EXHIBIT K

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DISTRICT COURT
CLARK COUNTY, NEVADA

TIFFANI HURST AND BRIAN * ABBINGTON, JOINTLY AND ON* BEHALF OF THEIR MINOR * CHILD, MAYROSE LILI * ABBINGTON HURST * CASE NO. A616728
Plaintiffs * DEPT. NO. XXIV
v. *
SUNRISE HOSPITAL AND * MEDICAL CENTER, ET AL. *
Defendants * Pages 1 - 83

Deposition of John J. Strouse, M.D.
Baltimore, Maryland
Friday, December 14, 2012

Reported by: Kathleen R. Turk, RPR-RMR

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December 14, 2012
12:35 p.m.

Deposition of John J. Strouse, M.D., held at the offices of:

John J. Strouse, M.D.
The Johns Hopkins Hospital
Division of Pediatric Hematology
Rubenstein Child Health Building
200 North Wolfe Street, Suite 3006
Baltimore, MD 21287

Pursuant to notice, before Kathleen R. Turk, RPR-RMR, a Notary Public of the State of Maryland.

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APPEARANCES:

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Also Present:
Martin Blahnik, M.D., via Skype

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Thereupon,

JOHN J. STROUSE, M.D.

A Witness, called for oral examination by counsel for the Defendant, having been first duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE DEFENDANT

BY MR. COTTON:

Q Doctor, please state your name.

A My name is John Strouse.

Q And, Doctor Strouse, what's the nature of your medical practice?

A I'm a pediatric and adult hematologist at Johns Hopkins University.

Q Do you have any kind of residency or fellowship in neonatology?

A I do not.

Q Have you ever had any employment as a neonatologist in the United States?

A I have not.

Q And at any point in time have you held yourself out in the medical community as being an

expert in neonatology practice?

A No, I had the same neonatology training as everyone else gets in pediatrics.

Q Basically a rotation through?

A A total of four months and some moonlighting experience in the, in the NICU.

Q And my question was do you hold yourself out in the medical community as an expert in neonatology practice.

A Only in neonatal hematology.

Q In your curriculum vitae, Doctor, there were a number of journal articles and projects that you worked on.

Are any of those -- do they deal with the diagnosis and treatment of Diamond-Blackfan anemia?

A No.

Q Have you ever done any extended research, other than for this lawsuit, on the diagnosis and treatment of Diamond-Blackfan anemia?

A I care for two patients with

Diamond-Blackfan anemia that I diagnosed, so I've had fairly extensive reading around those patients in my general practice.

Q Are those the only two patients that you've personally diagnosed with Diamond-Blackfan anemia?

A Yes.

Did you -- yes was my response.

Q No, we didn't hear the response. Thank you.

Doctor, how many occasions have you received patients with Diamond-Blackfan anemia that had been diagnosed in the Neonatology Intensive Care Unit?

A None.

One patient of mine was initially -- was initially anemic at birth and received their diagnosis when they saw me as they were born at a facility without a pediatric hematologist.

Q How many weeks after birth was it when the child saw you?

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A Sometime in the first month. I'm not exactly sure when.
Q Doctor, just generally, what's the initial treatment for Diamond-Blackfan anemia?
A Transfusions, typically, for the first year would be the standard of care in most centers in the United States.
Q And what sort of treatment is rendered to a child that's diagnosed with Diamond-Blackfan anemia?
A Typically, after the, after the first year or so of transfusions, a trial is made of high-dose corticosteroids to see if that will result in resolution of the anemia.
Q What impact does the giving of those corticosteroids have on the immune system of the child?
A It suppresses the ability of the child to fend off certain infections. They typically get treated with an antibiotic to reduce the risk of infection during that time.

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Q Doctor, outside of this lawsuit that we're involved with here, how many times have you acted as an expert witness in a medical malpractice case?
A This is the, I believe, the fifth case that I've been involved in and the first that has gone to deposition.
Q And how many times have you acted as an expert in a medical malpractice case for the claimant or plaintiff?
A It's about half and half.
Q Do you have any idea where the Plaintiffs got your name as a potential witness in this case?
A They used a headhunter.
Q Do you have a name for that headhunter?
A I do have his name. I would need to look it up to remember it.
He was from -- he lives in Pennsylvania, and he was a physician assistant.
Q But that would be something, I take it, that after the deposition you could get to

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Ms. Carmichael for our purposes.
A I could.
Q How many times have you acted as an expert witness in a medical malpractice case in the Maryland or Virginia vicinity?
A Twice.
Q Both of those times, were they for the claimant or for the defendant?
A One is -- one was for the claimant, and one was for the defendant.
Q And where was the one for the plaintiff?
A The one for the plaintiff was in -- was a case which was in Virginia, Northern Virginia.
Q And what about for the defendant? Where was that one?
A That's a case from University of Maryland, so Baltimore.
Q Ms. Carmichael has provided us with your report, Doctor.
Have you reviewed any documents in addition to those set forth in your report to

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prepare for your deposition today?
A I've reviewed some additional depositions from expert witnesses.
Q When you say depositions, do you mean reports?
A Yes, I'm sorry, so the reports from the, from the -- from the pediatric intensivist from Harvard, a report from two neonatologists, and a report from a neuroradiologist, Doctor Zimmerman.
Q Correct me if I'm wrong, Doctor, but you have not been retained to render opinions regarding the standard of care for a Board-certified neonatologist.
A I have not.
Q Did you conduct any form of a literature search in support of your opinions here?
A I did.
I looked up nuchal lucency as -- I did a literature search on that -- and I did a limited search on transfusions in, in very low birth weight infants and extremely low birth weight

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infants.
Q Do you have a list of the literature that you relied upon in coming up with your opinions or conclusions?
A I do not have a complete list.
Q Can you give us the names of any of the articles that you feel are supportive of your position?
A I can certainly give you the name of the article on nuchal lucency.
Q Okay.
A And I can give you -- there were, there were actually two references -- there were actually two references that were in one of the neonatology reports which I looked up.
Q And what were those two references?
A They were -- the reference was from this PINTS study and another study -- this was actually an expert witness for the defense -- the other study was a study from Iowa, which I could find the references again. One of them I have on my

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laptop.
Q The first -- how do you spell the first study that you mentioned?
A I think it was P-I-N-T-S was the, was the name of the study.
It was a multi-center study of transfusion in infants.
Q Was there any particular publication in which you found that study?
A It was -- I'm pretty sure that that was in Pediatrics in 2006 was the journal.
2005 or 2006.
Q What about in terms of the transfusions in very low birth weight infants, do you know what that article was?
A I would need to -- I would need to check. I would need to look it up on my laptop to remember what the author was.
I think that -- one was in Pediatrics, I think, in 2005, and the other was in 2006.
Q And, again, could you provide that to

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Ms. Carmichael when we get done with the deposition, the names of those articles?
A I can, yes.
Q Okay. Doctor, are you familiar with a concept of clinical observations in the practice of medicine?
A Can you be a little more explicit?
Q Well, a lot of doctors have told me that they were taught from Day One in medical school that clinical observations of a patient are very important in reaching a diagnosis and a plan of care.
Would you agree with that?
A I would agree with that.
Q And how do you define those clinical observations?
A So clinical observations include the information that you can collect directly from the patient without laboratory studies, so that would be history and physical exam, and then other, other observations that are recorded in the

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medical record. So I would include other observations by the nursing staff, respiratory therapy, other people on the care team.
Q In terms of an infant, how do you develop those clinical observations?
A So you, you -- it's generally from interactions with the parents of the infant. It might be from talking to the doctors that cared for the mother of the infant during the pregnancy and getting their clinical observations related to the pregnancy. And then direct observation and examination of the infant.
Q And as a practical matter in your profession, why is it important for a doctor to have clinical observations in the decision-making process?
A Well, I would say that history is at the core of, of diagnosis and treatment as well as physical exam.
As a rule of thumb, people say the history is the most important and after that

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physical exam and then laboratory observations --
Q In your personal --
A -- and tests.
Q -- practice at Johns Hopkins, do you develop a plan of care and initiate a plan of care without having had clinical observations of a patient and their records?
A For the -- for the most part, no.
I have done some medical second opinion which is from a distance, so where you review the records, sometimes collect some additional information, and then make recommendations.
But in, in general, we like to have direct observation and replication of the history.
Q So if someone's going to be your patient, you don't develop a plan of care for them without first having seen them, examined them, touched and held them, if you will?
A Right, for two reasons.
We think that is, in general, the best medical practice when possible and, also, because

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that's when we develop our, our relationship with the patient is usually with that first contact, not by telephone contact.
Q Would you consider it to be below the standard of care for you to initiate a long-term plan of care for a patient without first having ever seen them?
A So we -- like I said before, we do do medical second opinion where we provide that advice having looked at medical records as part of our International Medicine Program, so we do do it.
It is not the -- it is not the first choice, but --
Q For a patient that you could have hands-on experience with, would it be below the standard of care to develop a plan of care where you're the primary treating doctor without first having seen the child?
A It would be, yes.
Q Doctor, in looking at your report -- and

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I don't claim to be a doctor, so bear with me -- it appears that your opinion is that -- one of your opinions is that profound anemia was a major contributor to the brain injury in this little child, correct?
A That is true, yes.
Q And when you -- when you say profound, what do you mean by profound?
A When -- when Mayrose presented to the, to the hospital, she had a hemoglobin of 1.5.
In general, a hemoglobin of less than 7 would be considered severe, and that's really the -- that really is the -- among classification, that really is as low as the classification system for anemia goes.
But she had, she had a degree of anemia that is probably not compatible with life in many children and certainly is enough that you would expect to see significant complications from it -- have a high probability of significant complications.

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That's what I meant by profound. It's not a technical term in the classification of anemia.
Q Okay, that's what I thought.
When you say it was profound, are you talking about being profound within one month after discharge from Sunrise or within one month of the events here that caused her some problems?
A I was talking about at the time that she presented to the hospital with her, with her episode of, of severe illness.
I don't know what her hemoglobin was a month after she left the hospital. I can speculate on what it was and probably give an educated guess of what the range would be, but I can't say what her hemoglobin was a month after she was discharged from the hospital because it wasn't tested.
Q Are you able to state in relationship to the October 29th, 2008, hospitalization when her anemia became profound?

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A I cannot say exactly when her anemia became particularly severe.
Q You indicate that you thought the profound anemia was a major contributor to her brain injury.
Do you remember that statement?
A I do.
Q And what other contributory factors were involved in her brain injury?
A So her brain injury could have had some contribution from her having a respiratory illness and decreased oxygen saturation. That may have contributed to her brain injury as well.
There was the possibility that she had preexisting brain injury prior to this event, but that is unlikely given that she had imaging studies prior to this event which did not show significant brain injury.
Q Any others?
A I think those are the things that are, that are most likely.

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Q Doctor, in your report, you indicate that -- have you got a copy of your report right there?
A I can pull it up on my laptop.
I have it.
Q On the second page of your report, the paragraph starts you're already familiar.
Do you have that?
A Yes, I do.
Q Okay. The second sentence says additional details relevant to her anemia include nuchal lucency identified on prenatal ultrasound with normal chromosomal analysis.
What's the relevancy of the nuchal lucency?
A So a nuchal lucency has an association with a number of abnormalities, and one of those abnormalities would be anemia, anemia in utero.
So chromosomal abnormalities are the most common, and you can see thickening of the, the -- this nuchal region in children that have

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chromosomal abnormalities, including Trisomy 21, which is, I think, what is most well-known for it, but if you look this up in PubMed, this is one of the searches that I, that I did, it's associated with other genetic illnesses other than chromosomal abnormalities and anemia in utero as well.
Q And is that one of the articles that you were talking about, those studies?
A Yes.
Q The PINTS study and the Iowa study?
A No, those, those were -- those were actually studies of transfusion in neonates. This is -- this is another study.
There's some case -- there was a case report with Diamond-Blackfan anemia, but it's something that's well -- that was a single case report, but it's something that's well-described in, in the medical literature.
Q The article on nuchal lucency, that's the one you're going to get us the name of?

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A Sure.
Q Or do you actually have it right there on your computer?
A I do not think I have it on my computer that I can find very quickly.
Q Is there a difference between nuchal lucency and nuchal translucency, or is it the same thing?
A I think that it's referring to the same thing.
I am not a perinatologist, so this is not my area of expertise, but I believe that it refers to the same thing.
Q In the records that you reviewed, Doctor, from Sunrise Hospital, did you see any evidence in the records that the perinatologist had communicated any finding of nuchal lucency to the neonatologist at Sunrise?
A I did not see – I did not see that in their communication from the perinatologist documented.

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Q Doctor, I think you said you're not an expert, but do you know whether or not you can have false positives on nuchal lucency or translucency?

A I -- I can speak from my personal experience as someone that's had the testing done on their children. With all tests, you can see false positives and false negatives -- these are screening tests -- but, in general, the more extreme the value, the less likely it is to be incorrect in all, in all testing.

And there, obviously, there are things related to the ultrasonographer where they can have inadequate training or do the test incorrectly.

I know that the quality control is pretty strict at the institution that we went to to have our kids because you push pretty hard on it when people decide to have chromosomal testing based on those with some risk of losing their pregnancy.

Q Doctor, what is hydrops fetalis?

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A Hydrops fetalis is a condition where you basically have swelling of the, of the fetus because of severe anemia, congestive heart failure, and it can result in -- it can result in death of a fetus from severe anemia.

Q Did you see anything in any of the ultrasound or echos on this child that indicated that there was a presence of hydrops fetalis?

A I did not -- I did not have the -- are you talking about the prenatal, the prenatal evaluation of this child?

Q Yes, sir.

A I don't believe that I saw prenatal reports on, on Mayrose.

Q If this child was, in fact, anemic in utero, would you have expected to see the presence of hydrops fetalis on any ultrasound or echos?

A It depends on the severity of the anemia.

If the anemia is very severe, it's expected to occur. For a more mild to moderate anemia, it often does not occur.

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Q And how do you define mild to moderate anemia in a premature baby?

A It really depends -- it, it really depends on where they are in their development, so the, the normal levels of hemoglobin and hematocrit vary with gestational age.

So for any given gestational age, I would, I would -- if it's something that I'm very familiar with, I would just do it from memory. Otherwise, I would look it up in a reference table in a textbook.

Q If you had an ultrasound or an echo on this child a month before the actual delivery in May of 2008, what would you expect to see in terms of values on hematocrit or hemoglobin?

A So this would have been at like twenty-four weeks gestation?

Q Yes.

A Are you asking me what -- for normal values or for this child?

Q This child.

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A I would expect -- it's, it's really hard to say.

I would expect that they probably would have been a little bit lower than they were at birth because your hemoglobin increases as you get a bit older, but it's hard, it's really hard for me to know what it would be.

Q Would you expect to find enough anemia to show the presence of a hydrops fetalis?

A Hydrops fetalis doesn't usually get better in utero, so I would be surprised if the child would be so anemic that they would have hydrops.

In general, children that are thought to be at high risk for anemia in utero have testing done to evaluate for that. The non-invasive test is looking at the velocity of blood flow to the brain, middle cerebral artery velocities, and that's done by ultrasound.

If suspicion is high, they'll do -- they'll do umbilical cord blood sampling. So they

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go in and take a sample of blood from the baby from the umbilical cord, and if the child's particularly anemic, they will sometimes transfuse the blood at the same time that they're sampling.

Q If you have a child with the diagnosis of anemia of prematurity, would you expect to see the hydrops fetalis on the echos or on the ultrasounds?

A Only -- not, not usually because anemia of prematurity is really a physiologic anemia. It's not a pathologic anemia that you would expect to cause hydrops.

Q Doctor, what's the half-life of the red blood cells in a premature baby?

A Is this their, their own red blood cells or the red blood cells that are transfused into them?

Q Both.

A So it, it varies.

Red cell survival is decreased in a newborn baby, and that probably depends some on

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gestational age, but I think of something on the order of fifty to sixty days as opposed to about a hundred and twenty days for an older child or an adult.

For transfused blood, it depends on a number of factors. Most important probably is the, the compatibility of the blood. Most of the time the blood will be completely compatible, but if there's incompatibility, the half-life can be quite short.

And then the half-life of transfused blood can be shortened depending on the age of the blood. So older blood that's been sitting around in the blood bank for a longer time doesn't last as long as blood that has been freshly collected. And then when you give blood, some of the blood is right collected from people, some of the blood is old in their bodies, so you expect it wouldn't last quite as long, and then some's new.

So some centers try to collect the young portion of the blood and just transfuse that.

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That's pretty uncommon, though.

Q Is there roughly a day range on the half-life of those transfused bloods?

A I would say that, you know, something on the order of sixty days, but there's quite a bit of variation.

Q Is it normal in a premature baby to find macrocytic red blood cells?

A So, again, it comes down to the gestational age of the infant.

So all infants have large red blood cells, but it can be -- they can be abnormally large for the age of the infant.

Q Did you find abnormally large red blood cells in this child?

A So at birth, her red cells were right at the, right at the limit of normal versus abnormally large for her gestational age.

Q Did you see any persistent macrocytosis in this baby here?

A No, she actually became microcytic for

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gestational age, which is what you would expect when you're transfusing in adult red blood cells.

Q Is there any point in time when you saw any persistent macrocytosis?

A No, she was, she was actually in the -- rapidly went into the normal range, which is what you would expect because we were really seeing mostly transfused blood at that time.

Q You, also, then talk about the family history of alpha-thalassemia.

Do you see that?

A I -- I do.

Q Okay. And what is alpha-thalassemia? Which I have a hard time pronouncing.

A Sure.

Thalassemia means by the sea, and that's because it's common of people of Mediterranean ancestry; also, people of African ancestry and from large sections of Asia.

It is a hemoglobinopathy. That just means a defect in the development of hemoglobin.

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Hemoglobin is made up of four little pieces. Two of those are called beta chains, and two of those are called alpha chains.

Alpha-thalassemia is when you have a relative shortage of the alpha chains so you can't make hemoglobin as well, and that actually causes some injury to the developing red blood cells so you get what's called ineffective erythropoiesis that you have less ability to make red blood cells.

It's a production problem as opposed to a destruction problem.

Q Are you able to state to any reasonable degree of medical probability that the father here passed that on to this child?

A So I did not see testing of the father, so I can't tell you whether he had alpha-thalassemia or not.

If he did have alpha-thalassemia, you can have -- there are different types. He would have -- if he had alpha-thalassemia, he probably

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would have passed along at least one abnormal alpha gene to Mayrose.

There are four alpha genes that you carry, and typically you do not show any recognizable clinical or laboratory signs unless you have at least two of them that are changed, and that's a very mild condition called alpha-thalassemia trait or minor.

Q Okay. Is that something that could be determined by genetic testing on this little child today?

A It's something that could be determined by genetic testing, yes.

Q Doctor, does Maryland have a newborn screening program for hemoglobinopathies?

A It does, yes.

Q And, again, thalassemia is one of those, correct?

A Thalassemia is a hemoglobinopathy.

Q And are you aware of the fact that this child was screened for that?

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A Yes.

Actually, all children in the United States are screened for hemoglobinopathy unless they opt out.

The screening for thalassemia is somewhat effective at picking up severe versions of thalassemia but does not identify most cases of thalassemia minor or trait, the more mild forms of it.

Q When you --

A At least in --

Q I'm sorry, go ahead.

A At least in Maryland.

I -- I do not know the details of the newborn screening program for hemoglobinopathy in Nevada, but because of the technical aspects of it, it is fairly difficult to pick up the mild forms of thalassemia on newborn screening without doing genetic testing, which is fairly expensive and not something that is routinely done by most newborn screening programs.

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Q If someone has a mild or very mild thalassemic condition, is that something that, in any event, could be passed on to a child such as this child here and affect her production of red blood cells?

A It could.

It would cause a more mild decrease in production, but it could contribute to the degree of anemia in the neonatal period, especially in a child that had other reasons to be anemic.

Q Would you agree with me, Doctor, that you would be speculating as to whether or not the father's condition of alpha-thalassemia here would have any effect on this child's production of red blood cells?

A I would say it's a little bit more than speculation.

If -- if this child had two abnormal alpha-thalassemia genes, which she could have gotten from her father if her father had alpha-thalassemia which he reported, which is

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usually fairly reliable but not completely reliable, and the prevalence of alpha-thalassemia having at least a carrier mutation is about one -- is about ten percent. So -- in African-Americans.

So the mother of the child was African-American as well, I believe, so there's a reasonable chance that this child could have had alpha-thalassemia trait.

Q And are you able to state to a reasonable degree of medical probability as opposed to a possibility that this child, in fact, has alpha-thalassemia and that it's impacting her production of red blood cells?

A No, I cannot.

Q Doctor, is there any evidence at all that the father here was transfusion-dependent because of any alpha-thalassemia?

A So there was no mention made of that in the medical record, and I would be surprised if he was transfusion-dependent with alpha-thalassemia because it's relatively uncommon in people of

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African ancestry.

Q Macrocytic red blood cells, is that something consistent with a thalassemia condition?

A It is not.

Typically, children with alpha-thalassemia are microcytic compared to their gestational age normal range at birth.

Q Doctor, are you aware of the fact that this child had, I think it was four transfusions, at the time of surgery in mid-May of 2008?

A Was this the -- was this -- are you referring to the initial surgery, or is this the --

Q I'm talking about the initial surgery.

A Yes, I was aware of that.

Q I take it that that's appropriate to transfuse a premature baby for that condition.

A So that's -- I would say that is generally the standard of care.

Could I -- but wasn't this child transfused -- this child was anemic at birth prior

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to surgery?

Q I believe so.

Do you know what the other transfusions were for?

A So the, the trans -- are you talking about the remaining transfusions for this child?

Q Yes, sir.

A My understanding was that the transfusions were predominantly given as preoperative transfusions.

Q Did you see any transfusion that was specifically noted as being given for anemia of prematurity?

A I did not.

Q Are you able as a hematologist to rule out that any of those transfusions were not necessary based on the clinical judgment of the doctors treating the child at the time?

A So I believe that transfusion is a clinical decision that is challenging to make if the patient is not in front of you.

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So I would not -- I would not want to judge whether they were clinically indicated or not.

Q Doctor, is there a normal average, if you will, age of diagnosis of Diamond-Blackfan anemia?

A So I think that there's a -- yes, there's a -- that most -- some cases are diagnosed at birth -- that's the minority -- fifteen percent, maybe. And then most of the remaining cases are diagnosed in the first year of life, but there are patients that even get diagnosed as -- later in childhood and rarely in adulthood.

Q Is there a relatively large percentage of the children that do have Diamond-Blackfan anemia who present with other congenital anomalies?

A Yes.

Q Do you know what that percentage is that present with other congenital anomalies?

A So if you have a geneticist that's very good at dysmorphology, it's over half, probably approaching two-thirds, maybe three-quarters.

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I would say that in a clinical exam by someone that's not trained as a dysmorphologist, someone like myself, it would probably be less than that.

Q While this child was present at Sunrise Hospital, in the records you note there, did you see any reference to any congenital anomalies that would be consistent with Diamond-Blackfan anemia?

A I did not.

Q In fact, in looking at the records of Foothills Pediatrics or Summerlin Hospital or Denver Children's Hospital, did you see any notation that would indicate that this child was presenting with congenital anomalies consistent with Diamond-Blackfan?

A Actually, can I -- can I take a step back?

On the discharge paperwork, was there a mention of an ASD, or am I --

Q I don't -- I don't know.

THE WITNESS: Do you have the

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discharge paper?

MS. CARMICHAEL: Uh-hmm.

A I'm sorry, no, so no anomalies noted.

Q (By Mr. Cotton) Doctor, is it usual to have a high or low platelet count in an infant with Diamond-Blackfan anemia?

A So some patients with Diamond-Blackfan anemia have elevations of their platelet count and white count.

Q And I mispronounced this yesterday, but I'll try to pronounce it correctly today.

I want to talk about a retic count.

A Okay.

Q Are you familiar with that, sir?

A Sure, reticulocyte count?

Q Yes, sir.

Do you know what the reference rate was for the retic count at Sunrise Hospital in May of 2008 -- May, June, July, and August of 2008?

A So I believe it was 0.5 to 1.5 percent, and then there was also a normal range for the

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absolute reticulocyte count as well.

Q Is it your opinion, if I heard you correctly, that that retic count was likely low due to blood transfusions even if the child wasn't anemic?

A I -- I think that there are a number of reasons why the reticulocyte count was likely low at -- there were two separate occasions.

On the second occasion, I think that it was probably low because the child had been transfused up to a relatively physiologic or a hema -- a hematocrit which was in the normal range for an infant of, of that post-gestational age, maybe, post-birth age.

So in that, in that way, you decrease your signal to make more red blood cells, so you expect the reticulocyte count would be normal or, you know, low normal, could easily go into the, into the lower than normal range when you're approaching that, that -- when you get above the threshold to make red blood cells.

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Q What about the first retic count?

A The first retic count, I think, was also around the time that the child was ill which can also suppress the reticulocyte count.

So I think that there are -- there are many reasons why a reticulocyte count can be low, and there certainly are reasons other than not being able to make red blood cells when you're ill for, for both of those occasions.

Q Can you have a low retic count due to a lack of vitamins or iron in the child?

A You can.

It's -- it's unusual to be deficient in iron when you've been transfused because transfused blood is a very good source of iron, but there certainly are other nutrients that can cause a low reticulocyte count.

Q Okay. Beyond being ill on admission, could the lack of vitamins or iron at that point in time also result in a low retic count?

A Yes.

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Q Can you have a low retic count due to multiple antibiotic treatments?
A There are some antibiotics that can suppress the production of red blood cells.
Q Do you see any of those that were given here that can suppress the production of red blood cells?
A None that are -- that it's a particularly common occurrence with.
Q Any at all?
A Can you remind me what the antibiotics were?
Q No, I was just asking if you can recall any.
A None that, none that commonly -- none that commonly cause red cell suppression.
The ones that probably are most commonly used in children and not much in neonates, Bactrim can cause decreased red cell production, linezolid, chloramphenicol, which doesn't get used much anymore, are the ones that it could just

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decrease in production.
There are other antibiotics that cause anemia by other mechanisms.
Q Now, my statement, assuming that you can have a combination of transfusions, lack of vitamins or iron, multiple antibiotic treatments, that that could also result in a low retic count.
A That's true.
Q Doctor, how often do you -- are you called in to see an infant in the NICU when there's been only one low retic count?
A I -- I can't say because I know the NICU doesn't call me -- I don't know who they don't call me about.
Does that make sense?
Q I'm asking how many times you know that you were called when there was only one.
A Oh, being called because the retic count is low?
Q Right.
A That would be a very rare occurrence;

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that being the only reason that we were called to see a child would be for a low retic.
Q Can you have low retic counts in, in children -- infants, if you will -- who have anemia of prematurity?
A So anemia, yes, if you -- it depends when you check the retic count.
If you check the retic count when they have another reason that they shouldn't be able to make red blood cells, of course, you could have a low retic count, but then it's not necessarily anemia of prematurity. If it's because you have an infection, that's called anemia of inflammation, a little different than anemia of prematurity.
I think of anemia of prematurity as having a, a more pronounced physiologic nadir. Physiologic nadir's when everyone comes down normally until they start making their own red blood cells and it reflects that you get a lot, much higher levels of oxygen when you're outside

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your mother if your lungs are healthy than when you're inside because you're kind of getting second-hand oxygen off of mom's red blood cells. So you, you have less drive to make red blood cells once you come out into the world, so you drop-drop-drop until you, you kind of turn back on the gas to make red blood cells.
So anemia of prematurity is really a more pronounced version of that where you come out and you aren't as high because you were born early and you didn't have a chance to make enough blood, and then you fall faster and earlier before you kind of get caught back up, and that's compounded a little bit by the things that we do to premature infants, like taking a lot of blood.
Q Based on what you said, then, Doctor, if a patient has been transfused and it was shortly after a surgery or to address a sepsis situation, any kind of a procedure at all, I take it the retic count's going to be affected by those transfusions.

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A Certainly.
Q Doctor, are you aware of the fact that Doctor Piroozi recommended a complete blood count, a differential, and a reticulocyte count on this child within one month after discharge?
A I am aware of that.
Q And were you made aware of the fact that that recommendation in writing was in the pediatrician's file and that the mother had actually given a copy to the doctor?
A Yes.
Q Would you agree with me, Doctor, that pediatricians, Board-certified pediatricians, are knowledgeable and capable enough to diagnose and follow infants after a NICU discharge?
A It is within the scope of -- it is within the scope of training. I would say that for particularly complicated children, they might need the right pediatrician.
Q Generally, if the patient's gone out of the NICU but has to stay in the hospital in your

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institution, are they generally followed by pediatricians?
A They're often followed by general pediatricians and a collection of subspecialists.
Q But you agree if the pediatrician in this case had ordered the recommended tests for Mayrose within one month of her discharge that that likely would have shown some anemia?
A I think it would have almost certainly shown significant anemia.
Q And would you agree with me if that pediatrician had ordered those tests and looked at the results that the episode of profound anemia here could have been prevented?
A I do.
Q Is there any evidence in the records to show any operations or clinical sepsis or multiple transfusions while the pediatrician was caring for this child that would mask any underlying anemia?
A No.
Q Okay. Would you expect -- at least,

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based on the recommendations here -- would you expect a competent pediatrician to actually order and assess the complete blood count and retics recommended by Doctor Piroozi within one month post-discharge?
A Yes.
Q Doctor, outside of the opinions that you shared with us in your report of August 30th, 2012, and those opinions you've shared with me now, do you intend to offer any other opinions at the time of trial that you're aware of?
A I think that I may be offering an opinion about the, about the appropriate evaluation of anemia in the neonatal period.
Q Why don't you tell me what that opinion is?
A Sure.
So I think it's -- it's two things.
It's whether additional evaluation was appropriate for this infant in the, in the NICU and what that evaluation would be.

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Q Okay.
A So it is my -- it is my professional opinion that this child had enough concerning signs that additional evaluation of the anemia was appropriate in the NICU and closer follow-up upon discharge in the NICU.
Neonatology includes a great deal of hematology in practice, and some of the -- much of the work in neonatal hematology was done by neonatologists. So the appropriate provider for that could have been a neonatologist or a pediatric hematologist because I think it is within the scope of practice of, of some neonatologists and some would, would consult.
And if I had been consulted on this infant during that period, I think that the, the things that we discussed before -- the nuchal lucency, the family history of alpha-thalassemia, and the, the number of transfusions -- were all unusual and really would have led to additional evaluation in the -- during the hospitalization.

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I think that initial evaluation during the hospitalization would have been fairly limited because of the multiple transfusions, but it would have consisted of testing of the parents for thalassemia typically, given that the child had been transfused early on in life, and typically would have included probably some testing for nutritional deficiencies given the macrocytosis of the, of the infant if, if an early blood specimen was available, and then closer follow-up of the child after they had been discharged from the hospital.

It may have also included additional reticulocyte counts during the period of -- during the period that the child was in the NICU, but as I mentioned before, I'm not sure that they would have been, that they would have been illustrative.

Low reticulocyte counts are something that have many reasons, as we talked about, and Diamond-Blackfan anemia is not something that I think would have been diagnosed in the initial

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NICU stay, no matter what the evaluation would have been.

Q You say you would have recommended closer follow-up.

When you say closer follow-up, are you talking about post-discharge?

A Right, of the, of the complete blood count and reticulocyte count.

Q Would following up with a CBC and a reticulocyte count within one month after discharge have been a close-enough follow-up?

A If I had seen this child, I would probably typically either see them back if they were local, or if they were from farther away and had been transferred in here for their neonatal care, I probably would have gotten a CBC within two weeks.

Q Whether they were two weeks or one month in this case here, Doctor, wouldn't have made any difference in the outcome here, would it?

A It wouldn't have made a difference in

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the, in the end outcome, but if you really think of this as a -- I mean, there were multiple errors that -- there, there were multiple errors in my mind that led to this child having the brain injury, and if they had been diagnosed with significant anemia earlier or if it had been emphasized -- if they had been diagnosed earlier with the anemia or if they were being followed by someone that specialized in neonatal anemia, it would have been diagnosed before the pediatrician failed to get this lab test.

Q The practical matter is, if once the child's in the pediatrician's hands, whether he had diagnosed it in two weeks or thirty days, still would have had the same outcome here if he doesn't do the test, correct?

A That is true.

Q And would you agree with me, Doctor, that if a neonatologist does have skills and expertise in anemia and blood conditions, it is within their clinical judgment whether or not they need to call

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in a pediatric hematologist?

A Certainly, but -- I mean, I've reviewed many, many notes on this child, and the mention of the anemia was quite limited.

Anemia of prematurity is not what this child had when they were -- during this initial hospitalization.

Q During the initial hospitalization, there were sufficient transfusions, though, Doctor -- correct me if I'm wrong -- that it would have required some time frame for the baby to be removed from the time of those transfusions to get an accurate read on the complete blood count.

A That is true.

Q When you say there were enough conceming signs that additional evaluation of anemia should take place, what are the concerning signs you talked about?

A Sure.

Nuchal lucency, a family history of alpha-thalassemia which causes a

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hyperproliferative anemia, low reticulocyte count anemia, and a number of transfusions which is unusual for a child of this gestational age and birth weight in the modern era.

Q Recognizing that it's unusual for a child of this age and birth weight in this era, if a child has septic problems, bleeding in the stomach, operations, those -- that's not a normal child premature, is it?

A I would say that those are, those are common -- those are common complications of neonatal care -- and, again, I am not a neonatologist -- but NEC is a quite common complication in very low birth weight infants, especially ones that the mother had tocolysis that this child did, and NEC -- NEC requiring surgery is a little less common.

This child did have a -- more than -- more surgical procedures than your average child that weighs twelve hundred grams.

Q As you sit here today, though, Doctor --

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correct me if I'm wrong -- you're not in a position to criticize the number of transfusions given this child because you weren't treating the child?

A I'm not criticizing the number of transfusions. I'm saying that the number of transfusions is on -- is more than you would typically expect an infant of this gestational age and birth weight to get.

Q The mere fact that they're more than the number you would expect doesn't mean that the child has a Diamond-Blackfan anemia condition, does it?

A Certainly -- certainly not.

There are many causes -- there are many causes of anemia, and this child turned out to have a very rare one that is unrealistic to expect someone to diagnose in the NICU in a twenty-eight-week-old. I mean, it's very -- a very challenging diagnosis.

But this child was anemic, was anemic at

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birth, had borderline macrocytosis, nuchal lucency, and more transfusions than your typical infant like this, I believe, would get in the, in the NICU.

Q Doctor, if a child is being released or discharged from the NICU such as this child here, was there any reason to order up CBCs or retic counts if you didn't have some lingering concern that there might be anemia present?

A So that's -- that's an interesting question.

I do not know what the routine follow-up is of an infant of this gestational age and with these complications. I think it would be reasonable even in someone without a suspicion of a potential hyperproliferative anemia to follow up with a CBC and a retic just because of issues like iron deficiency that can be seen, but I, I -- I'm not a -- I don't know what the usual practice is in the, the NICU from Summerlin, and I don't know what even the usual practice is from our own NICU

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here.

Q Doctor, do you have any physical evidence, any documents you've seen, that indicates that the husband here actually had alpha-thalassemia?

A I do not.

Q And, in fact, I think you told us you have not had an opportunity to look at the perinatologist records.

A I do not believe I have.

I do have -- I have seen the testing done on the mother for hemoglobinopathy, and it did not appear that she had alpha-thalassemia or was a carrier for the seven most common alpha-thalassemia mutations, which picks up not all but many of the ones that are seen in people of African ancestry.

Q And my statement, assuming that the test results you saw, would have been the same test results had that test been done while this child was in the NICU?

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A Yes.
For the -- you mean for, for the mother?
Q Yes, sir.
A Yes.
Q Now, I'll ask the question again.
Any other opinions you intend to offer at trial other than those you've completely shared with us now and also your report?
A I don't think so.
Q Thanks.
MR. COTTON: That's all I've got, but other counsel may have other questions.
Thank you.
THE WITNESS: You're welcome.
EXAMINATION BY COUNSEL FOR THE DEFENDANT
BY MR. McBRIDE:
Q Doctor, good morning. My name is Robert McBride. I just have a few questions for you.
I take it, since you have not seen any records of the perinatologist, you have not seen any ultrasounds that might demonstrate any nuchal

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translucency; is that right?
A That's right. That's correct.
Q And have you asked Plaintiffs' counsel if there are any such documents or records that you could review in order to firm up your opinions?
A I have not.
Q Are there any documents that you specifically asked for that you have not been provided?
A No, there are not.
Q And do you feel that you've reviewed all the materials you need to review in order to render your complete opinions here today?
A There's certainly information that would be valuable for me to review, but I don't believe it's available.
I would have loved to have known what the father's CBC was, his blood smear, and some testing on, on him related to, related to his diagnosis of thalassemia.
Diamond-Blackfan anemia is often

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inherited as well, so if the parents had had testing done, even testing such as a CBC, sometimes you can see signs of an asymptomatic -- I would say a, a carrier state -- which can sometimes be asymptomatic and not diagnosed and that people can have the same Diamond-Blackfan mutation but be less affected.
So we see family members that have mild anemia and macrocytosis as a, as a clue that their child has Diamond-Blackfan anemia.
Q But you have not requested any of that information from Plaintiffs' counsel as of today, true?
A My -- no, I have not.
And my understanding is that there was not laboratory testing available on the father.
MR. McBRIDE: Doctor, would you mind if we take maybe just a five-minute break very quickly so I can look over my notes and see what follow-up questions I might have?
THE WITNESS: Certainly.

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MR. McBRIDE: Okay, thank you.
(Thereupon, a recess was taken.)
Q (By Mr. McBride) Doctor, just a few more questions.
Going back to the nuchal lucency, where did you obtain the information that this child had nuchal lucency identified on prenatal ultrasound?
A I -- I think that the information was in the, the mother's deposition, and I'm not sure if there was another -- maybe it was in some of the physician notes -- maybe it was in some of the physician notes as well from the -- I would need to go back and check. I think it -- I think it might have been in physician notes as well. It might have been when she had her hematology opinion or at an earlier date.
Q Are you aware of any mention of nuchal lucency in the records from Sunrise Hospital while the child was in the NICU?
A I would need to go back and check my notes.

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I did not see it in -- I certainly did not see it in the admission note or the progress notes from the neonatologist in the early portion of the child's admission.

Q Okay. How about in the discharge summary? Do you recall seeing that mentioned there?

A I do not believe it was in the discharge summary.

Q Okay. And the same question for the family history of alpha-thalassemia, where did you obtain that information?

A The family history of alpha-thalassemia, I believe, was in some of the physician notes as well as being in the, the deposition from Mayrose's mother.

Q All right. And are you aware of it being specifically mentioned in the physician notes while the child was in the NICU?

A I'm, I'm not -- I don't remember.

It certainly wasn't in the admission note

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family history, which is the typical place that the family history is obtained.

Q And would you expect if that information had been conveyed, either the nuchal lucency or the alpha-thalassemia, had been conveyed to any of the neonatologists taking care of this child that that would have been noted by those physicians in the records?

A I have to say that the admission note was very brief, so I think that there wasn't, there wasn't a lot of detail in the history in the admission note.

Q But would you expect that at some point that if that information had been conveyed by the parents to the physicians that that would have been contained in the, in the physician notes or somewhere in the Sunrise Hospital chart?

A That would have been the, the standard of care.

Q So as you sit here, you're not able to point specifically if it, in fact, appears

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anywhere in those records, right?

A I would need to go back -- I would need to go back and, and review it to tell you the specific -- to find the specific location.

Q Okay. Doctor, at the time that you were asked to review this case by Plaintiffs' counsel, were you aware that this was a case involving a patient who had Diamond-Blackfan?

A I did know the diagnosis of the patient at the, at the time that I agreed to review it.

Q And at the time you provided, or when you were first contacted regarding reviewing this case, did you offer any opinions at that time in your initial consultation with Plaintiffs' counsel?

A I did not -- I did not offer an opinion until I offered my formal opinion, I believe.

Q And are there any other opinions which you haven't already told us about which you intend to offer at the time of trial?

A There are not.

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Q Okay.

MR. McBRIDE: Thank you.

That's all I have.

MS. WHITEHEAD: Okay, I have just a few questions. I'll try to speak up nice and loud for you.

EXAMINATION BY COUNSEL FOR THE DEFENDANT

BY MS. WHITEHEAD:

Q Doctor, I noticed in your CV that you've given several lectures on anemia of prematurity. I believe it was in February of '07, Pediatric Grand Rounds at St. Agnes Hospital.

Does that sound familiar?

A Not anemia of prematurity specifically.

Q Common causes of anemia in children?

A Right.

Q That's correct.

Do you have any of the slides or presentation notes that you gave?

A I do have my slides from that lecture, yes.

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Q Okay. The same with -- I believe there was another one that you gave -- I'm assuming -- it says it was a CME, I'm assuming that you gave that lecture on anemia in children.
A Uh-hmm.
Q And do you have the slides or the notes on that as well?
A I certainly do, uh-hmm.
Q Could you provide those to counsel for us?
A I can.
I'll warn you that they don't talk about neonatal anemia. It's usually -- they don't focus on neonatal anemia because it's different, so it's really more older children, but I'm happy to provide it to you.
Q Okay. Is there any discussion in there about any anemia of prematurity?
A I don't believe there is.
Q Okay. Well, if we can have a look at it just to make sure.

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Okay. And other than the opinions that you've expressed today and that are in your report, do you plan on offering any other opinions in this case at time of trial?
A I do not.
Q Okay.
MS. WHITEHEAD: I have no more questions.
MS. CARMICHAEL: Just a couple follow-up. More clarification.
EXAMINATION BY COUNSEL FOR THE PLAINTIFFS
BY MS. CARMICHAEL:
Q Doctor, in that initial neonatology admission note, is there any evidence that the neonatologist admitting this child made any effort to take any kind of a history of the -- of what occurred during the child's neonatal period or, excuse me, prenatal period?
A Sure.
There was -- there was no, there was no mention of a, of a perinatal history other than, I

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think, all normal or something like, like that.
If I can look at the note, I can give you the exact words.
But there was -- I don't think there was a remarkable, anything that was noted to be remarkable, until the time that they had really presented to the hospital.
Q Okay. And you've read the deposition of Tiffani Hurst and Brian Abbington, the parents of the children --
A Yes.
Q -- the child?
A Yes.
Q And you've -- you've read the testimony that both parents indicated that the alpha-thalassemia and the nuchal lucency was reported to the physicians.
Do you recall that?
A Yes.
Q Okay. Is there any evidence anywhere in the neonatal records of Sunrise Hospital that any

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neonatologist ever requested any blood work on the father or the mother?
A I don't -- I don't believe so.
It's routine that there's some blood work done on the mother with delivery, so there's -- there is information -- there is information that would have been available on the mother from the time of delivery, including usually a CBC, but I did not see a mention of that in the notes.
Q Okay. And it is your opinion, given the abnormal things that you pointed out -- the nuchal lucency, the alpha-thalassemia, the higher number of transfusions, and the macrocytosis -- that this child should have had a more thorough workup in the NICU for her anemia?
A Yes.
MR. COTTON: Form and foundation and competency objections.
MR. McBRIDE: Join.
Q And in reading the discharge instructions, is it pretty clear to you -- is it

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clear whether or not there was any concern about anemia in the discharge instructions?
MR. COTTON: Same objections.
MR. McBRIDE: Join.
A So the discharge instructions had kind of two classes of recommendations. There were two recommendations that were prioritized, and that was the follow-up for cystic fibrosis testing at three months and the recommendation to repeat the head ultrasound, and then there were a series of other recommendations that were not emphasized to the same degree that were a list of six or seven recommendations that included the CBC and reticulocyte count.
Q Okay. Is there anything in the discharge instructions that show a concern, an ongoing concern, on the part of the neonatologist that this child has significant anemia that needs close follow-up?
MR. COTTON: Same objections.
MS. WHITEHEAD: Objection;

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speculation.
A There was -- there was no mention made of the evaluation or a specific concern about the anemia other than the diagnosis of anemia of prematurity.
Q Okay. And in the discharge summary, at least, the diagnosis of anemia of prematurity has a closure date on it of July 21.
Is that your memory?
A That is -- that is correct, that there was a start and closure date for the diagnosis of anemia of prematurity.
Q Okay. Based on the child's issues during the NICU period, is it your opinion that the child should have been followed after discharge by a hematologist?
MR. COTTON: Same objections.
MR. McBRIDE: Join.
A So I can, I can say that this -- if I had seen this patient in consultation, I would have followed them after discharge as a hematologist.

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If a neonatologist had evaluated them for their anemia and had been concerned about their anemia, they probably would have arranged for a follow-up with the hematologist.
We see the, the children in the NICU that have significant anemias diagnosed by the neonatologist that we usually see them prior to discharge.
Q Okay. And, Doctor, what was this child's rate of decline in her red blood cells during her period of time in the NICU?
MR. COTTON: Form and foundation objections.
A If you look at the amount of blood that she received in the, in the NICU, she was typically dropping her hematocrit eight or nine percent a week based on the amount of blood that she was getting and the expected rise in hematocrit from that blood.
Q And at a decline rate of eight or nine percent per week, what would be the standard of

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care for follow-up on that child?
MR. COTTON: Form and foundation objections regarding a neonatologist standard of care.
Q From a hematologic point of view.
MR. COTTON: Form and foundation objections.
MR. McBRIDE: Join.
A Typically, we would need to transfuse a child that was dropping that fast every one to two weeks.
MS. CARMICHAEL: Thank you, Doctor. Those are all the questions that I have.
MR. McBRIDE: I just have a couple of follow-up questions.
EXAMINATION BY COUNSEL FOR THE DEFENDANT
BY MR. McBRIDE:
Q Doctor, are you aware if you have reviewed portions of the medical records from Sunrise Hospital, or have you been provided with

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all of the medical records from that hospitalization?
A I believe that I was provided with all of the medical records for the hospitalization.
Certain portions of the record, including the respiratory therapy and some of the nursing record, I skimmed, so I did not review in detail.
Q And, Doctor, are you aware of when Doctor Blahnik, when his last involvement with this child was?
A I was reminded, reminded by counsel that his last involvement with this child was shortly before he went on vacation, which I believe was in mid-July.
Q And if I were to tell you July 13, 2008, does that sound about right?
A It does.
Q Okay. And are you aware that Doctor Blahnik was not involved at all with the discharge instructions for this patient?
A I, I was told that that was how the

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practice worked; that the, that the responsibility was shifted to the next physician.
Q And at the time of discharge, or I think you already somewhat answered this, are you aware if there's any evidence that this child had suffered an anoxic brain injury at the time of discharge from Sunrise Hospital?
A I think that there's pretty solid evidence that this child had not suffered anoxic brain injury at the time of discharge.
MR. McBRIDE: Thank you.
That's all I have.
MR. COTTON: Jackie, do you want to read the Doctor his rights about reading and signing?
MS. CARMICHAEL: Yeah, sure.
Doctor, you do have the right to receive a copy of the transcript of your deposition to review it for accuracy and make sure that your answers were correctly transcribed.
Would you like to exercise that

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right?
THE WITNESS: I would.
MS. CARMICHAEL: Okay. Madam Court Reporter, would you please send the transcript directly to Doctor Strouse.
MR. COTTON: Okay, thanks.
(Thereupon, at 1:48 p.m., the examination of the witness was concluded.)

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CERTIFICATE OF NOTARY PUBLIC

I, Kathleen R. Turk, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

_____
Kathleen R. Turk
Notary Public in and for the
State of Maryland
My Commission Expires:
March 17, 2015.

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DEPOSITION ERRATA SHEET

Our Assignment No. 393029
Case Caption: Tiffani Hurst, et al., vs. Sunrise Hospital and Medical Center, et al.

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me, and the same is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

Signed on the _____ day of _____, 20___.

_____
John J. Strouse, M.D.

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DEPOSITION ERRATA SHEET

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John J. Strouse, M.D.

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EXHIBIT L

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DISTRICT COURT

CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST, Plaintiffs, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC, MARTIN BLAHNICK, M.D., ALI PIROOZI, M.D., RALPH CONTI, M.D. and FOOTHILL PEDIATRICS LLC, Defendants.	CASE NO. A616728 DEPT NO. XXIV

STIPULATION AND ORDER REGARDING CERTAIN TRIAL EVIDENTIARY/PROCEDURAL RULINGS

Trial Date: February 18, 2014

IT IS HEREBY STIPULATED AND AGREED, by all parties, by and through their respective counsel of record, to entry of the following trial evidentiary/procedural rulings.

1. Alan H. Rosenthal, M.D., Kathleen Sakamoto, M.D., and Mark H. Rothschild, M.D., will not be called to testify at trial; and

2. It is uncontested and agreed by all parties that Plaintiff's Diamond Blackfan Anemia not being diagnosed in the NICU by Defendants Martin Blahnick, M.D., and Ali Piroozi, M.D., was not below the standard of care. All parties agree that it will not be argued before the jury that Plaintiff's Diamond Blackfan Anemia should have been diagnosed in the NICU by Defendants Martin Blahnick, M.D., and Ali Piroozi, M.D.; however, Plaintiff specifically reserves the right to argue, among other things, that the standard of care did require Defendants Martin Blahnick and Ali Piroozi to recognize (1) that MayRose Hurst's anemia was not "due to prematurity"; (2) that there was an undiagnosed pathological cause for the anemia; and (3) that further investigation into the cause of MayRose's anemia was warranted by said Defendants; and

3. It is uncontested and agreed by all parties and their respective experts that MayRose Hurst did not require further hospitalization at the time of her discharge from the NICU. However, Plaintiffs reserve the right to argue that MayRose Hurst's hematocrit and hemoglobin were not stable at the time of discharge and were in fact on a downward decline which indicated MayRose's need for both (1) investigation into the cause of her ongoing anemia on either an inpatient or outpatient basis; as well as (2) instructions to MayRose's parents and pediatrician that she had ongoing anemia that would need to be closely followed to determine if she would continue to require transfusions on a weekly and/or bi-weekly basis as she had done from the date of her birth. All parties agree that Defendants Martin Blahnick, M.D., and Ali Piroozi, M.D., did not fall below the standard of care by discharging Plaintiff from the NICU on August 2, 2008; however, Plaintiffs reserve the right to argue that the method and manner of

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MayRose's discharge, including the discharge plan, instructions, orders, as well as the information given to the parents and/or pediatrician at the time of discharge was below the standard of care; and

4. Settling-Defendant Ralph Conti, M.D., is deceased and is therefore unavailable to testify at trial. All parties agree to the use of his deposition testimony at trial; and

5. All parties agree that lay witnesses will not provide opinion testimony regarding medical care and treatment; and

6. All parties agree to refrain from arguing the "golden rule"; and

7. All parties agree that any evidence or inference regarding the relative wealth and/or "for profit" status of either party is of no consequence to the underlying issues and must be barred; and

8. All parties agree that in order to promote judicial economy, it will be beneficial to all parties concerned if the Court and all counsel know in advance the sequence of witnesses to be called. This will allow all of the parties to adequately prepare their examinations of the witnesses and to have the pertinent file material at court. This procedure is within the discretion of the Court and will serve to enhance the trial judge's control over the orderly flow of evidence; and

9. All parties agree that evidence regarding other lawsuits filed against the defendants and/or other negligence ascribed to the defendants should be barred because such evidence would allow the jury to infer the defendants' propensity for negligence. Such reference is completely irrelevant to a final determination of the merits of this particular case; and

10. All parties agree that all non-party lay witnesses shall be barred from the courtroom prior to their testimony, with the exception of expert witnesses; and

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11. All parties agree that the parties and their counsel shall refrain from any reference to or insinuation about the parties' settlement negotiations; and

12. All parties agree there shall be no mentioning or examining witnesses directly or indirectly, regarding the existence of professional liability insurance covering defendants as said information is irrelevant and prejudicial; and

13. All parties agree that parties and their counsel are barred from eliciting testimony or examining any health care provider with regard to that provider's personal treatment preferences, because that information is irrelevant to the issue of the standard of care and would be prejudicial and misleading to the jury, unless appropriately laid foundation that such treatment is within the generally accepted standard of care; and

14. All parties agree that the parties and their experts shall be restricted to the standard of care applicable in the medical community in May 2008; and

15. All parties agree that parties are barred from presenting evidence or making argument about discovery disputes which took place before trial. Such evidence or argument would be wholly irrelevant to any issue raised in this case, are highly prejudicial, and should be barred; and

16. All parties agree that parties are barred from making any insinuation about or reference to counsel being from Chicago and Utah. Such information is completely irrelevant to a final determination of the merits of this particular case and would be prejudicial and misleading to the jury; and

17. All parties agree that parties and their counsel will not make any insinuation about or reference to the origins of Plaintiffs Tiffani Hurst and Brian Abbington's sexual relationship; and

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18. All parties agree that parties and their counsel will not make any insinuation about or reference to the incident at Toys 'R Us involving Plaintiff Tiffani Hurst and her child in the car; and

19. All parties agree that no evidence exists to support a claim of agency and/or vicarious liability against Defendant Sunrise Hospital and Medical Center for the conduct of Defendant Ralph Conti, M.D.

The parties represent that this Stipulation is a full and accurate representation of certain evidentiary/procedural agreements that they wish for this Court to enter as a binding order for the upcoming trial.

IT IS SO STIPULATED.

Respectfully submitted by:

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EXHIBIT M

DISTRICT COURT
CLARK COUNTY, NEVADA

* * * * * * * * * * * * * * *

TIFFANI HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST,

Plaintiffs,

V.

Case No.: A616728

Dept. No.: 24

SUNRISE HOSPITAL AND MEDICAL CENTER; MARTIN BLAHNIK, M.D.; ALI PIROOZI, M.D.; RALPH CONTI, M.D.; and FOOTHILLS PEDIATRICS, L.L.C.,

Defendants.

* * * * * * * * * * * * * * *

DEPOSITION OF MARCUS HERMANSEN, M.D.

Deposition taken at Regus, 1 Tara Boulevard, Suite 200, Nashua, New Hampshire, on Thursday, December 13, 2012, commencing at 1:46 p.m.

Court Reporter: Michele M. Allison, LCR, RPR, CRR
NH LCR No. 93 (RSA 310-A)

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Also Present: Martin Blahnik, M.D.

* * *

INDEX

WITNESS: Marcus Hermansen, M.D.

(Exhibits copied and appended to transcript.)

MARCUS HERMANSEN, M.D.,
having been duly sworn by Ms. Allison,
was deposed and testified as follows:

EXAMINATION

BY MR. COTTON:

Q. Would you please state your name.

A. Dr. Marcus Carl Hermansen.

Q. Okay. Dr. Hermansen, my name is John Cotton, and I'm representing Dr. Ali Piroozi in this lawsuit here. And to my right is Robert McBride. He's representing Dr. Martin Blahnik. To his right is Dr. Martin Blahnik.

A. Good.

Q. What's the nature of your current medical practice?

A. I'm a hospital-employed neonatologist.

Q. In terms of education do you have any residency or fellowship programs in pediatrics hematology?

A. No.

Q. Any residency in any form of hematology?

A. No.

Q. Okay. Any residency outside of neonatology?

A. My residency was in pediatrics; that was followed by a fellowship in neonatology, and that's

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all.
Q. Okay. Doctor, in looking at your curriculum vitae, and I won't go through the whole thing, the articles and the lectures that you listed in there, did any of them deal with anemia of prematurity?
A. I can't remember any that do. I don't think so. Maybe one snuck in, but I don't remember any.
Q. Did you have any articles or lectures that you've ever presented on the diagnosis of Diamond-Blackfan anemia?
A. Not specifically. That may have come up as a possible cause of newborn anemia, but the lecture would not have been on that topic exclusively.
Q. How many children in your career have you actually diagnosed as the, if you want to call it the first diagnosing doctor for a child with Diamond-Blackfan anemia?
A. I don't know. Either none or one. I really would be shocked if it were more than one, but I -- it could be one or none. I don't know.
I've been -- I've been doing newborn medicine for 30 years, and I can't remember diagnoses I made a year ago, let alone 30 years ago.
Q. Well, let me ask you this: Have you diagnosed a case of Diamond-Blackfan anemia in the

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last 10 years?
A. No.
Q. Have you diagnosed a case of Diamond-Blackfan anemia in the past 15 years going back to around '97, '98?
A. Two answers: One is I don't know, but secondly, I don't make the diagnosis. I may have had such patients. I think a hematologist makes that diagnosis. I don't think I ever have -- I've never had -- I may have had patients with it, and I may have had patients I've referred to hematologists who made that diagnosis.
I could practice for the next hundred years and have a handful of patients with that disease, but I'll never be the one to make that diagnosis.
Q. How many cases in the last 10 years or patients in the last 10 years have you treated and referred to a hematologist where the subsequent diagnosis was Diamond-Blackfan anemia?
A. Two answers: Number one, I have no way to know, and number two, it's probably a very small number.
Q. As you sit here today are you able to state that there's even been one in the last 10 years?
A. I have no way to know. I don't make the

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diagnosis.
Q. Doctor, are you in charge of a neonatal intensive care unit back in New Hampshire?
A. Yes.
Q. And what's the name of that unit?
A. Southern New Hampshire Medical Center.
Q. And what level unit is the NICU back there at Southern New Hampshire?
A. Three.
Q. How many patients are normally in your NICU unit on any given day?
A. Eight to ten.
Q. Have you in the past described your NICU unit as small?
A. Yes.
Q. Have you represented in various articles that you don't have adequate staff specialists in order to fill up all the spots for cardiology, endocrinology, things of that nature?
A. I don't understand your question.
Q. Did you write an article in the Hospitalist at any point in time?
A. Yes.
Q. Did you describe your unit and the lack of subspecialists at your institution in that article?

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A. I don't remember if I said that or not.
Q. Do you have a peds hematologist who is, if you will, attached to your department there?
A. I'm not sure how to answer that. I have access to him. I can be on the phone with him. I can send patients to him. We share institutional affiliations. And yet, I don't know how to answer your question.
Q. Okay. I'll get back to that. Doctor, other than the documents that you've set forth in your expert report of August 28th, 2012 have you reviewed any additional documents in arriving at your opinions or conclusions? And feel free to look at your report.
A. Yes, I have.
Q. Tell me what else you've reviewed in addition to the items set forth on page 1 of your report.
A. Again, a two-part answer. Part one, expert disclosures on behalf of both the plaintiff and two expert disclosures for defendants. So there were three expert disclosures altogether: One for the plaintiff, two for the defendants.
Part two is I've reviewed the medical literature.
Q. Any specific medical literature, articles that you feel is supportive of your position on the

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standard of care?
A. Yes. And I brought a -- a one-page summary that lists eight references.
Q. Maybe we -- if you could give that to the court reporter and have her mark that, and then we'll get a copy made for everyone, then.
A. So I made three copies. I'm going to keep one. I'll give one to the court reporter and one to the two attorneys who are in the room with me.
Q. That's fine.
MR. COTTON: And Ms. Reporter, if you could just mark that as Exhibit 1, please.
(Exhibit 1 was marked.)
Q. BY MR. COTTON: And Doctor, correct me if I'm wrong, Exhibit 1, you described that as a summary of the medical literature that you feel is supportive of your opinions?
A. It's supportive of one specific opinion.
Q. Which one is that?
A. Not all my opinions of which there aren't that many. But I made a statement in my report. It's about two or three sentences. And it is in conflict with defense experts' opinions. And I'll tell you my opinion -- and I'm going to read from my report. This is on page 2 near the bottom. There's a section

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called, "Failure to recognize and evaluate." And I'm going to the second bullet. It says, "Few newborns of 28 and 6/7th weeks' gestation with anemia of prematurity require one transfusion. Fewer yet requires a second transfusion."
Now, I have read defense experts that say something like these babies require eight to ten transfusions. That seems to be a pretty significant discrepancy. And Exhibit 1 supports me and says that the defense experts are wrong.
Q. And just for our later record purposes when we're all split up, which of the articles on there do you believe supports your position on that?
A. All eight. There's nothing to support what they say in the medical literature that I could find. Now, maybe they're going to be able to come up with something new, but I spent about two hours looking and came up with eight references and stopped.
Q. How many times have you acted as an expert in a medical malpractice case on the standard of care?
A. Well, I would suspect I've given approximately 600 depositions in my career and -- now, that's an interesting question, because most of the time my opinion comes down to causation issues but I still say something about standard of care. I still

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am asked, "How was the newborn care?" and I usually say it was good. So probably most of those times I commented on the standard of care, and most of those times I found it to be acceptable.
Q. Let me ask you this: How many times have you been specifically retained to testify against another neonatologist on the standard of care?
A. I never view myself as testifying for or against anyone.
Q. Well, I can assure you my clients are perceiving that you're testifying against them.
A. They may.
Q. How many times -- how many times have you been retained by a plaintiff suing a physician neonatologist to testify on behalf of the plaintiff in that action on the standard of care?
A. Where a neonatologist was a defendant? If I've given 600 depositions they've probably been a defendant in 5 percent. At most there would be 30. Probably less than that. Maybe 10 to 20 cases out of the 600. There are very few instances.
Q. You've actually given presentations to NICU organizations about the proliferation of litigation in your area, correct?
A. No. No.

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Q. You don't recall? You don't recall giving a presentation at Johns Hopkins?
A. No. I published an article for them reviewing some recent literature on medical malpractice issues. It's an Internet article that you probably can obtain. It's listed in my CV. It was not a lecture at Hopkins but it was a continuing education program for Hopkins on the Internet.
Q. On how many occasions have you acted as an expert witness in a case that's lodged in the State of Nevada other than this one?
A. Either one or two. I remember one, and it's possible there were two.
Q. Do you remember when the last one was before this one?
A. Well, again, I only remember one. It was with Mr. Nielson, and that was probably four or five years ago. Now, if I had a second one it was with the same attorney. I just don't remember if I've had one or two with him.
MS. CARMICHAEL: Dr. Hermansen, he's in Utah.
A. Oh, I'm sorry. He's in Utah.
Q. Oh. I was talking about Nevada.
A. Oh, in Nevada? I've never done a case in Nevada.

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Q. Oh, okay.
A. I've never done a case in Nevada.
Q. Let me ask you this: How many times have you acted as an expert witness for a plaintiff in a medical malpractice action against a doctor in New Hampshire?
A. None. That would be unethical.
Q. Why would that be unethical?
A. Those are easily recognized conflicts of interest. I know those people. I work with those people. They're either friends of mine or enemies of mine and there's a conflict of interest. There would be some bias in any testimony I gave either favorable or unfavorable, or at least the appearance of bias, and I won't put myself in that situation.
If I defend people -- if I defend people in New Hampshire I could be accused of bias. If I criticize them people would claim they're competition of mine, and I have bias, and I won't put myself in a conflict of interest.
Q. And you also have to see those people around the hospital, I take it?
A. Well, around the state. We're a pretty small state. There are three hospitals in the state with newborn intensive care units, so we know each other

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pretty well.
Q. Are the other units around the state larger than yours or smaller?
A. They're both larger.
Q. How much larger?
A. Oh, Dartmouth has commonly 20 to 30 babies, and Manchester, I don't know how many babies they run.
Q. Comparable to Dartmouth?
A. I really don't know. I would think they're in that range of about 20 babies, but that's a guess, and I don't like to guess.
Q. Doctor, you've been retained to provide opinions regarding compliance or noncompliance with the standard of care by my client, Dr. Ali Piroozi, correct?
A. Yes.
Q. Would you tell us what opinions you hold regarding Dr. Piroozi's compliance or noncompliance with the standard of care?
A. I think there were two issues. I think number one is, in the management of this baby there's no consideration to diagnose this other than anemia of prematurity once we got beyond the initial newborn illness.
Now, I accept for the first few weeks of life

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the child had other medical complications that may have accounted for some of the anemia, but when I move to the months of June and July, they consider this to be anemia of prematurity and nothing else, and I think that's negligence.
And number two, there was poor discharge planning.
Q. What factual basis do you have to believe that the only diagnosis that the doctors had for this child in June and July was anemia of prematurity?
A. It's odd that everything has a two-part answer, but, again, a two-part answer. Number one, the medical records; number two, their deposition testimony.
Q. When you say "deposition testimony," whose testimony are you talking about?
A. In my report I refer to the deposition testimony of Dr. Blahnik and Dr. Piroozi.
Q. And specifically in the medical records what items contained in there support your position that the only diagnosis for this child's problems was anemia of prematurity in June and July, up to August?
A. The progress notes and discharge summary.
Q. Okay. And what in the progress notes and discharge summary do you believe supports your

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position?
A. They make that diagnosis. And every time they're talking about anemia, that's the only diagnosis that you come across. There's no consideration of other problems. There's never a differential diagnosis. There's never any thought process that something else might be going on expressed.
Q. Is it your belief and understanding after you reviewed the records that the diagnosis of anemia of prematurity was an active diagnosis all the way up to August 2nd, 2008?
A. Well, now we move into the second issue. Clearly in the discharge summary they say that that was not the problem, that that problem ended -- well, they have that having ended on July 21, and that's confusing. Now we don't know what they're thinking from July 21 until discharge.
Q. The answer to my question is it's your understanding, then, that the -- as an active diagnosis that anemia of prematurity was no longer an active diagnosis after July 21, 2008?
A. I'm going to spend a minute to look at their progress notes after July 21.
Q. Take your time, Doctor. Don't feel like I'm

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rushing you.
A. Thank you. (Witness peruses documents.)
MS. WHITEHEAD: Bob and John, while we're sitting here waiting, do you want me to see if they can fax over Exhibit 1 to Esquire out there so you can take a look at it?
MR. COTTON: No. I don't have any more questions. Thank you, Jonquil.
MS. WHITEHEAD: Okay.
A. I don't see anything after July 21 where they were considering it to be a problem at all.
Q. Do you see anything before June 16th of 2008 that it was being listed as a problem?
A. Are you asking specifically anemia of prematurity?
Q. Yes, sir.
A. Yes. Yes, I do.
Q. Tell me where it was an active diagnosis for the child before June 16th, 2008.
A. On the neonatal discharge summary, page 3, it says that that was the diagnosis from May 15 to July 21.
Q. Are you critical of including anemia of prematurity as one of the differential diagnoses for this child during the time frames we're talking about?

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A. I don't know if we're talking about -- I don't know how to answer that. I think that there may have been a role somewhere in the conversation. But if you look at the total time frame, if it's on the differential diagnosis it's not at the top. It's well down the list.
Q. Well, are you able to rule out that it was not some --
(Videoconference malfunction.)
(Discussion held off the record.)
Q. BY MR. COTTON: Doctor, are you able to rule out that anemia of prematurity was not one of the appropriate diagnoses for this child from May 2008 until August at the time of her discharge?
A. No. I think it may have had some role in the child's condition.
Q. If I heard your testimony earlier, Doctor, I think you testified that you don't believe you personally have ever diagnosed Diamond-Blackfan anemia, correct?
A. I don't think that's my role. I don't think that that's the role of a neonatologist; therefore, I doubt if I have ever, and I doubt if I ever will.
Q. Okay.
A. That's not my job.

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Q. Let me ask you this: Are you personally familiar with any physical anomalies on presentation of a child that would be associated with Diamond-Blackfan anemia?
A. My recollection is that some of them may have some anomalies, but I'd have to look it up in the book to see how common they are and what they are. If I were considering the diagnosis I'd look it up in a book, and I'd know what they were.
Q. Okay. And I take it in rendering your opinions here and preparing for the deposition you've not done so?
A. Correct.
Q. Would you agree with me, Doctor, that Diamond-Blackfan anemia is a rare condition?
A. Yes.
Q. Would you agree that it occurs in about one out of every 150,000 U.S. births?
A. I don't know the number, but I have no reason to question that. That may be right.
Q. In terms of the transfusions for this -- well, let me ask you this first: Tell me what criticisms you have first of Dr. Piroozi in terms of the discharge.
A. I'm looking at my report where I summarize

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that. I think waiting one month for a CBC or -- was too long. I think that there's poor communication with the follow-up pediatrician. I think there were multiple errors in the discharge summary that would be misleading to a pediatrician. Those three facts.
Q. Tell me why waiting one month for a CBC was too long for this child.
A. This child was needing transfusions more frequently than that. It was highly predictable the child would be a candidate for a blood transfusion prior to one month after discharge or five weeks or maybe five-and-a-half weeks after the last transfusion.
This child needed four transfusions in June, three transfusions in July. The child's sent home making no red blood cells, almost none, and yet, they're gonna say, "Oh, you can go five weeks from your last transfusion before we check it again."
That's dangerous. I don't think anyone can look at that and think that that's a safe plan, not for a child who is getting three or four transfusions a month.
Q. What were the transfusions ordered for in May?
A. I'm assuming the ones in May were

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attributable to the severe illness the child had. I believe it was necrotizing enterocolitis that we can just call NEC. But the child was sick, needed surgery, critically ill.

I'm going to assume all those were attributable to -- and it was reasonable to attribute them to the extreme critical illness of the child. I have no problems with the month of May.

Q. So those four -- correct me if I'm wrong, Doctor, those four transfusions for this little girl were within the standard of care based upon the little child's presentation?

A. Absolutely. And there was no reason to think she had a blood disorder going into the month of June.

Q. And whether the child had anemia of prematurity or not, these would have been appropriate orders of transfusions?

A. Absolutely.

Q. What was the transfusion for on June 7th of 2008?

A. I don't understand your question. Are you asking what did -- why did they do it? What was their indication for it?

Q. Yes, sir.

A. Or now --

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Q. Yes, sir.

A. -- today what was it for? Those may be different --

Q. I want to know -- I want to know what your understanding is of why the doctors ordered a transfusion on June 7th, 2008.

A. Well, maybe -- it's odd. I've got daily progress notes. And I've got one from the 6th that says, "Stable hematocrit," and then I have one on June 8, but I don't have a progress note from June 7. So either --

Q. Let me ask you --

A. Either it didn't make its way into my chart or they didn't put one in the medical records that day.

Q. Let me ask you this, Doctor: I want you to assume for a moment that the transfusion on June 7th, 2008 was ordered responsive to clinical sepsis. If that was the case would you agree that that was within the standard of care to order a transfusion?

A. Marginal. Some people would say yes, and some people would say no. I'll give them the benefit of the doubt. If the child was septic at that time -- most people don't think that blood transfusions treat neonatal sepsis, but let's put that on the table.

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It's an unusual therapy for neonatal sepsis. At least we have to agree it's an unusual therapy for sepsis.

Q. Would you agree with me it's judgmental on the doctor's part?

A. I'll give them the benefit of the doubt and agree to that.

Q. It wouldn't necessarily be below the standard of care to treat clinical sepsis with transfusion, correct?

A. But let me take -- while I will agree with that, the problem is there's no note on the 6th or the 8th saying they thought they were treating sepsis. I don't see why -- where you're getting the thought the child was septic on the 7th, because they don't write that on either the 6th or the 8th.

MR. COTTON: And for purposes of the record I just want a notation, Ms. Court Reporter, of move to strike the last portion of his testimony as nonresponsive.

Q. Doctor, I want you to assume that the June 25th transfusion was ordered to rule out fungemia. Would that be an appropriate reason to order a transfusion under the standard of care?

A. No.

Q. Why not?

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A. Because you rule out a fungal infection by sending the blood to the lab and having them grow it for a fungus. It's a culture test. You don't transfuse the baby to rule out a fungal infection.

Q. Are you aware of the fact that that transfusion was ordered by Dr. Greg Miller and not by Dr. Piroozi and not by Dr. Blahnik?

A. I don't remember who ordered which ones.

Q. You're not going to hold these doctors responsible for orders issued by other physicians not a party to this suit, are you?

A. I'm not faulting anyone for their orders for any transfusion. I'm not faulting -- whoever ordered the one on the 25th, I have no faults with them ordering that transfusion. Nowhere in my report or in my opinions do I fault them for giving a transfusion for any indication they wanted. That's not part of what I'm here to say.

Q. Doctor, if the doctors ordered up transfusions to rule out a GI bleed, is that an appropriate order for a transfusion under the standard of care?

A. No.

Q. If the doctor orders a transfusion for a surgery, ostomy take-down, in this particular child is

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that an appropriate order under the standard of care?
A. Maybe. That's beyond my field of expertise. I would ask either a surgeon or an anesthesiologist about that. I don't know. That one might be.
Q. That's outside your bailiwick?
A. Well, surgical preparation. Preparing a baby for surgery and what kind of numbers they want, you should ask the surgeon or the anesthesiologist.
Q. In your level-three NICU unit do you folks, the neonatologists, do surgical ostomy take-downs?
A. No.
Q. So you refer those out to surgeons?
A. Yes.
Q. Okay. Doctor, when ordering a transfusion for a Broviac placement surgery, would it be an appropriate order under the standard of care for this child?
A. It could be. It could be.
Q. Are you able to -- now, Doctor, I've gone through, in essence, 11 different transfusions that were given to this child. Are you able to point us to any transfusion that was specifically ordered to, if you will, address a condition of anemia of prematurity?
A. Well, in the discharge summary under

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"Hematology" they say she received transfusions, and for a diagnosis they say it was for anemia of prematurity. They don't give any other reason. That's one place to look. We can look at --
Q. Give us, Doctor, if you could, give us the page on that.
A. That's the discharge summary, page 3.
Q. Do you have Bates stamp numbers on them?
A. No. I'm sorry.
Q. Okay. So it would be page 3 of the discharge summary, then?
A. Correct.
Q. Doctor, in your review of this entire chart of Sunrise Hospital did you ever conclude that there was a point in time when this child was suffering from profound anemia?
A. No. I wouldn't call it profound.
Q. How would you define profound anemia?
A. I don't have a strict number. I think it would be an extremely low number, usually associated with clinical symptoms of anemia. I don't have an exact cutoff. I'll give you a number today, and I might say something different a week from now, so I'm a little afraid to do that.
I don't carry a number with me. I don't use

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that term is what it comes down to. If I use it I use it rarely and inconsistently.
Q. I take it you wouldn't use it for this child's condition?
A. I don't think I ever applied that term to this case, and I think we know why.
Q. I'm asking you as you sit here today, you're not applying that term to this case as you sit here today, are you?
A. No. I think they avoided profound anemia until -- that's until the ultimate problem happened when the child came back after being home for a while. That was profound anemia. But we're not talking about that. We're talking in the newborn intensive care unit there was not profound anemia.
Q. So the first time that you can see any -- anything that would document a condition of profound anemia would have been while the child was under the care of Dr. Ralph Conti not under the care of Dr. Blahnik or Dr. Piroozi, correct?
A. Correct.
Q. Doctor, what's a retic count?
A. You mean retic?
Q. You say tomato; I say tomato. R-e-t-i-c.
A. I'll call it retic.

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Q. Okay.
A. Retics are --
Q. Retics are what I get up in Minnesota, so...
A. It's good. Retics are young immature partially developed but not yet fully developed red blood cells. You can look in a blood count and determine how many retics are present. There are two different ways it can be presented, both of which would be considered a retic count.
You can either look at what percent of all the red cells are retics and give it a percent. It might be one, two, three, four, five, something like that. Or you can say within a certain volume of blood, let's say a milliliter or a liter, how many retics are there? That number is going to be big. It's going to be in the hundreds or thousands or millions.
So a retic count can be either of those two. It turns out both are presented in this medical record. Both methods are used in this case.
Q. Is there a particular level of which a retic count is too low for a child endangering a child?
A. No, not the retic count by itself. Just as an isolated number it's not harmful.
Q. Can a retic count drop after a transfusion?

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A. Yes.
Q. How does that happen?
A. It usually doesn't happen after one single transfusion, but after multiple transfusions the body will be -- will turn off its own red cell production. It will more or less become dependent on the transfusions. So it's not going to make new red blood cells, and your retic count will fall after multiple transfusions.
Q. Doctor, in looking at this chart here did you see anything to indicate that there was any manifestation of a bone marrow failure?
A. That's beyond my field of expertise.
Q. Whose field of expertise would that be, in your opinion?
A. A hematologist.
Q. I take it being outside your area of expertise you're not able to answer that question?
A. Well, let's hear the question again and see if I can give it a shot.
Q. Did you see any manifestation -- in the record did you see any manifestations of bone marrow failure in this child while she was at Sunrise Hospital?
A. I don't know what's meant by "bone marrow

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failure," so I don't know how to answer that. I think that the child was not producing red cells. I think many people would say that's bone marrow failure.
Q. Tell you what -- tell me what in the record you have to support your position that the child was not producing red blood cells.
A. Here's another two-part answer: Number one, 11 transfusions. Eleven. That's a shockingly high number. And number two are the retic counts at the time of discharge. Whether you measure it by either of the two techniques, this baby's not producing red cells at the time of discharge.
So you have a baby with multiple transfusions -- and that should raise a few red flags to people. That really is of concern. And then you say, "Well, let's look and see if the baby is making cells," and you see virtually none. I think that tells us that there's a red cell production problem.
Q. Can it tell you anything else based on this presentation and this course of treatment?
A. No. I think that the only conclusion you can draw looking at this case is that at the time of discharge there should have been a concern that the baby was not making red cells.
Q. By the way, to address that concern is to ask

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the follow-up doctor to perform tests to make sure that there isn't a concern, correct?
A. Yes.
Q. And do you believe you have the right to rely upon the professionalism of a board-certified pediatrician when you refer a patient out of the NICU?
A. I think that it's -- it's still a team approach. I'm going to give that clinician good information and a good plan and then turn it over to them and let them run with the ball.
Q. Is it your position that once you've transferred the patient out of the NICU and into the hands of a pediatrician that you remain responsible for the day-to-day care of that patient?
A. I'm responsible if I've produced a bad plan for them to work with.
Q. If you produced what you perceived to be a good plan, do you believe that you're responsible for the ongoing care of that patient?
A. I need to produce a good plan and communicate it to the pediatrician, and then once they take over it's theirs. But I have to produce a good plan and make sure I've communicated that in some way to the pediatrician.
Q. And in -- that can be either verbally or in

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writing, correct, Doctor?
A. I think so. I think so.
Q. Unless you have some basis to believe that the physician you're referring it to will not be responsive to your written communication?
A. I need to communicate to the pediatrician. If they're not going to respond -- if I know they're not going to respond to the written then I need to find another way. I think it would be wrong to know that they're not responding to the written and just send them written communication anyway and assume that was good enough if I knew they weren't going to respond to it.
But basically the answer is, if I've come up with a good plan and get that plan into the pediatrician's functions, to get the pediatrician aware of the plan, agreeing to the plan and taking it over, I think the neonatologist is off the case at that point.
Q. Okay. And once you've done that and gotten the plan into the hands of the pediatrician, if subsequently the pediatrician decides to ignore portions of your plan but doesn't tell you, do you think you're responsible for that conduct?
A. Not if I've given him a good plan and

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communicated it. If I've done those then -- and -- no, I don't feel responsible if they go on their own route.

Q. Doctor, as you sit here today, I think I know the answer to this from what you said earlier, do you know what the treatment is for Diamond-Blackfan anemia on initial diagnosis?

A. No.

Q. That's a one-part no not a two-part no, right?

Doctor, are you able to tell us how prevalent a condition of anemia of prematurity is in an infant as ill as Mayrose was when she came into Sunrise?

A. Well, traditionally, we don't make that diagnosis on admission. That diagnosis would be made after they're through the acute problems. I think on admission what you would say is she has a very high risk of developing that problem in the subsequent weeks and months.

Q. And why is that?

A. There are many reasons for anemia of prematurity. Number one, they're growing very fast. So whatever red cell production they have going on, they're trying to make cells, but they're growing so fast they can't keep up with their body growth. If

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their body doubles in size the red cell production can't keep up with that growth. That's why.

Number two, there's frequent blood sampling taking place. Now, in the last 20 years we've taken steps to minimize that. There's a lot less blood drawing taking place. Here we've got this baby trying to grow and make blood, and then we try and take it from the baby to do a laboratory analysis. That's another reason for it.

Number three, they just have an immature system, and they don't make blood very well.

Q. Doctor, correct me if I'm wrong, I'm safe in assuming that you yourself have been a treating physician for infants, premature infants who have been diagnosed with anemia of prematurity?

A. Yes.

Q. And in that situation I'm assuming that in most instances you were able to normally discharge those patients, correct?

A. Yes.

Q. And have you in the past discharged patients on multivitamins plus iron who had suffered at some point from anemia of prematurity?

A. Yes. It's very common.

Q. Is that within the standard of care to

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prescribe that on an out -- outpatient basis?

A. Yes.

Q. Have you ever discharged a patient who you at some point diagnosed with anemia of prematurity with a hematocrit of 30 or less?

A. Yes.

Q. Was that below the standard of care to do so?

A. No. I have -- I have no criticisms about them discharging the baby when they did and in the condition that she was.

Q. When you've had a child with anemia of prematurity as a diagnosis during your care, have you ever recommended to the pediatrician that you were transferring care to to have blood tests taken post discharge?

A. Yes.

Q. Have you ever recommended that a transferring pediatrician follow up with retic counts on a patient that you were transferring out? Retic, I should say. Retic.

A. I think if I look at my career, in the middle part of it maybe -- I did a lot of retic counts, and we believed in them. We used them, and we followed them. And in the latter part of my career we don't -- we rarely check them. They really aren't very useful.

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So I don't even check them in the nursery very often anymore. I don't think I recommend it to pediatricians very often, if at all.

Now, maybe -- but your question was have I ever done it? I may have done that 10 or 20 years ago. Then I believed in them. I followed them. We thought we were using them. But we're just as well off without that test it turns out.

Q. What do you order now when you want them to have some follow-up blood testing?

A. Just a measurement of the red blood cells. Usually the hematocrit. Or you could get a CBC, which would include the hematocrit.

Q. When you discharge your NICU patients out to the pediatrician for follow-up care do you generally see those patients again?

A. No.

Q. When you discharge a patient out for care to a known pediatrician do you explain the discharge plan to the parents themselves?

A. Yes, absolutely.

Q. And that's the standard of care to do so?

A. I don't know.

Q. Do you believe that the standard requires you to explain the discharge plan to the parents?

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A. Parts of it, yes, but not all of it. There's some parts of the discharge plan for which I know they should be aware and other parts they probably don't have to be.

Q. In this specific case were there any parts of the discharge plan that you believe the parents should have been made aware of?

A. Yes.

Q. And specifically what portions?

A. Well, I'm -- on the discharge summary, it's the last page of the discharge summary -- my discharge summary is actually five pages long and it's the fifth page. And this has one section called "Plans." And it says the family's instructed to call the pediatrician for an appointment in three days. Yes, they have to be told that. That's appropriate to tell them that.

Additional appointments, that's number two, three -- one, two, three, and four. Yes, they should know what the other appointments are. That's good to tell them.

Feeding at discharge. Yes, I think they should know the feeding plan at discharge.

Pending results. The child requires a sweat chloride by three months of age. That's optional.

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You can either tell the family or tell the pediatrician.

The infant requires a head ultrasound at one month after discharge. That's optional. I'd like to tell the family, but if the pediatrician wants to, that's fine.

Follow-up tests: Sweat chloride, head ultrasound, CBC one month after discharge. Again, we said sweat test and head ultrasound were optional. I guess then we should say CBC is optional. A lot of people would like to tell the family that these tests needed to be done. Some people would let the pediatrician do that.

Discharge medication, yes, the family should know that.

Special instructions, when to come to the emergency room, yes, the family should be told that.

So these plans, the family should know most of these. I don't care if they know the follow-up testing or not.

Q. If, in fact, Dr. Piroozi verbally explained these plans to the parents and gave them a written copy of the plans, would that comply with the standard of care?

A. Well, that's a hard question. I'm not sure,

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because, obviously, you know how I feel about what's in these plans. I think the plans are not good.

Q. I'm aware of what --

A. I'm glad the doctor talked to the family. I'm glad the doctor gave them something in writing. That's all good. The problem is the plans themselves are bad.

Q. Okay. Without regard to that -- and I understand that's your opinion. The fact that he discussed the plan with them and gave them a written copy, that complies with the standard of care for communication, if you will, correct?

A. Yes.

Q. And if, in fact, he gave that -- sent and then was found in the file of Dr. Conti those plans and that the mother said she actually hand-delivered a set of those plans to Dr. Conti, that would comply with the standard of care in communicating the plan, whether you like the plan or not, communicating the plan to the pediatrician, correct?

A. Probably. Probably.

Q. Are you familiar with guidelines for transfusions for asymptomatic anemic infants put out by the Vermont Oxford Network?

A. I know there's such a document. I know I've

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seen it at one time, but I don't know what's in it.

Q. As you sit here today do you believe that those guidelines set the standard of care for physicians?

A. I don't know. I'd have to look at it. They might.

Q. So you don't know?

A. If somebody shows it to me I could answer that. I'd have to look at it.

Q. All right. Doctor, other than the opinions that you've got in your expert report of August 28th, 2012 and those you've shared with us today, do you hold any other opinions regarding Dr. Piroozi's compliance or noncompliance with the standard of care?

A. No.

Q. Okay. And finally, Doctor, do you have -- separate and apart from that notebook that I find to be too heavy to carry around, do you have separate notes that you've kept and articles that you've kept as part of your expert services here?

A. I received electronically the documents with the expert disclosures. I've made no notes on those. I haven't highlighted them electronically or tagged them electronically. They're just as clean as they came to me. So number two, I do have electronic

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disclosures, and number three are the eight articles that I've referred to. And that would be all that I have.

Q. Do you actually have sticky notes on pages on the records themselves?

A. About six of them.

Q. If you could just copy those pages with the sticky note and give them to Ms. Carmichael, then she can give those to us. Okay?

A. That's fine with me.

Q. Do you have the actual articles with you that are on that sheet there or just the sheet?

A. There are eight references. For two of them I have almost nothing. Those articles are back in the 19 -- one published in 1989 and one in '91. And I couldn't get easy access to them.

That leaves us with six. Of those six I have the full article, I think, for four, and I have the abstract for two.

Q. And do you have those with you today?

A. Yes.

Q. If you could give those to the court reporter. She'll make copies of them for us and then send you yours back with you when she sends the deposition for your review. All right?

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A. That's fine.

MR. COTTON: I think at this point, Doctor, that's all I've got. I think Mr. McBride may have some, and the hospital's counsel may have some, too. I don't know if anyone wants to take a five-minute break or what.

MR. MCBRIDE: Doctor, is it all right to take a five-minute break to use the restroom?

THE WITNESS: Anything is fine with me.

MR. MCBRIDE: Okay.

MR. COTTON: We'll be back, guys.

(Exhibits 2-6 were marked.)

(Recess taken.)

EXAMINATION

BY MR. MCBRIDE:

Q. Dr. Hermansen, my name is Robert McBride. I introduced myself before, or rather, Mr. Cotton introduced me. I represent Dr. Blahnik in this case, and Dr. Blahnik is here seated to my right. I just have a few questions for you, if I can.

Of the approximate 600 cases in which you've testified in a medical-legal action, you've testified that only 10 to 20 of those cases were on behalf of a plaintiff as a plaintiff's expert; is that correct?

A. No, not at all.

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Q. Okay. Could you explain that answer a little bit more? How many of the 600 depositions you've given have you testified on behalf of the plaintiff in a medical-malpractice action?

A. Ninety percent.

Q. Okay.

A. The 10 -- the small number was how many cases did I find that the neonatologist provided negligent or substandard care.

Q. Okay. In those other cases were you testifying against another specialty, another area of specialty, a physician?

A. I don't view myself as testifying for or against anyone.

Q. In what states have you testified as an expert other than Utah -- other than Utah?

A. Well, that's good. When we go through the states, if we went through them all, it's about 35 states, and with today's deposition we would now say it's about 36.

So I've never testified in Nevada before, but we're up around 36 states. Not much in New England, northern New England. In fact, maybe nothing in northern New England. That's Vermont, New Hampshire, and Maine. And relatively little in the west. West

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of the Mississippi much less.

For example, I don't think I've ever testified in Oregon, Montana, Idaho, Wyoming, Alaska, Hawaii, and Nevada before today. North Dakota -- no, I did one case in North Dakota, but South Dakota. So those are states I have not.

Q. Okay. And Doctor, approximately what percentage of your annual income is devoted to doing expert medical-legal work?

A. Twenty percent.

Q. And has that been the same over the past 35 years?

A. No.

Q. Okay. How much do you charge an hour for review of records?

A. $350.

Q. Do you have an estimate of the total amount of time you spent reviewing the records in this case?

A. Well, there have been three different periods of activity. When I first looked at the case, that would have been two or three hours. Then when I wrote my report in August of 2012 that would have been 10 to 15 hours, because I spent a lot of time on it including reading depositions and writing a good report, what I thought was good. I might be the only

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person that thought so. That was 10 to 15 hours. And then preparation for this deposition is the third time period, and that was probably between five to eight hours this week.

Q. And Doctor, what is your hourly -- what is your fee for testifying at trial?

A. It's $2,500 per half day. Now, if I came to Nevada to testify that's a two half-day trial period or $5,000. If I could convince people to let me do it by video we'd have it down to one half day.

Q. Is it your current intention to testify in person at trial, at the trial of this matter?

A. I've expressed my willingness to do that, yes.

Q. And Doctor, are there any documents which you've asked for from plaintiff's counsel which you have not been provided?

A. No. No.

Q. Have you asked -- have you asked if you have been provided with all of the medical records from Sunrise Hospital?

A. No. And that's a good question since just now today we came across one day's progress notes that I don't have, so there may be others. I didn't ask for more. I assumed I had all the medical records,

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but we found something missing today.

Q. Do you feel that you have reviewed all the materials you need in order to render your complete opinions here today?

A. Yes.

Q. Okay. Now, specifically with regard to Dr. Blahnik, if you can, in what -- what opinions have you formulated specifically about Dr. Blahnik and whether he met the standard of care?

A. There's a fail -- I'll read from my report. There's a failure to recognize and evaluate the pathological aspect of Mayrose's anemia. He didn't recognize that he had a pathological process going on.

Q. Okay. And Doctor, at what point in your opinions was the first point that Dr. Blahnik should have recognized the pathological diagnosis?

A. I didn't attempt to make that determination, and I -- I'm not sure it happens as a one point in time. I think it's -- it's a process that developed over time; that first it just sort of pops into your mind, and then you begin thinking about it and taking it more seriously, and then you come to the realization it really is a problem. But it doesn't happen at just one point in time.

Q. Okay. Yeah. With that in mind when was the

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earliest that Dr. Blahnik, in your opinion, should have recognized the pathological diagnosis?

A. I don't -- I don't think I can pinpoint any point in time. And it wasn't important to me to do that, because I'm saying collectively he could have done it any time during his involvement, and we would have been okay.

If he'd done it any time during the child's care, during his involvement in the care, whether it was in May or June or July, any time in there could have saved this baby. And so I don't know the first time he could have.

Q. All right. And as you sit here today you're not able to tell me any particular dates, as I see your testimony, that Dr. Blahnik should have recognized the pathological diagnosis; is that right?

A. Well, I can't put one date on it. I think by the end of June -- by the end of June most people would be thinking that we have pathology going on, because we -- we've gotten the baby through the early problems in May, and even in June we've given four more transfusions and things aren't getting any better, and there's no end in sight. I think it's time to realize that something's going on.

Now, when I say it that way I don't want to

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say, "Well, okay, so June 30 at 11:59 p.m. he better have the diagnosis." Maybe before then. Even if he makes it a week or two after that, end of July or any time in July would be okay. But I think most providers would know that something abnormal and pathologic was going on by the end of June.

Q. And, again, what is your medical basis for that opinion, Doctor?

A. The fact that this child has now received eight transfusions and the baby's only about, what, six weeks old? That should be of concern. That should raise some red flags and make people ask about the baby's ability to make blood.

Q. Is it your opinion, Doctor, that any of the transfusions that Mayrose received were required?

A. I -- I'm going to assume they all were required. I have no trouble with them having given any of these transfusions. I said that earlier.

Q. Okay.

A. I think that that's the reason we could avoid profound anemia it turns out. If you want to say, "Well, they were required to avoid profound anemia," that's -- that's valid. They were successful. It kept this child from going into heart failure and shock. So with that in mind you could say they all

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were required. They just didn't know what they were treating when they were giving those transfusions.
Q. And what makes you say that?
A. The medical record and the deposition testimony.
Q. Okay. And specifically in the medical record what makes you believe that Dr. Blahnik did not know what he was -- what he was treating?
A. His only notes talking about anemia talk about anemia of prematurity. There's no consideration, no thoughts of other conditions going on.
Q. Okay. When were those notes that -- when -- the dates of those notes that you're referring to?
A. Well, if we go through, we're going to find the same, whatever day he wrote notes, but let's go through some. Okay. He writes a note on June 5. He writes the note --
Q. Doctor, on June 5 -- let me interrupt you. On June 5 where does he say -- does he specifically say "anemia of prematurity"?
A. No.
Q. Okay. How do you -- how do you arrive at that conclusion, then, that Dr. Blahnik was referring to anemia of prematurity on June 5?

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A. I think you have to look collectively at the medical records and his depositions. You don't find him ever expressing any other consideration. In deposition on page 43, 44 he says subsequent transfusions after the first few days were, quote, typical and expected for a premature baby. He said these are typical and expected for prematurity.
Now, that's from his deposition. But from the record you don't find anything to contradict that. He has no --
Q. Doctor --
A. He has nothing in the record to say, "What's going on here? Why has this baby needed eight transfusions? Are we dealing with more than anemia of prematurity?" And in deposition he says, "We're dealing with anemia of prematurity." That's all.
Q. Doctor, I want you to find for me, if you can, continue on, where Dr. Blahnik specifically makes a notation that in his opinion this child was suffering anemia of prematurity and that there was no consideration for anything else.
A. I think we're twisting it. Maybe I'm at fault for this. The issue really is more important than did he say it's anemia of prematurity. It's more important, did he realize there was pathology? The

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question should be: Can you show us anywhere in here where he's considering a pathological process? That's even more important, and the answer is no.
Now, does he say it's anemia of prematurity? We can look. But what's more important is that he never considered a pathological process. That's more important. And that's what's not in here that we should be looking for.
Now I'll look for anemia of prematurity.
Q. Now, Doctor -- because, Doctor, I'm just using your words that you said to me just a little while ago. You testified that Dr. Blahnik only referred to this child's condition as anemia of prematurity. And I -- that's why I want you to find for me where he specifically identifies that.
A. On his deposition, page 43 and 40 -- 43 and 44, he says these transfusions were, quote, typical and expected for a premature newborn.
Q. Okay. Doctor, I'm asking you now -- I understand you're looking at the deposition. I want you to find it for me in the medical records.
A. (Witness peruses documents.) Well, here's where I run into a problem. He wrote -- he wrote the note on June 8, and he wrote the note on June 6th, but June 7 was a transfusion day, and we don't have that

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note, at least I don't have it.
So I would like to see the note from June 7th as for what the transfusion was -- his thoughts about that transfusion. I'm going to go ahead, but I do have to put in the disclaimer that I'd like to see June 7.
Q. And before today you have not asked plaintiff's counsel for a copy of that note; is that right?
A. That's right, because it's not important to me.
Q. Is it -- Doctor, is it important for you in your work as an expert to review all of the significant medical records on a patient?
A. I think it's important to look at everything that's sent to me.
Q. Okay. If you don't know what was in that note, assuming there was a note of June 7th, how do you know as you sit here whether it was significant or not?
A. I know the records that were sent to me, those don't show any consideration. And, again, from his testimony it's not like he said, "Everything was from prematurity except June 7th, and I knew on June 7th, that one day, something else was going on."

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I think it's reasonable to assume he didn't make the diagnosis of pathology -- or it's not a diagnosis, but the conclusion that there was pathology going on on June 7th. I think it's unreasonable to think he did even without seeing that note. I would be interested in seeing that note, though.

Here's a note that -- it's not his. I'm sorry.

Okay. I'm through the month of June, and I don't see where he's made a diagnosis for the child's anemia at all of anything. He has not declared this to be anemia of prematurity nor has he shown any concern about the problem, and we're at the end of June.

Q. And Doctor, why do you say that he doesn't seem to have any concern for this child's problems?

A. Well, I'm talking about the anemia. He hasn't expressed any concern about the anemia. Generally his notes just say, "Stable, stable, stable." If he --

Q. Would you disagree --

A. If he showed concern you should show it to me, because I'm missing it.

Q. Doctor, my question goes back to the original. I was just asking you for you to identify

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for me where you saw in the medical records where Dr. Blahnik had referred to it specifically as anemia of prematurity.

A. I'm now into July. I see he wrote the note on July 5th. Again, he doesn't put any label on the problem. He says the baby got a transfusion two days ago, but he doesn't have any comments about what was going on. He has note after note in July, but, again, he's not putting any label on the problem. No diagnosis. No differential diagnosis. Nothing.

I think I made it to the end of July. No. He never called it -- well, he never -- he never called it anything, did he? And that's the problem. There's no thought behind this.

Q. Okay. Doctor, he never called what anything?

A. The anemia and the frequent transfusions that the -- the anemia, the -- he calls it hematologic -- the hematologic problem.

Q. What problem? What anemia are you referring to?

A. The fact that this is a baby that had 11 transfusions, that anemia. Eleven. Most 28-weekers have zero. A lot of them have one. Very few have two. This baby had 11. That's a problem.

Q. Doctor, in your experience what are some of

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the reasons a very low-birth-weight child may need transfusions in a hospital in the NICU?

A. A single transfusion or 11? Because it's a different list. It's a different list.

Q. All right. I'm asking for all of the reasons why a transfusion might be required in a very low-birth-weight child in the NICU.

A. Again, I need clarification; otherwise, we'll be here for the rest of the afternoon. Are we talking about the first day of life? Are we talking -- because that's a whole different baby than the second month of life. Are we talking about just red cell transfusions? I mean, I -- I don't even know where to begin with that. It's too broad.

Q. Okay. You're not able to give me any of the reasons why a child might require a transfusion --

A. No.

Q. -- in the NICU?

A. No. I can give you too many is the problem. I want to know, are we talking about a child that requires one transfusion, because that's a list, or a child that requires 11 transfusions? That's a different list.

Q. Doctor, just give me as many reasons why a child might require a transfusion that you're aware

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of.

A. Did you say "a" transfusion? A single transfusion?

Q. Any reason for any transfusions. Give me all the reasons you're aware of, Doctor.

A. Are we talking about red cells or other types of transfusions?

Q. Let's talk about the transfusions that Mayrose received.

A. Well, she received red cells. She received plasmas. She received platelets. You've taken a big question and tripled it.

Q. Okay. Tell me, what were the reasons for those transfusions?

A. Well, okay, let's begin with platelets. You give platelets if the count is too low, dangerously low.

Q. Who did?

A. I don't know who ordered it. They were given early. We can look and see. If I can tell you when, then we'd look at the orders. She received platelets, I think, at around May 15 when she was first born.

Q. I'm sorry. Anything else, Doctor?

A. For the platelets? No. She got one platelet transfusion on May 15. I can't tell you right away

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who ordered it.
Q. Oh, I thought we were going through the reasons why those were ordered, why those transfusions were ordered?
A. The platelets on May 15 --
Q. Doctor, let's try to shortcut it. I'll try to make it as easy as I can. In your experience why have you given orders for transfusions for children in the NICU?
A. I don't remember having given a baby 11 transfusions of red cells in a NICU. I don't think that that applies to me.
Q. Doctor, forget the number. Forget 11 transfusions. Tell me the reasons why you've ordered any transfusions --
A. If the baby --
Q. -- for a baby.
A. If the baby has anemia that may be harmful I would give red cell transfusions to avoid --
Q. Okay.
A. -- complications of anemia.
Q. Okay. Anything else?
A. I'm not aware of any other indications for red cell transfusions.
Q. Any other reasons for any other kind of

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transfusions for a child in the NICU?
A. Sure. You give white cell transfusions for infections for sepsis. You give plasma sometimes for clotting factors. Sometimes to give volume into the baby you may give plasma. Platelets for low platelets. Red cells for anemia.
Q. How about for any surgeries?
A. Well, it fits into my answer, to prevent complications of anemia during the surgery. You don't do it just because you're having surgery, because if you have an adequate red cell mass in your body you wouldn't top it off with more red cells just because you're going for surgery. But if you have the potential of suffering harm from anemia during the surgery you could get red cells at that time.
Q. Anything else that you're aware of in your experience?
A. No. I think I gave a -- I think we've ultimately come up with a good answer. It's to prevent complications and harm from anemia. That's when you give red cells.
Q. Okay. Doctor, from your review of the records when was Dr. Blahnik's last involvement with this child?
A. In -- sometime in July. I don't know the

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exact day. The last day he wrote a progress note, at least. After that I don't know the degree he was interacting with the other providers. But clearly, we have his final progress note somewhere mid to late July.
Q. You didn't happen to review anywhere in his deposition of where he said his last involvement was?
A. I probably did. I just don't remember it.
Q. Okay. If I were to represent to you that the records reflect that Dr. Blahnik's last involvement with the child was on July 13th, 2008, would you have any reason to disagree with that?
A. No.
Q. Okay. And would you agree with me that Dr. Blahnik would not be responsible for what occurred with regard to Mayrose's care and treatment after that date?
A. I don't know. I don't have an opinion on that. I don't know how the group practiced and how much they interacted and what involvement he may have had with the others that doesn't show up in the records, so I don't know.
Q. Okay. And I want to represent to you: If, in fact, Dr. Blahnik had no involvement whatsoever with this child after July 13, 2008, would you agree

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that he would not be responsible for what occurred after that date?
A. Well, that's -- that's not so easy to agree to. I mean, he has perpetuated the idea that this baby does not have pathological anemia. He's missed the chance to make the diagnosis, so he's therefore somewhat responsible for that diagnosis not being present at the time of discharge.
Q. So, Doctor, is it your testimony that Dr. Blahnik is somehow responsible for the actions of other physicians after July 13, 2008?
A. That's not how I said it. I said he is somewhat responsible for there being no diagnosis and no consideration of a pathological process at the time of discharge.
Q. And, Doctor, at the time of your original opinions that you formulated in this case had you already learned that this child had been diagnosed with Diamond-Blackfan anemia?
A. I don't know. I'm looking. I have the original correspondence that came to me. Yes, I was it turns out. I'm looking at it. It's a letter from December of 2009, and in that one-page cover letter it says the child was later diagnosed with Diamond-Blackfan anemia.

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And as I recall there are some records in the back of my binder -- or are there? Maybe not. I'm not sure if I had records or not, but it is in the cover letter, so I knew it then.

Q. Doctor, you're referring to a cover letter you received from plaintiff's counsel when you initially received materials on this case?

A. Yes.

Q. Okay. If you could, what we'd like -- what I'd like to do is attach a copy of that as well as an exhibit to the deposition that's next in order.

