'm for or against either side. I'm for the
10 evidence. I'm for the medical literature. I'm for
11 the truth. But, yes, 95 percent of the time, I'm
12 retained by defense, roughly, and 5 percent by
13 plaintiff, at least over the past 10 years.

14 Q. So you're not for or against any side. Is
15 that what I'm hearing you say?

16 A. Correct, I am not.

17 MS. SLATER: Your Honor, may I approach?

18 THE COURT: You may.

19 Q. (By Ms. Slater) I'm going to hand you
20 what we have marked as Exhibit 170-30.

21 what's that?

22 A. It looks like a document from 20 years ago
23 that I or we created. It's titled "Questions on Life
24 Expectancy for Deposition."

25 Q. And who prepared that document?

1 A. Dr. Strauss and I.

2 Q. Okay. And that -- please describe that
3 document to the jury.

4 A. It has questions that can be asked of
5 anyone who has an opinion on life expectancy to,
6 firstly, determine what their opinion is. Secondly,
7 to determine what they mean by it. And what it's
8 based on.

9 Q. And who was this created for?

10 A. I think a lawyer originally asked us to
11 create this or help them.

12 MS. SLATER: If you could turn to Section
13 8?

14 Q. (By Ms. Slater) This is a section here
15 where you guys -- or where you and Dr. Strauss -- it
16 says: when a plaintiff's doctor claims normal life
17 expectancy -- and this is a suggestion of questions
18 that the defense attorney should ask plaintiff about
19 life expectancy, correct?

20 A. Yes.

21 Q. Okay. And in this document, you talk
22 about the fanciful notion of the plaintiff's life
23 expectancy expert. And another common fantasy is
24 that a child is going to get such terrific care, that
25 despite the cerebral palsy, he is not at any risk of

1 early mortality.

2 And then you have some questions and
3 tactics to try if that is what's testified to,
4 correct?

5 A. I think these are standard scientific
6 questions when anyone makes an assertion or has a
7 hypothesis, yes.

8 Q. This is a playbook for defense attorneys,
9 right?

10 A. It's not a playbook. It's a set of
11 questions that could be asked by defense attorneys or
12 by plaintiff attorneys. You know, I've had to answer
13 all these questions myself without my own opinions.

14 Q. Are you aware of any jury trial where you
15 testified as a retained defense expert where the jury
16 found for the plaintiff, but the damage amount was a
17 number that reflected your life expectancy opinion?

18 A. Yes. Many times.

19 Q. Has that changed since January 31st, 2024,
20 that you recalled that information?

21 A. Maybe I misunderstand the question, but
22 there was a federal court in Missouri.

23 Q. Let me ask you the question again: Are
24 you aware of any jury trials where you testified as a
25 retained defense expert where they still found for

the plaintiff, but the damage amount was to a number that reflected your life expectancy opinion?

A. Oh, the case in Missouri was not a jury trial. It was just the judge's federal case, sorry.

Q. Okay. So -- so -- I mean, I can show you your answer to that question from January 2024.

would you like to see a copy of this deposition?

A. I don't think I need to. But in order to know for certain, I'd have to recall every trial I testified at. Right. I said nothing comes to mind, as I sit there. To be sure, I'd have to go through the list of trials.

Q. All right.

MS. SLATER: No further questions, Your Honor.

THE COURT: Anything further of this witness.

MS. PFIRMAN: Just briefly, Your Honor.

REDIRECT EXAMINATION

BY MS. PFIRMAN:

Q. Dr. Shavelle, you were asked about some underlying data related to your articles in this case.

Do you recall that question?

1 A. Yes.

2 Q. Okay. Were you ordered by this Court to
3 produce any underlying data related to the articles
4 you talked about today?

5 A. Not to my knowledge, no.

6 Q. If Ms. Slater or any of the plaintiffs'
7 attorneys retained you in this case, would your life
8 expectancy number be any different?

9 A. No.

10 Q. You were asked about this exhibit,
11 "Question on Life Expectancy for Deposition."

12 I think you said this was prepared over 20
13 years ago?

14 A. Let's see. This is 2025. It might have
15 been 20 years ago. That sounds about right.

16 Q. Okay. And you never provided this
17 document to me or any of the other defense attorneys
18 in this case, did you?

19 A. No.

20 Q. Okay.

21 MS. PFIRMAN: Those are all the questions
22 I have. Thank you.

23 MR. PERRON: Just briefly.

24 REDIRECT EXAMINATION

25 BY MR. PERRON:

1 Q. Doctor, just as a matter of principle. I
2 mentioned this already, but just to reassert it.
3 It's your understanding that Dr. Liles,
4 plaintiffs' life expectancy expert, relied on your
5 research to form his life expectancy opinion, is that
6 fair?

7 A. Yes.

8 Q. Okay. So if your statistical research is
9 unreliable, then by necessity, how reliable is Dr.
10 Liles' opinion on that same topic?

11 MS. SLATER: Objection, Your Honor.

12 Commenting on the credibility of the witnesses is
13 improper.

14 MR. PERRON: I believe this goes to the
15 foundation of the opinion, not Dr. Liles' propensity
16 to be credible or not credible himself.

17 THE COURT: I think I'm going to allow the
18 jury to determine what they believe to be a credible
19 assessment determination.

20 MR. PERRON: And I didn't use those terms
21 right, but I'll withdraw the question. Thank you.

22 MS. SLATER: Nothing further, Your Honor.

23 THE COURT: May this witness be excused?

24 MS. PFIRMAN: Yes, Your Honor.

25 THE COURT: Thank you very much. Thank

1 you very much, sir, you may be excused.

2 on behalf of the defendants?

3 MS. PFIRRMANN: Thank you, Your Honor.

4 Defense calls Dr. April Parker by way of
5 video deposition. This was taken on August 24th,
6 2023, and the total runtime is 43 minutes.

7 (Designated portions of the videotaped
8 deposition of Dr. April Parker were played for the
9 jury.)

10 MS. PFIRRMANN: That concludes the
11 deposition.

12 THE COURT: Ladies and gentlemen of the
13 jury, it's my understanding that that is all of the
14 evidence that we have today. I promise there will be
15 more later, but we are on track. What that means for
16 you is you get to go home early, they don't.

17 (At 2:55 p.m., the hour of adjournment
18 having arrived, the jury, being duly admonished by
19 the court, by agreement, is allowed to separate for
20 the evening, under the usual instructions of the
21 Court, until Monday, March 24, 2025, at 9:00 a.m.)

22 o o o

23 Monday, March 24, 2025

24 o o o

25 (At 9:07 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, everyone.

on behalf of defendant.

MS. KAMYKOWSKI: Yes, Your Honor.

on behalf of Mercy Hospitals, we call Nurse Maggie Hilt-McLeland.

THE COURT: Ma'am, if you'll step on up and be sworn.

Please raise your right hand.

MAGGIE HILT-MCLELAND, R.N., having been duly sworn, was examined, and testified as follows:

DIRECT EXAMINATION

BY MS. KAMYKOWSKI:

Q. Good morning, Maggie. Can you introduce yourself to the jury.

A. Good morning. My name is Maggie Hilt-McLeland.

Q. And I have a loud voice and oftentimes a very fast voice. I'm going to correct that today for the first time, I think.

You have a very soft voice. And I'm back here so that you can project your voice so that

1 everyone in the courtroom can hear you, okay?

2 A. Okay.

3 Q. And, Maggie, tell us -- let me ask you
4 this first: you've been here through the whole
5 trial, correct?

6 A. Yes.

7 Q. You have heard all of the evidence that's
8 been given by testimony of witnesses, review of
9 exhibits, you've been here the whole time and seen
10 everything the jury has seen, correct?

11 A. Yep.

12 Q. Can you tell us before I ask you the
13 ultimate question, what is your profession?

14 A. I am a registered nurse at Mercy Hospital
15 South.

16 Q. And what type of nursing do you practice?

17 A. Labor and delivery.

18 Q. All right. And we're going to talk a
19 little bit more about you in a minute.

20 But you've been here for the past now
21 we're in our third week of trial, and you have heard
22 the criticism that has been levied against you and
23 Nurse Jessie by --

24 MS. GUNN: May we approach, Your Honor?

25 THE COURT: You may.

1 (Proceedings were held at sidebar, outside
2 the hearing of the jury.)

3 MS. GUNN: Your Honor, I understand she's
4 going to be asked if she complied with the standard
5 of care, and that's not something that she was asked
6 in her deposition. And I understand she's been
7 sitting in the courtroom. She's not an expert
8 witness in this case. She's a party to this case
9 through her work as an employee of Mercy.

10 MS. KAMYKOWSKI: Your Honor, she was
11 disclosed as an expert to offer opinions in this
12 case. She has now listened throughout the trial, and
13 she is entitled to give her opinions in this case.

14 MS. GUNN: You asked her on page 101 of
15 the deposition, at which time, she looked back on
16 what the allegations were. She'd been preparing for
17 her deposition. She knew she was a target, so to
18 speak, as an employee of Mercy. She's been named in
19 the health care written statement. And I asked her
20 if she had any opinions, and she gave no opinions at
21 her deposition.

22 MS. KAMYKOWSKI: Well, I'm sorry. Did you
23 ask her if she had any opinions? I don't think she
24 was ever asked. She was disclosed prior to her
25 deposition as an expert in this case. The fact that

1 Ms. Gunn didn't ask her -- and there's case law --
2 and she's probably going to ask her her opinion. And
3 it's certainly not a surprise in this case. We're
4 now in to our third week of trial.

5 MS. GUNN: It certainly is a surprise
6 because now she's giving the opinion that she didn't
7 do anything wrong, when she was perfectly silent
8 about it in her deposition.

9 MS. KAMYKOWSKI knows this happens all the
10 time, because that's something that keeps things like
11 this from happening, to rule yourself. I'm going to
12 ask you a few questions. Did you think you did
13 anything wrong? No. Do you think you used the
14 standard of care? Yes.

15 And also the fact that we have now, for
16 the first time, this witness giving her important
17 medical opinions that are new to this case today.

18 THE COURT: The Court is going to overrule
19 the objection and allow you to impeach her, but she's
20 not allowed to speak with regards to whether or not
21 anybody else violated the standard of care, only
22 herself.

23 MS. KAMYKOWSKI: Thank you, Judge.

24 (Proceedings returned to open court.)

25 Q. (By Ms. Kamykowski) All right. Maggie,

1 going back to my question.

2 You were here when Nurse Shinn and Dr.
3 Warsof testified, correct?

4 A. Yes.

5 Q. And you heard them offer criticisms of the
6 care that you provided for Sarah and Remi Anyan on
7 May 4th of 2020, correct?

8 A. Yes.

9 Q. And we're going to get into the specifics
10 of those opinions.

11 But do you have an opinion, as you sit
12 here today, whether your care on May 4th of 2020, of
13 Sarah and Remi Anyan, met the standard of care?

14 A. Yes.

15 Q. And what is that opinion?

16 A. I -- I -- we met the standard of care.

17 Q. And when we talk about the standard of
18 care, I want to make sure we're on the same page.

19 Can you agree that when you speak about
20 the standard of care, you're following the legal
21 definition in Missouri, which is using that degree of
22 skill and learning ordinarily used under the same or
23 similar circumstances by members of your profession?

24 A. Yes.

25 Q. And that's the definition that you will

1 utilize when answering my questions?

2 A. Yes.

3 Q. And any opinions that you give here today,
4 Maggie, can we also agree that you hold those to a
5 reasonable degree of nursing certainty?

6 A. Yes.

7 Q. Okay. So tell us a little about yourself,
8 Maggie. You told us that you're currently -- are you
9 currently an employee of Mercy Hospital?

10 A. Yes, I am currently a labor and delivery
11 nurse at Mercy South.

12 Q. And tell us how your educational
13 background brought you to where you are today as a
14 labor and delivery nurse.

15 A. I started my associate's degree at Meramec
16 Community College originally in sonography,
17 ultrasound sonography. And then I changed my path
18 after I got my associate's degree and went to
19 Maryville and got my bachelor's in nursing.

20 Q. And when did that occur?

21 A. I graduated nursing school at Maryville in
22 December of '19.

23 Q. And prior to going to nursing school or to
24 school for ultrasound sonography, were you in a
25 different profession, or were you in the health care

1 industry?

2 A. I've been in the health care industry my
3 entire working career.

4 Q. So tell us about that. How did you start?
5 And what did you do?

6 A. Starting way back when I was a teenager, I
7 worked in a nursing home. My mom worked in a nursing
8 home, and she got me a job there.

9 And then I moved in to the hospital
10 setting and did home health care and radiology as a
11 tech assistant. And then I went to school for EMT
12 and firefighting and did that for a little bit. And
13 that was in Des Moines, Iowa. And then moved down
14 here and worked at St. Anthony's at the time in the
15 ER, and then moved up to surgical stepdown, and then
16 cardiac.

17 Q. And then after that experience, you went
18 into the formal schooling for nursing?

19 A. For sonography and then nursing, yes.

20 Q. Okay. So you graduated from Maryville
21 with a bachelor's of nursing, is that correct?

22 A. Yes.

23 Q. And are you a licensed nurse?

24 A. Yes.

25 Q. A registered nurse?

A. Yes.

Q. who gives you that license?

A. The State of Missouri.

Q. okay. so after you completed your nursing education at Maryville, what did you do?

A. I applied at Mercy St. Louis for their fellowship program in labor and delivery.

Q. And did you get offered a job?

A. Yes.

Q. And when did you start your fellowship in labor and delivery at Mercy Hospital?

A. Onboarding started in February of '20, and then actually being on the floor was March of '20.

Q. And we've heard a little bit about that time frame. The jury heard from Jessie, and we watched her testimony, correct?

A. Yes.

Q. tell us about your onboarding and then your fellowship that you worked with Jessie. Tell us -- explain that to the jury.

A. Onboarding is just your introduction to the hospital in the hospital setting and their mission and what that statement means to the hospital and how they would like you to reflect that in your patient care.

1 And then the fellowship, there was some
2 classrooms at first, and then we merged into working
3 with our preceptor, and then the classroom and
4 preceptor working on the floor intermixed throughout.

5 Q. And was Jessie your preceptor for the
6 entirety of your fellowship?

7 A. Yes.

8 Q. And how long was your fellowship?

9 A. It was 16 weeks, a little longer than 16
10 weeks, because of COVID pushed some of us into June.

11 Q. So on May 4th of 2020, how far were you in
12 to your fellowship on labor and delivery?

13 A. About 3 months.

14 Q. And at that point in time, just tell us
15 about your interactions with Jessie and the patients.
16 what were you doing on -- well, let me ask
17 you this: How -- how were you working? Were you
18 working 8 hours a day? what was your shift schedule?

19 A. 12-hour -- 12-hour shifts. Started off on
20 nights, and then Jessie moved into a day shift spot,
21 and I followed her.

22 Q. So when you followed her, you say 12-hour
23 shifts. Do you know, we talked about what was your
24 shift for this -- on this day, May 4th?

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

1 Q. And how many of those shifts did you work
2 a week?

3 A. Three.

4 Q. And did that consider you to be a
5 full-time nurse employee?

6 A. Yes.

7 Q. Okay. So you were on May 4th, how far
8 into your fellowship?

9 A. Oh, about -- about 3 months.

10 Q. And so 3 months in, what -- let me see.
11 well, let me ask you today, 5 years later --

12 A. Okay.

13 Q. -- can you estimate for us how many babies
14 you've helped come into this world?

15 A. Between 4- and 500.

16 Q. And as far as your fellowship, did you
17 have training, whether it was through Jessie

18 on-the-job or classroom, on fetal heart monitor
19 interpretation?

20 A. Yes.

21 Q. Tell us about that.

22 A. So a majority of it was on the job with
23 Jessie. I'm not sure -- I don't believe that in
24 classroom during fellowship we solely focused on it,
25 but I think part of fetal heart tones was

1 incorporated in some of the education.

2 Q. And prior to starting your fellowship or
3 your first job as a nurse in labor and delivery, had
4 you had any training in your nursing school on labor
5 and delivery?

6 A. Yes. During our maternal pediatric
7 semester with OBs as part of the education, we
8 covered briefly fetal monitoring.

9 Q. So is it fair to say, Maggie, that during
10 your fellowship with Jessie, you were the boots on
11 the ground on-the-job training in labor and delivery?

12 A. Yes.

13 Q. By the time May 4th rolls around, and you
14 and Jessie were assigned to care for Sarah and Remi
15 Anyan, tell us how independently you were able to
16 work at that time.

17 A. I would typically enter the room on my
18 own, introduce myself, go through my assessments.
19 Maybe discuss plan of care, see how the patient is
20 doing and stuff. And then after I did vitals, and
21 the patient was settled, I would step out and share
22 my information with Jessie.

23 More than likely she got reports also from
24 the nurse that gave me reports. But I would just go
25 and share more information with Jessie.

1 Q. And you heard Jessie's testimony, and you
2 heard Dr. McNeive's testimony in this case, correct?

3 A. Yes.

4 Q. With respect to kind of how things went on
5 May 4th, first, do you remember your shift that day?

6 A. Yes.

7 Q. Why do you have a memory of this case?

8 A. Well, because it was a long time pushing
9 with her. It was a prolonged second degree, and that
10 stood out to me.

11 Q. And anything else about that day that,

12 from what you heard from Dr. McNeive and

13 Dr. Jessie -- or sorry -- Nurse Jessie, that you
14 would have to add besides what they kind of explained
15 to the jury as to what was going on throughout that
16 day?

17 A. Just -- I'm not sure if I have more to add
18 to what everyone has shared. It was just a long day,
19 but it was a productive day. Things kept moving,
20 although slowly, sometimes it would pick up and then
21 slow down. But it was a steady progression through
22 the day with her.

23 Q. Okay. So can you just walk us through
24 when you first come on shift. We've heard from Alex
25 Greenwald that she -- and from Jessie -- that she

1 gave reports to both of them.

2 Do you have an independent recall, as you
3 sit here today, of the specifics of that report?

4 A. Not completely. I know that we talked
5 about when she -- approximately how long she had been
6 complete and pushing, and just some of the efforts
7 that Alex had been using to keep it moving along.

8 Q. Would you -- do you recall if you had been
9 aware that Dr. Mckillip had been called and Dr.
10 Parker had been consulted with respect to a pushing
11 evaluation prior to your shift?

12 A. Not at that moment. I'm sure she shared,
13 but later on, after looking through the charts and
14 stuff.

15 Q. Okay.

16 A. And talking to Jessie, yes.

17 Q. And what about Remi's position when you
18 came on shift?

19 Were you aware that Dr. Mckillip had found
20 him to be in the OP presentation?

21 A. Not -- I don't recall at that moment, but
22 it didn't take long to figure that out.

23 Q. And when you came in, do you have a
24 recall, or can you picture in your mind, how, like,
25 Sarah was doing?

1 A. She was -- she was going good. She was a
2 powerhouse. She had a lot of energy, a lot of
3 positive energy especially, which just helped
4 motivate keeping things going.

5 Q. Okay. Before you talk a little bit more
6 specific about May 4th, you know, I had Dr. McNeive
7 explain to me kind of the labor and delivery layout.

8 Can you tell us -- do you remember the
9 room that Sarah, Remi, and Blake were in?

10 A. Yes.

11 Q. Can you tell us just generally the layout
12 and how that was your work space for the day.

13 A. So the labor and delivery suites at Mercy
14 St. Louis, they're good sized.

15 But when you walk in the room, the bed is
16 at the far end of the room, up against the wall. And
17 then next to that to my right, if I'm standing at the
18 foot of the bed, is the admission cart. And on top
19 of that is the fetal heart monitor where the paper
20 prints out, and there's a screen where you can see
21 the numbers of the contraction number and the heart
22 rate number.

23 And then next to that, is a desk with a
24 computer where we can chart and open up Epic. And
25 there's a screen above that that has all of the heart

1 tracings for all the patients that are on that team.
2 So each team holds six patients. And I
3 don't remember how many patients were on that team
4 that day. So if there was four other patients, there
5 would be Mrs. Anyan's tracing and then those other
6 patients' tracing.

7 And then kind of to the back to me on the
8 right there is a closet that has supplies and linens,
9 and then next to that is the baby warmer.

10 Q. And the monitors that are in the room,
11 let's talk first about the actual monitor itself, the
12 electronic fetal monitor that has the plugs that go
13 from it to Sarah's belly.

14 Does it have sound?

15 A. Yes.

16 Q. Tell us about that.

17 A. So we can adjust the sound. Usually we
18 keep it down for the mom just for stimulation
19 purposes for rest. But we're in the room, and we're
20 doing position changes, you turn it up because you're
21 not always facing the monitors, so you want to be
22 able to audibly hear the heart tones. Because you
23 can hear decels. You don't always have to see it,
24 you can audibly hear it. And sometimes you hear the
25 change from the fetal heart tones going to mom's

1 heart tones.

2 Q. And when you say you can audibly hear a
3 decel, what does that mean?

4 A. So the baby could be like (indicating),
5 and then you hear (indicating).

6 Q. And that's something that you hear -- you
7 hear that on every shift every time you're taking
8 care of a laboring mom?

9 A. It is very often.

10 Q. Okay.

11 A. Yes.

12 Q. And then the monitor that is there that
13 you said was above the workstation where you can work
14 in Epic, how big is that monitor?

15 A. It's -- it would take up this space. It's
16 a pretty decent-sized monitor.

17 Q. Not as big as this one on the wall?

18 A. No.

19 Q. Okay. But bigger than the one in front of
20 you?

21 A. It's bigger than this screen, yes.

22 Q. Can you isolate a particular patient, or
23 do you have to look at every patient's strip?

24 A. No. I can isolate. And usually I isolate
25 the strips when we're doing an epidural and when

1 we're pushing.

2 Q. And what would be the purpose, in your
3 experience of having other patients' tracings on and
4 available for you, to look at in the room?

5 A. Sometimes we have more than one patient.
6 You want to be able to visually see those other
7 patients, especially your patient, to make sure that
8 everything is going well with them. So if there's
9 any changes, you finish up early right away what
10 you're doing and then move on to that next room.

11 Q. And as far as your care of Sarah and Remi
12 on May 4th, would all of those things have been
13 available to you: the fetal heart monitoring
14 tracings, the machine itself with the sound, and the
15 monitor up above?

16 A. Yes.

17 Q. And are you always able to see them?

18 A. Yes.

19 Q. Okay.

20 A. Unless I have my back to them, yes.

21 Q. And if you have your back to them, how are
22 you monitoring the baby?

23 A. Audibly hearing.

24 Q. So you came on shift about 7:00 a.m.

25 Do you remember what your first course of

1 action was with respect to -- I assume someone had to
2 tell you that Sarah was your patient?

3 A. Yes.

4 Q. How does that work?

5 A. So we do a huddle before we go to where
6 we're assigned. That's where we find out where we're
7 assigned. So we generally do a prayer, and then we
8 go over some updated information and education. And
9 then the charge nurse will read off the pink sheet --
10 it's a very large sheet -- of all the teams and areas
11 that we work in.

12 And they read your name off. So that day
13 they would say: on team 1, Maggie and Jessie. And
14 when huddle is done, then we just go to team 1, and
15 that's where we find out what our assignment is, who
16 we get assigned to.

17 Q. And how -- after you get assigned to team
18 1 for the day, how then are you further assigned a
19 patient or patients?

20 A. Usually night shift or the shift before us
21 would select. And if it isn't selected, we would,
22 you know, offer or volunteer to take certain
23 patients.

24 Q. And so when you came on shift on May 4th,
25 and it ultimately ended up that you were assigned as

1 the labor and delivery nurse with Jessie for Sarah,
2 you understood at that point you were going to start
3 your day with one patient, is that right?

4 A. Yes.

5 Q. And why is that?

6 A. Because she was pushing, and patients who
7 are in the pushing phase of labor, they are 1:1.

8 Q. So at that point, I think you told us you
9 would have walked in and introduced yourself to them?

10 A. Yes.

11 Q. And how do you do that?

12 A. So I would typically walk in and I'm like,
13 good morning. My name is Maggie. I'm going to be
14 your nurse today. I would write my name up on the
15 board. Generally I'd ask them how they're doing.
16 And she was pushing. And Alex was currently pushing
17 when I walked into the room.

18 And then we paused, and we did a hand off
19 at the foot of the bed. So usually that involves not
20 only the nurses but the patient and the spouse.

21 Q. Okay. And you've already told us what
22 that hand off likely entailed, correct?

23 A. Yes.

24 Q. And then after that, what happened? Did
25 Alex leave the room?

1 A. Yes.

2 Q. And what did you do when you stayed?

3 A. I continued pushing.

4 Q. Okay. So let's move forward. That was --

5 I know Alex's note was around 7:17 in the morning.

6 A. Yes.

7 Q. We know from being here for a couple of

8 weeks, that Dr. McNeive was at the bedside when he

9 charted that note, correct?

10 A. Yes.

11 Q. At 8:00 a.m.

12 A. Yes.

13 Q. Do you have a recall of Dr. McNeive coming

14 in to see and assess Sarah at 8:00 a.m?

15 A. Yes.

16 Q. Tell us what you remember.

17 A. So I don't remember specifics on what was

18 said in general. But always the conversation starts

19 off with, how are you doing? How are you feeling?

20 How are things going for you? Stuff like that.

21 That's just a given that that's how the conversations

22 usually start, either with the doctor and/or the

23 nurse.

24 Q. Prior to May 4th of 2020, do you have a

25 recall of working with patients that were -- Dr.

1 McNeive was the assigned obstetrician for?

2 A. Yes.

3 Q. How many times?

4 A. Oh, at least a handful of times. It was
5 very sporadic. I could work with Dr. McNeive, not
6 always necessarily delivering, but taking care of a
7 patient of his that is laboring, and having
8 communication with him, and him coming to bedside, I
9 would say at least greater than 5 -- to 5 or greater.

10 Q. And let's talk about that kind of
11 communication with obstetricians during the second
12 stage of labor, and if you remember specifically, let
13 us know.

14 But just in general, are you having
15 communications via medical records with doctors when
16 a patient is pushing?

17 A. Sometimes if they're in-house, like Dr.
18 McNeive was that day, we could do a private chat. We
19 could call their phone if we needed to speak to them.

20 Q. And what about in-person conversations?

21 A. Definitely in-person conversations. He
22 was very good at stopping -- when he was a house
23 doctor, he was very good at doing his rounds several
24 times a day and stopping in and checking in.

25 Q. And we've heard that it sounds like he

1 popped in and out of Sarah's room multiple times
2 throughout the day before Remi delivered.

3 Do you have a recall of that?

4 A. Yes.

5 Q. Can you give us an estimate as to how many
6 times you believe he popped in and out?

7 A. Oh, several. It's -- I wish I could give
8 an exact number. It was like 5, six, or more.

9 Q. And when he would pop in to check, what
10 would he do?

11 A. He would ask her how she's doing, checking
12 in how she's feeling about things. Usually would do
13 a vaginal exam to see where Remi is and how well her
14 pushing is and see how well he moves.

15 Q. Would he, in your recollection, would he
16 review the monitoring strips when you were talking?

17 A. Yes.

18 Q. And, you know, just to kind of cut to the
19 chase on one of these points. We know that you
20 didn't make any notes of Sarah's station or Remi's
21 progress after you came on shift at 7:00 a.m.

22 Is that uncommon for you when the patient
23 is in the second stage and pushing?

24 A. Not at all. Usually I'm more occupied
25 being at bedside with mom and dad. If I'm not

1 holding a leg in between pushing, we're resting. And
2 I am sitting there sometimes massaging their feet or
3 trying to get cramps out. That happens quite a bit.
4 And just encouraging them to relax and breathe and
5 taking that break. And just overall having a
6 conversation with them to just kind of just help keep
7 everything nice and positive.

8 Q. And from your recall of being involved in
9 this labor and delivery on May 4th, throughout the
10 day, were you visualizing and documenting, at least
11 in your head, that there was progress being made with
12 Sarah's pushing efforts?

13 A. Yes. And that was also shared through
14 communication when Dr. McNeive would come in. I
15 would share what I was experiencing, what I was
16 seeing, what I was feeling.

17 Q. And to hit another big point that we've
18 talked about in this case. At any point in time, do
19 you recall discussion that Dr. McNeive had that you
20 were present for with Sarah and Blake about a
21 C-section?

22 A. That word wasn't used, but before the two
23 o'clock hour --

24 MS. GUNN: Your Honor, may we approach?

25 THE COURT: You may.

1 (Proceedings were held at sidebar, outside
2 the hearing of the jury.)

3 MS. GUNN: Your Honor, this was -- I asked
4 her in her deposition if she had any recollection of
5 any conversations between -- on page 64. She has no
6 recollection of any conversations between Sarah and
7 Maggie. No recollection of any conversations between
8 Blake and Maggie. No recollection of any
9 conversations between she and McNeive. She is
10 basically -- these are new -- I don't know if they're
11 opinions or what. Maybe I could just do it on cross,
12 but --

13 THE COURT: I don't know what the
14 question -- what she was going to answer. I'm
15 assuming that at two o'clock, something changed.

16 MS. KAMYKOWSKI: what she was asking about
17 in her deposition is -- if you keep going before
18 those questions -- she was asking the plan of care
19 prior to 8:00 a.m., and she started talking about Dr.
20 McNeive coming into the room, continuing the plan of
21 care, continuing to push, continuing the pushing
22 changes.

23 And this doesn't -- the question is --
24 this note says, continued plan of care. It doesn't
25 say, we're going to have her labor down because he

1 was going to do a C-section. As far as him speaking
2 directly to me, no. And I'm sorry. Hold on. Dr.
3 McNeive really spoke to Jessie. Then he went into
4 C-section, take at a break.

5 So there were conversations that related
6 to this patient from Jessie that have already been
7 put into this case. And she further says she asked
8 her at one point in time -- she says that the word
9 "C-section" was never used.

10 But they came in, are you okay? How are
11 we doing? She's already said today she's not going
12 to say that he offered a C-section. I'm going to ask
13 her if she ever heard the Anyans refused a C-section.
14 She's going to say no. That's it.

15 MS. GUNN: She indicated she does not
16 recall any discussions about a C-section. No
17 discussions about a C-section, whatsoever.

18 THE COURT: That's what she testified
19 before she got into this portion of the question.
20 And I'm honestly not sure what her answer was going
21 to be. And I wish I knew how to rule on this one,
22 but I honestly don't think I do.

23 MS. GUNN: I understand.

24 MS. KAMYKOWSKI: She's not going to get in
25 to her opinion. She's going to stick with what she

1 said.

2 (Proceedings returned to open court.)

3 Q. (By Ms. Kamykowski) Just to clear it up,
4 you never heard Dr. McNeive recommend a C-section to
5 the Anyans, correct?

6 A. That is correct. There was no need for it
7 to be recommended.

8 Q. And you never heard Sarah and Blake refuse
9 a C-section, correct?

10 A. No.

11 Q. Okay. We've talked about the safety
12 rounds and the strips round. You've heard all of the
13 testimony thus far in this case about what happened
14 at 10:45 with the safety rounds.

15 Have you participated in that safety
16 round in your experience as a labor and delivery
17 nurse at Mercy?

18 A. Yes.

19 Q. Tell us what typically happens.

20 A. So typically, as Dr. McNeive had
21 explained, all these people show up: MFM, charge
22 nurse, residents, anesthesia, and at that time
23 midwives would show up, and they would discuss each
24 patient individually.

25 The -- the third-year and fourth-year

1 resident would pull up the patient's chart and the
2 monitors, and we would have a conversation about why
3 they're here. How are things going? what is the
4 current plan of care? what is the potential future
5 plan of care?

6 They would be reviewing the strips and
7 discussing them, if they had any concerns. And they,
8 whoever was reviewing the strips, would share their
9 opinion of them, and people -- the other staff would
10 agree. And if there was any disagreement, that would
11 be when the nurse or anyone would speak up and raise
12 concerns.

13 Q. And as far you recall, did you physically
14 participate in the safety rounds at 10:45?

15 A. I don't believe I did. I believe I stayed
16 in the room to push.

17 Q. Okay. And then the strip rounds, what --
18 we've heard the difference: no bedside nurse and no
19 Dr. McNeive or OB hospitalist participate in those,
20 correct?

21 A. No. It's typically the charge nurse, the
22 resident, and the midwife.

23 Q. Okay. And have you ever worked in either
24 the midwife or the charge nurse roles and participate
25 in those?

1 A. No.

2 Q. Have you ever been advised by your charge
3 nurse of a potential for a change in plan after those
4 strip rounds happen?

5 A. Absolutely. They will -- after review,
6 they will call and say that, we just reviewed, and we
7 want you to try this. Or we're noticing that. Can
8 you explain what's going on? And it's something like
9 that. But they definitely will call and talk to you
10 if they have concerns.

11 Q. And both times in this case, at the 10:45
12 safety rounds, and the 2:48 strip review, those
13 providers were outside of the room evaluating at
14 least portions of the strips talking about this case.

15 what was their conclusion?

16 A. To continue with the plan of care.

17 Q. And at both of those times, did you agree
18 with that?

19 A. Yes.

20 Q. Turning now to the second stage. We've
21 talked a lot in this case. I think you said from the
22 very beginning, was this a prolonged second stage of
23 labor?

24 A. Yes.

25 Q. Tell us what your experience is with

1 prolonged second stage, in your 5 years as a labor
2 and delivery nurse?

3 A. I've had a couple -- I've had a handful of
4 prolonged second stage. This is the longest. Second
5 to that, I've had two, 10-hour second stages with --
6 it was between 6 and 7 -- 6, 7 hours of pushing.

7 Q. And with respect to your knowledge as a
8 labor and delivery nurse, is there a cutoff that
9 you're aware of in the second stage?

10 A. Not at all.

11 Q. Is there a maximum time that you have to
12 say, a patient's been pushing this long, now I have
13 to do something else?

14 A. Not -- not at all. As long as progress is
15 being made, then there is no reason not to keep
16 going.

17 Q. And you already told us in this case you
18 recall progress being made?

19 A. Yes.

20 Q. Tell us how you can sit here today and say
21 that this woman that started her -- was completed
22 around 4:00 in the morning, started pushing, I think
23 you documented, 4:28 in the morning. Sometime around
24 that. That you can tell this jury, yeah, it took a
25 long time, but there was progress.

1 what does that mean to you?

2 A. So it's a very -- there's points at the
3 very beginning of pushing, and that can even be a few
4 hours into it, you would digitally use your fingers
5 to -- to check the station of the baby and see how
6 well the baby moves.

7 when I do that, I usually put my finger
8 under the head and feel how well the head rocks over
9 my fingers. That kind of gives me a good idea how
10 well she's pushing, and I can feel the vaginal
11 muscles when she does that.

12 And then it gets to the point where I
13 don't have to use my fingers, I can visually see.

14 Like Dr. McNeive had explained, the perineum will
15 start to bulge as the head moves down, the labias
16 will start to open up, and you'll see that head more
17 and more as she pushes. So you don't -- it gets to a
18 point that you do not have to digitally examine. You
19 can visually see it all.

20 Q. And were both of those present during your
21 time, as Sarah's labor and delivery nurse on May 4th,
22 that you would digitally examine her and also
23 visually document progress as you watched?

24 A. Yes.

25 Q. Okay. And that was -- how is this -- is

1 it slow progress? How do you describe what happened
 2 in this case different from, you know, other cases
 3 that don't have a prolonged second stage?

4 A. It was -- it was a slow process. And
 5 usually when the baby is not in the most favorable
 6 position, like Remi was, it takes even longer and
 7 more of mom's effort and pushing and position
 8 changes.

9 Q. All right. We're going to talk about your
 10 position changes here.

11 Dr. McNeive was aware of the length of the
 12 second stage, to your knowledge?

13 A. Yes.

14 Q. And as you said before, he was also
 15 evaluating whether she was progressing when he would
 16 pop in and evaluate her?

17 A. Yes.

18 Q. As a nurse, Maggie, are you able to
 19 diagnose an arrest of descent?

20 A. No.

21 Q. Why not?

22 A. That is -- a physician or a resident has
 23 to make that call. I can call and ask them to come
 24 and assess, but that is ultimately on them to make
 25 that decision.

1 Q. Did you call a resident just to come and
2 assess this in this case?

3 A. No. I didn't need to because I
4 continuously saw progression.

5 Q. And were you also in communication, at
6 least when he was in the room, with Dr. McNeive?

7 A. Yes. And also with Jessie.

8 Q. There's been a lot of talk about
9 variability of fetal heart rate in this case. And
10 we're going to go through the strips pretty quickly
11 here in a little bit.

12 But what, as a nurse, if you have a
13 patient whose fetal heart rate is showing moderate
14 variability, what does that tell you about the baby's
15 condition?

16 A. They are handling the situation very well,
17 they're getting good oxygen, and they're happy.

18 Q. And what about that fetal heart rate
19 acceleration? What does that tell you as a nurse
20 when -- if those exist?

21 A. That's a positive, a very positive sign,
22 on the fetal heart rate monitor when you see that
23 nice going up and down, good oxygenation, good
24 perfusion.

25 Q. Okay. So, Maggie, I want to turn to kind

1 of showing the jury your day, all right?

2 And to do that, did you and I work
3 together to come up with a demonstrative, it's a
4 video player of the fetal heart rate tracing in this
5 case?

6 A. Yes.

7 Q. And did you help me make sure that we put
8 on there not only the fetal heart rate and the
9 uterine contraction pattern, but we made some notes
10 that track the records of you and Jessie documenting
11 in the flow sheets?

12 A. Yes.

13 Q. And so before we show that player, I left
14 up there for you before we started, what we have
15 marked as Defense Exhibit F10-B.

16 Do you recognize that exhibit?

17 A. Yes.

18 Q. Can you tell us what it is.

19 A. It is the Epic record that I would chart
20 in for that day.

21 Q. And we're going to show a couple of pages
22 of that.

23 But for the record, this is F10-P. It's a
24 compilation of 19 pages of -- do you call those flow
25 sheets?

1 A. Yes.

2 Q. That start at -- on May 4th, at 6:45 in
3 the morning, which is also referenced as Exhibit A2,
4 page 212. And they go, not every single page, but
5 through delivery, right?

6 A. Yes.

7 Q. And the time after delivery, that some of
8 the pages ended at Exhibit 2, page 324.

9 So I don't think the jury has seen kind of
10 how you document or what Epic had you document. I
11 want you to walk through one of the assessments
12 before we show this list, okay?

13 Is that okay?

14 A. Yes.

15 Q. Can you look at page 15 of that exhibit.
16 we'll use this as an example.

17 MS. KAMYKOWSKI: And, Justin, if you could
18 pull up for me Exhibit A2, page 230.

19 Q. (By Ms. Kamykowski) So what are we
20 looking at here, Maggie?

21 A. I'm sorry?

22 Q. On your document, you're going to look at
23 page 15. I handwrote pages at the bottom.

24 A. Oh, I see.

25 Q. And I think it might also -- is it showing

1 up in front of you, as well, Maggie?

2 A. Yes.

3 Q. Okay. So at the bottom here, when we have
4 the row names, it shows entries at 7:30, 7:45, eight
5 o'clock, 8:15, and 8:30.

6 Under FHRA, can you tell us what each of
7 these rows, what are you documenting here, Maggie?

8 A. An FHRA is a fetal heart rate. So it's
9 the baseline of the fetal heart rate, is what I'm
10 charting there. And then the mode of the monitoring
11 is external. And then variability, what the baseline
12 looks like, which is moderate. And then the pattern
13 of that fetal heart rate, if there is any
14 decelerations, if there's variables, if there's any
15 earlier, anything, it includes all of that that I
16 would put there, as I did late decelerations.

17 And then the category. And then what is
18 being done. Like fetal monitoring, you can audibly
19 hear. You can hear movements. It's kind of cool
20 when you hear movement on the monitors on the baby.

21 Q. So on that last one it says: Present or
22 minimize Category II, indeterminate/Category III,
23 abnormal -- and then it goes to the next page. Fetal
24 heart rate tracing duration of decelerations, and
25 then the last one is fetal movement.

1 A. Uh-huh.

2 Q. Okay. Just really quickly, the fetal
3 heart rate baseline, so if you just use 7:30 as an
4 example, are you manually typing in 140, or does that
5 automatically get typed in the machine? How does
6 that work?

7 A. I manually put that in.

8 Q. And so that's based on your visual
9 assessment --

10 A. Yes.

11 Q. -- at the time?

12 A. Yes.

13 Q. So when you're charting in a flow sheet,
14 and if look -- your initials are that teeny tiny
15 initials after each of those?

16 A. Yes.

17 Q. And then it says, you know, 10:23. Is
18 what when you actually had time to put this in the
19 computer?

20 A. Yes.

21 Q. But you are charting for 7:30 a.m?

22 A. Yes.

23 Q. How do we know you're accurate?

24 A. So I am able to pull up the monitors, and
25 I'm able to scroll back and look at the previous

1 times. So I would scroll back to 7:00, and I would
2 look for 7:00 to 7:30, but in the case of second
3 stage pushing, it's every 15. So I would look from
4 7:00 to 7:15. And I would chart at 7:15 for that
5 previous 15 minutes. And then just keep working
6 forward to the current time that I'm working on it.

7 Q. And has that been your practice for
8 charting your assessments or fetal heart rate and
9 uterine contraction patterns since you began your
10 fellowship?

11 A. Absolutely.

12 Q. And do you continue that today?

13 A. Absolutely.

14 Q. And in the second stage, is there a
15 specific time line or period that you know you're
16 going to get to chart?

17 A. Sometimes I have had to stay an hour or
18 two after work to get it all caught up and done.

19 Q. But as far as -- and as far as the
20 objective information on the monitors, you have
21 that -- do you have that, just in your mind's eye,
22 the different things you were doing at the time, if
23 anything, with the mother or the baby to address
24 anything on the strips?

25 A. Yes. Usually it's -- a lot of it's from

1 memory. Sometimes on the monitors the paper prints,
2 and you can make a little mark on it real quick. And
3 some nurses will do a little initial like fetal
4 movement or maternal positions, and change and stuff
5 like that.

6 And you can take that paper off the
7 monitor, and you can take it to your desk, and you
8 can spread it out and go through it, along with
9 pulling it up on your screen and being able to scroll
10 back and forth.

11 Q. And the paper that comes out of the
12 machine, do you know what happens to it after a mom
13 delivers?

14 A. After a mom -- at that time, we -- we put
15 a -- I can't remember what the paper was, but we
16 would put a piece of paper with it. We would put our
17 sticker on it, put a rubber band on it, and we'd put
18 it in the box, and it went to medical records.

19 Q. And do you know what happens to it after
20 that?

21 A. I think after a period of time, it's
22 shredded.

23 Q. Okay. Let's continue now. So we've gone
24 through the flow sheet exemplar of fetal heart rate.

25 Then we get to the next assessment, the

1 uterine activity assessment. And, again, stay in the
2 same time row. So if we start at the 7:30 time
3 frame, what are you charting for a uterine activity
4 assessment?

5 A. Moderate.

6 Q. Let's start with this one. It says
7 "method," and you write "TOCO."
8 what does that mean?

9 A. Oh. TOCO, so it's the external monitor.
10 Anybody who's had a kid, you wear those uncomfortable
11 bands. And there's one that's here, and there's one
12 that sits low. The one that sits high on the
13 stomach, that's the TOCO. That's the one that's --
14 that picks up the contractions. It's meant to sit
15 higher on your stomach because it's meant to sit at
16 the top of the fundus. And that's where it picks up
17 the contractions.

18 Q. And then the next part of the flow sheet
19 says "contraction intensity by palpation."

20 Explain that to us and what the options
21 are for you.

22 A. So you have moderate, mild, and -- I can't
23 remember the other one, quite honestly.

24 Q. When it says "by palpation," what does
25 that mean?

A. By feeling.

Q. Where?

A. The top of the stomach.

Q. So you're putting your hands on Sarah's abdomen.

A. Uh-huh.

Q. And based on your assessment, was your experience as a nurse figuring out how you can feel the contraction intensity?

A. Yes.

Q. And then how about contraction frequency? How are you able to calculate that?

A. So it's a regular, you have regular and irregular or no contractions. And if they're in a nice pattern, one to two, two to three, and it's nice and regular, then we would pick regular, which I picked here.

If it's irregular, they might have some that are together every 2 or 3 minutes. And then they might space out for 10 minutes. And then another random one, and they pick a pattern. So there's not a good pattern to it. Nice and steady. Nice and steady. It's sometimes all over the place.

Q. Is the hope that when a patient is in the second stage of labor, that the contraction pattern

1 is regular?

2 A. Yes.

3 Q. Okay. And then what about contraction
4 frequency and duration?

5 what are you charting there?

6 A. How often I'm seeing contractions on the
7 monitor.

8 Q. Okay. And then uterine resting tone.
9 Tell us about that. And what does "soft by
10 palpation" mean?

11 A. In between the contractions you feel the
12 abdomen, and then if it's nice and soft, then the
13 fundus is relaxed.

14 Q. And in this flow sheet, is this -- when we
15 go back up to either side, this uterine activity
16 assessment or this fetal heart rate assessment, is
17 there a place there that asks you, built into this
18 Epic system, about fetal station or progress?

19 A. Not there. That's when we do vaginal
20 exams. That's when we would mark the station.

21 Q. And you already told us why you don't
22 necessarily document station in the second stage,
23 correct?

24 A. Correct.

25 Q. Okay. So without having to belabor

1 Exhibit F10-P, is the information that is here from
2 7:00 a.m. on May 4th, through delivery, information
3 that you assisted me in putting together with the
4 strip player so we could show the jury?

5 A. Yes.

6 Q. would it be helpful for us to go through
7 that now?

8 A. I think so.

9 Q. okay.

10 MS. KAMYKOWSKI: Justin, can we pull up
11 Exhibit P2?

12 Before everybody has a heart attack, I'm
13 going to have us start, just play it, Justin, just
14 push play.

15 Q. (By Ms. Kamykowski) And you won't be able
16 to tell it, but this is supposed to be in realtime.

17 And as you see, I think we're at 6:35 -- 6:55.

18 MS. KAMYKOWSKI: Let it play for a second.

19 Q. (By Ms. Kamykowski) But is that how the
20 paper is coming out of that monitor in the room?

21 A. It's pretty slow.

22 Q. okay.

23 A. Uh-huh.

24 Q. But we're not going to sit here for
25 10 hours because nobody wants to do that.

1 so I'm going to ask Justin to play it to
2 start with at 16 times speed. I'm going to try to
3 maybe even speed it up to 32 times speed.

4 But the top there, the yellow boxes, is
5 that the information from the flow sheet that you and
6 I put together?

7 A. Yes.

8 Q. okay. So at seven o'clock, why don't you
9 tell us just what was going on.

10 A. So it looks like Alex charted fetal heart
11 rate: 135, moderate variability, accelerations.
12 Semi-Fowler's is a position on how the mom is laying
13 flat or upright, repositioning, pushing with
14 contractions.

15 Q. And is that consistent with what you saw
16 prior to that seven o'clock time frame on the strips?

17 A. Yes.

18 Q. okay. what are we seeing as to playing
19 through here? what are we seeing both on the strip
20 when we look at comparing the fetal heart rate
21 pattern and the contraction?

22 A. I'm seeing great moderate variability in
23 between the decels. It doesn't look like she has
24 decels with every push.

25 Q. All right. And what's the next box that

1 pops up from our flow sheet?

2 A. Report given to RN Maggie and RN Jessie.

3 Q. Okay. And the next one, is that your
4 first assessment in the flow sheet?

5 A. Yes.

6 Q. What did you find?

7 A. So I did her vitals. Temperature: 98.5.

8 Q. Go ahead.

9 A. Respirations: 20 on room air. I
10 documented that: Patient is in active labor. And
11 she is currently pushing at that time.

12 Q. And explain that to us. You have a
13 pointer there next to you that might help.

14 How can you tell from this position
15 pushing?

16 A. Oh, sorry. So those little finger-looking
17 things on the contractions, that indicates that she's
18 pushing.

19 Q. All right.

20 MS. KAMYKOWSKI: Let's go forward, Justin,
21 if you can do it, 32, please?

22 Q. (By Ms. Kamykowski) So, again, here will
23 you just keep commenting on whether you -- what type
24 of variability you see, deceleration, acceleration,
25 all those things?

1 A. Moderate variability throughout. It's
2 hard to say whether these are variabilities or decels
3 because they're not connected.

4 And during these pushes at 7:31, 7:32, and
5 on, there is no decels or variables with those
6 pushes. Some disconnection at about 7:37.

7 Q. And do we see at the very top it says, in
8 the gray box, 5/4, and it's a running time line.

9 Do you see that, Maggie?

10 A. Yes.

11 Q. So what is your assessment now here at
12 7:45?

13 A. So moderate variability, fetal well-being
14 being monitored and maternal position changes.

15 Q. And so what would be the reason for those
16 maternal position changes that you're documenting
17 having happened before 7:45?

18 A. Those play two roles, especially in --
19 decels with variables with pushing is very common.
20 More times than not, you're going to see that.

21 But two reasons for position changes is to
22 help to facilitate the baby to rotate and also for
23 perfusion to help that uterus perfuse well, and to
24 help minimize, or even if you can, during pushing,
25 eliminate those labor variables.

1 Q. And when -- it says now made it close to
2 the eight o'clock time frame, so that last 60
3 minutes, what did you do in that 60 minutes?

4 Can you read that for us?

5 A. Moderate variability, late decelerations,
6 fetal well-being monitored. Dr. McNeive at bedside
7 discussing plan of care.

8 Q. okay.

9 MS. KAMYKOWSKI: And let's keep going,
10 Justin, at 32, please.

11 Q. (By Ms. Kamykowski) So we know now Dr.
12 McNeive is here. There have been some decelerations.
13 what happens in that -- we talked about 7:30, it's
14 now eight o'clock -- what happens to the heart rate
15 after that?

16 A. So moderate variability. It stays, and it
17 looks like Remi's heart rate was at that 150 with
18 some accels right there at about the 8:13 mark. It
19 looks like possibly a prolonged accel.

20 And during this time, it looks like she
21 was still pushing, and Dr. McNeive would evaluate it
22 at that time, her pushing.

23 Q. All right. And 8:15, you have a fetal
24 heart rate of 155, and this time you're not
25 documenting late decelerations.

1 Is that accurate?

2 A. That's accurate, yes.

3 Q. were there decelerations at all?

4 A. Yes.

5 Q. All right, after 8:15, what started to
6 happen?

7 A. So some decels still broken up. Some of
8 them noncontiguous, but you can't tell for sure. But
9 pushing has continued, moderate variability in
10 between.

11 So Remi recovers after each decel very
12 nicely and quickly. He goes right into a nice, good
13 moderate variability with some accelerations. So it
14 indicates he's perfusing well, good oxygen, good
15 circulation.

16 MS. KAMYKOWSKI: Can you pause that for a
17 second?

18 Q. (By Ms. Kamykowski) Let's just explore
19 that for a second.

20 what did you mean that after his
21 decelerations, he recovers well? what is that -- why
22 is that important for you in the second stage when
23 you're seeing a baby who has heart rate decelerations
24 like we're seeing here?

25 A. So sometimes the decelerations kind of

1 diminishes it, the delivery of oxygen and perfusion.

2 And when it's over, and he's recovering, he recovers
3 really fast. It's a good, positive sign to see.

4 And then his baseline in between the
5 variabilities and the decels is good variability,
6 moderate variability. So that oxygenation perfusion
7 is nice and strong.

8 Q. What we've seen so far, leading us to
9 right now, we pause in the middle at 8:37 in the

10 morning. In the second stage, when a mother is
11 pushing, and we have late and variable decelerations,
12 is that uncommon?

13 A. No, it's not uncommon.

14 Q. What do you see in the strip? How would
15 you describe this strip in comparison to other second
16 stage pushing laboring moms that you've evaluated and
17 cared for?

18 A. This is very typical. There's more times
19 than not, you're going to see something like this and
20 not seeing variables and decels with second stage
21 pushing.

22 Q. All right.

23 MS. KAMYKOWSKI: Justin, let's keep going
24 at 32...

25 Q. (By Ms. Kamykowski) Okay. Maggie, now

1 we're getting into the 8:45 time frame.

2 And what are you documenting as far as
3 you're assessing evaluation with surveillance?

4 A. Fetal heart rate, 145, moderate
5 variability, late decelerations, fetal well-being
6 being monitored.

7 Q. As far as the fetal well-being being
8 monitored, late decelerations, are those click-downs,
9 like things you can click on, or are you typing
10 those?

11 A. They're all click-down optional.

12 Q. The flow sheet offers you various ways to
13 chart what's going on?

14 A. Yes.

15 Q. Okay. All right. Let's keep going. Now
16 we're getting to the nine o'clock time frame.

17 what are we seeing here?

18 A. So it looks like there's a bit of
19 modification in the pushing.

20 MS. KAMYKOWSKI: Stop for a second.

21 Q. (By Ms. Kamykowski) How can you tell with
22 that?

23 MS. KAMYKOWSKI: You can go back.

24 A. Maybe just a smidgen.

25 Q. (By Ms. Kamykowski) Go back just a

1 smidgen?

2 A. That's good.

3 Q. What do you see here, Maggie?

4 A. So it looks like there's possibly a

5 contraction there and there, and we did not push, as

6 you see, with those fingers right there. Good

7 moderate variability in his heart tracing with those

8 contractions. There's one there that he didn't --

9 Sarah didn't push. Good moderate variability in his

10 heart tracing with those contractions. There's one

11 there that he didn't -- Sarah didn't push. Good

12 moderate variability with that. Contractions, some

13 decel there, but a quick recovery and good moderate

14 variability.

15 Q. And when you're talking about modification

16 pushing efforts, is that -- are you telling Sarah, or

17 how does that work?

18 A. That's something I would share with Sarah.

19 And that is in relation to like intrauterine

20 resuscitation. It's moderate -- modifying pushing so

21 that's one of the interventions we can apply. So

22 instead of with pushing with every contraction, we

23 might push with every other or every third.

24 Q. And is there other intrauterine

25 resuscitation efforts that you can ask or try to work

1 with oxygenation when you're doing these
2 decelerations of the heart rate?

3 A. Absolutely. And maternal position
4 changes.

5 Q. And did you document here that at nine
6 o'clock in your flow sheet that that happened?

7 A. Yes.

8 Q. And what did you do?

9 A. It looks like I charted that we moved her
10 to her side.

11 Q. And then what's HOBL mean?

12 A. Head of bed elevated. We never want them
13 laying flat. You always want them up a little bit.

14 Q. At the seven o'clock time frame -- I meant
15 to ask you this -- Alex had charted Semi-Fowler's.
16 what does that mean?

17 A. So she's not sitting up at a 90 degree.
18 she's more likely at a 45 degree.

19 Q. And then here head of bed elevated, is
20 there a specific degree of elevation of the bed?

21 A. Not necessarily. It's kind of a judgment
22 call.

23 Q. Just not flat?

24 A. Just not flat.

25 Q. Okay. So at this time, we've now seen the

strips where you have seen, while in between moderate variability, there were decelerations.

And you have now instituted some intrauterine resuscitation measures?

A. Yes.

Q. And as before -- and how long are you looking to see a response to those intrauterine resuscitation measures?

A. Sometimes it can be as quick at 10, 15 minutes. But typically 30 to 60 minutes, especially during the pushing stages because there's so much going on. The mom is crunching doing sit-ups sort of over the monitor, so things are being moved with the monitor. So you don't always continue to pick up it all the way.

There's some interruptions and interference that you see scrolling through right now. Going by, there's some broken up with those decels. So you give it a little more time. So the mom isn't just resting at that point, we're having her do some activity.

Q. And how about in this time frame where that's happening, what's the variability that you're seeing?

A. Moderate variability throughout.

1 Q. Okay. And so now we've made it to 9:15.

2 And these decelerations have continued.

3 what's this? what's happening here?

4 A. So this part where it's broken up, we
5 might be doing a position change. We might be
6 getting her comfortable because it looks like charted
7 for laboring down.

8 So we're getting her in a position of
9 comfort. And it's always in a spinning baby
10 position. It could be extreme running man. It
11 could -- I didn't make up the names. Whomever
12 created it had come up with some very creative names.

13 Q. And do you see what you did with her? Was
14 there a position change documented? A specific one?

15 A. So -- so this one, it looks like we went
16 to hands and knees for pushing. So all that
17 interference or interruption is changing her to her
18 hands and knees and then fixing the monitors.

19 Q. When she did that, let's play --

20 MS. KAMYKOWSKI: Justin, we can probably
21 go at 64. Go a little bit faster.

22 Q. (By Ms. Kamykowski) You let me know if
23 it's too fast.

24 A. Okay.

25 Q. What happens?

1 A. He was great. Babies love hands and
2 knees. They really do. So he looks great. He's
3 tolerating it well. Moderate variability with all of
4 the pushes.

5 Q. Now, we're at 9:46. What happens in her
6 contraction pattern? What's going on here?

7 A. So we're not doing any pushing. She's
8 contracting every minute to 2 minutes, moderate
9 variability, some accelerations. He's enjoying it.
10 He's handling it well.

11 MS. KAMYKOWSKI: Pause there for a second.

12 Q. (By Ms. Kamykowski) It looks like this
13 one, from hands and knees, is she going back to a
14 different position?

15 A. So from hands and knees, we would have her
16 go to her side. She might have. It depends -- I'm
17 not sure exactly what position we put her in. But
18 typically --

19 Q. Does it say left side right there?

20 A. Oh, left side, it sure does. So left
21 side, yes.

22 Q. And it says "no pushing." I think
23 everybody has heard that from around 9:45 to 10:30,
24 10:45, she was not pushing, she was laboring down.

25 A. Yes.

1 Q. Is that another -- well, let me ask you
2 this: Do you remember why that happened at that
3 time?

4 A. Two reasons: Dr. McNeive was doing a
5 C-section, and he wanted to make sure that he was
6 available for delivery. And also it's intrauterine
7 resuscitation, so to give Remi the breaks from the
8 contractions and the combination of mom pushing and
9 bending over and bearing down on that uterus. So
10 it's giving him a little break, letting that
11 perfusion happen.

12 Q. So let's keep going forward. When Sarah
13 is allowed to labor down, and Remi is allowed to
14 rest, what happens?

15 A. He looks good.

16 Q. Okay. What are we seeing here?

17 A. Moderate variability with some
18 accelerations. It looks like that might have been an
19 early right there at 10:10, 10:11. Overall, very
20 reassuring.

21 Q. So now we're at the, like 10:25, 10:30?

22 MS. KAMYKOWSKI: You can pause it there,
23 Justin.

24 Q. (By Ms. Kamykowski) How many hours are we
25 now into the second stage?

1 A. Oh, my goodness.

2 Q. Like 6, maybe?

3 A. Yeah, that's what it looks like.

4 Q. All right. And at this point in time, is
5 there anything that you have seen thus far, from when
6 you started your shift through 10:30, that you
7 believe required you to advocate for a C-section or
8 go up the chain of command because Dr. McNeive wasn't
9 performing?

10 A. Not at all.

11 Q. Why not?

12 A. She was doing amazing. She was a
13 powerhouse. And the energy in that room was
14 positive. She is a very positive spirit. She really
15 is. And she was doing great. And there was change
16 throughout that. Although slow, it was progressing
17 all the way. There was not a time where it stalled
18 or delayed or anything.

19 Q. Have you been involved, Maggie, in your
20 5 years as a labor and delivery nurse, in a situation
21 where the second stage was -- an arrest was called?

22 A. Yes. Not by me, but I had called for a
23 pushing evaluation, and the resident came in and
24 evaluated, and then they called the attending, and
25 it was discussed.

1 Q. And throughout this labor, did you ever
2 believe you needed to call for someone to evaluate to
3 see if they were seeing progress that you weren't?

4 A. No.

5 Q. Why is that?

6 A. Because there was -- I -- I was
7 continually seeing progress. Even in some of the
8 positions we put her in, she didn't feel like her
9 pushing was very optimal, so then we would adjust and
10 modify. And then she felt like her pushing efforts
11 were even better, and I could see it was reflected.

12 Q. And we've now gone through a few hours of
13 the fetal heart tracings and the uterine contraction
14 patterns.

15 Is that all you're looking at when you're
16 there with Sarah pushing?

17 A. Not at all.

18 Q. Kind of orient us to what's in your mind
19 as a nurse. What do you have to do to take into
20 account when you were evaluating, surveilling, and
21 assessing patients in the second stage?

22 A. So it's everything. It's -- I'm
23 evaluating the mom. I'm evaluating the heart tones.
24 And even though I may not be laying eyes on them
25 because I have my back to them, I always turn the

1 volume up so I can audibly hear.

2 But I'm assessing her. I'm assessing her
3 through her pushing. I am looking at her how her
4 body mechanics are. And then in between when she's
5 resting, I'm also evaluating that. When she tells me
6 she's doing fine, do I see that she's really doing
7 fine, or is she just trying to be champ for me?

8 Q. And at least through the 10:30 time frame,
9 do you recall what your assessment, your overall
10 assessment, was of the plan of care and whether there
11 was any need to change it?

12 A. I didn't see any reason to change it. And
13 throughout with her and all my patients, I always ask
14 them, how are you doing? How are you feeling about
15 things?

16 Q. And so let's keep going. We're getting
17 about to the point where the first safety rounds
18 occur. Understanding you would have still been in
19 the bed -- in the room.

20 Did she start pushing around this time
21 again?

22 A. Yes.

23 Q. Okay. And what happens when she resumes
24 pushing?

25 A. This might be some --

1 THE WITNESS: If you wouldn't mind slowing
2 it down just a little.

3 MS. KAMYKOWSKI: You can pause it.

4 THE WITNESS: Sorry.

5 A. So there might be some position changes.
6 we went to hands and knees. So that would explain
7 why it's broken up. And that might be maternal that
8 we are picking up right there.

9 Q. (By Ms. Kamykowski) So the heart rate
10 there?

11 A. Yeah. That might be mom.

12 Q. How does that happen? How does the baby's
13 monitor pick up mom's heart rate?

14 A. It's easy, honestly. You've got the
15 femoral artery right there, so it picks up mom's very
16 easily. But when we change to hands and knees, and
17 the monitors are now underneath her, and her belly is
18 hanging to gravity, those monitors get a little
19 loose. They don't keep that connection to her nice
20 and snug. So we have to adjust, maybe add some wash
21 cloths to tighten the belts that are around mom to
22 make sure that it's nice and snug against her skin.

23 Q. And does that take a couple of minutes to
24 figure out?

25 A. If it's, especially on hands and knees, it

1 takes a minute to find baby.

2 Q. Okay. So moved her to hands and knees
3 again after she starts pushing.

4 Is she pushing in hands and knees?

5 A. Yes.

6 Q. All right.

7 MS. KAMYKOWSKI: Let's keep going to 32.

8 That's too slow. Let's keep going.

9 Q. (By Ms. Kamykowski) Now we're heading to
10 almost the eleven o'clock, 10:45 time frame.

11 what are we seeing?

12 A. 10:45 time frame. So safety rounds. So
13 good moderate variability. Looks like a possible
14 variability there. A small one, not very
15 significant.

16 Q. And, again, variables mean what?

17 A. Variables are cord compressions. So it
18 doesn't necessarily mean the cord is around the neck
19 or anything. It could be between the head and the
20 uterine wall. Sometimes the baby is holding onto it
21 and squeezing it.

22 Q. Okay. Let's stop there.

23 when we get to eleven o'clock, and she's
24 now documented, tell us what your assessment at that
25 time was?

1 A. Fetal heart rate, 140, moderate
2 variability, variable decelerations, fetal well-being
3 being monitored, maternal position change.

4 Q. And we see in the flow sheets, you know,
5 sometimes you said hands to knees or head of bed
6 elevated or left side.

7 If you don't provide a descriptor, how do
8 we know these changes in positions?

9 A. That's an excellent question.

10 So not always do we add a descriptor to
11 it. At that time, the drop-down box didn't offer
12 like extreme running man or anything like that. So
13 sometimes I would just click the side that she's
14 laying on, but I wouldn't go into description on how
15 and what position on the left side I put her in like
16 extreme running man or something.

17 Q. Besides the more extreme positions, are
18 there more subtle position changes that you, as a
19 nurse, have utilized for either trying to move baby
20 down the birth canal or for intrauterine
21 resuscitation efforts?

22 A. Absolutely. You can do where you do --
23 put their knees together and their ankles out, and
24 it's almost like a fetal position that they're in.
25 So being in the woods, is what it's called.

1 Q. what about are there times that you may
2 maneuver her pelvis?

3 A. Yes. Oh, yes. Absolutely. when there's
4 position changes with pushing, it's not always all
5 the way onto the side, it could be something as
6 simple as a tilt. Just a left side tilt, right side
7 tilt. It might be sitting up in a higher Fowler's
8 position with a slight pelvic tilt. It could be a
9 tilt and then adjusting how you push, from one leg
10 for a while, and then crossing over to the next leg.

11 Q. And is it always the situation, Maggie,
12 that when you do your intrauterine resuscitations
13 with position changes, that you completely go out of
14 Category II?

15 A. Not always. Especially not in the stage 2
16 pushing. It's not very common that you go out of
17 Category II.

18 Q. That would be your hope.

19 A. That would be the hope, yes.

20 Q. But if you don't, is that a concern as you
21 are evaluating the patient as a bedside delivery
22 nurse?

23 A. No.

24 Q. Let's keep going.

25 Now we're past eleven o'clock. And we've

1 got another position change just prior to that? Not an O

2 MS. KAMYKOWSKI: You can probably go to

3 64, Justin, and we'll slow it down. Not an Official Court Do

4 Q. (By Ms. Kamykowski) what are we seeing

5 here? Not an Official Court Document Not an Official Court Document Not an Official

6 A. Some variable decels, some late decels,

7 moderate variability in between it all. It looks

8 very good. Not an Official Court Document Not an Official Court Document Not an Official Court D.

9 Q. You documented that, right? Not an Official Court Document Not an Official Court Document

10 A. Yeah. Not an Official Court Document Not an Official Court Document Not an Official Court Document

11 Q. Moderate variability, late and variable

12 decels. Not an Official Court Document Not an Official Court Document Not an Official Court Document

13 A. Yes. Not an Official Court Document Not an Official Court Document Not an Official Court

14 Q. And as we continue now at the 11:30 time

15 frame, more of the same, or what's happening? Not an Official Court Document Not an Official Court Document

16 A. More of the same. There is some

17 modification in the pushing. we're not pushing with

18 every contraction. Looks like around 11:30 -- 332 --

19 it looks every other contraction. Not an Official Court Document Not an Official Court Document Not an Offi

20 Q. Is that an intrauterine resuscitation

21 effort? Not an Official Court Document Not an Official Court Document Not an Official Court Document

22 A. That is an intrauterine resuscitation

23 effort. Not an Official Court Document Not an Official Court Document Not an Official Court Document

24 Q. So how is Remi doing when you make those

25 changes? Not an Official Court Document Not an Official Court Document Not an Official Court Document

1 A. He's doing well. He tolerates -- he
2 tolerates it all very well. Moderate variability in
3 between. And even -- although the decels don't
4 completely go away, they may not be as deep, is the
5 best way I can explain it or as long. They might be
6 a little shorter. They might be a little shorter in
7 their length.

8 Q. What does that tell you, as a labor and
9 delivery nurse?

10 A. That the modifications that we're doing is
11 working. It's beneficial.

12 Q. Okay. Now we get to a little bit -- until
13 noon that day. And now it's documented another
14 position change. And she's pushing.

15 Do you see that?

16 A. Yes.

17 Q. All right. Let's keep going and see what
18 happens here.

19 A. So still moderate variability. And then,
20 too, she wasn't pushing. There was no decels, no
21 variabilities. And around 11:50, right around
22 noon-ish, there's one, two, three contractions. She
23 didn't push four. No decels or variables with that.
24 Moderate variability, it looks like, modified pushing
25 again with every other.

1 Q. Modified the pushing, pushing changes, and
2 we know now that for the next, I think it's like 90
3 minutes, she labored down.

4 Again, do you remember what the reasons
5 her laboring down at this point was for?

6 A. It was again to give her a break with the
7 pushing and give Remi a break with that pushing, the
8 combination of her crunching onto her uterus and then
9 her uterus contracting for perfusion and stuff. And
10 then Dr. McNeive, I believe, was getting ready to go
11 do a C-section.

12 Q. And in your experience, when a doctor asks
13 you, says, I need you to let my patient labor down if
14 I can't come to the bedside, why are they telling you
15 that?

16 A. They want to be there for delivery.

17 Q. Okay. So --

18 A. And sometimes, like with this, if there is
19 late decels and variables, and they've been pushing
20 for a while, it's to give that uterus a break, to
21 give the baby a break, also.

22 Q. So when she labors down, we can start at
23 64. Let's see what happens? What do you see here?

24 A. Moderate variability, heart rate ranging
25 155.

1 Q. Okay. Somehow we made it to almost 12:30.

2 12:25, where that sticky is.

3 A. It looks like a late decel, moderate
4 variability.

5 Q. So when she's laboring down, how is Remi
6 appearing to you when you're at the bedside?

7 A. He's looking great.

8 Q. What about that dip right there?

9 A. That's a variable.

10 Q. That's a variable?
11 Tell us what that means again.

12 A. So it looks like I charted that Sarah was
13 vomiting, and right under -- right under that
14 variable, all that irritability artifact right there,
15 that's her vomiting.

16 Q. And tell us about vomiting during labor.

17 A. Well, vomiting, as unpleasant as it is, is
18 the best way to push. You use all the muscles and
19 your most optimal strength in all the right spots.

20 Q. Involuntarily.

21 A. Involuntarily. When a mom vomits, I've
22 had them, I hope I don't vomit. And I'm never -- if
23 you vomit while you're pushing, then I know you're
24 pushing a hundred percent perfect.

25 Q. And is it unusual to see a variable

1 deceleration of the baby's heart rate when a mom is
2 sick?

3 A. Not at all. That is usually the most
4 force the mom will give during pushing, is when she
5 vomits.

6 Q. All right. Let's keep going then at 64
7 here. We now at the 12:46/12:47 time frame.

8 A. Moderate variability. Her contractions
9 are spaced out a little bit. Kind of becoming --
10 they're still regular but slightly irregular at
11 times.

12 Q. All right. And now how about here? This
13 is new. I think Jessie starts charting at this time.

14 We talked a little bit about this. But
15 Jessie charts: Prepare for delivery at one o'clock?

16 A. Yes.

17 Q. What is your understanding of that click
18 box in the fetal heart rate flow sheet?

19 A. So some use it, some don't. I don't
20 particularly use it. But --

21 Q. Why don't you use it?

22 A. I just -- I just never think to use it,
23 honestly. And if I do use it, it's very rare. And
24 it's usually right before the doctor walks in for the
25 delivery, if I even think to use it. But I think

1 Jessie uses it to indicate --

2 MS. GUNN: Your Honor, I'm going to
3 object. calls for speculation.

4 THE COURT: Sustained.

5 Q. (By Ms. Kamykowski) You don't know why
6 she uses it?

7 A. Not really.

8 Q. It's just not something you use?

9 A. Yep.

10 Q. okay. Let's keep going.

11 So now we're at just after one o'clock.

12 And how is Remi looking? what do we see

13 here? Are there accelerations on here?

14 A. There's accelerations.

15 Q. And, again, what does that tell you, as a
16 bedside nurse?

17 A. This -- he's Category II. He's very
18 happy. He's getting good oxygen and perfusion.

19 Q. And how is the variability here?

20 A. Moderate variability. very good.

21 Q. And when we're charting here at the 1:30
22 time frame, what are they telling us?

23 A. Moderate variability, fetal well-being
24 monitored, prepare for delivery. That's what Jessie
25 charted. straight cath for residual urine, 50 mLs.

1 So --

2 Q. Tell us about that.
3 why would she get a catheterization to get
4 the urine out?

5 A. So when we start pushing with a patient,
6 we remove the catheter because that little bulb,
7 although it is small, it can cause a little wall for
8 the head to keep moving. So it's going to bump
9 against that, so we remove it.

10 Q. Hold on a second. I don't know anything
11 about what you're talking about.

12 A. Sorry.

13 Q. Why would a woman in labor have a catheter
14 with a bulb?

15 A. So the -- it's like a bulb to keep in the
16 bladder.

17 Q. But why do you have to catheterize her?

18 A. When she is epiduralized, she can't get up
19 to go the bathroom, so we need to keep her bladder
20 emptied. And when that bladder is distended, that's
21 another hurdle that baby has to work around. And
22 keeping it empty and flat, then the baby isn't
23 bouncing off that bladder.

24 Q. Is that something that is -- is it common
25 that you have to straight cath a woman in the second

1 stage?

2 A. It's not uncommon, especially if they've
3 been pushing for a little bit, yes.

4 Q. And so that's something that you are
5 familiar with and that you do.

6 And it's not an intrauterine
7 resuscitation, is it?

8 A. It can be, actually. But physically it is
9 used to keep that bladder emptied so that baby has no
10 obstructions, no hurdles to get by.

11 Q. And you heard and you've seen Ms. Gunn
12 with her tape measure and the 5 centimeters, and
13 you've heard Dr. McNeive talk about that.

14 In your experience as a labor and delivery
15 nurse, is every woman's birth canal the same? Does
16 the baby traverse them the same way?

17 A. No.

18 Q. No?

19 A. No.

20 Q. Explain that to us.

21 A. So especially when they're not in the most
22 optimal position, there's a lot more effort that has
23 to go into that baby coming. Not only do they have
24 to rotate, but in the rotation in the coming down,
25 and getting themselves all aligned in the right way

1 to get in that position of the path of least
2 resistance, which is the back of the head facing the
3 mom's belly button.

4 There's a lot of work. And when it's like
5 that, it takes longer. Even with a mom who, and I
6 had one a few months ago, it was her third baby, and
7 her baby was looking straight up. And we, for her
8 third baby, we pushed for 2 and a half hours, and
9 that baby, although didn't rotate, came out looking
10 straight up.

11 Q. And that rotation, if they're looking
12 sunny side up, that OP, that OA, so that's a 180
13 degrees?

14 A. Yes.

15 Q. And that takes some time, in your
16 experience?

17 A. Yes.

18 Q. And that rotation, is that a part of your
19 evaluation for whether progress is being made?

20 A. Yes.

21 Q. So let's keep going. I think we finished
22 the time where she's been -- she's finished laboring
23 down or maybe not.

24 can you tell?

25 A. It's kind of hard to tell. It looks like

1 there might be some position changes happening.

2 Q. If you look at your documentation, or
3 Nurse Jessie's documentation at 146, she says, "baby
4 is being monitoring."

5 what else are we seeing with respect to
6 his heart rate? And now are we seeing pushing?

7 A. Now we're seeing pushes. Now we're seeing
8 some decelerations. Still moderate variability in
9 between.

10 Q. Keep going down. This is right before Dr.
11 McNeive, as everybody has heard, comes to the
12 bedside --

13 A. Uh-huh.

14 Q. -- in this case, right?

15 A. Yes.

16 Q. Okay. So prior to 2:00 p.m., when Dr.
17 McNeive gets there -- if we pause it there --

18 throughout the time that you have been pushing off
19 and on with Ms. Anyan and monitoring Remi, did you

20 see any reason why you needed to advocate for
21 C-section or go up the chain of command because Dr.

22 McNeive had not recommended one?

23 A. No.

24 Q. Why not?

25 A. She was continually making progress. It

1 was -- it was just all positive forward motion with
2 this.

3 Q. And I want to interject the Pitocin here.
4 we haven't talked about that yet. That's another one
5 of the criticisms of you.

6 The Pitocin, you didn't turn it up until
7 Dr. McNeive ordered you to, right?

8 A. Correct.

9 Q. Okay. So from when you arrived at
10 7:00 a.m., until after 2:00 p.m., does it stay the
11 same rate that it had been previous to your shift?

12 A. Yes.

13 Q. And based on your evaluation of this baby
14 and your training on this Pitocin policy, is there
15 any reason why you would have needed to turn the
16 Pitocin down or turn the Pitocin off?

17 A. No.

18 Q. Why not?

19 A. Because with her position changes and the
20 laboring down, Remi looked good. So there was
21 changes in the decels and the variables, like I
22 explained, they were still there, but they might have
23 been a little more subtle, not as deep, not as long.
24 And at that point, there was no decelerations with
25 pushing, so it's -- there was no reason to turn the

1 Pit off or turn it down.

2 Q. And is the Pitocin necessary for fetal
3 heart tones only, or is it also evaluating the
4 contraction pattern?

5 A. It's for contraction.

6 Q. Did you ever see a time when her
7 contractions were not spaced out enough to give Remi
8 enough perfusion or enough rest time for the uterus
9 to receive oxygen?

10 A. Not at all. Every time between moderate
11 variability, he looked look.

12 Q. Now, I'm going just to go to 64 from this
13 two o'clock time. We're just going to let it run,
14 Maggie.

15 Now Dr. McNeive is at the bedside. And I
16 think Jessie talked about this, and I think you did,
17 too.

18 But what did he do when he got there?
19 What do you remember?

20 A. So he talked to her. He did a check to
21 see how things were moving, and at that point, Remi,
22 he was -- he was like a plus 3. So what I mean by
23 that is you can see the head. It was sitting right
24 there.

25 Q. You have a recall of this when Dr. McNeive

1 comes back after --

2 A. Yes, I do. Because he had a lot of hair,
3 and it was sticking out.

4 And -- and Dr. McNeive had a conversation
5 with her, asked her how she was doing, and if she
6 felt like she could keep going and stuff.

7 And there was a pause between Blake and
8 Sarah, and she stated to us that she could keep
9 going. So Dr. McNeive observed and just had
10 conversation. And then not too long after he got
11 into the room, he gowned up, so --

12 Q. What does that mean?

13 A. What I mean by that is we pulled the
14 delivery table up to the bed. He was at the foot of
15 the bed, and she was in stirrups.

16 Q. What is the delivery table?

17 A. The delivery table contains all the
18 instruments that may be needed for a vaginal
19 delivery. It has the Betadine, sterile bladder, a
20 syringe, if needed, for cord blood. So if the mom --
21 the RH factor, we would send that off.

22 And then the sterile drape that goes under
23 the mom's bottom and then one that goes on the floor.
24 And then his gown and gloves are on that table. So
25 he puts his gown on, and then I sealed in the back.

1 And then he put his sterile gloves on, and we had
2 everything ready to go to have a baby.

3 Q. And Dr. McNeive stayed where until the
4 baby delivered?

5 A. At the foot of the bed the whole time. At
6 one point, I even gave him a chair to sit on.

7 Q. Why?

8 A. I mean, he stood there for a little bit.
9 It didn't happen as fast as we thought it was going
10 to. So -- but that's okay because every time her
11 contractions would start, at that point when he got
12 there, you could see Remi pulsing a little bit.

13 Q. And we know after Dr. McNeive got there,
14 he ordered you and Jessie to increase the Pitocin by
15 2 microunits at a varying pace from 2:21. And then
16 the last one -- so that was -- and then the last one
17 was at 26 at 3:56.

18 Tell us about your thoughts when he gave
19 the order to increase the Pitocin.

20 Did you think, oh, my gosh, I have to tell
21 him no?

22 A. No. No, I did not. So because he was
23 sterile, he couldn't feel the top of her stomach like
24 I could, so when he would -- like he explained with
25 his fingertips, the contraction, and I was feeling on

1 top. If they didn't feel -- when a contraction
2 happens, it's hard as a rock. That stomach is solid.
3 So at points, it didn't feel as solid. It was a
4 little squishy. And so to keep the momentum going,
5 and to keep those contractions staying nice and
6 strong and effective, he asked us to turn the Pit up.

7 Q. Was there any reason at any time that Dr.
8 McNeive asked you to increase the Pitocin, where you
9 felt you needed to go over his head, go talk to your
10 charge nurse, and invoke the chain of command to stop
11 that?

12 A. Not at all.

13 Q. Why not?

14 A. I felt it was appropriate to keep things
15 going. We certainly, at that point, didn't want
16 contractions to get weaker and start to slow down.

17 Q. Let's go to 64. So after Dr. McNeive
18 comes to the bedside, tell us again what -- how is
19 Remi still doing?

20 A. Moderate variability. He looks very
21 reassuring. And I -- it looks like there was an
22 accel that happened there about 2:31.

23 Q. And when you say she looks really
24 reassuring, how can you say that when we know he
25 continues to have decelerations of his heart rate?

1 A. In between his recovery, his moderate
2 variability, in between the contractions, he gets
3 right back to it. There's no delay. There's no
4 prolonging. It is a good, positive sign.

5 Q. Okay. And is he decelerating with every
6 contraction?

7 A. Not with every contraction, no.

8 Q. And is that a good sign?

9 A. That is a good sign.

10 Q. Now we're getting to the 3:05/3:07 time
11 frame. Dr. McNeive is still there.

12 what's going on?

13 A. So it looks like some modifying in
14 pushing. Looks like there's some late decels. Still
15 moderate variability with it all.

16 Q. And when you say modifications in pushing,
17 would those now be at the direction of Dr. McNeive?

18 A. Yes.

19 Q. Okay. And how is this -- what's going on
20 here? Now we're at -- after 3:30. 3:30 right now,
21 what are we seeing?

22 A. Really no deceleration variables with the
23 pushing. And moderate variability and great
24 acceleration.

25 Q. And I know around this time, we heard from

Dr. warsof, that he also saw accelerations.

Is that what we're seeing here?

A. Yes.

Q. And what does that tell you about Remi's condition as late as, you know, close to four o'clock before delivery?

A. Good perfusion, excellent perfusion --

Q. Now what happens.

what are we seeing here?

A. So we're seeing an increase in his heart rate to 165.

Q. And tell us about that.

why is that concerning?

A. So the normal heart rate for a fetus is 110 to 160. And being 165 is a little tachy.

Q. Tachycardic?

A. Tachycardic, yes.

Q. And is he also still having decelerations with his heart rate increasing?

A. It looks like some decelerations with contractions. Moderate variability, still in between.

Q. Keep going to 32.

Now, do you remember this time frame in the delivery room after the three o'clock/four

1 o'clock time frame?

2 A. I do. This is when the energy in the room
3 really picked up.

4 Q. Tell us about that.

5 A. It was time to have a baby. So I believe
6 she started to develop a fever, a temperature.

7 Q. Is that at 1612?

8 A. Yes. 106.

9 Q. And what does that mean?

10 A. So there's an indication that there may be
11 an infection in the uterus. And usually th baby
12 gives us a sign of that with the -- his heart rate
13 going up. That usually coincides.

14 Q. And what about here on this page? It
15 says -- the middle of it is 1611. What about his
16 variability? Is there a change in his variability?

17 A. It's minimal.

18 Q. Has that been -- was it -- was it ever
19 minimal that you saw until we get to this point?

20 A. Not at all.

21 Q. What does a tachycardic baby with minimal
22 variability and late decelerations tell you?

23 A. That it's time to have a baby. And at
24 this point, he was like out to here. I do remember
25 that. He was almost, I would say, almost to here.

1 He was -- his head was very much sitting on the
2 perineum.

3 Q. What do you remember about that time?

4 A. Dr. McNeive expressing to her that it's
5 time to get Remi out. It's time to have this baby.
6 And this is when she really dialled up her powerhouse
7 and pushed like a champ. She needs -- she needs to
8 give a class on how to push. It's amazing, really.

9 Q. And we know -- so we're now at 4:11, 4:12.
10 we know he's born at 4:24, right?

11 A. Yes.

12 Q. Okay. You were there when he was born?

13 A. Yes.

14 Q. Do you remember the meconium that we heard
15 in this case?

16 A. I don't truly remember it.

17 Q. Tell us, then, what you remember after
18 Remi was born. I know -- tell us what your role is
19 at that point now that you have this baby in hand and
20 mom's still there? What is your role as her nurse?

21 A. So at that point, I would give Pitocin

22 bolus. And that is for hemorrhaging all moms get.

23 Those are boluses to make sure that uterus is being a
24 muscle and staying nice and contracted. That helps
25 with decreasing hemorrhage.

1 If Dr. McNeive is needing any sutures or
2 any position changes with mom, I am there to help
3 with all of that. And then all at the same time of
4 being at the bedside and giving things that Dr.
5 McNeive has, I'm also trying to admit baby and hurry
6 up and get his chart opened up and get that started
7 so he gets into the system.

8 Q. Now, we know NICU was called.

9 was that a call that you made?

10 A. No. Jessie made that call.

11 Q. And do you remember the reason?

12 A. Maternal temperature.

13 Q. Do you recall, as you sit here today, any
14 observations that you made of Remi after he was born?

15 A. I do not.

16 Q. All right. And your shift ended at
17 7:00 p.m.?

18 A. Yes.

19 Q. Did you take on any new patients after
20 Remi was born?

21 A. No. We were still in the recovery period.

22 Q. You stayed with them until the time for
23 you to leave, and they had went to mother-baby?

24 A. Yes.

25 Q. Is there anything else about the May 4th,

1 in your experience, that you recalled that you
2 haven't told us?

3 A. Not that I recall.

4 Q. Okay. We didn't talk about the Pitocin
5 policy. I just want to talk about it real quick.

6 A. Okay.

7 Q. You've seen the policy and the protocol
8 that's embedded in Epic, correct?

9 A. Yes.

10 Q. And you saw the policy.

11 Do you remember what it required you to do
12 when you have a Category II tracing?

13 A. There was -- there's suggestions that I
14 could do: maternal position changes, fluid bolus,
15 turning the Pit down or turning the Pit off, so...

16 Q. And in your training and your experience
17 with utilizing the Pitocin with a mother, are -- what
18 were you taught? Or what is your practice for how
19 you institute intrauterine resuscitative measures
20 that are outlined in those policies?

21 A. Usually we start with maternal position
22 changes. And then you've got to give your
23 interventions time to work. So you give it some time
24 and see if you see any positive reaction from it.
25 And with her pushing, like I explained, the variables

1 and the decels, they didn't -- they weren't as long,
2 and they weren't as deep. And at some times, there
3 wasn't any at all with some of the pushing.

4 Q. So is it -- so based on your -- now we
5 have gone through the entire strip, the position
6 changes that you did, which position changes, and I
7 think you told us some modification of her pushing
8 efforts and the laboring down, those were the -- and
9 her intrauterine resuscitative measures and also
10 attempts to help move baby down in the birth canal,
11 right?

12 A. Yes. It was a multifocal purpose for all
13 of that.

14 Q. Did you use anything other than position
15 changes to resuscitate Remi intrauterine? And the
16 modifications and the pushing? Anything else?

17 A. Honestly, I can't recall.

18 Q. Did you give her an IV bolus? Not an Official Court Document

19 A. No. There was no need to give an IV
20 bolus. And an IV bolus is -- and something you kind
21 of have to be mindful of, is they've had a lot of
22 fluid before, and especially with her getting Pit,
23 you've got to be kind of mindful of how much fluid.
24 You can over fluid the mom, which can cause swelling,
25 which can cause fluid on the lungs. They can affect

1 the heart which causes their heart to have to perfuse
2 even more, which ultimately can affect Baby Remi and
3 his perfusion and oxygen delivery. So you have to be
4 mindful of giving the fluid bolus.

5 Q. And, Maggie, we've now gone through the
6 strips. We've talked about all those resuscitative
7 measures that you utilized, both on your own and then
8 when you were instructed to labor down by Dr.

9 McNeive. Looking at this in total, even now sitting
10 here today, is there -- do you have the opinion that
11 you met the standard of care with respect to your
12 care on May 4th?

13 A. I believe I met the standard of care, yes.

14 Q. Thank you, Maggie, those are all the
15 questions I have.

16 MS. KAMYKOWSKI: Thank you, Judge.

17 THE COURT: All right. Ladies and
18 gentlemen, this seems like a good time for us to take
19 our morning recess.

20 (At 10:33 a.m., the Court duly admonished
21 the jury, and proceedings stood in recess. At
22 10:50 a.m., the following proceedings were held in
23 open court, in the presence of the jury:)

24 THE COURT: Go ahead and be seated,
25 everyone.

Cross-examination?

MR. PERRON: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. PERRON:

Q. Nurse Maggie, how -- you said, I think you touched on it in the direct exam. But just to -- just as a starting off point. How often do you see Category II tracings, from your experience during labor?

A. Often. Like practically every labor I have.

Q. Is Category II, by itself, alarming to you, as a provider?

A. Not always, no.

Q. Are you training on how to read and respond to Category II tracings?

A. Yes.

Q. What is the key finding you're looking for when you're interpreting Category II tracings to know something's alarming or something was not as alarming?

A. Because a baby lives in between. When they come back to baseline, what does that look like? Is it moderate variability? Is it minimal? It is absent? Is it marked? That's the one thing and how

1 quick they come back to baseline.

2 Q. Throughout your shift, which includes the
3 8:00 a.m. to 4:24 p.m. time line, did you detect a
4 return to moderate variability throughout that time
5 period up until the last 27 minutes?

6 A. Consistently.

7 Q. You mentioned that you had a recollection
8 of Dr. McNeive asking Sarah Anyan if she could keep
9 pushing?

10 A. Yes.

11 Q. Do you recall her response?

12 A. She said she could keep going.

13 Q. In general, in your experience, what is
14 the next step if the mom says, no, I'm -- I'm sorry.

15 I don't have the energy. I just can't keep pushing?

16 A. Then we would move to C-section. Dr.
17 McNeive would educate her on the risks and benefits

18 of C-section. And then we would call our charge

19 nurse and the charge nurse for the surgery and

20 anesthesia and let them know what the next step is,

21 and then we would start proceeding with it.

22 Q. Did you believe you needed to advocate to
23 your superiors that Dr. McNeive was ever recommending
24 or pursuing a harmful course of treatment for Remi
25 Anyan?

A. No.

Q. Did you detect ever any signs or indications from Dr. McNeive's conduct that he was making medical decisions with an intent to cause Remi damage or with malice or evil intent?

A. Not at all.

Q. Are you familiar with Dr. McNeive personally?

A. Yes.

Q. You've delivered several babies with him?

A. Yes.

Q. And in the course of all of that time working within your profession, have you ever known him or observed him to act with malice with a baby or attempt to harm a baby?

A. No.

Q. No further questions.

THE COURT: Cross-examination?

MS. GUNN: Thank you, Judge, if I may have a moment?

THE COURT: You may.

MS. GUNN: For a different location.

CROSS-EXAMINATION

BY MS. GUNN:

Q. Good morning.

A. Good morning.

Q. I know we've interacted this week, and I appreciate that you don't mind that I refer to you as Nurse Maggie.

A. You can say Maggie.

Q. You know I've never meant any disrespect on that.

A. None, at all.

Q. You've been here for all of it, so I appreciate that.

A. Absolutely.

Q. Now, I want to understand you graduated with your nursing degree in December of 2019.

A. Yes.

Q. And then you became employed with Mercy and started your orientation in February of 2020?

A. I was already employed with Mercy, and I just transferred to Mercy STL in February.

Q. Got you.

And then you would have started your work on the labor and delivery floor in March of 2020?

A. Yes.

Q. And that would have been -- you were sort of assigned with Jessie?

A. Yes.

1 Q. And prior to March of 2020, you had never
2 worked on a labor and delivery floor, correct?

3 A. Correct.

4 Q. I know you had a lot of work with, I
5 think, emergency departments and EMTs, and things
6 like that, and I think you told us a little bit about
7 maybe a nursing school you had a teeny bit of
8 interaction.

9 But March of 2020, is when you started
10 working on a labor and delivery floor?

11 A. Yes.

12 Q. And when you -- and all of your work on
13 the labor and delivery floor at Mercy starting in
14 March of 2020, was with Jessie?

15 A. Yes.

16 Q. So there weren't any other shifts that you
17 were taking with other nurses? It was all under the
18 supervision of Jessie?

19 A. Yes.

20 Q. So you would not have attended any labors
21 and deliveries independent of Jessie, correct?

22 A. Correct.

23 Q. So when Jessie testified that the longest
24 second stage of labor she had been involved in was 5
25 hours, you wouldn't have a different experience,

1 correct?

2 A. I'm -- not necessarily. But I'm not sure
3 when she experienced that 5 hours. It might have
4 been before she had me.

5 Q. I understand.

6 A. Yeah.

7 Q. But you remember when she testified --
8 you've reviewed her deposition?

9 A. Yeah. It's been a minute, yep.

10 Q. And you were here when we played it last
11 week?

12 A. Yes.

13 Q. And you will recall that she told me that
14 the longest second stage of labor that she had prior
15 to Sarah was about 5 hours, correct?

16 A. Yes.

17 Q. So if all of your work was with Jessie as
18 of May 4th, 2020, that would have also been your
19 experience, correct?

20 A. I -- I'm not sure if necessarily that
21 would be my experience because I don't recall if she
22 and I had a 5-hour one.

23 Q. Okay.

24 A. If I'm explaining myself correctly.

25 Q. Right. well, I'm just -- if she said that

1 the longest second stage of labor she had had was

2 5 hours --

3 A. Yes.

4 Q. -- and you did all of your work with

5 Jessie --

6 A. Yes.

7 Q. -- then yours would have been 5 hours or I

8 guess less, right?

9 A. If that happened during the time frame I

10 was with her --

11 Q. Sure.

12 A. -- Yes.

13 Q. Okay. Now, you told us on direct that you

14 had been involved in 3- or 400 deliveries.

15 That's up to this point, right?

16 A. Up to this point, it's like 4- or 500

17 deliveries, yes.

18 Q. But as of May of 2020 --

19 A. Yes.

20 Q. -- when you were involved in the care of

21 Sarah Anyan and Baby Remi, you had only had -- you

22 had less than a hundred, right?

23 A. Yes.

24 Q. Okay. Now, your work with Jessie, and I

25 just want to know there's -- time has gone by, but I

want to talk about May 4th, 2020, or the time frame prior to that.

A. Yes.

Q. So let's try to keep it --

A. Yes.

Q. -- you've learned things since then, but let's talk about what you knew at the time, okay?

A. Okay.

Q. Now, you would have been really the person on that date to take the lead with Sarah, correct?

A. Yes.

Q. And I think you said in your deposition that Jessie pretty much let you do it all?

A. Yes.

Q. And that you had the responsibility to read the fetal monitoring strips, is that correct?

A. We both did, but, yes.

Q. And that Jessie would kind of hang around in the room and maybe check the bed and just kind of observe you and be in the background, correct?

A. Yes.

Q. All right. And prior to May of 2020, regarding fetal monitoring strips, you agree that the work you did learning how to read those was on the job?

1 A. Yes.

2 Q. I think you told us that during school,
3 you would go over it kind of briefly, but there
4 wasn't any kind of in-depth like learning with
5 respect to that, correct?

6 A. No. It was just the fundamentals of it.

7 Q. Okay. And you don't recall whether prior
8 to May of 2020, you had any classroom training or
9 education on fetal monitoring strips at Mercy,
10 correct?

11 A. Correct. Nothing stands out. So I'm not
12 sure if some of it was just like blended in through
13 education as examples or references, but I don't
14 recall a specific class where we just honed in and
15 targeted on it.

16 Q. Right. So, again, your learning how to
17 read fetal monitoring strips started in March 2020,
18 doing two or three, 12-hour shifts a week under the
19 supervision of Jessie, correct?

20 A. Yep. Yes.

21 Q. Now, you were not certified to read fetal
22 monitoring strips as of May 2020, correct?

23 A. Correct.

24 Q. Now, that is something you can get
25 certified on. And I think you got certified to read

1 those strips in July of 2021, right?

2 A. Yes.

3 Q. Okay. So regarding the prolonged second
4 stage of labor, I heard you say on direct that it
5 was, I mean, you would consider this prolonged,
6 correct?

7 A. Yes.

8 Q. But you had received no specific training
9 or had been involved in any particular discussion
10 about how long a second stage of labor was supposed
11 to last before Sarah, correct?

12 A. There is no "supposed to last" definition
13 to second stage of labor. It is a situational.

14 Q. Right.

15 A. And there's a lot of factors that go in to
16 determining that situation.

17 Q. Right. And just so I'm clear, you
18 received no specific training or had any discussion
19 about how long a second stage of labor lasts, prior
20 to taking care of Sarah Anyan, correct?

21 A. Correct.

22 Q. And you couldn't give me, and I guess
23 maybe still can't give me, an exact definition of
24 what prolonged second stage of labor means, correct?

25 A. Over the course of a few weeks, we've all

1 kind of learned it --

2 Q. I understand what we've all learned
3 sitting here for 2 weeks listening.

4 A. But at that moment?

5 Q. Correct?

6 A. No. Correct.

7 Q. And you were not aware of any concerns
8 about a prolonged second stage of labor, correct?

9 A. There was no concerns.

10 Q. No, I want to say, I guess I'm asking a
11 bigger question.

12 As of May of 2020, you weren't even aware
13 that there could be any concerns about a prolonged
14 second stage of labor, correct?

15 A. I was aware of the potential of a long
16 second stage of labor, what it could -- what could
17 happen. Things could stop. The baby not looking
18 good. Stuff like that. That is a potential. That
19 is a potential with any second stage, short or long,
20 but that day, everything was reassuring to keep
21 moving forward.

22 Q. I understand that, Nurse Maggie. But what
23 I'm asking you is we're trying to understand what you
24 knew as of the date that you were taking care of
25 Sarah and Remi.

1 And you, as of that date, actually, as of
2 your deposition, were not aware of any concerns with
3 the prolonged -- not Sarah's -- but you were not
4 aware of any concerns with respect to a prolonged
5 second stage of labor, correct?

6 A. I don't completely agree to that because
7 although there's not a true definition to it, and I,
8 even then, not knowing a definition to it, I do
9 understand pushing for a long amount of time, there
10 is possibilities to it. And I understood that then.

11 Q. Like what do you mean? Like what
12 possibilities?

13 A. The mom getting tired, the baby not
14 progressing through the canal, potential heart tones,
15 not very good heart tones, those are potentials I
16 knew that could happen in a prolonged second stage.

17 Q. You knew that as of May 2020, you knew
18 that a prolonged second stage of labor could be
19 dangerous for the baby?

20 A. I wouldn't necessarily -- I don't want to
21 single it to a prolonged second stage. Any second
22 stage can be dangerous. I don't want to say that a
23 prolonged second stage in and of itself is always or
24 will be dangerous. But there is that potential,
25 correct.

1 Q. So as of the day that you were taking care
2 of Remi and Sarah, it sounds like you did understand
3 that a prolonged second stage of labor could be
4 dangerous for the baby.

5 A. Could be.

6 Q. And specifically the danger would be
7 hypoxia?

8 A. Yes.

9 Q. Based on late and variable decels?

10 A. Uh, I mean, yes.

11 Q. Now, I think we've heard a little bit
12 about the key measure going forward is progress,
13 right?

14 A. Yes.

15 Q. You want to see that progress?

16 A. Yes.

17 Q. And I want to understand you weren't aware
18 of what -- you weren't able to put a measurement on
19 what progress means, correct?

20 A. Correct.

21 Q. I think you told me that you were just
22 eyeballing it, right?

23 A. That's pretty much what you do, yeah.

24 Q. Yeah. And so that would be the same for
25 Sarah?

1 A. Yes.

2 Q. When you were -- you told us, and you told
3 me in a deposition, that you believe that she --
4 Maggie, that Remi was making progress, and you based
5 that on eyeballing it, correct?

6 A. Yes.

7 Q. We know that there were no -- there was no
8 documentation in Sarah's chart about any measurements
9 or digital exams or sterile vaginal exams that you
10 did, correct?

11 A. Correct.

12 Q. And you don't recall actually doing any,
13 right?

14 A. Oh, yeah, I did.

15 Q. Okay.

16 A. Yeah.

17 Q. So where was Remi?

18 A. As far as station wise?

19 Q. Yeah.

20 A. That, to tell you right now, I couldn't
21 tell you. It's been awhile.

22 Q. Okay. And we would know if you had
23 written it down, right?

24 A. Yeah.

25 Q. And we know that there are other folks in

1 the chart earlier before you and Jessie came on shift
2 that were writing down the stations, right?

3 A. During pushing, I think maybe Alex did it
4 once, yeah.

5 Q. Right. That's what I'm asking.

6 A. Yeah.

7 Q. I mean, it can be done?

8 A. Yes.

9 Q. There are places in the chart where
10 measurements and station and descent can be
11 documented?

12 A. Yes.

13 Q. And generally you agree that's good
14 practice and good medicine to document it when you
15 see it?

16 A. I don't know whether that would be
17 practice or good measurement. But it is something
18 that absolutely can be done. Is it commonly done?
19 Not necessarily. Not with the nurses I work with,
20 and even today, I don't do that myself.

21 Q. Hold on. Let me make sure I understand.
22 You don't agree with me that it's good
23 medicine or good practice to document what you're
24 seeing when you're taking care of a patient?

25 A. During the second stage of labor, it's a

1 little different. It's one thing when you're
2 laboring a mom, and you are checking, doing a vaginal
3 exam to see her progression through labor to document
4 that. But when you are at second stage of labor, I
5 don't want to say it's bad or it's inappropriate or
6 anything, it's just not common to pause what you're
7 doing to open up your chart and get into Epic to
8 chart that station.

9 Q. But on this day, there were two of you
10 there, right?

11 A. Correct.

12 Q. You and Jessie were there?

13 A. Correct.

14 Q. And neither one of you saw fit, whether
15 one of you was by the bed or not, to document Remi's
16 station, correct?

17 A. Correct. Jessie wasn't always in the room
18 with me the entire time.

19 Q. All right. And so you won't agree with me
20 that whether it's the second stage or first stage or
21 wherever you are in the stages of labor with a woman,
22 to document the progress?

23 A. In that first stages? It is appropriate.
24 It is good. When you are in second stage, it's kind
25 of another story.

1 Q. Okay. And in the second stage of labor,
2 which you've already told me if it goes on too long,
3 it could be dangerous to the baby, you don't think
4 it's common or good practice to document that
5 progress, correct?

6 A. I'm not saying it's good or bad. It's
7 just not something that is commonly done. There's so
8 much more that goes on to it. It's not that cut and
9 dry. There's a whole lot of other things that go on
10 to the second stage when you're in that room.

11 And when they're pushing, and asking them
12 to pause so you go up and catch up on your charting
13 of what just happened, that's not appropriate.
14 Staying at bedside, keeping with the patient, keeping
15 the motivation, keeping with education, keeping
16 things moving, that to me is more appropriate at that
17 time than asking her to pause, stop pushing, and let
18 me go get some charting.

19 Q. But you did chart eventually, right?

20 A. Chart eventually, yes.

21 Q. And when you charted the late decels, the
22 variable decels, and things like that, you could have
23 also charted his progress, right?

24 A. I could have, yes.

25 Q. I mean, you did take the time at some

1 point to go back and to chart what you saw on the
2 strips, correct?

3 A. Yes.

4 Q. And so if you were doing those checks and
5 were measuring his station, that could have been
6 input, as well?

7 A. It absolutely could have been added into
8 my charting at that time.

9 Q. Now, you agree that there -- we didn't
10 talk a lot about the Category III tracings, which you
11 got to at the end there, but you agree that there are
12 risks of injury to the baby when he or she is in
13 Category III, correct?

14 A. There is risks.

15 Q. And what are those risks?

16 A. Hypoxia.

17 Q. Now, Pitocin is a high risk -- or a high
18 alert medication.

19 You know that, correct?

20 A. Yes.

21 Q. And I want to be clear, we -- Ms.

22 kamykowski asked you about the Pitocin policy at
23 Mercy, right?

24 A. Yes. Yes.

25 Q. And you, when you were on orientation, you

1 were not made aware of any policies regarding labor
2 and delivery, and were not specifically aware of the
3 Pitocin policy, correct?

4 A. I was aware of the Pitocin policy.

5 Q. Ma'am, do you remember giving your
6 deposition in this case?

7 A. I do. I think -- I think I said no.

8 Q. So I'm going to hand you --

9 MS. GUNN: If I may approach, Your Honor.

10 THE COURT: You may.

11 MS. KAMYKOWSKI: Do you have a copy?

12 THE WITNESS: I do have a copy.

13 Q. (By Ms. Gunn) Okay. Then let's go to
14 page 17, starting at line 10. I asked you -- and
15 this was your deposition. It was taken on May 24th,
16 2023.

17 You were represented by counsel, correct?

18 A. Yes.

19 Q. And you swore to tell the truth then like
20 you did today, correct?

21 A. Yes.

22 Q. And I asked you: Now, when you were
23 onboarded at Mercy and went through the nurse
24 training, the student nurse training, were you made
25 aware of any policies that applied to labor and

1 delivery nurses?

2 "ANSWER: NO."

3 Did I read that correctly?

4 A. You read that correctly. Considering
5 onboarding, policies were not covered during
6 onboarding.

7 Q. When I asked you on page -- line 15: Do
8 you recall generally what you were trained on,
9 educated on, with respect to the Pitocin
10 administration and dosage?

11 And your answer was: So far as
12 administering it? Is that what you're asking?

13 Yes, ma'am.

14 "ANSWER: Sorry."

15 That's okay. Take your time.

16 "ANSWER: So administering it, that was
17 based off the nurse. You had to have at least

18 20 minutes of a Category I fetal monitoring strip.

19 we would up it by 1 or 2 at a time, but the policy

20 has since changed. And it is now by 2. And that is

21 how, when we put in the orders, you put it in by 2.