(Exhibit 7 was marked.)

Q. BY MR. MCBRIDE: Doctor, did you happen to bring with you or do you have any e-mail correspondence that you've communicated with plaintiff's counsel regarding this case?

A. I looked to see what was there, and I actually looked through the e-mails and did a search. There were a half-dozen or dozen just about scheduling the deposition. "Where can we do it? Do you have Skype? Can we do it at 1:30? What day works for you?" Blah, blah, blah. And that's all the e-mails say so I didn't bother with them. But if you want the e-mails related to scheduling of this deposition I could produce those.

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Q. No. That's okay. Doctor, have you told me all of the opinions which you formulated in which you intend to offer at the time of trial in which you believe that Dr. Blahnik fell below the standard of care?

A. Yes.

Q. Okay. Doctor, can you tell me as you sit here in what ways Dr. Blahnik met the standard of care in your opinion in his treatment of this patient?

A. Well, we'll have to go through each note. Yeah. The truth is I can't do it easily, because I knew this was a case about anemia and I focused on anemia, so I don't really know how he managed things like nutrition, respiratory support, and the like.

I'm assuming he met the other standards of care. My assumption is everything other than relating to anemia was okay, but I guess we could look. We might find some other problems. I wasn't looking for them.

Q. Doctor, you said -- let me ask you -- refer you to your report. You said that a consultation by a hematologist -- this is on page 2 of your report. A consultation by a hematologist would have been helpful. Do you remember that?

A. Yes.

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Q. And at what point in your opinion was the earliest that Dr. Blahnik should have consulted with a hematologist?

A. Once he realized he had a pathological process. Now, in this case it appears he never came to that realization, so it's hard to expect him to get a hematologist involved.

Q. Okay. You say it would have been helpful, a consultation by a hematologist. Is it your opinion that Dr. Blahnik's failure to consult with a hematologist was below the standard of care?

A. No. If you keep reading that same paragraph I imply he does not have to do that consultation as long as he does it well himself.

MR. MCBRIDE: Okay. Doctor, I think that's all the questions I have right now. I might have some follow-ups later.

THE WITNESS: Thank you.

MS. WHITEHEAD: I have just a few questions, guys. Can you hear me okay?

MR. COTTON: Yeah, we can.

EXAMINATION

BY MS. WHITEHEAD:

Q. Okay. Dr. Hermansen, I was looking through your CV and I noticed that you'd given, I believe, a

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lecture for the New England fall Nursing Conference regarding anemia of prematurity.

A. I don't remember that lecture.

Q. It was quite some time ago back in November of 1998.

A. It's 14 years.

Q. Do you have any recollection of that conference or what you may have discussed?

A. No. I forgot that completely. I'm surprised it's in there.

Q. Have you ever given any other lectures on anemia of prematurity?

A. If so it would have been to medical students and residents just part of an educational program but not to any graduate education program or continuing education. Never as a guest speaker but maybe medical students or residents.

Q. Do you keep any slides or PowerPoint presentations for that purpose?

A. Not for 14 years.

Q. Okay.

A. I wouldn't have that from 14 years ago.

Q. Even for this -- the lectures you've just spoken of?

A. I haven't given that lecture for a long time.

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Q. Okay. I believe one of the opinions that we've gone through quite a bit this afternoon is that you believe, and correct me if I'm wrong, that Dr. Blahnik and Dr. Piroozi should have evaluated or determined the pathological process for Mayrose's anemia; is that correct?
A. The wording here I have to be very careful of. I'm not sure that they can actually make a definitive diagnosis, but they should have known there was pathology going on and taken steps in that direction.
Q. What specifically should Dr. Blahnik or Dr. Piroozi had done to evaluate Mayrose's anemia to determine it was a pathological process?
A. Oh, it's pathologic once you realize this baby had 11 blood transfusions. In fact, before then, I said by the end of June you should know it's pathologic just reviewing the medical records and looking at all the transfusions this baby needs. That should tell you you're dealing with the potential for pathology.
Q. So the amount of transfusions alone should have put them under that belief that this was pathological?
A. Yes.

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Q. So there's nothing else in Mayrose's chart that should have raised any red flags that it was something other than one of her other numerous problems?
A. Correct.
Q. Okay.
A. Well, let's back up. You do have the absence of retics at the time of discharge. That would reinforce your concern about the pathology.
Q. At the time of discharge?
A. At discharge. I'd be concerned about the retic in light of a child who's had 11 transfusions who has modest anemia at discharge and has almost no retic.
Q. Okay. So then the retic count at discharge and the number of transfusions --
A. Right.
Q. -- those two factors should have caused an evaluation as to the pathological cause?
A. Yes.
Q. And those two alone?
A. Yes.
Q. Okay. Have we covered based on your report and this deposition today all the opinions you have, I guess, of the defendants in this case?

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A. Yes.
MS. WHITEHEAD: Okay. I have no further questions.
MR. COTTON: I've just got a couple more questions, Doctor.

FURTHER EXAMINATION

BY MR. COTTON:
Q. I want you to exclude for a moment the 11 transfusions from your equation for just one moment. All right?
A. Yes.
Q. Excluding those 11 transfusions, in your review of the record, the chart here, were there any objective findings, labs, showing any concern of anemia?
A. Well, to a lesser degree are the absence of retics at the time of discharge. That would be the only other issue that might, and that's pretty soft compared to the transfusions, but you should mention that there are no retic at the time of discharge.
Q. Anything in the hematocrit values that would cause concern for anemia?
A. That's impossible to do what you're asking me. It's impossible to look at those hematocrit values and comment on them without realizing that

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they're acceptable only because of the transfusions. They were what they were, and they're good numbers, but that's only because of the transfusions.
You can't take the transfusions out of it. You can't say, "All of those blood count values were okay, so everything's okay." They're only okay because of 11 transfusions. You can't separate the two.
Q. Are you critical of Dr. Miller or Dr. Nager in ordering transfusions on this child?
A. I have said -- now, this is the third time. I'm not going to criticize any of the transfusions that were given. I have no criticisms for transfusions. I'm going to assume that they had a valid medical indication.
Q. Okay. Doctor, do you advertise your services as an expert witness in any publications or by any expert services?
A. No.
Q. Do you have any idea how the plaintiffs here came to find you in the woods of New Hampshire?
A. Yes.
Q. How?
A. Attorney Carmichael told me that she got my name from the other attorney in Salt Lake City with

whom I acknowledged earlier today. Dr. Nielson --
Q. Okay.
A. -- provided my name.
MR. COTTON: Okay. Thank you. That's all I've got. Thanks a lot, Doctor.
MS. WHITEHEAD: No questions, Doctor. Thank you.
MR. COTTON: Dr. Hermansen, you have the right to read and review your transcript for errors if you would like to do so.
THE WITNESS: I'm okay with it. I'll pass.
MR. COTTON: Thank you.
(Discussion held off the record.)
MR. COTTON: This is John Cotton. I'll take a mini and an E-tran.
MR. MCBRIDE: Robert McBride. I would like a regular copy, a mini, and an E-tran as well.
MS. WHITEHEAD: Just a regular and an E-tran.
MS. CARMICHAEL: Regular and an E-tran.
(At 3:30 p.m. the deposition concluded.)
* * *

CERTIFICATE OF WITNESS

I, MARCUS HERMANSEN, M.D., do hereby swear/affirm that I have read the foregoing transcript of my testimony, and further certify that it is a true and accurate record of my testimony (with the exception of the corrections listed below):

Page Line Correction

MARCUS HERMANSEN, M.D.

Subscribed and sworn to before me this day of 2013.

Notary Public/Justice of the Peace
My commission expires

CERTIFICATE

I, Michele M. Allison, a Licensed Court Reporter, Registered Professional Reporter and Certified Realtime Reporter, N.H. Notary Public, do hereby certify that the foregoing is a true and accurate transcript of my stenotype notes of the deposition of MARCUS HERMANSEN, M.D., who was duly sworn, taken at the place and on the date hereinbefore set forth.

I further certify that I am neither attorney nor counsel for, nor related to or employed by any of the parties in the action to which this deposition was taken, and further that I am not a relative or employee of any attorney or counsel employed in this case, nor am I financially interested in this action.

THE FOREGOING CERTIFICATION OF THIS TRANSCRIPT DOES NOT APPLY TO ANY REPRODUCTION OF THE SAME BY ANY MEANS UNLESS UNDER THE DIRECT CONTROL AND/OR DIRECTION OF THE CERTIFYING REPORTER.

Michele M. Allison, LCR, RPR, CRR
N.H. Licensed Court Reporter
No. 93 (RSA 310-A)

EXHIBIT N

JOHNS HOPKINS
MEDICINE

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John J. Strouse, M.D., Ph.D.
Shirley Reddoch, M.D.
William H. Zinkham, M.D
Emily Barron-Casella, Ph.D.
Patricia Underland, R.N., M.S., C.P.N.P.
Phillip Seaman, PA-C
Kim Winship, LCSW-C
Yolanda M. Fortenberry, Ph.D

August 30, 2012

Jacquelynn D. Carmichael
Eisenberg, Gilchrist & Cutt
215 South State Street, Suite 900
Salt Lake City, Utah 84111

Re: MayRose Hurst
DOB: 5/14/08

Dear Ms. Carmichael

This letter is to provide my expert opinion as to the etiology and interventions that may have prevented MaryRose Hurst's severe brain injury. My opinion is based on my education, training, experience, and knowledge as well as my review of MayRose Hurst's medical records.

My qualifications as an expert witness include my education, training and expertise in the field of pediatric hematology and stroke. I obtained my medical degree from Johns Hopkins University School of Medicine and then completed a combined residency in Internal Medicine and Pediatrics at the University of Rochester. I then completed training in Adult Hematology at the National Institutes of Health and Pediatric Hematology/Oncology in Johns Hopkins University/National Institutes of Health Program. I have active board certification in Pediatrics, Pediatric Hematology/Oncology, and Adult Hematology. I am currently an Assistant Professor of Pediatrics and Medicine at Johns Hopkins University School of Medicine and care for neonates and children with hematologic disorders at Bloomberg Children's Hospital and in the associated outpatient facilities of Johns Hopkins Hospital. I have a clinical and research interest in stroke in children and have published extensively on this topic.

I have reviewed copies of the following medical records of MayRose Hurst:
1. Sunrise Hospital: MayRose's birth and stay in the NICU 5-14-2008 to 8-2-2008-physican notes, laboratory testing, and summaries
2. Foothills Pediatrics: 8-5-2008 to 10-24-2008
3. Summerlin Hospital 10-29-2008 to 11-30-2008-physician notes, laboratory testing, and summaries
4. Denver Children's Hospital 12-1-2008 to 12-15-2008-summaries and physician notes.

You are already familiar with the details of MaryRose's medical history. Additional details relevant to her anemia include nuchal lucency identified on prenatal ultrasound with normal chromosomal analysis, a family history of alpha thalassemia, and anemia at birth with borderline macrocytosis (large red blood cells). MaryRose had multiple transfusions of red blood cells during her initial hospitalization, which was unusual even in light of her complications including her need for surgery, multiple infections and significant inflammation. MayRose's anemia at birth was not "anemia of prematurity." Unfortunately, during MayRose's stay in the NICU her anemia was not evaluated, nor was her family history of thalassemia or the fact of her nuchal lucency taken into consideration.

At the time of her discharge, it was recommended that she have follow-up laboratory testing including a complete blood count and differential and reticulocyte a month after her discharge. This was not done and she was admitted to Summerlin Hospital nearly 3 months after her discharge from the NICU with apnea and poor oxygenation with profound anemia and influenza B infection. It is my expert opinion with a reasonable degree of medical certainty that her profound anemia was a major contributor to her brain injury. This is based on the severity of her anemia and the watershed distribution of her brain injury. The episode of profound anemia could have been prevented if her anemia had been properly evaluated while she was in the NICU. If this had occurred, it would have been discovered that MayRose's anemia was not due to prematurity and required, at a minimum, follow-up with more frequent laboratory testing (complete blood count and reticulocyte count) until such time as a determination as to the cause of her anemia could be made. Similarly, the episode of profound anemia could also have been prevented if the complete blood count that was recommended at 1 month had been obtained, because, with a reasonable degree of medical certainty, she would have been anemic one month after discharge given her hematocrit of 30% on 8/1/12 and a typical rate of decrease in the hematocrit of ~9% per month.

Sincerely,

John Strouse, MD, PhD

John Strouse, MD, PhD
Assistant Professor of Pediatrics and Medicine

EXHIBIT O

DEPOSITION OF
RALPH CONTI, M.D.

Hurst, et al. v. Sunrise Hospital and Medical Center, et al.
Case No. A-10-616728-C
June 19, 2012

CONDENSED TRANSCRIPT AND KEY WORD INDEX

TURNER REPORTING & CAPTIONING SERVICES, INC.
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DISTRICT COURT
CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST,

Plaintiffs,

vs.

Case No. A10616728C
Dept.No. XXIV

SUNRISE HOSPITAL AND MEDICAL CENTER, LLC; MARTIN BLAHNIK, M.D.; ALI PIROOZI, M.D.; RALPH CONTI, M.D.; and FOOTHILLS PEDIATRICS, LLC,

Defendants.

DEPOSITION OF RALPH CONTI, M.D.
Taken on Tuesday, June 19, 2012
At 2:12 p.m.
At 3441 South Eastern Avenue, Suite 401
Las Vegas, Nevada

Reported By: Karen J. Berry, RMR, CCR 836

APPEARANCES:
For the Plaintiffs: JACQUELYNN D. CARMICHAEL, ESQ.
EISENBERG & GILCHRIST
215 South State Street
Suite 900
Salt Lake City, Utah 84111
For Defendant Sunrise Hospital: JONQUIL L. URDAZ, ESQ.
HALL, PRANGLE & SCHOOLVELD
777 North Rainbow Boulevard
Suite 225
Las Vegas, Nevada 89107
For Defendants Blahnik and Piroozi: CHRISTOPHER G. RIGLER, ESQ.
JOSEPH H. COTTON & ASSOCIATES
2300 West Sahara Avenue
Suite 420
Las Vegas, Nevada 89102
For Defendants Conti and Foothills Pediatrics: PATRICIA EGAN DAEHNKE, ESQ.
BONNE BRIDGES MUELLER O'KEEFE & NICHOLS
3441 South Eastern Avenue
Suite 402
Las Vegas, Nevada 89169

Also present: TIFFANI D. HURST
BRIAN ABBINGTON
Videographer: Patti Lucchesi
Certified Legal Videography

EXAMINATION

EXHIBITS

THE VIDEOGRAPHER: This begins the deposition of Ralph Conti, M.D. Today's date is June 19, 2012. The time is 2:12 p.m. We are at Bonne Bridges Mueller O'Keefe and Nichols, 3414 South Eastern Avenue, Suite 402, Las Vegas, Nevada, 89169.

This case is in the District Court, Clark County, Nevada, entitled Tiffani D. Hurst and Brian Abbington, jointly and on behalf of their minor child, MayRose Lili-Abbington Hurst, versus Sunrise Hospital and Medical Center, Case Number A-10-616728-C.

I'm Patti Lucchesi representing Certified Legal Videography. The court reporter is Karen Berry on behalf of Turner Reporting and Captioning.

Will counsel please identify yourselves for voice identification, then the reporter will administer the oath.

MS. CARMICHAEL: Jackie Carmichael on behalf of the plaintiffs.

MR. RIGLER: Christopher Rigler on behalf of defendants Blahnik and Piroozi.

MS. DAEHNKE: Patricia Daehnke for Doctor Conti.

MS. URDAZ: Jonquil Urdaz for Sunrise Hospital.

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Thereupon--
RALPH CONTI, M.D.
was called as a witness by the Plaintiffs and, having been first duly sworn, testified as follows:
EXAMINATION
BY MS. CARMICHAEL:
Q Will you please state your full name and your address for the record?
A Ralph Conti. Spell it?
Q Sure.
A R-a-l-p-h, C-o-n-t-i. And home address?
Q Yes.
A 1675 Tangiers Drive, T-a-n-g-i-e-r-s, in Henderson, Nevada, 89012.
Q Thank you. Doctor Conti, have you had your deposition taken prior to today?
A Yes.
Q On how many occasions?
A I don't recall.
Q What were the circumstances of those depositions?
A Many, many different circumstances. I've been asked to testify for families. If they're having a legal problem against the police, against various businesses, I've had to testify. I've given my

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deposition for malpractice cases in the past.
Q As an expert or as a treater?
A As a treater.
Q Okay. Have you ever given testimony as an expert witness?
A I believe some of them, yes, have asked me to testify as an expert.
Q So you were a retained expert, an attorney retained you to give expert testimony in a case?
A Yes.
Q Okay, on how many occasions have you testified as an expert?
A I don't recall.
Q It's okay if you don't have a precise number, but can you give me a ballpark?
A Five to ten.
Q Okay. And do you remember what the issues were in any of those cases that you testified as an expert?
A One was a case of Munchausens by proxy. One was a case of a bruise on a child.
This is just the ones that come to mind.
Q Okay. When was the most recent occasion that you testified as an expert witness?
A I don't recall.

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Q Within the last five years?
A Perhaps.
Q And in the five to ten occasions that you testified as an expert witness, were you testifying on behalf of the plaintiff or the defendant?
A I think sometimes on behalf of the plaintiff, sometimes on behalf of the defendant.
Q Okay. Do you recall any of the attorneys that hired you?
A Breen Arntz.
Q Excuse me?
A Breen Arntz, A-r-n-z, is I believe how he spells it.
Q Okay. Any others?
A I don't recall any other attorney names besides Breen.
Q Were there other attorneys, or were you his expert on each occasion?
A I believe there were other attorneys.
Q Have you ever given a deposition as a party to a lawsuit?
A Yes.
Q And tell me about that.
A Three different times.
Q Okay.

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A The first one was a child with encephalitis, with viral encephalitis. The second was a child with a bowel obstruction. And the third was regarding a circumcision.
Q And these were instances where you were, where allegations of malpractice were made against you?
A Correct.
Q Okay. And what was the outcome of the case concerning the child with viral encephalitis?
A I believe it was settled.
Q Okay. And how long ago was that?
A I believe it was 2001.
Q Do you recall the plaintiff's attorney in that case?
A No.
Q Do you recall the name of the party suing you?
A I think it was Howard.
Q Okay. And who represented you in that case?
A I believe Breen Arntz was my lawyer back then.
Q Mr. Arntz?
A Yes.
Q Okay. What about the bowel obstruction

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case, what was the outcome of that case?
A That was also settled.
Q And do you recall the year?
A It was around 2002, I believe.
Q And did Mr. Arntz also represent you in that action?
A I think so.
Q And do you recall the name of the plaintiff in that case?
A No.
Q And then with regard to the last occasion, the circumcision case, what was the resolution of that matter?
A That also settled out.
Q In what year?
A It was about 2002 or three.
Q And who represented you in that case?
A I don't remember.
Q Do you remember the name of the plaintiff?
A I do remember. Wait. It was Bonnie Bulla, I believe was her name.
Q Bonnie Bulla?
A I think that was her name.
Q Do you recall the name of the plaintiff in that case?

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A Baby's first name was Jared. And I don't remember the last name.
Q Jerry?
A Jared, J-a-r-e-d. I don't remember the name.
Q In the viral encephalitis case, was that a failure to diagnose allegation? What was the allegation in that?
A I think so. I don't recall.
Q Do you recall what the allegation was in the bowel obstruction case?
A I think it was the same thing. I think they, you know, I think it was failure to diagnose.
Q What about in the circumcision case?
A The parents didn't like the result.
Q Okay. Why?
A They didn't like the way it looked, I guess.
Q So it was simply a matter of aesthetics?
MS. DAEHNKE: Well, I object to the form of the question. Might lack foundation, call for speculation, and other interesting things.
You can answer if you can.
THE WITNESS: I believe so. Just didn't like the way it looked, so.
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BY MS. CARMICHAEL:
Q Okay. All right. Okay. What did you review in preparation for your deposition today?
A I reviewed the chart.
Q Foothills chart?
A Yes.
Q Did you review anything else?
A Today what did I review?
Q Doesn't have to be confined to today. Just what have you reviewed in preparation for your deposition?
A I can't remember all the papers I've looked through regarding this case.
Q Well, other than the chart, what categories of papers have you reviewed?
A What categories of papers? I'm not sure if I understand.
Q Well, you're telling me you can't remember everything. What can you remember? What have you looked at in preparation for your deposition?
A There's a big notebook, there's a couple of big notebooks that are that thick.
Q Filled with what?
A Papers.
Q Medical records?

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A Some of --
MS. DAEHNKE: You know, counsel, I'll represent that the binders have copies of, photocopies of the chart. And I also made photocopies of the discovery responses. That's what's in the binders.
BY MS. CARMICHAEL:
Q All right. So you've reviewed some discovery responses?
A Yes.
Q Okay. Have you reviewed any depositions, deposition transcripts?
A I believe so.
Q Have you read the depositions given by Tiffani and Brian -- Tiffani Hurst and Brian Abbington?
A I believe I read Tiffani's.
Q Okay. Did you read Doctor Weber's deposition?
A Yes, I believe I read Doctor Weber's.
Q How about the depositions given by Doctor Blahnik or Doctor Piroozi, have you read those?
A I don't recall anything specific about them, but I believe I looked at them, yes.
Q And what have you brought with you today?
A This is my chart.

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Q That's the original chart?
A Yes.
Q Maintained at your office?
A Yes.
Q For MayRose Hurst?
A Yes.
Q Okay. And what dates of treatment does that span?
A Let's see. Let's see, the first progress note is from July 22 of '09. And the last one is August 5 of '08.
Wait. I'm sorry. The opposite. August 5 of '08 would be the first note, and then July 22 of '09 would be the last note.
Q Okay. All right. Other than counsel, who have you spoken with regarding the claims in this lawsuit?
A My counsel. That's pretty much it.
Q Have you talked with Kathleen Weber about her deposition?
A Not specifically about her deposition. I just, I remember the day that she did it, but I don't believe that I've talked to her about this deposition specifically.
Q You didn't ask her how her deposition went,

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or any details about her deposition?
A No.
Q Have you discussed the allegations in this lawsuit with Doctor Weber?
A Early on, we had mentioned it.
Q What do you -- tell me what you discussed with her.
A I don't recall exactly what we talked about. I said, "Do you remember MayRose?" And, you know, that we're being sued on her. So that was about it. That's all I recall.
Q What do you recall Doctor Weber telling you?
A I don't remember.
Q You don't remember anything she told you?
A Not really, no. Not specifically.
Q Have you spoken with any of the other defendants regarding the claims in this lawsuit?
A I remember speaking to Doctor Malixi. I don't remember like any of the specifics of what that conversation entailed. I don't recall.
Q Do you remember anything about the conversation you had with Doctor Malixi?
A Not much. I remember her being concerned that she had never been sued before. So she was just really broken up about it.

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Q And what did you tell her?
A I don't recall. I think I just said, you know, it's -- I don't recall.
MS. DAEHNKE: You're pounding your...
THE WITNESS: Oh, sorry.
BY MS. CARMICHAEL:
Q Have you ever spoken with Doctor Piroozi about the claims in this case?
A No.
Q Have you ever spoken with Doctor Blahnik about the claims in the case?
A No.
Q Do you know Doctor Piroozi or Doctor Blahnik?
A I believe I've spoken to them on the phone at various times, but I don't, I've never formally met them, no.
Q Okay. And on those occasions when you spoke to them over the phone, was it ever regarding MayRose Hurst?
A No.
(Plaintiffs' Exhibit A marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Conti, I'm handing you what will be

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Exhibit A to your deposition.
A Yes.
Q And I'll represent to you that this is a document that was provided to me by your counsel.
A Uh-huh.
Q As representing your curriculum vitae, is this document current and up to date?
A I believe it only goes up to, up to -- yeah, that seems, seems pretty accurate.
Q Okay.
A Uh-huh.
Q Are there any achievements or work experience that would need to be added to this to bring it current, or does this represent a current...
A It's pretty current.
Q Okay. All right. Let me ask you then, on your board certification, it indicates that you recertified in 1998. Is that correct?
A That's correct.
Q And are you due for another recertification?
A Yes. Yes.
Q When did that become due?
A It's due this year.
Q This year?
A Uh-huh.

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Q And do you plan to do that?
A Yes.
Q Okay. On your work experience, it indicates that you were working at Green Valley Pediatrics before Foothills Pediatrics?
A Correct.
Q Do you see that?
A Yes.
Q And you were the managing partner at that practice. Is that correct?
A Yes, that's correct.
Q Can you tell me why you changed practices, or how that came to be that you moved from Green Valley Pediatrics to Foothill?
A We just became a very big group, and I wanted to do something smaller at the time. It was a long time ago.
Q So you just left, you left Green Valley?
A Yes.
Q And you formed Foothill Pediatrics?
A Yes.
Q Okay. Do you have any publications? Have you ever published?
A Yes, I was published on a vaccine study.
Q When was that?

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A About 2003, maybe, 2004. Somewhere around there.
Q And what was the study about?
A Rotavirus vaccine.
Q Any other publications?
A Another one on what they call ProQuad, which is a combination of chicken pox and MMR.
Q Another vaccine study?
A Yeah.
Q Okay, and when was that published?
A Around the same time.
Q Anything else?
A I think that's mostly it.
Q Okay. So Foothill Pediatrics, LLC, does that organization continue today?
A I don't think so. I think it's been changed.
Q It's been changed?
A Yeah, I don't think the LLC exists anymore. I think it's an LLLC, or something like that. I don't understand all that.
Q When was that change made?
A Let's see, early this year, I believe, in January.
Q Okay, what is the new entity's name?

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A I believe it's still called Foothill Pediatrics, LLLC, I think is what it's called.
Q Why was the name changed?
A Because we wanted to make Doctor Garcia head of the group.
Q Doctor Garcia?
A Yes, correct.
Q So is Doctor Garcia now the managing partner?
A Yes.
Q What's Doctor Garcia's first name?
A Claudia.
Q So you have essentially stepped down then as managing partner?
A Correct.
Q And that was effective the first of this year?
A Around there.
Q And the old entity, what has become of it?
A I don't know.
Q We were informed at some point that there was a bankruptcy proceeding. Is it in bankruptcy?
A No. No longer.
Q Was it discharged?
A Yes.

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Q Who are the -- are there any other managing members of the new entity other than Doctor Garcia?
A I don't believe so. Just myself.
Q You're also a managing partner?
A I don't know exactly what my title is. Am I managing partner? I don't know.
Q Okay, well, what was the purpose of the reorganization?
A So that Doctor Garcia could be the main purpose -- could be the main person doing the contracting.
Q Okay. And how many physicians are currently employed by Foothill, by the new entity?
A One, two, three, four -- six, I believe. Six.
Q Does that include yourself?
A Yes.
Q And Doctor Garcia as well?
A Yes.
Q Is Doctor Weber still there?
A Yes.
Q And Doctor Malixi?
A Doctor Malixi is in retirement.
Q Here in Las Vegas?
A She lives here part of the time, and she's

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in the Philippines a lot.
Q Okay. So who then are the other physicians besides Doctor Weber, Doctor Garcia, and yourself?
A Doctor Mendoza, Doctor Faro, and Doctor Hyla.
Q What was the last one?
A Hyla, H-y-l-a.
Q Okay. So I've got paperwork from the Secretary of State for Nevada that indicates the business license of the old entity expired February 29. I assume that that license was not renewed to that entity? Is that true?
A I don't believe so.
Q Okay. And you're now doing business under a business license for the new entity?
A I believe so, yes.
Q Where do you currently hold hospital privileges?
A St. Rose Siena, and St. Rose -- and San Martin.
Q San Martin?
A Yeah.
Q Any other hospitals?
A I have my privileges on hold at several other hospitals.

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Q Let's talk about Sunrise. Has Sunrise placed your privileges on hold?
A Yes.
Q And why was that?
A Because of my indictment in the --
MS. DAEHNKE: To the extent that answer calls for him to assert his Fifth Amendment, I have to object.
MS. CARMICHAEL: Well, I think he can say why the hospital placed his privileges on hold. I mean we're not going to get into any details of your criminal indictment.
MS. DAEHNKE: I think he said as much as, based upon the advice of his criminal counsel and me, he said as much as he can about that.
BY MS. CARMICHAEL:
Q You have been criminally indicted. Is that correct?
A Yes.
Q Are your hospital privileges also on hold at Summerlin?
A Yes.
Q Are there any other hospitals in the area where you held privileges and in which they have been placed on hold?

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A Yes.
Q What other hospitals?
A Centennial Hospital, Southern Hills Hospital, Valley Hospital.
Q But none of those hospitals have -- well, have any of those hospitals terminated your privileges?
A None of the ones that I listed, no.
Q Huh?
A No.
Q Have you ever, during your medical career, had your hospital privileges terminated by a hospital?
A Once at Spring Valley Hospital. Just this year.
Q And why were your hospital privileges terminated at Spring Valley Hospital?
MS. DAEHNKE: I would object to the extent that it calls for anything regarding implication of his Fifth Amendment right, which he's asserting and which counsel and I discussed prior to the start of this deposition.
BY MS. CARMICHAEL:
Q And if you want to assert that Fifth Amendment right, it's, you're well within your right to do so, but you'll need to assert it.

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A Okay. Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Okay. Prior to -- well, let's see. Back in 2008.
A Yes.
Q Did you have a contractual relationship with Sunrise Hospital?
A Contractual relationship?
Q A business relationship with them. Did you have some kind of a business relationship with Sunrise?
A No.
Q Okay.
A I don't think so.
Q Have you ever signed a contract with Sunrise Hospital?
A I don't think so. Just, just privileges.
Q Okay. Back in 2008, you did provide pediatric care to newborn babies born at Sunrise Hospital?
A Yes.
Q Is it true?
A Yes, I did.
Q Okay. And why don't you explain to me a

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little bit about how that would work?
I assume that anybody that had a doctor/patient relationship with you and for whom you provided pediatric services, when that party would go into the hospital to deliver, you would be notified and you would provide pediatric care to that child? Would you do that?
A Yeah, we would call the hospital in the morning. And if we have any, do we have any new babies there to see. And if they say yes, we go over to the hospital and see the new babies.
Q Okay. And would some of those babies be, belong to families with whom you had not yet established --
A Yes.
Q -- a pediatric relationship with?
A Yes.
Q Okay. And I assume that the hope then would be that they would want to continue with your practice --
A Sure.
Q -- once the child was released from the hospital?
A Yes.
Q Okay. And in attending to those babies, I

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assume you had occasion to work with babies born prematurely?
A Yes. But in general, babies born prematurely would go to the NICU, and you wouldn't work with them.
Q You would not work with premature babies?
A No. I mean not until they got out of the hospital.
Q All right. With regard to the babies you would work with, however --
A Yes.
Q -- whether that baby was going to follow with you or follow with another pediatrician, would you make sure that there was a pediatrician on board to follow that child after they were released?
MS. DAEHNKE: Object to the form of the question.
MR. RIGLER: Join.
THE WITNESS: I don't understand the question.
BY MS. CARMICHAEL:
Q In caring for babies at the hospital, while they're still at the hospital.
A Right.
Q Right. Would one of the things that you would do be to make sure that they were set up to follow with a pediatrician after they were released?
A Yes, I mean you would write follow up with Foothills Pediatrics by this particular date.
Q Okay. All right. When I took the deposition of Doctor Weber, one of the things she said on page 20 of her deposition is that when she was attending to babies at the hospital, she would also send the discharge notes and the admission notes to the attending pediatrician that the parents chose for the baby. Is that something that you would do?
A Send the discharge notes and the -- not ordinarily, no.
Q You would not do that?
A I don't -- I mean if it's something that needed to be signed out to another doctor, I would call the other doctor and let them know if there was some specific issue that needed to be raised with, with the child.
Q So we've talked about the three occasions you've been sued for medical malpractice. Is that right?
A Yes.
Q Have there been any other occasions other than this action?

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A I believe that's it.
Q Okay. And other than the criminal indictment that's been mentioned, have you ever been charged with a crime?
MS. DAEHNKE: I do not know what the doctor is thinking. Can we take a break? Because I need to, if it's something that's protected.
MS. CARMICHAEL: Sure.
THE VIDEOGRAPHER: Off the record at 2:44 p.m.
(A short break was taken.)
THE VIDEOGRAPHER: We're back on the record. This marks the beginning of tape number two. It's 2:54 p.m.
BY MS. CARMICHAEL:
Q Doctor Conti, there was a question pending when you asked for a recess.
MS. CARMICHAEL: (To the reporter:) Would you please repeat the question?
(The last question was read back.)
MS. DAEHNKE: And I'm going to object to that question and instruct the doctor not to answer on the grounds of relevance, privacy, and privilege.
MS. CARMICHAEL: Okay, criminal crimes are relevant because it goes to credibility. They're

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discoverable, and they're admissible. Criminal convictions are admissible.
MS. DAEHNKE: That wasn't your question. You could -- well, that wasn't your question. I have the same objection.
BY MS. CARMICHAEL:
Q Other than the criminal indictment that we're aware of, Doctor Conti, have you been convicted of any crimes in your past?
MS. DAEHNKE: And I would object on privilege, privacy, and relevance. If you want to ask him if he's been convicted of any felonies, you're entitled to that.
BY MS. CARMICHAEL:
Q Have you been convicted of any felonies?
A No.
MS. CARMICHAEL: And, you know, I am entitled to know if he's been convicted of misdemeanors as well.
MS. DAEHNKE: You, if you would like --
MS. CARMICHAEL: It may not be admissible at court, but it is discoverable.
MS. DAEHNKE: I disagree with you, and I'm instructing him not to answer on the grounds of privilege, privacy, and relevance.

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MS. CARMICHAEL: Okay. All right.
BY MS. CARMICHAEL:
Q Do you still have an ownership interest in the Foothill practice?
A Yes.
Q And what is your ownership interest?
A I don't know. What is my ownership interest?
Q Yes.
A I, I'm a part owner of the practice.
Q Excuse me?
A I'm a part owner in the practice.
Q I understand that. How much? What part do you own? What is your interest?
A I, I don't know.
Q You don't know --
A No.
Q -- what the terms of your ownership interest are with your partner?
A No.
Q Are there any other owners besides you and Doctor --
A Garcia.
Q -- Garcia?
A No.

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Q But you're telling me today that you don't know what the split is between you and Doctor Garcia?
A No, we haven't worked out any details on that yet, at all.
Q Okay. Have you been convicted of any crimes involving moral turpitude or dishonesty?
A No. What's -- I don't know what moral turpitude is.
Q Well, maybe you should discuss it with your attorney and she can tell you --
MS. DAEHNKE: The answer was no. He said no.
MS. CARMICHAEL: And then he said he doesn't know what moral turpitude is.
MS. DAEHNKE: Well, do you want to define moral turpitude for him?
MS. CARMICHAEL: I thought I would leave that to his lawyer to do. I'm not going to define --
MS. DAEHNKE: Well, his lawyer already object -- well, you asked the question, counsel. You and your client asked the question. So he's a doctor. We got a lot of lawyers in here.
MS. CARMICHAEL: Okay. I'm entitled to know if he's been convicted of any crimes involving moral turpitude. And so if you're comfortable with his

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answer, then that can stand.
MS. DAEHNKE: Well, I, counsel, you asked the question. I instructed him. We could spend all day here, if you like, on this question. He said no. And I've instructed him. And I do not think that you're entitled to anything other than conviction of a felony.
BY MS. CARMICHAEL:
Q With regard to your current criminal indictment, what are, what have you been charged with? What are the charges?
MS. DAEHNKE: And I'm going to object. And the doctor has already asserted his Fifth Amendment privilege.
THE WITNESS: Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
BY MS. CARMICHAEL:
Q So you're declining to even tell me what the charges are?
A Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Okay. At what stage are the criminal proceedings at this point?

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A Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Do you know whether your case is going to go to trial?
A Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Have you thus far been offered any plea negotiations?
A Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Going back to the care that you provide to babies while they're in the hospital, have you ever cared for a premature baby that's not in the NICU? They were just born prematurely but they're not in the NICU?
A Yes.
Q And I want to read you some of Doctor Weber's testimony and just ask you if you agree or disagree.
A Okay.
Q I asked her on page 19 of her deposition, "And what, if anything, did you learn regarding

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concerns that would be specific to caring for premature babies following their discharge from the hospital?"
She answered, "That's a very broad question, but I'll answer it the best I can. All of them need follow-up. That's the first thing."
Do you agree with that?
A Yes.
Q She goes on to say, "So we would contact or make sure the parents have a pediatrician that they're ready to see. And if they don't, you get them connected to one."
Do you agree with that?
A Yes, we try and follow them ourselves.
Q Okay. And she goes on to say, "And that the pediatrician is aware and can accept the patient."
Do you agree with that? Is that something you would do?
MS. DAEHNKE: Object to form.
But if you can answer, go ahead.
THE WITNESS: Can you rephrase that?
BY MS. CARMICHAEL:
Q So what she's getting at here, I believe, is that in the instance when they're not going to go with your practice, that they're going to go with a

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different pediatrician, do you make sure that pediatrician is aware of the child and can accept the patient?
A If there's a specific concern regarding the patient. But if there was, they probably wouldn't be being followed by a general pediatrician. Probably would be a neo baby, a NICU baby.
Q Okay. I'm just repeating what she said --
A Okay.
Q -- she would do, or did.
Okay, she goes on to say, "If they can accept the patient, then we usually send the discharge notes or any admission notes to the attending pediatrician the parents choose for the baby."
Do you agree or disagree with that? Is that something you would do?
MS. DAEHNKE: I would object to the form. It's argumentative. It's compound. Possibly takes it out of context.
But if you can answer, go ahead.
THE WITNESS: So you're asking if, if they're not going to follow with somebody in our group, that they're going to go to somebody else, would I Xerox the discharge summary and send it to the other doctor? Typically, no.

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BY MS. CARMICHAEL:
Q Okay. Thank you.
Moving now to your office practice, your clinical practice --
A Yes.
Q -- how many premature babies have become your patients over the years?
A I have no idea. Over the course of 22 years, I don't know, maybe -- you want like a number?
Q A ballpark. Obviously, you don't know precisely.
A Say 300, 400.
Q Okay. In providing pediatric care to a premature infant, a baby that was born prematurely.
A Yes.
Q Do you believe it's important to know what occurred during the neonatal course?
A Yes.
Q Is it important to know what problems or medical conditions the infant experienced while in the NICU?
A Neos get about, there's about seven or eight problems, and they almost all have all of them.
Q Okay. Now if you could answer my question. Do you believe it's important to know what problems or

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medical conditions the infant experienced while in the NICU?
A Of course.
Q Okay. How do you go about finding out what problems or medical conditions the infant experienced while in the NICU?
A Usually, I just ask the parent. I mean it's fairly obvious.
Q You believe that the parents have the medical sophistication and knowledge to be able to explain to you completely and fully what medical problems and issues their child had in the NICU?
A Most parents, yes. I mean after their babies graduated from NICU, usually the parents take the crash course in neonatal medicine. And they're aware of what's going on. And they're usually very good historians.
Q Do you believe it is important to know and understand what medical issues continue to require follow-up after the baby's release from the hospital?
A Yes.
Q And how do you find out what those issues are?
A Again, typically, if there's a, sometimes the parents come in with a summary. Sometimes the

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NICU has called me and let me know there are certain specific issues. A lot of times, you don't have either one of those. And so, you know, the parent is a pretty accurate historian and, and that's how you do it.
Q So if the NICU doesn't call you regarding a premature infant that becomes your patient, and if the parents don't bring you a discharge summary, is it your testimony today that you would then just solely rely upon the parents' report regarding the problems that the infant had in the NICU and the problems that need following up?
A Yes, I could get enough information from the parent.
Q Do you think it is important to know about abnormal test results that the child had during the neonatal course?
A Yes.
Q And how do you find out about those abnormal test results?
A Either the NICU tells me, or it comes from a summary, or the parent lets me know.
Q So if the NICU doesn't call you, and the parents don't come with a discharge summary, you would expect parents to be able to recall and tell you

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accurately about abnormal test results their child had while in the NICU?
A Yes.
Q What do you do to educate yourself regarding your patient's neonatal course?
A What do I do -- can you rephrase that question?
Q Yeah, what do you do? What affirmative steps do you take to educate yourself regarding your patient's neonatal course?
A I, again, if there's specific concerns that were raised by the NICU doctor, if there's a summary, or if, you know, I can ask the parent questions.
Q Okay.
A Was the baby on parenteral fluid? Were they intubated? Were they on a ventilator? How long were they on the ventilator for? What's the most oxygen the baby required? Do they want us to follow up with ophthalmology? What was the state of the eyes? What's the state of the GS? What are the feeds right now? Is the baby pooping? Is the baby peeing? Was there a brain bleed?
Q These are questions though that you are asking the parents?
A Yes.

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Q Is that right?
A Yes.
Q Do you call the NICU doctor and ask him those questions?
A If there's a question, sometimes, yes.
Q Sometimes yes?
A If there's a question, if I can't understand it, or if there's something that went on that was very unusual, I would ask the NICU doctor. But that would be very rare.
Q Well, and the only way you would know whether or not something unusual went on without speaking to the NICU doctor is if the parents accurately convey that information to you. Right?
A Correct.
Q Okay. How in the world do you know if you're getting all of the facts and all of the information from the parents regarding the neonatal course?
MS. DAEHNKE: Object to the form and the tone.
But you can certainly answer.
THE WITNESS: How I do know? Because most parents are very accurate. They are. They, they learn a great deal about neonatal medicine while the

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baby is in the hospital. And they come out knowing a lot. And I have faith in my parents. I believe them.
BY MS. CARMICHAEL:
Q Is it your experience, Doctor Conti, that oftentimes, if not all of the time, the hospitals that care for premature babies in the NICU will send -- that then become your patient -- will send the discharge notes to your office? They'll copy you on those?
A Repeat that question. I'm sorry.
MS. CARMICHAEL: (To the reporter:) Will you read it back, please?
MS. DAEHNKE: Then I'll object to form and argumentative and vague and ambiguous.
(The last question was read back.)
THE WITNESS: Yes, oftentimes.
BY MS. CARMICHAEL:
Q That's pretty standard practice, isn't it?
A Yeah, oftentimes they will, they will send a discharge summary.
Q Okay. And what is your office protocol when that summary is received? What happens with that summary?
A It gets copied and put on the baby's chart.
Q By whom?

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A By Medical Records.
Q Okay. Do they notify you that the discharge summary arrived?
A No.
Q Okay. So then how do you learn, how do you come to know when a discharge summary has arrived in your office?
A You look in the chart. And if it's there, it's there. If it's not, it's not.
Q Okay. So when you review the chart and find these discharge summaries copied and placed into them, do you read them?
A Yes.
Q And in your experience, do parents -- well, I think you already testified that in your experience, parents will oftentimes bring you a copy of the discharge summary --
A Yes.
Q -- as well?
A Sometimes they do. Correct.
Q And when they do, do you read them?
A Yes, usually we, we copy them. And usually I leave the original to, to the parent, and use that copy and put it in the chart. And we read it right then.

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Q What about the prenatal course? Do you think it is important to know what occurred during that timeframe as well?
A Sure. If it's relevant.
Q Would it likewise be important to know about abnormal test results during the prenatal period?
A It depends on the test result. I mean, you know, there's lots of abnormal results that can come out that would be completely irrelevant to taking care of the baby.
Q Okay. If the birth mother was consulting with a perinatologist during the prenatal course, would it be important for you to know what condition the perinatologist who was treating them was concerned about?
A Sometimes, yes.
Q Did you receive any education or training regarding the clinical significance of an abnormal nuchal translucency or nuchal fold on ultrasound during the prenatal period?
A That's usually a sign for Down's Syndrome.
Q And other than MayRose, are you aware of ever caring for any other infant who had an abnormal nuchal translucency or nuchal fold on ultrasound prior to delivery?

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A I believe it was mentioned from time to time.
Q During your medical training and education, did you receive any training regarding the diagnosis and treatment of rare blood disorders?
A Yes.
Q What did that training consist of?
A I believe when I was a resident, we did rotations in hematology oncology.
Q Okay. And did you receive education or training with respect to how to differentiate between anemia due to prematurity and anemia caused by a specific blood disorder or genetic defect?
A Yes.
Q And what did that training consist of?
A Again, as, you know, part of your residency, you do a, you know, rotation or two in hematology oncology, and sometimes it comes up during that.
Q So how do, what do you do to differentiate between anemia during to prematurity and anemia caused by a specific blood disorder?
A You know, the diagnosis of anemia, you first look at the size of the red cells. They're either small, normal, or large.
If they're too small, you think about iron

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deficiency, you think about sideroblastic, you think about lead poisoning, you think about anemia of chronic disease.

If they're large, you think about B12 and folate deficiency.

If they're normal, you, you look at a retic count and you see if they're hemolyzing or if they're not.

I mean the diagnose -- you know, there's a thousand things that cause anemia. So.

Q And when you say small, normal, or large, you're talking about microcytic, normocytic, and macrocytic.

A Correct.

Q Correct?

A That's correct.

Q Okay. And I believe you said that -- well, we'll come back to that in a minute.

Okay. So I assume you've also then received education and training and understand how to differentiate between amenia that's the result of an iron deficiency and amenia that has nothing to do with an iron deficiency?

MS. DAEHNKE: Object to form.

You can answer if you can.

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THE WITNESS: I, I know how to diagnose anemia of iron deficiency. Is that the question?

BY MS. CARMICHAEL:

Q You would be able to determine, you know how to tell whether anemia is being caused by an iron deficiency?

A Yes.

Q Okay. All right. Other than MayRose, have you ever cared for an infant, to your knowledge, who had anemia as a result of a genetic defect or a specific blood disorder?

A I have a couple kids who have hereditary spherocytosis.

Q Did you diagnose that?

A No.

Q They came to you with that diagnosis?

A Correct.

Q Prior to MayRose, were you aware of a condition known as Diamond-Blackfan anemia?

A Yes, I've heard of it before.

Q What, what did you know about that disease?

A It's called pure red cell aplasia. It's usually -- what do I know about Diamond-Blackfan anemia is your question?

Q Yes.

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A Okay. It's called pure red blood cell aplasia. It's associated with absent radii, absent thumbs, limb defects. It's very rare. It goes under the category of normocytic anemias with a low retic count. What they call the production anemias.

Q Okay. Okay. Switching gears. Do you recall when you first met Tiffani Hurst?

A Yes, when she had her first baby Tristin.

Q And you remember caring for Tristin?

A Yes.

Q Do you have an independent memory of MayRose?

A Yes.

Q Did you or anyone from your office ever show up to see MayRose while in the NICU?

A No.

Q Why not?

A Because that typically wouldn't be the practice. That wouldn't be standard practice. Usually they're being taken care of by the NICU until, until the time they're discharged from the NICU, and then I would see the baby.

Q Okay. Do you recall any phone calls from Ms. Hurst while MayRose was in the NICU asking you to become involved in her care?

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A I have no memory of that, no.

Q Did you ever speak with Doctor Blahnik or Doctor Piroozi or any physician at Sunrise Hospital regarding MayRose Hurst prior to her discharge?

A I don't recall speaking to one of the doctors regarding MayRose, MayRose prior to discharge, no.

Q How about following her discharge?

A Following her discharge, yes, I met her in the office.

Q No, how about following her discharge, did you speak with Doctor Blahnik or Piroozi or any physician at Sunrise Hospital who had cared for her in the NICU?

A No, I do not believe so. I have no recollection of that.

Q Why would you -- why not? Why didn't you contact them?

A Because she seemed like a typical preemie.

Q So there -- okay. What do you mean by a typical preemie? What is a typical preemie to you?

A She had one of the, she had a couple of the conditions that preemies usually have a lot of times.

Q Such as?

A NEC, N-E-C. And that's what I remember

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primarily about her history, that she had NEC.
Q What is your understanding of MayRose's neonatal course?
A I've learned a lot, of course, since, since this case began, and before that, you know, after she got sick, you know. At the time, I learned what was important about it.
Q Okay, and realizing it may be difficult for you, but I want you to try to distinguish between what you know now and what you knew then. And I'm asking you specifically when MayRose started treating with you as her pediatrician, what was your understanding at that point of her neonatal course?
A Again, the thing that stands out the most to me is that she had developed necrotizing enterocolitis. And that was the most significant thing about her medical history.
Q And what was your understanding of her condition upon discharge from Sunrise?
A She was still of a low birth weight -- she was still of a low weight. So we were going to have to grow her.
And I remember, you know, I remember the thing about the NEC.
And I remember there was some question about

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her, her brain. And so at a later visit, we got an MRI of her brain.
That was the main things I remembered about her.
Q Okay.
A At the time.
Q And were you aware of, besides the MRI and the NEC, were you aware of any other medical issues that needed specific follow-up care on?
A I remember them asking me about cystic fibrosis. There was some question of cystic fibrosis based on her course, which I thought was unusual, because it's very rare in African Americans. So.
Q Anything else?
A Well, now I know about the anemia.
Q But you did not know about the anemia at the time?
A I have no specific, I don't remember whether I, whether or not I dealt with the anemia specifically. No, I mean it's very, almost all preemies, when they come out of the NICU, have the diagnosis of anemia. Most of them have received transfusions. It's just a typical part of the history.
Q And do you know as you sit here today

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whether or not you were aware that MayRose had received transfusions during her stay in the NICU?
A I believe the mom had mentioned it, yes.
Q So this information that you obtained about the NEC, the question about her brain, the cystic fibrosis, the anemia, the transfusions, how did you learn that information?
A I, I believe that the, that Tiffani, her mom, told me those things right at the time of when I met the baby.
Q Okay. Given this information that Tiffani provided to you, did you feel that it would be beneficial to review the discharge summary for MayRose, to find out specifically what the NICU physicians were recommending as far as follow-up?
A I've dealt with babies like that many, many, many times before. And I didn't feel any specific need at that point in time that, that a summary needed to be reviewed. I mean, you know, I've seen, you know, 500 kids like MayRose before and had no trouble dealing with them.
Q You've seen 500 kids with an undiagnosis -- undiagnosed case of Diamond-Blackfan anemia?
A No. Preemies.
Q Do you have any knowledge regarding Tiffani

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Hurst's hospital course before MayRose was delivered?
A Regarding the mother's hospital course?
Q Right.
A No. I, I don't recall. I know it was a difficult pregnancy.
Q Did you have any knowledge of what treatments or medications she and the baby received prior to delivery?
A I have no specific memory.
Q Did you know if MayRose was a vaginal birth or a C-section delivery?
A I believe she was a C-section, but I do not remember.
Q Were you, did you know of any medications that were administered to try to stop the labor?
A No, that would be, typically, when they try and stop labor they would use terbutaline. But that's really not very relevant.
Q Did you have an understanding as to why MayRose was delivered prematurely?
A Happens all the time. I mean like, you know, typically, there is no reason. I mean.
Q Okay. Anecdotal responses aside, in this specific instance, did you have an understanding as to why MayRose was delivered prematurely?

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A I don't think I, did I specifically know why MayRose was -- I mean almost never do you find out why the baby was delivered prematurely. I mean premature births happen all the time. I mean usually there is not a specific reason.

Q So the answer is no, you did not know why MayRose was delivered prematurely?

MS. DAEHNKE: The answer is what he said.

Doctor, if you want to look at your chart, or if you need to clarify the answer for counsel, given that you're not an OB.

THE WITNESS: I mean this is typically not something that we would deal with. As a general pediatrician, you wouldn't.

BY MS. CARMICHAEL:

Q What, if you know, what would be the clinical significance of delivery at 28 and a half weeks for the child? What are the biggest concerns at that point?

A The biggest concerns would be lung maturity. You know. The need for surfactin. Brain bleed, by far more that would be way up there. Did the baby have a PDA? Was there an infection that was treated? That's where the NEC comes in.

Almost all of them during the course of

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anemia hospitalization, particularly a 28-weeker, is going to develop anemia at some point. And almost always it's from the frequent blood draws.

So, you know, anemia is like pretty much the diagnosis of I would say virtually every 28-weeker who's ever been born. Usually requiring frequent transfusions. Or multiple transfusions, I should say.

Q Okay. What do Apgar scores tell you?

A Very little. An Apgar score is kind of an outdated, you know, it stands for appearance, respiration, grimace, activity, and reflex. So I mean it's sort of a gross approximation of what a baby's brain is doing at the time. Like their condition when they're born at one minute, and then at five minutes, and then again at ten minutes. But they have very little import on care anymore.

Q Okay. All right. Did you ever know what MayRose's Apgars were?

A I don't recall specifically, no.

Q Okay. With regard to hematocrit, do you know what the normal range for a premature infant is?

A It depends on the age at gestation.

Q Okay. So what would the normal hematocrit be, what would be the normal range be for a 28-and-a-half-week-old?

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A I do not know specifically.

Q And I think you've indicated that there are lots of different reasons for anemia. Is that true?

A Yes. But a preemie, there's primarily one.

Q And what is that?

A That would be blood loss anemia from the frequent blood draws.

Q Frequent blood draws to, to do CBC's?

A To monitor CBC, electrolytes, blood gases.

Q Okay. Did you ever review any of MayRose's neonatal lab results during the time she was your patient?

A I don't recall. I don't believe so, no.

Q Now, what is your understanding -- or what was your understanding when MayRose became your patient as to the status of her anemia at the time of her discharge from Sunrise?

A I don't recall. I believe -- I remember Tiffani mentioning that the baby had, had had anemia and required some transfusions.

Q Okay. Did you do anything to follow up on that to see if the baby was still anemic?

A You do what you need to do. You know. You give every baby the tests that they need, and you do nothing more.

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Q Did you do anything to follow up on MayRose's anemia to see if she was still anemic?

A You examine the baby. And I would examine MayRose, and on every patient you kind of do this to the eyes and you can see if they're anemic or not.

Q You can tell --

A Every baby.

Q You can tell --

A Absolutely.

Q -- on a baby by looking in their eyes if they are anemic?

A By looking at the conjunctiva of the eyes, yes, you can.

Q And was MayRose anemic?

A No.

Q What is your understanding, or what was your understanding, when MayRose became your patient, with regard to her reticulocyte count at the time of her discharge from Sunrise?

A I don't remember what her reticulocyte count was at the time of discharge.

Q You didn't know. You had no idea what the reticulocyte count was at the time of discharge, did you?

MS. DAEHNKE: Object to form. Are you

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asking what he knows now, what he knew then?
MS. CARMICHAEL: I'm talking about what he knew then, when she became his patient.
MS. DAEHNKE: That wasn't your question.
THE WITNESS: The reticulocyte count is not something you're typically going to look at on preemies who come out of the NICU. I mean.
BY MS. CARMICHAEL:
Q Unless, of course, they had an issue with their reticulocyte count. Right?
A Perhaps.
Q And if they had a very low reticulocyte count that basically demonstrated they weren't making any reticulocytes, that would be something that you would probably want to follow. Do you agree with that?
MR. RIGLER: Objection to form and foundation.
MS. DAEHNKE: Join. I'm joining the objection.
THE WITNESS: Again, a reticulocyte count is not, I mean it can be high or low on a preemie. And it's almost never relevant. I mean if a baby has iron deficiency anemia, the reticulocyte count is going to be low. So, you know, when you put them on iron,

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sometimes it goes up, and sometimes it doesn't.
BY MS. CARMICHAEL:
Q Isn't just the reverse the case, Doctor, that if it's an iron deficiency, the reticulocyte count will typically be high?
A Not if, as a matter of fact, you use the, you put them on iron. If the reticulocyte count goes up after that, then you think, gee, it could be iron deficiency anemia.
But then after you've had then on iron for awhile, the reticulocyte count is going to be normal or low anyway. So no, the reticulocyte count is typically not that important.
Q Okay. Do you know whether, or did you know, when MayRose became your patient, whether a different natural diagnosis regarding the cause of her anemia was ever undertaken during the neonatal course?
A Can you repeat that question? Did I know whether?
MS. CARMICHAEL: (To the reporter:) Will you repeat the question, please?
(The last question was read back.)
MS. DAEHNKE: Do you have that question clear? Is the question did you or did you?
MS. CARMICHAEL: Did, when she became his

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patient.
THE WITNESS: Yes.
I'm sorry, the question, can you repeat it?
MS. CARMICHAEL: (To the reporter:) Would you read it again?
MS. DAEHNKE: Well, the question as you phrased it, which she's going to read back, says do you or did you. And so did you want her to read it just saying did you?
MS. CARMICHAEL: I'll clarify.
BY MS. CARMICHAEL:
Q When MayRose became your patient.
A Yes.
Q Did you at that time have an understanding as to whether or not a differential diagnosis regarding the cause of her anemia was ever undertaken during her neonatal course?
A I don't recall that being a question, no.
Q Did you know that her father had thalassemia?
A No.
Q You don't recall --
A I don't recall that. I don't recall that being a question or an issue.
Q Do you remember Mr. Abbington telling you

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that he had thalassemia?
A I have no specific memory of him telling me that, no.
Q Did you --
A It's possible he might have. I don't recall that.
Q Okay. Did you ever do anything to determine whether she had, MayRose had inherited her father's thalassemia?
A To work up thalassemia, you wouldn't work that up until a little bit later date. You would look for an elevated hemoglobin A2 fraction. You get a hemoglobin electrophoresis. But that wouldn't kick in until months later. Weeks to months later.
Q Let me ask you this: When MayRose became your patient, did you have an understanding of whether her anemia was microcytic, normocytic, or macrocytic?
A You know, again, typically, you know, if you look at preemies, if you look at babies in general, the cells are a little bit larger than when you look at it for an older child of four and adult. So those numbers about macrocytic, microcytic on a preemie, on a newborn baby, they're kind of skewed. They're kind of skewed to the high side. So again, what looks to be a normocytic anemia can actually be a macrocytic

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anemia in an older kid, or a microcytic.
Q And my question was, did you have any understanding, when you assumed MayRose's care, as to what her anemia had been in the NICU? Normocytic, microcytic, or macrocytic?
A It wouldn't be something you would typically look at. I mean, you know, almost all the anemias that come from the nursery, there are the regular normocytic iron deficiency blood loss anemias that you see just from frequent blood draws.
Q Okay.
A It's true on almost all preemies.
Q And did you check to see if in fact MayRose's had been normocytic?
A I do not recall checking to see whether it was normocytic or not.
Q Okay. Diamond-Blackfan anemia is macrocytic, characterized by reticulocytopenia. Is that correct?
A Typically, Diamond-Blackfan is going to fall under the normocytic anemias.
Q Do you agree that Diamond-Blackfan anemia is characterized by reticulocytopenia?
A Yes.
Q Were you aware that within the ten days

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prior to MayRose's discharge she was transfused three times? Were you aware of that when you assumed her care?
A I have no specific memory of that. And again, that wouldn't be unusual in a preemie.
Q Were you aware that her hematocrit was also falling at the time of her discharge?
A Again, that wouldn't be unusual for a premature baby, that sometimes hematocrits are falling at the time of discharge. They're approaching their nadir, you know, their low point with the red cells.
Q So if it's --
A -- which occurs at around three months anyway, so.
Q If it's not uncommon then, if it's normal for a baby's hematocrit to be falling at the time that they're discharged from the NICU, is that an issue then that the pediatrician should follow up on or not?
MS. DAEHNKE: If you can answer -- object to form. If you can answer the question, just answer the question.
THE WITNESS: Okay, I'm sorry, repeat. Should I notice that the hematocrit is falling?
BY MS. CARMICHAEL:
Q No, my question is, I believe your testimony

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is that it's not uncommon for the hematocrit to be falling --
A Correct.
Q -- in a premature infant that's getting discharged from the NICU?
A At about three --
Q That's not uncommon?
A -- to four months. Correct.
Q Okay. So my question to you is, then should the pediatrician assuming the care of that infant, is that an issue that the pediatrician should follow up on?
A You should look at every child for anemia. I mean everyone who comes in gets looked at for anemia. It's just part of my routine exam. I look at the conjunctiva of the eyes, and you can see what the hemoglobin is pretty accurately.
Q Okay. So then why, Doctor, would the NICU doctors find it necessary to draw blood to check her hematocrit if they could just simply look at her eyes and, "Oh, she's fine"?
MR. RIGLER: Objection, form, foundation.
MS. DAEHNKE: Join.
MS. URDAZ: Calls for an expert opinion, speculation.

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MR. RIGLER: Join.
THE WITNESS: NICU doctors do a lot of blood tests. You know. That is the reason that the babies become anemic is because they do a lot of blood tests. And they know that, and we expect that. And, you know, they have to get some electrolytes. I mean they're looking at not only just what the hemoglobin is, there's looking at the platelet count. I mean there's a lot of reasons, you know, to get a blood test. And it's nice to, you know, if you're going to draw it for something else, you might as well look at what the hemoglobin is also.
So I don't see what your point is.
BY MS. CARMICHAEL:
Q Okay. But as you sit here today, it's your testimony that you can tell whether a child's hematocrit is normal simply by --
A Yes.
Q -- looking at their eyes?
A Yes, it is.
Q Were you aware that MayRose had not made it three weeks without needing a blood transfusion since the day she was born? Did you know that when you assumed her care?
A I have no specific memory of that. But

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again, that is very, very typical for preemies in the, in the NICU.
Q Okay. If a preemie is needing transfusions every three weeks at the time of their discharge, is that something that the pediatrician would need to follow-up on when they assume care of that baby?
MS. DAEHNKE: Object to form.
You can answer if you can.
THE WITNESS: You do test on the baby -- I mean you are following up on that. By looking at the baby, you are following up on it. I mean you are following up on that problem as it exists. I mean you don't want to draw a lot of blood when you don't have to.
BY MS. CARMICHAEL:
Q And for those babies that have serious genetic blood disorders, how does your eye test work for them?
A You should still be able to tell whether they have anemia or not. I can tell whether they have anemia or not. Whether it's, I mean by these rare, you know, like you're saying, these rare genetic blood disorders.
Q Were you aware that within the ten days prior to MayRose's discharge she had a low and falling

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retic count? Did you know what when you assumed her care?
A Didn't we just answer that question before?
Q I don't, I don't remember you answering that one.
A Repeat the question then.
Q Did you know when you assumed her care that she had a low and falling retic count at the time she came out of the hospital?
A I know you asked me that question earlier.
MS. DAEHNKE: Well, just for purposes -- asked and answered. You can answer again so we can just move on.
THE WITNESS: No, I do not believe I was specifically aware that her retic count was falling at the time.
BY MS. CARMICHAEL:
Q What is the clinical significance of a low and falling reticulocyte count?
A Didn't I answer that one also? Okay. A clinical significance of a falling retic count could be that the baby was just put on iron. You know. Like when you first put them on iron, the retic count initially rises, and then it falls, it goes back down to normal.

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So the fact that the retic count was falling, you know, usually it's not going to be very relevant.
Q And if they haven't just been put on iron, what would the clinical significance be, if you know, of a low and falling reticulocyte count?
A That it's probably iron deficiency anemia.
Q Are you aware that a low reticulocyte count can indicate bone marrow disorders or aplastic crisis?
A Yes. It goes under the production anemias, yes.
Q And in fact, it points to suppression of the bone marrow and aplastic anemia. Right?
A Or a viral infection which also suppresses the bone marrow.
MS. CARMICHAEL: (To the reporter:) Would you mark that?
(Plaintiffs' Exhibit B marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Conti, I've handed you what will be Exhibit B to your deposition.
A Yes.
Q And I'll represent that I pulled these from your chart.

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A Yes.
Q And I believe they represent the six office visits that MayRose had with your clinic.
Could you just look those over and tell me if that is correct?
A Yeah, these were the six from August -- before she got very sick. Before she got sick.
Q Okay, yes.
A Yes.
Q Thank you for that correction. Yes.
Okay, so August 5 being the first one, October --
A Yes.
Q -- 24th being the last?
A Correct.
Q Okay. All right, let's just look at the first visit. This visit, she actually saw you. Is that correct?
A Yes, that's correct.
Q And this was a well check?
A Yes, that's correct.
Q She had just been discharged from the hospital a couple of days earlier?
A Correct.
Q Is that right?

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A Uh-huh.
Q Okay. And who's writing is on this?
A It's probably Tiffani Rainstanos, probably like my nurse who writes my notes for me.
Q Okay. And here you note, she, I guess, Tiffany noted under "Development," she has a plus with "smiles." So the baby was smiling at this time?
A Correct. Correct.
Q All right. Did you, in addition to this chart note here, did you make any independent notes of your own?
A I don't believe so, no.
Q Is that not your practice, you don't do your own notes?
A Typically, no.
Q Okay. What do you recall the parents telling you on this visit?
A I remember hearing about the NEC. I remember hearing about -- I mean necrotizing enterocolitis. I remember hearing about the cystic fibrosis question. I remember, you know, we were concerned about the brain at that time. And, you know, but the fact that she was smiling was encouraging. We talked about how she was feeding, how she was pooping, peeing, sleeping. We talked about

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scheduling. We mentioned about development. How do you tell when the baby is going to get sick, feeding, lethargy, irritability.
Q And what did you tell the parents with regard to how to tell when the baby gets sick?
A Typically, a baby is going to be not eating well, lethargic, or irritable. Lethargic means not sucking on the feeder well. Irritable means weak, whining, crying, doesn't stop.
Q How did MayRose appear on this visit, do you recall?
A She appeared well. I mean she, you know, for a preemie who had just been through what she had been through, she appeared to be doing quite well.
Q Okay. If you'll turn to the next visit.
Well, and let me just ask you back on the first one. So have you told me everything you recall the parents telling you?
MS. DAEHNKE: Mr. Abbington, do you need to take a break? Because we could just take a quick break and you could get some water or something?
MR. ABBINGTON: I'm okay.
THE WITNESS: Okay. I'm sorry?
BY MS. CARMICHAEL:
Q Have you told me everything you recall the

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parents --
MR. ABBINGTON: What did I do?
MS. DAEHNKE: Nothing. I thought you needed a break. I'm sorry.
MR. ABBINGTON: I'm okay.
MS. DAEHNKE: Okay.
MR. ABBINGTON: Thank you though.
MS. DAEHNKE: Okay. Okay.
Okay, sorry, Doctor.
THE WITNESS: That's okay.
MS. CARMICHAEL: If anyone, including you, ever needs a break, just say so.
THE WITNESS: Okay, thanks.
BY MS. CARMICHAEL:
Q Back on the first visit. Do you, have you told me everything that you remember mom and/or dad discussing with you about MayRose on that visit?
THE VIDEOGRAPHER: Excuse me, you're covering the mic.
THE WITNESS: Oh, I'm sorry. Thank you.
Everything that they said to me? I mean that was four years ago. So I don't know if I can recall exactly everything that was being said to me at that time.
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BY MS. CARMICHAEL:
Q Well, sure. I'm asking you if you told me everything you remember about your conversations with mom and dad on that date?
A I'm sure if you asked me later, I could probably tell you a couple more things. But I believe to the best of my ability I'm telling you, the best of my memory I'm telling you what I remember.
Q Okay. And what do you remember about MayRose yourself on that occasion?
A She was little. You know, she had the typical preemie, like, it's not like exactly muscle wasting, but I mean, you know, real, real skinny.
But she was breathing well. She looked pretty good. I mean, you know, considering, you know, that she had been through the NEC.
And she had been through, you know, there was a question of cystic fibrosis. I thought that was unusual. But we went ahead and like, I remember the mom mentioning like, you know, she wanted, you know, I remember Tiffani mentioned she wanted that ordered. And I said, "Okay, if that's what, you know, if that's what we're doing, I mean, yeah." You know, if that's what, you know, mom wanted and, you know, the neos wanted, she mentioned the neos wanted it. And so.

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THE VIDEOGRAPHER: We need to change tapes.
MS. CARMICHAEL: Okay.
THE VIDEOGRAPHER: This marks the end of tape number two. It's 3:53 p.m. We're off the record.
(A short break was taken.)
THE VIDEOGRAPHER: We're back on the record. This marks the beginning of tape number three. It's 4:05 p.m.
BY MS. CARMICHAEL:
Q Doctor Conti, taking you then back to this first visit that you had with MayRose.
A Yes.
Q Do you have a memory of both of her parents being with her on that visit?
A Yes.
Q Okay. And we were going over sort of the, the information that you were discussing with the parents on that visit.
Do you remember whether or not the topic of the brain bleed came up on that visit?
A You know, the brain's always a concern and it tends to be kind of like where I tend to focus. I, I believe that did come up. I have no specific memory talking about a bleed in the brain. But I know that,

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you know, it's just such a common thing in preemies that I always ask about it.
Q Okay.
A And, and the degree of the bleed and, you know, how we're going to follow it up, and what it means for the development, and so on.
Q Do you remember what the parents told you with regard to the brain bleed?
A I do not specifically remember, no. I'm sure they would have mentioned it, but I don't remember specifically what they said, no.
Q Do you believe you had an understanding on this, as of this first visit as to the, to the degree of the bleed, or the seriousness of the bleed?
A I, I would have understood it at the time. But I, I, yes, I believe I would have had an understanding of the degree -- you rank them one to four. So depending on what the rank was.
Q And as we sit here today, what is your understanding as to the level of MayRose's brain bleed?
A I don't recall.
Q Do you know whether or not you ever knew the degree, what the degree of her bleed was?
A I'm sure I would have known at the time,

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yeah. If there was a brain bleed, I would have asked like what grade it was, and I can tell you based on that. Do I remember what they told me it was then or, you know, what it is now? Or, I mean I don't even, to be quite honest, I'm not even recalling that there was actually a brain bleed. But.
Q Okay. Do you, but any information that you would have obtained regarding the brain bleed would have come from MayRose's parents. Is that correct?
A Probably. Probably. I mean almost always the parent knows, you know, the degree of the bleed. I mean, you know, they know that that's a real important number, and they know it, you know, it really impacts the baby's future.
Q Okay. In MayRose's case, did you, do you know whether or not you did any independent research to determine what, whether she had a brain bleed and what degree of bleed it was?
A I do not recall specifically. I know I would have asked about it. I ask on every preemie: Do we have a bleed in the brain? Do we have a ventricular hemorrhage, is what it's called. And what was the grade of it.
I don't recall specifically whether she had one or not, or if she did, what grade it was.

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Q Okay. As of this first visit, what, if any, concerns did you have for MayRose?
A Mainly development.
Q In what regard?
A Any preemie, even one who has had an uncomplicated course, can show signs late of developmental problems.
Q What kinds of developmental problems?
A Stiffness, spasticity, anything ranging from ADHD's to severe mental retardation. I mean that's, you know, that's the range of things you can see. But I mean, you know, you're always hopeful, you know, based on what, you know, the -- typically, the thing that impacts that most is the history of, of a brain bleed. And if there's not one, if there's a low grade one, you say okay, we should be okay here. Let's, you know, let's remain cautiously optimistic.
Q Okay. And do you remember seeing anything in your examination of MayRose on this date that caused you to have concern for her?
A No. She was just a, a preemie. She had the unusual-shaped preemie head. I think the fancy medical word is plagiocephaly. But we affectionately call it "toaster head." You know, I mean it's typically what you see in a preemie who's been through

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a NICU course.
Q Did you express any concerns, share any concerns with mom or dad about MayRose on that date that you recall?
A I don't, I don't recall expressing any specific concerns. Again, you're always going to watch out for the brain. I mean that's one thing we really focus on, so.
Q Okay. All right, and in fact, at some point at, at Ms. Hurst's request, you helped her to obtain a follow-up MRI of MayRose's brain. Do you recall that?
A Correct. I believe it was the second visit. And I remember her mentioning about an ultrasound of the head. And I said let's get the real one, you know, because MRI's are much better tests, I think. I think it really shows even subtle defects.
Because they can have this condition called PVL, periventricular leukomalacia, that sometimes doesn't appear until late. And it can even appear like late, late. But I mean but that can, you know, the best sign of that, or the best test for that would be an MRI rather than a head ultrasound. Head ultrasounds sometimes does not show if it's there.
Q Okay. And you, and so you helped her order a follow-up MRI?

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A Correct.
Q Okay. And do you recall the test results of that MRI?
A I thought it was normal. To my recollection, it was a normal MRI.
Q Okay. All right. And that -- let's see if I have that.
MS. CARMICHAEL: (To the reporter:) Will you mark that, please?
(Plaintiffs' Exhibit C marked for identification.)
BY MS. CARMICHAEL:
Q And I'm handing you, or you've been handed what will be Exhibit C to your deposition. And are those in fact the MRI results that you received back on MayRose Hurst?
A Looks like it, yeah. I believe that's true.
Q And it appears from that document --
MS. CARMICHAEL: There you go, Patricia.
MS. DAEHNKE: Thank you.
BY MS. CARMICHAEL:
Q -- that that test was done on September 30. Is that right?
A Yes, correct.
Q Okay. So that was almost two months after

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her discharge from the NICU. Is that correct?
A That's about right.
Q Okay. And those results are indeed normal. Is that right?
A Yes, they are.
Q Okay. And do you remember that Mrs. Hurst also asked you to help her schedule some follow-up testing? I believe it's called a chloride sweat test?
A Yeah, that was the cystic fibrosis -- I thought we, I thought they were, it was more like a blood test we were looking for to -- I'm trying to remember now. It was, it was either there was like kind of a like a soft marker that she might have the gene for CF, cystic fibrosis, and so order the sweat chloride, or that we had to do the sweat chloride later. I thought they wanted genetic testing done for CF. I thought it was more like a blood test that we had ordered. But I don't recall specifically. I remember there was a test for CF that was ordered. Whether the sweat test or, or the actual genetic test, which is more accurate.
Q Okay.
A Sometimes a sweat test won't be abnormal until later.
(Plaintiffs' Exhibit D marked for

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identification.)
BY MS. CARMICHAEL:
Q I'm handing you what will be Exhibit D to your deposition, Doctor. And it's a two-page exhibit. Do you see that?
A Okay.
Q And does that refresh your memory --
A Yes.
Q -- regarding --
A Oh, yes.
Q -- what test was ordered by your office?
A Uh-huh.
Q And what test was ordered?
A They ordered a sweat test. And it was a Grade I intraventricular hemorrhage. So we ordered a, looks like they were going to order a head ultrasound, CT scan. But I know it was an MRI that we eventually ordered.
Q Okay. But you did order the sweat chloride test.
A Correct.
Q Is that right?
A Correct.
Q And do you remember the result from the sweat chloride test?

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A **I believe it was normal.**
Q Okay. All right. And then just taking you back to that first page of Exhibit D, where you've got Grade I IVH?
A **Yes.**
Q Her medical records reflect a Grade I germinal matrix bleed. Is there any distinction between a germinal matrix and an IVH?
A **Grade I is also known as a germinal matrix hemorrhage.**
Q Okay. And with Grade I, the prognosis is generally very good. Is that true?
A **Pretty good. Yes. Absolutely.**
Q Okay. All right. And as we discussed, the MRI came back normal. Correct?
A **Correct.**
Q Okay. And it is your memory that the sweat chloride test also came back normal?
A **Correct.**
Q All right. And then on that page one of Exhibit D, it indicates that you're also ordering I believe Synagis to start in September?
A **Yes.**
Q And is that a treatment that's preventive to avoid RSV?

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A **That's correct.**
Q Okay. All right. Do you remember also ordering a swallowing study? She was referred to speech therapy, I believe, for a swallowing test?
A **That's possible. I don't recall specifically doing that. But that's a lot of preemies will have difficulty eating, swallowing. So you order what they call a modified barium swallow test.**
Q Okay. And do you recall what the results of MayRose's swallow study was?
A **I do not recall.**
Q All right.
A **I imagine it was normal, otherwise we would have...**
Q Taking you back then to Exhibit B to your deposition, the chart notes, the visit notes?
A **Yes.**
Q If we could go to the next visit?
A **Okay.**
Q You saw her on this occasion. Is that correct?
A **Yes.**
Q And again, the writing on this chart note is not yours other than your signature. Is that true?
A **Correct.**

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Q Okay. So would you have filled out any other paperwork or notes --
A **No.**
Q -- in connection with this visit? Okay.
Do you have an independent memory of this visit?
A **An independent memory, no.**
Q Do you remember whether both parents were present, or just one?
A **I thought just mom was there.**
Q Okay. And do you remember how MayRose looked on that occasion?
A **I thought, again, I thought she was looking okay. She was gaining weight, which I thought was good. She -- what else? There was some questioning about that she was refluxing. But she wasn't -- I'm just taking that from the chart. Independent memory -- I believe that's when the conversation occurred regarding the MRI versus the head ultrasound.**
Q Okay. All right. And you can refer to your note for these next questions.
A **Uh-huh.**
Q So what, what was going on with her, according to your note, on this visit?
A **Let's see. She was breast feeding. Was**

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also being supplemented and Enfamil AR at the time. She was pooping and peeing good. We looked for signs of reflux. She wasn't screaming in pain. She wasn't losing weight. She wasn't turning blue. There was no diarrhea, vomiting, constipation. She was smiling. She was not rolling yet.
Let's see, we talked about head injury, ingestions, water injuries, thermal injuries, car seat. We asked about a pool. The baby was not colicky.
Immunizations were up to date at that point. And that's when we did the first set. It probably was actually the second set. The first set we give them in the hospital. Typically, that's what would be done.
Her exam was normal. Her neck supple without rash. Eardrums and throat were clear. The chest was clear. Heart without murmur. Abdomen was soft. Normal female.
Well child with a question, you know, with a question of static encephalopathy, which is like a kind of a code word for CP. So that's why we were getting the MRI.
Q Okay, and that's because she had the Grade I bleed?

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A **Correct.**
Q During her neonatal --
A **You have to sort of. Right.**
Q Okay. Did you see any other, I mean other than knowing that she had had the Grade I bleed that needed follow-up --
A No.
Q -- were there any other indications?
A **No memory of any problems at that point in time.**
Q Okay.
A **I remember, and I think the mom had said we needed to get a referral for PT, OT, and ST. I mean that's why we would typically do that. I believe the mom had requested that that referral be done, and so we did that as well.**
Q Okay. Do you remember Mrs. Hurst telling you that she, the baby was receiving those services through Summerlin -- or excuse me, through Sunrise, I believe, Hospital, and she wanted to have those services provided elsewhere, and asked you for the referrals?
A **That's a possibility. I have no specific memory of that. But...**
Q And those services --

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A **It's highly possible.**
Q -- are typical for a preemie?
A **I mean most of them don't require that. But some do. Some do.**
Q Okay. All right. Anything about MayRose on the second visit that caused you any concern?
A **No.**
(Plaintiffs' Exhibit E marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Conti, if you'll look at Exhibit E to your deposition. This document came from your chart. Is this something that you have parents fill out when you assume the care of their children?
A **Yes.**
Q Okay. And do you read these documents?
A **Almost never.**
Q So you're admitting that you don't typically read these?
A No.
MS. DAEHNKE: Object to form.
BY MS. CARMICHAEL:
Q Okay. How did you know -- you mentioned that you did give the baby some immunizations. How did you know what immunizations the baby had received

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and where to pick up with those?
A **I didn't. I mean typically if the baby is in the hospital in the NICU for two months or more, they'll usually do the first set of immunizations.**
Q So you would just make that assumption and then go from there as far as which immunizations to give next?
A **Well, you wouldn't just make the assumption. You would ask the mom, has the baby received any immunizations yet.**
Q And if the mom wasn't sure what had been given, what would you do in that case?
A **Then we would have to call the hospital. Because that would be, you know, very significant.**
But typically, you know, 99.9 percent of your moms are intelligent women, like Mrs. Hurst, like Tiffani. And so I would take her at her word. If she said immunizations had been given, and usually they will say, yeah, the first set has been given. I mean parents know that. They're, they're mostly a pretty intelligent crowd.
Q All right. If you will turn to page two of this document?
A **Uh-huh.**
Q Do you see down there in section G, where it

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says, "Has your child had," and it goes through a list of various immunizations. Do you see where Ms. Hurst has drawn a bracket and said, "Unsure, check the discharge statement"?
A **Yeah, I see that's written there.**
Q Now, your testimony is you wouldn't, you probably wouldn't have read this. Right?
A **Correct.**
Q So I'm just wondering, how do you, do you have any knowledge about how you would have determined what MayRose had had and where those immunizations should pick up at that point?
MS. DAEHNKE: Other than what he's already testified to?
MS. CARMICHAEL: That the mother told him?
MS. DAEHNKE: He testified what his custom and practice was if they weren't certain.
But go ahead, answer.
BY MS. CARMICHAEL:
Q I'm asking in this specific case of MayRose Hurst?
A **I don't recall. I mean I don't, again, this, I don't recall seeing this. So, okay, what is my typical practice?**
Q No, I'm asking you, do you have a memory of

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what you did in MayRose's case?
A No specific memory. I mean typically, again, the mom will mention it to me.
Q Okay. Where she's referring you specifically here to the discharge statement, do you have a memory of going then and reviewing the discharge statement at that time?
A The discharge statement? Oh, the discharge summary?
Q Right.
A I do not recall whether or not I saw the discharge summary at this point in time.
Q Okay. Okay, if we could go to the next office visit.
A Uh-huh.
Q Now, this does not -- this is a sick visit. Right?
A Correct.
MR. RIGLER: What is the date of that?
MS. CARMICHAEL: The date is September 30, 2008, Foothills Pediatrics 0122.
BY MS. CARMICHAEL:
Q Did you see the baby on this date?
A Yes.
Q Okay. And do you have an independent memory

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of this visit?
A No.
Q Okay. Based on your chart note then, or what we have here -- and again, none of this is in your writing. Correct?
A Correct.
Q Okay. What were the, what were the concerns or what was the purpose of the visit on this date?
A The baby was having some cough and congestion, as the chief complaint. There was no fever. Baby had some sniffles. Baby had some cough. There was no vomiting or diarrhea, no constipation. The baby didn't seem to be in pain. The baby had a little rash on the face. Was eating all right and peeing all right.
Baby had a history of NEC. Nobody smoked in the house. Baby didn't go to day care.
Exam was pretty normal except for a little rash on the face. Baby had a little congestion in the nose, a little redness in the throat. The lungs were clear.
So the baby ways diagnosed with seborrhea, upper respiratory infection, cough, pharyngitis, which is a sore throat. Come back if symptoms gets worse or temp is greater than 102.

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The RSV test was negative, so no RSV. Also we said usual URI treatment, which means suck out the sniffles with saline drops. Keep her sitting up. And one percent hydrocortisone cream for the face if necessary.
Q Okay. Do you remember anything about this visit, any conversation you may have had with Mrs. Hurst about MayRose?
A Specific conversation, no.
Q Okay. Was there anything about this visit that alarmed you or concerned you?
A No.
Q Okay. All right. And will you turn to the next page, please? Foothill Pediatrics Bates 0121. The date is October 1, 2008. So the very next day.
A Uh-huh.
Q And this is the regularly scheduled well visit. Is that right?
A Correct.
Q Okay. And do you have an -- did you see the baby on this date?
A Yes, I did.
Q Okay. And do you have an independent memory of this visit?
A No, I don't.

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Q Okay. Then based again on the chart note, what can you tell me about this visit?
A Baby was on formula. Had begun some stage one foods. Was pooping and peeing good. There was no diarrhea, vomiting, constipation, or pain with pee. The baby was smiling. The baby was not rolling yet.
We talked about head injury, ingestional injuries, water injuries, thermal injuries, and car seats. Baby was not a colicky baby. Shots were discussed and were apparently up to date. And mom didn't have a pool. Everything else was okay.
The exam was normal. Her neck supple. With without rash. Eardrums and throat were clear. Chest was clear. Lungs without murmur. Abdomen was soft. Was a normal female. Well child.
Come back at six months. Second hepatitis B shot was done.
Q Okay. And on the ENT portion of the exam?
A Uh-huh.
Q What does that say, TM and OP?
A Oh, tympanic membranes and oropharynx.
Q Clear?
A Yeah, ears and throat.
Q Is there any indication on this chart that the eyes were examined?

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A You wouldn't ordinarily note that.
Q You would not note that?
A No. I mean you always, I always examine the eyes. It's just one thing, you know, you look, you just go like that with the conjunctiva. You can look at the baby.
Q And that is something you do on every visit with every child?
A Pretty much.
Q But you never note it?
A No.
Q All right. So on this visit, this is just the day after she was there with the cough?
A Uh-huh.
Q She's assessed as a well child?
A Yes.
Q So she's better from whatever she, issues she was having? Yes?
A I would imagine, yes.
Q Okay. Any concerns at this point for the baby?
A Doesn't look like it, no.
Q Okay. All right. Okay, if you'll just turn to the next visit?
A Uh-huh.

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Q Dated October 18, 2008.
A Yes.
Q Foothill Pediatrics 0120.
A Uh-huh.
Q Now, on this occasion, you did not see the patient. Is that correct?
A No. Correct. It was Doctor Malixi.
Q Okay. Did you have any conversations with Doctor Malixi about this visit?
A No.
Q Did you ever discuss this visit with Doctor Malixi?
A I don't believe so.
Q All right. Did you ever review this chart note?
A I believe I've looked at this chart note since, yes.
Q Okay. In conjunction with this litigation?
A Yes.
Q All right. Did you look at it prior to this litigation being filed?
A No.
Q Okay. And just from your review of this chart note, what were the baby's, what was concerning about the baby on this occasion?

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A Baby had vomited three times the day before. Then she writes in her note, "Vomited three times yesterday. Last one was this morning, was about two hours before the office visit." Let's see. Something diaper. She was passing gas. She had a bowel movement the day before. Oh, she had had a wet diaper in the morning. She was passing gas. She had a bowel movement the day before.
Past history: Ex-preemie. History of NEC. Older sibling was throwing up five days ago. Nanny's children had also vomited. So looks like there was a virus going on in the house.
She writes, "No acute distress." I'm trying to see what she writes here. Not in distress -- oh, not sick looking, not in distress.
She looked at the mouth. She says the oral mucosa was moist. So the baby is not too dehydrated. Abdomen is soft. There's the healing midline scar, which would have been from the NEC, the N-E-C. The, let's see, abdomen was soft, flat, nontender, no guarding. Bowel sounds were nonreactive. That's good. Assessment then was vomiting with no dehydration.
She said continue the Pedialyte. Something as needed. I'll figure that out in a little bit. I'm

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not sure exactly what she says what the plan. Oh, no, no milk, it looks like. Or she can do milk. BRAT -- okay, there we go. I thought that means BRAT diet and milk as needed.
Q Okay. Do you have any criticisms of the care that was rendered by Doctor Malixi on this date?
A No.
Q Okay. All right. Then taking you to the next chart note.
A Uh-huh.
Q This is the visit on October 24, 2008, with Doctor Weber. Is that right?
A Uh-huh.
Q Foothill Pediatrics Bates 0119.
A Uh-huh.
Q Okay. Now, Doctor Weber had just recently started with your office as of the date of this visit. Is that true? Within a few months of that?
A I don't remember when exactly when she started. I suppose it's possible. Probably somewhere around there.
Q All right. And you had a policy, since she was a new doctor, of reviewing her chart notes?
A Correct.
Q At that time. Is that correct?

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A **Correct.**
Q All right. And why is it that you felt the need to do that?
A **You pretty much do it on all the, everybody when they first start.**
Q Okay. Just to make sure they're following your office protocols and that their treatment is in line with the kind of treatment you would want them to provide?
A **Uh-huh.**
Q As your employee?
A **(Nods.)**
Q Yes?
A **Yes.**
Q Okay. So you signed this note. Is that true?
A **Yes, correct.**
Q Okay. Did you, does that indicate that you read the note?
A **Yes -- no. Not necessarily. You know, there were like a thousand charts that would stack up. And so I would, you know, sign them and, you know, you, you -- I mean, you know, you glance through the note and you make sure it's decently written, and that the care is adequate and.**

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Q Are you acknowledging that you may not have read this chart note?
A **It's possible.**
Q At the time, in October of '08, how often would you, like what was your policy with regard to reviewing Doctor Weber's notes? Would you do it on a daily basis? Would you get to it a week later, a month later?
A **Weekly.**
Q Weekly?
A **Yeah.**
Q So her notes were accumulate over a week's period of time?
A **Correct.**
Q And then you would go through them?
A **Correct.**
Q And sign them?
A **Correct.**
Q Okay. So do you have any idea of the precise date you would have signed this note?
A **No.**
Q But it would likely have been at least a week later?
A **Probably less than a week. You know, they would accumulate up over a week. And so once a week I would go there and I would sign the notes.**
Q Was it a particular day of the week that you would dedicate to signing these notes?
A **Yes, but at the time I don't know what day of the week it would have been. Someone has to go to, I was going on Tuesdays sometimes, sometimes on Wednesdays, and sometimes on Thursdays at various times. And I don't know what, what day of the week I would have been there in this particular week in October of '08.**
Q Okay. Take a look at this note. And what does it, and what can you tell me about MayRose's presentation on this day and what Doctor Weber has noted as the assessment and plan?
A **Oh, okay, assessment and plan. She has GERD, gastroesophageal reflux disease. She's vomiting. And she's got some weight loss.**
MS. DAEHNKE: Doctor, hands away.
THE WITNESS: Oh.
MS. DAEHNKE: Thank you.
THE WITNESS: I'm sorry.
MS. DAEHNKE: That's okay.
THE WITNESS: She's got some gastroesophageal reflux disease, vomiting, and some weight loss. She wanted her back in a week. She

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planned to put her on Gentlease and Zantac.
BY MS. CARMICHAEL:
Q Okay. Is there any indication anywhere in this note that you can see that would lead you to believe that Doctor Weber suspected the baby may have the flu or a viral illness?
A **Not based on this note, no.**
Q Do you know as we sit here today whether or not you read -- do you recall reading this note?
A **I have no specific memory of reading this specific note. You mean before, before the legal thing began?**
Q Correct. Correct.
A **I have no specific memory of reading this note before. I've read it since.**
Q Okay. At some point in time, did you become aware that Doctor Weber had ordered some labs --
A **Yes.**
Q -- in connection with this visit?
A **Yes.**
Q And when did you first become aware of that?
A **I believe after I read through the case.**
Q Oh, so after the litigation was filed you became aware of that?
A **Correct.**

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Q And not before?
A I don't recall. I mean it, it may, like once I knew she was sick, I could have read through it back then. I don't recall specifically.
Q Okay. Do you remember having any conversations with Doctor Weber about this visit in close proximity to the time it occurred?
A I don't recall any specific conversations. I believe we had talked about it, and I said, "How did she look then?" She said, "Well, she looked like she was refluxing." And I don't really -- I don't recall any specific conversations with Doctor Weber regarding this particular note.
Q Shortly after this October 24, 2008 visit, did you learn that MayRose had been hospitalized at Summerlin Hospital?
A Yes.
Q Okay. And how did you come to learn that?
A Tiffani called me and told me.
Q Tell me what you recall about that conversation. What did she tell you?
A I remember she had said the baby was in the hospital. And she said she had a hemoglobin of one. And I thought, you know, are we sure that that's right? I remember, I remember that part of the

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conversation.
Q Because that would be quite highly incompatible with human life, wouldn't it?
MS. DAEHNKE: Object to form.
MR. RIGLER: Join.
THE WITNESS: It will be low. I thought it was a lab error.
BY MS. CARMICHAEL:
Q What else do you remember about that conversation?
A I remember we talked about what, what might be causing it. You know. We talked about perhaps a B12 deficiency. We needed to look at, you know, and then I called the, the PICU shortly after that and spoke to the other doctors there about her daughter.
Q You did? And tell me about that conversation. Who did you speak with?
A I don't remember. I don't remember the doctors' name.
Q One or more doctors?
A I think I spoke with, oh, over the course of the hospitalization, I spoke with, I think at least two doctors.
Q Okay, and what did they tell you?
A At the time we were looking at -- I remember

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they said she coded for awhile in the ER. And that they had brought her up. And that they were looking at could this be histio -- erythrophagocytic histiocytosis. So it's just a really unusual, you know, disease where the white cells get converted by a virus into like these red cell-eating cells. So.
Q Did you come to know, in discussing this with the PICU doctors, that she, when she presented to Summerlin she was in severe anemic shock?
A She was in hypovolemic. And -- she was in hypovolemic shock. Her blood fluids were really low. Her blood pressure was very low. And yes, incidentally, it was found that her hemoglobin was very low.
Q So someone did tell you that she had severe anemic shock?
A Yes. Tiffani was the first one to tell me though.
Q Okay. Did, did Tiffani ask you to come to Summerlin and participate in the care of her child?
A You know, we were talking on the phone quite often then. I don't recall her specifically asking me to go to Summerlin Hospital and look at the child. I mean, you know, once they're in the PICU, I mean the doctors who are looking at her there are quite good.

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And I have confidence in them, so.
Q Did you ever visit MayRose while she was at Summerlin?
A In the hospital, no.
Q How many conversations did you have with Tiffani while MayRose was in Summerlin?
A Several.
Q And can you recall the substance of any of the other conversations?
A How was she doing. You know. I remember us trying to get her to Denver. I remember talking about Denver. That's where she wanted her to go upon discharge.
Q And why Denver? Do you recall what --
A There's where.
Q -- MayRose's diagnosis was --
A Yeah, at the time, it was several days into the hospitalization they diagnosed she had watershed influx in her brain. We were expecting then, you know, her to have some neurologic deficit. So Tiffani had researched it and wanted her to go to Denver. And so we just made it happen.
Q Do you have any understanding, did anybody convey any information to you as to the cause of the watershed brain injury that MayRose sustained?

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A It can happen from hypotension. I mean, you know, she was a full code. So it could have happened anytime during that course. It could have even been directly from the virus itself. I mean we, we considered all those things. All that was talked about. It could have been from the, you know -- I mean I'm not an ICU doc, so.

Q I'm just asking you if anybody told you or gave you a diagnosis or a cause for that watershed brain injury? I'm not asking you for your theories.

A It's called hypoxic ischemic encephalopathy. So it can be from lack of oxygen, lack of blood flow. That's what this is called. Yeah.

Q Okay. All right. After learning about MayRose ending up at Summerlin Hospital, did you go back to Doctor Weber and discuss with her this clinic visit?

A I have no specific memory of talking with Doctor Weber right after this. I probably asked her, but I don't recall specifically about a conversation with Doctor Weber four years ago.

Q Do you recall going back and reading this chart note, taking a close look at it to see what was going on with the baby on this date?

A Yes, at the time, I believe I looked at the

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note. But again, I have no specific memory of right, right when, when I did that.

Q Okay. Did you look at lab values that came into your office from the labs that Doctor Weber had ordered?

A No, I do not believe seeing any lab values from the labs that Doctor Weber ordered. I mean not at the time.

Q Did you know from talking to Doctor Weber that she had ordered labs on that visit?

A I remember her mentioning something about labs being ordered.

Q But you didn't ever inquire as to the results of those labs?

A I may have. I don't recall.

Q Did you ever see the lab values that were taken in the ER room of Summerlin Hospital when MayRose presented there?

A I have no -- I may well have checked on them, but I do not recall specifically.

(Plaintiffs' Exhibit F marked for identification.)

BY MS. CARMICHAEL:

Q Doctor Conti, referring you to Exhibit F of your deposition -- let me just find my copy here. It

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is Foothill Pediatrics Bates 0159, 0160 and 0161.

I want you to look at those three documents together. They appear to be the same lab results, but each document's slightly different.

A Yes.

Q Do you see that? On the one Foothill Pediatric 0161.

A Uh-huh.

Q Do you see where it's listed the physician name Weber, K?

A Yup, uh-huh.

Q Okay. So I believe these are the labs that Doctor Weber ordered. And can you tell me, can you read for me the tests ordered there?

A Let's see. CMP14 -- Comprehensive Metabolic Panel 14.

Q What was that?

A Comprehensive Metabolic Panel is what you see listed underneath. Plus a GFR, glomerular filtration rate. Venipuncture. Non-LCA request. Okay, it was probably, that probably means it was a, it was requested from another lab, probably. And there was a request problem.

That's what it says under "Tests Ordered" that I'm reading.

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Q Okay. And if you look down under, do you see at the bottom of that page where it says "Request Problem"?

A Yes.

Q Okay. And there it identifies a test, a CBC with a differential platelet. Do you see that?

A Yes, I do.

Q And they're apparently indicating that they had an insufficient specimen to be able to do that test?

A Right.

Q Okay. Let me just ask you this: See the initials on that page KW?

A Uh-huh. KW.

Q Do you recognize those?

A Yes.

Q Are these Doctor Weber's --

A Yes.

Q -- initials?

A Yeah, looks like Doctor Weber's.

Q All right. And do you see the writing, "Was admitted Wednesday, October 29, 2008, due to severe anemia"?

A Yes.

Q Do you recognize that writing?

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A I don't know it, although -- I do not recognize that writing specifically, no.
Q Do you recognize the signature or the initials below that writing?
A No, I do not. I'm sorry.
Q Okay. Looking at this, these lab results, those that they were able to obtain?
A Uh-huh.
Q Is there anything of concern in those results?
A In retrospect, or right at the time? I mean the CO2 is low. So, you know, it shows like the baby's fluids are going to be low. So, yeah, there's a little cause for concern right there, the CO2.
Q So looking at that in the context of it coming back in October of '08, would that low carbon dioxide value indicate to you the baby was dehydrated?
A Yes.
Q Would it have any meaning beyond that to you?
A That would be the main thing I would be concerned about.
Q Okay. All right. Okay, looking at Foothill Pediatric 0160.
A Uh-huh.

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Q The middle sheet in that three-page document.
A Uh-huh.
Q Do you recognize the writing in the margin of the upper left-hand corner?
A No, I do not. EM.
Q Okay. Then we also have Doctor Weber's initials on this?
A Yes, correct.
Q This document as well. Correct?
A Yes.
Q Okay. If you compare the two documents, you've got a date the sample's collected. And those match as October 28?
A Uh-huh.
Q A date entered of October 29. And that matches on both documents. Correct?
A We're talking about the previous form?
Q Right.
A Yes.
Q The middle one and the last one.
A What they collected. Yes.
Q Do you see the date reported? Do you see where those differ? We've got one that says 10/31, and one that says 10/30?

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A Yes.
Q Do you have any explanation for why those dates would differ?
A Probably this was the first report that came out, and this was the second one, I would imagine. This sheet was printed up on the 31st, and this was printed up on the 30th.
Q Okay. And then if you'll look at the first page of that exhibit, Foothill Pediatric 0159?
A Yes.
Q Do you recognize the handwriting in the, at the bottom of the page, where it says, "Did not have enough for CBC and was in ER at the time, called for redraw and per mother did not need to be done at that time"?
A Yes.
Q Whose writing is that?
A I do not know.
Q Oh, you do not recognize?
A I do not recognize the handwriting, yeah.
Q Okay. Was any of this reported to you during this October 31st timeframe?
A I don't remember specifically it being reported. I have seen, there is this note on the front page of my chart where I've written on a

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prescription pad "MayRose Hurst," and I've written "October 27, hemoglobin hematocrit."
So was I aware -- I don't know what the significance of this is either. That may have just been something I wrote down. I don't know.
Q Is that your handwriting on that?
A Yes, this one is.
Q Okay. I have that. We'll talk about that next.
Before we go on to that though, do you see how the date the specimens collected is October 28; and then the date reported, depending on the document, is either the 30th or the 31st?
A Yes.
Q And this is, the lab we're talking about here is LabCorp. Right?
A Yes.
Q Does your office have experience dealing with LabCorp on a regular basis?
A Yes.
Q And is that two- to three-day lag in the date that the specimen is collected and the date it's called in and reported to your office, is that typical for LabCorp?
MS. DAEHNKE: Object to the form of the

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question.
THE WITNESS: At the time, I don't remember what would have been, you know, par for the course for them. You know, I haven't had any major problems with LabCorp in the past.
BY MS. CARMICHAEL:
Q How often do you typically get lab results back from LabCorp?
A Couple times a week, I would suppose.
Q No, no, no. How often, from the time you send the patient in for the blood draw to the time the result comes back, what is typically the length of time?
A Twenty-four to 48 hours.
Q Okay. So a day to two days is typical?
A Yeah.
Q And sometimes as many as three days?
A Depending on the result, but possible.
Q Okay. Do you ever expect to get those results as soon as four hours?
A Yeah, if they're markedly abnormal, then yes.
Q If they're markedly abnormal?
A Correct.
Q Okay. All right. If you sent a patient in

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with an order for labs and you mark the order stat, how soon would you expect to get those results back?
A For a CBC, if I drew it in the morning, I would expect to get it by that evening.
Q So a whole day, a whole business day? That is, not 24 hours, but eight hours?
A It could be as much as eight hours, yeah.
Q And that's for a stat order?
A Yeah.
Q Okay. And an order that's not stat, the 24 to 48 hours, is typical?
A Would be typical.
Q Okay.
(Plaintiff's Exhibit G marked for identification.)
MS. CARMICHAEL: Actually, that goes with that.
THE WITNESS: Yeah, it's on the back.
BY MS. CARMICHAEL:
Q Okay, Doctor, referring you then to what will be Exhibit G to your deposition?
A Uh-huh.
Q It's a two-page document. And I believe that you've just fairly testified that that is in your writing. Is that correct?

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A Yes, correct.
Q Is both page one and two of that document in your writing?
A Not the whole thing is in my writing. The word, on the first page, the word "Quest" is not in my writing. And on the second page, "Quest LabCorp, no labs reviewed" -- no labs reviewed. That's not my writing either.
Q Okay. All right. So this is, it looks like a prescription from your prescription pad. Right?
A Correct.
Q It has MayRose Hurst's name on it?
A That's correct.
Q And it appears that you're ordering a hemoglobin hematocrit test. Is that right?
A Not necessarily. It's probably just I was writing a note that on October 27, this was done, ordered, and -- but I don't know. I have a date written down, and I have hemoglobin hematocrit, and I have MayRose's name. So I mean as to what it means now, or what was being told to me, or when it was written, I really have no idea.
Q Okay. Well, in looking at your chart, MayRose saw Doctor Weber on October 24. Is that right?

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A Yes.
Q Okay. And there is no visit with your office on October 27. Is that right?
A Yes.
Q Okay. So do you have any memory of how you would have come to be writing this on October 27?
A It could have been a thousand ways. I mean that doesn't necessarily mean I was writing this on October 27. It may have been that someone showed up on October 27 to get a hemoglobin hematocrit drawn and they couldn't do it. It may have been -- I mean to ask me what it means now, I would have no idea.
Q Okay. But you're not suggesting that you, on October 27, ordered a hemoglobin and hematocrit lab to be done on MayRose, are you?
A I don't believe so. I, I don't know.
Q All right.
A It's possible I was.
THE VIDEOGRAPHER: We need to change the videotape.
MS. CARMICHAEL: Okay.
THE VIDEOGRAPHER: This marks the end of tape number three. We're off the record at 5:02 p.m.
(A short break was taken.)
THE VIDEOGRAPHER: We're back on the record.