22 whereas, before you could either choose 1 or 2, but

23 by the nurse's discretion.

24 So you're telling me -- so did I read that

25 correctly?

1 A. Yes.

2 Q. So you're telling me about like the
3 titrating up --

4 A. Yes.

5 Q. -- but what you're saying is that that is
6 something you learned on the job later?

7 A. When I started on the floor itself, yes.

8 Q. Okay. So -- but you with weren't
9 particularly trained on any policies at the time you
10 came on board, correct?

11 A. During onboarding? No. The onboarding
12 encompasses the entire hospital, all departments.

13 Q. Right.

14 A. So they can't go over policies for
15 departments during onboarding.

16 Q. And so just to be clear, the policy we're
17 talking about, you know that there is a policy
18 protocol in sarah's chart that's embedded in her
19 chart, right?

20 A. Yes.

21 Q. And it's actually also a nursing
22 communication order, correct?

23 A. Yes.

24 Q. So is that the one you were trained on
25 when you were on the floor?

1 A. No. She, Jessie, had printed one off, and
2 you could go into -- there's an area where you can
3 pull up policy, and you can look at policies there.

4 Q. Okay.

5 A. And that's usually what she had me review.

6 Q. Were you aware of the nursing protocol in
7 Sarah's chart?

8 A. At that time, I don't recall.

9 Q. Okay.

10 MS. GUNN: Let's see Exhibit 1, page 100
11 and actually 102.

12 Q. (By Ms. Gunn) I think -- I just want to
13 make sure we know what we're talking about here.

14 So the couple of pages before was the, you
15 know, the label of it, and then, yeah, "STLLB vaginal
16 Birth Protocol Mercy Hospital-St. Louis."

17 And then you go through a bunch of things.
18 And I want to focus your attention on page 102, which
19 is nursing communication orders, correct?

20 A. Yes.

21 Q. So these are within the protocol, these
22 are orders, correct?

23 A. Within the protocol?

24 Q. Yeah. Do you see that, ma'am?

25 A. Yeah, I can see that.

1 Q. It's a nursing communication order?

2 A. That's what it states.

3 Q. Did you understand that was an order that
4 applied to you on May 4th, 2020?

5 A. Oh, yes, I did. I don't -- according to,
6 well, the policy, the stating orders is being a
7 policy. This pretty much just states the same thing
8 that you would find in the policy.

9 Q. Right. So in here, we're talking about
10 the fetal heart rate. Indeterminate Category II:
11 The following measures will be initiated.

12 The jury has seen this. Lateral
13 positioning, IV fluid bolus of 500 milliliters of
14 lactated ringers solution.

15 And what is lactated ringers solution?

16 A. It's the fluid that we give the mom.

17 Q. And then discontinuation of oxytocin if
18 infusing, correct?

19 A. That's what it states.

20 Q. And then removal of Cervadil. Sarah
21 didn't have that.

22 A. No.

23 Q. Oxygen at 10 liters per minute via
24 nonrebreather face mask.

25 A. Correct.

1 Q. And, finally, modification of maternal
2 pushing efforts during -- during second stage of
3 labor, correct?

4 A. That's that it states.

5 Q. Okay. So let's -- let's talk about those.
6 You told me that with respect to
7 resuscitation measures, you believe that they were
8 all on the same plain, correct?

9 A. Yes.

10 Q. Meaning that they were kind of all on the
11 table, no particular order, correct?

12 A. No particular order, yes.

13 Q. And you usually try a maternal position
14 change first and the fluid bolus and see what
15 happens, correct?

16 A. Yes.

17 Q. Now, we know that was never a time that
18 sarah was given a fluid bolus, correct?

19 A. Correct.

20 Q. And I heard you say some general reasons
21 by -- why, but for sarah's case, not generally, but
22 for sarah's case, that was never given to her,
23 correct?

24 A. Correct.

25 Q. So that was never tried?

1 A. It -- it never came up to be needed to be
2 tried.

3 Q. Right.

4 A. Yes.

5 Q. Because you think maternal position
6 changes fixed everything.

7 A. Not that I think, I'm positive it did.

8 Q. Okay. Well, let's talk about that.

9 You also told me that it takes, I think I
10 heard you say on direct, it takes 30 to 60 minutes to
11 see if maternal position changes make a difference?

12 A. You can give it 10 to 15. You can give it
13 30 to 60, depending on the situation.

14 Q. Okay. So what you're saying then is that
15 that's the amount of time you would want to see
16 without any other decels to know whether the maternal
17 position change worked, correct?

18 A. Not minus the decels, considering we're in
19 the second stage and pushing, but if the decels and
20 variables looked better.

21 Q. So you can continue to have recurrent
22 decels, and in your mind, that means the maternal
23 position changes worked?

24 A. They weren't recurrent, they were
25 frequent. So they weren't happening every single

1 time consistently throughout the pushing efforts.
 2 There was recovery. They didn't last -- they weren't
 3 as long when they lasted, and they weren't always as
 4 deep.

5 so all of those little minute things, is
 6 stuff we take into consideration when we do those
 7 interventions.

8 Q. Well, let's take a look at your notes. I
 9 know we've seen the digi strips that you were
 10 interpreting for us.

11 But let's look at what you did document --

12 A. Okay.

13 Q. -- with respect to how Remi was doing.
 14 And let's go to Exhibit 1, page -- let's start at
 15 Exhibit 1, page 226. This one's a long one. Because
 16 it was the 7:15 one.

17 so just so we can follow along, this is
 18 the column where it starts. And MH, those are your
 19 initials, correct?

20 A. Yes.

21 Q. So just, again, the top line here is what
 22 is happening at this time?

23 A. Yes.

24 Q. And then you, if you, as you said,
 25 sometimes you go back and add things later. And so

1 at 7:15, you were documenting -- or whatever happened
2 at 7:15, you came back and documented at 9:11,
3 correct?

4 A. Yes.

5 Q. Okay. So we have to go to a whole page to
6 get to the fetal heart rate. We'll just scroll
7 through that. We're still -- yeah.

8 okay. So this is the FHR. That's the one
9 we've been mostly looking at, correct?

10 A. Yes.

11 Q. So at 7:15, that's pretty much right when
12 you got in there?

13 A. Pretty much, yes.

14 Q. You're noting late decelerations, correct?

15 A. Yes.

16 Q. And you're noting maternal position
17 change. So that's the first thing you did when you
18 got in there, was do a maternal position change?

19 A. Yes.

20 Q. And that's because you saw late
21 decelerations?

22 A. That, and I'm not -- I don't -- I don't
23 remember how long she was in the position that she
24 was in then, so I was just changing her comfort,
25 also.

1 Q. Okay. And then we talked a little bit
2 about this, this says "prepared." And then you
3 actually had to go to the next page to see the rest
4 of that for delivery?

5 A. Yes.

6 Q. You see that? So at 10:23, you wrote that
7 at 7:15, Sarah was prepared for delivery, correct?

8 A. Yes.

9 Q. And I thought I heard you say on direct
10 that meant baby was ready to come?

11 A. Not necessarily ready to come in minutes.
12 But that we were getting ready for that delivery.

13 Q. Okay. So at 7:15, you were -- Remi was
14 ready to be delivered?

15 A. We were getting there. Again, not going
16 to happen within that minute or two, but we were
17 getting there.

18 Q. So you believe at 7:15 a.m., right when
19 you got on shift, that Remi was ready to be
20 delivered?

21 A. Not -- again, not right at that moment,
22 but...

23 Q. Right. Within a few minutes? Within a
24 few moments?

25 A. Moments, minutes. It's -- it's

1 situational. It's -- I don't even use that for my

2 charting really anymore.

3 Q. But you did then?

4 A. Yeah, I did then.

5 Q. And what you meant by it again was that
6 Remi was ready to be delivered in minutes or moments?

7 A. I wouldn't say minutes or moments. But
8 that we were working on that progress, that it was --
9 we were getting there.

10 Q. Okay. Let's move on to page 230.

11 This is the 7:30. And we're looking at
12 every 15 minutes because that's what -- that's the
13 policy, the protocol, the guidelines, whatever that
14 Mercy Hospital says needs to be done to understand
15 what the progress is --

16 A. Yes.

17 Q. -- of a woman in the second stage of
18 labor, right?

19 A. Regarding heart tones, yes.

20 Q. To understand how the baby is doing?

21 A. Yes.

22 Q. Every 15 minutes, something needs to be
23 documented about how that baby is doing?

24 A. As far as heart tones, yes.

25 Q. And was it just heart tones?

1 A. Yes.

2 Q. That's all you have to do every 15
3 minutes, is do the heart tones?

4 A. Heart tones. I do not have to document
5 every 15 minutes, the baby's station.

6 Q. Okay. Well, I understand that. We know
7 that. We know that. It didn't get done.

8 But let's talk about what we're looking at
9 every 15 minutes, then.

10 A. Okay.

11 Q. Because it seems like, then, you would
12 agree that it's really important to know how that
13 baby is doing every 15 minutes?

14 A. Yes.

15 Q. So we have, at 7:30, you've documented
16 late decels, correct?

17 A. Yes.

18 Q. And then nothing is documented at 7:45.
19 Does that mean there's nothing to see
20 here, or there's nothing on that page?

21 A. Not necessarily. I'm not sure why I
22 didn't chart anything there.

23 Q. Okay. And then at eight o'clock, we've
24 got more late decels, correct?

25 A. Yes.

1 Q. And then at 8:15, we've got nothing,
2 correct?

3 A. Yes.

4 Q. And then at 8:30, we've got more late
5 decels, correct?

6 A. Yes.

7 Q. And then we go back, and under the prevent
8 minimize Category II -- because that's something that
9 the charting wants you to do, right? You want to
10 prevent and minimize Category II, right?

11 A. Yes.

12 Q. So I know that I've heard you say that
13 there's lots of Category IIs during the second stage
14 of labor, but the guidelines and protocols, good
15 practice, makes you want to prevent and minimize
16 that, correct?

17 A. And we minimized it.

18 Q. I know. And that's because it's important
19 to do so.

20 A. Absolutely.

21 Q. You don't want to stay in Category II,
22 right?

23 A. You don't want to not stay in Category II.
24 You can be in Category II and have a fine, healthy
25 labor and delivery in Category II.

1 Q. I understand that. But the opposite is
2 also true.

3 A. Yes.

4 Q. You can have Category II and not have a
5 healthy, happy baby at the end, correct?

6 A. Absolutely.

7 Q. So it's important to know what's
8 happening?

9 A. Yes.

10 Q. And it's important to take steps to
11 minimize and prevent it.

12 A. Yes.

13 Q. So what you did to minimize and prevent
14 late decelerations over this entire hour is maternal
15 position change, correct?

16 A. Yes. And modified pushing.

17 Q. Right. And I guess you can see that from
18 the strips.

19 A. Uh-huh.

20 Q. There's no indication in the flow sheets
21 what that modification can do, right?

22 A. No.

23 Q. It's not documented.

24 And so we wait 15 minutes, 30 minutes, 45
25 minutes, and you've still got late decels. You had

1 to go back to that maternal change --

2 A. Uh-huh.

3 Q. -- correct? Okay.

4 A. But just because it states late decels

5 there, doesn't mean that they were continuous.

6 Doesn't mean that they're minimized, they had

7 changed, or anything like that. And it's not charted

8 there, and there's no drop-down to click on that, but

9 that doesn't mean that the efforts were not

10 effective.

11 Q. I know. I know you think that.

12 So let's go to the next page, 8:45. This

13 is page 231. So we've got lates -- so at 8:45,

14 you're still documenting here. And you're

15 documenting, it looks like you did a whole lot of

16 documenting at about 10:23, right?

17 A. 10:23, you said?

18 Q. Yes, ma'am. You see this part where it --

19 A. Oh, I see what you're talking about.

20 Q. You see what I mean?

21 A. Yeah.

22 Q. So at 8:45, we got late decels. At nine

23 o'clock, we have late decels. And 9:15, we have late

24 decels, and at 9:30, we have late decels, correct?

25 A. Yes.

1 Q. And we know that at nine o'clock, it looks
2 like you're going to try a different position: left
3 side head of bed elevated, correct?

4 A. Yes.

5 Q. And then another half an hour goes by.
6 From that, we still have late decels. We're going to
7 try another position change: hands and knees,
8 correct?

9 A. Yes.

10 Q. And then we have a blank, right?

11 A. Yes.

12 Q. At 9:45. And then let's go to the next
13 page. This is at 231 -- or 232. Again, this is kind
14 of hard to follow because the timing is on a
15 different page. But if we go down, we're now at ten
16 o'clock, and there's nothing documented. And then at
17 10:28, we've got late decels, correct?

18 A. Nothing documented on ten o'clock?

19 Q. This one --

20 A. Oh, I see what you're talking about.

21 Q. Yeah. So you try another position change
22 at ten o'clock, and 15 minutes later, there's late
23 decels, right?

24 A. Yes.

25 Q. And then that column is empty. It says

1 10:30. But you've got 10:28, so whatever, that's the
2 same, basically.

3 And then at 10:43, another 15 minutes goes
4 by, you've got variable decels now, correct?

5 A. Yes.

6 Q. This is Category II the whole time, right?

7 A. Yes. So there is times throughout, he was
8 Category I.

9 Q. Yeah, I know. But not this time?

10 A. Not this time.

11 Q. And so at 10:43, you've got variable
12 decels, and so we're going to do our hands and knees
13 again.

14 A. Uh-huh.

15 Q. And then at 11:02, we've got variable
16 decels. And now we're going to do, it doesn't say
17 what, but you've got some maternal change, correct?

18 A. Yes.

19 MS. GUNN: And then the next page is --
20 let's see here. First -- sorry. Go back to 11:02.

21 Q. (By Ms. Gunn) 11:02, I just want to --
22 this right here, ma'am, where it says maternal
23 position change, that's -- now we're looking at this
24 set of timing that is all put in at 1:19, correct?

25 A. Yes.

1 Q. So there's a whole time check at 10:23 and
2 then another time check at 1:19. This is the last
3 time that I saw that a maternal position change was
4 documented.

5 Do you recall doing it after that?

6 A. Yes.

7 Q. You just didn't document it?

8 A. Didn't document it. That's probably the
9 time that Dr. McNeive was at bedside --

10 Q. Yep.

11 A. -- and we never left the room after that.

12 Q. No. This was at eleven o'clock in the
13 morning.

14 A. I mean, the charting. The charting, the
15 reason I didn't add more to the charting. The
16 charting shows that I did the charting at 1:19 in the
17 afternoon.

18 Q. Right.

19 A. Might have been during the laboring down
20 time when I had time to catch up.

21 Q. Right. Because she was down an hour and
22 20 minutes at that point?

23 A. Yeah. So that's probably when I took that
24 time to try and catch up on charting. And then
25 after, no more was added to the charting in the back

1 probably because we were in the room with Dr.

2 McNeive.

3 Q. Right. I think the next charting wasn't
4 until like six o'clock or something?

5 A. Yes.

6 Q. Okay. But my question, ma'am, is that you
7 did go back and chart things?

8 A. Yes.

9 Q. And you charted things that happened?

10 A. Yes.

11 Q. And there's no further documentation of
12 maternal positing changes after 11:00 a.m.?

13 A. Yes.

14 MS. GUNN: Okay. Next page.

15 Q. (By Ms. Gunn) Now, we've got 11:17. Late
16 decels -- this is your charting -- and variable
17 decels, right?

18 A. Yes.

19 Q. 11:37, late decels? variable decels?

20 A. Yes.

21 Q. 11:47, late decels. 11:55, late decels,
22 correct?

23 A. Yes.

24 Q. And you were looking at the strip when you
25 were writing all this down, correct?

1 A. Yes. Yes.

2 Q. And there's -- I mean, that's after
3 multiple hours of position changes, correct?

4 A. Yes. But, again, just because it says
5 late decels there, doesn't mean they were continuous
6 without a break or any minimizing or any change in
7 their appearance.

8 Q. I understand.

9 A. So it says late decels. There might have
10 only been one late decel in that 15 minutes. That
11 doesn't mean it was continuous. There might have
12 just been one or two.

13 Q. I understand. But they're continuing to
14 happen?

15 A. They're continuing to happen, yes.

16 Q. So let's go to the next page. So -- and
17 there was also -- let's see. we've got -- there was
18 laboring down from 12:12 and 1:32.

19 Do you remember that?

20 A. Yes.

21 Q. Now, that also is not documented?

22 A. It doesn't appear so.

23 Q. All right. So then we get to -- I need to
24 go -- now we need to go to page 215. I don't know we
25 need to go backwards, but that's the way the flow

1 sheets kind of turned out.

2 And now we've got Jessie documented. So
3 why did you document for so long, and then Jessie
4 documented after that?

5 A. To help me out getting caught up on
6 charting.

7 Q. Okay. So now we're at 1:15. Let's go
8 down. I want to stop here at 1:15 or 1:16.

9 MS. GUNN: A little bit further. Yeah.

10 Q. (By Ms. Gunn) Now -- now Jessie is
11 charting, and she writes "prepare for delivery"
12 again, right?

13 A. Yes.

14 Q. And at least, in your mind, that meant
15 baby was ready to come, correct?

16 A. We were getting there. I can't put a time
17 frame on it. And I can't speculate why Jessie puts
18 that in there.

19 Q. I understand. So at this point, you --
20 you believe, or are quite positive, I think you told
21 us, that the position changes were working, and
22 there's nothing, no problems, no concerns,
23 whatsoever, correct?

24 A. Correct.

25 Q. And so based on the position changes

1 working, you did not do the fluid bolus, correct?

2 A. Correct.

3 Q. You did not continue or turn down the
4 Pitocin? It never even crossed your mind?

5 A. Didn't need to, no.

6 Q. Now, you understand that Pitocin increases
7 contractions?

8 A. Yes.

9 Q. Increases the strength of contractions?

10 A. Yes.

11 Q. And if the contractions are stronger, that
12 affects the oxygenation of the baby?

13 A. Yes.

14 Q. And I think you did say that the fluid
15 bolus, the Pitocin, turning down or discontinuing,
16 and the maternal positions, those are all in the
17 same -- in the same plain?

18 A. Yes.

19 Q. Now, you knew, when you took over from
20 Alex at 7:17, that Sarah had had -- had been pushing
21 with Nurse Alex for 2, 2 and a half hours?

22 A. Yes.

23 Q. And that Dr. Mckillip had been in there.
24 And Dr. Mckillip had done a pushing evaluation and
25 had noted that Remi was not descending, correct?

1 A. I think she said minimal descent.

2 Q. with pushing?

3 A. Yes.

4 Q. So with pushing, Remi would come down, but
5 then he would go back up to zero station after
6 pushing was over, correct?

7 A. Yes.

8 Q. And also that he was malpositioned at OP,
9 correct?

10 A. Yes.

11 Q. So you would have known those things when
12 you took over care of Sarah, right?

13 A. Yes.

14 Q. Now, you've told us, and you understood
15 that if the baby was malpositioned, that could affect
16 the baby's descent, correct?

17 A. Yes.

18 Q. And you didn't understand at the time or
19 hadn't been trained at the time about what an arrest
20 of descent was, correct?

21 A. I knew what arrest of descent was then,
22 yes. And it wasn't like there wasn't literature that
23 I read on it. It was just on the job.

24 Q. And what was it?

25 A. Baby not moving at all.

1 Q. And what -- how do you measure that?

2 A. If you were to use your fingers, you feel
3 nothing. There is no movement. There is no rocking.
4 There's no pulsating. There's nothing. It's just
5 still.

6 Q. Okay. And so when Remi didn't move past
7 zero station after pushing, that was arrest of
8 descent?

9 A. He did not move. He made -- he made
10 progress. It was slow, and I understand that it
11 wasn't documented, so, therefore, there's no written
12 proof of what I say, but there was descent being
13 made. Slow, but yes.

14 Q. Well, and that's what I want to talk
15 about. Descent, I mean, you know, prolonged second
16 stage means it's taking a long time to get to
17 delivery?

18 A. Yes.

19 Q. And that can be dangerous to the baby?

20 A. It could be.

21 Q. And I know everyone has said there's no
22 time limit. There's no upper limit. But at some
23 point, you have to understand, I guess, that the
24 longer it takes, the more risk there is to the baby,
25 right?

1 A. And that all depends on what the fetal
2 heart strips look like through that progress.

3 Q. Sure. I agree.

4 A. Yes.

5 Q. I agree. I agree to that.

6 And we found ourselves in a Category III
7 at the end of his labor, right?

8 A. Yes.

9 Q. Tachycardic and minimum or absent
10 variability.

11 A. Minimal.

12 Q. So this progress that you eyeballed, I'm
13 trying to -- I just guess I'm still kind of confused
14 because we've heard testimony that, you know, Sarah
15 wasn't just kind of in the stirrups the whole time,
16 right?

17 A. No, correct.

18 Q. She was on a ball and moving around. And
19 so it's not as if you could look across the room and
20 see where the baby was, correct?

21 A. Well, no. But, yes, I did do digital
22 exams.

23 Q. I understand. But what I'm trying to
24 understand is if you're eyeballing it, you're not
25 really seeing where the baby's head is.

1 A. Oh, yeah. If I can see, in eyeballing it,
2 I can see where the head is. I can see that
3 movement. I can see that pulsation. I don't have to
4 put my fingers in her vagina to determine that.

5 Q. Okay. How much was caput?

6 A. I don't remember, other than what's in the
7 chart.

8 Q. And the chart was plus 1 and plus 2 caput.

9 A. Yes.

10 Q. And that was at 6:00 a.m., right?

11 A. Yes.

12 Q. And so hour after hour after hour, when
13 you're pushing and pushing and pushing, that swelling
14 is growing, correct?

15 A. It can, yes.

16 Q. So if you're eyeballing it, is there any
17 way to tell whether you're seeing progress, or
18 whether you're seeing growing caput?

19 A. No. You can see progress, yes. Not only
20 do you see the fetal head, you see the bulging of the
21 perineum, also.

22 Q. Yeah. And I think you also told us that
23 you saw a lot of that rocking, right?

24 A. Uh-huh. That's very normal. That's what
25 happens with every stage of pushing.

1 Q. yeah. Hour after hour after hour after
2 hour of rocking.

3 A. Yeah.

4 Q. And growing caput.

5 A. Again, I don't know about the growing
6 caput.

7 Q. well, we know -- I mean...

8 can you accept Dr. Landon's deposition --

9 deposition? -- can you accept Dr. Landon's definition

10 of failure to descend as being less than a centimeter

11 an hour?

12 A. I don't know. I really couldn't say.

13 Q. okay. well, in terms of this failing to

14 descend, if it was -- if the definition is less than

15 a centimeter an hour, we can agree that Remi failed

16 to descend, correct?

17 A. If, by definition, okay.

18 Q. Do you agree?

19 A. Yeah.

20 Q. Now, and this malrotation -- or

21 malpositioning, that can be a reason why baby doesn't

22 descend, correct?

23 A. That can slow the progress down, yes.

24 Q. Yeah. And that's something you knew at

25 8:00 a.m., that Pitocin was set at 18.

1 A. Yes.

2 Q. That Sarah's pushing effort was great.

3 A. Yes.

4 Q. That Baby Remi had been determined to be
5 malpositioned by the physician.

6 A. Yes.

7 Q. And had failed to descend just by pushing,
8 correct?

9 A. I wouldn't agree to the failed to descend.

10 Q. Okay. And baby was in Cat II,
11 particularly around the same time that you're getting
12 on service and for the next 2, 3 hours correct?

13 A. Off and on, yes.

14 Q. And I think you did tell me, you did agree
15 with me, that you knew late decels meant that there
16 was less oxygen going to the baby?

17 A. Yes.

18 Q. And that then if less oxygen was going to
19 the baby, then you understood that you would be
20 worried about a brain injury, correct?

21 A. Potentially, Yes.

22 Q. Exactly. I mean, specifically a hypoxic
23 brain injury.

24 A. Yes. That's always a potential.

25 Q. And you knew that -- taking light --

1 taking action in light of Category II tracings was an
2 important thing to do?

3 A. Yes.

4 Q. And failing to do so could lead to a
5 hypoxic brain injury to the baby.

6 A. It could lead to it. That's why
7 interventions were done.

8 Q. The safety rounds at 10:45, you weren't
9 there?

10 A. No. I don't believe I was. I believe
11 Jessie was out there.

12 Q. And you have -- then you wouldn't be able
13 to tell us anything about what was actually said
14 about Sarah, if anything, right?

15 A. I know that Jessie came in and told me
16 that safety rounds happened, but I don't recall the
17 conversation.

18 Q. Right. And so what was discussed about
19 Sarah, if anything, you won't be able to tell us?

20 A. No.

21 Q. And we do know that no -- the plan was the
22 same?

23 A. Yes.

24 Q. To keep pushing?

25 A. Yes.

1 Q. At no point did you ever run the Clark
2 algorithm with Sarah, correct?

3 A. Not verbally, but that Clark algorithm is
4 ran in our heads every time we enter the room,
5 whether they're in active labor, in latent labor, in
6 second stage of pushing, that assessment is done
7 every time we enter the room.

8 Q. And that was never documented, correct?

9 A. No. We don't document that.

10 Q. I heard for the first time that the fetal
11 monitoring strips were shredded?

12 A. That is after -- then that's what they
13 did. But that's -- it didn't happen at that moment
14 on that day. I don't know when exactly the time
15 frame that that happened.

16 Q. I think you told us that you would have
17 made notes on them?

18 MS. KAMYKOWSKI: Your Honor, can we
19 approach?

20 THE COURT: You can.
21 (Proceedings were held at sidebar, outside
22 the hearing of the jury.)

23 MS. KAMYKOWSKI: Seems like Ms. Gunn is
24 trying to set up some inference that Mercy Hospital
25 in some way improperly disposed of these fetal heart

1 tracings.

2 She's never asked this in discovery. But
3 had she done so, she would have known that there is a
4 standard procedure by which the paper is destroyed,
5 and it was well before this case was ever filed. It
6 seems like Ms. Gunn is trying to do discovery days
7 before the trial, and that is not proper and
8 prejudicial to the defense.

9 MS. GUNN: I have no idea how to respond
10 to the notion that I didn't ask for the strips in
11 this case. That is absolutely not the case. I
12 obviously asked for the entire chart, including the
13 fetal monitoring strips, which any reasonable read of
14 that request would include all copies of the fetal
15 monitoring strips.

16 And today, for the first time, I heard
17 that they were shredded. And I am simply asking this
18 witness, who obviously knows about them, to explain
19 what her understanding was of how that happened. And
20 the question that I specifically asked, before the
21 objection, was that she would have had notes on them.

22 MS. KAMYKOWSKI: So just for the record,
23 Your Honor, what has been produced is the entire
24 legal file, there are no -- there were no strips at
25 the time that the request was made. There were no

1 paper strips. They did not exist because there is a
2 standard policy for retention. They are not part of
3 Mercy's legal medical records. The strips are simply
4 captured in Epic. And that is how they are produced
5 every single time.

6 with respect to the questions of this
7 witness, I think she can ask her, and she said,
8 sometimes at my direction, sometimes I make notes.

9 She can certainly ask her if she did, other than
10 trying to make an assumption and try to get this jury
11 to believe that there was something nefarious for not
12 having to produce papers available to Ms. Gunn at
13 whatever time she put Mercy on notice of this claim.

14 It's improper and prejudicial. There's no
15 foundation for that, and this witness certainly isn't
16 going to know about this retention policy of Mercy
17 Hospital's Health Information Management System.

18 MS. GUNN: The door was opened on direct,
19 and it is absurd to think that that shredded part of
20 this medical file isn't relevant, and how --

21 MS. KAMYKOWSKI: How is it relevant to
22 this witness?

23 MS. GUNN: It is relevant to this witness
24 because she said she made notes on them and then sent
25 them to medical records.

1 And then also, that's my personal opinion,
2 that it is absurd to think that Mercy had to wait for
3 me to send a medical authorization to be on file to
4 be on notice of this particular claim.

5 I am simply going to ask this witness what
6 all she knows about this. If she doesn't know
7 anything else, that's fine. The door has been
8 opened.

9 THE COURT: Objection's overruled.

10 (Proceedings returned to open court.)

11 Q. (By Ms. Gunn) Nurse Maggie, you indicated
12 on direct that you -- when -- I think when you said
13 you went back to fill in the chart, you would take
14 the paper?

15 A. Uh-huh.

16 Q. So let's just understand. This is a --
17 monitor is actually, I mean, spitting out paper.

18 A. Yes.

19 Q. What we saw kind of rolling through,
20 that's coming out.

21 A. Yes.

22 Q. And you would take that.

23 A. Yes.

24 Q. You would make notes on it.

25 A. Not -- I didn't say I would make notes.

1 You could make notes. It's not my common practice.
2 Once in a blue moon, I might mark a little text to
3 remind me of -- that something was done at that time.

4 Q. Okay. You certainly don't recall not
5 making notes on this one, correct?

6 A. I know I did not make any notes.

7 Q. And how do you know that?

8 A. Because it's not something I commonly do.
9 And that day, I did not make notes on those papers.

10 Q. Okay. So regardless of whether you made
11 any notes on the papers or not, you then put them --
12 you wait for the whole day to be done, and then what?
13 Fold them up?

14 A. Yeah. When the patient usually has gone
15 over to mom and baby, then we would go in and clean
16 up the room. We'd take the papers. Fold them up.
17 We wrap them in another piece of paper with a rubber
18 band with a mom sticker on it, and then we put it in
19 a box under the desk at the nurses' station. And
20 then I'm not sure who comes around in the mornings
21 and collects them.

22 Q. Okay. And it's your understanding they go
23 to medical records?

24 A. I believe they went to medical records. I
25 don't know if that's where they went first. But I

1 really don't know what happened to them after they
2 left the nurses' station.

3 Q. where else could they go, other than
4 medical records?

5 A. Before that, I'm not sure if someone in
6 the department looked them over or tallied them up
7 and sent them to medical records. I really don't
8 know the protocol and steps to that.

9 Q. what -- what department? Someone in what
10 department?

11 A. Labor and delivery.

12 Q. And who?

13 A. I don't know. I don't know.

14 Q. And then your understanding is they've
15 been shredded?

16 A. I believe that after a period of time,
17 whenever that might have been, they were disposed of.

18 Q. Did you want to see them?

19 A. I did not want to see them.

20 Q. so -- but with respect to whether I wanted
21 to see them, your understanding is they've been
22 shredded?

23 A. I presume that's -- yes. Yes.

24 Q. And you don't know?

25 A. Don't know when. That's out of my hands.

1 Q. In these flow sheets, I think that Nurse
2 Alex was documenting accelerations?

3 A. Yes.

4 Q. You can document accelerations if you see
5 them, correct?

6 A. Yes.

7 Q. And there may have been documentation in
8 accelerations in the two o'clock hour?

9 A. Yes.

10 Q. Other than that, you did not document any
11 accelerations at any time, correct?

12 A. Let me look back. You said prior to the
13 two o'clock hour?

14 Q. I believe there was one documented, along
15 with other variables, I believe, at the -- excuse
16 me -- maybe 216? And that would have been Jessie, I
17 think. Yeah. If you look at 215, accelerations
18 along with variable decelerations. And that was
19 documented by Jessie.

20 Do you see that, ma'am? That's on page
21 216?

22 A. I see it.

23 Q. Okay.

24 A. Yes.

25 Q. And that's the only one I saw. I saw

1 quite a few Alex documented, but I saw none that you
2 documented.

3 would that be accurate?

4 A. It looks accurate that I did not document.
5 That was probably a mistake on my part for not
6 documenting that.

7 Q. That's all I have. Thank you.

8 THE COURT: Any redirect?

9 MS. KAMYKOWSKI: Just very briefly, Your
10 Honor.

11 REDIRECT EXAMINATION

12 BY MS. KAMYKOWSKI:

13 Q. Maggie, just to start, I want to follow up
14 on progress.

15 A. Yes.

16 Q. Can a baby just be delivered vaginally if
17 there isn't progress?

18 A. Yes. I mean, eventually progress has to
19 be made. And progress was made all day long for him
20 to come out vaginally.

21 Q. And I heard Ms. Gunn talk to you just a
22 little bit about, it sounded like she might be maybe
23 disbelieving your testimony here under oath today
24 when she --

25 MS. GUNN: Your Honor, I object to the

1 characterization of that.

2 THE COURT: Sustained.

3 Q. (By Ms. Kamykowski) So we -- you know
4 there was progress in this case?

5 A. Yes.

6 Q. That's your testimony here?

7 A. Yes.

8 Q. Has that testimony ever changed?

9 A. No.

10 Q. She also commented that she didn't see on
11 the chart and these flow sheets that we went through,
12 any further position changes after, like, I think, in
13 the eleven o'clock hour.

14 MS. KAMYKOWSKI: Justin, can you pull up
15 for me Exhibit A2, page 233?

16 Q. (By Ms. Kamykowski) Get out of your way.

17 A. I've got this right here, so you don't
18 have to worry.

19 Q. Oh, okay.

20 MS. KAMYKOWSKI: And can you go down to
21 the time line that has the 11:55, please?

22 Q. (By Ms. Kamykowski) what does it say
23 right there at the top?

24 A. It's patient position.

25 Q. Okay. So is that a position change?

1 A. Yes.

2 Q. All right.

3 MS. KAMYKOWSKI: Can you go to page 215 of
4 that exhibit, please, Justin?

5 Q. (By Ms. Kamykowski) And right at the top,
6 at 1:28, what are you documenting there?

7 A. Patient position. Nourishment offered.

8 Q. So more position changes occurred prior to
9 Dr. McNeive arriving, correct?

10 A. Correct.

11 Q. All right. And then I wrote down the time
12 frames that Ms. Gunn talked with the laboring down.

13 And I don't -- if you want me to me pull Exhibit C2
14 up and play it again.

15 we went through the flow sheets with Ms.
16 Gunn. But we went through the strips that correlate
17 with those flow sheets, did we not?

18 A. Yes, we did.

19 Q. And did you tell this jury that when you
20 looked at your flow sheet data and correlated that
21 with the strips, that when intrauterine resuscitative
22 measures were imp --

23 MS. GUNN: Object to the leading nature of
24 the question.

25 MS. KAMYKOWSKI: Did she tell, that's not

1 a leading question.

2 THE COURT: I don't know that you've
3 gotten the whole question out. It's a rather
4 lengthy-worded question.

5 Q. (By Ms. Kamykowski) Maggie, when you
6 looked at the strips and correlated them to your flow
7 sheets, were there responses that Remi had to have
8 intrauterine resuscitative measures?

9 A. Yes.

10 Q. Were there times on the strips that we saw
11 that he resumed Category I fetal heart rate patterns?

12 A. Yes.

13 Q. And were those intermittently short
14 periods of time?

15 A. Not really. Especially with the laboring
16 down.

17 Q. Did you only eyeball Remi's progress
18 throughout this time?

19 A. No.

20 Q. What else did you do to make sure he was
21 progressing?

22 A. Not only did I observe, but also when
23 needed, I would physically with my fingers check
24 where he was, how his head was positioned, how
25 rotation was going. And when doing so, I'm also

1 assessing the caput. That's just a given. You can't
2 get past that.

3 Q. Are you also assessing whether he's making
4 further rotation?

5 A. Yes.

6 Q. Is rotation from OP to OA progress?

7 A. Yes.

8 Q. Nothing further. Thank you, Maggie.

9 THE COURT: Anything further on cross?

10 MR. PERRON: Yes, Your Honor.

11 RE CROSS EXAMINATION

12 BY MR. PERRON:

13 Q. We talked quite extensively during your
14 testimony and throughout the last couple of weeks
15 about moderate variability.

16 If you don't see moderate variability,
17 that particular term is absent variability, correct?

18 A. Minimal.

19 Q. Minimal or absent variability?

20 A. Yes.

21 Q. Okay. So on -- just when we're talking
22 about variability, the two sides of the column are, I
23 do see it, moderate variability?

24 A. Yes.

25 Q. And the other side of the column is

1 minimal or absent variability?

2 A. Yes.

3 Q. Okay. So looking at a Category II strip,
4 so we've got one of those 8-minute or 10-minute
5 windows.

6 A. Yes.

7 Q. If you see 5 decels-

8 A. Yes.

9 Q. -- but every single time you see that
10 return to moderate variability, is that reassuring to
11 you?

12 A. Yes.

13 Q. Is that baby still healthy?

14 A. Yes.

15 Q. Okay. So let's take it, again, two sides
16 of the column. You've got 5 decels as one of those
17 windows, 8-minute windows, you've got 5 decels and

18 moderate variability. But on the other side of the
19 column hypothetically, you got one decel and absent
20 or minimal variability. Which one is more
21 reassuring? One decel with no variability? Or 5

22 decels for each time you see variability?

23 A. 5 decels with the moderate variability.

24 Q. Okay. So is it the number of decels that
25 trigger your concern? Or is it the presence or

1 absence of moderate variability?

2 A. Mostly the presence and absence of
3 moderate variability.

4 Q. we talked about the durations of the
5 second stage of labor and the possibility of risks to
6 the baby.

7 So, again, within the context of what we
8 were just talking about, is it the presence at all of
9 late decelerations on the strip that raised your
10 alarm for one of those risks, or, is it, again, the
11 presence or absence of moderate variability?

12 A. The presence or absence of moderate
13 variability.

14 Q. And, again, until even just the last 14
15 minutes really of labor --

16 A. Uh-huh.

17 Q. -- was there ever an absence of moderate
18 variability?

19 A. No.

20 Q. Okay. No further questions.

21 THE COURT: Any further cross?

22 RECROSS EXAMINATION

23 BY MS GUNN:

24 Q. The last 30 minutes of labor included
25 tachycardia?

1 A. Yes.

2 Q. As well as absent or minimum variability,
3 correct?

4 A. Minimal, yes.

5 Q. Thank you.

6 MS. KAMYKOWSKI: Nothing further, Your
7 Honor.

8 THE COURT: Ma'am, you may step down.
9 Thank you very much.

10 All right. Ladies and gentlemen, based on
11 the timing, this is probably a good time for us to
12 take our lunch recess.

13 (A break was taken at 11:54 a.m., and the
14 jury was duly admonished. At 1:03 p.m., the
15 following proceedings were held in open court, in the
16 presence of the jury:)

17 THE COURT: Go ahead and be seated,
18 everyone.

19 on behalf of the defendants?

20 MR. PERRON: Yes, Your Honor. The defense
21 next calls Dr. Matthews.

22 THE COURT: Sir, if you'll step on up and
23 be sworn.

24 Please raise your right hand.

25 DENNIS JEROME MATTHEWS, M.D.,

1 having been duly sworn, was examined, and testified
2 as follows:

3 DIRECT EXAMINATION

4 BY MR. PERRON:

5 Q. would you please state your name for the
6 record.

7 A. Dennis Jerome Matthews.

8 Q. And, Doctor, do you have a subspecialty in
9 the field of medicine?

10 A. Yes, I'm a pediatric rehabilitation
11 medicine specialist.

12 Q. And, Doctor, is there a document, also
13 called a cv, that explains your background and
14 training and experience?

15 A. Yes.

16 MR. PERRON: Justin, if you could put up
17 Exhibit F4-B.

18 Q. (By Mr. Perron) Is this a copy of your
19 cv? It should also be on the screen in front of the
20 jury.

21 A. Yes, that's a copy.

22 Q. And just take the jury a little bit
23 through your education.

24 A. Okay. I graduated from medical school at
25 the University of Colorado. I did my residency in

1 physical medicine and rehabilitation at the
2 university of Minnesota.

3 Q. And take us through a little bit of the
4 background, clinical experience, that's pertinent to
5 this case.

6 A. So I finished my residency in 1978. And
7 at that time, I became a member of the pediatric
8 rehabilitation and faculty at the University of
9 Minnesota. I stayed there and became -- eventually
10 became the director of pediatric rehabilitation
11 medicine at the University of Minnesota from 1979 to
12 '84.

13 In 1984, I moved to the University of
14 Colorado, particularly the Children's Hospital of
15 Colorado. Became the director of pediatric
16 rehabilitation medicine and the chairman of the
17 Department of Pediatric Rehabilitation Medicine at
18 Children's Hospital-Colorado.

19 Q. Did my office send you medical records and
20 other documents to review, as part of your opinions
21 in this case?

22 A. Yes.

23 Q. Did you arrive at opinions in this case
24 pertinent to plaintiff's life care expectancy and
25 life care plan?

A. Yes.

Q. Did you provide those opinions to a reasonable degree of medical certainty?

A. Yes.

Q. Did you review the life care plan prepared by Dr. Liles?

A. I did.

Q. In large part substantively on the whole, did you disagree with anything in Dr. Liles' life care plan as it pertains to the projected future medical needs of Remi?

A. No. There weren't any major differences. We had some small qualitative differences for therapies and different kinds of equipment, but overall I thought it was -- the life plan was okay.

Q. With regard to Dr. Liles' opinion on life expectancy, do you share his opinions of a 60-year life expectancy?

A. No, I do not.

Q. Within the scope of your clinical practice, did you have opportunities to treat and provide care for patients with Remi's condition, in particular cerebral palsy?

A. Yes.

Q. Unfortunately does that condition, even

1 with good care, tend to limit those patients' life
2 expectancies?

3 A. Yes.

4 Q. Generally, based on your clinical
5 experience and knowledge of available literature,
6 what ways does or can that condition limit a
7 patient's life expectancy?

8 A. Well, there's ways. The primary one is
9 his ability to move for mobility is gone, so his
10 ability to do -- to move around independently. At
11 this stage, Remi has fair head control, but he
12 doesn't have the precept requisite skills to move
13 much beyond that.

14 He can roll from side to side. But he
15 doesn't roll all the way over. If you know how
16 babies develop their ability to move, they start off
17 with a little bit of head control, and they start off
18 with the ability to roll.

19 And then they move from there to sitting,
20 and then they move from there to crawling. And then
21 you pull up to stand. And they you eventually walk.

22 So he's stuck at the level of having a
23 little bit of fairly good head control, but inability
24 to move much beyond the rolling phase. But he can
25 roll from side to side. So that's the primary

1 reason.

2 Then you look at the other associated
3 reasons. His overall development, as you can tell,
4 both motor, cognitive, intellect, social
5 interactions, he's not the same age as you would
6 expect a 4-year-old boy at this point.

7 He has feeding difficulties. He isn't
8 able to maintain his nutrition very well without
9 extensive feeding and modifications in his feeding
10 program. He has a seizure disorder which mildly
11 affects him.

12 And then overall there are some of the
13 other associated things like he's had hip surgery and
14 those kinds of things. So that's what we all looked
15 at.

16 Q. Have you arrived at your own opinion on
17 Remi's life expectancy based on your education and
18 training, your review of the literature, your review
19 of the materials in this case, and your general
20 experience?

21 A. I have.

22 Q. To a reasonable degree of medical
23 certainty, based on Remi's current diagnosis, what is
24 his life expectancy, more likely than not?

25 A. His life expectancy would be his early

1 30s. We would expect him to live into his early 30s.

2 Q. In your experience, have you ever known a
3 child with Remi's condition who survived to age 60 or
4 beyond?

5 A. No.

6 Q. Dr. Liles -- did Dr. Liles prepared a
7 table with his annual total for the expense for each
8 year starting from age 4 through Dr. Liles' opinion
9 of life expectancy?

10 A. Yes.

11 Q. You can use -- now Dr. Liles himself did
12 not add up those annual expenses to any year except
13 for his two life expectancy opinions.

14 A. That's correct.

15 Q. Did you or anyone look at Dr. Liles'
16 annual totals, but instead total them up to the life
17 expectancy opinions of yourself and Dr. Shavelle in
18 this case?

19 A. Yes.

20 Q. Is there an exhibit that applies
21 Dr. Liles' annual totals from year 4 to the range of
22 life expectancy offered by you and Dr. Shavelle?

23 A. Yes.

24 MR. PERRON: Your Honor, can we publish
25 Exhibit 54-K to the jury?

1 MS. LENIVY: No objection, Judge.

2 THE COURT: You may.

3 MR. PERRON: Justin, if you would put up
4 F4-A. I've been saying that all week long, F4-K.

5 Q. (By Mr. Perron) Dr. Matthews, does
6 this -- and I'll represent to you because you weren't
7 sitting here with us for Dr. Shavelle's testimony.

8 Dr. Shavelle testified, he offered a median
9 additional age of 27 years for -- if we add 27 to his
10 current age of 4, total of 31. And then a life
11 expectancy average of an additional 30 years which,
12 in adding to current age 4, coming to 34.

13 Does this have the range, adding up
14 Dr. Liles' annual expenses from age 4 to age 31 and
15 from age 4 to age 34?

16 A. Yes.

17 Q. And Dr. Liles provided two options. One
18 option considering that Remi might stay at home. And
19 one option that he might, after reaching, I think,
20 age 18 or so, go to a facility.

21 Are those two options also reflected in
22 this exhibit?

23 A. Yes.

24 Q. And so the total, adding up Dr. Liles'
25 annual numbers for the home option, up to age 31,

what is the total?

A. 5,537,059.

Q. And using the home option again, up to age 34, what is the total?

A. 6,578,754.

Q. Switching over to the facility options.

Using Dr. Liles' number up to age 31, what is the total?

A. 5,209,186.

Q. And then, again, the facility option up to age 34?

A. 6,121,603.

Q. Those are all my questions.

THE COURT: Cross-examination?

MS. KAMYKOWSKI: No additional questions.

THE COURT: On behalf of the plaintiffs?

MS. LENIVY: Yes, Your Honor.

CROSS-EXAMINATION

BY MS. LENIVY:

Q. Apologies, Dr. Matthews, while I get myself situated here.

Dr. Matthews, it's good to see you again.

I know we took your deposition a couple months ago, and you were actually here for trial last week, as well, correct?

A. Yes.

Q. For part of the trial. But then you flew back to Colorado.

A. Yes.

Q. And now you're joining us here today again.

And I know you just testified. And essentially you were asked to do two things in this case: offer life expectancy opinions, as well as review the life care plans prepared by Dr. Liles, correct?

Those are the two tasks you had?

A. Correct.

Q. And to be clear, you did not prepare a life care plan of your own, correct?

A. Correct.

Q. And you more or less agreed with Dr. Liles' plan?

A. Correct.

Q. I know you did not do any independent cost evaluation within Dr. Liles' plan, but you agree with me, there's nothing that he planned out or costed out that shocked you or seemed unreasonable?

A. That's correct.

Q. His costs seemed in line with what you

1 have done in cases where you have prepared life a
2 care plan?

3 A. I don't -- I don't do life care plans.

4 Q. Okay. You --

5 A. I don't do life care plans.

6 Q. You do reports in cases, though?

7 A. Right. Correct. But I don't do life care
8 plans.

9 Q. Okay. In this particular case, though,
10 you were not asked to prepare a report?

11 A. That's correct.

12 Q. Do you agree, though, that the purpose of
13 a life care plan or maybe a rehabilitation plan is to
14 optimize a patient's function and improve their
15 quality of life?

16 A. Yes.

17 Q. Okay. I did have a couple of questions
18 about Dr. Liles' life care plan.

19 MS. LENIVY: Zack, if I could have 125-15.

20 Q. (By Ms. Lenivy) Dr. Matthews, I will step
21 back here so I'm hopefully not in your way or the
22 jury's way whenever Zack gets the life care plan
23 pulled up.

24 And you've seen this plan before, correct?

25 A. Yes.

1 Q. Okay. This was one of the four projected
2 evaluations that Dr. Liles prepared, correct?

3 A. I'm just trying --

4 Q. Because he did age up to 60. And then age
5 up to 75, which is a normal life expectancy, as well
6 as home care and facility care, correct?

7 A. Correct.

8 MS. LENIVY: Zack, can we go to page 33?

9 Q. (By Ms. Lenivy) There's just a couple
10 things I wanted to ask you about, Doctor. This is a
11 page on diapers.

12 Do you see that?

13 A. Yes.

14 Q. And Dr. Liles, his plan for diapers for
15 Remi ends at age 8, correct?

16 A. Correct.

17 Q. And do you recall reading in Dr. Liles'
18 deposition the reason he had diapers stopped for Remi
19 at age 8 was because his plan predicted enough
20 progress that Remi would become continent and able to
21 use the restroom on his own?

22 A. Correct.

23 Q. All right. And do you agree that Remi
24 will continue to make good progress and be able to
25 use the restroom on his own without needing diapers?

1 A. No.

2 Q. Okay. So you disagreed with Dr. Liles
3 here?

4 A. Correct.

5 Q. So then if you disagree with what
6 Dr. Liles' plan is, then Remi's plan here is, as
7 we've seen, he may actually need more than what
8 Dr. Liles has planned out, correct?

9 A. Correct, I guess.

10 Q. Okay. Well, I didn't hear you mention
11 that when you were talking with Mr. Perron on your
12 disagreements with him. But Dr. Liles planned for
13 progress.

14 You don't plan for progress, correct?

15 A. Not progress that he will be able to be
16 independent in toileting, no.

17 Q. So this is an example where the plan
18 actually underfunds what Remi will even need,
19 correct?

20 A. Perhaps. I don't -- I don't know if it
21 will underfund it or over fund it.

22 Q. Well, it's not funded at all, which means
23 it's underfunded.

24 A. Okay. That's fine.

25 MS. LENIVY: Zack, could we go to page 36?

1 Q. (By Ms. Lenivy) There is "for information
2 purposes only" at the bottom there.

3 Dr. Liles has two surgeries in here
4 listed. First is a heel cord and hamstring.

5 what is that, Dr. Matthews?

6 A. If he develops contractures, then you
7 would release the Achilles tendon in the medial
8 hamstrings.

9 Q. Okay. And is that because of his
10 spasticity from --

11 A. Correct.

12 Q. All right. And so this is something that
13 Dr. Liles has put in there. You can almost put a
14 repeat hip surgery.

15 Do you remember the history of Remi's hip
16 surgery?

17 A. Yes.

18 Q. All right. And what is that?

19 A. He's had an adductor release and a
20 bilateral varus derotational osteotomy.

21 Q. Okay. And do you know about what he's had
22 since then?

23 A. No.

24 Q. Okay. Well, either way, Dr. Liles has
25 included in here a heel cord and hamstring release

1 and a repeat hip surgery. But he has not costed them
2 out, correct?

3 A. Correct.

4 Q. So this is another example of something
5 Dr. Liles has said Remi may need in the future, but
6 has not specifically included a cost amount, correct?

7 A. That's his opinion, that's correct.

8 Q. And do you agree with Dr. Liles that this
9 is something that Remi, these two surgeries, is
10 something Remi may need in the future?

11 A. No.

12 Q. And why don't you believe Remi --

13 A. Based on my 45 years of clinical
14 experience.

15 Q. Okay. But if the jury believes, and
16 Dr. Liles has testified to why he included this in
17 his plan, and if the jury does believe that Remi may
18 need these surgeries in the future, again, this is
19 something that hasn't been specifically funded in
20 that final number, correct?

21 A. Dr. Liles is incorrect with his opinion.

22 Q. And that wasn't my question. My question
23 was if the jury, after hearing Dr. Liles' testimony,
24 believes this is something Remi may need in the
25 future, we've talked about he's already had some hip

1 surgeries. And a hamstring and heel release, that's
2 because of his spasticity from his CP, correct?

3 A. Correct.

4 Q. And if a jury believes that either surgery
5 he may need, I just want to be clear --

6 MR. PERRON: Your Honor, may we approach?

7 THE COURT: You may.

8 (Proceedings were held at sidebar, outside
9 the hearing of the jury.)

10 MR. PERRON: I think -- I think this is a
11 complicated question that the jury would require

12 expert opinion testimony whether or not he needs a

13 particular future surgery and the likelihood that

14 he'll need -- I believe this is complicated enough

15 that they would require expert testimony to support

16 this finding.

17 I don't think this is something that we

18 just toss to the jury and say, you may think this, or

19 you may think that. Dr. Liles testified to a

20 reasonable degree of medical certainty, and he said

21 he ultimately included and added up in his life care

22 plan is what Remi, in his opinion, would be

23 reasonably likely to need.

24 If he put something in his plan,

25 ultimately he has to put a price and add it into the

1 final number. I don't think the jury has a
2 foundation to otherwise find, along with what Dr.
3 Liles has said or any of these other experts on
4 cross-exam.

5 THE COURT: I'm going to overrule the
6 objection. The witness has testified that he does
7 believe that Remi will need those surgeries, and he
8 has the ability to speak to those issues.

9 (Proceedings returned to open court.)

10 Q. (By Ms. Lenivy) Dr. Matthews, I'll try to
11 shortchange my question here.

12 These two possible surgeries that
13 Dr. Liles testified to, they're not specifically
14 costed out in the final number, correct?

15 A. Correct.

16 Q. Okay. Thank you.

17 MS. LENIVY: Zack, can you jump to page
18 38?

19 Q. (By Ms. Lenivy) This is for residential
20 care. This is, again, if Remi were to live at home
21 with his family.

22 Do you see that, Dr. Matthews?

23 A. Yes.

24 Q. And what Dr. Liles has planned out is
25 under resident care/attendant care -- well, I'll

1 pause here for a second.

2 You agree, Dr. Matthews, that Remi needs
3 24/7 care, correct?

4 A. Correct.

5 Q. And he will need that 24/7 care for the
6 remainder of his life, correct?

7 A. Correct.

8 Q. Currently Remi is getting that 24/7 care
9 by his parents, correct?

10 A. As far as I know. I don't know the
11 specifics of what other cares he's getting.

12 Q. You didn't see that in the records? In
13 all of the medical records you reviewed?

14 A. I saw that they were primary. Since -- I
15 don't -- I haven't seen any updated records.

16 Q. Okay. Well, I'll represent to you, and
17 this has been explained to the jury, that currently
18 his mother is his primary caretaker.

19 Can you accept that?

20 A. Sure.

21 Q. And they don't have any attendant or
22 nursing care to help her or help her husband, Remi's
23 father Blake.

24 You accept that?

25 A. Sure.

1 Q. So currently Remi is getting his 24/7 care
2 needs taken care of entirely by his parents.

3 A. Okay.

4 Q. Okay. And that's been the case for the
5 entirely of his life.

6 Can you accept that?

7 A. Okay.

8 Q. And you understand that his mother Sarah,
9 who was a licensed nurse, she actually quit her job
10 to take care of Remi 24/7?

11 A. Correct.

12 Q. And you've worked with families like the
13 Anyans, taking care of a child like Remi, who has
14 needs like Remi, that's a full-time job, right?

15 A. Correct.

16 Q. There's no days off.

17 A. Correct.

18 Q. No vacations, right?

19 A. Well, I don't -- a lot of times families
20 take kids with them on vacation.

21 Q. Remi still needs all of his care, though?

22 A. Sure.

23 Q. Right. It's not like Sarah and Blake get
24 a break from having to provide for Remi and take care
25 of his very special needs, correct?

A. Correct.

Q. Right. And what Dr. Liles has done here under respite care attendant, beginning at age 3 and ending at age 21, he's given them 10 hours a week to age 21, correct?

A. Correct.

Q. Those 10 hours, I think, are only Monday through Friday, to basically account for 2 hours a day, Monday through Friday.

Does that sound right? Or do you recall reading that in his deposition?

A. I don't recall reading that in his deposition, so...

Q. So 10 hours a week for this 24/7 job, all the way up to age 21, correct?

A. That's what he puts in the plan, yes.

Q. Okay. And do you agree, though, that taking care of Remi is only going to get harder as he gets older and bigger, right?

A. Perhaps some, yes.

Q. Well, lifting a 4-year-old is very different from lifting a 15- or 16-year-old, correct?

A. Correct. But you put in for some other adaptive equipment to help with that.

Q. Right. But, for example, we talked about

1 diapers earlier.

2 Changing a diaper for a 4-year-old is very
3 different from changing a diaper for a 15- to
4 16-year-old, correct?

5 A. Some, yes.

6 Q. Okay. And so, for example, if this jury
7 chooses, after hearing all the evidence, to provide
8 Sarah and Blake Anyan more help than just 10 hours a
9 week of respite care up to the age of 21 for Remi,
10 this plan would underfund that, correct?

11 A. I guess, technically.

12 Q. Okay. I just want to make sure that the
13 final numbers that we're looking at, if this jury
14 wants to give this family more help than just 10
15 hours a week for the next 17 years, they may actually
16 need to award more than what Dr. Liles has included
17 in the final number, correct?

18 A. I guess.

19 Q. Okay.

20 MS. LENIVY: Can we go to page 39?

21 Q. (By Ms. Lenivy) Dr. Liles included --

22 MS. LENIVY: At the very bottom, Zack,
23 there's a little box that's really hard to see.

24 Q. (By Ms. Lenivy) But it reads: Home care
25 scenario assumes that Remington will live with his

1 family until age 21, then transition to his own home
 2 with supportive services and participation in
 3 supported work program for 6 hours a day, 5 days per
 4 week, between the age of 22 and 65?

5 Do you see that, sir?

6 A. Yes.

7 Q. Okay. And you think that that's
 8 reasonable, correct?

9 A. Yeah, that's fine.

10 Q. Okay. For Remi to have some level of
 11 independence and be able to live in his own home
 12 around the age of 21 for the remainder of his life,
 13 correct?

14 A. To live in his own home?

15 Q. That's what the plan says.

16 A. It says live with his family.

17 Q. Okay.

18 A. Oh, transition to his own home, yeah.

19 That's an option that's available.

20 Q. And Dr. Liles, I don't think his plan
 21 specifically included an amount for the purchase of a
 22 home, correct?

23 A. I didn't see that.

24 Q. Right. So if this jury, after hearing all
 25 of the evidence, chooses to help Remi get a home,

1 that may be something that the plan actually
2 underfunds that particular resource for him, correct?

3 A. Given that scenario, I guess that's
4 correct.

5 Q. And certainly Remi's not in a position
6 where he'd be able to work and make his own income in
7 order to buy his own home like most adult children
8 try to achieve, correct?

9 A. That's correct.

10 Q. Right. So either this would have to come
11 from a life care plan funded for him, money damages
12 funded for him, or that burden would fall on his
13 family, correct?

14 MS. KAMYKOWSKI: Object to the form, Your
15 Honor. Speculative.

16 THE COURT: Sustained.

17 MS. LENIVY: Zack, we can take Exhibit 125
18 down. Thank you.

19 Q. (By Ms. Lenivy) Dr. Matthews, I know you
20 weren't here during Dr. Woodruff's testimony. But
21 you recognize Dr. Woodruff's name, correct?

22 A. Correct.

23 Q. Right. He is a pediatric neurologist the
24 defendants hired, and he actually examined Remi,
25 correct?

1 A. Correct.

2 Q. You've never examined Remi? You never met
3 with his family, right?

4 A. That's correct.

5 Q. The jury heard from Dr. Woodruff, and he
6 mentioned something called a vagus nerve stimulator.

7 Do you know what that is?

8 A. Yes.

9 Q. And what is that particular device or
10 surgery?

11 A. It is for seizure disorder.

12 Q. It basically helps someone get their
13 seizures under control?

14 A. Correct.

15 Q. Minimize them, correct?

16 A. Correct.

17 Q. And Dr. Woodruff testified that that is a
18 potential option for Remi.

19 Were you aware of that?

20 A. No.

21 Q. Did the defense attorneys that hired you
22 let you know what Dr. Woodruff testified as far as
23 future options for Remi?

24 A. No.

25 Q. Okay. You agree with me, a vagus nerve

1 stimulator, that was not included in the life care
2 plan, correct?

3 A. That's correct.

4 Q. And I've seen that those surgeries range
5 in tens of thousands of dollars, correct?

6 A. Correct.

7 Q. So, again, and I think there's also some
8 costs associated with some regular maintenance and
9 check-ups of that device, correct?

10 A. Correct.

11 Q. So, again, if the jury wants to allocate
12 funds for Remi to get this vagus nerve stimulator,
13 this plan that we have in front of us from Dr. Liles,
14 that would underfund it, correct?

15 A. Given that scenario, that's correct.

16 Q. So that's something that the jury could
17 include in their final amount, but we don't

18 necessarily see that total in the life care plan,

19 correct?

20 A. Correct.

21 Q. Okay. Something else that has come up in
22 the trial is Sarah Anyan, Blake's mother -- I'm
23 sorry -- Remi's mother, testified how Remi is scared
24 to go to sleep because he had a seizure, and he's
25 scared to be alone.

1 Did you hear about that?

2 A. No.

3 Q. Okay. There is something along the line
4 of, Remi is scared to go to bed by himself because if
5 he has a seizure, it's very upsetting for him. And
6 so Sarah has told him, if you start to feel a seizure
7 to yell and get really loud.

8 And that kind of communication, is that
9 something that you encourage families to have with
10 children like Remi? Give them instructions and then
11 workarounds for situations like that?

12 A. Based on my review of the records, I'm not
13 sure that he has the cognitive ability to do that.

14 Q. Okay. So as you sit here today, you don't
15 know what cognition skills Remi has.

16 A. Well, based on my review of the records,
17 and watching all the videos, I'm not sure that he's
18 making cognitive sounds or calling his mom based on
19 specific instances. I think he's responding to being
20 uncomfortable, but I'm not sure it's specifically
21 because he's understanding that he's having a
22 seizure.

23 Q. Understanding whether a child has
24 cognition and how the parents understand that child,
25 that's something you would be able to learn from

1 examining the child and speaking to the family,

2 correct?

3 A. Sometimes, yes.

4 Q. And you didn't do that here?

5 A. That's correct.

6 Q. You never asked to speak to Blake and
7 Sarah Anyan, correct?

8 A. Correct.

9 Q. You never asked to see Remi yourself,
10 correct?

11 A. Correct.

12 Q. You're relying solely on Dr. Woodruff's
13 examination from January of 2024, correct?

14 A. No. Dr. Liles, Dr. Woodruff, all of the
15 records. So I looked at all the records. I'm not
16 relying on just one specific record.

17 Q. And Dr. Liles does account for Remi's
18 cognition and includes augmentative communication
19 devices, correct?

20 A. Correct.

21 Q. So one of the two experts in this case who
22 did actually examine Remi and speak with his family,
23 says that he's got a level of cognition, correct?

24 A. He -- he -- he -- I'm not sure that they
25 said that.

Q. well, the jury has heard from Dr. Liles.

But as far as what Dr. Woodruff said about Remi's ability to communicate and use something, for example the Tobii device, the defense attorneys didn't tell you what Dr. Woodruff said about that, correct?

A. That's correct.

Q. So if Dr. Woodruff sat exactly where you're sitting a couple days ago and said he saw progress with Remi's cognitive ability in using communication devices, you have no reason to dispute that, correct?

A. That's correct.

Q. Okay. Either way, getting back to what Sarah Anyan told her son, which is, if you feel a seizure coming, and you're in bed alone, get real loud, and mom and dad will come.

Can you accept that that was testimony that you have not heard and you're not aware?

A. Sure.

Q. But has been said in this courtroom?

A. Sure.

Q. well, cognition or not, you know, I got to thinking after Sarah told that story, is that something that, for example, a smart dog -- a service

1 animal -- a service animal, sorry.

2 Is that something a service animal might
3 be able to help Remi with, detect seizures and alert
4 the parents if he's having a seizure?

5 A. In theory. But generally those service
6 dogs aren't used in that situation. The person that
7 uses the service dog has to be able to take care of
8 and use the service dog, and Remi won't be able to do
9 that.

10 Q. Could his family take care of a service
11 dog for him?

12 A. Sure. But -- it's -- it's a possibility.

13 Q. All right. And so, again, if this jury,
14 after hearing all of the evidence, decides that maybe
15 they want to give Remi a service animal to help him
16 alert his family when he has a seizure, or any other
17 medical issue that may need attention, that's
18 something that Dr. Liles did not include in his plan,
19 and, therefore, maybe it's underfunded.

20 would you agree?

21 A. Sure.

22 Q. Okay. Dr. Matthews, you charge for your
23 work, correct?

24 A. Correct.

25 Q. I think you bill at a rate of \$750 per

1 hour, correct?

2 A. That's correct.

3 Q. The invoice I saw at your deposition in
4 May of 2024, you had already billed \$7,867.

5 Does that sound right?

6 A. Correct.

7 Q. And then I think we took your deposition
8 about an hour. And I think you charge \$800 an hour
9 for your testimony?

10 A. Yes.

11 Q. All right. I saw in your fee schedule,
12 you charge, not only for your time testifying, but
13 also for your time travelling, correct?

14 A. Correct.

15 Q. What is your travel fee?

16 A. I charge \$750 for 12 hours of travel.

17 Q. All right. And so you have made two trips
18 to St. Louis now.

19 How are you charging for that?

20 A. I haven't figured it out yet, but I'll be
21 charging two days' worth of travel.

22 Q. Okay. Would that come out -- I mean, from
23 here to Colorado, is that about a 4-hour flight?
24 3-hour, 4-hour flight?

25 A. I, on Thursday I came, and I left at 6:00

1 in the morning, and I got back to Denver at ten

2 o'clock at night.

3 Q. Okay. So that's 16 hours of travel?

4 A. That's right. So I'm charging for 12.

5 Q. Okay. For 12. And then I'm guessing
6 you're doing the same thing again today?

7 A. Correct.

8 Q. And then I assume you also spent some time
9 reviewing records between the time we took your
10 deposition leading up to trial, correct?

11 A. There weren't very many new records. So
12 included in my travel time, is record review.

13 Q. Okay.

14 A. So I, when I'm on the airplane, I sit down
15 and read the records.

16 Q. So maybe an additional 24 hours at \$750 an
17 hour?

18 A. No.

19 Q. No. Between the travel and your review?

20 A. Correct.

21 Q. Okay. As far as your litigation work, you
22 stopped active clinical practice in 2021, correct?

23 A. I stopped my personal active clinical
24 practice in June 30 of '21.

25 Q. Congratulations on your retirement.

1 A. Thank you.

2 Q. You've been testifying in litigation
3 matters, though, since the early 1980s, correct?

4 A. Correct.

5 Q. And I think I heard you say 1984, was when
6 you went to Colorado?

7 A. Correct.

8 Q. And that's about the time you started
9 testifying in litigation, as well, correct?

10 A. A few cases in Minnesota probably. And
11 since then, Colorado.

12 Q. Okay. And I think you told me that over
13 the last 40 years of testifying in litigation, you do
14 about 5 cases a year?

15 A. Correct.

16 Q. So that would put you maybe around 200
17 cases that you reviewed total, right? Correct?

18 A. Correct.

19 Q. All right. The majority of the time that
20 you are retained in the case, I assume it involves a
21 child who has suffered some sort of an injury, right?

22 A. For the vast majority of cases.

23 Q. Okay. Vast majority of cases involves a
24 child who has suffered an injury. And the vast
25 majority of the time where we're talking about a

1 child who suffered an injury, it specifically
2 involved a medical legal case, a medical malpractice
3 case?

4 A. A majority, that's correct.

5 Q. And about 75 percent of that time, you
6 were hired by defendants, correct?

7 A. Correct.

8 Q. So looking at your 200 or so cases that
9 you have testified in litigation matters for, most of
10 them have been on behalf of defense -- defendant
11 medical providers against plaintiff children,
12 correct?

13 A. Correct.

14 Q. Okay. And of those cases, you are
15 typically being asked to render opinions on life
16 expectancy, correct?

17 A. A majority of the time, correct.

18 MS. LENIVY: Zack, could you pull up
19 165-3, please. 165-3, page 11.

20 Q. (By Ms. Lenivy) Dr. Matthews, this is
21 from some of the correspondence, and we reviewed some
22 of this in your deposition back in May.

23 So you were first contacted in this case
24 on July 31st, 2023, by Ms. Pfirrmann. And that first
25 line reads: Dr. Matthews, our office represents a

1 hospital in a lawsuit pending in St. Louis County,
2 Missouri.

3 Did I read that correctly?

4 A. Correct.

5 Q. so from the initial communication you
6 received in this case, you knew that you were going
7 to be asked to review a case on behalf of a defendant
8 provider, correct?

9 A. Sure.

10 MS. LENIVY: Could we scroll up to page 9?

11 Q. (By Ms. Lenivy) You responded that same
12 day, I believe, at the bottom there: May I ask where
13 you got my name?

14 And then if we scroll up -- oh, I'm sorry.
15 That's not Erin. It's not Ms. Pfirrmann, it's a
16 different Erin. My apologies.

17 But someone from Ms. Pfirrmann's office,
18 kamykowski & Taylor, responded: Dr. Matthews, we
19 found your name on a legal website, ERI. It has
20 resources for defense attorneys.

21 And so you understood -- did I read that
22 correctly, Dr. Matthews?

23 A. Sure.

24 Q. All right. And so you understood, from
25 the moment that you were first retained in this case,

1 that not only was it on behalf of a defense medical
2 provider, but that they found your name on a resource
3 for defense attorneys in handling these types of
4 cases, correct?

5 A. Correct.

6 Q. Okay. Now, I know you spoke about your
7 life expectancy opinions on direct examination.

8 Dr. Matthews, what was the last set of
9 medical records you reviewed? what was the date on
10 those?

11 A. I'd have to look. I can't tell you.

12 Q. Okay. Nothing in 2025, correct?

13 A. Not that I know of.

14 Q. Okay. And it sounds like you didn't get
15 any specific updates on how Remi was doing, from what
16 we've learned in this trial, correct?

17 A. That's correct.

18 Q. All right. So currently, what his
19 condition is, as of today, you have no idea, right?

20 A. well, as of the -- as of the -- not always
21 in my records, that's correct.

22 Q. okay. And I know that you are basing some
23 of your opinions on your clinical experience,
24 correct?

25 A. Correct.

1 Q. And you'd agree with me over the years,
2 you have seen improvements made in children's life
3 expectancies --

4 A. Sure.

5 Q. -- right?

6 And part of that is attributable to
7 improvements in medicine, right?

8 A. Correct.

9 Q. And part of that is improvements in
10 technology, correct?

11 A. Correct.

12 Q. And I know that you haven't had your
13 active clinical private practice since 2021.

14 But certainly you are aware that
15 technology to improve the quality and quantity of the
16 lives of children like Remi Anyan is being developed
17 even as we speak, correct?

18 A. There is technology being developed,
19 that's correct.

20 Q. Okay. And so what may be available 10, 20
21 years down the road for children like Remi, we don't
22 know, sitting here today, correct?

23 A. Correct.

24 Q. The jury has seen some videos of Remi
25 taken in August of 2024, using his gait trainer and

swimming.

Have you seen those videos --

A. Yes.

Q. -- taken in 2024?

Okay. Dr. Woodruff, the defense pediatric neurologist, did actually examine Remi, has testified that he saw progress between what he saw in his examination and then what he saw in the videos.

And you have no reason to dispute what Dr. Woodruff testified, correct?

A. Correct.

Q. Okay. And progress is a good thing, isn't it, Dr. Matthews?

A. Sure.

Q. Right. That's -- that's the entire point of all the therapy and all the work that Remi and Sarah and Blake do, correct?

A. Correct.

Q. And you have an understanding that Dr. Liles based his plan and his opinions with the goal of continuing progress, correct?

A. Correct.

Q. Okay. I know you based part of your life expectancy opinion on Remi's ability to feed, correct?

A. Correct.

MS. LENIVY: Zack, can you bring up Exhibit 620?

Q. (By Ms. Lenivy) I'm sure the jury has seen this, but we'll show it to them again.

Okay. Remi's -- you've seen his Mercy records, correct?

A. Correct.

Q. And they were initially talking about wanting to put him on a G-tube, right?

A. Correct.

Q. Remi has never been on a G-tube, correct?

A. That's correct.

Q. His nutrition and his feeding have come from the family working with him, correct?

A. Correct.

Q. And you've seen the records where it talks about him working to get a spoon up to his mouth, correct?

A. Correct.

Q. Right. And that's good, that's progress. Going from needing -- possibly needing a G-tube, to working to get a spoon up to his mouth, that shows a progression, right?

A. Sure.

1 Q. And that's what we want. That's the point
2 of therapy and all of the work that this family is
3 doing with this child, correct?

4 A. Correct.

5 Q. And have you seen in the parents'
6 deposition talk about how much Remi loves to eat?

7 A. Sure.

8 Q. Right. Let's -- I know it's on. But that
9 looks like a well fed child to me.

10 Do you agree, Dr. Matthews?

11 A. Looks fine.

12 Q. I think he looks great.

13 Dr. Matthews, I'm wrapping up here.

14 Just to clarify, you do not have any
15 standard of care opinions, correct?

16 A. That's correct.

17 Q. You also do not have any causation
18 opinions, correct?

19 A. That's correct.

20 Q. Right?

21 But you've seen in the depositions that
22 have been taken in this case that Remi's HIE is
23 hypoxic and ischemic in origin, correct?

24 A. Correct.

25 Q. Right?

1 But as far your opinions, they only relate
2 to what we call damages, right?

3 A. Correct.

4 Q. You agree that Remi's HIE is significant?

5 A. Sure.

6 Q. And I think I heard you tell Mr. Perron
7 that it's your opinion, because of Remi's HIE, his
8 life expectancy will be shorter than that of other
9 4-year-old boys.

10 A. Correct.

11 Q. If Remi didn't have that HIE and all the
12 injuries that come from that, you have no other
13 evidence he would have lived anything other than a
14 normal life expectancy?

15 A. No.

16 Q. Right?

17 Because his HIE is the basis for your
18 opinion that he's going to live fewer years than
19 other 4-year-old boys, right?

20 A. His whole constellation of his clinical
21 condition, correct.

22 Q. The constellation of his clinical
23 condition all stemming from that HIE, right?

24 A. Correct.

25 Q. So if the jury believes -- I want you to

1 follow me here, Dr. Matthews -- if the jury believes
2 that the defendants' negligence caused or contributed
3 to cause Remi's HIE, then that same negligence is the
4 very reason Remi will die so much younger than you
5 opined.

6 Correct, Dr. Matthews?

7 A. Correct.

8 Q. Okay. Let's say the jury chooses to award
9 Remi future medical damages. So they've gotten past
10 standard of care and causation. Now we're talking
11 about how much will it take to take care of this
12 child for the rest of his life, all right?

13 And if the jury chooses, when making that
14 decision to accept your life expectancy opinion and
15 only fund the amount you have opined to, and then
16 Remi outlives that, do you understand, Dr. Matthews,
17 that he doesn't get to come back to court and ask for
18 more money, correct?

19 A. That's correct.

20 Q. Right. He'll just have an under funded
21 plan because you have limited his life expectancy in
22 your opinions, correct?

23 A. I haven't limited his life expectancy,
24 I've rendered my opinion.

25 Q. All right. I'll rephrase it. That's a

1 good distinction, Dr. Matthews, and I'll rephrase it.
2 Remi would have an under funded life care
3 plan because you have opined and the jury has -- if
4 they choose to believe your opinions, that has
5 reduced his life expectancy which he may outlive,
6 correct?

7 A. I can only opine about my opinion, I
8 guess. If, in that scenario, you're probably
9 correct, but, you know, that's not the scenario I
10 believe.

11 Q. But you cannot testify within a reasonable
12 degree of medical certainty that Remi Anyan will be
13 dead by age 34?

14 A. I can, by a degree of medical certainty,
15 say that that is my expected life expectancy, that is
16 correct.

17 Q. okay. Dr. Shavelle -- and you rely on Dr.
18 shavelle's literature, correct?

19 A. I know his literature. I don't rely
20 solely on his literature.

21 Q. well, Dr. Shavelle sat in the same seat
22 you're in right now. He sat there last Friday, and
23 he told us that his opinions on life expectancy are
24 speculative. Remi could live fewer years, or he
25 could live many years beyond that.

1 were you aware of Dr. Shavelle's
2 testimony?

3 A. No.

4 Q. Okay. By the way, Dr. Matthews, you'd
5 agree with me that the goal with Remi is that he will
6 continue to make progress, as Dr. Woodruff testified
7 to, and that he'll live as many years as possible
8 with his family, correct? That's the goal.

9 A. Correct.

10 Q. Right. And that's the very purpose of a
11 life care plan, or really any rehabilitation plan, is
12 to give Remi the highest quality of life and highest
13 quantity of years of life, correct?

14 A. Correct.

15 Q. Thank you, Dr. Matthews.

16 THE COURT: Any redirect?

17 MR. PERRON: Yes, Your Honor, just
18 briefly.

19 REDIRECT EXAMINATION

20 BY MR. PERRON:

21 Q. Dr. Matthews, kids with Remi's condition
22 might continually make progress in their mobility for
23 years or even decades, but still not actually become
24 independently ambulatory, walking on their on.

25 Is that fair?

A. That's absolutely correct.

Q. Okay. Same type of questions. Kids with Remi's condition might continually make progress with being able to hold onto a spoon and maybe, in some way, use that spoon in a limited manner to bring food up to their mouth.

But does that mean, even if they make progress for years and years and years, they might not actually get to the point where they can be responsible for their own nutritional needs?

A. That's correct.

Q. And that's really the test. Not whether or not they can hold a spoon, but whether or not they can be responsible for their own nutritional needs.

A. That's correct.

Q. Okay. And you read -- did you read Dr. Liles' deposition?

A. His previous first deposition?

Q. Right.

A. Not -- nothing here.

Q. Not his trial testimony.

A. That's correct.

Q. But his original deposition.

A. I did.

Q. And you read his report?

1 A. Correct.

2 Q. And did Dr. Liles, in both his deposition
3 and his report, affirm that what he was including in
4 adding up his life care plan, was he, Dr. Liles, the
5 expert retained by plaintiffs' counsel, what
6 Dr. Liles himself believed Remi would be reasonably
7 necessary -- what Remi would reasonably necessarily
8 need for his future care?

9 A. Yes.

10 Q. That's what was in Dr. Liles' life care
11 plan?

12 A. Correct.

13 Q. Okay. Those are all my questions.

14 MS. LENIVY: Nothing further.

15 MS. KAMYKOWSKI: No recross, Your Honor.

16 THE COURT: May this witness be excused?

17 MR. PERRON: Yes, Your Honor.

18 THE COURT: Thank you very much, sir.

19 THE WITNESS: Thank you.

20 THE COURT: We'll be right back with you.

21 (The proceedings were held at sidebar,
22 outside the hearing of the jury.)

23 THE COURT: Yes?

24 MS. SLATER: Your Honor, this is the
25 plaintiffs' proposed spoliation instruction. We

1 learned information yesterday from Margaret
2 McLeLland -- we learned for the first time today, when
3 the plaintiff asked Mercy Hospital, questioning the
4 fetal monitoring strips, that the paper copies have
5 been shredded.

6 She was prepared for that question. And
7 she was ready to answer it. And Mercy Hospital
8 obviously wanted that information to be in front of
9 the jury to explain some things about what we are not
10 seeing in the case.

11 I had checked Yvette Cotton's deposition.
12 She's the corporate representative from Mercy
13 Hospital who we actually had sit and testify that we
14 have all of the records. She was asked about what
15 the additional records that she produced: And that
16 623 pages of records also includes the fetal
17 monitoring strips?

18 "ANSWER: It does. I did also produce to
19 you some extra pages that were not included in that
20 flash drive that are the clinical related documents
21 from the media tab that I had initially forgotten to
22 add to the flash drive."

23 So that's on page 8, all the way to 9.

24 In this deposition, there was no mention
25 of anything designated as the legal record. And so

1 in this case, I believe we have shown the Court
2 evidence that we have had of these records at Mercy
3 Hospital. Direct examination of their own nurse,
4 they brought up this issue, and there's evidence that
5 has been in front of the jury.

6 So we ask that this instruction be given.
7 And if you don't mind, I'll read it into the record:

8 Evidence has been presented that Mercy
9 Hospital East Communities shredded the physical fetal
10 monitoring tracings of Remi Anyan. You can infer
11 that the destroyed evidence would have been
12 unfavorable to Mercy Hospital East Communities.

13 MS. KAMYKOWSKI: Your Honor, in response,
14 first and foremost, I haven't had a chance to go back
15 and look at Yvette Cotton's deposition or the writer
16 of the corporate representative definition that she
17 gave.

18 However, I can tell this Court
19 unequivocally that there is no spoliation of evidence
20 in this case. There is an instruction, which by the
21 way in the MAI is the only spoliation instruction
22 that I've heard of, and this one is completely
23 improperly. Giving this instruction to the jury is
24 improper because there's absolutely no evidence, nor
25 does this witness have any evidence, that anything

1 untoward or un -- improper happened of the
2 preservation or lack thereof of any medical record
3 that was in Mercy Hospital's possession.

4 what Ms. Gunn and Ms. Slater, Ms. Gunn,
5 particularly, because she's done this work for years
6 and years knows, the paper copy of this fetal monitor
7 tracing that's been discussed at length, both in this
8 trial and in the pretrial discovery of this case.

9 There was never a request to find out, A,
10 after discovery is completed, what is their standard
11 process by which they instruct those papers are
12 either maintained or not maintained. That is
13 something that could have been discovered a long time
14 ago.

15 There has been no evidence in this case at
16 trial that the fetal monitor tracings were maintained
17 by Mercy Hospital and kept in their possession,
18 custody, or control beyond what the particular
19 records retention policy exists.

20 There has been no evidence they were
21 destroyed after Mercy was placed on notice of this
22 lawsuit. And to offer an instruction about that,
23 there's no opening the door to spoliation, Judge.
24 All this jury has heard throughout this trial is that
25 there were paper copies.

1 And I asked the witness what -- and she
2 was -- there's been an inference that there was
3 improper medical documentation made by this witness
4 in the medical records. So -- and I heard that
5 throughout the trial before she testified. So I
6 asked her, if you are making late notations with some
7 implication with an inference by plaintiffs' counsel
8 into the record, tell us how you know you're
9 accurate. And that's what she did.

10 If you're going to be now talking about
11 going into discovery, it's not a spoliation issue or
12 we're going to be having a trial within a trial. I
13 would be -- should be allowed to have somebody come
14 in and explain the records and retention policies.

15 There is absolutely nothing nefarious
16 about how Mercy Hospital maintains its fetal
17 monitoring tracings, and there's been nothing that
18 the plaintiffs have shown to the Court that they
19 don't have the right evidence to -- that they didn't
20 have the right evidence to investigate the claim. So
21 I think this MAI is improper, and it infers a huge
22 error in this case.

23 THE COURT: The Court is going to deny the
24 request of plaintiff because it doesn't find
25 sufficient basis to provide such an instruction at

1 this time.

2 MS. KAMYKOWSKI: Thank you, Judge.

3 MS. SLATER: You want me to withdraw it
4 now that the instruction has been offered and marked
5 denied, or do you want to retain the copy?

6 THE COURT: I'll retain it because I'm
7 going to write on it that I denied it.

8 MS. SLATER: Yes, Judge.

9 MS. KAMYKOWSKI: Thank you.

10 (Proceedings returned to open court.)

11 THE COURT: On behalf of defendants?

12 MS. KAMYKOWSKI: Thank you, Your Honor.

13 On behalf of Mercy Hospital, we call
14 Dr. Adriane Burgess.

15 THE COURT: Ma'am, if you'll step on up
16 and be sworn.

17 ADRIANE BURGESS, PH.D.,
18 having been duly sworn, was examined, and testified
19 as follows:

20 DIRECT EXAMINATION

21 BY MS. KAMYKOWSKI:

22 Q. Good afternoon, Adriane, how are you?

23 A. I'm fine. Thank you.

24 Q. Can you introduce yourself to the jury,
25 please.

1 A. Hi, everyone. My name is Adriane Burgess.

2 I am a nurse by background.

3 Q. And, Dr. Burgess, have you ever done this
4 before, sat in a courtroom and testified?

5 A. I have not.

6 Q. Okay. So since this is your first time,
7 I'll stand back here because when people are nervous,
8 I want to make sure they talk loud.

9 A. Okay. Talking loud is not my problem.

10 Q. So everyone can hear you.
11 All right. Tell us what is your
12 profession?

13 A. I am a labor and delivery nurse by
14 background. I teach, have taught, nursing, and
15 currently work in quality and safety.

16 Q. And when you say you "work in quality and
17 safety," can you just explain to us what you do?

18 A. Yeah. So I work with hospitals and health
19 systems and individual nurses and providers to help
20 them to evaluate the quality of care that they
21 provide.

22 Q. And did I ask you in this case to review
23 the fetal monitor tracings in Ms. Anyan's medical
24 record and render opinions about the nursing standard
25 of care?

1 A. You did.

2 Q. Okay. And did you reach conclusions in
3 this case about whether or not the nursing standard
4 of care was met?

5 A. Yes. And I believe the standard of care
6 was met.

7 Q. Okay. Just to make sure we're all on the
8 same page, when you are here offering opinions today,
9 will you agree that your opinions are held to a
10 reasonable degree of nursing certainty?

11 A. Yes.

12 Q. And when we talk about the standard of
13 care, will you follow that exact definition as
14 defined under Missouri law as utilizing that degree
15 of skill and learning ordinarily used under the same
16 or similar circumstances by members of defendants'
17 profession?

18 A. Yes.

19 Q. And other than from the medical records
20 perspective, other than the fetal heart monitoring
21 tracing and Ms. Anyan's May 4th, 2020, hospital
22 admission for labor and delivery, did you review any
23 other medical records in this case?

24 A. When you initially gave them to me or
25 later?

Q. well, is that what I initially sent?

A. Yeah. Initially you only sent Mrs. Anyan's records.

Q. And did you then receive additional records after that?

A. I did, yes.

Q. And depositions?

A. Yes.

Q. Okay. So just so that the jury hears from the get-go, and then we'll go into it, what is your overall opinion about whether the standard of care was met by Nurse Maggie and Nurse Jessie in this case?

A. That Nurse Maggie and Nurse Jessie met the standard of care.

Q. And is that opinion based on your review of the medical records, their depositions, other depositions in the case, as well as your training, education, and experience as a labor and delivery nurse and a nurse educator?

A. Yes. Initially I made that, you know, opinion even before seeing any of the depositions from anyone else, just in reading the medical records.

Q. Okay. And the jury -- you're going to be

1 the last expert we hear from, and the jury has heard
2 from lots of them in this case.

3 Do you have a curriculum vitae that you
4 use in your professional life?

5 A. I do.

6 Q. All right. Do you have a copy of it there
7 in front of you?

8 A. Oh, I do.

9 Q. I have marked for identification Exhibit
10 F1-B.

11 If you'll look through that and tell us if
12 that's a pretty up-to-date and accurate copy of your
13 CV?

14 A. It is.

15 MS. KAMYKOWSKI: Permission to publish
16 F1-B, Your Honor?

17 THE COURT: Any objection?

18 MS. GUNN: No, ma'am.

19 THE COURT: You may.

20 Q. (By Ms. Kamykowski) So, Dr. Burgess, why
21 don't you walk us through, and we're going to start
22 on page 1 about your education.

23 Can you tell us just about your education
24 that has brought you to -- and I call you Dr. -- let
25 me make sure we're -- are you a medical doctor?

1 A. I am not a medical doctor. Please, and
2 call me Adriane.

3 Q. Okay. Well, I'll call you Adriane, then.
4 Tell us, then, you do have a Ph.D. or a
5 doctorate in nursing?

6 A. I do.

7 Q. All right. Why don't you tell us about
8 your nursing education.

9 A. I received my bachelor's in nursing from
10 Villanova in 1997. And then a master's in nursing
11 education in 2012 at Drexel. And then completed my
12 Ph.D. in nursing, as well, at the University of
13 Wisconsin-Milwaukee in 2017.

14 Q. And did you ever practice as a bedside
15 labor and delivery nurse?

16 A. Yes.

17 Q. For how long?

18 A. 10 years.

19 Q. And so has it been awhile since you've
20 worked as Nurse Jessie and Nurse Maggie have?

21 A. Yes, as a bedside, yes.

22 Q. Okay. So instead of working shifts as a
23 bedside labor and delivery, tell us what your role is
24 in nursing now.

25 A. Sure, yeah. So I worked -- just to kind

1 of get up to that, I worked as a bedside nurse in
2 labor and delivery for probably the first 10 years of
3 my career. And then moved to maternal-fetal
4 medicine, where I worked as a nurse in that office.

5 After that, I started teaching childbirth
6 education but still worked PRN in the hospital at
7 that point. And that's when I started really being
8 into the nursing education, so I started teaching
9 nursing students. And then to teach, you have to get
10 a Ph.D., so got one, and taught nursing students
11 probably up until right before the pandemic, where I
12 decided to go back in the hospital and have a
13 full-time role there.

14 I was doing things kind of part-time but
15 went back full-time to the hospital to work as a
16 program director for the women and children's service
17 line, where we worked to write the policies and
18 procedures for 5 birthing hospitals across the
19 system.

20 MS. KAMYKOWSKI: So, Justin, can you
21 scroll down a little bit on page 1, under
22 professional experience.

23 Q. (By Ms. Kamykowski) So when you talked
24 about being a director of perinatal and neonatal
25 quality and safety, tell us about that.

1 A. Yeah. I work currently for the Maryland
2 Patient Safety Center. And when I initially started
3 there in September of 2022, I was the director for
4 perinatal and neonatal quality and patient safety.

5 And what we do is work with hospitals and
6 health systems and individuals, as well, to help them
7 develop safer systems of care, review cases, you
8 know, build stronger policies and procedures.

9 Q. And on here, you've got something called
10 Adriane L. Burgess & Associates --

11 A. Yes.

12 Q. -- from July 2022 to present.

13 what is that?

14 A. Yeah. So that started in -- about two
15 years ago as a way to support organizations outside
16 of those that I support in Maryland or in
17 Pennsylvania just with evaluating opportunities to
18 invoke quality and safety and specifically with
19 perinatal.

20 Q. You talked about your nursing education
21 roles, as well as being a program director and have
22 worked for hospital systems in Pennsylvania and
23 Maryland.

24 A. Uh-huh.

25 Q. what exactly are you doing for them?

1 A. So working with them individually, it
2 might be reviewing policies and protocols. It may be
3 helping them to evaluate cases where, you know, they
4 need to build stronger opportunities to dig into
5 maybe a root cause analysis or an adverse event. And
6 supporting individuals and learning more about
7 quality and safety.

8 I also work with residents. That's listed
9 on there, as well. So currently I'm the director for
10 OB/GYN residency research. And work with residents
11 in the OB/GYN residency at York Hospital, to do their
12 quality and research to meet their GME requirements.

13 Q. And has your nursing -- your educational
14 focus on nursing always been in labor and delivery or
15 perinatal health?

16 A. Except for one year, yeah.

17 Q. Has that been more recent, the one year?

18 A. No. The one year was my first year of
19 nursing. I was a med-surge nurse, and then went into
20 labor and delivery, and everything's been perinatal
21 since then.

22 Q. Okay.

23 MS. KAMYKOWSKI: Can you go, Justin, to
24 page 6. And we're going to look at certifications
25 and training on this CV.

1 Q. (By Ms. Kamykowski) I noticed on the very
2 front page you have, like a lot of our experts, many
3 initials or acronyms after your name.

4 Can you tell us the certifications that
5 you have with respect to labor and delivery nursing
6 or perinatal nursing?

7 A. Sure. I am certified in inpatient
8 obstetrics.

9 Q. What does that mean?

10 A. The care of patients during the labor and
11 delivery postpartum period.

12 Q. And what do you have to do to become
13 certified in inpatient obstetrics by the National
14 Certification Corporation?

15 A. We take a test. And then every 3 years,
16 you have to re-up that. You do self-assessments and
17 then have to insure that you've been completing
18 training or education to align with that. That kind of
19 thing.

20 Q. So for this year, are you going to choose
21 to retest this year?

22 A. Well, so they don't make you -- you can
23 choose to retest, yes, so...

24 Q. And then what is the same company or the
25 same corporation that gives you the obstetric and

1 neonatal quality and safety? what is that?

2 A. That's another test that is specific to
3 quality and safety in that space.

4 Q. okay. And then a fellow in the
5 Association for women's Health Obstetric and Neonatal
6 Nursing.

7 Is that also what we've heard as sort of
8 AWHONN?

9 A. Yes.

10 Q. So when you are a fellow in that group,
11 what does that mean?

12 A. It just means you've been evaluated by
13 your peers, that you're doing strong work in that
14 space, and working to advance obstetric nursing.

15 Q. And you got that in 2023, despite for not
16 being at the beside for many years?

17 A. Yes.

18 Q. okay. And then what is the fact that you
19 are electronic fetal monitoring certified by NIPS?
20 what does that mean?

21 A. Same thing. You take a test to show you
22 have knowledge and expertise in that specific space
23 around electronic fetal monitors.

24 Q. okay.

25 MS. KAMYKOWSKI: Can you go to page 7,

1 Justin?

2 Q. (By Ms. Kamykowski) Tell us about what
3 the courses you took from AWHONN.
4 what are those things? And what does that
5 mean?

6 A. Yeah. It's just in order to keep yourself
7 up to date. You know, it's lifelong learning. You
8 continue to take courses to make sure you're up to
9 date in the space. And I've taken obviously the
10 intermediate fetal monitoring course, and you just
11 need to re-up and retake them just to keep current.

12 Q. So the last time you completed your AWHONN
13 advanced -- or AWHONN fetal monitoring class, was
14 that in July of '23?

15 A. Yes.

16 Q. Okay. With respect to what you -- you've
17 got your honors and scholarships on the bottom of
18 that page.

19 Can you tell us what, first, the AWHONN
20 Award for Excellence in Nursing, what was that?

21 A. You are, you know, you're nominated for an
22 award, and you're evaluated by an awards committee at
23 AWHONN, and they choose a winner.

24 Q. Okay. And then a little bit further down,
25 it says that in the fall of 2018, the American

1 College of Obstetricians and Gynecologists gave you
2 second place for a project.

3 what was that project?

4 A. Yeah. As I mentioned, I work with the
5 residents on their quality, safety, and research
6 projects. And one of the projects that we worked on
7 was related to cesarean section. And there are
8 bundles. There's quality and safety bundles. There
9 are aim bundles. And one of them is related to
10 cesarean section reduction. And we had worked on a
11 project evaluating the work that we were doing at our
12 hospital and won an award for it.

13 Q. And I'm not going to go through it, but
14 pages 9 through 21 of your CV lists peer-reviewed
15 publications with presentations.

16 Are any of the publications of your CV
17 really germane to the issues of the standard of care
18 as it relates to this case?

19 A. I don't think that they're exactly. I
20 mean, there is some things that I've done around
21 guidelines, the labor and support and that, but none
22 specifically.

23 Q. Did you rely on any of your personal
24 publications to aid in the rendering of your opinions
25 here today?

1 A. None specifically, no.

2 Q. All right.

3 MS. KAMYKOWSKI: Can you go, Justin, to
4 page 21, under professional affiliations and
5 activities?

6 Q. (By Ms. Kamykowski) And I want to talk
7 about your -- it looks like you're pretty active in
8 AWHONN.

9 Is that fair to say?

10 A. I think that's fair.

11 Q. Tell us about that.

12 A. So I'm currently on the board of
13 directors. I've been a member of the section chair
14 for Pennsylvania from 2022. And I should say that
15 just stopped, actually, January, that I stopped as
16 section chair and became on the board of directors.
17 As you mentioned, I'm a fellow. I serve in a variety
18 of different capacities like standards review,
19 guideline writing.

20 Q. And I want to talk specifically about one
21 that says Lead AWHONN Evidenced-Based Guideline
22 workshop promoting vaginal birth from 2020 to 2022.

23 Tell us what that's saying.

24 A. AWHONN has a variety of guidelines and
25 standards that I'm sure you all have talked about,

1 and one of those is related to supporting vaginal
2 births. And I was the lead author on that, along
3 with a team, that evaluated the current evidence to
4 promote best practices in how you support women to
5 achieve vaginal births.

6 Q. All right. And then on page 22, you also
7 have a section that says you are a manuscript and
8 abstract reviewer.

9 what does that mean?

10 A. Yeah. That's pretty common in the space
11 that you should give back. And so as people submit
12 articles or, you know, abstracts for presentation or
13 for publication, that other peers review them and
14 provide feedback so that they can be published.

15 Q. And we've seen some peer-reviewed
16 publications in this case. So -- and just to make
17 sure the jury understands, you would be one of those
18 people that -- an author or a group of authors --
19 would submit research to you before, and you would
20 review and give them feedback, and you'd be one of
21 the people that would help them get published?

22 A. Yeah. So the process is that it's blind.
23 Nobody knows who's reviewing their paper. It goes in
24 through the journal, and then gets sent out to
25 different people who agree to do it. And then that

1 feedback is provided back to the author so they can
2 improve their manuscripts before publication.

3 Q. And these manuscripts and abstracts, the
4 publications that you have been a reviewer for, were
5 all in the women's health labor and delivery and
6 perinatal space?

7 A. Yeah.

8 Q. Let's talk about your service activities.
9 what -- and there are a couple I want to
10 talk about here, specifically for WellSpan Health.

11 Tell the jury what your role was with
12 WellSpan Health -- is with WellSpan Health.

13 A. So it's a little different now since I
14 moved to the Maryland Patient Safety Center. But
15 initially I was the program director for the women's
16 and children's service line. Which is basically
17 helping to develop their quality and safety program
18 for the women's and children's services. And that
19 includes inpatient obstetrics to outpatient OB/GYN to
20 pediatrics.

21 And so we would work across 5 birthing
22 hospitals to standardize the care provided and insure
23 we were all working on the same page, and that we'd
24 update our electronic health record and policies to
25 align with Epic.

1 Q. And one of the things you did, it looks
2 like, for about 5 years was, that you -- three years
3 -- so lead Cesarean Section Reduction Work Group from
4 2017 to 2020.

5 what was your role with wellspan Health?

6 A. Yeah. Hospitals receive data monthly from
7 the joint commission on their cesarean section rates.

8 And, you know, there's different feelings about that.

9 Hospitals are reported publically if their rates are
10 too high, and so we want to make sure we provide an
11 appropriate cesarean section. That's the really key
12 word.

13 And so we would review cases to assess for
14 their appropriateness, both good and bad. Like if
15 somebody should have proceeded to C-section, and they
16 didn't, or, you know, maybe we called a C-section too
17 early, that was the presentation -- the work that we
18 had the award for. As well as there was another
19 presentation for ACOG with one of the residents where
20 we reviewed tracings to see that they aligned with
21 the progress in labor guidelines from ACOG.

22 Q. okay. So the question that we asked you
23 here to review medical records and fetal monitor
24 strips to evaluate as to whether the standard of care
25 was met, is that something that you do a regular

1 basis in your role --

2 A. Yes.

3 Q. In your current role?

4 A. Yes.

5 Q. Even though you don't even work at the
6 beside anymore?

7 A. Correct.

8 Q. And then, lastly, on page 23 at the
9 bottom.

10 what is it from 2003 to present, you were
11 on the NCCRNCOB Item Analysis Committee?

12 what is that?

13 A. I'm on the content -- final page for
14 content. So the NCC, which is where all of those
15 certifications come from, they have an organization.
16 So nurses across the country commonly take tests.

17 I think that maybe Maggie shared that she
18 was certified in electronic fetal monitoring. They
19 take this test to become certified in any one of
20 these areas. So there has to be folks that review
21 the content that gets on the exam and review the
22 items, the actual questions, to make sure that
23 they're good, that they're actually entering what
24 they're supposed to. So I work on that.

25 Q. All right. So let's get to -- we reached

1 out to you, I think, back in August of 2023.

2 Does that sound correct?

3 A. That sounds correct.

4 Q. And I think from the very beginning, my
5 office told you we were defending a lawsuit.

6 So you knew from the beginning that we
7 were asking you to look at this case on behalf of the
8 defense, correct?

9 A. Correct.

10 Q. Does that in any way -- does that impact
11 the way that you reviewed this case?

12 A. No.

13 Q. Okay. And so we sent you initially just
14 medical records and fetal monitoring strips, correct?

15 A. Correct.

16 Q. Did you review those about any other
17 information from the beginning?

18 A. Correct.

19 Q. Did you have any idea about the outcome in
20 this case when you were sent these records?

21 A. I did not. Obviously I figured it wasn't
22 positive if you were sending it to me.

23 Q. Do you recall after you reviewed initially
24 the medical records from Mrs. Anyan's labor and
25 delivery and the fetal monitor strips, if you reached

1 any conclusions about them?

2 A. Yeah. I actually was wondering what the
3 direct comments were against the nursing care because
4 I didn't know, like, I thought they had met the
5 standard of care in my initial review.

6 Q. After your initial review, would you have
7 realized this case involves a 12-hour second stage of
8 labor?

9 A. Yes.

10 Q. And did that in any way make -- raise any
11 questions into your mind about the standard of care
12 initially?

13 A. It didn't.

14 Q. Why not?

15 A. Well, you know, as a nurse, we don't
16 diagnose, you know. If labor has stopped
17 progressing, we can have comments in collaboration
18 with our physician colleagues. But -- and also
19 there's no -- and I think we've heard that last time,
20 there isn't like an absolute length of time that we
21 say is too long, so, no.

22 Q. And in your initial review of the medical
23 records and the fetal monitor strips in this case,
24 did you identify any point in time where you
25 believed, as a nurse, a labor and delivery nurse,

1 that there were concerns on this strip that warranted
2 advocacy for a C-section?

3 A. No.

4 Q. why not?

5 A. So, you know, Maggie went into it earlier
6 regarding, you know, when you're looking at a fetal
7 heart rate tracing for working with a mom in labor,
8 you're looking at a variety of different things
9 coming in at the same time, a lot of different
10 clinical information.

11 You're looking at the fetal heart rate
12 tracing, you're looking at the contraction pattern,
13 you're looking at mom. How is she doing? what is
14 she saying? And you're also thinking about
15 situationally what's happening on your unit.

16 And so taking all of those things into
17 play, and so I, in looking at the tracing, we've
18 heard over and over again that if the variability
19 remains moderate up until the very end of the
20 tracing, that there were many times where Maggie and
21 the team interacted with Dr. McNeive.

22 So communication -- the things that I
23 usually think about where things may not go according
24 to the plan, there was people from outside the room
25 also reviewing it and huddling together to connect

1 around situational awareness about, you know, what
2 else was happening on the unit and to chime in, so...

3 Q. And you were here this morning when Maggie
4 testified.

5 You saw her entire testimony?

6 A. I did, yes.

7 Q. You were here when we went through with
8 the jury our Exhibit c2, that was the video player of
9 the fetal monitor strips with the associated flow
10 sheet data incorporated, therein?

11 A. I did, yes.

12 Q. And that's all information you had
13 reviewed before, correct?

14 A. It is.

15 Q. Okay. So I'm not going to belabor that
16 point, or we'll all be here for a very long time.

17 But you know that there are criticisms by
18 the plaintiffs' experts in this case of Maggie and
19 Jessie. And I know you've already told me in broad
20 strokes that they met the standard of care.

21 But I want to make sure we go through each
22 of those criticisms and explain why you think the
23 opinions are wrong, okay?

24 A. Okay.

25 Q. So the first one is that the standard of

1 care required nurses Maggie and Jessie to advocate
2 for a C-section at 8:00 p.m. and all times
3 thereafter, before Remi was born?

4 Do you agree with that opinion?

5 A. I do not.

6 Q. Why not?

7 A. So there was nothing, you know, clear on
8 the fetal heart rate tracing that required delivery
9 be expedited. Until the very end, the delivery was
10 being expedited. And Maggie and Jessie were having
11 very clear communication about the current state of
12 what was going on with both Dr. McNeive, as well as
13 the other folks on their unit, such as the charge
14 nurse, and MFH when they came in, or the CNM or the
15 resident.

16 So they had touch points and communication
17 with them, as well. And the tracing continued to
18 have moderate variability, which would make it a
19 Category II, which 80 to 90 percent of all tracings
20 are in Category II at some point during their, you
21 know, during their time.

22 So there wasn't anything at any point
23 until the very end when the delivery was being
24 expedited that they would have needed to.

25 Q. Okay. And you kind of brought this into

1 that question. And I asked you to say about whether
2 they needed to advocate, meaning to raise it to Dr.
3 McNeive or raise it to Sarah, hey, you might want to
4 move forward with C-Section.

5 But secondarily the criticism is they
6 didn't formally invoke the chain of command in this
7 case to change from the plan of care, which was a
8 vaginal delivery, to another type of delivery, from
9 8:00 a.m. until he was actually born.

10 Do you believe that the standard of care
11 required invoking the chain of command to change the
12 plan from vaginal delivery to some other method of
13 delivery?

14 A. So I think that's -- it's an interesting
15 statement because to invoke the chain of command, you
16 have to think something is happening in this case,
17 right?

18 But in between there, they were having
19 multiple conversations. I mean, I think we've heard
20 Dr. McNeive was in the room multiple times. We've
21 heard about the safety rounds. We've heard about the
22 fetal heart rate rounds. There was multiple times
23 when conversations were happening around the plan of
24 care to insure it was progressing the way they --
25 they thought was appropriate.

1 Q. And so it's fair to say that in order to
2 invoke the chain of command, that bedside nurses have
3 to first believe that the doctor who's managing the
4 patient's care is doing something inappropriate?

5 A. Yes. Yes.

6 Q. Okay. And based on your review of this
7 case, do you believe that that situation existed at
8 any time on May 4th of 2020?

9 A. No, I do not.

10 Q. All right. In your review, including what
11 you watched us take the jury through today with
12 Maggie, did the nurses appropriately implement
13 intrauterine resuscitative measures, you know, where
14 there were position changes, changes in maternal
15 pushing efforts, and laboring down in response to
16 Category II tracings? Were they appropriately
17 implementing those throughout their shift on May 4th?

18 A. Yes, I believe they were.

19 Q. And did you see that those appropriate --
20 application of those resuscitative measures actually
21 had an effect?

22 A. Yes.

23 Q. What effect did it have?

24 A. So the -- the thing with intrauterine
25 resuscitation that was not measured, it's not as if

1 you can just give them all to everyone. You're doing
2 them for specific purposes.

3 So if you're turning a patient, you're
4 turning it in response to certain deceleration types,
5 and you're doing it to influence perfusion to the
6 mother and to the baby.

7 I think we talked a little bit about other
8 types of intrauterine resuscitation efforts such as
9 giving fluids and all of that stuff. And as Maggie
10 describes, you can't just keep giving fluids all the
11 time. That has issues, as well. So I feel like what
12 they did with the ones they chose was appropriate for
13 what they were seeing on the fetal heart rate
14 tracings.

15 And as far as a response, they noticed a
16 response, for instance, when they decided to let her
17 labor down. They did see a response in that the
18 decelerations significantly decreased. Moderate
19 variability, you know, continued.

20 And as far as the positioning, they did
21 many different types of positioning in order to
22 achieve a response. And although the decelerations
23 did not go away completely, they did notice that
24 moderate variability, which is the best indicator of
25 fetal well-being.

1 Q. okay. I want to pull up what the jury has
2 seen before.

3 MS. KAMYKOWSKI: Exhibit I13, page 2,
4 please, Justin.

5 Q. (By Ms. Kamykowski) And this is a page
6 that Nurse Shinn brought with her to her deposition.
7 And we spoke with her about it a couple of weeks ago
8 now.

9 This is the -- do you recognize this
10 algorithm?

11 A. Yes.

12 Q. And where is it from?

13 A. ACOG. There's versions of it everywhere,
14 though.

15 Q. And it says at the bottom it's from the
16 "Management Of Intrapartum Fetal Heart Rate Tracings:
17 A Practice Bulletin 116."

18 And this algorithm from "Management of
19 Intrapartum FHR Tracing Categories Suggested by
20 ACOG," I'll tell you this came from Nurse Shinn, a
21 photograph of an AWHONN teaching book.

22 A. Yes. Yes.

23 Q. Do you recognize that from AWHONN?

24 A. Yes. Yes.

25 Q. All right. And when you look at this

1 algorithm, it first starts with "Assessments of
2 Intrapartum FHR Tracings."

3 And everyone here knows that for the
4 majority of this second stage, when nurses Jessie and
5 Maggie were caring for Ms. Anyan, we were in which
6 category, Dr. Burgess?

7 A. Category II.

8 Q. All right. And when you apply this
9 algorithm to what you saw in your review of the
10 records here, did the nurses appropriately manage the
11 Category II intrauterine heart rate tracing here?

12 A. Yes. So it goes to evaluation and
13 surveillance. They saw moderate -- the heart rate
14 variability, and they continued surveillance. And
15 they did other intrauterine resuscitative measures.

16 Q. And as it says, they also found in the
17 ACOG guidelines No. 116, I do want to look at that
18 really briefly.

19 MS. KAMYKOWSKI: If you pull up I1,
20 Justin, page 4 -- sorry -- page 5.

21 Q. (By Ms. Kamykowski) So we have this same
22 algorithm, and then we have Table 2. And this says
23 "Various Intrauterine Resuscitative Measures for
24 Category II or Category III Tracings or Both."

25 And the jury has seen this before, but

1 when you read this, can you explain to us if the goal
2 is to promote fetal oxygenation and improve
3 uteroplacental blood flow?

4 what are we looking at, if that's the
5 goal? And what are the potential interventions?
6 what does this tell us?

7 A. Right. So they initiated lateral
8 position, plus they had hands and knees and a variety
9 of other positions, so that was to, you know, promote
10 perfusion to the placenta.

11 And so through that, that should address,
12 work to address, and improve decelerations; namely,
13 late decelerations. If you're looking to improve
14 placental perfusion, sometimes in the case of
15 variable decelerations, that's the kind that just go
16 down the front and then come back up, that can be due
17 to cord compression which we see during pushing. And
18 we also see in patients whose waters are broken.

19 So, again, reposition. So try left side,
20 try right side, try all the different positions.
21 Those are -- those are some of those strategies, and
22 Maggie and Jessie tried those.

23 And then if they're not seeing an adequate
24 improvement in that and the fetal heart rate tracings
25 from those, then let's give mom a break and allow the

1 baby to rest and not have so much work during

2 contractions.

3 Q. And in this Table 2 from the ACOG

4 bulletin, under potential interventions, when it says

5 discontinue oxytocin, is that -- were they

6 recommending that in association with tachysystole

7 with Category II or III?

8 A. Yes.

9 Q. Not simply if you have a Category II?

10 A. Correct. Right.

11 Q. Is that your experience that -- and we're

12 going to talk about the policies in a minute -- but

13 your experience that if you have a Category II

14 tracing, are you required by the standard of care to

15 turn off or turn down the Pitocin?

16 A. No.

17 Q. Why not?

18 A. The intervention that you do has to align

19 with the physiologic cause of the problem.

20 Q. What does that mean?

21 A. So if you have a deceleration that that is

22 a variable decel, that happens because the cord's

23 compressed. So what could cause the cord

24 compression? There's numerous things. So it could

25 be contraction. It could be the baby's grabbing on

1 it. Could be mom's laying on it. Could be because
2 we don't have a lot of amniotic fluid, like a cushion
3 around it. So all these different things could
4 result in that variable decel.

5 So as a nurse, you have to take in all of
6 the data -- and the physician -- you have to think,
7 okay, what's potentially causing that decel?

8 And so they're thinking about do they need
9 to turn the mom to this side? That side? Some of it
10 is trying as you're going to try to figure out what's
11 going to improve that.

12 And so where would Pitocin come in?
13 Decrease in the Pitocin would come in if the
14 physicians were seeing repetitive contractions, and
15 that's what they saw as triggering the deceleration.

16 And so I -- you know, Maggie and Jessie's
17 interpreting of the full clinical picture, their
18 determination was to start with this repositioning
19 and to start with the laboring down. That would help
20 to decrease the decelerations that they noticed.

21 Q. In your review of the fetal heart monitor
22 that also has a uterine contraction pattern, was
23 there a concern, or should there have been a concern,
24 for tachysystole or increased uterine activity at any
25 time on May 4?

1 A. Not that I noticed.

2 MS. KAMYKOWSKI: You can take that down,
3 Justin.

4 Q. (By Ms. Kamykowski) Dr. Burgess, I'm
5 going to hand you what I have marked as Exhibit F1-Q.
6 I believe you brought this with you to your
7 deposition, if I'm correct.

8 If you could tell us that this is.

9 A. Okay. This is the Clark -- well, this is
10 a couple of algorithms. So if you remember, they
11 mentioned that there was a fetal heart rate tracing
12 huddle that they would hold, and they would review
13 the fetal heart rate tracing against an algorithm.

14 And I think Maggie was asked also about the Clark
15 algorithm. So the Clark algorithm is --

16 Q. The jury's heard about the Clark
17 algorithm.

18 A. Oh, all right. Okay.

19 Q. That's all right. We have talked about it
20 a lot. But this document is three pages, and it's
21 titled "California Maternal Quality Care
22 Collaborative."

23 What is that?

24 A. Yeah. So California has been kind of a
25 leader in maternal quality care initiatives and

1 safety initiatives and has been working really hard
2 to improve outcomes for moms and babies and eliminate
3 disparities.

4 And so they have lots of bundles on all
5 different topics. So bundles of just best practices.
6 Things you can do to try to improve. And one of them
7 related to C-section reduction is this algorithm.

8 MS. KAMYKOWSKI: Your Honor, permission to
9 publish Defendants' F1-Q?

10 THE COURT: Any objection?

11 MS. GUNN: Nope. No.

12 THE COURT: You may.

13 And after this series, we'll take a break.

14 MS. KAMYKOWSKI: Oh, sure, Judge. I think
15 you can kind of start to, if you want to take one
16 now.

17 THE COURT: Okay. That's fine.

18 All right, ladies and gentlemen.

19 (At 2:32 p.m., the Court duly admonished
20 the jury, and proceedings stood in recess. At
21 2:51 p.m., the following proceedings were held in
22 open court, in the presence of the jury:)

23 THE COURT: Go ahead and be seated,
24 everyone.

25 MS. KAMYKOWSKI: Thank you, Your Honor.

1 Q. (By Ms. Kamykowski) Dr. Burgess, when we
2 took a break, we were starting to talk about F1-G.

3 MS. KAMYKOWSKI: Justin, can you put that
4 back up?

5 Q. (By Ms. Kamykowski) We're not going over
6 this in detail, Dr. Burgess. But do you recall at
7 your deposition, we asked about application of this
8 algorithm in the May 4th fetal monitor strip in this
9 case?

10 Do you remember that?

11 A. Yes, I do.

12 Q. And did you -- you mentioned -- did you
13 mention there was any time where you could have
14 potentially have found significant decelerations with
15 greater than or equal to 50 percent of the
16 contractions for 1 hour?

17 A. Yes, I did mention 1 hour, I believe. It
18 was approximately 8:30 a.m. to 9:30 a.m., I think I
19 could have said.

20 Q. And did you actually review the strips
21 with this algorithm in mind at your deposition?

22 A. Yes, we did review those.

23 Q. At Ms. Gunn's request?

24 A. Yes.

25 Q. And since you looked at that strip, had

1 you gone back and looked at that hour time frame and
2 applied the algorithm?

3 A. I have.

4 Q. And does it -- you said initially it
5 potentially found significant decelerations with
6 greater than or equal to 50 percent contractions
7 around the 8:30 to 9:30 time frame.

8 Is that still accurate?

9 A. It did not meet the criteria.

10 Q. Okay. So you went back and checked it?

11 A. Yes. Yes.

12 Q. Okay. Okay. And then with respect to the
13 next page of Exhibit F1-G -- well, let me ask you
14 this: Other than that 1 hour that had a potential
15 when you reviewed the strips at your deposition, at
16 any other time when you reviewed the strips
17 initially, when you reviewed the strips to prepare
18 for your deposition, at the time you gave your
19 deposition, or even sitting here today watching us
20 play through the entirety of the 7:00 a.m. to
21 4:24 p.m. strips, is there any indication on there
22 that the Clark algorithm, if applied, would have
23 concluded anything other than observe?

24 A. The last 20 minutes.

25 Q. Okay. We'll talk about that in a minute.

1 So when we go to page 2 of your exhibit,
2 this is a new one, the jury's seen this, and we're
3 not going to go through it extensively.

4 But I just want you to tell us why did you
5 bring this to your deposition? What's the point of
6 Appendix Q?

7 A. It's another way to essentially visualize
8 the Clark -- the Clark algorithm. It's slightly
9 different, but just to show what Maggie and Jessie
10 were looking at related to moderate variability in
11 the Category II section. Because the Category II
12 tracing has such wide variations. There's so many
13 different types of tracings that can fall into
14 Category II. This provides a little bit more
15 structure around how to evaluate that.

16 Q. And the color coding, is it for us -- is
17 it like the color coding, is it like the color code
18 that you would use, for example, on a stoplight?

19 A. Yes.

20 Q. So green is good or go?

21 A. Yes.

22 Q. Yellow is what?

23 A. Proceed with caution.

24 Q. And red is?

25 A. Stop.

1 Q. okay. so until we get to that last,
2 around the four o'clock time frame, where on this
3 diagram was the majority -- or where was Remi Anyan's
4 fetal heart rate pattern?

5 A. For the majority of the time, in the green
6 moderate variability with decels.

7 Q. what about did he ever meet the Category
8 I?

9 A. Yeah. One time, yep.

10 Q. okay. And so then it drops down to this
11 green circle that says A, B, V, and then the
12 asterisk.

13 what does that tell us?

14 A. So essentially what we were talking about
15 before related to the nurse has to evaluate the cause
16 of the changes in the fetal heart rate tracing, so...

17 Q. on this algorithm, though, it says to go
18 to the next page --

19 A. Yes. which is assess.

20 Q. okay. so tell us what -- the next page,
21 tell us what providers A, B, and V.

22 what does that mean?

23 A. So they assess for what are the causes of
24 the variation in the fetal heart rate tracing.

25 Q. what does that mean?

1 A. So when they see different types of
2 decelerations, what's causing it?

3 The nurse has to think through what's the
4 cause. And then from determining the cause,
5 determines what the corrective measure should be.
6 And that's the v.

7 Q. Okay. And the corrective measures, are
8 those the intrauterine resuscitation efforts, the
9 measures that we talked about?

10 A. Yes.

11 Q. And then in this case, those were again
12 the position changes and the changing of the pushing
13 patterns, correct?

14 A. Correct.

15 Q. Okay. At any point did the application of
16 this algorithm get us to the T side. And if you see
17 T, it has a little line through the middle of that
18 page. What's in the white text there?

19 A. If minimal or absent variability for
20 greater than 20 minutes.

21 Q. Now, in your review of the strips in this
22 case, did Remi's fetal heart rate ever show minimal
23 or absent variability for greater than 20 minutes?

24 A. It was the very end of the tracing when
25 delivery was imminent. And I don't know that it was

1 greater than 20.

2 Q. Do you remember what you told us in your
3 deposition as to fit Category III --

4 A. I don't remember data facts.

5 Q. Okay. If I pointed to your deposition,
6 would that help refresh your recollection?

7 A. That would be helpful.

8 Q. You have a copy of your deposition up
9 there?

10 A. I do not.

11 Q. Okay.

12 MS. KAMYKOWSKI: May I approach?

13 Q. (By Ms. Kamykowski) So sorry. I meant to
14 have that here for you before we started. I'm going
15 to look briefly for you.

16 A. I found it.

17 Q. Okay. So you reviewed your deposition
18 transcript to help refresh your recollection as to
19 when you believe there was absent and minimal errors
20 on the strips?

21 A. Yes.

22 Q. What time was that?

23 A. I said 4:10 or 4:09.

24 Q. Okay. Is that greater than or less than
25 20 minutes before Remi was born?

A. Is delivery time 4:24?

Q. Yes.

A. Okay. I just wanted to make sure.

So that is less than 20 minutes.

Q. So based on your review of the strips in this case with this, applying this algorithm, has ever reached the C or the D?

A. No.

Q. Okay. Dr. Burgess, can a nurse diagnose arrest of descent in the second stage?

A. The nurse does not diagnose.

Q. And from your review of the medical records, the deposition testimony, having been here today at court, did you ever see any evidence to support or to determine whether or not if Jessie or Maggie had advocated for a C-section or gone up the chain of command, that a C-section would have been performed any sooner than he was delivered at 4:24 p.m.?

A. No.

Q. Based on your review of the strips in this case and the medical records, your knowledge, your training, your experience, do you have an opinion as to whether or not there was ever a time that a C-section was required in this case?

1 A. No.

2 Q. You don't know?

3 A. No.

4 Q. Do you have an opinion?

5 A. I have an opinion. A C-section was not
6 necessary.

7 Q. Can nurses order a C-section?

8 A. No.

9 Q. Can nurses perform a C-section?

10 A. No.

11 Q. Okay. We've talked Pitocin already, and I
12 think you already told me this, but you've reviewed
13 the Pitocin or the policy itself that the jury has
14 seen and embedded protocol in the Epic medical
15 records for Mrs. Anyan?

16 A. I have reviewed them.

17 Q. And do you have an opinion whether or not
18 the nurses complied with the nursing communication
19 orders and the protocol in Epic?

20 A. I believe they did, yes.

21 Q. And what about the Mercy protocols for the
22 policy with respect to addressing intermediate or
23 Category II or Category III tracings? Do you believe
24 they met the Mercy policy on how to address those
25 fetal heart patterns?

1 A. Yes.

2 Q. Okay. And do you recall -- do you recall
3 the indeterminate Category II/Category III fetal
4 status policy, what it mandated of these nurses?

5 A. Off the top of my head, I don't.

6 MS. KAMYKOWSKI: Justin, will you pull up
7 Exhibit G1, please. The bottom of page 4 and the top
8 of page 5.

9 Q. (By Ms. Kamykowski) The jury has seen
10 this before.

11 Do you see where it says "identification
12 of indeterminate"?

13 A. Yes.

14 Q. And what does this policy require if a
15 nurse at the bedside sees a Category II or Category
16 III fetal status?

17 A. Notification of physician and
18 documentation in the medical record of the
19 interventions they use to resolve.

20 Q. Did Nurse Maggie and Nurse Jessie follow
21 those policies, as far as you know?

22 A. They did.

23 Q. Did the policy or the protocol in the Epic
24 chart for Mrs. Anyan require them to turn down or
25 turn off the Pitocin at any time?

1 A. It did not.

2 Q. How about the clinical situation? What
3 you saw on the strips, absent these policies, simply
4 because there was a Category II strip, did that
5 require Jessie and Maggie to turn down or turn off
6 the Pitocin?

7 A. It did not.

8 Q. Why not?

9 A. A Category II tracing in and of itself
10 does not require the Pitocin to be turned off. When
11 you're thinking about, again, what are the causes of
12 the changes in your fetal heart rate tracings, you
13 want to think through what's driving that.

14 And so Maggie and Jessie chose to use the
15 interventions of moving the patient and changing
16 positions and laboring down, and they were effective.
17 And didn't see tachysystole because it wasn't
18 occurring. And that would be one of the reasons to
19 discontinue Pitocin.

20 MS. KAMYKOWSKI: Justin, will you, just
21 for one more time, pull up 8T, page 103, the embedded
22 protocols for vaginal birth protocol.

23 Q. (By Ms. Kamykowski) Dr. Burgess, does the
24 intrauterine resuscitation of this protocol, does it
25 apply to both Category II and Category III?

1 A. Yes.

2 Q. And does -- we've already talked about
3 your opinions with respect to a Category II tracing,
4 but was there a Category III tracing in this case?

5 A. At the very end, yes.

6 Q. I think you told us after 1610, is that
7 right?

8 A. Yeah.

9 Q. At that time, is there any mandate by the
10 standard of care that the nurses turn off the
11 Pitocin?

12 A. Not a mandate.

13 Q. Why?

14 A. The physician was in the room and was
15 managing the labor.

16 Q. And we know at that time, just prior to --
17 after Dr. McNeive was at bedside from two o'clock on,
18 you're aware that he instructed or ordered the nurses
19 to increase the Pitocin, is that correct?

20 A. That is correct.

21 Q. Do you believe that at any time when the
22 nurses received those orders in this case, under
23 those circumstances, that the standard of care
24 required them to go up the chain of command to refuse
25 those orders?

1 A. I do not.

2 Q. why not?

3 A. Because delivery needs to be expedited,
4 and the baby's head was, I think they described that
5 there was a large portion of the baby's head that was
6 visible, so a vaginal delivery had to happen.

7 Q. Are there circumstances, Dr. Burgess, in
8 which you would say that the standard of care would
9 require nurses to turn off the Pitocin in the face of
10 a Category III tracing?

11 A. Yes.

12 Q. And did any of those circumstances exist
13 in this case?

14 A. I do not believe so, no.

15 Q. why not?

16 A. The physician was in the room, that
17 delivery, vaginal delivery, was about to occur. And
18 the physician was making a decision on the best way
19 to deliver the baby.

20 Q. Dr. Burgess, again, just to short circuit
21 things. Do you have -- do you hold the opinion -- do
22 you hold an opinion as to whether or not all times on
23 May 4, 2020, the nurses in this care -- in this case,
24 met the standard of care?

25 A. Yes.

1 Q. And is that an opinion you hold to a
2 reasonable degree of nursing certainty?

3 A. Yes.

4 Q. You told us this was your first time
5 sitting in the courtroom. We had a little hiccup
6 because I talk quickly, and you're talking over me.

7 Have you done this type of work before,
8 medical legal work?

9 A. I have reviewed -- I've done one other
10 deposition.

11 Q. So one deposition in this case and one
12 other one?

13 A. Yes.

14 Q. And I know it's been asked of every
15 witness in this case, I think, but you're not doing
16 this out of the kindness of your heart, you're being
17 paid to be here, right?

18 A. I was, yes.

19 Q. Thank you, Dr. Burgess. Those are all the
20 questions I have.

21 THE COURT: on behalf of defendants?

22 MR. PERRON: Yes, Your Honor.

23 Justin, can you put up Exhibit F3-G, PDF
24 page 132.

25 Justin, if you could highlight for the

1 jury what time this is.

2 CROSS-EXAMINATION

3 BY MR. PERRON:

4 Q. 8:58 a.m. Doctor, the jury has seen these
5 a number of times. And I'll represent to you that
6 these colorful indications are markers of
7 decelerations.

8 Doctor, on this page, are you able to
9 identify whether or not there is moderate variability
10 on these strips?

11 A. There's moderate variability, yes.

12 Q. Okay. Does it return to moderate
13 variability each time after one of those
14 decelerations?

15 A. Yes.

16 Q. In general --

17 MR. PERRON: Justin, just for an example,
18 would you go to the next page?

19 Q. (By Mr. Perron) Again, is there moderate
20 variability returned to baseline after each of these
21 decelerations?

22 A. Yes.

23 Q. Okay. And then that moderate variability
24 does pick up even later on this strip within this
25 window of time?

1 A. Yes, I believe.

2 Q. And --

3 MR. PERRON: Justin, one more page. And
4 then if you can highlight this.

5 Q. (By Mr. Perron) Doctor, can you see what
6 window of time this in?

7 A. Yes.

8 Q. What time is it?

9 A. 9:14.

10 Q. Okay. And, again, is there moderate
11 variability on this page?

12 A. There, is yes.

13 Q. So, in general, what gives you at this
14 time, or the provider in realtime, more information
15 about the status of the baby from these strips? The
16 presence of a deceleration, or the presence of
17 moderate variability?

18 A. Moderate variability.

19 Q. Is that based on your experience?

20 A. Yes.

21 Q. Is that also in agreement with what ACOG
22 tells us?

23 A. Anyone, yes.

24 Q. Well, you -- that was my next question.

25 And then Dr. Steven Clark, who designed that

1 algorithm, is that also in agreement with how
2 Dr. Clark views the presence of moderate variability?

3 A. Yes, I believe so.

4 Q. Okay. Plaintiff has shown an exhibit to
5 the jury -- and I imagine they'll show it again --
6 displaying in colorful flags all of these
7 decelerations that have been marked on this strip but
8 without demonstrating or telling the jury any of the
9 moderate variability.

10 So I'll ask you this question: Does a
11 graph or demonstrative exhibit of a tracing that
12 shows decelerations, but doesn't tell you anything
13 about the presence or absence of moderate
14 variability, is that graph or demonstrative exhibit
15 communicating anything about what that tracing really
16 shows about the status of this baby?

17 A. No.

18 Q. Why not?

19 A. Because understanding the status of the
20 baby is multifactorial. It includes maternal vital
21 signs, the contraction pattern, variability of the
22 heart rate tracing. And it also includes the
23 baseline of the fetal heart rate tracing, any
24 decelerations that occur, whether the variables,
25 earlies, lates, and any acceleration. So it's like

1 you have to take into account the complete picture
2 that's going on with the moms and fetuses.

3 Q. what is the purpose of a safety round?

4 A. To increase situational awareness around
5 what's going on in rooms across the unit, so that
6 folks outside of the room have the opportunity to
7 review the clinical picture and provide guidance on
8 where they should proceed next.

9 Q. To a certain extent these are -- the
10 safety rounds include trained health care providers
11 who have not necessarily been involved in that
12 patient's care up to that point, and they come in and
13 perhaps look over the shoulders of the actual
14 providers to see what's going on?

15 A. Yes. It's the best practice.

16 Q. Okay. And one of the -- is one of the
17 purposes to maybe catch something that those
18 providers might be missing?

19 A. Yeah. When you've been in a room for a
20 while, and you've been looking at a tracing, and it
21 gives outside views and, you know, improves
22 situational awareness about what's going on.

23 It also helps them in the rooms know
24 what's happening outside like if there are other
25 people who need C-sections, you know, having to get

1 there timely, just helping to understand who's
2 available, as well.

3 Q. Now, with the safety rounds in this
4 particular instance at, I believe, 10:45 or
5 10:48 a.m., this included providers with different
6 backgrounds, is that correct?

7 A. I believe so.

8 Q. So why is it important in a safety round
9 to have providers from all different backgrounds in
10 the field of labor and delivery?

11 A. Well, obviously we have different
12 viewpoints, and so helping to put a collaborative --
13 well, caring for a patient is collaborative, right?
14 It's all different types of providers that are caring
15 for a patient. So the safety rounds, having
16 expertise in medicine and nursing and, you know,
17 administration all coming together to help to
18 determine, you know, what the best plan of care and
19 next step is is helpful.

20 Q. This safety round even included MFM. The
21 jury might have heard that term once before in this
22 case.

23 what is an MFM?

24 A. A maternal-fetal medicine specialist, so
25 they specialize specifically in obstetrics and high

1 risk obstetrics.

2 Q. Like a medical doctor?

3 A. Yes.

4 Q. Okay. And so a safety round includes both
5 a medical doctor specializing in OB, but does it also
6 include someone with a nursing background, as well?

7 A. It appeared that, from what I could see
8 signed on the safety rounds, it appeared that the
9 charge nurse was there, I believe the nurse midwife?

10 The MFM and the resident was there.

11 Q. So with all of these different
12 specialities, were they an extra set of eyes? At
13 that moment in time, at 10:45 a.m., looking at the
14 strips, looking at what was going on, provide their
15 input if some changes needed to be made?

16 A. Yes.

17 Q. Now, plaintiff in opening put quotation
18 marks around the "safety" when she talked about
19 safety rounds.

20 was this, in your opinion, looking
21 backwards and in retrospect looking at this baby,
22 first of all, did it recommend any different course
23 of treatment?

24 A. It did not.

25 Q. Did you come to an opinion that this

1 safety round was just some kind of a sham or not
2 really doing any kind of pertinent work?

3 A. No. And I believe Maggie testified to the
4 contrary in sharing that, you know, that the safety
5 rounds are robust, and they continued to occur on her
6 unit.

7 MR. PERRON: Justin, could you please put
8 up c2. Should be a tab for 12:20 p.m.

9 Q. (By Mr. Perron) Looking at about 12:20
10 p.m., and going forward in time, what do you see on
11 this strip?

12 MR. PERRON: Justin, if you want to please
13 pull that up.

14 Q. (By Mr. Perron) Was moderate variability
15 maintained here?

16 A. Yeah. Moderate variability baseline was
17 approximately 1:55.

18 Q. Nurse Shinn testified that using Pitocin
19 during this afternoon was pounding the baby's head
20 into the pelvic bone.

21 Looking at this tracing, does this appear
22 to be a tracing of a baby whose head is being pounded
23 into the pelvic bone?

24 A. It does not appear that way.

25 Q. In your practice and in your understanding

1 of literature, had the use of Pitocin ever been
2 described as pounding a baby's head into the pelvic
3 bone?

4 A. That's -- I have not seen it described
5 that -- that way.

6 Q. Okay. There was a neonatologist, Dr.
7 Kerzner, who testified that Remi was being punched
8 and punched during this afternoon on May 4th.

9 This strip that we just looked at, is that
10 consistent with a baby who's being punched and
11 punched?

12 A. That is not.

13 MR. PERRON: Justin if you want to pull up
14 F3-P, page 162.

15 Q. (By Mr. Perron) And I believe, Doctor,
16 you can look at the time stamp on there.

17 when does that window of time end?

18 A. 1309.

19 Q. Okay. Do you see moderate variability
20 maintained in this window of time?

21 A. I do. I do.

22 Q. Okay.

23 MR. PERRON: Justin, go to the next page.

24 Q. (By Mr. Perron) Moderate variability
25 throughout this entire window?

1 A. I do, yes.

2 MR. PERRON: And next page, Justin.

3 Q. (By Mr. Perron) But still, Doctor, what
4 do you see?

5 A. Moderate variability.

6 Q. Okay. Is this a Category I strip, more or
7 less?

8 A. Yes.

9 Q. We're into the one o'clock hour.
10 Is this a baby in fetal distress?

11 A. Not looking at that strip, no.

12 Q. What is Category I? What does that tell
13 us? What is Category I?

14 A. The baby has moderate variability. It can
15 have accelerations. It may have early decelerations
16 but no decelerations. And the fetal rate is within
17 110 to 160.

18 Q. Anything better than Category I?

19 A. No.

20 Q. Okay. Is this a hostile uterine
21 environment for a baby? Is that what that looks
22 like?

23 A. Not looking at that, no.

24 Q. Okay. Plaintiffs in opening said that
25 providers, or at least Dr. McNeive, was purposely

1 ignoring, this afternoon, purposely ignoring --

2 MS. GUNN: Your Honor, may we approach?

3 THE COURT: You may.

4 (Proceedings were held at sidebar, outside
5 the hearing of the jury.)

6 MS. GUNN: It's not appropriate for Mr.
7 Perron to get evidence in front of this jury -- I
8 mean, it's not appropriate to ask this witness about
9 anything that was said in opening statements because
10 she wasn't here, and it certainly would be considered
11 a new opinion.

12 MR. PERRON: I believe if the assertion
13 was the providers ignoring the baby in distress, I
14 can ask her if there was a baby in distress --

15 THE COURT: You have asked her whether or
16 not there was a baby in distress. Your specific
17 question was based upon what Ms. Gunn said in her
18 opening statement, which the Court notes for
19 everybody's purpose is not evidence.

20 MR. PERRON: I'll withdraw the question
21 and move on to my next one.

22 THE COURT: Okeydoke.

23 (The proceedings returned to open court.)

24 Q. (By Mr. Perron) Doctor, are these
25 reassuring tracings to a provider trained in labor

1 and delivery that we were just looking at?

2 A. Yes.

3 MR. PERRON: Justin, can you go to v2 to
4 the 2:20 p.m. tab?

5 Q. (By Mr. Perron) All right. So if this is
6 at about 2:20 p.m., and, again, I apologize, I can't
7 see it. But that looks to be around the 2:20 p.m.
8 time line, you see the maintenance of moderate
9 variability on that page?

10 A. I do, yes.

11 Q. And, again, even in the presence of
12 deceleration or decelerations, the presence of
13 moderate variability, is that reassuring to the
14 provider?

15 A. It is, yes.

16 Q. What is that telling the provider, at
17 least from a nursing standpoint?

18 A. At the time when you see moderate
19 variability, that there is not fetal acidemia.

20 Q. Okay. Now, there's another strip round at
21 2:45 p.m.

22 A. (Nodding head.)

23 Q. You have to answer out loud, I apologize.

24 A. Oh, yes.

25 Q. And does that strip round reaffirm the

1 assessment of Nurse Maggie and Nurse Jessie about
2 what those strips are telling us and the providers
3 who are in the room at the time?

4 A. It does. That's what's --

5 Q. Go ahead. I'm sorry.

6 A. It's that continued plan of care.

7 Q. Okay. And, again, at 2:45 p.m., it's
8 documented that those nurses during the strip rounds
9 actually used and applied the Clark algorithm at that
10 time.

11 A. They did.

12 Q. In your opinion, did they incorrectly
13 apply the Clark algorithm to those strips?

14 A. I don't believe so, no.

15 MR. PERRON: Justin, would you please put
16 up Exhibit AI please, PDF pages 182. Go back one.
17 PDF, maybe, it's the exhibit -- that's the one.

18 Q. (By Mr. Perron) Doctor, if you could look
19 at the corner and tell me what's the time stamp at
20 the far right?

21 A. 1548.

22 Q. Okay. So that's 3:48 p.m.?

23 A. Yes.

24 Q. That's, if I'm doing my math right, about
25 36 minutes before Remi was actually delivered and

1 born?

2 A. Correct.

3 Q. And what do we see in this window of time?

4 A. Moderate variability. There's a decel,
5 but there's actually also an acceleration.

6 Q. Is this -- does this describe, even as
7 late at 3:48 p.m., does this describe a baby that's
8 being punched, punched, and punched?

9 A. I do not think so, no.

10 Q. We talked a little bit about when, at the
11 time of your deposition, you believe that you saw the
12 Category III start.

13 MR. PERRON: Justin, can you put up F3-G,
14 PDF page 184.

15 Q. (By Mr. Perron) Doctor, on the left, so
16 the way I understand these strips, it goes in
17 chronological order from left to right.

18 Is that fair?

19 A. Correct.

20 Q. So at the very beginning of this strip,
21 for the first green line indicating a deceleration
22 there, is that a little period of time of moderate
23 variability on that page?

24 A. You wouldn't look at just a couple of, you
25 know, minutes. You'd have to look over a 10-minute

1 time period. So I, over -- the variability becomes
2 minimal towards the end of this, but it's not absent.

3 Q. Okay. Okay. Even at this time stamp that
4 I believe that's -- this is included, that this
5 period of time, 4:10, is when you believe that
6 Category III started?

7 A. That that's 1605.

8 Q. Okay. Sorry.

9 In general, switching gears, is there a
10 rule of thumb about a 30-minute window in which you
11 have to or should deliver a baby in Category III?

12 MS. GUNN: Objection. I'm going to
13 object. It's a new opinion.

14 MR. PERRON: Move on, Your Honor.

15 THE COURT: Okay.

16 Q. (By Mr. Perron) The jury has heard from
17 experts over the years who have had access to the
18 benefit of retrospect to neuroradiology imaging, to
19 Apgar scores, and lab results.

20 In realtime, nurses like Jessie and
21 Maggie, what tool do they have at their disposal to
22 have any idea about the status of the baby?

23 A. The fetal heart rate tracing.

24 Q. And according to that fetal heart rate
25 tracing, in realtime, up until 4:10 p.m., what was

1 tracing communicating to those providers?

2 A. That the baby had moderate variability
3 which is reassuring for them to continue the plan of
4 care.

5 Q. And that's not just your opinion, that's
6 consistent with what ACOG tells us?

7 A. Yes.

8 Q. That's consistent with what AWHONN tells
9 us?

10 A. Yes.

11 Q. Is that what the Clark algorithm and
12 Dr. Steven Clark tell us?

13 A. Yes.

14 Q. Do you hold those opinions to a reasonable
15 degree of professional certainty?

16 A. Yes.

17 Q. Those are my questions.

18 THE COURT: Cross-examination?

19 MS. GUNN: Yes, ma'am.

20 CROSS-EXAMINATION

21 BY MS. GUNN:

22 Q. Let's start with Clark, Dr. Burgess. I
23 noticed you changed your opinion, right?

24 In your deposition, you told me very
25 clearly that you believed between 8:30 and 9:30 in

1 the morning, that the Clark, had it been worked,
2 showed significant decelerations with greater than a
3 50 percent of the contractions for an hour, correct?

4 A. No. Could you tell me where I said that?

5 Q. Yeah. I was hoping you would ask.

6 Do you have your deposition in front of
7 you?

8 A. I do.

9 Q. Okay. So let's just be clear on what you
10 said on direct.

11 A. Sure.

12 Q. So we can show the jury what you said in
13 your deposition and how they're different.

14 A. Sure.

15 Q. So on direct, you said, yes, I remember
16 being asked about the Clark in my deposition. And at
17 the time, I said that it was probably a time,
18 possibly a time, that had the Clark been worked, it
19 would have shown more than 50 percent decelerations.

20 Do you remember that?

21 Potentially, is what you told me.

22 A. Yes.

23 Q. Okay. So let's start on page 116.

24 But now after your deposition, and let's
25 be clear, you had the fetal monitoring strips. You

1 looked at them thoroughly before your deposition,
2 right?

3 A. Yes.

4 Q. Because you knew you had to take an oath
5 and tell the truth at your deposition, correct?

6 A. I didn't count to the --

7 Q. I'm just asking you.

8 A. Oh.

9 Q. You understood that you gave a deposition,
10 and you raised your hand to tell the truth, correct?

11 A. Yes.

12 Q. And you had plenty of information to be
13 able to give those opinions, correct?

14 A. Yes. Correct.

15 Q. And we're here today to talk about the
16 fetal monitoring strips, correct?

17 A. Correct.

18 Q. And you had those?

19 A. Correct.

20 Q. You not only had a blank version of them,
21 but you had Heidi Shinn's version of them. You had
22 Dr. Landon's version of them. And you had Exhibit 5
23 that the jury had seen, as well, correct?

24 A. Correct.

25 Q. You had all the versions.

1 A. I did.

2 Q. well, maybe not the shredded version, but
3 you had all the versions, correct?

4 A. Correct.

5 Q. so you had reviewed those, and we were in
6 the midst of this conversation on page 116 of your
7 deposition.

8 And I said: when you're looking at
9 something like the Clark algorithm -- and we started
10 out by asking about normal progress.

11 Do you remember that? If you're on page
12 116.

13 A. Let me switch my glasses to my reading
14 version.

15 Q. Sure. Take your time.

16 MS. GUNN: Let's have page 185-7.

17 Q. (By Ms. Gunn) This is -- you brought the
18 Clark to your deposition, correct?

19 A. I think so.

20 Q. Yeah. This is yours. Okay. So 185-7,
21 let's do the top part.

22 So you've got -- we were actually talking
23 about normal progress.

24 A. Yes.

25 Q. So why don't we start there, okay?

1 A. Sure.

2 Q. Normal progress for -- you accept the
3 definition that ACOG endorses about, if it's a
4 first-time mom with an epidural, normal progress is
5 up to 4 hours, correct?

6 A. Yes, that's the definition, yeah.

7 Q. And you accept that?

8 A. Yeah.

9 Q. And anytime after 4 hours, it's considered
10 prolong, and that's no longer normal progress,
11 correct?

12 A. According to the definition, yes.

13 Q. Which you endorse?

14 A. Yeah.

15 Q. So we can agree that when we get to normal
16 progress, it's the 4-hour rule?

17 A. Correct. Yeah.

18 Q. Okay. So that's how that conversation
19 started.

20 A. Sure.

21 Q. And I asked you -- let's go at -- start at
22 page 116 on line 17.

23 "QUESTION: And then when you don't have
24 normal progress, which is -- your definition is
25 between 3 or 4 hours for a normal mom in second

1 stage, you go to a C-section or an OVD, true?

2 And you said: True. If you had
3 significant decelerations equal to 50 percent of your
4 contractions for an hour.

5 MS. KAMYKOWSKI: So, Your Honor, I'm just
6 going to object as improper impeachment. We haven't
7 had a question that has been asked contrary to what
8 she testified to in her deposition.

9 MS. GUNN: You're right.

10 Q. (By Ms. Gunn) Let me -- let me ask you.

11 Dr. Burgess, at 9:30, in your opinion,
12 were there significant decelerations with greater
13 than or equal to 50 percent of contractions for one
14 hour? Didn't you just tell me that?

15 "ANSWER: Yes, I did."

16 And I'm sorry if I didn't give you the
17 page. It's 119, line 23 through page 120, line 2.

18 Did I read that correctly?

19 A. Say the page again for me.

20 Q. Page 119, line 23, and I'll read it again:

21 "QUESTION: At 9:30, in your opinion, were
22 there significant decelerations with greater than or
23 equal to 50 percent contractions for 1 hour? Didn't
24 you just tell me that?

25 "ANSWER: Yes, I did.

1 "QUESTION: So that would have been hours
2 4 and a half to 5 and a half of the second stage of
3 labor, correct?"

4 Correct.

5 Did I read that correctly, ma'am?

6 A. You read that, yes.

7 Q. So at your deposition you told me that

8 had the Clark algorithm been run at 9:30, we would

9 have seen greater than or 50 percent significant

10 decelerations with contractions over that 8:30 to

11 9:30 hour, correct?

12 A. That is it what I said at my deposition,

13 yes.

14 Q. And then let's see what 185-7 -- let's

15 just follow it.

16 A. Okay.

17 Q. If this had been run at 9:30 by anybody,

18 according to you, we start with moderate variability.

19 So this notion of moderate variability, we talked

20 about that a lot.

21 Clark accounts for that, right?

22 A. Uh-huh.

23 Q. You start with moderate variability.

24 A. Uh-huh.

25 Q. We start with moderate variability.

1 A. Yes, correct.

2 Q. It doesn't end -- if you've got moderate
3 variability, you're done.

4 That's not what the algorithm is, right?

5 A. You are correct.

6 Q. You start with moderate variability or
7 algorithm -- acceleration.

8 A. Uh-huh.

9 Q. If you have that, then you go this way.

10 If you don't have that, then you go the other way.

11 So we're talking about the Clark algorithm
12 with moderate variability? And the answer is yes.

13 Then the next one is significant decelerations with
14 greater than or equal to -- I'm sorry -- significant
15 decelerations with greater than or equal to 50
16 percent of contractions for an hour, correct?

17 A. Correct.

18 Q. You answered that yes at 9:30. And then
19 we follow it down. There's three stages. Latent is
20 the first stage. Active is the first stage. And now
21 we've got second stage, correct?

22 A. Yes. Yes.

23 Q. Is there any debate that Sarah Anyan was
24 in the second stage of labor at 9:30 in the morning?

25 A. No, not at all.

1 Q. Then you go to normal progress. And
 2 you've already told us that normal progress for a
 3 first-time mom with an epidural ends at 4 hours,
 4 correct?

5 A. Correct.

6 Q. So at 9:30, Sarah Anyan was not making
 7 normal progress, correct?

8 A. She -- Maggie -- Dr. --

9 Q. Ma'am, my question at 9:30 a.m. --

10 A. She was at 4 hours. She was past 4 hours.

11 Q. Correct. She was not making normal
 12 progress, correct?

13 A. Correct.

14 Q. So according to your view in your
 15 deposition, before you changed it when you came here
 16 today, at 9:30 had anybody done that? We'd go to
 17 second stage, normal progress, yes -- sorry -- no,
 18 cesarean section, or operative vaginal delivery,
 19 correct?

20 A. Correct. I thought that in my
 21 deposition --

22 Q. Ma'am, I'm going to -- we're trying to get
 23 done here, so I'm going to ask you another question.

24 You have not been a bedside labor and
 25 delivery nurse since 2007, correct?

A. Correct.

Q. Now, what you do now, though, is you work with hospitals and health systems doing risk assessments, and you help them build -- to identify areas of risk to build safer programs of care, correct?

A. Correct.

Q. That's generally -- that's what you told me at your deposition.

So you deal with quality and safety --

A. Yes.

Q. -- right?

So part of that is to identify the risk. So do you work with risk managers at hospitals to identify those risks?

A. Sometimes.

Q. And make their programs less risky?

A. Sometimes, yes.

Q. I mean, isn't that why you -- isn't that the goal?

A. Yeah.

Q. To improve quality care and patient safety?

A. Yes.

Q. And that's kind of your life's work right

1 now, right?

2 A. Uh-huh.

3 Q. Is that a yes?

4 A. Yes.

5 Q. And so part of assessing risk and
6 understanding where hospitals are vulnerable with
7 respect to that risk is documentation, right?

8 A. Correct, yes.

9 Q. I mean, you want to see good documentation
10 of patient care, right?

11 A. Yeah.

12 Q. And good documentation of patient care is
13 important for two reasons: patient safety, right?

14 A. Yes.

15 Q. And continuity of care, right?

16 A. Yes.

17 Q. Those are two really important things when
18 you're talking about taking care of patients safely
19 in a hospital, correct?

20 A. Correct.

21 Q. And in this case, I know that you've seen
22 the fetal monitoring strips, and you based your
23 opinions on the charting and the fetal monitoring
24 strips, correct?

25 A. Correct.

1 Q. And you got stuff later. And you
2 developed your opinions before you read any
3 depositions, before any of the blanks that got filled
4 in, correct?

5 A. Correct.

6 Q. And the charting -- we've talked about
7 this -- there is no charting of Sarah's and Remi's
8 station, how far down he was, after 6:00 a.m.,
9 correct?

10 A. Correct.

11 Q. There's no documentation for anybody to
12 know, that looked at the chart, where Remi was at any
13 point after 6:00 a.m., whether it was 8:00 a.m. or
14 10:00 a.m. or 12:00, into her 10th, 11th, 12th hour
15 of labor, correct?

16 A. Correct.

17 Q. And you're saying to this jury, from your
18 perspective as a quality and safety professional,
19 that that's acceptable?

20 A. That -- it's not a standard documentation
21 point for nursing.

22 Q. So it's acceptable not to document a
23 baby's station in a prolonged second stage of labor.

24 Is that your testimony?

25 A. It's not a standard documentation point

1 for nursing.

2 Q. So am I correct, that's your testimony?

3 A. That's -- it's -- it's not a standard
4 documentation point.

5 Q. So it's okay not to document it?

6 A. It's not something that nurses typically
7 document.

8 Q. Would it be helpful to know those things?

9 A. I'm sure it would be helpful, but it's not
10 a standard documentation. If you looked at
11 quantities of documentation, you wouldn't find
12 nursing documents documenting the -- the -- like
13 where the station is.

14 Q. Could it improve patients' safety if you
15 document where the baby is at any point in time
16 during a prolonged second stage of labor?

17 A. It would decrease risk because then you'd
18 know, but it's not from a safety perspective.

19 Q. What on earth do you mean by that?

20 A. Safety and risk are two different things.

21 Q. No. I want to understand what you mean by
22 then I would know.

23 A. Because that's what you're asking about --

24 Q. No. I mean, as a lawyer who represents
25 people who have been injured by medical malpractice,

1 that's who you don't want to know about this risk?

2 A. No. That's not it at all. There's a
3 difference between safety and risk. In documenting a
4 station, is not improving safety, it's decreasing
5 risk.

6 Q. And those two things are different in your
7 mind?

8 A. They are different. They have different
9 definitions.

10 Q. What's more important?

11 A. Obviously safety.

12 Q. Then why wouldn't you document it?

13 A. I'm -- I'm here to document -- talk about
14 the standard.

15 Q. Are you familiar with ACOG guidelines
16 and -- are you familiar with the Obstetric Care
17 Consensus?

18 A. Yes.

19 Q. No. 1 from March 2014?

20 A. Not No. 1. You'll have to read that to
21 me.

22 Q. Well, it's called the "Prolonged Second
23 Stage." It's Obstetrics Care and Consensus No. 1.

24 A. Okay.

25 Q. Are you familiar with -- I think you

1 already told me that you were familiar with the
2 definition of prolonged second stage of labor,
3 correct?

4 A. Yes.

5 Q. okay. So this jury has seen this, but
6 I'll get it up really fast. 145-8.

7 MS. KAMYKOWSKI: Your Honor, I'm going to
8 object at this point. There's been no foundation
9 laid with this witness.

10 THE COURT: Okay.

11 Q. (By Ms. Gunn) I'm going to --

12 MS. GUNN: May I approach, Your Honor?

13 THE COURT: You may.

14 Q. (By Ms. Gunn) Dr. Burgess, this is an
15 ACOG clinical, Objective Care Consensus No. 1.

16 Are you familiar with this?

17 A. I have not read that.

18 Q. what about the table of which --

19 A. Progress in labor.

20 Q. Sorry.

21 A. I mean, I haven't looked at these

22 documents. I've seen them.

23 Q. So you're not familiar?

24 A. I have seen that before, but I wouldn't
25 be, you know, I can't tell you what's on each page.

1 Q. what about this definition here of the
2 prolonged second stage of labor that you told me
3 about earlier? Are you familiar with?

4 A. Yes.

5 Q. Okay. So maybe I can just show you this?

6 A. Sure.

7 Q. Okay.

8 MS. GUNN: So let's go to page 145 -- or
9 Exhibit 145-8, page 11.

10 Q. (By Ms. Gunn) So you told us, Doctor,
11 that you are familiar with this chart that talks
12 about second stage of labor, and the jury's seen it.
13 In fact, this is McNeive's star.

14 Did you read his deposition or see any of
15 his exhibits?

16 A. I did see his deposition, but I didn't
17 spend a whole lot of time on it.

18 Q. Okay. So this is his document that he
19 brought. That's his star. And I want to go down
20 where it says after the little bullet points: Longer
21 durations may be appropriate on an individualized
22 basis such as with the use of epidural anesthesia or
23 with fetal malposition as long as progress is being
24 documented.

25 Is that good practice?

1 A. Sure, yeah.

2 Q. So ACOG believes that it's critical --
3 well, let me withdraw that -- ACOG believes that you
4 can go longer in the 4 hours as long as progress is
5 being documented?

6 A. Yes.

7 Q. And do you agree that's a good practice?

8 A. Yes.

9 Q. Do you agree that that's a practice that
10 identifies patients' safety?

11 A. Yes.

12 Q. And it would be helpful for patients and
13 potentially increase their safety? Laboring mothers
14 and unborn babies in particular if the progress,
15 after a second stage of labor is prolonged, is being
16 documented?

17 A. I can't speak to this document because
18 this document is an ACOG document. I'm speaking to
19 the nursing documentation standards.

20 Q. would you agree?

21 A. Say your question again.

22 Q. would you agree that it is a good thing
23 potentially -- a good thing to document with the
24 patients' safety in mind?

25 A. The station and --

1 Q. The progress?

2 A. -- the progress?

3 I think it can be helpful. But I don't
4 think it's changing patients' safety.

5 Q. would you -- you heard Maggie testify
6 earlier today that she was documenting with her eyes
7 and her ears.

8 Did you hear that earlier when she was
9 testifying this morning? were you here?

10 A. Documenting with her eyes and her ears?

11 Q. Yeah. You don't remember that part of her
12 testimony?

13 A. I didn't hear her say "documenting." I
14 heard she was listening.

15 Q. Okay. Do you think it's appropriate --
16 would it be appropriate documentation in a patient's
17 chart merely to listen and hear things?

18 A. I'm sorry. I don't understand the
19 question. Can you rephrase?

20 Q. Of course. Documenting means actually
21 putting words or things in a patient's chart,
22 correct?

23 A. Correct, yes.

24 Q. You can't document a patient's chart by
25 listening to things or looking at things, correct?

1 A. Correct.

2 Q. Do you agree that the tracings were
3 overwhelmingly Cat IIs, the majority, except for the
4 last portion of the tracings, correct?

5 A. Yes.

6 Q. And I guess we're going to -- there's a
7 little bit of disagreement. Dr. Landon thinks that a
8 Category II tachycardia started on page 182, which is
9 one page after -- what Dr. -- Mr. Perron showed you.

10 But you don't doubt that the tachycardia
11 in Category III started shortly after that, correct?

12 A. Yeah. I think we said 4:10, 4:09.

13 Q. Well, Dr. Landon actually thinks it's
14 3:57?

15 A. Tachycardia or Category III?

16 Q. Both.

17 A. I -- I'm going with 4:10.

18 Q. Okay. Now, the -- the document that you
19 did bring in addition to the Clark to your deposition
20 with also this colorful one that you showed us --
21 that Ms. Kamykowski showed you. So let's look at
22 that one real quick. I just want to make one --
23 well, one little thing here.

24 Let's go to the second page.

25 Yeah. So you told us that the second

1 bubble there under Category -- first bubble under
 2 Category II -- would be appropriate for Sarah and
 3 Remi. And it would be moderate variability with
 4 decels. That's -- that's -- those are the phrases
 5 we're pulling out of there, correct?

6 A. Yes.

7 Q. And then you got down to A, B, C, D. And
 8 that goes on to the next page.

9 I just want to look at that real quick.

10 So we've got --

11 MS. GUNN: Just the next page, please,
 12 Zack.

13 Q. (By Ms. Gunn) Let's just look at A and
 14 then go down to B.

15 So I guess it means you need to do A, B,
 16 C, and D, correct?

17 Or at least A and B and then maybe go to C
 18 and D, correct?

19 A. You don't have to do -- it says begin
 20 conservative measures. So you don't have to do all
 21 of the bullets in there.

22 Q. Sure.

23 A. You're, you know, it's what's appropriate,
 24 based on the clinical picture and what you're taking
 25 in based on the --

1 Q. Right. So I just want -- the bullet
2 point -- the first bullet point under begin
3 conservative measures is administer oxygen, change
4 maternal position, and discontinue Pitocin, correct?

5 A. Correct.

6 Q. That's all in the same bullet point,
7 correct?

8 A. It is all in the same bullet point.

9 Q. And this doesn't say you only turn it off
10 if it's tachysystole, correct?

11 A. It's -- the intent behind it is not that,
12 to do all of those things. Because you don't
13 administer oxygen all the time. It actually can be
14 dangerous if you do that. So, by default, you
15 wouldn't just continue to dose it all the time.

16 Q. Right. My point is what you brought to
17 your deposition from the California Maternal Quality
18 care collaborative, begin conservative measures, the
19 first bullet point includes: administer oxygen,
20 change maternal position, and discontinue Pitocin,
21 correct?

22 A. Correct.

23 Q. And that is consistent with the protocol,
24 the nursing communication order, that was embedded in
25 Sarah's chart, correct?

1 A. They're all three things are intrauterine
2 resuscitation measures that you do based on the
3 clinical picture. You don't do all three all the
4 time.

5 Q. But you could certainly do all three if
6 you thought it was necessary?

7 A. If you thought it was appropriate, yes.

8 Q. I mean, no one's saying that it would have
9 been wrong to turn down Pitocin, are they?

10 A. The idea was to proceed with the delivery.
11 And the physician and the nurses felt that that was
12 necessary, and there wasn't tachysystole at that
13 time.

14 Q. Right. And you're talking about that's
15 it?

16 A. I'm sorry?

17 Q. You're not talking about the end of the
18 delivery?

19 A. Throughout the entire delivery.

20 Q. But it wouldn't have been wrong to turn
21 down the Pitocin, especially in light of the maternal
22 changes and the consistent decels coming back and
23 coming back.

24 A. No. It would never be wrong.

25 Q. The last thing I want to show on this

1 is --

2 MS. GUNN: Go back to this next -- the
3 previous page. The red bar at the end.

4 Q. (By Ms. Gunn) Tracing associated with
5 significant acidemia. Just defining these minimum or
6 absent variabilities for greater than or equal to 60
7 minutes with recurrent late or variable decels or
8 without acceleration. Category III for greater than
9 or equal to 20 minutes without response to acoustic
10 scalp stimulation, correct? Or bradycardia less than
11 60 minutes per minute.

12 So that second one is Category III greater
13 than or equal to 20 minutes, I mean, I know you
14 didn't think it started until 4:10 --

15 A. Uh-huh.

16 Q. -- but at least Dr. Landon and I think Dr.
17 warsof and Heidi shinn, believe that that Cat III was
18 going on for more than 20 minutes, right?

19 A. I'm not sure what they believed.

20 Q. But certainly this document that you
21 brought indicates that if you do have that situation,
22 that those tracings are associated with significant
23 acidemia, correct?

24 A. Yes.

25 Q. Now, Ms. Kamykowski asked you, and you're

1 being paid for your time here today, correct?

2 A. Correct.

3 Q. And I believe that the invoice before your
4 deposition was about \$8,000.

5 Does that sound right?

6 A. About, yeah.

7 Q. And then what do you charge to be here
8 today?

9 A. 2,500 for half a day.

10 Q. And how many half days were you --

11 A. Just this -- just here.

12 Q. So a full day, though?

13 A. To 5,000.

14 Q. Okay. And then there was this other
15 invoice that you paid between your deposition and now
16 which is about \$8,000?

17 A. Yes.

18 Q. All right. So we're in for about \$22,000.

19 Does that sound about right?

20 A. That sounds about right.

21 Q. That's all I have. Thank you, Doctor.

22 THE COURT: Any redirect?

23 MS. KAMYKOWSKI: Briefly, Your Honor.

24

25

REDIRECT EXAMINATION

BY MS. KAMYKOWSKI:

Q. You still have your deposition there, Dr. Burgess?

A. I do.

Q. So I want to make sure that we're clear about what you told us at your deposition, okay?

A. Yes.

Q. About the Clark algorithm and this time frame, 8:30 to 9:30.

MS. KAMYKOWSKI: So, Justin, can you pull up F1-G, and just keep the whole page up for right now?

Q. (By Ms. Kamykowski) Ms. Gunn read from Page 119 --

MS. GUNN: Your Honor, I don't think this is an appropriate way to impeach a witness or to direct a witness.

MS. KAMYKOWSKI: I believe the deposition can be for any purpose. She has attempted to impeach her with the deposition. I think putting context to it and letting the jury follow along is appropriate, Your Honor.

THE COURT: I think you can ask her the question.

1 MS. KAMYKOWSKI: Okay.

2 THE COURT: I don't know that the jury
3 would be in the best position for this -- not to give
4 it to them in the jury deliberation room.

5 MS. KAMYKOWSKI: All right. It would just
6 be for demonstrative purposes. But I understand the
7 Court's ruling.

8 Q. (By Ms. Kamykowski) Okay. So, Nurse
9 Burgess, you were asked about -- the question started
10 I think, the context of this, started at page 116.

11 Do you remember Ms. Gunn referring you to
12 that?

13 A. Yes.

14 Q. And that's where you were completing your
15 discussion -- were you completing your discussion
16 about progress in the second stage at that point?

17 A. Yes.

18 Q. And then the conversation in your
19 deposition turned to the Clark algorithm, correct?

20 A. Correct.

21 Q. Okay. I'd like just to refresh your
22 recollection to read for yourself from page 116, line
23 17, all the way through page 123, line 4. And then
24 I'll have a couple of questions for you.

25 A. And you want me to read to page 119?

Q. Actually 123 to line 4.

A. Okay.

Q. Does that refresh your recollection as to the entirety of the conversation and your opinion and testimony under oath at your deposition regarding your application of the Clark algorithm at the 8:30 to 9:30 time frame?

A. Yes.

Q. Okay. And what did you tell Ms. Gunn at that point in time in the total context of your review of that hour of the strips?

MS. GUNN: Your Honor, I object. Improper line of questioning.

THE COURT: Overruled.

A. That they potentially could have been significant during that time.

Q. (By Ms. Kamykowski) And were you looking for other parts in the strip or in the chart to see what the nurses were doing at that time?

A. Yes.

Q. And what did you tell her then that you were relying on with respect to the nursing interventions during time frame?

A. That they were implementing the position changes to see the response from the -- from the

1 fetus with each of the decelerations.

2 Q. (By Ms. Kamykowski) Okay. And is it
3 appropriate, when nurses are applying the Clark
4 algorithm, to implement intrauterine resuscitative
5 measures?

6 A. Yeah. That's kind of in fine print at the
7 bottom.

8 Q. Okay. Well, we're going to look at that.

9 MS. KAMYKOWSKI: Can you pull up Exhibit
10 F1-G.

11 Q. (By Ms. Kamykowski) And the first thing I
12 want to do is blow up year 1, including the little
13 asterisk or the "a."

14 Okay. So we just went through this with
15 Ms. Gunn. I want to make sure we're on the same page
16 and what you told her in your deposition.

17 when we look at moderate variability or
18 accelerations, what is your opinion about this time
19 frame we're talking about? The 8:30 to 9:30? where
20 do we go?

21 A. There is moderate variability.

22 Q. Okay. So we go to the yes, is that
23 correct?

24 A. Yes.

25 Q. All right. And then it says significant

1 decelerations with greater than or equal to 50
2 percent of contractions for one hour.

3 And what's that little thing at the end of
4 the hour? That little "a"?

5 A. The --

6 MS. KAMYKOWSKI: Can you just blow up the
7 subheading "a" at the bottom there, please?

8 Q. (By Ms. Kamykowski) That's hard to read.

9 Can you read that to the jury, what this
10 algorithm says as far as qualifying significant
11 decelerations with greater than or equal to 50
12 percent of contractions for 1 hour?

13 A. That haven't resolved with appropriate
14 conservative and corrective measures, which may
15 include supplemental oxygen, maternal position
16 changes, intravenous fluid administration, correction
17 of hypotension, reduction or discontinuation of
18 uterine stimulation, administration of a uterolytic,
19 and amnioinfusion, or changes in the second stage
20 pushing techniques.

21 Q. I think you missed part of it. Does it
22 say repositioning?

23 A. Oh, repositioning.

24 Q. Just for a complete record.

25 And in your review, and what you told Ms.

1 Gunn during your deposition, was that little subpart
2 "a" being done by Nurse Maggie and Nurse Jessie at
3 the time frame we were talking about, 8:30 to 9:30?

4 A. Yes. What I -- what I was trying to
5 clarify is, yes, there were potentially -- that was
6 the only time that I thought that there were
7 potentially significant fetal heart rate
8 decelerations and that they needed to insure that
9 they proceeded with the appropriate measures which
10 they saw, correct, yeah.

11 MS. KAMYKOWSKI: And then, Justin, can you
12 also then back out of that. And then let's go to
13 then the jury's seen this Table 2 on this page, the
14 clarifications for the use of algorithm.

15 Q. (By Ms. Kamykowski) But I think there are
16 a couple we haven't talked about. We've talked about
17 No. 3 a lot so we all understood what a significant
18 deceleration was as defined my Clark.

19 But what does No. 4 say?

20 A. Application of algorithm may be initially
21 delayed for up to 30 minutes while attempts are made
22 to alleviate the Category II pattern with
23 conservative therapeutic interventions such as
24 correction of hypotension, position change,
25 amnioinfusion, tocolysis, or reduction or

discontinuation of oxytocin.

Q. All right. So if we put together this clarification for use No. 4, and the footnote A, would you put that in context with your review of these strips and what was being done at the bedside by nurses Maggie and Jessie?

MS. KAMYKOWSKI: Go back to the algorithms, please.

Q. (By Ms. Kamykowski) would we be at significant decelerations of greater than or equal to 50 percent of contractions for 1 hour?

A. No.

Q. So where would we go on the algorithm?

A. To observe.

Q. Okay. And do you understand that's consistent with Nurse Shinn's testimony in this case?

A. Nurse Shinn's or mine?

Q. Nurse Shinn's.

A. I can't remember exactly what Nurse Shinn said.

Q. Thank you, Dr. Burgess. That's all I have.

THE COURT: Any recross?

MS. GUNN: Yeah.

RE CROSS EXAMINATION

BY MS. GUNN:

Q. At 9:30, in your opinion, were there significant decelerations with greater than or equal to 50 percent of contractions for 1 hour?

Didn't you just tell me that?

A. At some points during that hour, there were significant decelerations. It depends on when you're looking at the tracing.

Q. Doctor, look at page 119 of your deposition. Just follow along with me, then. Line 23:

"QUESTION: At 9:30, in your opinion, were there significant decelerations with greater than or equal to 50 percent of contractions for 1 hour? Didn't you just tell us that?

"ANSWER: Yes, I did."

So that would have been hours 4 and a half and 5 and a half of the second stage of labor, correct?

Correct.

And providers who were bedside between 8:30 and 9:30 were Jessie and Maggie, correct?

"ANSWER: Correct."

Did I read that correctly?

1 A. You did.

2 Q. Now, in your deposition, did you point to
3 Footnote A in the Clark algorithm?

4 A. We went on to have conversation about it.

5 Q. Did you say, but wait, look at footnote A?
6 Did you tell me that in your deposition?

7 A. I'd have to go back and look. I thought
8 we did have a conversation about the Clark algorithm
9 in his application.

10 Q. I'm asking you about footnote A. You just
11 spent 5 minutes reading a number of pages.

12 Did you tell me about footnote A in your
13 deposition?

14 A. I don't know if I said the words "footnote
15 A."

16 Q. Did you talk about clarification No. 4 in
17 your deposition?

18 A. I don't know if I said the word
19 "clarification" in footnote No. 4.

20 FURTHER REDIRECT EXAM

21 BY MS. KAMYKOWSKI:

22 Q. Just to put a fine pin on it.

23 Dr. Burgess, did the nurses in this case
24 between the 8:30 and 9:30 time frame implement
25 intrauterine resuscitative measures to address the

1 significant decelerations they had seen?

2 A. They did.

3 Q. Did they do that in accordance with the
4 Clark algorithm?

5 A. They did.

6 Q. Thank you.

7 MS. GUNN: I have nothing further.

8 THE COURT: May this witness be excused?

9 MS. KAMYKOWSKI: She may. Thank you,
10 Judge.

11 THE COURT: Thank you very much.

12 on behalf of the defendants?

13 MS. KAMYKOWSKI: Your Honor, at this time
14 on behalf of Mercy Hospital, we rest.

15 well, subject to -- I guess we need to
16 have a sidebar first.

17 THE COURT: well, why don't we hold off on
18 that, I understand subject to a number of different
19 things including exhibits and things of that sort.

20 MR. PERRON: with the same qualification,
21 Your Honor.

22 THE COURT: Thank you.

23 (Defendants rest.)

24 Any anticipated rebuttal evidence?

25 MS. GUNN: Only what we've discussed

1 previously.

2 THE COURT: Very good.

3 All right, ladies and gentlemen, based on
4 the timing and circumstances, the court is going to
5 give you your afternoon recess while I work with the
6 lawyers to get our final instructions ready for you
7 for tomorrow.

8 (At 4:00 p.m., the hour of adjournment
9 having arrived, the jury, being duly admonished by
10 the court, by agreement, is allowed to separate for
11 the evening, under the usual instructions of the
12 Court, until Tuesday, March 25, 2025 at 9:00 a.m.,
13 and the following proceedings were held in open
14 court, outside the presence of the jury:)

15 THE COURT: All right. We are outside the
16 presence of the jury, and both defendants have
17 rested, subject to a number of administrative issues.

18 I'm assuming the first one is a motion on
19 behalf of each of the defendants.

20 Offers of Proof by Defendant

21 Mercy Clinic East Communities d/b/a

22 Mercy Clinic OB/GYN and Dr. Daniel McNeive

23 MR. PERRON: Your Honor, first -- Your
24 Honor, first, we want to do a couple of offers of
25 proof.

1 First, it was an early ruling at a
2 pretrial conference to exclude the testimony of the
3 MFM, who was referenced only by title in the safety
4 rounds, but we later tracked her down, Dr. Fathian, I
5 believe. I want to spell this right: F-a-t-h-i-a-n.
6 we believe that if Dr. Fathian would have
7 been allowed to testify, she would have testified
8 that she believed that they appropriately made the
9 decision after review of the strips and the
10 circumstances in the case at 10:45 a.m. on May 4,
11 2020, to continue the plan of care.

12 Secondly, there was a ruling both at the
13 pretrial conference and then again at the time that
14 Dr. Dreyer testified to limit his testimony, both in
15 his expert opinion testimony, but also to limit his
16 testimony as a fact witness pertinent his knowledge
17 of Dr. McNeive along the same lines as testimony
18 permanent to punitive damages.

19 we believe that Dr. Dreyer, if allowed to
20 testify, would have testified as to the reliability,
21 in his mind, of providing care to Remington Anyan,
22 original Apgar scores, and, again, testimony that, in
23 his experience, he had never observed Dr. McNeive to
24 have intentionally harmed a baby or acted with malice
25 or evil intent with regards to one of his newborn or

1 not yet born patients.

2 MS. KAMYKOWSKI: And on behalf of Mercy
3 Hospital, I would join in on that offer of proof,
4 Your Honor.

5 THE COURT: The Court accepts those, for
6 the purposes of an offer of proof, and the Court
7 maintains its previous ruling as to those issues.

8 MS. KAMYKOWSKI: Thank you, Judge.

9 MS. SLATER: And, Your Honor, for the
10 record, I would just object to I believe the
11 untimeliness of the offer of proof.

12 And for the record I would like to make
13 sure that when the Court asked plaintiffs if there
14 were any rebuttal evidence that plaintiff would like
15 to offer, of course in front of the jury, we said the
16 issues we say had mentioned before.

17 of course the Court will know and
18 recognize that this record is the offer of John Paul
19 Gringas's testimony, at which were encompassed in our
20 previous offer of proof in Plaintiffs' Exhibit 141,
21 Exhibit 142 -- I'm sorry -- 141-2, Exhibit 141-24.

22 And then we would have used 11 demonstratives as
23 exhibits, as well, to help explain the opinion to the
24 jury, so just so that's clear.

25 THE COURT: I appreciate that, and the

1 Court maintains its previous ruling as to that issue.

2 MS. SLATER: Thank you.

3 MS. KAMYKOWSKI: If you're ready, Your
4 Honor, I would make a motion for a directed verdict
5 at the close of all evidence on behalf of Mercy
6 Hospitals East Communities.

7 Our position is that now that evidence has
8 closed, we have a tendered proposed instruction from
9 plaintiff with respect to the submissible elements
10 that they believe that they have met with respect to
11 the care of Mercy Hospitals employees, Nurse Maggie
12 and Nurse Jessie; namely, that they failed to
13 advocate for a C-section at 8:00 a.m. and thereafter,
14 or they failed to invoke the nursing -- the nursing
15 chain of command to change the plan of birth from a
16 vaginal birth at 8:00 a.m. and thereafter.

17 we believe that there has been no evidence
18 properly adduced in plaintiffs' case or through any
19 of the defense witnesses that had either of those
20 alleged breaches in the standard of care or acts of
21 negligence occurred, that the outcome would have been
22 changed in this case. And, therefore, there is no --
23 no causal connection between those alleged breaches
24 and the damages that are claimed here.

25 similarly, with respect to failing to

1 invoke the chain of command, when Dr. McNeive ordered
2 Pitocin increases at -- after 2:20 p.m. on May 4th,
3 we don't believe that there has been evidence adduced
4 to support that position, in that there's nothing to
5 say that had those actions been done by the nurses,
6 again, the outcome would have changed in any manner,
7 and, therefore, they are not causally tied to the
8 claimed damages in the case.

9 Finally, similar to all three of the prior
10 submissions, the failure to decrease or discontinue
11 Pitocin administration in response to Category II,
12 again, there has been no properly adduced evidence in
13 this case that would support that. Had that action
14 been done, any change to Remington Anyan's outcome
15 would have occurred.

16 On that basis, Judge, we would move to --
17 for a directed verdict at the close of plaintiffs'
18 evidence on behalf of Mercy Hospitals.

19 THE COURT: That motion will be denied.

20 MS. KAMYKOWSKI: Thank you, Judge.

21 THE COURT: On behalf of?

22 MR. PERRON: Your Honor, in addition to
23 Mercy Clinic and Dr. McNeive's motions for directed
24 verdict at the close of all the evidence, on the
25 alleged acts of negligence, we have separate motions

1 for directed verdict at the close of all evidence
2 with slightly different bases or arguments, first on
3 behalf of Mercy Clinic, but then separately on behalf
4 of Dr. McNeive personally.

5 The Court has heard the substance of these
6 arguments already, but just to reiterate with regards
7 to Mercy Clinic, we believe the punitive allegations
8 against Mercy Clinic have been improperly pled.

9 Section 510.261 states very plainly: Punitive
10 damages can properly be awarded against an employer
11 or other principal because of an act by an agent if
12 and only if, and then four different subparts.

13 So the fact that Mercy Clinic is the
14 employer of Dr. McNeive, is only the first step of a
15 many step process that plaintiff first even has to
16 plead, but then has to submit evidence of. And those
17 subparts include principal or managerial agent of the
18 principal authorized in doing -- in the manner of the
19 act. Or that the agent was unfit, and the principal
20 or managerial agent of the principal was reckless in
21 employing or retaining him. Or the agent was
22 employed in a managerial capacity and was acting in
23 the scope of employment. Or the principal or
24 managerial agent of the principal ratified or
25 approved the act.

1 I think that in the argument on our -- or
2 Mercy Clinic's motion for directed verdict at the
3 close of plaintiffs' evidence, there was some
4 argument that there existed some case law that they
5 were going to reference to the Court. And in the
6 event of a claim, there might be evidence of
7 ratification or something along those lines.

8 But, again, neither of those subparts have
9 even been pleaded to give us notice under which
10 theory of 510.261 they would even be presuming. But
11 certainly even setting aside the failure to even
12 plead, I don't believe there has been any evidence
13 entered for the jury to find either one, two, three,
14 or four sufficient to find punitive damages against
15 Mercy Clinic or the conduct of Dr. McNeive.

16 Separately, with regard to Dr. McNeive,
17 Your Honor, we'll just reiterate that the Missouri
18 statute sets a clear standard, both for clear and
19 convincing evidence. And clear and convincing
20 evidence must persuade the Court as the gatekeeper
21 that Dr. McNeive intended to cause damage or was
22 acting with malicious misconduct, which malice has
23 been defined as evil intent. And we don't believe,
24 especially in light of all of the testimony that
25 comes out, that there's been any evidence to suggest

1 an intent to cause harm or an evil intent to satisfy
2 malicious misconduct.

3 THE COURT: Sorry. I just want to make
4 sure -- I didn't want to interrupt you.

5 MR. PERRON: That's -- Your Honor, I'm
6 done. I'm sorry.

7 THE COURT: Okay.

8 MS. SLATER: Your Honor, this discussion
9 is going to necessitate holistically talking about
10 the standard and what we're going to adopt. It's
11 part of the same discussion that we would want to
12 have with the Court regarding any punitive damage
13 verdict directors.

14 we have a very tricky situation here
15 because we have conduct that occurred in May 2020,
16 the new statute, Senate Bill 591, was going into
17 effect in August 2020, and then this case being filed
18 in 2021, thereafter.

19 And the problem that that presents is only
20 specifically for this case because the conduct and
21 the filing of the case straddles the statute going
22 into effect, is -- and I'm going to cite for you the
23 Jones v. Director of Revenue case, a Missouri
24 appellate court case from 1993. Just for the record,
25 it's 855 S.W.2d 495, and the reference is 496 to -97.

1 It reads: with regard to the -- there are
2 two exceptions to this rule that statutes do not
3 operate retrospectively. One, where the legislature
4 manifests a clear intent that it do so. And, two,
5 the statute is procedural only and does not address
6 any substantive rights of the parties.

7 In Senate Bill 91, and also the Largent v.
8 Pelikan case, the Eastern District appellate court
9 has confirmed that the legislature had no intent for
10 the statute to apply retroactively if you had filed
11 before August 28th of 2020. That doesn't apply to
12 our case. Ours was filed after.

13 However, as we know, the history of Senate
14 Bill 51, it was not even passed until after the
15 conduct that happened in this case not signed by the
16 governor until July 2020, and was in effect in
17 August.

18 The problem we have here is that
19 plaintiffs have followed the procedural parts of the
20 changes to punitive damages overall and specifically
21 to med mal when it comes to the procedure that we
22 followed to ask the Court to allow us to plead
23 punitive damages in this case.

24 However, when we get to the question of
25 how we instruct and what language applies to instruct

1 the jury, plaintiffs have pointed out the
2 conflagration in the case law of the different
3 phrases that are used to describe punitive damages,
4 and the case law such as Coon and Rhoden, that, you
5 know, talk about conscious disregard being similar to
6 malicious conduct and the like.

7 However, if we look at Rhoden, which is
8 the Supreme Court's guidance, that distinguished that
9 the Rhoden case fell under the old standard, if you
10 will, or the standard that was specifically excluded
11 in the new statute, 538.210.08, said that the Rhoden
12 case with the punitives rose to that level, but it's
13 the new standard found in the statute after Senate
14 Bill 591, that it might not meet that standard.

15 So, here, the Court is in the position
16 that we need to determine -- and plaintiffs'
17 arguments is that Senate Bill 591 and the changes due
18 to the statutes that were made after the conduct in
19 this case, so, therefore, after Remi Anyan's claim
20 arose, are substantive changes in his right to
21 punitive damages before a jury.

22 As we know from the Rhoden case in the
23 footnote, I believe it's maybe footnote 3 or 4, the
24 Court has indicated that the standards meet the
25 difference. And of course the standard now reads

1 intentionally -- that you must find that the health
2 care provider intentionally caused damage to the
3 plaintiff, which seems to be a specific standard.

4 And then: or demonstrated malicious
5 misconduct that caused -- that happened to cause
6 damage to the plaintiff. And I put the word
7 "happened" in there because it's a more general
8 direction toward the plaintiff as opposed to intent
9 to harm the plaintiff specifically.

10 And that standard has been described by at
11 least one trial court recently as being above a
12 criminal standard, even for causing harm. So the
13 position that Your Honor is in is plaintiffs believe
14 that we have submitted clear and convincing evidence
15 that under Rhoden and the old statute language that
16 we believe applies to this case, shows easily what
17 the case law has discussed as conscious disregard for
18 the safety of others or reckless disregard for the
19 safety of others and willful conduct.

20 However, when we get to the other
21 standard, the newer standard, and the Court is to
22 instruct on that, the case law has indicated that it
23 may be a different burden, in which case, you know,
24 they're asking for a directed verdict on that
25 language.

1 So to summarize, plaintiffs' position is
2 that since the conduct arose and the claim arose, and
3 the substantive right for punitive damages in this
4 case specifically arose before the passage of 591 and
5 of course before 538.210 and 5 --

6 MR. PERRON: -10.262.

7 MS. SLATER: -10.262 that Mr. Perron
8 referenced, that those have been substantive changes
9 to Remi's rights. And so we believe the statute is
10 unconstitutional in that form. And so we believe
11 that the motion for directed verdict on punitive
12 damages should be decided under that standard. And
13 that plaintiffs easily passed that.

14 If the Court is to apply the different
15 standard, then we would need to show clear and
16 convincing evidence of this intentionally caused
17 damage to the plaintiffs, specifically or malicious
18 misconduct, which happened to cause damage to
19 plaintiffs. So that may be a different calculation
20 if I am bringing candor to the Court and saying that
21 the Missouri Supreme Court has indicated that there
22 may be a distinction.

23 MR. PERRON: Only with regards to
24 applicability, 510 -- I apologize -- 5 --

25 THE COURT: -- 261.

1 MR. PERRON: 261. 510.262 is
2 applicability of certain statute changes for cases
3 filed after August 28, 2020. Provisions for this act
4 shall apply to causes of actions filed on or after
5 August 28th, 2020.

6 So, again, the statute of the Missouri
7 legislature, 510.262, made it explicitly clear that
8 it applies to causes of actions filed after the
9 effective date which includes this case.

10 MS. SLATER: Your Honor, may I add one
11 more item?

12 As I'm sure Your Honor knows, the
13 committee on the MAI issued a 2022 revision that went
14 into effect on July 1st, 2022.

15 And in regard to 10.02, which is what
16 plaintiff would be offering as the instruction, there
17 is a caution that has now been added, and I'll be
18 happy to hand this to you. You probably understand
19 what I'm referencing. That -- and it says that
20 Senate Bill 591 purports to effect changes to the law
21 of punitive damages for cases filed after the
22 effective date thereof, as opposed to the accrual
23 dates, in the following areas. And it notes Section
24 510.261 that we've been discussing, as well as,
25 number 5 on that caution is additional distinct

1 changes for punitive damages in medical malpractice
2 cases citing 538.210.8.

3 And it says: Case law will determine the
4 extent of those changes and impacts on jury
5 instructions. The committee takes no position on the
6 constitutionality of any provision on Senate Bill
7 591.

8 So I think we do have a decision about the
9 constitutionality of whether the new standard changes
10 the substantive rights of Remi Anyan when his claim
11 accrued in May 2020. And so if the Court is inclined
12 to apply the new language in instructing the jury in
13 that the language that is going to be applied, then
14 if the Court were to direct the verdict under that
15 new language, then plaintiffs' argument would be that
16 that initial language applies, and it would be
17 specific to this case since it is the one that
18 straddles the filing of the statute.

19 THE COURT: I'm going to deny the motion
20 for directed verdict. I do believe that we have,
21 inherent in this situation, a built-in appeal should
22 the jury award punitive damages for both sides, which
23 ensures many more years of litigation for you all.
24 Fortunately I won't have to be part of that until it
25 comes back, by then, maybe I won't still be here.

1 But I am going to allow the punitive
2 damages to be instructed under the old statute, as I
3 do believe that it is definitely substantive law
4 changes, procedural changes.

5 MR. PERRON: Your Honor, is your
6 interpretation of which statute applies, just so
7 we've got clarity if/when we do have an appeal, is
8 there a particular --

9 THE COURT: Not if, when. We all know
10 that. I mean, there's no chance this case is done
11 with a jury verdict. I mean, nobody thinks that at
12 this stage, because no matter what they do,
13 somebody's going to appeal.

14 MR. PERRON: Well, hope springs eternal
15 with -- don't put that the record -- is there an
16 interpretation of the statute that is at the core or
17 foundation of the Court's ruling on the motion for
18 directed verdict as to Mercy Clinic?

19 THE COURT: I believe there's a previous
20 statute. And if there's not, I don't believe the
21 changes in it were procedural; I believe they were
22 substantive. Therefore, it affects the substantive
23 law, so I believe that based on the accrual of the
24 cause of action prior to August 28th of 2020, is what
25 it's dictating.

1 MR. PERRON: Does the Court believe that
2 the conduct meets the definition of both versions or
3 just the earlier?

4 THE COURT: I'm not going to provide an
5 advisory opinion.

6 shall we take a short break and then come
7 back to the instructions?

8 MS. KAMYKOWSKI: Yes, Your Honor.

9 (At 4:25 p.m., Court stood in
10 adjournment.)

11 o o o

12 Tuesday, March 25, 2025

13 o o o

14 (At 8:33 a.m., the following proceedings
15 were held in open court, outside the presence of the
16 jury:)

17 Instructions Conference

18 THE COURT: okay. We are outside the
19 presence of the jury and on the record. We have been
20 discussing the jury instructions since last night.

21 The Court proposes that Instruction No. 1
22 be 201, with the inclusion of the note taking.

23 Instruction No. 2 is 2.03.

24 Instruction No. 3 is 23 -- 2.03A.

25 Instruction No. 4 is 2.02.

1 Instruction No. 5 is 2.04.

2 Instruction No. 6 is 3.01.

3 Instruction No. 7 is 2.07, the insurance
4 instruction.

5 MS. KAMYKOWSKI: Your Honor, on behalf of
6 the defendants, just for the record, we had requested
7 that pursuant to discretionary language in the MAI,
8 that this not be given in the over packet, but
9 reserved unless and until the jury requests a
10 question.

11 THE COURT: And the Court is going to
12 overrule that objection and will give it with the
13 packet itself.

14 MS. KAMYKOWSKI: Thank you, Judge.

15 THE COURT: Instruction No. 8 is 11.06.
16 Instruction No. 9 is the verdict director,
17 MAI 22.02, modified by 19.01 and 37.01, offered by
18 the plaintiffs with regards to Defendants Mercy
19 Hospital.

20 MS. KAMYKOWSKI: Thank you, Your Honor.
21 May I make a record on our objections?

22 THE COURT: You may.

23 MS. KAMYKOWSKI: So on behalf of Mercy
24 Hospital, we believe -- we believe for a couple of
25 reasons that Instruction No. 9, tendered by

1 plaintiffs, is improper in that it needed to include
2 a modification by Coon v. Dryden, 46 S.W.3d 81, and
3 additional modifications by Rule 70.02(b) to include
4 a paragraph first that would follow and track
5 plaintiffs' evidence in this case that the disputed
6 facts, the timing of Mr. Anyan's -- Remi Anyan's
7 injuries, was that paragraph first should include a
8 finding first that he suffered an hypoxic ischemic
9 injury.

10 At some point, our -- our tendered
11 instruction would be that in the last 30 minutes of
12 labor on May 4th, that it tracks plaintiffs'

13 evidence, to not do so, would give the jury a roving
14 commission on the disjunctive negligence submission,
15 that it not be duplicative of the causation element.

16 Further, with respect to the disjunctive
17 submission the plaintiff has submitted in Instruction
18 No. 9, we believe that they are also overly
19 inclusive, and it is duplicative, and the dates
20 should simply result in a simple finding of a single
21 submission of the nurses failed to advocate for a
22 C-section before 4:00 p.m. on May 4th.

23 And for those reasons, we would tender an
24 alternative verdict instruction on behalf of Mercy
25 Hospital's response.

1 THE COURT: Thank you.

2 The Court is going to note that and is
3 rejecting that instruction at this time.

4 MS. KAMYKOWSKI: Thank you, Judge.

5 THE COURT: Instruction No. 10 is 37.04,
6 33.037, modified by 19.01., submitted by the
7 Defendant, Mercy Hospitals East, and references
8 Instruction No. 9.

9 Instruction No. 11 is 21.02, modified by
10 19.01 and 37.01, as submitted by plaintiff.

11 on behalf of the defendant, I know you
12 have objections.

13 MR. PERRON: Yes, Your Honor.

14 Number one, we adopt co-defendant's
15 argument as to the absence of some requirement that
16 the jury find one of the ultimate issues of fact that
17 is in dispute in particular, the timing of the
18 permanent hypoxic injury.

19 There's been evidence from plaintiffs'
20 experts about smaller, less permanent injuries
21 throughout the day, including 60 minutes before the
22 injury, that are unrelated to the actual permanent
23 hypoxic injury that is actually the root of
24 plaintiff's current disability.

25 we believe that not requiring the jury to

1 find on that specific ultimate disputed fact is err
2 and out of conformity with rules as described by the
3 Court in Coon v. Dryden, which has been cited already
4 in previous arguments.

5 with regards to the two different
6 instructions on C-section, we believe that they are
7 duplicative and raise concern of confusion with
8 regard to the two Pitocin instructions. We argue
9 that they are similarly duplicative and raise the
10 issue of confusion.

11 Separate from that, the instructions on
12 Pitocin as a disjunctive are improper because they do
13 not individually, by themselves, support the damages
14 that plaintiff is claiming. Dr. Warsof testified
15 that Pitocin by itself does not hurt the infant. It
16 is only the risk that you go into Category III that
17 the administration of Pitocin was negligent in his
18 mind.

19 If the jury believes that Dr. McNeive
20 acted within the standard of care as to the timing
21 and management of the delivery, or believes that in
22 some way he violated Mercy policies, this instruction
23 directs them to find against Dr. McNeive, even though
24 they would have believed that he did otherwise
25 everything right with regards to the delivery, and,

1 therefore, the administration of Pitocin alone would
2 not, under plaintiffs' explanation from their
3 experts, have actually caused any damage to Remi, and
4 for that reason, we believe the Pitocin as a
5 disjunctive is improper.

6 with regard to the cord gas, we believe,
7 again, that as a disjunctive, it's improper because
8 it does not individually support plaintiffs' claim
9 for damages. Dr. Kerzner testified that after Remi
10 was born, he already had significant HIE injury. But
11 that if the cord gas had been taken, then he might
12 have undergone this cooling intervention, which might
13 have lessened by 20 to 30 percent his disability.

14 If the jury believes that Dr. McNeive was
15 otherwise completely within the standard of care, but
16 should have ordered the cord gas, by the testimony of
17 plaintiffs' own experts, Remi would be exactly the
18 same as he is today with 20 to 30 percent less
19 disability.

20 Dr. Liles testified his life care plan was
21 for the entirety of his disability, and that it was
22 not speculative and beyond his ability at all to
23 reduce or distinguish the care that Remi would need
24 if he was only 80 percent of his current disability
25 as opposed to a hundred percent.

1 For that reason, the cord gas instruction,
2 as a disjunctive instruction, is improper and would
3 be err to leave in the instructions because it does
4 not individually support the entirety of plaintiffs'
5 claim for damages.

6 Now, we had previously offered our
7 proposed verdict director for Dr. McNeive and Mercy
8 Clinic, both incorporated the objections I've raised,
9 as well as that ultimate issue about the timing of
10 the HIE.

11 THE COURT: The Court is going to overrule
12 your objections and notes that that was submitted,
13 and the Court has rejected that instruction.

14 Instruction No. 12 will be 33.037 -- I'm
15 sorry -- 37.04 and 33.07, modified by 19.01, which
16 incorporates in Instruction No. 11.

17 No. 13 is 21.03, modified by 19.01.

18 14 is 21.05.

19 15 is Instruction 10.02, modified by 35.19
20 and 11.05, which then references Instructions No. 11
21 and No. 13.

22 I know the defendant has objections.

23 MR. PERRON: Yes, Your Honor.

24 And we had written out those objections,
25 both in our original amended and third amended

1 objections to plaintiffs' instructions, but just
2 briefly.

3 First, with regards to the question raised
4 yesterday as to the applicability of the new statutes
5 controlling punitive damages, both in general and in
6 particular, to medical malpractice claims.

7 On October 1, 2024, plaintiff filed their
8 motion for leave to amend the petition to add
9 punitive damages and wrote in that pleading RSMo Stat
10 510.261 governs pleading claims of punitive damages
11 filed after the effective date, August 28, 2020, and
12 they cite to the case Largent v. Pelikan, that's
13 P-e-l-i-k-a-n, which is the Eastern District 2021
14 writ of mandamus that said explicitly that based on
15 510.262, the new statute on punitive damages for all
16 civil claims is applicable to every case filed after
17 the effective date, August 28, 2020.

18 This is not just a writ of mandamus. This
19 is not just explicit wording of the statute itself,
20 this is plaintiffs' pleading put in writing to this
21 Court admitting to the applicability of this law not
22 even six months ago.

23 Further, in their motion, they -- they
24 reference 538.210. Similarly, RSMo 538.210 was
25 amended, effective, and applicable to cases filed

1 after August 28, 2020. This section changed the
2 standard applicable to punitive damages in a medical
3 malpractice case when the jury awards punitive
4 damages.

5 Again, not six months ago, plaintiff was
6 in a pleading representing to this Court and opposing
7 counsel that 538.210, as recently amended, was the
8 applicable standard to this case.

9 Further, when they amended their petition
10 to add punitive damages against Dr. McNeive, they
11 wrote in paragraph 94: The conduct of Defendant, Dr.
12 McNeive, as described above demonstrates that he
13 intentionally caused damage to plaintiff or
14 demonstrative malicious misconduct that caused damage
15 to plaintiff, thereby justifying award of punitive
16 damages.

17 Again, the defendants, first of all, in
18 general, in Missouri, parties are bound by their
19 pleadings. But even beyond that, the defense or
20 opposing counsel should have the ability to rely on
21 assertions made as officers to the Court in pleadings
22 within six months.

23 In any event, the petition was filed in
24 December of 2024, so just three months ago, as to the
25 applicable standard for punitive damages. The

1 defense aligned their further discovery on punitive
2 damages and trial strategy on the representations
3 made by counsel to the Court admitting to the
4 applicability of the new statute and those standards.

5 Under that new standard, it's our argument
6 that the instructions are flawed and improper with
7 regards to, number one, applying the wrong language
8 of the standard. And, number two, linking Dr.
9 McNeive and Mercy Clinic in the same instruction.

10 whereas, in 510.261, there is a different
11 and separate standard for the employer for the
12 conduct of the employee. With regards to punitive
13 damages, there should be a separate instruction that
14 instructs the jury to find according to those
15 separate criteria.

16 And for those issues, Your Honor, we
17 believe the punitive instructions as offered are
18 flawed, and it would be err to go to the jury.

19 THE COURT: The Court is going to overrule
20 those objections.

21 Instruction No. 16 is 33.164.

22 And then the verdict form.

23 The Court is not going to address any
24 additional punitive damages instructions until such
25 time as the jury is out deliberating.

1 MS. KAMYKOWSKI: Your Honor, for the
2 record, we also had tendered on behalf of, I think of
3 the defendants globally, and not an MAI instruction,
4 that tracks the language of section 538.215.2 that
5 would require the jury to make a finding of any
6 future damages itemized by the damages instruction to
7 be expressed at present value.

8 THE COURT: And the Court is going to,
9 again, reject that instruction.

10 MS. SLATER: And, Your Honor, plaintiff,
11 to preserve the issue, is offering you a verdict
12 directed on punitives directed to Mercy Hospital East
13 Communities and the nurses' conduct which follows
14 the -- and tracks the language on behalf of the
15 clinic.

16 THE COURT: That will be rejected, as
17 well.

18 Anything further for the record?

19 MS. KAMYKOWSKI: No, Your Honor.

20 MR. PERRON: No, Your Honor.

21 MS. SLATER: No, Your Honor.

22 THE COURT: Are we ready to bring the
23 jurors in?

24 (At 9:01 a.m., the proceedings stood in
25 recess. At 9:07 a.m., the following proceedings were

1 held in open court, in the presence of the jury:)

2 THE COURT: Good morning, everyone. Go
3 ahead and be seated.

4 (The instructions were read to the jury by
5 the Court.)

6 THE COURT: And then there is the verdict
7 form.

8 On behalf of all the parties, I do have
9 the instructions there. If somebody wishes to use
10 them, just make sure they get back in the folder in
11 the correct order.

12 THE COURT: On behalf of the plaintiff.

13 MS. GUNN: May it please the Court.

14 THE COURT: It does.

15 Plaintiffs' Closing Argument

16 MS. GUNN: Okay. Good morning, ladies and
17 gentlemen. It's been a long couple of weeks, into
18 our third week, and I haven't been able to talk to
19 you directly since voir dire. So on behalf of our
20 team and Blake and Sarah and Remi, in particular, I
21 want to thank you for your attention and how much
22 care you've taken in listening to the facts of this
23 case.

24 Ladies and gentlemen, right now you have a
25 right to know that when this case is over, you were

1 on a jury that followed the law. And when you go
2 back into the jury deliberation room in a little bit,
3 the first thing you're going to do is select a
4 foreperson. And then you will have three jobs: You
5 will need to answer the questions that the judge has
6 just posed to you in these instructions. You will
7 make sure -- need to make sure that everyone is
8 following the law. And, then, importantly, you will
9 need to express your opinions.

10 Each and every one of you has been
11 listening carefully. Some of you have been taking
12 notes. When you go into that room, it's your job to
13 advocate for what you believe. Talk about it. I
14 don't want to say argue, but discuss things. You
15 need to speak up and tell everybody what you're
16 thinking and why. You need to fight for what you
17 believe in.

18 Liz and Erica and I have been fighting for
19 Sarah and Blake and Remi now for over four years.

20 And let me tell you it's been a fight up to this very
21 moment. What's really, really hard to do right now
22 as a lawyer is to give up control. And what we're
23 asking you to do is take up that fight that we have
24 been giving for Remi.

25 we're asking you to take it up for him.

1 Lawyers, we get to choose who we represent. We get
2 to choose what clients we take. And it's a privilege
3 to do that. It's privilege to fight. We choose
4 that. Sarah and Blake didn't choose this fight.

5 Remi didn't choose this fight. What Sarah and Blake
6 chose was to go to Mercy Hospital on May 3rd to
7 deliver their first-born child.

8 So this is what -- how Remi has started
9 out, and here's how far we've come. And what we're
10 asking you to do now, as I go through these
11 instructions and hopefully give you some idea of what
12 those answers to those questions are, is to take up
13 this fight for Remi.

14 I'm going to give you the tools to do
15 that. So the first thing is, when we get to the
16 instructions that this judge just read, you'll have
17 those with you. You will see what we talked about in
18 voir dire which is the burden of proof. We have to
19 prove more likely than not, by a tipping of the
20 scales, that Dr. McNeive and the Mercy nurses were
21 negligent, and that that negligence directly caused
22 or directly contributed to cause harm. We have to
23 prove those things, all of those things, by a
24 preponderance of the evidence.

25 Now, if anyone in the jury deliberation

1 room says, you know, I'm just not convinced. I'm
2 just not totally sure about this thing or that thing,
3 I want you to refer to the instructions and remember
4 what we talked about in voir dire which is you can
5 have doubts. We're not talking about reasonable in a
6 criminal case, we're talking about more likely than
7 not, you may have doubts. You have to believe things
8 by a preponderance of the evidence. And if someone
9 says, you know, I'm just not convinced, remind them
10 of what the law is that you need to follow in this
11 case.

12 so we'll go with -- oops, sorry -- the
13 first thing, as I said, we've got liability,
14 causation, and damages. By the way, punitive, as the
15 judge just read to you, that is a different standard,
16 and I will be talking about that in a little. But in
17 terms of finding the negligence, that first part of
18 the case, it's more likely than not.

19 so let's start with negligence. You've
20 heard this, I don't know, so many times, every
21 expert, everybody that's testified. What does this
22 mean? Here are the words. What do they mean?

23 And I do find this one, there's a lot of
24 words. And I find it confusing, as well, and I've
25 worked through it many years. And here's what it

1 means: You can see the words: Means the failure to
2 use that degree of skill or learning ordinarily used
3 under the same or similar circumstances by members of
4 defendant's profession. But it is right there in the
5 definition. What would OBS do ordinarily in this
6 circumstance? What would ordinarily be done in this
7 circumstance?

8 So let's talk about the circumstances. We
9 have -- and time frames are important, but we're
10 going to go through them. So let's start at eight
11 o'clock. So I'm going to start with Dr. McNeive.
12 I'm going to start with McNeive, and we'll talk about
13 the nurses.

14 So McNeive, as we know, comes on service
15 at 7:00 a.m. And he gets to Sarah's room, according
16 to the chart, by 8:00 a.m. So what information is
17 known to him at that time? We know that Sarah was
18 complete at 3:50 a.m. No question about it. No
19 debate about it.

20 And by the time eight o'clock is there,
21 she is technically in a prolonged stage, second stage
22 of labor. And no one has said differently. I mean,
23 actually I think Landon said 3 hours is considered
24 prolonged, because even with a first-time mom with an
25 epidural, but the very outside, it's going to be 4

1 hours.

2 And that's ACOG. That's American College
3 of Obstetrics and Gynecologists. And those rules are
4 important. We've heard that over and over. So we
5 have a prolonged second stage of labor. So here is
6 the clinical guideline, the Obstetric Care Consensus.
7 You've seen that many times.

8 And we've got, you know, at least 3 hours
9 of pushing, and then it says you can do longer if you
10 have an epidural. That's kind of what -- we know
11 that's what Sarah was.

12 So let's look carefully -- what's also
13 indicated here, that longer durations, meaning past 3
14 hours or past 4 hours, longer durations may be
15 appropriate, may be appropriate, if, on an
16 individualized basis, such as with analgesia or fetal
17 malposition, as long as progress is being documented.

18 And I know I've mentioned over and over and over and
19 over.

20 This is the rule: You have to document.
21 If you're going to go outside that typical window,
22 which, by the way, we know that typically the average
23 for a second stage of labor is 2 hours. The average
24 is 2 hours. No one disputes that. So if you're
25 going to go outside the four-hour window, you'd

1 better be documenting it. why? Because it's
2 important because documenting is for a patient's
3 safety and continuity of care, so you better be
4 documenting it. And we know that isn't here, not at
5 all, after the night shift.

6 But also read on. we talked about this.

7 That last paragraph: Manual rotation of the fetal
8 occiput in the setting of fetal malposition in the
9 second stage of labor is a reasonable intervention to
10 consider before moving to operative vaginal delivery
11 or C-section.

12 In order to safely prevent C-sections, in
13 the setting of malposition, it is important to assess
14 the fetal position in the second stage of labor,
15 particularly in the setting of abnormal fetal
16 descent.

17 we have all of that. we have malposition,
18 as documented by kelsey mckillip, Dr. Mckillip. At
19 5:35 you'll remember -- remember, Alex Greenwald was
20 the night nurse. She starts pushing for an hour and
21 a half with Sarah. She notices because she knows
22 that typically after 2 hours of pushing, you've got a
23 baby.

24 she calls after an hour and a half for a
25 pushing evaluation by the resident. And Dr. Mckillip

1 duly comes and spends another 20 minutes with Sarah
2 pushing. And what does she note? She notes
3 malposition, that OP, which is the face-up, which is
4 a malposition. It's not an easy way to deliver. Has
5 it happened? sure. Is it optimal? No.

6 Baby rotates, getting closer to a facedown
7 position, the OA position, when she pushes, but then
8 rotates back when she doesn't. That is not descent.

9 That is not progress. Dr. McKillip notes plus 1,
10 plus 2 station. That's the caput. That's the
11 swelling on the baby's head. And so what she's
12 saying is that the baby is coming down when Sarah
13 pushes and then pulls back up. You can't count
14 caput. So even though caput says the plus 1, plus
15 2 -- remember, we're just going to plus 3 -- can't
16 count it.

17 So what does she say? Minimal descent
18 noted with pushing. Malposition and minimal descent
19 with pushing. But when they stop pushing, there's no
20 descent. Baby goes back to station zero. Back to
21 station zero.

22 So what happens next? Dr. McKillip
23 documents what she sees. And why is that important?
24 Because there's going to be a shift change. why is
25 that important? Because continuity of care increases

1 patient safety.

2 So it's there for everybody to see. We
3 know that Dr. McNeive saw it and understood it. We
4 know that Nurse Jessie and Nurse Maggie saw it and
5 understood it. We know that everyone at 8:00 a.m.
6 understood that at 4 hours, now 8:00 a.m., we're at 4
7 hours. We're at the limit, that limit of normal
8 progress is over in 4 hours. It's now prolonged.

9 And you can go forward if you understand and if you
10 document that's happening.

11 So back to this: This is another -- this
12 is what Dr. McNeive brought to his deposition, the
13 UpToDate literature. Just, I want to go over that
14 really quickly. This is risk of prolonging the
15 second stage. It's not without risk to keep going.
16 If it were, there wouldn't be a rule about it.

17 If you could just keep on pushing forever,
18 and not worry about what's going to happen, we
19 wouldn't have rules about it. But prolonging the
20 second stage of labor increases the risk of
21 occurrence of post-partem hemorrhage and maternal
22 infection. That's the mom part of it. Everyone
23 agrees there's risks going forward. Mom did get a
24 fever.

25 Prolonging a second stage worsens neonatal

1 outcomes, including trips to the neonatal intensive
2 care unit and sepsis. There's risks going forward.
3 At 8:00 a.m., Dr. McNeive didn't know which risks
4 were going to happen to go forward. He knew which
5 ones were possible.

6 what do we also know? what else was
7 known? This is the 93 percent of women deliver
8 within 4 hours in the second stage of labor. That's
9 what they knew. So when we get to 4 hours, she's an
10 outlier. You heard everyone say it. She's an
11 outlier. At 4 hours, she's already an outlier
12 because 93 percent of people, of women, have already
13 given birth.

14 Also half of the C-sections, half of the
15 C-sections that occur are because of arrested labor
16 and abnormal or indeterminate fetal heart tracings.
17 So having a C-section for failure to progress, baby's
18 not coming down, having a C-section because the fetal
19 heart tracings -- which we'll get to -- is why you
20 have them. Those are the reasons why you have
21 C-sections. There is noting surprising about this at
22 8:00 a.m.

23 Failing to descend. So I showed you the
24 slide that everything that was known. Prolonged
25 second stage, no question about it. Malposition, no

1 question about it. Dr. Mckillip noted it. Arrest of
2 descent, baby is not moving down despite pushing.

3 That's staying at zero station, no question about it.

4 Category II tracing. That's where we're
5 going next. There's been a lot of talk about these
6 tracings, and I understand -- whoops. There we go.

7 One more thing on arrest of descent. So
8 arrest of descent just means the baby's not coming

9 down. And that is the same thing as progress, or
10 lack thereof. So when you see progress, the baby's
11 not coming down. What is that? What is lack of
12 progress?

13 well, you've seen it from the literature
14 that it is less than a centimeter an hour, an hour to
15 an hour and a half. Dr. Landon told us that lack of
16 progress was less than a centimeter an hour. So
17 that's -- we're going to look at math, and we're
18 going to say, well, if she started pushing, let's
19 just say at 4:00 a.m., and she only had 2 inches to
20 go, that's about 3 and a half centimeters.

21 Then if you're making good progress, you
22 should be delivered. And that's just -- that's why
23 there's a rule about the 4 hours because that's how
24 far you have to go. It all fits. So if you're not
25 coming down in those hours, then you're not

1 progressing. And you have to make -- you have to
2 notice that because you know the risks.
3 So add that -- so there's two different
4 things going on, right? So you've got -- you've got
5 your failing to descend, failing to progress. That's
6 in and of itself a reason to do a C-section. But
7 then you add the fetal monitoring strips, which are
8 Remi's way to talk to the providers.

9 They're -- he's saying these
10 decelerations, variable decelerations, late
11 decelerations, everyone agrees that that is hypoxic
12 hits to the baby, okay? We talked about whether it
13 was transient, whether it was not transient.

14 Dr. Landon told us on Friday that each one
15 is pathologic. So what does that mean? It means it
16 matters. It means it adds up. We've heard from Dr.
17 Kerzner the baby takes those hits. Babies have
18 reserves. Babies are amazing.

19 Every baby goes through hits. And there
20 are Category II tracings in all of labors. So we
21 know that babies have reserves, and they can last for
22 a good, long while until they run out. It's like
23 driving your car across country on one tank of gas.
24 It's going to go great until you're out of gas. And
25 that's what we saw in Cat III.

1 But before we ever got there, there are
2 plenty of times Remi's telling everybody who bothered
3 to watch and look or listen that he's taking these
4 hits. So Category II, vast majority, vast majority
5 of the strips were Category II. No one doubts that.
6 Okay. We're going to quibble about going back into
7 Category I for 8 minutes. Okay. If you want to
8 consider that reassuring, that's fine. But there's
9 actually no reason why you believe that would keep up
10 after hour 5, after hour 6, after hour 7, 8, 9, 10,
11 11. why? Because nothing good happens in those
12 hours. We know that.

13 So what action needs to be taken in light
14 of the hypoxic hits the baby's taking. Okay.
15 Maternal position changes. I think what we know --
16 okay, here's my little -- everybody was, you know,
17 concerned about my demonstrative, which I made very
18 clear to everybody at the very beginning with every
19 expert, this was from Exhibit 5, which is all of the
20 defendants and the other treating folks there, were
21 writing down the fetal monitoring strips, what these
22 are.