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at 5:06 p.m. This marks the beginning of tape number four.
BY MS. CARMICHAEL:
Q Doctor, you've submitted some written answers to discovery requests in this case. Do you recall doing that?
A No.
Q Okay.
(Plaintiffs' Exhibits H and I marked for identification.)
BY MS. CARMICHAEL:
Q Would you review what will be Exhibit H and I to your deposition?
A Sure.
Q Take a look at those. Does that refresh your memory about providing discovery responses in this case?
A Okay.
Q Did you review those answers, those responses?
A I'm looking at them now.
Q Well, I appreciate you're looking at them now.
A Yes.
Q Did you sign these verifying that you had

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reviewed them, you knew the contents to be true, and that you're declaring under penalty of perjury that they are true?
A Yes, I did.
Q Okay. Okay, so they are your responses?
A Yes.
Q And you stand by them?
A Yes.
Q Okay. All right. Okay, have you ever reviewed the, MayRose's discharge summary?
A Yes.
Q You have. Okay.
(Plaintiffs' Exhibit J marked for identification.)
BY MS. CARMICHAEL:
Q Okay. When do you recall reviewing that discharge summary for the first time? When is the first time you reviewed it?
A My first very specific recollection of reading it is in 2010, in August of 2010, was the first time I specifically remember going through it.
Q Okay.
A But I may have seen it before that. I do not recall.
Q All right. And in response to request for

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admission number two, you acknowledge that your office was provided with the discharge orders, that you did receive those?
A Yes.
Q Okay. You just don't know when or how that occurred because you didn't ever read them until August of 2010. Is that correct?
A My first specific memory --
MS. DAEHNKE: I object. That misstates his prior testimony.
But go ahead.
THE WITNESS: My specific memory of reading it was in August of 2010. But I may have read it before. I do not have any specific memory of whether I did or whether I did not read it before.
BY MS. CARMICHAEL:
Q Well, if you had read it when you assumed the care of MayRose Hurst, you would have seen that you were being asked by the NICU doctors to follow up with her with a CBC and differential test within 30 days?
A Yes.
Q Is that correct?
A Yes, that would be correct.
Q Okay. And had you taken the time to read

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the discharge instruction and actually seen that order, I assume you would have executed on that. Is that true?
MS. DAEHNKE: Object to form.
THE WITNESS: Can I answer it?
MS. DAEHNKE: Yeah. Yeah.
THE WITNESS: Not necessarily. You know, you do what tests, you do what you do on the baby based on what the baby needs. Not necessarily what they're requesting here.
I mean if you didn't, you know, if you believe at the time the cause of the anemia is chronic blood loss anemia from blood draws and you get a kid that doesn't look very anemic, why are you going to bother drawing the blood at that point in time?
BY MS. CARMICHAEL:
Q Okay. So your testimony today is that even if a group of NICU doctors felt that part of her discharge orders required her to get a follow-up CBC in 30 days, you may disagree with that and may not actually do as they recommended. Is that your testimony today?
A That's, um -- okay, rephrase that question before I answer it. Can you, can you repeat the question before I answer it?

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Q I can. Do you need me to word it differently, or do you just --
A No, that's okay. You can just word it.
MS. CARMICHAEL: (To the reporter:) Go ahead and read it back then.
(The last question read back.)
THE WITNESS: Those discharge orders are a suggestion. And they're not requiring, I believe the word "require" is incorrect. I mean they're suggesting that that's what you get when you look at that.
But, you know, if you decide that it's not necessary, I, you know, I believe that you shouldn't do it. I mean you could give every kid what they need and no more and no less.
BY MS. CARMICHAEL:
Q Okay. And do you take into account the difference in knowledge that you would have seeing the baby as she comes into your care versus the knowledge that the NICU physicians would have of the entire course of their care while she was in the NICU?
MS. DAEHNKE: Object to form, foundation. It's ambiguous. Argumentative.
But go ahead. Answer if you can.
THE WITNESS: So am I totally discounting

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what they -- am I --
MS. DAEHNKE: Let's just try and answer her question. If you can't answer it, then ask her to rephrase it.
THE WITNESS: Okay, can you repeat it again?
(The last question was read back.)
MS. DAEHNKE: Same objections.
You can answer if you can.
THE WITNESS: Do I discount their opinion? No, of course not. Like I respect their, their opinion. But I'm going to have an opinion of my own. And it, you know, it's going to agree with them most of the time, and there may be some instances when I do not agree with them.
BY MS. CARMICHAEL:
Q Okay. So to be clear, in this case, is it your testimony that even if you had read this discharge order on the first day that MayRose came to you, on August 5, 2008, based on your assessment of her as time goes on that she was not anemic, you would have chosen not to do this test, the CBC with differential?
MS. DAEHNKE: Object to the form of the question. It's argumentative. It misstates -- mischaracterizes his testimony.

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But if you can answer.
THE WITNESS: I don't recall whether I read the discharge summary or not.
If I had read it, and I'm looking at the kid, and I'm looking at this, I'm looking at MayRose, and I think she absolutely didn't need this, I probably wouldn't do it.
Unless sometimes, for instance, patient comes in and mom wants an allergy referral. I've seen this kid for allergies. He's been well treated in the past. But he really doesn't need an allergy referral. But if mom wants and requests it, I would definitely do it.
Sometimes a patient comes in and they're being recommended, they're here to be cleared for ear, nose and throat surgery to put tubes in the ears. And you look at the ears and they look perfectly fine. And I would say, well, maybe we should, you know, maybe we should wait. Maybe just, you know, give th ears a week or so, and let's see how they look in a week.
So I might not agree with the specialist who recommended a certain thing. That's a possibility. If it was in the best interest of the child to avoid a procedure, avoid a test, you know, if it's not

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indicated, and then it's contraindicated and then it shouldn't be done.
So I, you know, I'm the one looking at the child right then. You know. I would expect a three-month-old preemie, like three months old after the date they were born, to be, you know, to be at kind of like at their low point for anemia. Like they would be hitting their nadir right around then.
So unless the kid was, you know, markedly anemic, I mean you could actually cause anemia by continuing to draw blood on the child, if they didn't, you know -- if they weren't that anemic -- if they were the anemic and you continue to draw blood on them, you could actually make them anemic.
So considering the cause of the anemia -- I'm sorry, go ahead.
BY MS. CARMICHAEL:
Q Are you done?
A Yeah.
Q Okay. All right. So without speaking to the neonatologist that cared for this child, you would only be guessing as to why they wanted a CBC diff and retic one month after her discharge. Is that true?
A No. Again, almost always -- I'm basing it on, you know, at this point in time, 18 years of

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experience, having taken care of preemies and, you know, knowing the neonatologists, you know, like, you know, they draw so much blood there, and so many of these kids come out of the NICU have anemia of chronic blood loss. I would, you know, I'm not trying to discount any of their opinions or say that my opinion is more valuable than theirs.

But I'm not just guessing, I'm basing it on past experience, and I'm looking at the child and trying to decide what is best for this child right now.

Q Okay. But I think we've discussed, and I really don't want to replow ground we've been over, but you've admitted that you didn't know that her hematocrit was still falling at the time of her discharge, you didn't know that her reticulocyte was low and still falling at the time of her discharge. There were things you did not know. Isn't that true, Doctor Conti?

MS. DAEHNKE: Objection. That misstates his testimony. If you want to replow that, go right ahead.

THE WITNESS: I don't agree that I didn't know. I...

BY MS. CARMICHAEL:

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Q You knew her lab results at the time of her discharge?

MS. DAEHNKE: Which lab results would you like him --

THE WITNESS: I don't recall like which, you know, I mean do I recall specifically knowing, do I have a specific memory of knowing exactly what the lab results were at the time? No, I don't.

But at the same time, I mean, you get a good feeling for what's going on with the kid just by looking at him and reviewing. I mean there was some lab result that stared out at me, you know, how common it is for a kid to have a falling hematocrit and a low, a borderline low, borderline low hematocrit and a low reticulocyte count at the time of discharge from the nursery? It's common.

BY MS. CARMICHAEL:

Q Well, you didn't review her labs though, any of her labs from her NICU stay. Correct?

A I don't know if I said I had been reviewing any of the labs from the NICU stay. I mean I'm sure we reviewed pertinent information from the NICU stay.

Q Did you review labs from the NICU stay?

MS. DAEHNKE: I object to the form, the tone. You're badgering the witness. If you would like him to re-answer questions you've asked before, show him a lab and ask him if he recalls if he reviewed it or not.

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MS. CARMICHAEL: Thank you for your advice. This is my deposition --

MS. DAEHNKE: Excuse me. This is my client and I'm entitled to assert objections on his behalf. Yes?

MS. CARMICHAEL: I understand that.

MS. DAEHNKE: And you've asked him certain questions. You're mischaracterizing his testimony. Just because it's late in the day and you have to get a flight doesn't mean that he needs to change or admit that he's testified differently than he already has.

MS. CARMICHAEL: Thank you.

MS. DAEHNKE: Uh-huh.

BY MS. CARMICHAEL:

Q Doctor Conti.

A Yes, ma'am.

Q Are you testifying now that you reviewed MayRose Hurst's labs from her stay in the NICU?

A I do not have any memory specifically of reviewing her labs, no.

Q Thank you. I did believe that we established that earlier. Okay.

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MS. DAEHNKE: It's a different question, Jackie.

BY MS. CARMICHAEL:

Q You -- knew, the things you did know though, you did know she had been in the NICU for almost three months. Right?

A Yes.

Q You did know that. And you do know that neonatologists issue discharge instructions. Right? You know that?

A Yes.

Q Okay. And you knew from her parents that she had had a complicated course. Correct?

A No more complicated than most other 28-week preemies.

Q Okay. But complicated nonetheless. She had had NEC. Right?

A Fairly typical course for a NICU grad.

Q You knew she had NEC. Correct?

A Yes.

Q You knew she had anemia. Correct?

A Yes.

Q You knew she had blood transfusions?

A Yes.

Q Okay. You knew that she had a brain bleed?

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A Yes.
Q Okay. All right. And you knew from your experience that hospitals typically send copies of the discharge orders to the pediatricians. You knew that as well. Right?
A Yes.
Q Okay.
A I mean they often do.
Q All right.
A I can't say usually. But they often do. And they often call me also. But...
Q But in this case, you did not find it important enough to go to the file, or go to the NICU doctors, or go to whatever source you needed to do to find out what the NICU doctors were recommending for her follow-up care. Is that true?
A No, it's not true that I didn't find it important enough. I found MayRose very important, as I find all my patients. And I wanted to give her the best care possible. So it's not like I didn't find her important enough to check it out.
I had done it the way I've always done it, which is to rely on, you know, what the mother can tell me. Knowing what I know about neonatology, which is, you know, quite a bit; and knowing the cause of

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the anemia in 99.9 percent of the cases of NICU grads; and knowing that a Grade I bleed is not usually a big serious thing; and knowing that, you know, NEC, once it resolves, the kid is usually fine; I mean do I think she wasn't important enough? Absolutely not. And I think that that's...
Q Well, not her necessarily. But whatever the NICU physicians were recommending was not --
A No --
Q -- that important to you?
A No, of course it's important to me. Okay.
Q Can you tell me then why you didn't read the discharge instructions in this case?
MS. DAEHNKE: Object. And that mischaracterizes once again his testimony.
THE WITNESS: I don't recall whether or not I read the discharge summary or not.
BY MS. CARMICHAEL:
Q Okay. In any event, whether you read it or whether you didn't, you did not comply with the NICU doctors' request that you draw a CBC and diff with retic count 30 days after discharge. Correct?
MS. DAEHNKE: Object to form with regard to comply.
But answer the question if you can.

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THE WITNESS: I did not order a CBC with retic count at the time. We order what the child needs and nothing more.
BY MS. CARMICHAEL:
Q And it was your opinion, based on your examination of MayRose, that she did not require a follow-up CBC with differential and retic count. Correct?
A Yes.
MS. DAEHNKE: Well, object as to what time.
MS. CARMICHAEL: Thank you. That will be all.
THE WITNESS: Thanks.
MS. URDAZ: No questions.
MR. RIGLER: No questions.
THE VIDEOGRAPHER: This concludes the deposition of Ralph Conti, M.D. It's 5:25 p.m. We're off the record. Digital tape number four.
(The deposition concluded at 5:25 p.m.)

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CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE

I, RALPH CONTI, M.D., deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my testimony in said action, that I have read, corrected, and do hereby affix my signature to said transcript.

RALPH CONTI, M.D.
Deponent

REPORTER'S CERTIFICATE

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Karen Berry, a duly commissioned Notary Public, Clark County, State of Nevada, do hereby certify:

That I reported the taking of the deposition of the witness, RALPH CONTI, M.D., commencing on June 19, 2012, at 2:12 p.m.

That prior to being examined, the witness was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate transcription of shorthand notes taken down at said time.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in my office in the County of Clark, State of Nevada, this____day of_____2012.

_____

EXHIBIT H

DEPOSITION
OF
ALI PIROOZI, M.D.

Hurst, et al. v. Sunrise Hospital and Medical Center, LLC, et al.
Case No. A-10-616728-C
January 18, 2012

CONDENSED TRANSCRIPT AND KEY WORD INDEX

TURNER REPORTING & CAPTIONING SERVICES, INC.
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DISTRICT COURT

CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST, Plaintiffs, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC; MARTIN BLAHNIK, M.D.; ALI PIROOZI, M.D.; RALPH CONTI, M.D.; and FOOTHILLS PEDIATRICS, LLC, Defendants.	)	Case No. A10616728C Dept.No. XXIV

VIDEOTAPED DEPOSITION OF ALI PIROOZI, M.D.

Taken on Wednesday, January 18, 2012

At 10:10 a.m.

At 2300 West Sahara Avenue, Suite 420

Las Vegas, Nevada

Reported By: Karen J. Berry, RMR, CCR 836

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VIDEOGRAPHER: BECKY ULREY
CERTIFIED LEGAL VIDEOGRAPHY

EXAMINATION

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EXHIBITS

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THE VIDEOGRAPHER: This begins the videotaped deposition of Ali Piroozi, M.D. Today's date is January 18, 2012, and the time is 10:10 a.m.

This deposition is taking place at the law offices of John H. Cotton and Associates, 2300 West Sahara Avenue, Suite 420, in Las Vegas, Nevada.

And the venue is the District Court of Clark County, entitled Tiffani D. Hurst and Brian Abbington, jointly and on behalf of their minor child, MayRose Lili-Abbington Hurst, versus Sunrise Hospital and Medical Center, LLC, et al; Case Number A-10-616728-C.

I'm Becky Ulrey with Certified Legal Videography, and the court reporter is Karen Berry with Turner Reporting and Captioning Services.

Will counsel please identify yourselves, and then the reporter will administer the oath.

MS. CARMICHAEL: Jackie Carmichael on behalf of the plaintiffs.

MS. URDAZ: Jonquil Urdaz on behalf of Sunrise Hospital.

MS. LUCERO: Laura Lucero on behalf of Ralph Conti, M.D., and Foothills Pediatrics, LLC.

MR. COTTON: John Cotton on behalf of Doctors Piroozi and Blahnik.

THE WITNESS: Ali Piroozi.

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Thereupon--

ALI PIROOZI, M.D.

was called as a witness by the Plaintiffs and, having been first duly sworn, testified as follows:

EXAMINATION

BY MS. CARMICHAEL:

Q Doctor Piroozi, will you please state your full name and your current address for the record?

A Ali Piroozi, 12075 Whitehills Street, Las Vegas, Nevada, 89141.

Q Thank you. Have you had your deposition taken prior to today?

A Yes.

Q On how many occasions?

A Two occasions.

Q And on those two occasions, were you testifying as a party, an expert, a treater, in what capacity?

A As party.

Q Okay. And when were those depositions taken?

A I believe it was 2007 or 2008. I'm not sure.

Q And in those two instances, were those separate cases?

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A No, just one case.
Q But you were deposed two times?
A Two times.
Q And were you a defendant in that case?
A I was dismissed, but I still gave the deposition.
Q Okay, you were initially named as a defendant?
A Correct.
Q And what were the allegations in that case?
A It was a malpractice.
Q And what specifically was being alleged against you?
A It was a baby that had infection, and there was allegation there was delay in treatment.
Q Okay. Other than that action, have you been involved in any other prior lawsuits?
A No.
Q And what was the name of that case?
A I believe Campen versus almost 40 physicians and staff of Cedar Sinai Medical Center. And then turned to Campen versus Cedar Sinai Hospital.
Q All right. Did you review any documents in preparation for your deposition today?
A Yes, I did.

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Q And what did you review?
A Progressive notes and lab values.
Q Okay. You're referring to the NICU progress notes of MayRose Hurst?
A Correct.
Q Did you review only your notes, or did you review all of the notes?
A Just my notes.
Q And then you also reviewed the lab reports?
A Yes.
Q Did you review any other documents?
A No.
Q Did you review the transfusion records?
A Yes.
Q Have you reviewed any depositions that have been given in this case?
A No.
Q Have you reviewed any summaries of depositions that have been given in this case?
A No.
Q Did you bring any records with you today?
A Yes.
Q What did you bring?
A Copy of progressive notes.
Q Excuse me?

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A Copy of progressive notes.
Q And where are those?
A I think I put it in the other room.
Q Okay. Is that your own personal copy of your progress notes?
A Yes.
Q I would like to review those just to make sure that my set of records is complete with regard to your progress notes.
A Sure.
Q We'll grab those on a break.
MR. COTTON: I can just give you the Bates stamped numbers, because that's all, I just gave him a copy of this.
BY MS. CARMICHAEL:
Q Okay, that was my next question is where did you receive your copy --
A Just --
Q -- of those notes?
A -- recently from John.
MR. COTTON: It's SH00005 through 01074.
MS. CARMICHAEL: Zero one?
MR. COTTON: 01074.
MS. CARMICHAEL: Okay. And John, does that include the lab reports that he referenced as well,

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or?
MR. COTTON: Yeah, I think those were in there, too. There was some -- what do you call them? Transfusion records in there.
MS. CARMICHAEL: Okay. Do those Bates numbers include all of the NICU progress notes from the other physicians?
MR. COTTON: I'll just make a copy when we take a break and you can have a copy.
MS. CARMICHAEL: Thank you. I appreciate it.
BY MS. CARMICHAEL:
Q We will attach as Exhibit 1 to your deposition the specific set of records that you were given and that you reviewed in preparation for today.
A Sure.
Q Okay? Have you spoken with anyone other than your counsel regarding the claims in this lawsuit?
A No.
Q Have you talked with Doctor Blahnik about the claims in the lawsuit?
A Yes.
Q Okay. On how many occasions have you spoken to him about the claims?

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A Few times initially.
Q All right. And what, and you said "initially," meaning shortly after the suit was filed, or when?
A Yes.
Q Okay. What was the subject of, what was the content of those conversations?
A The choice of attorney that is going to represent us, and very few details because we didn't remember the case that well.
Q Okay. During those conversations that you had with Doctor Blahnik regarding the claims in this suit, did the two of you review medical records together?
A No.
Q And when you were discussing your memory of MayRose, what specifically did the two of you recall in those conversations?
A Very limited. We remembered that we were taking care of MayRose, but we didn't know was the basically the allegation is. And that was it.
Q Okay. And then you also selected an attorney together to represent you?
A Actually, it was presented to us that John Cotton is going to represent us.

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Q Okay. Other than Doctor Blahnik, have you spoken to anyone else, again, excluding counsel, regarding the claims in this lawsuit?
A I believe I talked to Doctor Klein. And that's a hematologist.
Q Doctor Klein at what, did you say?
A Doctor Klein. Alan Klein.
Q Okay. And who is Doctor Klein?
A He's a hematologist at Sunrise Hospital.
Q At Cedar Sinai?
A No, at Sunrise Hospital.
Q Oh, at Sunrise. I'm sorry. And what did you discuss with Doctor Klein?
A It wasn't regarding this case, but he brought something about this case.
Q He, excuse me?
A It wasn't specifically about this case.
Q But he?
A He pointed out this case.
Q He pointed it out to you?
A Yeah.
Q In what way? What did he say?
A Because he's a physician taking care of MayRose at some point.
Q And what did he say to you specifically?

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A I asked him about the patients that we have and the standard of care that we have, similar cases with MayRose. And he specifically told me that the standard of care is the one that we rendered, and the follow-up blood test in one month.
And he pointed out if your concern is the MayRose case, that I was taking care of that baby, that is very, very rare, and the standard of care is the way that we are doing, basically.
That was, I think that was six, seven months ago.
Q And did Doctor Klein give you any understanding as to what records he had reviewed, if any?
A My understanding is he's a hematologist of MayRose.
Q Okay, so he's a current treating physician?
A At the time, yes.
Q Okay. And when did you have this conversation with him?
A I think about eight, nine month ago.
Q And did he say whether or not he had reviewed the medical chart from Sunrise Hospital?
A I don't know.
Q He didn't tell you, or you don't remember?

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A I, I don't remember.
Q Okay. Did you ask him to review any records?
A No.
Q Okay. Other than Doctor Klein and Doctor Blahnik, have you spoken with anybody else about the claims asserted in this case?
A No.
Q Have you ever spoken with Doctor Conti regarding these claims?
A No.
Q Do you know who Doctor Conti is?
A Yes.
Q How do you know him?
A I know through the MayRose follow-up that he's a pediatrician, but I don't know him in person.
Q You've never met him?
A One time briefly.
Q And what was, what were the circumstances of that meeting?
A It wasn't a meeting. It wasn't in a meeting. Just I was in NICU at Mountain View, and he came introduced himself as Conti. I don't recall if I introduced myself to him. And he shook my hand and he went and saw his patient.

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Q But that patient was not MayRose?
A No, it was just, it was like I think four, five months ago.
Q This was just four or five months ago?
A I believe so.
Q So at the time you cared for MayRose, you had never met Doctor Conti?
A No.
Q Okay. Nor had you spoken with him over the phone?
A I don't remember. I don't recall.
Q While we're on the subject, do you remember ever seeing him attend to MayRose during the time she was in the NICU under your care?
A I don't recall.
Q Okay. All right. I have your CV, and unfortunately, I don't have any copies made. So I'm going to ask you some questions and then we'll mark it as an exhibit.
A Sure.
Q First of all, just look at it. I was provided this copy by your counsel. And just tell me if that is a current up-to-date rendition of your CV?
A It seems like it's current. I believe so.
Q Okay. Okay. And so according to your CV,

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you obtained your medical degree in Tehran. Is that correct?
A Correct.
Q Okay. And then you completed a residency at Mt. Sinai in New York?
A Correct.
Q Okay. All right. And it was in pediatrics?
A General pediatrics.
Q Okay. And then it appears that you completed a fellowship in neonatology at UCLA, Cedar Sinai?
A Correct.
Q Okay. And you completed that in February of 2005?
A Correct.
Q Okay. And are you a board certified neonatologist?
A Yes.
Q And when did you obtain your board certification?
A I believe 2005.
Q How often do you have to renew those boards?
A Seven to ten years.
Q So will you be renewing in 2012 or 2015?
A I can retake it in 2000 -- in ten years.

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Every ten years.
Q Did you become cert -- did you receive your certification on your first attempt?
A Yes.
Q Okay. It appears then after completing that fellowship that you became a staff neonatologist at Cedar Sinai?
A Not immediately.
Q What did you do in the interim?
A I was working in under-serve area in North Las Vegas as a general pediatrician.
Q As a pediatrician?
A Correct.
Q And did that practice have a name?
A Guadalupe Medical Center.
Q Okay. When did you start there?
A It should be January 2005 or February 2005.
Q Okay. And then you, did you remain there until you took the position at Cedar Sinai in June of 2006?
A Yeah, actually, I was working at Cedar Sinai as well as working, continue working at Guadalupe. I was commuting.
Q Okay. And is this the Cedar Sinai in --
A Los Angeles.

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Q -- at UCLA?
A Yes.
Q Okay. And you worked there -- well, how long did you do both? How long did you commute and do both?
A I don't remember. I think at least maybe one or two years.
Q Okay. And then you were a staff neonatologist at Cedar Sinai through October of 2009?
A Yes.
Q Beginning in June 2006?
A Yes.
Q Okay. Okay. When did you start working as a staff neonatologist at Sunrise?
A Should be 2007.
Q Okay. And you've, you've identified your current position as a staff neonatologist at Sunrise Children's Hospital, as well as Medical Director of NICU at Mountain View Medical Center. Is that right?
A Correct.
Q And is it true that Sunrise Children's Hospital and Mountain View Medical Center are in fact affiliated?
A Yes.
Q They're, they have a common owner?

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A I don't know the owner, but.
Q Okay. All right. And as, you've identified yourself as a staff neonatologist at Sunrise. What does that entail?
A It means a board certified neonatologist working in a position of prenatal and neonatal physician at NICU.
Q Okay. And I assume indicating you're on staff there, it goes beyond saying you simply have hospital privileges there. Is that true?
MS. URDAZ: Objection --
THE WITNESS: I don't understand.
BY MS. CARMICHAEL:
Q Okay. Do you have some kind of a working relationship with Sunrise that requires you to work there as a neonatologist?
MR. COTTON: Him personally?
BY MS. CARMICHAEL:
Q Uh-huh.
A I'm part of a group. The group that I'm working for has a contract with Sunrise Children Hospital.
Q Okay. In discovery responses, Sunrise actually produced a contract between a company called Pickert's Children's Healthcare of Nevada, Limited,

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d/b/a Neonatal Physicians of Nevada, Limited. Is that the company that you're affiliated with?
A Currently, I'm working for Mednax. But at the time, it was Children Health Network. I believe that was it.
Q At the time meaning at the time you cared for MayRose?
A Yes.
Q Okay. And what, during that timeframe, what was your arrangement with Children's Health Care of Nevada?
A I was an employee.
Q You were an employee?
A (Nods.)
Q And is that a company that's run by a Doctor James Swift?
A Correct.
Q Okay. And what is your understanding with regard to the relationship that that organization has with Sunrise Hospital, or had during 2008?
A I didn't have any idea about any type of detail in their relationship. I wasn't involved in that.
Q Well, as an employee of that organization, what were your responsibilities towards Sunrise

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Hospital?
A I was working as a neonatologist in NICU. I rendered the care.
Q Okay. How were you paid for the services you provided at Sunrise Hospital?
A It was a set salary.
Q Paid by whom?
A By the group that I was working.
Q So your salary was paid to you by Children's Healthcare of Nevada?
A Yes.
Q And with regard to the services that you provided to Sunrise Hospital, did you, did your organization, Children's Healthcare of Nevada, do its own billing for your services to the patients that you cared for?
A Yeah, the billing was done by the group.
Q Were there occasions when Sunrise Hospital would bill for the services that you provided?
A I don't know.
Q If I told you that MayRose Hurst's bills from Sunrise Hospital included fees for neonatologists, would you have any reason to dispute that?
A I don't have any knowledge about the

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billing.
Q So for all you know, the billing was, for your services was done by Sunrise Hospital?
A I don't know.
Q Okay. In 2008, were there any other medical services that you provided under your, as an employee of Children's Healthcare of Nevada in addition to the services you provided to Sunrise Hospital?
A I believe I was working at Cedar Sinai still. And I don't recall other, like moonlights that I just doing other places. I don't recall.
Q Was your work at Cedar Sinai as an employee of the Children's Healthcare of Nevada?
A No. Separate.
Q That was a separate --
A Correct.
Q -- independent thing that you did?
A I was an employee of Cedar Sinai as well, part-time position.
Q All right. So did you sign a contract with Children's Healthcare of Nevada?
A Yes, I had a contract.
Q And do you have a copy of that?
A Unfortunately, I don't.
Q Did Sunrise Hospital ever pay you directly?

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A No.
Q Did you, and by "you" I mean your employer, Children's Healthcare of Nevada, maintain copies of the medical records generated for the care you provided at Sunrise Hospital?
A I don't know.
Q You don't know?
A I don't know kind of record-keeping.
Q Who determines your work schedule at Sunrise?
A Usually the medical director.
Q The medical director of Sunrise?
A Medical director of the group that I'm, we were working at, NICU. We have a medical director.
Q Of the NICU?
A Of the NICU.
Q At Sunrise?
A At Sunrise.
Q And how would you become aware of your schedule?
A Usually a month prior.
Q It would be posted somewhere in the hospital, or how?
A I believe that they would just email it to us.

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Q And the medical director of the NICU at Sunrise was, do you know if that person was a Sunrise employee?
A I don't know.
Q What was the medical director of the NICU's name?
A It was, last name is Fulrod.
Q Fulrod?
A Yeah.
Q Okay. Mr. Or Mrs.?
A Mr.
Q Mr., was Mr. Fulrod an employee of the Children's Healthcare of Nevada?
A I believe so.
Q Did you ever appear in any print, television, or any other kind of advertising for Sunrise Hospital?
A No.
Q Did you tell the patients that you treated at Sunrise Hospital that you were not an employee of Sunrise Hospital?
A I don't remember.
Q You don't remember ever having a conversation like that with your patients?
A No.

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Q So when you treated, provided treatment to MayRose in the summer of 2008, you had worked as a neonatologist since, since June of 2006; is that right, for two years?
A I believe so.
Q Okay. Okay. In providing neonatal care to a premature infant, do you believe it is important to know what occurred during the prenatal course?
A Yes, I do.
Q And do you have any methods or manner by which you go about finding out that information?
A Usually the information is provided to us from the Ob-Gyn record.
Q The Ob-Gyn record?
A Yes.
Q So you would review the records of the Ob-Gyn?
A Yeah, at the time of the admission of the newborns, we have some access to the record of the mom.
Q Okay.
A Usually.
Q And would you agree that it's important to know about any abnormal test results during the prenatal period?

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A Can you repeat the question?
Q Would you agree that it is important for you, as the neonatologist, to know about any abnormal test results that occurred --
A Yes.
Q -- during the neonatal period?
Okay. If the birth mother was consulting with a perinatologist during the prenatal course, would it be important for you to know what had happened during her course with the perinatologist?
A It's important if we have access to those information.
Q Okay. In your training, your education, and your experience, Doctor, did you receive, or did you come to have any understanding regarding the clinical significance of an abnormal nuchal translucency or nuchal fold on ultrasound during the prenatal period?
A That specifically is more limited to practice of perinatologists. We are not dealing with those specific kind of information. But we get aware of that by perinatology.
Q Okay. Would you, do you know as you sit here today what the clinical significance would be of an abnormal nuchal translucency or nuchal fold?
A It's not part exactly neonatologist kind of

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knowledge.
Q So the answer would be no?
A Is no.
Q Okay. So you don't know what the potential implications might be if a, if a baby in your care had had an abnormal nuchal translucency --
A This is information that --
MR. COTTON: You have to let her finish her question.
THE WITNESS: Sure. You can finish.
MS. CARMICHAEL: (To the reporter:) I'm going to have you read that back in just a minute.
BY MS. CARMICHAEL:
Q Generally, you're doing great. And this is my fault because I didn't go over any ground rules. But so that we can have a clean transcript, I know that you can anticipate what I'm saying, or the end of the sentence. If you'll just wait until I finish before you start your answer.
A Sure.
Q And likewise, I'll try never to cut you off. If you pause though and I think you're done and start in with another question and you're not done, just let me know, and then I'll let you finish your answer.
MS. CARMICHAEL: (To the reporter:) Could

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you repeat the last question, please?
(The last question was read back.)
BY MS. CARMICHAEL:
Q Or nuchal fold during the prenatal period.
A This is information that usually perinatologist they have. And the implication on the, on the baby's care has to be transferred to us. We are not the people that taking care of the mom or obtain the ultrasound. So the assessment and idea that was going to be the implication usually has to be transferred to us from the other specialist.
Q Okay. And I understand the answer you're giving me. My question is just a little bit different.
My question to you is whether or not you know what the potential implications to the baby would be after birth if the baby had had an abnormal nuchal translucency or nuchal fold test result during the prenatal period?
A It's not my field of expert.
Q So you would not know?
A It's the information that perinatologist has to provide to us. It's not a test that we do.
Q Okay. All right. So if, for example, a mother were to say to you, while you were caring for

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her baby in the NICU, "Are the problems that my baby is suffering from due to the abnormal nuchal translucency test," you would not be able to respond to that question. Is that true?
A I would get the record of the, the test and would contact the perinatology and discuss the test with the perinatologist.
Q Okay. All right. Doctor, during your education and training, did you receive any knowledge regarding the diagnosis and treatment of blood disorders?
A I did.
Q And tell me a little bit about that. What training did you receive?
A It's during the medical education in the medical school we get trained about different blood diseases. This training is going to get more specific for pediatrics age group during the residency, and during the neonatology training as well we continue having this kind of education.
Q Okay. And did that education include any kind of training with respect to how to differentiate between anemia due to prematurity and anemia caused by a specific blood disorder or genetic defect?
A Yes.

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Q Okay. And what training did you receive in that regard?
A It's just a very broad kind of training, and it's just a part of curriculum of American Academy of Pediatrics. And we take the board basically going over those format of differential diagnosis.
Q Okay. But you, you receive training that would help you to know, in reviewing a blood test, for example, that would help you to know if there was certain indices that would point to the cause of the anemia being something other than prematurity. Yes?
A It's part of the training, yes.
Q Okay. All right. Now, at some point during your care of MayRose, did you come to have an understanding that she in fact had experienced an abnormal nuchal translucency or nuchal fold test result on ultrasound prior to discovery?
A I wasn't a physician admitting MayRose, so those information was probably transferred to physician who admitted and reviewed the prenatal lab result or test.
Q Okay. And if in fact the admitting physician obtained that information, are you saying that that information was never passed on to you?
A I don't remember to come across that

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information.
Q Okay. Other than MayRose, have you ever cared for an infant in the NICU who had anemia as a result of a genetic defect or a specific blood disorder?
A I don't recall.
Q Okay. My understanding from the medical record is that MayRose Hurst was born or delivered when she was 28 weeks and six days. Is that your understanding?
A Correct.
Q Okay. So just one day shy of 29 weeks?
A Correct.
Q Okay. What are the, the biggest concerns for a baby of that age being delivered?
A Respiratory distress is going to be the main one. Also sepsis and infection is going to be another important diagnosis.
And all the premature babies, they are going to have premature systems, including the bone marrow. So they have always at risk for anemia. They are going to have premature intestine. They are going to have susceptibility to having problem with feeding. They are going to have premature immune system. They are going to have susceptibility to getting infection.

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Bottom line, all the systems are premature.
Q Okay. Statistically, what kind of a chance do 28-and-six-day-old babies have of surviving these days?
A These days, actually it's very close to 95 percent survival.
Q Okay. And also statistically what do babies of that age, the 28, 29-week-old babies typically have long-term problems?
A I have to review the statistics, but it should be about 40 percent.
Q Forty percent that would have long-term problems?
A Correct.
Q Okay. Is there a particular weight of baby in that age group that would be reassuring to you? Or is there kind of a cut-off point where you can say if, if they weigh 1,000 grams or more they have a better chance than if they're under 1,000 grams? Is there any kind of a marker with regard to weight?
A There is no magic number. But it depends to different cases are different.
Q Okay. From the medical record, it appears that MayRose weighed 1280 grams?
A Correct.

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Q Is that what you would consider a good weight for a baby of her age?
A She was very critically sick with different medical problems that made her very critical regardless of her birth weight.
Q Okay, I appreciate the comment, but if you could just answer my question about the weight right now. And we'll get to all of her problems.
A We are not assessing the babies based on the weight. And we are not prognosticate them based on the weight. That's just a simple number.
Q Okay. And I guess what I'm trying to find out is for her age, did she have a high weight, a low weight, an average weight? How was her weight given her age?
A For 28 weeks to 29 weeks gestation of age, that weight is still in the range that of the curve. So it just different percentage, but still that curve.
Q Okay, it's in the curve meaning?
A We have a curve of five percent to hundred percentile.
Q And you don't know where that weight lands in the curve?
A I have to just plot it.
Q Okay. That's fine. I understand that her

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Apgar scores were three, six, and seven. What can you tell me about the clinical significance of having, and let's start with the Apgar score of seven at ten minutes, what is the clinical significance of that?
A About MayRose or generally? Because I was not there and I wasn't taking care of her.
Q Generally.
A Generally. So the lower Apgar scores indicated more critical patient. Especially ten minutes of life.
Q Okay. And do you consider a score of seven at ten minutes to be a low score?
A Relatively low.
Q What would a normal baby be expected to have at ten minutes?
A Maximum number is ten.
Q I understand that, but what is your typical normal baby have at --
A It's very hypothetical, you know. Different babies are different. But you prefer to be closer to ten, after ten minutes of resuscitation.
Q Okay. What is your understanding as to why MayRose was delivered prematurely?
A That was part of the differential diagnosis. I was not there. I wasn't a physician taking care of

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her at that time.
Q Sure. I understand that. But as her NICU neonatologist, did you at some point come to an understanding as to why she had been delivered prematurely?
A I don't recall. I don't have any information at the time of admission. And I didn't review it recently.
Q And so I assume similarly you do not know who made the decision or recommendation to deliver her prematurely?
A I don't have any access to that information and I don't recall.
Q Do you know Doctor Dickens-Williams?
A I know the name, but I don't remember I ever met her or him.
Q Okay. How about a Doctor Wold, W-o-l-d?
A He's a perinatologist.
Q Okay. And you know him?
A In person, he was perinatologist of my ex. So that's the way that I know him.
Q Okay. Did you ever speak with either the Ob-Gyn who delivered MayRose or the perinatologist that was consulting on her case?
A No.

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Q Were you ever provided any knowledge regarding the birth mother Tiffani Hurst's hospital course before MayRose was delivered?
A No, I wasn't taking care of MayRose when she was born.
Q Do you have -- did you, were you provided any knowledge of what medications or treatments were provided to Ms. Hurst and MayRose prior to her C-section delivery?
A I believe those informations are part of the admission note. And I don't recall if I read it or not, because years before and I didn't review it recently.
Q Okay. So are you telling me that in your practice you might not review the neonatology admitting note if you were not the admitting neonatologist?
A The information in chart is accessible and usually we are going to read.
Q But in this specific instance, you don't recall whether you did or not?
A Years ago, I don't remember.
Q Okay. Did you ever become aware that the medication Indocin had been administered to Ms. Hurst to try to stop the labor?

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A It's part of the record, yeah.
Q You did become aware of that?
A Yeah, it's part of record.
Q And did you ever express the opinion or concern that perhaps the Indocin had caused or contributed to the development of MayRose's bowel perforation?
A I don't recall because I wasn't taking care of her the first day. But that can be a factor.
Q Okay. As we sit here today, Doctor Piroozi, can you recall what information or what knowledge you had regarding either MayRose or her mother as you assumed the care of this child?
A I remember MayRose was very sick, critical, and mom was involved. But not a specific, I don't recall specific things.
Q Okay. Now, specifically with regard to MayRose, do you believe you reviewed any of her prenatal records?
A I don't remember.
Q Do you believe you talked to her perinatologist or any of the specialists she saw prior to delivery?
A I wasn't involved with the admission, so I don't think so.

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Q Do you recall having any discussions with the parents wherein they gave you a history regarding MayRose's prenatal course?
A I don't recall.
Q Do you have an independent memory of MayRose Hurst as we sit here today?
A I remember I was taking care of her, but not specific unfortunately.
Q Do you specifically remember her though, what she looked like?
A No.
Q Okay. That's fine.
From your review of the records, your notes, the labs, et cetera, what do you recall were her issues after she was born?
A She had respiratory distress. She required intubation and ventilation. Seems like she had a need for CPAP and oxygen.
She had sepsis infection, required antibiotics.
She had perforation of intestine, required surgery and ostomy placement.
She had anemia.
She had rule out infectious, possibly fungal infection. She had mastoiditis, small sort of

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infection.
She had thrombocytopenia, low platelet. Required platelet transfusion.
She had DIC, required transfusion of FFP.
She had IVH, or bleeding in the brain, grade one.
She had abnormal newborn screening that required follow-up for cystic fibrosis.
She had, I believe pneumonia and tracheitis with Enterobacter. That's one sort of bacteria.
She had ROP, retinopathy of prematurity, require follow-up by eye doctor.
And she had a history of taking down the ostomy by surgery. She required central line Broviac.
She had apnea prematurity. She had --
Q She had, what was the last one?
A Apnea prematurity.
Q Apnea?
A Yeah. Breathing, actually. Just pausing breathing.
Q Okay.
A And so on. I have to think about it. But she had multiple problems.
Q Okay. And you believe that all of the problems you've identified here are identified in your

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NICU notes?
A I believe so. It's a part of the discharge summary and, or individual notes.
Q Okay. All right. We'll go through some of those.
A Sure.
Q Okay. So she certainly had low hematocrit. Yes?
A What do you mean? It's very general. So yes, she had some low hematocrit, yeah.
Q Okay. Indicative of anemia?
A Yes.
Q Okay. And you would agree with me that there are many different types of anemia? Yes?
A In general, yes.
Q Okay. And there are also many different causes of anemia? Yes?
A Yes.
Q Okay. Some of the causes can be a loss of blood from traumatic injury? Yes?
A Yes.
Q Internal bleeding?
A Yes.
Q Nutritional deficiencies in iron, vitamin B12, and folate?

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A Correct.
Q Bone marrow problems such as red cell aplasia?
A Could be.
Q Abnormal hematocrit, such as sickle cell anemia?
A Correct.
Q Okay. And did you, I assume your, with your training regarding how to differentiate between anemia, prematurity, and other anemias, you're also familiar with what a standard anemia workup to determine the cause of anemia would consist of? Yes?
A Yes.
Q Okay. And part of that work-up is certainly drawing blood? Yes?
A Correct.
Q Okay. And from the lab results, you are able to, some of the values, you are able to tell whether the anemia is microcytic, normocytic, or macrocytic. Is that right?
A Yeah, that's specific for more pediatrics patients. But newborns those indicis are not really that relevant but still important.
Q Okay. Did you note what MayRose's anemia was, whether microcytic, normocytic, or macrocytic?

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A I have to review the record.
Q Okay.
MS. CARMICHAEL: While we're at it, let's, let's mark his CV as Exhibit 2. And we'll mark this lab summary discharge report as Exhibit 3.
(Plaintiffs' Exhibits 2 and 3 marked for identification.)
BY MS. CARMICHAEL:
Q You can refer to that as we go through some of these questions.
A Sure.
MR. COTTON: If she refers to a Bates number, she's talking about these numbers down at the bottom here.
THE WITNESS: That she's saying? Sure.
BY MS. CARMICHAEL:
Q Going back to my prior question, Doctor. Just wondering if you had determined during your care for MayRose whether her anemia was microcytic, normocytic, or macrocytic?
A I don't recall.
Q Can you tell from reviewing the --
A This seems --
Q -- lab reports?
A These lines, first lines, 28, seems like

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it's normocytic.
On 27 is normocytic as well.
On 26 is normocytic.
Yeah. So it's ongoing. So I have to review everything. But seems like it's just for last three days it was normocytic.
Q Okay. And just go ahead and look back before that and see if that continues to be the case.
A Seems like on 21st is macrocytic. And --
Q Did you say micro or macro there?
A Macro.
Q Macro?
A Is 86, and max has to be 84.
Q Okay.
A It's persistent as macro on 7th, July 6th, again is going to get normocytic. Then is going to get some macrocytic on July 3rd. And it's going to be normocytic. Then it's macrocytic on 6/25th. Normocytic. Then it's normocytic here. Yes.
Q Okay. So is it fair to say that it kind of goes back and forth between normocytic and macrocytic?
A Correct.
Q But it's never microcytic. Is that right?
A Correct.
Q Okay. All right. And I believe there's a

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reference, I'll see if I can find it somewhere in this lab summary report, of microcytosis. Can you tell me what that means?
A It means the red blood cells are larger and bigger than normal.
Q Okay. And here we go. It's on Bates number 1043, page 17 of the lab report.
A Okay. Yeah, microcytic, macrocytosis, polychromasia, anisocytosis. Yeah.
Q Okay. All right. Okay. And in your education and training, Doctor, were you aware that Diamond-Blackfan anemia is characterized by macrocytic anemia?
A Yes.
Q Did you know that? Okay. All right.
And did you know it is also characterized by reticulocytopenia?
A Yes.
Q And MayRose, once somebody decided to take a reticulocyte test, she had, she had that condition as well. Correct?
MR. COTTON: I'm going to object to the form of the question as vague as to, "once she did," as to time. Are you talking about in the hospital or sometime?

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BY MS. CARMICHAEL:
Q In the hospital, when, when the neonatologist at Sunrise NICU finally decided to run a retic test, a reticulocyte test, her reticulocyte tests were low. Do you recall that?
A I, I reviewed the notes and the record. There are two values. One is normal, one is low.
Q What do you make of that?
A Low retic count after transfusion.
Q Okay. All right. So we've talked about some of the different causes of anemia. There are also different forms or types of anemia. There's iron deficiency. Right?
A Correct.
Q Sickle cell disease?
A Correct.
Q Thalassemia?
A Uh-huh.
Q Yes?
A Yes.
Q Spherocytosis?
A Yes.
Q Pernicious anemia?
A Yes.
Q Aplastic anemia?

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A Yes.
Q And that one is the inability of the bone marrow to produce blood cells. Is that right?
A Correct.
Q Okay. And then there's pure red cell aplasia, which is the inability of the bone marrow to produce only red blood cells. Is that right?
A Yes.
Q Okay. All right. So what are the most common symptoms of anemia due to prematurity?
A We can have a medical, like a physical findings that can reflect in the vital signs. Signs of tachycardia, higher heart rate.
The patients can have problems with breathing. It can be simply apnea.
We can have problem with blood pressure. The patient can be shocking with low blood pressure. These on the physical vital signs finding.
Another thing is by physical exam by looking at a baby, baby can be pale. Can be weak.
And the neuro exam can be normal -- abnormal with lethargy and absent of movement.
History is important. Maybe the baby is going to be unable to be fed, unable to be sucking and swallowing bottle.

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Q So these are all clinical signs and symptoms?
A Correct.
Q And then what about on lab value? What is the most common symptom of anemia due to prematurity?
A Usually is low hematocrit. And that's the main thing that we see in the CBC.
Q And would you expect that to be normocytic, microcytic, or macrocytic?
A It can be variant based on the patient's condition.
Q Okay. What are the most common symptoms of thalassemia?
A Thalassemia is a genetic disease. And basically it's hemoglobin problems.
Q So what are the most common symptoms of it?
A Exactly like anemia.
Q Excuse me?
A Like anemia. The same things --
Q Exact --
A -- I explained to you.
Q Okay. So the same, the same symptoms. Right?
A As anemia, yeah.
Q Okay. And what about, what are the most

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common symptoms of Diamond-Blackfan anemia?
A As well as anemia.
Q The same, the very same symptoms that you would expect to see in anemia prematurity. Is that right?
A Almost.
Q Okay. Okay, so what symptoms would a premature infant in your care, in the NICU setting, have to have in order for you to begin to explore or try to determine whether or not their anemia is just due to prematurity or whether it's due to some more serious condition?
A If it's unusual presentation, we are thinking about rare cases.
Q Okay. What about if the birth parent has a genetic history of thalassemia in his family?
A Routinely, all the babies they are given the newborn screening. And thalassemia on hemoglobin assessment is part of newborn screening of the state. Just getting screened.
Q Are you, did you, are you telling me that you screened MayRose for thalassemia?
A All the babies, all the babies in the state, they get newborn screening. And part of the newborn screening is a screening of hemoglobin, including

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thalassemia, sickle cell. So automatically everybody get that. She got that.
Q During NICU?
A Yes.
Q Okay. So those screenings, those screenings occurred?
A Yes.
Q And are those screenings in the medical record?
A Should be.
Q Excuse me?
A Should be. All the babies they get newborn screening. All of them.
Q Where would we find those records?
A It should be in the chart. As a matter of fact, sickle cell that's abnormal is part of it newborn screening. So she was screened.
Q This is a screening that the State of Nevada performs?
A Correct.
Q Like the cystic fibrosis screening?
A Correct.
Q Okay. And, but you don't know, you can't point me to anything in the medical chart. You're just saying that it would have been done?

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A Since the, the only thing abnormal for cystic fibrosis means that it was done, and the only finding that was abnormal was cystic fibrosis. That's a newborn screening result. So the rest of it I, I have to say it was normal. But I have to see it.
Q Okay. All right. What about the, a low reticulocyte count? Is that going to lead you to investigate further whether the baby's anemia is simply due to prematurity or due to some other cause?
A A low retic count is something that we have to just do an investigation. And for this specific case, I started vitamins and iron. And I ask for follow-up labs, including CBC and retic count.
Q And when did you start the iron?
A I think one day prior to discharge.
Q But other than starting iron, you didn't do any further testing to determine the type or cause of MayRose's anemia?
A That was one value immediate after transfusion. And it's very common to have a low retic count after transfusion. So with point information, I felt there is no need for any additional assessment at that time. So I ask for follow-up CBC and retic count.
Q I'm sorry, I missed some of that. Did you

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say that after transfusion it's common to have a low retic count?
A Correct.
Q And why is that?
A Because the bone marrow is shutting down because there's no need for bone marrow to produce red blood cells. Because the red blood cells are already provided by transfusion.
Q But you had never taken a retic count of MayRose that was in the normal range, had you?
A Point nine based on the value that we have at Sunrise is normal.
Q What other testing could have been done to solidify a diagnosis of the cause of MayRose's anemia?
A Can you repeat the question one more time, please?
Q Sure. What testing could have been done to solidify a diagnosis of the cause of MayRose's anemia?
MR. COTTON: Form and foundation objection. Go ahead.
THE WITNESS: MayRose anemia wasn't unusual and different based on her condition, based on illnesses and critical condition that she had. The retic count that was low initially was thought that it was related to blood transfusion. But to follow up to

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make sure there's nothing else, CBC and retic count was ordered for follow-up.
BY MS. CARMICHAEL:
Q How long after the blood transfusion would you expect a low reticulocyte count?
A About eight days.
Q Okay. Well, the first -- and you can flip to page 57, if you would like to.
A Sure.
Q The first reticulocyte test that was performed on MayRose was done July 14. She had not had a transfusion at that point for 11 days. It had been 11 days since her last transfusion --
A I'm sorry, 57?
MR. COTTON: What page are you on?
MS. CARMICHAEL: Page 57. I'm sorry. Up here. Let me give you a Bates stamp number, too.
THE WITNESS: No, no, that's okay. Fifty-seven.
MR. COTTON: Or later, it's 1083.
BY MS. CARMICHAEL:
Q Yes, 1083.
A Okay, 1083. I see CSF, stool, retic count. Okay.
Q So the first retic test, as far as I can

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determine, was performed on July 14.
Now, MayRose's last transfusion prior to that date was July 3rd, 11 days earlier.
MR. COTTON: That's the .9.
THE WITNESS: Yeah. You are talking about, you know, there are other values in the retic counts. There's retic count and different numbers.
So, let me see. Can I review this for a second?
BY MS. CARMICHAEL:
Q Yes, sure. I believe you're in search of page 19 of the lab report.
A Page 19.
Q Which is the other page that shows retic values. It's 1045.
A 1045, yeah. Yes. This is the one. So retic count that we are talking, this is value .9. And as you can see, the reference normal range that Sunrise labs is providing us is .5 to 1.5, and .9 is within that. At the time, I wasn't taking care of MayRose, but even .9 is normal.
Q Well, it is there, but like you said, over on page 1083, we're seeing a very low retic --
A Correct.
Q -- result.

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A But we are talking about retic count. And the retic count is this. It's basically the management is based on the retic count. More detailed kind of information there.
Q Okay. What is, what is the clinical significance or meaning of the test result on page 1083?
A I don't know that, but we are following the percentage of retic count based, and these percentages can get calculated based on the other red blood cells. So the percentage is important, and this .9 is a number that we are following.
Q Okay. A bone marrow aspiration test would have told you what kind of anemia MayRose had, wouldn't it?
A It's not my expertise, but bone marrow is one of the tests that's important, and, for differential signal diagnosis. But with just .5 and one abnormal retic count, nobody obtained a bone marrow on the patient.
Q Okay. Yeah, nobody followed up though on that one retic test either?
A Yeah, actually, we ordered CBC retic count to establish any possible differential diagnosis. But seems like it wasn't done.

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Q Okay. And we'll get to that and the timing of that follow-up as well.

But before we do, you've brought up a differential diagnosis. You would agree with me that some forms of anemia are not particularly dangerous to the patient while other forms can be potentially life threatening. Is that true?

A It's a very broad kind of, you know, suggestion. Yeah, we have different diseases. Some of them it can be very critical and dangerous. Some of them not.

Q Some anemias can be very critical and dangerous and some of them not?

A Correct.

Q Okay. And when a physician is faced with several possibilities regarding a patient's diagnosis, the physician generally uses a tool called differential diagnosis. Is that true?

A Correct.

Q Okay. And if the differential diagnosis includes any conditions that may be life threatening, then the very purpose of a differential is to rule out the potentially life-threatening conditions first in order to preserve the health and well-being of the patient. Is that right?

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A Correct.

Q Okay. Okay, but in MayRose's case, it was just simply assumed that her anemia was due to prematurity?

A No.

Q Is that right? No, that's not right?

A No.

Q Okay, tell me why that's not correct?

A We are not following a CBC and retic count on babies with anemia prematurity. So we had a retic count that was abnormal. And we wanted to establish the trend. If it's getting better or not. If it's related to blood transfusion or not. That was the reason the follow-up CBC and retic count ordered.

Q Okay. Well, a differential diagnosis regarding the cause of her anemia was never undertaken during her stay in the NICU, was it?

A There, there was, I don't know about other physicians, but basically she was a very critical newborn premature baby with multiple problems. And anemia was very much expected for the babies that go through multiple surgeries, requiring multiple blood draw, had six or seven times sepsis, fungal infection, pneumonia. Was not unusual to have a retic -- have a hemoglobin that's low.

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Q Okay. No efforts were made to conduct any testing to determine if she had a genetic blood disorder during her stay in the NICU. Correct?

A I can speak for myself. I did nothing about any genetic problems based on just one retic count that was abnormally low after transfusion.

Q Do you recall her learning or knowing or hearing from her father that he in fact had a history of thalassemia in his family?

A I don't recall.

Q Okay. No efforts, at least on the part of the NICU, were made to see if she had inherited her father's thalassemia. Correct?

A We routinely testing all the babies for hemoglobin problem, including thalassemia.

Q You are?

A All of them. Yes. That's a part of the newborn screening. So all the babies they get tested.

Q So I thought you said it was the State of Nevada that do those tests?

A Exactly. Not the State of Nevada. We do the newborn screening as part of a state program. All the babies that are born in the state of Nevada are getting tested for hemoglobin abnormalities including sickle cell.

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Q Okay. Are you done? I didn't mean to interrupt.

A Sure.

Q Can you show me in MayRose's medical chart where she was screened for thalassemia?

A I have to have chart. I have to look for it.

Q But you believe that was done?

A It's a part of a newborn screening.

Q No efforts were made to bring in a hematologist to consult on this case. Is that right?

A I had one retic count that was low. And there was no reason for hematology consult at that time.

Q Well, you had a baby who had received 13 transfusions. And her hematocrit was continuing to fall, even after 13 transfusions. At the time of discharge, her hematocrit was on the way down again. And you don't think that that would be a reason to bring in a hematologist for a consult?

A MayRose never had profound anemia. Now, in the NICU, N-I-C-U, we do not even transfuse babies that are asymptomatic even down to hematocrit of 20. And she, the lowest hematocrit that MayRose had was 24, I recall.

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The majority of these transfusions given for possible surgery, or maybe she was septic, or she was sick. And other reasons were the reason of transfusions. Not anemia.

Q Okay. Let's go to that then for a minute.

MS. CARMICHAEL: (To the reporter:) Can you mark that as four?

(Plaintiffs' Exhibit 4 marked for identification.)

BY MS. CARMICHAEL:

Q Doctor Piroozi, we'll mark the transfusion record as Exhibit 4 to your deposition, and you may refer to that as we go through this next set of questions.

A Sure.

Q So according to the transfusion record, MayRose had a total of 13 transfusions during her NICU stay. Do you agree with that?

A I believe two of transfusions the red blood cells. One was a FFB, and one was platelet, with just, I think it was 11 red blood cells. Yeah, platelet was on Bates 000687. That was a platelet transfusion. It wasn't red blood cells.

Q What is the date of that?

A I have May 15, 2008.

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Q Okay.

A Also, she received, yeah, on May 15 as well, she received fresh frozen plasma. That's not red blood cells.

So if you counted everything 13, should be just, minus two, is going to be 11 transfusions.

Q Okay. And the date that that platelet and plasma transfusions occurred was May 15. Is that right?

A Yes.

Q And that's the date of her surgery for necrotizing enterocolitis. Is that right?

A For GI perforation.

Q Okay. And fresh frozen plasma and platelet transfusions in connection with the surgery would be anticipated?

A Not necessarily. Most probably she had a very low platelet.

Q Okay.

A And she had a coagulation problem that is not routine to give all the babies platelet and FFP for surgery.

Q Okay. All right. You've indicated that at least as far as you're concerned, there were valid reasons for MayRose to be needing these transfusions other than being anemic. Is that right?

A Correct.

Q Okay. And one of the things mentioned was the surgeries. Is that correct?

A Correct.

Q Okay. Have you had an opportunity to review the operative reports?

A No.

Q Okay. MayRose had the exploratory laparotomy and ostomy and appendectomy, right, on May 15?

A I believe so.

Q The day after she was born? Yes?

A Yes.

Q And were you aware that she -- see if I can find that -- that during that surgery, according to the operative report, her estimated blood loss was five milliliters?

A I have to check the record. The blood transfusion is not necessarily to compensate the loss of blood. Basically, they are going to anesthetize the patient. And during the course of anesthesia and surgery, they have to have optimal level of the red blood cells. Usually they give additional transfusion not necessarily because of blood loss.

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Q Okay. Well, and as I was saying, during that first surgery she had an estimated blood loss of five milliliters, but her IV fluids included 20 milliliters of packed red blood cells. Were you aware of that?

A No.

Q Okay.

A At that time, maybe. But I don't know who was taking care of her at that time, but.

Q Okay. And then her estimated blood loss for the ostomy takedown, that was surgery number two. Right?

A Uh-huh.

Q And that was shortly before she was discharged. Is that correct?

A Correct.

Q Okay. Her estimated blood loss on that occasion was less than one milliliter?

A Uh-huh.

Q Were you aware of that?

A At that time, maybe. But I don't recall right now.

Q Okay. And during that surgery they gave her 50 milliliters of packed red blood cells. Were you aware of that?

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A It was, it wasn't ordered by me, but most probably anesthesiologist or surgeon gave it.
Q Okay. All right. So she certainly didn't have any significant loss of blood during those operations. Would you agree with that?
A It's, I wasn't there, and I wasn't part of the surgery. But based --
MR. COTTON: If you don't know, say you don't know.
THE WITNESS: I don't know.
BY MS. CARMICHAEL:
Q Well, based on what the medical record says, is five milliliters a significant loss of blood?
A I don't know. It's just, it's a surgical note, and I was not there. I am not sure even accurately documented.
I mean one cc for major surgery is a little bit unusual. If I injure myself, definitely I'm losing more than one cc. So, but one cc I think is very minimal.
Q Well, you're not a surgeon, correct --
A I am not.
Q -- Doctor Piroozi? Okay. So do you really have any basis to comment on what, what is, what is -- do you have any basis to doubt what the surgeon has

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reported in the medical record?
A I have to assume that it's accurate information.
Q Okay. Assuming that it is accurate information then, is an estimated blood loss of five milliliters a significant amount of blood?
A No, it's minimum. But I have to say that for the baby that's, for MayRose initially, she was 1,000-kilogram about, and 5 cc is significant. But for the second surgery, she was, had, she had, she was more, she had more weight, and one cc is not significant whatsoever.
Q Okay. All right.
THE VIDEOGRAPHER: Excuse me, counsel.
MS. CARMICHAEL: Okay.
THE VIDEOGRAPHER: The time is 11:31 a.m. This concludes digital tape number one. Off the record.
(A short break was taken.)
(Plaintiffs' Exhibit 5 marked for identification.)
THE VIDEOGRAPHER: We're back on the video record at 11:39 a.m., and this begins digital tape number two.
You may proceed.

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BY MS. CARMICHAEL:
Q Okay. Doctor Piroozi, does, if an infant is delivered with a short umbilical cord, does have any clinical significance?
A Yes, it can.
Q What would the clinical significance of that be?
A That's going to make the delivery more difficult. There will be more complications related to the short cord, including prematurity, placenta abruption, and lower Apgars. Those are the immediate complications.
Q Okay. All right. With regard to the CBC tests that were taken on MayRose, how, how was the blood taken for those tests? Was it with the heel prick or through the vein?
A It depends. They have different methods to draw blood. Majority of the sampling is going to be heel stick.
Q Heel stick?
A Yeah.
Q Okay. And how much blood is taken through the heel stick for a CBC?
A It's completely depend to the person who is doing it. They can just lose a lot of blood. They

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can just make sure that baby is not going to lose that much blood. So it's completely, different person is different.
Q You're talking about the nurses?
A Correct.
Q Okay.
A Or hospital trauma staff.
Q How much blood is needed or necessary in order to do the test?
A I don't know exact volume, but there is a small bowl that they have to fill. Should be .5 cc, but I'm not 100 percent sure, or 1 cc, or .5.
Q So generally, as a matter of course, the heel stick, in order to obtain a sample of blood for a CBC, would be getting .5 to 1 cc's of blood?
A I'm not sure about exact volume, but should be about that range, yeah.
Q Okay. And are cc's and milliliters synonymous?
A Similar.
Q Okay. All right. Do you know if -- I'm going to slaughter this word -- eyro -- let's see, erythropoietin injections. How do you say that properly?
A Erythropoietin.

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Q Erythropoietin injections were ever given to MayRose?
A No.
Q They were not?
A No.
Q Why not?
A There was no indication.
Q What would be the indication for that type of injection?
A If they established a diagnosis of poor bone marrow production of the red blood cells, or in our facility if the family are Jehovah Witness and refusing blood transfusion, we are going to provide that medication for bone marrow to produce more red blood cells.
Also indicated in patients with kidney disease, renal failure, and the recorded erythropoietin.
And the last but not least is the patients that they have a brain disease, and that ischemia of the brain, that because one effective erythropoietin is no protective effect that we use that.
Q Okay. Well, back to the poor bone marrow production, isn't continual low hematocrit readings indicative of perhaps poor bone marrow production?

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A Yes.
Q Okay. So when you say there were no indications, MayRose continued to have low blood cell production, low hematocrits throughout her NICU stay. Correct?
MR. COTTON: Form objection.
THE WITNESS: A course of hospitalization and the presentation was not different from other baby, premature babies in similar clinical conditions.
BY MS. CARMICHAEL:
Q Okay.
A So if you want to give erythropoietin, you have to give erythropoietin to all premature babies.
Q Well, but you've agreed with me earlier, we discussed that the symptoms of anemia due to prematurity are pretty much the same as the symptoms due to thalassemia, due to Diamond-Blackfan, due to a number of serious causes for anemia. Correct?
A Correct.
Q So the only way to know if you're dealing with an innocuous anemia prematurely, or something life-threatening like Diamond-Blackfan anemia is to test. Correct?
A Generally speaking in the time period of the prematurity in the NICU, we are dealing with anemia

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that the majority of them is anemia prematurity or related to critical condition of patients.
If you find that a patient has profound anemia and has other signs that very indicative of other differential diagnosis, we can establish those work-up.
For MayRose, her low hematocrit was very, very consistent with her clinical picture and diseases and problems that she had.
Q Okay. All right. One of those other indicators though that might lead to the need for further testing would certainly include a low reticulocyte count. Correct?
A One retic count was low, but it's just one retic count immediately after transfusion, few days after transfusion.
Q Okay. Well, it's my understanding that when you take a reticulocyte test, it's only going to give you a picture of what's happening that day?
A Correct.
Q Correct? Okay. So if you only order a reticulocyte count on July 13, and you don't order another one until August 1, then you can come and you can say, well, I only had one bad reticulocyte test. Right?

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A Correct.
Q But you can't tell me that her reticulocyte -- that she didn't have reticulocytopenia that entire time, can you?
A No.
Q Okay. Exhibit 5 to your deposition is a document entitled "Addendum Note." It's dated May 15. And I believe it is signed by you. Is that your signature?
A Correct.
Q Okay.
A And also on the document.
Q This is the first note I could find in MayRose's chart that involved you. Is it your understanding that this is the first contact you had with MayRose?
A I was on-call physician that night, yeah.
Q Okay. All right. So this is the day after she was born. Correct?
A Correct.
Q Okay. And beginning at the top of the page, "Interim events," it indicate -- or it reads, "The infant follow-up CBC after PRBC transfusion still consistent with low hematocrit, 31. The second transfusion was ordered. Due to persistent low

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hematocrit, had ultrasound ordered."
A Correct.
Q Do you see that? Okay. Is this your dictated note?
A No, most probably is Doctor Sam Mujica. I'm cosigning. He's a pediatrician, and I was specialist. So I cosigned his note.
Q Okay. So here, as a result of her anemia, the low hematocrits, at least Doctor Trench is suspecting she may have a bleed. Is that right?
A Correct.
Q Okay. So it wasn't just so common and every-day and normal for her presentation that it would just be written off as anemia due to prematurity. There was actually a concern here that she may have a bleed?
A If you continue reading it, you notice that the concern of a bleeding end up having him or me order the KUB and show the perforation of intestine. And bleeding was probably from intestine, so.
Q You said probably from the intestine?
A It says GI perforation. So diagnose immediately after. If you continue reading that, after, "Head ultrasound ordered. The chest x-ray showed an indication of possible free air." That's a

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sign of perforation of intestine. "So KUB, cross table, left decubitus x-ray ordered. The KUB confirmed the diagnosis of GI perforation."
Q Correct.
A So it was confirmed.
Q Okay. So a bleed is suspected. A head ultrasound is ordered. Correct?
A Uh-huh.
Q That ultrasound was normal?
A Yes.
Q Is that your recollection?
A I don't remember.
Q Okay. We'll pull it out in a minute.
But then the doctor goes on, orders some more tests, and they do find a GI perforation. Correct?
A Correct.
Q Okay. All right. And that necessitates the exploratory laparotomy that she had on this same day?
A Correct.
Q Okay. All right. Okay. All right. Let's see.
Okay, let's get to your notes.
(Plaintiffs' Exhibit 6 marked for identification.)

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BY MS. CARMICHAEL:
Q Okay, Doctor Piroozi, the next exhibit to your deposition is your clinic note, your NICU progress note. Excuse me --
A Can I, can I have it?
Q Yes. Sorry. I thought she handed it to you. Dated June 13.
A June 13, correct.
Q Excuse me?
A June 13, yeah.
Q Yeah, June 13. Okay.
And so it appears from the medical chart that you did not care for MayRose after your May 15 addendum note until June 13. Is that your memory?
A I don't remember, but.
Q Well, you've reviewed your notes. Do you know of any other care you provided to her in the interim?
A I think that there was no notes between, so it should be the first exposure to the patient after 15 is going to be 13, correct.
Q Okay. All right. So in reviewing her condition on the 13th --
MS. CARMICHAEL: Oh, thank you.
Let's just do a housekeeping matter for a

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moment.
John, are these the pages that he reviewed --
MR. COTTON: Right.
MS. CARMICHAEL: -- in preparation for his deposition?
MR. COTTON: Yes.
MS. CARMICHAEL: Okay. If we can have those marked as Exhibit 1 to his depo.
(Plaintiffs' Exhibit 1 marked for identification.)
MR. COTTON: You can have him flip through there to see if that is the first visit then.
MS. CARMICHAEL: Sure. That's a great idea. Keep that in front of you as well.
BY MS. CARMICHAEL:
Q So why don't you go ahead and just confirm with the records that you reviewed, Doctor Piroozi, that June 13 was the next occasion that you saw MayRose?
A Sure. Strangely, I don't have June 13 here. But first one here in this batch, June 14.
Q Okay.
A But I assume June 13 is prior to that.
Q Okay. Your signature does appear on the

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June 13 note?
A Yes.
Q Okay. All right. So let's just review how she appears to be doing then when you assume care of her on June 13. It appears that she is, has gained some weight? Yes?
A Correct.
Q And would -- she's about approximately a month old now. Is that a, a good amount of weight that she's gained in that timeframe?
A We're plotting the weight on the graph. And on top of my head, I can't say. But for that specific day, 30 grams is optimal. It's very good for that day.
Q Okay. And it appears that she's feeding slowly. And she is, as a result of her surgery, she is on TPN feedings. Is that right?
A Correct.
Q Okay. And she's having good output passing stool. So all of that appears to be going well?
A The feeding is seems like it has problems. So the baby is, she's, MayRose is on Erythromycin for feeding intolerance. So definitely she has a feeding intolerance in that feeding section. So it's not really complete, so.

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Q Okay.
A Breathing-wise, she's on nasal cannula required oxygen.
Q So she's no longer intubated?
A She's not intubated, but she seems like she's just on oxygen and nasal cannula.
Q Okay. Her neurologic exam indicates appropriate strength and tone for gestational age. Is that right?
A Yes.
Q Okay. And what is -- I mean that's good. Correct?
A Yes.
Q Okay. So no neurologic concerns for her on this date?
A Neuro exam seems like it's normal.
Q Okay.
A For her age.
Q All right. Down on the hematologic, it indicates there that on June 7, so about, just about a week before you assumed your care, she received a blood transfusion, is that right, for a low hematocrit?
A Yes.
Q Okay. And so you were aware of, of that having taken place?
A It was part of the note, yes.
Q Okay. All right. And you're monitoring her clinically for her hematology issues. Right?
A Sure.
Q Okay. And it looks like at this time there's a concern for infection in a number of cultures and work-up had been done, or was being done, and those cultures were negative. Is that right?
A Yeah, that's cultures for five, May 29 seems like the urine culture was negative.
Q Okay. Any issues of concern with, going on with MayRose on June 13?
A Beside feeding intolerance and oxygen requirement, and also the newborn screening that was abnormal. And seems like it says the family aware of that.
Q You're referring to the screening test for cystic fibrosis?
A Sure. Sure. Genetic.
Q And you knew that the mother had been tested for that and it was negative. Right?
A No. I don't remember that part.
Q Okay. Well, it's in your note that mom told you she was tested genetically and was negative for

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CF?
A Positive, family is aware. I don't see any information about the mom here in this note.
Q Under your IRT screening test for CFF, do you see that line?
A Uh-huh.
Q Okay, keep reading.
A Family is aware. Discuss with Doctor Wall, this number, indicating if high false positive rate in preemies. Nonetheless, mom stated she was tested genetically and is negative for CF.
Yeah, is part of the note. But I did not write it. But I was aware of it when reading it, sure.
Q Okay. All right. So I think you said breathing on nasal cannula and slow feeding were the issues that MayRose had as of June 13. Is that right?
A Yes. And also she was a little bit tachycardic. Heart rate was a little bit high range, 168, in the first part. And that's about it, yeah.
Q Okay. And tachycardia is one of the symptoms you indicated is associated with anemia. Right?
A Yeah, but is not, heart rate is 137 to 168. So in that range. It depends that, just majority of

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time she was 137. So it's completely normal, majority of time she was 168. This goes back to clinical judgment and clinical treatment of the patient's care, record, yeah.
Q If you flip to the second page of your June 13 note, you ordered some labs. Is that right?
A Correct.
Q Okay. And what was the basis, why did you want to order those labs?
A Usually we are doing one time weekly CBC differential and base on labs weekly. Most probably, that was the case.
Q Okay. Okay. Thank you. So you ordered those labs?
A Uh-huh.
Q And so let's go to your next note.
(Plaintiffs' Exhibit 7 marked for identification.)
MS. CARMICHAEL: Is that seven?
THE REPORTER: Yes.
BY MS. CARMICHAEL:
Q So Exhibit 7 to your deposition is your NICU progress note dated June 14.
A Uh-huh.
Q Do you see that?

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A Yes.
Q Okay. And it looks like there were no acute changes over the last day. Is that right? Up in "Interim event."
A Yeah, over there, yeah.
Q So she continues to do well?
A Lost weight and -- let's see. Still is on oxygen. And hematology monitored. The CBC is back. Hematocrit is 28.4.
Q Which is low. Correct?
A It can be normal for the babies. Asymptomatic babies, yeah, can be.
Q Well, is it classified as low on the lab report? Is that considered low?
A Quite honestly, almost hundred percent of premature babies, they have a crit that's similar to this. Based on the value, yes. But it's not unusual for premature babies if they are asymptomatic.
Q Okay. Let's go to your next note.
A Sure.
(Plaintiffs' Exhibit 8 marked for identification.)
BY MS. CARMICHAEL:
Q So Exhibit 8 to your deposition will be your chart note dated June 16 -- or excuse me, June 15.

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And did -- is that your signature on this note as well?
A Yes.
Q Okay. All right. So on this date, down on hematologic, her hematocrit is even lower. Is that right?
A Correct.
Q Okay. And so at that point a blood transfusion is ordered. Is that right?
A Correct.
Q Okay. So she had a blood transfusion administered on June 15.
And if you look at page two of your note, you also ordered additional labs?
A Correct.
Q Okay. All right. But no retic count at this point. Correct?
A She was septic with infection, with very high CRP. In hematology with CRP of 3.94 is very high, indicative of sepsis.
Q The CRP, you mean?
A Yes.
Q Okay. So she does have a high CRP?
A Correct.
Q Definitely. But all of the tests you've

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run, the, the -- I can't remember if you've had your ID consult yet at this point -- have all come back negative as far as?
A Majority of the cases you are not retrieving any bacteria. Because the baby always partially treated. But when they have the high CRP abnormal CBC for infection is a sepsis. But doesn't mean that negative blood culture does not rule it out.
Q Sure.
A So this baby has sepsis.
Q Well, she has an inflammatory process going on anyway. Right?
A She did not have these problems prior. So this CRP is indicative of something new.
Q Okay. And a high CRP is indicative of inflammation. Right?
A Can be inflammation. More in premature babies and babies in ICU very indicative, indicative of infection as well.
Q Okay. All right. Okay, let's go to your next note.
(Plaintiffs' Exhibit 9 marked for identification.)
BY MS. CARMICHAEL:
Q Okay. And you signed the note on June 17 as

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well?
A Yes, I did.
Q Okay, and this is Exhibit 9 to your deposition. Again, up in "Interim events" you've got good output, passed stool, no acute changes over the last day. Is that right?
A Yes.
Q And she's had a weight gain?
A Correct.
Q And her neurologic exam continues to be appropriate strength and tone for her gestational age?
A Correct.
Q Okay. Now, she just barely had a blood transfusion, so we note that her hematocrit is 31.5 on June 17. Is that right?
A Yes.
Q Okay. All right. But you have a hematological comment there that her last hematocrit taken just the day before was 33.7. Right?
A Yes, the day before that was lower, but it depends when the note's written and are updated. So it does not reflect the previous one.
Q Okay. So on June 16, her hematocrit was 33.7. Right?
A No, June 16 we went over -- this is 15. The

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16. I don't have a 16 note. I don't know.
Q Okay, what, look at your June 17 note.
A Yeah.
Q Hematological comments: Last hematocrit 33.7 on June 16. Do you see that?
A This information was not entered by me. So it's in the note, yeah, it says 16th, 33.7.
Q Okay. Do you have any reason to doubt that?
A I usually check the labs, but no.
Q Okay. And one day later, June 17, it's 31.5. Right?
A Yes.
Q So it's falling already, and she just had a transfusion. Correct?
A We are doing multiple labs. Each time that we draw the blood culture is about two to three cc's blood.
Q Wait a second. I asked you about that earlier, and you said .5 --
A That's CBC. That's blood culture. So when she's septic, we draw blood culture. And the blood culture, we need to draw more blood. That was a CBC.
Q So even though she's just had a blood transfusion, you think that the amount, it's your testimony today that the amount of blood that you draw

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to do a blood culture would cause her hematocrit to drop over two points -- two percent?
A We are talking about multifactorial reasons. She's septic. She's getting antibiotics. She's required a lot of blood draw. And altogether is not un, I mean like unusual to drop the crit that way. And she gained weight. So maybe is a little dilutional as well. So it's not unusual.
And the CRP is coming down, indicative of improvement of sepsis. The platelet was very low. That sign of sepsis now is limited to 226. All the signs responding to the antibiotic treatment. Improving, and, but the labs most probably are drawing the labs still, yes.
Q Okay. You have her "active issues" under "hematologic" as anemia of prematurity. Is that right?
A Yes, here is anemia of prematurity.
Q So you have, this is your note. Right?
A Uh-huh.
Q So you have diagnosed her anemia as being due to prematurity. Correct?
A Yes, I chose anemia of prematurity, yes.
Q Okay.
A Reason, yeah.

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Q All right. And down below, under "Infection," you've got the cultures that came back negative. You have your CRP. And details about the septic work-up performed on the 15th of June. You've got the clinical improvement that she's showing with a lower CRP.
And then you have "Active issues," it says, "Sepsis suspected." So are you not sure at that point that she has sepsis? You just suspect she may?
A No, she is, over here it says, "Possible purulent drainage at the site of PICC line, and high CRP. So that's the common term that when we retrieve the bacteria, we call it sepsis. But as long as we don't have a bacteria in the blood culture, we call it presumed.
But she had multiple reason to have sepsis, purulent drainage from the PICC line site is over there, high CRP, abnormal labs.
Q Okay.
A So it was infectious related for sure.
Q Okay.
(Plaintiffs' Exhibit 10 marked for identification.)
BY MS. CARMICHAEL:
Q Okay, Exhibit 10 to your deposition will be

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your next chart note of June 18. The top of that note, on "Interim Events," you indicate, "No acute changes over the last day, good output, passed stool, feeding slowly, status improved." Correct?
A Correct.
Q Okay. And you do note there a 60-gram weight gain. Correct?
A Yes.
Q Okay. So she's, she's stable and actually status improved. Right?
A Correct.
Q Okay. Let's move on to the next note.
(Plaintiffs' Exhibit 11 marked for identification.)
Q Doctor Piroozi, the next note I have for you is June 19.
A Yes.
Q And in the "Interim events," you've indicated at the top, "Improving feeds, no acute changes over the last day, good output, and passed stool." Is that right?
A Correct.
Q And she's had another ten-gram weight gain?
A Uh-huh.
Q Okay. And so there are no new issues going

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on with her as of this date. Correct?
A Correct.
Q Okay.
(Plaintiffs' Exhibit 12 marked for identification.)
BY MS. CARMICHAEL:
Q Now I would you to check this with your, with the records you reviewed, that your counsel provided you. But according to my records, you're, you're off track with her for about a week. You, so you last saw her on June 19. And then the next time you see her is June 27th. Is that what your records reflect?
A Yes.
Q Okay. All right. So when you come back on the 27th of June, during that one week you were away from MayRose, she actually had two -- let me confirm that -- she had two transfusions. Were you aware of that? When you came back, would someone have made you aware of that?
A I don't remember.
Q Okay. Let's have you look at the lab -- excuse me, the transfusion record.
A Okay.
Q So that you can confirm that. But according

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to, to my records, she had a transfusion on June 23rd, and another one on June 25th. Do you agree with that?
A Can you repeat it? What days?
Q June 23rd?
A Twenty-third, yes. Here it is, June 23rd, yeah.
Q And June 25th?
A Yes, there are two.
Q All right. She's also had a weight loss in that week?
A I don't have information -- I have information for the day, that minus 90, the day that I came back, yeah.
Q Okay. All right. Okay. And on your chart note of June 27th, let's see, you indicate that Infectious Disease was consulted. Do you see that?
A Which line?
Q Under "Infection."
A Okay, okay.
Q And if you go down one, two, three, four, five, six, six lines down, says, "CRP markedly up, will treat at least seven days and continue to search for source of infection. ID consulted."
A Yes.
Q Do you see that?

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A Yes.
Q So you're continuing to search for a source of the infection. You've never actually been able to identify or find a source of the infection. Is that right?
A You know, I don't know because these are, seems like it's just a work-up for last seven days prior to I come to service.
Q Okay.
A So I have to access the information or the record of previous days.
Q Well, do you have a recollection of --
A No.
Q -- of ever identifying a source of the infection?
A She had a pneumonia at one time Enterobacter, but I don't know it was coincide with that. And she had a clinical mastoiditis. That's a sign. And she had a purulent discharge from the PICC dose that can be source.
Q Her mastoiditis though was negative for abscess. Is that right?
A It wasn't abscess, but showed soft tissue swelling.
Q Okay. All right. So what she does though

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have is a markedly increased CRP. Right?
A You are just referring to again the same infectious --
Q In that paragraph and note, uh-huh.
A Yes, markedly off, yeah.
Q Okay. And that is indicating that there is a significant inflammatory process going on. Correct?
A Infection or inflammation.
Q Okay. For example, I mean people with vasculitis would have an elevated CRP. Right?
A Yes, but is very uncommon disease in newborns.
Q People with cancer would have an elevated CRP. Right?
A Extremely uncommon in a newborn.
Q Okay. What about severely depressed bone marrow? Would that lead to an elevated CRP?
A Not that I know of.
Q Okay. All right. Do people with leukemia typically see a high CRP?
A Very uncommon in newborns.
Q I'm not asking you that.
A Is not field of expertise. I haven't seen leukemia for ten years.
Q Okay. So you asked for an Infectious

Page 91

Disease consult. Is that right?
A Correct.
Q And they recommended continuing the current antibiotic and running some more screening tests for fungus. Is that right?
A Changed, yeah, it seems like they said they changed the antifungal to some other antifungal, Ambisome, to decrease IV fluid, yeah.
Q And in this quest to find of the source of infection, you've run all kinds of bacterial screens. Right?
A I wasn't there when they started the work-up. So I came on board after they started things.
Q Well, this concern for sepsis has been going on though. Right? It was going on the week earlier, when you were treating her?
A That seems like the time that I was taking care of her she responded to the treatment that given. Her CRP normalized, and her platelet normalized, and seems like the discharge from the PICC stopped. But seems like this thing is a new thing. I don't know how it started afterward, but...
Q Okay.
A Just made them concern enough to start

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antifungal.
Q In any event, they also test for viruses and C. diff and other sources as well. Right?
A Yes, here it said that.
Q And those tests are negative. Correct? Okay.
A I don't know. I don't have a result. Here is stool negative for rotavirus and C. diff, and, yes, negative, yeah.
Q Okay. Flip over to page two of your 6/27 note. You'll see that, under, "Assessment."
A Yes.
Q Let's see. When you get to number five, where it talks about the suspected sepsis, it indicates, "Suspected sepsis with elevated CRP, cultures negative thus far, but infant obtunded." And obtunded means just less responsive. Right?
A Correct.
Q Okay. And you had, or there was an abdominal CT on June 26 with no sign of abscess. Is that right?
A Correct.
Q Okay.
A I mean continuing that, seems like it says, "Behavior improving today," most probably I assume is

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less obtunded.
Q Okay.
(Plaintiffs' Exhibit 13 marked for identification.)
BY MS. CARMICHAEL:
Q Okay, the next exhibit is your NICU progress note dated June 28, 2008?
A Correct.
Q And under "Interim events," it indicates, "No acute changes over the last day." She's also had a weight gain. Is that correct?
A Correct.
Q Okay. I don't really have any other questions regarding this note. Do you see anything in this note that you would like to comment on? No? Okay.
(Plaintiffs' Exhibit 14 marked for identification.)
BY MS. CARMICHAEL:
Q Okay, the next exhibit is your NICU progress note dated June 29, 2008. Again, it indicates under "Interim events: No acute changes over the last day, status improved." Do you see that?
A Yes.
Q Okay. And in fact, she's had an 80-gram

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weight gain. Do you see that?
A Yes.
Q Okay.
(Plaintiffs' Exhibit 15 marked for identification.)
BY MS. CARMICHAEL:
Q The next exhibit is your NICU progress note dated June 30, 2008. And why don't you tell me about the interim events you're reporting there?
A Seems like there was a bloody residual happen overnight.
Q What does that mean?
A It's a GI bleeding. Gastrointestinal bleeding. And started on Zantac for gastric bleeding and some labs drawn.
Q Okay. All right. She's had another significant weight gain in that day?
A Correct.
Q Okay. But are you suspecting some digestive issues with her ostomy?
A No, it's upper GI bleeding. So it seems like she was made NPO. So she was losing blood, and I don't know how much. But seems like in the GI section she made NPO. And she started on IV fluid.
Q Okay. And this is where you note under

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"Hematologic" that she has thrombocytopenia. Is that right?
A Correct.
Q And that means low platelets?
A Correct.
Q And do you attribute that to this GI bleeding?
A It's, sometimes thrombocytopenia can cause bleeding. So just --
Q It's the other way around?
A Yeah.
Q Okay. All right. Anything else of note on this date?
A No.
Q Okay.
(Plaintiffs' Exhibit 16 marked for identification.)
BY MS. CARMICHAEL:
Q The next exhibit is your NICU progress note dated July 1, 2008. And you indicate "Interim events: No acute changes over the last day," and her status is improved. Correct?
A Yes.
Q Okay. And she's had a 50-gram weight gain?
A Correct.

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Q Okay.
(Plaintiffs' Exhibit 17 marked for identification.)
BY MS. CARMICHAEL:
Q Okay, on July 2, your NICU progress note indicates there are no acute changes over the last day. Her feeding intolerance, kept NPO overnight. Correct?
A Yes.
Q And she's had a ten-gram weight gain?
A Correct.
Q And she's now up to five pounds one ounce. Is that right?
A Correct.
Q Okay. All right. Okay. And on that date, June -- or July 2, you do order a CBC and a CRP test in the morning. Correct? Yes?
A I can't find it, so. You refer to?
Q Page two of the June 2 note. It says, "Labs ordered: CBC. CRP." Do you see labs ordered?
A CRP culture. Oh, yes.
Q Okay. So you ordered a CBC and a CRP. Correct?
A Yes.
Q Okay. So let's get to those results. The

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next -- sorry. I forget to stop talking.
(Plaintiffs' Exhibit 18 marked for identification.)
BY MS. CARMICHAEL:
Q Okay. The next exhibit to your deposition is your NICU progress note dated July 3. So you've just ordered a CBC. And you've got the results back. And it appears that her hematocrit is 28 percent. Is that right?
A Correct.
Q And so you order a transfusion on that day. Is that correct?
A Correct.
Q Okay. She's had, she had a 100-gram weight gain overnight? Is that right?
A Correct.
Q Okay. And you've indicated in "Interim events: No acute changes over the last day. Good output. Passed stool."
So other than the low hematocrit, she's, is she doing fairly well?
A She's tachycardic. The heart rate is 180.
Q Okay. Anything else?
A She has thrombocytopenia, low platelets still. The Infectious Disease doctor want to continue

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on antibiotic with the name of Meropenem. She's still not feeding that well. She's started on Erythromycin for GI motility problem. She's just getting one cc feeds.

Q Well, on those one cc feeds, she's gained 100 grams overnight. Right?

A Yeah, most probably is not, that thing is excessive IV fluid. It's not necessary. Sometimes gaining weight is bad for a newborn. So that can be sign of problems.

Q Okay. You don't find any of that to be an acute change though. Correct? According to your note?

A GI bleeding, that was like maybe one or two days prior. I order KUB for morning. And...

MR. COTTON: Did you hear the question?

THE WITNESS: Yeah, I heard it.

No. I just, those are the active issues that I explained.

BY MS. CARMICHAEL:

Q Okay. All right. And again, the tachycardia is a sign of anemia?

A Correct.

Q Okay. All right. Okay.

(Plaintiffs' Exhibit 19 marked for identification.)

BY MS. CARMICHAEL:

Q This next exhibit, Doctor, is not signed by you. It's an on-call note that appears to have been signed by Katherine Felongco, Neonatal Nurse Practitioner. However, she indicates the infant was discussed with you. And that is why I'm showing you this note.

This appears to be the date, July 6, when MayRose was noted to have left-sided swelling of the mastoid bone under the left ear. And I believe you were called to evaluate.

And she indicates a septic workup was performed with blood culture, urine culture, fungal culture, and a complete CBC with diff, CRP sent. She's, it also indicates she was started on Vancomycin and Cefotaxime. And a CT scan of the mastoid bone on the left was ordered to rule out abscess.

Is that right?

A Correct, yeah.

Q That's your memory?

A Yes.

Q Okay. And let's see if we can find that.

(Plaintiffs' Exhibit 20 marked for identification.)

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BY MS. CARMICHAEL:

Q Okay, so the next exhibit to your deposition is the CT of the middle ear without contrast. And you ordered this test. Is that right?

A Correct.

Q And that is due to the swelling that they noted on, on the left side of her ear?

A Correct.

Q Okay. And the impression, or what the radiologist reports is that there is soft tissue swelling in the left side of the face and ear region without evidence of mastoiditis or abnormality, and nothing to suggest abscess. Is that correct?

A Correct. Soft tissue infection just.

Q Okay. So she did not actually have mastoiditis?

A Seems like she had a soft tissue infection, not mastoiditis, based on the result of CT scan.

Q Okay. Thank you.

A Sure.

(Plaintiffs' Exhibit 21 marked for identification.)

BY MS. CARMICHAEL:

Q Okay, the next exhibit is your NICU progress note dated July 24. And this is the date that her ostomy takedown occurs. Is that right?

A Correct.

Q Okay. And under, let's see, up above under "Interim events," you've indicated, "No acute changes over the last day, good output, passed stool." Is that right?

A Correct.

Q She's had a 25-gram weight loss. And under "Hematologic comments," you're noting that hematocrit that was done on 7/21 of 29, and then also transfusion that took place on the 24th to address that. Is that right?

A No. Basically, the transfusion given just prior to the surgery.

Q Okay. All right. And to your knowledge, were there any complications or problems with the surgery?

A Not that I know of.

Q Okay. And you felt that a blood transfusion prior to surgery was necessary because of what?

A Usually, we optimize the level before any type of surgery.

Q Okay. And a hematocrit of 29 is not an optimal level. Is that true?

A It's optimal level for a baby that not

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require surgery.
(Plaintiffs' Exhibit 22 marked for identification.)
BY MS. CARMICHAEL:
Q Okay. The next note I have for you is NICU progress note dated two days later, July 26th of '08. And this is two days after her ostomy takedown. Is that correct?
A Correct.
Q And you've indicated there are no acute changes over the last day. Still NPO postop. Correct?
A Correct.
Q Okay. And down on "Hematologic," apparently labs were taken, because we have some blood results for 7/26/08 indicating a hematocrit of 26.8. Is that right?
A Correct.
Q Okay. And based upon that, you order a blood transfusion. Is that right?
A I have to look at that record right now.
Q Under "Hematologic Plan" on page one, it says "Plan"?
A Yeah, I saw that.
Q Okay.

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A But reason of transfusion.
It was related to the placement of the Broviac, the reason of transfusion. Also, crit was 26. So I believe the baby was taken to the OR because we did not have IV access. And they had to place the Broviac surgically.
Q You're talking about the central line?
A Correct.
Q Yes. That was done. And she lost less than one milliliter of blood during that procedure.
A Correct, but she --
Q Are you aware of that?
A Yeah, she could lose like 20 cc. So the transfusion was in preparation of central line placement.
Q For that procedure?
A Exactly.
Q Okay. All right. You still acknowledge that a hematocrit of 26.8 is low. Right?
A For a baby with her condition is expected.
Q Is it considered low or not?
A Based on the value, yes.
Q Okay.
A But expected.
Q Okay. And it also has fallen since the last

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hematocrit reading of 29 on July 21st. Correct?
A Yes.
Q Okay. In spite of a transfusion in the interim. Correct?
A She received a transfusion on 7/24 for the surgery.
Q Right.
A And on 7/26, has a crit of 26.
Q Okay. So she has a hematocrit of 29 --
A Uh-huh.
Q -- on July 21st. She then has a transfusion in preparation for surgery on the 24th?
A Correct.
Q And despite that transfusion on the 26th, she has an even lower hematocrit. Is that right?
A Correct.
Q Okay. So you do order another transfusion in preparation for the central line placement?
A Yes.
Q Okay. And that is the last transfusion that MayRose receives while at Sunrise. Is that right?
A I believe so.
Q Okay. All right. I want to flip you back to the, the labs.
A Okay, I have it.

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Q Let me see if I can find mine. If you'll just look at that first page, Bates number 1027.
A Uh-huh.
Q And start with me on the 21st of July. It shows a hematocrit there of 28.8. Do you see that?
A Yes.
Q And then come over to the 24th, when next it's tested and we see it's fallen to 26.6. Correct?
A Correct.
Q And that's the day she's transfused. Right?
A Correct.
Q And I presume that this result 32.9 is after her transfusion?
A Correct.
Q Okay. And then come up with me to 7/26. It has fallen again, hasn't it, to 26.8?
A Correct.
Q And that's the day that she has another transfusion. Correct?
A For line placement.
Q For line placement. Okay.
So the very next day, her hematocrit is up to a 34.3. Right?
A Correct.
Q Okay. Now, we're done with transfusions for

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the rest of the time she's at Sunrise. Right?
A Correct.
Q Okay. So on, on the very next day, after the, after the, the higher hematocrit reading following the transfusion.
A Uh-huh.
Q We come over to 7/28, and already her hematocrit has fallen four points, to 30.8. Correct?
A Correct.
Q And you come over just three days later to August 1, the day before her discharge, and we see that the hematocrit has again fallen to 30?
A Correct.
Q So we see that after that transfusion, her hematocrit is continuing to fall. Is that right?
A Correct.
Q Okay. Now, August 1 is the day before her discharge. You don't do a CBC on the actual day of discharge, August 2. Correct?
A No, baby was discharged in the morning.
Q But you know at the time of discharge that it is falling?
A Correct.
Q Okay. All right. Okay. On the day before her discharge, you also order, you order another

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ultrasound of the brain. Is that right?
A Correct.
Q Do you remember doing that? And you also ordered a retic count, a reticulocyte count?
A Correct.
Q Okay. Do you know who ordered the first one that was done earlier in July?
A I don't remember. I think it was Doctor Blahnik. But I'm not sure.
Q Okay. Nevertheless, it wasn't you. Correct?
A It wasn't me.
Q Okay. So you, you essentially ordered a follow-up reticulocyte count --
A Correct.
Q -- August 1. And what you saw in that test result was that her reticulocyte count was even lower than it was when the first one was taken in the middle of July. Right?
A Correct.
Q So at the time of discharge, you knew that not only was her hematocrit dropping, but her reticulocyte count had dropped substantially. Correct?
A Substantially, but from .9 to .5. So, but

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abnormal.
Q Okay. All right. Or if you look at the other reading. Let's see if I can find it --
A The source of --
MR. COTTON: Just --
THE WITNESS: Sorry.
BY MS. CARMICHAEL:
Q From 30 to 16.2?
A We are going based on retic count that's a percentage that's .5.
Q I understand. And I think what you told me is you don't really understand what those values even mean?
A Those are not the ones that the physicians are following. We are going based on the percentage.
Q Okay. So you order an ultrasound of the brain. And let's go to that.
(Plaintiffs' Exhibit 23 marked for identification.)
BY MS. CARMICHAEL:
Q And it reveals that she has had a grade one germinal matrix bleed. Is that right?
A Correct.
Q Okay. Were you concerned about that?
A Yes.

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Q You were?
A Yeah.
Q Well, you discharged her the very next day.
A I ask for follow-up.
Q Okay.
A And almost a large number of the babies that are premature, they have some level of bleed. And this was reported possible subacute. It wasn't acute bleeding.
Q It was not acute?
A No.
Q So it wasn't actively occurring at that moment?
A Yes.
Q Correct?
A Yeah.
Q Okay. And in fact, grade one germinal matrix bleeds have an overall very good prognosis. Correct?
A Correct.
Q All right. And no hydrocephalus was present on the ultrasound. Right?
A Correct.
Q Okay. And that's also a very good sign. Right?

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A Concerning because it's a grade one and it's the first time reported. But prognosis should be good.
Q Should be good. Right?
A Correct.
Q Okay. All right. And you ordered a follow-up MRI after -- or a follow-up head ultrasound. Right?
A Correct.
Q And, but you did not anticipate that this was an active bleed or anything to be overly concerned about?
A Right.
Q Is that fair? Okay.
And in fact, you discharged her the very next day. Right?
A Correct.
Q Okay. All right.
(Plaintiffs' Exhibit 24 marked for identification.)
BY MS. CARMICHAEL:
Q Okay, Doctor, you see the next exhibit is the Neonatal Discharge Summary?
A Yes.
Q And was that, has that been signed by you?

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A Yes.
Q And was that prepared by you?
A Yes.
Q Okay. Now, I understand from some discovery responses that you've provided in this case that you don't really recall the specifics of any conversation that you had with the parents. Is that correct?
A I don't recall the specifics.
Q Neither at any point, during the hospitalization or at the time of discharge. Is that right?
A I don't recall.
Q Okay. So you would have to defer to their memories regarding the content of those conversations. Correct?
A I, I noted that there are some information in the record that I explained to them about the discharge plan and follow-ups.
Q Okay. Do you have any memory of Ms. Hurst, MayRose's mother, expressing her concerns to you about whether May was really ready for discharge?
A I don't recall.
Q Okay. In your practice, do you get a lot of parents who are nervous about taking those babies home after they've had a complicated course in the NICU?

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A If we feel they are not comfortable, we do not discharge the babies.
Q Okay. Do you have any memory of reassuring her or telling her that you would not be discharging MayRose if she weren't a healthy baby?
A I don't recall that conversation.
Q Okay. Is that a true statement though?
A Premature babies, they are not necessarily healthy. We are talking about a baby that need, had ultrasound, multiple follow-ups, multiple visits. So statement of healthy is not something that we refer to at all for prematures.
Q Okay. Would you be discharging her if you felt that there was some ongoing issue that required hospitalization?
A She did not require hospitalization, but definitely she required close follow-up.
Q Okay. And you detailed the follow-up that was to be done in your discharge statement. Correct?
A Correct.
Q Okay. And as far as you were concerned, MayRose was ready to be discharged. Correct?
A Correct.
Q Okay. In spite of her falling hematocrit. Correct?

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A Correct.
Q In spite of her falling reticulocyte count. Correct?
A Correct.
Q Okay. And you understand and realize that within the ten days prior to her discharge, she had been transfused three times?
A She got transfusion for surgery and line placement.
Q Okay. But she also had abnormal hematocrits. Correct?
A We do not transfuse the babies just because the low crit of 26, 28.
Q But those hematocrits were low. Correct? They were abnormal?
A They are abnormal but expected for premature babies with her condition.
Q Okay. You realize from your review, going through all the records that we've gone through and your own independent review and having lived it, that -- well, let's look at your discharge note really quick.
On your -- let's see. Would you go to page three of your discharge summary? It's Bates number 1101. Under "Hematology." Do you see that paragraph?

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A Yes.
Q You have some information that you've provided there. Do you see the sentence that says, "She was given five transfusions"?
A Correct.
Q That is incorrect --
A Uh-huh.
Q -- isn't it?
A Yeah.
Q She was given 11 transfusions, one platelet procedure, and one fresh frozen plasma. Is that right?
A Yes.
Q Okay. Do you have any idea why you would have said she was given five transfusions in this summary?
A This information is transferred, pulled from the database that the people entered. So it just most probably reflect the entering data by other physicians.
Q So is it common for these discharge summaries to have errors of that magnitude in them?
A The, how it get the discharge summary, we press the "Discharge Summary" and it collect all the information that entered during the hospitalization.

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And we relay on the system and the data entry.
Q Well, when you reviewed this, didn't that number seem awfully low to you, having treated her for her --
A I was physician that was -- I wasn't the only physician was taking care of her.
Q Okay.
A And I wasn't involved with all the transfusions. But my information was limited to the time that I was taking care of her. And the information was in the chart --
Q Okay.
A -- at the time of discharge.
Q All right. Okay, let's -- it's interesting though, because do you see, continuing down to the next paragraph under "Hematology," see where it says "Treatments"?
A Uh-huh.
Q And then there's just very few of the treatments she actually received listed there. Again, do you have any explanation for that?
A It seems like they put a time period of between 5/15 and 6/23rd some transfusions done. And then separately it says two transfusion, two times transfused also 6/22. These are just data that pulled

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at discharge, yeah.
Q Okay. Okay, let's go to your -- now, I never did see anywhere in this record that she had pneumonia or, what did you call it? Enterobacter?
A Tracheitis. Tracheitis.
Q I didn't --
A When you have a positive blood culture from ET tube, that's called tracheitis. And she had a post ET tube culture. Enterobacter. Should be --
Q Enterobacter?
A Enterobacter was a bacteria that grew. In the microbiology, you can find it, yeah. Microbiology section.
Q It's not mentioned in your discharge summary, is it?
A No. So again, it depends when they diagnose it and who entered the, that diagnosis.
Q Okay. And there's, also, I didn't ever see any reference to pneumonia either. Do you claim that she had pneumonia while she was in the NICU?
A She had Enterobacter infection from the ET tube. That's the bacteria that's coming from the lungs.
Q Okay. At discharge, she weighed five pounds 14 ounces. Is that a, a good weight?

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A Reasonable for discharge, yeah.
Q Okay. All right. Let's go to the discharge plan on the last page of the summary.
So you're instructing the family to contact their pediatrician within three days. Make an appointment within three days. Right?
A Correct.
Q And you're indicating that additional appointments should be made with Occupational Therapy and Physical Therapy for some follow-ups?
A Correct.
Q Follow up with Pediatric Surgery. Correct?
A Yes.
Q Follow up with Early Intervention Clinic?
A Yes.
Q Follow up with the Pediatric Ophthalmologist?
A Yes.
Q Okay. And then it also indicates that the infant requires a sweat chloride test by three months of age?
A Correct.
Q Right? The infant requires a follow-up head ultrasound one month after discharge. Correct?
A Correct.