23 These are not Amy Gunn's notes. These are
24 the doctors' and the nurses' notes about when these
25 late and variable decels were happening. Then you've

1 got facts about when they were happening. And every
2 hour, thereafter, they kept happening. They didn't
3 go away. They kept happening.

4 And here they are. So, again, I'm not
5 going to -- I'm not going to be accused of putting
6 things in front of you that aren't true. We've got
7 the Category II, this is at 8:00 a.m. We're going to
8 flip through these, okay?

9 This one ends at 8:00 a.m. These are the
10 notes: late decels, late decels. There's one page,
11 no markings, one -- one 8-minute. Late decels, early
12 decels, variable decels, or you can't really tell.
13 Variable, can't really tell, variable. Now we're at
14 8:49: late, late, late, late. 8:58: late, early,
15 early, noncontiguous. 9:05: late, late. 9:14:
16 noncontiguous, possible variables, noncontiguous.
17 You can't tell. You can't assume it's good. 9:23:
18 noncontiguous, difficult to decipher, noncontiguous.
19 9:31: noncontiguous, unclear, noncontiguous.

20 So those are pages between 125 and 136,
21 between 8:00 a.m. and 9:30. And, remember, we also
22 have the flow sheets of what's going on. Maggie
23 talked about these yesterday. We've got, starting at
24 7:30, late decels. 7:45, nothing is noted. Eight
25 o'clock, late decels. 8:15, nothing noted. 8:30,

1 late decels. These are hypoxic, pathologic evidence
2 of hypoxia in Remi at this point in time. 8:45,
3 late. 9:00, late. 9:15, late. 9:30, late. There
4 are no accelerations mentioned here.

5 These are everything that was known to Dr.
6 McNeive and the nurses in this time frame, and
7 everybody pulled that out. why? Because if you'll
8 remember, Dr. Warsof, our OB gynecologist, fetal
9 maternal medicine expert testified, look, she was
10 prolonged at eight o'clock, okay. But I'm not going
11 to call an immediate C-section. I'm going to say,
12 take a look. Give it some time. Figure this out.
13 Take a look. Pay attention. And at nine o'clock --
14 or eight o'clock, what -- what happened?

15 well, other than Dr. McNeive at the
16 bedside, nothing was documented. Dr. McNeive
17 testified he doesn't even remember if he checked her
18 at eight o'clock. He doesn't even remember if he
19 checked her at eight o'clock.

20 And instead of saying, okay, look, I know
21 I've got a lot of things to do, but you're already
22 prolonged, okay, and I know what it means. I know
23 the risks going forward of what it means to be in a
24 prolonged second stage of labor.

25 I know what all these late decels mean for

1 your baby. And so here's what I'm going to do: I'm
2 going to -- I'm going to put a plan together, and I'm
3 going to come back at this time. The nurses are
4 going to document what's happening. We're going to
5 know whether Remi is moving down. We're going to
6 know whether he's positioning himself better. And
7 then we're going to come back, and then we're going
8 to make a decision. That didn't happen. That
9 conversation never happened.

10 Sarah and Blake were never given the
11 opportunity to know the danger that she and Remi were
12 in. I mean, you remember we started out in opening
13 statement hearing, like, she got the vaginal delivery
14 she wanted. And then we didn't hear that afterwards,
15 did we? No.

16 Everyone said there was no discussion of a
17 C-section, never ordered, never recommended as long
18 as Sarah -- this kills me, ya'll -- as long as Sarah
19 is going to keep going, as long she's not tired and
20 not going to give up, we're just going to keep going.
21 What do you think that does to her now hearing that?

22 So at 9:30, we know, however, that there
23 was no plan. McNeive came back, Dr. McNeive came
24 from time to time, we don't know when. We don't know
25 what he found. We don't know what he did. It's not

1 in the documents. But we know that this was
2 happening: late decelerations, hypoxic hits to the
3 baby, reserves being run out.

4 And at 9:30, Dr. warsof says, you got to
5 call it, man. You know now she's 5 and a
6 half hours into her second stage of labor. Dr.
7 McNeive told you the longest that he can remember was
8 seven in his 25-year career. We're 5 and a half
9 hours there. And not only do we have Category II
10 fetal monitoring strips indeterminate with late
11 decels, but, remember, we also have malposition and
12 failure to progress, two separately different things
13 that lead us to the same spot, which is cesarean
14 delivery.

15 So Pitocin. What else do we know at eight
16 o'clock, at 9:00, at 10:00, 11:00, 12:00, 13 --
17 11:00, 12:00, 1:00, 2:00? Pitocin is at 18. Pitocin
18 is not benign. Pitocin is not just a drug you turn
19 on, babies come out. Pitocin is a high-alert
20 medication because it strengthens contractions and
21 increases the pressure on the baby and reduces the
22 baby's oxygenation.

23 And even with Pitocin at 18 this entire
24 time, it was never turned down and never
25 discontinued. And you heard days of fighting about

1 policies and protocols. Look, this was in her chart.
2 I mean, this is what was in the chart. This wasn't a
3 policy that was produced later that was on a shelf
4 somewhere. This is the direction for these providers
5 in the chart.

6 And it says: These things will be
7 initiated, will be initiated: lateral positioning,
8 okay, we did that over and over and over. IV fluids.
9 Never done. Never. Never hooked up a bottle, a 500
10 millimeter, a little water bottle, full of bolus that
11 said to be done that could have been made a
12 difference. Never done.

13 Discontinuation of oxytocin, never done.
14 I don't know. Did they consider it? Did they not
15 consider it? Was it part of the policy? Was it not
16 part of the policy? I can't tell. I just know it
17 wasn't done, and there are multiple things in the
18 records, in the literature, nursing literature, ACOG
19 literature, that talks about how you should do that.
20 why? Because it's dangerous to keep going. And her
21 contractions were good, her pushing effort was good.

22 So 9:30, yes, 9:30 Remi should have been
23 delivered, and it was below the standard of care not
24 to do that. It was a violation of the standard of
25 care not to do that. why? Because ordinarily it

1 would have been done, and it should have been done.

2 skilled OBS, by that point in time with all this
3 information, would have delivered her.

4 Didn't get done. Just keep going. No

5 plan. Go about your business. Deliver another baby
6 by C-section at 9:42. Let's labor Sarah down. well,

7 listen, if she was doing great, and baby was coming

8 down, why are you laboring down? why you doing that?

9 To get time? She didn't have the time. Remi didn't
10 have the time.

11 10:27: McNeive reads a note in -- about

12 Sarah, so he's aware of what's going on. I don't

13 know. we don't know what the note says. It's just

14 an audit trail. we don't know. But note there's

15 something. He learned something. No response. That

16 we could tell.

17 The 10:45 safety rounds. All right. I've

18 got to talk about the safety rounds. So 10:45, we

19 heard a lot about this, right? oh, all these eyes,

20 lots of eyes on this. Obviously everybody was acting

21 great within the standard of care because all of

22 these eyes.

23 Did you see the names of any of these

24 people in her records, other than the certified

25 midwife? who are these eyes? The names aren't even

1 in the record. So a couple of things about that. At
2 10:45, first of all, 15 minutes of fetal heart
3 tracings? That's all they said they looked at, 15
4 minutes. Well, I don't know what you can tell from
5 15 minutes.

6 And we don't know -- Maggie doesn't even
7 know if she was there. They were supposed to
8 start -- by the way, I think maybe Jessie said they
9 were supposed to start at 9:30. They usually start
10 at 9:30. And at 9:42, Dr. McNeive was delivering
11 another baby by C-section.

12 Think about this: If that had started at
13 9:30, and they actually would have seen her strips in
14 that time frame, which ones would you have seen? The
15 ones -- these. The lates over and over and over.
16 Decels. Maybe if those folks had looked at it at
17 that time, and not just 15 minutes at 10:45, they
18 would have seen this. Maybe they would have had the
19 same reaction to those strips that Adrian Burgess had
20 yesterday and told us about, the Clark algorithm.

21 Now, there's no evidence in this case that
22 anybody actually ran the Clark algorithm. But since
23 we're going to look at everything, Dr. Burgess, Nurse
24 Burgess yesterday said, well, yeah, I mean, I have to
25 admit, there was a time frame that the Clark -- let

1 me see if I can find it. I'm getting a little out of
2 the ways.

3 Oh, here it is. Okay. This is the Clark
4 algorithm. And, remember, yesterday, yesterday she
5 said, okay, at 9:30, if -- if we looked at the strips
6 the way the Clark algorithm tells us to, which is
7 looking at this hour of strips, even if you start at
8 mad variability, then you go, yes, significant
9 decelerations if greater than equal to 50 percent of
10 the contractions, and she said yes, there were
11 significant decelerations at that time frame.

12 And I know she tried to take it back. I
13 mean, ya'll saw that. She tried to take it back. It
14 was in her deposition. And you go down to second
15 stage of labor, which is where we are, and you go to
16 normal progress, which we didn't have. Normal
17 progress is defined as delivering within 4 hours.

18 So you can run this Clark at any time.
19 You can run it in the first hour, the second hour.
20 But once you get to normal progress, no one disputes
21 is that 4 hours, she is outside of that 4 hours by
22 9:30 by an hour and half. She did not have normal
23 progress at 9:30.

24 And had anybody bothered to take a look at
25 the strips and really look at the situation, they

1 would have said cesarean section or operative vaginal
2 delivery at 9:30, but that's not what happened. And
3 it was negligent. It was below the standard of care
4 and what was owed to Sarah and Remi when that didn't
5 happen and every minute afterwards.

6 Yeah, okay, they went back to Category I.

7 That's fine. But you can't -- if it's negligent at
8 9:30, the baby should have been delivered, Remi
9 should have been delivered. You don't get the grace
10 of looking in hindsight afterwards and saying, oh,
11 but there was some time when there was Category I.
12 There's some time. Ignore all that. That's not how
13 it works.

14 we're going back. Okay. 9:30 to noon,
15 you know, safety rounds. Also, in the safety rounds,
16 I mean, I know everyone wants to fill in the blanks
17 of the safety rounds the way they want to, but what
18 does the record show about safety rounds? 15 minutes
19 of strips.

20 You know, Dr. Burgess yesterday was
21 talking about, well, I'm sure they talked about her
22 chart and looked at everything and discussed it
23 amongst the professionals. No evidence of that. So
24 all we know is what it says. It's Category II. They
25 saw Category II. Indeterminate. Doesn't know if

1 that's good or bad.

2 But we don't know what else they spoke of.

3 we don't even know if Maggie was there. But here's

4 what I can tell you: If they looked at the chart at

5 9:30, if they actually did that, and we don't know if

6 they did, would they see any progress? would they

7 have seemingly charted progress by Dr. McNeive or by

8 Nurse Maggie or Nurse Jessie -- Nurse Jessie? No.

9 Because it wasn't there. which is the point of

10 documenting: continuity of care and patient safety.

11 It wouldn't have been there to see.

12 Okay. Noon to 2:00. we've got recurrent

13 more late decels, more laboring down, more C-sections

14 for other moms, and then we get to two o'clock. And

15 this, ya'll, I just can't, you know, at this point,

16 at two o'clock, she's in her tenth hour, okay, tenth

17 hour of second stage of labor. And there's been no

18 documented progress.

19 As far as we know, the baby is still at

20 zero station, as far as we know. Now, Dr. McNeive, a

21 little bit after 2:00, after he finished that third

22 C-section and comes in. And this is -- this is hard.

23 And this is hard for Sarah and Blake because they

24 were doing everything they were told to do pushing

25 and hoping and following directions.

1 And McNeive comes in, Dr. McNeive comes
2 in, and all he asked was, can you keep going? And
3 what she's going to say? No. I'm going to give up
4 now. I've been doing this for 10 hours. Were they
5 told at two o'clock, okay, 10 hours, ya'll, the
6 longest I've ever seen. Ask Jessie, ask Maggie, ask
7 Dr. McNeive. Longest I've ever seen.

8 And -- but, hey, let's just keep going.
9 Let's see what happens. I don't -- and he also had
10 told us that the baby was -- Remi was still
11 malpositioned. Remember, he went from OP to OT,
12 right? OT. OT. So sort of sideways. So he was
13 still malpositioned. He thought maybe he was plus 2.
14 And then Maggie yesterday told us he was plus 3. I
15 mean, okay.

16 And he doesn't -- doesn't do it. I don't
17 know why. why? with everything he knew? why? No
18 documented evidence of progress. No documented
19 evidence of station. Minimal arrest of descent. Cat
20 II. Continue Pitocin. No documentation.

21 And then 2 to 4 at 24, ladies and
22 gentlemen, I mean, this just gets so hard because
23 you've got increasing Pitocin. So now we're at --
24 the reserves are running out, and they turn up
25 Pitocin? Do a C-section. Turn up the dangerous drug

1 that reduces oxygenation to the baby? Not just once,
2 but four times?

3 Do you think it's a coincidence that when
4 the last time it goes up to 26, it's the same time
5 that Remi's becoming tachycardic, that heart rate is
6 going over hundred -- beating over 160 times -- beats
7 per minute. 160 beats per minute. Tachy. He got up
8 to over 200 in that time frame. 30 minutes.

9 Dr. Landon, yeah, I mean, 357 -- 356, 357?
10 Not only tachycardic, but Category III. So being
11 tachycardic doesn't make a baby in Category III.
12 Minimal variability makes the baby -- or absent
13 Category III. So let's talk about that real quick.

14 Oh, I'm going to get out of line. Oh, shoot. Let's
15 go back.

16 okay. If moderate variability --
17 remember, we've heard that over and over -- if
18 moderate variability were the only thing that matters
19 when you're looking a strip, oh, he was moderate
20 variability, then why would you even have that second
21 line with contractions?

22 So the first line, the top, is baby's
23 heart rate. The second line are the contractions.
24 The decelerations are what happens to the heart rate
25 after you have a contraction. If all we cared about

1 was moderate variability, why even have the second
2 line? It has to matter.

3 If all that -- if the only thing that ever
4 mattered was moderate variability, then you wouldn't
5 even need the Clark algorithm. You wouldn't even
6 have to assess progress because the baby's heart rate
7 looks fine. You can't look at moderate variability
8 in a vacuum. As much as they want to talk about
9 that, it's totally reassuring, you cannot do that.

10 That's why you have the issue of progress because
11 it's going to run out. It's going to run out.

12 Okay. So Dr. warsof had told you --
13 you're going to get a verdict director. Here's what
14 we call the verdict director. Okay. This is an

15 instruction. I'm sorry I don't have the number on
16 there. It's in there.

17 This is one of those questions that you
18 have to answer. If you -- in your verdict you must
19 assess the percentage of fault to Mercy Clinic/Dr.
20 McNeive -- that's the practice. It's his
21 employers -- if you Dr. McNeive either -- so these
22 are disjunctive, you can believe all of these or only
23 one of these. All of these or only one of these in
24 order to move on to the second paragraph.

25 If you believe Dr. McNeive failed to

1 deliver Remi Anyan by C-section between 9:30 and when
2 he returned to bedside after two o'clock on May 4th.
3 Or he failed to deliver Remi by C-section between
4 returning to bedside after two o'clock and before a
5 C-section was no longer feasible. Remember, he told
6 us Remi was too low and too engaged by the time he
7 hit Category III. Is anybody really surprised by
8 that? Too low and too engaged. Too late. Too late.

9 The next one: Failed to order a decrease
10 in Pitocin. The policy mentions it. Everybody knows
11 it's a dangerous drug. He then turned it up. Turned
12 it up. Or failed to obtain cord gas. We'll talk
13 about that in a second. If all these things are
14 true, you have to believe they were negligent. You
15 have to believe that it was below the standard of
16 care that ordinary -- ordinarily careful OB/GYNs
17 would have done something different, which I think is
18 clear here.

19 You have to believe one or all of those
20 things were negligent, and that such negligence
21 caused or directly -- directly caused or directly
22 contributed to cause harm to Remi Anyan. And we're
23 going to get to that.

24 So nurses' negligence. It's a lot of the
25 same analysis, really. I don't want to keep going

1 through it, but we know that they didn't document the
2 progress. They had the same facts as Dr. McNeive at
3 eight o'clock and 9:00 and 10:00. They never
4 advocated for Remi and Sarah. They're not potted
5 plants. You heard Nurse Shin say that. And I
6 understand the idea that there was a doctor giving
7 the orders and a doctor overseeing everything, but
8 nurses have specific and important responsibilities,
9 too. And they are with the baby and with the mother.
10 And they failed Sarah and Remi on those things.

11 These are still variable decels, decels --
12 oh, one more thing, crazy, ya'll -- so this is a --
13 this is Dr. McNeive's literature that he brought.

14 And, remember, it says ineffective management
15 interventions: changing maternal position. And this
16 is regarding to the second stage of labor.

17 There's no strong evidence that a change
18 in the maternal position whether it is upright
19 posture, lateral, or hands and knees is useful for
20 treatment of prolonged second stage of labor. This
21 is the literature that maternal changes -- maternal
22 position changes don't even work when you're talking
23 about a prolonged second stage of labor. And that's
24 all they did. They just kept turning her over and
25 putting her on a ball.

1 okay. Here's Jessie.

2 (A designated portion of the videotaped
3 deposition of Nurse Jessie was played for the jury.)

4 MS. GUNN: Every patient is a learning
5 experience.

6 We saw Dr. Burgess yesterday. We've
7 already run the Clark on that. And this is just
8 another thing on the Clark, which is very clear that
9 fetal heart rate patterns cannot be interpreted in
10 isolation. You can't just look at the patterns and
11 not look at the complete picture.

12 You might hear this line a number of
13 times. It's, again, these are Dr. McNeive's
14 underlines: The superb reliability of accelerations
15 and moderate variability excluding any degree of
16 hypoxic related central nervous system depression or
17 risk of ongoing hypoxic injury would allow an
18 observation of patterns with these features in
19 adequate labor progress. Can't leave out progress,
20 ya'll. Can't just look at the fetal monitoring
21 strips and leave out progress.

22 However, intervention in patients with
23 certain Category II patterns in slow but technically
24 adequate progress within 4 hours, progress may also
25 be an appropriate option.

1 progress is key.

2 okay. Dr. -- Nurse Shin -- we've seen
3 this. This is going to be the verdict director for
4 the nurses, and it's everything we talked about:
5 chain of command. They did not stand up for Sarah
6 when they had the knowledge, and they should have
7 advocated for her, and they did not.

8 Next phase after liability is causation.

9 You have to believe that -- I said this in voir
10 dire -- you have to believe that it was a
11 coincidence. Anything that happened in the
12 hospital --

13 THE COURT: 5 minutes.

14 MS. GUNN: -- was a coincidence. I think
15 what you're going to see in this, and that's why they
16 spent so much time trying to tell you that this --
17 this HIE happened before Remi got to the hospital
18 because they know if you believe the evidence shows
19 that Remi was injured in the hospital, anything they
20 did directly caused or contributed to cause the HIE,
21 they're responsible for it.

22 So causation, you have to believe that
23 none of this fetal monitoring strips, all the decels,
24 no progress, the 12-hour second stage of labor, the
25 Category III tracings at the end, you have to believe

1 none of it had anything to do with Remi's HIE, but
2 also believe that he still has it. They've given you
3 no indication of what, if it wasn't what was going on
4 in the hospital, what was it? Did you have any --
5 have they brought any experts to tell you this is
6 what happened before she walked into the hospital?

7 MS. KAMYKOWSKI: Your Honor, I'm going to
8 object. This is a burden shifting argument. It's
9 improper.

10 THE COURT: The Court is going to sustain
11 the objection.

12 MS. GUNN: You've heard nothing about what
13 happened to Remi other than what we've brought you,
14 which is everything that happened --

15 MS. KAMYKOWSKI: Same objection, Your
16 Honor. She continues to burden shift.

17 THE COURT: Sustained.

18 MS. GUNN: what they brought you is Apgar
19 scores. we'll talk about that. But we know that she
20 came to the hospital perfectly fine. She got on
21 those monitors in Category I and stayed that way.
22 Category I, the evidence is, you heard from Dr.
23 Landon and other experts, if you start in Category I,
24 if Remi was brain damaged before he walked in the
25 hospital, he's not going to be on Category I with

1 wonderful accelerations and a perfect fetal
2 monitoring strip for the first 12 hours that he was
3 there. That doesn't fit. It doesn't fit.

4 Good fetal movement, clear fluid,
5 remember, we talked about that. Everything looked
6 great for this baby when he walked in the door to
7 Mercy Hospital. Category III strips, they didn't
8 want to talk about Category III with Dr. Landon,
9 remember? They didn't want to talk about prolonged
10 second stage of labor or Category III strips. But
11 here's what happens: Because they know that Category
12 III, that last 30 minutes, it's acidemia, it's
13 hypoxia. It's exactly what is happening. That's
14 exactly what happened to Remi when he was born.

15 So let's talk about ACOG. And I've got to
16 move on here. Apgar of 8. So I put it in quotes.
17 why? Because he had one off for tone -- one off for
18 tone -- plus the Apgar score itself -- this is --
19 you've seen this -- cannot alone be considered
20 evidence of a consequence of asphyxia.

21 THE COURT: 2 minutes.

22 MS. GUNN: Okay. I'm going to run over.

23 THE COURT: That's fine.

24 MS. GUNN: There are limitations. You
25 cannot look at Apgar scores alone and know anything

1 about a baby's neurologic status. We've seen that.

2 Baby Remi had low tone. And every expert that was
3 asked about it with these pictures in mind agreed.

4 Not just Dr. Kerzner, but Dr. Woodruff and Dr.

5 Cantey, he had one off for tone. No question about
6 it. It was not an 8.

7 Then we get to CPAP, okay? Nurse Younger
8 here she says.

9 (A designated portion of the videotaped
10 deposition of Nurse Younger was played for the jury.)

11 THE COURT: Encroached.

12 (A designated portion of the videotaped
13 deposition of Nurse Younger was played for the jury.)

14 MS. GUNN: Okay. Move on.

15 So we do. We have a time line. The baby
16 was still on CPAP at 5 minutes. It's in the medical
17 records. If baby was on CPAP at 5 minutes, he

18 shouldn't have gotten an 8, period. That's what that
19 means. He should have had one off, gone to a 7 for
20 tone, and gone to a 6 for respiratory efforts.

21 So when you hear evidence -- when you hear
22 defense talk about the Apgar, you've heard all their
23 experts say they would base their opinion that Remi
24 was not encephalopathic, he was fine, he didn't go to
25 the nursery, so he must not have suffered hypoxic

1 ischemic injury in the last 30 minutes, it's a house
2 of cards that falls because he was not an 8. He was
3 not an 8.

4 You heard Dr. Kerzner, our neonatologist,
5 talk about the constellation of markers. These are
6 all of the things that was going on with Remi when he
7 was born. And you heard Sarah and Blake -- and I
8 hate that I'm moving through this now, too -- where
9 she talked about reperfusion.

10 Reperfusion is what was happening. It
11 usually happens within 6 to 12 hours, and it was
12 happening to Remi, which is why he wasn't a zero or a
13 3 on his Apgar. It's why he was encephalopathic,
14 like his brain was on fire, but it was so depleted of
15 oxygen at that point, it took time to excite back.
16 Excitotoxicity. And that's what you saw.

17 He was frantic at the breast. He was
18 inconsolable. Sarah was worried that he had a
19 headache. He wouldn't eat. He started breathing
20 shallow and fast, and Blake knew that. We've seen
21 Dr. Nelson talking about, the pediatric neurologist
22 who was talking about, HIE, was caused the last 30 to
23 60 minutes.

24 Yes, the reserves were depleted, but every
25 minute from 9:30 on, when this negligence started,

1 mattered. Every minuet was getting us closer to the
2 point where Category III was going to be that
3 knockout punch. And we've got different things here.

4 Okay. We saw Dr. Zse, the normal
5 ultrasound, you remember, talking to Dr. Tekes about
6 and Dr. Zse about the normal ultrasound. And Dr.
7 Tekes throws it out because he didn't think it was
8 diagnostic. Here's -- Remi's on the left and a
9 textbook on the right. Pretty clear. It was normal.

10 If it was normal, it means the injury did
11 not happen within the last 24 hours. So if they say
12 that the ultrasound was -- if the ultrasound
13 occurred -- I know I'm getting my times mixed up. I
14 always have to remember that -- the ultrasound had
15 been normal, the injury would have been later. Why
16 am I messing that up still?

17 Okay. Ultrasound at 16 hours of life may
18 have been normal because Remi's injury was less than
19 24 hours old. If it was greater -- that's it -- if
20 it was greater than 24 hours, it would have been
21 abnormal. Okay. If it was greater than 24 hours
22 ago, it would have been abnormal. It was normal,
23 which is why Tekes had to get rid of it. All right.
24 Got through that.

25 window of time for the injury is 8:40 to

1 4:24. okay. Tekes, woodruff, you heard me say they
2 didn't consider it. Dr. Cantey was making guesses,
3 but he also says it's up to and including the time of
4 injury. Their own expert said, yeah, I got to admit,
5 it could have been happened then. Cantey, you heard
6 him. He also agrees, up to and including the time of
7 injury.

8 Damages. You're going to get all of these
9 damages. I hate it that I'm going through this fast
10 because I blew it on my time, but we've got past
11 economic damages of \$593,849.51. That's the medical
12 bills that we stipulated to. These are past medical
13 bills that have already been charged.

14 Life expectancy, yeah, I don't know. I
15 can't imagine what it was like for Blake to listen
16 Dr. Shavelle about -- and Dr. Matthews yesterday,
17 about how early your child is going to die based on
18 the defendant's negligence.

19 Listen carefully: Better care equals
20 longer life. Better care equals longer life. He
21 deserves every opportunity to live as long as he
22 possibly can. And the way to do that is to fund a
23 life care plan. Here's Remi. I'm going to skip
24 that.

25 (A designated portion of the video was

1 played for the jury.)

2 MS. GUNN: So cute. But we're going to
3 move on.

4 Okay. Dr. Liles -- you heard that. I'm
5 going to skip through. No one is really -- you heard
6 Dr. Matthews, no one is disagreeing about that.

7 Here's what I'm going to say about home care: I am
8 asking you to fund Remi's life care plan until he's
9 75 years old. I am asking for that because there's a
10 chance he's going to live that long, and he deserves
11 it.

12 He deserves the chance to be taken care of
13 for as long as he lives. No one knows how long
14 that's going to be. But also that's what his normal
15 life expectancy would have been had he not been
16 injured. He deserves to be funned at home to
17 \$21,437,932 -- whatever -- you heard.

18 But then you heard Dr. Matthews yesterday,
19 there's no money in there for respite care now. So
20 there's no respite for Blake and Sarah now. So if
21 you calculate that out, there's an additional
22 \$33.5 million if you want to give respite care to
23 them now, not just when he turns 21. Dr. Matthews
24 pointed out there's no house in the future. I think
25 a reasonable life care plan is \$25 million.

1 Oh, what has -- what has this meant for
2 this family? You've heard, Remi is trapped in his
3 body. We've heard Matthews yesterday there's no
4 cognitive -- there's no cognition there. What? Of
5 course there is, you've seen it. He's trapped in his
6 body. It doesn't work because of their negligence.
7 They don't get credit for that. They don't then get
8 to say that.

9 Here he is. These are their pictures.
10 This is their life. They spend every day taking care
11 of Remi in the best way they know, and this child is
12 making progress. This child is in there.

13 He's in his walker, he's walking. He
14 loves that dog. That dog. I have spent time at that
15 family's home with Blake and Sarah. I've spent time
16 with them. I have spent time with Remi. He will
17 hold your hand. He will look you in the face. He
18 will laugh with you. He will squeal with joy. I
19 think he loves me. I don't know. I'm pretty sure I
20 love him.

21 How much, y'all? How much am I asking
22 for? I'm asking for a lot. I'm asking for a lot.
23 whoops. What happened? I'm almost out of time.
24 we've got a punitive damage claim. You have to
25 believe that it's more convincing than not that he

1 did this with a conscious disregard. He did.

2 There's evidence of it.

3 where's my -- okay. Nine or more of you
4 must agree. Nine. Not twelve, nine. Here's what

5 I'm asking for: I'm asking for \$105 million.

6 593,849.50. Past economic, noneconomic, that's all

7 the pain and suffering. That's what this family has

8 been through and what they will continue to go

9 through.

10 This is what I'm asking for to take care

11 of Remi for the negligence of these defendants. It's

12 not too much. It's up to you, though. Give more,

13 give less, talk about it. Decide. Nine of you must

14 agree. When you have to decide who's at fault --

15 blew it there -- you've got to make the decision

16 about who's at fault: 20 percent/80 percent, the

17 nurses -- I think, it's 20 percent nurses, 80 percent

18 Dr. McNeive. It could be -- I struggled: 70/30.

19 75/25. 80/20. You all talk about it.

20 I believe that Dr. McNeive has acted

21 punitively. And you can talk about that and read the

22 instruction on that. So, I mean, I'm going to get to

23 come back with a little bit of time to talk more

24 about the punitive, what I believe was punitive. But

25 at this point, ladies and gentlemen, I appreciate it.

1 THE COURT: You'll have 5 minutes left.

2 All right. Ladies and gentlemen, so I
3 know the length of the arguments that we're going to
4 be dealing with. It seems like this is a good time
5 for us to take our morning recess.

6 (At 10:26 a.m., the Court duly admonished
7 the jury, and proceedings stood in recess. At
8 10:46 a.m., the following proceedings were held in
9 open court, in the presence of the jury:)

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

12 On behalf of Mercy Clinic and Dr. McNeive.

13 MR. WILLMAN: May it please the court?

14 THE COURT: Yes.

15 Defendants Mercy Clinic's and Dr. McNeive's
16 Closing Argument

17 MR. WILLMAN: Good morning, ladies and
18 gentlemen. What do we have in term of expectations
19 of our health providers, especially our physicians?

20 We demand, rightly so, that they have
21 training in their specialty. We require them that
22 they call on whatever experience they have built over
23 the years of practicing, and we want them to be in
24 command of guidelines, guidelines that have been
25 developed by peers, by colleagues, by members of

1 their specialty. Guidelines have been formed by
2 studies of patients, by a collaboration, by a
3 communication with peers in that specialty.

4 Dr. McNeive has met those expectations.

5 For more than 20 years, at the time that he was
6 taking care of Sarah Anyan and Remi Anyan, he had
7 completed a specialized training. He has delivered
8 and brought into this world 3,000 babies with a
9 hundred percent success rate.

10 And he has called on the guidelines that
11 the American College of Obstetrics and Gynecology
12 have developed to guide him and other OBs in
13 situations like this.

14 In this case, though, he's being attacked
15 for expectations that are not part of what the
16 community requires of him. He's being attacked for
17 working with an active mom who was able to push. He
18 was watching her, monitoring her fetal strips, he was
19 working with the nurses as a team. He was following
20 the guidelines and doing what he was supposed to do,
21 and he was being reassured that the baby, Remi Anyan,
22 was healthy and safe and ultimately ending up in a
23 successful vaginal delivery.

24 This case is about Dr. McNeive as an
25 obstetrician who relied on his training, his

1 experience, and most importantly, guidelines by the
2 American College of Obstetrics and Gynecology, ACOG.
3 And now he's being accused of not following
4 guidelines that are not -- do not exist. Tragically,
5 though, in this case, it ended with a brain injury
6 that happened before May 4th, 2020, even before Sarah
7 Anyan was admitted to Mercy Hospital.

8 Ms. Gunn talked about being a fighter. I
9 am proud to be a fighter for Dr. McNeive in this
10 case. I am proud to be here to show you and tell you
11 about the injustice of what is being said about his
12 care and treatment of Sarah Anyan.

13 So what I'm going to do in this closing is
14 take you through the burden of proof that Ms. Gunn
15 has on negligence and causation and point out to you
16 the holes, the gaping holes, that they have in their
17 case in proving that Dr. McNeive was negligent, and
18 he caused an injury to Remi Anyan.

19 This is the most important instruction
20 that you have: The burden is on the party who relies
21 on the proposition to prove is more likely true than
22 not true. It's not our burden. It's Ms. Gunn's
23 burden. We don't have to prove anything. But what
24 I'm going to take you through, are the holes in the
25 case that they have presented to you as to Dr.

1 McNeive's negligence and causation.

2 So the case is about a team approach to
3 taking care of a mom and a baby. In this case, Dr.
4 McNeive was the leader of that team. No question
5 about it. He worked with, not just one, but two
6 nurses during the entire time of the labor and
7 delivery of Remi Anyan.

8 He and Sarah Anyan, he said, they were on
9 the same page. She was pushing like a champ. They
10 were working together. They were working towards
11 this end goal of a successful vaginal delivery. That
12 is what they, as a team, wanted to do.

13 Included in that team were outside
14 observers, trained specialists who came in and
15 independently monitored what was going on with Remi
16 Anyan. And we'll -- I'll talk more about that in
17 just a moment. But that was what was going on. That
18 was the team approach that was being taken here.

19 Dr. McNeive was following guidelines.

20 These guidelines were developed by his peers, those
21 specialists in his field of obstetrics and
22 gynecology. Consensus of guidelines. How to
23 practice obstetrics. That's what these guidelines
24 tell him what he needs to do.

25 They're developed by a group of experts.

1 Dr. Landon even knows some of the people on that
2 because he's part of that group of leaders in the
3 field. That's what Dr. Landon told you. Dr. Landon
4 is an expert, by the way, that this firm has hired in
5 the past. why? Because he is recognized as a leader
6 in the field of obstetrics.

7 So Dr. McNeive was following guidelines,
8 but let's not -- let's rely on Dr. Warsof, the
9 plaintiffs' expert witness, OB/GYN. what did he say
10 about following the ACOG guidelines? He said:

11 "QUESTION: In the earlier part of your
12 questioning, I asked if you agree with me that an
13 obstetrician reads those guidelines, reads the actual
14 black and white texts, for the guidelines, relied on
15 their guidance, that that physician would be within
16 the standard of care."

17 Yes. Yes.

18 That's what Dr. Warsof had to say.

19 Now, here's the first hole: There is no
20 time limit for a second stage of labor. There is no
21 time limit. We've heard all about how long this
22 second stage lasted, but what does ACOG say about a
23 second stage of labor?

24 It's not a time limit. The 4 hours that
25 Ms. Gunn keeps talking about is the floor, not the

1 ceiling, meaning you don't do a C-section within 4
2 hours. Let the baby develop. Let the baby move down
3 the birth canal. Let the mother push. And if after
4 4 hours, then it becomes a prolonged stage of labor.

5 But it doesn't say: Then you must do a
6 C-section. Ms. Gunn, in her closing and in her
7 opening, talked about how this is 8 hours past what
8 ACOG says. ACOG doesn't say that there's a limit to
9 how long a second stage is. So long as there is
10 progress, so long as the mother is healthy, so long
11 as the baby is healthy, no time limit.

12 And Dr. Warsof agrees with that. Again,
13 this is their expert. This is from the Obstetrics
14 Care Consensus, a document I believe we've spent a
15 lot of time talking about in this case.

16 This is what they say: A specific
17 absolute maximum length of time spent in the second
18 stage of labor beyond which all women should undergo
19 operative delivery, has not been identified. This is
20 a Trojan horse that they've thrown out to try and
21 fool you to say that there's this time limit of 4
22 hours. It doesn't exist. That's a hole in their
23 case right there.

24 So if you don't want to believe me, listen
25 to Dr. Warsof, the expert they brought in. What does

1 he say about the ACOG time line?

2 So when we look at the plain text of the
3 ACOG consensus, would you agree with me these
4 authors, if they thought there was an obvious limit,
5 they could have put that guidance into this consensus
6 statement, correct?

7 "ANSWER: They could have, yes.

8 "QUESTION: And they chose not to.

9 "ANSWER: well, it's not there."

10 He agrees. No time limit on the second
11 stage.

12 It's a Trojan horse.

13 Second hole has to do with the role that
14 fetal monitoring has, and specifically the role of
15 moderate variability and accelerations.

16 You've heard the testimony that moderate
17 variability and accelerations are a good thing. That
18 means that the baby is getting oxygen into the brain,
19 and it's being helped.

20 what does ACOG say about reassuring heart
21 rates? Here's from -- this is a document you've seen
22 numerous times during the course of this trial: "The
23 Management of Intrapartum Fetal Heart Rate Tracings."

24 All of these organizations agree that you
25 can rely on moderate variability and accelerations.

1 ACOG says: Given the diverse spectrum of abnormal
2 FHR fetal heart rate patterns in Category II, the
3 presence of those tracings, accelerations are
4 moderate FHR variability for both, are highly
5 predictive of normal fetal acid base status, and thus
6 may help guide clinical management.

7 That's a good thing to have those moderate
8 variabilities and accelerations on those strips. And
9 you've heard everyone talk about how, throughout the
10 continuity of the labor and delivery of Remi Anyan,
11 there were moderate variability and accelerations on
12 those tracings. You heard it from Dr. McNeive. You
13 heard it from Nurse Maggie. You heard it from
14 Jessie. You heard it from everybody. Even Dr.
15 warsof.

16 Here's what he says about the moderate
17 variabilities:

18 "QUESTION: So when we're talking about
19 your opinions on causation, you believe all the
20 tracings of moderate variability are reliable, even
21 those tracings beyond 4 hours, beyond 5 hours, beyond
22 6 hours of the second stage of labor."

23 Those strips are reliable to exclude the
24 presence of hypoxic related ischemia, HIE, correct.

25 He agrees. He agrees. That those strips

1 tell you that there wasn't this damage to the brain
2 that was going on from 8:00 a.m., to 2:00 p.m. There
3 are periods of decelerations. There are periods of
4 late decelerations. But those are -- those periods
5 were then met with moderate variability and
6 accelerations. The baby came back. As Nurse Maggie
7 said, he was happy. He was happy when those tracings
8 were showing up.

9 Hypoxia is the absence of oxygen to the
10 brain. Think about if you ever go swimming. Hold
11 your breath, you go under water, you're hypoxic.
12 You're not getting oxygen to the brain. Does that
13 mean that there's injury to your brain? No. That's
14 the period of hypoxia, brief hypoxic, that this baby
15 was going through followed by great good things of
16 moderate variability and accelerations.

17 Moderate variability was maintained
18 constantly throughout that second stage. And in
19 fact, it would go back from Category II to Category
20 I. Category I is a good thing. And there were
21 periods, and we showed them to you, when this baby
22 was in Category I following Category II. This was
23 reassuring to the nurses and to Dr. McNeive.

24 And, again, Dr. warsof agreed, their
25 expert that they brought in. This was a healthy baby

1 until 14 minutes before delivery. That's what Dr.

2 warsof says.

3 Here is his direct testimony:

4 And so the strips tell us that from
5 admission, from at least 14 minutes before he's
6 delivered, those strips are not consistent with a
7 permanent neurologic injury?

8 "ANSWER: Correct."

9 That's what Dr. warsof says about those
10 strips from 8:00 a.m. to 2:00 p.m. That's his
11 testimony. Nurse Shinn said the same thing, that
12 acceleration, when you see those periods of

13 acceleration, that means this baby is getting
14 adequate oxygen. He was happy, as Nurse Maggie said.

15 Maintaining moderate variability. Again,
16 this is another hole in their case because they're
17 saying that he was -- that this baby was being hit in
18 the head with periods of hypoxic, and that damaged
19 his brain. That doesn't exist. There is no HIE with
20 moderate variability.

21 Again, Dr. warsof:

22 Those strips are reliable to exclude the
23 presence of hypoxic-related ischemia, correct?

24 "ANSWER: In general, yes."

25 But Dr. McNeive, he can't rely on those

1 strips at the time to know there's no hypoxic-related
2 ischemia, or can he?

3 "ANSWER: I would think yes."

4 So he, Dr. warsof, is saying, Dr. McNeive
5 when -- the multiple times that he saw those strips,
6 and the multiple times that the nurses saw those
7 strips, that they could be reassured that they knew
8 that this baby was doing well in the womb, in the
9 uterus.

10 Let's talk about progress. Everyone
11 agrees that progress is not just measured by this
12 elevator shaft that Dr. McNeive talked about. It's
13 going down into the birth canal. You also have to
14 take into account the rotation of the head.

15 we all know from the evidence, that Remi
16 Anyan's head was malpositioned. It was not in the
17 right position. So during the time that Ms. Anyan
18 was laboring, he was in the process of rotating his
19 head into the right position to allow the successful
20 vaginal delivery that happened.

21 Now, Ms. Gunn talked about no
22 documentation of descent. There is no documentation
23 of it. That's right. We can rely on Mr. Anyan.
24 what did Mr. Anyan tell us he saw during that time,
25 8:00 a.m. to 2:00 p.m.?

1 He remembers Dr. McNeive coming in at
2 least every hour or so, doing a digital examination,
3 looking at the fetal heart strips, and talking to
4 Sarah and saying, how are you doing? Can you keep
5 pushing? That's what the evidence is. We don't need
6 the documentation. We have his testimony to tell us
7 that.

8 Now, every time that Dr. McNeive would put
9 his fingers into do his digital exam, he's checking
10 to see if there's progress. Why would he have to
11 document that if he's seeing progress?

12 Ms. Gunn talked about how documentation is
13 important for continuity of care. Well, we have
14 continuity of care. Continuity of care would be an
15 issue if someone else takes over. But we have the
16 same team taking care of Sarah Anyan and Remi Anyan
17 from 8:00 a.m., through delivery at 4:24 p.m.

18 There's no need for documentation. They knew what
19 was going on. They were talking to each other. They
20 were in constant communication, those nurses and Dr.
21 McNeive. But -- and rely on what Mr. Anyan tells us
22 was going on with Remi Anyan.

23 But progress is progress is progress and
24 proved by the ultimate end, which was a vaginal
25 delivery. It is physically impossible to have a

1 vaginal delivery if there hasn't been progress. If
2 there hasn't been descent of the fetus during that
3 labor.

4 You heard Nurse Maggie talk about how his
5 head was actually halfway out sitting on the
6 perineum, on the belly of Sarah Anyan. So they were
7 watching. They saw that he was moving towards the
8 successful vaginal delivery that happened in this
9 case.

10 All right. So I just talked about
11 documentation. We heard from Dr. Burgess that
12 documentation is not for patients' safety, but it's
13 for risk management. What does she mean by "risk
14 management"? She means lawsuits that you need
15 documentation so that four years later, you can show
16 that something was written down.

17 But, again, we have Mr. Anyan telling us
18 that Dr. McNeive was in there every hour or so doing
19 a digital examination, looking at the fetal heart
20 strips, and talking to Sarah Anyan about the progress
21 she's making.

22 Nurse Maggie was by her bedside holding
23 her legs changing positioning and reviewing the
24 strips. She said to you, I'm not going to sit that
25 down, take off my gloves and down, and go over and

1 write in the chart. I'm focused on her and Remi as
2 patients because that is what I am there to do. That
3 was Dr. McNeive's focus, as well. He was focusing on
4 Sarah and Remi Anyan, not on documentation.

5 And what did you hear from Dr. Landon, the
6 expert that we brought in, the expert that they have
7 hired in the past? He said, I don't always document
8 everything that I'm doing. There are many things
9 that I do as an OB that are not documented.

10 Now, if that's a failure of the
11 guidelines, so be it. The guidelines are there when
12 we talk about documentation for continuity of care.
13 We have continuity of care here. We have the same
14 team taking care of Remi and Sarah Anyan from
15 beginning to the delivery.

16 All right. So I just talked about you can
17 fill in the blanks as to Dr. McNeive's exams of Sarah
18 Anyan during that morning and afternoon. You can
19 fill it in from Mr. Anyan's testimony, that he was
20 there talking to her doing the digital exam and
21 reviewing the heart strips. So we know that that
22 happened because Mr. Anyan has confirmed that.

23 We heard from Dr. McNeive that he was
24 doing those examinations, as well. He was there, he
25 was watching, he knew what was going on with Sarah

1 and Remi Anyan.

2 All right. The safety rounds and strip
3 rounds. Belt and suspenders. It's an added layer of
4 safety that the hospital requires to make sure that
5 their patients are -- are doing well. And that's
6 what happened in this case.

7 At 10:45 a.m., a team of objective
8 observers looked at those strips to look and
9 determine whether things were advancing the way that
10 they should. And if they had seen anything that was
11 problematic, that was of concern to them, they could
12 have talked to the team, to Dr. McNeive and the
13 nurses and said, boy, you ought to be doing something
14 different. They didn't. Because they saw the
15 reassuring strips that I talked about earlier, the
16 moderate variability and the accelerations.

17 They were independent observers of what
18 was going on. That also happened at 2:48 p.m.
19 Another team of objective observers looking at those
20 strips trying to see whether there is a problem
21 that's going on. They do not identify a problem to
22 tell Dr. McNeive about.

23 Dr. Burgess, the nurse told you, that's
24 the best practice. That's what this hospital was
25 doing, and that's what Dr. McNeive and the nurses

1 were relying on, as well. That if there was
2 something wrong with what they were doing, they would
3 have expected either the safety round or the strip
4 round participants to tell them about it. They
5 didn't because they didn't see anything there that
6 was alarming.

7 Okay. Now, so we know that those
8 independent observers were there. And so what does
9 Dr. warsof say about them? well, they missed the
10 boat, too. He's critical of them, but they're not in
11 the lawsuit. Yet, he still thinks that they messed
12 up, as well, because he thinks they missed these
13 decelerations and absence of variability that were on
14 the fetal heart strips. That shows you how far out
15 Dr. warsof has to go to criticize Dr. McNeive. He's
16 criticizing those independent observers as to what
17 their actions were.

18 All right. Pitocin. Everyone agrees that
19 Pitocin is a useful tool. It's not a dangerous drug
20 if it's used appropriately. And it was used
21 appropriately in this case.

22 what did Dr. McNeive do before 4:00 p.m.
23 when things changed? He increased the Pitocin for
24 her. why did he do it? Because she was having weak
25 and infrequent contractions. She was slowing down.

1 I think he said that it was like a car that slowed
2 down to 10 miles per hour. You want to put gas on to
3 keep that car going to increase the speed.

4 well, guess what happened? That's when
5 the delivery occurred. He was able to advance the
6 delivery by using Pitocin right before 4:00 p.m. And
7 that ended up in a successful vaginal delivery. Can
8 you imagine what the lawsuit would have been like if
9 he didn't do that, and we didn't have a successful
10 vaginal delivery? That that baby was stuck in the
11 birth canal because he didn't do what he could have
12 done in terms of increasing the contractions and
13 bringing that baby to the ultimate delivery?

14 Everyone uses Pitocin. There is no
15 mandate to turn it off or turn it down in either the
16 Mercy guidelines or the ACOG guidelines. I'm sure
17 Ms. Kamykowski is going to talk about it more. But
18 those guideline from Mercy give options to the nurses
19 as to what to do when you want to resuscitate a baby
20 in the uterus. And that is one of the options, is
21 turning off or turning down the Pitocin.

22 The first step that they took, and they
23 took it successfully every time that they
24 repositioned Sarah Anyan, those fetal heart strips
25 showed the baby was doing well. It worked. There

1 was no reason for them to go to that next step of
2 turning off or turning down the Pitocin.

3 If they had done that, then that would
4 have slowed the process of labor, and that would have
5 been a problem. We might have had a lawsuit here
6 because of that.

7 All right. So what was Remi's heart rate
8 before delivery? Category I tracings were there for
9 36 minutes before delivery. That was a good thing.
10 That means he was happy and healthy, and his heart
11 was doing fine. Right before delivery, 36 minutes,
12 there was no forewarning that there was going to be a
13 Category III. But as soon as there was, Dr. McNeive
14 leapt into action and got that baby out at 4:24 p.m.,
15 approximately just under 30 minutes from the time
16 that those tracings began.

17 Dr. Warsof said, he did fine. He did what
18 he was supposed to do when there was a Category III.
19 I have no criticism of him from what he was doing
20 during that stage of labor.

21 Here's what he had to say:

22 "QUESTION: Right. Dr. McNeive got Remi
23 out in 27 minutes, correct?

24 "ANSWER: Yeah. I'm not critical of what
25 he did starting at that moment in time.

1 "QUESTION: Just like you said, you're not
2 critical of Dr. McNeive's care at that point when
3 Category III tracing comes into play.

4 "ANSWER: That's correct."

5 He's saying that Dr. McNeive was following
6 the standard of care with those Category III
7 tracings. And, again, the reason he got there was
8 because he used Pitocin in the way that it should be
9 used: to increase the frequency and the strength of
10 contractions, and it worked. It got Remi out and
11 delivered at 4:24 p.m.

12 All right. The issue of blood gases and
13 cooling. You've heard that when there is a normal
14 Apgar score, and there was a normal Apgar score in
15 this baby's case, Ms. Gunn is now attacking it. I
16 guess they're criticizing the nurse who did the
17 score. She's not a party to this lawsuit. She's not
18 an employee of Mercy Clinic or Mercy Hospital. She
19 is the one that came up with the Apgar score.

20 Anyone on the NICU team could have ordered
21 those blood gases if they thought it was necessary.
22 They didn't think it was necessary. why? Because of
23 the Apgar scores and because of what they saw when
24 they took over the care and treatment of Remi Anyan
25 after delivery.

1 ACOG tells us, again, another guideline,
2 there's no need to obtain blood gases unless the
3 Apgar score is 5 or less. And Ms. Gunn said, well,
4 maybe it could have been a 6. Okay, fine. If you
5 want to believe that, the evidence doesn't support
6 it. There's no evidence that the Apgar should have
7 been 6. But if you want to believe that, that still
8 does not trigger getting the blood gases and doing
9 this cooling that some of the witnesses talked about.

10 Now, what is the effect of cooling? when
11 there is a baby who comes out who's severely
12 depressed and severely injured, which wasn't Remi
13 Anyan, but if you had a baby like that, Dr. Nelson
14 and Dr. Sze, two of the experts that Ms. Gunn brought
15 in, they told you that his injury was too severe to
16 benefit from cooling.

17 So even if they've done that, even if
18 they've gotten the blood gases and done the cooling,
19 it wouldn't have done any good. So Dr. McNeive
20 cannot be blamed for not getting blood gases when it
21 wouldn't make any difference. It had no impact on
22 what happens in this case.

23 Dr. Kerzner said it's only a 20 --
24 30 percent improvement if you do this cooling. And
25 it might benefit by 20 to 30 percent. And that's it.

1 Dr. Liles told us that he doesn't know
2 what the medical needs would have been if cooling had
3 been done for Remi.

4 All right. Dr. McNeive was ready to do a
5 C-section whenever he felt it was necessary. It's
6 undisputed that he never recommended it to her, and
7 she did not ask for it. There's no debate about
8 that. But he was ready to do a C-section.

9 How do we know that? Because on that day,
10 he did three C-sections. He recognized in all three
11 of those situations that what he needed to do was
12 call on his expertise doing, you know, thousands of
13 C-sections. Calling on his expertise to deliver
14 those babies, and doing so successfully during that
15 day.

16 During the time that he was doing those
17 C-sections, Sarah Anyan was laboring down, meaning
18 she was taking a break. And while she was taking a
19 break, remember what those tracings showed. They
20 were in Category I. They were in the best situation
21 that they had been in all day as she was resting and
22 laboring down. That was a good thing. That was not
23 something that Dr. McNeive had to be worried about if
24 he was gone.

25 But even if he had to come in in an

1 emergency basis, he was right there. They were in
2 constant communication. There are monitors
3 throughout the labor and delivery facility. So he
4 would be available and able to look at those strips
5 if he needed to. He didn't need to. The nurses
6 didn't feel the need to call him because those strips
7 were great, Category I tracings during the time of
8 laboring down and delivery.

9 But this shows that Dr. McNeive knows when
10 he needs to do a C-section when he should recommend
11 it. He knows that, from his experience of
12 successfully delivering 3,000 babies, bringing those
13 babies into the world.

14 All right. Let's put the puzzle pieces
15 together on causation. So those are the holes in
16 their claim that Dr. McNeive was negligent, what I
17 just went through. Let's talk about causation.

18 Did Remi Anyan experience a brain injury
19 within the last 14 minutes of his labor? That's what
20 plaintiffs' case is about. That's what Dr. warsof
21 says. It was in those last 14 minutes that the
22 injury occurred.

23 we have pieces of a puzzle that show us
24 that that is not the case. That that's not what
25 happened. And those pieces are the MRI of May 6th,

1 the normal Apgar score, the assessment by the NICU
2 team, and then the lab values for liver function.
3 Those four pieces put together tell us that this
4 injury occurred before May 4, and even before Sarah
5 Anyan was the patient at Mercy Hospital.

6 All right. So the first thing: May 6th
7 MRI of Dr. Tekes, who's at Johns Hopkins, a
8 neuroradiologist. Never testified before in a med
9 mal case like this. She looked at those images and
10 said this injury happened May 2nd or May 3rd.

11 The picture that she showed you tells
12 everything. It tells the story. She showed it to
13 you. This is her specialty. She specializes in
14 looking at images of babies who have been diagnosed
15 with HIE, which is what we have here. This is what
16 she does. This is what she studies. She looked at
17 that image and said, no, that injury happened May 2nd
18 or May 3rd.

19 But Dr. Sze agrees with her. He says,
20 yeah, an MRI shows an injury. It could have been it
21 happened three days before May 6th, which brings it
22 to May 3rd. But I will rely on the ultrasound.

23 If you look at the ultrasound, and you
24 look at the textbook that he referred to in saying,
25 well, if the ultrasound tells me it was earlier than

1 that -- or excuse me -- more immediate than that,
2 within the time period they're talking about, here's
3 what that textbook says about what an ultrasound
4 shows.

5 It shows an injury, if it shows anything,
6 that's two to ten days there. This is what Dr. Sze
7 relied on, this textbook in coming up with his
8 opinion. But this -- so this tells us that even with
9 the ultrasound, even if you don't believe that it was
10 a technically faulty study, that that image would
11 show an injury that occurred two to ten days before
12 delivery.

13 All right. The second piece of the
14 puzzle: the unchallenged normal Apgar scores. This
15 score was given by an independent observer, Nurse
16 Spencer Young. She has no dog in this fight. She's
17 not an employee of Mercy Hospital or Mercy Clinic.
18 You heard her testimony. You saw her testimony by
19 videotape.

20 Remi was not intubated. He was not
21 depressed. He was not on a ventilator. You heard
22 from Dr. Woodruff who told you that what they saw and
23 what the Apgar score shows us, it was physically
24 impossible that this injury occurred 14 minutes
25 before delivery. It just didn't happen. If that had

1 happened, he would have been severely depressed. He
2 would have looked completely different. The Apgar
3 score would have been significantly different than it
4 was, which was a normal score of 8.

5 Two other pieces of the puzzle. The
6 decision of the NICU team not to send Remi to the
7 NICU. They were there. They were evaluating how he
8 was doing. If he needed the care and treatment, the
9 specialized care and treatment that he could receive
10 in the NICU, they could have sent him there.

11 They believed, simply by their action, by
12 saying, you can go ahead, let's go ahead and give you
13 to your parents. Simply by their action, they're
14 telling us that he was not severely damaged, and that
15 his injury didn't happen 14 minutes before delivery.
16 If they had seen that, they would have sent him to
17 the NICU.

18 And the final piece is the recovery of
19 damage to the liver. You heard testimony about how
20 the body works. And the body is very smart. If
21 there is injury to the brain, it shunts oxygen to the
22 brain at the sacrifice of other organs such as the
23 liver, preserving the brain.

24 well, the liver function tests that you
25 saw showed that it was mildly elevated. That he had

1 recovered from whatever injury had happened to his
2 brain by the time that those lab tests were taken on
3 May 6th. That would simply be too fast for him to
4 have recovered with his liver if this injury happened
5 14 minutes before delivery. It doesn't fit the
6 picture. It doesn't fit the puzzle.

7 All right. One of the things you can do
8 when you're deliberating is talking with each other
9 and sorting through what you've heard over the two
10 weeks or so is, who is a credible expert?

11 And I'm asking you to look at the contrast
12 between the experts that have testified before you.

13 Dr. warsof, he stopped delivering babies three years
14 ago. 89 percent of the time, when he comes in and
15 testifies in court like this, he is doing so on
16 behalf of a patient or a patient's family, suing a
17 health care provider. That's what he does for a
18 living.

19 Dr. Nelson earns \$100,000 annually in
20 testifying in cases like this. And he's worked with
21 the Simon Law Firm before. Dr. Sze, one-third of his
22 annual income is from, is derived from, legal work.
23 So that's what he did here in this case.

24 An Dr. Liles, he has developed thousands
25 of life care plans, none of which he can say have

1 ever been followed, but he's developed thousands of
2 life care plans in cases like this. That's what
3 Dr. Liles does for a living.

4 Compare that to Dr. Landon. He must be a
5 good expert. They've used him before. They worked
6 with him before on cases. They must believe that he
7 is a leader in the field. He is a leader in the
8 field because he told you that he had been an
9 examiner for the board of the American College of
10 obstetrics and Gynecology. A leader, someone who
11 poses questions to other OBs so that they can become
12 board certified.

13 Compare that to Dr. Tekes. This is only
14 the second time that she's actually involved in a
15 legal case, and the first time that she's ever
16 testified in a medical malpractice case in her
17 career.

18 All right. Let me move on to the second
19 part of the case, and that has to do with punitive
20 damages.

21 Should Dr. McNeive be punished? well, the
22 first thing you have to look at are the instructions.
23 And the instructions tell you there must be clear and
24 convincing evidence that he had a conscious disregard
25 for the safety of others. Clear and convincing

1 evidence.

2 It's not more likely than not. It's not
3 preponderance of the evidence. It is right below
4 beyond a reasonable doubt. That's the burden that
5 you must reach to even decide whether he should be
6 punished or not. The evidence simply isn't there,
7 ladies and gentlemen. That's the burden that you
8 need to use to guide your deliberations.

9 You have to find that he was involved in
10 conduct that created a high degree of probability of
11 injury. And that he had a complete indifference to
12 or conscious disregard for the safety of others, that
13 he was doing some things that were just simply
14 unsafe, both with Remi and perhaps other patients.

15 well, let's examine what the evidence
16 says, then, about who he is, what kind of person he
17 is. what kind of OB is Dr. McNeive?

18 He had a good relationship with the
19 Anyans. They described him as being compassionate
20 and concerned. He was by her side for 2 and a half
21 hours, constantly examining her, talking to her,
22 making adjustments in her contractions during that 2
23 and a half hours.

24 He was concerned for that family. They
25 liked each other. And Sarah Anyan said, he's not a

1 bad guy. Dr. McNeive's professionalism: 3,000 safe
2 deliveries. This is the only time he has been sued
3 in a medical malpractice case. That is a remarkable
4 career, that's a remarkable stretch of deliveries for
5 him to have done that.

6 As a hospitalist that he worked for 15
7 years, he managed emergency things called on to help
8 other OBs. He had a hundred percent success rate
9 with emergency deliveries during that time that he
10 was a hospitalist. That's what he was doing. That's
11 the kind of OB he is. He's not the kind of OB that
12 would be consciously disregarding the safety of
13 others. That is what you must find to get him to
14 punitive damages, to award punitive damages in this
15 case.

16 why are they asking for punitive damages?
17 Could it be that perhaps they know their claim of
18 negligence is weak, and they're trying to paper it
19 over with some other claim? That's for you to
20 decide. Let me suggest that you think about that.
21 But there's not the evidence to even support a
22 finding that he had a conscious disregard for the
23 safety of others.

24 All right. Let's talk about Remi. I've
25 come to know the Anyans, and you've heard about them.

1 And they're wonderful, caring, loving parents.

2 They're doing extraordinary things with him. Remi is
3 fortune that they are the parents that they are for
4 him as they continue to take care of him.

5 And I'm sorry, Mr. Anyan, for having to
6 talk about this, but you have to also listen to the
7 evidence, the cold, hard reality of cerebral palsy.

8 We know from the testimony of Dr. Shavelle
9 and Dr. Matthews that babies who have CP, don't have
10 a long, normal life expectancy. That's a reality. I
11 wish it weren't so. Every life is precious. Remi's
12 life is precious. But that's what you have to take
13 into account in your deliberations and looking at the
14 facts of this case.

15 Dr. Shavelle, who specializes in life
16 expectancy, says 30 years. Could be more, could be
17 less. But 30 years is the average.

18 Now, Dr. Shavelle's testimony, is that
19 unreliable? No. Because Dr. Liles, their life care
20 planner, relied on Dr. Shavelle's article. Said, I
21 looked at his article, and part of the basis for my
22 opinions about life expectancy came from Dr.
23 Shavelle.

24 well, he was wrong in his interpretation
25 of Dr. Shavelle's work. But he relied upon Dr.

1 Shavelle. We also heard from Dr. Matthews, a paid
2 physician and medical rehabilitation specialist, that
3 he believes, it's his opinion, that it's somewhere in
4 the range of 31 to 40 -- 34 years.

5 So why do I want to talk about that? I
6 believe in your deliberations that you will find that
7 they have failed to meet the burden of proof that Dr.
8 McNeive was negligent, or that he caused an injury to
9 Remi Anyan. But I won't be doing my job if I didn't
10 give you some guidance on what, if you get past those
11 hurdles, give you some guidance as to what should be
12 the evidence, what should be a reasonable thing for
13 you to do.

14 And if you look at the testimony of Dr.
15 Shavelle and Dr. Matthews, the life care plan at age
16 30 to 34 is somewhere in the range of 5.5 million to
17 6.5 million. So that's something for you to consider
18 if you get to that point. But you have to get
19 through those steps. You have to go through those
20 gaping holes in the case to get to that point.

21 The other thing to reconsider is past
22 medical bills. Ms. Gunn was correct that the amount
23 charged is \$593,849.51. But the amount of this case,
24 which is also in front of you, and it's for you to
25 decide which one is the most appropriate, if you get

1 to that point. That amount is \$360,644.91 paid.

2 So, ladies and gentlemen, Dr. McNeive
3 relied on his training, his 20 years of experience
4 delivering 3,000 babies with success. He relied on
5 the ACOG guidelines in making his decisions during
6 that labor and delivery on May 4th, 2020.

7 He was looking at the fetal heart strips.

8 He was checking in on her on a periodic basis, he was
9 checking for progress, he was finding the progress.

10 Can you imagine if he was doing an examination of
11 her, as the defendants said he did, and he didn't
12 find progress? Would that make any sense for him not
13 to think to continue to go on?

14 He followed the ACOG guidelines. There's
15 no time limit to a second stage. Ms. Anyan was
16 pushing. She was strong. She was a champ. She was
17 doing what she needed to do to get the baby to
18 delivery, which ultimately was the success of what we
19 have today. We relied on guidelines. We relied on
20 his experience. We relied on his training as an
21 obstetrician.

22 I've gotten to know Dr. McNeive. He's a
23 good man, and he's a good OB, and his record shows
24 that he is -- knows what he's doing. That he's
25 competent. He's professional. He cares. And he's

1 compassionate about his patients. And for those
2 reasons, I'm asking you to return a verdict on behalf
3 of Dr. McNeive after you deliberate.

4 Now, one thing for you to consider, it's a
5 really difficult choice, a very difficult choice.

6 Mr. and Mrs. Anyan are wonderful people, and Remi is
7 a delightful boy. But Dr. McNeive is also a
8 wonderful person and good man, and a great physician.

9 You have a tough choice, but you have to
10 take sympathy out of your deliberations. You
11 committed to us, when we were picking you as jurors,
12 that you would set that aside. My heart goes out to
13 them. And it would be difficult for me to set that
14 aside. But that's what the law requires you to do.

15 And that's what the facts of the case require you to
16 do in this case, is return a verdict for Dr. McNeive.

17 Now, on the verdict form --

18 If you could put it up on the screen,
19 please.

20 well, the verdict form asks you whether
21 you find in favor of the plaintiff, Remi Anyan, or
22 the defendants. You have two defendants to choose
23 from. Let me suggest to you that you find zero
24 percent fault for each defendant, each group of
25 defendants.

1 I know Ms. Kamykowski is going to talk to
2 you a lot more about the role and the involvement of
3 the nurses. Dr. McNeive is fully supportive of them,
4 and he worked closely with them. He knew that they
5 were following him closely. So I'm asking you to
6 write here zero, zero, and zero.

7 Now, if you don't get to that point. If
8 you find there is some liability, then you have an
9 opportunity to consider the damage categories that I
10 talked about earlier, the ones that I suggested some
11 numbers for.

12 And on the second page. So as Ms. Gunn
13 said, the first thing you need to do is pick a
14 foreperson to lead you in the discussions. And then
15 nine or more of you must agree. So nine of you must
16 sign the verdict form. And you must agree not only
17 whether Dr. McNeive was negligent and agreed on
18 whether he caused an injury, but you also have to, if
19 you get to that point where you say yes to both, you
20 need to agree on what the damage amounts are.

21 And I would ask you to police yourself, to
22 talk to each other, and listen to each other, and
23 consider what each of you is talking about without
24 sympathy being something that is being considered.

25 So at the end of this case, as we are here

1 today, for the reasons I've talked about, Dr. McNeive
2 is a good physician, a good OB. He did what he was
3 supposed to do. It resulted in a successful vaginal
4 delivery. But tragically there was an injury that
5 occurred sometime before that May 4th date. For
6 those reasons, I ask you to return a verdict on
7 behalf of Dr. McNeive and Mercy Clinic. Thank you.

8 THE COURT: Thank you.

9 All right. Ladies and gentlemen, at this
10 time, we're going to take another short recess before
11 we go into our final stretch of closings.

12 (At 11:34 a.m., the Court duly admonished
13 the jury, and proceedings stood in recess. At
14 11:49 a.m., the following proceedings were held in
15 open court, in the presence of the jury:)

16 THE COURT: Go ahead and be seated,
17 everyone.

18 on behalf of Mercy Hospital.

19 MS. KAMYKOWSKI: Thank you, Your Honor.

20 May it please the Court.

21 Counsel.

22 Defendant Mercy Hospital's Closing Argument

23 MS. KAMYKOWSKI: Ladies and gentlemen,
24 none of us want to be here. Not the Anyans, not Dr.
25 McNeive, not Nurse Maggie, not Nurse Jessie. No one

1 envies the job that you have today. No one. But you
2 told the Court and all of the parties way back when
3 we asked you questions in voir dire, that you would
4 be able to decide this case fairly and impartially.

5 That you would and you could do that, and that you
6 would do it without sympathy.

7 We're going to hold you to that because

8 this case is so sympathetic. Everybody understands

9 that Remi Anyan is a child with a birth injury. It

10 would be really, really hard for you to do your job,

11 I think, especially when you know what I'm going to

12 ask you.

13 It's going to be hard to turn Remi away

14 without any of the fund of money that he has asked

15 you for. But when you review the facts and the

16 evidence in this case, and you apply those to the

17 jury instructions that the judge has given you, I

18 believe there's no other outcome. It's what the law

19 will require, and you will have to turn him away with

20 nothing. And that's hard.

21 As I told you in opening statement, this

22 case was premised on Monday morning quarterbacking

23 experts whose opinions were tainted by hindsight bias

24 from the get-go. They knew the outcome before they

25 ever looked at a record. And that tainted them.

1 They knew Remi was injured. We've all seen him,
2 right?

3 He was in here. We've seen him. We've
4 heard about him from his parents. They knew about
5 that, and they tried to find a way to be able to
6 manufacture a claim of negligence against his health
7 care providers.

8 They knew the outcome, and they worked
9 backwards, right? That's what hindsight bias is.

10 They work backwards there to form their narrative of
11 negligence. That's what we've heard in this
12 courtroom over the past two weeks, a narrative of
13 negligence that was told by you through a cherry
14 picking of the facts in this case designed to prey on
15 your sympathy, your sympathy for Remi. You can't let
16 that happen. We can't let that happen.

17 I submit to you, ladies and gentlemen,
18 that at the end of this case, you look at the
19 totality of everything, right? You look at the facts
20 and the evidence in their full context, not with
21 hindsight bias, not ignoring facts or excluding facts
22 from your analysis. And without sympathy. You will
23 determine, you will determine that the plaintiff has
24 not met his burden of proof, and you will have to
25 find in favor of Mercy.

1 I'm going to go back. This is the
2 hindsight that we talked about. Dr. Warsof sat on
3 this stand and told you it's all about the length of
4 the second stage. That's why we're here. Because of
5 the 12 hours, right? He started there, and a
6 severely injured child and said, okay, how can I say
7 this was a breach of the standard of care? That's
8 where he started, and that's where Nurse Shinn
9 started.

10 That's the evidence that plaintiff has to
11 find liability against Mercy Hospital against the
12 nurses, Nurse Maggie and Nurse Jessie. What I'm
13 going to show you is it started with them knowing the
14 outcome, and they backed into those negligence
15 causation opinions.

16 But despite that, I'm going to show you,
17 they couldn't even get on the same page on all of
18 those elements the plaintiff has the burden on.

19 Let's talk about some of the cherry picked
20 facts. And Ms. Gunn kind of admitted that this might
21 be a problem for her. Yes. This Exhibit 500 is
22 demonstrative. That means it's demonstrating what
23 she believes the evidence would be. But the fact of
24 the matter is, that demonstrative ignored key
25 important pieces of facts that everyone in this

1 courtroom told you you had to consider in evaluating
2 this case.

3 what are those? Moderate variability.

4 And Mr. willman did a great job of explaining to you
5 why that's important. Every expert in this case,
6 minus Nurse Shinn, said there was moderate
7 variability on those strips at all times.

8 And remember what moderate variability

9 tells us: Reliably ruled out Remi was academic at

10 that time. For the entire 10 and a half hours, until

11 that last half an hour, that existed in this case

12 while Nurse Maggie and Nurse Jessie were taking care

13 of Ms. Anyan and Remi.

14 The other thing that's excluded from this

15 demonstrative where we have lates after lates after

16 lates, we've seen that, right? That's their story.

17 It's just about documentation of lates. Or Exhibit

18 5, that exhibit -- well, let's talk about exhibits

19 real quick.

20 You can ask for them. Sometimes jurors

21 don't understand that. And I highly recommend you

22 do. Here's what I think you need to ask for first:

23 Ask for Exhibit A1. It's a blank copy of a strip.

24 Exhibit A1 will take you from even May 3rd. You just

25 need to start at that seven o'clock time frame.

1 And then ask for the medical records that
2 show Nurse Maggie and Nurse Jessie's documentation,
3 those flow sheets that Ms. Gunn showed you in her
4 closings. Put them together. I've been in a jury
5 room back there. Take them, take the eight and a
6 half pieces and spread them out over the page so you
7 can see them, just like Exhibit C2 that we showed
8 you.

9 I can't give that to you, but I would love
10 for you to be able to see, again, what happens when
11 you don't look at these in a single page. Or nine
12 pages, which is what you got shown on plaintiffs'
13 closings. One hour was nine pages. There's a
14 hundred and ninety pages of strips. Take them, put
15 them out, look at them. Look at what the nurses were
16 doing, okay? That's part of this cherry picking that
17 has gone on in this courtroom. You only see the bad
18 parts.

19 So getting back to what this doesn't
20 include. So it talks about what the -- the flow
21 sheet. It talks about that Exhibit 5. And let's
22 remember what Plaintiffs' Exhibit 5 is. That was a
23 copy of the strips that Ms. Gunn brought to every
24 deposition of a health care provider who was deposed
25 in this case of -- of not the experts, but just the

1 people who were involved in the care.

2 So what did they do? what did she ask
3 them to do? Mark the details. She didn't ask them
4 to run the Clark algorithm. She didn't ask them to
5 tell her what the baseline was. She didn't ask them
6 to tell them what the variability was at anytime.

7 Just tell me what -- when you see a decel. That's
8 it. That's all she asked them. They complied. And
9 then she put this exhibit together.

10 It doesn't include the fact that there was
11 moderate variability. And it doesn't show you what
12 these nurses were doing based on their training,
13 their education, including Maggie's education at the
14 time. Jessie was still teaching her. Ms. Anyan had
15 two nurses, two nurses taking care of her, right?
16 And they -- she didn't include that in here because
17 it's not -- not convenient to the plaintiffs' theory
18 to have you know all the facts of the case.

19 Other things that have happened in this
20 courtroom in the past two weeks. We did not look at
21 all of the strips until when? Yesterday. When Nurse
22 Maggie testified, second to the last liability
23 witness in this case, a key witness for my -- for my
24 case.

25 I took her through tediously, as you know,

1 that player starting at 7:00 in the morning. And we
2 walked through Maggie's strips. what did they look
3 like that day? what was she doing? what was Jessie
4 doing? what were their intrauterine resuscitative
5 efforts?

6 what you saw here, and what you just in
7 closing from Ms. Gunn was the bad stuff, that's what
8 she calls it. Bad. No, it's not bad. It's what 80
9 percent of second stage labors look like all the
10 time. You heard that. It's not unusual. what we're
11 talking about is lates, lates, lates, decels, decels,
12 decels. That's not what the trained nurses and Dr.
13 McNeive are worried about necessarily.

14 what did we talk about? Significant
15 decelerations, not every deceleration. And Maggie
16 told you that yesterday. when you looked at her walk
17 through that strip as they trailed along that screen,
18 oh, that's just a little decel. But you have to call
19 it. You can't ignore it. But it's a little one.

20 And then what did we do? what did we do?
21 she talked about her interventions. what did she
22 tell you? Left side, sit her up, hands and knees a
23 couple of times. Have her labor down, not push with
24 every contraction. Those are the intrauterine
25 resuscitative efforts that again have been ignored

1 when the plaintiffs talk about this case because all
2 they want to talk about is the heart rate and
3 decelerations.

4 Let's talk about -- I told you this in
5 opening -- that their own experts can't get on the
6 same page as far as what the case is about, right?

7 Heidi Shinn and Dr. Warsof. Heidi Shinn
8 testified first and then Dr. Warsof. She said
9 begrudgingly that there was some moderate
10 variability. Dr. Warsof agreed with everyone else in
11 this case, that moderate variability existed the
12 entire time until that last 30 minutes.

13 periods in Category I. We heard that from
14 Ms. Gunn in her closing, too. Oh, maybe there was
15 just an 8-minute period of time. Look at those
16 strips. You looked at them yesterday, you saw those
17 when they went back to that great no decelerations.

18 Category I returned multiple times in that 10-hour
19 period when the nurses did their intrauterine
20 resuscitative efforts, changed positions, modified
21 pushing efforts, they worked.

22 Tachysystole. Now, we still didn't hear
23 about that on closings. I told you in openings --
24 and Nurse Shinn sat back there and watched me -- her
25 entire theory of this case from the beginning,

1 remember that email that she sent to Ms. Lenivy? I
2 see tachysystole.
3 She looked in hindsight and said, oh,
4 tachysystole. Oh, that's a bad thing in these cases.
5 I'm going to tell them tachysystole. Because then
6 we'll talk about Pitocin, and then we'll talk about a
7 policy violation, and that's where we were in her
8 depo. She didn't say that here. I had to pull it
9 out of her. Because she heard me say she was
10 inconsistent with Dr. Warsof, right?
11 So just consider what you've been told by
12 the plaintiffs. Mr. Willman talked about filling
13 holes in their story. These are huge holes for them.
14 You knew it was coming. You knew we were going to
15 have to talk about this algorithm for a second,
16 right?
17 So we talked about the algorithm, and I
18 think it's important to remember what its purpose
19 was, right? Dr. Clark and his colleagues, in their
20 clinical opinion, came up with this algorithm to
21 provide some guidance to the bedside providers for
22 when you have decelerations, variables and late,
23 which occur in every labor, including in the second
24 stage, often in the second stage when pushing is
25 occurring, how do you distinguish between when they

1 get too many or too bad, and you have to do something
2 about it, right?

3 And so what did he tell us? we'll start
4 with Heidi Shinn. He told us, and he started again,
5 but he here said that the heart rate has moderate
6 variability always in that stage in the last 30
7 minutes.

8 And then you get the choose your own
9 adventure. And we're going to talk about Dr. warsof
10 choosing his own adventure. But we start with Nurse
11 Shinn. She came to her deposition and told me, you
12 always stay on the right-hand side. In her mind, no
13 variability, then there were lots of decelerations.
14 You've got to go down that side to cesarean or
15 operative vaginal delivery.

16 That's because she had to do that to
17 support the criticism she had of Nurse Maggie and
18 Nurse Jessie. Turn off the Pit when you have
19 Category II. Advocate for a C-section. Go up the
20 chain of command. Those all start with her
21 interpretation retrospectively -- remember, she knew
22 the outcome, so she's trying to make it look bad.

23 She tried to do that to support these opinions. But
24 what were her actual opinions when we took her
25 retrospective circling of the decels, counting of the

1 contractions? Do you remember?

2 At all times we started where she said, I
3 don't think those folks in that safety round -- or
4 that strip round in the afternoon, I don't think they
5 applied the algorithm correctly. I would have come
6 with a different conclusion. She told that to Ms.
7 Gunn or her direct, and then I got up here and proved
8 her wrong, right?

9 Remember this? This is 11 days ago. She
10 told me what the baseline was, and we worked this
11 algorithm in front of you from 1:48 to 2:48:
12 observed.

13 We're now at 2 -- we do it every half an
14 hour, it's important to this algorithm. 2:18 to
15 3:18: observed. 2:48 to 3:48, we're now less than
16 45 minutes before Remi is born: observed.

17 This is the guidance that these health
18 care providers rely upon to help them make these
19 bedside clinical decisions. But she said observed --
20 right? -- begrudgingly.

21 Then we get to Dr. Warsof. Do you
22 remember this: He brought this to his deposition.

23 And he had already filled it out. So, again, he
24 started with a different opinion than Heidi Shinn.
25 He starts by agreeing, and he had to, and he tested

1 up throughout the course of his testimony there was
2 moderate variability because you can't run away from
3 it. It's objective.

4 when you get those strips back there, go
5 look at them. 6 to 25 beats per minute. Remember
6 how I told you the boxes are 10-by-10. Look at it.
7 It always existed because it's objective. You can't
8 run away from it.

9 But then he says, when I look at it, I
10 think there was a significant deceleration for
11 greater than or equal to 50 percent of the time for
12 an hour.

13 And we're going to talk about that little
14 "a" that we talked about with Dr. Burgess yesterday
15 in a minute. So he says, yes, second stage, abnormal
16 progress. That's what tells him this was tied to the
17 time frame of 8:30 to 9:30 a.m., right?

18 He says, my review of this case at that
19 time, this very helpful algorithm says operative
20 vaginal delivery or a C-section. And I asked him, do
21 you know what Heidi Shinn had to say about that? Do
22 you remember? Dr. warsof, he and I went through
23 Heidi's at the same time: not more than 50 percent.

24 So what did I ask him? I said it says
25 observed. Now, I didn't write it down here because

1 remember that fight that he gave me? Oh, man. That
2 fight that he gave me about whether Heidi Shinn's
3 algorithm worked, and his time frame said no and
4 observed? Then he said, no, you go back up. You got
5 to go back over. You got to take two more steps.
6 That's not how an algorithm works.

7 So what did he do? He doubled down. He
8 tried to change the algorithm. He wanted to rewrite
9 it to fit the narrative. You can't do that, ladies
10 and gentlemen. You cannot rely on either of these
11 experts. Because when the rubber meets the road, the
12 objective evidence, this stuff they did themselves,
13 they can't even support it. Both of them say, at all
14 times, that the plaintiff says actions should have
15 been taken differently by Nurse Maggie and Nurse
16 Jessie. This algorithm says observe.

17 Remember Dr. Burgess. I wanted to make
18 sure we talk about this because there was a big deal
19 yesterday about whether she changed her opinion. No,
20 her opinion got taken out of context. When she read
21 her entire deposition and saw it, what she said was
22 potentially someone at 8:30 or 9:30 might see
23 significant decelerations between -- or greater than
24 50 percent of the contractions. But she stopped Ms.
25 Gunn in her deposition, and she said, I want to look

1 at the record.

2 why would she do that? Because this
3 algorithm says the definition of a significant
4 deceleration for greater than 50 percent of the time
5 or 50 percent of contractions over an hour -- dang
6 it. My fingers are too little -- it says that have
7 not resolved with appropriate, conservative,
8 corrective measures, which may include -- guess
9 what? -- position changes. Changes in the maternal
10 pushing patterns, laboring down.

11 And we got more guidance from subpart 4 of
12 the clarification for use of this algorithm. And
13 what did it say? Application of algorithms may be
14 initially delayed for up to 30 minutes while attempts
15 are made to alleviate Category II patterns with
16 conservative therapeutic interventions; e.g.,
17 correction of hypertension -- not here -- position
18 changed, and then other -- other things.

19 So she went and looked at her deposition
20 after Ms. Gunn said, so are you telling me that the
21 Clark algorithm says operative vaginal delivery under
22 your review at 8:30 to 9:30? And she said, well,
23 potentially. But she went back and looked, and she
24 said, no. Because the nurses at that point changed
25 her twice and put her on her hands and knees.

1 And do you remember when Maggie showed you
2 that, when that baby -- when mom got on her hands and
3 knees what that baby did? We had a Category I strip.
4 So nothing, nothing at that time frame required a
5 C-section.

6 If we take an honest look at the evidence
7 in this case, there is no need ever, ever by Maggie
8 or Jessie to advocate for a C-section, to invoke the
9 chain of command, or to discontinue or turn down the
10 Pitocin.

11 You're looking at this evidence again, and
12 Mr. Willman covered this. I'm not going to rehash
13 old ground. So we had two other times, two other
14 safety stops, if you will, for someone to come in and
15 tell Maggie and Jessie. Jessie was coming in and
16 out; Maggie was there the whole time. They could
17 have said, hey, this lady has been in labor for a
18 long time, what do you guys think? Do you think we
19 need to advocate for C-section?

20 No one did that, no. What they did was
21 they looked exactly like they did. They knew the
22 information. The safety round team absolutely knew.
23 Dr. McNeive was there, and Jessie was there. And Ms.
24 Gunn said there's no evidence of what those people
25 heard.

1 well, we heard it from Dr. McNeive and
2 from Jessie. And you heard it from Maggie what their
3 actual custom and practice is. We would have said,
4 this is her first baby. We would have said she had a
5 rupture of membranes 12 hours ago, or however long,
6 at noon. We would have said she's on Pitocin. We
7 would have said she's been pushing in second stage.

8 They knew all of those things, and they still
9 sanctioned it, because guess what? It met the
10 standard of care at that time.

11 You heard this definition already. What
12 we've got to talk about is what is this skill and
13 learning that Jessie and Maggie had, right? And what
14 are they doing ordinarily under these circumstances?

15 The circumstances where you have a strip with
16 moderate variability that never resides until the
17 last 30 minutes.

18 That whole day, even with decels -- Official Cou
19 right? -- they did what they were trained to do.

20 They used their skill and learning. They implemented
21 intrauterine resuscitative efforts, and they worked.

22 They followed ACOG and AWHONN. That's what they're
23 trained to do. You saw this algorithm, too. This is
24 what tells the nurses how do we do this?

25 If you have a Category II, you evaluate.

1 what's the reason? You surveil. You watch it. If,
2 in that time you see accelerations, which there were,
3 even Dr. warsof had to begrudgingly admit that, or
4 moderate fetal heart rate patterns, variability, then
5 what do you do? Continue to surveil and implement
6 intrauterine resuscitative measures as needed.

7 That's exactly what they did. You saw
8 this, too. And I wrote this down. And I thought Mr.
9 willman did a nice job of covering it. Ms. Gunn kept
10 pointing us to a rule and a limit. That's not a rule
11 or a limit. It's a guideline. And what it says is:
12 specific absolute maximum length of time spent in the
13 second stage of labor beyond which all women,
14 regardless of whether 93 percent previously --
15 right? -- 93 percent delivered by 4 hours.

16 which all women should undergo operative
17 delivery have not been identified. It's not a rule.
18 It's the bare minimum. You heard that from Dr. Official Cou
19 Parker. She and Ms. Gunn went round and round in her
20 testimony about what does this -- what do they mean?
21 Is there an upper limit? And she said no. what it
22 is is how long you must try for a vaginal delivery.
23 It's a 4.

24 Progress. I thought Dr. willman did a
25 nice job explaining progress, too, but let's just hit

1 it again. Progress was seen here. Progress included
2 Remi going 180 degree spin from OP, face-up, to OA,
3 facedown. That's how he delivered. We know that
4 happened.

5 And we know he made progress through the
6 birth canal from zero to delivery, right? It
7 refutes, the fact that there was a delivery at all in
8 this case vaginally wholly refutes the claim of if
9 it's not documented, it didn't happen.

10 But you also heard Maggie testified,
11 Jessie testified, Dr. McNeive testified, and
12 Mr. Anyan also confirmed it: They were in there
13 assessing the progress, visually with their eyes,
14 digitally with their hands, using their skill and
15 learning to assess the nuances of this strange
16 process, right? It happens. We notice it.

17 In order for you to find that there wasn't
18 progress in this case because there was no arrest.

19 It may have been slow. It may have gone in spurts.

20 Everybody agreed this was a very long second stage of
21 labor. Remember, that's why we're here because Dr.

22 warsof says it's all about the second stage. So if

23 the progress happened, in order for you to believe it

24 didn't, you have to believe that Maggie Hilt-McLeland

25 yesterday sat there and told you what she saw, and

1 she lied. And that Jessie said -- she lied -- she
2 lied, as well.

3 They followed the ACOG -- the ACOG and the
4 AWHONN guidelines because they knew they could

5 reliably -- that they could rely on moderate
6 variability in this case. Because what does that
7 tell you? You saw all the literature. Ask for it.

8 Read it again. It's not predictive in category II
9 that Remi was acidotic at any time. They know that.

10 You cannot rely on it to predict acidosis.

11 But what you can do is you can rely on
12 moderate variability to rule it out. They were doing
13 what they were supposed to based on their skills and
14 training what other nurses ordinarily do under these
15 circumstances where you have a woman in the second
16 stage with moderate variability Category II strips:
17 constant surveillance, re-evaluation, taking into
18 account the entire clinical circumstances.

19 And you heard it from Dr. warsof. You
20 heard it from Dr. Landon. You heard it from Dr.
21 McNeive. What are they supposed to be thinking
22 about? How is mom doing? Jessie told you -- Maggie
23 told you yesterday, I was looking at her. I'm
24 putting my hands on her. She's palpating her uterus
25 to see how she's doing. She explained to you,

1 sometimes moms will say, I'm doing great. But you
2 can look at them and know they're not. That was not
3 Sarah. Mom was doing well.

4 Baby -- again, go look at the strips --
5 baby was doing well, despite periods, yes, where he
6 had decelerations. And this progress was being made.
7 I think Ms. Gunn said something like, had anybody
8 bothered to watch this patient, they would have
9 delivered her much sooner.

10 Bothered to watch? The only evidence in
11 this case is that Maggie was at her bedside almost
12 the entire day. She was there watching the monitors.
13 She was listening to Remi's heart rate. She was
14 there supporting Sarah and Blake. And she was doing
15 what all other reasonable nurses would do under the
16 circumstances when she had good variability, a good
17 return to baseline, and her nursing interventions
18 worked.

19 So, again, this has been hit before. We
20 know they were reliably ruling out acidemia based on
21 the fetal heart rate tracings and what they saw. Dr.
22 warsof had to admit fetal heart rate accelerations
23 which rule out acidosis were present on these strips
24 within 40 minutes of this baby being born.

25 so he wasn't falling off a cliff. He

1 wasn't suffering from repetitive punches. He wasn't
2 in a hostile intrauterine environment. He was
3 handling and tolerating this labor until he didn't.

4 And we know why: his mom had a fever. Guess what?
5 Mom's temperature goes up, anything inside her body
6 is the same temperature. Remi got tachycardic
7 because his mom had a fever.

8 We know that the nurses met the standard
9 of care in this case because they followed all of the
10 recommendations, their training, and their education,
11 and they did intrauterine resuscitation measures that
12 worked to return this baby to a Category I, and he
13 had moderate variability throughout.

14 I think we need to remember what we talked
15 about a long time ago. That there's an unrealistic
16 expectation in the world, in the world of medicine,
17 maybe in this world that we're in here in this
18 courtroom, that a nonreassuring or a Category II
19 fetal heart rate is predictive of cerebral palsy or
20 predictive of acidemia.

21 what do we know from ACOG? It says:

22 Available data, although limited in quantity,
23 suggests that use of EFM does not result in a
24 reduction of cerebral palsy. we talked about this in
25 my opening. we talked about it with Heidi, Nurse

1 Shinn.

2 This is consistent with the data that
3 suggests the occurrence of cerebral palsy has been
4 stable over time, despite the widespread introduction
5 of EFM. This is a key part of this case, ladies and
6 gentlemen. The principal explanation for why the
7 prevalence of cerebral palsy has not diminished
8 despite the use of electronic fetal monitoring is
9 that 70 percent of cases occur before the onset of
10 labor.

11 The standard here is more likely than not.
12 70 percent is certainly much more likely than not.
13 70 percent of cases occur before the onset of labor.
14 And that's what happened here.

15 Just to quickly go through the verdict
16 director. There are four elements that have been
17 charged of negligence against Nurse Maggie and Nurse
18 Jessie. One is that they failed to advocate for a
19 C-section. And I already told you when look at this
20 total -- this totality of the evidence, all of the
21 pictures here, the overall clinical picture did not
22 indicate a C-section was needed, okay?

23 Even if it did, there's no evidence in
24 this case that had Maggie or Jessie come to the
25 bedside, called Dr. McNeive there, had a powwow with

1 Sarah and Blake, that the decision would have been a
2 C-section any sooner than he was already delivered.
3 we didn't hear that from anybody. we
4 didn't hear had they just mentioned a C-section, the
5 outcome would have changed. we don't know what would
6 have happened because we don't know. They say
7 anytime after eight o'clock. Eight o'clock to
8 delivery, that these nurses should have done that.

9 No one came in here and told you, yeah, had somebody
10 advocated for it, I would have changed my mind, and I
11 would have done something different.

12 On the chain of command, there's two
13 instructions you're going to get on that. One is not
14 going up the chain of command after eight o'clock
15 through delivery to change the care plan from a
16 vaginal delivery. And the other is not going up the
17 chain of command when Dr. McNeive ordered the Pitocin
18 turned up.

19 Let's talk about the first one. Just by
20 advocating, going up the -- well, first, going up the
21 chain of command first requires that the nurses
22 disagree with Dr. McNeive. Maggie told you she
23 didn't. Jessie told you she didn't. Because under
24 the circumstances, there was no need to change the
25 plan of care, right? so failed to go up the chain of

1 command? They didn't fail to, it wasn't necessary.

2 with respect to the Pitocin, again, Document

3 Mr. Willman covered this. The reason why at that

4 late part of the game, the Pitocin was turned up was

5 because Maggie told you, I had my hands on her belly,

6 and I could tell her contractions were spacing out,

7 and they were getting weaker.

8 And at that point, she's becoming

9 tachycardic -- or not at that point, let me go back.

10 At that point, Dr. McNeive was like, let's get this

11 baby out. He looks good. Turn up the Pitocin, guess

12 what happens? After the last turn, the baby is born

13 less than a half an hour later.

14 Again, talking about the policy, I know

15 Mr. Willman said I was going to talk about this. We

16 know, and I've proven to you that these policies were

17 not violated. The policy, the policy about turning

18 down or turning off the Pitocin only is triggered,

19 and Nurse Shinn had to give this to me, and that's

20 why she had tachysystole as her opinion because she

21 really wanted a policy violation in this case.

22 But the policy for Category II strips only

23 required identification of indeterminate Category II,

24 abnormal Category III fetal status requires

25 notification of the physician and documentation in

1 the medical record of the interventions they did.

2 Dr. McNeive knew, they let him know she
3 was in Category II, right? And they documented it.

4 we went through that yesterday. Pull those flow
5 sheets, position change: hands on knees. Position
6 change: left side. Position change: head of bed.
7 Not pushing. Laboring down. All of those things
8 were documented.

9 So then we get to the protocol what's
10 pulled in to Epic, which is a summary of this policy.
11 Then we have our intrauterine resuscitation nursing
12 communication order.

13 Now, again, I was shocked because we made
14 such a big deal about this. But Ms. Gunn again
15 omitted the key part, the key instruction to these
16 nurses, about what they do here. She read to you:
17 If the fetal heart rate pattern is indeterminate,
18 category II, or abnormal, Category III, the following
19 measures will be initiated, period.

20 well, that's not what it says. It says,
21 based on the maternal-fetal response, that's key.

22 Again, cherry picking the fact to make you think
23 these nurses didn't know what they were doing, and
24 that what they did wasn't working. It's not true.

25 Heidi Shinn: go big or go home. Remember

1 that? You have to turn the Pit off every time you
2 have a Cat II. I wonder how many C-sections we'd
3 have if we followed that policy? Probably a whole
4 lot because you'd stop labor altogether. You would
5 stop the purpose of Pitocin, to get a strong enough
6 and a frequent enough contraction to effectuate
7 vaginal deliveries.

8 She ignored the based on the
9 maternal-fetal response. The policy does not require
10 turning off or turning down the Pitocin. They
11 followed it, and their nursing interventions worked.

12 Now, we talked about this before. I think
13 before we get to causation, to me, ladies and
14 gentlemen, it is pretty clear that the plaintiffs
15 have not met their burden of proof to prove that
16 Nurse Jessie and Nurse Maggie did anything that was
17 negligent, that was -- that they didn't use that
18 degree of skill and learning ordinarily used by other
19 labor and delivery nurses under the circumstances.

20 Plaintiff wants you to get there because
21 12 hours. Do you remember in opening when Ms. Gunn
22 told you that you were not going to hear from a
23 single person who's ever heard of a 12-hour second
24 stage? Go back and look at your notes, she said it.
25 It's not true.

1 Resident Morgan Miller came in here. Do
2 you remember? She was by video. She was the cute
3 one with dimples, and she was pregnant. She said,
4 oh, yeah, I mean, I've seen it. I've seen it happen.
5 I've had it happen to my patients at Mercy Hospital.
6 It happens a couple of times a year.

7 So if we get to this place simply because
8 of the 12 hours, again, that's another red herring.

9 Yes, it's long. But this -- but the process of
10 evaluating, surveilling, instituting intrauterine
11 resuscitative measures, and re-evaluating is the
12 same, whether it's 2 hours of pushing or 12 hours of
13 pushing. And that's the degree of skill and learning
14 that Jessie and Maggie even did in this case, and
15 that's why they were not negligent. Plaintiffs have
16 not met that burden.

17 If you disagree, then you still have to
18 talk about causation. And I told you in my opening,
19 yeah, is it a coincidence? Absolutely not. 70
20 percent of babies with cerebral palsy were not
21 injured during labor. 70 percent more likely than
22 not. And we don't have to tell you why. We don't
23 know why. We wish we did. We wish that putting a
24 monitor on a mom would reduce the incidence of this
25 terrible, terrible birth injury. It doesn't.

1 The Apgar. So I'm still shocked that
2 we're getting blamed for relying on the independent
3 provider's analysis and assessment of Remi after he
4 was born. An Apgar of 7 or greater is not consistent
5 with an acute hypoxic ischemic event. That's the
6 plaintiffs' theory of causation in this case, an
7 acute hypoxic ischemic event.

8 Dr. Kerzner, do you remember? When Dr.
9 Kerzner was here, she told me -- she told Ms. Lenivy
10 about her constellation of markers. But she got
11 there again by cherry picking facts in this case.
12 She ignored medical records. She told you there was
13 no documentation of normal reflexes. She told you
14 there was no full neurological examination before he
15 got to the NICU.

16 Actually, she qualified it to begin with.

17 And I said, are you telling this jury that there was
18 never a neurological examination of him? And she
19 said no. She even took it out of the NICU. She
20 said, no, it never happened. Because had it
21 happened, she thought he was mildly encephalopathic,
22 and that would have changed the course of his
23 treatment in the NICU or before, right?

24 She told you that there was poor feeding
25 in the nursery, and she told you he was irritable in

1 the nursery. well, what did she not look at? she
2 relied on, to get to that opinion, she said, I don't
3 have any documentation. we have these Apgar
4 assessments by the neonatal nurse practitioner of 8,
5 but assisted, inflated, I don't believe it.

6 she doesn't believe it because she relied
7 on still photos and the testimony of the parents.

8 And I'm not saying that the testimony of Mr. and Mrs.

9 Anyan is incorrect. I am just saying it doesn't

10 track with what we know from the contemporaneously
11 charted assessments of Remi.

12 Remember I showed you this with Dr.

13 Cantey. This was the information that was not shown

14 to you with Dr. Kerzner. she didn't rely on it.

15 More cherry picking to fit her causation opinion.

16 Newborn assessments. Two newborn nurses

17 came to see him in the labor and delivery room.

18 Remember those. we showed them to you. Ask for

19 them. Look at them again. what did they find? Dr.

20 Cantey told you how they do that. If you've had a

21 baby, and you've seen them, they come in, they unwrap

22 them if their swaddled. They take off their onesie.

23 They bring them down to their diaper. Sometimes they

24 even take the diaper off.

25 At 5:38, an hour of 14 minutes of life,

1 what did they find? Normal reflexes, right? Dr.
2 kerzner said no. What did they find? They checked
3 his flexion -- flexion in his arms and his legs.

4 Remember Dr. Cantey said normal babies
5 want to stay curled up. That's how you know --
6 floppy babies are a puddle. That's what he told us.
7 They didn't find Remi as a floppy baby. They found
8 him with his right arm with decreased Moro. Remember
9 that's that startled reflex? His arm didn't move as
10 much. But he said, yeah, that's a big kid, and he
11 was in his mom's birth canal for a while. He
12 probably had a crush injury. He had an explanation
13 for it. Dr. Kerzner didn't even look at this stuff.

14 Normal respiration rate is bad at times.
15 A normal heart rate. And then if you look at the
16 other flow sheet, when he goes to the NICU, after he
17 does have -- we saw Dr. Thakadiyil's admission note.
18 Frantic at mom's breast. They had those troubles
19 between 8:00 and 8:30 of whether he would suck.
20 There was no suck, not interested in breastfeeding.

21 Now, looking back on that, I'm sure those
22 nurses were trying to figure out is that Sarah and
23 Remi trying to get to know each other? It's hard to
24 breastfeed your first baby. But he progressed,
25 right? He started to have some high breathing or

1 fast breathing. He was getting inconsolable.

2 But that didn't happen at 5:38. And it
3 certainly didn't happen before the pediatrician was
4 called. They brought him to the nursery. Tried to
5 feed him some Enfamil. And then decided to send him
6 to the NICU.

7 The reason why I bring this up is because
8 ignoring this helps -- is inconsistent with ignoring
9 it. They have to ignore it so they can keep their
10 causation theory alive.

11 So let's talk about what they also seem to
12 agree on, the timing of this injury, right? And I
13 know we're talking about minutes, but it's important
14 when we're talking about this, because everyone had
15 the same information, right?

16 Dr. Nelson said the acute profound injury
17 happened in the last 5 to 25 minutes, right? Dr.

18 Warsof, well, it was in the last 14 minutes. That's
19 kind of consistent, maybe. Dr. Kerzner, after four

20 o'clock, so still that 25, 24 minutes, 30. And then
21 Dr. Sze, he had to back it up, why? Because the

22 three above him, Dr. Nelson, Dr. Warsof, and Dr.

23 Kerzner were looking at their hindsight opinion on
24 causation to say, oh, I don't think that's quite up

25 to speed. Mom and dad say this is what he looked

1 like. I don't think he was showing signs of
2 encephalopathy that were missed. well, missed by
3 who? No one in this lawsuit.

4 But they had to do that so they can say
5 the Apgar was wrong, right? But it doesn't make any
6 sense. And then Dr. Sze interestingly he did agree
7 with Dr. Tekes. He and Dr. Tekes both say MRI is the
8 gold standard, right? And so if MRI is a gold
9 standard, Dr. Sze started with that, and we're going
10 to talk about that.

11 But when I had to ask him questions, you
12 know, he tried to tell, I think, on his direct, he
13 said, no, it could be anytime three days before all
14 the way through delivery. well, that's because he
15 relied on that head ultrasound.

16 And let's be clear: we're not arguing the
17 head ultrasound is not diagnostic. what Dr. Tekes
18 told you was the head ultrasound in this case is not
19 helpful to time his hypoxic ischemic injury. Not
20 that it wasn't diagnostic. She didn't throw it out
21 and say it was unusable. She said -- and who is she?
22 How many articles has she written on the use of
23 imaging modalities to evaluate the timing of hypoxic
24 ischemic injuries? She doesn't do this very often.
25 This is the first time she's testified.

1 she did this because she wants to make
2 sure people understand that MRI is the gold standard,
3 right? And what we heard from Dr. Sze was -- I wrote
4 this down -- he said -- this was the MRI that was
5 taken on May 6th at 3:07.

6 So three days, and then he had to admit
7 his real opinion wasn't all the way to delivery, it
8 was plus or minus 12 hours, right? He gets into
9 delivery by saying the ultrasound is negative. And
10 he, in this courtroom, said 24 hours.

11 Mr. Willman showed you the literature that
12 had he relied on that says two to ten days. And I
13 asked him some questions about, or maybe Mr. Perron
14 did, about prior testimony where he said, well, it's
15 generally 24 to 48 hours.

16 well, if you put Dr. Sze altogether with
17 what is really his opinion, not what he concluded
18 here to fit this backstory of a causation opinion
19 here. Is that the MRI shows this injury occurred at
20 least May 3rd at 3:07 p.m.

21 Dr. Tekes said it could have been older
22 than that. And Dr. Cantey, he said sometime
23 between -- so Dr. Tekes said between 5/2, so May 3rd,
24 at 3:07, and then May 3rd at 3:07. So between three
25 and four days before the MRI was taken on May 6th.

1 Dr. -- that is part of her window that Dr.
2 Sze has. And then Dr. Cantey says, yeah, sometime I
3 think based on the MRI findings, the key timing piece
4 of evidence, right? And the fact that this child was
5 not admitted to the NICU. His Apgar was 8. He
6 didn't have to be intubated. He just left with his
7 parents. That all does not match with a child who
8 has had a global diffused acute moderate to severe
9 hypoxic ischemic injury in the last 30 minutes before
10 he was born.

11 Dr. Woodruff and Dr. Cantey also told you
12 that. Dr. Cantey is the one who, in the NICU, said
13 most of these kids, as we know or were claiming that
14 he's saying that there was an acute injury in the
15 last few minutes or hours before birth, they don't
16 look like this kid.

17 So, ladies and gentlemen, I told you, and
18 Mr. Willman did, I thought, a very nice job of
19 talking about the damages aspect of this case. It's
20 a hard thing to talk about. I already told you we
21 are going to tell you to turn them away with nothing.
22 Nothing.

23 But if you don't, you know, I echo what
24 Mr. Willman said about the care that this child has
25 received. We didn't concede that he doesn't need

1 care because he does. It's unfortunate. It's sad,
2 right? But you only get there if you first believe
3 that plaintiff met their burden of proof. And we
4 don't believe that plaintiff met their burden of
5 proof because they relied on their experts who had
6 Monday morning quarterbacking, hindsight bias. They
7 got them into their narrative of negligence. They
8 withheld information from you and told you we had to
9 show it to you in our case. They cherry picked the
10 facts. Even in closing argument today, they talked
11 about all the things that we should have.

12 There are significant holes in this case.
13 And they're expecting your sympathy. That's how they
14 get a verdict: 12 hours and your sympathy. That's
15 not what the evidence is in this case. That's not
16 how you should be looking at this case.

17 I wholly hope and encourage you to ask for
18 evidence. Look at it. Study it. Go back and look
19 at your notes. And if somebody's on the fence, oh,
20 I'm just not real sure. Guess what? "I'm not real
21 sure" doesn't mean someone fights for you.

22 That means in your mind the plaintiffs
23 have not met their burden. And that's not on you,
24 that's on the plaintiffs. They have the burden of
25 proof. And if you are confused about any aspect of

1 the negligence claims, the causation claims, or the
2 damages in this case, if you have any question at
3 all, they failed to meet their burden of proof, and
4 you have to enter a verdict in favor of defendants.

5 At all times, in all respects, my opinion
6 is based on what I believe the evidence has shown in
7 this case, Nurse Maggie and Nurse Jessie met the
8 standard of care. Their goal was a vaginal delivery.

9 They had a Category II strip that they evaluated,
10 surveilled, did interventions when necessary, which
11 worked, again, objective evidence that that happened.
12 And then had reevaluations throughout the time frame.

13 Their interventions worked. Even in
14 hindsight, the plaintiffs' experts can't even tell
15 you that something different should have happened
16 based on the literature that teaches these nurses how
17 to act at the bedside.

18 Nothing about this labor, nothing on the
19 fetal monitor strips, nothing about Sarah's condition
20 warranted advocating or going up the chain of command
21 for a C-section, turning off or turning down the
22 Pitocin, or otherwise changing the plan of care.

23 And more likely than not, ladies and
24 gentlemen, Remi's injury happened before, before 8:00
25 a.m., before seven o'clock, before Jessie and Maggie

1 ever got on the floor that day. They didn't know.

2 Nobody knew it.

3 And what we saw at that 14 and a half

4 hours of life with the seizures, that's the

5 reperfusion. Dr. Kerzner didn't have to admit that,

6 she just didn't like the timing of it.