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Q And then you're recommending, or you're indicating follow-up tests are a sweat test, a head ultrasound, CBC diff, retic, one month after discharge?
A Correct.
Q Is that right?
A Yes.
Q Okay. And the discharge medications are Poly-Vi-Sol with iron.
Did you start iron in the, while she was in the NICU?
A I think it was started like one day or two days prior to discharge.
Q Okay. And if, if a baby has anemia due to an iron deficiency, you would expect to see a really high retic count, wouldn't you?
A No. Usually iron deficiency retic count is low.
Q Okay. All right. And then special instructions to family, take, go to the ER if the infant develops any distress, temperature above 100.3, poor appetite, or any unusual symptoms. Right?
A Correct.
Q Okay. Okay. All right. Knowing that MayRose had not made it more than two to two and a

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half weeks, let alone 30 days without requiring a blood transfusion during her NICU stay, how is it that you dared to hold off on that follow-up test for one month after discharge?
MR. COTTON: Form and foundation objection. It's argumentative. You state, using the term "dared" and things like that.
THE WITNESS: So MayRose crit on 7/3rd, like July 3rd, was 28. And by the time that she required transfusion on July 24, for elective surgery, she did not require transfusion for anemia. She required it for the surgery. It was about 26.
So we are talking about a decline of the hematocrit from 28 to 26 in about 20 days. And she was asymptomatic. And she went to the OR for surgery.
So that 20 days reflect what's going to happen in the future.
We did not, we, we, the unit at that time period that we call from July 3 to July 24 that she required the surgery and she got transfusion for surgery, she had some multiple blood draw illnesses.
But for her that going home to controlling environment at home with no blood draw, one month was very, very kind of safe.
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BY MS. CARMICHAEL:
Q Okay. So you were basing that judgment call on the July 3 to July 20 period and how she did during that timeframe. Correct?
A Correct.
Q Okay. Did you consider at all how she did during the ten days before she was discharged?
A During that ten days, she required transfusion for elective procedures. Those are not transfusion for anemia per se. Those are transfusions given to the actual surgeon to do their procedure or anesthesiologist to do what they do.
Q Okay.
A But the fact was her hematocrit was, on July 3 was 28. And on July 24 without transfusion was 26.
Q Okay. But during that ten-day period, Doctor, in spite of three transfusions in a ten-day period, her hematocrit, whether you want to say it was not, you know, you didn't consider it low, but technically it's low, whatever, her hematocrit was continuing to fall in spite of having three transfusions in a ten-day period. Did you not consider that to be clinically significant?
MR. COTTON: Form and foundation objections.

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THE WITNESS: On daily basis, we are discharging premature babies like MayRose with a hematocrit of 25 or 24. And as long as they are stable and condition is just dictate that they are going to have appropriate follow-up, and the physicians they are going to follow up, they are going to be under care of the physician, so it's going to be safe to send them home out of ICU care to general pediatrics care.
BY MS. CARMICHAEL:
Q Okay. And what about the fall in her retic count, reticulocyte count in a two-week period of time, from a .9 to a .5? What about that? What -- did you think it was really safe to wait 30 days to test that retic again, considering it was on the very bottom level of safe?
MR. COTTON: Form objection.
Go ahead.
THE WITNESS: Point nine was, based on our record, was normal. Point five was low, accurately low.
But the baby is going to be, based on my assessment of the history, the baby would be safe to get hematocrit and retic count within one month, considering the baby is going to be under supervision

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and care of pediatrician with close follow-up.
MS. CARMICHAEL: I think we have to change tapes.
THE WITNESS: Sure.
THE VIDEOGRAPHER: The time is 1:00 p.m., and this concludes digital tape number two. We're off the record.
(A short break was taken.)
THE VIDEOGRAPHER: The time is 1:05 p.m. We're back on the record with digital tape number three.
You may proceed.
MS. CARMICHAEL: Thank you.
BY MS. CARMICHAEL:
Q Doctor Piroozi, at the time of MayRose's discharge, did you consider possibly having her follow up with a hematologist?
A No.
Q Why not? Concerning, with regard to the, to the low retic, the low and falling retic count?
A That was one value that was low and out of normal based on the current practice and standard of practice at Sunrise NICU. We have to establish significant decline retic count outpatient to just ask the hematologist, Doctor Klein, for heme consult.

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Q Okay. Is that same standard applicable to have an inpatient consult while the infant is in the NICU?
A If the patient has a profound anemia or other signs, we occasionally ask Hematology to consult.
Q And what do you consider to be profound anemia?
A It's going to be, we are talking about in the babies that they are asymptomatic less than 20, and symptomatic less than 25. With no, with, not, no explanation of anemia.
Q Asymptomatic with less than 20, or symptomatic with less than 25?
A With no explanation of anemia.
Q Okay. Do you know from your training and education that a low reticulocyte count may be indicative of bone marrow disorders and aplastic crisis?
A And other reasons, yes.
Q Okay. And that particular thing, an aplastic crisis, can be life threatening. Is that true?
A Yes.
Q And you did nothing to rule out that that

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was what was going on with MayRose. Correct?
A I had one retic count was abnormal, and I ordered a CBC and retic count to follow.
Q Did, did anyone show up in the NICU that you recall claiming to be there as MayRose's pediatrician?
A No.
Q Okay. Following her discharge, did you call MayRose's pediatrician, Doctor Conti, to discuss with him the discharge instructions?
A I don't recall.
Q So do you believe you may, is it a possibility --
A It's possible.
Q -- that you may have done that?
A It's possible.
Q Is that part of your normal routine? Do you typically contact the pediatricians of your NICU patients and discuss the discharge instructions with them?
A We fax them, mail them the discharge summary. We provide one discharge summary to parents who take it to the pediatrician. And occasionally, we call the pediatrician as well.
Q Okay. You just don't know if you called Doctor Conti in this instance?

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A Yeah, I don't recall.
Q Okay. But you're certain that these discharge instructions would have been faxed to him?
A Hundred percent.
Q Okay. And they would have also been mailed to him?
A Mail, I'm not sure. But hundred percent we provide a fax. Somehow they record in the chart.
Q Okay. And when are the discharge instructions faxed to the pediatrician?
A The day of discharge.
Q Okay. Okay. Did you have any, at the time of MayRose's discharge or just prior to, did you have any discussions with Doctor Blahnik about her, the low retic result that you received?
A I don't recall.
Q Do you recall having any discussions with Doctor Blahnik about MayRose prior to her discharge?
A I don't recall.
(Plaintiffs' Exhibit 25 marked for identification.)
BY MS. CARMICHAEL:
Q Exhibit 25 to your deposition is a document called Detailed Discharge Disposition. Do you know, is this a document that is prepared by the nursing

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staff?
A I believe so, yeah.
Q Okay. Would you turn to the fourth page of that document, Bates stamped 1139?
A Uh-huh.
Q And there you'll see, under NICU Discharge Planning, about a third of the way down the page, OT/PT/ST. Do you see that?
A Yes. Yes.
Q And it says, "One to two times per week for six months, script given to parents"?
A Yes.
Q Is that a length of time -- is that a prescription you would have written?
A Yes.
Q Okay.
A I believe so.
Q And so was it your recommendation that she receive OT/PT/ST one to two times week for six months?
A All the premature babies, they get that.
Q Okay. And were you contemplating that that would be, that that should be the extent of the therapy that she would require?
A Usually we provide this service for about three to six month, and then they can extend it if

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they feel the baby is not physically just getting better.
Q Okay. So with a premature child, a child born prematurely, the parents need to expect that there's going to be some developmental delays initially. Is that true?
A Initially and eventually, yes.
Q Okay. All right. And those are delays that they can eventually catch up barring some other kind of complication?
A It depends to cases. Some of them not.
Q Okay. And what did you anticipate for MayRose as she left your care on August 2 of '08?
A Unfortunately, it's very difficult to anticipate unless that you developmentally follow these ex-preemies and to see how they are catching up, they are getting better or not.
Q Okay. All right. A lot would probably depend on what the follow-up head ultrasound demonstrated and the other follow-up testing that you had ordered. Correct?
A Not necessarily. It just the pediatricians, they are following developmental milestone. Basically when the babies are in NICU they do not need that much of bulk of brain to function. They are just taking

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bottles and crying.
But when they are six month or three month, they do other functions. And if they cannot do those functions, including sitting, standing, talking, those are signs of lack of developmental delay.
Q Okay. Okay. All right. Let's see.
(Plaintiffs' Exhibit 26 marked for identification.)
BY MS. CARMICHAEL:
Q Exhibit 26 to your deposition are some of your responses to my set of Requests for Admissions. I just had a couple clarifications I needed to ask you about.
A Sure.
Q Request number three, on page two, says, "Admit that you did not include in your discharge order instructions an order to obtain a CBC in a time period less than 30 days following discharge."
And you object because the question was unclear. And I apologize for that.
But then you denied, indicating that a follow-up CBC and differential and retic count was ordered in the discharge instructions.
I certainly don't take issue with that.
But the point I was trying to make is it

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wasn't ordered for a period of 30 days. Do you admit that?
A Yes.
Q Okay. Okay. Request number four states, "Admit that you represented to the parents of MayRose Hurst that her anemia was due to prematurity and was nothing to worry about."
You deny that due to the fact that you simply do not recall.
So my question to you is, do you believe that you said anything to her parents to cause them to be alarmed about MayRose's anemia?
A Having me to order the follow-up CBC and retic count, it means that they have to follow it up and it's not simply anemia prematurity.
Q Okay.
A So definitely it needs a follow-up.
Q So you --
A I did not reassure them, I bet, but I don't recall that I told them anything about prematurity.
Q So are you now stating that at the time of her discharge you're acknowledging that this was not just anemia due to prematurity --
A I acknowledge --
Q -- that there was something more going on?

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A I acknowledged that the retic count was low and has to be followed up.
Q Okay. And --
A And if the hundred percent say that's a benign condition, usually we do not do the follow-up. So this was abnormal retic count that has to have a follow up in one month, I ordered.
Q Okay, so do you admit that MayRose's anemia was not simply due to prematurity?
A There was not enough information to make that conclusion.
Q Okay. Until you got that retic test result, throughout her NICU stay, I think I understood your testimony today to be that you were not really concerned about this anemia because there were explanations for it, it was very common, it was what you saw with many, many other preemies. It was essentially to be expected.
Am I mischaracterizing you, or is that essentially the feeling that you had about it?
MR. COTTON: Form objection.
THE WITNESS: MayRose was very critically sick and had a lot of conditions that cause anemia. And her blood tests are not really alarming considering her medical condition at that time.

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BY MS. CARMICHAEL:
Q Okay --
A At the time that I was taking care of her.
Q So during her admission, do you believe you ever gave the parents reason to be concerned about the anemia?
A I don't recall.
Q Okay. At the time of discharge, do you believe you said anything to the parents to cause them to be concerned that she may have a serious anemia situation?
A I, I don't recall a specific, but I'm hundred percent sure I explained to them the follow-ups that has to come. Including the head ultrasound that was abnormal that could be something else. And the head ultrasound was ordered for follow-up.
I explained to them most probably the retic count is low and has to have a follow-up, as well as a cystic fibrosis, and other follow-ups that has to come.
So those follow-ups ordered for specific reasons, that those reasons are very important.
Q Okay. And I'm not doubting your testimony here today, that you told them what needed to be done following discharge. But what I want to know is if there was any kind of a conversation that you recall between you and the parents where you indicated: Something serious may be going on with MayRose. I do not believe this is anemia due to prematurity. I believe this could possibly be something very serious?
MR. COTTON: Are you asking if he said those words?
BY MS. CARMICHAEL:
Q Anything like that. Did you say anything to them --
MR. COTTON: Outside of --
MS. CARMICHAEL: -- that give --
MR. COTTON: -- what he's already told you --
MS. CARMICHAEL: -- to give --
MR. COTTON: -- that he said to them about follow-up tests. Right?
MS. CARMICHAEL: Right.
BY MS. CARMICHAEL:
Q To give them the idea that she was, that this was not anemia due to prematurity?
A If there was any concern of serious matter, we are not sending the baby home. And I don't recall any conversation that types.

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Q Okay. Did you consult with Doctor Blahnik or any other physician regarding the discharge plan?
A I don't recall.
Q Would you typically consult with the attending and admitting physician regarding the discharge plan, or, or would you just come up with it on your own?
MR. COTTON: Form objection.
THE WITNESS: Usually, it is the individual decision.
BY MS. CARMICHAEL:
Q So whatever neonatologist happened to be treating the child on the date of discharge would be responsible for coming up with the discharge plan?
A I have to say this is a teamwork, but the baby gets the condition that is not going to require any more additional ICU care, then the person comes based on the finding and based on the history is going to set a plan.
MR. COTTON: The doctor who is there that day is what you --
THE WITNESS: Exactly.
BY MS. CARMICHAEL:
Q Okay. And it's not a situation where you have to run things by the attending or admitting

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physician before you can act on something you would like to do?
MR. COTTON: Just to stop you on that question, because you may, because you can ask Blahnik, too, there isn't an attending physician. Whoever admits the patient admits them. But they continue to care from patient to patient. Like Doctor Blahnik is not the attending. He just admits the patient. And then each doctor is responsible for each shift. They don't call Blahnik and report to him or anything like that.
I just wanted to clarify.
MS. CARMICHAEL: Okay. And I think, there is some confusion, because I think actually in the medical record he might be referred to as the attending.
MR. COTTON: The hospital lists him that way. But in terms of functionality --
MS. CARMICHAEL: Function. That's what I'm getting at.
MR. COTTON: He's not somebody he really has to report to.
BY MS. CARMICHAEL:
Q How does it functionally work?
A We don't necessarily need to report it to

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the admitting physician, the plan of discharge.
Q Okay. Or anything else. Any plan of treatment you want to enact. Correct?
A Yeah, we are not discussing.
Q Okay. You may have answered this earlier, and I apologize if you did, but it didn't, it didn't register. In order for you to have brought in a hematologist for a consultation, what more would have needed to be in MayRose's clinical picture?
A If we could not explain her anemia or her anemia was profound, we would ask hematologist to get involved.
Q Okay. And I think you did define for me what you considered to be profound.
A I explained to you.
Q MayRose definitely was not septic at the time of discharge. Correct?
A Correct.
Q If she was septic, you would have kept her. Right?
A Correct.
Q And in the three or four days before discharge, was she septic?
A I believe she was receiving antibiotics for post line placement for surgery, yeah.

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Q Okay. All right. So I, that doesn't, that might probably mean something to you. It doesn't really answer my question for me. Was she septic in the three or four days before discharge?
A She wasn't septic.
Q Okay. When is the last time during her NICU stay that you would consider that she was septic prior to discharge?
A I would have to take a look at the record, but there was a time that her seroreactive protein was high. She had some cytopenia. She had signs of sepsis. I think the mastoid infection and soft tissue infection rule out mastoiditis was last one, I believe.
Q That was the tail end of it?
A I feel. But I have to look at the record again.
Q Okay. All right.
MS. CARMICHAEL: Those are all the questions I have. Thank you for your time today.
THE WITNESS: Thank you so much.
MS. URDAZ: No questions.
MS. LUCERO: I just have a few.
THE WITNESS: Sure.
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EXAMINATION
BY MS. LUCERO:
Q Have you had any conversations with Doctor Conti regarding the care and treatment of MayRose?
A I don't recall.
Q Have you ever reviewed any of Doctor Conti's records, medical records?
A No.
Q So if you haven't reviewed any of the medical records, do you intend to offer any opinions regarding the care and treatment he offered MayRose?
MR. COTTON: He won't be offering any opinions.
THE WITNESS: No.
BY MS. LUCERO:
Q You mentioned earlier that you had talked to a Doctor Klein?
A Correct.
Q In that conversation, did he criticize any of Doctor Conti's care and treatment?
A No.
Q Did he offer any opinions as to whether MayRose's outcome would have been any different had the follow-up blood results been ordered?
A I don't recall.

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Q Now, just to talk about the discharge instructions for just a second.
A Sure.
Q Are both the discharge, the discharge summary as well as the discharge disposition given to the parents?
A We usually give just discharge summary, two copies, yeah. One for the pediatrician, one for the family to give.
Q Okay. And that's something that you hand to them?
A The, the nurse at the bedside, she's going to give it to them, yeah.
Q Okay. And you said you were a hundred percent sure that this is faxed to the pediatrician?
A Yeah, that was the way that they do it.
Q Okay. How is it that you're a hundred percent sure?
A Because you have discharge coordinator, her responsibility to fax it. And occasionally, they mail it as well.
Q So it's the discharge coordinator's responsibility --
A Correct.
Q -- to ensure that it gets to the physician?

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A Faxed and they received it, yeah.
Q Okay.
MS. LUCERO: That's all the questions I have. Thank you.
MR. COTTON: Do you have anything else, Jackie?
MS. CARMICHAEL: No.
THE WITNESS: Thank you, and have a safe flight back.
MR. COTTON: Read and sign. You can send it through me.
THE VIDEOGRAPHER: The time is 1:26 p.m. This concludes the deposition. We're off the record.
(The deposition concluded at 1:26 p.m.)

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CERTIFICATE OF DEPONENT

PAGE LINE CHANGE

I, ALI PIROOZI, M.D., deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my testimony in said action, that I have read, corrected, and do hereby affix my signature to said transcript.

ALI PIROOZI, M.D.
Deponent

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REPORTER'S CERTIFICATE

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Karen Berry, a duly commissioned Notary Public, Clark County, State of Nevada, do hereby certify:

That I reported the taking of the deposition of the witness, ALI PIROOZI, M.D., commencing on January 18, 2011, at 10:10 a.m.

That prior to being examined, the witness was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate transcription of shorthand notes taken down at said time.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in my office in the County of Clark, State of Nevada, this____day of_____ 2012.

Karen J. Berry, CCR 836, RMR

EXHIBIT I

SUMMERLIN HOSPITAL MEDICAL CENTER
657 TOWN CENTER DRIVE
LAS VEGAS, NEVADA 89144

DATE OF SERVICE: 11/25/2008

REFERRING PHYSICIAN: Nathan D Heaps, MD

PRIMARY CARE PHYSICIAN: Ralph M. Conti, MD

ER PHYSICIAN: Nathan D Heaps, MD

CONSULTANTS:
1. Dr. Rashid.
2. Dr. Reyna.
3. Dr. Kufuor.
4. Dr. Nakamura.
5. Dr. Maller.

ADMISSION DIAGNOSES:
1. Anemic shock secondary to viral suppression.
2. Influenza B sepsis.
3. Neutropenia.
4. Systemic inflammatory response syndrome.

DISCHARGE DIAGNOSES:
1. Hypoxic ischemic encephalopathy.
2. Enterobacter pneumonia, status post treatment.
3. Gastroesophageal reflux disease.
4. Laryngomalacia.
5. Anemia, stable.

PAST MEDICAL HISTORY: This is a currently 6-month 11-day-old ex-28-week preemie with a history of necrotizing enterocolitis, germinal matrix bleed grade 1, anemia of prematurity, jaundice, hypoglycemia, septic work up, discharged after 80 days in the NICU at Sunrise Children's Hospital with a history of bowel resection secondary to necrotizing enterocolitis, no short gut syndrome, and discharge problems included anemia of prematurity.

OPERATIONS AND PROCEDURES:
1. Intubation from 10/29 to 11/05/2008.
2. Arterial line from 10/29 to 11/10/2008.
3. Central venous line from 10/29 to 11/06/2008.
4. Bronchoscopy on 11/14/2008.
5. Bone marrow aspiration on 10/30/2008.

HOSPITAL COURSE: This was a 5-month-old ex-preemie, who presented to the emergency room with a history of 1-week increased fussiness, inconsolable crying, with 2 days of lethargy. She presented to the emergency room with apnea and bradycardia. Patient was emergently resuscitated with fluids and placed on mechanical ventilation and antibiotics. Most significantly, her initial hemoglobin was confirmed at 1.5. A CT of the head and abdomen were found to be negative.

Hospital course will then be done by systems:

RESPIRATORY: Initially she presented in shock with apnea. Initial arterial blood gases read pH of less than 6.5, pCO2 of 22.2, and a pO2 of 98. She was intubated on 10/29 to 11/05 and never required high settings of HWB. On hospital stay day number 2 RSV and influenza were obtained, and she was found to have influenza B. She had a prolonged intubation secondary to secretions and atelectasis. Received albuterol treatments from 10/30 to 11/14/2008. Is

EGC - Hurst
Summerlin 00994

currently on Atrovent, which started on 11/02 to present. Received racemic epi for stridor, which initially started on 11/06. On 11/14 she received a bronchoscopy, which was done for stridor, and no evidence of subglottic stenosis was obtained. There was normal anatomy except for some laryngomalacia. The lipid-laden macrophage and hemosiderin were found to be negative. At that time there was no evidence of reflux. Upon discharge, she is currently on room air with saturations from 98% to 100%.

CARDIOVASCULAR: She has been able to maintain stability, and had an echocardiogram on 10/29/2008. The echo revealed that there was normal anatomy and no pulmonary hypertension.

INFECTIOUS DISEASE: She was influenza B positive, and on a trache culture she was positive for enterobacter, and was initially started on meropenem for a course from 10/29 to 11/03/2008. She was started on intravenous fluconazole from 10/30 to 11/05, which was added for neutropenia and prophylaxis for fungal infections. She was given gentamicin IM x1 on 11/08. Her last Synagis dose was on 11/12, and she received Septra from 11/17 to current, which will end on 11/27 for Enterobacter pneumonia from her bronchoscopy from a bronchial lavage.

GASTROINTESTINAL: She received TPN from 11/03 to 11/07/2008, and has had some difficulty with p.o. feeds. This was initially secondary to neurological status. She remained on NGT feeds; however, on November 14 post bronchoscopy her NGT was removed, and she was monitored for feeding intolerance. On 11/06 a swallow study was obtained and revealed that she had gastroesophageal reflux disease, and was started on Pepcid from 10/29 to 11/01, was started on Lactinex. She is currently on Reglan and Zantac, which were started from 11/06 to current. Since then, she has been having oral feeds with 24-calorie formula of Alimentum with 1 mL per ounce of corn oil. She has consistently been able to gain weight, with approximately 130 calories/kg per day. Discharge weight is 4.41 kg.

HEMATOLOGIC: Hematology/oncology was consulted for an initial hemoglobin on 10/29 of 1.5. She received PRBCs on 10/29 x3, and was given epoetin Mondays, Wednesdays, and Fridays, which was started on 11/07. She is currently receiving ferrous sulfate, which was started on 11/13, which is approximately 3 mg/kg per day. Hemoglobin was done on 11/20, was found to be 10.4. Her bone marrow aspiration on 10/30/2008 indicated that she had acellular marrow, per hematology/oncology, and neutropenia secondary to viral suppression. There was some mild thrombocytopenia, but no lower than 50,000, which continues to be a working diagnosis secondary to viral suppression. A hemoglobin electrophoresis was obtained prior to blood transfusion, and suggested alpha thalassemia, but followup DNA revealed that it was negative. Father has a history of alpha thalassemia traits. Patient has not had a blood transfusion since 11/2/2008.

NEUROLOGIC: Patient was sedated with Versed and fentanyl while she was intubated, and on 11/06 she was started on methadone for irritability. Tylenol with codeine was started from 11/07/2008 to 11/14/2008 also for irritability. She continues to be on a methadone wean, and is currently going to be sent home with methadone 0.7 mg p.o. once a day x1 week, then 0.6 mg p.o. x1 week, then 0.5 mg p.o. x1 week, then 0.4 mg once a day for 1 week, then 0.3 mg p.o. once a day x1 week.

RENAL/FEN/WEIGHT: Current weight is 4.41 kg.

DISCHARGE EXAMINATION:
VITAL SIGNS: T-max is 98.8, blood pressure 79/52, pulse 109 to 143, respirations 27 to 33, O2 saturations 98% to 100% on room air.
GENERAL: This is an awake and alert 6-month 11-day-old African-American female who is in no acute distress. Mother is at the bedside.
HEENT: The head is normocephalic, atraumatic. Ears are clear with no drainage. Landmarks are intact. Eyes: PERRLA. Nose is patent bilaterally. Throat is pink and moist.
NECK: Supple with no adenopathy.
RESPIRATORY: Lung sounds are clear, however has occasional rhonchi noted anterior, posterior, and lateral. Chest expansion is bilaterally equal and respiratory pattern is unlabored. She currently has started with a

nonproductive cough over the last couple of days.
CARDIOVASCULAR: S1 and S2 are audible. There are no murmurs or rubs noted. Capillary refill in upper and lower extremities less than 2 seconds. Pulses to the upper and lower extremities are +2.
ABDOMEN: Nice and soft, nondistended, nontender. Bowel sounds are present to all four quadrants. There is no hepatosplenomegaly. Last BM was last night.
GENITALIA: Tanner stage I.
EXTREMITIES: Patient is able to move all extremities; however, there is some hypertonicity noted through all four extremities, and some tightness noted. Patient is currently also wearing hand splints bilaterally, and is currently working with physical therapy.
NEUROLOGIC: Patient is awake and alert.
SKIN: Warm, dry, and intact. No rashes, bruising, wheezing, or petechiae noted at this time.

SUMMARY OF RELEVANT TESTS DURING HOSPITAL STAY:
LABS: Hemoglobin upon admission and presentation was 1.7. RSV was negative. Influenza B positive upon admission. Urine organic acids consistent with lactic acidosis and ketosis. A repeat specimen was obtained and continues to be pending at this time. Negative for alpha thalassemia. Negative lipid-laden macrophage. Plasma amino acids show weak peak cystathionine, possibly secondary to hepatic immaturity, and a repeat was also done and continues to be pending at this time. On 11/14 bronchial wash was positive for Enterobacter aerogenes. On 10/29 sputum culture was positive for Enterobacter cloacae. On 10/30 bone marrow aspiration revealed hypocellular marrow with blunted left shifted maturation. Normal B cells and T cells. No increase in the CD-34 cells.

RADIOLOGY STUDIES:
1. Positive swallow study for gastroesophageal reflux disease.
2. CT on 11/14, which was extensive for infarctions and gyral calcifications.

DISPOSITION: Patient is okay to discharge home with mother or parent.
Diet: Regular for age and ad lib. Patient is to have 24-calorie Alimentum with 1 mL of corn oil per ounce. Last Hgb 10.4, HCT 31.2, Retic Ct 0.64.
Activities: Ad lib; however, patient is to follow up with PT, OT and ST. PT needs to be evaluated three to four times a week for 1 month, and OT/ST needs to be evaluated three to four times a week x1 month, and pediatrician is to follow up on that.
Provider Follow-up:
1. Dr. Rashid in 1 week.
2. Dr. Conti in 1 to 2 days.
3. Dr. Nakamura in 2 months.
4. Dr. Maller in 1 week.
5. Patient is encouraged to have an outpatient BAER exam, and labs to be obtained are a CBC and a retic count prior to follow up with hematology/oncology.

Discharge Medications:
1. Methadone 0.7 mg p.o. once a day x1 week, 0.6 mg p.o. x1 week, 0.5 mg p.o. x1 week, 0.4 mg p.o. x1 week, and 0.3 mg p.o. once a day x1 week.
2. Reglan 0.4 mg four times a day, 30 minutes prior to meals.
3. Zantac 4 mg p.o. twice a day 30 minutes prior to meals.
4. Septra 1.5 mL p.o. twice a day for the next few days.
5. Albuterol 2.5 mg every 4 hours as needed for wheezing.
6. Butt cream for rash.
7. Iron 0.6 mL p.o. once a day.

Special instructions: Patient is to return to the emergency room for any increased work of breathing, shortness of breath, change in mental status, decreased p.o. intake, decreased urinary output, and family is to call the primary care physician for any other questions or concerns.

Signed by MARIANO PNP, CHRIS
on 05-Dec-2008 12:59:53 -0800

Dictated by: Chris Mariano, PNP

EGC - Hurst
Summerlin 00996

History reviewed in detail, patient examined and findings confirmed, except as noted above. Impression as noted above. Plan as noted and per orders.

Signed by VOVAN MD, BRIAN
on 15-Dec-2008 13:31:25 -0800

Dictated for: Brian Vovan, MD

114402/MedQ
DD: 11/25/2008 15:04:24
DT: 11/25/2008 15:49:22
Revised: 11/26/08 eab

DISCHARGE SUMMARY

PATIENT NAME:	HURST, MAYROSE	MR#:	4762163
ATTENDING:	BRIAN VOVAN, MD	ACCT#:	6271613
DATE OF ADMISSION:	10/29/2008	RM#:	0542
DATE OF DISCHARGE:	11/25/2008	DATE OF BIRTH:	05/14/2008

CC: Troy M. Reyna, MD
Nana Kufuor, M.D.
Craig T. Nakamura, MD
Alfreda Maller, MD
Ralph M. Conti, MD
Nik F. Abdul-Rashid, MD

EGC - Hurst
Summerlin 00997

EXHIBIT J

TABLE OF CONTENTS

I. INTRODUCTION

A life care plan is a dynamic document based upon standards of practice, comprehensive assessment, and data analysis and research, providing an organized and concise plan for current and future medical and medically related goods and services for individuals who have sustained catastrophic injury or disabling disease. Through the life care planning process, a systematic and logical approach is used to trace all of the needs relating from the disability to the end of life expectancy. This process requires the coordination and management of information from many sources. All past medical, social, psychological, vocational, educational, and rehabilitation data are taken into consideration to the extent that it is available and applicable. Medical literature germane to critical issues in the plan is surveyed to reflect current concepts of care for patients and disease state management.

Various experts within the field of rehabilitation and case management develop life care plans. Medical and therapeutic specialists may be consulted according to their clinical specialty. The goals and desires of the patient and family are expressed in the plan if they are known. The impact of aging with disability and the progression of disease are reflected. The life care plan provides for services that are needed to prevent or significantly reduce known complications over time. Potential complications frequently associated with the principle diagnoses are discussed, and the care needs for these complications are projected. The range of services in the geographic area or region and prevailing community costs and standards are utilized as available to provide an analysis of costs. These costs are typically expressed as present day costs derived from available data and resources. The plan serves as a guide for family members, case managers and health care providers. It is not a prescription for care but rather a logical blueprint for anticipated health care and other related needs based upon reasonable medical and rehabilitation probability and current concepts of patient care management. The information serves those charged with the fiduciary responsibility to provide for future care. The life care plan is often used by financial administrators tasked with selecting appropriate investment strategies to preserve funding over the life of the patient. Life care plans are typically requested by insurance carriers, litigants in personal injury or medical malpractice claims, worker's compensation boards, trust officers, annuity planners, economists, and rehabilitation specialists.

This life care plan is prepared for MayRose Hurst, a 4 year old who carries a diagnosis of anoxic/hypoxic brain injury. In addition to her pediatric brain injury , she also carries a diagnosis of Diamond Blackfan Anemia, although this life care plan does not consider the needs associated with this condition. While MayRose has made remarkable gains, especially over the last 6 months, she demonstrates very significant physical, developmental, and cognitive disabilities. Brian Buck, M.D. who conducted an IME on MayRose was instrumental in ensuring that the projections in the plan were necessary and sufficient to meet her needs and were consistent with current trends in patient care. In addition, her current treating neurologist, Dr. Terry Sanger, was kind enough to discuss MayRose's future needs in detail with us. Finally, Melissa Lynott, RN, BSN, CLNC was an active team member in the preparation of this report by assisting in the medical records review and acting as internal case manager. This document should be reviewed periodically and revised to reflect MayRose's current clinical presentation. The Life Care Plan may be modified based upon new information that becomes available at a later date, especially records that may reflect MayRose's response to recommended treatment and her ongoing development.

II. MEDICAL HISTORY

Record Sources:

Medical Records:

- Sunrise Hospital Vol. 1.pdf, pgs. 1-634, 05/14/08-08/02/08; Vol 2.pdf, pgs. 1-596, Vol. 3.pdf, pgs. 1-718, Vol 4.pdf, pgs. 1-756
- Foothill Pediatrics/Ralph Conti, MD.pdf, pgs. 1-375, 08/05/08-10/01/09 (includes records from Colorado Genetics Lab, Desert Radiologists, Comprehensive Cancer Center Pediatrics, Child Neurology Specialists, Speech therapy Center of Excellence, Children's Lung Specialists, CFCS/Dr. Michael Scheidler, PGNA/Dr. Carl Dezenberg, The Children's Hospital-Colorado, Sunrise Children's Hospital Chart, and Summerlin Hospital Chart)
- Summerlin Hospital.pdf, pgs. 1-1130, 10/29/08-11/25/08
- Children's Hospital of Colorado.pdf, pgs. 1-860, 11/28/08-12/19/08
- Children's Hospital of Los Angeles (CHLA) Vol 1.pdf, pgs. 1-281, 01/20/10-11/23/10; Vol 2.pdf, pgs. 1-273, 02/13/11-04/21/11; Vol 3.pdf, pgs. 1-586 05/11/11-05/27/11; 05/31/11; Vol 4.pdf, pgs. 1-278, 06/10/11-
- Current physicians Las Vegas.pdf, pgs. 1-539 (contains records from multiple providers including Roshan Raja, MD, Terry Sanger, MD)
- Current therapy providers Las Vegas.pdf, pgs. 1-295 (contains records from Hope Communication & Feeding Specialists, Jabber Jaws Pediatric Speech Pathology)
- Clark County School District IEP.pdf, pgs. 1-32, 06/01/12

Depositions:

- Deposition transcript of Tiffany Hurst (MayRose's Mother), paper document, pgs. 1-59

Summary of Medical Procedures:

- Sunrise Hospital, acute hospitalization after birth: 05/14/08-08/02/08
- Exploratory laparotomy; 3 cm bowel resection and ileostomy: 05/14/08
- Lumbar puncture: 06/24/08
- Ostomy takedown; extensive lysis of adhesions: 07/24/08
- Summerlin Hospital, acute hospitalization: 10/29/08-11/29/08
- Children's Hospital of Colorado, acute hospitalization for neurorehab: 12/05/08-12/18/08
- Bone marrow biopsy, lumbar puncture: 10/30/09
- Children's hospital of Colorado, acute hospitalization for G-tube placement: 06/10/11-06/15/11
- Gastrostomy tube placement, lysis of adhesions: 06/10/11

Summary of Diagnostic Procedures:

Chest and abdomen:

- Chest one view, 05/14/08: Within normal limits
- Chest/abd AP infant portable, 05/14/08: Faint granular lung infiltrates.
- Chest only, 05/15/08: Faint increased interstitial markings persist.
- Chest one view, 05/15/08: New, large pneumoperitoneum. A subsequent abdominal film has already been ordered and interpreted; mildly increased pulmonary interstitial markings are likely due to relatively decreased lung volumes.
- Abdomen two view, 05/15/08: New pneumoperitoneum suggesting bowel perforation.

- Chest one view, 05/15/08: Satisfactory intubation with the tip of the ETT at the T2-T3 level; Large pneumoperitoneum again identified; even after accounting for decreased lung volumes, there has been moderate interval progression of diffuse interstitial infiltrates.
- Abdomen two intraoperative views, 05/15/08: No radiopaque foreign bodies are identified.
- Abdomen 1 view, 05/15/08: No radiopaque foreign body identified; umbilical venous catheter projects 10 ml above the diaphragm. Recommend pulling back 10 mm.
- Chest and abdomen one view, 05/15/08: Stable RDS pattern. Small amount of free air remains in the right upper quadrant.
- Chest abd AP infant, 05/16/08: Worsening right upper lung infiltrate.
- Chest and abdomen one view, 05/17/08, 05/18/08: ET tube at T1. No change in RDS pattern.
- Chest one view, 05/19/08, 05/23/08, 05/24/08: Stable chest.
- Echocardiogram, 05/19/08: Normal echo evaluation with a patent foramen ovale.
- Chest and abd AP infant, 05/20/08, 05/21/08: ETT is in stable position; hazy lung infiltrates are again identified.
- AP chest, 05/21/08: New PICC line in the inferior right atrium or upper SVC; no significant change in hazy bilateral infiltrates. No change in other support tubes in place.
- Chest AP/PA portable, 05/21/08: PICC line in right subclavian vein. Granular infiltrates.
- Chest and abd portable, 05/22/08: Stable diffuse bilateral interstitial infiltrates.
- Abdomen portable, 05/27/08: Distended air-filled stomach is seen and there is air in the colon. There is no obstruction noted. NG tube is in place. Central line has been removed.
- Abdomen one view, 05/27/08: No obvious free intra-abdominal gas is identified.
- Abdomen portable, 05/28/08: Nonspecific small bowel distention. NG tube in stomach. No definite obstruction though. There is still some air in the left side of the colon as well.
- Abdomen one view, 05/29/08: Mottled bowel gas pattern suspicious for pneumatosis. Featureless-filled loops of bowel compatible with edema. No bowel obstruction.
- Chest and abdomen two views, 05/29/08, 05/30/08: Oral tube level of the stomach; right PICC catheter level of superior vena cava; mild perihilar interstitial infiltrates; distended bowel loops within the abdomen remain, which appears to include the small bowel.
- Abdomen portable, 05/31/08: No acute disease.
- Abdomen single view, 06/01/08, 06/02/08, 06/03/08, 06/07/08, 06/08/08, 06/29/08: Nondilated bowel gas pattern.
- AP chest and abdomen, 06/06/08: Nasogastric tube in the stomach; hazy granular infiltrates in the lung; PICC line in the right subclavian vein.
- Chest/abdomen single view, 06/09/08: Improving infiltrates. No evidence of bowel obstruction.
- Chest and abdomen one view, 06/22/08: Decreasing of inspiration. Stable hazy bilateral pulmonary infiltrates. No evidence of acute localizing intra-abdominal pathology.
- Chest one view, 06/23/08: Decreasing infiltrates.
- Abdominal ultrasound, 06/23/08: Negative study
- Chest/abd AP infant, 06/24/08, 06/25/08: NG tube in stomach. Nonspecific pattern. Chest shows minimal residual infiltrates.
- Chest one view, 06/25/08: There is a left arm PICC with the tip projecting over the supraclavicular region. This is not the expected location for a PICC catheter; stable bilateral infiltrates.

- Single view chest and abdomen, 06/26/08: Improved bilateral infiltrates. No obstruction in the abdomen.
- CT abdomen and pelvis w/ contrast, 06/26/08: Bibasilar pulmonary infiltrates. No evidence of abscess in the abdomen. Bowel is not well evaluated due to amount of oral contrast given. No evidence of obstruction.
- Abdomen single view, 06/27/08: Nonspecific gas pattern without evidence of obstruction.
- Abdomen two views, 06/30/08: Stable abdomen.
- Chest one view, 7/02/08: **1535 hours:** Incomplete visualization of the left arm PICC line. This may be within the left internal jugular vein; mild increased perihilar markings; the x-ray was resubmitted without cropping the top of the image. The PICC catheter extends up the left neck but appears somewhat lateral to be within the internal jugular vein. Recommend repositioning; **1633 hours**: The left upper extremity PICC line has been retracted, with tip projecting 2.2 cm above the clavicle in region of the lower left internal jugular vein or within a subclavian venous side branch. Consider withdrawing at least 3 cm before repositioning; lung stable with mild increased perihilar interstitial markings. No focal consolidation. Normal Cardiothymic silhouette; cardiac and mediastinal contours stable, allowing for patient rotated towards the right; **1715 hrs:** the PICC line remains directed up the left neck for a short distance; otherwise stable examination; **1900 hours**: slight decrease hazy bilateral infiltrates. Malplaced left PICC line; **2205 hours**: Left PICC line tip has been withdrawn to the region of left subclavian vein. Cardiac silhouette stable. Hazy bilateral infiltrates are unchanged. No pneumothorax.
- Chest one view, 07/04/08: No change in bilateral infiltrates.
- Single view chest, 07/05/08: Umbilical venous catheter tip at the entry of the right atrium, T8 level; prominent interstitial markings; orogastric tube tip in the stomach.
- Single view chest, 07/05/08: The right femoral venous catheter has been pulled back slightly to the T10 level and is approximately 7 mm below the right atrium; additional left upper extremity PICC line is not visualized past the left subclavian vein.
- Barium Enema, 07/15/08: Prominent bowel proximal to the ostomy although no obstruction or stricture identified. Microcolon from the ostomy to the rectosigmoid region with normal size rectum.
- Chest and abdomen one view, 07/24/08: The ETT appears to project outside of the tracheal air column.
- Single view chest and abdomen, 07/26/08: Increased bilateral infiltrates. Development of gaseous distention of the stomach.
- Chest portable, 07/26/08: The ETT and NG tubes are in satisfactory position; a right subclavian central line has been placed and advanced into the right atrium; no pneumothorax; bilateral lung infiltrates or atelectasis have improved; nonspecific bowel pattern.
- Chest and abdomen three views, 07/26/08: The ETT has been removed. Study otherwise nonspecific.
- Abdomen one view, 07/29/08: Mild gaseous distention of the small bowel loops in the central abdomen; this may represent an ileus.
- Chest 1 view, 10/29/08: ET tube tip has been retracted but terminates at the level of the carina. Retraction by at least 1.0 cm is recommended; right parahilar and left basilar pneumonia are present.
- Abdomen 1 view, 10/29/08: Nonobstructive bowel gas pattern.

- Chest 1 view, 10/29/08: ET tube tip terminates within 1 cm of the carina; stable bilateral pneumonia.
- CT abdomen/pelvis w/o contrast, 10/29/08: Bilateral basilar pneumonia present, right greater than left.
- Chest 1 view, 10/29/08: Improving left lower lobe pneumonia; right upper and lower lobe pneumonia is stable.
- Echocardiogram, 10/29/08: Normal echocardiogram, normal left ventricular function, mild tricuspid regurgitation with low velocity suggesting normal right-sided pressure, no pericardial effusion.
- Chest 1 view, 10/30/08: Significant interval improvement of bilateral pneumonia.
- Chest 1 view, 10/31/08: Interval development of complete right upper lobe atelectasis and discoid left lower lobe atelectasis.
- U/S left lower extremity, 10/31/08, 11/02/08: Limited study due to limited view of the common femoral vein and proximal SFV; otherwise, no evidence of DVT.
- Chest 1 view, 11/01/08: Decreased right upper lobe atelectasis; otherwise, stable.
- Chest 1 view, 11/02/08: Tip of endotracheal tube low position near the carina-retract 1.0 cm; developing right upper lobe pneumonia versus atelectasis-retraction of ETT and follow up; background mild diffuse increased interstitial markings.
- Chest 1 view, 11/03/08: Improved aeration of the right upper lobe likely related to resolving atelectasis.
- Chest 1 view, 11/04/08, 11/05/08: Resolving right infiltrate or edema.
- Abdomen 1 view, 11/06/08: Nasogastric tube in stomach, tip near the pylorus; left femoral line us present with tip at T11; Foley catheter is noted; bowel gas pattern is unremarkable.
- Modified barium swallow, 11/07/08: Only consistency tested was thin liquids. No penetration or aspiration was seen.
- Chest 1 view, 11/11/08: NGT present in satisfactory position; mild peribronchial and perihilar thickening.
- Chest 1 view, 11/13/08: Some improvement in the bilateral patchy opacities.
- Bronchoscopy, 11/14/08: Tracheomalacia
- NM Gastric Emptying/Reflux Study, 02/10/10: Mildly delayed gastric emptying with evidence of gastroesophageal reflux.
- Renal ultrasound, 02/22/10: Normal.
- Voiding cystourethrogram, 02/22/10: Normal VCUG without evidence of vesicoureteral reflux; severe osteopenia.
- MRI abdomen w/o contrast, 11/23/10: Severe hepatic iron overload with a LIC between 12 3-16 2 mg/g; unusually severe pancreatic iron overload; no renal siderosis; the patient should remain in a high-risk cardiac screening track-could progress rapidly.
- MRI Chest w/o contrast 11/23/10, 04/26/11: Normal cardiac function; early evidence of cardiac iron overload. Pt should be followed quite closely as cardiac iron overload can progress quite quickly in this disease. Aggressive therapy is warranted.
- Abdomen flat plate, 04/21/11: Stable exam with prominent bowel gas pattern and stool.
- Upper GI w/ small bowel, 04/22/11: Abnormally dilated small bowel throughout the abdomen, especially within the lower abdomen, without significant obstruction; GERD visualized to the level of the distal esophagus; severe osteopenia.
- Abdomen 2 view, 04/24/11, 04/25/11: Moderate gas-dilated bowel loops, without free peritoneal air; osteopenia.

- MRI abdomen w/o contrast, 04/26/11: severe hepatic siderosis with LIC with 15 and 23 1 mg/g. Interval worsening ~ 3 5 ng/g over the past 5 months; pancreas R2* could not be interpreted because of breathing artifact; no excess renal iron.
- Abdomen x-table lateral, 05/11/11: No free peritoneal air.
- Abdomen 2 view, 05/11/11, 05/12/11: There is decreasing amount of bowel gas but with disproportionate sized loops suggesting a partial obstruction; there may have been transient small bowel intussusception at the left abdomen on supine film but not seen on decubitus view and may have resolved.
- Barium enema, 05/11/11: Dilated colon with no evidence of a transition zone or stricture. Multiple small filling defects throughout the colon likely represent stool; severe osteopenia.
- Abdomen flat plate, 05/15/11: Prominent bowel gas loops, which have improved in the interval. The pattern could still represent a partial bowel obstruction pattern; bilateral coxa valga deformities (a deformity of the hip where the angle formed between the head and neck of the femur and its shaft is increased, usually above 135 degrees. It is caused by a slipped epiphysis of the femoral head) and osteopenic bones.
- NM Gastric emptying/reflux study, 05/16/11: Normal gastric emptying without evidence of GER.
- Pelvis 2 views, 05/21/11: Severe osteopenia with subluxation of femoral heads.
- EGD, 05/31/11: GERD

Head and neck:

- Ultrasound of the brain, 05/14/08: No acute process.
- Ultrasound of the brain, 05/18/08: Marked prematurity. No acute hemorrhage. Stable small amount of extra-axial fluid.
- CT middle ear without contrast, 07/06/08: Soft tissue swelling in the left side of the face and ear region without evidence of mastoiditis or abnormality in the middle ears. No subcutaneous fluid collections identified to suggest abscess.
- Ultrasound of the brain, 08/01/08: New left germinal matrix hemorrhage, grade 1. This may be subacute. No ventricular dilatation.
- MRI brain w/o contrast, 09/30/08: Normal noncontrast MRI of the brain
- EEG, 10/30/08: This EEG is essentially within normal limits for the age of the patient and in sleep state. No evidence of electrical seizures noted.
- FL-ESO motion study w/ video, 10/03/08: Unremarkable swallow study
- CT brain w/o contrast, 10/29/08: No evidence of acute abnormality. Possible mastoiditis.
- CT brain w/o contrast, 11/14/08: Extensive infarctions; gyral calcifications; suspect encephalitis as an etiology; small calcific foreign body in the left parietal scalp, very superficially located near the vertex.
- EEG, 11/15/08: This EEG seems to be abnormal due to a moderate, diffuse slowing of the background activity. However, the technical quality of the study was borderline for interpretation.
- MRI Brain w/o contrast, 12/01/08: Extensive encephalomalacia and abnormal signal throughout the brain in a watershed distribution, consistent with previous hypoxic injury and infarctions. Right subdural hematoma.
- X-ray skeletal survey infant, 12/02/08: No definite metaphyseal fracture. However, there are other findings concerning for injury including periosteal reaction of the left tibia, buckling of the distal radius metaphysis on the right and periosteal reaction of the left radius.

- ❖ Fluoro upper GI series, 12/05/08: The patient swallowed normally. The esophagus, stomach, duodenal bulb, and duodenal c-loop are normal in configuration with apparent location of the duodenojejunal junction in the left upper quadrant. During intermittent fluoroscopic observation there was no gastroesophageal reflux.
- ❖ EEG 11/20/09: Abnormal EEG. There is slowing of background frequencies consistent with a moderate encephalopathy. In addition, several events occurred originating from multiple areas. The findings on this EEG are consistent with both partial and generalized seizures. The findings on the EEG likely represent symptomatic generalized epilepsy disorder.
- ❖ EEG, 12/09/10: Abnormal EEG. There is excess slowing of background rhythms with no well defined posterior alpha and paucity of sleep architecture; the findings of which are consistent with a moderate encephalopathic pattern. In addition, there are epileptiform discharges detailed above, which represent an increased risk for partial and generalized seizure patterns

Spine and extremities:

- ❖ Skeletal survey infant, 12/02/08: No definite metaphyseal fracture. However, there are other findings concerning for injury including periosteal reaction of the left tibia, buckling of the distal radius metaphysis on the right and periosteal reaction of the left radius.
- ❖ Thoracolumbar spine, 02/10/10: Osteopenia, mild hip dysplasia and mild scoliosis

A. Current Medical History:

MayRose Hurst is a 4-year-old, ex-28-week preemie from Nevada who was hospitalized at Summerlin Hospital in Las Vegas from 10/29/08-11/25/08 when she was a little over 5 months old. She was suffering from severe influenza B syndrome complicated by severe anemic shock and hypoxic ischemic encephalopathy. Her initial presentation to the ER was significant for lethargy, apnea, and severe metabolic acidosis with initial hemoglobin of 1.5. She received multiple blood transfusions and a hematologic workup that included a bone marrow biopsy, which showed an acellular marrow consistent with viral suppression. Her hospital course included mechanical ventilation for 7 days, broad spectrum antibiotics and epoetin alfa therapy. After her course of mechanical ventilation she underwent a CT scan on 11/15/08 that showed *diffuse watershed area infarcts, hydrocephalus ex vacuole, and gyral calcification* consistent with her initial shock. Consequently, MayRose developed upper and lower extremity hypertonia, visual tracking difficulties, and poor oral motor skills. EEG showed *abnormal diffuse slowing of the background activity*. During her hospitalization at Summerlin, MayRose received intensive daily physical and occupational therapy. Clinically, she was stable from a hematologic, cardiac, infectious, and respiratory point of view. MayRose was then referred to the inpatient rehab facility at Children's Hospital of Colorado for continued care, as she would need continued therapy for feeding, mobility, flexibility, and function as well as a more complete neurologic evaluation. [See Colorado Children's Referral Letter (Summerlin Hospital.pdf, pgs. 1078-1079)].

MayRose was hospitalized at Children's Hospital of Colorado from 12/01/08-12/18/08. On admission, she was seen by physiatrist, Dr. Susan Gallagher and on initial presentation, was noted to be alert and irritable, moving all extremities equally but with slightly increased tone. She reportedly calmed with feeding and holding. Her pupils were equal, round and reactive to light and extraocular eye movements and gaze were symmetric. She was also found to be tachycardic, thought to be due to her profound anemia. She was to start physical, occupational

and speech therapy and neurology, hematology and infectious disease services were consulted. [See Children's Hospital of Colorado Rehab Admission H&P (Children's Hospital of Colorado.pdf, pgs. 21-24)]. A MRI obtained on the day of admission confirmed the previous diagnosis, noting *extensive encephalomalacia and abnormal signal throughout the brain in a watershed distribution, consistent with previous hypoxic injury and infarctions* as well what was felt to be a *chronic right subdural hematoma*. [See Children's Hospital of Colorado Radiology Report (Children's Hospital of Colorado.pdf, pgs. 105-106)]. MayRose had a skeletal survey done 12/02/08, which found *periosteal reaction with the left distal tibial shaft, buckling of the distal radial cortex with a small amount of periosteal reaction, and overall decreased bone density suggestive of osteopenia*. [See Children's Hospital of Colorado Radiology Report (Children's Hospital of Colorado.pdf, pgs. 106-107)].

For purposes of the rest of the discussion, MayRose's current history will discussed by developmental skill and/or system.

COGNITION:

Comprehension (hearing, auditory): On initial evaluation by the speech therapist at CHOC on 12/02/08, MayRose demonstrated inconsistent responses to auditory stimuli. She was intermittently attentive to her mother's voice. However, she did not respond to other voices or sounds by turning her head or shifting her eye gaze and she did not startle to loud noises. However, she calmed when being held and spoken to softly by her mother. [See Children's Hospital of Colorado ST Evaluation (Children's Hospital of Colorado.pdf, pgs. 55-57)]. MayRose underwent an audiologic evaluation on 12/05/08, and results were found to be consistent with normal hearing. [See Report of Diagnostic Audiologic Evaluation (Children's Hospital of Colorado.pdf, pgs. 148-149)]. At the time of discharge from CHOC on 12/19/08, MayRose had made significant gains during her inpatient stay. She was then demonstrating increased consistency in her responses to auditory stimuli. She was seeking her mother's voice and the voices of other caregivers by shifting her gaze more consistently and was beginning to occasionally turn her head toward a sound source. MayRose was beginning to show a differing comprehension of 'friendly sounds' vs 'non-friendly sounds' by becoming more agitated with screaming, crying, etc that she heard in her environment but she calmed with soothing voices. [See Children's Hospital of Colorado ST Discharge Summary (Foothill Pediatrics.pdf, pgs. 237-239/ Children's Hospital of Colorodo.pdf, pgs. 58-60)].

Expressive language, speech, voice, airway: MayRose was only observed to cry during the initial evaluation. She did occasionally repeat syllables when crying. Per parent report, MayRose occasionally produced cooing sounds. No happy vocalizations were observed and mom reported that the frequency of her vocalizations had decreased since her most recent hospitalization at Summerlin. [See Children's Hospital of Colorado ST Evaluation (Children's Hospital of Colorado.pdf, pgs. 55-57)]. However, by the time of her discharge from CHOC on 12/19/08, MayRose had increased her frequency and variability of vocalizations significantly. She was using primarily vocalic cooing at that time with occasional /m/ productions. She had increased her frequency of vocalizing when alert and happy and produced a variety of cries for differing reasons (mad, hungry, tired). MayRose was beginning to attempt to imitate non-speech sounds such as tongue clicks. [See Children's Hospital of Colorado ST Discharge Summary (Foothill Pediatrics.pdf, pgs. 237-239/ Children's Hospital of Colorodo.pdf, pgs. 58-60)].

Pragmatics: On admission, it was noted that MayRose looked to her mother's face during feeding and during interactions. Her mother reported, however, that this behavior had decreased

significantly since the most recent hospitalization. MayRose was observed to smile in reaction to her mother's voice. Her mother reported that she was smiling more prior to this admission. She was noted to be more interested in people than in objects. [See Children's Hospital of Colorado ST Evaluation (Children's Hospital of Colorado.pdf, pgs. 55-57)]. By discharge, MayRose was making and maintaining eye contact with familiar speakers. She was also beginning to turn her head to look when someone was talking to her. She smiled frequently with interaction and enjoyed being cuddled. [See Children's Hospital of Colorado ST Discharge Summary (Foothill Pediatrics.pdf, pgs. 237-239/ Children's Hospital of Colorodo.pdf, pgs. 58-60)].

Play, Attention: MayRose did not look at objects presented (rattle toys). She did not attempt to interact with the rattle or with her pacifier. Her mother reported that she was previously grasping a rattle but not yet playing with it. Per mother's report, MayRose enjoyed looking at black and white mobiles above her crib. She was not yet imitating facial expressions. [See Children's Hospital of Colorado ST Evaluation (Children's Hospital of Colorado.pdf, pgs. 55-57)]. At discharge, MayRose was showing an interest in looking at shiny objects as well as toys that were high contrast (black and white). In addition, she showed an interest in light-up toys. She was beginning to explore her fingers with her mouth and showed an interest in oral play with textured toys and rattles. She had been observed one time to bat her hand at a toy. MayRose still showed more interest in people and faces than objects at that time. [See Children's Hospital of Colorado ST Discharge Summary (Foothill Pediatrics.pdf, pgs. 237-239/ Children's Hospital of Colorodo.pdf, pgs. 58-60)]. When alert and feeling well, MayRose demonstrated excellent periods of alertness and ability to interact for play. [See Children's Hospital of Colorado OT Discharge Summary (Foothill Pediatrics.pdf, pgs. 214-216/Children's Hospital of Colorado.pdf, pgs. 52-53)].

PHYSIOLOGICAL:

Oral Motor Skills, Swallowing Skills: On 12/02/08, MayRose was observed to take approximately 2 ozs from a bottle from her mother. Her mother held her in an upright position to help with MayRose's significant reflux. MayRose demonstrated functional suck-swallow-breathe pattern with no clinical signs or symptoms of aspiration. MayRose had a swallow study at an outside hospital on 11/07/08, which revealed a functional swallow with no penetration or aspiration but did show significant reflux. [See Children's Hospital of Colorado ST Evaluation (Children's Hospital of Colorado.pdf, pgs. 55-57)]. By the time she was discharged from CHOC, MayRose was receiving her nutrition by breastfeeding and bottle-feeding. MayRose coordinated well with her bottle and when breastfeeding. Her bottle feeds were being thickened with rice cereal to assist with her severe reflux, however, the reflux continued to be a significant concern for her. [See Children's Hospital of Colorado ST Discharge Summary (Foothill Pediatrics.pdf, pgs. 237-239/ Children's Hospital of Colorodo.pdf, pgs. 58-60)]. She was switched to Prevacid from Zantac and placed on Reglan four times a day and although her reflux did not resolve completely, it did improve and she demonstrated good weight gain. [See Children's Hospital of Colorado Discharge Summary (Foothill Pediatrics.pdf, pgs. 225-226/Children's Hospital of Colorado.pdf, pgs. 119-123)].

Posture/Movement/Tone/Reflexes/Range of motion: At her admission evaluation on 12/03/08, MayRose presented with mild to moderate increased muscle tone in her trunk and extremities. No clonus was present, but frequent startles were noted. She was able to move both upper extremities within a flexor pattern. She presented with both hands fisted with thumbs indwelling. She was able to bring her right hand to her mouth when it was well supported in the swaddle position. She had difficulty bringing her hands to midline as she postured with scapular

retraction and elevation. When placed sidelying with lower extremity flexion, she was able to bring both hands together at midline. In prone, she elicited an extensor tone pattern for head elevation with arms and legs pulled back and extended. When she was in well supported sitting, she had fair head control with intermittent head bob. [See Children's Hospital of Colorado OT Baby Team Evaluation (Children's Hospital of Colorado.pdf, pgs. 49-51)]. At discharge on 12/19/08, MayRose was moving all extremities against gravity but with poor variety of patterns and decreased frequency for age. Occasionally, she was able to get her hands to her mouth but had difficulty maintaining that position. She inconsistently was able to pick her head up off her chest in supported sitting and in prone. She remained with mildly to moderately increased muscle tone in all extremities with both her hands fisted when awake, but open when asleep. Range of motion was within normal limits for age. [See Children's Hospital of Colorado PT Discharge Summary (Children's Hospital of Colorado.pdf, pgs. 125-127]. She was started on a low dose of clonazepam with good improvement in irritability and spasticity. [See Children's Hospital of Colorado Discharge Summary (Foothill Pediatrics.pdf, pgs. 225-226/Children's Hospital of Colorado.pdf, pgs. 119-123)].

Physiologic stability/state regulation: MayRose was intermittently irritable with higher levels of stimulation. Upon evaluation in a room with lots of environmental stimulation, MayRose presented in a hypervigilant state with widely dilated eyes, intermittent crying/fussiness, and splayed arms. When assisted to calm by mom, she attempted to sleep but when unable, was calmed by oral feedings. When seen in a quiet gym for evaluation, she was able to maintain a calm state much more efficiently with just the aide of a pacifier or being held by therapist. [See Children's Hospital of Colorado OT Baby Team Evaluation (Children's Hospital of Colorado.pdf, pgs. 49-51)]. By discharge, MayRose was still having difficulty with staying calm with position changes but that had improved significantly since her admission. She calmed well with deep proprioception input such as patting or bouncing and did best when positioned with boundaries such as in a Boppy (an infant support pillow). She smiled to people and occasionally to toys and it was noted that she loved to be held. [See Children's Hospital of Colorado PT Discharge Summary (Children's Hospital of Colorado.pdf, pgs. 125-127)].

Vision: On admission to CHOC, MayRose was able to visually locate and fix on adults faces better than toys. She was able to locate the therapist's face briefly to left and right of midline. No visual awareness of toys was noted except possibly once at midline. MayRose's mother reported that she responded to auditory stimuli but minimal response was noted during the OT evaluation. [See Children's Hospital of Colorado OT Baby Team Evaluation (Children's Hospital of Colorado.pdf, pgs. 49-51)]. However, at discharge on 12/19/08, MayRose was tracking in all directions fairly consistently for faces and objects when in a calm, alert state [See Children's Hospital of Colorado PT Discharge Summary (Children's Hospital of Colorado.pdf, pgs. 125-127)/ Children's Hospital of Colorado OT Discharge Summary (Foothill Pediatrics.pdf, pgs. 214-216/Children's Hospital of Colorado.pdf, pgs. 52-53)]. Ophthalmology exam done on 12/02/08 was normal with a normal fundus, no evidence of ROP (retinopathy of prematurity), no retinal hemes, well perfused optic nerves and no edema. However, regular followup was recommended. [See Children's Hospital of Colorado Discharge Summary (Foothill Pediatrics.pdf, pgs. 225-226/Children's Hospital of Colorado.pdf, pgs. 119-123)].

Given all of MayRose's physical problems and developmental delays, it was recommended that she continue all therapies (PT/OT/ST) in the home setting and return to CHOC for periodic followup. At one such followup visit on 02/05/09, MayRose was noted to be alert with good head control. She was able to bring her hands to her mouth, would smile with handling and her

mother's voice and showed some inconsistent visual tracking. However, she remained hypertonic in the extremities and trunk. [See Children's Hospital of Colorado Outpatient Rehab Clinic Visit (Children's Hospital of Colorado.pdf, pgs. 754-755)]. At another followup at CHOC in August 2009, MayRose was reported to be nursing well, gaining weight and maintaining her curve, as she was almost up to the 10th percentile. She was eating purees and trying some Stage 3 foods. She had also started drinking from a Sippy cup. However, there was some concern that she was not managing fluids well but she had not had any reports of coughing, choking or episodes of pneumonia, nor did she have any significant constipation problems. At that time, she was getting PT twice a week and her physical therapist was also addressing some of her fine motor concerns. She was also receiving ST once a week. There was concern that MayRose had cortical visual impairment. Her mother also voiced concern about her tone and her irritability. On exam, MayRose was noted to be alert and would smile in response to verbal interaction. However, she did become fussy and screamed, which was redirected by her mom. She was putting things in her mouth and biting quite a bit per mother. Her upper extremities were held in flexor synergy. The lower extremities were held in extension with scissoring, though full range of motion was noted in the upper extremities. The Galeazzi sign was negative (The Galeazzi test, also known as the Allis sign, is used in the assessment of congenital dislocation/developmental dysplasia of the hip) with generally symmetric hip abduction though limited. Popliteal angles were -20 degrees bilaterally. She was able to be dorsiflexed to neutral bilaterally. Neurologically, she was alert, did not appear visually attentive but would focus her vision more on auditory stimulation. She was interested in making a variety of sounds. She had low trunk tone and increased extremity tone, a modified Ashworth Score of 2 with resistance throughout her range up to 3 with some difficulty breaking it with her lower extremities and fisted hands. She had reasonably good head control and could hold her head up when held with mid-trunk support. She would take weight through her legs but in a scissoring pattern and she would bat at things with both hands. However, MayRose's non-verbal development and play skills were significantly delayed She was able to grasp a toothbrush and put it into her mouth but would occasionally gag. MayRose was able to bring toys to her mouth with assistance for grasping, and could bring her hands briefly to midline and shake a rattle briefly. Mom reported that she had rolled prone to supine and supine to prone. That day, she was observed rolling supine to sideline. However, she was still unable to sit unsupported and required maximal assistance to place upper extremities for prop sitting. Due to her ongoing problems with increased tone and posturing, Baclofen was added to her medication regimen and she was casted for bilateral AFOs. It was recommended that her mother obtain an adaptive stroller, a supportive stander and a bath chair for her. At that point, MayRose was communicating using facial expressions and body language. Based on observation and description of behavior at home, MayRose used a variety of cries to indicate her wants and needs. She also used a variety of vocalic sounds and a few consonants during play. Her mother reported that MayRose was just beginning to combine consonants into occasional reduplicated babble (dadada). She engaged in vocal play when she was alone and occasionally with others. Her mother reported that she had a variety of cries for different meanings (anger, hurt, hungry). With regards to vision, MayRose was able to fix her gaze on objects presented to her that were shiny, but appeared to be relying heavily on auditory input to attend to toys. Therefore, it was determined that MayRose was likely cortically vision impaired and it was recommended that her mother get suggestions from speech and occupational therapy with regard to maximizing her use of what vision she had and the strategies to work around it. [See Children's Hospital of Colorado Outpatient Rehab Clinic Visit (Foothill Pediatrics.pdf, pgs. 258-260/Children's Hospital of Colorado.pdf, pgs. 790-792)/ Speech-Language Evaluation (Foothill

Pediatrics.pdf, pgs. 203-206/Children's Hospital of Colorado.pdf, pgs. 798-800)/ Children's Hospital of Colorado Outpatient PT Re-Evaluation (Children's Hospital of Colorado.pdf, pgs. 805-806)]. MayRose underwent another ophthalmology exam on 08/20/09, which confirmed the diagnosis of cortical visual impairment in both eyes. [See Ophthalmology Exam (Children's Hospital of Colorado.pdf, pgs. 825-826)].

On 09/10/09, MayRose saw her pediatric neurologist, Roshan Raja, in followup. At that time, her mother reported noticing "staring" spells, where it seemed that MayRose was blanking out. She reported that these occurred 8-10 times a day. As there was a concern that these "staring spells" could be seizures, and EEG was recommended. [See Child Neurology Specialists Follow-up (Foothill Pediatrics.pdf, pgs. 169-170)].

In November 2009, MayRose's mother decided to transfer all of her care to Children's Hospital of Los Angeles (CHLA). The EEG was performed there on 11/09/09 and 11/20/09. It was determined to be abnormal, with *slowing of background frequencies consistent with a moderate encephalopathy. In addition, several events occurred originating from multiple areas, which were felt to be consistent with both partial and generalized seizures and likely represented symptomatic generalized epilepsy disorder.* [See CHLA EEG Report (CHLA Vol 1.pdf, pgs. 37-38)].

MayRose's mother had her vision re-evaluated at CHLA. She was seen by ophthalmologist, Dr. Angela Buffenn, MD on 01/20/10. At the end of the examination, Dr. Buffenn's diagnoses and impressions were as follows:

- Cortical visual impairment. MayRose's cortical visual impairment is secondary to her history of diffuse brain damage and developmental delay. MayRose's long-term visual potential is guarded.
- Bilateral temporal optic nerve pallor.
- Variable exotropia. Despite episodes of ocular misalignment, MayRose has fairly good control of her ocular alignment overall.
- Myopia with astigmatism in both eyes

Dr. Buffenn informed MayRose's mother that there was no known treatment for the patient's cortical visual impairment or temporal optic nerve pallor. As she was unlikely to benefit significantly from corrective lenses, Dr. Buffenn recommended that MayRose discontinue wearing her eyeglasses at that time. [See Children's Hospital of Los Angeles Ophthalmology Visit (CHLA Vol 1.pdf, pgs. 23-25)].

MayRose was seen by movement disorder specialist, Dr. Terry Sanger, on 01/20/10. At that time, she had stiffness in the lower extremities, including the hips, knees and ankles. She had fisting with fisted thumbs, for which her mother had purchased soft thumb splints. The stiffness seemed to be worse on awakening but was variable during the day. It was also worse when she was upset. It seemed to have improved slightly on her current treatment of baclofen 2.5 mg three times per day. MayRose also had difficulty using her hands. She was able to scoot around the room on her back but was not able to crawl. She did not attempt to roll over and did not use rolling to move around. She reportedly enjoyed close contact and stimulation as well as chewing on things. Her primarily nutrition was received by mouth but she reportedly had occasional coordination problems with eating, although she was able to take solids. She also continued to

breast feed. MayRose was noted to have two different types of seizures. The most evident ones consisted of sudden jerks, which initially were happening 5-6 times per day, but had reportedly reduced significantly in frequency since increasing her clonazepam. After each of these episodes, MayRose seemed to be quite upset but would rapidly recover. She also had brief petit mal episodes, which were seen on EEG but which were not clinically evident. At that time, treatment consisted of clonazepam, phenobarbital and gabapentin, which seemed to be providing reasonable control of both types of seizures. Examination was significant for variable tone, consistent primarily with dystonia. Although some spasticity in the adductor muscles and clonus was present, Dr. Sanger suspected that most of the tone was dystonic in nature. Therefore, he felt that MayRose would benefit from an anti-dystonia medication. Thus he started her on Artane three times a day. Then after the Artane was stabilized, he would consider a trial of Sinemet or an increase in the baclofen that she was already taking. Dr. Sanger also recommended tapering her Neurontin and her phenobarbital. If the tone in her adductors persisted after initiation of the Artane, then he would consider Botox injections. [See Children's Hospital Los Angeles Letter to Dr. Raja (Current Physicians Las Vegas.pdf, pgs. 487-489/CHLA Vol 1.pdf, pgs. 32-33)].

MayRose was seen by pediatric orthopedic surgeon, Dr. Karen Myung at CHLA on February 10, 2010 for concerns about scoliosis. Examination revealed a healthy appearing female with good nutritional status overall. She demonstrated reasonable head control. In the supine position, she lifted her head off the bed. However, when seated, she had trouble sitting for an extended period of time and her head fell into flexion. She had full range of motion at the neck in rotation, lateralization, flexion and extension. Her spine overall was midline. She had wide symmetric abduction at the hips. Galeazzi was negative. She had tight adductors, but she could abduct to 25 degrees bilaterally. She also had tight hamstrings but no flexion contracture. Her feet were plantigrade and the neutral position could be achieved plus up to 10 degrees beyond neutral with her knees extended depending on how relaxed she was. Her DAFOs were felt to be too small. Imaging studies of her spine taken that day showed no appreciable scoliosis with mild spinal asymmetry felt to be related to positioning as it was less than 10 degrees. Therefore, Dr. Myung determined that MayRose did not have scoliosis at that time. [See Children's Hospital of Los Angeles Endo-Metabolism MD Note (CHLA Vol 1.pdf, pgs. 127-128)].

MayRose saw Dr. Sanger in followup on 04/28/10. At the previous visit, Dr. Sanger had started her on Artane, which had since been increased to a target dose of 5 ml three times a day without any significant side effects. Her mother reported that on this dosage, she had shown some improvement in her hand and arm motion and overall felt that her tone was better. He had also recommended decreasing the Neurontin and phenobarbital. The phenobarb was stopped with no adverse effects, although she continued on the Neurontin. She was also been started on Keppra, which led to significant, violent jerking movements. These improved on stopping the Keppra but still persisted and she continued to have jerking movements approximately once per day. Neurological exam showed that she had improved tone in the elbows with better passive and active range of motion at the elbows and shoulders. She reached forward, and appeared interested in a toy placed in front of her but had difficulty opening her hands to grasp. An objected placed in her hand was grasped, and the grasp was maintained well for long periods of time and she was able to play with the object and bring it to her mouth. There was continual surface EMG activity in the forearm flexor muscles and finger flexor muscles on both sides, and she had difficulty opening her hands. The biceps and triceps showed varying contraction, but this appeared to be under greater voluntary control. She had intermittent back arching and this made

it difficult for her to sit in a propped seating position. However, this appeared to be partially under her voluntary control as it did not seem to respond to the environment. She was able to pull her trunk forward and there was no head lag on pull to sit. DTRs were 3/4 at the knees and ankles, 1/4 at the biceps, triceps, and brachial radialis. Toes were bilaterally down going. Sensation was intact throughout. When held upright in suspension, she had bilateral scissoring of her legs but was able to support her weight against gravity with variable head control. As MayRose seemed to have achieved some benefit from the Artane but remained with significant dystonia, Dr. Sanger recommended increasing the Artane to a target dose of 10 ml three times a day. He also recommended another EEG to evaluate for seizure activity. [See CHLA Movement Disorder Followup (CHLA Vol 1.pdf, pgs. 221-222)].

At a followup visit with Dr. Sanger on 11/24/10, it was noted that MayRose had been started on Sinemet. Her mother reported that her neck was more stable and overall she was less floppy than she was. She was starting to bat at objects, but could not quite do reach and grasp. She used both hands well. She had also started some hippotherapy at home which had led to better positioning of her legs and better leg motion and she now scissored when held upright but not otherwise. She continued to use soft splints on her wrists. Otherwise, she was reportedly doing well. She continued to have brief myoclonic type seizures 4-5 of these per day and remained on Neurontin and clonazepam for treatment of this. On exam, MayRose was an alert, cheerful girl sitting in her mother's lap. General physical exam was unremarkable. Neurological exam showed increased tone in the arms, legs, and trunk. Her movements were somewhat slow in the upper extremities, but she was able to bat at objects. When an object was placed in her hand, she would bring it slowly to her mouth on either side. She seemed attentive to a toy in front of her and could track into the left hemi field but not far into the right hemi field. She consoled with distraction. She clearly was aware of being held by her mother. When held upright she had scissoring of the legs, and when placed in a seated position, she was unable to support herself but had better head control than seen previously. On pull to sit, she had relatively good head control. No back arching was noted, although by report this happened frequently. Dr. Sanger determined that MayRose had hypoxic ischemic encephalopathy and consequent generalized hypotonia with secondary dystonia and the combination of dyskinetic and tetraplegic cerebral palsy. He recommended increasing her Baclofen and obtaining a new EEG. [See CHLA Movement Disorder Followup (CHLA Vol 1.pdf, pgs. 271-272)]. The EEG was performed on 12/09/10 and showed *excess slowing of background rhythms with no well defined posterior alpha and paucity of sleep architecture; the findings of which are consistent with a moderate encephalopathic pattern. In addition, there are epileptiform discharges, which represent an increased risk for partial and generalized seizure patterns*. [See Child Neurology Specialists EEG Report (Current Physicians Las Vegas.pdf, pg. 507)].

MayRose was seen again in followup at CHLA's Movement Disorders Clinic on 03/02/11. At that time, her mother reported significant changes with the increased dose of Baclofen. She stated that MayRose stopped seizing and felt that maybe the "seizures" had actually been spasms. The medication had definitely decreased the tone in her arms, legs and hips, and her head control was not affected negatively by the increased dose of Baclofen. Her exam showed decreased tone in her arms, legs and trunk from her previous exam, with less arching backward. She was able to sit with help but she did flop forward. She seemed to have relatively good control of her head when she wanted to. While lying on her back, she was able to lift her head up from the table for approximately 2 seconds. None of the spasms seen in prior exams were noted.

Toes were bilaterally downgoing and reflexes were trace at the biceps, triceps, and brachial radialis. Her hands were relaxed. At the knees, she was brisk at 3/4. Sometimes she seemed to track by face but otherwise did not track at all. She was now saying, "da" and "ta" and babbling more. [See CHLA Movement Disorder Followup (CHLA Vol 2.pdf, pgs. 7-8)].

MayRose saw her pediatric neurologist, Dr. Roshan Raja, in Las Vegas on 04/06/11. At that time, he noted that she demonstrated improved eye contact, localized better to sound and seemed attentive when addressed. Her arm movements and spasticity were also improved. However, she still exhibited and Ashworth score of 2+ in the upper extremities and 3-4+ in the hips and ankles. She also demonstrated fisting of the hands and scissoring of the legs. Therefore, Dr. Raja recommended Botox injections to hip adductors. Furthermore, he did not recommended placement of a Baclofen pump, as he felt the oral doses had not been optimally efficacious. [See Child Neurology Specialists Followup Visit (Current Physicians Las Vegas.pdf, pgs. 509-511)].

MayRose was seen at the CHLA Outpatient rehab clinic on 04/21/11. At that time, her mother reported that she had been doing well overall and had not had any medical problems. According to mom, she was still unable to sit unsupported for any length of time but when placed in a sitting position she was able to maintain for a few seconds. She was able to roll but when she rolled onto her stomach, she got stuck but was able to scoot on her back in the house. She was receiving PT and OT at least 2 times per week and hippotherapy 1 time per week. Examination revealed spastic quadriparesis; spasticity was more in the lower extremities than upper extremities. Her Ashworth scores were generally 3 in bilateral hamstrings and gastrocnemius-soleus complexes. She had clonus in bilateral ankles with increased muscle stretch reflexes. She continued to have significant truncal hypotonia. As mom had reported, she was unable to sit. However, when she was placed in a sitting position she slouched over but was able to maintain it for a few seconds and before falling all the way over. Given her continued truncal hypotonia, it was pondered if the Baclofen and Neurontin could be contributing to that somewhat. Therefore, possibility of referral to neurosurgery for evaluation regarding selective dorsal rhizotomy was discussed. [See CHLA Rehab OP MD Note (CHLA Vol 2.pdf, pgs. 259-260)].

At a followup with Dr. Sanger on 05/25/11, it was noted that MayRose looked better from a neurological point of view as she presented with less dystonia and was more interactive. Arching appeared behavioral without any obvious discomfort. However, GI issues continued to be a significant problem for MayRose and insertion of a G-tube and/or possible fundoplication was being considered. Since both Artane and Sinemet had known side effects of reflux, delayed gastric emptying, and constipation, Dr. Sanger recommended rapid taper of both to determine if this was a significant reversible cause of her reflux and constipation. [See CHLA Movement Disorder Followup (CHLA Vol 3.pdf, pg. 107)].

Unfortunately, tapering of these medications had no significant effect on her reflux. MayRose was admitted to CHLA on 06/08/11 with vomiting. She had been unable to take oral nutrition and had largely been fed through an NG tube. Per her mother's report, the biggest issue seemed to be more related to vomiting than reflux. An upper GI was done and was concerning for some mild reflux, but no malrotation. She had a scintiscan, which showed some mild delayed gastric emptying but no significant reflux. She then underwent Bravo study, which also demonstrated no significant reflux. Because vomiting seemed to be the issue more-so than reflux it was decided that a G-tube insertion was the best option rather than fundoplication surgery. [See CHLA Pre-

operative H&P Note (CHLA Vol 4.pdf, pgs. 46-47)]. Therefore, on 06/10/11, MayRose underwent Laparoscopic gastrostomy with G-tube placement and lysis of adhesions. [See CHLA Operative Report (CHLA Vol 4.pdf, pg. 60, 62)]. She was discharged home on 06/15/11 and was tolerating her G-tube feeds well. [See CHLA Endocrinology Note (CHLA Vol 4.pdf, pg. 77)].

While hospitalized for the G-tube surgery, MayRose was seen by endocrinologist, Dr. Lynda Fisher, for concerns regarding osteopenia. X-rays showed osteopenia, which was felt to most likely be due to immobilization/lack of movement. However, laboratory studies revealed normal active vitamin D levels as well as normal calcium levels. Therefore, at that time, supplementation with vitamin D or calcium was not recommended, nor was bisphosphonate therapy as there was no history of fractures. [See CHLA Endocrinology Note (CHLA Vol 4.pdf, pg. 19)].

MayRose was seen again in followup at the CHLA Movement Disorders Clinic on 07/08/11. At that time, her mom reported that she had been doing very well since her discharge approximately two weeks prior. Her Sinemet and Artane were discontinued as those medications could potentiate constipation. Mom said she had been doing well since stopping these medications and had not seen any significant change in MayRose's movements since stopping them. On exam, MayRose was sitting comfortably in her wheelchair. Her head was flexed forward. She had intermittent smiling and grasping at things that she could feel such as her wheelchair. She was alert to sound. Tone was mildly increased but mobile. DTRs were 3 throughout and toes were downgoing. Her hands remained open. She was able to hold her head up when pulled into a sitting position and she was able to lift her head up while lying down on her back. No changes were recommended at that time, however, it was noted that MayRose was going to be getting Botox injections into the bilateral hip adductors by Dr. Raja in Las Vegas for better diapering and cleaning. [See CHLA Movement Disorders Clinic Note (CHLA Vol 4.pdf, pgs. 236-237)].

As MayRose was now four years old, on 06/01/12, MayRose was evaluated by the Clark County School District for development of an IEP. Her levels of functional performance at that time were as follows:

- ***Vision:*** MayRose appeared to have limited depth perception, ability to fixate and light sensitivity. The identification of objects by color, tracking of objects vertically/horizontally was not observed. MayRose was beginning to reach out with purpose and was turning her head to locate sound origin. Her primary learning mode as auditory with limited use of residual vision to gain access to her environment. She was dependent of adults for all transfers and mobility needs. She demonstrated a blink reflex. Her primary mode of learning was auditory and tactile. Dr. Mary Grant had prescribed glasses for what mother reported was *mild mixed astigmatism and near-sightedness* but glasses were not required at all times.
- ***Gross Motor Skills:*** MayRose had bilateral ankle foot orthotics and hip splints. She had a personal stander in the home and a Leckey chair. A Tumble Forms floor sitter was used during school activity as well as a Kaye bench. MayRose presented with generalized low tone in her trunk with overriding spasticity in her extremities. She fluctuated between strong extensor and flexor tone. MayRose had functional range of motion in both her upper and lower extremities. She was dependent on caregivers for all mobility, transfers and self-care needs. When positioned prone over a small bolster, MayRose would bear weight on her forearms when given cues at her shoulders and would lift her head 2-5

seconds at a time. MayRose could be positioned in sidelying propped up on her elbow and maintain this position with moderate assistance. She would often pull into flexion when positioned prone or sidelying. When in tailor sitting, MayRose required maximum assistance at her trunk to maintain. In this position, MayRose usually demonstrated a rounded back posture with forward flexion of the head. With facilitation at her cervical muscles to initiate head lifting, MayRose would lift her head up to midline and hold it there for 2-3 seconds at a time. She required full support at her trunk to maintain a bench sitting posture. While bench sitting, MayRose went between strong flexion and extensor thrust patterns with poor midrange control. She tolerated being positioned in her Tumble Forms floor sitter but often sat with her head flexed forward. MayRose would occasionally reach out to objects or switches that made noise, but most activities were done with hand-over-hand assistance. MayRose tolerated standing in her stander daily but did not consistently weigh bear on her lower extremities during sit to stand transitions. MayRose was not ambulatory but did roll from back to stomach by report. She wore hip braces, a Benik vest, and AFOs and spent some time in a stander and gait trainer daily. Her hips had been injected with Botox by report.

- ***General Health Update:*** At that time, MayRose had a port implanted in her right upper chest. She was receiving blood transfusions every three weeks at LA Children's Hospital for her Diamond Blackfan anemia. These regularly scheduled blood transfusions provided the necessary red blood cells but those transfusions led to elevated iron levels in the body. A medication called Exjade was being administered daily with orange juice to provide chelation therapy to rid the body of the excess iron. Most of the medical care was done in Los Angeles. Her medications and primary nutrition were given by gastrostomy tube. Medications also included Baclofen, clonazepam (which was slowly being weaned) Exjade, vitamins, Senna and Lactaid. She was weaned from Neurontin approximately three months prior per parent report. Her parent also reported that MayRose was seen by Dr. Tottori for allergy concerns: her allergy meds include Triamcinolone Acetonide Nasal Spray, and Zyrtec. She had passed previous audiological testing. Her mother reported that MayRose said some words, including "up", "mama", "happy", "Tristan" and also "I love you". The bulk of her nutrition was received via G-tube. She ate some regular foods in small bites and preferred crunchy foods. Within the past year, MayRose was sedated and received dental care.. She was diapered and became fussy when soiled.
- ***Teacher Observations:*** MayRose was noted to be a very happy little girl, who smiled and laughed often. She often made vocalizations during sessions and enjoyed when the sound was imitated and would sometimes then repeat the vocalization. She also enjoyed music activities, but did not attempt to do any of the actions in the songs. She required hand-over-hand assistance to participate in songs and finger-plays. She had certain songs that as soon as she heard them, she started laughing hard. She was co-actively & independently operating basic switches and cause and effect toys but mostly in her Tumble Forms floor sitter. She was not as consistent in other positions. She would reach/bat at an auditory toy/educational material but mainly if she could feel it first and she did better in her floor sitter or if she were lying on her back and it was dangled above her. She would reach out and feel for the toy/switch. She seemed to recognize her switches and what to do with them. When presented something new she would move her extended arm towards it and hit at it to see what happened. She tended to use her left hand/arm more to activate toys and switches. She would grasp items placed in or near her

hands but always with the intent to put them in her mouth to chew. Almost everything placed in her hands she brought to her mouth to chew.

- ***Fine Motor Skills:*** MayRose was described as a sweet girl who enjoyed interactions with adults and would often laugh and smile during therapy sessions. MayRose was unable to sit without support. She presented with low muscle tone in her torso with overriding spasticity. MayRose could maintain unsupported head and neck control for about 5 seconds when seated on the floor with the therapist or teacher supporting her torso or while seated in the Tumble Forms. MayRose displayed some purposeful movements in her upper extremities when activating a switch toy on the lap tray directly in front of her. Sometimes hand over hand assist was required. MayRose would often try to bring her head to her hand to mouth toys. MayRose was dependent in all self-help activities. MayRose is dependent with all activities and mobility thus requires adult assistance throughout the day.

Records stop here.

B. Current Medications:

As of July 2012, MayRose was taking the following medications:

- Clonazepam (.1mg /ml sus) 3.75 ml 2x per day at 7 am & pm (weaning initiated)
- Baclofen (10mg/ml sus) .75 ml 3x per day at 7am, 2pm and 7 pm. (spasticity)
- Neurontin 250mg/5ml oral 1 ml 3x per day at 8am & 8pm (seizures)
- Prevacid (3 mg/ml susp) 2 x per day at 8:30 am (reflux)
- Exjade (125 mg tablets) 3 tablets 1 x per day at 10:30 a.m. (iron removal)
- Poly-Vita A/F .25mg drops 50 ml at 8:30 a.m. (daily vitamin)
- Lactose Fast Act Relf Cap 60s taken with Exjade and milk products
- Miralax (527gm) 1/4 cap once daily at bedtime as needed (dysmotility)
- Zofran (4mg/5ml susp) 2.5 mls every 6 hours as needed (nausea)

C. Current Complaints:

MayRose's mother stated in interview on July 15, 2012 that she really had seen a big change in MayRose over the last six months and that she felt MayRose had reached a new level cognitively. She reported that MayRose was really starting to discriminate her environment. She showed definite preferences for people, activities, places, etc. She also demonstrated some separation anxiety when her mother left the room. Mother also reported that she saw a really big change in MayRose developmentally after the recent G-tube placement. She noted that MayRose will eat finger foods, such as dried cereal and cookies, but is really slow. Her mother also reported that MayRose does not handle mixed consistencies very will. MayRose also reportedly continues to explore her world with her mouth. She attempts to bring almost all objects to her mouth and will bite and chew things, especially utensils. Furthermore, she related that MayRose had not had any real seizures and that they pretty much went away after her Baclofen was increased, and thus were likely not seizures at all, but just spasms. MayRose's mother also reported that she was being weaned off of her clonazepam and should be off of it in three weeks.

MayRose was observed to be very responsive to her environment and seemed very affectionate. She smiled and giggled and appeared very happy. When the conversation was about sounds or words MayRose was able to make, she was observed to say, "Tristan", "I love you", "good girl" and "up".

Per MayRose's mother's written report, her current diagnoses are as follows [See MayRose medical history.doc]:

- Diamond Blackfan anemia (currently gets blood transfusions every three weeks at CHLA)
- Diffuse brain damage (currently receives PT, OT, ST several times a week. She also wears hand splints and AFOs for spasticity issues)
- Cortical vision impairment (wears glasses, but no vision therapist currently)
- Seizures (currently taking Neurontin three times a day)
- Future hip displacement predicted (currently wears legs braces and received Botox injections to the hip adductors in July 2011)
- Reflux (currently has a G-tube, but also takes some nutrition orally. She takes Prevacid twice a day and Zofran as needed if not tolerating G-tube feeds well).
- Severe osteopenia (currently being monitored by endocrinology)

D. Past Medical History:

MayRose was born on May 14, 2008 premature at 28 weeks gestation. Initial Apgars were as follows: 1 min: 3, 5 min: 6, 10 min: 7. She weighed 2 lbs, 13 oz, was 37 cm long with a head circumference of 27.5 cm. Due to her extreme prematurity and resultant complications, she was hospitalized in the NICU for approximately 80 days. [See Sunrise Hospital Neonatal Admission H&P (Sunrise Hospital Vol. 1.pdf, pgs. 11-12)/ Sunrise Hospital Neonatal Progress Note (Sunrise Hospital Vol. 2.pdf, pgs. 547-551)].

As MayRose's past medical history is so complicated, it was will discussed by system.

Neurological:

Initial ultrasound of the head on 05/14/08 found no acute process. [See Sunrise Hospital Neonatal Radiology Report (Sunrise Hospital Vol. 1.pdf, pg.616)]. A repeat ultrasound of the brain on 08/01/08 found a grade 1 germinal matrix bleed. However, an MRI of the brain was performed on 09/30/08 and was read as normal by the radiologist. [See Desert Radiologists MRI Report (Foothill Pediatrics.pdf, pg. 157)].

GI: Shortly after birth, MayRose had a small bowel perforation due to NEC (necrotizing enterocolitis) and required a small bowel resection and ileostomy [See Sunrise Hospital Addendum Note (Sunrise Hospital Vol. 1.pdf, pg. 18)], which was later reversed. [See Sunrise Hospital Neonatal Operative Note (Sunrise Hospital Vol. 1.pdf, pg. 191)]. She has had ongoing problems with reflux and GERD and has been taking anti-reflux medications. [See Summerlin Hospital Discharge Summary (Summerlin Hospital.pdf, pg. 1042-1045)]. Because of her brain injury, she became unable to take sufficient oral nutrition and required G-tube placement. [See CHLA Pre-operative H&P Note (CHLA Vol 4.pdf, pgs. 46-47)/ CHLA Operative Report (CHLA Vol 4.pdf, pg. 60, 62)].

Hematological: MayRose has been diagnosed with Diamond Blackfan anemia. (Diamond–Blackfan anemia (DBA), also known as Blackfan–Diamond anemia and Inherited erythroblastopenia. Her care and treatment for this condition will not be the subject of this care plan.

Infectious Disease: MayRose had multiple admissions to Sunrise Hospital throughout 2009 things such as low white blood cell count, RSV and bacterial infection, each requiring antibiotic treatment.

Respiratory: As MayRose was born so premature, her lungs were underdeveloped. She was on the ventilator for a total of 8 days after birth. She received Surfactant to help mature her lungs. Eventually, she was able to be extubated and did well on room air, except for times when blood count dropped, during which she would become tachycardic and require oxygen therapy. [See Sunrise Hospital Neonatal Progress Note (Sunrise Hospital Vol. 2.pdf, pgs. 547-551)].

E. Psychosocial History:

MayRose lives with her mom, Tiffany, and her older brother, Tristan, in 2-story home in Las Vegas, Nevada. Her parents are not and have never been married to each other. MayRose's mom is an attorney with the Federal Public Defenders Office, as is her father. Her father is not involved with MayRose day-to-day but pays child support. Extended family members live out of state but paternal grandmother and maternal uncle come to see MayRose from time to time. As MayRose's mother is single and works full-time, she has a nanny who comes Monday through Friday from 8:00 to 3:00 and then a sitter who comes from 3:00 until whenever she gets home from work. Mom cares for MayRose alone on Saturdays and Sundays.

F. Educational History:

Due to her severe developmental delays, MayRose has participated in the Las Vegas Early Intervention program, which terminated at age 3. Furthermore, the Clark County School District developed an IEP for her in August 2011. Per her physician recommendation, MayRose received her education at home for the 2011-2012 school year. MayRose's IEP was updated in June 2012 and according to that report, her physicians have released her to return to school on campus for the 2012-2013 school year. [See CCISD IEP.pdf, pg. 5].

III. PROJECTED MEDICAL SERVICES NEEDS

Dr. Brian Buck conducted an in home IME on 7/15/2012 and consulted in the development of the life care plan. Among his findings were the following:

- Status post hypoxic-ischemic encephalopathy
- Multiple developmental delays
- Seizure Disorder
- Cortical visual disorder with bilateral optic pallor and variable exotropia
- Limited capacity for toilet training or functional ambulation
- No capacity for independent living or gainful/competitive work

A telephone conference was conducted with MayRose's treating neurologist/movement specialist, Dr. Terry Sanger, on August 29, 2012. In that conversation, Dr. Sanger remarked that, given MayRose recent gains in both motor skills and cognitive function, she warrants another MRI of the brain to assess current status; however, he does not recommend MRIs or CTs be performed routinely unless there is a significant change in neurological status. Furthermore, Dr. Sanger opined that MayRose's risk of developing problematic seizures as a result of her brain injury is about 60%, and thus remaining on prophylactic antiseizure medication was warranted. However, he did not recommend obtaining another EEG unless she has a documented seizure

event. Regarding her spasticity and contractures, Dr. Sanger stated that both are likely to worsen as she ages, so the goal of any conservative treatment would be to delay the need for surgical intervention. Thus, MayRose is a candidate for periodic Botox injections given 4 times a year for a 2-year course initially. He stated that although oral Baclofen has helped MayRose, she would not be a candidate for an intrathecal Baclofen pump for another 5-6 years due to her age. Dr. Sanger indicated that he felt that MayRose's ability to become an independent ambulater with adaptive equipment (walker) in her home was < 50% due to lower extremity weakness, spasticity and contractures. Dr. Sanger indicated that with proper supportive care and equipment and in the absence of complicating conditions such as pneumonia, inability to protect her airway, failure to thrive, etc., MayRose's life expectancy is approximately 45-60 years of age due to accumulating problems over time as she ages.

A Vineland-II Adaptive Behavior Scales interview was conducted with MayRose's mother. She rated MayRose's overall adaptive behavior in the low range (SS = 46; PR = <1). Specific domain scores were as follows:

A. Low Communication	(SS = 54; PR = <1)
Low Receptive	(AE = 1:3
Low Expressive	(AE = 1:6)
B. Low Daily Living Skills	(SS = 46; PR = 1)
Low Personal	(AE = 1.1)
Low Domestic	(AE = 0:7
Moderately Low Community	(AE = <0:1)
C. Low Socialization	(SS = 63; PR = 1)
Low Interpersonal Relationships	(AE = 0:11)
Moderately Low Play & Leisure Time	(AE = 1:5)
Moderately Low Coping Skills	(AE =0:10)
D. Low Motor Skills	(SS = 31; PR = <1)
Low Gross Motor Skills	(AE = 0:2)
Low Fine Motor Skills	(AE = 0:7)

Based upon the review of available records, clinical interview with the mother, IME and consultation with Dr. Brian Buck, interview and consultation with Dr. Terry Sanger, and my background and experience with these matters, it can be stated to a reasonable degree of certainty that MayRose's needs include the following:

Outpatient Physician and Therapeutic Care from the following specialties:

- Pediatrician (Dr. Elizabeth Burgamy)
- Pediatric Neurologist (Dr. Terence Sanger-CHLA, Dr. Roshan Raja-Las Vegas)
- Ophthalmology (Dr. Angela Buffenn-CHLA, Dr. Mary Grant-Las Vegas)
- Orthopedics (Dr. Karen Myung)
- Othotics (Wayne Eguchi)
- Dentist (Dr. John Morzov)
- Endocrinologist (Dr. Pisit (Duke) Pitukcheewanont)
- Gastroenterologist (Dr. Brynie Collins)

- Physiatrist (Dr. Kevan Craig)
- Obstetrics/gynecology (in the future)
- Home Health Care (Walgreen's Option Care Nevada)
- Allied Health- (PT (Susan Knight-CHLA, Beth Ward, Kristen Barbour-Las Vega), OT (Gina Kim-CHLA, Shannon Holman, Rebecca Keaton-Las Vegas), Hippo Therapy (Dream Therapies-Las Vegas, ST (Kim Koch-Las Vegas, Vision Therapy (Sylvia Leggett-Las Vegas)
- Nutritionist (Megan ?)
- Case management (to be established; used to be Danielle Smith)
- Psychological services for family (recommended
- Neuropsychological services (recommended)

Diagnostics Services needed to evaluate and oversee medical management

- EEG
- Routine laboratory studies to monitor effects of medication on liver and kidneys
- Radiological studies to include x-rays of the chest, abdomen, and extremities, MRI and CT scans of the head
- Ophthalmological studies
- Swallow studies
- Neuropsychological evaluation
- Allied Health Reevaluations

Long-Term Care/Aide Assistance/ Household services

It is anticipated that MayRose will require continuous supervision and support throughout the remainder of her life. The manner in which this is modeled will be dependent in large part on her degree of medical stability and the family's ability to continue to participate in her care. Given that this plan considers services that are needed over a lifetime, multiple options for long term care will likely be utilized. For the purpose of this preliminary report, the following options are considered:

- If residing in home with family support, modeling direct hire of attendant level care at $11.91 per hour 16 hours per day 300 days per year ($57,168.00), and 65 days of 24 hours per day (during times of illness or respite for the family ($18,579.60) yields an average annual rate of $75,747.60.
- Agency Contracting for the same service at $21.21 per hour: 300 days @ $339.36 ($101,808.00) and 65 days @ $509.04 per day ($33,087.60) yields as annual rate of $134,895.60.
- Live-In Assistance using the average annual salary of CNA/HHA ($24,772.80), LVN ($39,000.00), and RN ($64,690.00), the average estimated salary of $42,820.93 is considered. This figure does not consider incidental costs associated with having a live in caregiver such as their impact on utilities, room and board. To this figure, consideration would have to be given to respite needs of family and caregiver. Using the average costs considered above, $26,114.40 per year would be added to yield an average annual cost of $68,935.33 for the live in option of care.

If the family is unable to continue to provide oversight and participate in her care, then placement options would have to be considered. Given her current clinical presentation, the following options are reasonable considerations:

- Private group home or assisted living facility at $250 per day; $91,250.00 annually

- Placement in a private brain injury program at a cost of $700 per day (range from $600 to $1000/day); $255,500.00 annually.

Residential placement and in home care are not mutually exclusive considerations. As the time window for consideration expands (in this case over decades), it is likely that multiple options for care will be utilized. It is incumbent on the life care planner to try to determine the central tendency of costs by examining how one might access the care in the marketplace as it exists today. Some version of the in home options may be utilized for a period of time followed by some version of the placement options. The average of these five options is **$125,265.71 per year**. This annual figure is utilized in the Cost Analysis section of this report.

Medications

- Anticonvulsant (Neurontin)
- Bronchodilator and Mucolytic agent (episodic use)
- Muscle relaxant/antispasmodic (currently managed with Baclofen and Botox)
- Antibiotic therapy (episodic use)
- Vitamins and mineral supplements
- Laxatives and stool softeners
- Anti-nausea
- Antiemetic-ulcer; GERD

Durable Medical Equipment and Supplies

- Glasses
- Ambulation and Community access- walker/gait trainer; standard wheelchair with adjustable head support and spider base (to be replaced as she ages), car seat, wheelchair, van, etc.
- DME to include Feeder chair, Standing Frame, Tumble Forms floor sitter, Hoyer lift as she ages to reduce caregiver burden
- Miscellaneous adaptive equipment to include but not limited to feeding utensils and items that promote development
- G-tube supplies (including pump, tubing, syringes for flushing, skin care items, etc.)
- Incontinence care- diapers, wipes, creams, gloves, chux, Linen savers =
- Bathroom safety- Leckey bath chair; shower chair as she ages
- Home modification- wheelchair ramps, widening of doorways, flooring suitable for rolling a wheelchair, widening of hallways, bathroom modification to include a roll in shower for ease of bathing, nonskid flooring, grab bars (High likelihood that current home cannot be remodeled, the family is considering moving to a ranch-style home that can be modified)
- Floating bed or hospital bed with pressure reducing memory mattress
- PAFOs and AFOs- bilateral hip braces, ankle splints, hand splints
- Specialized developmental toys that flash and vibrate for cognitive stimulation

Inpatient Care/ Outpatient procedures; Anticipated and Potential Complications

- Infection
- Problematic seizures
- Scoliosis
- Contractures
- Hip displacement

- Long bone fractures from falls as she ages
- Decubitus ulcers (non surgical)
- Dental procedures requiring sedation
- G-tube revision/replacement
- Spasticity management with Botox and/or Phenol injections; potential need of Baclofen pump in later years
- Tendon transfer and muscle and tendon lengthening procedures once she has reached maturity if significant contractures develop
- Selective dorsal rhizotomy (as recommended by CHLA Rehab clinic for treatment of her truncal hypotonia)
- Femoral or pelvic osteotomy for treatment of hip displacement is a potential need

IV. COST ANALYSIS

Outpatient Physician and Therapeutic Care

Service/Item	Start Age	Target Age	Units/ Year	Average Unit Cost	Average Annual Cost
Allied Health (OT/PT/ST)	4	10	120	$192.00	$23,040.00
Allied Health (OT/PT/ST)	10	18	96	$192.00	$18,432.00
Allied Health (OT/PT/ST)	18	52.5	12	$192.00	$2,304.00
Behavioral specialist	4	18	12	$198.00	$2,376.00
Case Management	4	18	32	$118.00	$3,776.00
Case Management	18	52.5	16	$118.00	$1,888.00
Dentist	4	52.5	2	$150.00	$300.00
G. Tube Replacement	4	52.5	1	$874.33	$874.33
MD consultation	4	52.5	1	$229.20	$229.20
Nutritional Therapist	4	12	2.5	$188.00	$470.00
Nutritional Therapist	12	52.5	1	$188.00	$188.00
Ophthalmologist	4	52.5	1	$123.75	$123.75
Outpatient Physician Care	4	52.5	6	$104.80	$628.80
Psychotherapy Family	4	18	90 / 14	$150.50	$967.50

Long Term Care

Service/Item	Start Age	Target Age	Units/ Year	Average Unit Cost	Average Annual Cost
Attendant Care	4	52.5	1	$125,265.71	$125,265.71

Medications

Service/Item	Start Age	Target Age	Units/ Year	Average Unit Cost	Average Annual Cost
Anti Nausea Agent	4	10	365	$0.96	$350.40
Anti Nausea Agent	10	52.5	120	$0.96	$115.20
Antibiotics	4	52.5	1	$195.30	$195.30
Anticonvulsant	4	52.5	365	$8.14	$2,971.10
Antipyretic/Analgesic	4	52.5	90	$0.04	$3.60

Antispasticity	4	52.5	365	$12.16	$4,438.40
Antiulcer/GERD	4	10	365	$7.41	$2,704.65
Antiulcer/GERD	10	52.5	120	$7.41	$889.20
Bowel Program	4	52.5	365	$0.18	$65.70
Bronchial Dilator (Neb.)	4	52.5	90	$4.26	$383.40
Flu Vaccine	4	52.5	1	$11.69	$11.69
Mucolytic Agent (Neb.)	4	52.5	90	$23.09	$2,078.10
Multivitamin/ Supplement	4	52.5	365	$0.06	$21.90
Pneumovax	4	52.5	1 / 5	$65.87	$13.17

Diagnostics

Service/Item	Start Age	Target Age	Units/ Year	Average Unit Cost	Average Annual Cost
Allied Health Eval/Re-eval	4	18	3	$190.66	$571.98
Cultures	4	52.5	1	$62.60	$62.60
EEG	4	52.5	1 / 3	$540.50	$180.17
MRI/CT Brain	4	52.5	1 / 10	$1,510.88	$151.09
Neuropsychological Eval.	4	20	3 / 16	$2,631.00	$493.31
Routine Diagnostic Studies	4	52.5	2	$101.33	$202.66
X-Ray - Extremity	4	18	1	$118.88	$118.88
X-Ray - Extremity	18	52.5	1 / 5	$118.88	$23.78
X-ray Chest	4	52.5	1 / 3	$166.75	$55.58
X-ray Spine	10	14	1	$118.88	$118.88

Inpatient Care/Outpatient Procedures

Service/Item	Start Age	Target Age	Units/ Year	Average Unit Cost	Average Annual Cost
Dental inpatient services	4	18	1	$3,707.00	$3,707.00
Gastrostomy Revision	4	52	2 / 48	$48,161.02	$2,006.71
Long Bone Fracture	40	52.5	1 / 12	$16,761.01	$1,396.75
Problematic Seizures	4	52.5	1 / 10	$17,273.34	$1,727.33
Respiratory Infection	4	52.5	1 / 10	$12,019.67	$1,201.97
Soft Tissue Surgery	4	18	2 / 14	$30,251.78	$4,321.68
Spasticity Mgt. with Botox	4	18	1	$1,313.50	$1,313.50

DME & Supplies

Service/Item	Start Age	Target Age	Units/ Year	Average Unit Cost	Average Annual Cost
Adaptive Home Equipment	4	52.5	1 / 5	$2,123.73	$424.75
Adult Standing Device	10	52.5	1 / 7	$3,516.75	$502.39
Ankle Foot Orthotic	4	52.5	2	$55.67	$111.34
Arm/Wrist Splints	4	52.5	2	$21.32	$42.64
B.P monitor-digital	4	52.5	1 / 5	$80.98	$16.20
Diapers	4	52.5	182	$0.87	$1,587.75

Electric Hospital Bed	4	52.5	1 / 7	$1,982.87	$283.27
Enteral Feeding w/ solution	4	11	12	$1,051.05	$12,612.60
Exercise Mat	4	52.5	1 / 5	$152.84	$30.57
Feeder Chair & Tray	4	15	1 / 5	$921.80	$184.36
Gait Trainer, Pediatric	4	10	1 / 6	$1,249.83	$208.31
Gloves (Clean)	4	52.5	12	$6.75	$81.00
Home Mod. Mainten.	10	52.5	1	$500.00	$500.00
Home Modification	4	52.5	1 / 20	$44,000.00	$2,200.00
Humidifier	4	52.5	1 / 5	$154.61	$30.92
Linen Savers	4	52.5	365	$0.95	$346.75
Mattress Cover	4	52.5	2	$43.32	$86.64
Mattress-Anti-Pressure	4	52.5	1 / 7	$2,817.27	$402.47
Misc Adaptive Equip.	4	52.5	1	$200.00	$200.00
Nebulizer	4	52.5	1 / 5	$84.96	$16.99
Nebulizer Admin. Sets	4	52.5	90	$2.09	$188.10
Pedi Stander & Tray	4	6	1 / 2	$1,871.70	$935.85
Pediatric Adaptive Activity	4	20	1 / 5	$1,590.64	$318.13
Percussor (handheld)	4	52.5	1 / 5	$453.42	$90.68
Shower/Commode Chair	4	52.5	1 / 5	$1,481.65	$296.33
Skin Care Products	4	52.5	12	$25.17	$302.04
Stroller	4	6	1 / 2	$325.75	$162.88
Thermometer - Digital	4	52.5	1 / 5	$21.99	$4.40
W/C Maintenance	4	52.5	1	$350.00	$350.00
Walker	4	52.5	1 / 5	$149.61	$29.92
Wheelchair Manual	4	52.5	1 / 5	$2,252.09	$450.42
Wheelchair Seating System	10	52.5	1 / 5	$8,350.00	$1,670.00

Potential Complications

Service/Item	Start Age	Target Age	Units/ Year	Average Unit Cost	Average Annual Cost
Baclofen Pump Replace	21	52.5	1 / 10	$32,500.00	$3,250.00
Baclofen Pump Trial	11	12	1	$32,500.00	$32,500.00
Baclofen Pump-FU/Refill	11	52.5	1	$3,750.00	$3,750.00
Scoliosis Surgery	10	14	1 / 4	$60,165.68	$15,041.42
Strabismus Surgery	4	18	1 / 14	$6,195.44	$442.53
VP Shunt Revision/Replace	4	52.5	1 / 15	$69,275.11	$4,618.34

Selective Rizotomy need to be determined

Femoral or pelvic osteotomy to be determined

COST ANALYSIS SUMMARY

	Average Annual Cost
Outpatient Physician and Therapeutic Care	$13,318.29
Long Term Care	$125,265.71
Medications	$11,440.45
Diagnostics	$1,040.98
Inpatient Care	$7,972.02
Equipment and Supplies	$11,953.17
Potential Complications	$11,976.30
GRAND TOTAL	**$182,966.93**

No consideration is made for future price changes associated with inflation or industry growth factors. Likewise, no attempt has been to discount to present value. This is deferred to an economic expert experienced with this industry.

V. DISCUSSION

MayRose sustained an injury to her brain. The disabilities associated with her brain injury will cause her to develop along a unique trajectory that is different from her age mates. She will face problems during key developmental stages and her deficits will take shape in different forms over the course of her life. In many ways, the manifestations and the clinical course among similarly diagnosed individuals are as diverse as the group of syndromes that characterize the diagnosis (CP, anoxic encephalopathy, traumatic brain injury, etc). Literature that addresses clinical management of conditions associated with these diagnoses is drawn upon to help inform decisions regarding patient management.

The natural history of tonal abnormalities in pediatric brain injuries, the most frequently observed symptom, is typically described as evolutionary. Children with a brain injury can differ significantly based on the severity of motor deficits. This has implications for functional limitations, secondary medical complications (comorbidity), and ultimate functional outcomes. Those with more severe motor deficits generally have more severe delay of developmental milestones. There is usually excessive extensor spasticity.

Predicting long-term functional outcome prior to the age of three is difficult. The interactions of motor dysfunction, associated disabilities, natural history, and the effect of treatment modalities all affect outcome. Certain skills are helpful in establishing an ultimate motor prognosis. It has been estimated that 75% of children with cerebral palsy ambulate. Those that cannot sit by the age of two years or ambulate by the age of seven years rarely walk (Molnar, G.E.).

There are many problems commonly associated with pediatric brain injury that represent additional functional limitations. Mental retardation is considered the most serious associated disability with an overall incidence of 30-50% commonly cited. Cognitive deficits can range from profound to mild in cerebral palsy and pediatric brain injury. The greatest retardation is usually seen in children with rigid, atonic and severe spastic tetraparesis. Other disorders that are commonly seen in individuals with cerebral palsy and pediatric brain injury include oculomotor dysfunction, oral motor dysfunction (swallowing, chewing, sucking), seizure disorders, and asymmetry of linear growth. Approximately one-half of children with cerebral palsy have a seizure disorder. Seizure disorders can be variable in severity and range from minor motor or partial seizures to generalized and focal. With spastic tetraplegia, seizures are generally more severe with tonic-clonic manifestations as seen with grand mal seizures. An uncontrolled or poorly managed seizure disorder may further delay development. Other associated disabilities found in children with cerebral palsy and pediatric brain injury include incontinence, gastroesophageal reflux disease, constipation, and hearing deficits. The presence of mental retardation, seizures, and wheelchair dependency are factors reducing the likelihood of living independently. Other factors include social inappropriateness, behavioral dyscontrol and impaired vocational skills. Vocational skills can be affected by the inability to complete secondary education or physical limitations.

Dental problems are common in cerebral palsy and pediatric brain injury. Motor deficits and oral sensitivity with brushing present difficult challenges for oral hygiene. Tooth enamel development may also be affected in some children. Malocclusion is twice as frequent in

children with cerebral palsy in comparison to their non-disabled peers (Herman, S.C.). The combination of enamel dysplasia, mouth breathing, and poor hygiene leads to caries and periodontal diseases. These problems can be compounded by gingival hyperplasia, a common side effect of some anticonvulsants.

Defective or slow language often reflects an intellectual disability (Eicher, P.). Disorders of receptive, expressive, and written language are often encountered. Speech defects can be variable depending on the degree of impaired coordination of articulation, phonation, and respiration, and range from slightly distorted sound production to complete mutism. Communication disorders may be related to hearing impairments, defective motor control of speech production, central language dysfunction, or cognitive deficit (Molnar, G.E.). It is important to distinguish impaired speech associated with oromotor dysfunction from impaired language competence secondary to cognitive deficits.

Children with cerebral palsy and pediatric brain injury require extensive functional training. A multidisciplinary team of therapists experienced in the application of neurodevelopmental techniques provides the child with important therapeutic modalities to help overcome primitive reflexes and develop improved postural and motor control. These allied health professionals are invaluable for the child with cerebral palsy to achieve optimal functional outcomes. Compensatory functional techniques and adaptive devices are aids to independence. Gross motor abilities and hand dexterity are physical determinants for planning a program in activities of daily living. When complete independence of a task is not realistic, the child is encouraged to learn and consistently perform at least part of the task. It is important to encourage performance at a level of success, and each therapeutic session should end in success with interval therapeutic goals timed and planned for successful achievement.

Therapy will be intensive throughout the development years, and evaluation and follow-up will be required lifelong. Therapeutic strategies are taught to parents and other family members, as well as teachers and school attendants to assure carry-over in the home and educational settings where specific activities and therapeutic techniques are performed multiple times each day. This requires an ongoing training and educational process for all who are involved in the care and supervision of a child with cerebral palsy.

Orthotics are often employed for individuals with spastic limbs to provide support, limit motion, improve function, and delay or prevent contractures and other deformities caused by spastic muscles. Ankle foot orthoses (AFO), often referred to as "braces," are the most commonly prescribed orthotic. These orthotics are used to control spastic equinus, promote alignment of the hindfoot, and control midfoot and excessive knee extension in stance. When spasticity impairs upper extremity alignment, orthotics can provide maintenance of functional joint position. By splinting or bracing the upper extremity, the child has an opportunity to practice a functional skill or motor activity with optimal positioning of the hand.

Postural alignment for sitting requires a level pelvis and a reasonably straight spine. Close monitoring of the pelvis, hips, and spine is required, including serial radiographs to anticipate potential deformities. (Moreau, M.).

Asymmetric muscle imbalance, postural abnormalities and biomechanical and structural factors can contribute to structural scoliosis and kyphosis of the spine (Braddom, R.L.). Careful monitoring including serial radiographs is indicated throughout the growth years. Orthotics may be indicated in an effort to reduce spinal deformity or progression. Surgical intervention is indicated when there is development of a severe degree of curvature (> 40 degrees).

In addition to the management of the more obvious physical complications in pediatric brain injury, the medical and therapeutic treatment team must be sensitive to the psychosocial issues encountered. There are enormous societal issues that represent additional challenges for the child and adult with a brain injury along with their families. The parents must contend with the fact that the child they had long awaited will not be the same as most others and will have special needs throughout life. The demands of child rearing are greatly intensified by the addition of physical and perhaps mental and behavioral disability. The learning curve for parents is tremendous as is the burden of care. This places additional stress on marriage and relationships such that divorce rates are significantly higher in marriages where disability is subsequently encountered. The child with disability must contend not only with physical impairment, but also the social stigma attached to disability. This becomes increasingly evident as the child approaches school age and begins the educational process. Building healthy self-esteem is particularly challenging for the child who is uniquely aware that he or she is different from other children.

Early Childhood Intervention programming (offered through the age of three) is an important time to enhance environmental exposure. As children with a brain injury transition through the elementary years, there is generally increased social isolation when it is difficult for them to be included in many of the regular activities enjoyed by their non-disabled peers. Mainstreaming in school represents an attempt at full inclusion of children with disabilities, and where feasible, this can have a positive affect on the development of the child with cerebral palsy. "The transition into high school can be a stressful time but also a time of emotional maturation. The child may become independent or more regressed. Things such as drooling and incontinence take on a negative social perspective, whereas active participation in group activities enhances social interaction" (Molnar, G.E.). Problematic behavior, often seen in teenage years, represents a significant factor in social isolation of individuals with cerebral palsy and can itself preclude autonomous living. The parents of children with cerebral palsy or pediatric brain injury will require consistent education, professional counseling and support from the treatment team, and appropriate peer support groups throughout the developmental years as difficult decisions are made to help the disabled child reach his or her optimal potential. Supportive counseling should also be provided for those disabled children and young adults whose intellectual capacity is sufficient to understand that they are disabled and different from others.

There are a number of health-related problems associated with aging and cerebral palsy in addition to those encountered by most able-bodied individuals. Cervical neck pain occurs in approximately 50% of individuals with spastic type cerebral palsy. There is a higher incidence of disc degeneration and more rapid progression of degenerative disc disease, particularly for those with athetoid cerebral palsy. There is also a higher incidence of cervical canal narrowing. Other age-related problems often encountered by those with cerebral palsy include non-cervical back pain, pain in weight-bearing joints, contractures, overuse syndromes, and a high incidence of carpal tunnel syndrome (Murpy, K.P.). Fractures are more common in ambulators, while

scoliosis is more common in non-ambulators. There is a high incidence of chronic constipation and gastroesophageal reflux disease. Dental problems are much more common for those with cerebral palsy relative to the non-disabled population, particularly where there is persistent drooling into adulthood.

A child with a brain injury will continue to need routine medical management and monitoring by a experienced team of physician specialists. Routine follow-up is recommended with physicians specializing in physical medicine and rehabilitation/ developmental pediatrics as a child an adolescent, adult physical medicine and rehabilitation, orthopedics, and gastroenterology. Additional consultations are anticipated periodically to address acute complications and as may be required for second medical or surgical opinions. Physicians will provide medical monitoring and prescriptive services as may be needed for medication management, orthotics, spasticity management, diagnostics, and acute medical or surgical intervention.

Neuropsychological evaluations are used to define deficits in aspects of thinking and behaving evaluating such areas as memory, language, problem solving, reasoning, judgment and other cognitive functions. This form of testing is very useful for determining long-term functional outcomes, evaluating a therapeutic program's effectiveness, and to guide learning and compensatory strategies employed on a daily basis.

It is anticipated that with appropriate implementation of habilitative services, a patient with a pediatric brain injury will continue to show improvements. Gains should be expected in the areas of speech, motor skills and potentially self-help skills. Therapeutic support services are required to provide these patients with the tools they need to enhance learning and functionality. Therapeutic services will include speech and language pathology, occupational therapy, physical therapy, recreational therapy, and psychologists or other licensed professional counselors. These patients may also benefit from other adaptive organized activities, which further enhance physical and mental achievement and progress.

Therapeutic services should employ strategies to address physical and cognitive needs within a neurodevelopmental program design. This is important as it has implications for educational and therapeutic programming, as well as planning for life care transition and long-term placement options. Habilitation programming should focus on improvements in speech production and the development of motor skills to enhance the child's level of independence. Case management services are needed to assure access to quality goods and services in the most cost efficient manner.

The most important people in any child's life are, of course, the parents. Children require time, patience, love, dedication, and preparation. Raising a child with a severe brain injury associated with physical, cognitive, and behavioral challenges requires more of these qualities. The emotional burdens brought about by raising a child with mental and physical disability inevitably pose challenges to those raising the child and their siblings. There is no universal parent's guide to raising a child with neurobehavioral, neurocognitive, and neuromotor deficits. Each parent must find his or his own way. The parents of these special children play an indispensable role in the development of their child. Each child will develop different abilities and talents. Some will be able to do things that others will not. The key is to enable the child to reach his potential.

MayRose' family will need ongoing education and guidance from the team of health care providers working with her.

As part of follow-up and monitoring, radiographic studies and lab work will be required. Provisions are made for diagnostic testing related to her disability and the medications she requires as a result.

A clinical psychologist or other licensed professional counselor specializing in disability adjustment therapy should be available to work with MayRose' family as needed. This ongoing education and support is critical. A wide scope of topics is covered in counseling, such as the availability of community resources, the nature of the disability, and the implications of its resulting deficits. Teaching effective coping skills, developing insights into family expectations and interactions, and perceiving and anticipating problem areas are crucial to promoting adaptation and development. It is recommended that there be access to counseling services on a routine basis as the child progresses from childhood through adolescence and into adulthood, when she will be able to transition from the family home.

Given the anticipated need for assistance with activities of daily living, home attendant care services are included with this plan to provide for assistance with activities of daily living and household maintenance (i.e. laundry, bed making, and food preparation). Additionally, home attendant care services are projected to provide for a reasonable level of respite services for the parents. This is crucial so that they can normalize their life, take care of their other children's needs, and reduce the burden on them for ongoing care. The personal and emotional requirements for home-based care giving require the mobilization of appropriate support services. Home-based care giving by family members of persons with chronic disabilities represents a considerable burden. The burden of this care, while usually readily assumed initially by most families, takes its toll upon individual family members. Disruptions in marriages and family relationships are often seen. The primary caregiver typically will "burn-out" with either physical or mental signs of stress and fatigue. Depression, anger, feelings of resentment, and guilt are common among family caregivers who themselves need supportive counseling services.

It is expected that MayRose will require structure and supervision throughout her life. The extent to which she receives appropriate services, and thus improves her skills, will have a direct impact on the skill level of support services that will be required to attend to her over time and the quality of the relationships that will be established between her and her caregivers. It is typical in a life care plan to consider multiple options of care when examining needs that extend over decades. This will typically include in home and placement options using varying types of caregiver specialists with varying degrees of skill (e.g. RN, LVN, HHA, etc).

Life Expectancy: Maintaining Funding for Lifelong Care

The average residual life expectancy for a 4-year-old black female is 77.6 years. This is based on information provided by the National Center for Health Statistics, *National Vital Statistics Report, 2006.* The U.S. Life Table Values represent the population as a whole, with gender and race differentiation. Mortality and morbidity among individuals diagnosed with mental impairment are primarily associated with physical handicaps, and specifically with immobility. Independence with ambulation and mobility in general, continence, self-feeding skills, and quality of care will

have the greatest impact upon life expectancy for handicapped individuals as a whole. This is usually the case, regardless of the cause of chronic disability. The diagnosis of Diamond Blackfan Anemia has negative implications for life expectancy. Gains are made in the aforementioned areas by MayRose will mitigate the negative implications of the disabilities associated with her brain injury. There is no authoritative medical literature available for discounting life expectancy. Quality of care will have a direct impact on life expectancy. It is imperative that an adequate funding stream is maintained over her lifetime to ensure the highest quality care, irrespective of how long she lives. It is typical in these matters for an annuity to be purchased and the proceeds to be paid into a medical special needs trust so that this goal can be accomplished. In this manner, the risk is taken entirely by those who have the financial incentive and fiduciary responsibility to pay for future care. The issue of how long to carry out the life care plan was discussed in detail between Dr(s). Harrell, Buck, and Sanger. 52.5 was determined to be an adequate endpoint. There is nothing about the use of 52.5 that should be construed as a life expectancy estimate. Rather, this endpoint is used for calculating an average estimated annual expenditure for the purpose of financial reserve allocation and cash flow needs to pay for future care associated with MayRose's brain injury and resulting disabilities.

Cost Projections

The cost analyses include those recommendations for health care goods and services that can reasonably be expected to improve functional capacity, maintain health, minimize complications, and provide for an improved quality of life. Every attempt was made to model care that is readily accessible in the marketplace. While there may be less expensive options for long term care, projecting a rate lower than what is utilized for this analysis would not allow for consistent and reliable accessibility. Where appropriate, services are CPT and/ or ICD-CM code specific, based upon publications of *Physician's Current Procedural Terminology* and the *International Classification of Diseases, Clinical Modification.* National cost data is utilized, except in those categories where only survey data is available. The cost data come from several sources that are detailed in Data Sources section of this report. No consideration is made within this plan for future price changes associated with inflation or industry growth factors. Likewise, no attempt has been made herein to discount to present value. This is deferred to an economic expert experienced with this industry. Similarly, no consideration is made for physical pain, mental anguish, physical impairment, disfigurement, or loss of earning capacity. While these may be elements of the damages and are associated with a legal claim, they are not the purview of this type of analysis and are not projected in this document.

VI. DATA SOURCES

Survey data for cost of services, supplies, durable medical goods and equipment, etc. has been collected by MediSys, Inc., annually since its inception. In addition, specific resources are utilized, including but not limited to the following:

- Apria Medical
- Alamo Mobility
- APC Home Care
- Girling Health Care
- Maximum Health Care Services, Las Vegas
- Nursing Core, Las Vegas
- Integrity Home Health, Las Vegas
- Columbia Case Management, Inc.
- Crawford and Company Healthcare Management
- Environmental Rehabilitation Consultants
- Independence Builders, Inc.
- Independent Mobility Systems, Inc.
- Interim Health Care
- US Department of Labor 2010-2011
- Payscale.com and Salary.com
- Miller, Inc.
- Novacare, Inc. (Limb and Brace)
- Sammons Preston
- Southwest Health Services
- Metlife 2011 Rates
- Genworth 2011 Rates
- John Hancock 2011 Rates
- The Institute for Rehabilitation and Research
- Transitional Learning Community
- Transitional Services
- CORE Rehabilitation
- Rescare Premier
- Brinlee Creek
- Wheelchairs Plus
- Wasserman Y. *Physicians' Fee Reference, Pricing Program.* Medical Publishers Limited.
- National Center for Health Statistics. National Vital Statistics Report, 2006 Life Tables
- Ingenix
- National Inpatient Profile, HCIA
- DRX.com
- Physicians Current Procedural Terminology, American Medical Association,
- National Hospital Directory
- Epocrates.

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Cerebral Palsy

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Gaidosik, C.G., & Cicirello, N. (2001). Secondary conditions of the musculoskeletal system in adolescents and adults with cerebral palsy. Physical and Occupational Therapy Pediatrics, 21(4), 49-68.

Glassrock, R. (2000). A phenomenological study of the experience of being a mother of a child with cerebral palsy. Pediatric Nursing, 26(4), 407-10.

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Roscigno, C.L. (2002). Addressing spasticity-related pain in children with spastic cerebral palsy. Journal of Neuroscience Nursing, 34(3), 123-33.

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Life Care Planning

Deutsch, P.M. (1999). Learning to question research: A Methodology for analysis. In P. Deutsch and H. Sawyer, Eds., A Guide to Rehabilitation. New York: Matthew Bender.

Deutsch, P.M., & Sawyer, H.W. (2002). A Guide to Rehabilitation, Volumes I, II, and III. White Plains: Ahab Press.

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McCollom, P. (2000). Proposed practice guidelines for excellence in life care planning. The Case Manager, 11, 67-71.

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Thomas, R. (1999). Life care planning: Defining procedures and process. NARPPS Forensic News, 2(1).

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Zasler, C. (1996). Primer for the rehabilitation professional on the life care planning process. Neurorehabilitation, 7, 79-93.

VIII. CURRICULUM VITAES

T. Walter Harrell, Ph.D., ABPP

EDUCATION:

September 1983 - May 1985
Postdoctoral fellow, Clinical Neuropsychology. The University of Houston, Houston, Texas.

December 1983
Doctor of Philosophy, Educational Psychology. The University of Texas at Austin.

August 1982
Master of Arts, Program Evaluation. The University of Texas at Austin.

May 1977
Bachelor of Arts (with Honors). The University of Texas at Austin. Major: Psychology with minor in the Natural Sciences.

EXPERIENCE:

July 1985 - Present
Private practice, Clinical Neuropsychology/Rehabilitation Psychology. Clinical emphasis on evaluation and treatment of cognitive and behavioral disturbances associated with neurological disease/trauma and specific developmental disorders. Consultation services include: rehabilitation staff development/training, program development, in-service training, and program evaluation. The private practice described above is performed under the name of MediSys Rehabilitation, Inc., a firm specializing in life care planning, catastrophic case management, direct clinical services, and medical/legal/claims consultation.

April 2002 to April 2012
Founder, Clinical Director, Therapeutic Communities, LLC; Provides therapeutic assisted living options and long term care for patients with chronic mental conditions, including acquired brain injury, developmental disabilities, and other neuropsychiatric disorders

November 1998- September 2002
Clinical Coordinator, Tangram Premier (Currently Rescare Premiere). Responsibilities include patient evaluation, treatment planning and support, program development, patient staffing, staff education and training, and administrative support. Consultant to Tangram since 1985; currently on Community Advisory Board.

January 1988 - August 1991
Director of Clinical Services, Spring Hill Rehabilitation Network. Responsibilities included development, coordination, and supervision of comprehensive out-patient rehabilitation facility

and transitional living services. Position changed in February 1991 to Neuroscience Program Coordinator.

September 1983 - June 1985
Postdoctoral fellow; University of Houston and Clinical Affiliation with Department of Neurology, Baylor College of Medicine; Medical Center Del Oro.

LICENSURE/CERTIFICATIONS:

Licensed Psychologist, Texas, #2-2975, May 1985 - present.
Diplomate, Rehabilitation Psychology, American Board of Professional Psychology (1997)
Senior Analyst and Diplomate, American Board of Disability Analysts (1997)
Fellow and Diplomate, American Board of Medical Psychotherapists and Psychodiagnosticians
APA, Certification in Treatment of Alcohol and other Psychoactive Substance Use Disorders

TEACHING:

January 2000 - Present
Practicum supervisor at the Brown Schools, for doctoral students at the University of Texas at Austin, Department of Educational Psychology

August 1987 – 2001
Clinical Associate Professor, Department of Physical Medicine and Rehabilitation, University of Texas Health Science Center, San Antonio, Texas.

August 1987
Six lecture series on Traumatic Brain Injury Rehabilitation for Physical Medicine and Rehabilitation, Neurology, and Neurosurgery residents, University of Texas Health Science Center, San Antonio, Texas

Spring 1987
Lecturer, St. Mary's University, Department of Psychology, small undergraduate class in Physiological Psychology.

1980 - 1982
Assistant Instructor, University of Texas at Austin. Large undergraduate and small graduate classes in statistics and measurement and evaluation. Responsibilities included curriculum design, lectures, and student evaluation.

RESEARCH:

1983 – 1985: Postdoctoral fellow, Clinical Neuropsychology, University of Houston,
1978 – 1982: Research assistant, University of Texas at Austin.

HONORS:

2008	Fellow, National Academy of Neuropsychology
1983	Finalist, TPA Student Research Competition
1980	Phi Kappa Phi National Honor Society

1978	Psi Chi National Honor Society
1977	B.A. with Honors, The University of Texas at Austin
1971	Exchange Student, Yokosuka, Japan.

PUBLICATIONS:

Watts, C and Harrell, T. W., Brain Injured Patients, *Legal Medicine, sixth edition.*, American College of Legal Medicine, Mosby, Spring 2006

Harrell, T.W., Planning for a Lifetime; *Long Term Planning for Individuals with Brain Injuries and other chronic disabilities;* Seaton Foundation 2005

Harrell, T. W., Krause, J. S., "Personal Assistance Services in patients with SCI: Modeling an appropriate level of care in a Life Care Plan", Topics in Spinal Cord Injury Rehabilitation, Spring 2002, Vol. 7, 4

Bagwell D, Willingham A, Harrell T. Life care planning: the interdisciplinary team approach, *In Disability Analysis In Practice*, 1st (ed.). Nov., 1998.

Harrell, T. W., Bagwell, D. M., and Coupland, M., "Building a Future: Teaming Up for a Life Care Plan" Continuing Care, July 1997.

Becker, H., Harrell, T.W., and Keller, L. "A Survey of Professional and Paraprofessional Training Needs for Traumatic Brain Injury Rehabilitation". Journal of Head Trauma Rehabilitation, March, 1993.

Becker, H., Harrell, T.W. Outcome: Guidelines and Principles. Viewpoints, Spring 1993, Vol. 23.

Harrell, T.W. Quality of Life After Brain Injury: Implications for Rehabilitation. Viewpoints, Winter 1992, Vol. 22.

Harrell, Walter Staff Training and Development: The Time Has Come. Insight, October 1992, Volume 2, Issue 3.

Pirozzolo, F.J., and Harrell, T.W. The Neuropsychology of Learning Disabilities, in L.C. Hartlage and C.F. Telzrow The Neuropsychology of Individual Differences; A Developmental Perspective, Plenum Press, 1985.

Harrell, T.W. The Neuropsychological Profiles of Empirically Derived Subgroups of Learning Disabled Adolescents. Unpublished doctoral dissertation. The University of Texas at Austin, 1983. Available through The University of Texas at Austin microfilms.

Harrell, T.W. Evaluating the Effects of Density and Proximity on the Human Response to Crowding, unpublished Master's thesis, The University of Texas at Austin, 1982.

Harrell, T.W. CMHC Program Evaluation in the State of Utah. A publication of the Community Mental Health Center Evaluation Project, E.M. Glaser and K.E. Kirkhart co-principle investigators, sponsored by the National Institute of Mental Health Grant Number R01 MH 33540.

Harrell, T.W. CMHC Program Evaluation in the State of Wyoming. A publication of the Community Mental Health Center Evaluation Project, E.M. Glaser and K.E. Kirkhart co-principle investigators, sponsored by the National Institute of Mental Health Grant Number R01 MH 33540.

PRESENTATIONS:

Numerous invited presentations at professional conferences on topics about or related to traumatic brain injury, neuropsychology of learning disabilities, chronic pain management, life care planning, and program evaluation. This includes Individual Case Management Association Conference, Texas Head Injury Association Conference, Texas Association of Rehabilitation Professionals in the Private Sector, American Congress of Rehabilitation Medicine, University Health Science System, National Brain Injury Society (2005 –2007), Texas Brain Injury Society, Michigan Brain Injury Association (2006), and the Houston Conference on Neurotrauma, etc.

IN-SERVICES AND INVITED LECTURES:

Over 50 on topics ranging from the neuropsychology of Alzheimer's disease, neurotoxicology, learning disabilities and learning impairments following trauma to the brain, brain injury, spinal cord injury, life care planning and chronic pain management.

CURRENT HOSPITAL AND FACILITY AFFILIATIONS:

San Marcos Treatment Center

PROFESSIONAL SOCIETIES:

Texas Psychological Association
American Psychological Association
International Neuropsychological Society
National Academy of Neuropsychology (fellow 2008)
Austin Neuropsychological Society
Brain Injury Association

PROFESSIONAL ACTIVITIES:

Spring 1997 - 1999

Traumatic Brain Injury Planning Advisory Group, Texas

April 1989 - December 1995; 2003-present

Board of Trustees, Seaton Foundation, Austin, Texas.

January 2006 – present

Editorial Advisory Board of Brain Injury

BRIAN C. BUCK, M.D.

CERTIFICATIONS:

Workers' Compensation, Sub-Specialty of American Board of Quality Assurance and Utilization Review Physicians, 1999, #31067

American Board of Independent Medical Examiners, May 1999, #99-01447

American Board of Quality Assurance and Utilization Review Physicians, August 1994, #31067

American Board of Electrodiagnostic Medicine, April 1989, #1189

American Board of Physical Medicine and Rehabilitation, May 1987, #2573

LICENSURE: Texas # H4878

EDUCATION:
University of Texas Medical Branch, Galveston, Texas; M.D.; September 1979 to May 1983

Austin College, Sherman, Texas; B.A., Natural Science; September 1975 to May 1979

POST-GRADUATE TRAINING:

The University of Utah School of Medicine, Division of Physical Medicine and Rehabilitation; Salt Lake City, Utah; Resident, Physical Medicine and Rehabilitation; June 1983 to June 1986

PRACTICE EXPERIENCE:

Texas Orthopedics, Sports and Rehabilitation Associates; Austin, Texas; Physical Medicine and Rehabilitation Specialist, 1993 - present

Solo/Private Practice; Austin, Texas; Physical Medicine and Rehabilitation Specialist, 1991 - 1993

Private Practice, Part Time, San Antonio, Texas; Physical Medicine and Rehabilitation Specialist, 1989 – 1991

PROFESSIONAL OR TEACHING APPOINTMENTS:

Clinical Assistant Professor, Part Time, University of Texas Health Science Center/San Antonio; Department of Physical Medicine and Rehabilitation, 1989 - 1991

Assistant Professor, Full Time, University of Texas Health Science Center/San Antonio; Department of Physical Medicine and Rehabilitation, 1988 - 1989

Instructor, Full Time, University of Utah, School of Medicine; Division of Physical Medicine and Rehabilitation, 1986 – 1988

OTHER PROFESSIONAL ACTIVITIES:

Physician Peer Review and Utilization Review, Workers' Compensation and Disability Cases; Texas Workers' Compensation Insurance Fund. 1997 - present

Physician Peer Review and Utilization Review; National Medical Reviews. 1997 - present

Physician Peer Review and Utilization Review, Workers' Compensation and Disability Cases; Texas Association of School Boards. 1997 - present

Member, Planning Committee, Texas Brain Injury Advisory Council. 1997 - 1999

Physician Peer Review and Utilization Review, Workers' Compensation Cases; CorVel Corporation. 1996 - Present

Physician Peer Review and Utilization Review, Workers' Compensation Cases; PRO Healthcare Management, Inc. 1996 - Present

Member, Travis County Medical Society Geriatrics Committee. 1996 - 1997

Chairman, Continuous Quality Improvement Committee, HealthSouth Rehabilitation Hospital of Austin, Austin, Texas. 1995 - November 1996

Designated Doctor, Independent Medical Examinations for Texas Workers' Compensation Commission; Austin, Lufkin, Lubbock, Laredo, Eagle Pass, Del Rio, Midland and El Paso, Texas. 1994 - Present

Chairman, Intraoperative Monitoring Program, Brackenridge Hospital, Austin, Texas. 1994 - Present

Vice-Chair, Specialty Care Center Committee, Brackenridge Children's Hospital, Austin, Texas. 1994 - 1997

Physician Peer Review, Insurance Utilization Review for Rehabilitation, Foundation Health Federal Services, Austin, Texas. 1993 - 1996.

Physiatrist Member, National Advisory Committee, Development of the Standards for Comprehensive Subacute Rehabilitation for 1994, including Pediatric substandards; CARF, Tucson, Arizona. February 1993

Physician Peer Review, PRO, Texas Medical Foundation, Austin, Texas. 1992 - 1994

Physiatrist Member, National Advisory Committee, Comprehensive Inpatient Rehabilitation Standards for 1993, including Pediatric substandards; CARF, Tucson, Arizona. January 1992

Member, Peer Review Physician, Quality Assurance and Utilization Review Committee, The Rehabilitation Hospital of Austin, Austin, Texas. 1991 – 1994

Member, Physical Medicine and Rehabilitation Committee, St. David's Hospital, Austin, Texas. 1991 - Present

Member, Medical Executive Committee, The Rehabilitation Hospital of Austin, Austin, Texas. 1991 - November 1996

President, Medical Staff, Warm Springs Rehabilitation Hospital, San Antonio, Texas. 1989 - 1991

Member, Peer Review Physician, Quality Assurance and Utilization Review Committees, Warm Springs Hospital, San Antonio, Texas. 1989 - 1991

Manuscript Reviewer, Archives of Physical Medicine and Rehabilitation, Pediatric Rehabilitation and Electromyography topics. 1988 - 2000

Physician Surveyor - Commission on Accreditation of Rehabilitation Facilities (CARF). 1988 - 1995

Chairman, Stroke Rehabilitation Development Committee, University of Utah Health Science Center, Salt Lake City, Utah. 1986 - 1988

AWARDS/HONORS:
Beta-Beta-Beta, National Honor Biology Society, Austin College, Sherman, Texas. 1978

National Science Foundation grant, Summer Training Project, Genetics and Mathematical Computer Modeling, Mississippi College, Clinton, Mississippi. 1974

SOCIETY MEMBERSHIPS:

American College of Occupational and Environmental Medicine, 1998
Travis County Medical Society, 1991 - Present
Texas Medical Foundation, 1991 - Present
Texas Physical medicine and Rehabilitation Society, 1988 - Present
American Medical Association, 1988 - 1997
Texas Medical Association, 1988 - Present
American Academy of Physical Medicine and Rehabilitation, 1987 - Present
American Academy for Cerebral Palsy and Developmental Medicine, 1987 -Present
American Association of Electromyography and Electrodiagnosis, 1986 - Present
American Academy of Clinical Neurophysiology, 1986 - Present

DATE OF BIRTH: January 27, 1957

PLACE OF BIRTH: Austin, Texas

MARITAL STATUS: Married, Six Children
Wife: Kate

BIBLIOGRAPHY:

In Walsh NE (ed.): Rehabilitation of Chronic Pain, Physical Medicine and Rehabilitation: State of the Art Reviews 5(1): Rogers JN, Buck, BC: Acute and Chronic Pain in Children. p. 155-163. February, 1991. Philadelphia, Hanley Belfus, Inc.

Buck B: Spinal Cord Injury in Partial Down Syndrome. Arch Phys Med Rehab 68:523-525, 1987.

Currie DM, Nelson M, Buck B: Guillain-Barre Syndrome in Children: Evidence of Axonal Degeneration and Long-Term Follow-up. Arch Phys Med Rehab 71:244-247, 1990.

Buck B: Electromyography of Brachial Plexus Birth Injuries. Developmental Medicine and Child Neurology. 31:691-692, 1989.

Buck B: Corticosteroid Iontophoresis. Arch Phys Med Rehab 67:348, 1986.

Editor, Department of P.M. & R., Resident Manual, Warm Springs Hospital, 1989. Editor, Pediatric Rehabilitation Policies, Warm Springs Hospital, 1989.

INVITED LECTURES

06/14/95: "Designated Doctor Exams and the Problems with Impairment Ratings." Texas Workers' Compensation Fund, Austin, Texas.

11/05/94: "Newest Approach to Cerebral Palsy - Update on Spasticity." Embassy Suites, Pediatric Update, Central Texas Medical Foundation, Austin, Texas.

10/27/94: "Fundamentals of the Impairment Rating Process." Vonco Seminar, CEU Credits, Holiday Inn, Dallas, Texas.

05/19/94: "Electrophysiology of Back Pain." Seton Medical Center/Grand Rounds, Austin, Texas.

05/4 & 5/94: Instructor, TWCC Impairment Rating Training Course; CME Credits; Texas Medical Association Annual Meeting, Convention Center, Austin, Texas.

04/14/93: "Biomechanics of Soft Tissues." The Rehabilitation Hospital of Austin, Central Texas Medical Foundation, Austin, Texas.

03/13/93: "Cervico-Thoracic Dysfunction." Sheraton Hotel, Austin, Texas.

02/22/93: "Metabolic Bone Disease." The Rehabilitation Hospital of Austin, Austin, Texas.

01/30/93: "Cervico-Thoracic Dysfunction." Sheraton Hotel, Houston, Texas.

12/16/92: "Pediatric Rehabilitation Therapies." Brackenridge Hospital, Austin, Texas.

11/19/92: "Peripheral Neuropathies." Brackenridge Hospital, Austin, Texas.

10/24/92: "Carpal Tunnel Syndrome." Hilton Hotel, Houston, Texas.

03/12/92: "Spasticity - Current Aspects of Origin and Treatment." The Marriott Hotel, Central Texas Medical Foundation, Austin, Texas.

01/09/92: "Pediatric Brain Injury." Comal County Medical Society, New Braunfels, Texas.

07/12/89: "Pediatric Rehabilitation - Special Concerns." Presented to the Bexar County Rehabilitation Nurses Association, Warm Springs Hospital, San Antonio, Texas.

12/02/88: "Other Aspects of Brain Injury: From Prevention to Recovery." Presented at Warm Springs Symposium on Childhood Brain Injury, San Antonio, Texas.

08/26/88: "Psychological Aspects of Spinal Cord Injury." Presented to Department of Psychiatry Grand Rounds, University of Texas Health Science Center, San Antonio, Texas.

03/25/88: "Possible Complications After Spinal Cord Injury - Prevention and Management." Presented at Spinal Cord Injury - The Continuum of Care, University of Utah Health Science Center, Salt Lake City, Utah.

12/04/87: "Selective Posterior Rhizotomy." Presented to Rehabilitation Staff, Primary Children's Rehabilitation Center, Salt Lake City, Utah.

09/03/87: "Single Fiber Electromyography and Its Role." Presented to Department of Neurology EMG Conference, University of Utah Health Science Center, Salt Lake City, Utah.

05/29/87: "Low Back Pain: Causes and Treatment." Presented to Staff Physicians, Hill Air Force Base, Ogden, Utah.

11/18/86: "Sensory Nerve Conduction Studies - Reducing Their Stimulus Artifact and the Challenge of the Lateral Femoral Cutaneous Nerve." Presented at Department of Neurology EMG Conference, University of Utah Health Science Center, Salt Lake City, Utah.

IX. IME

Brian C. Buck, M.D., P.A.
4201 Bee Cave Road, Suite C-106
Austin, Texas 78746
Phone 512-279-2386
Fax 512-279-2387

July 15, 2012

RE: MayRose Hurst
Date of Birth: May 14, 2008
Referring Physician: MediSys Rehabilitation

INDEPENDENT MEDICAL EVALUATION

DIAGNOSES

1. STATUS POST HYPOXIC-ISCHEMIC ENCEPHALOPATHY
2. MULTIPLE DEVELOPMENTAL DELAYS
3. SEIZURE DISORDER
4. CORTICAL VISUAL DISORDER WITH BILATERAL OPTIC PALLOR AND VARIABLE EXOTROPIA

HISTORY OF PRESENT ILLNESS

The patient is a 4-year-old female who is referred to me by Dr. Walter Harrell at MediSys Rehabilitation for an independent medical examination. Dr. Harrell and MediSys Rehabilitation have prepared all of the medical records and presented them to me in the form of a timeline and initial history. In addition, I was provided with a disk that contained all of the medical records in their possession. The patient was seen in the presence of her mother at their home in Las Vegas, Nevada. She has a complicated past medical history, wherein she was born premature and initially was in the neonatal intensive care unit. These factors will be discussed in the past medical history section of this report. The patient was hospitalized in Las Vegas on 10/29/08 and was suffering from an influenza type syndrome, which then became complicated by severe anemic shock. Her initial presentation to the emergency room was with lethargy, apnea, severe metabolic acidosis, and a very low hemoglobin. She underwent a hematological workup and she required mechanical ventilation and antibiotics. She was followed by the hematology service. She had a head CT scan on 11/15/08, which showed diffuse watershed area infarcts, hydrocephalus ex vacuo, and gyral calcification consistent with her initial shock. She developed upper and lower extremity hypertonia and visual tracking difficulties and poor oral motor skills. Her EEG was abnormal, showing diffuse slowing of the background activity. She began receiving physical therapy and occupational therapy and then was referred for inpatient rehab at Children's Hospital of Colorado. She was hospitalized there from 12/01/08 through 12/18/08, and was followed by physiatrist Dr. Gallagher. She was noted to be alert and irritable and moving all extremities equally with increased tone. She started in PT, OT, and speech therapy. An MRI scan obtained on the day of admission showed extensive encephalomalacia and abnormal signal throughout the brain in a watershed distribution, consistent with a previous hypoxic injury and infarctions. There was also felt to be a chronic right subdural hematoma. She had a skeletal survey, which showed periosteal reaction in the left distal tibial shaft, buckling of the distal radial cortex with a small amount of periosteal reaction, and overall decreased bone density suggestive of osteopenia. At that time, she was able to take a couple of ounces of fluid from a bottle from her mother. She had to be held in the upright position because of reflux. She was initially noted to have minimal response to auditory stimulation by OT, but by discharge she was tracking in all directions. Ophthalmology exam done on 12/02/08 was normal with a normal fundus and no evidence of retinopathy.

Regular followup was recommended. At discharge, she was recommended to be in a comprehensive therapy program and to follow up periodically. In followup on 02/05/09, she was noted to show inconsistent visual tracking and she remained hypertonic in the extremities and trunk. In August 2009, she was noted to be nursing well and gaining weight, and she was almost up to the tenth percentile. She had started drinking from a sippy cup. There was concern about her visual status and that she might have a cortical visual impairment. She became fussy and irritable at times, and developed a biting habit and putting objects in her mouth repetitively. Her upper extremities were kept in high flexion tone and her lower extremities were in extension tone with scissoring. Neurologically she was noted to have some visual inattention, but she was making a variety of sounds. Her spasticity was at a Modified Ashworth score of 2. She had what was felt to be reasonably good head control, but continued to scissor in her lower extremities. Her non-verbal development and play skills were deemed to be delayed. In August 2009, she could roll prone to supine and supine to prone. She was unable to sit unsupported. The medication baclofen was added to her regimen, and she was casted for bilateral ankle-foot orthosis braces. Various adaptive equipment was recommended to the mother. It was felt that she could fix her gaze on objects presented, but relied heavily on auditory input to attend to toys. She had an ophthalmology examination on 08/20/09, which confirmed the diagnosis of cortical visual impairment in both eyes. On 09/10/09 the patient saw neurologist Dr. Raja, and she was having staring spells up to eight to ten times a day. The patient's mother transferred the patient's care to Children's Hospital of Los Angeles in November 2009. An EEG performed there in November was abnormal with slowing of background frequencies consistent with a moderate encephalopathy. There was also activity consistent with a partial and generalized seizure disorder. The patient was seen by ophthalmologist Dr. Buffenn on 01/20/10 and was given the diagnosis of cortical visual impairment and bilateral optic nerve pallor with variable exotropia. She was also felt to have myopia with astigmatism in both eyes. Dr. Buffenn recommended that the patient discontinue wearing her eyeglasses at that time. The patient also began being seen by Dr. Sanger regarding her movement disorder and stiffness in her lower extremities. She was noted to be fisting with her thumbs, and the child was using soft thumb splints. The baclofen dose was adjusted. Nutritional evaluation was performed, and by this time she was able to take some solid foods and she had continued to breastfeed. The patient's seizure disorder was felt to be complicated and she was placed on different medicines, including clonazepam, phenobarbital, and gabapentin. Dr. Sanger suspected that most of the tone was dystonic in nature, and he started her on Artane. Dr. Sanger mentioned that he would consider Botox injections. The patient was seen by orthopedic surgeon Dr. Myung on 02/10/10 about possible scoliosis. The patient demonstrated reasonable head control, but had trouble when placed in a seated position when her head would eventually fall forward into flexion. Her spine was midline and she was noted to have tight hamstrings and plantigrade feet. Imaging studies of her spine showed no scoliosis with mild spinal asymmetry related to positioning. Dr. Sanger continued to follow the patient closely, and multiple medication adjustments were made. The patient was on Keppra for a while. The Artane dose was later increased. At a followup visit with Dr. Sanger on 11/24/10, the patient had been started on Sinemet and it was felt that she was less floppy and her neck was more stable. She was not able to quite reach and grasp, but she was using both hands. She had started in some Hippotherapy at home and was continuing to use soft splints on her wrists. She was noted to still have some type of seizure activity during the day, and her exam showed increased tone in the arms, legs, and trunk. Dr. Sanger diagnosed hypoxic-ischemic encephalopathy with generalized hypotonia with secondary dystonia, and a combination of dyskinetic and tetraplegic cerebral palsy. EEG performed on 12/09/10 showed again findings consistent with a moderate encephalopathic pattern, and there were epileptiform discharges. The patient was placed on increased dosages of baclofen. The patient seemed to have better control of her head at this time and was now noted to be babbling some. She saw neurologist Dr. Raja on 04/06/11, who noticed that she localized better to sound and had improved eye contact. Her spasticity was improved and she had an Ashworth score of 2+ in the upper extremities and 3-4+ in the hips and ankles. She still demonstrated leg scissoring and fisting of the hands. Dr. Raja recommended Botox injections. There was a discussion about a baclofen pump versus oral baclofen. In followup at the Children's Hospital of Los Angeles on 04/21/11 she was unable to sit unsupported for any length of time. She was able to roll, but when she rolled onto her stomach she got stuck. She was receiving PT and OT

two times a week and Hippotherapy once a week. Exam was consistent with spastic quadriparesis with more spasticity in the lower extremities than in the upper extremities. She had clonus in both ankles and truncal hypotonia. There was a discussion of a referral to pediatric neurosurgery about the possibility of a selective dorsal rhizotomy. In followup with Dr. Sanger on 05/25/11, there was a discussion about her continued gastrointestinal problems and it being complicated by side effects of her medicines of Artane and Sinemet. Dr. Sanger recommended a taper of both of these to see if some of her gastrointestinal problems were alleviated. Unfortunately, there was no significant effect on her gastroesophageal reflux. She was admitted back to the hospital on 06/08/11 with vomiting. She was unable to take oral nutrition at this time and was fed through a nasogastric tube. A workup revealed delayed gastric emptying, but no significant reflux. A gastric tube insertion was felt to be the best option, and the patient had a G tube placement on 06/10/11, along with lysis of adhesions. She was discharged home on 06/15/11 and was tolerating her G tube feedings. During this hospitalization, she was also seen by endocrinologist Dr. Fisher regarding her osteopenia. Lab studies showed normal vitamin D and calcium levels. The patient was seen at the movement disorder clinic on 07/08/11, and it was decided not to place her back on the Artane and Sinemet medications. Her tone was mildly increased and she was able to hold her head up when pulled into a sitting position. There was a discussion about the patient getting Botox injections into her hip muscles to allow better diapering and cleaning. The patient had an evaluation by the Clark County School District on 06/01/12, and she was not able to identify objects by color, could not track objects, and was felt to have limited depth perception. Her primary learning was considered by auditory and tactile means, and she was felt to be dependent for all transfers and mobility needs. Dr. Mary Grant had prescribed glasses for mild mixed astigmatism and nearsightedness. She was noted to have multiple rehabilitative devices, including a stander in the home and specialized chairs and sitting devices. She had bilateral AFO braces and hip splints. She had overriding spasticity in her extremities with generalized low tone in her trunk. She was dependent in all care. She could bear weight on her forearms when placed prone and could lift her head up to 5 seconds at a time. She was not ambulatory, and there was a note that her hip muscles had been injected with Botox. She was noted to be happy and smiling, and laughed often, and often made vocalizations during sessions. She enjoyed music activities. She demonstrated some purposeful movements with her upper extremities and would often try to bring toys with her hands up to her face.

PAST MEDICAL HISTORY
She was born premature on 05/14/08 at 28 weeks gestation. Initial APGAR scores were low with a score of 3 at 1 minute, 6 at 5 minutes, and 7 at 10 minutes. She weighed 2 pounds 13 ounces and was 37 cm long with a head circumference of 27.5 cm. She was hospitalized for 80 days in the NICU. Initial ultrasound on 05/14/08 found no acute process; however, repeat ultrasound on 08/01/08 found a grade 1 germinal matrix bleed. A brain MRI scan was performed on 09/30/08 and was read as normal. The patient developed a small bowel perforation due to NEC and required a small bowel resection and ileostomy, which was later reversed. She was diagnosed with reflux several months after birth and had swallow studies, which revealed GERD. She was placed on anti-reflux medications. Her initial hematocrit was 31% and she was given multiple transfusions. She was initially diagnosed with anemia of prematurity, but later determined to have Diamond Blackfan anemia. She requires close followup with a hematology service for regular blood transfusions for this condition. Also, at the time of her birth, her lungs were underdeveloped and she was on a ventilator for a total of eight days. She received Surfactant. She was later extubated and did well on room air.

ALLERGIES
None known.

CURRENT MEDICATIONS
Clonazepam 0.6 ml b.i.d., and the mother mentioned that this is being gradually tapered down. Prevacid 5 ml b.i.d. Baclofen 1.5 ml t.i.d. Exjade. deferasirox, 1 a day. Triamcinolone nasal spray once a day. Zyrtec 2.5 mg/cc q. day. Multivitamin 1 cc q. day. Zofran 2.5 ml q.i.d. p.r.n. nausea, given typically

preceding a feeding. MiraLax 2.5 teaspoons q. day. Albuterol inhaler p.r.n. Budesonide nebulized in 60 cc p.r.n.

FAMILY HISTORY
No definite reported familial illnesses.

SOCIAL HISTORY
The patient lives with her mom and her older brother in Las Vegas, Nevada. The patient's mom is an attorney, as is her father. The parents have never been married and the father provides child support. There is an attendant caregiver and a nanny who comes in Monday through Friday while Mom is at work. The patient was in the early intervention program, but is in the Clark County School District ever since August 2011. She receives her education at home.

REVIEW OF SYSTEMS
This was obtained from the mom. She has multiple therapeutic devices in the home. The mother reports that the child gets Hippotherapy once a week and gets PT, OT, and speech therapy services. She needs to get visual therapy services. The mom reports that she flies to Los Angeles, California every three weeks for blood transfusions for the child's anemia. The patient has several specialists, including a pediatrician, a hematologist, a gastroenterologist, a physiatrist, a neurologist, an orthopedist, an endocrinologist, and an ophthalmologist. The child gets OT once a week. The child can tolerate 20 minutes a day on the Hippotherapy device and goes to Hippotherapy once a week. The child is fed in a full support feeding chair. There are three caregivers, which include the mom, a nanny, and a babysitter. The child wears bilateral AFO braces several hours a day. They use a stroller for quick trips and otherwise have a wheelchair. Mom says that surgery is planned on both hips in November 2012. She changes diapers six to seven times in a 24-hour time period. The child has regular bowel movements once a day with the use of regular MiraLax. The gastrostomy tube care is done anywhere from a minimum twice a day to four times a day, depending on how the site looks. She has had one hospitalization in the past year for an upper respiratory infection. The mom states that she feeds her finger foods and she is very slow. She does sometimes bite utensils. She does not tolerate mixtures too well and will tend to gag. She can chew noodles and French fries and cookies and mashed food. She gets 2 ounces of thickened water by mouth a day and takes that very slowly. She gets three gastrostomy tube feedings a day of 90 cc each time, which is Nutren Junior solution. This is by gravity drainage followed by 20 cc water afterwards. At night she gets the same formula, 450 cc pumped over 10 hours, followed by 150 cc water.

PHYSICAL EXAMINATION
Weight is 32 pounds. Height is 97 cm. I did not witness any seizures during the examination. Positive ATNR is present to a mild degree. She appears well groomed and is easily comforted by Mom. She vocalizes sounds and will yawn. She is not dysmorphic. She is alert and responsive by facial expressions. She can lift her head very briefly from supine. She can cry and laugh, and will smile. Her voice is dysarthric and has about 7 words that I learned to recognize. She tends to repeat some words over and over. She will repeat after her mother says a word. Her pupils are equal and responsive to light and accommodation. She has roving extraocular motions. She does not track visually to light in any consistent manner. She will open her mouth spontaneously and there is no drooling. She moves her head and neck spontaneously. Her cough is felt to be strong. She seems to have normal primary teeth in her mouth and she will move her tongue spontaneously. Her nose and nares appear normal. Cardiovascular exam shows regular rate and rhythm without murmurs. Lungs are clear to auscultation bilaterally. Abdomen exam has positive bowel sounds. There is a gastrostomy tube in the left upper quadrant. There is a transverse supraumbilical scar. The gastrostomy tube has some mild erythema around it, but no purulence or odor. Her movement analysis shows that when she is placed supine, she is not able to roll over on a rug. She can raise her arms up. She will occasionally kick with her left leg. She has positive head lag and does not have full head control. When placed in prone, she will arch up her head and upper back. She is not able to crawl. She is able to roll from prone to supine on carpet. She is not able to pull

up to a sit or stand. She cannot long sit. When placed in a seated position, she slumps forward and sideways and does not have pelvic or trunk control. She is not able to sit independently. When Mom places her into a gait training device, she remains stationary. In standing in the trainer, her head will slump forward and she will briefly voluntarily extend her head up. With coaxing from her mother, she is able to flex the left hip and propel only inches at a time with this left hip movement and slow progress. Her musculoskeletal exam shows no joint deformities. Her skin exam is normal without any soft tissue swelling or tenderness or rashes or sores. She has a very weak grasp. She has bilateral cortical thumb deformities. Bilateral thigh muscle circumference is 23 cm and bilateral calves are 17 cm. Her mid humeral circumferences are 19 cm bilaterally and her proximal forearm circumferences are 17 cm bilaterally. She has an intravenous port on the right upper chest. The left upper chest has scars from previous IVs. She has full range of motion of both shoulders. Bilateral upper extremities have flexion spasticity and an Ashworth score of 2. The left ankle is spastic, but I can get full passive range of motion. She has spastic toes bilaterally and tight heel cords bilaterally. The lower extremities show extensor spasticity. She will occasionally arch her head and neck into extension. She has full passive range of motion of the hips and knees, and she is able to flex both of her hips at times. There are no hip clicks and painless hip movement. Her extremities show no cyanosis, clubbing, or edema. Otherwise on neurological exam, her stretch reflexes are 2+ and spastic in the upper extremities and lower extremities. She has a Babinski's sign bilaterally. She is too spastic to elicit any definitive clonus.

PLAN

1. At this time, I will assist Dr. Walter Harrell in development of an appropriate life care plan. There are several concerns, obviously, in a child this significantly involved and with multiple developmental delays. Clearly, she will need very close medical followup by her specialists.

2. This child, in my medical opinion, does not likely have any capacity for development of toilet training, and has very limited potential for independent ambulation. Thus, appropriate assistive care and assistive devices will be necessary for these goals. The child's spasticity is going to be problematic and she will need continued care by her neurologist and physiatrist for this. This will include PT/OT, oral medications, Botox injections, and, in all likelihood, some future soft tissue surgery to allow easier care. I think this child will need a specialized bed at home and continued use of adaptive home equipment for the best outcome. Please see the life care plan for further details.

Brian C. Buck

Brian C. Buck, M.D.
American Board of Physical Medicine and Rehabilitation
Diplomate, American Board of Electrodiagnostic Medicine
American Clinical Neurophysiology Society
BCB:jdb

cc: Dr. Walter Harrell at MediSys

EXHIBIT C

DISTRICT COURT

CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST,	)	
Plaintiffs,	)	
vs.	)	Case No. A10616728C Dept.No. XXIV
SUNRISE HOSPITAL AND MEDICAL CENTER, LLC; MARTIN BLAHNIK, M.D.; ALI PIROOZI, M.D.; RALPH CONTI, M.D.; and FOOTHILLS PEDIATRICS, LLC,	)	
Defendants.	)	

VIDEOTAPED DEPOSITION OF MARTIN JOSEPH BLAHNIK, M.D.

Taken on Wednesday, January 18, 2012

At 2:06 p.m.

At 2300 West Sahara Avenue, Suite 420

Las Vegas, Nevada

Reported By: Karen J. Berry, RMR, CCR 836

APPEARANCES:
For the Plaintiffs: JACQUELYNN D. CARMICHAEL, ESQ.
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For Defendant Sunrise Hospital: JONQUIL L. URDAZ, ESQ.
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For Defendants Blahnik and Piroozi: JOHN H. COTTON, ESQ.
JOHN H. COTTON & ASSOCIATES
2300 West Sahara Avenue
Suite 420
Las Vegas, Nevada 89102
For Defendants Conti And Foothills Pediatrics: LAURA S. F. LUCERO, ESQ.
BONNE BRIDGES MUELLER
O'KEEFE & NICHOLS
3441 South Eastern Avenue
Suite 402
Las Vegas, Nevada 89169

VIDEOGRAPHER: BECKY ULREY
CERTIFIED LEGAL VIDEOGRAPHY

EXAMINATION

EXHIBITS

THE VIDEOGRAPHER: This begins the videotaped deposition of Martin Blahnik, M.D. Today's date is January 18, 2012, and the time is 2:06 p.m.

This deposition is taking place at the law offices of John H. Cotton and Associates, 2300 West Sahara Avenue, Suite 420, Las Vegas, Nevada.

This case is in the District Court, Clark County, Nevada, entitled Tiffani D. Hurst and Brian Addington, jointly and on behalf of their minor child, MayRose Lili-Abbington Hurst, versus Sunrise Hospital and Medical Center, LLC, et al., Case Number A-10-616728-C.

I'm Becky Ulrey with Certified Legal Videography, and the court reporter is Karen Berry with Turner Reporting and Captioning Services.

Will counsel please identify yourselves, and then the reporter will administer the oath.

MS. CARMICHAEL: Jackie Carmichael on behalf of the plaintiffs.

MS. URDAZ: Jonquil Urdaz on behalf of Sunrise Hospital.

MS. LUCERO: Laura Lucero on behalf of Doctor Conti and Foothills Pediatrics.

MR. COTTON: John Cotton on behalf of Doctor Blahnik and Doctor Piroozi.

Thereupon--
MARTIN JOSEPH BLAHNIK, M.D.
was called as a witness by the Plaintiffs and, having been first duly sworn, testified as follows:
EXAMINATION
BY MS. CARMICHAEL:

Q Will you please state your full name and your current address for the record?

A Martin Joseph Blahnik, 1047 Taber Hill Avenue, Henderson, Nevada, 89074.

Q Thank you. Doctor Blahnik, have you had your deposition taken prior to this occasion?

A No.

Q Okay. I'm sure you've had an opportunity to talk to counsel about the process, but I'll just give you a few pointers.

The goal today is to have a very clear transcript. In order to do that, let me finish my whole question before you start your response. I know in normal everyday conversation we anticipate where someone's going and we might talk at the same time. But let's try not to do that here today.

And likewise, if you're giving an answer, I'll do my best not to interrupt you with another question until you're done. If you do, however, pause

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and I assume you're done but you're not, just let me know, and I'll allow you to finish.
A Okay.
Q Okay. Also, make sure that you answer audibly instead of nodding or shaking your head. And if the answer requires a yes or no response, say yes or no instead of uh-huh or huh-uh, so that again the transcript is clear. Okay?
A Okay.
Q All right. Also, if I ask a question that's unclear, which I'm prone to do at times, feel free to ask me to clarify it.
Also, if you need a break for any reason, just let me know. We can take a break. Okay?
A Okay.
Q All right. Have you ever had any lawsuits filed against you prior to this occasion?
A No.
Q Okay. What did you prepare -- or excuse me, what did you review in preparation for your deposition today?
A I sought by recollection of the case, and I looked at medical records.
Q Okay. What records specifically did you review?

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A The MayRose medical record at Sunrise.
Q The entire record?
A Not the entire record.
Q Okay. Did you review all of the NICU notes?
A I looked at NICU notes.
Q Okay. Did you review all of the labs, lab results?
A I looked at some of the labs.
Q How about the transfusion records?
A I looked at the transfusion, the, the dates of those.
Q Okay. Did you bring any of the materials that you reviewed with you today?
A No. Those are in the possession of Sunrise Hospital.
Q Okay. All right. So you reviewed them -- are they electronic copies, or hard copies?
A Hard copies.
Q So you pulled the original medical chart and spent time reviewing it while at Sunrise Hospital?
A That's correct.
Q Okay. And when did you do that?
A I don't have the dates in front of me.
Q Well, just roughly. Was it within the last month? Was it a year ago?

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A I don't recall.
Q Well, did you take a look at it recently?
A No.
Q Did you review any depositions that have been given in this case?
A Yes. The original depositions that were part of the civil complaint.
No. I misspoke. Those were -- what are they called?
MR. COTTON: Affidavits?
THE WITNESS: Yes, affidavits. No depositions.
BY MS. CARMICHAEL:
Q Okay. All right. And have you spoken with anyone regarding the claims that have been raised in this lawsuit, with the exception of your counsel?
A Counsel I spoke with.
Q Anyone else?
A No.
Q Have you discussed the claims with Doctor Piroozi?
A In, only to the extent of getting access to the medical records which we knew of.
Q Okay. On that occasion, what did you discuss with him?

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A Well, the, the Medical Records Department at Sunrise will move the records to, I think it's called Risk Management Department, or something like that. And they are categorized differently. So when they're checked out for review, they have a policy on how that works.
Q Okay. So what did you speak to Doctor Piroozi about?
A About obtaining the records.
Q Anything else?
A No.
Q Okay. Have you spoken with Doctor Conti regarding these claims?
A No. I've never talked to Doctor Conti.
Q Do you know Doctor Conti?
A I do not.
Q And you have never spoken with him?
A No.
Q Have you ever met him?
A I have not.
Q Okay. Did you do anything else in preparation for your deposition today?
A In what sense?
Q Medical research. I don't know. Anything else to prepare for today?

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A When we prepared materials for the State response to the complaint, there was some documentation regarding anemia and anemia prematurity and this kind of thing. Those documents I looked at. From like medical text kind of thing.
Q Okay, who pulled those documents?
A I can't remember if I did, part of it. I don't recall.
Q Do you still have those documents in your possession?
A Yes, I do.
Q Okay, and they are journal articles?
A No. They are from hematology textbooks.
Q Okay. And how did you come by a hematology textbook?
A Oh, they're in the library. They're in our physicians lounge.
Q Okay.
A Some of the material I have myself in textbooks on neonatology in the hematology section. That kind of thing.
Q Sure. Okay. And did you make copies of some of the text in those textbooks?
A At some point, yes.
Q Okay. And you still have those copies?

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A I have copies that were sent to the State.
Q That were sent to the State?
A The State board. Right. That's who you originally sent it, materials that the State was asking for.
Q Got it.
A Nevada State Board of Medical Examiners. That's what they're called.
Q Okay. So the Nevada State Board of Medical Examiners investigated this claim?
A Yes.
Q Okay.
A That's their standard procedure.
Q All right. And when was that proceeding held?
A Can I ask what was the date of the original complaint?
Q You can. I don't know if I can tell you. May of --
MR. COTTON: May 14, 2010.
BY MS. CARMICHAEL:
Q 2010.
A Okay. So this is probably within six months from that time.
Q Okay. And who attended those proceedings?

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A None, no, no meetings were required. Just a written response.
Q I see. Okay. And did you have the assistance of counsel in preparing that response?
A Yes.
Q Okay.
MS. CARMICHAEL: Is that response protected, John, under your state laws here?
MR. COTTON: Uh-huh.
BY MS. CARMICHAEL:
Q Okay. All right. Your counsel provided me with a copy of your CV. And prior to the commencement of your depo, I asked you to review it. Is that indeed a current, up-to-date copy of your CV?
A Yeah, from what I looked at, it looks this is pretty much so.
Q Okay, great. We will mark that as Exhibit 1 to your deposition. I have just a few questions.
It appears that you attended medical school at the University of Wisconsin?
A Yes.
Q And graduated in 1993?
A Yes.
Q Okay. And you then completed a pediatric internship at the University of California at Irvine?

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A That's correct.
Q And a pediatric residency at UCLA?
A That's correct.
Q Okay. And then a neonatal fellowship at USC. Correct?
A Yes, University of Southern California.
Q Okay. And you completed that fellowship in 1999?
A That's correct.
Q Okay. Are you board certified in neonatology?
A Yes.
Q And when did you obtain your board certification?
A Soon after 1999, but I apologize, I forget the date.
Q That's okay. And how long is that certification good for?
A Nine years.
Q Are you due to renew?
A I renewed.
Q Okay. And did you pass your boards on your first attempt?
A Yes.
Q Okay. Okay. It appears that after the

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completion of your neonatal fellowship at USC, you remained there in a number of capacities for quite a few years. Is that right?
A That's correct.
Q Through 2007?
A Yes.
Q Okay. And following that, it appears that you moved to Las Vegas? Yes?
A Yes, ma'am.
Q And you've listed on your CV your current employment is with Sunrise Children's Hospital. Is that right?
A I think it's Pediatrics where I'm employed. And I'm credentialed at Sunrise.
Q Okay.
A If I have that correct.
Q Through your -- okay, you're referring to Pokroy Medical Group of Nevada?
A Yes.
Q D/b/a Pediatrics Medical Group of Nevada?
A That's correct.
Q Okay. And is that group affiliated with the Children's Healthcare Network?
A No.
Q Two separate entities?

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A That's correct.
Q All right. You were with the Children's Healthcare Network through 2009?
A Yes, ma'am.
Q And then just moved in 2009 over to Pediatrics?
A That's correct.
Q Okay. But during both of those employments, it looks like you pretty much exclusively worked at Sunrise Children's Hospital and Mountain View Hospital as a staff neonatologist. Is that right?
A That's correct.
Q Okay. In your capacity as a staff neonatologist at Sunrise Children's Hospital from 2007 to the present, who bills for your services? Who bills the patients for your services, if you know?
A Well, we generate codes, and those are reviewed. And if they're wrong, then it's brought back to us.
Q Well, and what I mean is, does the patient receive a bill for your services from Sunrise Hospital, or from Pediatrics Medical Group, if you know?
A I don't know.
Q Okay.

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A I'm just doing my job.
Q Okay. Who pays, or how are you compensated for your services?
A I'm salaried.
Q You're salaried by Pediatrics?
A Uh-huh. That's right.
Q All right. Who sets your schedule?
A The medical director.
Q Of Sunrise Hospital?
A No.
Q Of Pediatrics Medical Group?
A Of the Neonatal Intensive Care at Sunrise.
Q Okay.
A Who is also an employee of Pediatrics.
Q Okay. So the medical director of the NICU at Sunrise is an employee of Pediatrics Medical Group?
A That's correct.
Q Okay.
A But not in 2008.
Q Okay. In 2008, who was setting your schedule?
A It was the medical director, who worked for Children's Healthcare Network, just like me.
Q Got it.
A There was no Pediatrics.

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Q Okay, I understand.
A At Sunrise.
Q All right. And these medical directors that you're referring to, do they also set the schedule, your schedule for your work at Mountain View Hospital?
A That's correct.
Q Okay. Do you have a contract with Children's -- did you have a contract with Children's Healthcare Network in 2008?
A Yes, I did.
Q And do you still have a copy of that contract?
A I do not.
Q Do you have a contract, copy of your contract with Pediatrics Medical Group?
A I think so. But I would have to dig for it.
Q Okay. All right. Have you ever been paid directly by Sunrise Hospital?
A Only when my son was born, I was getting physicians, employee, employee compensation for medical bills for my wife's birth. And they extend that to all employees.
Q Okay. Sunrise extends that to all employees?
A Yes.

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Q So anyone that works at Sunrise Hospital receives a benefit in the form of employee compensation when their family members deliver at Sunrise?
A I believe that's correct, yes.
Q Okay. Any other form of compensation you receive from Sunrise?
A We get physicians lounge, food.
Q They feed you there?
A Limit, on a limited basis.
Q No steak and lobster. Okay.
Do you consider yourself an employee of Sunrise?
A Pediatrics.
Q Okay.
A I'm an employee of Pediatrics.
Q All right. But it's Sunrise Hospital that extends the benefit of the employee compensation when your wife gave birth there? Did I understand that correctly?
A That's, that's what I said, yes.
Q Okay. Okay. Do you know whether or not Pediatrics maintains the medical charts, or is it Sunrise Hospital that maintains the medical charts?
A I believe it's the latter.

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Q Okay. Have you ever appeared in any print, television, or any other kind of advertising for Sunrise Hospital?
A No.
Q Okay. Do you tell your patients -- or considering that your patients are babies -- their parents, those that you treat at Sunrise that you're not an employee of Sunrise Hospital?
A Such a conversation doesn't arise.
Q Okay. All right. In providing neonatal care to a premature infant, do you believe it is important to know what occurred during the prenatal course?
A Yes.
Q Okay. How do you go about finding that information out?
A Several ways.
Q Such as?
A We get consults from the obstetricians for us to come and speak with the families, review the obstetrical history.
Q Review the obstetrical history through conversations with the Ob-Gyn and the patient?
A Several things can happen in that regard.
Q Such as?

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A If it's a consultation, then I'll review the chart in addition to maybe or maybe not speaking with the obstetrician.
But sometimes I may receive a call from the obstetrician not requiring, not requesting a consult, but alerting me as the attending neonatologist about the issues of the delivery.
Q Okay.
A Or if there's prenatal diagnosis, particularly if it's cardiac in nature, we'll receive the fetal echo.
Q Okay.
A And maybe have a conversation with the cardiologist regarding that case.
Q All right. Do you believe it is important for you as the neonatologist to know about any abnormal test results that might have occurred during the prenatal period?
A Possibly, but not necessarily.
Q Depending on the test. Right?
A Yeah, if it's relevant.
Q Okay. If the birth mother was consulting with a perinatologist during the prenatal course, would it be important for you to know that?
A Maybe.

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Q During your education and training as a neonatologist, did you receive any training or knowledge regarding the clinical significance that an abnormal nuchal translucency or a nuchal fold test result might have?
A Yes.
Q Okay. And what did you receive in that regard?
A In, in what way do you mean that?
Q Well, what information did you receive regarding the clinical significance of an abnormal nuchal translucency or nuchal fold test?
A That it might mean nothing. Or it might be associated with trisomy 21. And there are other possibilities as well, so.
Q Trisomy 21 is Down's Syndrome?
A That's correct.
Q Okay. And so an abnormal nuchal translucency could indicate Down's. Correct?
A Yes.
Q It may also indicate other chromosomal abnormalities?
A I believe so.
Q Okay.
A I'm not certain.

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Q Are you aware of whether or not it may indicate cardiac problems?
A No.
Q Okay. Are you aware of whether or not it may indicate possible genetic birth defects?
A Well, we've already mentioned that.
Q Okay.
A We already mentioned also they may be normal.
Q Sure. Okay. Is that something you would want to know about though when you go to treat a newborn in the NICU? Would you want to know whether or not that baby had had an abnormal nuchal translucency or nuchal fold result?
A Not necessarily.
Q Okay. Did you come to know that MayRose Hurst had, was, was a child that had an abnormal nuchal translucency result?
A At what point in the pregnancy?
Q I can't remember which week.
A This baby was delivered at 28 weeks. And often these findings are 12, 13, 14 weeks, from what I call, and then they spontaneously resolve. That's why I mention that it's not necessarily indicative of pathology.

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Q Okay. But did you, did you ever learn -- I'm asking you from your memory now. Do you remember finding out or learning, when you assumed MayRose's care, that she had had an abnormal nuchal translucency result?
A I don't remember.
Q You don't remember? Okay.
During your medical education and training, did you receive any information regarding the diagnosis and treatment of blood disorders?
A Yes.
Q Okay. And what did you receive in that regard? How extensive was that?
A At what point in my training are you referring?
Q At any point in your training.
A That would include during medical school, during residency, and during fellowship.
Q Okay. So during all three of those you received training regarding the diagnosis and treatment of blood disorders?
A Yes.
Q Okay. Did you receive any education or training with respect to how to differentiate between anemia due to prematurity and anemia caused by a

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specific blood disorder or genetic defect?
A Yes.
Q Okay. And other than MayRose, have you ever cared for an infant in the NICU who had anemia as a result of a genetic defect or a specific blood disorder?
A Yes.
Q On how many occasions?
A It's impossible for me to say.
Q Are they numerous?
A I don't recall.
Q Okay. Well, on any of those occasions, were you the physician that diagnosed the blood disorder?
A Possibly.
Q You don't remember?
A I don't recall specifically.
Q Okay. All right. What are the most common symptoms of anemia due to prematurity?
A There may be no symptoms. Or there may be some mild symptoms.
Q Such as?
A That could include tachycardia. That could include pallor. That could include inadequate oxygen delivery to tissues.
Q Which would manifest in what way?

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A Metabolic acidosis, lactic acidemia.
Q Okay. Low hematocrit, is that a symptom of anemia due to prematurity?
A That's a, a lab finding.
Q Okay. Is it -- all right. Anything else you want to include in that?
A Yeah, there are other things, too.
Q What are the most common symptoms of thalassemia?
A Which type of thalassemia?
Q Let's go with alpha.
A Alpha thalassemia?
Q Uh-huh.
A It depends on the type of alpha thalassemia you're referring to.
Q Okay. Well, what are some common symptoms of that disease condition?
A Like I said, it depends on the type of alpha thalassemia you're referring to.
Q Well, you can differentiate that for me in your response.
A And it also depends on at what age you're looking at the disease condition.
Q Okay. In an infant that has thalassemia, what symptoms would you expect to see?

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A Well, if alpha thalassemia involves abnormality in the alpha genes, and there's four alpha genes, if all four are gone, all four are mutations, then the child is not going to make it to term.

If there's three missing, then there can be some -- there probably won't be any signs in that as well.

But if you've got only one good alpha gene, then as a result of that they can have hemoglobin Bart's, which is four bated chains, and those don't carry oxygen very well, and they have abnormalities in the shape of the...

Q Hemoglobin?

A The, well, the red blood cell.

Q Okay. What about the beta version of thalassemia? What are the symptoms, most common symptoms in that?

A You wouldn't see anything because there would be the gamma and the fetal hemoglobin present, which is alpha 2, gamma 2.

Q Okay. Would you expect to see a low hematocrit with thalassemia?

A It depends.

Q Well, are there occasions when you would?

A Yes.

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Q Okay, what about tachycardia?

A If it's associated with significant anemia, yes.

Q Okay. What are the most common symptoms of Diamond-Blackfan anemia?

A Bone marrow failure, I believe.

Q Which manifests in what way?

A If there's profound anemia, then the child would have symptoms of anemia.

Q Which would include a low hematocrit?

A Yes.

Q Pallor?

A Yes.

Q Tachycardia?

A Yes.

Q So essentially the same symptoms that are common to anemia due to prematurity. Correct?

A No. That's incorrect.

Q Well, I asked you what are the most common symptoms of anemia due to prematurity, and I believe you told me tachycardia --

A No.

Q -- pallor --

A You didn't. That's not correct.

Q -- low hematocrit.

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A No. You asked me when there are symptoms present, what are those symptoms. And I listed those symptoms.

Anemia prematurity most commonly is not going to be associated with any symptoms.

Q Okay.

A There's a big difference there.

Q So what you're telling me is that generally, in most cases, anemia of prematurity will have no symptoms?

A Let me put it this way: Somewhere between 90 to 100 percent, at least in the neonatal practice I'm at now, and I know this is true historically, in, with respect to other NICU's I've worked and the colleagues I've worked with, 90 to 100 percent of very low birth weight, which is a specific category, and extremely low birth rate babies get this diagnosis of anemia prematurity.

Q Based on what?

A Based on the fact that they're only one to two pounds, two and a half pounds, and have very little blood volumes, and require repeated phlebotomy. So their ability to compensate by producing red blood cells is limited. So they're all going to go through a phase of anemia prematurity.

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So there's nothing spectacular about ever having that diagnosis.

Q Okay. And just so I can be sure then, are you saying that generally, not always, but generally, babies with anemia of prematurity are not going to have tachycardia, or pallor, or low hematocrit? They're not going to have those things present?

A In the majority of cases, what you want to do is look at the clinical situation that the child's in. And that makes a big difference. Okay? Because one baby may have a hematocrit of 25 and is ready to go home, another baby may have a hematocrit of 35 and needs to have a blood transfusion.

Q Okay.

A So there's a lot to consider when you're asking that kind of question.

Q Okay. Understood. But this deposition will literally take until midnight if you -- I just need you to answer the question put to you. If you would do that, that would be great.

So my question to you is, are you telling me that the majority of babies diagnosed with anemia due to prematurity do not have symptoms of tachycardia, pallor, or low hematocrit?

A That's right -- well, low hematocrit maybe.

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But that doesn't imply they have symptoms. That's a lab value. Talking about, there's two things here. So, they have -- by definition, if you're saying this child has anemia, the hematocrit is low.

Q By definition?

A And it becomes a relative thing of how low is low.

Q Okay. All right. Okay. What symptoms or lab values would a premature infant in your NICU, that you're caring for, have to have in order for you to begin to suspect that their anemia may not just be due to their prematurity? In other words, that there's some more serious cause at work?

A That's a good question. This is going to depend as well. But looking for an actual value, I would definitely say any hematocrit less than 20 is very abnormal and needs to seek an explanation.

Q Okay.

A But if I can qualify in another way. A hematocrit that, for that age, gestational age and postnatal age, two standard deviations below the norm, by definition, is anemia, with or without symptoms. And that can be very different values depending on what specific patient you're looking at.

Q Okay. But I would, I would suspect that if

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you have an infant in your NICU that has been having low hematocrits, you're never going to let them get below 20 before you transfuse, are you? I mean you'll transfuse them before they ever get below 20, wouldn't you?

A Your question was what value is, would I consider significant anemia requiring transfusion. Twenty is the value.

Q Oh, so you don't even think transfusion is necessary until they get below 20?

A I didn't say that. Some patients need to be transfused when their hematocrit is 35 or even 40. Some babies can go home if their hematocrit is 25.

Q Okay.

A Okay?

Q And where we started with all of this was I asked you what symptoms an infant in your NICU would have to have for you to suspect that something more than anemia and prematurity was going on. And I believe your answer was they would have to have a hematocrit lower than 20. Is that what you told me?

A I'm not sure.

Q Well, is that true?

A Can you restate that, please?

Q Yeah. What symptoms would a premature

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infant that you're caring for in your NICU have to have in order, symptoms or lab values, in order for you to suspect that their anemia is not simply due to prematurity, that there's a more serious cause?

A There's, this is such a difficult question to answer, because there are multiple scenarios that would require me as a clinician to consider different aspects of why that child may be having some symptoms. And for me to just give a single blanket answer is really not possible.

Q If the child's birth parent has a genetic history of thalassemia and the child is showing up with low hematocrits, is that factor, the parent with thalassemia in their history, is that going to lead you to conduct, to test for thalassemia?

A Absolutely. As a general rule, this is correct. Because that's an inheritable condition. Yes.

Q Okay. And do you know whether or not MayRose Hurst was tested for thalassemia?

A She had a State blood standard newborn screen that looks for hemoglobinopathies, and that's one of them.

Q Okay. And do you know the results of that test?

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A I don't know the result of that test.

Q Is that a test result that would come back to you?

A Yes, we would know it's abnormal.

Q Okay. Incidentally, I can't find that test result in the medical chart. Do you know where it would be?

A Yeah, it's usually at the beginning of the chart. The nurses keep all of that in there. At least now.

Q Okay.

A But this state has an obligation to, to contact us when we have an abnormality they find in that test.

Q Okay. What about knowing that the infant had an abnormal nuchal translucency test result, would that lead you to consider testing for a genetic blood disorder in lieu of assuming that the anemia was due to prematurity?

A I don't understand the connection between the nuchal translucency and anemia prematurity.

Q That's what I'm asking you is if in your view there is a connection between a nuchal, an abnormal nuchal translucency result and the possibility that the child might have a genetic blood

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disorder, is there any connection in your mind?
A That's a different question. Anemia prematurity is not a blood disorder.
Q Yes, I understand that. I'm asking you if you knew that your patient had an abnormal nuchal translucency test result during the prenatal period, you knew that, and she's demonstrating low hematocrits after birth, is the fact that she had the abnormal nuchal translucency test going to create in your mind a consideration that this low hematocrit might be related to a genetic blood disorder, and might not just be due to prematurity?
A Not necessarily.
Q Okay. What about a low reticulocyte count? Would that cause you to believe that a newborn's hematocrit, the cause for it might be something more serious than just prematurity?
A That depends.
Q On what?
A It depends on the clinical scenario of the patient's history and status. Lots of factors.
Q Well, what is the clinical significance of a low reticulocyte count?
A Well, reticulocytes are produced by the bone marrow in response to erythropoietin as red blood

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cells break down, and there are new cells coming into the circulation.
Q Right. So what is the clinical significance of a low reticulocyte count?
A It depends on the clinical scenario that you're referring to.
Q Okay. Are you aware that a low reticulocyte count is consistent with Diamond-Blackfan anemia?
A Yes.
Q Okay. Are you aware that a low hematocrit is consistent with Diamond-Blackfan anemia?
A Yes.
Q Okay. Now, I assume that there are lots of testing, or various tests that can be done to get to the bottom of the actual cause of an infant's anemia. Yes?
A Yes.
Q Okay. Bone marrow aspiration is one such test? Yes?
A Yes.
Q Okay. Analyzing red blood cells under a microscope might be one?
A Yes.
Q Okay. Bringing in a hematologist to consult might be another avenue?

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A Yes.
Q Okay. Would you agree with me that some forms of anemia are not particularly dangerous to a patient, while other forms can be potentially life threatening?
A It's a very broad question. It's hard to answer.
Q Well, you can disagree, I mean. Are some anemias more serious than others?
A Absolutely.
Q Okay. And are some anemias in fact potentially life threatening if not properly treated?
A Yes.
Q Okay. When a physician is faced with several possibilities regarding a patient's diagnosis, the physician generally uses a tool called differential diagnosis. Right?
A That's correct.
Q Okay. And if that differential diagnosis includes any conditions that may be life threatening, then the whole purpose of the differential is to rule out those potentially life-threatening conditions first in order to preserve the health and well-being of the patient. Right?
A No.

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Q Okay. Tell me how you disagree with that.
A Well, you bring up -- if that were true, we would bring up scenarios that both would not be practical as well as potentially invasive and costly. So clinical decision-making has to be prudent first and foremost.
Q Okay. If you have in your differential diagnosis a potentially life-threatening condition, are you telling me then that it would not be appropriate to rule it out?
A No, I'm not saying that.
Q Okay, what are you saying?
A The issue is whether or not I'm going to put that diagnosis in my differential in the first place.
Q Okay. And that would be based on whether it would be costly to test for?
A Based on a number of scenarios. Not costly, per se. But if you're talking, what you said, potentially life-threatening diagnosis, that's, needs to be considered to be put in the differential diagnosis. There are many that are just not prudent, it's not -- not not practical, but they're not high in the radar, as we say.
Q Okay.
A With respect to likelihood given the

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information for that case.
You could not practice medicine if you're going to include 20 things on your differential diagnosis every day that you look at the patient. Because there's lots of things that could be potentially life threatening.
Q Okay. But if you have an infant in your neonatal unit that has anemia, and continues to have anemia throughout her course in your neonatal unit, and as of the time of her discharge shows a pattern that her hematocrit is continuing on the downward trend based on the last several CBC's that were done, and also has a very low and falling reticulocyte count, don't you think it would be important to get to the bottom of what was going on?
MR. COTTON: Form objection, argumentative, assumes facts not remotely in evidence.
Go ahead. Go ahead and answer if you can.
BY MS. CARMICHAEL:
Q You can answer.
A That assumes a lot of different things in this scenario. I would have to specifically look at the numbers you're referring to, to make a proper judgment about whether that's the case.
Q You, of course, know and understand that

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there are many different types of anemia? Yes?
A Yes.
Q And there are also many different causes for anemia? Yes?
A Yes.
Q Okay. And that notwithstanding in MayRose Hurst's case, it was assumed that her anemia was due to her prematurity. Is that your understanding?
A No, that's incorrect.
Q Okay. Correct me then.
A Like I mentioned before, anemia of prematurity in critically ill, very low birth weight, extreme low birth rate babies that have long hospitalizations is a diagnosis that's in the chart probably 90 to 100 percent of the time. So there's nothing surprising about that. But that doesn't explain other things that can happen to patients, specifically MayRose. So we have other reasons for her anemia and her choices that were made by clinicians to give her blood transfusions.
Q Okay. Do you dispute that the diagnosis of anemia due to prematurity appears throughout her medical chart?
A No.
Q You're just disagreeing with that diagnosis?

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A No. I'm saying that's not the reason necessarily that she received blood transfusions.
Q Well, in your opinion, did she or did she not have anemia due to prematurity?
A Yes.
Q She did?
A Yes.
Q Okay. A differential diagnosis regarding the cause of her anemia was never undertaken by your NICU staff, was it?
A Yes, it was.
Q In, in what way?
A Well, when you look at the day-to-day management of this patient, this child was reviewed in great detail by systems: Neurologic, respiratory, cardiovascular, fluids, nutrition, infectious diseases, hematology, renal, all these different systems on a day-to-day basis. And orders were written to take care of this child, maintaining the standard of care. So she got excellent care.
Q I'm talking about testing to determine what the cause of her anemia was. I'm not talking about, you know, what Doctor Scheidler did during his necrotizing enterocolitis surgery. I'm not talking about, you know, what Infectious Disease did to treat

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her sepsis. I'm talking about efforts, testing, efforts made to determine the cause of her anemia.
A We knew the cause of her anemia.
Q You knew she had Diamond-Blackfan anemia?
A No. But we knew the cause of her anemia.
Q Well, how can you say that when you -- well, let me ask you this: No efforts were made to conduct any testing to determine if she had a genetic blood disorder. Correct?
A There was a State screen.
Q By you and your staff, any --
A That's, that's done by state law. It's required.
Q In that test for thalassemia?
A Yes.
Q Does it test for Diamond-Blackfan anemia?
A It does not. It's too rare.
Q No tests were conducted of her bone marrow?
A No. That's very invasive to do that.
Q Okay. No efforts were made to bring in a hematologist to consult on the case. Correct?
A Maybe, maybe not. But from my perspective, I don't know of any indication to have a hematologist involved.
Q Okay. No outpatient follow-up with a

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hematologist was ever recommended. Correct?
A I didn't generate the discharge summary, but I looked at it and I didn't see it in there, that's correct.
Q Okay. No tests were conducted in the NICU to determine if her hemoglobin was abnormal. Correct?
A The State screen was done. Yeah, State screen, hemoglobin.
Q So there was no workup though on the cause of her anemia?
A It wasn't necessary. We knew the cause of her anemia.
Q Well, we've been through this before. You've testified you did not know she had Diamond-Blackfan anemia. Correct?
A That's correct.
Q Okay.
A But we know why she had anemia, nonetheless.
Q Maybe you knew of some contributing factors to anemia. But you did not know that she had bone marrow problems, did you?
A It didn't manifest with bone marrow failure.
Q Okay. Okay. Did you ever consider giving, I'm going to slaughter this word again, erythropoietin injections to MayRose?

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A No.
Q And why not?
A The use of EPO, as we call it, to make it easier --
Q I like that.
A -- fell out of significant use relative to what it was ten years ago because of high cost, its ineffectiveness, and third its association with significant eye disease.
Q Okay. You've said a couple of times that you -- we, we knew what the cause of her anemia was. So what, what was it that you knew? What was the cause of her anemia?
A There's two phases you want to break it down into.
Q Go ahead.
A The baby received 11 blood transfusions during the course of an 80-day hospitalization.
Q Uh-huh.
A And four of those, which is, what, 40 percent or so, were received within the first 72 hours. And we know why that is.
And now you've got seven blood transfusions in 77 days, if my math is correct, which for a baby that's only two and a half, a little more than two and

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a half pounds at birth, and only has this much blood volume to begin with, that's what I would refer to as typical and expected.
Q What about the low reticulocyte count? Is that typical, expected?
A Who said it's a low reticulocyte count?
Q Your lab values and your lab report.
A No, it didn't say that.
Q It didn't say that?
A No. No. That's a reference range. It doesn't say abnormal, normal, high. It's a reference range.
Q Okay.
A And those values were within the reference range.
Q Point five is within the reference range?
A In the low values.
Q Okay. And you know that only two weeks earlier it was .9. Right?
A That's correct.
Q So it fell from a .9 to .5 in two weeks. Is this something that would be anticipated and expected by you for a child like MayRose?
MR. COTTON: Form objection.
Go ahead and answer.

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THE WITNESS: We know that giving a blood transfusion suppresses endogenous erythropoietin production, which means they don't have reticulocytosis until the blood level goes down again. So it's expected that the hematocrit -- the retic count would be low.
BY MS. CARMICHAEL:
Q For about eight days after the transfusion. Right?
A I don't know.
Q You don't know?
A I'm not certain. It's a, it's a, it's a gradual process. So that's, so to be specific, I don't know.
Q Okay.
A It's not like all of a sudden the bone marrow starts making all these cells and the reticulocyte count might be normal. It's a gradual process.
Q Was it, is it -- I understand you weren't treating her there at the end. But knowing the information now, that on July 14 her reticulocyte count was .9, and on August 1 it was .5, is that kind of a decrease in that short amount of time, does that have any clinical significance to you?

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A I don't know.
Q You don't know. Might a hematologist know if that has clinical significance?
A The hematologist would say that it's expected.
Q A hematologist would say that that is expected?
A Yes. And that's consistent with published data of levels that go down to .2, .1, this kind of thing.
Q You're talking about in the face of blood transfusions?
A Not necessarily.
Q In the aftermath --
A No, it's what's called a nadir. The endogenous production of erythropoietin does not kick in, so to speak, until the nadir is reached, which may be a hematocrit of 20 to 22.
So the level of the reticulocyte count is expected to be on the lower side. Especially in the case of transfusions. So it doesn't have a great deal of, of meaning in signifying disease processes.
Q Okay. Well. Are you aware of types of anemia where the reticulocyte count would actually be high?

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A Yes.
Q Because of the anemia?
A Yes.
Q Okay. What, when does that occur?
A When you got rapid red blood cell destruction. Hemolysis, it's called.
Q Okay.
A And hemolysis occurs in a number of conditions.
Q Do you know whether or not MayRose's anemia was microcytic, normocytic, or macrocytic?
A Yes.
Q What was it?
A It was macrocytic which is consistent with prematurity. The MCV was high. But after multiple transfusions, because she was of course bleeding internally, then it becomes an impossible value to follow.
So this question is only relevant at the time of birth.
Q Are you familiar with medical literature that says that anemia due to prematurity is characterized by normocytic cells?
A There's lots of types of prematurity. There's a spectrum of prematurity. So you have to be

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specific when you ask that kind of question.
Q Okay. Are you aware that Diamond-Blackfan anemia, that macrocytic is consistent with Diamond-Blackfan anemia?
A Yes. Yes.
Q Okay. A low reticulocyte count is also potentially indicative of bone marrow disorders, or aplastic crisis, isn't it?
A That's a rare thing. It's not common.
MS. CARMICHAEL: Let's go ahead and mark that as 1.
(Plaintiffs' Exhibits 1 and 2 marked for identification.)
BY MS. CARMICHAEL:
Q Okay, Doctor Blahnik, Exhibit 2 to your deposition will be the Neonatal Admission History and Physical. Did you prepare this document?
A Yes.
Q Okay. It's my understanding that you were actually the admitting -- MayRose's admitting physician? Is that correct?
A I'm the admitting physician of record, yes.
Q Okay. In several places throughout the medical record, it refers to you as the attending physician as well. Was, was that your understanding

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of your role in MayRose's care?
A I was the physician of record. I was the neonatologist that was on the day the child was born.
Q Okay. Does that mean then that she's essentially your patient and you are going to follow her all the way through to discharge?
A Absolutely not.
Q Okay. Tell me what it means then to be the admitting physician?
A It's, it's required in the multiple NICU's where I've worked, there always must be an attending neonatologist as a physician of record.
The way it works at Sunrise, whether it's under the new medical director in Pediatrics, the old medical director at Children's Healthcare Network, or the NICU's I worked with when I was on faculty at USC, I've come across the same thing. There must be a physician of record at the time the child is admitted.
If a new neonatologist comes in the next day, technically, that should be changed. And the day after that. It would become a logistic secretarial nightmare to change 50 patients on an almost daily basis.
Now, when I was at Children's Hospital in Los Angeles, we would have an attending, as you call

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it, attending hematologist who might be on two weeks, three weeks, and maybe four weeks, once upon a time. We went through changing that by the secretary. But even they abandoned it because it's just too cumbersome to switch that name.

And in our practice where we may be on three days, four days, one day, two days, and multiple patients, to change the neonatologist physician of record for that day is not possible. So our medical director did the correct thing by just leaving it alone.

So it means nothing other than I admitted the patient that day. And the responsibility from one day to the next came upon the group.

Q Got it. Okay. So reviewing your neonatal admission history and physical for MayRose, it appears that she was born at 28 and 6/7 weeks. So one day short of being 29 weeks. Correct?

A Yes.

Q Okay. Tell me, in your experience and with your training, what is the viability generally of an infant of that age?

A In the 21st Century in this day and age?

Q Yes.

A It's very good.

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Q Okay.

A So when you mean viability, I assume you mean survival?

Q Yes.

A Yeah. So it's going to be 90 percent.

Q Okay. And when you look at her birth weight, the 1280 grams, is that, for a premature baby of her age, is that a fairly typical weight? Is it lower than you would expect for that age? Is it higher than you would expect?

A This is what we would call AGA, which is appropriate for gestational age.

Q Okay. All right. Knowing that -- well, were you present for the delivery of the baby?

A Yes.

Q Okay. You were standing by ready to address whatever issues she may have?

A Let me restate that. I'm not a hundred -- I remember that night. But I'm not a hundred percent sure I was actually at the delivery.

Our policy at the time was 27 weeks and younger the neonatologist would attend the delivery. We are always on -- this is at night, you know, just after midnight -- we're always on with either a hospitalist or a neonatal nurse practitioner. In this

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case, it was Katherine Felongco, if I remember correct.

It's entirely possible that she went to the delivery, brought the child down, called me, middle of the night kind of thing, and I came out of my call room, because I remember being by the bedside. But I don't want to misspeak and say I was actually at the C-section.

Q Okay. Fair enough. So knowing though that you were about to assume the care of a premature baby of this age, before we get specifically to MayRose's issues, what types of concerns or issues would you be anticipating in a child of this age?

A Again, we look at our children by systems. So there's neurologic, respiratory, cardiovascular, going down the line, head to toe, so to speak. And number one in this age group is, generally speaking is going to be the respiratory status.

Q Okay.

A Then we go through what we call A, B, C's, which is part of that airway, breathing, circulation, circulate, critical. That means is the heart doing what it's supposed to? If the lung is doing what it's supposed to, we can assist the lung, but we need to make sure the heart is as well. Receiving blood

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that's got oxygen in it, sending it to all the organs of the body to keep the child safe and protected. That's blood pressure, heart rate, acid base status, urine output, capillary refill, these types of things that are the way we approach it. Consider infection, of course. And whatever else might be relevant to the particular case at that time.

Q But the big ones at this age would be the respiratory, the circulation, and the infection issues?

A As a general rule, those are the major things. But we have cases that have very special circumstances based on the obstetrical history or the fetal history that can modify the priority.

Q Okay. And let me ask you, now that you bring that up. Before, before assuming care of MayRose, did you have an opportunity to get a prenatal history --

A No.

Q -- from any of the --

A No, the obstetrician --

MR. COTTON: You have to let her finish her question.

BY MS. CARMICHAEL:

Q Any of the mother's physicians?

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A No. The obstetrician did not call for a neonatal consult in this case, as far as I'm aware of.
Q Okay. Did you obtain that history later?
A We have some information, yes. You can see it in the history here.
Q Okay. Do you know how you came by that information?
A It, it comes with the, the baby from the OB nurses, they send down the obstetrical history, yes.
Q That the nurses have taken orally from the mother?
A No, it's in her chart.
Q Okay. Okay. Do you recall whether or not you spoke with Ms. Hurst's perinatologist at any point in time?
A I don't recall.
Q And do you recall whether or not you spoke with the Ob-Gyn at any point in time?
A I don't recall.
Q Okay --
A We had -- sorry. Can I answer? Just saying it's important.
Q Go ahead.
A We had a practice at the time with actually a sign-in book that the medical director wanted us to

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maintain, where admissions, all admissions to the NICU received a phone call -- given a phone call to the obstetrician after the delivery. It wouldn't happen necessarily that night, but like the next day or certainly when the surgery was required, to call the obstetrician and say this is what's going on with the baby.
Q Okay.
A We didn't, we weren't always perfect as a group, but, you know, we really strove to do a good job in keeping them updated.
Q Okay. And did you have, as you assumed the care of MayRose, did you have any knowledge regarding Tiffani Hurst's hospital course before the baby was born?
A Yeah, a little bit.
Q For example, did you have any knowledge of what medications had been administered to her prior to the C-section?
A Yes. You can see some of them I put in the note.
Q Where are you referring?
A Under, "Maternal diagnoses and procedures," there's Terbutaline, Indocin, and beta-methasone, that's the steroid.

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Q Okay. And the day after MayRose was delivered, bowel perforation was discovered. Did, did you believe that possibly the Indocin could have caused or contributed to that?
A Yeah, there's medical data that shows that.
Q Okay.
A In fact, the combination of indomethacin and cortical steroid is, is contraindicated in our world. And these are pregnancy risk factor drugs, cause bleeding.
Q Those drugs are contraindicated, when you say in your world, you mean, what do you mean?
A Neonatal world.
Q Okay.
A Yeah, they're known GI complications when those are used together. Indocin itself we know has an issue with platelets, bleeding. Of course, this is exactly what happened to MayRose.
Q Are you critical of the administration of those medications?
A I'm not an obstetrician.
Q And do you know what went into the decision-making as to why they were administered?
A Yes.
Q What was that?

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A Indocin is used as a tocolytic, and steroids are used to accelerate lung maturation.
Q Okay. But it's your position that the steroid and the tocolytic should not have been administered together, that they're contraindicated?
A They're, we don't use them in neonatology because of the risk for GI pathology. And I know that the FDA has warnings on the use of these medications during pregnancy because of these issues.
Q Okay. Okay. There's a coding summary in the chart that indicates that you, at some point you gave MayRose an influenza type B vaccination. How long does that vaccination last? How long is that good for?
A I'm not certain. I believe it's once per season. But it's possible that infectious disease in prematurity it's not as effective.
Q Okay. Okay. Did you ever speak with Mrs. Hurst about any of the testing that had been done during the prenatal period?
A What testing are you referring to?
Q She was tested for cystic fibrosis. The perinatologist had her do some chromosomal abnormality testing. Were you aware of --
A Oh, she's advanced maternal age, yeah. I

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don't recall.
Q Okay. Do you have an independent memory of MayRose?
A I remember the bed she was at. I remember she was very low birth weight, small baby.
Q Okay.
A And I remember her being sick. But I don't remember like what her face looked like, so to speak.
Q I'm sure you see a lot of baby faces between now and then.
A Yeah.
Q Okay. From your review of the record, what do you recall were May's issues when she was born?
A Well, one of the, you'll notice that the baby was intubated and received surfactant. So was on a respiratory and was getting this medicine for the lungs.
And then the breathing tube was pulled out fairly quickly. And if it was a colleague instead of me, they probably would have kept it in a little longer. Because I push the idea of early extubation. So that's my bias.
And then of course the next day she got really sick. That didn't come into play with, you know, obviously, her GI pathology. But that's what

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was going on. So we had, she was back on the respirator within that first day.
Q But it was not due to lung issues, it was due to her need to go to surgery. Right?
A That's incorrect. It was really both.
Q Okay.
A Yeah.
Q All right. So you had perhaps extubated her prematurely?
A You can say that in retrospect. It's okay, because the ventilator has risk factors to injuring the lung with inflation. So it's a good practice to get the tube out. There's nothing controversial about that.
Q Okay. Not taking issue with that.
What -- so you were telling me about her issues?
A Yes. The impressive thing about this case is a perforation through the bowel wall and necrotizing enterocolitis. So those two diagnoses she had in less than 24 hours from birth.
The impressive thing about that is that's not really how that disease really occurs. NEC is associated with feedings. MayRose was never fed. NEC is associated with after day ten, or two weeks, even

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three, four weeks. This is very early.
So I put it in the note, and that's my original thinking, especially because the hematocrit was on the low side, is this could be a gastric perforation. Isolated gastric perforation.
But that's not what it was. It was NEC.
And why is that? And so we have to go back to these medications. This combination that we don't use in neonatology. Both of these drugs readily cross the placenta. We know that. And so she was bleeding internally.
Q Okay. And that is what caused the NEC, the N-E-C?
A The, I don't know what caused it. But we know these are risk factors.
Q Okay.
A And the FDA has warnings about those drugs.
Q Okay. So --
A We would presume that that's, that's -- it's risk/benefit. There's benefits to stopping preterm labor. There's benefits to steroids. They do a great job in improving lung function, issues with the brain, and this kind of thing.
Q Okay.
A So it's a risk/benefit decision-making tree

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that, you know, the obstetrician was making.
Q Okay. What other issues were you aware of that May experienced during her stay in the NICU?
A Well, this one issue stands out. Because of the 11 transfusions, four of them occurred in the first 72 hours. And we know why. She was bleeding internally. And that stands out as being one of the most impressive things. Because it's unusual. NEC doesn't behave this way, like I said. Gastric perforations we know are an issue. But that's impressive.
And then after that what stands out in my mind is, you know, her critical status over and over.
Q For?
A Multiple medical problems.
Q Such as? Just keep going. Lay it out.
A Well, she had recurrent infections. She had --
Q What kind of infections?
A Rule out sepsis. Sometimes they couldn't prove it, but there was clinical symptoms and lab abnormalities. Line infections, possibly in, in the breathing tube, bacteria growing. Urine. I don't remember everything.
Q Okay. Taking you back to your rule out

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sepsis couldn't prove it statement. The NICU thoroughly tested her for bacteria, viruses, fungal causes for the sepsis. Correct?
A Let me put it this way: Preterm babies, very low birth weight, will undergo multiple sepsis workups during the course of their long hospitalization. That's expected. And it's not uncommon, despite blood tests and antibiotics, that we actually don't grow something out of the blood.
Q Well, in MayRose's case, you never did grow anything out of the blood. Correct?
A I don't remember.
Q Okay. You say though that she, there were lab values that were indicative of sepsis. You're referring to her elevated CRP?
A That's one thing.
Q Okay. And an elevated CRP indicates an inflammatory process?
A That may be, yes, that may be infectious or noninfectious.
Q Okay. All right. Okay. All right. Okay, so we've talked about the GI issues. We talked about the sepsis. Was there any, anything else of note that comes to your mind regarding MayRose's course in the NICU?