7 So as Mr. Willman told you, and I think I

8 told you this at the beginning, I think that the

9 plaintiff has failed to meet their burden of proof

10 here. And because of that, you're going to see an

11 instruction that says, you must find in favor of

12 Mercy Hospital East Communities unless you believe

13 plaintiffs met their burden of proof.

14 Because I don't believe so. I think that

15 this is how you fill out the verdict form: zero for

16 Mercy Hospitals. And then I know that Mr. Willman

17 asked you to put a zero for Mercy Clinics and Dr.

18 McNeive, and a total of zero. And with what, you

19 won't ever get to damages. And with that, I'm going

20 to sit down and tell you thank you very much for all

21 of your attention.

22 Thank you, Your Honor.

23 THE COURT: Thank you.

24 On behalf of the plaintiff, you have 5

25 minutes remaining.

1 MS. GUNN: Thank you.

2 Plaintiffs' Closing Argument

3 MS. GUNN: Remi suffered for 9 hours
4 before he got to the NICU, and then a few hours later
5 he started seizing. why? why was he suffering for 9
6 hours? Because there were no cord blood gases
7 obtained. Dr. McNeive admitted that he was in charge
8 of that.

9 why are we having to talk about Apgar
10 scores when we could have had a cord blood gas that
11 would have said definitively that Remi was hypoxic?
12 Dr. McNeive tried to tell you it slipped his mind.
13 This was the longest stage of labor, second stage of
14 labor, he'd ever had. You heard chaotic, difficult
15 delivery. No cord blood gases were drawn or
16 obtained? Or were they discarded? why? we would
17 have known. We would have known. You heard the
18 evidence. They would have been positive. He would
19 have been cooled. And Kerzner said, and it was
20 repeated by Ms. Kamykowski, 20 to 30 percent
21 improvement with cooling.

22 You know how hard that is for them to
23 hear? No cord blood gases were drawn. But what
24 else? Remi's in the NICU. Goes to the NICU. Then
25 Dr. McNeive finds out that Remi's in the NICU. And

1 the NICU called him, I think he said, and said,

2 where's your delivery note?

3 Oh, I don't have a delivery note. 1:35.

4 So then after he finds out that Remi is in the NICU,

5 he drafts a delivery note and files it on May 7th.

6 And let's look at that.

7 Go down to the next page.

8 This is so whitewashed, I can't even stand

9 it. The second stage proceeded slowly but with

10 steady progression. Fetal status remained reassuring

11 throughout, other than a brief stretch, a brief

12 stretch, of fetal tachycardia. And you heard him on

13 the stand, a brief stretch was 30 minutes? well,

14 compared to 12 and a half hours, that's what he told

15 you. I guess so.

16 But then look at the NICU note -- oh, wait

17 complication: late chorioamnionitis. Okay. Look at

18 the NICU note. Now, these folks are in there trying

19 to figure out what's wrong with Remi, and they don't

20 even have a delivery note to find out what's going on

21 with Remi. They draft one that says pregnancy

22 complication: Late fetal heart rate deceleration,

23 maternal fever, meconium staining, prolonged ruptured

24 membranes, and prolonged labor. None of that was in

25 Dr. McNeive's delivery note. The NICU's figuring

1 this out because they have a seizing baby now.

2 But then what is the worst? 1:38 --

3 THE COURT: 2 minutes.

4 MS. GUNN: After he goes and drafts this,
5 ladies and gentlemen, Sarah wasn't even his patient
6 on May 7th. Sarah had discharged. And this is what
7 he chooses to write in her chart. Nothing else in
8 her chart except for the delivery note and this.

9 Met with the patient. This is
10 manufactured. Ms. Kamykowski talked about
11 manufactured. We spent several minutes discussing
12 her son's condition, as well as how they are holding
13 up as a couple.

14 Let's talk about their son's condition.

15 Remi can't brush his own hair, he'll never steal
16 snacks from the pantry, put his own coat on, chase
17 lightning bugs, build a snowman, go to school, fall
18 in love, get his heart broken. He'll never drive a
19 car, he'll never know what it means to lie to his
20 parents about failing a test. Living things that we
21 do good and bad, what makes us who we are.

22 we've got all the happy pictures. We know
23 that. But think about the things he's missing that
24 he is going to know he's missing. He is cognitively
25 there. He is trapped in a body that doesn't work.

1 He knows what is happening, and so do his parents.

2 He will know because other people around him will
3 surpass him, and those things will hurt him.

4 He will know what he can't do. He knows
5 what he can't do when he goes to this playground
6 right now. And every single day will be a struggle
7 for him and his family, but they are up for it. Remi
8 is up for it. And they're not asking for your
9 sympathy. We don't want it. That time is gone.

10 THE COURT: Time.

11 MS. GUNN: We need your fight, and that's
12 what we're asking for. We need full compensation.

13 Thank you.

14 (The bailiff was sworn.)

15 THE COURT: Very good.

16 Ms. Sullins, I'm going to have you go back
17 to the jury room and collect your things, as well as
18 your lunch, and have you come back out, and I'm going
19 to give you different instructions.

20 But for the rest of you, you can head on
21 back into the jury room, and you can take your
22 notebooks with you for the first time, and enjoy
23 lunch.

24 (At 12:42 p.m., the alternate juror was
25 discharged, and deliberations commenced. At 1:59

1 p.m., the following proceedings were held in open
2 court, outside the presence of the jury:)

3 THE COURT: We are on the record outside
4 the presence of the jury. Prior to submitting the
5 case to the jury, we had reserved any issues with
6 regards to exhibits, as well as the instructions with
7 regards to the punitive damages phase.

8 So on behalf of the defendant before I
9 turned to the plaintiffs to supplement their exhibit
10 list.

11 Do we have...

12 MS. PFIRMAN: Yes, Your Honor. I will
13 start with A1, which is the fetal monitor strips.

14 THE COURT: And are there any objections
15 to these?

16 MS. SLATER: No, I mean, Liz went through
17 them with Ms. Pfirman yesterday, and I missed it.

18 MS. GUNN: I think we all agree.

19 THE COURT: Okay.

20 MS. SLATER: So I'll let you know if for
21 some reason we go through that, something catches my
22 ear.

23 THE COURT: Go ahead.

24 MS. PFIRMAN: Okay. Thank you.

25 Next is A2, which is Sarah Anyan's records

1 from Mercy Hospital of which we show page 108, 102,
2 100 through 101, 107, 103, 251, 109 to 110, 250, 230,
3 233, 215, 96 through 97.

4 Next is Exhibit A3, which is Remington
5 Anyan's chart from Mercy Hospital, of which we showed
6 pages 1506 through 1507, 1573, 2396, 2390 through
7 2994, 1984, 1572, 2395, and 1571. C2, which was our
8 fetal heart monitor player. C3, which was a fetal
9 rotation demonstrative. C4, which was an animation
10 of C-section feasibility. C5, which was a
11 demonstrative of Pitocin during labor. C6, which was
12 a demonstrative of fetal station. C9, which shows
13 the shape of the pelvis shapes. C10, which was the
14 forceps. And C11, which was the vacuum.

15 Exhibit E2-S, which was Dr. Liles'
16 research on TBI. Exhibit E4-E, which was Heidi
17 Shinn's invoices. Exhibit E4-H, which was Heidi
18 Shinn's correspondence, of which we showed pages 1,
19 3, 4, 5, 7, 9, 11, and 12.

20 Exhibit E4-B, which was marked fetal
21 monitoring strips. Exhibit E6-C, which was AJOG
22 clinical opinion. Exhibit F1-B, Adriane Burgess's
23 CV.

24 Exhibit F1-G, fetal heart rate algorithm
25 used by Adriane Burgess. Exhibit F2-B, Dr. Cantey's

CV: F2-J, demonstrative of lab values used with Dr. Cantey.

F3-B, CV of Dr. Landon. F3-G, fetal monitor strips marked by Dr. Landon. F4-B, CV of Dr. Matthews. F4-K, cost of life care plan through age 31 and 34, which was used with Dr. Matthews.

F5-B, Dr. Shavelle's CV. F5-L, the U.S. Life Expectancy table. F5-O, life table for Remi Anyan.

F5-P, Effects of Cognitive and Motor Sensory Disabilities on Survival with Cerebral Palsy.

F5-Q, life expectancy of Remi Anyan.

F5-R, article of Dr. Shavelle, Recent Trends in Cerebral Palsy Survival.

F5-S, Survival in Children with Severe Cerebral Palsy. F5-T, Survival of Individuals with Cerebral Palsy Born in Victoria, Australia. F5-V, Dr. Shavelle's summary of literature on cerebral

palsy. F6-B, CV of Dr. Tekes. F6-F, index of materials produced Dr. Tekes.

F7-B, CV of Dr. Woodruff. F6-H, PowerPoint of Dr. Tekes. F6-I, head ultrasound article by Dr. Tekes. F7-I, typed notes of

Dr. Woodruff. G1, Mercy's policy on induction with oxytocin. F11-A, the CV of Dr. McNeive, F10-B, flow sheets from Sarah Anyan's chart used with Nurse

1 Maggie.

2 I1, ACOG Practice Bulletin No. 116. I2,
3 ACOG Clinical Obstetrics Care Consensus No. 1.

4 I6, AJOG Clark algorithm. F13, deposition

5 Morgan Miller. F13-A, CV of Dr. Morgan Miller. F14,

6 deposition of Dr. April Parker. F16, deposition of

7 Jessica Wagner. F16-A, CV of Jessica Wagner. I9,

8 ACOG Practice Bulletin No. 106. I10, AWHONN article,

9 Fetal Heart Rate Monitoring Principles on

10 Intrauterine Resuscitative Techniques.

11 I11, AWHONN Response to ACOG's Practice

12 Advisory on Oxygen Supplementation. I13, AWHONN

13 Fetal Heart Monitoring Diagnosis and Intervention.

14 I14, OBG Management: A Reasoned Plan to

15 Manage a Persistent Category II Fetal Heart Rate

16 Tracing article. I16, AJOG clinical opinion. I17,

17 JAMA neurology article. I18, AWHONN Principles and

18 Practices Figure 5-3 Visual Variability Scale.

19 That is the extent of our list. And we

20 would move for the admission of all of those

21 exhibits.

22 MS. SLATER: Your Honor, there's no

23 objection in general. I think some of the exhibits

24 that were used as demonstratives, and have been noted

25 as demonstratives on the record, such as the C2, the

1 annotated NICU strips. But other than that, no
2 objection.

3 MS. PFIRMAN: Agreed.

4 THE COURT: The Court will admit the
5 exhibits. And prior to sending any of them back to
6 the jury, the Court will have a discussion as to
7 whether or not they are demonstrative or not.

8 MS. PFIRMAN: Thank you, Your Honor.

9 THE COURT: Any additional exhibits?

10 MS. PFIRMAN: No, Your Honor.

11 THE COURT: Okay. On behalf of the
12 plaintiff?

13 MS. SLATER: Yes, Your Honor, I do need to
14 correct one exhibit number that we moved to admit in
15 our case-in-chief, and that is Dr. Warsof's CV. I
16 noted it as 100-2. That number is actually 110-2.

17 And then the additional exhibits that we
18 used by and large on cross with witnesses: 190-3,
19 page 24, which is Dr. Tekes's correspondence.
20 Exhibit 358, which is an article reference -- or
21 written by Dr. Tekes. We used page 185 and 192. And
22 those are the articles and pages on that actual
23 exhibit.

24 From Exhibit 3, which is Remi's Mercy
25 chart, we added 19, page 1985. And crossing Dr.

1 woodruff, we used Exhibit 6, which is one of Sarah
2 Anyan's prenatal records, page 163. Exhibit 3, Document
3 Remi's Mercy chart, we added pages 3185 through 3186.
4 Exhibit 632 was a video of Remi using the Tobii
5 device, T-O-B-I-I. 643, a video of Remi swimming.
6 656 is a video of Remi using his gait trainer.
7 Exhibit 150-14 is an empty file. And then
8 the exhibits that we used with Dr. Miller during her
9 video deposition included 226-6, which was
10 Dr. Miller's CV. Exhibit 226-3, which were Mercy's
11 Pitocin policies, which I believe were numbers 19
12 through 24.
13 Exhibit 226-4, that was a portion of the
14 audit trail that included Dr. Millers' touches to the
15 record. With Nurse Jessie Wagner, we used
16 Exhibit 200-3, which was her resume. With Dr.
17 McNeive, we used Exhibit 145-8, which was his copy
18 with notations of the ACOG OB Care Consensus. We
19 looked at pages 7 and 11.
20 Exhibit 145-16, again, is with Dr.
21 McNeive's annotations on an UpToDate article. We
22 used pages 4, 5, and 7. Exhibit 145-4, this was
23 McNeive's annotations on ACOG Bulletin No. 116. We
24 used page 6.

25 And then from Exhibit 3, Remi Anyan's

1 Mercy chart, we added page 1528, which is a part of
2 the discharge record. With Dr. Landon, we used, or
3 we added from Exhibit 1, which was Sarah's Mercy
4 chart, which was page 78. We added from Exhibit 5,
5 which was annotated fetal monitoring strips, which
6 was page 182. And we used 353, which is an article
7 including Dr. Landon as an author from 2018.

8 With Dr. Shavelle, we used 170-30, which
9 was a deposition question outline that he had
10 prepared. With Nurse Maggie McLeland, we added to
11 Exhibit 1 from Sarah's Mercy chart, pages 227 and
12 228.

13 With Matthews, we used 165-3, pages 9 and
14 11. And with Burgess, we used Exhibit 185-7, pages 1
15 and 2. And those were the algorithms she brought
16 with her to her deposition.

17 That is it.

18 THE COURT: Are there any objections?

19 MS. KAMYKOWSKI: No objection.

20 MS. SLATER: We move to admit those.

21 THE COURT: The Court will admit those,
22 subject to any requests if there's any demonstratives
23 in there.

24 with regards to the punitive damages
25 instructions, so that we have them prepared to go in

1 the event that that happens.

2 So 2.05, modified by 35.19, is in essence
3 the bundling instruction. I am not sure which
4 instruction is asking for me to put in here?

5 MS. SLATER: Oh, I can help out with that.

6 THE COURT: Because I kind of feel like
7 it's almost all of them.

8 MS. SLATER: So the general instructions,
9 I believe, run 1 through 8.

10 THE COURT: 1 through 8.

11 MS. SLATER: And that goes up to and
12 through the definition instruction in the initial
13 packet. Instruction 9 is starting the first verdict
14 director.

15 And then I believe for the first two
16 blanks, it's really only going to be instructions
17 behind that. If you would like me to remove the
18 second and the blank.

19 Does that make sense?

20 THE COURT: You disagree with only being
21 this page?

22 So the Instruction 18 and general
23 instructions 1 through 8 apply.

24 MR. PERRON: Okay. Subject to previously
25 made objections.

1 THE COURT: Of course.

2 So then 17 would be the 2.05 with
3 Instruction 18, and then general instructions 1
4 through 8. Then instruction No. 18 would be MAI
5 10.02, modified by 35.19. And then the verdict form
6 B, which is 36.12, modified by 35.19.

7 other than the objections that have
8 already been addressed as to punitive damages in
9 total, are there any form or other objections?

10 MR. PERRON: No, Your Honor.

11 THE COURT: Do you want to --

12 MS. SLATER: Yeah.

13 THE COURT: Can we go off the record.

14 (A discussion was held off the record.)

15 THE COURT: Anything else we need to put
16 on the record?

17 MS. SLATER: No, not from plaintiffs.

18 MR. PERRON: Not at this time.

19 (At 2:21 p.m., the Court stood in recess.

20 At 3:06 p.m., the following proceedings were held in
21 open court, outside the presence of the jury:)

22 THE COURT: All right. So we are on the
23 record outside the presence of the jury. The jury
24 has sent a note at 3:04 p.m.: Charts to see life
25 care and expenses calculated by all experts.

1 There is no punctuation. I'm assuming
2 that is a question. And I'm not sure which exhibits
3 that would be.

4 MS. SLATER: which chart?

5 THE COURT: Chart to see life care and
6 expenses calculated by all experts.

7 MS. KAMYKOWSKI: So on behalf of the
8 defense, Your Honor, we would object to any of those
9 demonstratives. These were testified to. They
10 either wrote down the numbers or they didn't. That
11 comes from Davolt.

12 MS. SLATER: And, Your Honor, as far as we
13 have four charts for the life care plan for Liles,
14 which are exhibits that were entered, the cost tables
15 were entered specifically as exhibits, and that's
16 what I would offer in response to their message.

17 MS. KAMYKOWSKI: Well, I know I wasn't
18 here -- well, I was here when there were exhibits,
19 and we talked about what we would say was
20 demonstrative only previously, and that when we
21 admitted things, I would have objections to things
22 that were demonstrative when it was time, and --

23 MS. SLATER: That's not what I'm referring
24 to, Your Honor. We did have a chart that we used.
25 It's like it's a grid. But what I would offer is the

1 four life care tables that we entered that did have
2 the costs on them. I believe they were 125-11 and
3 like 125-12, and they're going to get me the numbers
4 which will help us all.

5 MS. KAMYKOWSKI: So those are part of the
6 experts' reports, and experts' reports are hearsay.
7 So it would be just like giving -- and this is Davolt
8 v. Highland, directly touches on this, Judge. You
9 cannot send an expert's report back to the jury. It
10 is hearsay. It would be like sending a transcript of
11 their testimony. They were here to testify about
12 their opinions, that's what they did. This is --
13 they were allowed to be shown to the jury as
14 demonstrative only, and this should not be going
15 back.

16 THE COURT: So one thing that I note is
17 that they asked for not just the life care, but they
18 also ask for the expenses calculated by all the
19 experts. I don't know if that's in part of a
20 stipulation with regards to the medical bills paid
21 versus charged.

22 MS. SLATER: I understand how you could
23 read it that way. I interpret it as associated with
24 the life care plan, but, I mean, if you're inclined
25 to answer them in a way --

1 THE COURT: I happen to agree that the
2 exhibits themselves are hearsay. And I think the
3 only answer I can give them is: You must be guided
4 by your recollection of the evidence.

5 MS. KAMYKOWSKI: Agreed, Judge.

6 MS. SLATER: And, Your Honor, I just want
7 to be clear for the record, the exhibits that we
8 would be offering in response to that question are
9 not -- like, it's not a narrative report. It's only
10 the cost tables.

11 THE COURT: No, I know. And I think to
12 make the record super clear, we can put on the record
13 the specific numbers of those.

14 MS. SLATER: Sure. And, Your Honor, so we
15 would be offering 125-11, 125-12, 125-16, and 125-17,
16 and those are a cost tables that we discussed with
17 Dr. Liles.

18 THE COURT: Thank you.

19 The Court is going to respond with: You
20 must be guided by your recollection of the evidence,
21 and see how frustrated they get.

22 MS. KAMYKOWSKI: Thank you, Judge.

23 (The proceedings stood in deliberations at
24 3:17 p.m. At 3:26 p.m., the following proceedings
25 were held in open court:)

1 THE COURT: Okay. So the question at 3:22

2 is: Calculator.

3 So I propose that I give them my
4 calculator.

5 MS. SLATER: That's fine.

6 MS. KAMYKOWSKI: No objection.

7 MS. SLATER: No objection.

8 (The proceedings stood in deliberations at
9 3:30 p.m. At 4:11 p.m., the following proceedings
10 were held in open court:)

11 THE COURT: Question at 4:05: I thought I
12 saw a form on the projector during trial that showed
13 percentage nurses'/percentage doctors' fault. I
14 don't see that in our folder.

15 I'm assuming it was this.

16 MS. GUNN: In my PowerPoint, I suggested
17 percentages. That's probably what they're thinking.

18 THE COURT: Got it. So that would have to
19 be answered: You must be guided by your recollection
20 of the evidence.

21 The other question: Does definition
22 punitive damages include or equal all of the monies
23 awarded, question mark.

24 I don't think they understand that the
25 punitive damages come --

MS. GUNN: Come next.

THE COURT: The phase is -- it's in the instructions. So I think the only answer I can give them is: You must be guided by the Court's instructions.

MS. GUNN: Is there a particular instruction we can point them to?

MS. SLATER: Is it the one for second stage of trial?

MS. GUNN: That would make that a little bit easier.

THE COURT: So it would be in 15.

MS. SLATER: And the director.

THE COURT: Yes.

MS. SLATER: Yeah, I think we could just --

THE COURT: Because it's the second page of that that says: If you find them liable for punitive damages in this stage, you will be given further instructions for assessing the amount of punitive damages in the second stage.

MR. WILLMAN: Pretty clear.

THE COURT: Are you okay with me referencing Instruction No. 15?

MR. WILLMAN: Yes.

1 THE COURT: I'm assuming you'll abstain?

2 MS. KAMYKOWSKI: Not my issue, I abstain.

3 MR. WILLMAN: Yes.

4 THE COURT: So the first one -- it's still
5 signed by 12. I assume it's still the same person,
6 but her name has gotten smaller.

7 (A discussion was held off the record.)

8 THE COURT: So I said on the second one:

9 You must guided by the instructions, specifically No.
10 15?

11 MR. WILLMAN: That sounds good, Judge.

12 THE COURT: You all abstain?

13 MS. PFIRMAN: Right.

14 (The proceedings stood in deliberations at
15 4:16 p.m. At 4:56 p.m., the following proceedings
16 were held in open court in the presence of the jury:)

17 THE COURT: Go ahead and be seated,
18 everyone.

19 It's my understanding that you've arrived
20 at a verdict.

21 THE FOREPERSON: Yes.

22 THE COURT: All right. Pass the paperwork
23 to my bailiff.

24 (The foreperson complied.)

25 THE COURT: Thank you.

1 On the claim of Plaintiff Remington Anyan
2 for personal injury, we, the undersigned jurors,
3 assess percentages of fault as follows:

4 Defendant Mercy Hospitals East
5 Communities, 25 percent; Defendant Mercy Clinic East
6 Communities, Dr. Daniel McNeive, 75 percent, for a
7 total of 100 percent.

8 For the past economic damages, including
9 past medical damages, 600,000. For past noneconomic
10 damages, 500,000. For future medical damages,
11 7,000,000. For future noneconomic damages,
12 20,000,000, for a total of 28,100,000.

13 we, the undersigned jurors, find that the
14 Defendant Mercy East Clinic Communities, Dr. McNeive,
15 is liable for punitive damages.

16 And it is signed by all 12 jurors.

17 Does either side wish for the jury to be
18 polled? You want me to poll the jury?

19 MS. GUNN: Yes, please.

20 (The jury was polled by the Court, and all
21 jurors answered in the affirmative.)

22 THE COURT: All right. The Court will
23 accept the verdicts of the jury.

24 At this time I'm going to read to you
25 another instruction. I anticipate that this portion

1 of trial will take us probably about 20 to 25
2 minutes, and then we will send you back for further
3 deliberations.

4 I recognize that that may get a little bit
5 late, some people might have somebody looking for
6 them at dinnertime. So what we can do is, we can
7 give you access to your cell phones for a short
8 period of time to make a phone call to let them know
9 you're going to be staying with us a little bit
10 later. We'll work out trying to figure out if we can
11 get some dinner up here for you guys, as well. That
12 will take us a little bit of time, but we'll work on
13 that, as well, okay?

14 Anybody have a problem with us staying to
15 do that tonight?

16 All right.

17 (The instructions were read to jury by the
18 court.)

19 THE COURT: At this time on behalf of the
20 plaintiffs?

21 MS. GUNN: Thank you, Your Honor.

22 THE COURT: I think we talked about 10
23 minutes?

24 MS. GUNN: Sure.

25 Punitive Damages Argument on Behalf of Plaintiffs

1 MS. GUNN: Ladies and gentlemen, this is
2 the part where you get to consider additional money
3 damages to punish and deter. And I know those are
4 harsh words, but based on your verdict, you've
5 already determined that those type of damages should
6 be considered.

7 This is my very brief opportunity to talk
8 to you about what I think that should look like. And
9 I just want to call your attention to the idea of why
10 we're here and the conduct that got us here, that got
11 you here, to your original verdict.

12 And that includes that Dr. McNeive and
13 Mercy Clinic operated under the idea that they could
14 walk away from the situation and not provide care in
15 a way that insured the safety of Sarah and Remi.

16 We don't want this to happen to other
17 people. I can't tell you how many conversations I've
18 had with Sarah and Blake about how they wished they
19 didn't have to be here and wished they didn't have to
20 do this, but how important it was to them that they
21 had the opportunity to speak to you. And how they
22 didn't want this to happen to anybody else, to any
23 other family.

24 And so how do you make that happen? You
25 make that happen by sending a message to Mercy Clinic

1 telling them you can't have policies that make us
2 sick. You can't have discretion in these things.
3 You can't allow a woman to go on for 12 hours without
4 checking in and documenting. You can't do those
5 things.

6 And it's never going to change, ladies and
7 gentlemen. I've done this for a long time. It's
8 never going to change unless you send that message,
9 not just to Mercy Clinic, but to the community. You
10 don't understand how loud your voice is. I know
11 we've just been in this courtroom all week. I know
12 that you have just spent time together. I know
13 you've come here every day, and you listened well.

14 Your voice will ring out. It will tell
15 Mercy Clinic and anybody else who's listening that
16 this is not an acceptable way to treat people. Sarah
17 was an employee of Mercy. She was an employee. And
18 this is what -- this is how they get treated? Not
19 only the first time, but to have to come and do this
20 up to this point?

21 So how much is that? What do you think
22 it's going to take not to have this happen again?

23 It's not going to be a small number. I mean, it's
24 just not. It's going to have to be a number that
25 makes people think about what they're doing and makes

1 people understand that it has to end.

2 And the only way it can end is your
3 actions. This is No. 18, which is what Judge Ribaudo
4 just read to you: You may consider harm to others in
5 determining whether defendants' conduct showed
6 complete indifference to or conscious disregard for
7 the safety of others.

8 That means you get to consider whether
9 this happens again to somebody. I mean, look at --
10 look at corporate -- the corporate structures that we
11 have. Small numbers do nothing. They don't move the
12 needle.

13 So what's that number, ya'll? I don't
14 know. I could tell you what I think. I don't think
15 a hundred million dollars is going to tell them
16 anything. I don't think it will. But you all have
17 to make that decision. You all have to decide
18 whether your voice is going to be small or it's going
19 to be loud. And the only way I know to do that is to
20 put numbers to it. Thank you.

21 THE COURT: on behalf of the defendant?

22 MR. WILLMAN: Yes.

23 Punitive Damages Argument on Behalf of Defendants

24 MR. WILLMAN: Good evening, ladies and
25 gentlemen. Your verdict speaks loud and clear, and

1 that verdict will be taken seriously by Dr. McNeive
2 and certainly Mercy Clinic.

3 Mercy Clinic is a nonprofit Catholic
4 institution. And I'll read from its mission

5 statement: As the Sisters of Mercy before us, we
6 bring to life the healing ministry of Jesus for
7 compassion, care, and exceptional service.

8 They will take this verdict to heart,
9 trying to make sure that they follow through on that
10 mission statement. Any profits that come to Mercy
11 Clinics go into services that they provide for the
12 underserved in the community, especially women. No
13 profits go to anyone from the activities of Mercy
14 clinic.

15 I'll tell you Dr. McNeive will take this
16 to heart. And you heard the evidence during the
17 trial, he's had 3,000 deliveries and has not had this
18 happen to any of his patients. He will take it to
19 heart, as well, and he will make sure he follows
20 safety for his patients.

21 So I don't know what to tell you in terms
22 of what amount you would award. I would suggest that
23 the amount that you've already told us in your
24 verdict, is a message loud and clear that will be
25 taken to heart certainly by Dr. McNeive and by Mercy

1 Clinic. So I'm asking you to take all that into
2 consideration when you're deliberating about putative
3 damages. Thank you.

4 THE COURT: Thank you.

5 All right, ladies and Gentlemen, I'm going
6 to send you back with the additional paperwork. I've
7 placed that on top in the folder, along with all of
8 the other paperwork, and we will await your final
9 verdict.

10 (At 5:08 p.m., deliberations commenced.

11 At 5:50 p.m. the following proceedings were held in
12 open court:)

13 THE COURT: So the question purposed at
14 5:10: Do we vote majority or 9/12?

15 MS. GUNN: I think you've got to give them
16 the 9/12 instruction.

17 THE COURT: We have given them that.

18 Do you want me to point to that
19 instruction?

20 MR. WILLMAN: Yes.

21 MS. GUNN: Yes.

22 THE COURT: Which one is it?

23 MS. SLATER: This question was at 5:10,
24 though?

25 THE COURT: So it would be in Instruction

1 No. 5 that I would be pointing to which is: The
2 verdict form included in these instructions contains
3 directions for completion and will allow you to
4 return the permissible verdict in the case. Nine or
5 more of you must agree in order to return any
6 verdict.

7 MR. WILLMAN: Yes.

8 MS. SLATER: Any verdict, yeah. Thank
9 you, Your Honor.

10 (At 5:51 p.m., proceedings stood in
11 deliberations. At 5:59 p.m., the following
12 proceedings were held in open court in the presence
13 of the jury:)

14 THE COURT: Go ahead and be seated,
15 everyone.

16 If you'll pass the paperwork to my
17 bailiff.

18 THE FOREPERSON: Yes, Your Honor.

19 THE COURT: Thank you.

20 we, the undersigned jurors, assess
21 punitive damages against Defendant Mercy Clinic East
22 Communities, Dr. Daniel McNeive, at \$20,000,000.

23 All the jurors signed the verdict forms.

24 Does either side wish for the jury to be
25 polled?

1 MR. WILLMAN: No, Your Honor.

2 MS. GUNN: No, Your Honor.

3 THE COURT: Very good.

4 The Court will accept the jury's verdict.

5 (At 6:01 p.m., the jury was discharged.

6 At 6:15 p.m., the following proceedings were held in
7 open court, outside the presence of the jury:)

8 THE COURT: We are back on the record

9 outside the presence of the jury after the Court has

10 received the verdict. It's my understanding that the

11 parties had been in discussions with regards to what

12 is called a high-low agreement, and there is now some

13 dispute or disagreement or some misunderstanding

14 relative to that.

15 so on behalf of the plaintiffs, I'm going

16 to have you state what it is that you understand the

17 agreement to have been.

18 MS. SLATER: Your Honor, there are

19 confidential numbers involved, and I guess I would

20 ask the procedure of whether we report those to you

21 on the record and the record is sealed.

22 MS. KAMYKOWSKI: I don't think it's

23 necessary to have the numbers on the record. We can

24 make this record as to the terms without it.

25 THE COURT: I'm going to disagree with

1 that, based on where we're at right now. But I guess
2 the Court will entertain a motion at the appropriate
3 time for the record, this portion of the record, to
4 be sealed.

5 MS. SLATER: Sure, Your Honor. And the
6 plaintiff would make that motion on the record now,
7 and that the record be sealed starting at this point
8 going forward for the rest of the record made this
9 evening.

10 THE COURT: The Court will grant that
11 request.

12 MS. SLATER: Your Honor, while the jury
13 was deliberating in the first stage of the trial, the
14 defendants approached plaintiff and offered
15 \$12 million. We rejected that amount and came back
16 and told them we would do a what's referred to as a
17 high-low agreement of 10 million and \$20 million. We
18 went back and reported that to them. That was
19 rejected, and we were offered a high-low agreement
20 of --

21 Mandy, do you remember what the first
22 offer was for that?

23 MS. KAMYKOWSKI: I think it was 8 and 17.

24 MS. SLATER: I believe it was 8 and 15.

25 And, Mandy, Ms. Kamykowski, I believe it

1 was 8 and 15.

2 If you have the text message to confirm,
3 that would be great.

4 MS. KAMYKOWSKI: I don't think I do. I do
5 not.

6 MS. SLATER: Your Honor, we rejected that
7 high-low agreement and said 10 and 20 was the
8 agreement. The first time we communicated that
9 high-low, we told Ms. Kamykowski that was
10 non-negotiable.

11 The settlement discussions continued as
12 the jury had questions. Then a high-low agreement of
13 17 million and 8 million was offered, and we rejected
14 that. Ms. Kamykowski came back to me and said that
15 the high number of 17 -- this was communicated to me
16 when she was whispered to me in the courtroom -- that
17 the high number would always be 17 because of
18 erosion, but that they could adjust the low number
19 up. I believe they offered 9, so 9 and 17. I had
20 told her that that was also rejected, and that our
21 proposal of 10 and 20 was non-negotiable.

22 I believe there were some more questions
23 from the jury at that point asking about the punitive
24 damages. And then I believe the verdict came in, and
25 I went to Ms. Kamykowski and said, as we all walked

1 in, and said it's 10 and 20. And she said, I can't
2 get that --

3 I'm sorry. Prior to that, they came back
4 and offered 18 -- 8 and 18, and said that the new
5 high number was 18. And then we learned -- we
6 rejected that -- and then we learned that there was a
7 verdict.

8 I talked to Ms. Kamykowski right before
9 the Court brought the jury in and said, so you want
10 to do 10 and 20? She said no. It's 8 and 18. And
11 that is when, as the Court witnessed, we took our
12 client out in the hallway and asked for a brief pause
13 for all parties before the verdict was read.

14 We came back into the courtroom and
15 communicated to Ms. Kamykowski that 8 and 18 would be
16 accepted as the high-low. Let me add that prior to
17 walking into the courtroom for the verdict, I had
18 told Ms. Kamykowski, when I asked her about the 10
19 and 20, she said, no, it's 8 and 18. And I said we
20 could do -- to make the low point lower and do 9 and
21 20 if that would help. And she said, no, it's 8 and
22 18.

23 When I communicated to Ms. Kamykowski in
24 the courtroom that 8 and 18 would be accepted, at
25 that point, there had never been any words used other

1 than "high-low" and the word "verdict." Then Ms.
2 Kamykowski asked me to come out and clarify the
3 terms. I had typed them into my phone. And as I've
4 shown the Court, I have a message that we will print
5 out and send the Court as Exhibit A.

6 There's a message that I sent to Ms.
7 Kamykowski, and it reads: 8 and 18, all the way to
8 verdict, confidentiality to high-low, no
9 nondisparagement. Ms. Kamykowski wanted to confirm
10 that those were the terms and then proceeded to call
11 her client, who is Joe Crawford with MedPro, in I
12 believe Cincinnati, Ohio, who was here at trial on
13 Friday last week.

14 I was asked to come back out in the hall,
15 and Ms. Kamykowski and Mr. Willman confirmed that
16 this settlement of the high-low would buy all claims,
17 including the punitive damages. I confirmed, yes,
18 but we were going to go all the way to verdict.
19 Mr. Willman asked me if that was necessary to go
20 through with the punitive phase, and I said, yes,
21 that we wanted to do that.

22 That was then accepted and agreed to by
23 all parties. At no time was the word "judgment" used
24 or "net verdict" or anything to indicate to me or my
25 client, who is a minor brain-injured child

1 represented by his parents, that the amount that we
2 were entering into and agreeing was anything but
3 the -- a verdict over 18 being paid to 18, and a
4 verdict under 18 -- or under 8 being paid at 8.

5 Mr. Willman did say that the amount that
6 would be paid would not be paid on punitive, which is
7 typical and customary that insurance policies don't
8 pay for punitive damages. I accepted that, that the
9 8 and 18 on the verdict would not be paying for any
10 punitive damages, as understood by all parties.

11 We have asked to -- we asked earlier to
12 put this on the record and came over to sidebar and
13 informed the Court, after receiving a verdict for
14 28.1 million in the first phase of trial and 20
15 million in punitive in the second phase of trial, I
16 informed the Court that we had reached an agreement,
17 a settlement agreement, through a high-low, and that
18 the numbers were 8 and 18. And so the settlement was
19 an \$18 million settlement.

20 I was then informed by Ms. Kamykowski that
21 I was incorrect in my understanding of what our
22 agreement was, and I believe her -- we had a lengthy
23 discussion at sidebar where I expressed my
24 frustrations to the Court of learning for the first
25 time, after agreeing to the settlement, that I must

1 have not understood the terms.

2 Ms. Kamykowski informed me prior to us
3 making this agreement, that she never entered into a
4 high-low agreement before, and I am -- have asked Ms.
5 kamykowski at sidebar whether the word "judgment" was
6 ever used. She confirmed it was not. Whether the
7 words "net verdict" was ever used. She confirmed it
8 was not.

9 There was never any discussion that there
10 was any other understanding of what our settlement
11 agreement was, other than a verdict over \$18 million
12 would be paid at \$18 million. A verdict under \$8
13 million, would be paid at \$8 million. And if a
14 verdict came in in between those numbers, that that
15 would be the settlement amount.

16 So we are making an oral motion at this
17 time to enforce settlement based on contemporaneous
18 understanding of the conversations between Ms.
19 kamykowski and myself and Mr. Willman on behalf of
20 Dr. McNeive and Mercy Clinic, and Ms. Kamykowski on
21 behalf of Mercy Hospitals.

22 She had been on the phone with Joe
23 Crawford, was my understanding, from MedPro
24 throughout the evening, and this was an extremely
25 important and easily identifiable term of the

1 settlement agreement, if that was her understanding.
2 And if it was not, clarify. And so the plaintiffs
3 would make on oral motion to enforce the settlement
4 of \$18 million.

5 THE COURT: Response?

6 MS. KAMYKOWSKI: well, at this point, Your
7 Honor, I have an objection to this being -- and any
8 record being made. I don't think this is within the
9 Court's purview. This is not an issue that is ripe
10 for any discussion with the Court. We just had a
11 jury verdict entered this evening. There has not
12 been any dis -- any judgment entered on that verdict
13 yet. And I think that it is inappropriate for this
14 issue to be in front of this Court, and I would
15 decline to further make a record at this time.

16 MS. SLATER: And, Your Honor, I asked Ms.
17 Kamykowski, during this record, if she had any text
18 messages from Joe Crawford, I would ask that she not
19 destroy text messages or any evidence of
20 communications between she and her clients about
21 this, ask that that evidence be preserved. And that
22 I am frustrated by the fact that defense counsel will
23 not make a record at this point about what her
24 understanding of our communications were, as I am
25 extremely clear of the agreement that we reached

1 moments before a verdict being read.

2 And if I was drawn into an agreement that
3 I understood, that would be taking advantage of my
4 client and the moment by Mercy Hospitals. So I ask
5 that the Court entertain our motion, and that defense
6 counsel respond about what the position is on what
7 the agreement was.

8 THE COURT: I am a bit confused as to what
9 you think a high-low means.

10 MS. KAMYKOWSKI: So, Your Honor, I have 8
11 to 18, all the way to verdict, confidentiality to
12 high-low, no nondisparagement. Those were --

13 THE COURT: But what I'm asking is what
14 does that mean? So that if you get more than 8
15 million, you get 8 million?

16 MS. KAMYKOWSKI: No.

17 THE COURT: So if you get more than 18
18 million, you get 8 million?

19 MS. KAMYKOWSKI: No, Your Honor.

20 So a high-low is based on -- have the jury
21 give a verdict, the Court enters a judgment. From
22 the judgment, if the judgment is more than the high,
23 the high is the cap. If the judgment is less than
24 the low, then the low is paid. And if the judgment
25 lands in between, that is the amount that is to be

1 paid.

2 THE COURT: And the judgment in this case,
3 based upon the jury's decision, is 28,100,000 and
4 then 20 million on punitive damages.

5 MS. KAMYKOWSKI: And the punitive damages
6 were specifically excluded from the settlement
7 negotiations.

8 THE COURT: Even assuming that that's
9 accurate, which I'm not assuming, we're still above
10 18 million in the 28 million.

11 MS. KAMYKOWSKI: The judgment would have
12 to reflect the tort reform application to the
13 noneconomic damages. The cap would have to applied
14 in this case before final judgment could be entered.

15 THE COURT: And what do you believe would
16 be reduced based upon the caps?

17 MS. KAMYKOWSKI: The \$20,500,000.

18 THE COURT: Specifically what is that
19 referencing?

20 MS, KAMYKOWSKI: The past noneconomic
21 damages of the compensatory award of 500,000 and the
22 future noneconomic damages of \$20 million.

23 THE COURT: And were discussions with
24 regards to the caps involved in this settlement
25 agreement at all?

1 MS. KAMYKOWSKI: There was no discussion
2 of caps, Your Honor.

3 A purpose of a high-low, in a medical
4 malpractice case, is to buy the peace of all of the
5 parties.

6 THE COURT: Well, I understand that. And
7 I don't think we've bought any peace today.

8 MS. KAMYKOWSKI: And the purpose of a
9 high-low in a case where there isn't statutory caps,
10 then that would be a different story, but everyone
11 knows that the statutory caps apply. They've always
12 been part of the negotiations in the case, including
13 the fact that part of our negotiations were buying
14 the peace of the potential for application of future
15 periodic payments pursuant to the statute. So we had
16 discussions about the caps in the ongoing settlement
17 negotiations that we had in this case.

18 THE COURT: But there were no discussions
19 with regards to the high-low about the caps?

20 MS. KAMYKOWSKI: There were discussions
21 ongoing all day starting with a total number offered,
22 and then into high-lows that, from the beginning,
23 included talk about statutory caps or statutory
24 provisions.

25 MS. SLATER: Your Honor, I have not heard

1 the word "cap" or "statutory provisions" out of
2 defense counsel's mouth today until right now.

3 MS. KAMYKOWSKI: And I just told you what
4 we talked about before, was buying the peace that
5 would include for the plaintiff not having a verdict
6 and the final judgment be subject to future periodic
7 payments.

8 THE COURT: I'm not going to rule on the
9 motion to enforce today because I don't think that
10 that's appropriate.

11 I am going to require counsel to not
12 destroy any evidence of any communications with your
13 client with regards to those issues and any
14 communications with any of the other counsel in this
15 case.

16 I'm not sure why the high would have gone
17 up to 18 if caps had been involved because if caps
18 were involved, you would never get to that number.

19 MS. KAMYKOWSKI: well, Your Honor, the
20 plaintiffs request that closing argument was for
21 future economic damages of \$25 million and past
22 economic damages of around \$600,000. So, yes, it
23 would have. We were buying our peace for an economic
24 judgment that was at risk of \$25 million plus
25 \$600,000 in past, plus the caps. So we were --

1 THE COURT: But the caps would have never
2 allowed it to go to 25 million, based upon your
3 argument.

4 MS. KAMYKOWSKI: Your Honor, the cap only
5 applies to noneconomic damages. Ms. Gunn's request
6 to this jury of economic damages exceeded 25 -- it
7 was 25 million, plus the pasts economics. So we were
8 looking at buying our peace at something less than
9 that.

10 So we knew exactly what that potential
11 number was. That potential number -- and there was
12 argument, and part of the exposure in this case was
13 argument that this was going to be underfunded, and
14 they should get more than the 25 million that she
15 asked for? So 25 million in future economics, plus
16 the \$600,000 in past economics, plus the caps, that
17 is about \$830,000. We were taking that into
18 consideration and looking at buying our peace with a
19 high of \$18 million.

20 So the judgment on what Ms. Gunn asked
21 for, would have been exceeding the high, and that's
22 the benefit of that bargain. Which also goes into
23 the discussion about the future periodic payment risk
24 that the plaintiff had by not entering into a
25 high-low.

1 THE COURT: Well, the fact that there's a
2 verdict, and a verdict finding not just malpractice
3 on behalf of Dr. McNeive and Mercy Clinic and Mercy
4 nursers and punitive damages, I would imagine might
5 have a chilling effect on their operations, and that
6 is the benefit of the bargain that you were trying to
7 avoid.

8 From my perspective, let this case
9 continue you. Appeal it for years. I told you that
10 was what was going to happen anyway and let everybody
11 know that there's been a finding of malpractice
12 against this specific doctor, that clinic, as well as
13 the hospital, and that there's punitive damages.
14 Bank on the community to decide whether or not to
15 keeping going to them.

16 MS. SLATER: Your Honor, it's important to
17 note that my former firm, Simon Law Firm, recently
18 had an experience with Ms. Kamykowski where a case
19 was settled at mediation, and the child, who was
20 severely brain damaged, passed away within days of
21 the mediation.

22 A motion was filed to withdraw the amount
23 or reduce the amount that they owed that child that
24 they had agreed to at mediation. That motion was
25 unsuccessful, and the Court enforced the judgment.

1 so, as you can imagine, being on the other
2 side of this counsel again, and Ms. Lenivy, who tried
3 this case, was directly involved in the case that I
4 am referring to that was resolved, and that amount
5 was enforced. This it now repeated behavior, and I
6 would move --

7 MS. KAMYKOWSKI: No, Erica --

8 MS. SLATER: Your Honor --

9 MS. KAMYKOWSKI: Ms. Slater, this is
10 inappropriate. I wasn't at that mediation. You
11 bringing this into this courtroom is absolutely
12 insane right now.

13 MS. SLATER: Your Honor, I'm moving for
14 sanctions against Ms. Kamykowski and specifically her
15 client, Mercy Hospitals, who I am told controls the
16 amount of the money that was offered to us this
17 evening and induce Blake Anyan to enter a settlement
18 moments before a judgment was entered. So that is
19 also part of the motion that we are moving for this
20 evening and directly against their client for this
21 behavior in these settlement negotiations today as
22 we've reported on the record.

23 THE COURT: The Court is going to require
24 you to file a motion.

25 MS. SLATER: Yes, Your Honor.

1 THE COURT: AS with every motion for
2 sanctions, as well as any motion for enforcement of
3 settlement, there has to be a written motion. And we
4 have to give the opportunity to due process at that
5 time.

6 MS. SLATER: Sure.

7 THE COURT: And so the Court will
8 entertain any evidence and all of those factors. And
9 I told you guys this before we started the trial that
10 I thought it should be settled. My opinions have not
11 changed. But I also know that that isn't going to
12 change a darn thing.

13 So we will deal with the motion, and if it
14 is not successful, we will deal with years of
15 appeals. I don't know what else to tell you.

16 MS. GUNN: Your Honor, that's what we
17 thought we were doing. That's exactly the deal that
18 we had.

19 THE COURT: Apparently that's not what the
20 other side wants.

21 MS. GUNN: So it will be a motion to
22 enforce the settlement, is what Your Honor is
23 requesting be written, as well?

24 THE COURT: Yep.

25 MS. KAMYKOWSKI: Okay. Thank you, Judge.

MS. SLATER: Thank you, Your Honor.

(At 6:38 p.m., court stood in
adjournment.)

o o o

Monday, May 5, 2025

Posttrial Motions

o o o

(At 9:01 a.m., the following proceedings
were held in open court:)

THE COURT: We are here on the record in
the matter of Remington Anyan vs. Mercy Hospitals, et
al., Cause No. 21SL-CC03944.

This matter is on the Court's docket this
morning with regards to Motion to Stay Execution of
Judgment and Motion to Amend Judgment.

Any other motions that I'm missing?

MS. SLATER: No, Your Honor.

MS. KAMYKOWSKI: No, Your Honor.

THE COURT: Very good.

Are the parties ready to proceed?

MR. PERRON: Yes, Your Honor.

MS. SLATER: Yes, Your Honor.

THE COURT: Very good.

MR. PERRON: Your Honor, on behalf of the
defendants, I think it makes sense to take up the

1 motion for amended judgment first. I'll try to
2 restrict oral argument to where I think the
3 controversies have been identified in plaintiffs'
4 response to our motions.

5 Our motion to amend is more or less
6 substantively in two parts: One, to reduce the
7 noneconomic awards pursuant to the cap, and setting
8 aside for the moment the constitutional argument
9 plaintiffs have made, which I believe they have
10 preserved for appeal and will be taken up.

11 But setting that aside, I believe, if I'm
12 reading their memo correctly, we are in agreement
13 with setting aside the constitutional issue as the
14 catastrophic cap on noneconomic damages is the
15 appropriate cap, and that we are in agreement as to
16 reducing the awarded past and future noneconomic
17 damages total to the 2025 catastrophic damages cap.

18 Moving on, the next substantive issue is
19 periodic payments, which we noted are mandated and
20 requested by 538.220 RSMo. And, again, I don't think
21 that it's in controversy whether or not the Court has
22 to take the future awarded economic medical expenses
23 and apply them over time in periodic payments by
24 statute, as intended, which was to provide some
25 benefit and protection to defendants in these types

1 of cases in particular.

2 And I think that's acknowledged, at least

3 to some degree, in plaintiffs' memorandum. So,

4 again, I don't think that that's in controversy. The

5 only question is as Missouri case law has laid out,

6 the Court has some discretion to make a finding based

7 on the evidence that was presented at trial that

8 there is an immediate need on the part of the

9 plaintiff for some of these futures damages, and due

10 to that immediate need, it could justify pulling some

11 of the damages that have been laid out to be

12 dispensed in the future, or, where the evidence

13 suggested, they would be needed in the future, but,

14 instead, pull them forward to be paid in one lump

15 sum. And I think that's where the chief controversy

16 is.

17 So, number one, sort of breaking that into

18 smaller pieces, there is a controversy or

19 disagreement as to what the life expectancy should be

20 used to set the boundary for the periodic payments.

21 Pursuant to the statute, I know in

22 plaintiffs' memo, they mentioned that the defendants

23 put on our own evidence as to life expectancy, and

24 that it's significantly lower than the plaintiffs'.

25 But pursuant to 538.220.2, the Court can only look at

1 the plaintiffs' life expectancy numbers.

2 So to -- to a certain extent and to a
3 complete extent, any evidence that the defense put on
4 as to life expectancy by explicit limitation of the
5 statutory language, is irrelevant to the question of
6 periodic payments. The Court can only consider the
7 evidence of life expectancy that was introduced and
8 argued by the plaintiffs' counsel.

9 It's the defense position that during
10 trial, they presented two life expectancy options for
11 the jury to consider, both the 60 years and the
12 longer 75 years. And, in particular, it was over
13 defendants' objection that the court allowed evidence
14 of the longer possible life expectancy of 75 years.

15 And in closing argument, the numbers
16 presented by plaintiffs' counsel to the jury were
17 based on Dr. Liles's life care plan presuming a life
18 expectancy of 75 years. So I think, as we sort of
19 mentioned as not quite a legal term of art, but
20 argumentative issue, you know, good for the
21 goose/good for the gander, if it was fair and, you
22 know, over defendants' objection with the endorsement
23 of the court's ruling, then to ask the jury to award
24 future medical expenses up to a life expectancy of
25 75, then the defendants should get the benefit of

1 that when it comes to periodic payments.

2 Plaintiffs made a strategic choice,
3 knowing that the periodic payment issue was out
4 there, to argue for a longer life expectancy, and
5 it's the defendants' position that, pursuant to the
6 statute, the Court must use 75 as the life expectancy
7 if that is the life expectancy chosen by plaintiffs
8 during closing arguments to persuade the jury toward
9 a larger future medical expense award.

10 Moving to the lump sum issue, again, how I
11 think I can rely on the representations made by
12 plaintiffs' counsel as to the way the case law has
13 described this issue. And in plaintiffs' own memo,
14 they state that the way Missouri case law is -- has
15 outlined this issue of lump sum versus future
16 medical, is if the Court finds, based on the trial
17 that was presented and evidence, that there is an
18 immediate need for expenses for medical care or
19 treatment or equipment, then the Court can order a
20 lump sum to be paid from those future medical
21 expenses.

22 we can look -- and plaintiff hopefully
23 sent over the life care plan of Dr. Liles to the
24 Court a second time, Dr. Liles testified that his
25 life care plan included annually the medical care,

1 treatment, and equipment that he believed was
2 reasonably necessary. And we can use Dr. Liles's
3 life care plan and his cost summary sheet to
4 determine effectively what he believes Remi would
5 require every year, I think he started at age 3, and
6 then Remi is now 5.

7 There is one specific -- one specific
8 payment that Dr. Liles contemplated at the very
9 beginning, and he had not repeated, a one-time
10 estimate of 219,972 for home evaluation and
11 modifications. But other than that, every year has a
12 specific cost calculated for the care and treatment
13 that Dr. Liles considers necessary starting --
14 considering the 219,000 home evaluation
15 modifications, starting at age 5, which is where Remi
16 is right now, and going to age 8, in the next three
17 years. That is a sum total of \$735,823.

18 Even with the home modification and using
19 the numbers that Dr. Liles himself utilized, it is
20 well under what plaintiffs are asking in terms of the
21 lump sum that Remi needs right away.

22 Addressing some of the issues that
23 plaintiffs brought up, the fact that Dr. Liles's life
24 care plan might be underfunded, plaintiffs solicited
25 from Mr. Matthews, the defense's expert, that it was

1 possible that Remi might need things that were not
2 contemplated by Dr. Liles.
3 And in closing argument, plaintiff made
4 that argument to the jury, that even though Dr. Liles
5 has his life care plan up to age 75 that totaled 21
6 million, that they should consider the possibility it
7 was underfunded and award excess of 21 million for
8 future economic damages, and, in fact, asked the jury
9 for a total award of 25 million in future economic
10 damages, and the jury was not persuaded by those
11 arguments.

12 So I do not believe the Court now can make
13 a finding that Dr. Liles's life care plan was
14 underfunded, and specifically underfunded for some
15 unknown or speculative immediate need, beyond what's
16 in Dr. Liles's own life care plan, and ask the Court
17 to award a lump sum for an immediate medical need
18 that was not contemplated by Dr. Liles, and under an
19 argument that appears to be rejected by the jury that
20 Dr. Liles's life care plan underfunded Remi's needs
21 for the future.

22 Again, just to highlight, there are
23 medical expenses detailed and argued in plaintiffs'
24 memo as to the immediate needs of Remi that are
25 outside of what Dr. Liles put in his life care plan.

1 Dr. Liles was plaintiffs' own expert who testified
2 under oath at his deposition and later in trial
3 deposition, that he put into his life care plan what
4 he believed Remi would be reasonably likely to need,
5 as a consequence of his injury suffered due to the
6 negligence of the defendants.

7 The Court, it is the defendants' position,
8 the Court cannot go outside of what Dr. Liles
9 contemplated in his life care plan and testify as to
10 the reasonably likelihood of Remi needing these
11 things.

12 And, again, I put the numbers to the
13 Court. Even under the best case scenario, even going
14 up to age 8, the sum total is well below what they're
15 asking for, and I think the defense put the number
16 back in there, is 735,823. Even considering all of
17 the, you know, the next three years, beyond where
18 Remi is right now, plaintiff makes a, in their memo,
19 a specific argument about the present value.

20 And, again, this has sort of been a
21 sticking point all throughout the lead up to trial,
22 through trial, and now continuing in the post-trial
23 motions, plaintiff made a strategic decision leading
24 up to the deadline to disclose their experts, not to
25 disclose an economic expert to opine on present

1 value.

2 At trial, the defendants wanted to offer
3 an instruction to the jury asking them to award the
4 damages for future medical expenses at present value,
5 and the plaintiffs objected. And the Court did not
6 allow that instruction to go to the jury. Through
7 strategic decisions plaintiffs' counsel has made,
8 they took present value as an issue off the table for
9 the jury to consider at trial.

10 And we do not believe the Court can
11 consider, at this point, the fact that inflation
12 might outstrip what the contemplated statutory
13 interest would be on the periodic payments. If the
14 jury didn't get to consider present value and the
15 inflationary aspect of health care, I think it is
16 outside of the Court to make an evidentiary finding
17 in terms of periodic payments contrary to what the
18 jury was allowed to consider.

19 And, finally, with regards to lump sum
20 versus care that was contemplated by Dr. Liles to
21 only be needed into the future, again, again,
22 referring to Exhibit 125-17, this is one of the Excel
23 spreadsheets that was sent to the Court, and it's
24 referenced specifically at trial. This is Dr.
25 Liles's cost table for the home plan up to age 75.

1 This is a specific table that counsel
2 referenced during closing argument to support their
3 request for the \$21 million life care plan. And in
4 this table, Dr. Liles contemplates attendant care, a
5 day program, and housecleaning only to come in when
6 Remi is age 22. And this, the attendant care, the
7 day program, and the housecleaning, totals
8 \$14,050,430. Of the excess of 21 million, the
9 attendant care, at age 22 forward, the day program,
10 and the housecleaning, represents 65 percent of the
11 total projected future medical expenses that Dr.
12 Liles has in this plan.

13 So in the specific plan the plaintiff used
14 in closing argument to argue for their future
15 medical, 65 percent of that future medical care, is
16 care that Dr. Liles contemplated to only be needed
17 when Remi gets to age 22.

18 So, again, if under Dr. Liles's own
19 testimony and plan, 65 percent of the future medical
20 expenses is not needed now, nor within the next 18 or
21 17 or so years, we don't believe the Court can make
22 an evidentiary finding as to periodic payments
23 contrary to what Dr. Liles found.

24 And if we apply 65 percent, if we're
25 talking about the 7 million awarded for future

1 medical, if we prorate Dr. Liles's plan to the 7
2 million, 65 percent of 7 million is \$4,550,000.
3 According to the prorated percentages from
4 Dr. Liles's plan, \$4,550,000 of that 7 million, would
5 only be necessary in attendant care, the day program,
6 and then the housecleaning after Remi turns 22.

7 So for those reasons, Your Honor, we
8 believe that the offered amended judgment comports to
9 what is demanded of the Court under 538.220.

10 MS. KAMYKOWSKI: Briefly just to add to
11 that, I won't re cover anything that Mr. Perron just
12 argued, Judge.

13 It was pointed out in plaintiffs' response
14 that there was a typo as to the statutory per annum
15 interest rate that would apply to the periodic
16 payments that the Court would enter in this case. So
17 I've updated a proposed amended judgment that has the
18 coupon equivalent treasury interest rate as of
19 May 2nd, and it's 4.02 percent. And that's reflected
20 in an update that I will hand the Court and counsel
21 in a second.

22 The only other issue that I wanted to
23 raise with respect to the constitutional challenge
24 that had been raised with respect to the statutory
25 periodic future payments in 538.220. well, one case

1 has addressed that, and it's the Williams v. Mercy
2 case. And in that case, the Court found that there
3 might be circumstances where the periodic future
4 payments could be unconstitutional as applied to a
5 particular plaintiff.

6 And in that case, the issue was the fact
7 that the parties had put on present value evidence of
8 the future award. They had had different economists
9 come in and testify as to a discount rate of the
10 award, and the jury awarded the exact amount that the
11 present value evidence showed at trial.

12 Thereafter, in the post-trial motions
13 where the party -- the defendants -- sought to apply
14 this same statute, they asked for yet another
15 interest rate to be applied to the periodic future
16 payments that was different than the present value,
17 the interest rates, that had been used at trial.

18 And, therefore, the court, on appeal,
19 found that the plaintiff, in that case, had had their
20 damages reduced twice because of the disparate
21 interest rate that was applied in the posttrial final
22 judgment. That issue is not present here. As Mr.
23 Perron testified -- or stated earlier in his
24 argument, there was no present value argument made.
25 There was no law given to the jury about present

1 value. And there was no evidence in the case talking
2 about present value.

3 And to -- what we see in the plaintiffs'
4 response to this request to amend the judgment, is
5 simply after the fact offering new scenarios that
6 possibly might occur for Remi in the future,
7 including his parents are no longer with him before
8 age 22, when the attendant care kicks in. Lots of
9 possibilities, lots of speculation that this Court
10 may not consider with respect to determining and
11 applying the periodic future payments to this -- to
12 the jury's award.

13 And it is -- it is correct that the
14 statute says once a party requests it, there must be
15 a determination by the Court that the periodic
16 payments be made in whole or in part. And so the way
17 that we have requested it, the evidence came in
18 through Dr. Liles that there are finite expenses,
19 which is what plaintiffs even cite to Watts in their
20 memo.

21 There are finite expenses delineated
22 line-by-line, item-by-item, cost-by-cost from the
23 plaintiffs' evidence. And on page 6 of their memo,
24 each plaintiffs' medical costs will be spread over
25 different time periods, some requiring uncertain and

1 costly medical care directly after trial, and others
2 having consistent care over many years for a
3 predictable condition.

4 what we have in this case from Dr. Liles
5 is the latter. A plaintiff that has consistent care
6 over many years for a predictable condition that he
7 put out step-by-step, line-by-line for the jury to
8 consider. And that's what the award, if that's what
9 the statute mandates, and we are requesting that the
10 Court enter -- enter the judgment as tendered by the
11 defendants.

12 Alternatively, Judge, what -- if -- if --
13 if the parties are unable to reach a conclusion,
14 there is a contemplation within the statute for the
15 Court to have an evidentiary hearing so -- to take
16 evidence, not simply hearsay and other arguments,
17 which is what we see in the plaintiffs' response by
18 way of the first exhibit that's an opinion piece
19 published about tort reform, and the speculation as
20 to what the possible scenarios that could happen to
21 Remi in the future.

22 we would request that if the Court does
23 not enter defendants' amended judgment based on the
24 totality of the evidence that plaintiff presented at
25 trial, that this matter be set for an evidentiary

1 hearing for further analysis.

2 MS. SLATER: So let me go back a little
3 bit. I'd like to start with the constitutional issue
4 of these two statutes. They are relying on 538.210
5 for the reduction in the medical malpractice damages
6 cap. As you know, we have pled a constitutional
7 challenge to that section, and also the other one at
8 issue 538.220, since our first pleading in this case.
9 And I've continued that throughout.

10 So to the extent -- Mr. Perron referenced
11 it a few times -- but we, first and foremost, our
12 argument that these statutes, especially as applies
13 in this case, are unconstitutional, and that Remi's
14 award should not be reduced a multitude of times
15 through the jury's award and then on to the caps on
16 damages, and then spacing that out in periodic
17 payments.

18 Shall I proceed beyond those arguments?

19 THE COURT: (Nods head.)

20 MS. SLATER: Thank you, Your Honor.

21 As far as addressing the substance of
22 538.210, it's correct that we agree that the
23 catastrophic injury cap applies, and that the 2025
24 amount is 828,529. That reduces Remi Anyan's
25 judgment in the case in total by over \$19 million.

1 As we know, the future medical, the 7
2 million that he was awarded, is nowhere near
3 plaintiffs' life care plan that Dr. Liles put forth
4 in any scenario. And the argument that you heard had
5 a lot of statements about what evidence you can
6 consider and what evidence you can't consider in
7 making this determination.

8 The case law says that the court has
9 absolute discretion to, when a party requests, decide
10 what amount is put in a lump sum payment and what
11 amount is potentially projected out. The two things
12 that the Court does not have discretion over under
13 the statutes is that the periodic payments are equal
14 payments and over life expectancy.

15 And that's extremely important in this
16 case because the situation that we found in the
17 Williams case where the recovery was discounted twice
18 because a higher interest rate was used over time to
19 discount it to present value, and then the defendants
20 tried to apply a lower interest rate to the periodic
21 payments.

22 Judge Russel, in that case, said that that
23 was an unconstitutional application of periodic
24 payments to that specific plaintiff because that
25 clearly discounted his money as twice, because the

1 jury took that evidence into consideration from the
2 verdict, and then the statute was causing an effect
3 based on the evidence that was improperly discounting
4 that plaintiff.

5 we have the same situation here. And it
6 comes into the discussion of the life expectancy.

7 So, as you know, defendants presented evidence of a
8 reduced life expectancy, as did plaintiffs, just not
9 as severely as defendants' numbers.

10 And the jury, as evident from the future
11 medical care costs, that that was likely considered
12 evidence. And without speculating what the jury was
13 thinking or what, you know, their verdict was
14 compromised to, the effect on Remi is that he has
15 \$7 million to work with over the entirety of his
16 life.

17 So the jury unanimously found that the
18 defendants are responsible for causing his injuries,
19 which means they're responsible for paying for the
20 result of those injuries, which are complex care for
21 an extremely disabled child who has no other outlet
22 to manage his care or, you know, make his own income.
23 He's entirely reliant on others to survive.

24 And the cost of his survival is now in the
25 defendants' corner. And that amount of money he has

1 to work with on that line item is 7 million. So
2 there's no pro rata of his expenses. Nothing that
3 the jury determined changes the cost that it takes to
4 care for Remi and his condition.

5 And the information I heard about Dr.
6 Liles' life care plan about the 65 percent and, you
7 know, the -- what the costs would be, that ignores
8 the fact that the court has to award equal periodic
9 payments over a lifespan.

10 So there's no accumulation of the amount
11 of money that the defendants are suggesting the Court
12 apportion out in the future. So defendants' plan is
13 that for the next 70 years, that the remainder after
14 attorneys' fees and expenses, be apportioned out
15 year-over-year, and that's about \$58,000 a year.

16 As I pointed out in our briefing, the very
17 lowest year of costs that appear in Dr. Liles' life
18 care plan is \$67,880. And that one year of low costs
19 for age 20 for Remi is kind of an outlier anyway.

20 So on year 1 of defendants' plan, Remi's
21 costs are underfunded. So there's no accumulation of
22 the money that would be awarded year-over-year that
23 would allow him to hedge to future costs when they
24 may increase if his parents weren't available to take
25 care of him.

1 or, you know, when his family decides that
2 he should, for his own dignity, have a different
3 scenario that they testified at trial about whether
4 he is, you know, living in their basement with
5 attendant care, or maybe another house that they are
6 able to secure for him, either close by or on their
7 property.

8 And that -- that's the problem here when
9 we get into the scenario of an extremely disabled
10 child who has no ability to offset any of their
11 medical costs with their own funds. If we apply the
12 periodic payments in the way defendants state, then
13 he's underfunded immediately.

14 And it's that problem that will require
15 that the -- and plaintiffs are asking that the Court
16 award the majority, 97.2 percent of the sum upfront,
17 because that gives him that amount of money to use in
18 his lifetime, whatever that may be.

19 And the evidence that the Court can
20 consider, there's no mandate from the jury that the
21 Court can consider one thing or can't consider
22 another thing. The only mandate from the statute is
23 that the life expectancy comes into the plaintiffs'
24 evidence, and then it's equal payments over that life
25 expectancy.

1 so to take an amount that is discounted
2 from plaintiffs' proposed amount for future medical,
3 that's discounted once. And the only evidence we see
4 at trial that would have discounted that amount, was
5 not present value, was not a different costing
6 structure that we often see. Of course, as the Court
7 knows, they had evidence from Mr. Bishop about
8 present value, and they had evidence of that from
9 Mr. Russo about different costing figures to fit in
10 to the life care plan.

11 Defendants elected not to present that
12 evidence. I believe it was represented that
13 plaintiffs elected not to present that evidence.
14 Plaintiffs very much wanted to present that evidence,
15 and of course we've gone to great lengths to preserve
16 our arguments regarding our evidence through
17 Mr. Gingras.

18 So as far as that goes, the -- the present
19 value discussion is just the mere fact that we know
20 health care costs have gone up over time. And the
21 reason I mention that is because Dr. Liles, in his
22 plan, provides a cost for medication, for example.

23 So the costs that he provides for medication for Remi
24 for the rest of his life, is about \$26,000 a year.

25 And that is the same for this year, when Remi is 5,

1 as he provided in his longest term plan when Remi is
2 75.

3 There is no -- it is just a common sense
4 argument that the same medications today will not
5 cost the same amount 70 years from now. And of
6 course we know that those medications could be
7 different, and things will shift and change.

8 The problem that plaintiffs always have,
9 especially with a minor in -- at trial, is experts
10 have to do their best to project out what they
11 believe is most reasonable for this child for the
12 future. The costs in Dr. Liles' plans -- or the care
13 provided for in Dr. Liles' plans, that did not
14 include a cost, were pointing out complications that
15 could happen along the way.

16 And indeed the very basis of defendants'
17 reduced life expectancy are based on children like
18 Remi experiencing complications that lead to a
19 reduced life expectancy. That's just the reality.

20 And plaintiff isn't trying to fit their
21 evidence into one, you know, advantageous scenario
22 over another, we are working against laws that we
23 believe are unconstitutional when a jury awards money
24 to take care of a child in the future.

25 As we mentioned, the effect of the cap

1 already reduces Remi's available funds, which of
2 course on the other side of a jury award, could be
3 used to hedge any additional costs that he has after
4 that 7 million, but those are wiped away by the caps.
5 So that in regard to Remi's situation also is an
6 unconstitutional application to his situation.

7 Another data point that I provided to the
8 Court, other than the lowest year of care that
9 Dr. Liles provided at age 20, is also some of the
10 highest year cost of care. That includes, at age 27,
11 his projected costs are \$409,000, slightly over that.
12 At age 63, when he is also in attendant care,
13 \$432,000.

14 And then if we average Dr. Liles'
15 scenarios together, the average yearly cost is
16 between \$250,000 a year to \$293,000 a year. So to --
17 to provide for this child when the defendants are
18 fully responsible for his lifetime medical, to
19 undercut the expenses that we reasonably have
20 presented will occur, is an unconstitutional
21 application of the periodic payments scheduled to
22 Remi.

23 The last data point that I want to leave
24 you with is we already have a little over four years
25 of data of what it has cost Remi in medical costs to

1 take care of him.

2 The stipulation for medical, as you will
3 recall, the charged amount provided for about
4 \$141,000 per year, and even the paid amount, if you
5 reduce it to that, totals about \$85,000 a year.

6 So we ask that the Court provide the
7 majority in the lump sum upfront because Remi has no
8 other choice. There's -- there's no scenario where
9 the defendants can be charged with his lifetime
10 medical where that amount is not available to him
11 upfront and can be used and, you know, that overall
12 amount reduced as he needs it as he goes through.

13 It would be different, and I would be not
14 able to make this argument, if the amount as
15 stretched out over those periods of payment, were
16 closer to the amount he requires year-over-year. But
17 it's simply not.

18 I do want to address the life expectancy.

19 As you know, Dr. Liles, our expert that we presented,
20 his opinion was that Remi's life expectancy is
21 reduced to an average life expectancy of 60. He
22 provided the normal life expectancy numbers to -- as
23 a comparison and at our request. Of course we
24 argued, given the application of the statute that
25 plaintiffs face in this situation to maximize his

1 future medical damages, and the jury did not follow
2 that argument. So that's a reality that we have to
3 deal with when applying the statute. And to that
4 extent, the evidence that we presented, not the
5 argument, was to age 60, so we ask that that be
6 applied.

7 Lastly, the reason in plaintiffs' plan
8 that we provided for 2.5 percent to be stretched out
9 over those periodic payments, is because it does
10 satisfy the statute. The words in the statute say
11 that the Court can consider what amount will be
12 sectioned a lump sum and what amount will be in
13 periodic payments.

14 what it doesn't say, and what I haven't
15 argued to the Court, is that the entirety can be put
16 in lump sum once the statute it invoked. So I think
17 that putting a small amount, which does relieve
18 defendants' total payment of that amount, meets the
19 requirements of the statute and allows it to be
20 statutorily and constitutionally applied to Remi
21 Anyan.

22 Lastly, if the 4.02 percent is correct, as
23 the interest rate from Friday, we did provide the
24 website where that rate is found. It's 4.02 percent.
25 we would agree that that is the applicable percent to

1 include in the judgment.

2 The request for the evidentiary hearing,
3 this motion was set unilaterally, and it was set for
4 this hearing today. If defendants require testimony
5 evidence, then that would need proper notice, and it
6 would to have been requested on their motion. We
7 have presented evidence to the Court in our briefing,
8 and believe that that the -- between the Court
9 sitting through the entire trial, and the arguments
10 and evidence presented to the Court today, that there
11 is sufficient information to rule and enter a final
12 judgment if, in fact, the Court is to find the
13 statute as constitutional.

14 THE COURT: Thank you.

15 MS. SLATER: Thank you.

16 MR. PERRON: Very brief response, Your
17 Honor.

18 The argument that the Court should
19 circumvent the stated intent of 538.220 because it is
20 unconstitutional, we disagree with the substance of
21 that argument. It's a binary question before the
22 Court whether or not the statute is unconstitutional.
23 If the Court does not believe it is in a position to
24 strike or otherwise ignore 538.220 based on the
25 constitutionality, the Court can't then circumvent

1 the intention of the statute because of an alleged
2 constitutional issue.

3 The only way is to first decide whether or
4 not it's constitutional. And if it is, at the trial
5 level, deemed constitutional, then the Court must
6 follow 538.220 and not seem to circumvent the
7 intention as laid out in the statute and leave that
8 constitutional argument to the upper courts.

9 Again, just to reiterate in one statement,
10 plaintiffs' counsel made the argument that Dr. Liles'
11 plan is underfunded and requested the jury award more
12 than the 21 million. And, in fact, requested a total
13 of 25 million to overcome the amount that Dr. Liles'
14 plan was underfunded.

15 And the jury did not seem inclined to
16 agree or be persuaded by that argument in evidence.
17 In terms of the 97 percent of the 7 million future
18 being awarded in lump sum, even if we look at Dr.
19 Liles' life care plan unadjusted, there is nothing to
20 suggest that Remi needs an immediate payment of
21 \$6.8 million. Even unadjusted, Dr. Liles' life care
22 plan does not even approach a total of 6.8 million
23 for many years in the future.

24 And then last, Your Honor, we did not
25 bring up the issue of insurance because the door has

1 been opened in argument. As counsel pointed out,
2 insurance has been paying up to this point for much
3 of the care contemplated in Dr. Liles' life care
4 plan. So if it is fair for plaintiff to point out
5 the past medical, which has already been paid, the
6 evidence demonstrates that insurance has been
7 covering most of the care that Remi is -- is
8 receiving right now.

9 MS. KAMYKOWSKI: And just briefly, Your
10 Honor, I think with respect to the constitutionality
11 claims, Sanders v. Ahmed, and a bunch of other cases
12 in the medical malpractice realm have evaluated the
13 constitutionality of a prior statute, and now we have
14 certain cases that have already evaluated the
15 constitutionality of the current statutory statute.
16 And the statute -- the statutes are presumed to be
17 constitutional and cannot be held unconstitutional
18 unless they clearly and undoubtedly contravene the
19 Constitution. The Courts will enforce a statute
20 unless it plainly and palpably affronts fundamental
21 law embodied in the Constitution. The party claiming
22 that the statute is unconstitutional bears the burden
23 of proof.

24 And I think we've -- we've seen multiple
25 bases in the pleading for -- in the -- when they

1 raise their constitutionality, but in this particular
2 scenario under 538.220, in the response to our motion
3 to amend, the plaintiff argued that the statute is
4 unconstitutional because it failed to achieve a
5 general goal of reducing malpractice costs by
6 permitting defendants to satisfy judgments for future
7 damages in periodic or installment payments, thus
8 violating equal protection and due process.

9 with respect to the evidence that was put
10 forth of that, there's no evidence. They attached an
11 article that's hearsay. That's not something this
12 Court can or should consider in evaluating the
13 constitutionality of the statute. There was no other
14 basis argued at all for why this statute is
15 unconstitutional. And Williams found it
16 constitutional except as applied to a particular
17 plaintiff.

18 So the statute itself is not
19 unconstitutional; you look at its application. And
20 to stand here and say that this child had his award
21 reduced first by the jury is false. The jury is the
22 factfinder, and the jury, hearing all of the evidence
23 as they agreed to fairly and impartially, and in
24 applying that evidence to the law that the Court gave
25 them and the instructions to compensate this child

1 for the reasonable losses he suffered as a result of
2 the defendants' negligence, is what they did.

3 If plaintiffs disagree with that, then
4 that's their prerogative, but that does not mean that
5 he was reduced, that his constitutional rights to a
6 verdict were reduced, because the jury disagreed with
7 their evidence. To then say it was secondarily going
8 to be reduced again, thus finding a statutory
9 provision that is constitutional, is also not a valid
10 argument.

11 The factfinder in this case simply
12 disagreed with the evidence that they put on. And to
13 continue to stand here today and say that the
14 defendants are responsible for all of the 21 or
15 \$25 million of Dr. Liles' life care, when the
16 factfinder disagreed with them on that, is something
17 that the Court needs to consider in evaluating what
18 we're going to do with this judgment.

19 Because it's not the defendants who
20 decided that -- that Remi's future care needs were
21 only \$7 million, that was the jury. That wasn't
22 based on a particular number offered by either party.
23 And it would be invading the province of the jury for
24 this Court to decide that that number is inaccurate,
25 somehow discounted, whatever it is. We don't know

1 why the jury came up with that number, other than
2 they disagreed with both sides' evidence in the case.

3 And they, in that jury room, the 12 of
4 them deliberated and unanimously agreed that 7
5 million, pursuant to the Court's instructions, is
6 what would reasonably compensate this child for his
7 future care needs.

8 So, again, we don't -- we don't know what
9 the jury decided from Dr. Liles' life care plan was
10 necessary or unnecessary. All we know is that they
11 gave a lump sum future damage award of \$7 million,
12 and that the only evidence that was put on in this
13 case for future economic damages was for medical
14 care. And with that award now comes the request for
15 the defendant to apply the constitutional provisions
16 of 538.220 in the way that it was mentioned.

17 with respect to the argument that we
18 didn't ask -- we could have set this for an
19 evidentiary hearing, what the statute contemplates is
20 the parties' attempt to work out a resolution. We
21 attempted to work out that resolution, we're told no,
22 we filed our motion. And in that motion, we asked
23 the Court to set an evidentiary hearing if the Court
24 cannot, based on the pleadings, reach a final amended
25 judgment, and that's what we got here today, Judge.

1 MS. SLATER: Your Honor, I'd like to
2 respond at this point to that portion in that is Mr.
3 Perron's argument about bringing up insurance. My
4 reference in my argument was to the past medical
5 bills that came in with both amounts.

6 whether the jury realizes the difference
7 in the amounts, only the language in the stipulation
8 is what they had. The example was to show that we do
9 have real data of what it costs to take care of Remi
10 in the past. And either way you cut it, their plan
11 underfunds the costs in year 1 that he will continue
12 to have if the past is the predictor as opposed to
13 Dr. Liles' life care plan.

14 There is still a collateral source rule
15 that exists, and the defendants do not get the
16 benefit of the insurance that Remi gets because his
17 father works.

18 That's all I can respond to you from their
19 argument.

20 MS. KAMYKOWSKI: And, Your Honor, I do
21 have a proposed amendment that does have that correct
22 interest rate from last week.

23 THE COURT: Did you email me this?

24 MS. KAMYKOWSKI: This is -- this is the
25 defendants'. I have not. would you like me to email

1 it to you to have it in word format?

2 THE COURT: Yeah.

3 MS. KAMYKOWSKI: I will do that right
4 away, Judge.

5 THE COURT: Yeah.

6 Anything further on the motion to amend?

7 MS. KAMYKOWSKI: No, Your Honor.

8 THE COURT: The Court will take that
9 motion under submission.

10 with regards to the motion to stay.

11 MS. KAMYKOWSKI: So, Your Honor, we had

12 filed a motion to fix a supersedeas bond for appeal

13 that was heard, I think, back on April 9th. We

14 determined that was premature at the time because the

15 Court had not entered any judgment. The Court did

16 enter its initial judgment that date, which the Court

17 retains jurisdiction over this matter for the first

18 30 days, which expires at the end of this week.

19 And while we were awaiting for this

20 hearing to occur and for an amended judgment to be

21 entered, as the Court knows the appellate rules on

22 fixing a bond for an appeal allow, once the Court has

23 fixed a bond and entered an order to have that bond

24 be posted, it essentially stays execution of the

25 judgment. Until that order is entered, there would

1 be no stay of execution in this case.

2 It is a substantial judgment that is out
3 there, and it potentially could be executed on.

4 However, I think the parties here are all aware that
5 appeals are going to be filed, and the contemplation
6 and the appellate rules also indicate that if steps
7 have been made to execute on a judgment, that then is
8 stayed by posting of a supersedeas bond, and those
9 must be reversed or backed out.

10 And so just to avoid any unnecessary, you
11 know, expenses and procedural steps, the defense is
12 asking that the Court stay execution of the judgment,
13 and we are waiting for the amended judgment to be
14 entered so that we can then, at the same time, call
15 up the previously premature motion to fix the
16 supersedeas bond to get that process going. So
17 essentially, just as judicial economy, request to
18 stay the execution at this time.

19 MS. SLATER: Your Honor, I don't -- I
20 don't believe it's necessary, considering we are
21 having this hearing in advance of the April 9th
22 judgment becoming final. And if the court is to
23 order an amended judgment by May 9th, then I believe
24 that resets our time period for post-trial motions.
25 of course the next hearing within -- with this case

1 is May 20th. And if the defendants want to re notice
2 their motion for bond at that time, that timing seems
3 to not have a procedural issue. So I'm not sure this
4 is necessary, and I think it is moot by the timing
5 that exists.

6 MS. KAMYKOWSKI: I think that that could
7 be true, but I don't presume to know what's on the
8 Court's calendar for this week to know whether an
9 amended judgment can actually be finalized and
10 entered by the deadline. I mean, I think if
11 plaintiffs' counsel is representing that they don't
12 plan to seek to enforce the judgment at all until we
13 get final judgment and the appeal process is going,
14 that's probably true, but it's -- it's just we're
15 trying to protect, you know, the defendants from
16 having the judgments begin to be executed and then
17 those have to be unraveled. As we all know, this
18 case is going on appeal.

19 THE COURT: I think I have to get it done
20 or else I lose jurisdiction.

21 MS. KAMYKOWSKI: I think that's true,
22 Judge, I mean I know we --

23 THE COURT: As much as I would like to
24 lose jurisdiction over this case, I'm not going to do
25 it in that way.

1 MS. KAMYKOWSKI: And I think the other
2 reason, in case it was late, you know, we have to
3 then -- we have to file our post-trial motions
4 before, you know, the 30 days, and then potentially
5 have another round of amended. There's a lot of
6 appellate uncertainty with the appellate courts as to
7 how -- what can be waived if we do not follow the
8 original judgment if the amended judgment is not
9 entered, so it's just really, you know, triple
10 protecting the defense at this time -- at this point,
11 Judge.

12 THE COURT: Well, I have every intention
13 of getting the judgment out before the 9th.

14 MS. KAMYKOWSKI: Thank you, Judge.

15 So we'll show that denied as moot at this
16 point.

17 THE COURT: Thank you.

18 Anything further for the record?

19 MS. SLATER: Not from plaintiffs, Your
20 Honor.

21 MS. KAMYKOWSKI: Not from defendants, Your
22 Honor.

23 THE COURT: Thank you very much.

24 MS. KAMYKOWSKI: Thank you.

25 MS. SLATER: Thank you.

(The proceedings were concluded at 9:57 a.m.)

o o o

Tuesday, May 20, 2025

Posttrial Motions

o o o

(At 9:33 a.m., the following proceedings were held in open court:)

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 Hospitals East Communities, Mercy Hospital St. Louis, Mercy Clinic East Communities d/b/a Mercy Clinic, Mercy OB/GYN, and Dr. Daniel McNeive, Cause No. 21SL-CC03944.

This matter is on the Court's docket this morning with regards to motions to enforce settlement, filed on behalf of plaintiff, as well as a joint motion filed on behalf of defendants.

we have had other motions and discussions about other motions that I believe are being addressed later this week, but other than that motion, is there anything else that we're dealing with today?

MS. SLATER: Your Honor, we had noticed

1 for hearing a motion to amend the judgment regarding
2 an interest calculation issue.

3 THE COURT: Okay.

4 MS. KAMYKOWSKI: And there's also a motion
5 to fix the supersedeas bond, Judge.

6 THE COURT: That's right. I did remember
7 that one.

8 All right. Shall we take the easy ones
9 first?

10 MS. SLATER: Sure.

11 MS. KAMYKOWSKI: Sure.

12 MR. PERRON: Sure.

13 THE COURT: Okay. The motion to amend
14 based on the interest calculation.

15 MS. SLATER: Sure.

16 Your Honor, we have filed a motion to
17 amend the May 9th amended judgment and submitted a
18 second amended judgment that has Exhibit A. In the
19 original amended judgment from May 9th, the interest
20 calculation is under calculated, and I have fixed
21 that interest calculation to be a future payments
22 interest calculation, as reflected in Exhibit A.

23 That reflects payments that are to start
24 this year, or May 31st, 2025, through 2079, which
25 total 55 payments, and I have not seen a response

1 filed to that, so I am hoping that that's unopposed.

2 THE COURT: Response?

3 MS. KAMYKOWSKI: We have no objection,
4 Your Honor.

5 MR. WILLMAN: No objection.

6 THE COURT: Okay. Then that will be
7 granted.

8 With regards to the motion for supersedeas
9 bond?

10 Mr. BRUSATI: May I approach, Your Honor?

11 THE COURT: You may.

12 MR. BRUSATI: Paul Brusati for defense.

13 We're just asking that the supersedeas
14 bond be set for the full amount of the judgment, plus
15 interest and \$10,000 in court costs. I think there
16 was a response filed by the plaintiff, but Rule
17 81.09(b) requires.

18 MS. SLATER: Your Honor, on behalf of
19 plaintiffs, the -- Rule 81.09 says that the bond
20 should be fixed on the judgment. The question here
21 of course is we have a judgment and an amended
22 judgment and now a second amended judgment, but for
23 all intents and purposes, the judgment on the verdict
24 and then the judgment as amended by the medical
25 malpractice statutory caps and future periodic

1 payments.

2 As know you, we have preserved argument on
3 the application of all of those statutory sections,
4 and we believe that, therefore, the bond should be
5 set at the amount of the verdict of 48.1 million.

6 The Rule 81.09(b) says that the bond
7 should be set, and it includes: To satisfy such
8 modification of the judgment and such cost and
9 damages as the appellate court may have judged an
10 award.

11 And, importantly, I want to note that in
12 the -- we've talked about the Kansas City v. Mercy
13 Hospital case that was tried last year against the
14 same defendants, of course with the exclusion of the
15 doctor here.

16 In that case, Mr. Brusati represented the
17 appellants, and a supersedeas bond was not entered at
18 the trial court level, and they asked the appellant
19 court to remand the case so Judge McLaughlin could
20 set the bond. They suggested and provided bond for
21 the full 10 million plus verdict in that case,
22 although they had the exact same situation here where
23 the \$10-plus million verdict was reduced by the caps.

24 So I am confused by the change in
25 providing a bond here, and we believe that that bond

1 should be set at the full verdict amount because
2 that's what we will have preserved to potentially
3 take up at the appellate level.

4 THE COURT: Thank you.

5 MR. BRUSATI: Your Honor, 81.09(b) is
6 clear, that the amount of the bond is the judgment
7 plus interest and costs. The first clause regarding
8 the bond -- what the bond is conditioned on, mentions
9 even damages for delay. I don't think that then
10 requires the Court to guess at what perhaps those
11 damages could be in calculating the bond. And so
12 Rule 81.09(b) the second sentence makes it clear,
13 judgment should be set -- the bond should be set at
14 judgment plus interest and costs, and that's what
15 we're asking for.

16 THE COURT: And did you provide the Court
17 with a specific amount that you believe is
18 appropriate?

19 MR. BRUSATI: We did. And I think that
20 may change, Your Honor, with the amended judgment.
21 we filed the papers, and I haven't -- I don't know if
22 they have accepted them on Case.net, so they may not
23 have gotten to you yet. But whatever the Court --
24 whatever the judgment the Court enters, we ask that
25 the bond be set at that.

1 THE COURT: So I would ask is that you
2 provide the court with a proposed bond amount on each
3 side, since yours doesn't necessarily, the 48
4 million, doesn't include the interest and costs
5 necessarily.

6 MS. SLATER: Right. Our court costs are
7 forthcoming, and those are over \$30,000, just as a
8 minor point.

9 THE COURT: Okay. Yeah. So by amending
10 the judgment again today, do we have an additional
11 30 days?

12 okay. So if you could provide me with
13 each of your side's proposed bonds by this Friday?

14 MS. SLATER: No problem.

15 MR. BRUSATI: Yes.

16 THE COURT: Okay. Then that will give me
17 into early next week, and I get that done the early
18 part of next week.

19 MR. BRUSATI: Sounds good.

20 MS. SLATER: Thank you, Your Honor.

21 MR. BRUSATI: Thank you, Your Honor.

22 THE COURT: Now that we've got the easy
23 stuff out of the way, I guess we should start with --
24 does it matter if we start with plaintiffs or start
25 with defendants? or should we do it all sort of in

tandem?

MS. GUNN: Your Honor, I'm prepared to begin. I believe ours was filed first.

THE COURT: That's fine.

MS. GUNN: Thank you.

THE COURT: You may proceed.

MS. GUNN: Thank you, Your Honor.

Promises made should be kept. If they aren't because one party has buyer's remorse, the Courts must order specific performance of those promises to protect the non-breaching party and the integrity of the process.

Despite the underlying claims in this case sounding a medical malpractice against nurses and a physician, resulting in a now 5-year-old child with brain damage, the issue before the Court today is one of contract law.

Contract law enforces the basic moral duty to keep promises. I had Professor Immel in law school as did Your Honor? Yes. And I learned largely through fear, which can be very motivating, that a contract consists of an offer, an acceptance of the offer, consideration, and a meeting of the minds. And that also, I took Immel for remedies, and there are so many remedies when a contract is found.

1 we are asking today for a specific
2 performance of the high-low agreement that was
3 enforceable, clear, and unambiguously developed on
4 the afternoon of March 25th, 2025.

5 Here, the defendants, in their first
6 sentence in their memo supporting their motion to
7 enforce, admit that on March 25th, 2025, the party
8 reached an enforceable high-low settlement of this
9 matter during the jury's deliberation following the
10 close of evidence and closing argument in the 11-day
11 trial.

12 Parties reached an enforceable high-low
13 agreement. We agree the material terms of the
14 high-low agreement were negotiated among the parties
15 by their counsel who had sufficient authority to do
16 so, and reduced to writing at 4:47 p.m., literally
17 recorded as heads were together, resulting in a
18 written instrument, a contract with four terms:
19 8 and 18, all the way to verdict, confidentiality to
20 high-low, and no non-disparagement.

21 Defendants do not argue that these terms
22 are ambiguous, nor have they argued that they're
23 unenforceable or confusing or lack definition.

24 Rather, they are imploring the Court to use an
25 inappropriate remedy of reformation or revision of

1 that contract to add non-negotiated, self-serving
2 material terms to the defendants' sole benefit after
3 they learned of the verdict.

4 The burden of proof in this situation to
5 enforce a motion to settle must -- the party must
6 prove the fact of the agreement, the fact of the
7 agreement, by clear, convincing, and satisfactory
8 evidence. We have done that.

9 The parties all agree to the facts of the
10 agreement. There's no dispute that there was an
11 agreement, and there are four terms to that
12 agreement. Plaintiff wishes to have the agreement as
13 negotiated and written enforced. The verdict was for
14 \$48.1 million, which is more than \$18 million.

15 There are three methods the courts in this
16 state have utilized when faced with a motion to
17 enforce the judgment:

18 You can have an evidentiary hearing, which
19 I believe all the parties agree is happening today, a
20 motion for judgment on the pleadings pursuant to
21 55.27, or a summary judgment motion pursuant to
22 74.04.

23 We're not engaging, I see no indication
24 that we're going with judgment on the pleadings,
25 which is 55.27, or summary judgment. So we're

1 engaging in an evidentiary hearing. And the standard
2 of review for an evidentiary hearing upon a motion to
3 enforce the settlement is discussed in our briefing,
4 and there's a few cases that are cited.

5 Specifically, St. Louis Union Station
6 Holdings, Incorporated, that says: Since a motion to
7 enforce settlement seeks specific performance, which
8 is an equitable remedy, appellate courts, quote, will
9 afford the trial court great deference in granting a
10 motion to enforce a settlement.

11 The appellate courts will defer to the
12 trial court's findings of fact, recognizing the
13 superior ability of the trial court to judge the
14 credibility of the witnesses. A reviewing court will
15 only set aside a judgement in this circumstance and
16 against the weight of the evidence and only upon a
17 firm belief that a trial court was wrong.

18 So what must the trial court look at in
19 determining whether there was an enforceable
20 agreement subject to specific performance?

21 We adopt the post-verdict record that was
22 made at our insistence after the jury announced their
23 punitive damage award. We've also found an affidavit
24 that Ms. Slater has signed, and if the Court will
25 certainly recall, Ms. Slater methodically and in

1 detail went through the afternoon documenting the
2 negotiations that had occurred.
3 Defense counsel was -- refused to make a
4 record at that time. She did answer questions of the
5 Court with respect to the high-low agreement, what it
6 said, and what the terms were. And we'll talk about
7 that. Mr. Willman, on behalf of Mercy Clinic and Dr.
8 McNeive, was silent.

9 So the time line -- and real quick -- the
10 Court may consider context, contemporaneous context.
11 Not things that happened two months before in letters
12 of settlement that were wholly and -- wholly
13 rejected, the context in the afternoon.

14 And so, Your Honor, I have developed a
15 time line, if I may. It's not -- it's demonstrative
16 only, if I may. I've got a couple of copies, as
17 well.

18 May I approach?

19 THE COURT: You may.

20 MS. GUNN: Thank you.

21 Your Honor, the source is noted there on
22 the -- what I've just handed you. It largely
23 consists of the record that was transcribed, as well
24 as some of the text messages between and among
25 defense counsel and the insurance company and the

1 client, and they're noted there.

2 So at 12:42, the jury is discharged to
3 deliberate. At 3:04 -- there was, I have to say, a
4 chalkboard request, pretty much as soon as they went
5 in, and I couldn't find that on the record, but I do
6 remember that.

7 At 3:04, there's a jury question, quote,
8 charts to see life care and expenses calculated by
9 all experts. And then at -- we discussed whether it
10 was appropriate for that. And then at 3:18, there
11 was a text from Ms. Kamykowski to Mr. Crawford, who I
12 believe is appearing via Webex today, and Anne
13 Rucker, who is a representative of the hospital, of
14 the system, informing Ms. Rucker that, quote, jury
15 just asked for the life care plan, cost tables, and
16 expenses for all parties.

17 I do have to note that in the defendants'
18 memo in support of their motion to enforce, there is
19 a notion in quotes taking about how the jury, in this
20 context, asked for the life tables, which is
21 incorrect. There was no request for any life tables,
22 it was the life care plan and the expenses, just for
23 clarification.

24 At 3:22, the question from the jury was:
25 calculator.

1 At 3:32, Mandy informed Joe Crawford and
2 Anne Rucker that they have now asked for a
3 calculator.

4 At 3:41, a text comes through to Ms.
5 kamykowski from Joe Crawford, again. Now we have an
6 affidavit from Mr. Crawford to indicate that he is a
7 consultant and works for MedPro. Basically my
8 understanding was, he was the insurance guy, he was
9 the money guy.

10 He tells Ms. Kamykowski, quote, I want to
11 go ahead and make the argument regarding 12 million
12 now versus periodic payments. That offer was
13 conveyed and rejected. That offer was conveyed to
14 Mr. Anyan, and it was rejected.

15 At 4:05 p.m., there -- excuse me --
16 there's a -- Ms. Rucker texted Ms. Kamykowski at
17 3:56 p.m.: Let me know when you have a few minutes.
18 And at 4:05 p.m., as the Court knows, there are
19 redactions to -- so this isn't a complete recitation
20 of those, only what was not redacted.

21 At 4:05, the jury had another question,
22 quote, I thought I saw a form on the projector during
23 trial that showed percentage nurses'/percentage
24 doctor's fault. I don't see that in our folder.

25 And this, as we discussed, is likely

1 referring to my PowerPoint slide where I showed the
2 jury the verdict form and suggested a 25 to the
3 nurses, 75 to the doctor apportionment of fault.

4 At 4:05, there was another question: Does
5 definition punitive damages include or equal all of
6 the moneys awarded, question mark.

7 At 4:20, that question was relayed from
8 Ms. Kamykowski to Mr. Crawford, quote -- the question
9 was: Do punitive damages include or equal all moneys
10 awarded?

11 And also Ms. Kamykowski texts Anne Rucker
12 at 4:20 and says, They're asking about punitives.

13 At 4:23, Ms. Rucker tells Ms. Kamykowski,
14 quote, we are okay with the high-low.

15 Not a high-low, not some amorphous
16 high-low, but the high-low.

17 what else is going on in this time frame?

18 After the \$12 million was rejected, plaintiff --
19 plaintiff went to the defense and offered a 10 and 20
20 high-low agreement: 10 being the low, 20 being the
21 high. That was a discussion. After more discussion,
22 ultimately the high-low numbers were 8 and 18, as
23 reflected in the text message from Ms. Slater at
24 4:47 p.m.

25 Now, at 4:23, this is explicit authority

1 from Mercy to enter into the high-low. There's going
2 to be argument later on that Ms. Kamykowski didn't
3 have authority to do it. This is explicit authority.

4 Then there's a discussion in the text
5 regarding the 10 and 20. And at 4:43, a text from
6 Mandy -- Ms. Kamykowski -- to Mr. Crawford: Verdict.
7 And I told them 8/18 was it.

8 At 4:47, Your Honor might remember the
9 bell had rung, the jury is in the hallway. We were
10 close to this number, and a discussion was had in the
11 hallway -- or somewhere -- excuse me.

12 And Ms. Kamykowski and Ms. Slater and
13 Mr. Willman, they literally had their heads together,
14 and Ms. Slater dictated the terms of the high-low
15 settlement agreement, those four terms that I
16 mentioned earlier: 8 and 18, all the way to verdict,
17 confidentiality as to high-low, and no
18 non-disparagement.

19 Those terms were clear. They were
20 negotiated together. There was a literal and
21 figurative meeting of the minds. That was texted.
22 That was read and received -- received and read by
23 Ms. Kamykowski. The verdict gets read at 4:56 in
24 open court, a \$28.1 million phase one award.

25 Now, in that same time frame that we're

1 all sitting in court waiting -- listening to the
2 verdict being read, there are texts between
3 Mr. Crawford and Ms. Kamykowski which are also
4 documented here.

5 And at 4:47, the same time that the
6 agreement was memorialized and read and received, Mr.
7 Crawford asks Ms. Kamykowski: Does the jury give a
8 puni number, or do they know more testimony is needed
9 regarding the puni phase?

10 There was no response to that immediately.
11 At 4:55, there was another text, it was redacted. I
12 don't know -- I see two Ls. I'm just putting my mind
13 together. Perhaps it said: Please call.

14 At 4:56, the Court accepts that jury
15 verdict, and at 4:58, Mr. Crawford again texts Ms.
16 Kamykowski and says: High-low for compensatory only,
17 extinguishes puni exposure. Please make that clear.
18 Thanks.

19 This is more than -- this is 12 minutes --
20 excuse me -- 11 minutes after the deal was done, and
21 Mr. Crawford is adding additional terms to a done
22 deal. Ms. Kamykowski texts back a minute later, yes,
23 another minute. Thanks. From Mr. Crawford.

24 Then we have another -- we have a closing
25 argument with respect to punitives. The jury goes

1 back, deliberates for another 40, 45 minutes or so,
2 has one more question about: Do we vote majority on
3 9/12? That was at 5:10.

4 And then there are texts between Ms.
5 Kamykowski and Ms. Rucker regarding, you know,
6 details of the 28.1 million. And at 5:59, the
7 punitive verdict was read in open court: \$20 million
8 as against Dr. McNeive and Mercy Clinic.

9 The jury was discharged at 6:01.

10 And at 6:15, or prior to 6:15, because it
11 was 6:15 when the record began. There was a sidebar.
12 At that point, Ms. Slater went to Ms. Kamykowski and
13 said, let's put this high-low settlement agreement on
14 the record. That was done. Ms. Slater announces a
15 settlement at \$18 million. Ms. Kamykowski disagrees.

16 The record ensues. Ms. Slater, as I
17 mentioned before, goes through the details of the
18 negotiations. And Ms. Kamykowski initially refuses
19 to make a record. The Court asks questions.

20 It's important to note the answers to
21 those questions. Specifically when asked about
22 understanding of a high-low agreement, Ms. Kamykowski
23 indicates -- excuse me -- she recites the terms of
24 the agreement. I don't -- there's two different
25 versions -- apologies -- of the record. I have

1 different numbers.

2 But essentially the question is the Court
3 asks: I'm a bit confused as to what you think a
4 high-low means.

5 Ms. Kamykowski says: So, Your Honor, I
6 have 8 to 18, all the way to verdict, confidentiality
7 to high-low, and no non-disparagement. She recites
8 accurately her understanding of the high-low
9 agreement, which not surprisingly, reflects the text
10 that Ms. Slater and Ms. Kamykowski developed
11 together. That's the agreement. That's the
12 contract.

13 And further, after Ms. Kamykowski
14 indicates that there's caps and compensatory damages
15 have to be reduce to the caps. There's a further --
16 there's further discussion about that. And the Court
17 asks Ms. Kamykowski whether specifically: And were
18 discussions with regards to the caps involved in this
19 settlement agreement at all?

20 Answer from Ms. Kamykowski: There was no
21 discussion of caps, Your Honor. No discussion of
22 caps.

23 And, yet, when we announce the verdict, a
24 \$48 million verdict, it settled pursuant to the
25 high-low agreement at 18, the hospital, the

1 defendants, whoever, backs out of it.

2 So what is really instructive, almost
3 surprisingly so, Your Honor, is there's a case in

4 Missouri that is very similar in facts and law. And
5 it's the Fiegenger case, Fiegenger v. Freeman-Oak Hill.

6 And, Your Honor, I have a copy of it. May
7 I approach?

8 THE COURT: You may.

9 MS. GUNN: You probably already have it.

10 And that case is from 1999, the Southern
11 District of Missouri. There was a lengthy trial,

12 similar underlying case: birth injury versus a

13 hospital, by and through the nurses, and a physician.

14 After the lengthy trial, the jury was
15 deliberating. All of the defendants offered a

16 high-low agreement of 1 and 4. It's very important

17 to note that that was on the record before the jury

18 came back.

19 And Your Honor will see that the
20 recitation of that, and it's on the second page of

21 the handout, it's 769, but the cite is

22 996 S.W.2d 767. And you'll see that Mr. Hyde, on

23 behalf of all defendants, and he was the hospital

24 defendant -- excuse me -- the hospital attorney. But

25 the doctor attorney was also there and the

1 plaintiffs' attorneys.

2 They go to the Court, and they get on
3 record, and they announce this high-low agreement of
4 1 and 4. Importantly, six times there's mention of
5 net judgment: net judgment of \$1 million, net
6 judgment against the defendants of over \$4 million,
7 and a net amount of the judgment to be enforced.

8 Plaintiffs' counsel -- there's discussion
9 about periodic payments on the record. There's a
10 discussion about whether there's a trust that needs
11 to be implemented.

12 Mr. Fischer, who is the plaintiffs'
13 counsel says: And just for the record, we're talking
14 about net judgment, after the application of any
15 applicable caps there might be by Missouri law.

16 It's also important to note, Your Honor,
17 that noneconomic caps were first instituted by
18 legislature in 1986. So in 1999, that's the -- those
19 are the caps that they're talking about which were
20 clearly discussed in this settlement agreement.

21 Mr. Hyde says: Yeah. Chapter 538, you
22 are correct.

23 what happens next in this case is that
24 the, after that goes on the record, I don't know, 11
25 minutes later or so, the hospital's attorney, Mr.

Hyde, comes back, and he says -- he makes a unilateral statement on the record basically saying: Hey, between the hospital and the doctor, we're talking about who's going to do that apportionment of fault.

And then 2 minutes later, the jury verdict is announced, and the jury verdict is 1.35, essentially. The doctor had a million dollars in coverage. So now we've got \$350,000 with a doctor who is uncovered for \$350 million -- excuse me -- \$350,000. And the hospital backed out of that deal. And, interestingly, the doctor and the plaintiffs filed a motion to enforce the settlement.

The trial court allowed discovery, depositions, whatnot, finally the trial court decides, you know, I just can't figure it out. I don't see a meeting of the minds, everybody is saying different things. And the court of appeals reverses. And the court of appeals says that: In Missouri, courts look to the parties' objective manifestations of intent to determine whether there was a meeting of the minds.

A person's subjective intent is irrelevant. What someone meant to say or thought they said or thought about afterward is irrelevant.

1 Courts seek to ascertain the intent of the parties by
2 giving to the language its natural, ordinary, and
3 common sense meaning, but they also look to the
4 entire contract.

5 Importantly, courts can look at collateral
6 facts and circumstances to aid in interpreting the
7 contract, but such facts cannot cause the Court to
8 read into the contract something it does not say.

9 The defendants are imploring the Court to
10 add material terms to this contract, including caps,
11 application of statutory caps, recoverable
12 compensatory amounts. The Court is being asked to
13 rewrite this contract in a way that waives punitive
14 damages from this party. That waives punitive
15 damages. That is what the defense is asking the
16 Court to do.

17 Now, the court of appeals goes on to say
18 in Fiegenger that our job is to decide what the
19 parties intended by what they said. And we cannot
20 be concerned with what they may have subjectively
21 intended to say. The unilateral act of supplementing
22 the record cannot alter the terms of the contract
23 entered into earlier.

24 You cannot come back later and say, whoa,
25 I know this is clear. Remember, they believe there's

1 an enforceable high-low agreement here. You cannot
2 come back later and say, but it's what I think it
3 says, when I had every opportunity to be clear about
4 it in the written instrument.

5 The Court says: At best Hyde -- who's the
6 lawyer for the hospital -- at best, the hospital's
7 lawyer's actions belatedly revealed the subjective
8 intent of the client.

9 How do we know that's what happened here?
10 Look at the text from Mr. Crawford to Ms. Kamykowski.
11 Subjective after the deal was done. He's asking
12 about: High-low for compensatory only extinguishes
13 punitive exposure. Please make that clear. The deal was
14 done. This is subjective intent.

15 That cannot be considered. The court of
16 appeals in Fiegenger says: We must consider what the
17 parties to the contract actually said and not what
18 the hospital defendants secretly intended or what
19 they might have said if they had decided to further
20 explain their intentions.

21 And in that case, the court of appeals
22 directed the trial court to enter a judgment of
23 specific performance and made the hospital pay the
24 additional approximately \$350,000.

25 So what else happened? Well, what's

1 interesting about Fiegenger is that Mr. Hyde, when up
2 even before the jury got back, and said, Hey, I need
3 to clarify who's going to split this fault.

4 And even in that situation, the court of
5 appeals says: This is a unilateral alteration of an
6 already agreed to contract. And you can't do it.

7 But what happens here? The jury awards
8 \$28.1 million. We closed the case in punitives. The
9 jury goes back for another, you know, 50 minutes or
10 so. If it was truly settled with all of terms that
11 the defendants believe, that the compensatory award
12 only, punitives were waived, that there was the
13 application of statutory caps, why on earth didn't
14 the defendant run up to the Court and announce this
15 settlement on the record?

16 \$8.4 million after a \$28.1 million verdict
17 when the jury's deliberating on punitives? Nothing.

18 They did nothing. And when the time came to announce
19 it, as it was truly part of the deal, as the deal was
20 clearly written, as we did, to inform the Court after
21 we went all the way to verdict, which was part of the
22 deal, they backed out or refused to make a record.

23 The contemporaneous context is important. The Court
24 was here for that.

25 Now, what can the Court consider? The

1 Court is allowed to -- and this is Good Hope
2 Missionary Baptist Church v. St. Louis Alarm
3 Monitoring, 306 S.W.3d 185, Eastern District of
4 Missouri 2010: where a settlement agreement is
5 unambiguous and complete, it must be enforced as
6 written. Defendants agree. Enforceable high-low
7 agreement. They just want you to believe -- they
8 want you to -- well, I'll keep going.

9 Even if a term, phrase, or entire contract
10 is unambiguous, some extrinsic evidence may be needed
11 to interpret rather than construe the contract or the
12 terms.

13 So I had to look up the difference between
14 interpret and construe. Interpret means to explain
15 the meaning of something. Explain what car means.
16 Explain what 8 means. Explain what verdict means.

17 Construe is to interpret a word in a
18 particular way. Add construction to it. The Court
19 is clear: Some extrinsic evidence may be used to
20 interpret rather than construe the contract or its
21 terms.

22 The defense asked you to construe words
23 that don't exist in this agreement, important
24 material terms, such as waiving a punitive damage
25 award, abandoning a punitive damage award,

1 application of statutory caps, recoverable
2 compensatory. None of that was part of this
3 agreement. It is buyer's remorse. They looked at
4 the verdict, they looked at the compensatory amount
5 and said, wait a minute, we're looking at 8.4.

6 And that's what they're trying to do. To
7 ask the Court to rewrite two key terms that didn't
8 exist at the time. Not just one, not just
9 interpreting the word, but construing and rewriting
10 it, number one. Adding words such as "net verdict,
11 net judgment," all the things that the Fiegenger
12 lawyers put on the record, which was clearly part of
13 that.

14 And all the way to verdict is a very clear
15 term of the agreement. Somehow you're being asked to
16 construe that to mean waiving punitive damages? Your
17 Honor was around the many times we argued and fought
18 for a submission of punitive damages, and we're just
19 going to waive it?

20 Good Hope goes on to say: According to
21 Missouri law, the Court's role is to determine the
22 intention and manifested not by what the parties now
23 say they intended, but by the document. In that
24 inquiry, however, the Court is justified in
25 considering more than just mere words of the

1 contract.

2 The surrounding circumstances at the time
3 of contracting, and the positions and actions of the
4 parties are relevant to the judicial interpretation
5 of the contract.

6 At the time of contracting, defendants
7 asked you to consider a letter they sent in February,
8 which, again, was wholly rejected as part of the
9 contemporaneous negotiations? Buyer's remorse.

10 There has to be meaning to the law of contract.

11 And it cannot be changed post hoc, when
12 one party believes that they're going to be better
13 without the contract. Here, it would be similar to
14 saying it's simple: I have a car to sell you for
15 \$10,000. I'll bring it tomorrow. A deal. We have
16 it. Write it down: car, 10K, tomorrow. I bring you
17 my car tomorrow.

18 In the meantime, you found a car, the same
19 car, you like it. You get it for \$9,000 from
20 somebody else. So suddenly what you decide to do is
21 say, no, no, I didn't mean car. I know the word says
22 car, but I meant truck. So I'm going to create
23 different meanings after the fact and say I need a
24 truck. And then somehow void the initial deal
25 because you got a better deal in the meantime?

1 That's not the point of an enforceable contract.

2 That's the point of rule of law.

3 There are a couple other issues. Again,
4 the waiver of punitive damages. I mean, I don't,

5 when the contract says, all the way to verdict, and
6 the contract does not say plaintiffs are waiving

7 their punitive claims, I know there was some

8 discussion on the record about the -- how a punitive
9 payment -- that none of the settlement money will be

10 considered as a punitive payment. And this is an
11 important distinction.

12 Because a punitive payment is treated a

13 lot differently. There are tax consequences for the

14 plaintiffs. There are policy issues that I assume

15 come up with the insurance company, which, by the

16 way, plaintiffs weren't even aware there was punitive

17 policies. Those weren't provided and discussed. We

18 got them after the Court ordered them after the fact

19 that weren't even policies that covered punitive

20 damages in that case or other cases.

21 So there is an agreed upon idea. It was

22 very clearly discussed on the record by Ms. Slater

23 that at no point was the high-low agreement, the

24 settlement, going to pay for a punitive claim.

25 That's common. No case settles with an

1 agreement to pay for punitives. That is not the
2 same -- the defendants want to conflate that -- that
3 is not the same as waiving punitive claims in terms
4 of a high-low agreement where the clear term of the
5 agreement is all the way to verdict.

6 But, again, that's part two. You first
7 have to believe that the deal included -- that we had
8 agreed somehow to a net verdict versus -- versus the
9 full 28.1 or the full compensatory award without
10 regards to net or application of the caps.

11 The third issue, Your Honor, is
12 authority -- or I guess that's the second issue. So
13 Mr. Crawford's affidavit is not referenced in terms
14 of the defendants' agreement -- or the defendants' --
15 defendants' argument that there is an enforceable
16 agreement, it's just at 8.4, not at 18. That's
17 argument one.

18 In the alternative, they offer
19 Mr. Crawford's affidavit. And in that, Mr. Crawford
20 speaks for paragraphs about his understanding of
21 things and how he has worked on high-low agreements
22 and how there were discussions months ago about
23 application of caps. And if, alternatively, if -- if
24 the Court is inclined to read the contract as it's
25 written, then Ms. Kamykowski or whoever they were

1 talking to didn't have authority. Didn't have
2 authority.

3 So in Eaton v. Mallinckrodt, which is in
4 our briefing, Your Honor, holds that expressed
5 authority to settle is presumed where the attorney of
6 record asserts such authority. There's no question
7 that Ms. Kamykowski was negotiating on behalf of all
8 defendants that day.

9 To come back -- and, in fact, remember
10 that Anne Rucker, 24 minutes before the text message
11 was sent of the contract, says, we are okay with the
12 high-low. So the client, not the insurance company,
13 but the client, is clearly giving authority for entry
14 into the high-low agreement.

15 Moreover, only a party can dispute the
16 authority of the attorneys. Mr. Crawford's not the
17 party. MedPro's not the party. The party is the
18 hospital, Dr. McNeive, and Mercy Clinic.

19 Eaton goes on to say the presumption, so
20 you're presumed to have authority. If you entered
21 your appearance, and you're negotiating on behalf of
22 a party, that is authority. You don't get to come
23 back later, where would that end? Oh, no, my
24 attorney didn't have authority. Oh, okay, no deal.
25 I mean, we'd never settle anything.

1 The presumption may be overcome by the
2 party disputing the attorneys' authority. Although
3 that party bears a substantial burden of proof. I've
4 seen no evidence from Mercy, McNeive, Mercy Clinic
5 that their attorneys didn't have authority, only from
6 Mr. Crawford. There was authority to settle this
7 case under the four terms as negotiated and written
8 down.

9 Now, the third argument defendants made is
10 that we breached first. So we're back -- in the
11 third argument, we're back to an enforceable
12 agreement. The second argument regarding authority,
13 means there was no meeting of the minds, and there is
14 no settlement.

15 So for the third argument, we are back to
16 the plaintiff breached first. We're back to an
17 enforceable agreement, but you broke it first. So,
18 remember, the two other terms of the agreement: no
19 non-disparagement, meaning there's no limit on what
20 you can say. There's a verdict. Say what you want
21 to say in open court. No non-disparagement.

22 So they were in the weeds about things.
23 Plenty of time to say, oh, I mean net verdict. I
24 mean compensatory only. I mean this. I mean that.
25 No non-disparagement and confidentiality as to the

1 high-low, meaning that you can't tell anybody that we
2 settled. Those are the terms.
3 So the defendants point out in their third
4 argument that I breached it because I had a quote in
5 the newspaper. So what's curious about that, Your
6 Honor, is there's no remedy requested for my alleged
7 breach. I breached first. Well, truly, if I
8 breach -- if they believe that I breached the
9 agreement, then file that and ask for relief. What
10 is the request for relief? What is the remedy for
11 that breach? There's not one. It's just a shot at
12 me, fine. I can handle it.

13 So, Your Honor, what we have is an
14 enforceable high-low agreement with clear terms: 8
15 and 18, all the way to verdict, confidentiality to
16 high-low, and no non-disparagement. They were clear,
17 enforceable, unambiguous, taken in context.
18 Miscellaneous context, at the time of contracting,
19 requires specific performance that in light of a
20 \$48.1 million verdict, which is more than 18, that
21 the defendants should be ordered to pay 18 million.

22 Thank you.

23 THE COURT: Thank you.

24 Before I switch it over, can we take just,
25 like, a 5-minute recess to have a restroom break?

MS. GUNN: Absolutely.

(The Court stood in recess from 10:24 a.m. to 10:33 a.m.)

THE COURT: On behalf of the defendants, I apologize.

MR. PERRON: Your Honor, first, my understanding is that plaintiff has rest -- rested, is that correct?

MS. GUNN: I'm complete. My argument is currently complete.

MR. PERRON: Okay.

Your Honor, just, we will be calling witnesses. My understanding from plaintiffs' counsel and from what plaintiff has presented, that plaintiff has presented no evidence for the Court to consider at this evidentiary hearing.

Defendants will call Mr. Joseph Crawford as our first witness.

THE COURT: Mr. Crawford, can you hear us? Mr. Crawford can you hear us? Mr. Crawford, can you hear? Mr. Crawford can you hear us? We are having a very difficult time hearing you.

Is the volume turned up all the way?

Mr. Crawford, can you say something?

Mr. Crawford, can you say something again?

1 Mr. Crawford can you say something? Mr. Crawford,

2 can you say something again?

3 THE WITNESS: Yes. Good morning.

4 THE COURT: Thank you.

5 So, Mr. Crawford, I'm going to ask you to
6 raise your right hand.

7 JOSEPH CRAWFORD,
8 having been duly sworn, was examined, and testified
9 via Webex as follows:

10 DIRECT EXAMINATION

11 BY MR. PERRON:

12 Q. I don't know if you can see me. It
13 probably isn't important for you to see me. But if
14 you can hear me okay, just let me know. And if you
15 can't hear one of my questions, just let me know.

16 would you identify yourself for the court?

17 A. I'm Joe Crawford. I'm a claims consultant
18 for MedPro.

19 Q. were you the claims consultant handling a
20 lawsuit on behalf of Mercy Health, which includes
21 Mercy Hospital East Communities, Mercy Clinics and
22 their employees, as a layer of excess coverage?

23 A. Yes. Yes.

24 Q. And what was your understanding of the
25 limits of this excess coverage?

1 A. Our limits are \$10 million.

2 THE COURT REPORTER: I'm sorry. I didn't
3 understand what he said.

4 Q. (By Mr. Perron) would you say that one
5 more time, Mr. Crawford?

6 A. Our limits are \$10 million.

7 Q. And if you could explain how this excess
8 coverage stacked within the larger tower of coverage,
9 as you understood it.

10 A. Mercy has a \$10 million SIR which is
11 eroded by Dr. McNeive and the clinic's 1 million plus
12 1 million. And then the \$10 million of MedPro's
13 first excess layer sits on top of that \$10 million.
14 There's also excess coverage above us.

15 Q. To what extent might such excess coverage
16 that you had authority over be triggered, either in
17 settlement negotiations or by a verdict?

18 A. Our coverage is triggered if Mercy tenders
19 their remaining SIR to us, or if any compensatory
20 verdict, it's above their -- above their limits.

21 Q. So, in other words, if Mercy -- if there's
22 a verdict between 10 and 20 million, that's when your
23 policy would come in?

24 A. That is correct.

25 Q. Or if there was a settlement agreement or

1 a settlement being negotiated in excess of 10 but
2 less than 20, that's when your policy would kick in?

3 A. Yes. Correct.

4 Q. Okay. On or about March 25, 2025, did you
5 become aware that the jury was deliberating in this
6 case? The Anyan case?

7 A. Yes.

8 Q. Did you become aware of juror questions
9 indicating they were debating the issue of damages?

10 A. Yes.

11 Q. Did you have an understanding what this
12 might indicate in terms of whether a plaintiff or
13 defendants' verdict was likely?

14 A. Yes. It oftentimes means a plaintiff
15 verdict is likely.

16 Q. Did you become aware whether the jury had
17 requested information about the future medical
18 expenses or life care plan as proposed by the
19 defense, as well as the plaintiff?

20 A. Yes --

21 MS. GUNN: Your Honor, I am going to
22 object to the leading nature of the questions.

23 THE COURT: why don't you ask a
24 non-leading question.

25 MR. PERRON: Okay. I guess my question

1 was if he became aware.

2 Q. (By Mr. Perron) Was it conveyed to you
3 whether or not the jury was asking questions related
4 to the life care plans proposed by plaintiff and
5 defendants?

6 A. Yes, I knew that.

7 Q. Based on that communication with defense
8 counsel and your own experience, did you form an
9 opinion about the likely range of the award for
10 future medical expenses?

11 MS. GUNN: Same objection.

12 THE COURT: Overruled.

13 THE WITNESS: So I can answer, correct?

14 Q. (By Mr. Perron) Yes.

15 A. The expectation would be somewhere between
16 6 and a half million and 25 million.

17 Q. Did you have an understanding of the
18 likely range of the full compensatory award,
19 considering this possible range of future medical
20 damages?

21 A. Yes. Again, between 6 and a half million
22 and 25 million.

23 Q. Did you have an understanding of the
24 Missouri cap on noneconomic damages and how they
25 would apply to any award of noneconomic damages in

this case?

A. Yes. I believe the noneconomic cap was about 846,000.

Q. Did this understanding about the cap inform your understanding about the possible range of verdict and case value?

A. Yes.

Q. Did this understanding about the cap and how it affected the possible verdict range in case value inform your decision making on possible settlement offers?

A. Yes.

Q. Did you authorize a settlement offer while the jury was still deliberating the verdict?

A. Yes.

Q. What was that offer?

A. \$12 million.

Q. Did you relay any further message to counsel regarding the settlement, if accepted, with regards to extinguishing plaintiffs' pending claims, including claims for punitive damages?

A. Yes. It would be with the same terms that were outlined in the early February letter prior to mediation, as well as extinguishing all punitive damages claims with no payment for punitives.

1 Q. were your communications with counsel
2 during this time restricted to just text messages?
3 Or were there phone calls?

4 A. No, there were phone calls.

5 Q. Okay. was the \$12 million offer accepted?

6 A. It was not.

7 Q. Did you come to an understanding from
8 defense counsel whether plaintiff made a
9 counterdemand to the \$12 million offer?

10 A. Yes. Their counterdemand was a 10
11 million/20 million high-low.

12 Q. Leading up to March 25, had you become
13 informed about settlement negotiations up to the
14 point of trial and throughout trial?

15 A. I'm sorry. Could you please repeat that?

16 Q. Yes. Leading up to March 25, had you
17 become informed about settlement negotiations up to
18 that point?

19 A. Yes.

20 Q. To your understanding, had defense counsel
21 highlighted the case value with regards to
22 compensatory damages throughout negotiations, in
23 particular, the application of the cap on noneconomic
24 damages?

25 A. Yes.

1 MR. PERRON: Your Honor, at this time, I
2 would like to introduce what defendants had marked as
3 Exhibit A in their memo in support of the motion to
4 enforce. This is a letter dated February 7, 2025.

5 Q. (By Mr. Perron) Mr. Crawford, had you
6 reviewed the February 7, 2025, offer letter?

7 A. Yes.

8 Q. Does that letter accurately describe your
9 understanding of the defendants' framing of
10 settlement negotiations, specifically with regards to
11 the reasonable expectation of recovery of any
12 verdict?

13 A. Yes, it does.

14 Q. Does the value of the recoverable amount
15 typically form the basis of how you value a case for
16 purposes of settlement?

17 A. It always does.

18 Q. Were you made aware, prior to March 25,
19 whether plaintiff had made representations as to
20 their own estimation of their best day on
21 compensatory damages?

22 MS. GUNN: Object to form. Calls for
23 speculation.

24 THE COURT: Overruled.

25 THE WITNESS: Yes, I was.

1 Q. (By Mr. Perron) What was your
2 understanding, from defense counsel, of plaintiffs'
3 own estimation of their best day on compensatory
4 damages?

5 MS. GUNN: Object to form. Calls us for
6 hearsay.

7 MR. PERRON: This is forming the basis of
8 his consideration in terms of settlement value and
9 how he later interpreted, later communications from
10 plaintiff. This is talking about the context of what
11 was in his mind. Talking about meeting of the minds.
12 His understanding of the context of negotiations up
13 to the point of March 25.

14 THE COURT: He can speak as to what he
15 thought, but there is hearsay.

16 MR. PERRON: Okay.

17 Q. (By Mr. Perron) Joe, did you have an
18 understanding of what plaintiffs' belief was as to
19 their best day on compensatory damages?

20 A. Yes. Close to 25 million.

21 Q. Okay. Did that belief that their best day
22 in court was approximately in the range of 25
23 million, considering the upper limits of plaintiffs'
24 claims for future medical expenses, hold any
25 significance to you in how you considered the

1 settlement value of the case?

2 A. Yes, it did.

3 Q. In general, how does a plaintiff's,
4 quote/unquote, best day, impact your value of what
5 the value of the case is?

6 MS. GUNN: Judge, we object to the
7 relevance at this point of this witness's testimony.
8 I probably should have objected earlier, but I am
9 asserting it now.

10 THE COURT: The Court is going to overrule
11 the objection.

12 Q. (By Mr. Perron) Go ahead, Joe.

13 A. Well, yes. It's a part of the evaluation
14 as far as the, number one, what they think the best
15 day is, as well as what the evidence presents, as
16 well, and what the defense's evidence is.

17 Q. And so skip back in time in terms of the
18 chronology on March 25, the jury is still
19 deliberating. They've been asking questions. Like
20 you said before, but just to reiterate, did you come
21 to understand that in response to our 12 million
22 offer, plaintiff had made a counterdemand of a
23 high-low?

24 A. Yes. And that was 10 million/20 million.

25 Q. Okay. Were you surprised that plaintiffs'

1 high mark in their counterdemand was set at 20
2 million within the context of the negotiations up to
3 this point?

4 A. Surprised? Maybe a little bit.

5 Q. Did it seem reasonably aligned with the
6 previous representations of plaintiffs' estimation of
7 the high end of their possible recoverable damages?

8 A. Reasonably aligned, yes.

9 Q. Have you negotiated high-low agreements in
10 the past as part of your duties as a claims
11 specialist?

12 A. Many times.

13 Q. In your experience with other high-low
14 agreements, have you interpreted the high of those
15 agreements to be triggered by jury awards beyond what
16 might be possibly collected after adjustments or
17 amendments of the judgment to conform with
18 controlling state law?

19 A. No. The high is not triggered by a jury
20 award. You have to take into account recoverable
21 amounts and application accounts.

22 Q. Are high-low agreements, in your
23 experience, interpreted to be applicable to the
24 recoverable amount?

25 A. They are only applicable to the

1 recoverable amount.

2 Q. In your experience, would a noneconomic
3 award beyond a state cap, trigger a high limit on a
4 high-low agreement?

5 A. It does not.

6 Q. Why?

7 A. Well, attorneys and insurance people only
8 negotiate in terms of recoverable amounts, and that
9 is the vehicle that the high-low addresses.

10 Q. Not just in your text messages, but
11 throughout your communication with counsel, did you
12 make it clear that you wanted the punitive damages
13 extinguished, claim for punitive damages,
14 extinguished, from any high-low agreement?

15 A. Yes.

16 Q. Would there be any incentive, based on
17 your experience in understanding the high-low
18 agreements, for a defendant to agree to a settlement
19 amount or range of amounts, beyond what the plaintiff
20 could ultimately recover or otherwise collect?

21 A. No, there would not be.

22 Q. Did you grant authority to defense counsel
23 for Mercy Clinic or Mercy Hospital to agree or offer
24 any high-low agreement according to the terms
25 suggested in plaintiffs' motion to enforce, but in

particular triggering the high with an unadjusted noneconomic award?

A. No, I did not.

Q. Did you grant authority to defense counsel or Mercy Hospital or Mercy Clinic to agree to a high-low agreement where the high could be triggered by a punitive damages award?

A. No, I did not.

Q. would you have ever agreed to grant authority on such terms in this particular case?

A. No, sir.

Q. Did you have an understanding as to the terms of the high-low agreement that you were granting authority to offer and then agree to?

A. Yes.

Q. What were those terms, specifically with regards to whether the adjusted compensatory verdict or the unadjusted compensatory verdict would control the high-low?

A. The adjusted compensatory verdict would control the high-low.

Q. Did you make it clear to the defense counsel that the high-low agreement would be on compensatory damages only?

A. Correct.

1 Q. In your mind, did your understanding of
2 the compensatory award include an unadjusted award
3 for pain and suffering beyond the statutory caps and
4 beyond what plaintiff would ever be able to recover?

5 A. No.

6 Q. Did you have an understanding that
7 plaintiffs' counsel would not publish the names of
8 Mercy or Dr. McNeive as part of any communication to
9 the press about the verdict?

10 A. Yes, I did.

11 Q. What was that understanding?

12 A. It's that the plaintiffs -- the plaintiffs
13 would not.

14 Q. Did you have any concern that Mr. or
15 Mrs. Anyan would not be gagged, especially in light
16 of their testimony about Dr. McNeive?

17 A. No. Because there was no disparaging
18 testimony offered at trial.

19 Q. Did anyone else other than you have the
20 authority to consent to a high-low agreement that
21 would include any amount beyond Mercy's primary
22 coverage up to 10 million?

23 A. No.

24 Q. Did you hold that sole authority, at least
25 between 10 million and 20?

1 A. Yes.

2 Q. Did you grant authority to counsel for
3 defendants to offer or agree to a high-low agreement
4 under the terms suggested in plaintiffs' motion to
5 enforce?

6 A. No.

7 Q. Specifically would you ever, in similar
8 circumstances, grant authority to agree to a high-low
9 agreement where the high might be reached with
10 nonrecoverable damages beyond the statutory caps?

11 A. No, sir.

12 Q. Why?

13 A. Because high-low agreements only consider
14 principal recoverable amounts.

15 Q. Based on your communication with defense
16 counsel, do you believe they had the same
17 understanding of the essential terms of the high-low
18 agreement?

19 MS. GUNN: Object to form. Calls for
20 speculation.

21 THE COURT: Overruled.

22 A. Yes. Yes.

23 Q. (By Mr. Perron) Is there any question, in
24 your mind at least, whether -- sorry. Is there any
25 question in your mind, at least, whether this term

1 was essential to understanding the high-low
2 agreement?

3 A. Yes. There was no question.

4 Q. Did you believe that understanding the
5 trigger for the high-low agreement was an essential
6 part of the high-low agreement?

7 A. I'm sorry. Could you please repeat that?

8 Q. Sorry. The -- in your opinion, was the
9 trigger, what the actual trigger was, for the
10 high-low agreement, an essential part of the high-low
11 agreement?

12 A. Yes.

13 Q. Did you become aware of a disagreement
14 between the parties as to the specific terms of the
15 high-low agreement?

16 A. Yes.

17 Q. When did you become aware?

18 A. When?

19 Q. Not an exact time, but in the general
20 chronology.

21 A. I mean, after the verdict sometime that
22 evening, I believe. I honestly don't remember when.
23 I would have to go back and look at my notes to
24 determine when.

25 Q. Okay. After the final verdict was read on

1 March 25, was there a discussion whether to make an
2 offer to resolve the claim at 18 million?

3 A. No.

4 Q. would that have been a new offer distinct
5 from the high-low agreement?

6 A. Yes, it would have been.

7 Q. Did counsel for Mercy Hospital or Mercy
8 Clinic ultimately have any authority to agree to a
9 high-low settlement that would be controlled by the
10 unadjusted award for noneconomic damages or punitive
11 damages?

12 A. No, sir.

13 MR. PERRON: Those are my questions, Your
14 Honor.

15 THE COURT: Anything else on behalf of the
16 defense?

17 MS. PFIRMAN: No, Your Honor.

18 MS. KAMYKOWSKI: with this witness? No.
19 we have -- with this witness, no.

20 THE COURT: Cross-examination?

21 CROSS-EXAMINATION

22 BY MS. GUNN:

23 Q. Good morning, Mr. Crawford. I'm Amy Gunn.
24 It's a pleasure to see you.

25 A. Good morning.

1 Q. who wrote the affidavit that has been
2 submitted?

3 A. who wrote it? I collaborated with Mandy
4 regarding my recollections about what's contained in
5 the affidavit.

6 Q. So who wrote it, sir?

7 A. who wrote it? Again, I collaborated with
8 Mandy, and she put it to paper, based on my
9 recollections.

10 Q. So that was based on a telephone call that
11 you had with Ms. Kamykowski recently?

12 A. well, phone calls and emails, yes.

13 Q. And is she your lawyer?

14 A. Is she my lawyer?

15 Q. Yes.

16 A. No.

17 Q. Do you have a lawyer representing you here
18 today, sir?

19 A. I do not.

20 Q. So what did you and Ms. Kamykowski talk
21 about with respect to put this affidavit together for
22 this proceeding?

23 A. It may be needed -- it may be needed to
24 help address the facts regarding the high-low
25 agreement.

1 Q. Are there emails between the two of you
2 regarding this affidavit, as well?

3 MR. PERRON: Your Honor, I'm going to
4 object for the record. It's still insurer-insured
5 and attorney-client privilege. There were limited
6 exceptions made for communications made at the time
7 of the settlement agreement, but we don't believe
8 that we have waived any such later privilege to do
9 with developing defenses subsequent to the
10 discussions leading up to and immediately after the
11 high-low agreement.

12 THE COURT: I'm not sure I understand what
13 you mean by "developing defenses."

14 MR. PERRON: Well, Your Honor, regardless
15 of what we talked about, we're raising -- we're
16 asserting privilege -- we are asserting privilege for
17 anything outside of the scope of what the Court has,
18 in a limited way, allowed discovery on, which was, I
19 think, communication, between attorney and clients, I
20 think between, what was it? 4:00 p.m. or noon or
21 March 25, up to 8:00 p.m., March 25. And outside of
22 the scope of that, I think there's still an unwaived
23 privilege.

24 THE COURT: which privilege are you
25 relying on?

1 MR. PERRON: Attorney-client and insurer-
2 insured.

3 THE COURT: well, he's already testified
4 that she's not his attorney, so attorney-client would
5 not apply.

6 MR. PERRON: Insured -- we represent the
7 insured; he represents the insurance company, so us
8 speaking on behalf of the insured, the
9 insurer-insured privilege.

10 THE COURT: Response?

11 MS. GUNN: I think any alleged privilege
12 has been waived by the presentation of Mr. Crawford
13 in this proceeding today. It is not a
14 pick-and-choose with respect to what you want -- what
15 they want Mr. Crawford to say to support their
16 defenses that they are developing, versus a waiver of
17 those -- that alleged privilege based on the facts
18 that we are here today discussing what happened in
19 the time frame and thereafter.

20 MR. PERRON: There are very specific
21 elements that are now relevant because we're
22 contesting the motion to enforce. Specifically
23 authority is a defense to a motion to enforce.
24 Mr. Crawford is testifying as to those specific
25 elements that are relevant to the motion to enforce.

1 That is not a waiver of all communications that are
2 otherwise privileged between the insurer and the
3 insured.

4 THE COURT: I don't disagree that that
5 doesn't open the door to all communication, but I
6 think any communication specifically regards to the
7 motion to enforce and any defenses to the motion to
8 enforce, which is a bit confusing since you're also
9 filing a motion to enforce. So to defend against it
10 and say there is no motion -- there was no statement
11 but there is a settlement, the court is going to
12 allow counsel to inquire into those communications.

13 Q. (By Ms. Gunn) Mr. Crawford, do you recall
14 the question?

15 A. I do not.

16 Q. I'm interested in the conversations that
17 you've had with Ms. Kamykowski regarding the
18 affidavit that was presented as support of the motion
19 to enforce the settlement.

20 A. I understand.

21 Q. Can you tell us what those communications
22 have been?

23 A. They were largely over the phone regarding
24 the facts.

25 Q. And when did they start?

1 A. when did the facts start or the
2 conversation?

3 MS. GUNN: Your Honor -- excuse me.

4 Q. (By Ms. Gunn) Sir, I'm talking about the
5 facts -- I'm asking about conversations that you had
6 with Ms. Kamykowski when it was determined that the
7 motion to enforce -- well, when it was determined
8 that the settlement, as dictated and agreed upon by
9 the defendants, was not going to be honored. When
10 did those discussions start?

11 MR. PERRON: Object to the form of the
12 question. Phrasing it as not honored, especially
13 based on Mr. Crawford's testimony.

14 Mr. Crawford, if you understand, you can
15 answer.

16 A. It was a bit convoluted. But
17 conversations regarding the need for an affidavit, is
18 that the question?

19 Q. (By Ms. Gunn) Let's start, sir, with what
20 you told us a moment ago, is after the verdict, it
21 sounds like you got a phone call from somebody. Who
22 was that from?

23 A. After the verdict, I got a phone call from
24 Mandy advising me of the verdict.

25 Q. And what did she tell you?

1 A. She told me what the verdict was.

2 Q. which was?

3 A. I don't remember -- recall the exact
4 numbers. But I would have to look at my notes to see
5 what -- off the top of my head, I don't know what the
6 verdict was right now. I can look it up if you need
7 me to.

8 Q. You don't remember, as we sit here today,
9 and then the testimony that you're giving about this
10 case, what the verdict was?

11 A. I -- I -- I generally know what it was,
12 but, I mean, I can't exactly tell you.

13 Q. Do you know what the compensatory award
14 was versus the punitive award?

15 A. Again, I would have to look at my notes to
16 figure out exactly the amount.

17 Q. what notes are you talking about?

18 A. My notes in my file.

19 Q. when did those notes start?

20 A. when did my notes in my file start?

21 Q. Yes, sir.

22 A. After the ver -- you mean before the
23 verdict or after the verdict?

24 Q. whichever ones you're referring to.

25 A. Ma'am, I -- I -- I have notes -- I know

1 what the verdict -- I knew what the verdict was.

2 Right now I can't give you a complete recall of
3 exactly what it was. I would have to look it up.

4 Q. Was your understanding that the verdict
5 was over \$18 million?

6 A. Yes. I believe the verdict was, in total,
7 48 million-ish.

8 Q. The notes -- and the notes that you've
9 referenced, I'm assuming that you have a
10 claims file -- is that the right term? -- that you
11 would use for this matter?

12 A. Correct.

13 Q. And then do you have a separate trial
14 notebook, or is it all just part of the same claims
15 file?

16 A. It's not separate.

17 Q. All right. Is that electronically kept?

18 A. Yes.

19 Q. So the notes that you had that you've
20 referenced, that's all just part of one file?

21 A. Correct.

22 Q. And you would have had notes, I assume,
23 throughout the course of this matter, including that
24 you understood there were punitive damage claims
25 pending against two out of this, as well? It was

1 originally asserted against all three defendants.

2 Did you understand that?

3 A. Yes.

4 Q. Do you -- did you understand that the
5 Court had hearings with respect to those punitive
6 damages claims, and that ultimately the Court allowed
7 punitive damages claims to go forward against two of
8 your insurers: Dr. McNeive and Mercy Clinic?

9 A. Yes.

10 Q. And you understood that as of March 25th,
11 2025?

12 A. Yes.

13 Q. And you understood that after additional
14 argument by lawyers for Dr. McNeive and Mercy Clinic,
15 that the decision by the Court to allow punitive
16 damage to go forward was appealed, if you will, taken
17 on a writ to the appellate court. Did you know that?

18 A. Yes.

19 Q. And you knew that the appellate court
20 denied that writ?

21 A. Yes.

22 Q. And you knew that when we started the
23 trial, punitive damages were a part of the claims the
24 entire trial?

25 A. Yes.

1 Q. And that the judge allowed punitive claims
2 to be submitted to the jury against McNeive and Mercy
3 clinic?

4 A. Yes.

5 Q. Is there punitive coverage for McNeive and
6 Mercy Clinic?

7 A. Yes.

8 Q. Were you ever asked to provide those
9 policies in discovery of this matter?

10 MR. PERRON: Objection, Your Honor. I
11 think that it is now outside the scope of the
12 settlement agreement and the high-low discussions.

13 THE COURT: Sustained.

14 Q. (By Ms. Gunn) What was the punitive
15 coverage in this case, Mr. Crawford?

16 MR. PERRON: Same objection, Your Honor.

17 THE COURT: Overruled.

18 A. The \$10 million limits are for
19 compensatory and punitives.

20 Q. (By Ms. Gunn) The \$10 million coverage
21 that you have sole authority over, included coverage
22 for compensatory and punitives, correct?

23 A. Yes.

24 Q. And you understood that punitives were
25 part of this case, correct?

1 A. Yes.

2 Q. And that the punitive coverage that you
3 solely controlled, was part of the discussions that
4 you had with Ms. Kamykowski?

5 A. I'm sorry. Could you please rephrase
6 that? I'm not sure I understand that question.

7 Q. When you all were talking about settling
8 this case and making different offers, you understood
9 that your sole -- you were the one with sole
10 authority to settle the punitive and the compensatory
11 claims, correct?

12 A. Yes.

13 Q. So with a verdict, whether it was punitive
14 or compensatory, it was the same coverage?

15 A. Yes. Our coverage is for compensatory and
16 punitive.

17 Q. The -- do you -- back to your notes.
18 Have you been keeping those
19 contemporaneously with the discussions you've had
20 throughout the course of this case, including the
21 trial and any settlement negotiations?

22 A. Yes.

23 Q. And have you referred to those recently?

24 A. Yes.

25 Q. Have you provided those notes to anyone?

A. No.

Q. Have you spoken with any other person at MedPro about this matter?

MR. PERRON: Object to the form -- object, Your Honor, again, going beyond the scope of the negotiations for the high-low.

THE COURT: I would ask you to limit it to the settlement discussions, not just anything about this case.

MS. GUNN: Fair enough. Thank you, Judge.

Q. (By Ms. Gunn) Mr. Crawford, when you were discussing settlement on the afternoon of March 25th, 2025, were you also checking in with anybody else on your side within your company?

A. Yes.

Q. And who was that?

A. My boss, Dave Zielinski.

Q. who's that?

A. My boss, Dave Zielinski.

Q. How do you spell that?

A. Z-i-e-l-i-n-s-k-i. He's the VP for the claims hospital division.

Q. where does he work? I mean physically.

A. He's in Pennsylvania.

Q. How often did you speak to him that

afternoon?

A. A few times.

Q. Do you recall the content of those conversations?

A. We talked about the questions the jury had and potential settlement offers in our valuation of the case.

Q. Were those conversations memorialized in your notes, as well?

A. Yes.

Q. Now, if -- if this case -- if the high-low, as you've explained it, only required or required a settlement at \$8.4 million, would MedPro have to pay anything?

A. If the high-low -- at 8.4, yes, MedPro would.

Q. And what would MedPro have to pay?

MR. PERRON: Object to the form, Your Honor. I think the specific amounts are outside the scope of settlement negotiations.

THE COURT: Overruled.

A. 2 million.

Q. (By Ms. Gunn) And that would be those -- that first couple of policies: a million for Dr. McNeive and a million for Mercy Clinic?

1 A. Correct.

2 Q. And then the hospital, Mercy Hospital,
3 would be required to pay the next 6.4?

4 A. Correct.

5 Q. And so your sole authority, between 10 and
6 20, based on your testimony here today, would not be
7 at issue, correct?

8 A. Right. That layer would not be impacted
9 if the payment would be below that.

10 Q. However, if the Court reviews this
11 contract and believes that there is a settlement at
12 18, MedPro would owe \$8 million, correct?

13 A. I'm sorry. What contract are you
14 referring to?

15 Q. The high-low agreement.

16 A. The high-low -- I'm sorry. Would you just
17 please rephrase that.

18 Q. You understand that there's a written
19 agreement to the high-low. Is that your
20 understanding?

21 MR. PERRON: Object to the question.

22 Presumes facts not in evidence.

23 THE COURT: Overruled.

24 A. What is it written agreement to the
25 high-low?

1 Q. (By Ms. Gunn) So that's my question to
2 you.

3 A. Is there a written agreement to the
4 high-low?

5 Q. Are you indicating that at no point in all
6 the conversations that you've had after this verdict
7 with anyone, that you were not informed that there
8 was a written agreement with respect to the high-low?

9 MR. PERRON: Same objection, Your Honor.
10 Characterizing the text message as a written
11 agreement is a fact in dispute.

12 THE COURT: Overruled.

13 A. So I -- I -- I'm a little bit confused. I
14 don't think that text message was a written
15 agreement.

16 Q. (By Ms. Gunn) Oh, you're aware of the
17 text message, but you're -- you're disagreeing it was
18 an agreement? A legally-binding, enforceable
19 agreement?

20 A. And -- and -- and which text message are
21 you referring to?

22 Q. The text message at 4:47 p.m.

23 A. That says what?

24 Q. Sir, were you never made aware of the
25 written agreement regarding the high-low in this

1 case?

2 MR. PERRON: Same objection, Your Honor.

3 A. Ma'am, there was no written agreement.

4 Q. (By Ms. Gunn) well, Mr. Crawford, the
5 Court is the one who's going to be able to make that
6 decision. My question to you is were you ever
7 informed of the terms of the high-low agreement?

8 A. The terms of the high-low agreement are,
9 were and are, that they are based on the compensable
10 award after reduction with noneconomic caps, and any
11 punitive award is extinguished, and no payments would
12 be made for the punitives. So the high-low of 8/18
13 encompasses that, along with confidentiality and
14 non-disparagement.

15 Q. And what is that based on, sir?

16 A. I'm sorry. What do you mean, what is it
17 based on? That was the agreement that we put
18 forward.

19 Q. Were you ever told that the written
20 agreement was 8 and 18, all the way to verdict,
21 confidentiality to high-low, and no
22 non-disparagement?

23 A. That was not a written agreement.

24 Q. Sir, were you ever informed by anyone of
25 those terms?

1 A. I didn't think those were the terms, and
2 they're not in agreement. I thought that was a text
3 from the plaintiff lawyer. It's incomplete. It's
4 not an agreement.

5 Q. Was it your intent to settle this case
6 with the caps in mind?

7 A. The intent when we offered the
8 \$12 million? Is that what you mean?

9 Q. No. At the end of the day, sir -- well,
10 let me ask you this: Do you think, I mean, in your
11 mind, was there a high-low agreement at any point?

12 A. Yes.

13 Q. And was it your intention that that
14 high-low agreement be based on net verdicts and net
15 judgments with application of the statutory caps?

16 A. Yes. Always, attorneys and insurance
17 people always negotiate in terms of recoverable
18 amounts --

19 Q. So --

20 A. -- of --

21 Q. I'm sorry. So that was your understanding
22 and your intent that was part of what you understood
23 the negotiations included?

24 A. Yes.

25 Q. On the afternoon of March 25th?

1 A. Yes.

2 Q. And -- and did Ms. Kamykowski tell you
3 that she stated to the Court, upon questioning of the
4 Court after the punitive damage verdict, that she
5 never mentioned net judgment or net verdict at all
6 during the negotiations on March 25th?

7 A. I'm sorry. Could you please say that
8 again. I...

9 Q. Yeah. Were you aware of the post-verdict
10 record?

11 A. The post-verdict record in regard to?

12 Q. Mr. Crawford, were you told that after the
13 jury rendered its punitive damage verdict, that a
14 record was made in front of this Court discussion the
15 high-low agreement?

16 A. I believe it was.

17 Q. Have you been provided a copy of it?

18 A. I don't know if I have a copy. I may
19 have.

20 Q. Were you aware that the Court asked Ms.
21 kamykowski: And were discussions with regards to the
22 caps involved in this settlement agreement at all?

23 And Ms. Kamykowski's answer was: There
24 was no discussion of caps, Your Honor.

25 A. I don't know.

1 Q. Do you disagree with that?

2 A. I don't know. I would have to look at
3 what the record says.

4 Q. There were text messages between you and
5 Ms. Kamykowski on the afternoon of March 25th, is
6 that correct?

7 A. Yes.

8 Q. Have you seen those, sir?

9 A. Yes.

10 Q. You were informed that the jury was asking
11 questions about punitive damages?

12 A. Yes.

13 Q. Were you informed that the text message
14 memorializing the high-low agreement was accepted by
15 Ms. Kamykowski?

16 MR. PERRON: Your Honor, I would object to
17 the characterization of that transcript. I think
18 that calls for a legal interpretation of what she's
19 describing Ms. Kamykowski's statements to mean.

20 THE COURT: The Court will allow the
21 witness to testify as to his understanding.

22 A. Could you please ask that question again?
23 I'm sorry.

24 Q. (By Ms. Gunn) Did you come to an
25 understanding that upon questioning by the Court on

1 the record, when asked about what Ms. Kamykowski
2 understands the high-low agreement means, she
3 responded: So, Your Honor, I have 8 to 18, all the
4 way to verdict, confidentiality to high-low, and
5 no non-disparagement? Were you aware of that
6 exchange.

7 MS. KAMYKOWSKI: I'm going to object to
8 the form. It mischaracterizes the record, Your
9 Honor. It's not being read verbatim. It's also --
10 it mischaracterizes what the actual record is. I can
11 show Your Honor the transcript if you would like it.

12 THE COURT: I have the transcript.

13 why don't you read it verbatim.

14 Q. (By Ms. Gunn)

15 "THE COURT: I'm a bit confused as to what
16 you think a high-low means.

17 "MS. KAMYKOWSKI: So, Your Honor, I have 8
18 to 18, all the way to verdict, confidentiality to
19 high-low, no non-disparagement. Those were --"

20 And then the Court asks another question.

21 "Did Ms. Kamykowski tell you that she had
22 recited the terms of the agreement into the record on
23 the afternoon of March 25th, 2025?"

24 MS. KAMYKOWSKI: Same objection, Your
25 Honor. Mischaracterizes the record.

1 THE COURT: Overruled.

2 Q. (By Ms. Gunn) Sir?

3 A. I'm sorry. I don't understand the
4 question. Are you asking me if that's what the
5 record says?

6 Q. No, sir. I'm asking you whether that was
7 your -- whether you knew that she had said that.

8 A. Is there -- I, afterwards, yes, I knew
9 that she said that afterwards, as reflected in the
10 record.

11 Q. When did you learn that?

12 A. I don't know.

13 Q. Did you talk to Ms. Kamykowski between the
14 phase one of the trial, where the jury delivered the
15 compensatory verdict, and phase two of the trial,
16 where the verdict -- when the punitive damages award
17 was read?

18 A. Yes.

19 Q. And did you tell her to go up to the --
20 make a record that this case was settled at
21 \$4.8 million -- excuse me -- \$8.4 million?

22 A. Did I tell her to make a record that the
23 case was settled at \$8.4 million?

24 Q. Yes, sir.

25 A. No.

1 Q. I mean, you understood at that moment
2 that, according to your negotiations and your
3 understanding, that the case was settled at
4 \$8.4 million, right?

5 A. Right. That would have been -- yes.

6 Q. Okay. You had, back to your text
7 messages, which were marked as Exhibit 2 to the
8 Plaintiffs' memo in support of the motion to enforce
9 the judgment, I don't know. I can't tell whether you
10 knew this or not, but at 4:47, this was a text
11 message outlining the terms of the high-low
12 agreement.

13 And then also at that moment, at 4:47, you
14 sent a text to Ms. Kamykowski that says: Does jury
15 give a puni number, or do they know more testimony
16 needed regarding puni phase?

17 Do you remember sending that text?

18 A. Yes.

19 Q. So at that point, you didn't know whether
20 there was a bifurcated trial with respect to
21 punitives?

22 A. I knew there was a bifurcated trial.

23 Q. Do you know what you were asking?

24 A. I just -- I just had a question about the
25 mechanism.

1 Q. You knew at that point that the jury had
2 been asking about punitives, correct?

3 A. At that point that I wrote the text?

4 Q. Yes, sir.

5 A. I believe they had, yes.

6 Q. Then 7 minutes later, at 4:55, there was
7 no answer, and you text something else. And then at

8 4:58, 11 minutes, when there was no answer, you say:

9 High-low is for compensatory only, extinguishes puni
10 exposure. Please make that clear. Thanks.

11 Correct?

12 A. (No audible response.)

13 Q. Sir, do you remember sending that text?

14 A. Yes. In line with the prior

15 communications as far as the high-low agreement and
16 the premediation statement, as well.

17 Q. And you're asking at 4:58, you want to
18 make that clear, correct?

19 A. Right. In line with all the other
20 negotiations.

21 Q. And you don't say high-low is for
22 recoverable compensatory, correct?

23 A. I did not say that, but that is implied,
24 as it always is, when you're working with a high-low.

25 Q. You don't say high-low is for a net

1 verdict, do you?

2 A. I did not say that, but that is implied,
3 as it is with all high-lows.

4 Q. You didn't say the high-low is for the --
5 the recoverable after application of caps pursuant to
6 Chapter 538? You said none of those things, did you?

7 A. I did not. That is, again, implied based
8 on how high-lows work.

9 Q. And you also ask about whether punitive
10 exposure is extinguished, correct?

11 A. I don't believe I asked if it was
12 extinguished. That was -- that was a condition.

13 Q. That's something that you're relating now,
14 that you need the punitive exposure, needs to be
15 extinguished, right?

16 A. Just it's a reminder to follow up through
17 all the other negotiations where that was a
18 condition.

19 Q. And Ms. Kamykowski, at 4:59, says, yes,
20 correct?

21 A. Yes.

22 Q. Which was 12 minutes after the text
23 message setting out the terms of the high-low? Can
24 you accept that?

25 A. Setting out after -- after my text message

1 to her?

2 Q. No. The one that sets out the terms of
3 the high-low, sir.

4 A. I didn't send her a text message setting
5 out the terms of the high-low.

6 Q. Sir, we've been talking about the text
7 message that --

8 A. From the plaintiffs?

9 Q. -- that sets out the terms --

10 A. You mean --

11 Q. Sir, we're talking about --

12 A. Excuse me. I'm sorry. Do you mean the
13 text -- I'm sorry -- do you mean the text message
14 from the plaintiffs? From --

15 Q. The one that was drafted together with Ms.
16 Kamykowski?

17 MS. KAMYKOWSKI: Object to the form.
18 Mischaracterizes the evidence.

19 THE COURT: Overruled.

20 A. I'm -- I'm really confused.

21 Q. (By Ms. Gunn) I understand. I
22 understand.

23 Did you ever revoke or rescind Ms.
24 kamykowski's authority to negotiate on behalf of your
25 company, MedPro?

1 A. Revoke or rescind? No.

2 Q. And that didn't happen on March 25th,
3 correct?

4 A. Correct.

5 Q. That didn't happen on the next day or the
6 next day, correct?

7 A. Correct.

8 Q. You're still not doing that, are you, sir?

9 A. No.

10 Q. You've drafted, or participated in
11 drafting, an affidavit that now asserts that Ms.
12 kamykowski didn't have authority to settle upon the
13 terms that were listed, correct?

14 A. What do you mean by "the terms that were
15 listed"?

16 Q. Sir, I've mentioned a number of times, and
17 I wish I could show you here in person, that text
18 that Ms. Slater and Ms. kamykowski drafted.
19 Apparently, I guess, you have never seen a copy of
20 that --

21 A. Oh, I --

22 Q. -- but I want to talk about --

23 A. Well, I --

24 Q. Hold on. I understand --

25 A. No. No.

1 Q. Go ahead.

2 A. I'm really sorry to interrupt, but, yes,
3 that text is not -- is not an agreement. That --
4 that text from Ms. Slater is not an agreement.

5 Q. well, I understand that's what you're --
6 what you're indicating the intention was after the
7 fact. But all I'm asking you is, is whether you were
8 provided a copy of that -- the four terms that we've
9 mentioned today?

10 A. Was I provided a copy of Ms. Slater's
11 text?

12 Q. Yes, sir.

13 A. Yes. I knew that she sent a text, but
14 it's not an agreement.

15 Q. Okay. I understand your -- I understand
16 your -- the reason why you're mentioning that.

17 Regardless, the affidavit that you filed,
18 you understand -- well, I'll ask you this: You
19 understand that the affidavit you've filed -- that
20 you filed has been in support of the notion that
21 there was not a meeting of the minds with respect to
22 the high-low agreement, and that it should not be
23 enforced? Is that your understanding of the purpose
24 of your affidavit?

25 MR. PERRON: Object to the form. That

1 mischaracterizes what the affidavit was used in
2 support of.

3 THE COURT: Overruled.

4 A. Okay. Okay. So please repeat that
5 question.

6 MS. GUNN: Melissa, I apologize. Would
7 you read back the last question?

8 (The question was read back by the court
9 reporter.)

10 THE WITNESS: I'm sorry. There are --
11 there are glitches and scratches, and I -- you're
12 every other word. I'm sorry.

13 Q. (By Ms. Gunn) Let me just go on.

14 what was the purpose, as you understood,
15 of your affidavit?

16 A. To outline the facts regarding
17 negotiations in the high-low agreement.

18 Q. And was it also the purpose, as you
19 understood it, to provide evidence to the Court that
20 there's not an enforceable agreement?

21 A. I believe that there was an agreement, a
22 high-low agreement. I understand that there is a
23 dispute, yes.

24 Q. You mentioned a letter from February 7th,
25 2025. You understand that that letter was not

1 referenced on March 25th, 2025, at all, correct?

2 A. Do I understand that it wasn't referenced
3 on that day --

4 Q. Yes, sir.

5 A. -- or shortly thereafter? I'm -- I don't
6 know. I thought that it was -- you're asking me if
7 it was not referenced on that day? I'm sorry.

8 Q. Yeah. I just want to know whether you
9 instructed Ms. Kamykowski to pull out this letter and
10 add that to the negotiations. I'm just trying to
11 understand what you think the effect of the letter
12 from two or so months earlier --

13 A. On the negotiations in February?

14 Q. No, sir, on March 25th.

15 A. When we talked about negotiations, the
16 terms of that letter laid the groundwork for how the
17 negotiations began and therefore continued with the
18 same conditions.

19 Q. That was your intent?

20 A. Yes.

21 Q. You understood that \$12 million offer was
22 rejected by plaintiffs?

23 A. Yes.

24 Q. And you've done this enough to know that
25 in order to have an agreement, you have to have an

1 offer and acceptance of that agreement. And once the
2 offer is rejected, there's no more offer, correct?

3 A. Once that offer is rejected, correct.
4 That offer is -- yes.

5 Q. And that at no point on March 25th, did
6 you speak to myself or Ms. Slater, is that correct?

7 A. Correct.

8 Q. And you have no firsthand knowledge of
9 what communications were occurring between Ms. Slater
10 and Ms. Kamykowski?

11 A. Correct.

12 Q. You weren't on the phone listening in to
13 any negotiations, is that correct?

14 A. Correct.

15 Q. You weren't on the phone listening in to
16 when the verdict was read, correct?

17 A. Correct.

18 Q. Did you ever speak to Mr. Willman
19 directly?

20 A. No.

21 Q. Or Mr. Perron?

22 A. No.

23 Q. Or Dr. McNeive?

24 A. No.

25 Q. Or Anne Rucker?

1 A. I have spoken to Anne Rucker directly,
2 yes.

3 Q. On March 25th?

4 A. I believe so. I'm not positive. I
5 believe so.

6 Q. Did you all text each other?

7 A. I believe so.

8 Q. Do you still have those texts, as well?

9 MS. KAMYKOWSKI: well, Your Honor, I'm
10 going to object to that. Absolutely there is
11 insured-insurer privilege there.

12 THE COURT: I don't know that she's asking
13 for the context of the text. Whether or not he still
14 has them, is a different question.

15 A. Do I still -- I don't know.

16 Q. (By Ms. Gunn) Were they just texting on
17 your regular -- do you have a personal phone or a
18 company phone or both?

19 A. Do I have either one? I have both.

20 Q. And would you have texted Ms. Rucker on
21 your personal phone or your company phone?

22 A. No, ma'am.

23 Q. Thank you, sir. That's all the questions
24 I have at the moment.

25 A. You're welcome.

1 THE COURT: And before I turn it over to
2 you, I just want make sure I'm clear in understanding
3 the sequence of events.

4 Mr. Crawford, at some point, was an offer
5 made by the plaintiffs conveyed to you of 8 and 18,
6 all the way to verdict, confidentiality to high-low,
7 no non-disparagement agreement?

8 THE WITNESS: You mean as reflected in the
9 text from Ms. Slater?

10 THE COURT: Yes. Was that conveyed to
11 you?

12 THE WITNESS: It was -- it was conveyed to
13 me, yes, when she had sent that text, yes.

14 THE COURT: Okay. At what point did you
15 reject that offer?

16 THE WITNESS: Shortly thereafter because
17 it's not -- it's not -- it's not complete in its
18 description of terms, so it's not -- it's not an
19 agreement.

20 THE COURT: Okay. And she has --

21 THE WITNESS: It was a response -- it was
22 a response to our -- our offer.

23 THE COURT: And at what point -- I'm
24 sorry -- how did you convey you were rejecting that
25 offer?

1 THE WITNESS: How did I convey that?

2 THE COURT: Yes.

3 THE WITNESS: I did not speak to Ms.
4 Slater direct, and my negotiations were through Ms.
5 kamykowski.

6 THE COURT: I understand that.

7 Did you convey to Ms. kamykowski that that
8 offer was being rejected?

9 THE WITNESS: well, yes, because it was
10 incomplete --

11 THE COURT: And how did you convey --

12 THE WITNESS: -- not and aligned.

13 THE COURT REPORTER: I'm sorry. I did not
14 hear him.

15 THE WITNESS: It's not aligned with our
16 prior offer.

17 THE COURT REPORTER: Thank you.

18 THE COURT: How did you convey that to Ms.
19 kamykowski?

20 THE WITNESS: Either -- probably by phone.

21 THE COURT: Okay. And that would have
22 been after 4:47 p.m., and before the verdict was read
23 at 4:56 p.m., is that right?

24 THE WITNESS: Correct.

25 THE COURT: Okay. So at that point, at

1 4:56 p.m., there's no agreement, is that correct?

2 THE WITNESS: (No audible response.)

3 THE COURT: when the verdict is read,
4 according to your understanding, there is no
5 settlement agreement?

6 THE WITNESS: At 4:46? I -- well -- I
7 thought the agreement --

8 THE COURT: I'm not asking you what you
9 thought. I'm going through linearly.

10 You said that the agreement that was
11 conveyed by the plaintiffs to the defense of 8 and
12 18, all the way to verdict, confidentiality to
13 high-low, no non-disparagement was rejected by you in
14 a phone call with Ms. Kamykowski. And that would
15 have been done prior to the acceptance by the Court
16 of the verdict.

17 THE WITNESS: I thought -- I thought that
18 they had agreed to the high-low, including the terms
19 of punitives.

20 THE COURT: when did -- when did that
21 happen? Because you're saying that you rejected flat
22 out their offer of 8 and 18. The next thing that
23 happened is that you're sending a couple of text
24 messages, including one saying "please call." Then
25 there's the verdict that's read. And you're

1 indicating after that, that the high-low for
2 compensatory only extinguishes punitive exposure.
3 Please make that clear.

4 At what point was there an agreement that
5 I'm missing?

6 THE WITNESS: I believe there was an
7 agreement of 8 and 18.

8 where the compensatory award, after
9 reduction with the caps, that did not include any
10 payments for punitives. And the punitive exposure
11 was exhausted.

12 But the reply from Ms. Slater in that text
13 was -- was incomplete. I believe that the high-low
14 agreement was in place, and I was not sure about the
15 reasons for the text from Ms. Slater.

16 THE COURT: Well, you understand that if a
17 term and agreement is not agreed to, then the offer
18 is rejected?

19 THE WITNESS: Yes.

20 THE COURT: Okay. So as you've testified,
21 at 4:47, Ms. Kamykowski becomes aware of the specific
22 terms: 8 and 18 -- 18, all the way to verdict,
23 confidentiality to high-low, no non-disparagement.
24 At which time you have a phone conversation,
25 according to your testimony, with Ms. Kamykowski, in

1 which you reject those terms, correct?

2 THE WITNESS: I think that what she meant
3 was --

4 THE COURT: I'm not asking what she meant.
5 I'm asking you, according to your understanding, you
6 said you rejected that -- those terms, correct?

7 THE WITNESS: Well, I rejected the terms
8 from the text?

9 THE COURT: Correct. Ms. Kamykowski
10 conveyed that offer to you, and you rejected the
11 terms, is what you've been testifying here to.

12 THE WITNESS: Well, right. I think the
13 text was -- was incomplete, but before that, I
14 thought that we had a high-low agreement.

15 THE COURT: At what point before that, did
16 you believe you had a high-low agreement?

17 THE WITNESS: At what point? I guess it
18 was right -- right before that, when I think it was a
19 discussion between Ms. Slater and Ms. Kamykowski, and
20 then it was confirmed with the text. But the text
21 was incomplete as far as -- as far as I'm concerned
22 regarding the terms.

23 THE COURT: Well, but if a text is
24 incomplete regarding the terms, then you would have
25 rejected the agreement, correct?

1 THE WITNESS: I agreed that the text does
2 not encompass the terms of the agreement. I do agree
3 with that, yes.

4 THE COURT: And you're saying that you
5 believe that there was an agreement before that text,
6 correct?

7 THE WITNESS: Yes.

8 THE COURT: And the agreement that you
9 believe was agreed to by everybody was 8 and 18, is
10 that correct?

11 THE WITNESS: The high-low of 8 and 18,
12 correct.

13 THE COURT: with a confidentiality
14 provision?

15 THE WITNESS: Confidentiality and
16 non-disparagement. Exhausted punitive. Any payment
17 for punitives and no punitive exposure.

18 THE COURT: But you don't mention anything
19 about high-low for compensatory only until 4:58 p.m.,
20 which is 11 minutes after you believe there's an
21 agreement.

22 THE WITNESS: well, I -- I had mentioned
23 it in phone conversations.

24 THE COURT: But you wanted to make sure
25 she got the point, so you sent her a text to that, as

1 well?

2 THE WITNESS: Right, I just -- correct.
3 Just as a reminder to follow up on all the other
4 conditions back from February and earlier in the day.

5 THE COURT: So let me ask this question:
6 If that's in fact something that you wanted to
7 reinforce with her, it means that it may not have
8 been agreed to by the plaintiff, is that right?

9 THE WITNESS: Just wanted to emphasize it.

10 THE COURT: But why would you need to
11 emphasize something that was already agreed to?

12 THE WITNESS: For the sake of
13 completeness.

14 THE COURT: So did you also emphasize to
15 her that the terms of the agreement that say: All
16 the way to verdict, confidentiality to high-low, and
17 no non-disparagement, did you make sure that you
18 clarified that those were rejected?

19 THE WITNESS: I'm -- I'm sorry. But those
20 were -- I didn't think they were rejected.

21 THE COURT: Well, you just testified quite
22 a bit that you did not agree there was a no
23 non-disparagement agreement.

24 THE WITNESS: I'm -- I'm sorry. I thought
25 there was an agreement, but it's not reflected in

Ms. Slater's text, if that's what you mean.

THE COURT: So when somebody has an agreement, and then somebody else makes an offer after that agreement, what is the purpose of making an offer after there's an agreement?

THE WITNESS: I do not know.

THE COURT: Okay. And the agreement that you believe was there, to your knowledge, was that ever texted to Ms. Kamykowski by you?

THE WITNESS: No.

THE COURT: Okay. So as far as you're concerned, by the time the verdict was read in open court, this agreement was already solidified and applied to everybody?

THE WITNESS: Yes. I understood the agreement was for 8 and 18 high-low, but if it was a compensatory award, that extinguished any payment for punitive exposure.

THE COURT: So then why were you asking questions --

THE WITNESS: With non --

THE COURT: So then why were you asking questions with regards to the jury deliberating about punitive damages amounts?

THE WITNESS: (No audible response.)

1 THE COURT: You'd already had an
2 agreement, right?

3 THE WITNESS: well --

4 THE COURT: Your agreement, according to
5 you, was there would be no punitives paid, correct?

6 THE WITNESS: But you always want to know
7 what the jury is doing.

8 THE COURT: But it wasn't going to affect
9 the outcome of the case because you'd already had a
10 settlement.

11 THE WITNESS: That is correct.

12 THE COURT: Additional direct?

13 MR. PERRON: Yes, Your Honor.

14 REDIRECT EXAMINATION

15 BY MR. PERRON:

16 Q. Mr. Crawford, I'll read from the
17 February 7th letter: Defendants will not negotiate a
18 settlement to include payment of possible punitive
19 damage recovery.

20 If I read that correctly from the letter,
21 is that consistent with your understanding of the
22 defense's position throughout the negotiations?

23 A. Yes.

24 Q. Was that true at the beginning of trial,
25 in March 2025?

1 A. Yes. All settlement negotiations were
2 predicated upon that condition, the conditions in the
3 February letter.

4 Q. Was that your understanding of the
5 defense's position all throughout March 25, 2025?

6 A. It was, yes.

7 Q. Did you come to an understanding that
8 specifically plaintiffs' counsel did not want Mr. or
9 Mrs. Anyan to feel, quote/unquote, gagged, by any
10 settlement?

11 A. Yes, that's true.

12 Q. So even if the settlement agreement did
13 not prevent Mr. and Mrs. Anyan from disparaging
14 potentially the defendants, were you still okay
15 signing off on the high-low agreement?

16 A. Yes.

17 Q. The specific wording all the way to the
18 verdict -- just to back up -- did you have an
19 understanding that despite the agreement to resolve
20 all the claims, the plaintiffs wanted the jury to
21 continue to deliberate on punitive damages and award
22 a verdict on punitive damages?

23 A. Yes.

24 Q. The line from the text message: 8 and 18,
25 and then a new line, all the way to verdict, absent

1 later knowledge that plaintiff was disagreeing with
2 the terms of the 8 and 18 high-low, does the language
3 in quotes, all the way to verdict, close quotes, did
4 that language alter your understanding that the 8 and
5 18 high-low agreement would be triggered only by the
6 recoverable amount?

7 A. No. I believe that note was for a
8 reminder that they wanted to have the verdicts read,
9 even though there was an agreement in place. They
10 just -- a reminder they wanted that to be read
11 anyway.

12 Q. After the plaintiffs' counsel went on the
13 record to say they believed the terms of the
14 agreement entitled them to the high of 18 million,
15 when you were made aware of the plaintiffs' counsels'
16 interpretation of the high-low agreement, did you
17 agree with their interpretation of that high-low
18 agreement?

19 A. No, I did not.

20 Q. At the time that counsel made the high-low
21 agreement, to your understanding, was there a valid
22 understanding of the terms of the high-low agreement,
23 and that it would be governed by the recoverable
24 amount of the compensatory verdict?

25 A. Yes, that is correct.

1 Q. Does anything in the text, without later
2 context of plaintiffs' counsels' interpretation
3 change, or did it change your understanding of the
4 terms of that high-low agreement?

5 A. No. The text didn't change the
6 understanding of the terms of the agreement. Again,
7 I thought it was a reminder that they wanted the
8 verdict read irrespective of having the agreement in
9 place.

10 Q. Did you -- and that, as you've just
11 described, was that your understanding of the
12 high-low agreement, even with the language of the
13 text, until you were told of plaintiffs' counsels'
14 interpretation after the total verdict?

15 A. I'm sorry. Please repeat that. I
16 don't -- I didn't hear the first part.

17 Q. As you just stated, your understanding of
18 the terms of the high-low agreement, was it in any
19 way -- did the language of the text change your
20 understanding of what you believed the high-low
21 agreement to be until after learning of plaintiffs'
22 interpretation?

23 A. No, the language of the text did not
24 change my understanding of what the agreement was.
25 Again, I thought the text was a reminder that they

1 wanted to have the verdict read.

2 MR. PERRON: Those are my questions.

3 THE COURT: Any further cross?

4 MS. GUNN: No, ma'am.

5 THE COURT: Anything further of this
6 witness?

7 MR. PERRON: No. Except, Your Honor, we
8 wanted to admit the February 7th, 2025, letter
9 previously marked as Exhibit A.

10 THE COURT: Any objection?

11 MS. GUNN: No objection.

12 THE COURT: That will be admitted.

13 Shall we have a quick scheduling
14 discussion, that doesn't need to be on the record,
15 about how much more evidence we happened to have on
16 the record?

17 (A discussion was held off the record.)

18 THE COURT: Okay. On behalf of defense,
19 you may call your next witness.

20 MR. PERRON: Your Honor, the defense will
21 call Phil willman.

22 THE COURT: Sir, if you'll step on up and
23 be sworn. I don't need to tell you about the
24 microphone, do I?

25 Please raise your right hand.

1 PHILIP WILLMAN,
2 having been duly sworn, was examined, and testified
3 as follows:

4 DIRECT EXAMINATION

5 BY MR. PERRON:

6 Q. would you please state your name for the
7 record.

8 A. Phil Willman.

9 Q. And what was your involvement in this
10 case?

11 A. I was lead counsel for Dr. McNeive and
12 Mercy Clinic.

13 Q. within the course of your practice, have
14 you had experience negotiating high-low agreements?

15 A. I have.

16 Q. Here, did you have an understanding of the
17 high-low agreement with regards to this case?

18 A. I believe I do.

19 Q. did you believe at the time the agreement
20 was first made, while the jury was deliberating, that
21 plaintiff could trigger the high of the high-low
22 agreement with an award beyond the recoverable amount
23 of compensatory damages?

24 A. No.

25 Q. Did you believe the plaintiff could reach

1 the high amount of the high-low agreement with an
2 award of punitive damages?

3 A. No.

4 Q. were you a part of conversations with
5 counsel about a potential high-low agreement while
6 the jury was deliberating?

7 A. Counsel for plaintiffs?

8 Q. Yes.

9 A. The only conversation I had was to assure
10 that -- I wanted to make sure that punitives were
11 going to be addressed in whatever settlement was
12 reached, so I asked -- I want -- I made that certain
13 that that was covered.

14 Q. Did you understand -- and I suppose the
15 chronology now is important -- at the time that the
16 jury was still deliberating, did you understand that
17 the high-low agreement would extinguish any punitive
18 damages claims?

19 A. Yes.

20 Q. Did you have a belief that any punitive
21 damages awarded would have any effect on the high-low
22 agreement?

23 A. Have an effect, no.

24 Q. Did you ask of plaintiffs' counsel whether
25 or not there was any further necessity for the jury

1 to deliberate on punitive damages if they were
2 resolved by the high-low agreement?

3 A. I did ask about that. why would it go to
4 verdict, if it was being covered? Yes, I asked about
5 that.

6 Q. And did you receive any response?

7 A. They wanted to pub -- get the verdict on
8 record, and would not -- would not affect the
9 agreement.

10 Q. The line in the text that we've been
11 discussing, quote/unquote, all the way to verdict,
12 did you interpret that at the time to be a
13 qualification of the 8 and 18 terms of the high-low
14 agreement?

15 A. Qualification meaning addition to it?

16 Q. That it would specifically qualify what
17 would trigger the high-low agreement?

18 A. No, it wouldn't trigger it.

19 Q. So what did -- how did you interpret all
20 the way to verdict within the scope of the
21 conversations you had been having?

22 A. I interpreted that we had an agreement
23 that was, you know, based on the -- whatever the
24 verdict was going to be in the -- in the negligence
25 case and was not affected at all by a punitive --

1 whatever -- whatever decision the jury would make on
2 a punitive claim.

3 Q. And, in particular, with regards to your
4 conversation with plaintiffs' counsel, that they
5 wanted the jury to continue to deliberate on punitive
6 damages, how did you interpret the quote all the way
7 to verdict?

8 A. That they wanted to hear what the jury's
9 decision was on the punitive claim, and that was it.

10 Q. And just to be explicit, did you
11 interpret, quote/unquote, all the way to verdict, to
12 be a description of the trigger for the high-low
13 agreement?

14 A. No.

15 Q. When you heard the reading of the specific
16 damages awarded during the compensatory phase, did
17 you form an opinion about roughly the final
18 settlement amount?

19 A. Yes.

20 Q. What was your opinion or understanding
21 after the compensatory verdict had been read, but
22 before going onto the punitive?

23 A. Well, I did a quick calculation knowing
24 the cap and estimated in my own mind what the
25 compensatory would be.

1 Q. And not an exact number, if you don't know
2 off the top of your head, but roughly what did you
3 believe the final settlement amount would be after
4 hearing the compensatory verdict read?

5 A. I would say approximately 8.4 million.

6 Q. Did you have -- did you speak to
7 plaintiffs' counsel, Ms. Slater, the evening of
8 March 25, after everyone had left the court?

9 A. Yeah.

10 Q. What prompted that conversation?

11 A. I had been asked to reach out to see
12 whether they -- there would be an interest in not
13 acting on the -- on the verdict until we had a
14 discussion about trying to get things resolved.

15 Q. And at that time, during this conversation
16 with Ms. Slater the evening of March 25, did you
17 concede or admit that you or defendants had an
18 original understanding of the high-low agreement that
19 matched their representation to the court?

20 A. No, it did not match.

21 Q. Did you concede in that conversation that
22 the defendants originally believed the high-low
23 agreement included noneconomic awards beyond what
24 might be recovered under the cap?

25 A. No. That wouldn't make any sense.

1 Q. Did you advise Ms. Slater that there was
2 still one more person that you needed to speak to
3 before going forward with a new offer to settle the
4 case?

5 A. Yes.

6 Q. Did you believe, on the phone with
7 Ms. Slate on March 25, that you had authority to
8 agree to a settlement of \$18 million?

9 A. No.

10 MR. PERRON: Those are all my questions.

11 THE COURT: Cross-examination?

12 CROSS-EXAMINATION

13 BY MS. GUNN:

14 Q. Did Mandy Kamykowski have full authority
15 to negotiate on behalf of all defendants on
16 March 25th, 2025?

17 A. Yes.

18 Q. You were there when Ms. Kamykowski and
19 Ms. Slater were, heads together, typing out the text
20 that ultimately was sent at 4:47, correct?

21 A. Was I there? Yes.

22 Q. Yes. You watched that happen?

23 A. Yeah.

24 Q. And you made no suggestions or alterations
25 or edits to those words, correct?

1 A. well, I didn't know what the words were,
2 so, no.

3 Q. So it's true that you made no edits or
4 alterations or suggestions with respect to the words
5 that were being typed, correct?

6 A. Yeah. Because I didn't know what the
7 words were they were using.

8 Q. And prior to that, had you been a part of
9 all the conversations between Ms. Slater and Ms.
10 kamykowski?

11 A. No.

12 Q. Which ones were you a part of?

13 A. The only one where all three of us were
14 together, was when I was making sure that the
15 punitives were being resolved before the punitive
16 verdict came back.

17 Q. Well, that conversation occurred before
18 the first phase verdict came back, correct?

19 A. Yes.

20 Q. So at that point, you didn't even know if
21 the jury had said yes or not to the punitive --

22 A. That's true.

23 Q. -- verdict, correct?

24 A. True.

25 Q. In that conversation, your concern was

1 whether there were to be no payments on behalf of the
2 punitive claim, correct?

3 A. I wanted to make sure that my clients, in
4 particular, Dr. McNeive, were not going to be subject
5 to any further claims, so I wanted it all resolved to
6 make sure that everything was getting resolved.

7 Q. Right. Because you represented Mr. --
8 Dr. McNeive and Mercy Clinic. And those were the
9 only two parties against whom punitives had been
10 submitted, correct?

11 A. True.

12 Q. And so you asked Ms. Slater to confirm
13 that any settlement, regardless of what the number
14 was, because we had no idea, any settlement was not
15 going to be paid with respect to punitives, correct?

16 A. I don't know whether it was going to be
17 paid for punitives or -- well, no, I think I assumed
18 that it was going to be paid for compensatory. My
19 goal was to make sure that everything was being
20 resolved fully.

21 Q. For Dr. McNeive and Mercy Clinic?

22 A. Right.

23 Q. And -- and just to be clear, the idea is
24 common, is it not, when you're settling claims on
25 behalf of physicians or hospitals or clinics, there

1 are punitive damages alleged, developed, and in this
2 case, submitted to a jury, it's very important that
3 at the end of the day, when there's a settlement,
4 there is no actual payment on behalf of punitives,
5 correct?

6 A. I'm not sure what you mean by that. Could
7 you ask it --

8 Q. It was important you, in that moment, the
9 only thing that you spoke up about was to make sure
10 that the punitives -- that the settlement amount
11 paid, was not going to be on behalf of punitives,
12 correct?

13 A. No. It didn't really matter to me what --
14 where the payment was going to be applied to, whether
15 it was compensatory or punitives, because I wanted to
16 make sure everything was resolved.

17 Q. Okay. Whatever the settlement ended up
18 being, as long as it was resolving punitives, that
19 was the purposes for your adding that or having that
20 conversation?

21 A. Right. True.

22 Q. And, in fact, whether the case settled at
23 8.4 or 18, the punitives were being extinguished,
24 correct? -- because it was a settlement?

25 A. Yeah.

1 Q. So in order for your client, even today,
2 to have the punitive award, now a \$20 million
3 punitive award, to be extinguished, the only way to
4 make that happen today, is for a settlement to be
5 enforced, correct?

6 A. That's not the only way, no.

7 Q. That's -- there's a judgment against your
8 client, Dr. McNeive, and your client, Mercy Clinic,
9 for \$20 million --

10 A. Correct.

11 Q. -- in punitive damages. That's the
12 Court's current judgment, correct?

13 A. Yes.

14 Q. That can be extinguished and can be
15 resolved with the settlement, correct?

16 A. Yes.

17 Q. Is that what you're asking the Court to
18 do, to find an enforceable settlement today?

19 A. Well, I -- sure.

20 Q. Yeah.

21 A. I thought we had an agreement, 8 and 18,
22 based on what would be the recoverable amount for the
23 plaintiff, yes.

24 Q. Because you agree there was no discussion
25 that you had with Ms. Slater, that 8 and 18 implied a

recoverable compensatory amount, correct?

A. That's true.

Q. So the terms, however, that -- the other term 8 and 18, you agree that that was a term, correct?

A. Yes.

Q. You agree that the phrase "all the way to verdict" was important to the plaintiff, as

Ms. Slater indicated, and as you've also testified, correct?

A. Yes.

Q. You agree that an additional term was confidentiality as to the high-low?

A. I didn't know that.

Q. Okay.

A. I -- I had thought -- and I knew that confidentiality was being discussed. I assumed it was standard confidentiality which would be to everything except that a settlement was reached.

Q. That's something you assumed?

A. I assumed. I was not a part of discussions about what exact context was of the confidentiality.

Q. And you knew that there was court, and the jury was deliberating, and that a high-low in and of

1 itself means the verdict is read, correct? In open
2 court, if there's a high-low agreement, in order to
3 trigger the high-low agreement, the verdict has to be
4 read?

5 A. Yes.

6 Q. There's also a fourth term expressed in
7 that text message that you saw being typed out
8 between Ms. Kamykowski and Ms. Slater which was no
9 non-disparagement. Were you aware of that part?

10 A. No. As I said, I didn't see the words
11 that were being typed out, so, no, I was not aware of
12 that.

13 Q. So you can't speak to whether any -- what
14 anybody's objective intent was after the fact with
15 respect to those words, correct?

16 A. Right.

17 Q. And you would agree that the phrase "no
18 non-disparagement" is pretty straightforward?

19 A. I hope so.

20 Q. After the first phase of the verdict, the
21 compensatory part of the verdict was read, you and I
22 both made additional closing arguments with respect
23 to the punitive phase, correct?

24 A. Yeah. Apparently mine wasn't very
25 persuasive.

Q. Don't make me laugh, Phil.

A. Sorry.

Q. The jury went back to deliberate?

A. Yes.

Q. And there was a 45-minute/50-minute time frame, correct? -- before the jury returned their verdict?

A. Yes.

Q. And at no point in that time, did you come to the Court or come to the plaintiffs' counsel saying, we want to tell the Court that we're settled at \$8.4 million, correct?

A. Right.

Q. You mentioned that you called Ms. Slater, I think the time frame -- well, let me -- I don't know -- we had this --

MS. GUNN: Your Honor, may I approach?

THE COURT: You may.

Q. (By Ms. Gunn) Mr. Willman, we had this Exhibit 4 marked to our memorandum in support of our motion to enforce.

I know this is a screen shot of Ms. Slater's phone, but do you agree that this accurately represents the phone call, the time frame of that phone call, that you made to her?

1 A. Yes.

2 Q. Thank you.

3 And that was a phone call that, according
4 to Exhibit 4, lasted 9 minutes?

5 A. Yes. That's --

6 Q. Sorry.

7 A. Yes.

8 Q. And you said, in your direct testimony a
9 moment ago, that you were asked to call Erica.

10 who asked you to do that?

11 A. I know it was Anne Rucker and maybe
12 somebody else, but I don't know whom, because I know
13 that I had discussions with Anne about what -- making
14 the call to see if we could buy some more time to get
15 things resolved.

16 Q. Would you have spoken to Joe Crawford at
17 that time?

18 A. No.

19 Q. And you heard Mr. Crawford speak a moment
20 ago that he had the sole authority to settle the case
21 between 10 and \$20 million, correct?

22 A. I heard him say that.

23 Q. But you didn't talk to Joe that night?

24 A. I did not.

25 Q. Who was the one more person you needed to

1 talk to?

2 A. I think it was Joe Crawford, but it was
3 not me that was going to make the contact, but I
4 believe the reference was to Joe Crawford, I believe.

5 Q. And at this point, you testified that you
6 understood the case was settled pursuant to the
7 high-low agreement at 8.4 million, correct?

8 A. Yeah.

9 Q. So there's a verdict of \$48.1 million, 20
10 million of which is against your two clients, and
11 it's -- you're testifying that the case was done at
12 8.4 million, correct?

13 A. Well, so we thought. But there was not,
14 after -- after the agreement was reached, there was
15 no agreement apparently. So that was the intent of
16 my call, was to see if we could get that taken care
17 of.

18 Q. But -- and what you're trying to indicate,
19 and I guess I'm just not understanding, it was
20 you-alls' belief that 8 -- the case was settled at
21 \$8.4 million, in light of a \$48.1 million verdict,
22 and you're -- you're the one calling us saying, we
23 want to settle, is that accurate?

24 A. I was calling to see if we could resolve
25 the dispute that had arisen after the verdict. There

was apparently not an agreement that there was an agreement.

Q. And what -- you're testifying that you did not tell Ms. Slater that you needed to make a call to someone, and you'd have the 18 million?

A. No.

Q. You're saying that that didn't happen?

A. It did not happen.

Q. But you're not disputing the phone call happening?

A. Oh, no. No.

Q. I think that's all I have, Mr. Willman. I appreciate your time.

A. Thank you.

Q. I'm sorry. One more. Sorry. With respect to the letter, this February letter that was sent, you understood that whatever

terms were in that letter were unilateral terms, correct?

A. Yeah.

Q. And that they were fully rejected by my client, Mr. Anyan?

A. I understood that, yes.

Q. Thank you.

THE COURT: Anything further of this

witness?

MR. PERRON: A brief follow-up.

REDIRECT EXAMINATION

BY MR. PERRON:

Q. In your mind, at the time the agreement was coalescing on the high-low, did you believe there was a need for the jury to still deliberate on punitive damages?

A. No.

Q. Why?

A. Because we already had an agreement. It wouldn't matter, they could have said zero, they could have said a hundred million. It wouldn't have had any bearing on what we had agreed to.

Q. Did you have an understanding that plaintiffs' counsel still wanted the jury to deliberate, even though, in your mind, it was moot by the terms of the agreement?

A. Yeah.

MR. PERRON: No further questions.

THE COURT: Anything further?

MS. GUNN: No. No.

THE COURT: Thank you, sir, you may step down.

THE WITNESS: All right. Thank you.

1 THE COURT: Okay. I'm going to go do my
2 interviews, and we will see everybody back here
3 Thursday morning at 10:00.

4 MS. SLATER: Thank you, Judge.

5 MS. GUNN: Thank you.

6 MR. PERRON: Thank you.

7 (At 12:30 p.m., the hearing was
8 concluded.)

9 o o o

10 Thursday, May 22, 2025

11 Posttrial Motions

12 o o o

13 (At 10:08 a.m., the following proceedings
14 were held in open court:)

15 THE COURT: We are back on record in the
16 matter of Remington Anyan vs. Mercy Hospitals, et
17 al., Cause No. 21SL-CC03944.

18 This matter is on the Court's docket this
19 morning in part for continuation of the motions to
20 enforce settlement, and we'll address the other
21 motion after we finish this one, I guess. I would
22 ask that everybody turn on their microphones.

23 On behalf of the defense, you may call
24 your next witness.

25 MR. PERRON: Your Honor, the defense calls

Mandy Kamykowski.

THE COURT: Step on up and be sworn.

MANDY KAMYKOWSKI,

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. Mandy Kamykowski.

Q. Were you retained as counsel for one of the defendants in this case?

A. I was. I represent Mercy Hospitals East Communities.

Q. Is Mercy Hospitals East Communities interchangeable with Mercy Health or Mercy?

A. It is one of the entities that can be encompassed by that trade name, I believe.

Q. Had you made attempts throughout the pendency of this claim to negotiate a settlement to resolve the claims against the defendants?

A. Yes.

Q. Did you make a settlement offer in February of 2025, to resolve all of the claims?

A. A written offer was relayed to Ms. Gunn

1 via email on behalf of my client and also your client
2 and Mr. Willman's clients, Dr. McNeive and Mercy
3 clinic, yes.

4 Q. Is that the February 7 letter previously
5 marked as Exhibit A?

6 A. Yes.

7 Q. Does Exhibit A capture the extent of the
8 offer itself and the terms of the agreement?

9 A. Yes.

10 Q. Does Exhibit A accurately reflect the
11 frame of the negotiations from the standpoint of the
12 defense?

13 A. Yes.

14 Q. Specifically, in the first paragraph, can
15 you read the sentence starting with please note?

16 A. It reads: Please note that all offers,
17 conditions, and/or terms included herein are -- and
18 then bold and underlined -- material terms to any
19 final settlement reached by the parties, and must be
20 included in any final settlement release agreement
21 finalized by parties in this case.

22 Q. Did Exhibit A reference the statutory caps
23 on noneconomic damages?

24 A. It did, on the second page.

25 Q. In what way did the letter specifically

1 reference the caps?

2 A. Beginning on the first page, the letter
3 reads: while we are confident your clients have
4 already been advised of the risks of taking this case
5 through trial, our clients want to reiterate the
6 following points, with conveyance of this global
7 offer to plaintiff.

8 The first bullet point that dealt with
9 punitive damages, and the second bullet point on page
10 2, incorporate the discussion of Missouri law
11 affording certain statutory limits on any jury
12 verdict that may be awarded to the plaintiff at
13 trial.

14 It specifically then enumerates the
15 noneconomic damages cap, identifies that the case is
16 subject to that cap, that that cap for the trial in
17 2025 is \$828,000 -- or \$828,529. And then
18 specifically stated: Regardless of the award
19 included on the verdict form by the jury for the
20 noneconomic damages, the Court is mandated to apply
21 the statutory caps before entering a final judgment
22 in the plaintiffs' favor.

23 Q. Did Exhibit A's use of the cap limitation
24 on recovery to frame -- did Exhibit A use the caps
25 limitation on recovery to frame the value of the case

1 for purposes of settlement?

2 A. Absolutely.

3 Q. Throughout negotiations in this case, did
4 you continually reference the settlement value in
5 terms of the likely recoverable amount, including
6 caps on noneconomic damages?

7 A. Yeah. There would be no other way for us
8 to advise our clients as to the potential risk
9 exposure they have in a Missouri medical malpractice
10 claim.

11 Q. And that's talking to your/our clients,
12 but when you were discussing the case with
13 plaintiffs' counsel, was that also continually
14 referenced in terms of framing the case value and
15 settlement value?

16 A. Yes. We had a disagreement as to what the
17 upper limit of the economic exposure in the case was,
18 but always encompassed in that was the discussion, or
19 included an evaluation of the noneconomic damages
20 being limited to the extent of the caps.

21 Q. In addition to the February 7th, 2025,
22 letter, did the defense continue to employ a mediator
23 to facilitate discussions on case settlement?

24 A. Yeah. In fact, a mediator had been
25 employed for the prior year, when the case was set

1 for trial, I believe, in April of 2023 -- or 2024.

2 Q. Was there a mediation date set at one
3 point in 2025?

4 A. Yes. This case was agreed by the parties
5 to be mediated on February 14th of 2025.

6 Q. Did plaintiff ultimately appear, or agree
7 to appear, at mediation at that assigned date in
8 2025?

9 A. I mean, there was an agreement, which is
10 why we set it, but the mediation did not go forward
11 because -- for various reasons.

12 Q. What was the offer conveyed in the
13 February 7th letter in terms of a dollar amount?

14 A. 2.5 million.

15 Q. As you mentioned, ultimately did the
16 parties appear for mediation at that time?

17 A. No.

18 Q. Why?

19 A. The plaintiff had a precondition to
20 participate in mediation that \$5 million be on the
21 table, and that demand was not met, and mediation was
22 cancelled.

23 Q. Was that the first time that the case
24 almost went to mediation?

25 A. No. As I said, we had an agreement to

1 mediate the case, I believe it was maybe in March or
2 April, sometime prior to the original trial setting
3 in this case of April of 2024.

4 Q. Did defendants continue to employ the
5 mediator to solicit some or any demand from
6 plaintiff?

7 A. We did.

8 Q. Did you discuss with the mediator his
9 conversations with plaintiffs' counsel?

10 A. Many times.

11 Q. What does the term "best day in court"
12 mean in terms of ongoing negotiations in general?

13 A. In this context of a medical malpractice
14 case pending in the State of Missouri?

15 Q. Yes.

16 A. So the best day in court, as I understand
17 it from the defense perspective throughout my career
18 has been, whatever a jury might award on the
19 economic, both the past and the future economics,
20 since our jury instructions mandate the damages be
21 awarded by the jury in categories, and the categories
22 are determined by the evidence that's adduced at
23 trial.

24 so for this case, it included past
25 economic damages and future economic damages. Those

1 are not subject to any cap. They are subject, in the
2 future, to some other tort reform provision, such as
3 periodic future payments in the event of a
4 plaintiffs' verdict.

5 The other categories that are at play in
6 evaluating the plaintiffs' best day in court, are the
7 noneconomic damages. And for purposes of the
8 defense, we always evaluate those based on what the
9 number the legislature, through the Department of
10 Insurance, has published for, as the case law
11 describes it, the year that the trial occurs. So, in
12 this case, that's that \$828,529 number.

13 Q. From the defense's perspective, does the
14 plaintiffs' belief in their own best day in court,
15 impact how the defense evaluates case value?

16 A. Of course it comes into play when we are
17 discussing, for example, in this case, there was a
18 dispute as to which of the plaintiffs' offered pieces
19 of life expectancy evidence would be relied on for
20 negotiations for the ceiling, if you will, of the
21 plaintiffs' best day. But certainly the plaintiffs
22 are also taking into account what their best day in
23 court is under those same scenarios.

24 Q. From your discussions with the mediator,
25 did you come to an understanding that the mediator

1 had been in contact and continuously talking with
2 plaintiffs' counsel?

3 A. Yes.

4 Q. Did you form an understanding about how
5 plaintiffs' counsel valued their best day in court?

6 A. Yes. After mediation was cancelled, but
7 prior to trial beginning, there were numerous

8 discussions that I had with the mediator where we
9 were talking about ways that we could potentially

10 resolve this case, short of having to pick a jury and
11 try the issues in that manner.

12 In doing so, the discussion always came

13 to, well, what does the plaintiff think their best

14 day? And will they come off of that number for our

15 clients to be able to evaluate whether they can offer

16 enough money to make the case go away?

17 And in those discussions, it was relayed

18 to me that the plaintiffs' belief was the full value

19 of their life care plan from Dr. Liles at the 75-year

20 life expectancy, which we know was I think was around

21 21 or \$22 million, plus past economics charged to --

22 for the care for Mr. Anyan at around \$600,000, then

23 the cap on noneconomic damages. So the total was

24 somewhere in the 22 to \$24 million range, as I

25 understood it, as plaintiff had explained their best

1 day to our mediator.

2 Q. Did that understanding continue to inform
3 your assessment of the value of the case for
4 settlement as the case continued?

5 A. Of course it did, yes.

6 Q. Did plaintiff eventually make a demand?

7 A. Yes.

8 Q. On or about February 28, 2025, did
9 plaintiff make a demand?

10 A. Yes. It was the day following our
11 pretrial conference, when some substantial pretrial
12 rulings had been made, I received a phone call from
13 Ms. Gunn, and she was giving me a head's up that a
14 written demand was going to be made, that it was
15 likely to be very high, and she wanted to let me know
16 that her clients -- she was meeting with her clients
17 that day, and she would get back to me. Sometime on
18 February 28th, which I believe was a Friday, I
19 received an email, we all received an email, with a
20 demand of \$45 million.

21 Q. Between February 28 and the first day of
22 trial, did defendants increase their offer?

23 A. They did, yes.

24 Q. To what?

25 A. I believe initially there was a \$5 million

1 demand that was rejected with -- I can't remember if
2 at that point a \$40 million was made, but the numbers
3 were up to 5 and 5 and a half million, which were
4 rejected.

5 And I think the plaintiffs were at 40
6 million -- 45 million and then 40 million. And that
7 was prior to trial. The morning of our final
8 pretrial, and just before voir dire, when the Court
9 has their parties and their counsel present, to have
10 a -- one last attempt to discuss settlement, a \$10
11 million offer was made on behalf of all defendants,
12 to which I believe there was a reduction to 38
13 million and then ultimately 35 million, which was
14 rejected, and at that time, a trial ensued.

15 Q. Around about March 6, so going back in the
16 chronology a little bit, did you have another
17 conversation with plaintiffs' counsel wherein you
18 discussed the case value and the likely recovery on
19 compensatory damages?

20 A. We did. I had a phone call with Ms. Gunn
21 and Ms. Slater on March 6th, after a pretrial, a
22 further pretrial hearing, where the plaintiff had
23 asked the Court to reconsider its ruling excluding --
24 or limiting Mr. Gingras as a rebuttal witness. And
25 that certainly was continuing to frame the economic

1 exposure risks that were at play for both sides in
2 the case.

3 After that hearing, a phone call occurred
4 with both of them where we had a frank discussion
5 about the fact that plaintiffs' demand was still far
6 in excess of what any defendant would ever be
7 obligated under a final judgment in this case to pay
8 to satisfy any verdict that might be awarded to the
9 plaintiff. And it inquired what the plaintiffs'
10 attorneys could justify for not making a demand that
11 would entice our clients to potentially pay at
12 something close to the best day the plaintiff could
13 have from a judgment perspective.

14 And, again, at that point, it was
15 reiterated it was in that \$20-plus million range,
16 right around there, that the plaintiffs' evidence
17 would be, and that they did not believe their clients
18 would be willing to take a discount, if at all, on
19 that number to settle the case short of trial.

20 Q. Getting back on track with the time line
21 and chronology, on March 11, at the request of the
22 Court to make another attempt at trying to settle the
23 case, did the defendants increase their offer?

24 A. Yes.

25 Q. To what?

1 A. To \$10 million -- on March 11th to
2 \$10 million.

3 Q. What was the demand in response?

4 A. Initially, it was 38 million. And then I
5 believe, when it was reiterated that the 10 was the
6 offer, there was going to be no other pretrial offer,
7 another reduction to 35 million, and we were told
8 that was their lowest number. And negotiations
9 stopped at that point, and a trial began.

10 Q. Even after March 11th, that same evening,
11 or within that 24 period, did you hear again from the
12 mediator?

13 A. Yes.

14 Q. Did you come to an understanding from the
15 mediator about plaintiffs' assessment of the case
16 value and what they would be willing to accept?

17 A. Again, the case value had remained the
18 same. He was expressing a little bit of uncertainty
19 as to why the demand was still in the 35 million --
20 the \$35 million amount, but indicated that in his
21 conversations that day with plaintiffs' counsel, that
22 they reiterated that it was very likely something
23 with a 2 in front of it would settle the lawsuit,
24 meaning in the \$20 million range.

25 Q. Within all of the back-and-forth, were

1 both sides consistently discussing settlement and
2 case value in terms of the recoverable amounts,
3 specifically after application of the cap on
4 noneconomic damages?

5 A. Yes.

6 Q. Was that consistently the frame at which
7 the case value and settlement value was discussed?

8 A. Yes.

9 Q. Skipping ahead in the chronology to
10 March 25th.

11 while the jury was deliberating, did the
12 jury send back questions suggesting the direction of
13 their likely verdict plaintiff versus defendants?

14 A. Yes.

15 Q. In particular, what were they asking for
16 from your recollection?

17 A. And I think we heard this on Tuesday in
18 the record, we have the records that the Court made
19 at the time. The first request was for some sort of
20 chalkboard. That was given to them. And then the
21 next request was for, I think they called them the
22 life care tables or the life cost tables of both
23 sides. That began the questions of the jury with
24 respect to the damages analysis.

25 Q. Was that question conveyed to the insurer

1 clients?

2 A. It was -- it was conveyed to the clients
3 themselves and Ms. Rucker on behalf of Mercy
4 Hospitals. I know Dr. McNeive was still here, and
5 your client, Anne Rucker, also with Mercy Clinics,
6 and then the insurance carrier involved for Medical
7 Protective, Joe Crawford.

8 Q. Did you have a discussion over the phone
9 with Mr. Crawford about a response to that jury
10 question?

11 A. Of course, yes.

12 Q. Was a new offer discussed?

13 A. So at that time, we relayed what the
14 question was, the Court's plan to advise the jury in
15 response thereto, and then did again, then, discussed
16 should we make an attempt to try to resolve this
17 short of a verdict? And at that point in time, we
18 were authorized to offer a new hard \$12 million
19 number to the plaintiff.

20 Q. From February 7, the date of first letter,
21 through March 25, were all of those offers made
22 pursuant to the same terms and conditions as conveyed
23 in the February 7 letter?

24 A. Yes.

25 Q. Going back to that letter marked as

1 Exhibit A, was one of those terms full
2 confidentiality?

3 A. Yes.

4 Q. was one of those terms mutual
5 non-disparagement?

6 A. Yes.

7 Q. was one of those terms plaintiffs'
8 responsibility for all liens?

9 A. Yes.

10 Q. was one of the terms to resolve all
11 claims?

12 A. well, actually, I take that back. I don't
13 know that that's in here, but that is a standard
14 term. And throughout the course of this, we talked
15 about the standard terms that we always enter in
16 these cases.

17 Q. was -- going back -- was one of the terms
18 that any settlement would resolve all claims?

19 A. Yes.

20 Q. was one of the terms explicitly that
21 nothing would be paid for settlements on punitive
22 damages?

23 A. Yes. And, in fact, it says that in case
24 this offer didn't get done, that the defendants would
25 not negotiate a settlement to include payment for

1 possible punitive damage recovery.

2 Q. was one of the terms that the frame of the
3 discussion of case value, was the application of the
4 cap on noneconomic damages?

5 A. Yes. That regardless of the award
6 included on the verdict form by the jury, the case
7 would be subject to the caps.

8 Q. Both in terms of the letter and continuing
9 negotiations, was one of the benefits to plaintiff
10 argued in favor of settlement to avoid periodic
11 payments on future economic damages?

12 A. Yes.

13 Q. was one of the benefits to plaintiff in
14 terms of settlement to avoid delay in payments due to
15 appeal?

16 A. Yes.

17 Q. When you continued to discuss with the
18 insurers about authority for further offers, did you
19 repeat back to them all of this long list of explicit
20 terms incumbent on every subsequent offer?

21 A. No. Our clients are sophisticated. They
22 are experienced. And these are all standard terms
23 that we utilize in every case that we settle.

24 Q. Did everyone understand, from your
25 perspective, did everyone understand that those

1 remain the terms in the frame of the agreement unless
2 specifically mentioned otherwise?

3 A. Yes.

4 Q. when you conveyed the \$12 million offer to
5 plaintiff on March 25, did you convey that it would
6 be with the same terms and conditions as had already
7 previously been conveyed in every other offer?

8 A. The offer that was relayed to Ms. Slater,
9 she and I were the only ones in the room at the time,
10 was in the context, can we try to resolve this case?
11 we were having a friendly conversation about what
12 could happen. The jury was deliberating. We were in
13 the room across the hall. And I said, I have a
14 number for you. And she said, do you only have one
15 number for me? And I said, I have one number for
16 you, it's 12 million, and the message that they would
17 like for you to consider with that is this is going
18 to make sure there's no appeal.

19 Because we think that there are errors in
20 this case that could be reversed on appeal, and
21 that's a possibility, and that might take years, and
22 we know that your client is a child who has care
23 needs now and needs to have some money. And,
24 further, the discussion specifically at that time was
25 buying -- buying their peace from an appeal and

1 avoiding the periodic future payments that would be
2 on the economic numbers because that's the only
3 number at that point that mattered.

4 Q. when plaintiff made the counterdemand of a
5 high-low at 10 and 20, did counsel specify that the
6 trigger would be on the unadjusted verdict or mention
7 the term "verdict" at all?

8 A. Absolutely not. The relay was, your 12
9 million was rejected, but I have a high-low of 10 and
10 20 is nonnegotiable. That was the extent of that
11 offer.

12 Q. And within the context of all previous
13 negotiations, did you come to an understanding about
14 what the 10 and the 20 were referring to in terms of
15 framing what you guys were discussing?

16 A. Yeah. As you asked me before, in all of
17 the conversations that I had, both directly with Ms.
18 Slater and Ms. Gunn, and through the mediator,
19 everybody understood that plaintiffs' best day,
20 meaning the most that they could recover from any
21 defendant on a judgment that would be entered in this
22 case, understanding that no punitives were part of
23 the discussion, so we're talking compensatory
24 judgment only, would be somewhere in that \$20 million
25 range.

1 And the 10, I'm not really sure where that
2 came from, other than the evidence adduced at trial
3 by the defense was economic numbers between 5 and a
4 half and 6 and a half million. It really got closer
5 to the 8, which was -- which comes into play when the
6 defense's counter to that high-low was made.

7 Q. From the perspective, asking -- hearing
8 the jury questioned asking for both the defense's
9 life tables and the plaintiffs' life tables, and I
10 don't want to misquote, I think the specific wording
11 was the life care plan and the -- and the numbers
12 from both sides, but I'll defer back to the record
13 for the specific language. within the context of
14 that question, was it likely that the compensatory
15 verdict was going to be lower than 5.5?

16 A. No, absolutely not. The jury had already
17 asked for damages information. So we put an anchor
18 of 4. And I don't believe -- I mean, I guess it's
19 possible, but was it likely? Not in our mind.

20 Q. was it likely that the recoverable amount
21 of the compensatory damages would be beyond 21
22 million, within the context of the jury asking for
23 both the defense's and the plaintiffs' life care
24 plans?

25 A. Yes. At that time, Ms. Gunn had argued to

1 the jury economic numbers of 600,000 of past economic
2 for the charged medical bills, plus the life care
3 plan of Dr. Liles' up to age 75, or the 21 million
4 that was -- and then argued that there were some
5 items that Dr. Liles did not include in his life care
6 plan, such as additional respite care for the parents
7 while the child was under 18, maybe a new home, a
8 service dog, other things that she argued the life
9 care plan, as Dr. Liles tendered to them, was
10 underfunded, and she suggested a number of 25 million
11 in future economic damages to the jury.

12 Q. Did the jury question requesting both the
13 defense and the plaintiff life care plans suggest a
14 likelihood that their final number on future economic
15 would be somewhere between what plaintiff asked and
16 what defense asked for?

17 A. I don't know if you could say it was
18 suggested. But it certainly said they were
19 considering the evidence offered by both sides.

20 Q. Did you convey the high-low demand back to
21 Mr. Crawford and Anne Rucker?

22 A. Yes, we did.

23 Q. Did the defendants make a counteroffer?

24 A. Yes. I think at that point in time, and I
25 know we had some discussions post, I didn't make

1 notes of it, but it was something either 8 and 15,
2 but ultimately we rested on 8 and 18.

3 Q. The text from Ms. Rucker at 4:23 p.m., we
4 are okay with the high-low, did Ms. Rucker herself
5 have ability to grant authority to settle beyond
6 \$10 million?

7 A. I don't believe so. I think the extent of
8 her authority for the SIR for Mercy for all of the
9 defendants was up to 10 million.

10 Q. Even with Ms. Rucker signing on to a
11 high-low agreement, who had the exclusive authority
12 to agree to a high-low that implicated a settlement
13 amount beyond 10 million?

14 A. That would be Medical Protective who had
15 that first layer of excess coverage which was being
16 handled by their claims adjuster, Mr. Crawford.

17 Q. And that was who we saw on Tuesday?

18 A. Yes.

19 Q. Did Mr. Crawford appear live at trial?

20 A. He did not.

21 Q. Several counteroffers were made back and
22 forth within the context of the high-low?

23 A. That's true.

24 Q. In your mind, in conveying context of
25 different offers back to Joe and Anne Rucker, did you

1 understand that each offer, at least in your mind,
2 carried the same terms and conditions of every
3 previous offer?

4 A. Yes.

5 Q. Did every offer and counteroffer within
6 the context of high-low negotiations, at least in
7 your mind, carry an understanding that the context of
8 the high-low was the final recoverable amount?

9 A. And I don't think -- you keep saying at
10 least in my mind. I think it was the position of the
11 defendants and the authority that we were granted by
12 our clients, was within those -- within that context,
13 yes.

14 Q. What was defendants' last offer within the
15 high-low negotiations?

16 A. It was -- the high-low, the low would be 8
17 million, and the high would be 18 million, and that
18 was reiterated right at the time that the Court
19 announced there was a verdict.

20 Q. Was this, the 8 and 18 high-low agreement,
21 was that the defendants' offer to resolve the case?

22 A. Yes.

23 Q. Did you understand that final offer to
24 carry any different terms or conditions than the
25 previous offers?

A. No.

Q. Now, that -- did you understand that offer would exclude any payment for punitives -- punitive damages consistent with all of the previous offers?

A. Yes. It resolved all claims, including the claims for punitive damages, against Dr. McNeive and Mercy Clinic, but there was -- but it also carries the additional terms that payment would not be made to satisfy any award of punitive damages.

Q. Did you understand an offer to pay any money beyond what defendants would be obligated to pay under the Missouri state cap on noneconomic damages?

A. No.

Q. Why not?

A. Because we would never give up that protection that has been afforded to medical malpractice defendants in this state. It is how we evaluate claims. It is how insurance carriers evaluate their risk exposure. And it's how cases are negotiated and settled every day.

Q. Did you agree to pay settlement money on an award of noneconomic damages beyond the cap amount?

A. No. And that was never an offer that was

1 made to the plaintiffs by the defense.

2 Q. Did you ever agree to pay settlement money
3 on punitive damages?

4 A. No.

5 Q. Back to the chronology in the series of
6 events. Ms. Slater, on the record, immediately after
7 reading of the punitive verdict, described the last
8 bit of negotiations. And this is reflected in what
9 has been marked Plaintiffs' Exhibit 6. At the end,
10 she spoke to you right before the jury came back, if
11 defendants would do 10/20, or perhaps lower the low
12 amount below 8 to get a higher high.

13 A. Are you asking me if she --

14 Q. Yes.

15 A. Yes, that occurred.

16 Q. And what was your response to that?

17 A. No. There was discussion and a request.
18 I believe if we look at page 19 of that record, the
19 record that was made by Ms. Slater accurately
20 reflects that the verdict came in, she asked me in
21 kind of whispered tone at counsel table there, can we
22 do 10 and 20? I said, no, 8 and 18 is it.