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A She had checks for retinopathy prematurity. She had feeding issues recurrently. I recall her heart function was an issue, where we had the cardiologist involved. Her lungs were always a concern. Her growth was a concern. And, of course, her hematologic system was always a concern. Her renal function, from what I recall, was good.
Q Okay. She -- now, as far as the cardiology consult goes, you did have a cardiologist consult, but he found her heart to be in good condition, didn't he?
A Yes.
Q Okay.
A From what I remember.
Q So she didn't have any cardiac issues, did she?
A Not that I remember.
Q Okay. You indicate her lungs were always a concern. She was, received some oxygen via nasal cannula. Correct?
A She received various forms of respiratory support.
Q Okay.
A Long term, yes.
Q Then you said her growth was always a concern. She gained weight and was discharged at a

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very satisfactory healthy weight, wasn't she?
A That's the way our group practices. I didn't do the discharge.
Q Okay.
A I know that that's how they practice.
Q Well, how was her growth a concern? Are you --
A Our growth.
Q -- indicating that she was not growing?
A Sorry. Our growth is always a concern in very low birth weight babies. It's a challenge to have them feed appropriately. So it takes a great deal of attention to care, to address their nutritional needs.
Q Okay. But you're not telling me that she wasn't growing properly?
A It's possible. I don't recall.
Q You don't know. Okay.
A It's not uncommon that we struggle with growth issues in very low birth weight babies that are critically ill.
MS. CARMICHAEL: Go ahead.
She's going to change the tape. If you would like to take a break, bathroom break.
THE VIDEOGRAPHER: The time is 3:27 p.m.

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This concludes digital tape number one. Off the record.
(A short break was taken.)
THE VIDEOGRAPHER: We're back on the record at 3:34 p.m. This begins digital tape number two.
You may proceed.
BY MS. CARMICHAEL:
Q Doctor Blahnik, following your admission of MayRose to the NICU, you, on May 14, you continued to treat her off and on as her neonatologist through to what date?
A I believe it was mid-July.
Q Okay. And I believe the last progress note I have from you is July 12 -- oh, excuse me, July 13. Does that sound right?
A Yes.
Q Okay. And do you have a memory of, without looking at your records, I mean do you have a sense of how she was doing during that timeframe, and her status when you ended your treatment of her?
A Yes.
Q Tell me what you remember.
A I remember that, you know, given her complicated history, she was lucky. Because she didn't have any interventricular hemorrhage in the

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brain.
She didn't have any eye disease, which is associated with very low birth weight babies, called retinopathy prematurity.
She didn't have bad BPD, which is bronchopulmonary dysplasia.
And even though she had multiple infections or concerns for infections on and off, she never went into septic shock, as an example. Or had infection in, in the brain, like a meningitis.
She struggled with feeds. I remember having recurrent feeding intolerance. But she was, you know, as far as I remember, she was growing quite well.
She had, you know, lots of issues, but was showing steady improvement.
Q Okay. And after your last, the last time that you prepared a NICU progress note on July 13, did you see MayRose after that?
A No, I was out of state, on vacation for three weeks.
Q Okay. And do you recall when you returned from vacation?
A I don't recall.
Q Okay. Do you, at any point in time did you review her discharge summary?

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A Not until the case.
Q Okay. Did you discuss with Doctor Piroozi, prior to the case being filed, did you ever discuss with him MayRose's discharge?
A No.
Q Did you ever review her labs after you returned from vacation? Did you take a look at her labs?
A No, she was discharged.
Q Okay. So you didn't, after July 13, you didn't look at her records, or review anything that the other NICU doctors had done?
A No.
Q Okay. Do you remember any of the conversations that you had with either her mother or father during the treatment -- the time that you provided care to her?
A I remember conversations. And I remember them being the way I treat all parents, you know, equally, sensitively, and that kind of thing, providing, you know, information about their baby's clinical status, and answering their questions.
Q Okay.
A That's how I approach all my families, with lots of experience, of course. There's nothing, few

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things, but not a great deal stands out with these parents. Obviously, they're educated people. That makes a difference in the nature of the conversations that we have with our, our families. It makes a difference what type of questions they may ask.
Q Okay. Anything else stand out about them? You noted they were educated. Do you remember anything else?
A About conversations?
Q Yes.
A No.
Q Okay. Do you remember one or both of them being extra inquisitive about what was going on?
A Well, MayRose's mother was there more than the father. I remember that.
Q Okay.
A They were there together. I don't remember the father being there alone. I remember her being there alone. But no.
Q Okay. Do you recall the father telling you about his thalassemia?
A No.
Q Okay. Do you --
A I remember the issue of the cystic fibrosis. That came up. But the thalassemia, that would have

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been something we would automatically get attuned to from the, the newborn screen. So it kind of happens blindly. A hundred percent of those cases must be done, they have to be documented by the State.
Q Do you have a memory of seeing that test result come back?
A Generally, we don't look at them unless they're abnormal.
Q Okay.
A It's in their record -- well, we do see them, but it gets in the medical record. At least based on the program we have now.
Q Is there someone that spearheads the, the screening for the thalassemia at the hospital?
A It's automatic that the nursing staff gets an order to test for the newborn screen on every single patient admitted to the NICU.
Q For example --
A That's State mandated.
Q Okay. For example, with regard to the CF test, there was a Doctor Michael Wall that kept coming up as, as far as, you know, asking that a follow-up CF test be done because of a, of a abnormal result, screening result.
Is there somebody like that who would be

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spearheading the thalassemia test?
A Yes, there's a, a State director of the newborn screening program. And rarely, when an, a unique finding is in the newborn screening they will call us, for a specific concern they will call us.
More commonly, especially in preterm babies, we get lots of false negatives. So repeat testing is necessary. Or sometimes it's even impossible to do the testing until later times.
Q Okay. Do you know who was in charge of that in '08 for the State?
A No. I don't know that person now.
Q Okay.
A All of those are uncommon diseases.
Q Okay. It's noted in MayRose's records that she had a normal suck, root and grasp. Is there any specific clinical significance that that would signify?
A That signifies that neurologically she would be intact, depending on her gestational age.
Q Okay. All right. And while you provided care to her, you didn't see any neurological abnormalities or things that would cause you concern about her neurologically, did you?
A I don't know. I know that her, from what I

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recall the studies of her brain, her head ultrasounds were okay. I don't recall her being on phenobarbital for seizures.
But the most common thing is head ultrasound early on in these types of admissions. That's routine looking for interventricular hemorrhage.
Q And there were two of them done early on, and both of them were normal. Is that your memory?
A I don't know. It's possible she had a grade one IVH, as we call it, which is germinal matrix hemorrhage. It generally speaking doesn't have significance.
But a grade three or grade four is something that I would know and would stick in my mind. And she didn't have those. Because those would have long-term significance for neural developmental defects.
Q Sure. And the germinal matrix finding was late in her NICU stay. It was the day before she went home.
But let me, let's just go through these, to be thorough. I thought there were two of them. Let's see. Okay.
(Plaintiffs' Exhibit 3 marked for identification.)
//

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BY MS. CARMICHAEL:
Q Okay, so Exhibit 3 is an ultrasound of the brain that was done on the day of her birth. And it appears that it was unremarkable or normal. Is that true?
A Yes. Yes.
Q Okay. And then -- find it.
(Plaintiffs' Exhibit 4 marked for identification.)
BY MS. CARMICHAEL:
Q Okay. And then Exhibit 4 is another ultrasound of the brain that I believe you ordered four days later. And again, there's no hemorrhage seen. Is that correct?
A Yes, I would call this a reassuring head ultrasound.
Q Okay, great.
(Plaintiffs' Exhibit 5 marked for identification.)
BY MS. CARMICHAEL:
Q Okay, and then on August 1, the day before her discharge, there was another follow-up head ultrasound done. And this is the one that shows the grade one germinal matrix bleed.
And did you say that a grade one is not

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concerning?
A That's correct.
Q Okay. And tell me why that is?
A There's data that say that it's not associated with any long-term neural developmental outcomes. But I would actually dispute this finding.
Q Why?
A Germinal matrix involutes quickly after birth, even in prematurity. There should be no germinal matrix.
Now, this is one of our best radiologists. So I would have to have a discussion with him about why he says that.
It may have been just what we call an incidental finding.
Q Okay.
A But by itself, grade one IVH just does not have long-term significance. So.
Q Okay. Great. Okay. And, let's see. It also indicates in that that it's subacute. There's no acute bleed going on. Correct?
A Correct.
Q All right.
A It may have been just a certain kind of shadowing of the, the technician who did it at the

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time. Because the radiologist, they read the studies. They're not there at the bedside.
Q Right. Okay. All right. Let's see.
(Plaintiffs' Exhibit 6 marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Blahnik, this next exhibit appears to be a developmental evaluation that was done by Physical Therapy, I believe.
A Extra copy. (Indicates.)
Q Oh, sorry.
On the day of her birth? Is that, does that seem right?
A No.
Q I was wondering about that. It's dated the date of her birth. And then it, you know -- I don't know.
A I, I think this is, if I could say. Go back to our original orders. It's part of the original orders to do a developmental evaluation.
Yes, consult Developmental Team. So that gets generated that way.
Q Okay.
A But the baby was too sick for this to be a relevant issue at that point.

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Q Okay. Well, at some point, it appears that the evaluation was conducted. Do you know when it might have been conducted?
A No, I don't know.
Q Okay. In any event, of the 30 -- let's see, not 30 -- of the various categories that they test, it appeared that she was appropriate for age with the exception of two of the items, being the suck, which was abnormal, and the, is that m-o-r-o-?
A Where are you looking? Moro, yes, okay.
Q Moro. Everything else appeared to be appropriate for age.
Do you recall reviewing this or being aware of this result?
A It, it depends if this was generated after or before when I went on vacation.
Q Okay. Based on --
A But I signed -- sorry. I signed it. It's not dated. But that may have been a signature that was generated and I had to go to Medical Records to sign. So that becomes hard to identify.
Q Okay. Based on the results, or the physical therapist's findings, what do you conclude?
A Well, this was a critically ill, very low birth weight baby that had multiple medical problems

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and was on a respirator for a significant period of time or had other respiratory issues. And that's relevant in being able to learn the suck/swallow reflex that's part of development, and often it can be delayed.
This is not only associated with her having recurrent feeding intolerance, but also being able to feed by bottle. You can put a tube in the tummy and you can tolerate feeds that way. But suck/swallow is a much more complex skill that can take a lot of time.
Q Okay.
A So I wouldn't be surprised that you would have this finding.
Q Okay. But do you have a memory of MayRose overcoming those issues and essentially becoming appropriate for age in those two areas?
A She would have to. Otherwise she couldn't go home.
Q Okay.
A At least with respect to suck. If that, if this is saying the baby, the child is unable to take by bottle.
Q Going back to your neonatal admission history and physical. It reports that her Apgar scores were three -- or excuse me, one -- no, three,

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six, and seven. Are those scores what you would expect to see from a 28-and-six-day preemie?
A There's no expectation. Baby could be born dead. Baby could be born with Apgars of eight and nine. Across the spectrum.
Q Okay.
A So there's no expectation, except for the worst.
Q Are those Apgars alarming to you?
A No. They're actually reassuring, because a three Apgar is quite low, telling me this child needs assistance. By five minutes, as long as we're six or higher, that tells us the resuscitation team did their job.
Q Great. Okay. And what is the clinical significance of a seven? Is that, is that a relatively good score at ten minutes?
A Yes, it's great. Especially for prematurity because they're neurologic tone is expected to be decreased. So they get points off for that already.
Q Okay.
A So that's a good, that's a good sign.
Q Okay. Thank you. All right.
As of the time that you stopped seeing MayRose, what were your expectations for her going

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forward?
A Well, we go back to, you know, her internal bleeding. She required an ostomy, surgeries, and all of that.
And she's lucky, and she didn't have significant bowel resection, where a lot of her GI tract had to be removed. It gets pretty scary to have what's called short gut syndrome. Sometimes they can't even survive.
And she didn't have bleeding into her brain. That was significant. That's a good sign.
She didn't have significant lung disease. That's a good sign.
So I think that the team group, you know, did a good job with this baby.
Q Would you have expected MayRose to be able to go on and, and -- well, would you, would you have expected that she would have had some developmental delays?
A It's always possible.
Q Okay.
A Prematurity is high risk by itself. There's no question. Especially when you're talking about this degree of prematurity, 1200 grams, only two and a half pounds. It's a small, small human being.

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Q And by developmental delays, tell me what you are meaning by that?
A Well, there's multiple things that they can have. They can develop cerebral palsy later on.
They can develop learning defects. Have poor growth. And the learning defects can be variable. They need to be followed potentially through a pediatrician through a developmentalist, if that's available.
Q I suppose they can also go on to have no problems?
A Yes.
Q Given what you saw in your treatment of MayRose up through July 13, did you have any specific expectations as far as she was concerned about what she would experience post discharge?
A I thought she would do okay.
Q Okay. I'm just going to ask you. On this -- let's see.
(Plaintiffs' Exhibit 7 marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Blahnik, Exhibit 7 to your deposition is the, the comprehensive lab report for MayRose's NICU stay. And I wanted to ask you if you could shed

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some light on a value for me.
If you would turn to page 57 of that report. And it's Bates numbered, let's see, so at the bottom it's 1083.
And down towards the bottom, do you see on the left-hand side where it says retic number? Retic number?
A Yes.
Q Do you know what those values, where they came from and what they mean?
A There's different dates here. Are you referring to a particular date?
Q The 8/1 date and the 7/14 date. Those two lab values. The reference range, the results. Do you understand, do you understand what those lab values are indicating?
A Yes. I think I do.
Q Okay.
A They're not usually reported that way. But I think this is just the precursor to what's finally reported. This is where they do the calculation.
Q Okay. This is where they're doing the calculation?
A I would assume so.
Q Okay. Well, according to the reference

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range they're providing, both results are indicated in the report as being low. Is that true?
A There's an "L" there. That doesn't say normal. It says reference.
Q Okay.
A Which I think is significant.
Q In what way? I mean if you look throughout this lab report, that's what they give you as reference ranges?
A Yeah. That means it needs to be interpreted in light of the clinical scenario you're dealing with. I would assume.
Q Do you have any understanding of why these results are being reported as low?
A Well, I wasn't involved with the patient at this point. That's 7/14 and 8/1. So I was never confronted with looking at these numbers.
Q Sure. And I understand that. I'm just wondering within your practice, as a neonatologist looking at these lab reports every day, if you can explain to me what this particular lab finding is indicating?
A It's telling the number of reticulocytes counted under a microscope by a technologist in the lab.

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Q Okay. And how then is that different from the, the retic, the retic results we have on a different page in here, I don't know that I can find that right away, of .9 and .5?
A Well, like I said, this is probably the calculation to get to that number.
Q But --
A This is the same date the retic counts were done.
Q Correct.
A And the same time. Right?
Q Yes. And you're saying it's probably the calculation. So does that mean you're unsure?
A That's correct. Because I'm not usually seeing them reported this way.
Q Okay.
A I know what they mean. They're reported as a percentage.
Q Okay. And you think that rather than being reported as a percentage, those are actually the number of cells they visualized?
A I'm not sure.
Q Okay.
A Talk to the lab.
MS. CARMICHAEL: Those are all the questions

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I have for you today. Thank you for your time.
MR. COTTON: Questions?
MS. URDAZ: None for me.
MS. LUCERO: None for me.
MR. COTTON: We'll read and sign.
THE VIDEOGRAPHER: This concludes the deposition. The time is 3:59 p.m. We're off the record.
(The deposition concluded at 3:59 p.m.)

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CERTIFICATE OF DEPONENT

PAGE LINE CHANGE

I, MARTIN JOSEPH BLAHNIK, M.D., deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my testimony in said action, that I have read, corrected, and do hereby affix my signature to said transcript.

MARTIN JOSEPH BLAHNIK, M.D.
Deponent

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REPORTER'S CERTIFICATE

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Karen Berry, a duly commissioned Notary Public, Clark County, State of Nevada, do hereby certify:
That I reported the taking of the deposition of the witness, MARTIN JOSEPH BLAHNIK, M.D., commencing on January 18, 2011, at 2:06 p.m.
That prior to being examined, the witness was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth.
That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate transcription of shorthand notes taken down at said time.
I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in my office in the County of Clark, State of Nevada, this ____ day of _____ 2012.

Karen J. Berry, CCR 836, RMR

EXHIBIT D

Patient: **Hurst, Mayrose**	DOB: **05/14/2008**	Date/Time: **12/19/2008 154**
Author: **Susan E Gallagher** (Fellow)	Service: **Rehabilitation**	Category: **D/C Summarie**

DISCHARGE SUMMARY

PATIENT NAME: Mayrose Hurst
ADMIT: 12/1/2008
DISCHARGE:
ATTENDING: Wilson,Pamela E.
REFERRING PHYSICIAN: Summerlin Hospital
PCP: Ralph M. Conti, M.D.

PRINCIPAL OR FINAL DIAGNOSIS: severe anoxic brain injury

SECONDARY DIAGNOSES: Red cell aplasia thought to be Diamond Blackfan

HISTORY OF PRESENT ILLNESS: Mayrose is a 7 month old female with a history of being an ex-28 week premie with an 82 day NICU course. Her neonatal course was complicated by NEC. She had a colostomy at 1 DOL which was then closed on 7-28-2008. She also had iron deficiency anemia and required multiple transfusions in the NICU. After her discharge, she continued to have issues with reflux and was receiving outpatient OT to work on reaching and midline control.

About a week prior to her admission to Summerlin hospital on 10-29-2008 she was fussy and thought to have constipation.On the day of admission became limp and lethargic and was brought to the ED, was intubated and given fluids via IO. Initial blood gas had a pH of <6.5 pCO2 of 22, pO2 98, bicarb of 10, BE 10. Initial head CT with no evidence of bleed. CBC remarkable for Hgb 1.8, Hct 5.7, WBC 15.6, ANC 126, plt 334. She was felt to be in anemic shock. Influenza B test was positive and was felt to have caused bone marrow suppression and she was felt to have SIRS. She was positive for enterobacter in her sputum and was treated with fluconazole and meropenem

Hematology consulted and bone marrow biopsy performed which showed acellular marrow.. She received 3 PRBC transfusions on 11-2-2008 and then got epo MWF while inpatient and was discharged on iron. Last CBC on 11-20-2008 had a Hct of 31.2 and retic count of 0.64. Initial hgb electrophoresis prior to transfusion showed alpha thalassemia but DNA studies were negative.

Most recent CT report on 11-14-2008 indicated by written report: Extensive infarctions. Gyral calcifications, suspect encephalitis as an etiology ans small calcific foreign body in left parietal scalp.

EEG on 11-15-2008 showed moderate diffuse slowing but was of poor technical quality

Seen by Optho on 11-23-2008 at Summerlin and no papilledema noted.

Swallow study on 11-7-2008 at OSH with swallow essentially WFL, no penetration, aspiration but did reflux, recommended reflux precautions.

She was felt to be medically stable and discharged from Summerlin. Her mother was interested in her having a full work up from a brain injury and rehabilitation standpoint. She drove here from Las Vegas and was medically cleared in the ED on 11-28-08 and then went to Ronald McDonald House with her 2 1/2 yo brother. Her mother and brother have both had some GI distress in the past 24 hours and Mayrose did vomit earlier on the day of admission. She has otherwise been tolerating her feeds and there has been no history of trauma.

EVALUATION AND MANAGEMENT:

FEN/GI: Mayrose took all nutrition by mouth and was determined to be swallowing safely by review of records and bedside eval. She had issues with reflux and was switched to Prevacid from Zantac and placed on Reglan four times a day. Her feeds were thickened with rice cereal and she required occasional prune juice for constipation. An upper GI was performed and no anatomic anomalies noted. Her reflux was improved though not resolved and she demonstrated good weight gain.
RESP: Blow by O2 provided during sleep and feeding for tachycardia due to anemia

EGC - Hurst
Denver Children's 0785

CV: Mayrose was tachycardic, more so as her hemaglobin would drop, but maintained hemodynamic instability
NEURO: MRI obtained upon admission showed Extensive encephalomalacia and abnormal signal throughout the brain in a watershed distribution, consistent with previous hypoxic injury and infarctions. Right subdural hematoma. Review of previous head CT from Summerlin Hospital by our Radiology department found the SDH was present up previous imaging. BAER showed Results are consistent with normal hearing sensitivity bilaterally in the frequency range important for speech understanding (500-4000 Hz). This does not preclude a hearing loss at discrete frequencies within or beyond that range. Opthalmology exam showed: Normal eye exam: Pt with normal fundus exam, No evidence of ROP. No retinal hemes, ONH appear well perfused, no onh edema. Mayrose was started on low dose of clonazepam with good improvement in irritability and spasticity, this will be continued upon discharge.

HEME: Mayrose was found to have had a substantial >10 point drop in Hct from her last CBC on 11-23-2008 until recheck upon admission without a source of bleeding and with a very low reticulocyte count. This prompted a very thorough investigation into a primary hematologic disorder, including review of records, repeat bone marrow biopsy, multiple labs and a Genetics consult. The result of this work up revealed a pure red cell aplasia likely secondary to Diamond Blackfan anemia (DBA). Her bone marrow biopsy revealed no erythroid precursors despite an elevated lev of erythrpoeitin. This likely signifies that her underproduction is not from a lack of stimulus but rather a lack of the rec cell line. The current plan from hematology at the time of discharge is:

1. We will follow up on outstanding labs including adenosine deaminase, which is usually elevated in DBA; however transfused blood can also lead to elevated levels. This lab was drawn at her Hb nadir, 13 days after most recent transfusion. .

2. Transfuse as needed for Hb less than 6, Hct less than 18. Transfuse sooner if there is evidence of cardiovascular compromise.

3. We will check with the blood back to determine if Mayrose is Kel negative as this is a common phenotype in Africa Americans and can set her up for alloimmunization in the setting of frequent transfusions. We would recommend minor antigen matched blood in the future (at our hospital this is known as the Sickle Cell protocol).

4. We appreciate Genetics input.

. Continue with biweekly Hb/Hct measurements, once weekly reticulocyte count.

6. We will continue to determine if the best course for Mayrose would be steroid treatment with the likely event that she will require HSCT for definitive cure. Unfortunately, Mayrose's brother is a half sibling, decreasing the likelihood he will be a match. Matched related donors entail the least number of HSCT complications, but we would certainly pursue unrelated matched cord blood donation.

REHAB: Intensive Physical, Occupational and Speech therapy
Physical therapy

Short term goal #1

Mayrose will remain calm with changes in positions

Today's progress:Mayrose calm throughout therapy session today.

Short term goal #2

Mayrose will bring hands to midline for hand to hand play

Today's progress: Hands to mouth today, with some calming ability. Minimal ability to interact with toys.

Short term goal #3

Mayrose will pick head up off chest in well supported sitting

Today's progress: Prefers to hold neck in flexion in supported sitting with tendency towards shoulder elevation, some intermittent neck extension when shoulders are down. Actively turning side to side.

Short term goal #4

(**yrose will lift head to turn face side to side in prone**

day's progress: Place prone on ball with intermittent ability to lift head and hold briefly.

Occupational therapy

Feeding: Mayrose nurses intermittently throughout the day, but also takes breast-milk thickened with rice cereal (for reflux) via the Dr. Brown's y-cut nipple (narrow shape). She does present episodes of spit up after most feedings due to reflux, but this has been improving over the past few weeks. There are no swallow safety concerns.

Developmental Skills: Mayrose has improved in her ability to visually fix and track on faces and objects. She requires moderate to maximum assistance to bat at objects or to hold objects in her hands. Mayrose is able to bring her hands to mouth with moderate assist at the shoulder girdle but with explore her hands with her lips and tongue. I prone, Mayrose is able to lift her head to either side and can briefly hold it up when upper body is supported in prone position. Mayrose continues to be somewhat fussy and enjoys being held and bounced, or provided with proprioceptive input.

Leisure/Play: Mayrose enjoys shiny, musical toys, as well as lighted toys. She interacts well with caregivers when in a calm, alert state.

Neuromotor/Sensory Function: Mayrose presents with slightly increased tone throughout upper extremities. Hands are both open and fisted at times during alert times, but are open when she is asleep. Passive ROM is WNL. Sensation appears grossly intact.

Cognitive/Behavioral Function: Mayrose, when alert and feeling well, has excellent periods of alertness and ability to interact for play. Mayrose can be fussy after feeds and typically calms when held during these times.

Visual Perceptual / Oculamotor: Tracking fairly consistently for faces and working on objects when in calm alert state. Vision will need to be monitored as she develops.

Speech therapy

Comprehension (Hearing, Auditory, Written): Mayrose has made significant gains during her inpatient stay. She is now demonstrating increased consistency in her responses to auditory stimuli. She is seeking her mother's voice and the voices of other caregivers by shifting her eye gaze more consistently and is beginning to occasionally turn her head toward a sound source. Mayrose is beginning to show a differing comprehension of 'friendly sounds' vs 'non-friendly' sounds by becoming more agitated with screaming, crying, etc that she hears in her environment. She calms with soothing voices. Mayrose had her hearing evaluated while she was here as an inpatient which revealed normal hearing sensitivity bilaterally.

Expressive Language (Spoken), Speech/Voice, Airway Status: Mayrose has increased her frequency and variability of vocalizations significantly. She is using primarily vocalic cooing at this time with occasional /m/ productions. She has increased her frequency of vocalizing when alert and happy and produces a variety of cries for differing reasons (mad, hungry, tired). Mayrose is beginning to attempt to imitate non-speech sounds such as tongue clicks.

Pragmatics: Mayrose makes and maintains eye contact with familiar speakers (mother, brother, therapists). She is beginning to turn her head to look when someone is talking to her. She smiles frequently with interaction and enjoys being cuddled.

Cognition: Play, Attention: Mayrose shows an interest in looking at shiny objects as well as toys that are high contrast (black and white). In addition, she shows an interest in light up toys. She is beginning to explore her fingers with her mouth and show an interest in oral play with textured toys and rattles. She has been observed x 1 to bat her hand at a toy. Mayrose has more interest in people and faces than objects at this time.

Oral Motor Skills, Swallowing Skills: Mayrose's oral structures appear intact and symmetrical. She receives her nutrition by breastfeeding and bottle-feeding. Her bottle feeds are thickened with rice cereal to assist with her severe reflux. Mayrose's reflux is being better managed since this admission, however continues to be a significant concern for her. Mayrose coordinates well with her bottle and when breast-feeding. She has a modified barium swallow study at her previous hospital, with no aspiration documented. Mayrose will need to be followed as her oral feeding skills progress on to purees and other textures when appropriate to provided support for her family.

Summary of labs
gb/Hct 12-1-2008 7/20.5, 12-2-2008 7.6/22.3, 12-4-2008 6.6/19.3, 12-5-2008 hct 27.2, 12-8-2008 9.5/27.6, 12-9-008 8.2/24, 12-12-2008 8.3/23.9, 12-15-2008 hct 17.7, 12-18-2008 hgb 8
Normal WBC and diff and Plt ct

Retic 12-01-2008 0.5, 12-04 -2008 0.37, 12-8-2008 0.29, 12-9-2008 0.12
Normal coags
Negative direct and indirect Coombs
Normal Thyroid studies
Normal lactate and pyruvate
Normal bilirubin
Normal BMP
Negative CMV, EBV , Hep B and C, and parvovirus

OPERATIVE PROCEDURES: 12-15-2008 PICC line placed

PENDING STUDIES: Serum Amino and Urine Organic acids, genetic testing for Diamond Blackfan and Fanconi's anemia

CONDITION ON DISCHARGE: Good

DISCHARGE MEDICATIONS AND TREATMENTS:

methadone (conc: 1mg/mL) oral solution 0.2 mg
lansoprazole (conc: 3mg/mL) oral suspension 4.55 mg
clonazepam (conc: 0.1mg/mL) oral suspension 0.09 mg
metoclopramide (conc: 5mg/5mL) oral syrup 0.45 mg

Physical, Occupational and Speech Therapies
Home health services for PICC line care
Home BBO2 while eating or sleeping

DISCHARGE DISPOSITION / FOLLOW UP:
Follow up with Dr Nik Abdul Rashid 12-22 or 23-2008 for CBC and to manage transfusion issues while in Las Vegas
Follow up with Hematology at TCH in 8 weeks for repeat bone marrow biopsy as scheduled by Dr Silliman on February 17, 2009
Follow up with Rehabilitation Medicine with Dr Wilson to coordinate with Hematology visit
Follow up visits with PT/OT and Speech to coordinate with appointment with Dr Wilson

Susan Gallagher M.D.
Pediatric Rehabilitation Fellow

The Children's Hospital

Affiliated with University of Colorado at Denver and Health Sciences Center

The Center for Cancer and Blood Disorders
13123 East 16th Ave.
Aurora, CO 80045
Notice of Hospital Admission

Date:	December 19, 2008	**Regarding:**	Mayrose Hurst
To:	Nik F. Abdul-Rashid, MD	**MRN:**	1219264
	Las Vegas, NV	**DOB:**	5/14/2008
	Fax# 702-688-6184	**AGE:**	7 month old
	Phone# 702-688-6180		

Dx: Pure red cell aplasia

Dear Dr. Rashid:

Thank you very much for helping us take care of Mayrose Hurst a 5 month old NICU graduate (ex 28 week gestation) with red cell aplasia most likely due to Diamond Blackfan anemia. We have been transfusion every 7-13 days for hemoglobins < 6.0 g/dl. Importantly, 13 days is the longest interval that she has maintained her hemoglobin > 6.0 g/dl. We have used split units from the same unit of packed red blood cells to minimize the exposure to different blood donors.

As you know, the bone marrow done here demonstrated red cell aplasia with only hematogones present and no red blood cell precursors. She has chromosomal breakage analysis pending to rule out Fanconi's anemia. Another bone marrow will be required and she is scheduled to have it done here in Denver on February 17th, 2009 in Propofol Clinic at the Center for Cancer and Blood Disorders here in Colorado with Dr. Taru Hays. At this time we will send the molecular tests for DBA to Children's Boston and to reassess if she still has oure red cell aplasia.

Mayrose also has significant Rehabilitation needs as outline in the discharge summary from the Rehab. Unit and will maintain all of her therapies.

Please do not hesitate to call us for any questions and thank you very much for all of your help in taking care of Mayrose. The clinic number here is 720-777-8357 and my pager is 303-851-4081.

Many thanks,

Christopher C Silliman, MD, PhD
Professor of Pediatrics and Surgery
School of Medicine
University of Colorado Denver
Associate medical Director
Bonfils Blood Center

Post-it® Fax Note 7671	Date	# of pages ▶ 2
To Dr. Lipman	From Taru	
Co./Dept.	Co.	
Phone # 715-343-1642	Phone # 727-6337	
Fax #	Fax #	

The Children's Hospital

Affiliated with University of Colorado at Denver and Health Sciences Center

Rehabilitation Discharge Instructions

Patient name: Mayrose Hurst
Medical Record Number: 1219264
Discharge Date: 12/19/08
Last Vital Signs: **BP 98/51 | Pulse 142 | Temp 99 | Resp 35 | Ht 57 cm | Wt 5.1 kg | HC 39.5 cm | SaO2 97%**

Additional Patient Information:
Immunizations:
Immunization History
palivizumab (SYNAGIS) *IM* inj
12/13/2008
Allergies:
no known allergies

When to call for help:
Call 911 if your child needs immediate help - for example, if they are having trouble breathing (working hard to breathe, making noises when breathing (grunting), not breathing, pausing when breathing, is pale or blue in color)

Poison Control 1-800-222-1222 (Deaf Access TTY 303-739-1127)

Call your primary care provider for:
- Fever greater than 101.3F
- Pain that is not well controlled by medication
- Poor food intake
- Decrease number of wet diapers
- Lethargy, or change in mental status
- Or with any other concerns

If you cannot reach your surgeon and your child's symptoms are worsening, please call:

- Your primary care provider - Ralph M. Conti, M.D.
- Nursing Hotline at 720-777-0123
- Or go to The Children's Hospital Emergency Department or the nearest Emergency Department in your area

Discharge Orders:

Discharge Procedure Orders
Home Oxygen

Order Specific Question	Answer	Comments
Diagnosis (required)	severe anemia	
Room air saturation (include date and result)	92% with hemoglobin of 5.5	

Discharge Instructions (continued)

PCP Name Ralph Conti,M.D.

PCP Phone Number 702 614 5437

Oxygen Flow Rate at Discharge (Lpm) 1/4 L

Oxygen Usage CONTINUOUSLY

Estimated length of need (maximum 6 months) 6 months

Oxygen Delivery Method NASAL CANNULA

Special Instructions while sleeping and feeding

Discharge Line Care

Order Comments: 1. No prefilled normal saline or heplock syringes.

2. No positive displacement machanical valve caps. Recommended system: Baxter Interlink Injection Site Cap # 2N3399 with B-D Interlink Threaded Lock Cannula # 303369 and B-D Interlink Vial Access Cannula # 303367.

Order Specific Question	*Answer*	*Comments*
Type of line	PICC	
Line care	ROUTINE PICC CARE (as needed)	PICC dressing last changed 12/19/2008. Cap last changed 12/18/08.

Discharge Follow-up Appointment

Order Specific Question	*Answer*	*Comments*
Follow-up appointment(s)	Dr Nik Abdul Rashid on Monday or Tuesday for CBC 702 688 6180	
Follow-up appointment(s)	Hematology at TCH for bone marrow biopsy in 8 weeks, appointment to be scheduled by Dr Silliman	
Follow-up appointment(s)	Rehabilitation medicine with Dr Wilson to coordinate with Hematology follow up	
Follow-up appointment(s)	Therapy update visit with PT/OT and Speech to coordinate with Dr Wilson's visit	

Discharge Activity

Discharge activity AS TOLERATED

Discharge Diet

Discharge diet REGULAR FOR AGE

Discharge Instructions

Order Comments: Please seek medical attention for any change in status

START taking these medications

Discharge Instructions (continued)

clonazepam 0.1 mg/ml SUSPENSION
0.9mL (0.09mg) by mouth twice a day. ***Last dose given 12/19/2008 at 8:30am. May give next dose at 8pm, then resume on following schedule:8am and 8pm***

lansoprazole 3 mg/ml SUSPENSION
1.5 mL (4.5mg) by mouth twice a day. ***last dose given 12/19/2008 at 8:30am. May give next dose at 8pm, then resume on the following schedule: 8am and 8 pm***

metoclopramide 5 MG/5ML ORAL SYRUP
0.45mL (0.45mg) by mouth four times a day. ***last dose given 12/19/2008 at 8:30am. May give next dose at 2 pm, 8pm, 2am.;then resume on following schedule: 8am, 2pm,8pm, 2 am (if already up for feed)***

CONTINUE these medications which have **NOT CHANGED**

METHADONE HCL INTENSOL ORAL
0.2 mg Oral twice day. ***Last dose given 12/19/2008 at 8:30 am. May give next dose at 8pm; then resume following schedule: 8am and 8pm.***

STOP taking these medications

REGLAN ORAL

ZANTAC ORAL

SEPTRA ORAL

IRON ORAL

albuterol (2.5 MG/3ML) 0.083% INH NEBU

Please be aware that pharmacies may use different concentrations of medications. Be sure to check with your pharmacist and the label on your prescription bottle for the appropriate amount of medication to give to your child.

Handouts explaining medicine use, precautions and safety tips discussed and given to caregiver: (yes)

Outpatient Therapies: mother to return to previous therapists until she finds new agencies.

The discharge instructions have been reviewed with the adult assuming responsibility for care of the patient and a printed copy was given to them on **12/18/08**. Their questions have been answered and they have stated that they will be able to provide the appropriate care.

Name of person receiving printed copy of discharge instructions: Tiffani Danielle Hurst
Relationship to patient: mother

RN Giving Instructions: Andrea C. Coffman

1219264 Mayrose Hurst

You may be receiving a follow-up phone call after you are discharged home. The call will be a phone survey to find out how we can continue to provide our families with excellent services. We know that

Discharge Instructions (continued)

your time is valuable but we would like you to take a few minutes to answer these questions. The Children's Hospital takes to heart all of the comments from our patients and families. Thank you!

EXHIBIT E

Marcus C. Hermansen, MD

August 28, 2012

Jacquelynn D. Carmichael, Esq.
Eisenberg and Gilchrist
215 South State Street, #900
Salt Lake City, UT 84111

Re: Hurst

Dear Ms. Carmichael:

I am a board certified Pediatrician and Neonatologist. I am licensed to practice medicine in the State of New Hampshire. I am the Medical Director of the Neonatal Intensive Care Unit at Southern New Hampshire Medical Center in Nashua, New Hampshire and am an Associate Professor of Pediatrics at Dartmouth Medical School. At your request I have reviewed the following materials:

- Medical records of Tiffani Hurst
  - prenatal records
  - Center for Maternal Fetal Medicine
  - Sunrise Hospital and Medical Center
- Medical records of MayRose Hurst
  - Sunrise Hospital and Medical Center
  - Foothills Pediatrics (Dr. Conti)
  - HCA Hospital Corporation of America (Admission of September 23, 2009)
  - Desert Radiologists (Brain MRI of September 30, 2008)
  - Summerlin Hospital (Admission of October 29, 2008)
  - Denver Children's Hospital (Admission of December 1, 2008)
  - Deposition of Martin Joseph Blahnik, MD
  - Deposition of Ralph Conti, MD
  - Deposition of Tiffani Hurst
  - Deposition of Ali Piroozi, MD

MayRose Hurst was born by C-section at 28 6/7 weeks gestation on May 14, 2008 at Sunrise Hospital. Her birth weight was 1280 grams and her Apgar scores were 3 and 6, at one and five minutes, respectively. During her stay in the Sunrise Neonatal Intensive Care Unit she

14 Gregg Road, Nashua, NH 03062 Phone: 603-883-5955 e-mail: DoubleThis@gmail.com

experienced numerous complications of prematurity including respiratory distress syndrome, apnea of prematurity, neonatal sepsis, retinopathy of prematurity, bowel perforation with pneumoperitoneum, and hyperbilirubinemia. Despite her numerous complications of prematurity she had no evidence of brain damage at the time of her discharge. (Footnote 1) MayRose was discharged on August 2, 2008 and "The family was instructed to call Dr. Conti for an appointment in 3 days."

MayRose suffered from anemia during her neonatal hospitalization and required multiple transfusions with packed red blood cells. (Footnote 2) Her hematocrit was 30.0% on August 1, 2008, just one day prior to her discharge. At that time her reticulocyte count was < 0.5%. On August 1 the progress notes indicate that a "Hct = 30%, Retic = 0.5%" with a plan to "monitor clinically, start Poly vi sol with iron." MayRose's diagnosis at discharge was "Anemia of prematurity (5/15/2008 – 7/21/2008)" and the plans included a "CBC, Dif, Retic 1 month after discharge." At the time of discharge she was taking 1 mL of Poly-Vi-Sol with iron daily.

Dr. Conti saw MayRose on August 5, 2008. The office note indicates that MayRose was taking no medications at that time; however, the note of September 9, 2008 indicates that she was taking "vitamins with iron." She was admitted to Summerlin Hospital in October 2008 with anemic shock with an admission hemoglobin of 1.5 mg/dL and a pH of 6.5. A brain CT on November 14 showed "multiple intracranial infarcts and calcifications secondary to hypoxemia" and MayRose was discharged with a diagnosis of hypoxic ischemic encephalopathy. She subsequently was treated at Denver Children's Hospital and diagnosed with "severe anoxic brain injury" and "red cell aplasia thought to be Diamond Blackfan."

Relative to MayRose's anemia, there were two primary departures from the standards of care by the neonatology providers at Sunrise Hospital. These departures were:

<u>Failure to recognize and evaluate the pathological aspect of MayRose's anemia:</u>

- The providers made a diagnosis of the relatively benign condition of "anemia of prematurity" for the period of May 15, 2008 through July 21, 2008. There is no other explanation for MayRose's anemia given and no alternative diagnoses offered. Interestingly, the diagnosis of "anemia of prematurity" is only given though July 21 and there is no explanation for her anemia or her need for blood transfusions after July 21.
- Few newborns born at 28 6/7 weeks gestation with "anemia of prematurity" require one transfusion. Fewer yet require a second transfusion. MayRose required eleven transfusions (!), yet the cause of this requirement was never investigated. While the early transfusions (those given within 72 hours of birth) were probably due to her immediate post-birth medical and surgical problems, as time went by it should have become apparent that another cause was in play. And clearly that cause was not simply "anemia of prematurity" – the diagnosis of "anemia of prematurity" was incorrect and improper.
- A thorough investigation of the problem was indicated and a consultation by a hematologist would have been helpful. Dr. Blahnik still does not acknowledge "any indication to have a hematologist involved" (deposition, page 41). Dr. Piroozi also feels

that "there was no reason for hematology consult at that time." (deposition, page 57) Once the neonatologists chose not to obtain a hematology consultation, then they assume the responsibility to conduct a hematology evaluation of the anemia themselves and they failed to do so.

- In deposition testimony Dr. Blahnik does not attribute all of MayRose's anemia to prematurity. He states there were "other reasons for her anemia" (deposition, page 39) and "we knew the cause of her anemia" (deposition, page 41). Dr. Blahnik attributes the transfusions in the first 72 hours of life to MayRose's initial medical/surgical problems, and her subsequent transfusions to "typical and expected" needs of a premature newborn. (deposition, pages 43-4) The number and volume of subsequent blood transfusions far exceeds those expected for any premature newborn and should not have been attributed simply to "prematurity of anemia."
- Dr. Piroozi feels that MayRose's "anemia wasn't unusual and different based on her condition, based on illnesses and critical condition that she had." (deposition, page 50) He attributes her anemia to more than just prematurity, attributing the problem to the fact that "basically she was a very critical newborn premature baby with multiple problems" (deposition, page 55). Dr. Piroozi felt that the lack of "profound anemia" was justification for a failure to evaluate for the cause of MayRose's anemia. (deposition page 68) However, Dr. Piroozi's logic is faulty – MayRose never had the opportunity to demonstrate "profound anemia" because of the numerous transfusions that were given. Had it not been for the multiple transfusions MayRose would have demonstrated "profound anemia".

<u>Inadequate discharge planning:</u>

- Even though MayRose was anemic and diagnosed with anemia of prematurity and required frequent blood transfusions, she was discharged with a plan to re-check her red blood cell counts (CBC) one month after discharge. This was extremely dangerous knowing that she was requiring transfusions as frequently as every two weeks (she was transfused 4 times in June and 3 times in July) and was discharged anemic with a hematocrit of 30.0% and had virtually no reticulocytes. (Footnote 3) It was predictable that she would be "due" for a transfusion in less than one month after discharge. Dr. Piroozi felt "the baby would be safe to get hematocrit and retic count within one month, considering the baby is going to be under supervision and care of pediatrician with close follow-up." (deposition, page 121-122). But there was no effort to inform the follow-up pediatrician, Dr. Conti, about the need for close follow-up. There was no communication by e-mail, by fax, or by telephone. The communication was left to the family and to a discharge summary, a discharge summary with incomplete and inaccurate information:
    - The discharge summary provided no indication that this infant's anemia needed to be followed closer than that of any other premature infant.
    - The discharge summary provided inaccurate information about the number of transfusions (5 vs. 11).
    - The discharge summary provided no information regarding the lack of reticulocytes on the day prior to discharge.

- The discharge summary implied that the last transfusion given was on June 22 and gave no indication of the three transfusions administered in July.
- The discharge summary provided a diagnosis of "anemia of prematurity" without any expressed concern for other possible causes of anemia.
- The discharge summary indicates that a blood count one month after discharge would constitute adequate follow-up.

The acts of negligence by the neonatologists at Sunrise Hospital caused MayRose to suffer delayed diagnosis and treatment of Blackfan-Diamond anemia.

My opinions are expressed to a reasonable degree of medical probability.

Sincerely,

Marcus C. Hermansen, MD

Footnote 1: A head ultrasound on May 14 was normal. A head ultrasound on May 18 was also normal. A head ultrasound on August 1 showed "new left germinal matrix hemorrhage, grade 1. This may be subacute." Dr. Blahnik acknowledges that a grade 1 hemorrhage "doesn't have significance." (deposition, pages 71-73) Dr. Piroozi was "concerned" about the hemorrhage (deposition, page 108) although he acknowledges that she had "an overall very good prognosis." (deposition, page 109) MayRose's discharge examination on August 2 showed "normal suck, symmetric Moro, good strength and tone." Her physical examination in Dr. Conti's office on August 5 showed a normal neurological examination. A brain MRI on September 30 was normal. Dr. Conti did make a determination of "static enceph" on his September 9 note, but gives no basis for that determination – the child had no subjective findings suggesting brain injury and had a normal neurological examination on September 9. It is unlikely that May Rose had suffered any brain damage at the time of Dr. Conti's assessment on September 9, 2008 and that all of her brain damage occurred at the time of her re-hospitalization for anemic shock.

Footnote 2: The discharge summary indicates "she was given 5 transfusions." Dr. Blahnik and Dr. Piroozi both testified that there were 11 red blood cell transfusions, a number of transfusions consistent with the Blood Bank records in the Laboratory Discharge Summary. Dr. Piroozi explains the discrepancy by blaming "the system and the data entry." (deposition, page 115)

Footnote 3: The progress notes indicated a reticulocyte count = 0.5% on August 1, 2008 although the laboratory print-out actually indicates "< 0.5%" (with a laboratory reference range

of 0.5-1.5%). In deposition testimony Dr. Blahnik acknowledges that low reticulocyte counts are consistent with Blackfan-Diamond anemia (deposition, page 35), but he believes that the value was "within the reference range" (deposition, page 44, lines 14-5) when it was actually less than the reference range. Dr. Piroozi felt the reticulocyte count was low (deposition, page 49 and 56) and started iron therapy in response to the low value (deposition, page 49). Dr. Piroozi is still under the belief that the reticulocyte count was 0.5 (deposition page 53, line 18) when it was actually less than 0.5.

EXHIBIT F

*** MED REC DISCHARGE REPORT ***

MEDICAL RECORDS COPY
08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY ***

Date / Time	08/01/08 0500		07/28/08 0415		07/27/08 0510		07/26/08 0330		Reference	Units
WBC			8.38		12.44		15.69	H	(6.00-13.32)	K/MM3
RBC			3.79		4.28		3.26	L	(3.45-4.75)	M/MM3
HGB			10.9		12.2		9.5	L	(10.0-13.4)	GM/DL
HCT	30.0		30.8		34.3		26.8	L	(29.5-37.1)	%
MCV			81		80		82		(72-84)	FL
MCH			28.8		28.5		29.1		(25.0-35.0)	PG
MCHC			35.4		35.6		35.4		(28.0-36.0)	G/DL
RDW			14.3		14.6		15.4		(13.0-18.0)	%
PLT			131	L	131	L	167		(150-450)	K/MM3
MPV			11.7		12.0		12.8	H	(9.4-12.4)	FL
SMEAR REVIEW					(A)		(B)			

(A) BLOOD SMEAR REVIEWED BY TECH.
(B) BLOOD SMEAR REVIEWED BY TECH.

Date / Time	-------07/24/08------- 1700		1025		07/21/08 0350		07/14/08 0345	Reference	Units
WBC	6.65		12.21		15.15	H		(6.00-13.32)	K/MM3
RBC	4.08		3.16	L	3.34	L		(3.45-4.75)	M/MM3
HGB	11.9		9.3	L	9.9	L		(10.0-13.4)	GM/DL
HCT	32.9		26.6	L	28.8	L	29.7	(29.5-37.1)	%
MCV	81		84		86	H		(72-84)	FL
MCH	29.2		29.4		29.6			(25.0-35.0)	PG
MCHC	36.2	H	35.0		34.4			(28.0-36.0)	G/DL
RDW	14.5		15.4		15.5			(13.0-18.0)	%
PLT	175		333		284			(150-450)	K/MM3
MPV	12.6	H	12.9	H	13.2	H		(9.4-12.4)	FL
NRBC #	0.00								K/MM3
SMEAR REVIEW			(C)						

(C) BLOOD SMEAR REVIEWED BY TECH.

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
3186 Maryland Pkwy
Las Vegas, Nevada 89109

LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

MEDICAL RECORDS COPY
08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)
COMPLETE BLOOD COUNT

Date / Time	07/07/08 0505		07/06/08 0507		07/05/08 0400		07/03/08 0530		Reference	Units
WBC	12.94		18.66	H	18.80	H	18.12	H	(7.05-14.99)	K/MM3
RBC	3.71		3.51		4.02	H	3.24		(2.93-3.87)	M/MM3
HGB	11.0		10.5		12.2		9.3		(9.2-12.4)	GM/DL
HCT	33.1		31.3		35.3	H	28.5		(27.7-35.1)	%
MCV	89	H	89	H	88		88		(72-88)	FL
MCH	29.6		29.9		30.3		28.7		(28.0-40.0)	PG
MCHC	33.2		33.5		34.6		32.6	L	(33.0-38.0)	G/DL
RDW	15.6		15.6		15.2		15.9		(13.0-18.0)	%
PLT	160		161		136	L	133	L	(150-450)	K/MM3
SMEAR REVIEW	(D)		(E)		(F)		(G)			

(D) BLOOD SMEAR REVIEWED BY TECH.
(E) BLOOD SMEAR REVIEWED BY TECH.
(F) BLOOD SMEAR REVIEWED BY TECH.
(G) BLOOD SMEAR REVIEWED BY TECH.

Date / Time	06/29/08 0415		06/27/08 0415		06/26/08 0415		06/25/08 0400		Reference	Units
WBC	17.58	H	15.05	H	15.99	H	8.04		(7.05-14.99)	K/MM3
RBC	4.22	H	4.19	H	4.43	H	3.59		(2.93-3.87)	M/MM3
HGB	12.3		12.4		13.1	H	10.4		(9.2-12.4)	GM/DL
HCT	36.3	H	35.9	H	38.2	H	31.8		(27.7-35.1)	%
MCV	86		86		86		89	H	(72-88)	FL
MCH	29.1		29.6		29.6		29.0		(28.0-40.0)	PG
MCHC	33.9		34.5		34.3		32.7	L	(33.0-38.0)	G/DL
RDW	16.3		16.0		15.7		16.0		(13.0-18.0)	%
PLT	145	L	160		128	L	219		(150-450)	K/MM3
MPV	12.6	H					13.2	H	(9.4-12.4)	FL
SMEAR REVIEW	(H)		(I)		(J)		(K)			

(H) BLOOD SMEAR REVIEWED BY TECH.
(I) BLOOD SMEAR REVIEWED BY TECH.
(J) BLOOD SMEAR REVIEWED BY TECH.
(K) BLOOD SMEAR REVIEWED BY TECH.

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
3186 Maryland Pkwy
Las Vegas, Nevada 89109

LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

COMPLETE BLOOD COUNT

Date / Time	06/24/08 0400		06/23/08 1700		06/23/08 0920		06/22/08 2130		Reference	Units
WBC	7.44		7.29		6.62(L)	L	5.26(L)	L	(7.05-14.99)	K/MM3
RBC	4.23	H	4.47	H	4.61	H	3.33		(2.93-3.87)	M/MM3
HGB	12.5	H	12.7	H	14.0	H	9.9		(9.2-12.4)	GM/DL
HCT	36.7	H	38.9	H	39.8	H	29.3		(27.7-35.1)	%
MCV	87		87		86		88		(72-88)	FL
MCH	29.6		28.4		30.4		29.7		(28.0-40.0)	PG
MCHC	34.1		32.6	L	35.2		33.8		(33.0-38.0)	G/DL
RDW	15.9		15.7		15.7		15.5		(13.0-18.0)	%
PLT	267		248		225		319		(150-450)	K/MM3
MPV	12.9	H	12.8	H	13.2	H	12.4		(9.4-12.4)	FL
SMEAR REVIEW	(M)		(N)		(O)		(P)			

(L) Please note: Hematology reference values have changed due to new instrumentation.

(M) BLOOD SMEAR REVIEWED BY TECH.
(N) BLOOD SMEAR REVIEWED BY TECH.
(O) BLOOD SMEAR REVIEWED BY TECH.
(P) BLOOD SMEAR REVIEWED BY TECH.

Date / Time	06/22/08 1515		06/19/08 0400		06/17/08 0200		06/16/08 0345		Reference	Units
WBC	7.08(Q)		7.09(Q)		6.08(Q)	L	7.14(Q)		(7.05-14.99)	K/MM3
RBC	3.52		3.58		3.70		4.01	H	(2.93-3.87)	M/MM3
HGB	10.5		10.6		11.1		11.9		(9.2-12.4)	GM/DL
HCT	30.9		31.8		31.5		33.7		(27.7-35.1)	%
MCV	88		89	H	85		84		(72-88)	FL
MCH	29.8		29.6		30.0		29.7		(28.0-40.0)	PG
MCHC	34.0		33.3		35.2		35.3		(33.0-38.0)	G/DL
RDW	15.6		15.9		15.8		15.3		(13.0-18.0)	%

(Q) Please note: Hematology reference values have changed due to new instrumentation.

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

COMPLETE BLOOD COUNT

Date / Time	06/22/08 1515	06/19/08 0400	06/17/08 0200	06/16/08 0345	Reference	Units
PLT	326(R)	207	226	168	(150-450)	K/MM3
MPV	13.3 H	13.1 H	13.6 H		(9.4-12.4)	FL
SMEAR REVIEW	(S)	(T)	(U)	(V)		

(R) RESULTS CONFIRMED ON REPEAT ANALYSIS

(S) BLOOD SMEAR REVIEWED BY TECH.
(T) BLOOD SMEAR REVIEWED BY TECH.
(U) BLOOD SMEAR REVIEWED BY TECH.
(V) BLOOD SMEAR REVIEWED BY TECH.

Date / Time	06/15/08 1010	06/14/08 0330	06/08/08 0530	06/07/08 0045	Reference	Units
WBC		(W)	9.60(X)	8.88(X)	(7.80-15.91)	K/MM3
WBC	9.14(Y)				(7.05-14.99)	K/MM3
RBC		3.25 L	3.61	2.64 L	(3.32-4.80)	M/MM3
RBC	2.81 L				(2.93-3.87)	M/MM3
HGB		9.4 L	10.8	7.9(Z) *L	(10.8-14.6)	GM/DL

(W) 11.97
See also (X)

(X) Please note: Hematology reference values have changed due to new instrumentation.

(Y) Please note: Hematology reference values have changed due to new instrumentation.

(Z) RESULTS CONFIRMED ON REPEAT ANALYSIS
Critical result(s) called on 06/07/08 at 0158 by DLAB.TRM1 have been verbally verified with DAWN LADUE,RN.

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

COMPLETE BLOOD COUNT

Date / Time	06/15/08 1010	06/14/08 0330	06/08/08 0530	06/07/08 0045	Reference	Units
HGB	8.2(AA) *L				(9.2-12.4)	GM/DL

(AA) RESULTS CONFIRMED ON REPEAT ANALYSIS
Critical result(s) called on 06/15/08 at 1037 by
DLAB.LDC have been verbally verified with KARLA CLARK,RN.

HCT					31.4	L	24.3	L	(32.0-44.5)	%
HCT	24.2	L	28.4						(27.7-35.1)	%
MCV			87		87		92		(86-110)	FL
MCV	86								(72-88)	FL
MCH			28.9	L	29.9	L	29.9	L	(33.0-39.0)	PG
MCH	29.2								(28.0-40.0)	PG
MCHC			33.1		34.4		32.5		(32.0-36.0)	G/DL
MCHC	33.9								(33.0-38.0)	G/DL
RDW	16.5		16.8		18.1	H	18.4	H	(13.0-18.0)	%
PLT	184		191		143	L	166		(150-450)	K/MM3
MPV	12.8	H			13.2	H	13.1	H	(7.4-10.4)	FL
SMEAR REVIEW	(AB)		(AC)		(AD)					

(AB) BLOOD SMEAR REVIEWED BY TECH.
(AC) BLOOD SMEAR REVIEWED BY TECH.
(AD) BLOOD SMEAR REVIEWED BY TECH.

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

COMPLETE BLOOD COUNT

Date / Time	06/02/08 0500		06/01/08 0530		05/31/08 0520		05/29/08 1950		Reference	Units
WBC	(AE)		(AG)		(AH)		(AI)		(7.80-15.91)	K/MM3
RBC	3.14	L	3.38		3.55		4.20		(3.32-4.80)	M/MM3
HGB	9.6	L	10.4	L	10.8		12.9		(10.8-14.6)	GM/DL
HCT	29.3	L	31.2	L	32.9		38.8		(32.0-44.5)	%
MCV	93		92		93		92		(86-110)	FL
MCH	30.6	L	30.8	L	30.4	L	30.7	L	(33.0-39.0)	PG
MCHC	32.8		33.3		32.8		33.2		(32.0-36.0)	G/DL
RDW	19.3	H	19.2	H	19.3	H	20.1	H	(13.0-18.0)	%
PLT	148	L	154		110	L	137	L	(150-450)	K/MM3
SMEAR REVIEW	(AJ)		(AK)				(AL)			

(AE) 8.71
See also (AF)
(AF) Please note: Hematology reference values have changed due to new instrumentation.
(AG) 9.44
See also (AF)
(AH) 9.19
See also (AF)
(AI) 11.58
See also (AF)

(AJ) BLOOD SMEAR REVIEWED BY TECH.
(AK) BLOOD SMEAR REVIEWED BY TECH.
(AL) BLOOD SMEAR REVIEWED BY TECH.

Date / Time	05/26/08 0400	05/24/08 0310	05/23/08 0200	05/20/08 0220	Reference	Units
WBC				10.6	(6.8-14.3)	K/MM3

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Las Vegas, Nevada 89109

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

COMPLETE BLOOD COUNT

Date / Time	05/26/08 0400		05/24/08 0310		05/23/08 0200		05/20/08 0220		Reference	Units
WBC	(AM)		(AO)	H	(AP)	H			(8.04-15.40)	K/MM3
RBC							4.86		(3.60-6.20)	M/MM3
RBC	4.48		4.93		5.13				(4.12-5.74)	M/MM3
HGB							15.5		(13.5-21.5)	GM/DL
HGB			15.6		16.3				(13.4-20.0)	GM/DL
HGB	14.1								(13.4-19.9)	GM/DL
HCT							44.1		(42.0-60.0)	%
HCT	41.6		45.2		46.9				(39.6-57.2)	%
MCV							91	L	(95-121)	FL
MCV	93	L	92	L	91	L			(95-125)	FL
MCH							31.9		(28.0-37.0)	PG
MCH	31.5	L	31.6	L	31.8	L			(33.0-39.0)	PG
MCHC							35.1		(32.0-37.0)	G/DL
MCHC	33.9		34.5		34.8				(32.0-36.0)	G/DL
RDW							16.1	H	(11.5-14.5)	%
RDW	21.3	H	21.6	H	21.5	H			(13.0-18.0)	%
PLT	117	L	112	L	91	L	94	L	(150-450)	K/MM3
MPV							8.5		(7.4-10.4)	FL
SMEAR REVIEW			(AQ)		(AR)					

(AM) 9.44
See also (AN)
(AN) Please note: Hematology reference values have changed due to new instrumentation.
(AO) 16.36 H
See also (AN)
(AP) 16.80 H
See also (AN)

(AQ) BLOOD SMEAR REVIEWED BY TECH.
(AR) BLOOD SMEAR REVIEWED BY TECH.

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

COMPLETE BLOOD COUNT

Date / Time	05/19/08 0000	05/18/08 0415	05/17/08 0350	05/16/08 0410	Reference	Units
WBC	5.7 L	5.3 L	4.2 L	3.9 L	(6.8-14.3)	K/MM3
CORRECTED WBC				3.4(AS) *L	(6.8-14.3)	K/MM3

(AS) NOTIFICATION NOT REQUIRED BECAUSE OF KNOWN PREVIOUS ABNORMAL RESULTS.

RBC	4.91	4.95	3.75	3.43 L	(3.60-6.20)	M/MM3
HGB			(AT) *L	(AU) *L	(14.5-22.5)	GM/DL

(AT) 12.0 *L
RESULTS CONFIRMED ON REPEAT ANALYSIS
Critical result(s) called on 05/17/08 at 0438 by
DLAB.TRM1 have been verbally verified with LAYLA MEJIA ,RN.

(AU) 11.5 *L
Critical result(s) called on 05/16/08 at 0521 by
DLAB.LCS have been verbally verified with WHITE,SHERLYN,RN.

HGB	15.6	(AV) D			(13.5-21.5)	GM/DL

(AV) 15.8 D
RESULTS CONFIRMED ON REPEAT ANALYSIS
Previous reported result: 15.8 GM/DL
Edited by: DLAB.TRM1 on 05/18/08:0455

HCT	45.8	45.1			(42.0-60.0)	%
HCT			34.6 L	32.5 L	(45.0-67.0)	%
MCV	93 L	91 L	92(AW) DL	95 L	(98-118)	FL

(AW) RESULTS CONFIRMED ON REPEAT ANALYSIS

MCH	31.8	32.0	32.0	33.6	(28.0-37.0)	PG
MCHC	34.1	35.0	34.7	35.4	(32.0-37.0)	G/DL
RDW	16.7 H	16.5 H	16.2 H	15.9 H	(11.5-14.5)	%
PLT	99 L	109 L	127 L	151	(150-450)	K/MM3
MPV	8.9	8.5	8.4	7.8	(7.4-10.4)	FL
NEUT %		44.0			(MEAN 45.0)	%
LYMPH %		37.4			(24.0-70.0)	%

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

COMPLETE BLOOD COUNT

Date / Time	05/19/08 0000	05/18/08 0415	05/17/08 0350	05/16/08 0410	Reference	Units
MONO %		17.1			(MEAN 9.0)	%
EOS %		1.1			(0.0-4.0)	%
BASO %		0.4			(0.0-2.0)	%
NEUT #		2.3			(1.5-10.0)	K/MM3
LYMPH #		2.0			(2.0-17.0)	K/MM3
MONO #		0.9			(0.0-2.0)	K/MM3
EOS #		0.1			(0.0-0.5)	K/MM3
BASO #		0.0			(0.0-0.2)	K/MM3

Date	05/15/08			05/14/08		
Time	1725	1135	0600	2005	Reference	Units
WBC	4.5 L	5.3 L	6.1 L	5.3 L	(9.0-38.0)	K/MM3
CORRECTED WBC	3.0(AX) *L	4.0 *L	5.0(AY) *L	4.2(AZ) *L	(9.0-38.0)	K/MM3

(AX) Critical result(s) called on 05/15/08 at 1952 by DLAB.MXC have been verbally verified with ,RN.CHARLENE CRUZ
(AY) NOTIFICATION NOT REQUIRED BECAUSE OF KNOWN PREVIOUS ABNORMAL RESULTS.
(AZ) NOTIFICATION NOT REQUIRED BECAUSE OF KNOWN PREVIOUS ABNORMAL RESULTS.

RBC	3.54 L	3.24 L	3.56 L	2.79 L	(3.60-6.20)	M/MM3

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

COMPLETE BLOOD COUNT

Date	05/15/08			05/14/08		
Time	1725	1135	0600	2005	Reference	Units
HGB	(BA) *L	(BB) *L	13.0 L	(BC) *L	(14.5-22.5)	GM/DL

(BA) 11.7 *L
Critical result(s) called on 05/15/08 at 1759 by DLAB.LCT have been verbally verified with CHARLENE CRUZ ,RN.
RESULTS CONFIRMED ON REPEAT ANALYSIS

(BB) 11.6 *L
RESULTS CONFIRMED ON REPEAT ANALYSIS
Critical result(s) called on 05/15/08 at 1217 by DLAB.RDM have been verbally verified with CHARLEEN CRUZ,RN.

(BC) 10.9 *L
NOTIFICATION NOT REQUIRED BECAUSE OF KNOWN PREVIOUS ABNORMAL RESULTS.

HCT	34.1 L	33.3 L	36.5 L	31.0 L	(42.0-60.0)	%
MCV	96 DL	103	103(BD) D	111 D	(98-118)	FL

(BD) QNS FOR REPEAT

MCH	32.9	35.7	36.6	39.1 H	(28.0-37.0)	PG
MCHC	34.3	34.7	35.6	35.1	(32.0-37.0)	G/DL
RDW	16.3 H	32.3 H	32.2 H	32.1 H	(11.5-14.5)	%
PLT	157	229(BE) D	131 L	135 L	(150-450)	K/MM3

(BE) RESULTS CONFIRMED ON REPEAT ANALYSIS

MPV	8.2	8.0	8.0	7.6	(7.4-10.4)	FL

Date	05/14/08				
Time	1830	0515	0100	Reference	Units
WBC	4.8 L	4.7 L	5.6 L	(9.0-38.0)	K/MM3

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

COMPLETE BLOOD COUNT

Date	05/14/08					
Time	1830	0515	0100		Reference	Units
CORRECTED WBC	4.5(BF) *L	3.8(BG) *L	4.4(BH) *L		(9.0-38.0)	K/MM3

(BF) Critical result(s) called on 05/14/08 at 2029 by DLAB.PLT have been verbally verified with ,RN.MARILYN MONTGOMERY

(BG) NOTIFICATION NOT REQUIRED BECAUSE OF KNOWN PREVIOUS ABNORMAL RESULTS.

(BH) Critical result(s) called on 05/14/08 at 0237 by DLAB.GAD have been verbally verified with DIANE REESE,RN.

RBC	2.74	L	2.06	L	2.06	L		(3.60-6.20)	M/MM3
HGB	(BI)	*L	9.3(BJ)	*L	9.6(BK)	*L		(14.5-22.5)	GM/DL

(BI) 10.7 *L
NOTIFICATION NOT REQUIRED BECAUSE OF KNOWN PREVIOUS ABNORMAL RESULTS.

(BJ) NOTIFICATION NOT REQUIRED BECAUSE OF KNOWN PREVIOUS ABNORMAL RESULTS.

(BK) Critical result(s) called on 05/14/08 at 0137 by DLAB.ANQ have been verbally verified with JENNIFER DENSLEY ,RN.

HCT	31.2	L	26.8	L	27.4	L		(42.0-60.0)	%
MCV	114	D	130	DH	133	H		(98-118)	FL
MCH	38.9	H	45.2	H	46.5	H		(28.0-37.0)	PG
MCHC	34.2		34.8		34.9			(32.0-37.0)	G/DL
RDW	31.4	H	17.4	H	16.6	H		(11.5-14.5)	%
PLT	129	L	167		176			(150-450)	K/MM3
MPV	7.6		7.6		7.7			(7.4-10.4)	FL

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
3186 Maryland Pkwy
Las Vegas, Nevada 89109

LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

DIFFERENTIAL

Date / Time	07/28/08 0415	07/27/08 0510	07/26/08 0330	07/24/08 1700	Reference	Units
NEUTROPHILS	43	48	70	41		%
BANDS	5 H		2	2	(0-4)	%
LYMPHS	51	50	22	48		%
MONOS	1	2	6	9		%
EOS	0	0	0	0		%
BASOS	0	0	0	0		%
RBC MORPH		NORMAL	NORMAL	NORMAL		
PLT ESTIMATE	(BL)	NORMAL		NORMAL		
PLT MORPHOLOGY		NORMAL				

(BL) DECREASED

Date / Time	07/24/08 1025	07/21/08 0350	07/07/08 0505	07/06/08 0507	Reference	Units
NEUTROPHILS	22	41	46	72		%
LYMPHS	61	47	43	21		%
MONOS	16	12	11	6		%
EOS	0	0	0	1		%
BASOS	1	0	0	0		%
RBC MORPH			NORMAL	NORMAL		
POIKILOCYTOSIS	2+					
PLT ESTIMATE	NORMAL	NORMAL	NORMAL			
PLT MORPHOLOGY		GIANT	GIANT			

Date / Time	07/05/08 0400	07/03/08 0530	06/29/08 0415	06/27/08 0415	Reference	Units
NEUTROPHILS	68	57	52	22		%
BANDS				6 H	(0-4)	%
LYMPHS	25	40	43	55		%
VARIANT LYMPHS				1		%
MONOS	7	3	5	16		%
EOS	0	0	0	0		%

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

DIFFERENTIAL

Date / Time	07/05/08 0400	07/03/08 0530	06/29/08 0415	06/27/08 0415	Reference	Units
BASOS	0	0	0	0		%
RBC MORPH	NORMAL	(BM)	NORMAL			
TARGET CELLS				PRESENT		
STOMATOCYTES				PRESENT		
PLT ESTIMATE		(BN)		NORMAL		

(BM) DIMORPHIC POPULATION

(BN) DECREASED

Date / Time	06/26/08 0415	06/25/08 0400	06/24/08 0400	06/23/08 1700	Reference	Units
NEUTROPHILS	7	5	22	7		%
BANDS	9 H	6 H		16 H	(0-4)	%
LYMPHS	57	54	65	44		%
MONOS	25	35	13	33		%
EOS	0	0	0	0		%
BASOS	0	0	0	0		%
METAMYELOCYTES	1					%
MYELOCYTES	1					%
RBC MORPH			NORMAL	NORMAL		
POIKILOCYTOSIS		2+				
TARGET CELLS	PRESENT					
PLT ESTIMATE	(BO)	NORMAL		NORMAL		
PLT MORPHOLOGY	GIANT	GIANT		GIANT		

(BO) DECREASED

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

DIFFERENTIAL

Date / Time	06/23/08 0920		-------06/22/08------- 2130		1515		06/19/08 0400		Reference	Units
NEUTROPHILS	25		29		33		15			%
BANDS	17	H	14	H	12	H	5	H	(0-4)	%
LYMPHS	45		42		38		68			%
VARIANT LYMPHS	1									%
MONOS	12		15		16		12			%
EOS	0		0		0		0			%
BASOS	0		0		0		0			%
METAMYELOCYTES					1					%
POLYCHROMASIA			1+							
MACROCYTOSIS	1+									
TARGET CELLS							PRESENT			
OVALOCYTES							PRESENT			
PLT ESTIMATE	NORMAL		NORMAL		NORMAL		NORMAL			
PLT MORPHOLOGY	GIANT		GIANT		GIANT					

Date / Time	06/17/08 0200	06/16/08 0345	06/15/08 1010	06/14/08 0330	Reference	Units
NEUTROPHILS	18	22	32	49		%
BANDS		2	8		(0-4)	%
LYMPHS	74	62	47	43		%
MONOS	7	14	13	7		%
EOS	1		0	1		%
BASOS	0		0	0		%
RBC MORPH				NORMAL		
HYPOCHROMIA	1+		1+			
OVALOCYTES		PRESENT				
HELMET CELLS		PRESENT				
PLT ESTIMATE	NORMAL	NORMAL	NORMAL			
PLT MORPHOLOGY	GIANT	GIANT	NORMAL			

Pt Name: HURST,BG-TIFFANI
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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (Continued)

DIFFERENTIAL

Date / Time	06/08/08 0530	06/07/08 0045	06/02/08 0500	06/01/08 0530	Reference	Units
NEUTROPHILS	40	25	23	30		%
BANDS			1		(0-8)	%
LYMPHS	49	67	57	55		%
MONOS	9	7	13	14		%
EOS	2	1	6	1		%
BASOS	0	0	0	0		%
HYPOCHROMIA		1+	1+	1+		
TARGET CELLS			PRESENT			
STOMATOCYTES		PRESENT				
PLT MORPHOLOGY			GIANT	GIANT		
PLT CLUMPS				PRESENT		

Date / Time	05/31/08 0520	05/29/08 1950	05/26/08 0400	05/24/08 0310	Reference	Units
NEUTROPHILS	22	35	58	60		%
BANDS	4	8		1	(0-8)	%
LYMPHS	59	42	29	28		%
ATYPICAL LYMPHS				1		%
MONOS	15	14	12	10		%
EOS	0	1	1	0		%
BASOS	0	0	1	0		%
POLYCHROMASIA	1+		1+			
MACROCYTOSIS	1+					
TARGET CELLS	PRESENT					
OVALOCYTES				PRESENT		
PLT ESTIMATE	(BP)					

(BP) DECREASED

PLT MORPHOLOGY	GIANT	GIANT	GIANT	GIANT	

Pt Name: HURST,BG-TIFFANI
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Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

DIFFERENTIAL

Date / Time	05/23/08 0200	05/20/08 0220	05/19/08 0000	05/18/08 0415	Reference	Units
CELLS COUNTED		100	100	100		#CELLS
NEUTROPHILS	66	45	34	34		%
BANDS	3	5		2	(0-8)	%
LYMPHS	22	49	54	49		%
MONOS	9	1	10	12		%
EOS	0		2	3		%
BASOS	0					%
NUCLEATED RBCS	1 H			5 H	(0-0)	/100WBCS
RBC MORPH		(BQ)	NORMAL	(BR)		

(BQ) ANISOCYTOSIS 1+
(BR) ANISOCYTOSIS 1+, POLYCHROMASIA 1+

PLT ESTIMATE	(BS)					

(BS) DECREASED

PLT MORPHOLOGY	GIANT	(BT)	(BU)	(BV)		

(BT) DECREASED COUNT
(BU) DECREASED COUNT
(BV) DECREASED COUNT

Date / Time	05/17/08 0350	05/16/08 0410	-------05/15/08------- 1725	1135	Reference	Units
CELLS COUNTED	100	100	100	100		#CELLS
NEUTROPHILS	56	61	55	42		%
BANDS	5		3	6	(0-8)	%
LYMPHS	34	34	33	36		%
MONOS	4	4	7	13		%
EOS	1	1	1			%
METAMYELOCYTES			1	2		%
MYELOCYTES				1		%
NUCLEATED RBCS	2 H	14 H	48 H	34 H	(0-0)	/100WBCS

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

DIFFERENTIAL

Date / Time	05/17/08 0350	05/16/08 0410	05/15/08 1725	05/15/08 1135	Reference	Units
RBC MORPH	(BW)	(BX)	(BY)	(BZ)		

(BW) ANISOCYTOSIS 1+, POLYCHROMASIA 1+
(BX) ANISOCYTOSIS 1+, POLYCHROMASIA 1+
(BY) ANISOCYTOSIS 1+, POLYCHROMASIA 1+
(BZ) ANISOCYTOSIS 3+, MACROCYTOSIS 1+, POLYCHROMASIA 1+

PLT MORPHOLOGY	(CA)	(CB)	(CC)	(CD)		

(CA) DECREASED COUNT
(CB) NORMAL COUNT
(CC) NORMAL COUNT
LARGE AND GIANT PLATELETS NOTED
(CD) NORMAL COUNT

Date / Time	05/15/08 0600	05/14/08 2005	05/14/08 1830	05/14/08 0515	Reference	Units
CELLS COUNTED	100	100	100	100		#CELLS
NEUTROPHILS	39	38	35	62		%
BANDS	7	1	3	3	(0-8)	%
LYMPHS	43	48	48	26		%
ATYPICAL LYMPHS				1		%
MONOS	11	11	10	8		%
EOS			1			%
METAMYELOCYTES		2	3			%
NUCLEATED RBCS	22 H	27 H	6 H	25 H	(0-0)	/100WBCS
RBC MORPH	(CE)	(CF)	(CG)	(CH)		

(CE) ANISOCYTOSIS 3+, MACROCYTOSIS 1+, POLYCHROMASIA 1+
(CF) ANISOCYTOSIS 2+, MACROCYTOSIS 3+, POLYCHROMASIA 1+,
ACANTHOCYTES 1+, POIKILOCYTOSIS 1+
(CG) ANISOCYTOSIS 2+, MACROCYTOSIS 3+, POLYCHROMASIA 1+,
BURR CELLS 1+
(CH) ANISOCYTOSIS 1+, MACROCYTOSIS 3+, POLYCHROMASIA 1+

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

DIFFERENTIAL

Date	05/15/08	05/14/08				
Time	0600	2005	1830	0515	Reference	Units
PLT MORPHOLOGY	(CI)	(CJ)	(CK)	(CL)		

(CI) DECREASED COUNT
(CJ) DECREASED COUNT
PLATELET CLUMPS NOTED
(CK) DECREASED COUNT
(CL) NORMAL COUNT

Date	05/14/08					
Time	0100				Reference	Units
CELLS COUNTED	100					#CELLS
NEUTROPHILS	10					%
LYMPHS	81					%
ATYPICAL LYMPHS	1					%
MONOS	8					%
NUCLEATED RBCS	28 H				(0-0)	/100WBCS
RBC MORPH	(CM)					

(CM) MACROCYTOSIS 3+, POLYCHROMASIA 1+, ANISOCYTOSIS 1+,
POIKILOCYTOSIS 1+, SCHISTOCYTES 1+

PLT MORPHOLOGY	(CN)				

(CN) LARGE PLATELETS 1+

CBC PATH INTERP	(CO)				

(CO) Pathologist review agrees with CBC and differential as reported. Prematurity and presence of many reticulocytes likely explain the high MCV. Clinical correlation is required.
INTERPRETATION (Rivera-Begeman,A. DO)

Pt Name: HURST,BG-TIFFANI
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Pt Name: HURST,BG-TIFFANI D.2033-0

*** HEMATOLOGY *** (continued)

ROUTINE HEMATOLOGY

Date / Time	08/01/08 0500		07/14/08 0345	07/06/08 0507	Reference	Units
SED RATE				4	(0-15)	MM/HR
RETIC COUNT	<0.5	L	0.9		(0.5-1.5)	%

MISCELLANEOUS HEMATOLOGY

Date / Time	07/03/08 2030	Reference	Units
POLY SOURCE	FECES		
POLY/HPF	NONE SEEN		\HPF

Pt Name: HURST,BG-TIFFANI
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Pt Name: HURST,BG-TIFFANI D.2033-0

*** COAGULATION ***

ROUTINE COAGULATION

Date / Time	07/01/08 0300	06/29/08 2300	05/15/08 0820	Reference	Units
PLT		122 L		(150-450)	K/MM3
PROTIME			11.8(CP)	(11.6-14.4)	SECONDS

(CP) PT and aPTT values for preterm newborns may be 20% higher than than the stated upper reference limit.

PROTIME	10.7			(10.5-13.4)	SECONDS
INR			1.2	(1.2-1.4)	
INR	1.1			(1.1-1.3)	
PTT			53 H	(30-45)	SECONDS
PTT	36			(23-40)	SECONDS
FIBRINOGEN			250	(150-375)	MG/DL
FIBRINOGEN	280			(150-400)	MG/DL
D-DIMER			0.43	(0.43-2.69)	MG/L FEU

*** CHEMISTRY ***

ROUTINE CHEMISTRY

Date / Time	08/01/08 0441	07/30/08 0455	07/30/08 0438	07/28/08 0725	Reference	Units
NA		137			(136-145)	MMOL/L
K		5.1			(4.1-5.3)	MMOL/L
CL		110 H			(98-107)	MMOL/L
CO2		21 L			(22-31)	MMOL/L
ANION GAP		11			(9-18)	MMOL/L
GLUCOSE RANDOM		86			(70-139)	MG/DL
GLUCOSE METER	78(a)		101(a)	92(a)	(70-110)	MG/DL
BUN		10			(7-18)	MG/DL
CREATININE		0.18 L			(0.60-1.20)	MG/DL
CALCIUM		9.2			(8.8-11.2)	MG/DL

NOTES: (a) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	-------07/28/08-------				-------07/27/08-------			
Time	0415		0356	0400	0400		Reference	Units
NA	134	L			133	L	(136-145)	MMOL/L
K	3.1	L			3.5	L	(4.1-5.3)	MMOL/L
CL	100				98		(98-107)	MMOL/L
CO2	27				26		(22-31)	MMOL/L
ANION GAP	10				13		(9-18)	MMOL/L
GLUCOSE RANDOM	82				84		(70-139)	MG/DL
GLUCOSE METER			88(b)	98(b)			(70-110)	MG/DL
BUN	11				12		(7-18)	MG/DL
CREATININE	0.19	L			0.19	L	(0.60-1.20)	MG/DL
TOTAL PROTEIN	4.0						(4.0-7.6)	GM/DL
ALBUMIN	1.9	L					(2.3-4.7)	GM/DL
A/G RATIO	0.9	L					(1.7-2.2)	
CALCIUM	8.7	L			9.1		(8.8-11.2)	MG/DL
PHOSPHORUS	5.2	H					(2.5-4.9)	MG/DL
TOTAL BILIRUBIN	2.82	H					(0.10-1.00)	MG/DL
UNCONJ BILI	(CQ)							MG/DL

(CQ) 0.99
See also (CR)
(CR) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

CONJ BILI	(CS)							MG/DL

(CS) 1.83
See also (CT)
(CT) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

SGOT/AST	40	H					(3-37)	U/L
SGPT/ALT	42						(13-65)	U/L
TOTAL ALK PHOS	338						(118-354)	U/L
MAGNESIUM	1.6	L					(1.8-2.4)	MG/DL
TRIGLYCERIDES	70						(35-125)	MG/DL

NOTES: (b) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	07/26/08							
Time	1302	1001	0330		0312		Reference	Units
NA			132	L			(136-145)	MMOL/L
K			4.7				(4.1-5.3)	MMOL/L
CL			103				(98-107)	MMOL/L
CO2			21	L			(22-31)	MMOL/L
ANION GAP			13				(9-18)	MMOL/L
GLUCOSE RANDOM			100				(70-139)	MG/DL
GLUCOSE METER	110(c)	90(c)			126(c)	H	(70-110)	MG/DL
BUN			13				(7-18)	MG/DL
CREATININE			0.22	L			(0.60-1.20)	MG/DL
CALCIUM			8.5	L			(8.8-11.2)	MG/DL

Date	07/25/08							
Time	2251	1417	1115		1113		Reference	Units
GLUCOSE METER	131(c)	H 150(c)	H 157(c)	H	48(c)	L	(70-110)	MG/DL

Date	07/25/08		07/24/08		Reference	Units
Time	0339	0337	2347	2346		
GLUCOSE METER	181(c) H	176(c) H	180(CU) H	178(CV) H	(70-110)	MG/DL

(CU) physician notified-
See also (c)
(CV) will repeat-
See also (c)

Date	07/24/08					
Time	2152	2150	1700	1642	Reference	Units
NA			136		(136-145)	MMOL/L

NOTES: (c) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
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Unit#: D001796258 Status: DIS IN
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Pt Name: HURST,BG-TIFFANI D.2033-0

ROUTINE CHEMISTRY *** CHEMISTRY *** (continued)

Date / Time	07/24/08 2152		07/24/08 2150		07/24/08 1700		07/24/08 1642		Reference	Units
K					4.3				(4.1-5.3)	MMOL/L
CL					104				(98-107)	MMOL/L
CO2					20	L			(22-31)	MMOL/L
ANION GAP					16				(9-18)	MMOL/L
GLUCOSE RANDOM					110				(70-139)	MG/DL
GLUCOSE METER	201(CW)	H	197(d)	H			115(d)	H	(70-110)	MG/DL

(CW) physician notified~
See also (d)

BUN					7				(7-18)	MG/DL
CREATININE					0.26	L			(0.60-1.20)	MG/DL
CALCIUM					8.7	L			(8.8-11.2)	MG/DL

Date / Time	07/24/08 1025		07/21/08 0350		07/21/08 0335		07/16/08 0549		Reference	Units
NA	135	L	135	L					(136-145)	MMOL/L
K	6.3(CX)	*H	5.7	H					(4.1-5.3)	MMOL/L

(CX) RESULTS CONFIRMED ON REPEAT ANALYSIS
Critical result(s) called on 07/24/08 at 1318 by
DLAB.AMF have been verbally verified with BROOK SALAZAR
,RN.

CL	105		108	H					(98-107)	MMOL/L
CO2	17	L	15	L					(22-31)	MMOL/L
ANION GAP	19	H	18						(9-18)	MMOL/L
GLUCOSE RANDOM	75		67	L					(70-139)	MG/DL
GLUCOSE METER					82(d)		84(d)		(70-110)	MG/DL
BUN	6	L	7						(7-18)	MG/DL
CREATININE	0.29	L	0.27	L					(0.60-1.20)	MG/DL
TOTAL PROTEIN			5.1						(4.0-7.6)	GM/DL

NOTES: (d) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
3186 Maryland Pkwy
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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	07/24/08		-------07/21/08-------		07/16/08			
Time	1025		0350		0335	0549	Reference	Units
ALBUMIN			2.9				(2.3-4.7)	GM/DL
A/G RATIO			1.3	L			(1.7-2.2)	
CALCIUM	10.1		9.8				(8.8-11.2)	MG/DL
PHOSPHORUS			5.8	H			(2.5-4.9)	MG/DL
TOTAL BILIRUBIN			3.99	H			(0.10-1.00)	MG/DL
SGOT/AST			113	H			(3-37)	U/L
SGPT/ALT			86	H			(13-65)	U/L
TOTAL ALK PHOS			556	H			(118-354)	U/L

Date	-------07/14/08-------		07/10/08	07/08/08			
Time	0345	0320	0456	0456	Reference	Units
NA	137				(136-145)	MMOL/L
K	4.5				(4.1-5.3)	MMOL/L
CL	110 H				(98-107)	MMOL/L
CO2	22				(22-31)	MMOL/L
ANION GAP	10				(9-18)	MMOL/L
GLUCOSE RANDOM	77				(70-139)	MG/DL
GLUCOSE METER		86(e)	80(e)	97(e)	(70-110)	MG/DL
BUN	5 L				(7-18)	MG/DL
CREATININE	0.26 L				(0.60-1.20)	MG/DL
TOTAL PROTEIN	4.8				(4.0-7.6)	GM/DL
ALBUMIN	2.6				(2.3-4.7)	GM/DL
A/G RATIO	1.2 L				(1.7-2.2)	
CALCIUM	9.5				(8.8-11.2)	MG/DL
TOTAL BILIRUBIN	3.00 H				(0.10-1.00)	MG/DL
TOTAL BILIRUBIN	2.16 H				(0.10-1.00)	MG/DL
UNCONJ BILI	(CY)					MG/DL

(CY) 0.66
See also (CZ)
(CZ) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

NOTES: (e) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date / Time	07/14/08 0345		07/14/08 0320	07/10/08 0456	07/08/08 0456	Reference	Units
CONJ BILI	(DA)						MG/DL
SGOT/AST	163	H				(3-37)	U/L
SGPT/ALT	50					(13-65)	U/L
TOTAL ALK PHOS	581	H				(118-354)	U/L

(DA) 1.50
See also (DB)
(DB) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

Date / Time	07/07/08 0505		07/07/08 0446	07/05/08 0326	07/04/08 0400		Reference	Units
NA	137				139		(136-145)	MMOL/L
K	5.0				4.8		(4.1-5.3)	MMOL/L
CL	110	H			112	H	(98-107)	MMOL/L
CO2	22				20	L	(22-31)	MMOL/L
ANION GAP	10				12		(9-18)	MMOL/L
GLUCOSE RANDOM	78				82		(70-139)	MG/DL
GLUCOSE METER			94(f)	99(f)			(70-110)	MG/DL
BUN	9				6	L	(7-18)	MG/DL
CREATININE	0.23	L			0.21	L	(0.60-1.20)	MG/DL
TOTAL PROTEIN	4.1						(4.0-7.6)	GM/DL
ALBUMIN	2.0	L					(2.3-4.7)	GM/DL
A/G RATIO	1.0	L					(1.7-2.2)	
CALCIUM	8.8				8.4	L	(8.8-11.2)	MG/DL
PHOSPHORUS	6.6	H					(2.5-4.9)	MG/DL
TOTAL BILIRUBIN	1.27	H					(0.10-1.00)	MG/DL
UNCONJ BILI	(DC)							MG/DL

(DC) 0.45
See also (DD)
(DD) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

NOTES: (f) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

ROUTINE CHEMISTRY *** CHEMISTRY *** (continued)

Date / Time	07/07/08 0505	07/07/08 0446	07/05/08 0326	07/04/08 0400	Reference	Units
CONJ BILI	(DE)					MG/DL
SGOT/AST	79 H				(3-37)	U/L
SGPT/ALT	8 L				(13-65)	U/L
TOTAL ALK PHOS	357 H				(118-354)	U/L

(DE) 0.82
See also (DF)
(DF) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

Date / Time	07/04/08 0349	07/03/08 0511	07/02/08 0530	07/02/08 0511	Reference	Units
NA			142		(136-145)	MMOL/L
K			4.6		(4.1-5.3)	MMOL/L
CL			116 H		(98-107)	MMOL/L
CO2			18 L		(22-31)	MMOL/L
ANION GAP			13		(9-18)	MMOL/L
GLUCOSE RANDOM			92		(70-139)	MG/DL
GLUCOSE METER	92(g)	84(g)		104(g)	(70-110)	MG/DL
BUN			8		(7-18)	MG/DL
CREATININE			0.23 L		(0.60-1.20)	MG/DL
CALCIUM			8.7 L		(8.8-11.2)	MG/DL

Date / Time	06/29/08 2257	06/29/08 1405	06/29/08 0415	06/29/08 0408	Reference	Units
NA			135 L		(136-145)	MMOL/L
K			5.1		(4.1-5.3)	MMOL/L
CL			105		(98-107)	MMOL/L

NOTES: (g) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	06/29/08							
Time	2257	1405	0415		0408	Reference	Units
CO2			24(DG)	D		(22-31)	MMOL/L
(DG) RESULTS CONFIRMED ON REPEAT ANALYSIS							
ANION GAP			11			(9-18)	MMOL/L
GLUCOSE RANDOM			87			(70-139)	MG/DL
GLUCOSE METER	108(h)	102(h)			98(h)	(70-110)	MG/DL
BUN			14			(7-18)	MG/DL
CREATININE			0.23	L		(0.60-1.20)	MG/DL
CALCIUM			9.2			(8.8-11.2)	MG/DL

Date	06/28/08		06/27/08				
Time	1530	0412	0415		0352	Reference	Units
NA			133	L		(136-145)	MMOL/L
K			3.8	L		(4.1-5.3)	MMOL/L
CL			94	L		(98-107)	MMOL/L
CO2			34	H		(22-31)	MMOL/L
ANION GAP			9			(9-18)	MMOL/L
GLUCOSE RANDOM			77			(70-139)	MG/DL
GLUCOSE METER	102(h)	103(h)			97(h)	(70-110)	MG/DL
BUN			18			(7-18)	MG/DL
CREATININE			0.25	L		(0.60-1.20)	MG/DL
CALCIUM			9.1			(8.8-11.2)	MG/DL

Date	06/26/08			06/25/08		
Time	0946	0415	0336	1747	Reference	Units
NA		133 L			(136-145)	MMOL/L
K		3.9 L			(4.1-5.3)	MMOL/L
CL		91 L			(98-107)	MMOL/L
CO2		36 H			(22-31)	MMOL/L

NOTES: (h) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

ROUTINE CHEMISTRY *** CHEMISTRY *** (continued)

Date	06/26/08				06/25/08		
Time	0946	0415	0336	1747	Reference	Units
ANION GAP		10			(9-18)	MMOL/L
GLUCOSE RANDOM		78			(70-139)	MG/DL
GLUCOSE METER	96(i)		101(i)	103(i)	(70-110)	MG/DL
BUN		16			(7-18)	MG/DL
CREATININE		0.31 L			(0.60-1.20)	MG/DL
TOTAL PROTEIN		4.6			(4.0-7.6)	GM/DL
ALBUMIN		2.3			(2.3-4.7)	GM/DL
A/G RATIO		1.0 L			(1.7-2.2)	
CALCIUM		8.9			(8.8-11.2)	MG/DL
TOTAL BILIRUBIN		1.30 H			(0.10-1.00)	MG/DL
TOTAL BILIRUBIN		0.77			(0.10-1.00)	MG/DL
UNCONJ BILI		(DH)				MG/DL

(DH) 0.36
See also (DI)
(DI) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

CONJ BILI		(DJ)				MG/DL

(DJ) 0.41
See also (DK)
(DK) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

SGOT/AST		43 H			(3-37)	U/L
SGPT/ALT		12 L			(13-65)	U/L
TOTAL ALK PHOS		223			(118-354)	U/L

Date	06/25/08		06/24/08			
Time	0400	0342	1641	0400	Reference	Units
NA	126 L			133 L	(136-145)	MMOL/L
K	3.9 L			4.4	(4.1-5.3)	MMOL/L

NOTES: (i) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	-------06/25/08-------		-------06/24/08-------			
Time	0400	0342	1641	0400	Reference	Units
CL	90(DL) *L			97 L	(98-107)	MMOL/L
CO2	33 H			29	(22-31)	MMOL/L
ANION GAP	7 L			11	(9-18)	MMOL/L
GLUCOSE RANDOM	100			102	(70-139)	MG/DL
GLUCOSE METER		124(j) H	109(j)		(70-110)	MG/DL
BUN	13			7	(7-18)	MG/DL
CREATININE	0.27 L			0.29 L	(0.60-1.20)	MG/DL
TOTAL PROTEIN				4.8	(4.0-7.6)	GM/DL
ALBUMIN				2.6	(2.3-4.7)	GM/DL
A/G RATIO				1.2 L	(1.7-2.2)	
CALCIUM	8.9			9.4	(8.8-11.2)	MG/DL
PHOSPHORUS				4.2	(2.5-4.9)	MG/DL
TOTAL BILIRUBIN				1.48 H	(0.10-1.00)	MG/DL
SGOT/AST				32	(3-37)	U/L
SGPT/ALT				17	(13-65)	U/L
TOTAL ALK PHOS				251	(118-354)	U/L
TRIGLYCERIDES	39				(35-125)	MG/DL

(DL) Critical result(s) called on 06/25/08 at 0506 by DLAB.RBM have been verbally verified with LISA HYDOCK,RN. RESULTS CONFIRMED ON REPEAT ANALYSIS

Date	06/24/08	----------06/23/08----------				
Time	0348	2348	2011	1647	Reference	Units
GLUCOSE METER	109(j)	142(j) H	142(j) H	105(j)	(70-110)	MG/DL

Date	06/23/08	06/22/08	-------06/19/08-------			
Time	0920	1454	1218	0355	Reference	Units
GLUCOSE METER		110(j)	95(j)	84(j)	(70-110)	MG/DL

NOTES: (j) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	06/23/08	06/22/08	-------06/19/08-------			
Time	0920	1454	1218	0355	Reference	Units
TOTAL BILIRUBIN	1.38 H				(0.10-1.00)	MG/DL
UNCONJ BILI	(DM)					MG/DL

(DM) 0.73
See also (DN)
(DN) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

CONJ BILI	(DO)					MG/DL

(DO) 0.65
See also (DP)
(DP) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

Date	06/18/08	06/17/08	-------06/16/08-------				
Time	0252	0155	0358	0345		Reference	Units
NA				136		(136-145)	MMOL/L
K				4.7		(4.1-5.3)	MMOL/L
CL				101		(98-107)	MMOL/L
CO2				21	L	(22-31)	MMOL/L
ANION GAP				19	H	(9-18)	MMOL/L
GLUCOSE RANDOM				90		(70-139)	MG/DL
GLUCOSE METER	96(k)	86(k)	114(k) H			(70-110)	MG/DL
BUN				14		(7-18)	MG/DL
CREATININE				0.48	L	(0.60-1.20)	MG/DL
TOTAL PROTEIN				5.4		(4.0-7.6)	GM/DL
ALBUMIN				3.3		(2.3-4.7)	GM/DL
A/G RATIO				1.6	L	(1.7-2.2)	
CALCIUM				8.5	L	(8.8-11.2)	MG/DL
PHOSPHORUS				8.2	H	(2.5-4.9)	MG/DL
TOTAL BILIRUBIN				1.42	H	(0.10-1.00)	MG/DL
TOTAL BILIRUBIN				1.19	H	(0.10-1.00)	MG/DL

NOTES: (k) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date / Time	06/18/08 0252	06/17/08 0155	06/16/08 0358	06/16/08 0345	Reference	Units
UNCONJ BILI				(DQ)		MG/DL

(DQ) 1.00
See also (DR)
(DR) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

CONJ BILI				(DS)		MG/DL

(DS) 0.19
See also (DT)
(DT) NO REFERENCE RANGE AVAILABLE FOR THIS AGE GROUP

SGOT/AST				48 H	(3-37)	U/L
SGPT/ALT				13	(13-65)	U/L
TOTAL ALK PHOS				245	(118-354)	U/L
MAGNESIUM				1.9	(1.8-2.4)	MG/DL
TRIGLYCERIDES				112	(35-125)	MG/DL

Date / Time	06/15/08 0954	06/15/08 0603	06/13/08 0530	06/13/08 0526	Reference	Units
NA			133 L		(136-145)	MMOL/L
K			4.8		(4.1-5.3)	MMOL/L
CL			100		(98-107)	MMOL/L
CO2			26		(22-31)	MMOL/L
ANION GAP			12		(9-18)	MMOL/L
GLUCOSE RANDOM			76		(70-139)	MG/DL
GLUCOSE METER	90(1)	109(1)		94(1)	(70-110)	MG/DL
BUN			16		(7-18)	MG/DL
CREATININE			0.56 L		(0.60-1.20)	MG/DL
CALCIUM			9.7		(8.8-11.2)	MG/DL

NOTES: (1) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	06/09/08		06/08/08	06/07/08			
Time	0530		0517	0528	0823	Reference	Units
NA	134	L				(136-145)	MMOL/L
K	4.3					(4.1-5.3)	MMOL/L
CL	104					(98-107)	MMOL/L
CO2	24					(22-31)	MMOL/L
ANION GAP	10					(9-18)	MMOL/L
GLUCOSE RANDOM	87					(70-139)	MG/DL
GLUCOSE METER			104 (m)	103 (m)	91 (m)	(70-110)	MG/DL
BUN	18					(7-18)	MG/DL
CREATININE	0.51	L				(0.60-1.20)	MG/DL
TOTAL PROTEIN	4.5					(4.0-7.6)	GM/DL
ALBUMIN	2.6					(2.3-4.7)	GM/DL
A/G RATIO	1.4	L				(1.7-2.2)	
CALCIUM	9.8					(8.8-11.2)	MG/DL
TOTAL BILIRUBIN	1.10	H				(0.10-1.00)	MG/DL
SGOT/AST	29					(3-37)	U/L
SGPT/ALT	12	L				(13-65)	U/L
TOTAL ALK PHOS	221					(62-368)	U/L

Date	06/07/08	06/06/08			06/04/08		
Time	0047	2151		0414	0459	Reference	Units
GLUCOSE METER	80 (m)	113 (m)	H	100 (m)	102 (m)	(70-110)	MG/DL

Date	06/03/08	06/02/08			06/01/08		
Time	0558	0500		0431	0530	Reference	Units
NA		133	L			(136-145)	MMOL/L
K		5.7	H			(4.1-5.3)	MMOL/L
CL		104				(98-107)	MMOL/L
CO2		22				(22-31)	MMOL/L
ANION GAP		13				(9-18)	MMOL/L
GLUCOSE RANDOM		82				(70-139)	MG/DL

NOTES: (m) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
3186 Maryland Pkwy
Las Vegas, Nevada 89109

LABORATORY DISCHARGE SUMMARY

J.H. HUGHES, M.D.,Ph.D-DIRECTOR
J.E. BEECHAM, M.D.
M.A. ERLING, M.D.
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A.C. RIVERA-BEGEMAN, D.O.
S.M. RUHOY, M.D.
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J.L. UNGER, M.D.
N.S. YUMIACO, M.D.

*** MED REC DISCHARGE REPORT ***

MEDICAL RECORDS COPY
08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	06/03/08		-------06/02/08-------		06/01/08			
Time	0558		0500		0431		Reference	Units
GLUCOSE METER	97(n)				101(n)		(70-110)	MG/DL
BUN		19	H				(7-18)	MG/DL
CREATININE		0.60					(0.60-1.20)	MG/DL
TOTAL PROTEIN		4.9					(4.0-7.6)	GM/DL
ALBUMIN		4.8	H				(2.3-4.7)	GM/DL
A/G RATIO		1.3	L				(1.7-2.2)	
CALCIUM		10.2					(8.8-11.2)	MG/DL
TOTAL BILIRUBIN		2.23	*H				(0.10-1.00)	MG/DL
TOTAL BILIRUBIN					(DU)	*H	(0.10-1.00)	MG/DL

(DU) 2.85 *H
RESULTS CONFIRMED ON REPEAT ANALYSIS

UNCONJ BILI				2.85	H	(0.00-0.70)	MG/DL
CONJ BILI				(DV)		(0.00-0.60)	MG/DL

(DV) 0.00
See also (DW)
(DW) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

SGOT/AST		58	H			(3-37)	U/L
SGPT/ALT		14				(13-65)	U/L
TOTAL ALK PHOS		263				(62-368)	U/L

Date	06/01/08		-------05/31/08-------		05/30/08			
Time	0516		0520		0452		Reference	Units
GLUCOSE METER	94(n)				105(n)	103(n)	(70-110)	MG/DL
TOTAL BILIRUBIN		(DX)	*H				(0.10-1.00)	MG/DL

(DX) 3.44 *H
RESULTS CONFIRMED ON REPEAT ANALYSIS

NOTES: (n) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
3186 Maryland Pkwy
Las Vegas, Nevada 89109

LABORATORY DISCHARGE SUMMARY

J.H. HUGHES, M.D.,Ph.D-DIRECTOR
J.E. BEECHAM, M.D.
M.A. ERLING, M.D.
J.W. HUSSONG, DDS,M.D.
R.J. KNOBLOCK, M.D.
S.E. KOLKER, M.D.
D.P. MARMADUKE, M.D.