23 Q. Does this also line up with the text
24 message with Mr. Crawford at 4:43 p.m.?

25 A. Yes. Where I told him -- I told her it's

1 8 and 18 or something. I don't have -- I want to --
2 let me make sure I accurately reflect what that text
3 message was. Verdict. And I told them 8/18 was it.
4 That was at 4:43 p.m.

5 Q. And, again, page 20 of Plaintiffs'
6 Exhibit 6, Ms. Slater related that she asked the
7 Court for a pause before the jury was brought back in
8 and took her client in the hall to discuss your last
9 offer. Does that match your recollection?

10 A. Yes.

11 Q. Ms. Slater, in that same next couple of
12 lines, described that she came back into the
13 courtroom and communicated to Ms. Kamykowski that 8
14 and 18 would be accepted as the high-low.

15 Does that match your recollection?

16 A. Yes. They walked in with their client,
17 she nodded to me yes, and we were settled.

18 Q. The final agreement on the high-low, was
19 that plaintiff accepting defendants' last offer?

20 A. Yes.

21 Q. And that was an offer that had been made
22 with the same terms and conditions as previously
23 mentioned?

24 A. Yes.

25 Q. offer made to resolve all claims?

1 A. Yes.

2 Q. with no payment on punitives?

3 A. Correct.

4 Q. Is that an offer made with the framework
5 that it would be paid after the application on the
6 noneconomic cap on the recoverable amount of
7 compensatory?

8 A. Yes.

9 Q. Up to that point where Ms. Slater agreed
10 to the 8 and 18 as high-low, accepting our last
11 offer, had the word "verdict" been mentioned as a
12 trigger for the high-low?

13 A. No. But a verdict is a trigger for the
14 high-low. we all know that. A -- a -- a verdict
15 that comes from the jury is part of how you have to
16 determine it. And that's what we were looking at
17 here. Because if the verdict had come back with
18 their 25 million in economic damages, the high would
19 have been triggered.

20 MR. PERRON: I'm going to -- Your Honor,
21 may I approach with a demonstrative exhibit?

22 THE COURT: You may.

23 THE WITNESS: Thank you.

24 Q. (By Mr. Perron) Does the chronology in
25 Exhibit B accurately reflect your recollection of not

1 a complete time line of events, but of the time line
2 of events that we've been discussing?

3 A. Yes.

4 Q. So after Ms. Slater comes back in and
5 says, we accept, did you guys go back into the hall
6 to flesh out some additional details?

7 A. We did. With Mr. Millman, Ms. Slater, and
8 I.

9 Q. To your recollection, you were listening
10 when Mr. willman was testifying as to his
11 recollection of that conversation.

12 Did you and Mr. willman or Mr. willman
13 himself reiterate that the high-low would resolve all
14 claims?

15 A. Yes.

16 Q. Did you reiterate that no payments would
17 be made on punitive?

18 A. Yeah. I think that was Mr. willman
19 confirming that because that was an issue for his
20 clients.

21 Q. Did Ms. Slater agree that the high-low
22 resolved all claims?

23 A. She did.

24 Q. Did she agree that no payment would be
25 made on the punitives?

1 A. She acknowledged that, yes.

2 Q. Did Mr. Willman ask if it was -- if that
3 was the case, if it was still necessary to let the
4 jury deliberate and come back on a punitive award?

5 A. He did.

6 Q. And Ms. Slater -- did Ms. Slater disagree
7 that the punitive phase was moot in terms of the
8 high-low agreement?

9 A. So the conversation was -- I don't know --
10 I can't say that she said it was moot. But the
11 conversation was around, if we know we have an
12 agreement of 8 and 18 that's based on the recoverable
13 compensatory amount, why does the jury have to
14 deliberate? Why do we need to argue? Even if they
15 award -- which we didn't know, there was a question
16 about punitives at that time. But why would we need
17 to move forward with the second phase?

18 It seems unnecessary since everyone has
19 agreed that claim will be released with this
20 settlement agreement and no payment. So the amount
21 that they would award is irrelevant to any further
22 part of the settlement that was negotiated to and
23 agreed to at that time.

24 At that point, that was when Mr. Willman
25 was asking those questions, and in that context, as

Ms. Slater just said, we need to hear the verdict.

That was the response.

Q. And in the transcript, Plaintiffs' Exhibit 6, page 21, line 2, Ms. Slater said on the record, Mr. Willman asked me if that was necessary to go through with the punitive phase, and I said, yes, that we wanted to do that.

A. She did.

Q. Does that match your recollection?

A. And the conversation at that point was, I know Phil was understandably frustrated with why that had to continue with the fact that we had an agreement, and I pointed out to him that it's pretty obvious that the reason why that would want to be done is not for any sort of collection or to any trigger of what that agreement already was, but it was so that the plaintiff could publicize it.

Q. When Ms. Slater said, yes, we wanted to do that, did she state or imply or in any way communicate that they wanted to hear the punitive verdict because it might affect the high-low or that it would be a trigger for the high-low?

A. No.

Q. Would you have objected, if you had understood that them wanting to hear the punitive

1 award, would have affected the payment of the
2 high-low in any way?

3 A. Yes.

4 Q. Did you interpret "yes, we want to do
5 that," regarding hearing the punitive phase, to be a
6 qualification of the terms of how the high-low
7 payments would be made, or a separate and distinct
8 term that they wanted to add in, that the jury would
9 get to deliberate and announce their punitive award?

10 A. It was the latter. Just as were the
11 additional terms that were discussed, that I think
12 we're going to talk about, the confidentiality and
13 the non-disparagement.

14 Q. Page 21, line 21 of Plaintiffs' Exhibit 6.
15 Ms. Slater stated, I accepted that, that the 8 and 18
16 on the verdict would not be paying for any punitive
17 damages as understood by all parties.

18 Does that match your recollection of Ms.
19 Slater's statements at that time?

20 A. Yes. Which is why I didn't correct the
21 record at the time because it was true.

22 Q. Is there any way to interpret Ms. Slater's
23 comment then on the record, or out in the hall
24 earlier, except to mean that she understands the
25 agreement to the settlement would not be paid on

1 punitives?

2 MS. GUNN: I'm going to object. calls for
3 speculation, legal conclusion.

4 THE COURT: Sustained.

5 Q. (By Mr. Perron) At the time Ms. Slater
6 was typing the note on her phone, as we heard a
7 little bit about earlier, did you believe that
8 plaintiff had already accepted the high-low offer as
9 you had made it?

10 A. I didn't believe it was true. The
11 acceptance happened in the courtroom. That was
12 outside of the courtroom after the acceptance had
13 occurred.

14 Q. And that excluded punitive damages?

15 A. Yes.

16 Q. And it was covered by the recoverable
17 amount, the same conditions that it had been in every
18 previous offer.

19 A. Absolutely. we would never have given up
20 the cap applying to a settlement in this case.

21 Q. was the next message jointly drafted by
22 you and Ms. Slater?

23 A. No.

24 Q. was there a drafting process?

25 A. There was not a -- I mean, not on my part.

1 There was, clearly there was, a draft process by Ms.
2 Slater on her -- on her phone as I was standing next
3 to her, yes, but I had no input on it.

4 Q. Did you have any input in the wording of
5 the text?

6 A. No.

7 Q. First line --

8 MR. PERRON: This is, again, just a
9 demonstrative, Your Honor. May I approach?

10 THE COURT: You may.

11 A. Thank you.

12 Q. (By Mr. Perron) Does this demonstrative
13 match the language and form of the writing that Ms.
14 Slater made on her note on her phone?

15 A. Yes.

16 Q. Okay. Does the first line, 8 and 18,
17 accurately reflect your understanding of the high-low
18 agreement?

19 A. Yes. That the parameters of the payment
20 amounts that were at play was a low of \$8 million and
21 a high of \$18 million.

22 Q. Does each line of this note, in your
23 opinion, address anything above it, or is each
24 separate line its own separate additional part of the
25 agreement?

1 A. So they were all separate in addition.
2 The 8 and 18 was what was agreed to in this -- in
3 this courtroom. Accepted -- the plaintiff accepted
4 that offer. The next three lines are part of what
5 the totality of the conversation between Mr. Willman,
6 Ms. Slater, and I were outside of the courtroom
7 before the verdict was read.

8 Q. When you saw on the next line below 8 and
9 18, all the way to verdict, did you interpret that as
10 a change in the previous understanding, that all the
11 way to verdict would be the trigger for the high-low
12 agreement?

13 A. No.

14 Q. How did you interpret this line, all the
15 way to verdict?

16 A. That was part of the total context of the
17 conversation with Mr. Willman about, why do we have
18 to go through with the punitive damage phase if the
19 jury does say that his clients were liable for
20 punitive damages in the compensatory? So on verdict
21 form A.

22 And so that was confirming that the
23 plaintiff or his attorneys wanted to go through both
24 verdicts, understanding that we all needed to hear
25 the compensatory verdict to then be able to figure

1 out the final recoverable amount that would be the
2 payment between 8 million on the low end and 18
3 million on the high end. So all the way to verdict
4 was memorializing that further discussion about why
5 the punitive phase had to go forward.

6 Q. Did you discuss confidentiality further in
7 the hall with Ms. Slater?

8 A. We did. Because all that day when we had
9 been going back and forth, as well as seen from the
10 February 7th date forward, full confidentiality and
11 mutual non-disparagement had been demands that were
12 part of the offers made by the defense. There was no
13 pushback on either of those terms until that
14 conversation in the hallway where Ms. Slater just
15 looked at Mr. Willman and said, I'm not going to gag
16 these parents. They've been through enough. And we
17 certainly had been through a public trial
18 understanding there was going to be a public verdict.
19 And so confidentiality to high-low, that's the
20 standard that we do with any settlement case.

21 That would be our standard language we
22 would incorporate into the release agreement that we
23 would ask the Court to approve, which is stuff that
24 we've done with -- not at that time with Ms. Slater,
25 but Simon Law Firm, Mr. Willman, your firm and mine,

1 many times in the past.

2 And the no non-disparagement was specific
3 to that. It was a limited agreement that we had
4 there that the Anyans would certainly be able to talk
5 about the trial, the verdict. But we had sat here
6 through 11 days of trial, and they had not disparaged
7 any of the defendants at that time. We didn't think
8 that was going to be an issue.

9 Those two -- those -- this text, when it
10 was shown to us, and then ultimately sent to me, we,
11 in discussing those, we certainly, Mr. Philman -- Mr.
12 Willman and I -- indicated, because that was a
13 departure from our prior discussions about
14 confidentiality, non-disparagement, and the second
15 phase, that we necessarily had to then call our
16 clients and get their buy-in and their approval for
17 these additional now renegotiated terms of the
18 standard offer that had been made before on the 8 and
19 18.

20 Q. Did you still desire and express the
21 desire that outside of allowing Mr. and Mrs. Anyan to
22 say whatever they wanted, you still wanted Mercy
23 Clinic, Dr. McNeive, and Mercy Hospital protected
24 from press releases from counsel and any other
25 publishing from counsel of a negative outcome beyond

1 the individual social media account that plaintiffs
2 might have?

3 A. Well, yeah. That's the understanding, and
4 that's how we do these in all these cases. We
5 don't -- the plaintiff certainly can scrub or kind of
6 de-identify their accolades for purposes of marketing
7 and social media.

8 And, again, because this was a public
9 trial, and there would be a verdict that would be in
10 the public record and ultimately a judgment entered
11 that would be the trigger for the final settlement
12 that we would be asking the Court to approve, we
13 couldn't control who -- what outside parties might be
14 getting access to these open -- to the court files,
15 but it was certainly part of the discussion that the
16 plaintiff would not overtly be going out and making
17 press releases about the case.

18 Q. Did you relay the terms, as you understood
19 them, to Mr. Crawford and Ms. Rucker?

20 A. Yes. And we specifically had a
21 conversation about whether -- it was possible that
22 with these new changes, the confidentiality and
23 non-disparagement, and having to go to the punitive
24 verdict, they may have said, no, let's just take our
25 chances and see what happens. But they did agree

1 then.

2 Q. On the -- on the chronology in Exhibit B,
3 the text from Mr. Crawford at 4:47 p.m., does jury
4 give a puni number, or do they know more testimony
5 needed, R.E., puni phase.

6 Did that come in at the same exact time,
7 4:47, as the text from Ms. Slater?

8 A. According to my phone, it does. I don't
9 know when I saw either of those. I know I had seen
10 the four-line message on Ms. Slater's phone in her
11 Notes app. I don't -- I know that it was then
12 reduced or forwarded in a text format. And my phone
13 shows both of those times, but I can't tell you when
14 I saw them.

15 Q. When you spoke to Mr. Crawford and
16 Ms. Rucker, did you understand all the way to
17 verdict, to mean that Mercy would pay out a
18 settlement on nonrecoverable, noneconomic damages?

19 A. Absolutely not.

20 Q. Did you understand that all the way to
21 verdict to mean Mercy would pay out settlement money
22 on punitive damage?

23 A. No, never.

24 Q. Would that have been contrary to the
25 context of all previous negotiations up to that

1 point?

2 A. Yes. And contrary to the authority that
3 Mr. Willman and I had to negotiate a settlement on
4 behalf of clients.

5 MR. PERRON: And one more demonstrative
6 exhibit, Your Honor, if I may approach?

7 THE COURT: You may.

8 Q. (By Mr. Perron) This is marked as Exhibit

9 D.

10 Now, this is taken from plaintiffs' memo
11 in response to defendants' motion to enforce on page
12 7 of that pleading prepared by plaintiffs' counsel.

13 This language in bold that qualifies each
14 line of the text message that was sent, is this bold
15 language, was that ever communicated in print, in
16 writing, or verbally, when you guys were discussing
17 the high-low agreement?

18 A. The bold language, no.

19 Q. Would seeing this qualifying language,
20 like the bold word "trigger" with regards to all the
21 way to verdict, would that have changed or altered
22 your understanding of this line of the text?

23 A. Yes. I wouldn't have understood why the
24 second line of all the way to verdict was the
25 trigger, when the trigger was the final judgment to

1 be entered by the Court based on the compensatory
2 verdict.

3 Q. If you had seen this bold language
4 attributed to all the way to verdict, would you have
5 agreed that that was consistent with your
6 understanding of the terms of the agreement?

7 A. No.

8 Q. Did you understand the text message that
9 was sent to you to be an exhaustive and exclusive
10 binding contract encompassing all the terms and
11 conditions of the settlement?

12 A. Certainly not.

13 Q. Does the text say that it dismisses or
14 resolves all claims?

15 A. No.

16 Q. The additional language added by
17 plaintiffs' counsel in describing this text writes,
18 amount in exchange for dismissal of all claims. That
19 bold language was not in the text, is that fair?

20 A. It was not.

21 Q. Does that mean that the text agreement
22 didn't resolve all claims because it didn't have that
23 language in it?

24 A. Well, the text was not in agreement. The
25 agreement had already been agreed to orally between

1 Ms. Slater, myself, and Mr. Willman, that 8 and 18
2 would resolve all claims, including the punitive
3 damages.

4 Q. So already, even using the bolded version
5 of the text that we have, there is a concession on
6 both sides that the text message was not an exclusive
7 list of all the terms of the agreement?

8 A. Yeah.

9 Q. Are the individual parties named in the
10 text message, including Mercy Hospital, Mercy Clinic,
11 Dr. McNeive?

12 A. No.

13 Q. Is there any question that the 8 and 18
14 high-low agreement was resolving claims for all
15 parties?

16 A. No question.

17 Q. Is that another element that was not
18 included in the text that was understood by both
19 sides to be an essential element of the settlement?

20 A. Yes. It would never be only releasing
21 part of the parties in this case.

22 Q. Does the text say that punitive damages
23 would not be paid for the settlement?

24 A. No.

25 Q. Ms. Slater, on the record, said that she

1 understood payment would not be made for punitive
2 damages.

3 Even though that's not mentioned in the
4 text, does that mean it wasn't an essential part of
5 the agreement?

6 A. No. It was an essential part of the
7 agreement, and Mr. Willman made sure of that.

8 Q. Typically, in any ultimate release
9 agreement, plaintiff requests a settlement payment be
10 made at a certain, or within a certain, amount of
11 time.

12 Is there any such time limit on settlement
13 payment in this text?

14 A. No.

15 Q. Does that indicate to you that defense
16 counsel or the insurance can wait however long after
17 the settlement is agreed to proffer payment?

18 A. No.

19 Q. The fact that the text was silent about
20 whether or not the settlement could be broken up into
21 annuity payments or a structured settlement, does
22 that silence indicate to you that plaintiffs wouldn't
23 be upset if defense took the position that you were
24 going to pay any settlement in periodic payments?

25 A. I'm certain they would be very upset if

1 the defense tried to do that in satisfying the
2 obligations under the settlement agreement.

3 Q. All these terms and conditions, all these
4 things were understood to be true, despite not being
5 included in this text?

6 A. Yes.

7 Q. Did you believe you had authority March 25
8 at 4:47 p.m., or shortly in the minutes thereafter,
9 did you believe you had authority to agree to a
10 high-low agreement that would be triggered by the
11 unadjusted verdict, including noneconomic damages in
12 excess of what defendants would ever have to pay?

13 A. Absolutely not.

14 Q. Did you believe that authority to agree to
15 a high-low agreement, that would be triggered by a
16 punitive damages award?

17 A. No.

18 Q. Did you believe you had authority to
19 negotiate, offer, and ultimately agree to a high-low
20 that extinguished punitive damages and would be paid
21 according to the recoverable amount of the
22 compensatory verdict?

23 A. Yes. The final judgment that would be
24 entered in the case applying the cap.

25 Q. Did you negotiate, offer, and accept the

1 final terms of what you believed to be the agreement,
2 based on the authority you thought you had?

3 A. So we negotiated and made an offer that
4 was accepted. That offer then had some additional
5 terms that are modified that are expressed in the
6 text message. I then obtained additional authority
7 to accept those new terms, and, yes.

8 Q. At one point in his testimony on Tuesday,
9 Mr. Crawford testified that he rejected the terms of
10 the text message.

11 In your memory, on March 25, did you send
12 him the actual text message?

13 A. No.

14 Q. Did you discuss with him verbally over the
15 phone the content of these additional terms that Ms.
16 Slater wanted to add onto the agreed high-low?

17 A. Yeah. As I said before, there was a
18 discussion between all defense counsel, Ms. Rucker,
19 and Mr. Crawford on the phone after the meeting with
20 Ms. Slater in the hallway about the reason why they
21 wanted to have the punitive damage verdict read, the
22 modification to the non-disparagement to not gag the
23 Anyans, and the confidentiality, yes.

24 Q. Did Mr. Crawford, as he testified, have
25 any problem with the 8 and 18 high-low agreement

1 itself?

2 A. No.

3 Q. Did he have any problem with allowing the
4 jury to deliberate and announce a punitive damages
5 award, as long as everyone understood that the
6 punitives would not be paid on the -- in the
7 settlement?

8 A. Well, I think everyone was a little
9 frustrated. I don't know if you'd say problem. I
10 think everyone on our side was frustrated because it
11 was certainly not something that we wanted to have --
12 Dr. McNeive to go through when we had reached a
13 settlement on the case, but everyone understood that
14 was a condition that plaintiffs had put on the final
15 settlement so we accepted it.

16 Q. Did Mr. Crawford, when you spoke to him,
17 express any objection to carving out an exception to
18 the non-disparagement for Mr. and Mrs. Anyan
19 themselves?

20 A. No.

21 Q. Did you accurately relay terms, as you
22 understood them, to Mr. Crawford and Ms. Rucker?

23 A. Yes.

24 Q. Did they accept those additional
25 modifications of what had already been accepted in

1 the high-low agreement?

2 A. Yes.

3 Q. When Mr. Crawford learned that plaintiff
4 had a different interpretation of the high-low
5 agreement, did he agree to go along with plaintiffs'
6 subsequent disclosure of their different
7 understanding?

8 A. No, not understanding wasn't learned by
9 any of us until after the verdicts were read and we
10 had a sidebar with the judge. And so he wasn't aware
11 of it until we left the courtroom that evening.

12 Q. On March 25th, did you stand to gain -- in
13 responding -- start over.

14 In responding to Ms. Slater on the record,
15 after reading of the punitive damages when the
16 disagreement became apparent as to the terms of the
17 high-low, in responding to Ms. Slater and the Court's
18 questions, did you represent the facts accurately as
19 you believed them to be at that time?

20 A. Yes.

21 MR. PERRON: Those are all my questions.

22 THE COURT: Cross-examination?

23 MS. GUNN: Yes, Your Honor.
24
25

1 CROSS-EXAMINATION

2 BY MS. GUNN:

3 Q. Ms. Kamykowski, did you have authority to
4 negotiate on behalf of all of defendants: Mercy
5 Hospital, Mercy Clinic, and Dr. McNeive, on
6 March 25th, 2025?

7 A. I negotiated on behalf of my clients.
8 Mr. Willman was present to negotiate on behalf of his
9 clients. And I was the spokesperson for globally the
10 defendants.

11 Q. Did you have authority to negotiate on
12 behalf of Mercy Clinic? Yes or no?

13 A. No.

14 Q. Did you have authority to negotiate on
15 behalf of Dr. McNeive?

16 A. No. Mr. Willman did.

17 Q. So did you negotiate on behalf of Mercy
18 Clinic?

19 A. I did not.

20 Q. You didn't negotiate on behalf of Dr.
21 McNeive?

22 A. I did not.

23 Q. So that was solely Mr. Willman's
24 responsibility?

25 A. And Mr. Willman was present throughout the

1 day and negotiated on their behalf, yes.

2 Q. were you here two days ago when I asked
3 Mr. willman whether you negotiated on behalf of all
4 three defendants, and he said yes?

5 A. Yeah.

6 Q. And you disagree with that?

7 A. I do. I didn't have -- I've never had
8 authority. They're not my clients.

9 Q. Right.

10 A. But I was the spokesperson for the global
11 defendants in -- on that day, yes.

12 Q. So you were the spokesperson and spoke on
13 behalf of all three defendants attempting to get the
14 case resolved, correct?

15 A. I relayed the authority that Mr. willman
16 and I had been given by our clients on behalf of the
17 insureds to -- to negotiate settlement, yes.

18 Q. And that would be through MedPro?

19 A. It was through Anne Rucker with Mercy who
20 was Mercy Clinic, and then MedPro for all -- both
21 Mercy and Dr. McNeive.

22 Q. And you heard Joe Crawford testify two
23 days ago that he had the sole authority to settle all
24 the claims, correct?

25 A. I think that that was in the context of

1 what level we were talking about. But, yes, he had
2 the authority.

3 Q. Between 10 and \$20 million?

4 A. Yes.

5 Q. And you were speaking to Mr. Crawford that
6 day?

7 A. We were in the anteroom out here. There
8 were multiple members of our trial team, including
9 Mr. Willman, Mr. Perron, Ms. Pfirrmann, myself, other
10 members -- Dr. McNeive and other members of our trial
11 team on a telephone that was on speaker. Yes, and I
12 think there was actually a MedPro representative, as
13 well as Ms. Rucker, at some point, with us.

14 Q. So you had authority on behalf of all the
15 defendants to negotiate a settlement on behalf of all
16 the defendants on March 25th?

17 A. Are you asking me individually or the
18 group that was involved in the negotiation?

19 Q. I'm asking you. I said you.

20 A. And so now I've told you multiple times,
21 there were multiple parties involved in the
22 conversations, and the authority was granted
23 collectively to us as representatives of our clients.
24 I was the person who then physically mentioned the
25 words to your team, which was Ms. Slater.

1 Q. And you heard Mr. Crawford two days ago
2 indicate to you he did not have authority to settle
3 the case on the terms that were texted and
4 negotiated, correct?

5 A. I don't think that's what he said. I
6 think what the point is, I've never, and Mr. Willman
7 nor I, ever had authority to settle this case on
8 amounts that could never be part of a compensatory
9 judgment.

10 Q. So when that discussion happened, and
11 there was an ultimate decision on the 8 and 18, did
12 you have authority to make the 8 and 18 on behalf of
13 all three defendants?

14 A. I want to make sure I understand what you
15 mean by "that discussion." What discussion are you
16 talking about?

17 Q. The last discussion before it was agreed
18 to.

19 A. So the defense attorneys were authorized
20 by Mr. Crawford to respond to the plaintiffs'
21 previously nonnegotiable high-low of 10 million
22 low/20 million high, with a high-low globally for all
23 defendants, bind all claims of 8 million and 18
24 million.

25 Q. So yes?

1 A. The defense had the authority to make that
2 offer, yes.

3 Q. And you were the person, the spokesperson,
4 for the defense?

5 A. Yes.

6 Q. And you also filed or signed a pleading
7 entitled "Defendants' Joint Memorandum in Support of
8 Their Motion to Enforce Settlement," correct?

9 A. Either Mr. Willman or Mr. Perron signed
10 that, yes.

11 Q. Yes. And that was filed on April 18,
12 2025. It's a matter of the record, correct?

13 A. I mean, I'll take your word for it. I
14 don't have a copy up here with me, but maybe I can
15 grab one from my file if I need to.

16 Q. Can you take my word that I'm looking at
17 it, and it was filed on April 18th, 2025?

18 A. That's what I just said.

19 Q. And the indication here, the argument, in
20 fact, is that there was an enforceable high-low
21 agreement, and the terms of that high-low agreement
22 were 8 and 18, correct?

23 A. Yes. That's that -- I was -- Ms. Slater
24 accepted the offer of the defense of 8 and 18, and
25 that is true.

1 Q. And on the record, on the evening or
2 March 25th, 2025, when Your Honor, Her Honor, asked
3 you about your understanding of the high-low
4 agreement, you recited the four terms, correct?

5 A. Well, the -- no. She asked what a
6 high-low agreement means, and I was using the
7 four-line message from Ms. Slater to start to explain
8 it to the judge. And I know you -- and this was at
9 page 24 of the Court's question is -- or the Court's
10 comment begins at line 21, and I began my response,
11 and the Court interrupted me and asked me a different
12 question that I then did answer.

13 So, no, I did not recite -- I know that's
14 what you'd like it to be -- I was not reciting the
15 four-line text message as the agreement in this case
16 because it's not.

17 Q. And I understand that you like to
18 explain -- you've spent a lot of time explaining
19 things that weren't clear on the afternoon and the
20 evening of March 25th.

21 I'm going to ask you specifically do you
22 have the record in front of you?

23 A. I do. I dropped a page, but I don't know
24 that it's relevant.

25 Q. Oh, let me get that for you.

A. Thank you.

Q. So on page 24, I starting at line 21.

A. I'm there.

Q. The Court says: I'm a bit confused as to what you think a high-low means. And your response is, So, Your Honor, I have 8 to 18, all the way to verdict, confidentiality to high-low, no non-disparagement, and those were, and then the Court proceeded to the next question, correct?

A. That is correct, and I --

Q. And that's what you said on that evening in this record, correct?

A. Yes, and I don't --

Q. And then later --

A. -- you were in the courtroom at that time, but I was actually looking at my phone, and that became a big part of that -- that record. So I was reading that to the Court and had not finished answering her question about what I think a high-low means.

Q. But there's no question that the record is clear that when the judge asked you what a high-low was, you recited four terms that had been drafted in your presence with Ms. Slater earlier in the afternoon, correct?

1 A. So that was the beginning of my answer,

2 MS. GUNN --

3 Q. Yes, I understand that.

4 A. -- that was not --

5 Q. I'm just trying to -- I'm just trying to
6 get to my point.

7 THE COURT: And I know that you both are
8 very much aware of how difficult it is for my court
9 reporter to take down you both speaking at the same
10 time.

11 MS. KAMYKOWSKI: Sorry, Your Honor.

12 MS. GUNN: My apologies.

13 Q. (By Ms. Gunn) So my question, Ms.
14 Kamykowski, was that that was your response to the
15 judge's question, correct?

16 A. It was the beginning of my response to the
17 judge's question, yes, Ms. Gunn.

18 Q. And the text that you were reading from
19 your phone in answering this question was the notes
20 that Ms. Slater dictated on her phone in your
21 presence, correct?

22 A. She typed them. I don't think she
23 dictated them. But, I mean, she did type them on her
24 phone in my presence, yes.

25 Q. And then texted them to you, correct?

1 A. Yes.

2 Q. And you were reading from your phone when
3 you put these four terms on the record, correct?

4 A. So I know you're using your words very
5 specifically for the record. They are terms, they
6 are words. They are not terms, as far as if you want
7 to try to argue that they are in agreement or a
8 written contract because they are not, and I will not
9 agree with that.

10 Q. If you want to turn to page 26, we'll just
11 go through the rest of the comments here. Some of
12 them.

13 A. You don't want to go through page 25 where
14 I actually answered the question about what a high --
15 how I understand a high-low?

16 Q. No. I'm going to talk about page 26.

17 A. Okay.

18 Q. which starts at line 11.

19 The Court asks you: And were discussions
20 with regards to the caps involved in this settlement
21 agreement at all?

22 And what was your answer?

23 A. My answer was: There was no discussion of
24 caps, Your Honor.

25 And that was truthful that day and still

remains truthful.

Q. Right. And so with respect to the letter from February 7th, 2025, that was a unilateral offer made by the global defendants on behalf of, I guess, Mercy and MedPro? Or was it just Mercy at that point?

A. So as the letter indicates, it was a global offer made on behalf of all of the defendants.

Q. And was that offer rejected?

A. It was.

Q. Referencing back to the Defendants' Joint Memorandum in Support of Their Motion to Enforce Settlement --

A. Could I maybe have a copy so I can follow along with you?

THE WITNESS: And, Mr. Perron, do you have a copy of our memo in support? Or Ms. Pfirrmann?

Q. (By Ms. Gunn) Let's look at page 10. I have two copies, but they're rather marked upon.

A. You said page 10, Ms. Gunn?

Q. Yeah, but let's -- let's look at the back page first: Page 19 of 19.

Is that your signature block and your electronic signature?

A. Yes. My electronic signature is on here,

as well as Mr. Perron's.

Q. And this is a pleading that you filed on behalf of your client, correct?

A. Yes. Mercy Hospital East Communities.

Q. And the argument made here, obviously you made a truthful argument, correct?

A. Yes.

Q. So page 10, you -- there's a copy of the text message and the sentence that precedes is: The agreement was solidified in a text message from plaintiffs' counsel, Ms. Slater, to Mercy Hospital's counsel, Ms. Kamykowski, which read: 8 and 18, all the way to verdict, confidentiality to high-low, no non-disparagement.

Is that what this pleading says?

A. Yes. Ultimately that was after the conversation, after the 8 and 18 high-low agreement had been reached orally, additional terms were then negotiated with Ms. Slater that included the all the way to verdict, confidentiality to high-low, and no non-disparagement, as I testified to previously.

Q. Right. The agreement was solidified or --

A. And ultimately reached, yes, absolutely.

Q. And the text message that you received was the written instrument of that agreement?

1 A. It was the final recitation of what the
2 ultimate agreement of the parties was in this case,
3 yes.

4 Q. And that ultimate recitation of the
5 agreement between the parties indicated 8 and 18,
6 correct?

7 A. That is correct. That was the original
8 agreement.

9 Q. This doesn't -- excuse me -- that doesn't
10 say anything about application of statutory caps,
11 correct?

12 A. It doesn't. It doesn't say anything about
13 punitive damages either, but you released those.

14 Q. It doesn't say anything about recoverable
15 compensatory damages, correct?

16 A. No.

17 Q. It doesn't say anything about application
18 of Chapter 538, correct?

19 A. Correct.

20 Q. It doesn't say anything about net verdict?

21 A. It doesn't.

22 Q. It doesn't say anything about net
23 judgment, correct?

24 A. True.

25 Q. It doesn't say judgment at all, correct?

1 A. True.

2 Q. The next line is all the way to verdict.
3 You understand what a verdict is, correct?

4 A. Of course.

5 Q. And the verdict in this case was how much?

6 A. There were two verdicts. So there were
7 two verdict forms, two different verdicts from the
8 jury. The first was a compensatory verdict of 28 --
9 I think 28.1 million and a finding that Dr. McNeive
10 and Mercy Clinic were -- were or is -- I think is how
11 it was worded -- liable for punitive damage, and a
12 second verdict of 20 million in punitives.

13 Q. So the verdict total was how much?

14 A. The verdict total from the jury was
15 \$48.1 million.

16 Q. The next line is confidentiality to
17 high-low.

18 you understand what those mean, those
19 words mean, correct?

20 A. I think that's what we had negotiated. In
21 every other case you and I have had, confidentiality
22 to the settlement terms, yes.

23 Q. No. My question is the words on this text
24 that solidified and was a recitation of the agreement
25 that day include confidentiality to high-low,

1 correct?

2 A. which is the agreement, yes.

3 confidentiality to the high-low agreement, Ms. Gunn,

4 yes.

5 Q. Right. And so that doesn't include

6 confidentiality as to the identity of the parties in

7 general, correct?

8 A. In general, I don't think it could at that

9 point, as I said before, and I think you mentioned it

10 in your opening argument, the argument on your

11 behalf, that this was a public proceeding, and a

12 verdict would not be able to keep the parties

13 confidential.

14 Q. But, generally, confidentiality as to

15 high-low, so you're not going to tell anybody what

16 the high-low agreement was, correct?

17 A. No. The conversation we had with Ms.

18 Slater outside was beyond that with respect to these

19 next two lines. It was more involved than that.

20 Q. What was it?

21 A. As I said before, the standard

22 confidentiality that we do in medical malpractice.

23 That -- that the fact of the settlement could be

24 relayed, but the terms and the parties involved

25 therein would not.

1 Q. And that was a conversation you say you
2 had with Ms. Slater?

3 A. Mr. Willman, Ms. Slater, and I were
4 standing right outside that courtroom door.

5 Q. And you specifically said what?

6 A. We were talking in the context of why we
7 had to go through the punitive stage because it was
8 kind of a question, in particular for Mr. Willman,
9 why do we need to go through that when we have an
10 agreement that this high-low is going to be triggered
11 by the final judgment from the compensatory amount?
12 why would you ever need to hear that part of it? And
13 the conversation went to the fact that as is
14 customary, the plaintiffs' lawyers like to be able to
15 use verdicts and settlements in some fashion for
16 marketing purposes.

17 And that was something that was raised and
18 discussed. It was not rebutted or refuted by Ms.
19 Slater. And so our understanding of the
20 confidentiality would be that you certainly could go
21 on your website and say, we've reached a settlement
22 of a case, and it involved a health care provider,
23 but not specifically identify the parties, despite
24 the fact that we knew that in this courtroom, it was
25 a public record, and that also was part of the

1 non-disparagement.

2 Q. And all of those words were said -- all of
3 those words were said to Ms. Slater by Mr. Willman?

4 A. The -- the -- the conversation with Mr.
5 Willman, Ms. Slater, and I was specific about why the
6 necessity of the punitive damage phase of the trial
7 would need to go forward. And in the context of
8 that, I looked at Mr. Willman and said, it's because
9 they want to publish the verdict, and that was the
10 conversation.

11 Q. You said to Mr. Willman, it's because they
12 want to publish the verdict?

13 A. Yes.

14 Q. And I was asking you about
15 confidentiality.

16 A. Which is all encompassing, Ms. Gunn. The
17 publication would be talking about, as we typically
18 do in these cases, the full confidentiality and the
19 mutual non-disparagement is, that it would be what we
20 all understand, because you're a sophisticated
21 attorney in this realm, as well.

22 But it would be like a scrubbed version of
23 any settlement or verdict that doesn't identify the
24 parties, but let's the plaintiffs and their lawyers
25 say, we had this trial. This is the verdict that we

1 got, or this is the settlement we got, without
2 further identifying the parties. So it's all
3 encompassing in that conversation about why we would
4 need to go forward with the punitive damage part of
5 the case.

6 Q. And how many of those words you just said
7 were actually spoken?

8 A. I mean, the -- the conversation was Mr.
9 willman asking -- and I'll say it again -- Mr.
10 willman imploring of Ms. Slater why, if we have a
11 settlement, do we have to go through with this
12 process? Because he was certainly looking out for
13 his client at that point and wanting to know why
14 would that be important when clearly that had nothing
15 to do -- it was not part of any trigger for the
16 high-low that we had.

17 And she demurred from answering, and I
18 just looked at him and said, it's because they want
19 to publish the verdict. That was the conversation,
20 and that's -- that's the context of how we were
21 discussing these terms.

22 Q. And I understand that you're trying to
23 describe the context as you understood it and as you
24 remember it.

25 Did you, when this solidified recitation

1 of the agreement was sent, did you push back at all?
2 Did you send a text back saying, this is a
3 fundamental misunderstanding of what we've just
4 spoken about?

5 A. No. Because it actually -- now, when you
6 put it into context, as I have told you, all the way
7 to verdict, we now know why. That was the
8 conversation that Mr. Willman specifically raised,
9 and we know why that was included in there.

10 And then we had discussed changes to the
11 original full confidentiality and mutual
12 non-disparagement. And those were things that I had
13 to confirm, and Mr. Willman had to confirm with me,
14 with Mr. Crawford and Ms. Rucker before we could then
15 accept the new three terms of the plaintiff beyond
16 the 8 and 18 high-low.

17 Q. When did that happen?

18 A. After that conversation happened, Ms.
19 Slater came back in here, we went into that room, and
20 called our client.

21 Q. What time was that?

22 A. Sometime -- I don't know. But sometime
23 before, I have in my trial notes that the jury was in
24 the box.

25 THE WITNESS: And I apologize, Your Honor,

1 I don't -- I can't remember if I was writing the
2 notes based on the clock on the wall or the clock --
3 the clock on my watch because there's a 5-minute
4 discrepancy. But I had written in my trial notes
5 that the jury was in the box to read the verdict at
6 5:46 p.m., so sometime before 4:56 p.m. because I was
7 sitting at counsel table listening to the verdict.

8 Q. Sometime between --

9 A. I'm sorry -- 4:50 -- 4:56 p.m., I
10 apologize.

11 Q. So sometime after 4:47, you had that
12 conversation?

13 A. I presume it was sometime either right
14 around, because as I said before, I got two text
15 messages at 4:47: one from Ms. Slater and one from
16 Mr. Crawford. I don't believe that I would have been
17 on the phone with him while he was texting me. I
18 think that that would have been a conversation.

19 I know that the four-line note was showed
20 to me by Ms. Slater. And after that note was shown
21 to me, I had a conversation with -- in that room with
22 Mr. Willman. I don't know exactly -- I know we are
23 talking about the text. I don't know when the text
24 came to my phone.

25 I just know sometime between the

1 conversation outside and when I was at counsel table
2 making notes, that the jury was reading -- or that
3 the verdict was being read at 4:56. The four lines
4 had been memorialized and shown to us in a
5 conversation with our clients, and the carrier
6 occurred.

7 Q. So the text was sent at 4:47 to you?

8 A. That's what my phone shows.

9 Q. Yes. And then you would have had a
10 conversation with Mr. Crawford after that?

11 A. I can't agree with that time line because
12 I don't know -- I don't know exactly -- I don't think
13 that the phone conversation was based on my reading
14 of the text because I had already seen the note on
15 her phone. I can't -- I can't agree specifically. I
16 don't know that it really matters. Maybe it matters
17 to you.

18 But I know sometime after the
19 conversation, Mr. Willman and I told Ms. Slater that
20 we -- that we had to confer with our client. We did
21 that. We came back to counsel table, and the verdict
22 was read. Whether it was before or after that text
23 message, I don't know.

24 Q. Do you think you would have had a
25 conversation with Mr. Crawford before 4:47 about

1 clarification of the text?

2 A. It wouldn't have been clarification of the
3 text because I want to make sure that we're
4 understanding. The text meaning the actual physical
5 iPhone blue message coming through from Ms. Slater's
6 cell phone to mine, versus the text of the note. I
7 don't -- I don't -- I want to make sure that we're
8 clear. Yes, I had a conversation with him, Ms.

9 Rucker, Ms. -- our team -- our team in that room,
10 about the four lines because it was a departure from
11 our previous agreement.

12 I cannot say that it was based on,
13 quote/unquote, the text message from her iPhone to my
14 phone, but it was certainly, the content of those
15 four lines were discussed, sometime after we went out
16 into the hallway, before we returned to the courtroom
17 for the verdict to be read.

18 Q. Sometime after the four lines were
19 developed, is when you had a conversation with Joe
20 Crawford and Anne Rucker?

21 A. Yes. Because before that time, I would
22 not have known that we had modified needing to hear
23 the punitive damage verdict, the confidentiality to
24 the high-low portion of it, and the modification of
25 the non-disparagement, so, yes.

1 Q. And the phrase "no no-disparagement," is
2 that -- is that something that you had to clarify
3 after the fact, as well?

4 A. With our clients, yes, because that was
5 the context of Ms. Slater, and I think rightly so, no
6 one -- I think that it's right, and they agreed to
7 it, and we encouraged them to agree to it, not to gag
8 your clients.

9 Q. And in your argument, in your Defendants'
10 Joint Motion in Memorandum in Support of Their Motion
11 to Enforce the Settlement, it is -- it is your
12 contention that this is a binding settlement
13 agreement, correct?

14 A. Yeah. That's why we moved to enforce it
15 just like you do. We have competing motions to
16 enforce here.

17 Q. I understand that. And that's why I'm
18 just trying to clarify because I've heard a lot of
19 discussion today, in particular, about how there is
20 certainly a misunderstanding about what this
21 recitation of the settlement agreement, this binding
22 settlement, that you're moving to enforce actually
23 means, correct?

24 A. The settlement that we are moving to
25 enforce is the settlement offer of 8 and 18 that

1 carried all the prior terms that we had negotiated
2 that Ms. Slater accepted in this courtroom.

3 Q. That Ms. Slater accepted in this
4 courtroom?

5 A. She --

6 Q. Hold on. You're testifying today that
7 every term of the previous letter is a part of this
8 four-line text settlement agreement?

9 A. I am testifying that the settlement
10 agreement that was reached was a high-low of 8 and
11 18. So, no, no. I mean, clearly, Ms. Gunn, not all
12 the terms of February 7th are included in the
13 settlement agreement.

14 Q. Not all of them?

15 A. No, they're not.

16 Q. So --

17 A. There -- there is not a structured
18 settlement that is part of it. There are other terms
19 in there that were not continued to be negotiated.

20 Q. So some of them, but not all of them?

21 A. That's what I just said.

22 Q. And how many times did you pull out the
23 February 7th letter and reference specifically
24 March 25th, 2025?

25 A. I didn't.

1 Q. How many times did you talk about caps on
2 noneconomic damages on the afternoon of March 25th,
3 2025?

4 A. On the afternoon of March 25th, 2025, we
5 talked about caps on noneconomic damages in the
6 post-trial verdict record.

7 Q. That's a fair -- and I appreciate the
8 clarification.

9 How many times before 4:47 p.m., did you
10 talk or mention or discuss with Ms. Slater or anyone
11 on the plaintiffs' trial team application of
12 statutory caps or net verdicts or recoverable
13 compensatory amounts?

14 A. On that day, it was not discussed. That
15 had been discussed at length with you many times
16 prior to that as to what your best day was in this
17 case.

18 Q. And how often did I discuss those terms?

19 A. You acknowledged that -- you didn't accept
20 my recitation of it, which was in the \$18 million
21 range, you always told me it ws somewhere north of 21
22 because that was Dr. Liles' --

23 Q. I don't think you -- how many times did I,
24 on behalf of the Anyans, accept the terms in your
25 February 7th, 2025, letter?

1 A. Oh, you rejected them.

2 Q. Fully?

3 A. You rejected them, and they were renewed,
4 yes.

5 Q. When were they renewed?

6 A. They were renewed in emails that you and I
7 had leading up to the trial.

8 Q. And when were those renewed offers
9 accepted?

10 A. You never accepted an offer until -- you
11 never accepted an offer. Ms. Slater accepted an 8
12 and 18 high-low in this courtroom on the afternoon or
13 early evening of February 25th.

14 Q. Which, by your own testimony, did not
15 contain any discussion of statutory caps, net
16 verdicts, application of Chapter 538, correct?

17 A. It did not, you are correct. And I have
18 maintained that to be the truth since the beginning
19 of this, right.

20 Q. Right. And there is a text message from
21 Anne Rucker, I think it was mentioned earlier, that
22 at 4:23 p.m., we are okay with high-low.

23 Do you recall that text?

24 A. I have it here in front of me, yes.

25 Q. And that was at 4:23 p.m., correct?

1 A. Yes, ma'am.

2 Q. And that is also providing authority for
3 you to continue down the high-low, or giving you the
4 authority to accept the high-low, correct?

5 A. I don't think it was giving me authority
6 to accept it. It was giving us authority to
7 negotiate with the high-low.

8 Q. Now, do you recall a time that Ms. Slater
9 specifically said, we are waiving punitive damages?

10 A. I don't know that the word "waiving" was
11 ever used, no.

12 Q. Do you recall a time that Ms. Slater ever
13 said we were abandoning punitive damage claims?

14 A. No. The way I understand it was when Mr.
15 willman was asking, he confirmed the settlement
16 released all claims, and confirming that there would
17 be no payment for any punitive award.

18 Q. And that would not indicate in specific
19 terms that there was a waiver of the punitive damage
20 claims, correct?

21 A. I don't know what you mean by "waiver."
22 we were talking about settling all claims. The
23 settlement included release of it when it was --
24 would be reduced to a formal agreement signed by
25 their clients and mine or yours, at least. That it

1 would be releasing the punitive damage claim, and
2 that, again, the confirmation was there would never
3 be a payment for any punitive verdict that was handed
4 down.

5 Q. And why is it important to clarify that
6 your clients or the insurance companies aren't going
7 to pay for a punitive claim?

8 A. I don't know.

9 Q. You don't know?

10 A. I was not involved in the punitive damage
11 coverage in this case because my client did not have
12 a claim for punitive damages against it.

13 Q. Have you ever had a client with claims for
14 punitive damages?

15 A. No. Because they're very rarely allowed
16 to be pled into the cases that I defend.

17 Q. And my question is, you've never had a
18 case where a punitive damage claim has been submitted
19 to the jury?

20 A. I have had a case, yes. It's a case that
21 your firm was involved in, yes, and it's on appeal
22 right now.

23 Q. And so that was -- I'm just trying to lay
24 the foundation. You don't have any idea why an
25 insurance company doesn't want to pay a claim --

1 doesn't want to pay for a punitive damage claim?

2 A. I don't know why insurance companies would
3 or would not want to pay for a punitive damage claim.

4 Q. whenever that recitation and
5 solidification of the high-low agreement was texted
6 from Ms. Slater to you, and you acknowledged that you
7 received, and you acknowledged it was a settlement
8 agreement, did you at any point respond to it?

9 A. No. Well, I mean, I did not respond in
10 writing. I certainly responded to it on the record
11 and have since then.

12 Q. Sure. And that's what I'm getting to.
13 You never responded in the moment or ever to the
14 text, correct?

15 A. The text accurately reflects the defense's
16 understanding of what we had agreed to, which was a
17 high and low of 8 and 18, based on the recoverable
18 judgment in the case, all the way to verdict, based
19 on Mr. Willman's discussion with Ms. Slater that the
20 plaintiff desired to have the punitive damage verdict
21 read, regardless of its impact on the settlement
22 because it was irrelevant at that point. The
23 modifications to the non-disparagement agreement as
24 was discussed, and the reiterating the high-low would
25 be -- that the agreement would be confidential, so,

1 yes.

2 Q. Did Ms. Slater ever indicate that
3 punitives were irrelevant?

4 A. We -- that's what -- how Mr. Willman
5 argued to her, asked her the question.

6 Q. No. No. Did she ever say punitives were
7 irrelevant?

8 A. No. Because it wasn't irrelevant to you
9 or to her. The verdict on punitives was never
10 irrelevant --

11 Q. Ms. Kamykowski --

12 A. -- to the plaintiffs.

13 MS. GUNN: And, Melissa, I apologize.

14 Q. (By Ms. Gunn) I'm just -- I'm trying to
15 keep it yes or no. I'm going to try, okay?

16 My question is: Did Ms. Slater ever say
17 whether, in response to something that you said or

18 Mr. Willman said or you heard, that at any point,
19 with respect to this settlement agreement, that
20 punitives were irrelevant?

21 A. With respect to the settlement agreement?

22 she didn't say they were irrelevant --

23 Q. Thank you.

24 A. -- but she acknowledged that it had
25 nothing to do with the agreement.

1 Q. Did she say that we were waiving
2 punitives?

3 A. So we've been through this already. You
4 already asked me that. That word was never used, no.

5 Q. Thank you.

6 The time frame after 4:47, after the
7 recitation of the settlement agreement was reduced to
8 writing and texted to you and not responded to or
9 edited or suggested any changes, we are now at the
10 verdict. And there are text messages after that
11 verdict with Joe Crawford, correct?

12 A. Yes.

13 Q. Do you have a copy of your text messages?

14 A. I do.

15 Q. So at 4:47, Mr. Crawford asks you: Does
16 jury give a puni number, or do they know more
17 testimony needed regarding puni phase?

18 Did I read that --

19 A. You did.

20 Q. I'm sorry. I didn't give you time to get
21 there.

22 A. That's okay. You did read that correctly.

23 Q. And that was at 4:47, and you didn't reply
24 at that time. He texted again at 4:55. I don't know
25 what that exactly says, do you?

1 A. I'm sure I do. But the Court reviewed en
2 camera and ordered that we didn't have to disclose
3 that information.

4 Q. Yeah. And I did a little guesswork on my
5 part and thought maybe it said "please call."

6 You didn't respond to that, probably
7 because we're sitting in the courtroom. And because
8 the record indicates at 4:56, the verdict is read in
9 open court, phase one of the verdict is read in open
10 court.

11 And at 4:58, Mr. Crawford asks you:
12 High-low is for compensatory only, extinguishes puni
13 exposure. Please make that clear. Thanks.

14 Did I read that correctly?

15 A. You did.

16 Q. So at least at 4:58, Mr. Crawford's not
17 clear about what the high-low indicates, is that
18 accurate?

19 A. I don't know that I would classify that or
20 characterize his testimony of him not being clear.
21 He was confirming. You had asked him about this, and
22 I responded yes because we had already made that
23 clear when we stood outside and had reached the
24 ultimate agreement on this case before the verdict
25 was ever read.

1 Q. And did Mr. Crawford, in this text,
2 indicate any words such as "recoverable compensatory
3 only"?

4 A. He wouldn't need to because that was all
5 we were negotiating.

6 Q. I understand. My question is does this
7 text say recoverable compensatory only?

8 A. It doesn't.

9 Q. Net judgement?

10 A. It does not.

11 Q. Application of statutory caps?

12 A. It does not.

13 Q. what he's saying to you is high-low is for
14 compensatory, extinguishes puni exposure. please
15 make that clear, correct?

16 A. That's exactly what it says, yes.

17 Q. And you say a minute later, yes?

18 A. Yes.

19 Q. And the jury goes out to deliberate on the
20 punitive claims after they've already decided there
21 is punitives, now we're just talking about the
22 punitive amount, correct?

23 A. Yes.

24 Q. And you don't go to the Court at that
25 point and announce a settlement, correct?

1 A. No. Because the settlement agreement had
2 not been completed because the plaintiffs, one of the
3 conditions was, that the verdict on the punitive had
4 to be read.

5 Q. You don't take the time to go to the Court
6 after the jury goes back to the deliberation room to
7 decide how much punitives to award, correct?

8 A. Correct.

9 Q. And there's nothing stopping you from
10 doing that, correct?

11 A. No. There was nothing stopping you or Ms.
12 Slater from doing it either.

13 Q. And the Court -- or the jury, actually
14 asked for -- had a question, correct?

15 A. I believe so. I don't know. I wasn't
16 really...

17 Q. Sure. At 5:10, the jury -- there was a
18 jury question: Do we vote majority or 9 to 12?

19 Do you remember that?

20 A. I vaguely do. I know I wasn't really
21 paying attention to this part of the case. It didn't
22 really impact my client, so...

23 Q. Were you not in the courtroom when that
24 was read?

25 A. I believe I was, but I'm not sure.

1 Q. You didn't take the time at that point,
2 while we were all here on the record to say, hey,
3 Judge we're settled. Here's the terms of the
4 settlement. It doesn't really matter what's going to
5 happen with the punitive damage verdict because we're
6 settled, correct?

7 A. No. But the Court had already been aware
8 that we had settled because the parties had announced
9 that. We delayed reading of the compensatory
10 verdicts to finalize the settlement.

11 Q. So my answer is -- your answer is yes?

12 A. Yeah. But the record was not made until
13 later.

14 Q. And the record was made after the jury
15 returned the punitive damage verdict of \$20 million?

16 A. Yes.

17 Q. And at the suggestion of Ms. Slater?

18 A. Yes.

19 Q. You had no intention of going on the
20 record and explaining to the judge what the
21 settlement was, correct?

22 A. No. We were going to wait for the
23 judgment to be entered and then make the record
24 asking the Court to approve the settlement at that
25 amount.

1 Q. And when the record was made on the
2 evening of March 25th, you initially declined to make
3 a record, correct?

4 A. I did.

5 Q. You were, though, able to answer the
6 Court's questions, correct?

7 A. I was.

8 Q. And you were answering them truthfully on
9 that evening?

10 A. Of course.

11 Q. And then after the fact of the verdict,
12 were you a part of a phone call that Mr. Willman made
13 to Ms. Slater?

14 A. I was not.

15 Q. Were you aware that a phone call was being
16 made to Ms. Slater?

17 A. I believe I was aware that he had been
18 asked to make a call.

19 Q. Were you involved in any conversations
20 with Joe Crawford after the verdict?

21 A. I had been involved in many conversations
22 with Mr. Crawford since this verdict.

23 Q. How about the evening of March 25th?

24 A. I don't -- I don't know, Ms. Gunn. I
25 probably, I mean, after the -- after the post-verdict

1 record was made, I do believe we went into the room
2 out there and had conversations with Mr. Crawford at
3 that time, yes.

4 Q. And what were those discussions about?

5 THE WITNESS: well, Your Honor, do I have
6 to answer that question? It's a
7 post-verdict/post-record. We've had this discussion
8 about what is continuing to be privileged. I'm not
9 sure that it's relevant at this point.

10 MR. PERRON: Your Honor, I'll just
11 reiterate that objection, if the question is re-asked
12 within the scope of the high-low agreement.

13 THE COURT: Can we limit it to discussions
14 with regards to what the settlement agreements were?

15 MS. GUNN: Yes. Sorry.

16 A. I believe at that time, and I don't have a
17 specific recall of it, but I believe at that time the
18 conversation centered around the fact that the
19 settlement had blown up because the plaintiff had a
20 different understanding of what the high-low terms
21 were than we did.

22 Q. (By Ms. Gunn) Are you asking the Court to
23 enforce the settlement at roughly 4.8 because you
24 believe there was a clear, unambiguous settlement
25 with all the material terms as dictated in the -- in

1 the text message at 4:47?

2 A. So -- so the way you asked that question,

3 no. We are not asking the Court to enter a

4 settlement of 4.8 million. I think you may have

5 transposed those numbers. I think that our memo was

6 clear, and I also don't believe that I think the end

7 of that question was as defined by the terms in the

8 text message, no.

9 what the defense has asked this Court to

10 do is enforce the high-low settlement agreement based

11 on the final judgment of the compensatory verdict

12 which is 8.426 and change, which was the agreement

13 that was reached.

14 Q. So do you think there was a meeting of the

15 minds with respect to your version of that?

16 A. I do believe there was, as it was accepted

17 in this -- in this courtroom by Ms. Slater, yes.

18 Q. And that was the nod that you're

19 describing?

20 A. Yes. And then we went out and continued

21 to negotiate the additional three lines.

22 Q. which was reduced to writing in the text

23 message.

24 A. The all the way to verdict, the

25 confidentiality to high-low, and the no

non-disparagement, yes, as we've discussed.

MS. GUNN: Your Honor, that's all the questions I have.

THE COURT: Thank you.

Any redirect?

MR. PERRON: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. PERRON:

Q. You -- you said you had a copy of the post-trial record in front of you?

A. I do, Mr. Perron.

Q. Is that Plaintiffs' Exhibit 6, to make sure we are on the same page?

A. Yes.

Q. Okay. If I could direct your attention to page 20 starting at line 2. This is Ms. Slater speaking on the record. She's talking about, in line

1: For all parties before the verdict was read -- starting on line 2, next new paragraph: we came back into the courtroom and communicated to Ms. Kamykowski that 8 and 18 would be accepted as the high-low.

Did I read that correctly?

A. You did.

Q. Is it your understanding that what I'm reading from is Ms. Slater speaking about her

1 recollection on the post-trial record?

2 A. Yes.

3 Q. So does that match your recollection that,
4 just as Ms. Slater described, that she came back into
5 the courtroom before the verdict was read and said --
6 communicated to Ms. Kamykowski that 8 and 18 would be
7 accepted as the high-low?

8 Does that match your recollection?

9 A. Yes.

10 Q. Is that plaintiff accepting defendants'
11 offer of the high-low?

12 A. Yes.

13 Q. Okay. And Ms. Gunn was asking you about
14 whether the word "waiver" was used in the back and
15 forth with Ms. Slater.

16 Is the word "waiver" a special magic word
17 that has to be used for a party to acknowledge that a
18 claim is resolved?

19 A. No.

20 Q. Is it a special word that has to be used
21 to acknowledge that settlement money won't be paid on
22 that particular claim?

23 A. No.

24 Q. Okay. Let me read again from the
25 post-trial record, and we'll go to page 21, line 18.

1 It's still Ms. Slater: Mr. Willman did say that the
2 amount that would be paid would not be paid on a
3 punitive, which is typical and customary that
4 insurance policies don't pay for punitive damages.

5 Is Ms. Slater admitting on the record that
6 Mr. Willman made clear that the amount that would be
7 paid for the settlement would not be paid on the
8 punitive damages?

9 A. Yes. She goes on to say: I accepted
10 that, that the 8 and 18 on the verdict would not be
11 paid for any punitive damages, as understood by all
12 parties.

13 Q. That recollection by Ms. Slater as put on
14 the record, does that match your recollection of the
15 conversation out in the hall when discussing the
16 final terms of the high-low agreement?

17 A. Yes.

18 Q. Is the word "waiver" used anywhere in
19 that?

20 A. No.

21 Q. Even though the word "waiver" isn't used,
22 did you have a clear understanding that Ms. Slater
23 understood that punitive damages were resolved by the
24 settlement agreement, and no settlement payment would
25 be made for any punitive award?

1 A. Yes.

2 Q. Going to -- back to page 20, starting at
3 line 20, Ms. Slater, again, she's describing the
4 text: 8 and 18, all way to verdict, comma,
5 confidentiality to high-low, comma, no -- I
6 apologize -- comma, no non-disparagement, period.

7 And then she goes on to say: Ms.

8 Kamykowski wanted to confirm that those were the
9 terms and then proceeded to call her client who was
10 Joe Crawford with MedPro.

11 Just as you said earlier on direct, does
12 that match more or less your recollection that you
13 saw some version of the note of Ms. Slater, and that
14 you excused yourself to go speak about those terms
15 with Mr. Crawford?

16 A. It wasn't some version. It was -- there's
17 only that one version, but, yes.

18 Q. So there's no, even under Ms. Slater's
19 recollection, put on the record what you said on
20 direct about the chronology of the events, seeing
21 the -- seeing the four lines, and then going and
22 talking about that with Mr. Crawford? That's how Ms.
23 Slater remembers it, and that's how you described it
24 more or less on direct?

25 A. That is what happened.

1 Q. Going to page 21 of Plaintiffs' Exhibit
 2 No. 6, starting at line 2. This is Ms. Slater still
 3 speaking: I was asked to come back out in the hall,
 4 and Ms. Kamykowski and Mr. Willman confirmed that
 5 this settlement of the high-low would buy all claims,
 6 including punitive damages, period.

7 I confirmed, yes, that we were going to go
 8 all the way to verdict, period. Mr. Willman asked if
 9 that was necessary to go through the punitive phase.
 10 And I said, yes, that we wanted to do that, period.
 11 That was then accepted and agreed to by all parties.

12 Did I read that correctly?

13 A. You did.

14 Q. Okay. Does that match your conversation
 15 that prior to final agreement, that Mr. Willman
 16 asked: why is it necessary to go all the way to the
 17 punitive stage, the punitive phase?

18 Did Ms. Slater, at that time, make any
 19 indication to you that she believed the punitive
 20 phase would be the trigger for the high-low
 21 agreement?

22 A. No.

23 Q. And how -- in what way did she describe
 24 wanting to go to the high-low -- sorry. In which way
 25 did she describe that they wanted to hear the

1 punitive phase?

2 A. As I said before, I don't know that she
3 ever elucidated a reason specific for the plaintiff.

4 But Mr. willman, when he was questioning, my
5 conclusion, based on experience was, that this was so
6 that the plaintiffs' attorneys could publish a
7 punitive verdict for marketing purposes. That was
8 stated out loud, and there was no response. So there
9 was no -- there was no either acceptance that that
10 was the purpose, and there was no, you know,
11 righteous indignation that that was the purpose.
12 There was no response at all.

13 Q. You discussed it earlier, but Mr. Crawford
14 and you had a text exchange where you relayed to him
15 8 and 18, that's it. And that text is time stamped
16 several minutes before the text from Ms. Slater about
17 the 8 and 18 and the rest of those lines?

18 A. Yeah. That was the text message to Mr.
19 Crawford of verdict, and I told him 8/18 was it, was
20 at 4:43 p.m.

21 Q. So Mr. Crawford -- let me -- had Mr.
22 Crawford, at that time, already conveyed authority to
23 you for an 8 and 18 high-low agreement?

24 A. Yes.

25 Q. Did you and Mr. Crawford have an

1 understanding about the trigger of the 8 and 18? Not an Official Court Document
2 A. Yes. The trigger was always the final
3 compensatory judgment in the case. That would be the
4 final number that was set, whether the plaintiff
5 would receive \$8 million, \$18 million, or somewhere
6 in between. Not an Official Court Document

7 Q. When Ms. Slater recalled and put on the
8 record that you went and spoke with Mr. Crawford
9 after reviewing the four lines of the text, did you
10 relay to Mr. Crawford your understanding of those
11 terms? Not an Official Court Document

12 A. Yes. Because at that time, the terms had
13 changed. The 8 and 18 had not changed, but the
14 confidentiality and non-disparagement and the need to
15 go through the punitive phase was the new additional
16 terms from the plaintiff. Not an Official Court Document

17 Q. Did Mr. Crawford have any objection to
18 those terms as you explained them to him? Not an Official Court Document

19 A. I mean, objection? He ultimately accepted
20 them. He may not have been happy with them, but he
21 accepted them. Not an Official Court Document

22 Q. Did you explain to him that your previous
23 understanding of the trigger for the high-low was any
24 different than you had previously understood? Not an Official Court Document

25 A. No. Because I didn't understand that the

1 trigger was anything other than what I -- what we all
2 believed it to be.

3 Q. Talking about the post-verdict record that
4 you all made with the Court and Ms. Slater, did you
5 have a sidebar before going on the record?

6 A. We did.

7 Q. Did you make it clear, both at the sidebar
8 and then on the record, the difference of opinion
9 that you all had as to the terms of the high-low
10 agreement?

11 A. Absolutely. That was the first that I've
12 heard the plaintiffs believe that they were entitled
13 to an \$18 million high based on the full compensatory
14 uncapped verdict.

15 Q. You mentioned on cross-examination that
16 there's a portion of your testimony, a portion of
17 your statement on that record, on page 25, that you
18 believe discussed the details as you understood them.

19 A. Yes. So beginning on the post-verdict
20 record, which I think is Plaintiffs' Exhibit 6,
21 starting at page 24, when the Court begins to ask me,
22 she was confused as to what I thought a high-low
23 means.

24 I began to give my answer at the bottom of
25 page 24, and then there was further discussion with

1 questioning by the court where I believe that I laid
2 out -- not I believe -- I did lay out my
3 understanding as defense counsel in this case and
4 defense counsel handling medical malpractice claims
5 in the state of Missouri, how high-lows are
6 negotiated, what they mean, and how those terms are
7 reached. And that ensued through page 27, I think,
8 through line 20.

9 Q. Did Ms. Slater or anyone on plaintiffs'
10 side indicate or communicate in any way that all the
11 way to verdict was the new trigger for the high-low
12 agreement of 8 and 18?

13 A. No.

14 Q. Ms. Gunn was asking you, did you use ever
15 the specific term of "cap."

16 well, on the reverse side, did plaintiff
17 ever use the specific language of "trigger" or

18 describe the raw, unadjusted verdict as the trigger
19 for the high-low agreement?

20 A. No.

21 Q. Did anyone specify with specificity what
22 the trigger would be beyond what they understood in
23 their own mind it to be?

24 A. No.

25 Q. Was the term "unadjusted verdict" or the

1 word "trigger" ever used by plaintiff in describing
2 the terms of the high-low agreement?

3 A. No.

4 Q. You mentioned this before, but just to
5 close, at least my portion of the redirect, is there
6 any question in your mind that both sides were
7 agreeing to the same trigger for the high-low, at
8 least until after the award on punitive damages?

9 A. There was never a question in my mind that
10 we were in disagreement.

11 Q. Would there be any reason for you to run
12 up to the Court and preserve your version of the
13 high-low agreement before you knew that there was any
14 disagreements?

15 A. No.

16 MR. PERRON: Those are my questions.

17 THE COURT: Any further cross-examination?

18 MS. GUNN: Nothing further. Thank you.

19 THE COURT: Thank you. You may step down.

20 THE WITNESS: Thank you, Judge.

21 THE COURT: Are we going to have any
22 additional witnesses with regards to the motion to
23 enforce?

24 MR. PERRON: I don't think so, Your Honor.

25 THE COURT: Any rebuttal witnesses with

regards to the motion to enforce?

MS. GUNN: Yes.

THE COURT: Can you tell me who?

MS. GUNN: Erica.

THE COURT: Okay. why don't we take a short recess before we put on that so that my court reporter doesn't kill me.

why don't we take -- I'll go back to my standard. It's 11:56 a.m., why don't we take until 12:03.

(Court stood in recess from 11:56 a.m. to 12:11 p.m.)

MR. PERRON: Your Honor, before we proceed with the next witness, I wanted to be able to do rebuttal evidence?

THE COURT: okay.

MR. PERRON: Briefly.

THE COURT: okay.

MR. PERRON: Your Honor, both sides had submitted pleadings citing the case Eaton, E-a-t-o-n, v. Mallinckrodt as one of the controlling cases that discussed a motion to enforce settlement. And in Eaton, they lay out the three possible ways for a Court to consider a motion to enforce.

It could deal with the motion on the

1 pleadings themselves, which is only applicable if
2 there's no disagreement as to any fact, and only a
3 question of interpreting the law. I think both sides
4 agree that's not the case here.

5 The number two way is to take the motion
6 as a summary judgment, but there's a qualifier that
7 that this case -- the facts, if they're submitted on
8 affidavits, have to be submitted pursuant to the
9 Missouri rules on motion for summary judgment,
10 including a statement of uncontroverted facts and 30
11 days to allow the other side to respond.

12 And in Eaton, in particular, the appellate
13 court concluded that because the moving party relied
14 only on affidavits, but not according to the rules
15 governing a motion for summary judgment, that the
16 Court had no foundation to find on behalf of the
17 moving party, and sent it back to the trial court
18 level for a further evidentiary hearing.

19 The Court set this and noticed it up as an
20 evidentiary hearing. Plaintiff rested without
21 putting on any evidence. As I mentioned, Eaton makes
22 clear you cannot rely on affidavits for an
23 evidentiary hearing, specifically in a case like
24 this.

25 Plaintiff rested without putting on any

1 evidence. Defense put on live testimony. We object
2 to plaintiffs now, after they have had the
3 opportunity to cross examine our live witness, and
4 after they have submitted affidavits only, to come
5 back and put on additional evidence.

6 we believe that it is improper and against
7 how the law is laid out in deciding these cases to
8 allow plaintiff, after resting, without putting on
9 evidence, to come back around and attempt to put
10 evidence on.

11 And even in that instance, if the Court
12 allows, we ask the Court to strictly limit any
13 rebuttal evidence to evidence outside of what has
14 already been attempted to be placed on the record in
15 the affidavits.

16 THE COURT: Do you agree with me that when
17 the plaintiffs' counsel asked questions of the
18 witnesses you presented, that would be evidence the
19 court could consider?

20 MR. PERRON: Yes.

21 THE COURT: But it's not evidence you
22 presented. It would be evidence the plaintiffs
23 presented.

24 MR. PERRON: Well, it was our witness
25 during our part of the evidentiary hearing.

1 THE COURT: I understand that.

2 So I'm not permitted to consider any of
3 the testimony provided when they were being
4 questioned by plaintiffs' counsel, is your statement?

5 MR. PERRON: No. I don't believe the
6 Court can rely on anything in an affidavit or
7 anything in a pleading.

8 THE COURT: I understand that, but you're
9 objecting to her testifying at this point?

10 MR. PERRON: Yes.

11 THE COURT: And you would agree with me
12 that they have presented evidence during the course
13 of this hearing through cross-examination?

14 MR. PERRON: Through -- right. To the
15 extent that I said they didn't put on evidence, I was
16 limiting what I said to evidence during their case.

17 THE COURT: I understand.

18 And you're objecting to me allowing them
19 to testify in rebuttal to what has been presented?

20 MR. PERRON: Yes, Your Honor. Because
21 we --

22 THE COURT: With any legal prohibition
23 that you're aware of from being able to rebut
24 evidence that's presented at an evidentiary hearing?

25 MR. PERRON: Yes, Your Honor.

1 I think if they had put on evidence during
2 their case-in-chief, including a specific witness
3 that they attempted to introduce an affidavit for,
4 and they choose not to put her on the stand, and then
5 only attempt to put her on the stand in rebuttal, I
6 believe that would be improper.

7 THE COURT: So if you did not believe that
8 they met their burden at the time they sat down from
9 their opening statement, by default, wouldn't you
10 have just won?

11 MR. PERRON: That's, again, Your Honor, I
12 believe that we are still entitled to put our best
13 foot forward, but that would have been -- if we had
14 been allowed to argue at the close of us putting on
15 our witnesses, that would be my argument is that by
16 default, we would have been the only -- we would be
17 entitled to defeat their motion to enforce as the
18 nonmoving party.

19 THE COURT: The Court will note your
20 objection for the record but will allow the witness
21 to testify.

22 MS. GUNN: Your Honor, we call Erica
23 Slater.

24 THE COURT: Ma'am, if you will step on up
25 and be sworn.

1 ERICA SLATER,
2 having been duly sworn, was examined, and testified
3 as follows:

4 THE COURT: Thank you. You understand the
5 rules.

6 DIRECT EXAMINATION

7 BY MS. GUNN:

8 Q. Please state your name.

9 A. Erica Slater.

10 Q. Ms. Slater, what is your profession?

11 A. I am an attorney, and I represent the
12 Anyans as plaintiffs in this case.

13 Q. How long have you been practicing?

14 A. Since 2011.

15 Q. And you and I were members of the Simon
16 Law Firm until January 31st of this year, is that
17 correct?

18 A. Correct.

19 Q. When we started our own firm, Gunn|Slater,
20 and in that capacity, have been representing the
21 Anyans since that time, correct?

22 A. Correct.

23 Q. Now, there was a letter dated
24 February 7th, 2025, that was an offer by the
25 defendants that's been mentioned here today with

1 respect to this case, is that correct?

2 A. Correct.

3 Q. what was done in response to that offer to
4 settle this case?

5 A. we rejected it.

6 Q. was that based on conversations with our
7 clients?

8 A. Yes.

9 Q. was any part of that offer accepted?

10 A. No.

11 Q. At any point?

12 A. No.

13 Q. On March 25th, 2025, did Ms. Kamykowski or
14 Mr. willman mention the February 7th, 2025, letter in
15 any capacity?

16 A. No.

17 Q. Did they bring it out?

18 A. No.

19 Q. did they show it to you?

20 A. No.

21 Q. Did you see them show it to me?

22 A. No.

23 Q. or did you see any reference to that
24 letter reminding us that clearly these are the terms
25 of settlement in any medical malpractice case?

1 A. No.

2 Q. were they conveyed to you as implied terms
3 in any way?

4 A. No.

5 Q. Do you understand that the -- what are
6 you -- what is your basic understanding of the
7 principles of a contract?

8 A. That when an offer is put forth with
9 certain terms, if it is rejected, it is off the
10 table, and you start from a clean slate.

11 Q. You don't carry over the ones that one
12 party likes?

13 A. No.

14 Q. when the case was closed, on March 25th,
15 2025, were you approached by Ms. Kamykowski about
16 potentially reengaging in settlement negotiations?

17 A. Our paralegal, Claudia, told me that Mandy
18 had asked to talk to us, and I went out to meet her
19 in the hallway.

20 Q. At any point in that conversation, or in
21 any other conversation the rest of the day, were the
22 terms of the February 7th, 2025, letter renewed?

23 A. No.

24 Q. or referenced in any way?

25 A. No.

1 Q. what was the offer made by Ms. Kamykowski
2 at that time?

3 A. She said that the -- it was a lump sum of
4 12 million and warned me that it would avoid periodic
5 payments.

6 Q. what was your understanding of periodic
7 payments?

8 A. A tort reform statute that applies to a
9 judgment that you would avoid any statutory
10 implications if you settle a case.

11 Q. Are there other statutory provisions that
12 apply to medical malpractice cases?

13 A. Yes. An entire chapter.

14 Q. which chapter?

15 A. 538.

16 Q. Was ever -- was Chapter 538, or any of its
17 specific terms, other than the periodic payments,
18 ever mentioned to you on the afternoon of March 25th,
19 in terms of this potential settlement?

20 A. No, they were not.

21 Q. And periodic payments, do they apply if
22 there's a settlement?

23 A. No. And if they were offered, we would
24 reject them.

25 Q. And as we had done before?

1 A. Correct.

2 Q. And so what was your response to this
3 notion that they were talking about periodic
4 payments?

5 A. Well, when they offered the 12, I came
6 back into our room out off the hallway in the
7 courthouse and talked with our team, and we
8 determined to reject that. And I went back into the
9 hall and either said no or shook my head when Mandy
10 saw me, and rejected that, and then I walked away.

11 Q. And based on your understanding of the
12 application of law, were there any offers on the
13 table at that point?

14 A. No.

15 Q. From either side?

16 A. No.

17 Q. What do you recall happening next with
18 respect to any settlement negotiations?

19 A. I came back into our room, and without
20 revealing the substance of the conversation, what
21 came out of the discussion is that I was going to
22 suggest to the other side a high-low with the bounds
23 of 10 and 20, and we were going to stand on that.

24 Q. And did you do that?

25 A. I did that.

1 Q. who did you speak with specifically?

2 A. I found Mandy Kamykowski and told her,
3 we're not going to do a lump sum, but we'll offer a
4 10 to 20 on the verdict.

5 Q. But did she tell you whether she'd ever
6 done a high-low before?

7 A. Much later on in the day, after we had
8 reached one, she had said -- she had made the
9 statement that she had never entered a high-low
10 before, and that it was fine.

11 Q. And at the time that she conveyed the
12 offer of 10 and 20 for the high-low, were there any
13 other terms discussed at that time?

14 A. There were not.

15 Q. Did Ms. Kamykowski, at that time say,
16 well, anything to the extent that she would take that
17 back to her clients, but by -- we've got to talk
18 about noneconomic caps and application of recoverable
19 amounts? Anything along those lines?

20 A. No. The only thing that was communicated
21 is I repeated several times that the 10 and 20 was
22 nonnegotiable, which we stood on that through many
23 different rounds of trading numbers.

24 So as I reported to the Court in the
25 post-verdict record on March 25th, there were several

1 exchanges of the bounds of the numbers to the
2 high-low, but no other discussions of terms or what
3 would -- anything outside of trading the numbers.

4 Q. In this time frame, did you believe or
5 share with me or any other person on the plaintiffs'
6 trial team, that the high-low was going to be reduced
7 by a statutory cap?

8 A. No.

9 Q. Was that ever in your mind?

10 A. No.

11 Q. Now, after you mentioned a 10 and 20, were
12 there further negotiations as to the amounts?

13 A. Yes.

14 Q. And can you tell us about those?

15 A. So what I reported to the Court on the
16 record on the 25th, I stand by that exchange because
17 my memory of each round of exchange was fresh at that
18 time. So what I can tell you, without looking at
19 that record, is that we exchanged back and forth. We
20 stayed on the 10/20 until we learned that there was a
21 verdict.

22 while walking into the courtroom, right
23 before walking in the doors, I met with the -- with
24 Mandy Kamykowski and said, do you want to do the 10
25 and 20? And she told me, no, 8 and 18 is it. And I

1 said, well, give me a minute. And that's when we
2 asked -- or Ms. Kamykowski asked the Court, she said
3 something to the effect of, Your Honor, you'll be
4 happy. we need a couple of minutes.

5 well -- I'm sorry. we talked to our
6 client in the hallway, and we came back in, and I
7 told Mandy that 8 and 18 would get it done. And then
8 that's when she said to the Court, can we have a
9 couple of minutes? You'll be happy. And that's when
10 we walked out right beyond on the doors and drafted
11 the four phrases on my phone.

12 Q. Prior to drafting the terms of the
13 settlement agreement that were memorialized in the
14 text message, had you -- when you described the 10
15 and 20 or the 8 and 18, did you use the word
16 "verdict"?

17 A. Yes.

18 Q. Yeah. And explain that.

19 A. That's the only word I had used up until
20 the post-verdict record, which is what I explained on
21 the record, which was very important to me that
22 evening to tell the Court everything I remembered
23 about the negotiations while it was fresh.

24 Q. And what did "verdict" mean?

25 A. Verdict meant on the verdict as the jury

1 reported it.

2 Q. Did you mean just the first part of the
3 verdict?

4 A. No. Because at that time, since the
5 defendants asked for bifurcation, in order to get to
6 the end of the verdict, we didn't know at that time
7 if it would, you know, say, if plaintiffs won, and
8 there was a money verdict announced, we didn't know
9 what their answer to the question would be.

10 So I was clear in the phrasing that the
11 entire verdict was going to play out, and that's why
12 we phrased "all the way to verdict," not meaning, you
13 know, we stop after compensatory. The entire verdict
14 will be read, whether there's a second phase or not.
15 we didn't know at that time.

16 Q. And with respect to the punitive claims,
17 you were involved in the efforts to secure submission
18 of those claims, correct?

19 A. Correct.

20 Q. In other words, plaintiffs had filed
21 motions to allow the -- our pleadings to be amended
22 to include a punitive damage claim?

23 A. Correct.

24 Q. Those -- that had been argued and allowed
25 by the Court?

1 A. Right. You argued it on December 4th. We
2 discussed it at that time, and of course our
3 discussion continued after we had formed our firm and
4 continued it. I had then entered my appearance.

5 Q. And there were -- there was plead -- I
6 guess briefing with respect to summary judgment on
7 the punitive submission? Do you recall that?

8 A. Correct.

9 Q. And Her Honor denied that summary
10 judgment?

11 A. Correct.

12 Q. That had been renewed. We go through the
13 trial, there had been, I think, request for a
14 directed verdict on the punitives, which was also
15 denied, correct?

16 A. Right. And I argued those.

17 Q. And was there ever a time that we, on
18 behalf of the Anyans, had ever indicated that we
19 weren't going to ask the jury for a punitive award if
20 the Court allowed it?

21 A. No.

22 Q. Did you, at any time on the afternoon of
23 March 25th, 2025, when the settlement negotiations
24 were ongoing, indicate, either through your words or
25 actions, that punitive claims were being abandoned or

1 waived?

2 A. No. And at the time that we wrote the
3 four-phrase text message, there were questions from
4 the jury basically asking where to write it or
5 whether what they wrote down included it.

6 Q. So I think what you're referencing is a
7 question from the jury that was timed at 4:20 p.m.,
8 and this is part of the record: Quote, the question
9 was -- excuse me -- it's 4:08 -- 4:05 p.m. the jury
10 question is: Does definition punitive damages
11 include or equal all the moneys awarded?

12 Do you remember getting that question?

13 A. Right.

14 Q. Did that indicate to you that the jury was
15 certainly considering punitive damages?

16 A. I, from that question, I believed that we
17 were going to see a -- the second phase of trial.

18 Q. And based on that, as well as everything
19 else that we've discussed, was it ever the spoken
20 words or the intent that punitive damage would be
21 waived or abandoned or moot or irrelevant?

22 A. No.

23 Q. Did you ever say any of that to Ms.
24 kamykowski or Mr. willman?

25 A. No.

1 Q. Now, there has been discussion about the
2 punitive payment, and tell us what that discussion
3 involved.

4 A. So prior to 4:47, Mandy and I wrote the --
5 or I'm sorry -- Ms. Kamykowski and I wrote the four
6 phrases of the text message. I pulled out my phone,
7 we wrote them together, negotiated each of them. I
8 texted that to her, and she said that, okay, let me
9 call our client.

10 Then she and Phil asked me to come out in
11 the hallway, or found me in the hallway, and we had
12 the additional conversation. And, again, I reported
13 that evening, where Phil wanted to confirm that it
14 settled all claims, which of course it did. And that
15 the payment would not be made on punitive damages.
16 when we settle cases that involve punitive damages,
17 both sides have reasons for construing the payment in
18 the settlement agreement as only paying for punitive.

19 On the plaintiffs' side, there are IRS
20 complications, and it will trigger different laws
21 under the tax code, and Missouri laws allow for
22 plaintiffs to contract punitive damages in this way
23 to avoid those laws.

24 For defendants, if a -- if the insurance
25 coverage excludes payment for punitive damages, which

1 in this case we had insurance contracts that did,
2 then that's why the coverage can't pay for punitive
3 damages, but there was never any discussion that it
4 wouldn't be included. And, in fact, when I was asked
5 whether it would be, I confirmed that if it was to
6 occur, the second stage was going to go forward.

7 Q. Was there ever any indication that Ms.
8 kamykowski wasn't authorized to negotiate on behalf
9 of all of the defendants?

10 A. No, that was never stated. And she had
11 been the one I had been talking with the entire
12 afternoon, up until my conversation with Mr. Willman
13 that we just discussed.

14 Q. Was Mr. Willman helping draft the
15 settlement agreement in your notes?

16 A. No. It was just Mandy and I standing
17 together and going through, basically hashing out
18 what our terms were, and we stopped once we were done
19 doing that.

20 Q. And let's look at those. I think it was
21 previously Exhibit C, also Exhibit -- it was also an
22 exhibit to our memorandum in support, which of course
23 I can't find right now.

24 A. So my -- I took three screen shots from my
25 phone that we submitted as exhibits. In my

1 affidavit, that we also submitted, my intention was
2 to lay the foundation for those. The text in my
3 Notes app is Exhibit 1, and then my text of that from
4 the Notes app to Mandy is Exhibit 2.

5 Q. Okay. And are you laying the foundation
6 for those at this point?

7 A. Yes. These are screen shots from my
8 phone. They're fair and accurate representations.
9 And they are -- they were not altered, and I did not
10 redact or do anything to them.

11 Q. And with respect to the Exhibit 1, the
12 settlement agreement in your Notes app, let's talk
13 about that.

14 The first line is 8 and 18 -- first of
15 all, just in terms of all four terms, 8 and 18, all
16 the way to verdict, confidentiality to high-low, no
17 non-disparagement, those were the terms that were
18 negotiated and agreed upon on that afternoon,
19 correct?

20 A. Yes. Each one individually negotiated.

21 Q. With Ms. Kamykowski and Mr. Willman?

22 A. No. These were negotiated with Ms.
23 Kamykowski, and then Mr. Willman didn't come into the
24 conversation until we had the subsequent conversation
25 about settling all claims and punitive.

1 Q. And was he aware of those additional
2 terms?

3 A. I don't know what he was aware of.

4 Q. The 8 and 18 -- so all four of these
5 terms, do you agree that they are clear?

6 A. Yes.

7 Q. In their wording?

8 A. Yes.

9 Q. Unambiguous?

10 A. Yes.

11 Q. Material?

12 A. Yes. We stopped when we were done hashing
13 out what the material terms were.

14 Q. And the 8 and 18, based on your
15 conversations and the negotiations, what did 8 and 18
16 reference?

17 A. That was the monetary bonds of the
18 high-low, so that would be the exchange of money for
19 us to settle and release all the claims.

20 Q. The next term "all the way to verdict,"
21 what was negotiated with respect to that?

22 A. So it's phrased "all the way to verdict"
23 because at that point, we didn't know whether there
24 would be a second phase of trial. So if the jury had
25 answered the question about punitives, no, Dr.

1 McNeive and the clinic are not liable, then that
2 first verdict form would stand as the verdict.

3 Since the verdict wasn't complete upon the
4 first phase of the jury deliberating, and that did
5 come to pass, that second phase occurred. And
6 verdict B came back, which encompasses the verdict.
7 So this is phrased this way, and this isn't my
8 phrasing, we wrote it together. It's phrased that
9 way to represent that, whether it's the first verdict
10 or -- or the jury tells us there's second a phase,
11 we're going all the way through till the end.

12 Q. And that was important with respect to the
13 total amount of the high-low?

14 A. Correct. And that's why it's phrased that
15 way.

16 Q. Was that -- that part simply self-serving
17 so it could be a marketing tool for us?

18 A. That was never discussed until the
19 post-verdict record when I heard the word
20 "marketing."

21 Q. And that was from Ms. Kamykowski?

22 A. Correct.

23 Q. The next term is "confidentiality to
24 high-low."

25 That was negotiated and discussed?

1 A. Right. And it carved out because she had
2 asked, you know, it will all be confidential, and I
3 wanted to limit that to, since we had had a public
4 trial, and we were going to have a public verdict, I
5 limited that to just the high-low settlement and the,
6 of course the amounts of that.

7 Q. And was it, in fact, the defendants, when
8 they filed some pleadings in this court, that
9 revealed the circumstances of the high-low agreement?

10 A. Right. The numbers of the high-low were
11 not on the record until defendants' filings.

12 Q. The last phrase is "no non-disparagement."
13 was that also negotiated as a material
14 term?

15 A. Right. And defendants asked for not -- or
16 Ms. Kamykowski said, and we'll do non-disparagement.
17 And I said, no, we're not doing that. And it was a
18 flat-out rejection, any non-disparagement terms, it
19 wasn't clarified or discussed about lawyers versus
20 clients. I did say, the Anyans aren't doing that,
21 and we're not doing that. And that's why it says no.

22 Q. And during those, when you were talking it
23 up, or during those negotiations, was there an
24 opportunity for Ms. Kamykowski to otherwise populate
25 these terms with additional information or intent?

1 A. In the record that we made afterwards, a
2 lot of my frustration came from the fact of what they
3 were saying were very clear things to communicate.

4 And I believe I said that if that's what they
5 intended, that's a very easy thing to communicate.

6 And I was very frustrated that I was hearing it was a
7 different understanding when that's a very simple
8 thing to have communicated, given the fact that we
9 did this part together.

10 Q. And was there ever any -- a reply, an
11 actual physical reply, from Ms. Kamykowski as to
12 these four terms of the settlement agreement?

13 A. No.

14 Q. And, again, while you were typing them
15 out, she was there with you?

16 A. Right. I mean, she could have just as
17 easily been typing them. We were doing them
18 together. I didn't type them without her looking at
19 my screen, and then come back and say, please review
20 this. We wrote them together.

21 Q. And, in fact, the defense has filed a
22 memorandum in support of their motion to enforce the
23 settlement indicating that these were the four terms
24 of the settlement agreement, correct?

25 A. Right.

1 Q. with respect to your affidavit,
2 Ms. Slater, it was marked as Exhibit 5 to our
3 memorandum in support of the motion to enforce.

4 And does this affidavit clearly and
5 accurately reflect your recollection?

6 A. Right.

7 Q. And --

8 A. Yes.

9 Q. Sorry. And everything stated in there is
10 true?

11 A. Correct.

12 Q. And accurate?

13 A. Yes. And I wanted to -- to the extent
14 that the Court wanted my sworn testimony, I adopted
15 my statements that we made, or that I made, on
16 March 25th as my sworn testimony.

17 Q. And additional exhibits to our memorandum
18 in support included the post-verdict record as
19 Exhibit 3, which had been unsealed on April 9th,
20 2025, correct?

21 A. Correct.

22 Q. And you consider that part of the evidence
23 that we are presenting in support of our motion to
24 enforce the settlement, correct?

25 A. Right. And that was my intention that

1 evening. We moved for an oral motion to enforce at
2 that time.

3 Q. And the judge requested that we put it in
4 writing.

5 A. Correct.

6 Q. Exhibit 4 is a screen shot of the phone
7 call from Mr. Willman?

8 A. Yes.

9 Q. I believe that Mr. Willman identified
10 that, as well.

11 with respect to that phone call, Exhibit 4
12 indicates that there was an incoming call from
13 Mr. Willman at 7:39 p.m., so about an hour after the
14 record was concluded, correct?

15 A. Right.

16 Q. And what was the substance of that phone
17 call?

18 A. What I put in my affidavit. He asked me
19 to hold on everything, which I asked him for
20 clarification because he said it couple of times, and
21 I didn't know what that meant, "hold on what"? Hold
22 on everything. And he clarified that that was --
23 don't file anything. And he said that he needed to
24 talk to one more person, and then we'd have a
25 settlement at 18?

1 Q. And did you mishear that --

2 A. No.

3 Q. -- with respect to the 18 part?

4 A. No.

5 Q. Any question in your mind that that phone
6 call was indicating that, just give us another day.

7 we're going to make another phone call, and we're
8 going to honor this agreement at 18?

9 A. Yes. And when he called that night, I
10 mean, not that it was accepted, but I'm, like, this
11 makes sense because we did settle the case for 18.

12 Q. Exhibit 5 is your affidavit. I think
13 we've talked about that. Exhibit 6 is the trial
14 proceedings from March 25th. And just the difference
15 between Exhibit 3 and Exhibit 6, is Exhibit 3 is just
16 the post-verdict record, and Exhibit 6 is pretty much
17 the minute the jury goes out and includes all the
18 questions, correct?

19 A. Right. And we requested this from our
20 court reporter, and I asked her to leave out the very
21 long discussion about entering exhibits for the trial
22 that was in the middle of all this.

23 Q. Thank you.

24 Exhibit 7 is an email correspondence
25 regarding mediation.

1 And, Ms. Slater, you're on this email. I
2 think the point of adding this as evidence in this
3 case, is to make it very clear that whatever terms of
4 the February 7th, 2025, letter, were rejected,
5 correct?

6 A. Right. And I was with you when you had a
7 conversation with Ms. Kamykowski over the phone that
8 was rejecting their \$2.5 million global offer with
9 the terms. And then Ms. Kamykowski followed up with
10 the email that confirmed that we were rejecting it.

11 Q. Exhibit 7 are the text messages that were
12 ordered to be produced to this Court and were
13 redacted, as well, is that correct?

14 A. That's Exhibit 8.

15 Q. Excuse me. Did I say 7? Pardon me.
16 Exhibit 8. And you consider this evidence in this
17 matter, as well?

18 A. Right. We were able to view this after
19 the Court ordered it, reviewed it en camera, and
20 produced the responsive communications.

21 Q. Ms. Slater, I think that's all the
22 questions I have, thank you.

23 A. Thank you.

24 THE COURT: Cross-examination?

25 MR. PERRON: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. PERRON:

Q. The first offer from defendants was 2.5 million, fair?

A. I believe so. That's understanding. I don't -- I wasn't as involved in the settlement discussions actually until the 25th.

Q. Okay.

A. I was sidelined to them before that.

Q. From that first offer, through the end of the day, March 11, defendants increased their offer from 2.5 to 10 million. Does that match your recollection? There might have been some jumps in between there?

A. Before the jury was called in, the last offer from defendants was 10 million, which we rejected.

Q. Right. And just, if I'm doing my math, 2.5 to 10 is about 7.5 million?

A. Sure.

Q. Okay. Your first demand -- and I'm saying "you" globally. You have an understanding that plaintiffs' first global demand was 45 million, correct?

A. I believe that's correct.

1 Q. Okay. And from that first demand till the
2 end of the day, March 11, that decrease was from 45
3 to 35. That was your last demand as of March 11?

4 A. So our last -- the last negotiations were
5 not at the end of the day. It was before the jury
6 came in. So those negotiations did not continue past
7 calling the jury in.

8 Q. Okay.

9 A. You said up until the end of the day.

10 Q. Okay. But still, regardless of whether
11 it's when the jury came in at the end of the day,
12 March 11, by March 11, defendants had come up from
13 2.5 to 10, and plaintiffs had come down from 45 to
14 35, is that fair?

15 A. I think that sounds right.

16 Q. Okay. So just --

17 A. I don't know if we had come off of 45
18 before that day.

19 Q. And that's why I'm -- I know there's a lot
20 in between -- but that's why I'm using March 11. So
21 if we use March 11 as the day, defendants had
22 increased 7.5, and plaintiffs had come down 10, fair?

23 A. Sounds fair.

24 Q. Okay. So if we skip ahead to March 25,
25 the jury's deliberated, they send back the question

1 wanting -- I said it wrong before, and I was
2 corrected, so I want to make sure I say the right
3 thing -- life care plan cost tables and expenses for
4 all parties. That was the question or the request
5 from the jury while they were deliberating, fair?

6 A. Right.

7 Q. Okay. So in response to that request,
8 defendants increased their offer from 10 to 12, an
9 increase of \$2 million -- is that correct? -- if my
10 math is right?

11 A. I would have to look at the time line to
12 understand when that 12 million fell into the jury's
13 deliberations.

14 Q. If you want to refer back, that's fine.

15 A. So I don't have a time on when the 12
16 million was offered. My -- the only thing I can do
17 is surmise from the text messages between

18 Mr. Crawford and Ms. Kamykowski. And it was sometime
19 after he sent the text message that said, I want to
20 go ahead and offer the 12 now. I mean, that's an
21 assumption I'm making. I think it's a fair
22 assumption, but...

23 Q. Right. If you've got in your time line
24 that the jury question for life care plan, cost
25 tables, is at 3:18, and that text to Joe

1 authorizing -- or from Joe to Mandy authorizing 12
2 million as 3:41, you'd agree with me that likely that
3 12 million offer came after that question from the
4 jury, is that fair?

5 A. I don't have that information, but it
6 doesn't seem like a stretch, so, I mean...

7 Q. Okay. So the offer is increased by 2
8 million, from 10 to 12, fair?

9 A. Correct.

10 Q. And that in re -- sometime after that, you
11 guys made a counterdemand to settle of a high-low at
12 10 and 20?

13 A. Right. We were not interested in
14 negotiating on a lump sum.

15 Q. Okay. So if my math is correct, in
16 response to us for the defense increasing just 2
17 million, plaintiffs had decreased their demand from
18 35 to a high of 20 and as low as 10, is that fair?

19 A. Well, so that high-low negotiation was not
20 a continuation of the treating of the lump sum
21 amounts. In between the last lump sum negotiation
22 that was had, we tried an entire case.

23 Q. Right.

24 A. And we have a jury deliberating and asking
25 questions. So for plaintiffs, that was a different

1 calculus, which is why we did not accept negotiating
2 on a lump sum. We were resetting the negotiations,
3 so to say, on our terms, which were not a
4 continuation of the prior exchange which did not
5 occur between March 11th and March 25th.

6 Q. Sure. Just as you said, part of your
7 recalculating was in response to the case that you
8 tried and also the jury questions that were coming
9 back?

10 A. So --

11 Q. I thought that's what you said, but
12 correct me if I'm wrong.

13 A. Well, so it was a new negotiation after
14 the case had been tried. We had never negotiated
15 between the parties on a high-low up until
16 March 25th. Sometimes that's done that you go ahead
17 and start a trial with a high-low in place.

18 Sometimes those negotiations are made while the jury
19 is deliberating.

20 As we've discussed several times, it's a
21 way to reduce risk on both sides because you allow
22 the verdict to go forward so the jury's thoughts come
23 through, but we know there's no appeal of that
24 amount, that we can still go forward to verdict and
25 it's still over.

1 Q. Sure.

2 A. It's intent.

3 Q. I guess a better way to ask my question
4 would be, in choosing the high limit of the high-low,
5 you could have said 10 and 35. You could have said
6 10 and 30. But my understanding is, you came back,
7 and you said 10 and 20, is that fair?

8 A. It is. And 10 and 20 matched the -- our
9 understanding of the limits of coverage that the
10 insurance adjuster who was engaged had.

11 So if we had asked for a high of 35 after
12 the jury had been deliberating for 3 hours, it would
13 put defendants in a position to potentially bring in
14 a brand new insurance level that was either one or
15 two levels above the person whose attention we had.

16 Q. Sure. But you wouldn't -- I guess to
17 understand, even if you didn't have the right
18 insurance adjuster's attention right at that moment,
19 I don't want to take it for granted, but you wouldn't
20 want to limit your negotiation to something far less
21 than you legitimately thought that you could win on
22 the verdict, is that fair?

23 A. Well, so there's been a lot of statements
24 in the briefing, and with the testimony about
25 plaintiffs' intentions and our thought process, and

1 what our numbers were.

2 To explain that, I believe some of that is
3 attorney-client privilege, and I haven't been
4 authorized to breach those. However, what I can tell
5 you is to repeat what I just said is, 10 and 20 match
6 the limits of coverage of the understanding that we
7 had about who -- whose attention we had.

8 And if we were actually trying to settle
9 the case and avoid an appeal, it would be fruitless
10 to make a demand outside of the limits that the
11 adjuster, whose attention you all have -- had. So if
12 we were to go above 20, we would have engaged a
13 different level of insurance, which is not something
14 that can be done quickly when you have a jury out,
15 and you're waiting for a verdict. So if we were
16 going to limit everyone's risk, and also have them be
17 in a range that we believed would be acceptable to
18 all parties.

19 Q. So the question from the jury is both life
20 care plan, cost tables, and expenses for all parties,
21 is that fair?

22 A. I'm not looking at the record. I'll --
23 I'll trust your representation of the question.

24 Q. Okay. And I hope you don't have to trust
25 me too, too far, but if I represent the defendants

1 presented two different numbers of life care plan
2 totals, the lower of which was 5.5 million, does that
3 come close to matching your recollection?

4 A. Yes.

5 Q. Okay. And on the plaintiffs' side, the
6 plaintiffs -- the upper limit of Dr. Liles' plan for
7 the more expensive option up to age 75, was about 21
8 million. Is that fair, to your recollection?

9 A. Something like that, yeah.

10 Q. Okay. So theoretically if the jury is
11 deciding the future medical award, between 5.5 and
12 21, the end net judgment, after application of the
13 caps for the compensatory award, would be between
14 7 million and 22.4 million. Is that fair, if my math
15 is coming close?

16 A. So when you're talking about that
17 calculation, that wasn't part of our estimation in
18 offering the high-low. As far as I offered a 10 to
19 20 on the verdict, so that thought process of what
20 Dr. Liles was offering, or what the past medical was,
21 it wasn't a part of our calculations because we had
22 the -- we had the jury questions indicating that they
23 were on damages, and we had a question asking about
24 punitives that we took as they're looking where to
25 write the number.

1 so when we're thinking about what's
2 appropriate to the high-low, and our clients trading
3 lack of risk for certainty, while still getting the
4 verdict, our calculation was that we believe that
5 we're going to get a compensatory verdict that may
6 also include punitives.

7 So I understand what you're saying about
8 the numbers, that they just weren't part of the
9 plaintiff calculation that day, and defendants were
10 not privy to why we chose the numbers we did, nor was
11 there a question of why they are --

12 Q. No. I just wanted you to double check my
13 math, so that when I talk about it later, I can say
14 that we agreed on it.

15 so if -- if the range of -- if the jury is
16 choosing something between defendants' future medical
17 5.5 and plaintiffs' future medical of 21, then the
18 range of the net compensatory award, if you add in
19 agreed upon past medical of about 600, and the cap on
20 noneconomic of 800 something, something, that the
21 range of the net judgment of the compensatory award,
22 if the jury picked somewhere in between those
23 numbers, would be in between about 7 million and 22.4
24 million, is that fair?

25 A. I mean, those are the numbers that are in

1 evidence. What the jury does with those numbers, I
2 mean, that's what we're all doing, is making our
3 informed decisions of what they might do with it. As
4 you know, Ms. Gunn asked for more than the life care
5 plans, so --

6 Q. She did.

7 A. -- if they had used her number and put
8 that on the future economic line, that would have
9 exceeded Dr. Liles' life care plan.

10 Q. So I don't disagree. But I just -- I
11 apologize for belaboring the point. I just want to
12 make sure that you don't disagree with where my
13 numbers are.

14 A. I mean, the evidence is what it is. What
15 you said the numbers of what you -- defendants asked
16 for and what the top of Dr. Liles' life care plans
17 were, is what they are.

18 Q. Right. So somewhere in between, if the
19 jury is choosing between the two plans, the final net
20 judgment on compensatory, would be between 7 and 22.4
21 million?

22 A. I disagree. Because the final net
23 judgment is whatever the jury said it would be based
24 on the arguments of counsel. I can tell you what it
25 is in this case, based on what the jury determined.

1 what you're talking about is everyone's estimation of
2 what the judgment might be.

3 Q. Right. So you don't disagree with me that
4 600,000 is the past medical, fair?

5 A. It was 593,000.

6 Q. Thanks for checking me out.

7 A. And they put 600-.

8 Q. Okay. The cap on noneconomic is what it
9 is.

10 A. Sure.

11 Q. Okay. If, again, I'm asking a
12 hypothetical question. Hypothetically, knowing those
13 two numbers, past economic and the cap on
14 noneconomic, if the jury is choosing between the
15 defendants' low of future medical, and the
16 plaintiffs' life care plan high of future medical,
17 the net judgment on compensatory damages would be
18 between 7 million and 22.4.

19 A. I'm not trying to be difficult. We asked
20 for 25.

21 Q. Right.

22 A. If they wanted to give our numbers, they
23 would have given 25. The defendant -- in future
24 medical. The defendants asked for either 5.5 or 6.5
25 in future medical, and the jury could have done

1 either of those things. I'm not trying to be
2 difficult, I'm just...

3 Q. I -- we're probably just not going to
4 agree.

5 A. Okay.

6 Q. You said that we can't get inside your
7 mind, you, being the plaintiffs' counsel working with
8 Mr. and Mrs. Anyan about how you are deliberating and
9 calculating and taking in the context of the jury
10 questions, is that fair?

11 A. Uh-huh.

12 Q. I hate to do this to you --

13 A. Yes.

14 Q. Yeah. You had been doing so well.
15 So is it fair, then, in the reverse that
16 you, as plaintiffs' counsel, can't get inside the
17 minds of the defendants and know how we are
18 perceiving your counter-demands and what is in your
19 mind when you say a high-low of 10 to 20, is that
20 fair?

21 A. All I can do is go on what is said to me
22 and be clear in my words.

23 Q. Okay. And 10 and 20 million is between
24 what was in the Dr. Liles' life care plan of 21
25 million and what the defense put on as future

1 medical, is that fair?

2 A. So if the -- if it's the premise of the
3 high-low, which is 10 and 20 million, that's the
4 limit of coverage that Joe Crawford controlled.

5 Q. Okay. And I understand from your
6 perspective, in the depths of your mind and
7 consideration, you were exclusively thinking about
8 the insurance policy that Joe Crawford has in control
9 but objectively, objectively, the numbers 10 and 20
10 are within a range of 7 and 22.4, is that fair?

11 A. Sure.

12 Q. Okay, great.

13 Exhibit D, which I marked, do you need a
14 copy of that?

15 A. Yeah, if you don't mind.

16 Q. Okay, sure.

17 A. There's a clean one on our table if you
18 don't want to give me your marked-up copy.

19 Q. No. I happen to just luckily have a
20 spare, clean copy.

21 So I blew this out and put it on a single
22 piece of paper, but does this match what the
23 plaintiff prepared as part of your all memo in
24 response to our motion to enforce? I think on page 7
25 of that pleading.

1 A. Correct. I drafted this.

2 Q. Okay. So you would agree with me Exhibit
3 D is an accurate reproduction of something that you
4 prepared to bolster your argument for the motion to
5 enforce, is that fair?

6 A. This text appears in our motion, yes.

7 Q. Okay.

8 A. It -- the -- yes.

9 Q. Okay. So the -- the -- what's not in bold
10 in Exhibit D, that's part of the original four lines
11 that was exchanged between you and Ms. Kamykowski, is
12 that fair?

13 A. Right.

14 Q. Okay. The bold language is what you added
15 when you prepared this for your pleading, is that
16 fair?

17 A. Right. And in context of our argument,
18 the case law supports what I added here. There's a
19 purpose of why I added the bold text. It's not
20 trying to add to the agreement. It's explaining our
21 four-line agreement in relation to the case law. So
22 this is obviously taken out of a 26-page brief.

23 Q. Sure. But just talking about this, just
24 as you said, using your words, you are adding this
25 bold language to explain the text message language,

1 fair?