P.J. MICHAELS, M.D.
T.C. MURRY, M.D.,Ph.D
A.C. RIVERA-BEGEMAN, D.O.
S.M. RUHOY, M.D.
J.D. SIGMAN, M.D.
J.L. UNGER, M.D.
N.S. YUMIACO, M.D.

*** MED REC DISCHARGE REPORT ***

MEDICAL RECORDS COPY
08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date / Time	06/01/08 0516	05/31/08 0520	05/31/08 0452	05/30/08 0255	Reference	Units
UNCONJ BILI		3.22 H (DY)			(0.00-0.70)	MG/DL
CONJ BILI					(0.00-0.60)	MG/DL

(DY) 0.22
See also (DZ)
(DZ) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

Date / Time	05/29/08 2003	2000	1950	0300	Reference	Units
NA			133 L	134 L	(136-145)	MMOL/L
K			5.4 H	5.0	(4.1-5.3)	MMOL/L
CL			103	105	(98-107)	MMOL/L
CO2			21 L	22	(22-31)	MMOL/L
ANION GAP			14	12	(9-18)	MMOL/L
GLUCOSE RANDOM			92	83	(70-139)	MG/DL
GLUCOSE METER	96(o)	281(EA) *H			(70-110)	MG/DL

(EA) physician notified-will repeat~
See also (o)

BUN			19 H	18	(7-18)	MG/DL
CREATININE			0.62	0.63	(0.60-1.20)	MG/DL
CALCIUM			9.8	10.0	(8.8-11.2)	MG/DL
TOTAL BILIRUBIN				(EB) *H	(0.10-1.00)	MG/DL

(EB) 5.02 *H
RESULTS CONFIRMED ON REPEAT ANALYSIS

UNCONJ BILI				5.02 H	(0.00-0.70)	MG/DL

NOTES: (o) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/29/08					
Time	2003	2000	1950	0300	Reference	Units
CONJ BILI				(EC)	(0.00-0.60)	MG/DL

(EC) 0.00
See also (ED)
(ED) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

Date	05/29/08	05/28/08				
Time	0233	1432	0237	0230	Reference	Units
GLUCOSE METER	111(p) H	107(p)	102(p)		(70-110)	MG/DL
TOTAL BILIRUBIN				(EE) *H	(0.10-1.00)	MG/DL

(EE) 5.72 *H
RESULTS CONFIRMED ON REPEAT ANALYSIS

UNCONJ BILI				5.72 H	(0.00-0.70)	MG/DL
CONJ BILI				(EF)	(0.00-0.60)	MG/DL

(EF) 0.00
See also (EG)
(EG) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

Date	05/27/08			05/26/08		
Time	1454	0320	0256	0400	Reference	Units
NA		136		137	(136-145)	MMOL/L
K		5.0		4.7	(4.1-5.3)	MMOL/L
CL		107		107	(98-107)	MMOL/L
CO2		24		24	(22-31)	MMOL/L

NOTES: (p) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
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Acct#: D00097976535 Age/Sex: 02M 19D/F
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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/27/08			05/26/08				
Time	1454	0320		0256	0400		Reference	Units
ANION GAP		10			11		(9-18)	MMOL/L
GLUCOSE RANDOM		87			89		(70-139)	MG/DL
GLUCOSE METER	110(q)			113(q)	H		(70-110)	MG/DL
BUN		20	H		21	H	(7-18)	MG/DL
CREATININE		0.62			0.61		(0.60-1.20)	MG/DL
TOTAL PROTEIN					5.0		(4.0-7.6)	GM/DL
ALBUMIN					2.7		(2.3-4.7)	GM/DL
A/G RATIO					1.1	L	(1.7-2.2)	
CALCIUM		10.3			9.9		(8.8-11.2)	MG/DL
PHOSPHORUS		6.0	H				(2.5-4.9)	MG/DL
TOTAL BILIRUBIN					6.38	*H	(0.10-1.00)	MG/DL
TOTAL BILIRUBIN		(EH)	*H				(0.10-1.00)	MG/DL

(EH) 7.12 *H
RESULTS CONFIRMED ON REPEAT ANALYSIS

UNCONJ BILI		7.12	H			(0.00-0.70)	MG/DL
CONJ BILI		(EI)				(0.00-0.60)	MG/DL

(EI) 0.00
See also (EJ)
(EJ) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

SGOT/AST				41	H	(3-37)	U/L
SGPT/ALT				12	L	(13-65)	U/L
TOTAL ALK PHOS				206		(62-368)	U/L
TRIGLYCERIDES				80		(35-125)	MG/DL

Date	05/25/08						
Time	1933	0947	0230	0212		Reference	Units
GLUCOSE METER	111(q) H	91(q)		108(q)		(70-110)	MG/DL

NOTES: (q) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/25/08					
Time	1933	0947	0230	0212	Reference	Units
TOTAL BILIRUBIN			(EK) *H		(0.10-1.00)	MG/DL
UNCONJ BILI			9.31 H		(0.00-0.70)	MG/DL
CONJ BILI			(EL)		(0.00-0.60)	MG/DL

(EK) 9.31 *H
RESULTS CONFIRMED ON REPEAT ANALYSIS

(EL) 0.00
See also (EM)
(EM) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

Date	05/24/08		05/23/08			
Time	0310	0249	2039	0200	Reference	Units
NA				136	(136-145)	MMOL/L
K				5.6	(3.7-5.9)	MMOL/L
CL				101	(98-107)	MMOL/L
CO2				25	(22-31)	MMOL/L
ANION GAP				16	(9-18)	MMOL/L
GLUCOSE RANDOM				96	(70-139)	MG/DL
GLUCOSE METER		117(r) H	103(r)		(70-110)	MG/DL
BUN				40 H	(7-18)	MG/DL
CREATININE				0.95	(0.60-1.20)	MG/DL
CALCIUM				8.9	(8.8-11.2)	MG/DL
TOTAL BILIRUBIN	(EN) *H			8.48 *H	(0.10-1.00)	MG/DL
UNCONJ BILI	8.88 H			8.48 H	(0.00-0.70)	MG/DL

(EN) 8.88 *H
RESULTS CONFIRMED ON REDRAWN SPECIMEN

NOTES: (r) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

ROUTINE CHEMISTRY *** CHEMISTRY *** (continued)

Date	-------05/24/08-------		-------05/23/08-------			
Time	0310	0249	2039	0200	Reference	Units
CONJ BILI	(EO)			(EQ)	(0.00-0.60)	MG/DL

(EO) 0.00
See also (EP)
(EP) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.
(EQ) 0.00
See also (EP)

Date	----------05/22/08----------					
Time	2243	1434	0225	0158	Reference	Units
NA			135 L		(136-145)	MMOL/L
K			4.8		(3.7-5.9)	MMOL/L
CL			96 L		(98-107)	MMOL/L
CO2			28		(22-31)	MMOL/L
ANION GAP			16		(9-18)	MMOL/L
GLUCOSE RANDOM			112		(70-139)	MG/DL
GLUCOSE METER	103(s)	125(s) H		140(ER) H	(70-110)	MG/DL

(ER) physician notified~
See also (s)

BUN			44 H		(7-18)	MG/DL
CREATININE			1.24 H		(0.60-1.20)	MG/DL
CALCIUM			9.0		(8.8-11.2)	MG/DL

Date	----------05/21/08----------			05/20/08		
Time	1358	0220	0206	1933	Reference	Units
NA		136			(136-145)	MMOL/L

NOTES: (s) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/21/08				05/20/08		
Time	1358	0220		0206	1933	Reference	Units
K		4.8				(3.7-5.9)	MMOL/L
CL		96	L			(98-107)	MMOL/L
CO2		27				(22-31)	MMOL/L
ANION GAP		18				(9-18)	MMOL/L
GLUCOSE RANDOM		107				(70-139)	MG/DL
GLUCOSE METER	132(t) H			132(ES) H	125(ET) H	(70-110)	MG/DL

(ES) physician notified~
See also (t)
(ET) physician notified~
See also (t)

BUN		43	H			(7-18)	MG/DL
CREATININE		1.46	H			(0.60-1.20)	MG/DL
CALCIUM		9.4				(8.8-11.2)	MG/DL
TOTAL BILIRUBIN		(EU)	*H			(0.10-1.00)	MG/DL

(EU) 9.47 *H
RESULTS CONFIRMED ON REPEAT ANALYSIS

UNCONJ BILI		9.47	H			(0.00-0.70)	MG/DL
CONJ BILI		(EV)				(0.00-0.60)	MG/DL

(EV) 0.00
See also (EW)
(EW) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

Date	05/20/08					
Time	1447	0951	0220	0205	Reference	Units
NA			138		(136-145)	MMOL/L

NOTES: (t) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/20/08					
Time	1447	0951	0220	0205	Reference	Units
K			4.5		(3.7-5.9)	MMOL/L
CL			103(EX) D		(98-107)	MMOL/L
(EX) RESULTS CONFIRMED ON REPEAT ANALYSIS						
CO2			25		(22-31)	MMOL/L
ANION GAP			15		(9-18)	MMOL/L
GLUCOSE RANDOM			115		(70-139)	MG/DL
GLUCOSE METER	137(u) H	141(u) H		139(EY) H	(70-110)	MG/DL
(EY) physician notified- See also (u)						
BUN			35 H		(7-18)	MG/DL
CREATININE			1.46 H		(0.60-1.20)	MG/DL
CALCIUM			9.9		(8.8-11.2)	MG/DL
TOTAL BILIRUBIN			10.34 H		(0.10-1.00)	MG/DL
UNCONJ BILI			10.18 H		(0.00-0.70)	MG/DL
CONJ BILI			(EZ)		(0.00-0.60)	MG/DL
(EZ) 0.16 See also (FA)						
(FA) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.						
TRIGLYCERIDES			49		(35-125)	MG/DL

Date	05/19/08			05/18/08		
Time	1925	1252	0000	1927	Reference	Units
NA			146 H		(136-145)	MMOL/L
K			4.6		(3.7-5.9)	MMOL/L

NOTES: (u) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
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Unit#: D001796258 Status: DIS IN
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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/19/08			05/18/08		
Time	1925	1252	0000	1927	Reference	Units
CL			116 H		(98-107)	MMOL/L
CO2			23		(22-31)	MMOL/L
ANION GAP			12		(9-18)	MMOL/L
GLUCOSE RANDOM			97		(70-139)	MG/DL
GLUCOSE METER	131(FB) H	119(v) H		105(v)	(70-110)	MG/DL

(FB) physician notified-
See also (v)

BUN			30 H		(7-18)	MG/DL
CREATININE			1.33 H		(0.60-1.20)	MG/DL
CALCIUM			10.0		(8.8-11.2)	MG/DL
PHOSPHORUS			5.5 H		(2.5-4.9)	MG/DL
TOTAL BILIRUBIN			10.34		(0.10-13.00)	MG/DL
UNCONJ BILI			10.34		(0.00-13.00)	MG/DL
CONJ BILI			(FC)		(0.00-0.60)	MG/DL

(FC) 0.00
See also (FD)
(FD) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

Date	05/18/08		05/17/08			
Time	1354	0415	2315	2315	Reference	Units
NA		146 H			(136-145)	MMOL/L
K		4.5			(3.7-5.9)	MMOL/L
CL		120(FE) *H			(98-107)	MMOL/L

(FE) Critical result(s) called on 05/18/08 at 0504 by DLAB.RBM have been verbally verified with KRISTIN GALLAWAY ,RN.
RESULTS CONFIRMED ON REPEAT ANALYSIS

NOTES: (v) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
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Unit#: D001796258 Status: DIS IN
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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/18/08		05/17/08			
Time	1354	0415	2315	2315	Reference	Units
CO2		22			(22-31)	MMOL/L
ANION GAP		9			(9-18)	MMOL/L
GLUCOSE RANDOM		84			(70-139)	MG/DL
GLUCOSE METER	121(w) H		106(w)		(70-110)	MG/DL
BUN		28 H			(7-18)	MG/DL
CREATININE		1.20			(0.60-1.20)	MG/DL
CALCIUM		9.4			(8.8-11.2)	MG/DL
TOTAL BILIRUBIN				9.79	(0.10-12.00)	MG/DL
TOTAL BILIRUBIN		10.19			(0.10-13.00)	MG/DL
UNCONJ BILI				9.79	(0.00-12.00)	MG/DL
UNCONJ BILI		10.19			(0.00-13.00)	MG/DL
CONJ BILI		(FF)		(FH)	(0.00-0.60)	MG/DL

(FF) 0.00
See also (FG)
(FG) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.
(FH) 0.00
See also (FG)

Date	05/17/08			05/16/08		
Time	1252	0350	0342	2055	Reference	Units
NA		144			(136-145)	MMOL/L
K		3.8			(3.7-5.9)	MMOL/L
CL		117 H			(98-107)	MMOL/L
CO2		24			(22-31)	MMOL/L
ANION GAP		7 L			(9-18)	MMOL/L
GLUCOSE RANDOM		96			(70-139)	MG/DL
GLUCOSE METER	97(w)		123(w) H	131(w) H	(70-110)	MG/DL
BUN		26 H			(7-18)	MG/DL
CREATININE		1.13			(0.60-1.20)	MG/DL
CALCIUM		8.6 L			(8.8-11.2)	MG/DL

NOTES: (w) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
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Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/17/08				05/16/08		
Time	1252	0350		0342	2055	Reference	Units
TOTAL BILIRUBIN		9.12				(0.10-12.00)	MG/DL
UNCONJ BILI		9.12	D			(0.00-12.00)	MG/DL
CONJ BILI		(FI)				(0.00-0.60)	MG/DL

(FI) 0.00
See also (FJ)
(FJ) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

TRIGLYCERIDES		25	L			(35-125)	MG/DL

Date	05/16/08				05/15/08		
Time	1300	0410		0349	2349	Reference	Units
NA	140	139				(136-145)	MMOL/L
K	4.0	3.4	L			(3.7-5.9)	MMOL/L
CL	114 H	113	H			(98-107)	MMOL/L
CO2	25	25				(22-31)	MMOL/L
ANION GAP	5 L	4	L			(9-18)	MMOL/L
GLUCOSE RANDOM	113	115				(70-139)	MG/DL
GLUCOSE METER				144(x) H	102(x)	(70-110)	MG/DL
BUN	22 H	19	H			(7-18)	MG/DL
CREATININE	1.13	1.13				(0.60-1.20)	MG/DL
CALCIUM	8.3 L	7.4	L			(8.8-11.2)	MG/DL
PHOSPHORUS		5.5	H			(2.5-4.9)	MG/DL
TOTAL BILIRUBIN		6.56				(0.10-11.00)	MG/DL
UNCONJ BILI		6.56				(0.00-11.00)	MG/DL
CONJ BILI		(FK)				(0.00-0.60)	MG/DL

(FK) 0.00
See also (FL)
(FL) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

NOTES: (x) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/15/08									
Time	2135		1725		1135		0600		Reference	Units
NA			140		139		137		(136-145)	MMOL/L
K			3.1	L	3.2	L	3.6	L	(3.7-5.9)	MMOL/L
CL			110	H	110	H	110	H	(98-107)	MMOL/L
CO2			22		22		21	L	(22-31)	MMOL/L
ANION GAP			11		10		10		(9-18)	MMOL/L
GLUCOSE RANDOM			223	H	90		93		(70-139)	MG/DL
GLUCOSE METER	64 (y)	L							(70-110)	MG/DL
BUN			19	H	21	H	20	H	(7-18)	MG/DL
CREATININE			1.01		1.22	H	1.20		(0.60-1.20)	MG/DL
CALCIUM			7.7	L	8.6	L	8.4	L	(8.8-11.2)	MG/DL
TOTAL BILIRUBIN							5.94		(0.10-8.00)	MG/DL
UNCONJ BILI							5.94	D	(0.00-8.00)	MG/DL
CONJ BILI							(FM)		(0.00-0.60)	MG/DL

(FM) 0.00
See also (FN)
(FN) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

TRIGLYCERIDES							13	L	(35-125)	MG/DL

Date	05/14/08									
Time	2005		1830		1817		1608		Reference	Units
NA	129	L	124	L					(136-145)	MMOL/L
K	4.0		3.5	L					(3.7-5.9)	MMOL/L
CL	105		102						(98-107)	MMOL/L
CO2	23		21	L					(22-31)	MMOL/L
ANION GAP	5	L	5	L					(9-18)	MMOL/L
GLUCOSE RANDOM	91		73						(70-139)	MG/DL
GLUCOSE METER					92 (y)		113 (y)	H	(70-110)	MG/DL
BUN	18		15						(7-18)	MG/DL
CREATININE	1.20		1.02						(0.60-1.20)	MG/DL

NOTES: (y) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date / Time	2005	1830	1817	1608	Reference	Units
	05/14/08					
CALCIUM	8.2 L	6.6(FO) *L			(8.8-11.2)	MG/DL
PHOSPHORUS		4.4			(2.5-4.9)	MG/DL
TOTAL BILIRUBIN		3.37			(0.10-5.00)	MG/DL
UNCONJ BILI		3.37			(0.00-5.00)	MG/DL
CONJ BILI		(FP)			(0.00-0.60)	MG/DL
MAGNESIUM		1.6 L			(1.8-2.4)	MG/DL

(FO) Critical result(s) called on 05/14/08 at 1941 by DLAB.JBF have been verbally verified with MELANIE MONTGOMERY ,RN.
RESULTS CONFIRMED ON REPEAT ANALYSIS

(FP) 0.00
See also (FQ)

(FQ) THIS TEST CONFORMS TO THE AAP GUIDELINES FOR HYPERBILIRUBINEMIA - Pediatrics. 114(1):297-316,2004.

Date / Time	1404	1218	1136	0958	Reference	Units
	05/14/08					
GLUCOSE METER	66(z) L	38(FR) *L	36(FS) *L	<30(FT) *L	(70-110)	MG/DL

(FR) physician notified-
See also (z)

(FS) physician notified-
See also (z)

(FT) physician notified-
See also (z)

NOTES: (z) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

ROUTINE CHEMISTRY

Date	05/14/08					
Time	0956	0507	0224	0153	Reference	Units
GLUCOSE METER	37(FU) *L	102(aa)	45(FV) L	<30(FW) *L	(70-110)	MG/DL

(FU) physician notified~will repeat~
See also (aa)
(FV) physician notified~
See also (aa)
(FW) physician notified~
See also (aa)

Date	05/14/08				
Time	0150	0109	0102	Reference	Units
GLUCOSE METER	<30(FX) *L	30(FY) *L	<30(FZ) *L	(70-110)	MG/DL

(FX) physician notified~will repeat~
See also (aa)
(FY) physician notified~
See also (aa)
(FZ) physician notified~will repeat~
See also (aa)

SPECIAL CHEMISTRY

Date	07/28/08			
Time	0415		Reference	Units
C REACTIVE PROTEIN	7.17	H	(<0.90)	MG/DL

NOTES: (aa) *TEST PERFORMED BY: NURSING SERVICE

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

SPECIAL CHEMISTRY

Date / Time	07/27/08 0400		Reference	Units
C REACTIVE PROTEIN	12.90	H	(<0.90)	MG/DL
Date / Time	07/26/08 0330		Reference	Units
C REACTIVE PROTEIN	21.30(GA)	H	(<0.90)	MG/DL
(GA) VERIFIED BY DILUTION				
Date / Time	07/21/08 0350		Reference	Units
C REACTIVE PROTEIN	1.10	H	(<0.90)	MG/DL
Date / Time	07/16/08 0605		Reference	Units
C REACTIVE PROTEIN	0.93	H	(<0.90)	MG/DL
Date / Time	07/08/08 0500		Reference	Units
C REACTIVE PROTEIN	4.63	H	(<0.90)	MG/DL
Date / Time	07/07/08 0505		Reference	Units
C REACTIVE PROTEIN	5.60	H	(<0.90)	MG/DL

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

SPECIAL CHEMISTRY *** CHEMISTRY *** (continued)

Date		07/06/08			
Time		0507		Reference	Units
C REACTIVE PROTEIN	11.50(GB)	H		(<0.90)	MG/DL
(GB) VERIFIED BY DILUTION					
Date		07/05/08			
Time		0400		Reference	Units
C REACTIVE PROTEIN	6.60	H		(<0.90)	MG/DL
Date		07/03/08			
Time		0530		Reference	Units
C REACTIVE PROTEIN	7.11	H		(<0.90)	MG/DL
Date		06/29/08			
Time		0415		Reference	Units
C REACTIVE PROTEIN	5.83	H		(<0.90)	MG/DL
Date		06/27/08			
Time		0415		Reference	Units
C REACTIVE PROTEIN	17.50(GC)	H		(<0.90)	MG/DL
(GC) VERIFIED BY DILUTION					

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

SPECIAL CHEMISTRY

Date	06/26/08				
Time	0415			Reference	Units
C REACTIVE PROTEIN	28.95(GD)	H		(<0.90)	MG/DL
(GD) VERIFIED BY DILUTION					
Date	06/25/08				
Time	0400			Reference	Units
C REACTIVE PROTEIN	31.10(GE)	H		(<0.90)	MG/DL
(GE) VERIFIED BY DILUTION					
Date	06/24/08				
Time	0400			Reference	Units
C REACTIVE PROTEIN	19.38(GF)	H		(<0.90)	MG/DL
(GF) VERIFIED BY DILUTION					
Date	06/23/08				
Time	1700			Reference	Units
C REACTIVE PROTEIN	14.80(GG)	H		(<0.90)	MG/DL
(GG) VERIFIED BY DILUTION					
Date	06/22/08				
Time	2130			Reference	Units
C REACTIVE PROTEIN	3.40	H		(<0.90)	MG/DL

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

SPECIAL CHEMISTRY *** CHEMISTRY *** (continued)

Date	06/22/08			
Time	1515		Reference	Units
C REACTIVE PROTEIN	2.96	H	(<0.90)	MG/DL
Date	06/19/08			
Time	0400		Reference	Units
C REACTIVE PROTEIN	0.80		(<0.90)	MG/DL
Date	06/17/08			
Time	0200		Reference	Units
C REACTIVE PROTEIN	1.60	H	(<0.90)	MG/DL
Date	06/16/08			
Time	0345		Reference	Units
C REACTIVE PROTEIN	3.20	H	(<0.90)	MG/DL
Date	06/15/08			
Time	1010		Reference	Units
C REACTIVE PROTEIN	3.40	H	(<0.90)	MG/DL
Date	06/08/08			
Time	0530		Reference	Units
C REACTIVE PROTEIN	0.53		(<0.90)	MG/DL

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

SPECIAL CHEMISTRY

Date		06/07/08			
Time		0045		Reference	Units
C REACTIVE PROTEIN	0.23			(<0.90)	MG/DL
Date		06/01/08			
Time		0530		Reference	Units
C REACTIVE PROTEIN	0.80			(<0.90)	MG/DL
Date		05/31/08			
Time		0520		Reference	Units
C REACTIVE PROTEIN	1.51		H	(<0.90)	MG/DL
Date		05/29/08			
Time		1950		Reference	Units
C REACTIVE PROTEIN	1.00		H	(<0.90)	MG/DL
Date		05/26/08			
Time		0400		Reference	Units
C REACTIVE PROTEIN	1.40		H	(<0.90)	MG/DL
Date		05/20/08			
Time		0220		Reference	Units
C REACTIVE PROTEIN	0.40			(<0.90)	MG/DL

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** CHEMISTRY *** (continued)

SPECIAL CHEMISTRY

Date / Time	05/18/08 0415	Reference	Units
C REACTIVE PROTEIN	0.42	(<0.90)	MG/DL
Date / Time	05/17/08 0350	Reference	Units
C REACTIVE PROTEIN	0.76	(<0.90)	MG/DL
Date / Time	05/15/08 0600	Reference	Units
C REACTIVE PROTEIN	0.40	(<0.90)	MG/DL
Date / Time	05/14/08 1830	Reference	Units
C REACTIVE PROTEIN	0.26	(<0.90)	MG/DL
Date / Time	05/14/08 0100	Reference	Units
C REACTIVE PROTEIN	<0.20	(<0.90)	MG/DL

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D00179625B Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

J.H. HUGHES, M.D.,Ph.D-DIRECTOR
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*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** NEAR PATIENT TESTING/POINT OF CARE TESTING ***

Date / Time	07/25/08 UNK	06/23/08 0920	06/18/08 0300	06/15/08 0304	Reference	Units
NA NPT		134 L	134 L	133 L	(136-145)	MMOL/L
K NPT				5.1	(4.1-5.3)	MMOL/L
CL NPT			100	103	(98-107)	MMOL/L
GLU NPT	138	119		87	(70-139)	MG/DL
CA IONIZED NPT			1.36 H		(1.00-1.25)	MMOL/L
LACTATE NPT				1.3	(0.4-2.2)	MMOL/L

Date / Time	06/14/08 0328	06/04/08 0515	05/25/08 0221	05/15/08 1651	Reference	Units
HGB NPT				(GH) *L	(14.5-22.5)	GM/DL

(GH) 10.4 *L
Critical Value - Testing performed by the OR staff at POC

NA NPT	135 L	134 L	140	139	(136-145)	MMOL/L
K NPT				3.1 L	(3.7-5.9)	MMOL/L
K NPT	4.8	4.6	5.8 H		(4.1-5.3)	MMOL/L
CL NPT	100	103	108 H	107	(98-107)	MMOL/L
GLU NPT	90		88	301(GI) *H	(70-139)	MG/DL

(GI) Critical Value - Testing performed by the OR staff at POC

CA IONIZED NPT		1.31 H	1.27 H	1.12	(1.00-1.25)	MMOL/L
LACTATE NPT	1.0		0.8		(0.4-2.2)	MMOL/L

Date / Time	05/15/08 1620	Reference	Units
HGB NPT	9.0(GJ) *L	(14.5-22.5)	GM/DL

(GJ) Critical Value - Testing performed by the OR staff at POC

NA NPT	134 L	(136-145)	MMOL/L

Pt Name: HURST,BG-TIFFANI
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Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** NEAR PATIENT TESTING/POINT OF CARE TESTING *** (continued)

Date / Time	05/15/08 1620	Reference	Units
K NPT	2.8(GK) *L	(3.7-5.9)	MMOL/L
CL NPT	105	(98-107)	MMOL/L
GLU NPT	271(GL) *H	(70-139)	MG/DL
CA IONIZED NPT	1.15	(1.00-1.25)	MMOL/L

(GK) Critical Value - Testing performed by the OR staff at POC

(GL) Critical Value - Testing performed by the OR staff at POC

*** TOXICOLOGY ***

THERAPEUTIC DRUG MONITORING

Date / Time	07/25/08 2250	07/25/08 1115	07/07/08 0025	07/06/08 2200	Reference	Units
VANCO PEAK	20.05		29.24		(20.00-40.00)	MCG/ML
VANCO TROUGH		(GM)		(GO)	(10.00-20.00)	MCG/ML

(GM) 10.45
See also (GN)

(GN) Guideline based trough recommendations:

HAP/VAP/HCAP: 15-20 mcg/mL (2005, IDSA/ATS)
Infective Endocarditis: 10-15 mcg/mL (2005, IDSA/AHA)
Bacterial Meningitis: 15-20 mcg/mL (2004, IDSA)

(GO) 10.14
See also (GN)

Date / Time	06/25/08 2045	06/25/08 1755	06/17/08 0200	06/16/08 1630	Reference	Units
TOBRA PEAK	5.99				(4.00-10.00)	MCG/ML
TOBRA TROUGH		<0.18			(0-2.00)	MCG/ML
VANCO PEAK				27.55	(20.00-40.00)	MCG/ML

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** TOXICOLOGY *** (continued)

THERAPEUTIC DRUG MONITORING

Date / Time	06/25/08 2045	06/25/08 1755	06/17/08 0200	06/16/08 1630	Reference	Units
VANCO TROUGH			(GP) L		(10.00-20.00)	MCG/ML

(GP) 7.19 L
See also (GQ)
(GQ) Guideline based trough recommendations:

HAP/VAP/HCAP: 15-20 mcg/mL (2005, IDSA/ATS)
Infective Endocarditis: 10-15 mcg/mL (2005, IDSA/AHA)
Bacterial Meningitis: 15-20 mcg/mL (2004, IDSA)

Date / Time	05/30/08 1520	05/30/08 1300	05/22/08 0225	05/16/08 0410	Reference	Units
GENT PEAK				8.60	(4.00-10.00)	MCG/ML
GENT TROUGH			0.90		(0-1.00)	MCG/ML
VANCO PEAK	31.63				(20.00-40.00)	MCG/ML
VANCO TROUGH		(GR)			(10.00-20.00)	MCG/ML

(GR) 16.39
See also (GS)
(GS) Guideline based trough recommendations:

HAP/VAP/HCAP: 15-20 mcg/mL (2005, IDSA/ATS)
Infective Endocarditis: 10-15 mcg/mL (2005, IDSA/AHA)
Bacterial Meningitis: 15-20 mcg/mL (2004, IDSA)

Date / Time	05/16/08 0200	Reference	Units
GENT TROUGH	0.70	(0-1.00)	MCG/ML

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** URINALYSIS ***

	Date 06/23/08 Time 0000		Date 05/30/08 Time 0010			Reference	Units
UA COLOR	DK YELLOW		YELLOW			(YELLOW)	
UA APPEARANCE	CLEAR		CLOUDY	*		(CLEAR)	
UA GLUCOSE	NEGATIVE		NEGATIVE			(NEGATIVE)	MG/DL
UA BILIRUBIN	SMALL	*	NEGATIVE			(NEGATIVE)	
ICTOTEST	NEGATIVE					(NEGATIVE)	
UA KETONES	NEGATIVE		NEGATIVE			(NEGATIVE)	MG/DL
UA SPECIFIC GRAVITY	1.031	H	1.020			(1.003-1.030)	
UA BLOOD	NEGATIVE		NEGATIVE			(NEGATIVE)	
UA PH	6.5		5.5			(5-9)	
UA PROTEIN	100	*	30	*		(NEGATIVE)	MG/DL
UA UROBILINOGEN	NORMAL		1.0	*		(NORMAL)	E.U./DL
UA NITRITE	NEGATIVE		NEGATIVE			(NEGATIVE)	
UA LEUK ESTERASE	NEGATIVE		NEGATIVE			(NEGATIVE)	
UA RBC	NONE SEEN		NONE SEEN			(0-2)	/HPF
UA WBC	0-2	*	NONE SEEN			(NONE SEEN)	/HPF
UA EPITHELIAL CELLS	2-5		0-2			(2-5)	/HPF
UA BACTERIA	TRACE	*	TRACE	*		(NONE SEEN)	
UA CRYSTALS OTHER	NONE SEEN		(GT)	*		(NONE SEEN)	

(GT) CALCIUM OXALATE 1+ *

UA CASTS	NONE SEEN		NONE SEEN			(NONE SEEN)	/LPF
UA OTHER	NONE SEEN		NONE SEEN			(NONE SEEN)	
UA REDUCING SUBST	1%(GU)		NEGATIVE			(NEGATIVE)	

(GU) Critical result(s) called on 06/23/08 at 0057 by
DLAB.DLL2 have been verbally verified with MILLIE MUNOZ,RN.

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
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Las Vegas, Nevada 89109

LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

MEDICAL RECORDS COPY
08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** BODY FLUID STUDIES ***

FLUID CHEMISTRY

	Date	Time		Reference	Units
	06/24/08	1440			
CSF GLUCOSE	67			(40-75)	MG/DL
CSF PROTEIN	106	H		(15-45)	MG/DL

BODY FLUID HEME

	Date	Time		Reference	Units
	06/24/08	1440			
FLUID SOURCE	CSF TUBE 3				
BODY FLUID VOLUME	5.0				ML
BODY FLUID COLOR	COLORLESS				
FLUID APPEARANCE	CLEAR				
FLUID WBC	1				/MM3
FLUID RBC	86				/MM3

*** FECAL ANALYSIS ***

	Date	Time		Reference	Units
	07/03/08	2030	06/25/08 0915		
STOOL OCCULT BLOOD	POSITIVE	*		(NEGATIVE)	
ROTAVIRUS ANTIGEN			NEGATIVE	(NEGATIVE)	

Test	Date	Time	Result		Reference	Units
RETIC#	08/01/08	0500	16.2	L	(48.2-88.2)	X10E9/L
RETIC#	07/14/08	0345	30.0	L	(48.2-88.2)	X10E9/L
IRF	08/01/08	0500	11.6	L	(13.4-23.3)	%
IRF	07/14/08	0345	3.7	L	(13.4-23.3)	%

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

NONE

Col Date	Time	Specimen #	Source	Sp Desc	P/F	Organisms ...
07/26/08	0640	08:SZ:B0041605R	TRACH ASP		F	E CLOACAE

*** BACTERIOLOGY ***

SPEC #: 08:SZ:B0027287R COLL: 05/15/08-UNK STATUS: COMP REQ #: 10238201
RECD: 05/15/08-2031 SUBM DR: BLAHNIK,MARTIN J
SOURCE: ABDOMINAL
SPDESC:

ORDERED: SURG CULT

GRAM STAIN *Final 05/15/08*
GRAM STAIN NO ORGANISMS SEEN

CULTURE SURGICAL *Final 05/19/08*
NO GROWTH

SPEC #: 08:SZ:B0035067S COLL: 06/24/08-1440 STATUS: COMP REQ #: 10340711
RECD: 06/24/08-1513 SUBM DR: MILLER,GREG S
SOURCE: CSF
SPDESC: CSF

ORDERED: CSF CULT/GRAM

GRAM STAIN CSF *Final 06/24/08*
GRAM STAIN FEW WHITE BLOOD CELLS
NO ORGANISMS SEEN

CSF CULTURE *Final 06/28/08*
NO GROWTH

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** URINE CULTURE ***

SPEC #: 08:SZ:B0029962R COLL: 05/30/08-0010 STATUS: COMP REQ #: 10273628
RECD: 05/30/08-0020 SUBM DR: PIROOZI,ALI

SOURCE: URINE
SPDESC: FOLEY

ORDERED: URINE CULT

CULTURE URINE W/COLONY COUNT *Final 06/01/08*
<1,000 COL/ML - NO GROWTH

SPEC #: 08:SZ:B0031498S COLL: 06/07/08-0045 STATUS: COMP REQ #: 10294209
RECD: 06/07/08-0140 SUBM DR: PIROOZI,ALI

SOURCE: URINE
SPDESC: CATHETER

ORDERED: URINE CULT

CULTURE URINE W/COLONY COUNT *Final 06/09/08*
NO GROWTH

SPEC #: 08:SZ:B0033237R COLL: 06/15/08-1430 STATUS: COMP REQ #: 10316708
RECD: 06/15/08-1436 SUBM DR: PIROOZI,ALI

SOURCE: URINE
SPDESC: CATHETER

ORDERED: URINE CULT

CULTURE URINE W/COLONY COUNT *Final 06/17/08*
NO GROWTH

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** URINE CULTURE *** (continued)

SPEC #: 08:SZ:B0034772R COLL: 06/23/08-0000 STATUS: COMP REQ #: 10336572
RECD: 06/23/08-0015 SUBM DR: NAGAR,DEEPA
SOURCE: URINE
SPDESC: CATHETER

ORDERED: URINE CULT

CULTURE URINE W/COLONY COUNT *Final 06/25/08*
NO GROWTH

SPEC #: 08:SZ:B0037386S COLL: 07/06/08-0520 STATUS: COMP REQ #: 10369054
RECD: 07/06/08-0530 SUBM DR: PIROOZI,ALI
SOURCE: URINE
SPDESC: CATHETER

ORDERED: URINE CULT

CULTURE URINE W/COLONY COUNT *Final 07/08/08*
NO GROWTH

*** BACTERIOLOGY ***

RESPIRATORY CULTURE

SPEC #: 08:SZ:B0027215R COLL: 05/15/08-1135 STATUS: COMP REQ #: 10237262
RECD: 05/15/08-1311 SUBM DR: BLAHNIK,MARTIN J
SOURCE: ENDOTRACH
SPDESC:

ORDERED: TRACHEAL CULT

GRAM STAIN SPUTUM *Final 05/15/08*
GRAM STAIN FEW WHITE BLOOD CELLS
NO ORGANISMS SEEN

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** BACTERIOLOGY *** (continued)

RESPIRATORY CULTURE

SPEC #: 08:SZ:B0027215R COLL: 05/15/08-1135 STATUS: COMP REQ #: 10237262
RECD: 05/15/08-1311 SUBM DR: BLAHNIK,MARTIN J

SOURCE: ENDOTRACH
SPDESC:

ORDERED: TRACHEAL CULT

TRACHEAL CULTURE *Final 05/17/08*
NO GROWTH

SPEC #: 08:SZ:B0041605R COLL: 07/26/08-0640 STATUS: COMP REQ #: 10422194
RECD: 07/26/08-0722 SUBM DR: MORKOS,ASHRAF A

SOURCE: TRACH ASP
SPDESC:

ORDERED: TRACHEAL CULT

GRAM STAIN SPUTUM *Final 07/26/08*
GRAM STAIN — RARE POLYMORPHONUCLEAR LEUKOCYTES
RARE EPITHELIAL CELLS
NO ORGANISMS SEEN

TRACHEAL CULTURE *Final 07/28/08*
CULTURE WORKUP — *** NO NORMAL FLORA ISOLATED ***

Organism 1 — ENTEROBACTER CLOACAE
QUANTITATION — LIGHT GROWTH

1. ENTEROBACTER CLOACAE

	MIC	INTERP
AMIKACIN	<=16	S
AMPICILLIN	>16	R
AMP/SULBACTAM	>16/8	R
AMOX/CLAVULAN	>16/8	R
AZTREONAM	>16	R
CEFAZOLIN	>16	R
CEFEPIME	<=8	S
CEFTRIAXONE	>32	R

*** MED REC DISCHARGE REPORT ***

MEDICAL RECORDS COPY
08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** BACTERIOLOGY *** (continued)

RESPIRATORY CULTURE

SPEC #: 08:SZ:B0041605R COLL: 07/26/08-0640 STATUS: COMP REQ #: 10422194
RECD: 07/26/08-0722 SUBM DR: MORKOS,ASHRAF A

SOURCE: TRACH ASP
SPDESC:

ORDERED: TRACHEAL CULT

TRACHEAL CULTURE (continued)
1. ENTEROBACTER CLOACAE (continued)

	MIC	INTERP
CEFUROXIME	>16	R
GENTAMICIN	<=4	S
IMIPENEM	<=4	S
LEVOFLOXACIN	<=2	S
MEROPENEM	<=4	S
PIPERACIL/TAZO	>64	R
TETRACYCLINE	<=4	S
TOBRAMYCIN	<=4	S
TRIMETH/SULFA	<=2/38	S

MIC = LOWEST CONCENTRATION (MCG/ML) OF ANTIBIOTIC WHICH INHIBITS ORGANISMS IN VITRO.
SENSITIVE OR RESISTANCE IS BASED ON ACHIEVABLE BLOOD LEVEL, USUALLY 2 TO 4 TIMES THE MIC.
ABL= (ACHIEVABLE BLOOD LEVEL) - THE APPROXIMATE PEAK CONCENTRATION LEVEL (MCG/ML) IN AVERAGE SIZE ADULTS USING THE RECOMMENDED DOSAGE.
-UR- INDICATES LOWER URINARY TRACT ONLY.

*** MED REC DISCHARGE REPORT ***

MEDICAL RECORDS COPY
08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** BLOOD CULTURE ***

SPEC #: 08:SZ:BC0012494S COLL: 05/14/08-0110 STATUS: COMP REQ #: 10232999
RECD: 05/14/08-0121 SUBM DR: BLAHNIK,MARTIN J
SOURCE: BLOOD
SPDESC: UAC

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 05/20/08*
NO GROWTH

SPEC #: 08:SZ:BC0012631R COLL: 05/15/08-1135 STATUS: COMP REQ #: 10237271
RECD: 05/15/08-1311 SUBM DR: BLAHNIK,MARTIN J
SOURCE: BLOOD
SPDESC: UAC

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 05/21/08*
NO GROWTH

SPEC #: 08:SZ:BC0012632R COLL: 05/15/08-1135 STATUS: COMP REQ #: 10237271
RECD: 05/15/08-1311 SUBM DR: BLAHNIK,MARTIN J
SOURCE: BLOOD
SPDESC: UVC

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 05/21/08*
NO GROWTH

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** BLOOD CULTURE *** (continued)

SPEC #: 08:SZ:BC0013769S COLL: 05/29/08-2010 STATUS: COMP REQ #: 10273284
RECD: 05/29/08-2046 SUBM DR: PIROOZI,ALI
SOURCE: BLOOD
SPDESC: ART LINE

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 06/04/08*
NO GROWTH

SPEC #: 08:SZ:BC0013770S COLL: 05/29/08-2010 STATUS: COMP REQ #: 10273284
RECD: 05/29/08-2046 SUBM DR: PIROOZI,ALI
SOURCE: BLOOD
SPDESC: PICC LINE

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 06/04/08*
NO GROWTH

SPEC #: 08:SZ:BC0014433S COLL: 06/07/08-0045 STATUS: COMP REQ #: 10294209
RECD: 06/07/08-0139 SUBM DR: PIROOZI,ALI
SOURCE: BLOOD
SPDESC: ARM RIGHT

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 06/13/08*
NO GROWTH

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** BLOOD CULTURE *** (continued)

SPEC #: 08:SZ:BC0015126R COLL: 06/15/08-1430 STATUS: COMP REQ #: 10316706
RECD: 06/15/08-1453 SUBM DR: PIROOZI,ALI
SOURCE: BLOOD
SPDESC: ARM LEFT

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 06/21/08*
NO GROWTH

SPEC #: 08:SZ:BC0015774R COLL: 06/22/08-2130 STATUS: COMP REQ #: 10336404
RECD: 06/22/08-2149 SUBM DR: NAGAR,DEEPA
SOURCE: BLOOD
SPDESC: ARTERIAL P

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 07/24/08*
NO GROWTH

SPEC #: 08:SZ:BC0015997R COLL: 06/25/08-1755 STATUS: COMP REQ #: 10343732
RECD: 06/25/08-1819 SUBM DR: BLAHNIK,MARTIN J
SOURCE: BLOOD
SPDESC: ARM RIGHT

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 07/01/08*
NO GROWTH

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

*** BLOOD CULTURE *** (continued)

SPEC #: 08:SZ:BC0016846R COLL: 07/06/08-0507 STATUS: COMP REQ #: 10369045
RECD: 07/06/08-0520 SUBM DR: PIROOZI,ALI
SOURCE: BLOOD
SPDESC: PERIPHERAL

ORDERED: BLOOD CULT

BLOOD CULTURE *Final 07/12/08*
NO GROWTH

*** MYCOLOGY ***

FUNGUS

SPEC #: 08:SZ:F0001208S COLL: 06/23/08-1700 STATUS: COMP REQ #: 10338521
RECD: 06/23/08-1810 SUBM DR: BLAHNIK,MARTIN J
SOURCE: URINE
SPDESC: CATHETER

ORDERED: FUNGUS

FUNGUS CULTURE *Final 07/21/08*
NO GROWTH

SPEC #: 08:SZ:F0001230S COLL: 06/26/08-1000 STATUS: COMP REQ #: 10345255
RECD: 06/26/08-1011 SUBM DR: BLAHNIK,MARTIN J
SOURCE: BLOOD
SPDESC: ARTERIAL P

ORDERED: FUNGUS BLD

FUNGUS CULTURE BLOOD *Final 07/24/08*
NO GROWTH

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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LABORATORY DISCHARGE SUMMARY

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Pt Name: HURST,BG-TIFFANI D.2033-0

*** VIROLOGY ***

SPEC #: 08:SZ:V0003718R COLL: 06/25/08-0915 STATUS: COMP REQ #: 10342512
RECD: 06/25/08-0937 SUBM DR: BLAHNIK,MARTIN J

SOURCE: STOOL
SPDESC:

ORDERED: C. DIFF

C. DIFFICILE TOXIN ASSAY *Final 06/25/08*
NEGATIVE

SPEC #: 08:SZ:V0003863R COLL: 07/03/08-2030 STATUS: COMP REQ #: 10363734
RECD: 07/03/08-2055 SUBM DR: MILLER,GREG S

SOURCE: STOOL
SPDESC:

ORDERED: C. DIFF

C. DIFFICILE TOXIN ASSAY *Final 07/04/08*
NEGATIVE

SPEC #: 08:SZ:B0026917R COLL: 05/14/08-0100 STATUS: COMP REQ #: 10233001
RECD: 05/14/08-0119 SUBM DR: BLAHNIK,MARTIN J

SOURCE: NASAL
SPDESC: LFT & RGHT

ORDERED: MRSA-VRE SCREEN

MRSA SURVEILLANCE SCREEN *Final 05/16/08*
NO METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS ISOLATED

VRE SURVEILLANCE SCREENING *Final 05/16/08*
NO VANCOMYCIN RESISTANT ENTEROCOCCUS ISOLATED

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

SPEC #: 08:SZ:B0027287R COLL: 05/15/08-UNK STATUS: COMP REQ #: 10238201
RECD: 05/15/08-2031 SUBM DR: BLAHNIK,MARTIN J
SOURCE: ABDOMINAL
SPDESC:

ORDERED: SURG CULT

ANAEROBIC CULTURE *Final 05/19/08*
NO ANAEROBES ISOLATED

SPEC #: 08:SZ:B0029267R COLL: 05/26/08-1200 STATUS: COMP REQ #: 10264576
RECD: 05/26/08-1208 SUBM DR: BLAHNIK,MARTIN J
SOURCE: NASAL
SPDESC: LFT & RGHT

ORDERED: MRSA-VRE SCREEN

MRSA SURVEILLANCE SCREEN *Final 05/28/08*
NO METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS ISOLATED

VRE SURVEILLANCE SCREENING *Final 05/28/08*
NO VANCOMYCIN RESISTANT ENTEROCOCCUS ISOLATED

SPEC #: 08:SZ:B0032205R COLL: 06/10/08-1150 STATUS: COMP REQ #: 10302531
RECD: 06/10/08-1158 SUBM DR: BLAHNIK,MARTIN J
SOURCE: NASAL
SPDESC: UNSPECIFIE

ORDERED: MRSA-VRE SCREEN

MRSA SURVEILLANCE SCREEN *Final 06/12/08*
NO METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS ISOLATED

VRE SURVEILLANCE SCREENING *Final 06/12/08*
NO VANCOMYCIN RESISTANT ENTEROCOCCUS ISOLATED

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

SPEC #: 08:SZ:B0034871R COLL: 06/23/08-1215 STATUS: COMP REQ #: 10337854
RECD: 06/23/08-1226 SUBM DR: BLAHNIK,MARTIN J
SOURCE: NASAL
SPDESC: LFT & RGHT

ORDERED: MRSA-VRE SCREEN

MRSA SURVEILLANCE SCREEN *Final 06/25/08*
NO METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS ISOLATED

VRE SURVEILLANCE SCREENING *Final 06/25/08*
NO VANCOMYCIN RESISTANT ENTEROCOCCUS ISOLATED

SPEC #: 08:SZ:B0037638R COLL: 07/07/08-1450 STATUS: COMP REQ #: 10372840
RECD: 07/07/08-1635 SUBM DR: BLAHNIK,MARTIN J
SOURCE: NASAL
SPDESC: LFT & RGHT

ORDERED: MRSA-VRE SCREEN

MRSA SURVEILLANCE SCREEN *Final 07/09/08*
NO METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS ISOLATED

VRE SURVEILLANCE SCREENING *Final 07/09/08*
NO VANCOMYCIN RESISTANT ENTEROCOCCUS ISOLATED

SPEC #: 08:SZ:B0040955R COLL: 07/23/08-0930 STATUS: COMP REQ #: 10414548
RECD: 07/23/08-1023 SUBM DR: BLAHNIK,MARTIN J
SOURCE: NASAL
SPDESC: LFT & RGHT

ORDERED: MRSA-VRE SCREEN

MRSA SURVEILLANCE SCREEN *Final 07/25/08*
NO METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS ISOLATED

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

SPEC #: 08:SZ:B0040955R COLL: 07/23/08-0930 STATUS: COMP REQ #: 10414548
RECD: 07/23/08-1023 SUBM DR: BLAHNIK,MARTIN J
SOURCE: NASAL
SPDESC: LFT & RGHT

ORDERED: MRSA-VRE SCREEN

VRE SURVEILLANCE SCREENING *Final 07/25/08*
NO VANCOMYCIN RESISTANT ENTEROCOCCUS ISOLATED

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

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Pt Name: HURST,BG-TIFFANI D.2033-0

**** BLOOD BANK ****

BLOOD BANK

	COLLECTED: May 14, 2008 1:10am	Flag	Reference Units
BLOOD TYPE	O POS		
DIRECT COOMBS	NEGATIVE		(NEGATIVE)

	COLLECTED: May 14, 2008 0:06am	Flag	Reference Units
CORD TYPE	O POS		

	COLLECTED: May 14, 2008 0:06am	Flag	Reference Units
CORD DAT	NEGATIVE		(NEGATIVE)
MOTHER'S TYPE	O POS		

PCBABYS SYR C	W042208024043C	PRSMD TRFSD	O POS	07/26/08
PCBABYS SYR A	W042208024043A	PRSMD TRFSD	O POS	07/24/08
PCBABYS SYR E	W042208014120E	PRSMD TRFSD	O POS	07/03/08
PCBABY SYR D	W042208011688D	PRSMD TRFSD	O POS	06/25/08
PCBABY SYR A	W042208011688A	PRSMD TRFSD	O POS	06/23/08
PCBABYS SYR D	W042208012265D	PRSMD TRFSD	O POS	06/15/08
PCBABY SYR G	W042208000986G	PRSMD TRFSD	O POS	06/07/08
PCBABY SYR F	W042208000986F	PRSMD TRFSD	O POS	05/17/08
PCBABY SYR E	W042208000986E	PRSMD TRFSD	O POS	05/16/08
FLP QUAD 4	220167982A	PRSMD TRFSD	AB POS	05/15/08
PP BABY2 SYR A	W042208000504A	PRSMD TRFSD	O POS	05/15/08
PCBABY SYR D	W042208000986D	PRSMD TRFSD	O POS	05/15/08
PCBABY SYR B	W042208000986B	PRSMD TRFSD	O POS	05/14/08
PCBABY SYR C	W042208000986C	PRSMD TRFSD	O POS	05/14/08

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
3186 Maryland Pkwy
Las Vegas, Nevada 89109

LABORATORY DISCHARGE SUMMARY

*** MED REC DISCHARGE REPORT ***

MEDICAL RECORDS COPY
08/05/08 0113

Pt Name: HURST,BG-TIFFANI D.2033-0

Mother and Child Comparative Results

Mother: HURST,TIFFANI D00097975761 (D001662301)
Child: HURST,BG-TIFFANI D00097976535 (D001796258)

Laboratory Tests

Collected	Mother Result	Abn	Range	Child Result	Abn	Range
HEPATITIS B SURFACE AG						
05/12/08-1225	NEGATIVE			NEGATIVE		

Blood Bank Tests

Collected	Mother Result	Abn	Range	Child Result	Abn	Range
BLOOD TYPE						
05/14/08-0110				O POS		
05/12/08-1045	O POS					
BLOOD TYPE						
05/14/08-0006				O POS		
AB SCREEN						
05/12/08-1045	NEGATIVE					
CORD DAT REPORT						
05/14/08-0006				NEGATIVE		NEGATIVE

Sunrise - MayRose
001098

Pt Name: HURST,BG-TIFFANI
Attend Dr: BLAHNIK,MARTIN J
Acct#: D00097976535 Age/Sex: 02M 19D/F
Unit#: D001796258 Status: DIS IN
Adm Date: 05/14/08 Dis Date: 08/02/08

SUNRISE HOSPITAL & MEDICAL CENTER
3186 Maryland Pkwy
Las Vegas, Nevada 89109

LABORATORY DISCHARGE SUMMARY

EXHIBIT G

NEONATAL DISCHARGE SUMMARY

Abdominal radiograph (7/30/2008 - 7/30/2008)
Ileostomy (5/16/2008 - 7/26/2008)
Exploratory Laparotomy (5/16/2008 - 5/16/2008)
Broviac placement (7/26/2008 - 7/26/2008)
Osteomy takedown (7/24/2008 - 7/24/2008)
Ranitidine (6/29/2008 - 7/31/2008)
Motility agent(Erythromycin) (7/2/2008 - 7/22/2008)

RESPIRATORY

The highest oxygen percentage used was 55%.
DIAGNOSES:
pneumoperitoneum (5/15/2008 - 5/16/2008)
Atelectasis (5/16/2008 - 5/26/2008)

TREATMENTS:
Ventilation (5/15/2008 - 5/21/2008)
Ventilation (7/24/2008 - 7/26/2008) Reintubated for surgical reanastomosis
Oxygen (5/14/2008 - 6/29/2008)
Continuous positive airway pressure (5/14/2008 - 5/15/2008)
High flow nasal cannula oxygen (5/21/2008 - 5/29/2008)
High flow nasal cannula oxygen (6/7/2008 - 6/29/2008)
Chest X-Ray (5/14/2008 - 5/29/2008)
Intubation (5/14/2008 - 5/14/2008)
Surfactant (5/14/2008 - 5/14/2008)
Caffeine (6/23/2008 - 7/4/2008), 10 mg/day Given 20/kg load and 5/kg/day for increased alarms and periodic breathing with desaturations and decelerations

HEMATOLOGY

The initial hematocrit was 31% on 5/15/2008. The most recent hematocrit was 30% on 8/1/2008. She was given 5 transfusions. The blood type is O+. The DAT is negative. The highest bilirubin level was 10.34 mg/dl on 5/20/2008 The last bilirubin level was 2.8 mg/dl on 7/28/2008.
DIAGNOSES:
Anemia of prematurity (5/15/2008 - 7/21/2008)
Jaundice due to prematurity (5/16/2008 - 5/26/2008)

TREATMENTS:
Red blood cell transfusion (5/15/2008 - 6/23/2008), 2 times Transfused also 6/22
Phototherapy (5/16/2008 - 5/26/2008)
Phototherapy (5/28/2008 - 5/31/2008)
Platelet transfusion (5/15/2008 - 5/15/2008)
Transfusion of coagulation factors (5/15/2008 - 5/15/2008)

INFECTIOUS DISEASE

DIAGNOSES:
Sepsis suspected (>5 days therapy) (5/14/2008 - 6/21/2008)

TREATMENTS:
Lumbar puncture (6/24/2008 - 6/24/2008)
Ampicillin and Gentamicin (#1) (5/14/2008 - 5/24/2008)
Antibiotics (1st course) (5/15/2008 - 5/24/2008)
Antibiotics (2nd course) (5/30/2008 - 6/4/2008) vanco / cefotaxime for ileus/bilious emesis
Cefotaxime and Vancomycin (#3) (6/15/2008 - 6/21/2008)

8/2/2008 10:06

NEONATAL DISCHARGE SUMMARY

Ampicillin and Cefotaxime (#4) (6/22/2008 - 6/23/2008) Started on 6/22 for lethargy, increased CRP and left shift. Note: just completed Vanco and Claforan course 6/21-will watch closely and consider changing abx if poor respons
Antibiotics (4th course) (6/23/2008 - 7/4/2008) Vanco and Claforan switched to Meropenem, Tobra, and Ampho due to clinical worsening.
Vancomicin and Cefotaxime (7/6/2008 - 7/14/2008)
Cefotaxime and Vancomycin (#6) (7/24/2008 - 7/29/2008)
Hib Vaccine (8/1/2008 - 8/2/2008)
Pediatrix (DaPT/Hep B/inactive polio) (8/1/2008 - 8/2/2008)
Pneumococcal vaccine (8/1/2008 - 8/2/2008)
Antifungal therapy (6/27/2008 - 7/1/2008)

CARDIAC No issues

NEURO & SCREENING

The most recent neurological tracking showed: Head ultrasound: WNL on 5/18, subacute IVH G1 on 8/1, Eye exam: St 1, Z 2 bilaterally 7/24, Hearing test: due before discharge.

DIAGNOSES:
Germinal matrix bleed (grade 1) (8/1/2008 -)

TREATMENTS:
Head ultrasound (5/15/2008 - 7/31/2008), 2 exams 2nd HUS 5/18
ROP screen immature (7/3/2008 -)

GENITOURINARY No issues

MUSCULOSKELETAL No issues

GENETIC / ENDOCRINE No issues

ADDITIONAL ISSUES

r/o mastoiditis (7/6/2008 - 7/6/2008) CT showed normal mastoid air cells, soft tissue swelling posterior to left ear with no evidence abscess
Morphine sulfate (5/15/2008 - 5/18/2008)
Analgesia / Sedation (5/18/2008 - 5/26/2008) start fentanyl prn
Fentanyl drip (7/26/2008 - 7/27/2008)
Morphine sulfate (7/27/2008 - 7/29/2008)

Blood type: O+. DAT: negative
Social issues: Mom is comfortable to take care of the infant at home, discussed care with the family, family visiting frequently, discharge planning underway, over 30 minutes of discharge activities, mom is getting CPR classes prior discharge.
INTERIM Hx: good output, passed stool, no acute changes over last day, status improved, tolerates full feeds,

EXAM

Weight (g): 2680 (5 lbs, 14 oz) Length (cm): 45 Head circ (cm): 34
VITAL SIGNS: Temperature: 36.8 Heart rate: 135 Respiratory rate: 47 Blood pressure: 84 / 59 Mean BP: 69
Oxygen saturation: 100
GENERAL: alert and active, pink and well perfused
SKIN: no rashes
HEAD: open, flat anterior fontanelle
EYES: no anomalies, equal red relexes
EARS: normally set, no anomalies

8/2/2008 10:06

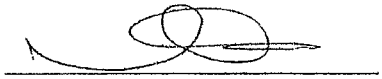
NEONATAL DISCHARGE SUMMARY

NOSE & MOUTH: nares patient, palate intact
NECK & CLAVICLES: no neck masses, intact clavicles
LUNGS & CHEST: no distress, clear and equal breath sounds
CARDIAC: normal rate and rhythm, no murmurs, good femoral pulses
ABDOMEN & CORD: soft, non-tender, no masses or organomegaly, drying cord
GENITALIA: normal external genitalia
BACK & SPINE: straight spine
LIMBS & HIPS: moves all 4 limbs, stable hips
NEUROLOGIC: normal suck, symmetric Moro, good strength and tone

Special considerations: 1) The infant requires a Sweat Chloride test by 3 months of age due to abnormal CF(IRT) newborn screening test. 2) The infant requires a Head U/S within 1 month after discharge to follow grade 1 subacute IVH.
State newborn screen: abnormal

PLANS

May was discharged to home on 8/2/2008.
The family was instructed to call Dr. Conti for an appointment in 3 days.
Additional appointments: 1) OT and PT follow ups.
2) Follow up with Peds Surgery, 2weeks after discharge.
3) Follow up with early intervention clinic 2weeks after dischrage.
4) Follow up with Peds. Ophthalmologist on 8/13/2008.
Feeding at discharge: MBM ad lib Po Q3-4.
Pending results: The infant requires a Sweat Chloride test by 3 months of age.
The infant requires a follow up Head U/S one months after discharge.
Follow-up tests: 1) Sweat test; 2) Head U/S; 3) CBC, Dif, Retic 1 month after discharge.
Discharge medications: Poly- Vi-Sol with iron 1ml po qd
Special Instructions to family: Peds ER if the infant develops any distress, T> 100.3, Poor appetite, or any unusual symptoms.



Ali Piroozi, M.D.

CC's to: Ralph M. Conti, M.D. 6301 Mountain Vista Suite 205 Henderson, NV 89014
Troy Reyna, M.D. Las Vegas, NV
Michael G. Scheidler, M.D. 3121 S. Maryland Pkwy, Suite 400 Las Vegas, NV 89109
Bruce E. Snyder, M.D. 2090 E. Flamingo Road, Suite 200 Las Vegas, NV 89119

NEONATAL DISCHARGE SUMMARY

Hurst, baby girl
aka May Hurst
Mother: Tiffani Hurst
Birth weight: **1280 g** **(2 lbs, 13oz)**
Singleton Gestation

Neonatologist: **Martin Blahnik, M.D.**
Follow Up Physician: **Ralph M. Conti, M.D.**
Delivering Obstetrician:
Delivery date: 5/14/2008 time: 00:06
Discharge: 8/2/2008 Time: 12:00 LOS: 80 days

ADMISSION DIAGNOSES
Hypoglycemia (admit), Prematurity (admit), Respiratory distress (admit), Suspected sepsis (admit)

DIAGNOSES
Gastrointestinal perforation, Bowel perforation, Delayed gastric emptying, Slow feeder, pneumoperitoneum, Atelectasis, Germinal matrix bleed (grade 1), Anemia of prematurity, Jaundice due to prematurity, Sepsis suspected (>5 days therapy), Hypoglycemia (<40), Hyperphosphatemia, r/o mastoiditis

PROCEDURES & TREATMENTS
Intravenous fluids, Parenteral nutrition, Umbilical artery line, Umbilical venous line, Central venous line, PICC line, Continuous drip feeds, Gavage feeding, Gastric suction tube, Abdominal radiograph, Ileostomy, Exploratory Laparotomy, Broviac placement, Osteomy takedown, Motility agent(Erythromycin), Ranitidine, Ventilation, Oxygen, Continuous positive airway pressure, High flow nasal cannula oxygen, Chest X-Ray, Intubation, Surfactant, Caffeine, Head ultrasound, ROP screen immature, Red blood cell transfusion, Phototherapy, Platele transfusion, Transfusion of coagulation factors, Lumbar puncture, Ampicillin and Gentamicin (#1), Antibiotics (1st course), Antibiotics (2nd course), Cefotaxime and Vancomycin (#3), Ampicillin and Cefotaxime (#4), Antibiotics (4th course), Vancomicin and Cefotaxime , Cefotaxime and Vancomycin (#6), Hib Vaccine, Pediatrix (DaPT/Hep B/inactive polio), Pneumococcal vaccine, Antifungal therapy, Analgesia / Sedation, Fentanyl drip, Morphine sulfate

MATERNAL HISTORY
May was born at 28 6/7 weeks (by dates) to a 39 year old woman who was G 3 and P 2 (TAB 1) at the time of delivery.

Prenatal Labs: Blood Type: **O** Rh: **pos** Antibody: **nonrespon** Hepatitis B: **negative**
Rubella status: **immune** RPR: **nonreactive** Length ROM: **Ruptured at delivery.**

GBS Status: **unknown**

Maternal diagnoses and procedures during the pregnancy, labor and delivery included:
Antepartum events: None noted. L&D events: Advanced Maternal Age (multiparous), Preterm labor with delivery, Terbutaline, Indocin, Steroids - complete course
Mom admitted 5/12 to the hospital. PTL w/ FHR decels and non-reassuring strip, AROM at the time of repeat C-section. AFI WNL. Pt admitted for flank pain / then non-reassuring FHR. Meds included PNV, beta-methasone, procardia, terbutaline, indocin, pitocin. Urine tox negative.

DELIVERY **Cesarean, unspecified**
Apgars 1 min: **03** 5 min: **06** 10 min: **07**
Resuscitation: 02, mask vent
Martin Blahnik, M.D. was called to the delivery room because of Preterm baby. Delivery analgesia used: spinal. Suctioning at delivery: bulb. The respiratory effort at birth was delayed 1 min. Delivery outcome: live birth admitted to ICN.
CPAP given for poor respiratory effort. Pulse ox increase on 60% 02 to low 80s, then higher on CPAP so that 02 wa weaned to less than 50% with good sats and improved respiratory effort after 5min.

ADMISSION HISTORY

NEONATAL DISCHARGE SUMMARY

ADMIT EXAM

Weight (g): 1280 (2 lbs, 13 oz) Length (cm): 37 Head circ (cm): 27.5 GA Exam: 28 6/7 wks AGA
VITAL SIGNS: Temperature: 36.8 Heart rate: 150 Respiratory rate: 30 Blood pressure: 40-40 / 18-20 Mean BP: 22-23 Oxygen saturation: 93
GENERAL: CPAP in place, immature infant, exam consistent with dates
SKIN: no icterus or rashes
HEAD: open, flat anterior fontanelle
EYES: normal shape and size
EARS: immature cartilage, normally set, no anomalies
NOSE & MOUTH: nares appear patent, intact palate
NECK & CLAVICLES: no masses, clavicles intact
LUNGS & CHEST: CTA with some grunting
CARDIAC: normal rate and rhythm, no murmurs, pulses equal in all 4 extremities
ABDOMEN & CORD: no hepatomegaly, 3 vessel cord
GENITALIA: immature female external genitalia, appropriate for age
BACK & SPINE: straight spine
LIMBS & HIPS: symmetric, moves all 4 limbs, 10 fingers and toes
NEUROLOGIC: appropriate strength and tone for gestational age

CUMULATIVE SUMMARY

May was cared for in the ICN for 80 days.The hospital course will be summarized by a problem list.

FLUID AND NUTRITION

Her nadir in weight was 1280 grams(2 lbs, 13oz) on 5/14/2008. She gained an average of 18 grams a day to a current weight of 2680 grams. A caloric intake of 80 kcal/kg or more was reached on day 7.
DIAGNOSES:
Hypoglycemia (<40) (5/14/2008 - 5/14/2008)
Gastrointestinal perforation (5/15/2008 - 5/16/2008)
Bowel perforation (5/15/2008 - 5/16/2008)
Hyperphosphatemia (6/16/2008 - 6/29/2008)
Delayed gastric emptying (7/2/2008 - 7/31/2008)
Slow feeder (7/29/2008 - 8/1/2008)

TREATMENTS:
Intravenous fluids (5/14/2008 - 6/18/2008)
Intravenous fluids (6/19/2008 - 6/27/2008)
Intravenous fluids (7/24/2008 - 7/26/2008)
Intravenous fluids (7/31/2008 - 8/1/2008)
Parenteral nutrition (5/14/2008 - 6/19/2008)
Parenteral nutrition (6/27/2008 - 7/6/2008)
Parenteral nutrition (7/25/2008 - 7/31/2008)
Umbilical artery line (5/14/2008 - 5/22/2008)
Umbilical venous line (5/14/2008 - 5/21/2008)
Central venous line (5/21/2008 - 5/27/2008) PICC placed by nursing, tip in subclavian near SVC
PICC line (7/5/2008 - 7/8/2008)
Central venous line (7/29/2008 - 8/1/2008)
Gavage feeding (5/25/2008 - 5/27/2008) Ileus 5/27, made NPO
Gavage feeding (6/10/2008 - 6/29/2008)
Gavage feeding (6/18/2008 - 7/1/2008)
Continuous drip feeds (7/5/2008 - 7/14/2008)
Gastric suction tube (5/15/2008 - 5/18/2008)

BEFORE THE SUPREME COURT OF THE STATE OF NEVADA

* * * *

ALI PIROOZI, M.D.,

Petitioner,

v.

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, AND THE HONORABLE JAMES BIXLER, DISTRICT COURT JUDGE,

Respondent.

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST,

Real Parties in Interest.

Supreme Court No. 64946

EJDC Case No. A-10-616728-C

APPENDIX TO REAL PARTIES IN INTEREST, TIFFANI HURST, BRIAN ABBINGTON AND MAYROSE LILI-ABBINGTON HURST'S ANSWER TO PETITIONER'S EMERGENCY PETITION FOR WRIT OF MANDAMUS

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CERTIFICATE OF SERVICE

I hereby certify that on this 10th day of February, 2014, I forwarded a copy of the above and foregoing **APPENDIX TO REAL PARTIES IN INTEREST, TIFFANI HURST, BRIAN ABBINGTON AND MAYROSE LILI-ABBINGTON HURST'S ANSWER TO PETITIONER'S EMERGENCY PETITION FOR WRIT OF MANDAMUS**, via e-filing and first class, postage prepaid to:

The Honorable James Bixler
Eighth Judicial District Court
Department 24
Regional Justice Center
200 Lewis Avenue
Las Vegas, Nevada 89155
Respondent

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/s/ Candace Gleed

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CLERK OF THE COURT

NEO

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DISTRICT COURT
CLARK COUNTY, NEVADA

Tiffani D. Hurst and Brian Abbington, jointly and on behalf of their minor child, MayRose Lili-Abbington Hurst,

Plaintiffs,

vs.

Sunrise Hospital and Medical Center, LLC, Martin Blahnik, M.D., and Ali Piroozi, M.D.,

Defendants.

CASE NO. A-10-616728-C

DEPT. NO. XXIV

NOTICE OF ENTRY OF ORDER

Please take notice that an order regarding the parties' pre-trial motions and Motions for Summary Judgment was entered in this matter on the 3rd day of February, 2014. A copy of said Order is attached hereto.

DATED this 4th day of February, 2014.

EISENBERG, GILCHRIST & CUTT

/s/ Jacquelynn D. Carmichael
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Salt Lake City, Utah 84111
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on the 4th day of February, 2014, I emailed and mailed a true and correct copy, postage prepaid, of the foregoing **NOTICE OF ENTRY OF ORDER** to the following:

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CLERK OF THE COURT

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DISTRICT COURT
CLARK COUNTY, NEVADA

Tiffani D. Hurst and Brian Abbington, jointly and on behalf of their minor child, MayRose Lili-Abbington Hurst,

Plaintiffs,

vs.

Sunrise Hospital and Medical Center, LLC, Martin Blahnik, M.D., and Ali Piroozi, M.D.,

Defendants.

CASE NO. A-10-616728-C

DEPT. NO. XXIV

PRETRIAL ORDER
re: Motions for Summary Judgment and Motions in Limine

Plaintiffs and Defendants filed several Motions in the above-captioned case that came before the Court for hearing on November 6, 2013, January 8, 2014 and January 23, 2014. Jacquelynn D. Carmichael, Jeff Sbaih and Robert G. Gilchrist appeared on behalf of Plaintiffs. Marie Ellerton and Robert McBride appeared on behalf of Dr. Blahnik. Christopher G. Rigler appeared on behalf of Dr. Piroozi. Jonquil Whitehead and Kenneth Webster appeared on behalf of Sunrise Hospital.

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The Court, having reviewed the parties' Motions, and having heard argument from the parties, HEREBY ORDERS the following:

1. Defendants' Motion for Summary Judgment is **DENIED**. The parties dispute whether Dr. Blahnik and Dr. Piroozi caused MayRose's injuries. Causation is a question of fact traditionally resolved by the jury. In this case, there is a dispute regarding material facts surrounding the issue of causation. Therefore, this issue is left for the jury to decide and summary judgment is inappropriate.
2. Plaintiffs' Motion for Partial Summary Judgment is **DENIED**. Defendants may allocate fault to Plaintiffs provided they are able to introduce evidence during the trial that would support such an allocation of fault.
3. Plaintiffs' Motion in Limine No. 1 to exclude evidence of Dr. Conti's criminal matters and indictments is **GRANTED**. Defendants may not introduce evidence of Dr. Conti's criminal matters unless it is for the purpose of impeaching his credibility. Defendants will not be permitted to introduce Dr. Conti's deposition testimony favorable to them and also attempt to impeach him with evidence of his criminal matters unless Plaintiffs open the door for such impeachment by attempting to introduce evidence of Dr. Conti's good character. Accordingly, Dr. Conti's deposition testimony that will be played for the jury will be edited to exclude any references or discussion with regard to his criminal matters. If Defendants believe that Plaintiff has opened the door so as to permit impeachment of Dr. Conti with his criminal matters, the parties shall address this issue with the court outside the presence of the jury in order to obtain a ruling.
4. Plaintiffs' Motion in Limine No. 2 regarding Dr. Conti's settlement is **GRANTED.** Specifically, (1) The fact that a settlement has occurred and the amount of the settlement paid by Dr. Conti and Foothills Pediatrics will not be discussed at trial; (2)

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Defendants are not permitted to allocate fault to Dr. Conti and/or Foothills Pediatrics, compare their fault to Dr. Conti's and/or Foothills Pediatric's fault or place Dr. Conti and/or Foothills Pediatrics on the jury verdict form pursuant to NRS 41.141 and Banks v. Sunrise Hospital, 120 Nev. 822, 102 P.3d 52 (2004); (3) Defendants may argue to the jury that they are not at fault for MayRose's injuries and/or that Dr. Conti and/or Foothills Pediatrics is 100% at fault for her injuries; and (4) Plaintiffs are permitted to introduce the full measure of their damages and the Defendants will receive an offset if any verdict is rendered in the amount of any previous settlement amounts pursuant to NRS 41.141.

5. Plaintiffs' Motion in Limine No. 3 regarding collateral sources is **GRANTED**. The court finds that NRS 42.021 is expressly preempted by 5 U.S.C. § 8902(m)(1) and thus evidence of collateral sources is inadmissible at trial. In addition, the Court finds that the billed amount of MayRose's medical bills is the reasonable amount of her medical services, not the amount that was paid. Accordingly, any evidence of collateral sources showing reductions or write-offs to the billed amounts is excluded.

6. Plaintiffs' Motion in Limine No. 4 to exclude discussion of the cap on non-economic damages is **GRANTED IN PART and DENIED IN PART**. The court declines to rule on the constitutionality of the damages cap at this time. If necessary, an award for non-economic damages may be reduced post-trial by motion. Accordingly, evidence of or discussion about the non-economic damages cap under NRS 41A.035 is inadmissible.

The parties previously stipulated to a portion of Plaintiff's Motion in Limine No. 2, the entirety of Plaintiffs' Motion in Limine No. 5 and other issues relating to the admissibility of evidence. These Stipulations are attached as Exhibits A and B.

APPROVED AS TO FORM:

John H. Cotton
Christopher G. Rigler
Attorneys for Dr. Piroozi

1/31/14

Robert C. McBride
Marie Ellerton
Attorneys for Dr. Blahnik

DATED this 31st day of February, 2014.

CLARK COUNTY DISTRICT COURT

Honorable James M. Bixler

Eisenberg Gilchrist & Cutt
215 South State Street, Suite 900
Salt Lake City, Utah 84111
(801) 366-9100 Fax (801) 650-0065

CERTIFICATE OF SERVICE

I hereby certify that on the 20 day of January, 2014, I mailed a true and correct copy, postage prepaid, of the foregoing **[Proposed] PRETRIAL ORDER** to the following:

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crigler@jhcottonlaw.com
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/s/ Candace Gleed

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4812-2502-8376, v. 1

EXHIBIT A

ORIGINAL

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DISTRICT COURT

CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST, Plaintiffs, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC, MARTIN BLAHNICK, M.D., ALI PIROOZI, M.D., RALPH CONTI, M.D. and FOOTHILL PEDIATRICS LLC, Defendants.	CASE NO. A616728 DEPT NO. XXIV

NOTICE OF ENTRY OF ORDER

PLEASE TAKE NOTICE that an Stipulation and Order Regarding Certain Trial Evidentiary/Procedural Rulings was entered in the above-entitled Court on the 21st day of October, 2013, a copy of which is attached hereto.

DATED this 23rd day of October, 2013.

HALL PRANGLE & SCHOONVELD, LLC

By: */s/: Jonquil Whitehead*
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 23rd day of October, 2013, I served a true and correct copy of the foregoing **NOTICE OF ENTRY OF ORDER** in a sealed envelope, via U.S. Mail, first-class postage pre-paid to the following parties at their last known address:

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-and-
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Ali Piroozi, M.D.

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4824-7233-3334, v. 1

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CLERK OF THE COURT

DISTRICT COURT

CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST, Plaintiffs, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC, MARTIN BLAHNICK, M.D., ALI PIROOZI, M.D., RALPH CONTI, M.D. and FOOTHILL PEDIATRICS LLC, Defendants.	CASE NO. A616728 DEPT NO. XXIV

STIPULATION AND ORDER REGARDING CERTAIN TRIAL EVIDENTIARY/PROCEDURAL RULINGS

Trial Date: February 18, 2014

IT IS HEREBY STIPULATED AND AGREED, by all parties, by and through their respective counsel of record, to entry of the following trial evidentiary/procedural rulings.

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1. Alan H. Rosenthal, M.D., Kathleen Sakamoto, M.D., and Mark H. Rothschild, M.D., will not be called to testify at trial; and

2. It is uncontested and agreed by all parties that Plaintiff's Diamond Blackfan Anemia not being diagnosed in the NICU by Defendants Martin Blahnick, M.D., and Ali Piroozi, M.D., was not below the standard of care. All parties agree that it will not be argued before the jury that Plaintiff's Diamond Blackfan Anemia should have been diagnosed in the NICU by Defendants Martin Blahnick, M.D., and Ali Piroozi, M.D.; however, Plaintiff specifically reserves the right to argue, among other things, that the standard of care did require Defendants Martin Blahnick and Ali Piroozi to recognize (1) that MayRose Hurst's anemia was not "due to prematurity"; (2) that there was an undiagnosed pathological cause for the anemia; and (3) that further investigation into the cause of MayRose's anemia was warranted by said Defendants; and

3. It is uncontested and agreed by all parties and their respective experts that MayRose Hurst did not require further hospitalization at the time of her discharge from the NICU. However, Plaintiffs reserve the right to argue that MayRose Hurst's hematocrit and hemoglobin were not stable at the time of discharge and were in fact on a downward decline which indicated MayRose's need for both (1) investigation into the cause of her ongoing anemia on either an inpatient or outpatient basis; as well as (2) instructions to MayRose's parents and pediatrician that she had ongoing anemia that would need to be closely followed to determine if she would continue to require transfusions on a weekly and/or bi-weekly basis as she had done from the date of her birth. All parties agree that Defendants Martin Blahnick, M.D., and Ali Piroozi, M.D., did not fall below the standard of care by discharging Plaintiff from the NICU on August 2, 2008; however, Plaintiffs reserve the right to argue that the method and manner of

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MayRose's discharge, including the discharge plan, instructions, orders, as well as the information given to the parents and/or pediatrician at the time of discharge was below the standard of care; and

4. Settling-Defendant Ralph Conti, M.D., is deceased and is therefore unavailable to testify at trial. All parties agree to the use of his deposition testimony at trial; and

5. All parties agree that lay witnesses will not provide opinion testimony regarding medical care and treatment; and

6. All parties agree to refrain from arguing the "golden rule"; and

7. All parties agree that any evidence or inference regarding the relative wealth and/or "for profit" status of either party is of no consequence to the underlying issues and must be barred; and

8. All parties agree that in order to promote judicial economy, it will be beneficial to all parties concerned if the Court and all counsel know in advance the sequence of witnesses to be called. This will allow all of the parties to adequately prepare their examinations of the witnesses and to have the pertinent file material at court. This procedure is within the discretion of the Court and will serve to enhance the trial Judge's control over the orderly flow of evidence; and

9. All parties agree that evidence regarding other lawsuits filed against the defendants and/or other negligence ascribed to the defendants should be barred because such evidence would allow the jury to infer the defendants' propensity for negligence. Such reference is completely irrelevant to a final determination of the merits of this particular case; and

10. All parties agree that all non-party lay witnesses shall be barred from the courtroom prior to their testimony, with the exception of expert witnesses; and

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11. All parties agree that the parties and their counsel shall refrain from any reference to or insinuation about the parties' settlement negotiations; and

12. All parties agree there shall be no mentioning or examining witnesses directly or indirectly, regarding the existence of professional liability insurance covering defendants as said information is irrelevant and prejudicial; and

13. All parties agree that parties and their counsel are barred from eliciting testimony or examining any health care provider with regard to that provider's personal treatment preferences, because that information is irrelevant to the issue of the standard of care and would be prejudicial and misleading to the jury, unless appropriately laid foundation that such treatment is within the generally accepted standard of care; and

14. All parties agree that the parties and their experts shall be restricted to the standard of care applicable in the medical community in May 2008; and

15. All parties agree that parties are barred from presenting evidence or making argument about discovery disputes which took place before trial. Such evidence or argument would be wholly irrelevant to any issue raised in this case, are highly prejudicial, and should be barred; and

16. All parties agree that parties are barred from making any insinuation about or reference to counsel being from Chicago and Utah. Such information is completely irrelevant to a final determination of the merits of this particular case and would be prejudicial and misleading to the jury; and

17. All parties agree that parties and their counsel will not make any insinuation about or reference to the origins of Plaintiffs Tiffani Hurst and Brian Abbington's sexual relationship; and

18. All parties agree that parties and their counsel will not make any insinuation about or reference to the incident at Toys 'R Us involving Plaintiff Tiffani Hurst and her child in the car; and

19. All parties agree that no evidence exists to support a claim of agency and/or vicarious liability against Defendant Sunrise Hospital and Medical Center for the conduct of Defendant Ralph Conti, M.D.

The parties represent that this Stipulation is a full and accurate representation of certain evidentiary/procedural agreements that they wish for this Court to enter as a binding order for the upcoming trial.

IT IS SO STIPULATED.

Respectfully submitted by:

HALL PRANGLE & SCHOONVELD, LLC

KENNETH M. WEBSTER, ESQ.
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JONQUIL L. WHITEHEAD, ESQ.
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Attorneys for Defendant
Sunrise Hospital and Medical Center LLC

Approved as to form and content:

PRINCE & KEATING

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Attorney for Plaintiffs
-and-
Jacquelynn D. Carmichael, Esq.
EISENBERG & GILCHRIST
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Attorneys for Plaintiffs

. . .

. . .

. . .

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Approved as to form and content:

COTTON, DRIGGS, WALCH, HOLLEY, WOLOSON & THOMPSON

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4581

10/10/13

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2012 Hamilton Lane
Las Vegas, NV 89106
Attorneys for Defendant
Martin Blahnick, M.D.

Case Name: Hurst vs. Sunrise Hospital, et al.
Case Number: A616728

ORDER

Pursuant to the foregoing stipulation of counsel for all parties, and good cause appearing therefore,

IT IS SO ORDERED.

DATED this 17th day of OCT., 2013.

DISTRICT COURT JUDGE

Respectfully submitted by:

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EXHIBIT B

ORIGINAL

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DISTRICT COURT

CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST, Plaintiffs, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC, MARTIN BLAHNICK, M.D., ALI PIROOZI, M.D., RALPH CONTI, M.D. and FOOTHILL PEDIATRICS LLC, Defendants.	CASE NO. A616728 DEPT NO. XXIV

NOTICE OF ENTRY OF ORDER

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PLEASE TAKE NOTICE that a Stipulation and Order Regarding Plaintiffs' Motions in Limine Nos. 2 and 5 was entered in the above-entitled Court on the 27th day of December, 2013, a copy of which is attached hereto.

DATED this 30th day of December, 2013.

HALL PRANGLE & SCHOONVELD, LLC

By: */s/: Jonquil Whitehead*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 30th day of December, 2013, I served a true and correct copy of the foregoing **NOTICE OF ENTRY OF ORDER** in a sealed envelope, via U.S. Mail, first-class postage pre-paid to the following parties at their last known address:

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-and-
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Ali Piroozi, M.D.

Robert McBride, Esq.
Kim Mandelbaum, Esq.
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Martin Blahnick, MD

/s/: Diana Cox
An employee of HALL PRANGLE & SCHOONVELD, LLC

4846-8110-9527, v. 1

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CLERK OF THE COURT

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DISTRICT COURT

CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST, Plaintiffs, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC, MARTIN BLAHNICK, M.D., ALI PIROOZI, M.D., RALPH CONTI, M.D. and FOOTHILL PEDIATRICS LLC, Defendants.	CASE NO. A616728 DEPT NO. XXIV

STIPULATION AND ORDER REGARDING PLAINTIFFS' MOTIONS IN LIMINE NOS. 2 AND 5

Trial Date: February 18, 2014

IT IS HEREBY STIPULATED AND AGREED, by all parties, by and through their respective counsel of record, as to the following:

1. All parties agree not to mention to or before the jury the settlement between Plaintiffs and Defendant Dr. Conti; and

2. All parties agree to refrain from use of arguments as stated within PLAINTIFFS' MOTION IN LIMINE NO. 5: EXCLUDE IMPROPER ATTORNEY ARGUMENTS.

The parties represent that this Stipulation is a full and accurate representation of certain evidentiary/procedural agreements that they wish for this Court to enter as a binding order for the upcoming trial.

IT IS SO STIPULATED.

Respectfully submitted by:

HALL PRANGLE & SCHOONVELD, LLC

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Approved as to form and content:

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Attorneys for Plaintiffs

Approved as to form and content:

COTTON, DRIGGS, WALCH, HOLLEY, WOLOSON & THOMPSON

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Attorney for Defendant Ali Piroozi, M.D.

Approved as to form and content:

MANDELBAUM, ELLERTON & MCBRIDE

Marie Ellerton 12/9/13

Marie Ellerton, Esq.
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Case Name: Hurst vs. Sunrise Hospital, et al.
Case Number: A616728

ORDER

Pursuant to the foregoing stipulation of counsel for all parties, and good cause appearing therefore,

IT IS SO ORDERED.

DATED this 9th day of December, 2013.

DISTRICT COURT JUDGE

Respectfully submitted by:

HALL PRANGLE & SCHOONVELD, LLC

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Attorneys for Plaintiff

DISTRICT COURT
CLARK COUNTY, NEVADA

Tiffani D. Hurst and Brian Abbington, jointly and on behalf of their minor child, MayRose Lili-Abbington Hurst, Plaintiff, vs. Sunrise Hospital and Medical Center, LLC, Martin Blahnik, M.D., and Ali Piroozi, M.D., Defendants.	Case No.: A-10-616728-C Dept. No.: XXIV DATE OF HEARING: 11/6/13 TIME OF HEARING: 9:00 a.m.

PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANT SUNRISE HOSPITAL'S MOTION FOR SUMMARY JUDGMENT AND THE JOINDERS IN THAT MOTION OF DEFENDANTS MARTIN BLAHNIK, M.D. AND ALI PIROOZI, M.D.

Comes now Plaintiff Tiffani Hurst, on behalf of her daughter and minor child, MayRose Lili-Abbington Hurst ("MayRose"), by and through her attorneys of record, Jacquelynn D. Carmichael, Robert G. Gilchrist and Jeff Sbaih of Eisenberg, Gilchrist & Cutt, and hereby submits her Opposition to Defendant Sunrise Hospital's Motion for Summary Judgment as well as the Joinder in that Motion of Defendants Martin Blahnik, M.D. and Ali Piroozi, M.D.

I. INTRODUCTION

Defendants' Motion for Summary Judgment is without merit and should be denied. Defendants attack the causation opinions of Plaintiff's experts on 3 grounds, namely (1) that they are predicated upon a "false" assumption that Dr. Conti would have followed the directions given by the Defendants if correct directions had been given; (2) that Dr. Conti's negligence is an "intervening cause" that relieves the Defendants of their own negligence; and (3) that the negligence of the Defendants is not a proximate cause of MayRose's injuries. It is well established that causation is generally a question of fact for the jury. In this case, material issues of fact exist with respect to each of the Defendants' theories, thereby precluding summary judgment on the issue of causation as a matter of law.

In summary, the causation opinions of Plaintiff's experts are not based upon false assumptions. Defendants have misconstrued and misrepresented the facts with respect to Dr. Conti's testimony concerning his willingness to follow the Defendants' discharge instructions. Had the Defendants informed the family or the pediatrician that MayRose had ongoing pathological anemia and was transfusion-dependent, there is no question that Dr. Conti would have performed a follow-up CBC. Dr. Conti merely testified that based upon what was contained in the discharge instructions given, he did not feel it was necessary to perform the follow-up CBC in question. That is entirely the fault of the Defendants who withheld critical information from the discharge instructions and replaced it with false information that provided absolutely no reason for

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Dr. Conti or MayRose's parents to believe or understand that MayRose had ongoing anemia that required a follow-up CBC.

Furthermore, Defendants' argument that Dr. Conti's negligence was an intervening act, thereby somehow canceling out their own negligent care of this child, is equally without merit. It is the very negligence of the Defendants that led to and ensured Dr. Conti's negligent decision not to perform the follow-up CBC. The Defendants were apprised of all of the relevant and critical information needed to understand why a follow-up CBC was necessary. Unfortunately, Defendants chose not to share that information with either the parents or the pediatrician. Instead, Defendants told the parents that MayRose's anemia was innocuous and simply due to her prematurity—that it was commonplace and nothing to worry about. They failed to report the true number of transfusions she had during her NICU stay in the discharge instructions and again indicated that her anemia was "due to prematurity" and had resolved. There is nothing in the discharge instructions to indicate that MayRose had ongoing anemia, that she continued to be transfusion dependent, or that there was any reason why she would need a follow-up CBC, despite the medical evidence known to Defendants at the time of MayRose's discharge.

Accordingly, the Defendants' negligence was a direct precipitator and predictor of Dr. Conti's negligence. Indeed, it is entirely foreseeable that based upon the false information given to the parents and contained in the discharge instructions, that Dr. Conti may determine that the requested follow-up CBC was not necessary. Thus, Dr. Conti's negligent decision not to perform the follow-up CBC was NOT an intervening cause and instead was the direct result of the NICU physicians' negligence and most certainly does not excuse their negligence.

Finally, it is well established that there can be more than one proximate cause of an injury. Just as Dr. Conti had an opportunity to act to prevent MayRose's brain injury from occurring, so did the Defendants, who had many more opportunities to do so. The NICU physicians were the ones who

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possessed of all of the critical and relevant information to recognize that something was seriously wrong with respect to MayRose's ongoing anemia and transfusion dependence and should have taken action to discover the cause of MayRose's anemia or, at the very least, to ensure that she continued to receive the transfusions she needed until the cause of her anemia could be ascertained by others.

Defendants had many options available to them. They could have conducted the necessary tests themselves; they could have referred MayRose to a hematologist for testing; they could have provided discharge instructions that would ensure proper and timely transfusions until a specialist could diagnose the cause of her anemia. They simply could have informed MayRose's parents, as well as her pediatrician, that MayRose had ongoing anemia of unexplained origin and would continue to need transfusions until a diagnosis could be made. Any one of these actions would have prevented MayRose's brain injury just as surely as the follow-up CBC that Dr. Conti failed to perform. Unfortunately, Defendants took none of these actions. Instead, they misdiagnosed MayRose with Anemia due to Prematurity, told her parents and her pediatrician that the anemia had resolved, misrepresented the number of transfusions she had during her NICU stay, gave no importance whatsoever to the anemia in the discharge instructions and provided no explanation as to why a follow-up CBC was being requested and/or was needed. Defendants' failures are a direct and proximate cause of MayRose's brain injury.

Said Defendants cannot escape liability because Dr. Conti also had an opportunity to prevent the brain injury and failed as well, particularly in light of the fact that the defendants' actions set the stage and are to blame for Dr. Conti's tragic and uninformed decision not to conduct the follow-up CBC. Based on the foregoing, it is clear there are material issues of fact with respect to the causation of MayRose's brain injury that preclude the entry of summary judgment in this matter. Accordingly, Defendants' respective Motions and/or Joinders should be denied.

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II. STATEMENT OF FACTS

Before MayRose was born, a prenatal test was conducted that showed MayRose had an abnormal and significantly thick nuchal fold. MayRose's mother, Tiffani Hurst, was referred to a perinatologist for further testing due to the abnormal nuchal fold test result. The perinatologist advised MayRose's parents that due to the severity of the abnormal result, MayRose would most certainly be born with some form of genetic birth defect. With further testing, the perinatologist was able to rule out down syndrome as well as cardiac abnormalities, but the perinatologist advised that there was no way to test for every possible genetic defect so the parents would simply have to wait until MayRose was born to see what the genetic defect would be. *See*, Deposition of Tiffani Hurst, attached as Exhibit A.

MayRose was born prematurely one day shy of 29 weeks gestation. Due to MayRose's prematurity, she spent 88 days in Sunrise Hospital's NICU (neonatal intensive care unit). During that time, she was primarily under the care of Defendants Martin Blahnik, M.D. (her admitting and attending physician) and Ali Piroozi, M.D (her discharging physician). At the time of MayRose's admission to the NICU, Dr. Blahnik examined MayRose but did not inquire about or take a history of her prenatal course. *See*, NICU Admission History & Physical, attached as Exhibit B.

Shortly after her birth, MayRose developed necrotizing enterocolitis ("NEC") and required surgery to repair the same. When MayRose's parents were informed of this condition, they asked if the NEC was the genetic birth defect the abnormal nuchal fold test forecast. They were told it was not but was likely the result of the tocolytic medications administered to MayRose's mother in an attempt to prevent MayRose's premature delivery. *See* Exhibit A.

When MayRose was born, she was anemic and transfusion-dependent and remained so throughout her 88 day NICU stay, requiring multiple transfusions. Her anemia at birth was slightly

macrocytic in nature. Dr. Blahnik was confused by MayRose's macrocytic anemia at birth and did not know the cause of it. He later attributed it to blood loss as a result of her NEC, even though macrocytic anemia is inconsistent with anemia caused by blood loss. Dr. Blahnik admitted at his deposition that he knew MayRose's anemia at birth was *not* "anemia due to prematurity." He also admitted that he knew macrocytic anemia is a characteristic of a genetic blood disorder called Diamond Blackfan Anemia. *See,* Deposition of Martin Blahnik, attached as Exhibit C. Several months after MayRose's discharge from the NICU and after MayRose developed anemic shock and suffered the ensuing brain injury that gave rise to this action, it was determined that MayRose's unknown but anticipated birth defect was Diamond Blackfan Anemia. *See*, Discharge Summary from Denver Children's Hospital, attached as Exhibit D.

Throughout MayRose's NICU stay, she continued to be anemic and require transfusions. She had 11 transfusions in all. According to Plaintiff's expert Marcus Hermansen, M.D., premature infants born with the same types of problems MayRose suffered during her NICU stay, namely NEC and sepsis, rarely require 1 transfusion, let alone 11. *See,* Expert Report of Marcus Hermansen, M.D. attached as Exhibit E. Notwithstanding the inordinate number of transfusions MayRose required, her NICU physicians maintained that MayRose's anemia was simply due to her prematurity and would go away. MayRose's parents questioned Defendants about MayRose's anemia and her need for transfusions. They asked if the anemia could be the genetic defect the perinatologist was expecting as a result of MayRose's abnormal nuchal fold test result. They informed the Defendants that MayRose's father had a family history of Thalassemia, a genetic blood disorder. However, Defendants maintained that MayRose's anemia was not the result of a genetic blood disorder. They repeatedly indicated that it was due to her prematurity; that it was perfectly normal and commonplace in premature infants, and that it was not dangerous or anything about which to be concerned. *See,* Exhibit A.

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During the course of MayRose's NICU stay, two reticulocyte tests were ordered to determine if MayRose could produce red blood cells on her own. These tests were ordered even in light of the fact that repeated transfusions will temporarily suppress the recipient's red blood cell production and MayRose was receiving repeated transfusions. The subject tests were conducted approximately 3 ½ weeks apart, with the second test being taken the day before MayRose's discharge from the NICU. The test results established that MayRose's ability to produce red blood cells was compromised and, in fact, at the time of her discharge from the hospital, she was not producing any red blood cells at all. *See,* Labs, attached as Exhibit F. Of the 11 transfusions MayRose received during her hospitalization, two of them were within the two-week period prior to her discharge. On the day before her discharge and less than one week from her last transfusion, the NICU physicians took a CBC to measure MayRose's blood count to determine if she was able to maintain her blood count following her last transfusion. That test result demonstrated that MayRose's blood count was once again falling. *Id.*

Throughout MayRose's NICU stay, the longest she was able to go without requiring a transfusion was less than 2 ½ weeks. Usually, she required a transfusion every one to two weeks. Notwithstanding these facts, MayRose was discharged home without any orders for further transfusions and with an order for a follow-up CBC in 30 days. *See*, Exhibit F and Neonatal Discharge Instructions, attached as Exhibit G.

At the time of her discharge, MayRose's parents were told that MayRose was "a healthy baby." Defendants did not tell MayRose's parents at discharge or at any time during her NICU stay that she was transfusion-dependent or had any ongoing anemia or concerns relating to the same. MayRose's parents understood at the time of discharge that MayRose's "Anemia due to prematurity" had resolved and there was nothing further that needed to be done with regard to the anemia. *See*, Exhibit A.

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The discharge instructions reported that MayRose received 5 transfusions while in the NICU. It also reported that MayRose was born with "Anemia due to Prematurity" that had resolved on July 21, 2010, nearly two weeks prior to MayRose's discharge. Specifically, the discharge instructions read under the "Hematology" section:

> **HEMATOLOGY**
> The initial hematocrit was 31% on 5/15/2008. The most recent hematocrit was 30% on 8/1/2008. She was given 5 transfusions. The blood type is O+. The DAT is negative. The highest bilirubin level was 10.34 mg/dl on 5/20/2008. The last bilirubin level was 2.8 mg/dl on 7/28/2008.
> DIAGNOSES:
> Anemia of prematurity (5/15/2008 – 7/21/2008)
> Jaundice due to prematurity (5/16/2008-5/26/2008)

See, Discharge Instructions attached as Exhibit G. The discharge instructions do not mention that MayRose had actually received 11 transfusions, nor do they mention the results of her reticulocyte tests demonstrating that she was not producing any red blood cells. The discharge instructions similarly are silent with respect to the fact that MayRose required two transfusions within the two week period prior to her discharge and that in spite of those transfusions, the results of the CBC drawn the day before her discharge demonstrated that she was not able to maintain her own blood count and that it was falling again. *Id.*

In the discharge summary, there is a section devoted to "special considerations" and those items are in bold-faced type and read:

> **"Special Considerations: 1) The infant requires a Sweat Chloride test by 3 months of age due to abnormal CF (IRT) newborn screening test. 2) The infant requires a Head U/S within 1 month after discharge to follow grade 1 sub-acute IVH."**

There is no mention of any concerns pertaining to ongoing anemia or the need for close follow-up, testing or possible transfusions under the "Special Considerations" section of the discharge instructions. *See*, Discharge Instructions, attached as Exhibit G.

Towards the very end of the discharge instructions, it asks for a "CBC, Dif, Retic 1 month after discharge." The NICU physicians never discussed with MayRose's parents MayRose's

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"reticulocyte" test results, what those results meant or even why those tests were performed. The NICU physicians similarly failed to discuss with MayRose's parents the recommendation for a follow-up CBC, Dif, Retic 1 month after discharge, what those tests were for or why they were needed. On the contrary, Dr. Piroozi told MayRose's mother that MayRose was a healthy baby and there was nothing to worry about, particularly with respect to her past diagnosis of Anemia due to prematurity. *See*, Exhibit A. The NICU physicians also did not contact or have any discussions pertaining to MayRose or her NICU history with Dr. Ralph Conti, her pediatrician. *See*, Deposition of Ali Piroozi, M.D. attached as Exhibit H; *See also*: Deposition of Martin Blahnik, M.D. attached as Exhibit C.

When MayRose began treating with Dr. Conti, Dr. Conti had no reason to suspect that MayRose had any ongoing issues with anemia or that she was, indeed, transfusion-dependent. Over the course of the next two and half months, MayRose's condition slowly deteriorated until such time as she became ill and went into anemic shock. Following her episode of anemic shock, it was discovered that she sustained a massive watershed-distribution injury to her brain. *See*, Discharge Summary from Summerlin Hospital, attached as Exhibit I. MayRose received treatment for her anemic shock at Summerlin hospital where she again required repeated transfusions. Following her discharge from Summerlin, her mother took her to Denver Children's hospital for rehabilitation for her severe brain injury. While at Denver Children's, MayRose continued to require transfusions and a diagnosis of Diamond Blackfan Anemia was made. *See*, Discharge from Denver Children's Hospital, attached as Exhibit D. The diagnosis was later confirmed with genetic testing at Schneider's hospital in New York.

The majority of individuals suffering from Diamond Blackfan Anemia can lead relatively normal lives, go to school, become gainfully employed and pursue ambitions, dreams and goals like everyone else, even though many of them are often required to have regular transfusions and

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chelation therapy to remove iron stores from their transfused blood. Some individuals with DBA can have bone marrow transplants and go into complete remission. As a result of MayRose's brain injury, she is not eligible for bone marrow transplant. *See*, Exhibit A. Furthermore, as a result of her brain injury, she will never experience a normal life. She will never be able to walk or pursue goals and dreams. She will not be able to become gainfully employed, and she will always be dependent upon others for her care and support. Due to her brain injury, she will also experience painful muscle spasticity and contractures throughout her life and will have to have multiple surgeries to address those issues. *See*, Life-Care Plan prepared by Walter Harrell, Ph.D., attached as Exhibit J. In the absence of her brain injury MayRose would have had a relatively normal life, filled with opportunities, promise and joy. Defendants' negligence has deprived her of those opportunities and instead has given her a life-long sentence of disability and dependence on others.

III. PLAINTIFF'S ADDITIONAL RESPONSE TO DEFENDANTS' STATEMENT OF UNCONTESTED FACTS.

Plaintiff contests many of the facts contained in Defendants' Statement of Uncontested Facts and has demonstrated that in Plaintiff's own Statement of Facts above. However, Plaintiff feels that a few of the facts set forth in Defendants' Statement of "*Uncontested*" Facts warrant closer and more direct focus and are herein discussed.

For example, Plaintiff specifically disputes that MayRose required 11 blood transfusions "due to the numerous issues she battled in the NICU." MayRose's need for serial transfusions during her stay in the NICU was the result of the fact that she was born with a genetic blood disorder known as Diamond Blackfan Anemia. *See*, Deposition of John Strouse, M.D. attached as Exhibit K. Plaintiff also disputes that MayRose had "numerous surgical procedures." She had surgical repair of her NEC and a follow-up Ostomy take-down. All other alleged "surgical procedures" were for the simple placement of lines such as central and broviac lines. Plaintiff also dispute that

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MayRose had "internal bleeding." There is no evidence of internal bleeding in the record. *See*, Discharge Instructions, attached as Exhibit G.