2 A. I mean, it's out of context. The way I
3 used this in our briefing, is what's in the briefing.

4 Q. Okay. Did I misconstrue what you said
5 earlier that the bold language was explaining the
6 text message?

7 A. Well, I mean, we're not trying to add any
8 terms to the text message.

9 Q. Oh, I don't disagree. Just like you said,
10 the bold language is explaining the terms of the
11 text, fair?

12 A. I mean, the terms of the text are what
13 they are. My briefing is an argument that -- in the
14 context of this litigation. So any implication or
15 any insinuation that I'm trying to add terms is not
16 --

17 Q. No.

18 A. -- accurate.

19 Q. I think we're too far along to ask you to
20 trust me. But if you would trust me, I'm not trying
21 to trick you into saying that you're trying to add
22 terms --

23 A. I do believe that's what you're doing.

24 Q. Okay.

25 A. I'm not adding terms to the four lines of

1 the text message. what you've pulled out of my
2 briefing is part of my briefing, and I don't have
3 that in front of me.

4 Q. okay.

5 A. So I'm not going to state something in
6 court that is different or not what I have in my
7 briefing.

8 Q. okay. That's fine. So I think we are
9 on --

10 A. It speaks for itself.

11 Q. Sorry. We are on the same page. I think
12 so, too. But if we can't agree on what it says, we
13 can't agree.

14 I think you did agree with me, though,
15 that looking at Exhibit D, the language in bold was
16 not part of the original text, is that fair?

17 A. Yes, that's fair. I'm not trying to be
18 difficult. I just -- this is not -- this is out of
19 my brief, yes.

20 Q. Right. It's demonstrative only, fair?

21 A. Yes.

22 Q. Okay. Demonstrative only.

23 So just as Ms. Gunn was asking of Ms.
24 kamykowski, the defense, at any time, could have made
25 use of explicit language to say recoverable amounts,

1 and we didn't, fair?

2 A. Fair.

3 Q. Okay. So at the time you were preparing
4 the original text, you, too, could have used explicit
5 language to describe all the way to verdict as this
6 is the trigger for the high-low, is that fair?

7 A. Well, a verdict is a trigger for --

8 Q. Sure. I'm sure that's what you're arguing
9 right now, I understand. But you could have used the
10 explicit language of "trigger," or this is the
11 trigger for the high-low, is that fair?

12 A. All the way to verdict is the trigger.

13 Q. Okay. You're saying that now. Does this
14 say "all the way to verdict" is the trigger?

15 A. All the way to verdict.

16 Q. Okay. It does not say "trigger" anywhere
17 in here.

18 A. 8 and 18, all the way to verdict.

19 Q. Sure. Sure.

20 A. And --

21 Q. I understand.

22 A. And these were drafted with Ms.
23 Kamykowski.

24 Q. Sure. They were drafted with Ms.
25 Kamykowski, just as she had the ability to use

1 explicit language to say, the trigger is the net
2 judgment. She could have used that explicit
3 language, and Ms. Gunn pointed out that she did not
4 do so, fair?

5 A. Right. And I think we both agreed that
6 these terms are complete and unambiguous.

7 Q. Sure. And they're so unambiguous, that
8 when you put it in your pleading to demonstrate to
9 the Court what they meant, you added this bold
10 language to explain it, fair?

11 A. That's your position.

12 Q. Okay. Certainly, it is.

13 you could have used the explicit language
14 of "trigger" in the text message to explain that all
15 the way to verdict was the trigger, is that fair?

16 A. I believe that's your argument.

17 Q. So it's --

18 A. I mean, so -- so Ms. Kamykowski and I
19 drafted these together, it was a complete
20 conversation. We stopped when we were done. It's my
21 understanding that, yeah, I'm aware of your argument,
22 and I believe that's your argument. And I think we
23 can sit here all day and talk about, you know, what's
24 in the agreement, but we both have a position.

25 Q. Sure.

1 A. And the Court will decide.

2 Q. Sure. I supposed we can't come to an
3 agreement on that, and that's fine. But I think you
4 did agree that the word "trigger" was not used in the
5 text message. At least we agree on that, is that
6 fair?

7 A. My words were complete to defense counsel
8 in context. All the way to verdict is the trigger.

9 Q. Okay. So it's your position now that you
10 did use the word "trigger," but only orally. Is that
11 what you're saying?

12 A. No.

13 Q. Okay. What are you saying?

14 A. Exactly what I just said.

15 Q. Okay.

16 A. My words were complete. We drafted these
17 terms together. In context, it says 8 and 18. The
18 next phrase is all the way to verdict, describing
19 verdict as the trigger. Confidentiality as to
20 high-low, which is a limiting confidentiality
21 agreement. And no non-disparagement which is --
22 means there is an exclusion of any non-disparagement
23 provisions that we have seen in other settlement
24 treatments.

25 Q. Okay. And just to clarify, are you saying

1 in your mind you thought it was clear that all the
2 way to verdict was the trigger for the high-low? Or
3 are you saying that verbally, with explicit language,
4 you said, Mandy, all the way to verdict is the
5 trigger for the high-low?

6 A. So my -- I think what is in my mind
7 doesn't matter in the calculation. What is in
8 anyone's mind doesn't matter to the calculation.

9 Q. Well, it's meeting of the mind, I thought,
10 but I --

11 A. Right. I would need to say out loud
12 anything that was in my mind that I hadn't talked
13 about. This says all the way to verdict. We used
14 the word "verdict." When I first offered the
15 high-low, we said 10 and 20 on the verdict. I
16 reported that to the Court on March 25th.

17 Q. After?

18 A. Within moments of the agreement becoming
19 in dispute.

20 Q. Right.

21 A. Right.

22 Q. In moments of the agreement coming into
23 dispute, you made it clear that was in your mind, 10
24 and 20, on the verdict?

25 A. No. In my record, I reported that the

1 only word used up until the post-verdict record, was
2 the word "verdict."

3 Q. Right. So that's referring to the text
4 line all the way to verdict, fair?

5 A. No. In the record that we filed as
6 Exhibit 3, and I think it's Exhibit 6, as well, I
7 reported to the Court that the only words that had
8 been used the entire day, up until hearing them
9 differently at sidebar, was the word "verdict." And
10 that is also what is reflected in the terms in the
11 four-line agreement.

12 Q. Right. And just as you said, in your
13 opinion, within your own mind, it's obvious in the
14 context that all the way to verdict is the trigger
15 for the high-low, fair?

16 A. I just can't agree with your
17 characterization of in my opinion in my own mind.
18 The agreement speaks for itself. We each have
19 opposing arguments.

20 Q. Okay.

21 A. I did not conceal my intention of using
22 the word "verdict." It was not just in my own mind.
23 The word "verdict" was used before this text message
24 was written, and it was repeated in the text of the
25 agreement.

1 Q. I just want to know if you're taking the
2 position that you communicated explicit language to
3 opposing counsel, when I say all the way to verdict,
4 Mandy, I mean the verdict is the trigger for the
5 high-low?

6 A. I believe that's communicated by 10 and 20
7 on the verdict, and then repeating it in our
8 negotiations all the way to verdict under the
9 conditions of a bifurcated trial.

10 Q. Okay. Skipping ahead to the telephone
11 call with Mr. Willman later on.

12 You mentioned that Mr. Willman advised he
13 still had to speak to one more person, is that fair?

14 A. Correct.

15 Q. Okay. But you don't know, or did you have
16 any inclination, of who that one person might be?

17 A. No, actually. I wish I would have asked
18 that at the time, but I think we learned on Tuesday
19 who that was.

20 Q. Okay. But I just, for the clarity in my
21 own mind, did you believe that when Mr. Willman was
22 speaking to you that evening, that he believed he had
23 authority right then to agree to an \$18 million
24 settlement?

25 A. No. I believe exactly what he said, is he

1 asked us to keep the status quo, not to file
2 anything, and that he had to speak to one more
3 person.

4 Q. Even though you don't know the specific
5 identity --

6 A. Right.

7 Q. -- it was your understanding he did not
8 believe, sitting there, that he had authority to
9 agree to an \$18 million settlement.

10 A. So I don't know what he believed. I don't
11 know what was going on on your side. I know what
12 happened that night, and it was immediately followed
13 an hour later by a call saying that, we have to have
14 a discussion with one more person, and then we're
15 settled at 18, which I thought was appropriate
16 because of how this all had happened. I thought it
17 was -- it made sense to hear that they were
18 regrouping, and that they still wanted the settlement
19 that we made.

20 Q. Still, I think you agreed with me that it
21 was your understanding the one more person
22 Mr. Willman needed to talk to was someone that could
23 grant authority to settle the case for 18 million.

24 A. Yeah. That's my understanding from his
25 words. He didn't say, I have authority for 18. He

1 said, I need to talk to one more person, and then I
2 believe we are settled at 18.

3 Q. Right. So if Mr. Willman, at 4:47 p.m.,
4 believed that he had authority to settle the case at
5 18 million, why would he, at 7:10 p.m., still need
6 additional authority?

7 A. So I don't have the facts about that. I
8 can tell you what our argument is about that. That
9 Ms. Kamykowski backed out, and after there was a
10 punitive damage verdict against the doctor that Mr.
11 Willman represented, that there was a conflict
12 between those parties. Maybe one wanted it, and one
13 did not.

14 So it made sense to me that there was some
15 sort of disagreement from people, I do not know, I'm
16 not privy to these conversations, that maybe the
17 settlement at 18 is still desired, even though Ms.
18 Kamykowski communicated that they were not settling
19 at 18.

20 Q. And it's just not possible that the
21 defense and the insurers had a good faith
22 misunderstanding of the high-low?

23 A. I can't tell you what their understanding
24 was, whether it was in good faith or bad faith. I
25 know what our argument is, that it was not in good

1 faith to back out of this agreement, based on the
2 very clear nature and unambiguous agreement that we
3 entered, and that is exactly what I stated to the
4 Court on March 25th, that I was extremely clear of
5 the agreement that we had entered.

6 Q. So you don't know, but you're going to
7 argue it was bad faith?

8 A. We have a motion for sanctions pending
9 that I moved that evening.

10 Q. Okay.

11 A. I can't say what is in anyone's mind.
12 That's not for me to decide.

13 Q. Just like you said, on March 25, you made
14 every effort to accurately convey your understanding
15 of the facts to the Court on the record?

16 A. I've learned that one of those facts is
17 incorrect.

18 Q. Which one?

19 A. The person I thought was Joe Crawford in
20 the courtroom the week before, once I saw him on the
21 video, I realized it was not.

22 Q. Okay. And I believe, and we discussed a
23 little bit of this on direct, I think, but on the
24 record on March 25, you expressed to the Court that
25 there was a misunderstanding between the two parties

1 on the terms of the high-low agreement?

2 A. I don't believe there was a
3 misunderstanding.

4 Q. Is that what you said on March 25, though?

5 A. Well, so the entire conversation started
6 on the record of, there appears to be a
7 misunderstanding.

8 Q. Okay.

9 A. Yes. I learned that there was not the
10 same understanding at sidebar. At the time the
11 agreement was entered, I do not believe there was a
12 misunderstanding.

13 Q. Okay. Those are all my questions. Thank
14 you.

15 A. You're welcome.

16 THE COURT: Any redirect?

17 MS. GUNN: No, ma'am.

18 THE COURT: Thank you. You may step down.

19 THE WITNESS: Thank you.

20 THE COURT: Any additional evidence on
21 behalf of the plaintiffs?

22 MS. GUNN: No, ma'am.

23 THE COURT: Any additional on behalf of
24 the defense?

25 MR. PERRON: Counsel reminded me that I

1 didn't move to admit the exhibits already. So, to
2 that extent, we'll move to admit our exhibits. I
3 think A is the letter. B is the demonstrative. C is
4 the text blown up. And D is another demonstrative.
5 A, B, C, and D.

6 THE COURT: Any objection?

7 MS. GUNN: No, ma'am.

8 I think we'd like to do the same, to the
9 extent that they haven't been officially admitted.
10 And that would be the ones I just recited with Ms.
11 Slater.

12 Exhibit 1, the agreement in the Notes app.

13 Exhibit 2 is the text to Ms. Kamykowski. Exhibit 3,
14 the post-verdict record that was unsealed on
15 April 9th, 2025. Exhibit 4, the screen shot for the
16 call with Mr. Willman. Exhibit 5, the affidavit of
17 Erica B. Slater. Exhibit 6, the trial proceedings
18 from March 25th, 2025, starting at the time the jury
19 went out, but excluding the discussion about
20 admitting exhibits.

21 Exhibit 7, email correspondence regarding
22 mediation and the rejection of the February 7th,
23 2025, letter. And Exhibit 8, the defendants' text
24 communications as ordered to be produced by Her
25 Honor, and with redactions.

1 THE COURT: Any objections?

2 MR. PERRON: Your Honor, a general
3 restatement of our earlier objection, which we'll
4 stand on without belaboring. But, too, in particular
5 to adopting the affidavit, again, I think to the
6 extent the Court allows it over objection, the live
7 testimony, I still don't believe the affidavit can be
8 used as evidence for these purposes.

9 THE COURT: Do you believe that the Court
10 can use the testimony that was provided or the record
11 that was made after the verdict, or is that not
12 permissible in your mind?

13 MR. PERRON: I mean, certainly we used it
14 in cross-examination, and people said, to the extent
15 they -- they endorsed certain excerpts, certainly
16 those excerpts can be used. This is getting -- this
17 is testing the limits of my understanding. I -- I'm
18 not sure.

19 THE COURT: I'm just asking what you think
20 I'm allowed to consider because you --

21 MR. PERRON: I think you -- I think
22 because they were discussed at length, and both sides
23 endorsed the accuracy of what they said.

24 THE COURT: And to what extent is there a
25 difference between what Ms. Slater testified to in

1 her affidavit, versus what was put on the record on
2 the night of March 25th, 2025?

3 MR. PERRON: It may be practically
4 redundant, which makes me feel silly for making an
5 objection, and I apologize.

6 But to the extent that there is anything
7 in the affidavit that wasn't overtly re-expressed in
8 live testimony, I don't believe that that can form a
9 foundation for the Court's opinion.

10 THE COURT: Any response?

11 MS. GUNN: Grant v. Sears, Your Honor, is
12 379 S.W.3d 905, a 2012 case. That was an evidentiary
13 hearing on a motion to enforce settlement.

14 In that case, the trial court made sure to
15 clarify on the record what was being considered for
16 purposes of the hearing. And the Court, in that
17 case, considered the motions, the exhibits attached
18 to the motions of -- to be evidence that was by
19 stipulation. And so my objection is, it's the record
20 of the Court. Of course the Court can rely on it, in
21 addition to the exhibits and the testimony and the
22 affidavits.

23 THE COURT: Any further response?

24 MR. PERRON: I thought I heard it was
25 agreed to by stipulation. I think that might be a

1 sticking point. If it was stipulated by both sides,
2 certainly the Court can consider it. I think that's
3 a difference of opinion here.

4 THE COURT: I'm not sure both sides could
5 agree that today is Thursday.

6 MS. GUNN: Your Honor, with respect to --
7 I apologize -- I was thinking and trying to listen at
8 the same time. With respect to exhibits offered by
9 the defendant, I do think that they were noted to be
10 demonstrative only, so to the extent that makes a
11 difference since you are the factfinder, I would
12 object on that basis.

13 MR. PERRON: B and D, I believe they can
14 be referenced for the purposes of demonstrating, but
15 I, again, if there -- I don't think that there is,
16 but if there is evidence of a disputed fact contained
17 in B and D, I don't think the Court can unilaterally
18 rely on any facts conveyed in B or D. I think that's
19 fair. But A is the letter, and C is a blown-up
20 version of the text message.

21 THE COURT: Okay. The Court will admit
22 the exhibits proffered to the Court that are
23 denominated as not demonstrative.

24 Does that conclude the hearing with
25 regards to the motions to enforce settlement?

1 MR. PERRON: Your Honor, I had anticipated
2 making a brief argument. I have a pretrial hearing
3 down the hall at 1:30. I apologize. I don't have
4 anything relevant to say about the motion for
5 sanctions, which I think is due next. I will make
6 myself -- I'm at the Court's disposal if you want me
7 to just continue on. The codefendant might be able
8 to argue for a bit on the pretrial conference at
9 1:30, but that's...

10 THE COURT: I don't know that I need any
11 more argument on these motions. I'm -- I think that
12 I've been somewhat generous with giving you time to
13 present the motions. I don't know that I require
14 further argument.

15 MR. PERRON: would you allow us, Your
16 Honor, maybe a final briefing?

17 THE COURT: The final briefing is going to
18 say what we've all been saying.

19 MR. PERRON: You're right.

20 THE COURT: I don't know that hearing the
21 same thing more is going to change anything. And
22 that's all I think it's going to be, so I don't know
23 that it's necessary. So I'm going to take the
24 motions to enforce settlement under submission at
25 this time.

1 shall we move to the motions for
2 sanctions?

3 MS. GUNN: Yes, Your Honor.

4 THE COURT: So why don't we take 10
5 minutes so that my court reporter can get a break.

6 (Court stood in recess from 1:28 p.m. to
7 1:46 p.m.)

8 THE COURT: We are back on the record in
9 the matter of Remington Anyan vs. Mercy Hospitals, et
10 al., Cause No. 21SL-CC03944.

11 We are here with regards to the
12 plaintiffs' motions for sanctions against Mercy
13 Hospitals East Communities. The Court notes for the
14 record that we have now additional counsel
15 representing --

16 Are you representing Mercy Hospitals? Are
17 you representing Ms. Kamykowski? Or both?

18 MR. SHOREY: Your Honor, Matt Shorey,
19 s-h-o-r-e-y, representing Mercy Hospitals East
20 Communities, along with Ken Bean.

21 MR. O'TOOLE: And Terry O'Toole on behalf
22 of Mandy Kamykowski and Kamykowski & Taylor, PC.

23 MR. SHOREY: And, Your Honor, our entry is
24 a limited entry under Rule 55.03, just related to
25 this motion for sanctions against Mercy Hospitals.

1 THE COURT: Thank you.

2 MR. SHOREY: Thank you.

3 THE COURT: All right. On behalf of the
4 plaintiff, you may proceed.

5 MS. GUNN: Thank you, Your Honor.

6 On the afternoon of March 25th, 2025, a
7 binding settlement agreement was reached between the
8 parties that was reduced to writing in a text message
9 at 4:47 p.m., transferred from Ms. Slater on behalf
10 of the plaintiffs to Ms. Kamykowski on behalf of what
11 we understood to be settlement counsel, if you will,
12 for all defendants.

13 After the verdict was rendered in full at
14 a \$48.1 million total, Ms. Slater approached Ms.
15 Kamykowski to put the settlement on the record. A
16 brief sidebar was had wherein a dispute arose, and
17 then a record was made shortly, thereafter.

18 During that record, Ms. Slater orally
19 moved for sanctions related to the backing out of the
20 settlement agreement on behalf of what we understood
21 Ms. Kamykowski and her firm and the hospital.

22 Thereafter, on March 28th, 2025, we filed
23 a written motion for sanctions against both Mercy
24 Hospital East Communities and Ms. Kamykowski and her
25 law firm under 55.03. The -- Ms. Kamykowski -- well,

1 no, actually all defendants responded on April 2nd,
2 2025, with a written response to the sanctions
3 motions. Plaintiffs filed a memorandum in support on
4 May 15th, 2025. And just last night, Mercy Hospital
5 filed an additional response in opposition to the
6 motion for sanctions.

7 As I indicated, this motion is brought
8 pursuant to 55.03, which is sort of a compilation
9 rule on a number of things, including limited entries
10 of appearance coincidentally. But we are focusing
11 today, Your Honor, on subpart paragraph (c), entitled
12 "Representation to the Court."

13 And my understanding is that 55.03 is
14 similar to a Rule 11 under Federal Rules, in that:
15 when a -- an attorney or party certifies certain
16 things to the Court, including that under Section
17 (c)(1), a claim, defense, request, demand, objection,
18 contention, or argument is not presented or
19 maintained for any improper purpose, such as to
20 harass or to cause unnecessary delay or a needless
21 increase in the cost of litigation.

22 So that is one section upon which the
23 Court can issue sanctions.

24 we also believe that (c)(3) so
25 55.03(c)(3), is at issue here today, which indicates

1 that: A party or an attorney certifies that the
2 allegations or other factual contentions have
3 evidentiary support, or if specifically so
4 identified, are likely to have evidentiary support
5 after a reasonable opportunity for further
6 investigation or discovery.

7 what we -- what we believe happened here,
8 which is sort of at the heart of the motion for
9 sanctions, either one of two things, both of which
10 are violations.

11 The first is that this case was settled by
12 Ms. Kamykowski without authority or Joe Crawford, who
13 is the claims representative for an insurance
14 company, MedPro, that had the coverage between 10
15 million and \$20 million, the excess coverage, for all
16 the Mercy defendants, for Mercy Health, which would
17 include Dr. McNeive, Mercy Clinic, and Mercy
18 Hospital.

19 I will refer to testimony by Mr. Crawford
20 from two days ago: On May 20th, 2025, in this
21 courtroom, wherein he denied that Ms. Kamykowski had
22 authority to settle the case under the terms as they
23 were dictated and memorialized in a text message of
24 March 25th, 2025, at 4:47 p.m., which were
25 specifically 8 and 18, all the way to verdict,

1 confidentiality as to high-low, and no

2 non-disparagement.

3 So point one, according to Mr. Crawford,

4 this case was settled without authority, which is

5 problematic under this rule. Or perhaps this case

6 was settled under the terms, as indicated just in

7 testimony earlier today, as well on May 20th, terms

8 that were agreed upon by all sides and were

9 solidified and -- in that text message, and then were

10 backed out of on behalf of what Ms. Kamykowski

11 indicated was the hospital.

12 So one of two scenarios: Either the case

13 was settled without authority, or the case was

14 settled, and the settlement was reneged on or backed

15 out of.

16 According to 55.03(c)(1), that those facts

17 would be a contention that -- either one of those is

18 a contention -- of an improper purpose such as to

19 harass or cause unnecessary delay, or needlessly

20 increase the cost of litigation.

21 So as the Court is well aware, from

22 previous records, when the settlement agreement was

23 memorialized and introduced, if you will, to the

24 Court, Ms. Kamykowski indicated that that was not the

25 agreement, refused to make a record at first, but

1 then did answer Your Honor's questions, including one
2 on page 24 of the record, which has been previously
3 marked as Exhibit 3, indicating that the question
4 from the Court is: I'm a bit confused as to what you
5 think a high-low means.

6 And Ms. Kamykowski answers: So, Your
7 Honor, I have 8 to 18, all the way to verdict,
8 confidentiality to high-low, no non-disparagement.
9 Those were -- and then another question was posed.

10 Further, on page 26, the Court asks: And
11 were discussions with regards to the caps involved in
12 this settlement agreement at all?

13 And Ms. Kamykowski answers: There was no
14 discussion of caps, Your Honor. A purpose of a
15 high-low in a medical malpractice case is to buy the
16 peace of all the parties.

17 So as -- what happened as a result, is the
18 case wasn't settled at \$18 million, despite a verdict
19 of \$48.1 million. According to defendant, they have
20 not agreed, despite the settlement agreement, that
21 the case is settled. They have also filed a motion
22 to enforce the judgment, wherein, again, I will note
23 that they have indicated that there was in fact an
24 agreement with those four terms, so what is the harm
25 of what I believe is very much indicated by the

1 evidence of a contention that was presented and
2 maintained for an improper purpose.

3 So the maintain part is important, Your
4 Honor, because there is notice requirements or
5 procedural requirements, if you will, with respect to
6 55.03 motions. And as I mentioned a minute ago, we
7 filed ours orally on the 25th, written on March 28th.
8 And the -- we didn't -- we had other hearings between
9 then and now, and didn't call up that motion in order
10 to give defendant the time, the safe harbor time, to
11 perhaps no longer maintain that there wasn't a
12 settlement at \$18 million.

13 That was not chosen. And so now nearly
14 two months has gone by, the defendant has -- excuse
15 me -- the -- well, the hospital and Ms. Kamykowski
16 and her firm have responded and have maintained their
17 position that there is no settlement at 18 million.

18 when you look at -- so that's speaking
19 with respect to (C)(1). If you look at 55.03(C)(3),
20 when you talk about evidentiary support or lack,
21 thereof, as I mentioned, Mr. Crawford testified that
22 Ms. Kamykowski didn't have authority to enter into
23 the settlement agreement that she did. Or that
24 she -- what we also believe, part of this is that she
25 backed out of it without proper factual or

1 evidentiary support to do that.

2 what you heard, Your Honor, in the last
3 couple of days, and with the filings, is multitudes
4 of testimony about understandings, and post hoc
5 recollections of settlement -- or offers to settle
6 from two months before the case started that were
7 clearly rejected, admittedly rejected, in light of
8 very sophisticated attorneys who understand contract
9 law.

10 And no one offered an acceptance or
11 consideration of what the meetings of the minds is,
12 continuing to hold the position that there was no
13 agreement to settle this case at \$18 million.

14 And we believe that the continued
15 insistence that no settlement agreement was reached
16 is sanctionable under 55.03. And the remedy allowed
17 Her Honor, in addition -- just really quickly -- in
18 addition to 55.03, the Court does have inherent
19 powers, as you probably know, to sanction. So while
20 we reference 55.03, the Court certainly has inherent
21 authority to do that, as well.

22 In addition to the -- I mentioned a moment
23 ago about your question, Your Honor's question, about
24 caps. As you know, the argument from defense is that
25 clearly, when these terms were typed out and agreed

1 to, there were other terms mentioned, again, two
2 months earlier about how the 8 to 18 was only going
3 to be for compensatory, and then only for recoverable
4 or application of caps.

5 And the record is clear, in both in terms
6 of what was made on March 25th, as well as the
7 statement from Ms. Kamykowski, that was never
8 mentioned on that date. So to continue to insist
9 that caps and application of caps, and Chapter 538
10 was a legitimate part of this negotiation, we believe
11 is improper and unfounded, and the same is true for
12 punitives.

13 As you know, there's also a separate
14 argument that plaintiffs must have waived punitives,
15 even though it says all the way to verdict. And the
16 support for that is also lacking. There was a
17 discussion about payment of punitives. This is not
18 going to be a payment for punitives, which everyone
19 agrees to. And anyone who has worked in this
20 business for as long as we all have knows that that's
21 what that meant.

22 So, again, to continue to insist that this
23 settlement agreement did not include clear terms, we
24 believe, and to continue to maintain that, we believe
25 is improper and subject to sanctions.

1 Now, what are those sanctions?

2 55.03 allows for, I believe it is, (d)(2)?

3 Allows for the nature of sanctions. And it can be
4 monetary or nonmonetary. And specific to

5 nonmonetary, we'd ask the same thing that we're
6 asking for the motion to enforce, which is specific
7 performance of the \$18 million settlement.

8 With respect to monetary, the rule allows
9 monetary sanctions for attorneys' fees and other

10 expenses incurred as a direct result of the

11 violation. And referring back to (C)(1), it's

12 improper to cause unnecessary delay or needless

13 increase in the cost of litigation.

14 And Ms. Slater and I have spent many

15 hours, as detailed in our motion, and we have time

16 sheets also since -- beginning on March 25th, 2025,

17 communicating with clients, researching, writing,

18 arguing, consulting with attorneys about the way

19 forward.

20 And it is -- whereas, if this matter had

21 not been needlessly delayed through these arguments,

22 the case would be settled, and our clients would be

23 well on their way to being able to take care of their

24 son. Now, of course they've done that from the

25 moment he was born, but certainly monetary awards and

1 being able to buy the things that they believe he
2 needs that aren't readily available to him, is very
3 important to them, and also motivated the idea to
4 settle to begin with.

5 The purpose of the settlement agreement,
6 Your Honor, was to -- was to be done with this
7 litigation, which has not been easy on this family.

8 That was the purpose of it. That is what
9 we believed we achieved on the afternoon of March

10 25th. we believe the evidence is clear that that was
11 what was achieved, and that sanctions should be
12 issued for failing to comply with that. Thank you.

13 THE COURT: Thank you.

14 Response on behalf of Mercy Hospitals?

15 MR. SHOREY: Thank you, Your Honor.

16 I've got an extra copy of our brief filed
17 last night.

18 would the Court like that?

19 THE COURT: Yes, please.

20 MR. SHOREY: A new voice, Your Honor.

21 I took note of what you said: The
22 parties, if asked to agree on the date or the day of
23 the week, might not be able to agree. I know that
24 was an attempt at some levity, and it was welcomed, I
25 think. But I want to build on that and start with a

1 concept that's important, I think, for all of us as
2 we're considering a motion of this magnitude, and
3 that is grace.

4 I think this is a very important
5 counterbalance to our zealous advocacy. We have a
6 duty to advocate zealously. Upon that, we must be
7 graceful in our dealings with the court. We must be
8 graceful in our dealings with our opponents. And I
9 submit, Your Honor, grace is at the heart of Rule
10 53.03, which is all over this motion today, Your
11 Honor.

12 It's a motion -- sorry -- it is a rule
13 under which they move. It's the rule under which I
14 appear. You will not find in that rule the word
15 "grace." I've got a copy of the rule if it's
16 helpful, Your Honor. Would you like a copy?

17 THE COURT: Sure.

18 MR. SHOREY: Ms. Gunn?

19 MS. GUNN: I have one, thank you.

20 MR. SHOREY: The word's not there. But
21 what is there is a grace period. It's built right
22 into the rule. It's a good, good check and balance
23 on our duty of advocacy, our zealous advocacy. It's
24 a safe harbor. It's a cooling off period. It's just
25 like what's in Rule 11. Before one files a motion

1 for sanctions, before one puts that line in the sand,
2 first send your note to the other side, your proposed
3 motion, and give them a chance to consider it.

4 And then that 30 days, which can be, as I
5 say a safe harbor, if someone thinks they should
6 withdraw something. If -- it can be a cooling off
7 period. It also can be valuable. It's also an
8 opportunity to try to come together and understand
9 each other's positions that are driving this
10 particular motion.

11 And ultimately what we have here, Your
12 Honor, in 55.03, it's not about -- let me say it a
13 different way -- it's about what you write down and
14 sign and say here. It's about writing facts as if
15 they're true when they're not. It's about taking
16 positions that you don't have a good faith to believe
17 in. That's what the rule it about, but that's not
18 what we're here for today. That's not what we're
19 faced with with the oral motion back on March 25th,
20 or the written motion, three days later, on March
21 28th.

22 And I submit, Your Honor, the parties
23 might have benefitted greatly by doing that before
24 doubling down on a motion for sanctions that layers
25 over on top of competing motions to enforce.

1 The grace period was skipped, and I don't
2 think that's something that should be overlooked or
3 glossed over. I'm not submitting that counsel
4 intended to break that rule, but I think it was an
5 opportunity lost. I think it was an opportunity lost
6 for all the parties and for the Court. An
7 opportunity, as I said, to try to understand each
8 others' positions, perspectives, try to reach a
9 resolution on this argument before we get to ugly
10 accusations and hard words in writing, signed and
11 filed with the Court.

12 And I'm here only representing Mercy, Your
13 Honor. And my first question is: what is it that
14 Mercy wrote down and did wrong here? what is it we
15 said wrong? We see a lot of words like
16 "misrepresented," all right?

17 It's four or 5 different characterizations
18 as if Mercy has lied about something. I am not
19 seeing it. The record I heard today surely doesn't
20 show it.

21 what I heard was that Ms. Rucker approved
22 a high-low agreement, and that things went on, then,
23 to MedPro to make a decision on things. I don't
24 understand what the argument is as to Mercy for
25 having come forward and put in writing some false

1 statement. I don't see it.

2 So I submit, Your Honor, you have a lot of
3 hard things to decide with this case, but this isn't
4 one of them. With motion under Rule 53.05, I submit
5 that basic failure on the front end to first serve
6 before filing. And there's a case law that says if
7 you were to enter sanctions in this case, it would
8 have to be reversed because of the lack of giving
9 that 30-days' notice. It's in our brief, right?

10 So, to me, this is not a hard one. This
11 is one of the easy ones for you. And we shouldn't be
12 further burdening you dealing with this one.

13 I do want to address a few other things,
14 Your Honor. Again, I don't think you can be reversed
15 for denying this motion. I want to build on
16 something that Ms. Gunn said. A couple of days ago
17 she was citing Professor Immel: contracts, remedies,
18 right?

19 I suppose the three of us all had that
20 same training, perhaps not at the same time. And I
21 remember remedies quite well. Maybe apart from trial
22 ed, there was no better class I had. And I remember
23 remedies for breach of contract were -- can be --
24 specific performance sometimes, can be damages
25 sometimes, right? And some cases, you might have

1 both. I don't remember sanctions ever being a remedy
2 for breach of contract.

3 And I don't believe that it is. I
4 couldn't find any authority for it, all right?

5 There's authority for sanctions under 53.03, but
6 you've got to follow the rule. And that hasn't
7 happened.

8 And if we're going to talk about fraud,
9 and we're going to talk about misrepresentations,
10 then we're entitled -- due process entitles us to
11 know what is it you're saying we did? What is it we
12 said that was lost?

13 What I hear from the plaintiffs is,
14 there's no evidence to support your position,
15 defendants. But you just heard two days' worth of
16 evidence -- right? -- in terms of what the
17 defendants' position is.

18 We heard Ms. Slater today say she doesn't
19 know that anybody -- what was in anybody's mind, but
20 our position is that you should be sanctioned, right?
21 So what their position requires there have been a
22 knowing misrepresentation. It requires that there
23 have been some mens rea. They don't have that.

24 Finally, just briefly. There's no
25 evidence here at all on the sanctions they request.

1 There's a mention of an hourly rate that they bill.
2 There's a mention of hours spent, and we got -- get a
3 sense of their time. They filed this motion
4 March 28th. They filed their brief here this month.

5 And what they've said is, in that time,
6 they've spent lots of time, and do the math. If you
7 do the math, it's \$180,000. I would submit, Your
8 Honor, when it comes to fee shifting -- and, again,
9 there's no fee shifting. No one's said anywhere that
10 the text agreement or the agreement orally in court
11 or any other agreement has a fee shifting clause. It
12 doesn't -- right? -- that I know of.

13 So if you're going to shift fees, even if
14 you agree with them, there needs to be evidence of
15 reasonableness, the rates of the work that's done, of
16 the time that's spent. And you do not have those
17 things. You just have a motion and a brief, Your
18 Honor. We submit this is not a case for sanctions,
19 and we'd ask you to deny it. Thank you.

20 THE COURT: Thank you.

21 MR. SHOREY: Thank you.

22 THE COURT: On behalf of Ms. Kamykowski
23 and her firm?

24 MR. O'TOOLE: Thank you.

25 I'm not going to belabor the point. I

1 would agree with everything that Mr. Shorey said.

2 But then I think it's helpful to talk about the
3 evidence because that is what the Court makes
4 determinations on. That's what the Court makes
5 rulings on. I didn't have the benefit of sitting
6 through the hearing on Tuesday.

7 I did have the benefit of reviewing the
8 parties' briefing, the exhibits, the record
9 post-trial, and I got to sit here and have a front
10 row seat on the evidence that was adduced during the
11 hearing today.

12 And I think what is abundantly clear to
13 everyone sitting in this courtroom is, that there is
14 a profound dispute between the parties about what the
15 terms of the settlement were. But a profound dispute
16 between two opposing parties is not the basis for
17 sanctions.

18 we heard from -- today we heard from Ms.
19 Kamykowski about what happened, what the evidence
20 was, and, more importantly, what her good faith
21 belief was, based on not only what happened on March
22 25th, but all of the discussions between the parties.

23 I know each and every lawyer that's
24 involved in this case. Each and every lawyer that's
25 involved in this case is a zealot advocate for their

1 client. They do a fantastic job. They're
2 experienced lawyers, and they're experienced in
3 medical malpractice, and they're -- they know what
4 statutes go along with that type of work.

5 And you heard about not only what happened
6 on March 25th, but in the discussions leading up to
7 it. And, most importantly, Judge, you heard Ms.

8 Kamykowski's good faith belief on what she believed
9 the terms of the settlement were based on her
10 discussions.

11 And then you heard from Ms. Slater about
12 what her belief was about the discussions and about
13 what the terms were. And we heard things, and, if
14 you remember, Judge, both defendant and plaintiff
15 questioned witnesses about things they could have
16 done to make the terms more specific, things that
17 they could have done, each one of them, to clarify
18 those terms.

19 Lack of specificity, lack of clearness to
20 the terms, none of that on either side is
21 sanctionable conduct. And if you take a step back
22 and look at what's going on here, we have two parties
23 that clearly believe that their view and their
24 interpretation of what the settlement terms is is
25 correct, and, thus, they filed motions to enforce the

1 terms of those settlements that they believe exist.

2 The only difference is that one side has filed a
3 motion for sanctions based on the very same behavior
4 that they are engaged in.

5 And with all due respect, the reason why
6 we have not filed a motion for sanctions is because
7 disagreement that led us to this point is not
8 sanctionable conduct, Your Honor. And so in addition
9 to the issues that Mr. Shorey raised regarding Rule
10 55.03, there are the findings and the basis of the
11 evidence.

12 And what you've heard from plaintiffs is
13 that, that we believe things. We suspect that these
14 things happened, but there isn't any evidence of any
15 of the actions on the part of Ms. Kamykowski that
16 would demonstrate lack of good faith or lack of
17 candor.

18 And, Judge, you -- you remember, and I
19 think one of the most telling things that I read in
20 the transcript was when you asked Ms. Kamykowski
21 about what was said, and, more importantly, what
22 wasn't said. And she was honest about what was said
23 and what wasn't said. And, in fact, I think everyone
24 that I heard today has made it very clear about what
25 was said and what wasn't said. And that's important,

1 and that's critical to the determination.

2 So, Judge, I think at the end of the day,
3 it's obvious, the only thing that is clear is that
4 there is a profound disagreement between the parties
5 about what they believe the terms of the settlement
6 are, but that in no way, shape, or form can
7 constitute sanctions on the part of the attorneys.

8 Thank you.

9 THE COURT: Thank you.

10 Response?

11 MS. GUNN: Your Honor, a couple of things.
12 With respect to our time sheets, we would be offering
13 those for an in camera review at Your -- Your Honor's
14 request. We believe there are some work product
15 issues involved in providing those as an exhibit, so
16 that's what we will offer at that point. We have
17 them today, if you so wish.

18 We'd also like to incorporate the record
19 from our -- the motion to enforce from May 20th, as
20 well as the continued motion from today, May 22nd.

21 THE COURT: Is there any objection to
22 incorporating the record from the previous hearings?

23 MR. SHOREY: Your Honor, I don't object to
24 the incorporation of the record. With regard to the
25 time sheets, I would submit, we're entitled to know

1 and to have known the evidence that's being used
2 against us in Court today. If you're inclined to
3 grant the motion and want to leave opportunity for us
4 to deal with discovery and briefing afterwards, we
5 would ask that we deal with it that way.

6 MR. O'TOOLE: Agreed.

7 THE COURT: So I think what he's saying,
8 if the Court finds sanctions and is going to grant
9 any attorneys' fees, we will have a further
10 discussion about what is submitted for that and what
11 access you have to be able to see that.

12 MS. GUNN: Yes, ma'am. Thank you.

13 THE COURT: Anything further on the motion
14 for sanctions?

15 MS. GUNN: No, ma'am.

16 MR. SHOREY: No, Your Honor.

17 MR. O'TOOLE: No, Your Honor.

18 THE COURT: Do you all want to write up a
19 couple memos indicating that the motions were called,
20 heard, and submitted?

21 MS. GUNN: Yes, ma'am.

22 MS. SLATER: Yes, Your Honor.

23 MR. SHOREY: Yes.

24 (At 2:19 p.m., the hearing was concluded.)

25 o o o

Tuesday, July 15, 2025

Posttrial Motions

Taken by Susan Lucht, CCR#332

Official Court Reporter

o o o

The following took place on Tuesday, July 15, 2025, at 10:01 a.m., in Division 18 of the Twenty-First Circuit Court of St. Louis County, State of Missouri, Honorable Nellie Ribaudo presiding, with Plaintiffs appearing by Ms. Amy Gunn, Ms. Erica Slater, and Ms. Elizabeth Lenivy, and Defendants appearing by their attorneys, Mr. David Perron, Ms. Mandy Kamykowski, and Ms. Erin Pfirrmann.

THE COURT: We are here on the record in the matter of Remington Anyan v. Mercy Hospitals, et al, 21SL-CC03944.

This matter is on the Court's docket this morning with regards to an approval of a minor settlement.

The Court notes that it received a couple of motions last night, or actually this morning, relative to the motion to enforce.

I guess the first one we should start with is the motion to shorten time.

MR. PERRON: Your Honor, procedurally

1 we're asking the Court to grant the motion to shorten
2 time for the notice of the motion.

3 Obviously, it took us some time between
4 July 8 and the time of filing the motion to review
5 the necessary documents, put our arguments in order,
6 and put our motion together.

7 I guess, theoretically, the Court could
8 rule on the motion to reconsider after today's
9 hearing. But we thought it would make more sense to
10 present to the Court at the same time that the Court
11 was considering the petition for approval.

12 THE COURT: Any response on behalf of the
13 plaintiffs?

14 MS. GUNN: We have no objection.

15 THE COURT: The Court will grant the
16 motion to shorten time.

17 So with regards to the motion to
18 reconsider.

19 MR. PERRON: Your Honor, on behalf of Dr.
20 McNeive at Mercy Clinic, we will rest on our
21 pleadings.

22 MS. KAMYKOWSKI: Your Honor, on behalf of
23 Mercy Hospital we'll also rest on the pleadings.

24 THE COURT: Have you filed pleadings on
25 behalf of the hospital?

1 MS. KAMYKOWSKI: The pleadings that were
2 filed yesterday were filed by Mr. Perron's office but
3 on behalf of all defendants.

4 THE COURT: Okay.

5 MS. GUNN: Your Honor, likewise, with one
6 exception. We will rest on our pleadings and
7 argument and everything from the evidentiary hearing
8 that was adduced on May 20th and May 22nd.

9 My only comment is, I don't understand why
10 this motion is being filed by Dr. McNeive and Mercy
11 Clinic. It is curious to me that Dr. McNeive and
12 Mercy Clinic have a \$20 million punitive damage award
13 that was entered, a verdict that was awarded by the
14 jury in this matter. And by the Judge's order on
15 July 8th, 2025, ordering and agreeing that a
16 settlement took place prior to the judgment that was
17 entered as the jury's verdict, why Dr. McNeive would
18 be filing a motion to reconsider that order,
19 considering that the order vacates the judgment
20 against him for a \$20 million punitive damage award.

21 I suppose that's more of a comment than an
22 argument. With that said, again, we will rest on and
23 rely on the previous filings and evidence.

24 THE COURT: I guess I do have a question.
25 Because in the pleadings it indicates that the Court

1 was acting outside of its jurisdiction in enforcing
2 the plaintiff's proposed settlement.

3 would the Court have also been acting
4 outside of its jurisdiction if it was granting the
5 defendant's proposed settlement? Because how can I
6 be outside my jurisdiction on one and not on the
7 other?

8 MS. KAMYKOWSKI: If it was ordered on July
9 8th, that is our position, yes, Judge.

10 THE COURT: So why would you have
11 requested the Court to enforce your settlement if I
12 couldn't do that?

13 MS. KAMYKOWSKI: We requested the Court
14 enter an order enforce defendant's settlement on May
15 22nd, not on July 8th.

16 THE COURT: Well, I understand the date,
17 but the Court takes time to make these decisions, and
18 it had to have a hearing.

19 And I do find it curious that rather than
20 saying the Court lost jurisdiction, you say the Court
21 acted outside of its jurisdiction. I would assume
22 that that is so if there's an argument that the Court
23 has some sort of liability relative to this, that the
24 Court will be acting in an extrajudicial capacity.

25 MR. PERRON: Your Honor, I think we -- the

1 language employed in our prayer for relief in the
2 pleadings filed yesterday was carefully constructed
3 to reflect our position. And I think the best I
4 could offer to the Court is just to rest on our
5 pleadings because of the, you know, careful choice
6 and thinking we put into how we phrased our prayer
7 for relief.

8 THE COURT: Well, and I guess I'm also
9 confused, if the Court is acting outside of its
10 jurisdiction, how can the Court reconsider that?

11 MR. PERRON: Right, Your Honor. That's
12 why in our footnote on the motion to reconsider, we
13 were careful to explain the motion to reconsider is
14 an alternative pleading.

15 THE COURT: But again, I go back to the
16 question of, is it your position that the Court
17 personally is acting in such a way that would remove
18 it from its judicial immunity? That's what I'm
19 getting at. And that's what you're, in essence,
20 trying to set up by calling it outside of the
21 jurisdiction versus having lost jurisdiction.

22 MR. PERRON: I don't think I understand it
23 in the same way the Court is describing it. And I
24 apologize if there's a significant distinction
25 between the way you -- the two things you phrased it.

1 I think, again, the way we carefully
2 phrased it in our prayer for relief was describing
3 the scope of the Court's jurisdiction as we
4 understood it pursuant to Missouri Rules of Civil
5 Procedure and how we understood the July 8th order
6 with respect to the limited scope of jurisdiction
7 under the Missouri rules.

8 THE COURT: Anything further with regards
9 to the motion to reconsider?

10 MS. GUNN: Your Honor, I was responding to
11 the motion to reconsider. Your Honor's questions, as
12 I read it, the jurisdictional issue was raised in the
13 defendant's memorandum in law in opposition to the
14 plaintiff's motion to approve the settlement. So I
15 am prepared to respond to that as well if you would
16 allow.

17 So I would cite the Court to a number of
18 cases. If I may, the first one is Matthes v.
19 wynkoop. And that's M-A-T-T-H-E-S v. wynkoop,
20 W-Y-N-K-O-O-P.

21 And if I may approach. Your Honor, this
22 was a motion to enforce settlement 2014 western
23 District. And the Court in that matter held: A
24 motion to enforce a settlement as to the underlying
25 case. A collateral action seeking specific

1 performance of the agreement.

2 And it cites Eaton v. Mallinckrodt, which
3 was a case that we -- both sides talked about at
4 length in the initial hearings that we had on 20th
5 and 24th.

6 So if I might, I'll hand that to you, Your
7 Honor.

8 THE COURT: Thank you.

9 MS. GUNN: That notion was also reinforced
10 in -- and Eaton, if I recall was a Supreme Court
11 case. But Puga v. Nephrite Fund One LLC,
12 N-E-P-H-R-I-T-E from September 2024 also listed
13 district cites Matthes for the same principle. A
14 motion to enforce the settlement as to the underlying
15 case the collateral action seeking specific
16 performance of the agreement.

17 I'll hand that to you as well, Judge.

18 So a couple of things. The first is, this
19 notion that you don't have jurisdiction to rule on
20 today's motion to approve the settlement is without
21 merit entirely based on a number of things. Not the
22 least of which is that the motion to enforce
23 settlement is a collateral issue.

24 Rule 75.01, a rule of civil procedure
25 cited by the defendants in this matter, talks about

1 judgments that are controlled by the trial court and
2 specifically states: Except as otherwise provided in
3 Rule 81.045, the trial court retains control over
4 judgments during 30-day period after entry of the
5 judgments, etcetera.

6 so the rule cited by the defense in this
7 opposition today do talk about judgments and when the
8 Court loses jurisdiction over judgments.

9 That's not what we're here to talk about
10 today. In fact, we believe the Court's order of July
11 8th, 2025, in essence, vacated any of the judgments,
12 the judgment, the amended judgment, the second
13 amended judgment that were in this case because Your
14 Honor found that there was a settlement enforceable
15 by specific performance that was entered into on
16 March 25th, 2025, prior to the jury's verdict.

17 Now, if you take the defendant's argument
18 to its -- I don't know, anywhere -- then no
19 settlement at all would ever be approved for a minor.

20 You settle the case. And let's say, for
21 example, even in this case, we decide today we're
22 going to settle the case for a million dollars.

23 Fine. Okay. Fine. Let's settle this case for a
24 million dollars.

25 According to the defendant's argument,

1 that could never happen because this Court has lost
2 jurisdiction to control anything else about this case
3 other than to rule on the defendant's post-trial
4 motions.

5 That's simply not logical and not
6 supported by the rules or the law in this state.

7 Now, one more point is that plaintiff did
8 file a motion on July 3rd that could be construed as
9 a post-trial motion under 78.04, which indicates:

10 Any motion for a new trial and any motion to amend
11 the judgment or opinion shall be filed not later than
12 30 days after the entry of the judgment.

13 So what we filed, if you don't think what
14 the defendants filed was enough to keep jurisdiction
15 on anything, including collateral matters, which I
16 don't think you needed anyway by any filing of any
17 post-trial motions, but if we're going to go down
18 that road, then what we filed on July 3rd certainly
19 would qualify as a post-trial motion, which allows
20 the Court to retain jurisdiction to rule on today's
21 motion to approve the settlement.

22 So based on the case law, Matthes and Puga
23 and Eaton, etcetera, the reading of -- the clear
24 reading of 71.01 and 78.04, we believe that this
25 Court does have jurisdiction and ask that the Court

1 hear our petition to approve the minor settlement.

2 THE COURT: Any response?

3 MR. PERRON: No, Your Honor.

4 THE COURT: The Court is going to deny the
5 motion to reconsider. The Court is going to further
6 deny the opposition to the approval of the
7 settlement. And the Court will proceed with the
8 approval hearing on behalf of the plaintiff.

9 MS. GUNN: we call Blake Anyan.

10 PLAINTIFF'S EVIDENCE

11 BLAKE ANYAN,

12 Having been duly sworn by the Court, testified:

13 DIRECT EXAMINATION

14 BY MS. GUNN:

15 Q. Please state your name.

16 A. My name is Blake Anyan.

17 Q. what is your date of birth?

18 A. 05-16-1988.

19 Q. where do you live?

20 A. Pacific, Missouri.

21 Q. who lives with you there?

22 A. I live with my wife, Sarah McDonald Anyan;
23 my son, Remington Anyan; and a baby girl, Rory Anyan.

24 Q. And how old is Rory now?

25 A. Eight months.

1 Q. Now, are you employed, sir?

2 A. Yes, ma'am.

3 Q. And where are you employed?

4 A. I'm employed at St. Louis Community
5 College.

6 Q. How long have you been employed there?

7 A. This will be my eighth year of employment
8 there.

9 Q. What do you do there?

10 A. I'm an associate professor of respiratory
11 care and director of clinical education for our two
12 respiratory programs at the college.

13 Q. What about Sarah? Is she working right
14 now outside the home?

15 A. Sarah no longer works outside of the home.
16 She had to step away from her previous job as a
17 registered nurse to provide all of Remi's care. He
18 needs assistance with every aspect of his daily life.

19 Q. And Remi was your first child?

20 A. That's correct.

21 Q. Born May 4th, 2020?

22 A. That's correct.

23 Q. Now, Blake, you were here for the trial of
24 this matter between March 11th and March 25th; is
25 that correct?

A. That is correct.

Q. And to back up from that, there was a time after Remi was born that you and Sarah decided to investigate the details around his labor and delivery. Is that true?

A. That's correct.

Q. And that investigation led you to me?

A. Correct.

Q. And at that time I was employed with Simon Law Firm?

A. Yes.

Q. And you signed an employment agreement, professional employment agreement, at that time with The Simon Law Firm enabling me to investigate the facts surrounding Remi's labor and delivery. Is that accurate?

A. That's correct.

Q. And that was in the latter part of 2020?

A. I believe so, yes.

Q. And we did so. We investigated this matter, and suit was filed in August of 2021. Does that sound right?

A. That does.

Q. Now, my law partner Erica Slater and I left The Simon Law Firm on January 31st, 2025. And

1 at that time it was your decision and Sarah's
2 decision on Remi's behalf to sign a contract with the
3 Gunn Slater office, is that correct?

4 A. without hesitation, that's correct.

5 Q. You and Sarah have worked closely with me
6 and our team, both at The Simon Law Firm and Gunn
7 Slater law firm since first being hired, correct?

8 A. Correct.

9 Q. This is self-serving question, but have
10 you been satisfied with the representation?

11 A. Unbelievably so.

12 Q. When you signed a professional employment
13 agreement with respect to the investigation and
14 pursuing Remi's claim, that was a 40 percent
15 contingency fee?

16 A. That's correct.

17 Q. And you determined that to be reasonable
18 at the time, and that is still your opinion today?

19 A. That's correct.

20 Q. And you understand that there is a
21 separate agreement between Gunn Slater and The Simon
22 Law Firm with respect to how those attorneys' fees
23 will be distributed between those two firms?

24 A. Correct.

25 Q. You have been appointed by this Court,

1 along with your wife, Sarah, to be Remi's next
2 friend, next friends. Is that correct?

3 A. Yes.

4 Q. And it was explained to you and you
5 understood that as your role as Remi's next friend,
6 legally you were able to pursue claims on his behalf,
7 litigate the case, and settle the case as well.
8 Correct?

9 A. Correct.

10 Q. Now, you know that, even though it was
11 your decision, and we'll talk about that in a minute,
12 your decision to settle the case, you understand that
13 ultimately it's Judge Ribaud's decision as to
14 whether the settlement as proposed is fair and
15 reasonable and in Remi's best interest. Is that
16 correct?

17 A. Yes, I do understand that.

18 Q. Now, I want to ask whether you can
19 describe in your own words briefly Remi's injuries?

20 A. Remi suffered a irreversible brain injury
21 which ultimately carries a sequela of other problems
22 that he struggles with every single day. The main
23 one being spastic quadriplegia cerebral palsy. He's
24 lost effective control of his motor function for all
25 four of his limbs, and he struggles holding his head

1 upright.

2 That, obviously, carries a lot of
3 significant needs, and that's where a majority of
4 Remi's needs really stem from. He has some other
5 secondary diagnoses that he developed because of that
6 injury from his birth, mainly epilepsy, cortical
7 visual impairment. He struggles to perceive the
8 things that his eyes can see.

9 Q. Based on those injuries as you've
10 describe, and I think you told us a little bit about
11 Sarah taking care of Remi, does he need 24-hour care?

12 A. He does. Everything that he does
13 throughout his day he needs hands on him at all
14 times. He can't play independently. Can't feed
15 himself. He can't even turn in bed. So 24/7.
16 Sometimes we get a reprieve for his sleep. But a lot
17 of times -- I haven't slept through a night since
18 Remi has been born. We have to go down and
19 reposition him, and he needs somebody for everything
20 he does every single day.

21 Q. Now, he also is able to do some things for
22 himself, and you all encourage that?

23 A. With assistance, yes.

24 Q. And I think, you know, harken back to the
25 trial, he's got a gait trainer. He is able to, with

1 help, feed himself, those types of things?

2 A. with the appropriate assistive equipment
3 he can do some things on his own. He knows what he
4 wants to do. He just struggles with the motor
5 function side of things to do it on his own.

6 Q. Now, as I mentioned, you were here for the
7 trial of this matter between March 11th and March
8 25th, 2024 each and every day?

9 A. Yes.

10 Q. You were fully involved in the trial team,
11 in that we would talk after court, before court,
12 during court as to what was going on; right?

13 A. I would say very involved, yes.

14 Q. And you would agree that throughout the
15 course of this litigation, including during trial,
16 that you and Sarah were fully informed of the
17 progress that was being made and the depositions that
18 were being taken, and generally about the process.
19 correct?

20 A. Every step along the way, yes.

21 Q. Now, prior to the jury returning a verdict
22 on March 25th, 2025, we had a discussion about
23 entering into potential high-low settlement
24 agreement. Is that correct?

25 A. we had quite a bit of discussion as to

1 considering settlement, correct.

2 Q. And prior to the jury verdict, were you
3 involved in the decision to settle this matter and
4 the high-low agreement of 8 million as a low and 18
5 million as the high?

6 A. Very much so, yes.

7 Q. And you understood that the number between
8 8 and 18 would be determined by the jury verdict?

9 A. Correct.

10 Q. In that process did you consult your wife,
11 Sarah, with respect to gaining authority to go
12 forward with that settlement agreement?

13 A. I did.

14 Q. And was it her decision as well to enter
15 into that settlement agreement?

16 A. Yes. We were both in agreement.

17 Q. Did you provide that authority to
18 Ms. Slater and Ms. Lenivy and I on that afternoon of
19 March 25th?

20 A. I did.

21 Q. You understand that after the jury's
22 verdict was returned on both compensatory and
23 punitive damages in the amount of \$48.1 million that
24 Ms. Slater went -- came back into the courtroom and
25 announced to the Court that settlement had been

1 reached? Did you understand that?

2 A. I did.

3 Q. In fact, I think you and I were in the
4 hallway crying and hugging jurors. Do you remember
5 that?

6 A. I do.

7 Q. I do. And you understand that at that
8 time when Ms. Slater came back into the courtroom
9 that the defendants' counsel raised dispute about the
10 amount of the settlement?

11 A. Yes, unfortunately so.

12 Q. And at that time an oral motion to enforce
13 the settlement of \$18 million was made and was not
14 ruled on at that time. But instead, an evidentiary
15 hearing occurred on May 20th and May 22nd, 2025, for
16 the Court to determine whether settlement agreement
17 occurred and was a valid agreement. Correct?

18 A. Correct.

19 Q. And you were also here on May 20th and May
20 22nd for that evidentiary hearing?

21 A. That's correct.

22 Q. And you understand that on July 8th, 2025,
23 the Court ruled to enforce the settlement agreement
24 at \$18 million and ordered specific performance of
25 the payment of that settlement?

A. That's correct.

Q. And you understand the terms of that settlement are that there will be an \$18 million dollar payment made on behalf of the defendant in exchange for a release of all claims in favor of all defendants?

A. That's correct.

Q. Now, you understood that the jury verdict was \$28.1 million compensatory and an additional \$20 million in punitive damages against the defendant. The punitive was against Dr. McNeive and Mercy Clinic, is that correct?

A. Correct.

Q. Now, despite the fact that the verdict was \$48.1 million and despite the fact that there are statutory provisions in place that will further reduce that, it is your request today to this Court to approve the \$18 million settlement in favor of your son?

A. That is correct. I feel that's in his best interest.

Q. And you understand that this settlement replaces that jury verdict?

A. Correct.

Q. And you understand that the judgments that

1 had been entered on the jury's verdict will be
2 vacated or have been vacated based on the settlement
3 in this matter for \$18 million?

4 A. Yes, I understand that.

5 Q. And you understand that fully, and that's
6 what you're asking the Court to do?

7 A. That's correct.

8 Q. You understand that there are appeals
9 involved if the judgment were to go forward, and you
10 believe that there is a settlement, and you're asking
11 the Court to approve it in Remi's best interest?

12 A. I am.

13 Q. With respect to the distribution of the
14 \$18 million, you understand that 40 percent
15 contingency fee applies to that?

16 A. Correct.

17 Q. And that is for \$7.2 million?

18 A. Correct.

19 Q. You understand that there are expenses
20 that have been incurred from the very first day up to
21 this point litigating this case. Is that correct?

22 A. That's correct.

23 Q. And I have provided you prior to now
24 copies of --

25 A. You have yes.

1 Q. -- expenses incurred by both The Simon Law
2 Firm and Gunn Slater from the beginning of this
3 matter. Is that correct?

4 A. That is correct.

5 Q. And the total expenses incurred litigating
6 this matter to date are \$381,596.44. Is that your
7 understanding?

8 A. That is.

9 Q. Now, in addition to the 40 percent
10 attorneys' fee and expenses as described, you're
11 asking the Court to set aside \$100,000 in escrow in
12 anticipation of potential future expenses, the
13 balance of which will be distributed once this case
14 is finally resolved. Is that correct?

15 A. Yes, that's correct.

16 Q. So the net settlement for distribution for
17 the benefit of Remi is \$10,318,403.60, is that your
18 understanding?

19 A. Yes, it is.

20 Q. And do you believe, knowing what that net
21 settlement amount is, that an \$18 million settlement
22 is in Remi's best interest?

23 A. I do.

24 Q. And is fair and reasonable?

25 A. Yes.

1 Q. And you're asking the Court to approve
2 that settlement as noted?

3 A. Yes, I am.

4 Q. Now, because \$10 million is a significant
5 sum, you are not yet prepared to suggest or offer or
6 agree to a particular vehicle for preserving that
7 money for Remi's benefit. Is that accurate?

8 A. That's correct. I needed some additional
9 time to get a trust finalized for allocation of the
10 funds.

11 Q. Okay. So as of today, you're asking the
12 Court to approve \$18 million settlement, the fees,
13 expenses, and escrow amount as described?

14 A. Yes, I am.

15 Q. And are further asking the Court for a
16 certain amount of time to put pieces together to best
17 protect that additional \$10 million on Remi's behalf?

18 A. That's correct.

19 MS. GUNN: If Your Honor so desires, we
20 can provide a copy of the professional employment
21 contract and a copy of the expenses for the record or
22 just for your review.

23 THE COURT: I think just for my review. I
24 don't know that they need to be made part of the
25 court file.

1 MS. GUNN: Yes, ma'am.

2 MS. SLATER: Erica Slater for the
3 plaintiffs. Judge, I'm handing you the Gunn Slater
4 contract as Exhibit 1 to review, and Exhibit 2 is the
5 combined expenses held by The Simon Law Firm and Gunn
6 Slater.

7 THE COURT: Thank you.

8 MS. SLATER: And this is our proposed
9 order that we will distribute as well.

10 Q. (By Ms. Gunn) Mr. Anyan, with full
11 knowledge and authority of next friend, both from
12 yourself and from your wife, are you asking the Court
13 to approve the settlement as described here today?

14 A. I am.

15 Q. And for distribution as well?

16 A. Yes.

17 Q. Thank you.

18 A. Thank you.

19 THE COURT: Any questions of this witness?

20 MR. PERRON: Yes, Your Honor.

21 CROSS-EXAMINATION

22 BY MR. PERRON:

23 Q. Mr. Anyan, to the best of your knowledge
24 do you know if Medicaid, Medicare, or MO HealthNet
25 has paid any medical bills associated with Remi's

1 care?

2 A. we do not qualify for any public
3 assistance.

4 Q. okay. Do you have an understanding -- I
5 don't know -- do you have an understanding if there
6 are existing any liens against your recovery in this
7 case with regards to Remi's medical bills, you might
8 be obliged to pay those bills?

9 A. Not to my knowledge.

10 Q. okay. In your answer to one of the
11 questions you mentioned that the \$18 million would be
12 in exchange for a future release. Did I hear that
13 correctly?

14 A. The 18, my understanding was us agreeing
15 to the \$18 million would ultimately cover all claims.

16 Q. okay. But with regard to the release, do
17 you have any understanding about what the terms of
18 that release might be?

19 A. Can you be little more clear?

20 Q. I guess I don't know. You used the term.
21 Typically we have the release already and so both
22 sides know what might be in it. But I just want to
23 know from your perspective if, as you used the term,
24 your expectation was that there would be a release,
25 do you have an understanding, at least sitting here

1 today, what might be in that release?

2 A. So my understanding is by accepting the
3 settlement, even though, you know, we went all the
4 way to verdict, this is public knowledge, that there
5 actually wouldn't be a judgment filed against Dr.
6 McNeive and Mercy. The settlement would cover all of
7 that.

8 Q. Okay. But besides that, at least to your
9 knowledge, you don't know what might be in that
10 release?

11 A. That's correct. I have not seen anything
12 that specifies.

13 Q. Just like you mentioned the term or the
14 phrase "all claims", do you have an understanding
15 whether or not the settlement terms covers all the
16 claims that might have been asserted based on Remi's
17 treatment from the defendants or just those claims
18 that were at issue during the trial?

19 A. Can you specify that?

20 Q. I guess I can only use the language as
21 well as I understand it myself.

22 Do you have an understanding whether this
23 resolves all claims that might have been asserted
24 that maybe you could have but didn't bring or if this
25 only resolves the claims that were tried in the

1 actual trial?

2 A. Are you asking if we plan to bring forth
3 any other charges against somebody else?

4 Q. well, if you know whether or not you could
5 even if you wanted to?

6 A. Everybody that was named in this case,
7 that's who we're considering, yes. That's who we're
8 considering when speaking of, you know, additional
9 charges.

10 Q. Sure. And I think you described it. I
11 just want to be clear for the record. Did you
12 understand that this settlement resolved the claims
13 for punitive damages --

14 COURT REPORTER: I didn't hear the end of
15 your question.

16 MR. PERRON: I'm sorry. I trailed off at
17 the end of my question. I apologize. I'll say that
18 again.

19 Do you have an understanding that the
20 terms of the settlement agreement specifically also
21 resolved the punitive damages claims?

22 A. I was well aware this was a bifurcated
23 trial and what that meant. I realize that the jury
24 is going to rule on the compensatory as well as the
25 punitive. when we made the decision to go all the

1 way to the verdict, yes, we were considering all or
2 both aspects of what the jury's deliberating on, yes.

3 Q. Right. And so you understood that the
4 terms of the original agreement covered both
5 compensatory and punitive damages?

6 A. Yes, we were considering both.

7 Q. Okay. Do you have an understanding
8 whether any aspect of the confidentiality is part of
9 the settlement agreement?

10 A. As I had mentioned, I was very much so
11 involved in negotiations and in conversations that
12 took place on the 25th. To my knowledge the only
13 confidentiality was really pertinent to the details
14 of the high-low.

15 Q. Okay. And then with regards to
16 non-disparagement do you have an understanding
17 whether the settlement agreement included any aspects
18 of non-disparagement?

19 A. The term was there was no
20 non-disparagement.

21 Q. We talked, and I apologize, it's a term of
22 art, but there's a separate issue of court costs. Do
23 you know if under the original agreement or the
24 perspective release if each side's court costs will
25 be resolved or if -- do you have any understanding at

1 all about how the release for the settlement
2 agreement addressed that issue?

3 A. Those were not things that we specifically
4 discussed on the 25th, no.

5 Q. I suppose just as a final question, do you
6 have any further understanding other than we've
7 already discussed what obligations Mercy Clinic or
8 Dr. McNeive might owe Remi with regards to terms of
9 the settlement?

10 A. Can you rephrase your question?

11 Q. Yeah. Beyond anything that we've already
12 discussed, do you have any other understandings about
13 what obligations Dr. McNeive or Mercy Clinic might
14 still owe Remi in terms of the agreement?

15 A. I do not have any other understanding.

16 MR. PERRON: Those are all my questions.

17 MS. KAMYKOWSKI: No questions, Judge.

18 THE COURT: Anything further on behalf of
19 the plaintiff in regards to the settlement?

20 MS. GUNN: No, ma'am.

21 THE COURT: Anything else on behalf of the
22 defendant?

23 MR. PERRON: No, Your Honor. Except to
24 the extent that our pleadings did not also
25 incorporate all of our previous pleadings and the

1 evidence adduced at the evidentiary hearing and the
2 arguments made at the evidentiary hearing. Just to
3 make it as clear as hopefully possible that we are
4 hoping to incorporate in our argument in opposition
5 to the settlement all of our previous pleadings,
6 arguments, and evidence.

7 MS. KAMYKOWSKI: I join on that on behalf
8 of Mercy Hospital.

9 THE COURT: Any objection to them
10 incorporating?

11 MS. GUNN: No, ma'am.

12 THE COURT: The Court will grant that
13 request.

14 The Court, having heard the testimony
15 adduced, having sat through the trial, and having a
16 good deal of familiarity with this case, does find
17 that the settlement as outlined by the plaintiff's
18 proposed order and decree is in the best interest of
19 the minor child and is fair and reasonable. The
20 Court will approve the settlement.

21 Anything further for the record?

22 MS. GUNN: Your Honor, I have an order, a
23 proposed order drafted. Was it filed?

24 MS. SLATER: No, but I gave her a copy.

25 MS. GUNN: Oh, okay. Here's a couple

1 copies.

2 THE COURT: Anything further for the
3 record?

4 MS. GUNN: No, ma'am.

5 MS. KAMYKOWSKI: Your Honor, just on
6 behalf of all defendants, with respect to this new
7 order that we just received in the courtroom today,
8 we would incorporate all of our previous objections
9 that were raised to the prior petition for approval
10 and the Court's July 8th order.

11 THE COURT: Thank you. Anything further
12 for the record?

13 MS. GUNN: No, ma'am.

14 MS. KAMYKOWSKI: No, Your Honor. Thank
15 you.

16 THE COURT: Thank you.

17 -0-

Reporter's Certificate

I, Susan M. Lucht, 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 July 15, 2025, I was present and reported all the proceedings had in the case of Remington Anyan v. Mercy Hospitals, et al; and I further certify that the foregoing pages contain a true and accurate reproduction of the proceedings had on that date.

/s/Susan M. Lucht, CCR #302

official Court Reporter
Twenty-First Judicial Circuit
(314) 615-2685

Wednesday, August 20, 2025

Posttrial Motions

o o o

(At 10:56 a.m., the following proceedings were held in open court:)

THE COURT: We are here on the record in the matter of Remington Anyan vs. Mercy Hospitals, et al., cause No. 21SL-CC03944. This matter is on the Court's docket this morning with regard to a number of motions.

Are the parties ready to proceed?

MS. GUNN: Yes, ma'am, for the plaintiffs.

MR. PERRON: Yes, Your Honor.

THE COURT: Very good.

Does it make sense to start with a specific motion?

MR. PERRON: I believe plaintiff noticed it up, but I'll concede to whatever you think is best.

MS. GUNN: Judge, is it okay if I remain seated?

The -- we have filed a motion to amend the July 15th order and decree to provide for postjudgment interest.

Defense has filed, previous to our motion,

1 has filed a motion to set the supersedeas bond, as
2 well as a stay in compliance with the July 15th
3 order.

4 we filed a response to that. They do
5 dovetail, I think. So with your permission and with
6 Mr. Perron's permission, feel free -- I can start.

7 THE COURT: Go ahead.

8 MS. GUNN: Of course the background is
9 well known to everyone in this room. But just bear
10 with me. On March 25th, 2025, there was a high-low
11 agreement that was entered into between the parties,
12 the plaintiff and the defendant: a high of 18
13 million and a low of 8 million, and three other terms
14 that were documented.

15 After the verdict of \$48.1 was rendered,
16 the defense, in my words, backed out of that
17 agreement, and both sides filed competing motions to
18 enforce that settlement.

19 Your Honor held a hearing lasting two
20 days, May 20th through May 22nd, or two separate
21 days, hearing evidence on the competing motions to
22 enforce the settlement. And on July 8th, entered an
23 order granting the plaintiffs' motion to enforce the
24 settlement at \$18 million.

25 A week later, on July 15th, 2025, upon our

1 petition to approve the minor settlement, Your Honor
2 entered an order and decree, which is now the
3 judgment of the case, approving that the \$18 million
4 settlement was in the best interest of the minor and
5 ordering payment of \$18 million.

6 The fees and expenses were ordered to be
7 paid within 14 days, or July 29th, 2025, with the net
8 amount, 10.3 million, to be settled later because
9 there's quite a bit of planning, as you can imagine
10 to be done, on the best way to invest that money for
11 the minor child.

12 We then -- no money was forthcoming. On
13 July 29th, 2025, the defense had filed a writ of
14 prohibition indicating its belief that this Court
15 didn't have jurisdiction to enter the July 8th order,
16 and thereby the July 15th order, that is currently
17 pending, the Eastern Direct of Missouri denied that
18 writ. It is pending in front of the supreme court
19 fully briefed. I expect a response to that
20 forthcoming, unsure of the time line for that.

21 Regardless, this motion was filed, our
22 motion, the motion to amend the order to add
23 postjudgment interest was filed on August 1st and
24 noticed up for today, August 20th.

25 The argument, Your Honor, is that once a

1 settlement was agreed upon on March 25th, and thereby
2 ordered and entered by this Court on July 8th, and
3 further delineated, if you will, on July 15th, the
4 July 15th order and decree became the judgment.

5 And as I mentioned before, that is agreed
6 upon by the parties. The defendants' own filings,
7 including the one that we are here today to discuss,
8 admits that the July 15th order is the judgment on
9 the case.

10 That July 15th order also vacated all
11 previous judgments based on the jury's verdict, which
12 of course was probably by operation of law, but also
13 necessary because of the settlement.

14 Once there was a settlement that this
15 Court determined was enforceable and proper, this
16 case is no longer a medical malpractice case. This
17 case is no longer -- no longer has a medical
18 malpractice judgment. It is a judgment enforcing a
19 settlement which is operation of contract.

20 And you'll see I've cited numerous cases
21 supporting the notion that when you have a
22 settlement, it is now dictated and governed by the
23 rules of contract. Of course the July 8th and the
24 July 15th orders ordered specific performance of the
25 settlement agree, which is a contract remedy.

1 Postjudgment interest is dictated by
2 statute, specifically 408.040, and that statute has
3 two, essentially two, sections: one that governs
4 nontort actions, and one that governs tort actions.

5 The nontort action provides that
6 postjudgment interest shall accrue at 9 percent per
7 annum, and that is what we're requesting the judge --
8 requesting this Court do.

9 Now, Dennis is a ninth circuit Missouri
10 Supreme Court case authored by Justice Powell from
11 2017, which is cited in our brief, or in our motion.
12 That is an interesting case and quite applicable
13 because it talks about how nontort cases with
14 postjudgment interest applicable doesn't actually
15 need to be in the judgment because it is by operation
16 of the statute, operation of law.

17 However, Justice Powell indicated that
18 best practice is to include an award of postjudgment
19 interest in the judgment, which is why we're here
20 today asking for the July 15th order to be amended --
21 order and judgement to be amended.

22 If I may back up very quickly. I
23 anticipated that defense would argue that Section
24 538.300 would apply to the case. Now, 538.300 is a
25 statute that is part of the tort actions based on

1 improper health care Chapter 538, and exempts medical
2 malpractice claims from a certain number of statutes,
3 including remittitur, there's one on hazardous waste,
4 there's product liability issue, and specifically the
5 postjudgment interest statute.

6 Now, if this were a judgment that were
7 going forward on the jury's verdict in the medical
8 malpractice claimed, then I would agree that there
9 would be no postjudgment exists on that judgment.

10 That's not where we find ourselves, by the
11 defendants' own choosing.

12 Instead, we have a contract action now
13 that has -- that is the judgment of the case. A
14 settlement of the claims, whether it's medical
15 malpractice, or any other cause of action, breach of
16 contract, any of it, is a contract. A contract is a
17 nontort action. 538.300 does not -- does not come
18 into play.

19 Now, if you look at 408.040, you will see
20 again operation 9 percent per annum. I also
21 anticipate, having been provided a copy of the
22 defendants' response this morning -- although I will
23 have to say I had anticipated it -- reference to the
24 McGuire case. So McGuire is a 2014 Missouri Supreme
25 Court case authored by Justice Breckenridge. And it

1 is an interesting -- I use that term loosely --
2 discussion on nunc pro tunc jurisprudence.
3 However -- which I had to look up, it means
4 retroactive, you probably already know that -- but
5 what happened in that case is there was a nuisance
6 case against large scale hog farmers, a jury verdict
7 was entered in favor of the plaintiffs in that case.

8 No -- and that's a tort claim, but not a medical
9 claim. But no postjudgment interest was noted in the
10 judgment.

11 The case got appealed. No one filed
12 posttrial motions, or at least the plaintiffs -- I
13 don't know, actually, now that I say that out loud.

14 But there was no posttrial motion asking to amend the
15 judgment to add postjudgment interest, so it goes up.

16 And Judge Breckenridge indicates that
17 because Section 408.040 dealing with torts, not the
18 nontort section, but the tort section, requires that
19 it shall bear a per annum interest rate equal to the
20 intended federal funds rate as established by the
21 Federal Reserve Board, plus 5 percent, that
22 essentially there is a calculation that needs to be
23 done, and it needs to be done in the judgment itself.

24 So based on that, the McGuire court indicated that
25 without the postjudgment interest award in the

1 judgment, it's not allowed.

2 The difference is -- and of course I cite
3 Dennis in our motion -- the difference is that Judge
4 Powell made a distinction, appropriately so, between
5 the section in 408.040 regarding nontort and the
6 section regarding torts.

7 So the difference is that the section
8 regarding nontorts, which is what we're dealing with
9 here today, does not require a calculation. It is
10 straight up 9 percent.

11 So the supreme court distinguished McGuire
12 saying, that is true, you need to have the
13 postjudgment interest in the order or in the judgment
14 in a tort claim, but you don't really need it in a
15 nontort claim, but, again, it's good practice.

16 So it is our request that the July 15th,
17 2025, order and decree, which is now the judgment in
18 this case, be amended to allow 9 percent interest
19 postjudgment starting on that day, July 15th, 2025.

20 And just in response to the defendants'
21 motion, if I may, for the supersedeas bond, it is
22 essentially the same argument, Your Honor, wherein
23 they want to offer a supersedeas bond of straight up
24 18 million. And the statute regarding the
25 supersedeas bond, or bond in general, Rule 81.09

1 requires that the bond shall be conditioned for the
2 satisfaction of the judgment in full, together with
3 costs, interests, and damages for delay, if for any
4 reason the appeal is dismissed or if the judgment
5 gets affirmed.

6 so I think statutorily it's required that
7 the bond cover not only the judgment itself, but any
8 attenuate amounts, including costs and interests.

9 So the calculation that we've made in our
10 response to their motion is really in anticipation
11 that basically banks on we're now four and a half
12 months post settlement and working our way through
13 the system, that we anticipate a two-year time frame
14 before unfortunately, quite frankly, before this
15 matter is fully resolved.

16 And at an interest rate of 9 percent on
17 \$18 million, that is equal to -- let's find it --
18 \$4,438.35 a day or \$135,000 a month, or \$1,620,000
19 per year. Simple math. Two years plus 18 million,
20 we believe the bond should be set at \$21,240,000.

21 And with that, I will rest.

22 THE COURT: Thank you.

23 On behalf of the defendants.

24 MR. PERRON: Yes, Your Honor. Thank you.

25 Just for a point of clarity, I think you

1 mentioned this, Counsel, am I correct in going
2 forward in my argument, that your objection to our
3 motion for supersedeas bond is simply a disagreement
4 about the amount, is that fair?

5 MS. GUNN: You know, I struggled with
6 whether to argue against the stay part of it, but was
7 talked out of it, so yes.

8 MR. PERRON: Fair enough.

9 Your Honor, I think, based on
10 representations made by counsel, I think the question
11 before the Court on both pleadings boils down to two
12 items: number one was the July 15th order and
13 decree, a judgment on the nontort action, number one.

14 And then, number two, in terms of the
15 amount and interest, whether or not the entire 18
16 million was due to plaintiff at the time the Court
17 entered the judgment on July 15th. And I think both
18 of those questions are easily answered, looking at
19 the plain text of the order.

20 when I look at the July 18th order and
21 decree, the number one paragraph says: This is a
22 medical malpractice action arising out of injuries
23 suffered by R.A., a minor, during his labor and
24 delivery on May 4th, 2020.

25 I think, Your Honor, in terms of demands

1 on defendants to prepare their pleadings in response
2 to this order and decree, we should be allowed to
3 rely on the text of the order in deciding what is
4 proper and how to govern ourselves and advise our
5 clients.

6 The order itself identifies this action,
7 not as a nontort breach of contract judgment, but
8 instead, an order and decree on a medical malpractice
9 action arising out of injuries suffered by R.A., a
10 minor, during his labor and delivery on May 4th.

11 I cited to the 538.210 statute creating a
12 cause of action for damages against a health care
13 provider for personal injury or death arising out of
14 or rendering of -- or failure to render health care
15 services.

16 So, Your Honor, number one, our first
17 point is that a motion to enforce does not itself
18 transform this case from a medical malpractice action
19 into a nontort action, which has separate elements of
20 breach and remedy.

21 And just on that one item or element, this
22 Court finding that there was a contract that can be
23 enforced, does not create any subsequent findings,
24 either by this Court or any trier of fact, that
25 defendants were in breach of such a contract, such

1 that this is a nontort claim with a, as counsel put
2 it, a nontort remedy.

3 Instead, even at the date of this order
4 and decree, the court acknowledged in its order,
5 which was prepared by plaintiffs' counsel, that this
6 was still a medical malpractice action arising out of
7 injuries suffered by a minor during labor and
8 delivery.

9 Not only that, Your Honor, but question
10 number two, as cited, and as described in plaintiffs'
11 pleading, the underlying purpose of postjudgment
12 interest on nontort claims, is a penalty on the
13 defendant for delay of paying money to the plaintiff
14 that the court has decided the plaintiff is owed.

15 so while the defendant delays in paying
16 the judgment, money that is due to the plaintiff on
17 the day of the order, that there is a penalty of
18 accruing interest for every day, every week, every
19 month that that money isn't paid.

20 Again, looking back to the actual,
21 quote/unquote, agreement from this court, in its
22 July 8th order, found that there was a settlement
23 agreement, it referred to a text message and other
24 writings that was four lines of text that did not
25 include any deadline for payment.

1 And when we had the hearing to approve the
2 settlement, Mr. Anyan testified under oath that there
3 was no deadline for payment in any of the discussions
4 or in the text message itself. In terms of the -- in
5 terms of the contract agreement, there was no
6 deadline for payment.

7 When the Court entered its order and
8 decree, it qualified payment several different ways.

9 Number one, it qualified that the attorneys' fees,
10 the attorneys' expenses, and additional 100,000 for
11 future expenses.

12 Now, again, none of the money ordered to
13 be paid within the 14-day deadline, is money that is
14 going, or contemplated to be going, to Mr. and Mrs.

15 Anyan for Remi. Instead, all of the money
16 contemplated to be paid by the 14-day deadline, is
17 litigation expenses and attorneys' fees.

18 But even beyond that, the order itself
19 contemplates future hearings, future orders on how
20 and when the remainder of the money, the money that
21 will actually go to Mr. and Mrs. Anyan for the
22 benefit of their son, all of that is to be later
23 decided.

24 what the Court is asking you to do is not
25 just retroactively change the substance of the order

1 and decree from a medical malpractice judgment to a
2 nontort judgment, but also as a penalty to
3 defendants, accrue interest on money that, by the
4 plain text of the order, plaintiff isn't even due to
5 receive yet.

6 So for those reasons, Your Honor, number
7 one, we don't believe that the Court can
8 retroactively change the substance of the order and
9 decree from a medical action to a judgment on a
10 nontort breach of contract action.

11 But, number two, Your Honor, plaintiff is
12 requesting that penalty against defendant for a delay
13 in payment of \$10 million to start accruing against
14 us retroactive to July 15, that we haven't even
15 decided how it's going to be paid or a deadline for
16 anything.

17 Your Honor, number one, I think that the
18 Court should deny the motion to amend. But if the
19 Court is contemplating adding interest, at the very
20 least, we, defendants, need to know exactly when this
21 money is going to be due, so -- and the interest
22 should only accrue as a penalty for delay beyond the
23 point that the money is actually due.

24 And just as a final point, I think there
25 has to be, in order for there to be a judgment on a

1 nontort action, there at least has to be some
2 pleading alleging duty, breach, and damages related
3 to a nontort allegation, which, again, is absent in
4 the face beyond a motion to enforce which only
5 required and, again, the court only found that there
6 was a contract not a breach in damages.

7 THE COURT: Thank you.

8 Anything further with regards to your
9 motions?

10 MS. GUNN: Your Honor, if I just may
11 respond to the second to last issue, which was the
12 whether it's due and owing or that.

13 I mean, the plain language of the statute:
14 In all nontort actions, interest shall be allowed on
15 all money due upon any judgment or order of any court
16 from the date the judgment is entered.

17 I can anticipate that there are numerous
18 things in judgments that require time lines or dates
19 due and that type of thing, which is why the
20 legislators decided to add a date specific.

21 In my research, there were many cases
22 arguing about what date does it accrue. Is it from
23 the jury verdict? Is it from the judgment? Is it
24 from the final judgment? And that was creating a lot
25 of confusion, which is why this statute was amended

1 specifically. In my research, I recall that it is
2 that, it is from the date the judgment is entered.

3 If it's only when the money is actually
4 due and owing -- due and owing, wouldn't that be the
5 date the final appellate court decides that it's
6 final, or is that it's affirmed? What would be the
7 point of a postjudgment interest award if that were
8 unknown, which is why there's a specific date.

9 Also, really quickly, back to that stay, I
10 was reminded that we do object to the stay if it's --
11 the judgment interest should run from the date of the
12 judgment, postjudgment interest, versus, I don't
13 agree that the stay will allow the postjudgment
14 interest not to run. Sorry. I didn't say that very
15 well for it.

16 THE COURT: I think I understand.

17 MS. GUNN: Okay.

18 MR. SCHROEDER: Judge, if I may?

19 THE COURT: You may.

20 MR. SCHROEDER: Michael Schroeder on
21 behalf of Mercy Hospital.

22 And when we're talking about the cause of
23 action, it is dictated by the actual pleading. And
24 the operative pleading is solely medical malpractice.
25 And if you look at the Rules for Civil Procedure, it

1 defines pleadings as a petition and an answer if one
2 is required. Therefore, the motion to enforce, I
3 think is what Mr. Perron was hitting on, does not
4 transform the underlying action. There must be a
5 pleading for a breach of contract.

6 THE COURT: I guess the question that I
7 have is that the posture that we're in right now, if
8 no money was to ever be paid, there would be no
9 consequences to the defendants. They could go
10 forever without paying, and there's no consequences,
11 according to the defense's argument.

12 You would agree?

13 MR. SCHROEDER: No, Judge, there is --
14 there is a remedy, which is a breach of contract
15 case.

16 THE COURT: So you think they need to file
17 another lawsuit in order to ever recover any money in
18 this case?

19 MR. PERRON: Well, in order to recover,
20 you have to make a claim, prove the elements of the
21 claim, prove your damages, and then recover on that
22 claim. And I don't think that's an impossibility.

23 It's something that is demanded by the law. Plus, if
24 what the Court is describing is if we, in a medical
25 malpractice case, withhold payment, except for

1 putting up the bond while we appeal, and then the
2 bond releases when we lose the appeal, that's how
3 this works. The consequences are that we have to put
4 up a bond if we want to appeal. That's the
5 consequence. But it doesn't accrue interest if it's
6 a medical malpractice case.

7 THE COURT: I understand. But in essence
8 what you're saying is that people should enter into
9 settlement agreements, then say no. Then do the
10 motions to enforce. And then if the Court finds in
11 favor of either side moving to enforce, that there's
12 no obligation on the part of the person who's
13 supposed to pay to ever pay without another lawsuit
14 being filed.

15 MR. PERRON: No, Your Honor. My -- my
16 claim is that, again, what we are requesting is to
17 put up a bond while we appeal the Court's finding on
18 the motion to enforce, but not the penalty of
19 interest. If they wanted the additional penalty of
20 interest, we're entitled to make defenses against a
21 nontort action, which are different than a motion to
22 enforce the settlement.

23 I mean, for example, if there was a
24 release agreement, and we, you know, instead of a
25 motion to enforce, there was a release agreement, and

1 there was a term in the release agreement that within
2 21 days of the execution of this release agreement,
3 you've got to pay us \$18 million.

4 And then they execute the release, and
5 then 21 days passes, and there's no settlement
6 payment, the appropriate remedy would be a nontort
7 action failure to comply with the settlement
8 agreement, the contract, governed by the terms of the
9 release agreement.

10 THE COURT: And correct me if I'm wrong on
11 the record with regards to this issue, a supersedeas
12 bond was previously entered in this case for the
13 total amount of the judgment, is that correct?

14 MR. PERRON: Yes, Your Honor.

15 THE COURT: And that bond still remains?

16 MR. PERRON: I think so. We're getting
17 somewhat in the area of -- the part that I'm less
18 familiar with because it was handled by appellant
19 counsel, so I don't know -- I don't know if that bond
20 survives the new order which vacated the previous
21 judgment that was governing that supersedeas bond.
22 Does that make sense? I don't know if it survives
23 the July 15th order and decree.

24 THE COURT: But there's still a direct
25 appeal as to the underlying medical malpractice

1 verdict entered by the jury.

2 MR. PERRON: NO. My -- again --

3 THE COURT: That was dismissed.

4 MR. PERRON: Qualifying -- qualifying my
5 answer, only to the degree that I understand the law,
6 but my understanding is that we cannot simultaneously
7 appeal portions of the verdict and the order and
8 decree. You know, we have to proceed as though the,
9 you know, obviously we filed a writ, but the order
10 and decree vacated all previous judgments.

11 So until that order and decree is -- is
12 ruled void or null, that's all there is. There is no
13 previous judgment on -- on the verdict. I don't know
14 if that makes sense. That's -- that's my general
15 understanding, is that we can't appeal the verdict
16 while the order and decree which vacated those
17 previous judgments is in effect.

18 THE COURT: But my recollection was there
19 was a notice of appeal done prior to the Court
20 entering its July judgment. No?

21 MR. PERRON: No. There was a -- the notice
22 of appeal that was just recently filed was a notice
23 of appeal on the July 15th order and decree. And the
24 sum of that notice of appeal was just on the
25 substance of the July 15th order and decree.

1 THE COURT: But was that filed as a
2 direct appeal, or was it filed as a writ?

3 MR. PERRON: There were two things. There
4 was a writ filed and separate -- separately a notice
5 of appeal. But both of those, the writ that's
6 pending before the Missouri Supreme Court and the
7 notice of appeal, are both focused exclusively on the
8 July 15th order and decree.

9 MS. GUNN: I'm unaware of a notice of
10 appeal being filed.

11 MR. PERRON: Oh, did that not --
12 Then I'm wrong. I think the only thing
13 is, if that is correct, there's no notice of appeal,
14 there's only the writ, and then there's the posttrial
15 motions pending before this Court and this juris --
16 at the trial court level.

17 MS. GUNN: On the July 15th order only.

18 MR. PERRON: Yes. Yes.

19 THE COURT: So reading directly from the
20 writ that was filed with the supreme court in terms
21 of the relief sought by the realtor: A writ of
22 prohibition vacating the July 8th order and July 15th
23 order and a decree and entering an order prohibiting
24 the trial court from taking any action in this matter
25 other than addressing the limited authorized after

1 trial motions timely filed by realtors, is what the
2 request was.

3 I have a hard time squaring the idea of
4 entering a supersedeas bond on an amount which
5 they're asking for the supreme court to say isn't the
6 amount.

7 MR. PERRON: Well, Your Honor, we have to
8 proceed on two tracts. The filing the writ doesn't
9 cause the dead lines that accrue on a judgment. And
10 as plaintiffs' counsel noted, the order and decree,
11 especially using the term "decree," even though we
12 disagree with that judgment, we are obligated to
13 treat those dead lines as real and file appropriate
14 posttrial postjudgment motions in response to that
15 order and decree.

16 THE COURT: I'm going to take the matters
17 under submission and continue to try to figure out
18 the right answer.

19 Anything further that we need to address
20 today?

21 MS. GUNN: No, Your Honor.

22 THE COURT: Somebody do a memo indicating
23 that the motion was called, heard, and submitted.

24 MS. GUNN: Yes, ma'am.

25 (At 1:43 p.m., the hearing was concluded,

and the Court stood in recess.)

Wednesday, September 17, 2025

Posttrial Motions

O O o

THE COURT: We are here in the matter of
Remington Anyan vs. Mercy Hospitals, et al., Cause
No. 21SL-CC03944.

This matter is on the Court's docket this
morning with regards to a motion to amend and for
relief under Rule 74.06(b)(4).

Is that correct?

MS. GUNN: Yes.

MR. PERRON: That's my understanding.

THE COURT: Do we have any other motions?

MS. GUNN: We have a few outstanding
motions that have been briefed and argued, Your
Honor, but nothing before the Court today.

THE COURT: Okay. All right.

Who wants to start?

MR. PERRON: Your Honor, this was
defendants' two motions, but it had been noticed up
by plaintiff. We intend on standing on our
pleadings. I will seek the first word from
plaintiffs' counsel.

1 MS. GUNN: Your Honor, we are here today,
2 as we have been every day in this matter, to move
3 this case forward to resolution for Remy Anyan.

4 Today is really no different than any day
5 over the last number of months and years. It
6 shouldn't be lost on anyone here, or reading this
7 transcript, that in fact we, plaintiffs, were the
8 ones who noticed defendants' motions.

9 The first motion is -- on the dockets
10 is -- Defendants' Motion to Amend the July 15th,
11 2025, Degree -- Decree -- excuse me.

12 This is nothing more than a rehashed
13 motion to reconsider. And I do have a, perhaps a
14 technical question. Your Honor might remember that a
15 motion for reconsideration of the July 8th order
16 granting the motion to enforce settlement under the
17 plaintiffs' terms was filed on July 14th. And then
18 we had our motion to approve the settlement formally,
19 the minor settlement, on the 15th.

20 I recall it being argued, but I don't see
21 any actual order entered not denying the motion to
22 reconsider. I believe I remember it being denied, so
23 that's just a technicality that perhaps we can fix
24 today.

25 But regardless of that, I do believe that

1 the motion to amend that is before Your Honor today
2 is really the same argument rehashed. And I do
3 intend of course to stand on our previous briefs,
4 arguments, and evidentiary hearing from May 20th and
5 22nd, and any other piece of evidence that has been
6 duly considered by Your Honor.

7 I -- I will just point out that it -- it
8 appears the defendants have taken issue with Your
9 Honor's lack, alleged lack, of consideration of any
10 actual evidence. There are many references in the
11 pleading to no substantial evidence. The record
12 contains no clear and convincing evidence to support
13 the order. And of course I take issue with that.

14 I believe that the evidence was quite
15 robust that supported the settlement in this case
16 under the high-low agreement. I will note
17 defendants' paragraph 19 in their motion to amend
18 states: Further, the lack of record citations in the
19 July 8 order is indicative of a lack of substantial
20 evidence, much less clear and convincing evidence, to
21 support the Court's enforcement of settlement.

22 Indeed, the Court's July 8 order's references to
23 essential facts as, quote, undisputed, is
24 contravened -- excuse me -- contravened by the
25 record.

1 And then the rest of the 20 or so pages of
2 the defendants' motion to amend wholly lacks any
3 citation to any record, other than one reference by
4 Ms. Slater in the post-trial record. We, on the
5 other hand, have supplied, as exhibits to our
6 response to the motion to amend, the full 300-plus
7 pages of the hearings from May 20th and 22nd of this
8 year.

9 Now, the Court, as everyone realizes, was
10 the factfinder, is the factfinder, with respect to
11 the motion to enforce the settlement, can judge the
12 credibility of witnesses. And from our -- we believe
13 that the Court's July 8 order is in fact supported by
14 substantial and robust evidence that meets the
15 requirements of the motion to approve the settlement,
16 and, in fact, for specific performance of the
17 \$18 million settlement.

18 So, Your Honor, with that, we will
19 continue to await for the resolution of this matter.

20 THE COURT: And just from my recollection,
21 and to make sure the record is clear, I do not recall
22 at the time of the evidentiary hearing on the motion
23 to enforce settlement, that either side requested
24 findings of fact or conclusions of law.

25 MS. GUNN: We, the plaintiff, did not so

1 request.

2 THE COURT: Does the defendant believe
3 that they did?

4 MR. PERRON: I'm not sure how to answer
5 that because I think, you know, the record is
6 preserved in the pleadings and in the transcripts.

7 I -- I -- my understand -- limited, limited
8 understanding of caselaw on motions to enforce, that
9 there's three ways for the court to decide it. To
10 decide it only on the pleadings, if there is no fact
11 or controversy.

12 The second method, which I completely
13 forget and it just flew out of my mind. And then the
14 third method, which is the full evidentiary hearing
15 had been decided as if it were a motion for summary
16 judgment, which I think both sides had agreed that we
17 would hold an evidentiary hearing because, despite
18 what was in the pleadings, there were some
19 disagreements about the facts.

20 And my understanding in order for the
21 Court to decide on the motion to enforce,
22 necessarily, you know, it had to resolve some of the
23 facts and controversy. So I -- that's -- that's my
24 understanding of the law. I'm doing my best to
25 answer the Court's question. I don't remember if any

1 side made an affirmative statement requesting that
2 the order be structured in such a way, but I confess
3 I don't remember specifically.

4 THE COURT: Anything further on behalf of
5 the defense?

6 MR. PERRON: Your Honor, just on the -- on
7 the minor technical point that counsel brought up
8 about whether or not the motion to reconsider was
9 decided on, and I think we were on the record, so it
10 probably is in the transcript somewhere.

11 Again, I haven't looked at that, so I
12 don't know, but I would presume that if the Court
13 decided on it, it would have been on the record. I
14 don't know that it matters either way. If the Court
15 ruled on the motion to reconsider, I don't know that
16 that matters one way or the other in terms of ruling
17 on a motion to amend. But it should be in the
18 transcript if it's listed there.

19 THE COURT: For purposes of clarity, the
20 Court believes that it placed on the record that it
21 denied the motion to reconsider the July 8 order.

22 And the Court reenforces that the Court is denying
23 that motion, if it was not stated clearly enough with
24 regards to the record.

25 with regards to the motion for the

1 defendants under Rule 74.06(b)(4), and a motion to
2 amend, the Court is going to deny those motions. The
3 Court does note that it still has under submission
4 the order approving the supersedeas bond, as well as
5 the motion to amend the 7/15/25 order to include
6 post-judgment interests. I believe those are the two
7 motions that I have to still rule on.

8 MS. GUNN: Yes, ma'am.

9 THE COURT: Any inkling from the supreme
10 court as to the timing as to when they might make a
11 ruling?

12 MS. GUNN: I know they're all -- not
13 all -- but most of them are in Branson right now for
14 the Missouri bar meeting, so I'm not holding out hope
15 the week, Judge.

16 THE COURT: No. They are in Branson.

17 Anything further for the record today?

18 MS. GUNN: Your Honor, we have one issue
19 that does go along with at least a motion I think for
20 relief. And that is before a judgment or any of
21 these things can be final, before any 30-day period
22 or any of that jurisdictional time starts running, a
23 judgment has to be final.

24 And part of that is, in fact, I think what
25 we learned from the Hittrich? Hittrich decision,

1 which I'm looking for it -- oh, there it is -- is
2 that all issues have to be resolved before it's
3 actually ready for an appeal. All issues have to be
4 resolved. And as much as it pains me to say, I
5 believe we need a dismissal of the underlying claims
6 without prejudice obviously.

7 So I believe, when we write up an order
8 today for Your Honor's signature, it will include, as
9 I understand, a denial of the two motions on the
10 docket today, as well as just so that final
11 technicality of a dismissal as to all the underlying
12 claims without prejudice. So we will in fact be set
13 up for what will likely be an appeal.

14 MR. PERRON: I will respond to that.

15 First, as a practical matter, I understood
16 from counsel's emails that we were going to be ready
17 to answer the Court's questions about the issue of
18 the dismissal, but there's no pending motion before
19 this Court, especially one that's been noticed up for
20 argument today about a motion to dismiss claim.

21 And per the terms of the July 15 order and
22 decree, there was going to be a separate contemplated
23 order on a particular trust or some other instrument
24 for the remainder of the settlement funds after the
25 attorneys' fees were taken out. And that pending

1 release agreement and payment pursuant to the
2 settlement, then there would be a dismissal with
3 prejudice after all payments were made.

4 So, again, I think it is -- I don't know
5 under what action the court would dismiss without
6 prejudice any remaining claims because under the July
7 15 order and decree, there would be a dismissal with
8 prejudice after payment and after exchange of the
9 release. So I think if the court were to dismiss
10 without prejudice, it would be against the plain
11 wording of the July 15 decree.

12 So that would in fact be two judgments
13 disagreeing with each other out there, and I don't --
14 it seems somewhat muddled as to what we were
15 presenting to the court of appeals as to the issues
16 before them.

17 And so my understanding is that a
18 dismissal without prejudice does not become final for
19 appeal unless there's no opportunity for plaintiffs
20 to refile. I think this is only -- I don't think --
21 did you have to make a nonsuit previously?

22 THE COURT: Huh-uh.

23 MR. PERRON: So I think if this were
24 dismissed without prejudice, theoretically plaintiffs
25 would still have one year to refile. And I -- like I

1 said, I'm, you know, certainly not the authority, but
2 I don't understand under what action the Court would
3 dismiss without prejudice, especially given the
4 context of the previous order and decree. And I
5 don't know what effect that would have on the issues
6 on the appeal. But, again, I --

7 MS. GUNN: Your Honor, the result is we'll
8 never get there. We're just going to sit and come
9 back every couple of months, say hello, and argue
10 about the same things we've been arguing about for
11 six months.

12 The procedure is, Your Honor determined
13 there was a settlement. That's what gets appealed.
14 All other judgments on the verdict, pretending like
15 there wasn't a settlement, have been vacated.

16 The judgment now to be appealed is the
17 July 15th order and decree approving the settlement.
18 We are now talking about contract law. We're talking
19 about a settlement that has been ordered. The tort
20 claims are done. The tort claims are done. They'll
21 be a dismissal of the underlying tort claims without
22 prejudice. That's the end of that case.

23 Hittrich, one of the appellate team's own
24 opinions, dictates and instructs that in order for
25 the case to be final and appealable, all underlying

1 claims have to be dismissed. And, again, I started
2 out saying, how uncomfortable does that make me?
3 Very. Is it what needs to happen to get this case
4 resolved? Yes.

5 You don't need a motion to do that. The
6 judge obviously has the authority to dismiss this
7 matter, in order to move the case forward to full
8 resolution, which, in this matter, and in this case,
9 is going to be apparently an appeal on the judge's
10 July 8th and/or July 15th orders. So we are asking
11 the Court, under her inherent authority, to dismiss
12 the underlying tort claims without prejudice.

13 THE COURT: I think the best way to phrase
14 a dismissal would be that it is being done
15 specifically with regards to the underlying tort
16 claims based upon the fact that the Court had found
17 that there is an enforceable settlement.

18 should the Court be reversed on appeal, I
19 don't want there to be an inability to then, in
20 essence appeal the underlying judgment, which I think
21 would be the next step, if the Court were wrong on
22 the motion to enforce.

23 So I do believe that it's appropriate with
24 that caveat to go ahead and dismiss the other
25 underlying tort claims. That there is an enforceable

1 settlement, as found by this Court, on July 8th and
2 July 15th with the approval.

3 MS. GUNN: Your Honor, if you -- we'd be
4 happy to draft that, and then with your approval,
5 tweak that, if necessary.

6 THE COURT: I think that's the best way to
7 do it.

8 MS. GUNN: okay. we can do that right
9 now.

10 THE COURT: Anything else we need to
11 address?

12 MS. GUNN: No, ma'am.

13 MR. PERRON: Nothing at the moment for the
14 defense.

15 THE COURT: Okeydokey. Thank you.

16 MS. SLATER: Thanks, Your Honor.

17 THE COURT: And I do have special
18 permission not to be at the meeting.

19 (The hearing was concluded at 11:20 a.m.)

20 o o o

21 Thursday, December 4, 2025

22 Posttrial Motions

23 o o o

24 (At 1:20 p.m., the following proceedings
25 were held in open court:)

1 THE COURT: We are here on the record in
2 the matter of Remington Anyan vs. Mercy Hospitals,
3 Cause No. 21SL-CC03944.

4 This matter is on the Court's docket this
5 afternoon with regards to motions filed by the
6 defense, is that correct?

7 MR. PERRON: Yes, Your Honor.

8 THE COURT: Any other motions, other than
9 the three from the defense?

10 MS. GUNN: None from us.

11 THE COURT: Very good.

12 Then on behalf of the defense, I will let
13 you proceed.

14 MR. PERRON: Your Honor, it is our intent
15 on behalf of the defendants to rest on our pleadings
16 more or less as we did at the previous hearing.

17 THE COURT: Do you wish to make any
18 responses?

19 MS. GUNN: Your Honor, likewise. For
20 expediency, we likewise will rest on our pleadings.
21 we have filed responses to all the other
22 motions, and we ask respectfully that Your Honor deny
23 these motions today so we can move forward.

24 THE COURT: I did have an opportunity to
25 review all of the pleadings ahead of the court date

today, and in anticipation of that, as well, and so
the court is prepared, as to all three motions, to
deny those motions.

MS. GUNN: Thank you. I have prepared an
order to that effect, and I left the last word open,
and I will add "denied."

THE COURT: Yes.

MS. GUNN: And share that with my counsel.

(At 1:22 p.m. the hearing was concluded,
and court stood in recess.)

*** End of Volume 2 of 2 ***

1 REPORTER'S CERTIFICATE

2
3 I, Melissa A. Schardan, a Certified Court
4 Reporter, hereby certify that I was the official
5 court reporter for Division 18 of the Circuit Court
6 of the County of St. Louis, State of Missouri; that
7 on the 11th day through the 25th day of March, the
8 5th day of May, the 20th and 22nd day of May, the
9 20th day of August, the 17th day of September, and
10 the 4th day of December of 2025, I was present and
11 reported all the proceedings had in the case of R.A.,
12 a minor, by and through His Next Friends and Natural
13 Parents, Sarah Anyan and Blake Anyan, Respondents,
14 vs. Mercy Hospitals East Communities d/b/a Mercy
15 Hospital St. Louis, Mercy Clinic East Communities
16 d/b/a Mercy Clinic OB/GYN and Dr. Daniel McNeive,
17 Appellants, Appeal No. ED113824/Cause No.

18 21SL-CC03944; and I further certify that the
19 foregoing pages contain a true and accurate
20 reproduction of the proceedings had on those dates.
21

22 /s/ Melissa A. Schardan

23 Melissa A. Schardan, CCR #0743
24 Official Court Reporter
25 Twenty-First Judicial Circuit
(314) 615-8078