Plaintiff further contests the allegation that MayRose's Diamond Blackfan Anemia was not diagnosed "until nearly a year" after her admission at Denver Children's hospital. On the contrary, MayRose was diagnosed with Diamond Blackfan Anemia while she was a patient at Denver Children's hospital. *See*, Discharge from Denver Children's Hospital, attached as Exhibit D. The genetic testing that is required to confirm the diagnosis in order to become a member of the Diamond Blackfan Anemia registry was not conducted until much later.

Additionally, Defendants repeatedly assert throughout their brief that it is uncontested that MayRose's Diamond Blackfan Anemia *could not* have been diagnosed in the NICU. No one in this litigation has ever stated that Defendants Blahnick and Piroozi would not be capable of diagnosing MayRose's Diamond Blackfan Anemia during her NICU admission. The testimony on that subject and the stipulation of counsel has been that it was not a breach of the standard of care for said physicians not to make the diagnosis at that time. This is because the disorder is not a condition that is traditionally diagnosed in the NICU (not because it cannot be diagnosed in the NICU). Typically, when a child demonstrates signs of pathologic anemia, they would be referred to a hematologist for further testing and follow-up. However, there are certainly instances where a neonatologist can take on that task and make the diagnosis himself. It's just not usually done that way. Regardless, Plaintiff's experts as well as Plaintiff's counsel in the Stipulation at issue have stated that while the standard of care did not require Defendants to make the actual diagnosis, it did require Defendants "to recognize (1) that MayRose Hurst's anemia was not 'due to prematurity'; (2) that there was an undiagnosed pathological cause for the anemia; and (3) that further investigation into the cause of MayRose's anemia was warranted by said Defendants." *See*, Stipulation and Order Regarding Certain Trial Evidentiary/Procedural Rulings, attached as Exhibit

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L. Dr. Hermansen testified that it was a breach of the standard of care for these defendants not to *recognize and evaluate the pathological aspect of MayRose's anemia.* Specifically, he wrote: "A thorough investigation of the problem was indicated and a consultation by a hematologist would have been helpful . . . Once the neonatologist chose not to obtain a hematology consultation, then they assume the responsibility to conduct a hematology evaluation of the anemia themselves and they failed to do so." *See*, Expert Report of Dr. Marcus Hermansen, attached as Exhibit E.

Plaintiff's further contest the blatantly false and blanket assertion by Defendants that "MayRose's discharge from the NICU was within the standard of care." Plaintiff have stipulated that MayRose did not require further hospitalization at the time of her discharge and therefore, it was not a breach of the standard of care to allow her to leave the hospital at that time. However, the Stipulation in question specifically states "the method and manner of MayRose's discharge, including the discharge plan, instructions, orders, as well as the information given to the parents and/or pediatrician at the time of discharge was below the standard of care." *See*, Stipulation attached as Exhibit L.

Finally, Defendants contend in the body of their brief at page 14 that Plaintiff's experts agree "that once MayRose was discharged from the NICU, and Dr. Conti had taken over care, the NICU doctors were no longer responsible if Dr. Conti chose to ignore their recommendations." *See*, page 14 of Defendants' brief. This contention is false and has been completely distorted by the Defendants in the context of their brief. In support of this contention, Defendants then quote testimony from Dr. Hermansen's deposition. The quoted testimony illuminates the false nature of Defendants' contention. Specifically Dr. Hermansen testifies that the general proposition stated by Defendants *would* be true *if* certain conditions were met by the NICU physicians:

> . . . **if I've come up with a good plan [discharge plan] and get that plan into the pediatrician's functions, to get the pediatrician aware of the plan, agreeing to the plan and taking it over, I think the neonatologist is off the care at that point.**

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Q: Okay. And once you've done that and gotten the plan into the hands of the pediatrician, if subsequently the pediatrician decides to ignore portions of your plan but doesn't tell you, do you think you're responsible for the conduct?

A: Not if I've given him a good plan and communicated it. If I've done those then – and—no, I don't feel responsible if they go on their own route.

See: Deposition Transcript of Dr. Hermansen, 32:15-33:3, attached as Exhibit M. The Defendants chose not to share Dr. Hermansen's further testimony on this topic:

Q. Is it your position that once you've transferred the patient out of the NICU and into the hands of a pediatrician that you remain responsible for the day-to-day care of that patient?
A. I'm responsible if I've produced a bad plan for them to work with.
Q. If you produced what you perceived to be a good plan, do you believe that you're responsible for the ongoing care of that patient?
A. I need to produce a good plan and communicate it to the pediatrician, and then once they take over it's theirs. But I have to produce a good plan and make sure I've communicated that in some way to the pediatrician.

Id., at 31:11-24

With respect to whether or not Defendants "came up with a good plan" and "communicated it to the pediatrician" in this case, Dr. Hermansen has specifically testified and given expert opinion that Defendants failed in both respects. Specifically, Dr. Hermansen found the subject discharge plan to be "inadequate," "dangerous," "incomplete," and "inaccurate." He has also opined that the plan was not communicated to the pediatrician. Specifically, he wrote that there was no effort on the part of the NICU physicians "to inform the follow-up pediatrician, Dr. Conti, about the need for close follow-up. There was no communication by e-mail, by fax or by telephone. The communication was left to the family and to a discharge summary, a discharge summary with incomplete and inaccurate information." *See,* Exhibit E. *Accordingly*, Defendants' contention that Plaintiff's experts agree "that once MayRose was discharged from the NICU, and Dr. Conti had taken over care, the NICU doctors were no longer responsible if Dr. Conti chose to ignore their recommendations" is totally false and hotly contested.

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IV. ARGUMENT

I. DEFENDANTS' MOTION FOR SUMMARY JUDGMENT IS WITHOUT MERIT AND SHOULD BE DENIED.

It is widely accepted that questions regarding causation are questions of fact to be determined by the trier of fact. Klasch v. Walgreen Co., 264 P.3d 1155, 1161 (Nev. 2011) ("Breach of duty and causation are classically questions of fact."); Frances v. Plaza Pac. Equities, Inc., 109 Nev. 91, 94 (1993) ("In Nevada, issues of negligence and proximate cause are usually factual issues to be determined by the trier of fact."); see also Nehls v. Leonard, 97 Nev. 325, 630 P.2d 258 (1981); Price v. Sinnott, 85 Nev. 600, 460 P.2d 837 (1969).

The Nevada Supreme Court has explained that it is "hesitant to affirm the granting of summary judgment in negligence cases, because such claims generally present jury issues." Sims v. General Telephone & Electric, 107 Nev. 516, 521, 815 P.2d 151, 154 (1991) (citing Van Cleave v. Kietz-Mill Minit Mart, 97 Nev. 414, 417, 633 P.2d 1220, 1222 (1981)); see also 73 Am.Jur.2d *Summary Judgment* § 6 (1974); Riley v. OPP IX, L.P., 112 Nev. 826, 830, 919 P.2d 1071, 1074 (1996).

When deciding summary judgment motions regarding causation, all inferences must be drawn in favor of the non-moving party and **only** if the plaintiff then cannot recover as a matter of law is summary judgment appropriate. Van Cleave v. Kietz–Mill Minit Mart, 97 Nev. 414, 417, 633 P.2d 1220, 1222 (1981). If the plaintiff can show that she can present evidence at trial to support her claim, then summary judgment is not appropriate. Id.

In the present case, and as demonstrated below, many questions of fact exist with respect to the issue of causation that preclude the entry of summary judgment in this case. Accordingly, Defendants' Motion for Summary Judgment should be denied, and the issue of causation should be given to the jury.

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A. THE CAUSATION OPINIONS OF PLAINTIFF'S EXPERTS ARE NOT BASED UPON A FALSE ASSUMPTION.

Dr. Marcus Hermansen is a board-certified pediatrician and neonatologist. He is the medical director of the Neonatal Intensive Care Unit at Southern New Hampshire Medical Center and is an Associate Professor of Pediatrics at Dartmouth Medical School. Dr. Hermansen identified several acts of negligence on the part of the NICU physicians including their failure to recognize and evaluate the pathological aspect of MayRose's anemia and inadequate discharge planning. With regard to these breaches, Dr. Hermansen's opinion is that **"the acts of negligence by the neonatologists at Sunrise Hospital caused MayRose to suffer delayed diagnosis and treatment of [her] Diamond Blackfan Anemia"** thus leading to and resulting in her brain injury. *See,* Exhibit E.

Dr. John J. Strouse is board certified in pediatrics, pediatric hematology/oncology and adult hematology. He is an Assistant Professor of Pediatrics and Medicine at Johns Hopkins University School of Medicine and cares for neonates and children with hematologic disorders at Bloomberg children's Hospital and associated outpatient facilities of Johns Hopkins Hospital. Dr. Strouse's causation opinion with regard to the NICU physicians, as stated in his expert report is as follows:

> It is my expert opinion with a reasonable degree of medical certainty that [MayRose's] profound anemia was a major contributor to her brain injury. This is based on the severity of her anemia and the watershed distribution of her brain injury. The episode of profound anemia **could have been prevented if her anemia had been properly evaluated while she was in the NICU.** If this had occurred, it would have been discovered that MayRose's anemia was not due to prematurity and required, at a minimum, follow-up with more frequent laboratory testing (complete blood count and reticulocyte count) until such time as a determination as to the cause of her anemia could be made.

See, Expert Report of John Strouse, M.D., attached as Exhibit N. The causation opinions given by Plaintiff's experts as summarized above do not rely upon any false assumptions as to Dr. Conti's conduct and deal directly with the failings of the NICU physicians. With respect to Dr. Conti's subsequent actions, however, it is unfair to say that if he had been provided with the

relevant information, that he would have intentionally chosen to ignore it and in so doing, jeopardize a patient's life.

It is true that Dr. Conti testified that whether he read the discharge instructions or not, he would not have performed the requested CBC. That testimony does not lead to the conclusion, however, that if MayRose's mother had been told that MayRose had a serious pathological anemia, was transfusion dependent and required serial testing and reported that to Dr. Conti, or Dr. Conti had been provided that information by the Defendants, that he would have ignored that information and refused to perform the follow-up CBC. For Defendants to make that argument is a stretch to say the least but more importantly, it completely misses the point.

The reason Dr. Conti determined in his medical judgment that the follow-up CBC was not necessary and did not perform it was not to willfully refuse to follow the subject discharge instructions and was not because he may not have read the instructions. Rather, it was because there was NOTHING in the discharge instructions, or any of the information given to MayRose's parents, that suggested that MayRose needed a follow-up CBC let alone that such a test was critical to her future well-being.

In Dr. Conti's words, quoted by Defendants in their brief, "I did not order [the Blood Count] at that time. We order what the child needs and nothing more." Deposition of Ralph Conti, M.D., pages 130: 19-131:9, attached as Exhibit O. If Dr. Conti had been given any information that suggested that MayRose "needed" a follow-up CBC, it stands to reason that he would have ordered it. Unfortunately, the information that would have helped him to understand the necessity of the test was NOT given to him. Specifically, he was not told that MayRose was transfusion dependent during her NICU stay. He was not told that she had received 11 transfusions. He was not told that at the time of her discharge, her blood count was falling in spite of the fact that she had just received a transfusion less than a week before discharge. He was not told that MayRose

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was still transfusion dependent at the time of her discharge. He was not told that MayRose was still anemic at the time of her discharge. He was not told that MayRose's anemia was pathological. Thus, he did not have the information that would have allowed him to understand the necessity for the follow-up CBC. *See*, Exhibits A and G.

Instead, he was told that MayRose had experienced "anemia due to prematurity." He was provided information that she had received only 5 transfusions in the hospital and that her anemia due to prematurity had resolved on July 21, 2010, almost two weeks before her discharge. *Id.* Based upon this information, it is entirely *foreseeable* that Dr. Conti may conclude that MayRose did not need the follow-up CBC.

An assumption that Dr. Conti would have provided appropriate tests and ordered appropriate transfusions if he had known that this child had pathological, ongoing anemia, the cause of which remained undiagnosed, cannot possibly be considered *false*. What care provider would withhold medical care critical to a patient's survival if, in fact, the necessity for that medical care was properly explained and understood? It was the duty of the NICU specialists to convey relevant and accurate information regarding the medical condition of MayRose Hurst as well as the course of her NICU stay and the future medical care of which she was in need, including the reasons why that care was needed, to her parents and the pediatrician who would be providing the follow-up care. Defendants failed to do that. It is Defendants' negligent failures that led to the subsequent negligent decisions made by Dr. Conti.

Based upon the foregoing, Defendants' argument pertaining to the opinions of Plaintiff's experts being based upon false assumptions is without merit and Defendants' motion for summary judgment should be denied.

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B. THE NEGLIGENCE OF MAYROSE'S PEDIATRICIAN IS NOT AN INTERVENING CAUSE THAT RELEASES DEFENDANTS' FOR THEIR OWN NEGLIGENT CONDUCT.

Proximate cause is based upon foreseeability. It is "any cause which in natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury complained of and without which the result would not have occurred." Frances v. Plaza Pac. Equities, Inc., 109 Nev. 91, 94, 847 P.2d 722, 724 (1993); Taylor v. Silva, 96 Nev. 738, 741, 615 P.2d 970, 971 (1980) (citing Mahan v. Hafen, 76 Nev. 220, 225, 351 P.2d 617, 620 (1960)). Therefore, "an intervening act will only be superseding and cut off liability if it is ***unforeseeable***." Bower v. Harrah's Laughlin, Inc., 125 Nev. 470, 491-92, 215 P.3d 709, 724 (2009). Foreseeable fault operates only to reduce recovery from that defendant under the doctrine of comparative negligence. Taylor v. Silva, 96 Nev. 738, 615 P.2d 970 (1980). It "does **not** negate a finding that respondents' negligence was a proximate cause of her injuries." Id. Nonetheless, the question of proximate cause and foreseeability is generally one for the jury." El Dorado Hotel, Inc. v. Brown, 100 Nev. 622, 629, 691 P.2d 436, 441 (1984) (overruled on other grounds); Lee v. GNLV Corp., 22 P.3d 209, 212 (Nev.2001); Tai-Si Kim v. Kearney, 2010 WL 3433130 (D. Nev. Aug. 30, 2010).

Courts from across the country have held that **the negligence of subsequent health care providers is a concurring, rather than intervening, cause.** The case of Williams v. Le, 276 Va. 161, 662 S.E.2d 73 (2008), is a perfect example and is dispositive of Defendants' Motion. There, a patient who died from a pulmonary embolism brought a medical malpractice action against the radiologist who, after diagnosing the patient with deep vein thrombosis, did not make direct communication with the patient's treating physician concerning the diagnosis. Instead, the radiologist only sent the physician a message via facsimile that contained test results showing the diagnosis, which the physician failed to read prior to the patient's death. The radiologist claimed that the subsequent negligence of the patient's treating physician (in failing to check the diagnostic

report) completely broke the chain of events between the radiologist's negligence and the patient's death. Based on that theory, the trial court gave an intervening cause instruction.

On appeal, the Virginia Supreme Court concluded that the trial court erred in giving the intervening cause instruction. The court pointed out that there may be more than one proximate cause of an event. In explaining that a subsequent proximate cause may or may not relieve a defendant of liability for his or her negligence, the court reiterated the following rule: " 'In order to relieve a defendant of liability for [a] negligent act, the negligence intervening between the defendant's negligent act and the injury **must so entirely supersede the operation of the defendant's negligence that it alone, without any contributing negligence by the defendant in the slightest degree, causes the injury."** Williams, 276 Va. at 167, 662 S.E.2d 73. (Emphasis Added) Conversely, "an intervening cause does not operate to exempt a defendant from liability **if that cause is put into operation by the defendant's wrongful act or omission**." Id. at 167 (Emphasis added). The Williams court concluded that under the evidence in that case the radiologist had put the cause into operation because the communication problems began with his failure to make direct contact with the treating physician, a member of his team, or the patient. Id. at 167.

The facts of the Williams case are directly on point. Just as the radiologist failed to communicate important facts and information to the patient and treating physician, so too did Defendants fail to communicate critical information to MayRose's parents and Dr. Conti. As in Williams, the Defendants' wrongful acts and/or omissions served to "put the intervening cause into operation," and allowed Dr. Conti to conclude that the follow-up CBC was not needed. In failing to recognize and communicate to others that MayRose had pathological anemia and was transfusion-dependent, and instead misdiagnosing and reporting MayRose's anemia as "due to her prematurity" and fully resolved prior to her discharge, Defendants created a false sense of well-

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being with regard to MayRose's health that allowed Dr. Conti to exercise his professional medical judgment and conclude that the follow-up CBC was not needed.

A plethora of other courts from across the country have held similarly to the Williams case. See Brilliant v. Royal, 582 So.2d 512, 523–24 (Ala.1991) (finding that failure of second examining physician to diagnose patient's warning leak was not intervening cause relieving first physician of liability for his failure to diagnose patient's cerebral aneurysm); Osborn v. Irwin Memorial Blood Bank, 5 Cal.App.4th 234, 253, 7 Cal.Rptr.2d 101 (1992) (finding Restatement § 439 applicable because "[a] 'continuous' chain of cause and effect is manifest" where a boy received blood from blood bank's donor pool because blood bank misrepresented that directed donations were not available; the boy contracted AIDS because the blood was contaminated, just as his parents feared it would be); Schnebly v. Baker, 217 N.W.2d 708, 730–31 (Iowa 1974) (overruled on other grounds) (finding laboratory's negligence in reporting blood results set stage for subsequent negligence of doctor's reliance on those results despite other conflicting results and, therefore, doctor's negligence was not superseding cause to laboratory's liability); Rudeck v. Wright, 218 Mont. 41, 51–52, 709 P.2d 621 (1985) (holding doctor is not relieved from liability for negligent act of leaving lap mat in patient following surgery because doctor's negligence "actively and continuously act[ed] to cause harm to his patient" along with the "active and substantially simultaneous negligent act of the nurses" in failing to account for lap mat); Johnson v. Hillcrest Health Center, Inc., 70 P.3d 811, 819 (Okla.2003) ("When a cause merely combines with another act to produce injury, or several events coincide to bring about a single injury, each negligent actor may be held accountable."); Hawkins v. Walker, 238 S.W.3d 517, 523–24 (Tex.App.2007) (finding failure of other physician to diagnose patient's ectopic pregnancy did not constitute superseding cause of patient's death to relieve physician of liability for his negligence in failing to discover patient's condition); Wilson v. Brister, 982 S.W.2d 42, 45 (Tex.App.1998) (finding

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summary judgment inappropriate where evidence supported the contention that physician was concurring cause of patient's suicide despite negligence of friend that gave patient the gun and bullets).

Section 439 of the Second Restatement of Torts also concludes the same:

> If effects of the actor's negligent conduct actively and continuously operate to bring about harm to another, the fact that the active and substantially simultaneous operation of the effects of a third person's innocent, tortious, or criminal act is also a substantial factor in bringing about the harm does not protect the actor from liability.

Restatement (Second) of Torts § 439 (1964). The Nevada Supreme Court has relied on this section to resolve issues related to proximate cause. See, e.g., Coty v. Washoe Cnty., 108 Nev. 757, 760, 839 P.2d 97, 99 (1992).

The Nevada Supreme Court has in one instance ***only*** relied upon section 442 of the Restatement of Torts (cited and relied upon by Defendants in their brief) to determine whether a cause is unforeseeable. That section provides the following factors to be used when making this determination:

1. Whether the intervention causes the kind of harm expected to result from the actor's negligence,
2. Whether the intervening event is normal or extraordinary in the circumstances,
3. Whether the intervening source is independent or a normal result of the actor's negligence,
4. Whether the intervening act or omission is that of a third party,
5. Whether the intervening act is a wrongful act of a third party that would subject him to liability, and
6. Whether the culpability of the third person's intervening act.

Bower v. Harrah's Laughlin, Inc., 125 Nev. 470, 492, 215 P.3d 709, 725 (2009) (citing Restatement (Second) of Torts § 442 (1965). It does not appear that Nevada has adopted this section to resolve issues of intervening causes. However, even when these factors are analyzed, Dr. Conti's negligence does not qualify as an unforeseeable intervening cause.

Based upon the information Dr. Conti had available to him, it was entirely foreseeable that he may exercise his professional medical judgment and conclude that the follow-up CBC that was

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recommended in the discharge instructions was not needed, particularly when the doctor recommending the test failed to inform the parents or the pediatrician of the information that would allow them to understand that the test was not only necessary, but critical to MayRose's well-being.

In a nutshell, this case involves two NICU physicians who are attempting to escape responsibility for their negligent acts and omissions in the care and treatment they provided MayRose Hurst by placing the blame for her injuries on her pediatrician, notwithstanding the fact that the negligent conduct of these NICU physicians set the stage for and essentially guaranteed Dr. Conti's failure to provide proper follow-up care for this child.

As a result of the many failures on the parts of Defendants Blahnik and Piroozi, there was no reason for MayRose's parents or her pediatrician to understand or believe that MayRose was suffering from ongoing anemia. Furthermore, there was no reason for MayRose's parents or her pediatrician to understand or believe that MayRose was transfusion dependent at the time of her discharge from the NICU, nor was there any reason for MayRose's parents or her pediatrician to understand the necessity for a follow-up CBC when Dr. Piroozi represented to MayRose's parents, as well as in the discharge instructions, that the anemia had resolved.

By withholding critical information about MayRose's condition and NICU course from her parents as well as her pediatrician, the NICU physicians essentially required Dr. Conti to operate in the blind. Defendants should not be allowed to withhold critical information from the parents and pediatrician, replace it with false information that creates a false sense of security and then, when the pediatrician makes the wrong decision, claim that the pediatrician's negligence was an intervening cause when, in fact, the pediatrician's negligence was the result of the negligence of the NICU physicians themselves.

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Based upon the foregoing, it is clear that Dr. Conti's negligence in failing to perform the requested CBC was not an unforeseeable intervening act that operates to excuse the Defendants from their own negligent conduct. Accordingly, Defendants' Motion for Summary Judgment should be denied.

C. DEFENDANTS' NEGLIGENCE IS A PROXIMATE CAUSE OF MAYROSE'S BRAIN INJURY.

It is well established that there can be more than one proximate cause for the same injury. The Nevada Supreme Court has explained this well-accepted tenet of law as follows:

> [B]efore negligence can be actionable, that is to say before it can be charged against a party to a lawsuit, such negligence must be a proximate cause of the damage complained of. This does not mean that the law seeks and recognizes only one proximate cause of an injury, consisting of only one factor, one act, one element of circumstance, or the conduct of any one person. ***To the contrary, the acts and omissions of two or more persons may work concurrently as the efficient cause of an injury, and in such a case, each of the participating acts or omissions is regarded in law as a proximate cause.***

Alex Novack & Sons v. Hoppin, 77 Nev. 33, 39, 359 P.2d 390, 393 (1961) (emphasis added). Accordingly, "[w]here two or more causes proximately contribute to the injuries complained of, recovery may be had against either one or both of the joint tortfeasors." Banks ex rel. Banks v. Sunrise Hosp., 120 Nev. 822, 842, 102 P.3d 52, 66 (2004), citing Mahan v. Hafen, 76 Nev. 220, 225, 351 P.2d 617, 620 (1960) ("Where two or more causes proximately contribute to the injuries complained of, recovery may be had against either one or both of the joint tortfeasors.")

This case concerns claims against Blahnik and Piroozi for their negligent failures to take a prenatal history of the infant MayRose Hurst at the time she became a NICU patient, to understand the clinical significance of her abnormal nuchal fold test result when it was reported to them by MayRose's mother, to recognize clear signs and symptoms of a pathological anemia disorder in the infant, to further explore and attempt to diagnose the disorder and/or put MayRose into the hands

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of a specialist better qualified to diagnose the anemia disorder and instead negligently misdiagnosing and concluding that her anemia was innocuous and merely "due to prematurity."

The case further concerns these defendant-physicians' failure to provide MayRose's parents with critical information regarding MayRose's ongoing anemia and transfusion dependence and her need to continue to receive transfusions until such time as the cause of her anemia could be determined. Instead, said physicians advised MayRose's parents that her anemia was simply due to her prematurity, was normal and was nothing to worry about, in spite of MayRose's parents specifically advising said defendants that MayRose's father had a history of Thalassemia, a genetic blood disorder, and questioning them as to whether MayRose's need for transfusions had anything to do with her abnormal nuchal fold test result and whether or not this was the "genetic defect" the perinatologist warned them to expect.

With respect to Defendant Piroozi, this case involves additional claims against him for his further failure to provide not only MayRose's parents but also her pediatrician with critical information regarding her ongoing anemia and transfusion dependence, as well as the details of her NICU course, so that proper follow-up care could be provided. Dr. Piroozi further failed to create a true, accurate and complete discharge plan that would ensure MayRose would receive the testing and transfusions she needed until such time as the cause of her anemia could be determined. Instead, Dr. Piroozi omitted critical facts from the discharge instructions and replaced them with false and misleading information that created a false sense of security with regard to MayRose's health condition. To make matters worse, at the time of discharge, Dr. Piroozi reassured MayRose's parents that she was a "healthy" baby and there were no further concerns regarding anemia or the need for any additional transfusions. It is clear that the negligent failures of these physicians were proximate causes of MayRose's eventual brain injury. MayRose was transfusion-dependent from the day she was born as a result of her genetic blood disorder. This was

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manifested in the NICU, as Defendants knew or should have known that the longest time period MayRose was ever able to last without requiring a transfusion was just over 2 ½ weeks. Without transfusions, it was inevitable that MayRose's blood count would eventually drop low enough to become a serious health risk. That day arrived on October 29, 2010 when MayRose slipped into anemic shock and nearly died.

From the time MayRose was born, she manifested clear signs of ongoing, problematic anemia. She could not maintain her own blood count. Defendant Piroozi was aware on the day before her discharge that MayRose's blood count was on its way down again since her most recent transfusion. Defendants were in the best position to recognize that MayRose had a serious blood disorder and was transfusion-dependent and either take action themselves to diagnose the problem or refer MayRose to a hematologist to undertake the task.

In the meantime, these physicians were in the perfect position to see to it that MayRose continued to receive the transfusions she required until the diagnosis could be made. These actions would have prevented MayRose from ever getting to a point where she could lapse into anemic shock. These actions would have prevented her from sustaining the subject brain injury that has forever changed her course and her life. Unfortunately, the defendants didn't take any of these actions. Instead, they sent MayRose and her parents out the door without informing them of MayRose's ongoing anemia and transfusion-dependence and with only a recommendation for a follow-up CBC in 30 days. Defendants' acts and omissions were direct proximate causes of MayRose's brain injury that occurred months later.[1]

[1] Defendants incorrectly attempt to make the focus of the causation case the diagnosis of the Diamond Blackfan Anemia and place great import on Plaintiffs' stipulation that Defendants did not breach the standard of care in failing to make that diagnosis. The failure to diagnose the *cause* of MayRose's anemia is not what led to her brain injury. Rather, it was the Defendants failure to *recognize* that she had pathological anemia—not anemia due to prematurity—and evaluate it further themselves or by referring her to others, and most importantly to ensure that she received the tests and treatment she needed until such time as the diagnosis could be made.

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In sum, Defendants had all of the knowledge and information in front of them necessary to recognize the seriousness of MayRose's condition, having spent the better part of 3 months caring for her on a daily basis. Not only did they miss the writing on the wall, they also refused to share relevant information with MayRose's parents and pediatrician. In light of those facts, for these Defendants to now try to blame Dr. Conti as the sole cause of MayRose's brain injury because he elected not to perform a follow-up CBC for which he was given no reason or explanation as to its necessity, is without merit or legal justification and should not be countenanced by the Court.

CONCLUSION

Based on the foregoing, Plaintiff asserts that Defendant Sunrise Hospital's Motion for Summary Judgment, including Defendant-physicians' Joinders therein, are without merit and should be denied.

RESPECTFULLY SUBMITTED this 14th day of October, 2013.

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CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of October, 2013, I mailed a true and correct copy, postage prepaid, of the foregoing **PLAINTIFF'S MEMORANDUM IN OPPOSITION TO PLAINTIFF SUNRISE HOSPITAL'S MOTION FOR SUMMARY JUDGMENT (INCLUDING DEFENDANT PHYSICIANS' JOINDERS THEREIN)** to the following:

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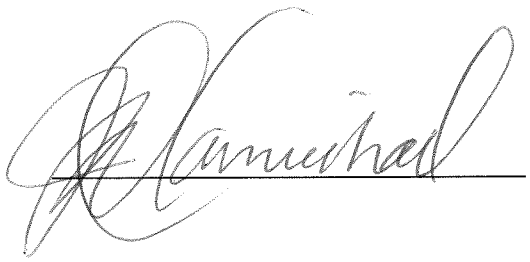

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EXHIBIT A

DISTRICT COURT
CLARK COUNTY, STATE OF NEVADA

TIFFANI D. HURST AND BRIAN ABBINGTON, JOINTLY AND ON BEHALF OF THEIR MINOR CHILD, MAYROSE LILI-ABBINGTON HURST,

Plaintiffs,

vs.

CASE NO. A-10-616728-C
DEPT. XXIV

SUNRISE HOSPITAL AND MEDICAL CENTER, LLC, MARTIN BLAHNIK, M.D., ALI PIROOZI, M.D., RALPH CONTI, M.D. and FOOTHILLS PEDIATRICS, LLC,

Defendants.

DEPOSITION OF TIFFANI HURST
Taken on Tuesday, August 23, 2011
At 9:36 o'clock a.m.
At 3441 S. Eastern, Ste. 402
Las Vegas, Nevada 89169

REPORTED BY: MARY DANE McCOY, RPR, CA CSR NO. 8216
NV CCR NO. 219

INDEX

EXHIBITS

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Also Present: BRIAN ABBINGTON

(In an off-the-record discussion counsel agreed to waive the court reporter requirements under Rule 30(b)(4) of the Nevada Rules of Civil Procedure.)

TIFFANI HURST,

having been first duly sworn to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. ROSENTHAL:

Q. Please state your name for the record.

A. Tiffani Danielle Hurst.

Q. Ms. Hurst, my name is Amanda Rosenthal and I represent Dr. Conti and Foothill Pediatrics in the medical malpractice action that you filed regarding your daughter, MayRose Hurst. I'm going to let other counsel identify themselves for the record.

MS. URDAZ: Jonquil Urdaz for Sunrise Hospital.

MR. COTTON: John Cotton for Drs. Blahnik and Piroozi.

BY MS. ROSENTHAL:

Q. All right. Have you ever had your deposition taken before?

A. Not -- no.

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Q. But you are an attorney, I understand, right?
A. Yes. Which is my hesitation, but no, I haven't.
Q. Taken depositions before?
A. I think I've taken one maybe twice.
Q. Do you want me to go over the ground rules with a deposition or do you feel comfortable skipping them?
A. I feel comfortable skipping.
Q. Okay. So you said you have never had a deposition taken before?
A. I don't believe I have. If I have, I don't remember it.
Q. Have you ever been a party to a lawsuit before?
A. Yes.
Q. What lawsuit was that?
A. Well, let's see, in connection with child support and divorce, and in connection with a bankruptcy, and in connection with bill collection.
Q. So you said first in relation to child support and divorce. Were you the plaintiff or a defendant in that lawsuit?
A. Well, with my son I was the -- I was a plaintiff in connection with child custody, and I was a

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defendant in connection with the divorce. So there were two separate suits.
Q. Okay. Who were you married to that the divorce is related to?
A. Robert Johnson.
Q. What year was the divorce filed in the divorce case?
A. I believe it was 2005.
Q. When were you married to Mr. Johnson?
A. I believe we got married 2003.
Q. If I understand you right, he filed for divorce in 2005?
A. That's correct.
Q. Then you later filed a separate action in child custody; is that correct?
A. Correct.
Q. Who was the child in that marriage?
A. Tristin Hurst.
Q. Then you said -- are there any other child support matters?
A. I'm sorry?
Q. Are there any other child support cases?
A. Yes.
Q. Which one is that?
A. In connection with Mr. Abbington.

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Q. When was that action filed?
A. Let's see, approximately a year ago.
Q. Going back to Mr. Johnson, was the divorce case filed in Clark County?
A. Yes.
Q. The child custody case was also filed in Clark County?
A. No.
Q. Where was that child custody case filed at?
A. Oh, wait a minute, Clark County, I'm getting confused. Okay, the divorce case was filed in Chicago, Illinois, that was Cook County, not Clark County. And then the custody case was in Clark County, yes.
Q. Is the custody case regarding Tristin resolved?
A. Yes.
Q. What is the agreement currently for custody of Tristin?
A. We have joint legal, and I'm the person that he lives with, so I have sole physical custody of Tristin. And he visits once a month for the entire weekend with his dad for that, and then he goes with his dad for a couple of weeks twice a year.
Q. Are the expenses for Tristin split 50/50? How are his expenses paid?

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A. Well, in Cook County there is -- a percentage of your income is, I believe, how they come to the figure. And in addition to that, I'm reimbursed for maintaining health insurance. And I think there is a small amount of that that goes towards his schooling.
Q. Does Mr. Johnson give you a set amount each month?
A. Yes.
Q. What is that set amount?
A. Approximately 1400.
Q. Going to the custody case regarding MayRose, you say that was filed last year sometime?
A. Yes.
Q. Okay, who filed that action?
A. I did.
Q. Why did you file that action?
A. To make certain that Brian and I were on the same page regarding the amount to be paid for contribution.
Q. What did you want Brian to pay for contribution as far as MayRose?
A. I was asking that he contribute to the nanny costs and the medical costs as well as the standard amount that is to be assessed. And also my perspective was anything could happen in the future, and I wanted

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to make sure that was all set in stone with MayRose.
Q. Are you acting as your own attorney in the custody case for MayRose?
A. Yes.
Q. Does Mr. Abbington have counsel or is he acting as his own attorney?
A. He had counsel.
Q. In the custody case for MayRose, were you seeking to have sole physical custody or how were you going to divide physical custody of MayRose?
A. I was pretty open. I mean, we have done unlimited custody. I just wanted to make sure that he was at a level where he understood her medical needs depending upon, you know, whatever it was he needed to -- or was looking to do with her on a given point in time. Because she has some pretty significant medical regimens.
Q. Did you have a concern that he wasn't understanding her medical needs at the time you filed the case?
A. Yes.
Q. Why were you concerned about that?
A. Because I went to the majority of the appointments, and so they just were evolving over time, and you just couldn't really keep up with them unless

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you were at the appointments. So it was hard to convey all the different things that were going on at any point in time.
Q. Was Mr. Abbington interested in what was going on at the appointments and was he asking about what would happen at them generally?
A. I'm sure he was interested.
Q. The custody case was filed in Clark County for MayRose, correct?
A. Yes.
Q. I looked at the printout from the court system for the custody case, and there are a few things I wanted to ask about. What specific child support -- how much were you asking for in child support?
A. I don't remember the initial figure that I put in the complaint. I think I put the maximum from the perspective of half of the nanny costs, and half of the medical costs at that time, I think. However, it fluctuates so much in terms of the costs that I can't say for certain. I don't even remember the exact amount that I filed the complaint for.
Q. Do you have a copy of that complaint and all the pleadings you filed in that case?
A. I do.
Q. Okay, if we requested them by a request of

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production, could you provide those?
A. I could.
Q. One of the motions is regarding also visitation. What was the visitation request?
A. That also evolved over a period of time. And I believe I put in my complaint unlimited, if I'm recalling correctly. And then but I wanted it to be in the house because of her medical scenario. And at some point it evolved into him seeing her with the nanny, who is the one other person besides me who has attended a large portion of the medical appointments. So we ended up evolving to unlimited through the nanny, he would just arrange it with her.
And then he was attending an appointment once a week, one of her physical therapy appointments once a week. And then from there we went back to unlimited with at bare minimum he has the ability to see her every Saturday from set hours should he choose to exercise that option, but it is still unlimited. And it is no longer confined to the house.
Q. So the current arrangement, just so I understand, it is unlimited visitation, he has set hours on Saturday he can see her, but he no longer has to come to the house?
A. No.

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Q. Is that correct?
A. That's correct.
Q. Okay. There is also one of the motions requests medical insurance. What was the specific request related to that?
A. I was paying for the medical insurance and I was asking for a contribution for that.
Q. Was MayRose ever covered under Mr. Abbington's insurance?
A. No, she has always been covered under mine.
Q. Do you know, was there a discussion why she wouldn't be covered under Mr. Abbington's insurance as well?
A. My main concern about that just was I take her to the overwhelming majority of the appointments, both in-state and out of state. I didn't want to have to worry about fooling around with his insurance because sometimes issues arise when we get to the doctors' office about what insurance is covering, what it is not. And just the other day I had to go on my cell phone internet and pull up my coverage and show someone. So it is just -- I felt it would be too difficult to have her on his.
Q. How much did you specifically want him to pay towards the medical insurance?

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A. I think I was asking for one third, but like everything else, the numbers just constantly changed.
Q. Did you want him to pay one third of the medical insurance premium or one third of the bills that were not covered by medical insurance?
A. Of the premium is my recollection.
Q. How much is your medical insurance premium?
A. I don't remember. But it is on my pay stub.
Q. Did Mr. Abbington file countermotions for custody as well in the child custody case?
A. He filed countermotions. I don't think he was ever looking for custody.
Q. What was he specifically requesting, based on your recollection?
A. Well, I know he did not want to visit her in my house, so it was -- there was something related to that, wanting to work out a different arrangement. Which we ended up doing. And then the amount of child support.
Q. Do you remember how much he wanted to pay in child support?
A. I just remember he didn't want to pay the initial amount that I had in the paperwork, which, like I said, was really just a starting point for discussion.

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Q. Did you and Mr. Abbington eventually come to an agreement on your own regarding MayRose's custody and child support issues or did the judge end up making a decision for you?
A. We came to an agreement on our own.
Q. Okay. So can you go through the current child custody and child support agreement you have with Mr. Abbington?
A. Joint legal, sole physical to me. Unlimited visitation with a minimum on Saturdays, should he desire to exercise that. And in terms of the amount, he pays, I believe, it is 1700 a month. Part of that is for the nanny costs. I think a significant part of that is for the nanny costs, and then there is a medical contribution of $250.
Q. How much do you pay -- well, sorry.
Do you have just one nanny or more than one?
A. I have two. I have one nanny and one person that I consider to be a sitter.
Q. Who is your nanny?
A. Tobi Whittaker.
Q. How many hours a week does she work; what is her schedule?
A. She works the entire day on Monday starting at around between 8:00 and 8:15. Then she works until

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around 6:30ish, depending upon the demands of my job on that day. The rest on Tuesday through Thursday she works from 8:00, somewhere between 8:00 and 8:15 to about between 2:30 and 2:45, at which point the sitter comes in and she stays with the kids until I get home from work.
Q. Is that usually around 6:30 when you come home?
A. Ish. It depends on the demands of my job.
Q. I see. What is the name of the babysitter?
A. Katrina Fornesi.
Q. How do spell her last name?
A. F-O-R-N-E-S-I.
Q. How much do you pay Ms. Whittaker a month?
A. I pay her every two weeks, and I pay her -- during the school year I pay her $1265 every two weeks. During the summer I pay her 1200 every two weeks. And that has evolved over time as well, that amount.
Q. What did you initially pay Ms. Whittaker for --
A. I really can't remember. Different things have transpired over the years that have brought different changes in hours or --
Q. Okay, sorry. Has the amount that you pay Ms. Whittaker generally increased over the years?

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A. Yes.
Q. How much do you pay Ms. Fornesi to babysit?
A. I pay her $12 an hour.
Q. She babysits from 2:30 till when you get off work from Tuesdays through Friday?
A. Right, except for on Fridays she takes that entire day, so she starts at 8:00 on Fridays.
Q. So her schedule is 2:30 to 6:30ish Tuesday through Thursday, and all day on Friday?
A. Correct.
Q. So then the child support that Mr. Abbington is paying pays part of the nanny costs. Is there a certain allocation that goes to the nanny of the 1700 each month?
A. Yeah, there is an allocation. I can't remember exactly what it is, but here there are set guidelines for support, and so a portion of that is under -- you know, is the amount assessed under the guidelines. Then the rest of it goes towards nanny costs, and then there is the 250 that is going towards the medical costs.
Q. The court records show that in the custody case with Mr. Abbington there was at least one motion for contempt and order to show case for failure to comply with temporary order of child support. What

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were those motions about?
A. We had a disagreement over what the temporary order meant entered by the judge. And I thought it meant something that involved a higher payment than what was being paid.
Q. What amount of payment did you think it involved?
A. That he was supposed to -- I believe I thought he was supposed to be paying half of the medical costs.
Q. Was this motion ruled on by the judge or did you and Mr. Abbington come to an agreement?
A. We came to an agreement.
Q. Is that the 1700 a month or was it something different?
A. That was that ultimate agreement.
Q. There is also in the court record a notice for taking deposition of the custodian of records for Las Vegas Metropolitan Police Department. What is that?
A. That's correct. It was about Brian and I being unhappy with each other at that point in time in the litigation.
Q. Okay, who requested to receive the records from the Las Vegas Metropolitan Police Department?

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A. We both did.
Q. What records were you both seeking?
A. Any arrests or open cases.
Q. Do you have arrests or open cases with the Las Vegas Metro police department?
A. I do not.
Q. Does Mr. Abbington, to your knowledge?
A. I don't know.
Q. Did anyone end up taking the deposition of the custodian of records of the Las Vegas Metropolitan Police Department?
A. No.
Q. Did anyone ever receive any records from the Las Vegas Metropolitan Police Department?
A. Yes, I did.
Q. What did those records show?
A. I think a traffic stop. I don't remember the details.
Q. So what is the reason for wanting those records at that point? What was the purpose of getting them?
A. Well, I think that at that point in time there had been -- we had reached a point where we were not happy with each other, and so we were both kind of fishing around as attorneys -- we are both attorneys --

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we were just kind of going overboard in the situation. And it required us to both kind of take a step back and recognize that we were unnecessarily going off track. The only question that needed to be on the table was the best way to resolve or put an agreement in writing that would work for MayRose.
Q. I want to just talk briefly about -- step back a little bit and talk a little bit about your relationship with Mr. Abbington. MayRose, of course, is your daughter?
A. Yes.
Q. Mr. Abbington is her father?
A. Yes.
Q. How did you meet Mr. Abbington?
A. I met him when I first moved to Las Vegas.
Q. Where did you meet him at?
A. In my workplace.
Q. Where do you work or where did you work at the time?
A. Federal Public Defenders Office.
Q. Do you still work there today?
A. I do.
Q. What was Mr. Abbington's position when you met him?
A. He was -- when I first met him, he was in

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some weird position, I don't even understand what his position was at that time. He was, I guess, in charge of some things, and but not in charge of the unit, so --
Q. What was your position when you came to the Federal Public Defenders Office?
A. Well, we were both assistant federal public defenders.
Q. Was Mr. Abbington your supervisor?
A. Initially, I'm not sure. Eventually, yes.
Q. How long after you met Mr. Abbington did you start a relationship with him?
A. I'm not sure. Maybe, well, I know it was more than a year after I met him. That is the closest I can come to.
Q. What year did you meet him or when did you begin at the Federal Public Defenders?
A. I began January of 2006.
Q. So approximately sometime in 2007 you began a relationship?
A. It might have been the end of 2006 or the beginning of -- I think it may have been the end of 2006, but the fact is that I just don't remember exactly. It was after I had my son, several months after I had my son. And his birthday is in April. So

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it was -- I believe it was towards the end of 2006.
Q. Tristin was born in 2006?
A. Yes.
Q. Was MayRose a planned pregnancy?
A. No.
Q. At some point did you begin living with Mr. Abbington or were you maintaining separate residences?
A. We maintained separate residences.
Q. Was there ever a time when you lived with Mr. Abbington?
A. No.
Q. At the time of MayRose's birth, were you and Mr. Abbington still a couple?
A. Yes.
Q. At what time did you end your relationship or did he end the relationship with you?
A. It is really hard to say. Our perspectives on that I think are a little different. From my perspective, it was when I filed for child support.
Q. That was approximately March of 2010?
A. Right. That sounds right.
Q. What would you believe his perspective to be, from what he has told you, of when your relationship ended?

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A. I don't think that I ever pinned that down with him.
Q. But you would consider yourself a couple with Mr. Abbington up until March of 2010?
A. I did, yes.
Q. Do you think that prior to MayRose's injuries in this case, would you go do things as a family together, or could you describe how that relationship worked just shortly after her birth?
A. Yeah, we would do things, I mean, we would do things together. Maybe go to the park, or, yes, we would do things together. He would cook us breakfast.
Q. Would he generally come to your house or would you go to his house?
A. He would come to my house. It was mostly him coming and cooking breakfast, he did a lot of that.
Q. You still work with Mr. Abbington; is that right?
A. I do.
Q. What is his current position?
A. We are both team leaders.
Q. So are you basically equals within the Federal Public Defenders?
A. Yes.
Q. You each have your own staff to manage and

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caseload?
A. Yes.
Q. Go back for a few background questions. Did you review any records or documents in preparation for your deposition today?
A. I reread some of the pleadings.
Q. Which pleadings did you read?
A. The complaint, and the interrogatories.
Q. Did you review just your responses to interrogatories or anyone else's responses to interrogatories?
A. Just mine.
Q. Did that include your responses as far as MayRose?
A. Yes.
Q. Did you review any other documents in preparation for your deposition today?
A. No.
Q. Have you turned over to your attorneys all the documents that you have in your possession in this case pertaining to this case?
A. Yes.
Q. In your interrogatory responses you mentioned you kept a calendar of schedules of doctors' appointments and things like that. Do you remember

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that response?
A. Yes.
Q. Have you conducted a search for those calendars?
A. Not a search. But I know where some of them are located in my office. I would write appointments on my business calendar sometimes and --
Q. Can you turn those over to your attorney so she can produce them?
A. I can.
Q. Did you discuss, other than with your attorney, coming here for your deposition today with anyone?
A. Discuss it, no.
Q. Did you just mention it to anybody?
A. Yes.
Q. Who did you mention it to?
A. Tobi Whittaker, the nanny.
Q. Anyone else?
A. A couple coworkers.
Q. Did you discuss with the nanny or the coworkers any specific testimony you would be giving today?
A. No.
Q. Did you discuss any of the particulars

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regarding any of the medical care and treatment MayRose receives in this case with the nanny or coworkers?
A. In connection with coming here today? No.
Q. Other than your attorney, who have you talked to regarding the allegations in this lawsuit?
A. I've mentioned it to different friends and coworkers at various times over the years.
Q. Can you give me a list of people you recall mentioning it to?
A. Oh, Gary Taylor, Gerald Bierbaum, Denise Paris, maybe Ben Scroggins, I'm not sure. Those would be coworkers.
Q. Anyone else you have discussed the allegations in this lawsuit with?
A. You know, I don't think I've actually discussed the allegations of this lawsuit with family members now that I think about it. I think I've just over time talked about what has transpired in her medical scenario, but not in connection with this lawsuit.
Q. Which family members have you talked to about what medical things have transpired with MayRose?
A. My aunt and uncle, great aunt and uncle, so that would be Carolyn Hurst and Jim Hurst.
Q. Anyone else?

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A. Gee, Leticia Brown.
Q. Who is Ms. Brown?
A. My cousin.
Q. Anyone else?
A. My grandfather.
Q. What is his name?
A. Charles Hurst.
Q. Anyone else?
A. Not that I can remember at this time.
Q. Are your parents still living or in your life?
A. Yes.
Q. Did you discuss this case with them or --
A. No.
Q. What are your parents' names?
A. Frederick Hurst, Sr., and Marjorie Hurst.
Q. Are they involved in MayRose's life?
A. They send gifts.
Q. Do they come and visit?
A. No.
Q. Does Mr. Abbington have any family who spends time regularly with MayRose?
A. Carolyn is married to his cousin, and she watched MayRose for a while while we were looking for an afternoon babysitter.

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Q. Is that Carolyn Hurst?
A. No, that is a different Carolyn.
Q. Okay. What is Carolyn's last name?
A. That I don't remember.
Q. Do you remember the name of the cousin she is married to?
A. Bruce -- Reed, that is right, it is Reed.
Q. All right. What is your date of birth?
A. 2/2/69.
Q. Where were you born?
A. Springfield, Massachusetts.
Q. What is your Social Security number?
A. XXX-XX-4422.
Q. Have you ever been convicted of a felony?
A. No.
Q. Have you ever gone by any other names?
A. Sort of. My birth certificate is Tiffani Hurst, and I did take Johnson as my last name. And when I moved here in the middle of the divorce, I may have done a Hurst-Johnson or something. I made it known there were two names involved because -- to the people in my office, so that they would know because I planned to return to Hurst. And so there was some combination I used for a few months.
Q. Any other names?

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A. Not that I actually went by, no. Well, nicknames, I guess.
Q. But no other last names?
A. I never took a different last name than Hurst or Johnson.
Q. What is your current address?
A. 3116 Villa Colonade.
Q. How long have you lived there?
A. Going on three years in October.
Q. Who do you live there with?
A. My son, Tristin, and my daughter, MayRose.
Q. Anyone else live there?
A. No.
Q. Has there ever been a time when anyone else has lived there?
A. No.
Q. Where did you live prior to that address?
A. What is the name of the street -- another address in Summerlin that I just can't remember off the top of my head.
Q. I'm going to show you a form I think you filled out on August 5, 2008 at Foothills Pediatrics, it lists your address as 8636 --
A. That is what it is.
Q. -- Sierra --

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A. Yeah, Sierra, you would do better to ask Brian, he probably remembers. But, yeah, that's correct.
Q. I wanted to ask you about that form for just a minute. Can you read the Bates stamp number on the bottom for the record?
A. Foothills Pediatrics 18.
Q. It lists your address as 8636 Sierra Cima Lane, C-I-M-A?
A. Uh-huh.
Q. So how long had you lived at that address? In what years did you live there?
A. Pretty certain I was there for a year, for almost a year.
Q. On that form it asks for information for both yourself and for Brian Abbington. It also lists Brian Abbington's address at 8636 Sierra Cima Lane.
A. Yeah.
Q. Was that his address at the time?
A. No.
Q. Why did you list that address?
A. Probably because I couldn't remember his because I have a bad memory for names.
Q. Do you remember what his address was at the time?

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A. No.
Q. But you weren't living together, you just couldn't remember so you put down your address?
A. Right. Spanish Oaks, he was in Spanish Oaks, I just don't remember the street in Spanish Oaks. He owned his own house there.
Q. You lived at Sierra Cima Lane for approximately a year you said?
A. Approximately.
Q. And that was your immediate address prior to the Villa Colonade address?
A. Yes.
Q. Other than those two addresses, have you ever lived at any other address here in Las Vegas?
A. Yes.
Q. What was that or approximately, what you remember?
A. Yeah. Well, I lived at an address in Spanish Oaks as well.
Q. Did you live there with anyone?
A. It was just me and the kids.
Q. Was that prior to MayRose's birth or after?
A. Prior to her birth.
Q. Other than those three addresses, have you lived anywhere else in Las Vegas?

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A. Yes. On Decatur and -- off of Decatur.
Q. Is that the first address you moved to?
A. That was the very first address I lived at.
Q. Approximately how long did you live there?
A. Close to a year.
Q. Did you live there with anyone other than your children?
A. No, and my son was born while I was living at that address.
Q. Did anyone other than your children live with you at Sierra Cima Lane?
A. No, I have never had anyone live with me here other than my children.
Q. Do you have any plans to move in the future?
A. Probably.
Q. Where are you planning on moving?
A. I don't know, a place with less rent, and with no carpeting.
Q. Why do you want a place with no carpeting?
A. Because MayRose is hopefully going to transfer to a gait trainer, and that obviously won't work well on the carpeting.
Q. Can you describe for me what a gait trainer is?
A. It is like a thing that helps her try to

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walk.
Q. Does your entire house right now have carpeting?
A. Except for the kitchen and the bathrooms, yes, and the entry area when you walk in the front door.
Q. How much is your rent at that address?
A. $1500 a month.
Q. Are you already in the process of looking for a new place to live or you haven't started that yet?
A. Well, interestingly enough this past weekend was the first time I actually really went online to see what was out there price wise. And I did visit one location.
Q. Are you looking to rent another house?
A. I don't know at this point. I'm looking to reduce costs, but find a place that is conducive to MayRose's needs.
Q. What other factors will go into that decision as far as MayRose's needs? What else does she need other than less carpeting?
A. Well, she has a lot of equipment, so got to be a place where we can set up all her therapy-related equipment. Preferably one floor because eventually carrying her upstairs is probably going to become

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problematic.
Q. Any other requirements for the new house that you move to?
A. Those are the first ones that I've given thought to. There could be more eventually.
Q. You are not currently married, correct?
A. Correct.
Q. You and Mr. Abbington never married; is that right?
A. That's correct.
Q. Other than Mr. Johnson, have you ever had any previous marriages?
A. Yes.
Q. What marriages were those?
A. Richard Thompson.
Q. What years were you married to Mr. Thompson?
A. Well, shortly after I graduated from law school in 1993.
Q. When were you divorced from Mr. Thompson?
A. A couple years later.
Q. Where did you marry Mr. Thompson?
A. In Springfield, Illinois.
Q. Did you file for divorce or did he file for divorce?
A. I did.

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Q. Where did you file for divorce at?
A. Springfield, Massachusetts.
Q. Did you have any children with Mr. Thompson?
A. No.
Q. Other than MayRose and Tristin, do you have any other children?
A. No.
Q. Other than Mr. Johnson and Mr. Thompson, do you have any other prior marriages?
A. No.
Q. Does Mr. Abbington have any other children other than MayRose?
A. Yes.
Q. How many?
A. Two that I am aware of.
Q. Boys or girls?
A. Girl.
Q. Do you know approximately how old they are?
A. In their 20s, I believe.
Q. Where do they live?
A. The last I knew it was in Texas.
Q. Have those girls ever met MayRose to your knowledge?
A. I am unaware of that.
Q. They have never come to visit her in Las

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Vegas that you are aware of?
A. I do not know whether they have or have not.
Q. Do you know who their mother is?
A. Yes. Shaniece.
Q. Do you know her last name?
A. Reed.
Q. Other than your divorce cases and your custody cases for Tristin and MayRose, have you ever been a party to any other lawsuit?
A. Well, I had a dispute with my landlord at the very first place I lived here.
Q. What was the dispute about?
A. The air conditioning wasn't working, and so I refused to pay rent until the air conditioning was fixed. Because at that time I had just had Tristin. And so he filed to evict me because I wasn't paying the rent, and I countersued, seeking damages because of his refusal to fix the air conditioning.
Q. Earlier you mentioned collections actions; is that right?
A. Right, and I was thinking of that as a collections action.
Q. Is that the only collection action you are a party to?
A. No. I know that at some point I think I had

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a collections action in connection with a utility.
Q. Do you know how long ago that was approximately?
A. I would say about ten years ago, and I probably had some others during that time, I really don't remember exactly. It was -- I did have, as I mentioned earlier, a discharge in bankruptcy, so I know around that period of time there were some civil actions, and I don't remember exactly what they were.
Q. Where did you file bankruptcy at?
A. In Massachusetts.
Q. In Springfield?
A. Yes.
Q. Were those collections actions discharged in bankruptcy?
A. Yes.
Q. You said that -- was the bankruptcy approximately ten years ago?
A. It was more than that, actually now that I think about it. But not much longer. I mean, it is hard for me to remember the date of that, but I know it has been more than ten years because it stays, I guess, on your credit for 10 years, so, but I just -- I can not give you an exact date, 10, 15 years ago, somewhere around there.

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Q. Is the bankruptcy off your credit report now?
A. Yes.
Q. Other than the bankruptcy, the collections actions, child custody, divorces, and this action, any other actions you have been a party to, a lawsuit other than those?
A. Can I have a moment?
Q. Sure.
A. Because I need to ask you something. Is that okay?
Q. Sure.
A. Thank you.
(Whereupon, a recess was taken from 10:34 to 10:41.)
BY MS. ROSENTHAL:
Q. Prior to the break, I had asked you, other than the lawsuits we have already discussed, have you ever been a party to any other lawsuit?
A. I do not recall being a party to any other civil suits.
Q. Have you ever been a witness in any lawsuit?
A. A witness in a lawsuit, no.
Q. Have you ever been a subject of any kind of investigation by a government agency?
A. Yes.

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Q. When was that?
A. It was a couple years ago.
Q. What government agency was doing the investigation?
A. Metro.
Q. What was the investigation regarding?
A. About my decision to let my son stay asleep in the car while I ran inside to price swing sets for him.
Q. When did this happen?
A. It was a couple years ago, I don't remember the exact time period. It was shortly before his April birthday, it was like in March.
Q. How did Metro become aware of this?
A. Because someone in the parking lot observed me walk inside the store, and although I had parked in front of a window, and had the car, the automatic starter running with the AC on, even though it wasn't a hot day by any means because it was in March, a person felt that it was -- that I should not have left him. So they called the police.
Q. How long was your son in the car on this incident?
A. I don't know.
Q. Do you remember approximately?

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A. I remember not feeling like I was gone very long. I had to walk to the back of the store where the swing sets were, and I could see the car through the window. I looked at the prices on the big sets and small sets, and then I walked back out. So the amount of time it took me to do that.
Q. When you came out of the store, was Metro already there?
A. Yes.
Q. And did they interview anyone at --
A. The person who called them.
Q. To your knowledge, what happened after Metro came and investigated? Did they turn it over to another agency?
A. Not to my knowledge.
Q. Do you know if Metro or another agency contacted anyone else for information regarding your care of your son?
A. I don't -- I don't know that they contacted anyone else. They did come in my house and talk, and I think they were looking for me and my nanny answered the door. And I remember her telling me that she just was amazed that they could think I had done something wrong.
Q. Was this investigation ever turned over to

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Child Protective Services?
A. I know that -- I know that I was contacted by CPS or whatever the organization here is, and but they didn't have me do anything, they didn't --
Q. What was the end result with the Child Protective Services or Metro?
A. It was dismissed.
Q. Did you ever talk to Dr. Conti about that incident?
A. Oh, I think he was called, now that you mention it. I think they did mention to me that he had been called.
Q. What did he say about that to you?
A. I don't remember the -- it was kind of like in passing. Oh, like I got a call, and I told them you were a good mother or something like that.
Q. So based on your conversation with Dr. Conti, it was your understanding he gave a statement in support of you?
A. That is my recollection. And I didn't actually remember until you just brought it up, that he had been called. And it was a very short, brief, in passing sort of mention that he had been called.
Q. Have you ever been the subject of any other investigation by a government agency?

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A. Not in -- well, I think to get my job they had to do a background check.
Q. On the court system here in Clark County there is a case, I believe it has to do with the Department of Work Force Services, do you know what that is?
A. No.
Q. Have you ever applied for any unemployment benefits in Clark County?
A. No. Department of Work Force Services -- is that taxes?
Q. Possibly, I think it involves payment of a few hundred dollars.
A. Yeah.
Q. What was that about?
A. The first nanny I had for Tristin, I think I still owe some taxes in connection with her.
Q. All right. Do you have any medical training or background?
A. No, I have a degree in psychology, but I don't think that is medical.
Q. Does anyone in your family have medical training or background?
A. No. I may have a cousin who started nursing school or something, but -- that would be the extent of

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it. I don't really know whether she finished.
Q. You never discussed MayRose's care with that cousin?
A. No.
Q. Do any of your friends have any medical training or background?
A. Training, no. We have a paralegal in our office who knows a lot about various medical things, but that is --
Q. Have you talked about MayRose's care and treatment with her?
A. Vaguely. Not specifically.
Q. How does she know a lot about medical care, if you know?
A. Well, she has a lot of medical difficulties herself, and she also handled or assisted in an ACLU suit in connection with the medical treatment of prisoners.
Q. Does that paralegal offer any opinions regarding this case?
A. No.
Q. As an attorney, have you ever worked on medical malpractice cases?
A. No.
Q. During your career, have you focused on

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criminal defense work?
A. Mainly.
Q. What other areas of law have you practiced?
A. Well, I was a general practitioner for a little while, and so I did a little bit of employment law, some immigration, employment discrimination law, immigration law, a little bit of mental health care law, a little bit of care and protection law, half or maybe a quarter of a divorce case.
Q. Where did you receive your law degree from?
A. University of Chicago. When I first graduated, I was in the corporate department of a law firm.
Q. Where did you get your undergraduate degree from?
A. Wellesley College.
Q. What year was that?
A. 1990.
Q. When did you get your law degree?
A. 1993.
Q. What states are you licensed to practice in?
A. Illinois, I have a special license here. Then I have nonactive licenses in Connecticut and Massachusetts.
Q. Have you ever taken any CLEs or any other

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training specifically in medical malpractice law?
A. No.
Q. Do you have any other certifications or licenses other than the law degree?
A. Just a master's in general psychology.
Q. Where did you get that at?
A. Springfield College.
Q. What year?
A. I believe '9 -- '9 -- '97.
Q. You got that after you received your law degree?
A. I did.
Q. I apologize, you came to Nevada in what year again?
A. January of 2006, I believe it was.
Q. Since coming in January 2006, you have worked at the Federal Public Defenders Office?
A. Yes.
Q. Where did you work just prior? Did you work at a federal public defender in Chicago?
A. Yes.
Q. How long had you worked --
A. Actually it wasn't in Chicago, it was in Illinois, it was in Peoria was the main branch, but Champaign-Urbana was the branch I worked out of.

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Q. How long had you worked at the Federal Public Defenders in Illinois?
A. For three years.
Q. Your current position with the Federal Public Defender is as a team leader, correct?
A. Yes. I'm an assistant federal public defender in a capital habeas unit, and I'm one of five team leaders.
Q. How many approximately hours a week do you work?
A. It varies. Bare minimum 40, but --
Q. Are you able to work from home or do you have to be in the office to do your job?
A. Well, if you are not out on an investigation, then you are supposed to be in the office.
Q. Who is your supervisor at the Federal Public Defenders?
A. Mike Pescetta.
Q. Is your supervisor aware of MayRose's medical problems?
A. To a certain extent, yes.
Q. If you have to leave work due to doctors' appointments or a medical issue, do you have to tell your supervisor or somebody else or do you just go?
A. It depends. If it is something I can do on

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my lunch hourish, then I don't need to tell anyone. But if it is during the time that people would expect me to be available, then I take it -- I send an e-mail out to everyone, and if it is going to be for an entire day or for a series of days, then I have to request leave time for that.
Q. Do you request vacation time or do you use FMLA time or neither?
A. I use sick leave and annual leave.
Q. Have you ever used FMLA?
A. I did, but I haven't recently because it is really not separate time, it is still using your sick time or your annual leave. It is just that when you put it under FMLA, then they can't, you know, get upset with you for taking the time off. But if you put it -- if you don't use FMLA, then technically I guess they can get upset with you for taking the time off. I haven't been using FMLA because they have been good about letting me take the necessary time, and I just want to save that in case that ever changes. So --
Q. How much sick leave do you receive per year?
A. I get four hours every two weeks.
Q. How much annual leave do you get per year?
A. I get six hours every two weeks.
Q. Recently has your annual and sick leave been

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enough to cover the time off?
A. Twice I've had to get donations.
Q. Is that where you ask coworkers to donate their sick or annual leave time to you?
A. Yes.
Q. When is the last time you had to do that?
A. Just recently. In June and July of this year.
Q. How much did you have them donate you?
A. I don't know the actual amount. Because our administrator handled that.
Q. When was the other time you got donations?
A. It was when MayRose first collapsed.
Q. Do you know how much time was donated then?
A. No.
Q. Has anyone at the Federal Public Defender ever told you that your job performance has suffered because of MayRose's condition and her medical issues?
A. No.
Q. Has anyone ever told you that your job was in jeopardy because of the time you took off?
A. No.
Q. What is your annual salary?
A. Approximately 150,000.
Q. Other than your salary and the child support

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you receive from Mr. Abbington, is there any other income that you use to help support MayRose?
A. Any other income, no.
Q. No one else gives a donation regularly to help you?
A. No. Since she has been born, one person paid a medical bill, and once I received an anonymous donation for $1,000, which was a wonderful thing.
Q. Who paid a medical bill?
A. My aunt and uncle.
Q. How much was the medical bill?
A. $100.
Q. Is that the aunt and uncle you talked about earlier?
A. Yes. And actually I had an old coworker, I think she sent me maybe $50.
Q. Can you estimate how much time you have missed from your job because of MayRose's medical condition?
A. No, but I can certainly get access to that.
Q. Based on your discovery responses, it appears you are not claiming any lost wages for any time you missed from work?
A. No.
Q. Is that correct?

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A. That's correct.
Q. Has your medical insurance with the Federal Public Defender been the same throughout your employment there?
A. Yes. It has always been Blue Cross Blue Shield Federal, although when I was with the Federal Defender in the Central District of Illinois I guess it was a different version of it for that location.
Q. But since MayRose has been born, you have had the same medical insurance?
A. Yes.
Q. Has MayRose been covered on your medical insurance since the time of her birth?
A. Yes.
Q. She has only been covered on your medical insurance, no other medical insurance?
A. That's correct.
Q. You still currently have medical insurance?
A. Yes.
Q. Has there ever been a time since MayRose has been born for some reason you lost your medical insurance?
A. No.
Q. Are you claiming any physical injuries personally as a result of MayRose's injuries in this

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lawsuit?
A. No.
Q. In your discovery responses you talked about some physical problems you have, like back problems from carrying MayRose, but you are not claiming those as damages now, right?
A. No. They did not arise from -- directly from MayRose. They are just getting exacerbated, but it is not, you know, it wasn't originally -- I have some torn disks in my back, and I didn't even know I had them when I first found out that they existed. They did not cause me any problems. I'd say in the last few months my back has started protesting as she is getting heavier and, you know, but it didn't arise from her injury.
Q. So any medical care you receive as a result of those torn disks, you are not seeking those as damages?
A. No.
Q. Are you claiming any emotional injuries as damages as a result of MayRose's care and treatment in this case?
A. No.
Q. Have you sought any kind of counseling since MayRose's injuries in this lawsuit?

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A. No.
Q. Do you plan on doing that in the future?
A. Because of the lawsuit? Or just in general, you know, I mean, there is --
Q. Because of the stressors that MayRose's care and treatment put in your life?
A. Well, I could always use somebody to complain to because of my stressors, but it wouldn't be something that I would be trying to collect in connection with this lawsuit.
Q. Have you had to seek any medical care at all since MayRose's birth that you believe is related in any way to the allegations in this lawsuit?
A. Directly, absolutely not.
Q. Did you have any complications during your pregnancy with Tristin?
A. Not until the day he was born.
Q. What happened the day he was born?
A. He was born on schedule, but he was having a decelerated heart rate, and so I was given a choice to either have a C-section or to wait it out for a regular birth. And I chose to do the C-section.
Q. Where was Tristin born?
A. Sunrise Hospital.
Q. Who managed your pregnancy for Tristin? Who

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was your OB-GYN?
A. I don't remember.
Q. Has anyone ever told you that you will have any health problems in the future because of the allegations in this lawsuit?
A. No.
Q. Who managed your pregnancy with MayRose?
A. I'm actually not very good with remembering names. There were a couple of doctors. There was an OB-GYN and it is hard for me to remember her name. I want to -- I know there was a Kneesel involved, but it is hard to remember the OB-GYN's name because early on we were sent to a specialist. And it was that specialist who we kept reporting to. So I think I only saw the OB-GYN a couple of times. Then it turned out that she couldn't deliver at Sunrise, so she wasn't even there for the delivery. I really can't remember her name. I can't even remember what she looks like. I have only seen her a couple of times.
Q. Do you remember what practice you were going to? The records show it was Women's Specialty?
A. Yes, that is where I went, Women's Specialty Clinic.
Q. Was there any reason in particular that you picked that practice?

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A. I don't recall.
Q. Do you remember the name of the practice who was the specialist who helped manage your care?
A. No.
Q. Center for Maternal Fetal Medicine?
A. Yes.
Q. Do you remember which doctors you saw at the Center for Maternal Fetal Medicine?
A. No.
Q. So when was the first time you were aware of any possible complications in the pregnancy with MayRose?
A. Well, the very first time was when we were at the regular OB-GYN's office, we got an ultrasound that was supposed to tell us the sex of the baby, I believe, or I don't know if it was the sex at that time, but we got an ultrasound, and we went to the appointment for the ultrasound, she gave us this picture and it was really nice. And we left and we were all excited, went home. And then we got a call saying that there was something wrong and we needed to talk -- come in and talk to the doctor about it or something like that.
We found out that she had a thick nuchal fold, and that could mean it was a chromosomal problem or a heart defect. So she was sending us to a

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specialist.
The first specialist she sent us to was male, I do not remember his name nor the name of his practice, although all of this stuff, names and practices are easily ascertainable, I just don't remember it off the top of my head. We went to see him. And he told us that he never saw a baby with a thick nuchal fold along the thickness as mine come out in a healthy way. There were two things that it usually signified, either a chromosomal defect or a heart condition. And so that would -- and that was like the case in a large percentage of the babies with thick nuchal folds, they had one or two of those problems. But even if she didn't have one or two of those problems, she could have some kind of genetic problem, which can't be tested for in advance because there is too many possible things.
So we had to get -- we needed to get tested for the chromosomal defect. And he couldn't do that, and that is how we ended up going to the center because she was able to do the testing. She did the testing, and there was no chromosomal defect. So then it was a series of appointments to monitor the heart. And after a while she said the heart looks great. So we were hopeful that maybe we had, you know, one of the few

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cases where there wasn't a problem. But we were definitely aware that there still could be some kind of genetic issue.
Q. Okay, let's go back and talk about this a little bit more. You said the ultrasound when you went to find out the sex of the baby --
A. I'm not sure if it was the sex. It may have been like the first ultrasound, but it was during an ultrasound.
Q. Who was with you at that appointment?
A. Brian.
Q. Anyone else?
A. No.
Q. So during the ultrasound no one told you about any problems, it was only after that they called you?
A. Right. The woman who did the ultrasound was not a doctor, and apparently it would -- they told me later that it would have been better practice if she had not sent us home as happy parents, because she knew something was not right, and she should have called the doctor in at that time. But I guess they called us shortly thereafter to talk about it.
Q. Do you remember which doctor called you to tell you something was wrong?

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A. No, I don't.
Q. Was it a doctor in your OB-GYN's office?
A. OB-GYN's office. This was all in the OB-GYN's office.
Q. What specifically do you remember about that conversation?
A. She said that there was a thick nuchal fold, and that usually that signified either a chromosomal defect or a heart defect in the overwhelming majority of babies. And so we needed to go see a specialist.
Q. The specialist that she sent you to was at the Center for Maternal Fetal Medicine or somewhere else?
A. The first specialist was a man, it was at a different location than the Center for Maternal Fetal Medicine.
Q. It was here in Las Vegas?
A. It was here in Las Vegas.
Q. When you went to that first specialist, what did he tell you again?
A. He told us that -- he confirmed what was originally said, which was that there was a thick nuchal fold, he told us. I received the impression it was in the middle in terms of normal versus really, really bad. But that it was thick enough so that there

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was no doubt in his mind that there was going to be something wrong with the baby. He said that generally the overwhelming majority of babies that had something wrong have a chromosomal defect or have a heart defect. But so then I remember asking, Well, you know, if we find out there is no chromosomal defect, we find out there is no heart defect, are we good to go? He said, that doesn't -- those tests don't account for genetic defects, and there is not enough testing in the world to figure out if a baby has a genetic defect, so that would just be something we wouldn't know until after the baby was born. He said but in his experience he had never seen a nuchal fold like that where the baby didn't have some kind of defect.

Q. When this doctor was talking about a chromosomal defect, did he explain what that means, what did that result in?

A. Well, he said that, you know, you can have a Down's Syndrome child or something like that from chromosomal defects and that can be tested -- that could be tested for in the womb. And so I decided I wanted to have the test, but he couldn't do it. And so it was -- so that is how we ended up going to the Center for --

Q. Maternal --

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A. -- Maternal Medicine because she was able to do the test.

Q. Was there any discussion with this doctor about sending you out of state to have that test done?

A. Yeah, I think we did talk about where the -- where we would be able to get it done sooner rather than later.

Q. But so you never traveled out of state to have the tests done?

A. No, because we found a person in state to do it.

Q. Did Brian go with you to all of your OB-GYN appointments?

A. I'm pretty sure if not all, most.

Q. Did he go with you to all of your appointments with any of the specialists?

A. Same thing. The majority, if not all.

Q. Other than Brian, was there anyone else who went with you to any of your appointments?

A. No.

Q. Were you taking any medications during your pregnancy?

A. Yes.

Q. What were you taking?

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A. Lexapro and iron.

Q. What were you taking the Lexapro for?

A. Genetic depression.

Q. Did you ever discuss with anybody stopping that medication during your pregnancy?

A. Yes.

Q. Who did you talk to about that?

A. The specialists and the OB-GYN.

Q. Did they talk about any risk of taking that medication?

A. They said that it would probably be better for me to continue taking it because of the difficulties involved with weaning me off during pregnancy was more problematic than -- especially considering all the stresses that were going on, was more problematic than the potential risks.

Q. How long have you taken Lexapro for?

A. Many, many years.

Q. Over ten?

A. Let's see, that would be '93 -- or no -- yes, over ten.

Q. You also said you were taking iron during your pregnancy?

A. Yes.

Q. What was that to treat?

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A. I became very anemic.

Q. At what point in your pregnancy did you have to start taking iron?

A. I don't remember exactly, maybe approximately halfway through.

Q. Were you anemic during your pregnancy with Tristin?

A. Yes.

Q. Were you put on iron during his pregnancy as well?

A. Yes.

Q. Did anyone ever explain if there was any risks that the baby would be anemic because you were anemic or did it have any effect on the baby at all?

A. Nobody said that iron medication could have any effect on the baby at all. Or connected me being anemic to the baby during the pregnancy. And I've been tested for the type of anemia I have, and it is not anything like what -- it is a completely different type of anemia.

Q. To your knowledge does Mr. Abbington's family have any history of blood disorders?

A. Yes.

Q. What disorders?

A. Some kind of thalassemia.

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Q. Do you know who has that disorder in his family?
A. I don't remember exactly who has it, but it is something that definitely runs in his family.
Q. Other than your anemia, does anyone in your family have any blood disorders?
A. My mom, iron deficiency, the same thing as me, iron deficiency.
Q. Other than Lexapro and iron, did you take any other medications during your pregnancy?
A. No.
Q. Okay, so when Brian would come with you to the appointments, did he always go in the exam room with you?
A. Yeah.
Q. Was there ever a time he wouldn't?
A. I don't recall a time.
Q. So after the first male specialist explained what he thought a nuchal fold meant, he sent you to have more testing done by another specialist, right?
A. Right.
Q. So what happened at this second specialist's office?
A. Well, she determined that the chromosomes were fine, no chromosomal defects. And so then the

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next step was monitoring the baby's heart to see if there were any heart defects.
So we went back for several appointments because the heart had to be a certain size for them to know if there were any problems. And the last appointment before I was hospitalized, we got a positive thumbs up that there were no heart defects.
Q. Was it the same specialist? Did you see the same specialist at the second specialist's office or did the doctor change each time you went?
A. I believe it was the same doctor there. The doctor who ended up attending us when I went into the hospital was a different one from that practice.
Q. Okay. The first specialist, do you remember was he the person who did your genetic consultation or do you remember?
A. I believe I remember the second one doing a genetic consultation. I don't remember whether or not we had one with the first -- with the first specialist.
Q. At the time before MayRose was born, did you report to the specialist or your OB-GYN the history of blood disorders in Mr. Abbington's family or were you unaware of it at that time?
A. I'm sure he reported it because he constantly reported it to whomever he saw during this process.

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Q. Do you remember approximately how many ultrasounds you had throughout your pregnancy?
A. No.
Q. Other than the thick nuchal fold, do you remember any other problems that were detected on ultrasound during your pregnancy?
A. No, not until the birth time.
Q. Prior to going to the hospital for the birth, do you remember an ultrasound ever showing an echogenic bowel?
A. That sounds familiar. It sounds familiar.
Q. Do you remember anyone explaining to you what that meant?
A. I can't remember.
Q. Did it seem to be something that was a large concern at that time?
A. I remember that -- I just don't remember. The thing that just stood out for me was the thick nuchal fold. Just because that was such a serious possibility of something abnormal happening. And I also remember that it was just a long process of being on the edge of my seat, wondering what is wrong next, what is not wrong, what -- so I vaguely remember that. But then I think it turned out that there was nothing to it, so it doesn't really stick out in my mind

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because I think that might have been some kind of false alarm.
Q. Have you ever reviewed any of your prenatal care records?
A. No.
Q. Do you remember anyone talking to you about a cystic hygroma?
A. If they did, I don't recognize the name. You would -- maybe if you explained what it was, I might recall one way or the other.
Q. I'm not sure either. Did anyone ever ask you whether you wanted to be checked for cystic fibrosis or hemoglobin electrophoresis?
A. I do remember them asking me if I had cystic fibrosis and checking to see if I was a carrier, and I wasn't. So I believe it was explained that that meant the baby couldn't be -- couldn't have it because I was not a carrier.
Q. Do you remember anyone ever offering you a hemoglobin electrophoresis test?
A. I don't remember. But what I do remember is I agreed to whatever test they thought should happen in order to, you know, figure out what was going on with the baby.
Q. Do you remember ever declining any tests that

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they offered to try and diagnose what was going on?
A. I don't remember declining a test. The only way that I would have would have been if they said that it could be dangerous to the fetus and that they didn't recommend it even though it was an option. Other than that, I know I was very much trying to find out what was happening.
Q. Did anyone ever tell you they thought your pregnancy with MayRose was a high-risk pregnancy?
A. Yes, because I was over 30 something.
Q. How old were you when you got pregnant with MayRose?
A. I think I was 39.
Q. Did anyone ever tell you what the risks were because of your age in the pregnancy?
A. The older you are, the more likely you are to have complications.
Q. Do you have any concerns with any of the prenatal care you received?
A. I really, like I said, I didn't read any of the records, I am unaware of any issues except for one thing. That was when we were in the hospital, they gave me a drug to try to stop the pregnancy, and that drug has been known to cause spontaneous perforation, which is exactly what happened to me. I did not know

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that the drug was known to cause spontaneous perforation. That was not explained to me as a possible side effect. So that is the only, you know -- ultimately I don't know what I would have chosen at that time, but I would have liked to have had a choice to decide which was the riskier way of proceeding. So that is the only thing that I know that I didn't appreciate about the prenatal stuff.
Q. Other than that, do you have any other complaints about the prenatal care you received?
A. I'm unaware of any other bases for complaints.
Q. So how was it or what caused you to end up being admitted to Sunrise Hospital?
A. Well, the weekend after our last appointment where the doctor said that her heart looked great was Mother's Day. And Brian took me to dinner and I had -- or lunch maybe -- and I had a pain, I had been feeling kind of a nagging pain in my side. And the following Monday I told my paralegal medical friend about the pain in my side. And I asked her opinion as to whether she thought I should, you know, go in and get it checked out or whether she thought it was just the normal thing. And she told me that it could be a bladder infection and that I should probably call.

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So I called my OB-GYN and I said, Well, I might have a bladder infection because of where the pain is located in my side. What do you think I should do? She said, Well, just go straight into the hospital because if it is a bladder infection, you can not be treated outpatient for that, you have to be treated inpatient.
So I went to Sunrise, they tested me for a bladder infection. I did not have a bladder infection. They said, Oh, by the way, we don't like the baby's heartbeat. So we are going to keep you for a while. And that ended up being when she was born, in that time period.
Q. You mentioned earlier your OB-GYN didn't end up having the privileges at Sunrise; is that right?
A. Right.
Q. So who was caring for you at Sunrise, if you remember?
A. Well, a male came from the Center for Maternal Services, but he just came as a consultant, I think. It was the person on call, the OB-GYN on call who actually called the shots, Kendricks, I believe.
Q. So when you went to Sunrise, they did a physical exam and workup based on your complaints of a possible urinary tract infection; is that right, and

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they determined you didn't have a urinary tract infection?
A. (No audible response.)
THE REPORTER: Excuse me, you have to answer out loud.
THE WITNESS: Yes. It was actually a bladder infection, which I think is a little different than a UTI, but yes, that is what happened.
BY MS. ROSENTHAL:
Q. Did they ever determine that there was anything physically wrong with you or was their only concern for the baby?
A. Their only concern was for the baby.
Q. Approximately how far into your stay at Sunrise Hospital did they first tell you about their concerns for the baby?
A. Within a few hours.
Q. When you went, did they hook you up immediately to fetal monitors?
A. I believe so. But I don't remember exactly how immediately, I mean, it was something they did, I believe, before they sent me down for testing. But I'm not a hundred percent sure of that.
Q. Who was the first health care provider that you remember telling you about their concerns for the

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baby? If you don't know names, male, female?
A. I don't remember.
Q. Was it a male, female, do you remember?
A. I just don't remember.
Q. So when they told you about their concerns for the baby, what was the plan at that point? What were they going to do?
A. The plan was to monitor.
Q. Did they tell you how long they wanted to monitor you?
A. I think they said for 24 hours initially. Or it might have been for a few hours initially, then it moved to 24 hours, then it moved to me taking steroids just in case to develop lung capacity. Meanwhile, they administered the drug to try to prevent the pregnancy.
Q. Do you remember after you were told initially of the potential problems that they were concerned about how it progressed? Did it continue to get worse or what were they telling you about what was going on with the baby?
A. Well, what they told me was that there were these periodic drops in vitals or there was these periodic periods of distress, then things would even out. Then there would be the distress, and then things would even out. And ultimately, I believe it was

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Kendricks, said to me, the OB-GYN on call said to me that we could continue like this, and see if it gets better, but the longer we go with these episodes of distress, the weaker the baby would be if we had to deliver her early and the lower her chances for survival.
So at some point in time the OB-GYN recommended that before she became too weak, we should just deliver her.
Q. It was the OB-GYN that ultimately made the recommendation to deliver?
A. Yes.
Q. Was it the OB-GYN that made the recommendation for steroids?
A. That I don't know.
Q. Do you remember the name of the drug that they gave you to try to stop labor?
A. No. But I know that I read it in the medical records.
Q. Do you remember who talked to you about giving you that drug?
A. I don't remember who talked to me about it, but it is my recollection that it was the specialist's recommendation.
Q. When did the specialist talk to you about

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that? Do you remember anything he told you about why he wanted to give it to you?
A. No, I mean, I remember that it was to try to stop the -- what was appearing to be a possible premature labor.
Q. Did that specialist tell you any risks of taking that medication?
A. I don't remember him telling me any risks, but I know this, he definitely did not tell me about a potential for spontaneous perforations. I didn't learn that until later.
Q. When did you learn that that drug may contribute to potential spontaneous perforation?
A. It was either Dr. Blahnik or the other primary doctor when we were trying to figure out why she had the spontaneous rupture, and different theories were being tossed about. One of them said to me that they believed it was that drug that caused it. Even though it looked like NEC, the fact that she had not eaten first made it less likely to be NEC. And they had not seen anything like it, and so they weren't sure why it happened. And then, you know, finally they came up with this potential theory was that the drug is known to cause spontaneous perforation.
Q. You said NEC, what does that stand for?

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A. I don't remember.
Q. Do you mean necrotizing enterocolitis?
A. Yes, that is I mean.
Q. The steroids that you were given, those were to help mature the fetal lungs; is that right?
A. Yes.
Q. Did you have any problems with taking those?
A. No.
Q. Did you have any ultrasound performed in the hospital prior to MayRose's delivery?
A. Yes.
Q. Do you remember the results of those ultrasounds?
A. Well, I think they were monitoring me partially via ultrasound, and that was part of their assessment of the distress.
Q. Other than the assessment of her heart rate decelerations, did they express any other concerns they had for the baby at that time?
A. Well, they just didn't know what was causing it, so they were concerned because they didn't know why it was happening.
Q. Did you have any concerns about the decision to move forward with delivery?
A. Well, you know, there was definitely

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concerns, but it seemed to make sense that, you know, if she was going to be premature, it was better to do it when she was stronger than when she had been worn out from constant distress episodes.

Q. Do you remember how far in your pregnancy you were when MayRose was born?

A. A day away from 29 weeks.

Q. Did anyone ever explain to you the possible complications a baby born at 28 weeks may have?

A. Yeah. They said that they worry about lung development, and which is why they gave me the steroids. They worry about RSBP(sic)in premature babies with lung problems. And just in general there can be complications for preemies.

Q. What general complications are you talking about?

A. I don't think they spelled out all of the general complications, but they did -- we understood that if you are a preemie, then you have to kind of fight to get out of that preemie stage.

Q. Did anyone ever discuss with you any possible developmental problems MayRose may have from her developmental stage when she was born?

A. My recollection is the biggest worry was about her lung development.

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Q. Did anyone ever discuss any possible developmental delays?

A. Well, I don't know that that was the topic prior to her birth. During that time period I don't remember the full specifics of potential problems. I mean, I know that after she was born, that was when we kind of got into all of the different -- what to expect over the next few months. But in terms of the decision making for whether to do the C-section, the discussion -- the discussion was basically about just survival, not about complications other than the lung thing.

Q. Who visited you prior to delivery at Sunrise Hospital, did anyone?

A. Who visited me -- well, Brian was definitely there.

Q. Anyone else?

A. There may have been, I really just don't remember.

Q. Did Brian speak to any of the doctors at Sunrise prior to the delivery?

A. Yes.

Q. Did you make the decision with Brian to go ahead with delivery or did you make that decision on your own?

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A. It was a joint decision, although once again, it was strongly recommended. So it was kind of like the inevitable conclusion of a couple of days of distress.

Q. Other than Brian, are you aware of anyone speaking to any health care providers prior to the delivery at Sunrise? Other than Brian, did anyone else -- and you -- anyone else speak to any health care providers at Sunrise that you are aware of?

A. Yeah, at Sunrise, I don't believe so.

Q. Who was present in the delivery room?

A. Brian.

Q. Anyone else?

A. You mean nonmedical person?

Q. Yes.

A. No.

Q. Do you remember when MayRose was born what anyone told you about her condition at that time?

A. No. Because they gave me drugs. So they didn't really tell me anything.

Q. Go ahead.

A. Well, because it was Caesarian, so --

Q. Did they show you MayRose in the operating room?

A. I don't remember seeing May, but once again,

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I just don't know. Because they had given me anesthesia for the C-section.

Q. Were you under general anesthesia, a spinal anesthesia --

A. I just don't remember.

Q. What is the first thing --

A. I mean, they took my insides out, I remember laying there and just, you know, thinking, Oh, my gosh, I hope I survive. That is what I remember.

Q. Can we go off the record for just a minute?

(Whereupon, a recess was taken from 11:52 to 12:09.)

BY MS. ROSENTHAL:

Q. So after MayRose is born, when was the first time anyone spoke to you about her condition?

A. Well, I am sure that it was the same day, although I don't think that there was that much that was said at that time other than she is stable and --

Q. Who do you remember speaking to that day?

A. I don't remember.

Q. Do you believe it was a doctor? Was it a health care provider?

A. Well, it was definitely a health care person at the NICU.

Q. Did you speak with someone in the NICU or did

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they come to your hospital room?
A. I believe the NICU people came to my hospital room. But I really don't have a lot of memory in connection with the immediate time surrounding the birth.
Q. Do you remember generally -- they said she was stable, do you remember if they said anything that they had to do to make her stable?
A. I just don't remember at that time, if I was told at that time or later.
Q. When was the first time that you saw MayRose?
A. I remember being taken to the NICU, being wheeled to the NICU. And in terms of exactly when that was, I'm not sure. She was born in the wee hours of the morning, I believe. So it was, I'm sure, sometime that day I was wheeled to the NICU.
Q. What is the first conversation you had with any health care provider in the NICU that stands out in your mind that is memorable to you?
A. The first really memorable conversation was when I was being told there was something going on with her stomach. Something that was wrong with the x-rays and concerning her stomach.
Q. Do you remember when that conversation happened?

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A. It was within the first, I guess, 24 hours after she was born.
Q. Do you remember who you were speaking to?
A. I spoke to so many different people, I don't remember exactly.
Q. When was the first time that you met Dr. Blahnik that you remember?
A. I just -- the whole experience in the NICU is one big blur. That I remember different things that transpired, but if you are asking me for dates and days, there aren't too many that I'm going to be able to give you.
Q. Do you remember, what does Dr. Blahnik look like, do you know? Do you remember?
A. I remember one of the doctors was a bit on the dark side, like he could be maybe Mediterranean or something along those lines, his complexion was a little bit darker. He was of average height, a little stocky, but not heavy.
Q. Do you remember what Dr. Piroozi looks like?
A. I don't even remember if I just described Dr. Blahnik or Dr. Piroozi. They are just a blur what they looked like, back then is kind of a blur.
Q. So if you saw them on the street today, would you know that is Dr. Blahnik or Dr. Piroozi?

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A. I saw one of them maybe like a couple of years ago, and I recognized that he was from the NICU, he was one of the two.
Q. Were those two doctors the main doctors that were caring for MayRose when she was in the NICU?
A. Yes.
Q. Were there other doctors that would see her --
A. Yes.
Q. -- temporarily, but it was always those two --
A. That is my understanding.
Q. Do you remember specifically any of the nurses who cared for MayRose in the NICU?
A. Not really.
Q. Have you ever contacted any of the nurses from the NICU since MayRose left?
A. No, not that I recall.
Q. So after MayRose was born, you remember a conversation about problems with her stomach?
A. Yes.
Q. Can you tell me what they determined was wrong with her stomach?
A. That she had a perforation in her intestine.
Q. The perforation happened within the first 24

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hours of life?
A. That is my understanding.
Q. What treatment did she have to receive for that perforation?
A. She had to have surgery, and they put a colonoscopy(sic)bag on her.
Q. How long did she have that bag on her?
A. For the majority of her stay in the NICU.
Q. At some point did she have surgery to remove the bag in the process?
A. Yes.
Q. Do you remember when that was approximately?
A. It was towards the end of her stay, maybe a couple of weeks, two or three weeks prior to her discharge.
Q. Other than the intestinal perforation, what other complications did she have when she was in the NICU?
A. She had to be put, I believe, under some bilirubin light, she had high white counts at different points in time that required anesthesia -- I'm sorry, not anesthesia, antibiotics. She had chronic blood transfusions. She -- those are the things that stick out in my mind the most.
Q. When she was put under the bilirubin light,

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did that treatment work for her or did she have continuing problems with bilirubin levels?
A. Ultimately it worked.
Q. Did the doctors express any ongoing concerns about her bilirubin levels?
A. Definitely not when she was discharged. It ended up being taken care of while she was there.
Q. You said she had high white counts and was on antibiotics. Was that throughout the entire time in the NICU or a certain period of time she was on antibiotics?
A. It happened a couple -- a few times.
Q. Did any health care provider tell you what significance that had, and if they were concerned about that long term?
A. They couldn't tell us why. They had a number of potential theories, but ultimately they couldn't give us a reason for why she was getting the high white count.
Q. Did they express any potential complications or problems that would result from high white counts?
MR. COTTON: A foundation objection as to "they", who "they" is.
BY MS. ROSENTHAL:
Q. Well, back up. Who was telling you about

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MayRose's high white count?
A. That would have been one of the doctors.
Q. Is that Dr. Blahnik or Piroozi or another doctor?
A. I don't remember which doctors. I know at different points in time Dr. Blahnik and Dr. Piroozi talked to us about the white counts. But we may have been spoken to by other doctors as well.
Q. Did Dr. Blahnik or Dr. Piroozi ever express any concerns they had with MayRose continuing to have a high white count?
A. No. There was one period of time where it was lasting for a while, and they had to switch up antibiotics. So they had to do a number of different antibiotics, and it lasted longer than the other times, and I remember we were quite worried during that time period. But then she came out of it, and that was the last time in Sunrise that she experienced that. And I think that was a few weeks prior to her discharge.
Q. You said that MayRose had chronic blood transfusions while she was in the NICU?
A. Yes.
Q. What do you mean by chronic?
A. I think they were every one or two weeks. They were pretty often.

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Q. Who first talked to you about the reasons that MayRose was receiving blood transfusions?
A. I don't remember which doctor first talked about it.
Q. Was it Dr. Blahnik or Dr. Piroozi?
A. I really don't remember which one it was, who talked to me about it.
Q. What do you remember being told about the need for transfusion?
A. That anemia of prematurity is common in preemie babies, so needing a blood transfusion was normal for preemies.
Q. Did the person you spoke to explain anything else about what anemia of prematurity was?
A. No.
Q. Did the person you spoke to explain anything about how long anemia of prematurity was expected to last?
A. No.
Q. Do you remember specifically asking that person anything in particular about anemia of prematurity?
A. Well, I remember that every opportunity we got Brian would talk about his thalassemia because he was always worried that that might be part of what was

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going on with her. And then I would always bring up the thick nuchal fold because I would constantly ask could this be a reason -- is this an indication that something is still wrong with her or are we still, you know, are we still good, did we survive this thick nuchal fold thing. And each time we were told that there was nothing -- that what was going on -- that the thick nuchal fold didn't matter now. And that there was nothing to indicate any kind of thalassemia stuff.
Q. Do you remember speaking to anyone in particular about the thick nuchal fold after MayRose was born?
A. I don't remember specific names, I just know I brought it up often because it had been so traumatizing, the experience of having the thick nuchal fold and I kept wanting to know, did we survive it or did we not survive it, could any of the complications be because of that or not. So I know I brought it up a lot to whomever -- whenever there was a problem, I would say, Well, do you think it could be related to this or are we still in the clear with that?
Q. Do you remember specifically talking to Dr. Blahnik or Dr. Piroozi about the thick nuchal fold?
A. I know I spoke to those guys about it.
Q. Do you remember anything in particular about

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the specific conversation?
A. I would just tell them we went through this traumatic experience, so we are still wondering did we survive it or didn't we.
Q. And they told you it was nothing to worry about at that point?
A. They did. They said we are past that, that is done. Now we are just looking at normal preemie stuff.
Q. Do you know how many transfusions MayRose had while in the NICU?
A. There were a lot. At one point I counted them, but I didn't commit the number to memory.
Q. As MayRose continued to have transfusions, did you begin to have any concerns about her continued transfusions and did you talk to anybody about that?
A. I -- once they told me that it was normal, I believed them. And then also because I have an iron deficiency, and my mom has an iron deficiency, and they made it sound like it was just a normal iron deficiency sort of thing, I figured, okay, well, I guess three generations of iron deficient women.
But Brian kept talking to them about thalassemia because that was -- he was very worried about his -- you know, for them that was a bigger

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concern than, you know, I've lived with iron deficiency, I know that is not a serious thing at all. Whereas the thalassemia, you know, his family has some kind of problematic history with it.
Q. You said Brian kept talking to them. Who do you remember him talking to about his thalassemia or his family's thalassemia?
A. Everybody.
Q. Would that include Dr. Blahnik and Dr. Piroozi?
A. Yes, he brought it up all the time. In fact, we ended up getting into a disagreement because I told him I thought, you know, he had kind of belabored the subject and maybe he should relax a little bit because they weren't communicating any sense of concern to us.
Q. At what point after MayRose was born, did you go back to work?
A. I don't remember.
Q. Did you go back to work at some point during MayRose's stay in the NICU?
A. Yes.
Q. Prior to going back to work, how often would you be in the NICU with MayRose?
A. I was there most days and Brian was there most nights. I think I was there like almost every day

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and he was there almost every night.
Q. When you were there during the day, what time would you arrive and what time would you go home approximately?
A. I don't remember. It was a blur.
Q. Were you there approximately eight hours a day or less?
A. It is so hard to remember. But, I just -- my recollection is feeling like I was there all the time. That is how I felt. I was -- the only constraints were, you know, my son, so I couldn't bring him to the NICU. And then eventually my job.
Q. Did you have a nanny or some kind of day care for your son at that time?
A. Yeah. He was in day care. And there was like a transition because I was going to -- he had a nanny for the first two years, but then I was transitioning him to day care.
Q. Do you remember at that time how long each day he was in day care or with a nanny?
A. Well, day care would have been done like 5:30, but he might have only gone part time at that point. I just don't remember.
Q. You said you were there days and Brian was there nights?

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A. Yes.
Q. Do you have any knowledge how long he would be there at night, when he would arrive and when he would leave?
A. No. I know it was after work for him. We tried to be there as much as possible because they told us the sound of our voice and --
Q. After you went back to work, how often would you go see MayRose?
A. I don't even -- I mean, I'm pretty sure a day never went by without me being there, but it is just hard to remember when I went back to work at that point. For all I know, I might not have gone back to work until she was discharged. I just really don't remember that period very well. I just know that my life was in the hospital during that time.
Q. Did MayRose's anemia of prematurity that they told you, the doctors told you she had, was that just something that was brought up in the beginning when she started having transfusions or did it come up regularly?
A. Well, after a few transfusions, she wasn't doing well, and they couldn't figure out why, and then they said, Well, let's try giving -- let's check her levels. And they checked her levels and they said, We

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are going to try transfusing her. And they did, and she did better. So then I remember asking, you know, Why is she needing -- why did she need a transfusion? That is when they told me that anemia of prematurity was a common thing.

And so after that, I remember when she needed a transfusion, at that time I was thinking, okay, well, they said anemia of prematurity is a common thing, so it must be another need in connection with that. So I was a little more accepting of what they told me than Brian was.

But every time something new came up, I would talk about the thick nuchal fold because once again, I was like, uh-oh, is this it, is this the genetic defect they are talking about? Then they would say, No, no, no, this is normal. And so I would accept that. Whereas Brian was a lot less accepting. He was more aggressive about trying to understand -- well, asking them to explain things and also about talking about his thalassemia.

Q. Did you ever express to any health care provider at Sunrise Hospital any concern you had about the continuing transfusions MayRose was having?

A. Yes.

Q. When was that?

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A. It was after she had had a few. And I wondered why -- and I expressed my concern about why she was needing them.

Q. Who did you speak to?

A. I don't remember which doctor it was, it was definitely one of the doctors.

Q. Dr. Blahnik or Dr. Piroozi or a different doctor?

A. It is likely that it was to one of them.

Q. What do you remember specifically telling that doctor?

A. Well, I just asked why is she needing, you know, why did she need a transfusion. Why was she doing poorly prior to the transfusion and why did the transfusion make her feel better? That is when they told me that she had anemia of prematurity and that that was normal, that the majority of the babies in the NICU get some kind of anemia of prematurity.

Q. Do you remember anything else the doctors told you in that conversation?

A. No. I remember that at first he wasn't sure that the transfusion would make her feel better. Then when it did, I wondered -- I expressed my -- I questioned why it had made her feel better, what was going on that she needed a transfusion to feel better.

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And I know I told them about me having an iron deficiency.

Q. What did the doctor tell you about why the transfusion would have made her feel better?

A. Because she had anemia of prematurity.

Q. Did he give any other explanation other than anemia of prematurity?

A. No, because I remember feeling relieved, that it wasn't something significant, that it was something that he felt was normal.

Q. Do you remember any other conversations at Sunrise Hospital with a health care provider about MayRose's anemia of prematurity?

A. Well, I remember there was a prescription for multivitamins, and that I was left with the impression that she was going to have to take iron. Which once again seemed normal, since that is what I've had to do most of my life.

Q. Was that discussion at the time of MayRose's discharge?

A. We definitely had that discussion then, that she needed to take a multivitamin.

Q. Do you remember another time that discussion occurred?

A. About the -- just with me personally?

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Q. Yes.

A. I can't recall in connection with just the anemia of prematurity. I remember being present when Brian had discussions about the anemia of prematurity and thalassemia, and it wasn't so much the anemia of prematurity as it was the blood transfusions and anemia in general.

Q. How many conversations do you remember Brian having with a health care provider about the anemia and the blood transfusions?

A. Well, I can't give you a specific number, but I do know that he brought it up so much that one day he and I got into an argument over the fact that he just was constantly hyper about this topic. And I remember it was on Father's Day, where I was just saying to him, You know, can you just relax, you know, you are driving them crazy with these questions that you are constantly asking.

Q. Who do you remember Brian specifically talking to about the anemia and blood transfusions?

A. I'm sorry?

Q. Who do you remember Brian specifically talking to?

A. I remember it was everybody because he just wouldn't let it go. He was constantly talking about

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it, and it was freaking me out frankly because I was trying to, you know, feel positive and hopeful for the future, and I was trying to remain upbeat. And I felt him constantly asking all these questions and being concerned and talking about the potential for disaster was hard for me. And so we ended up on Father's Day -- and I don't remember what day Father's Day is, I always forget -- but I just remember it was horrible because we, instead of being happy that it was Father's Day, you know, we are in the NICU, and I just kind of gave him his gift, we had an argument over the fact he wouldn't stop asking all these questions and constantly bringing up the potential for disaster, and I left.

Q. What concerns would Brian particularly bring up about the anemia and transfusions?

A. He was constantly bringing up the thalassemia. And his rationale for that was because his aunt, I guess, had told him to make sure that he let any medical profession person know in connection with his children that that was something that ran in his family. So he was doing that all the time. It wasn't just that, it was also, you know, Well, what is this test for, well, why do you need to do this test, what do you expect this test to produce, how is this test different from that test? He was constantly --

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Q. Do you remember anything -- you said that what he would say was freaking you out, and he was talking about potential for disaster. What kind of potential for disaster was he talking about?

A. Well, just anything not going well for her. He had had an experience with his father passing, and then he also had had an experience with his youngest daughter being in the NICU for a little bit. And based upon those two experiences, he was very -- he was much less accepting of generalizations than I was, coming from a completely healthy background. It never even occurred to me that doctors might not know what they were doing. I mean, it just wasn't part of my experience with doctors in the past. And so I would ask a question, they would give an answer, and I would accept it. He would ask a question, they would give an answer, he would ask another question.

After all of this occurred, now when I go to hospitalizations with May or I go to appointments, I'm more like he was. Because now I understand what can go wrong, and if you don't ask all these questions, maybe it turns out that the person hasn't read the file or, you know, doesn't know what they need to know to make the decisions. And now I'm much more aggressive about the question and answers that I have and the exchanges

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that I have with doctors. And I'm much more like he was back then.

But back then, because I had never had a negative experience, I thought maybe he was pushing it. I could tell they would just -- they just wanted him to go away because he just kept pushing the questions and this thalassemia thing, he was constantly -- anyway, that is what we had the disagreement over.

Q. Did you ever hear any health care provider give Mr. Abbington a more detailed description of what was going on with the anemia and blood transfusions than you were given?

A. No.

Q. Did Mr. Abbington ever tell you that a health care provider had given him a more detailed description about the anemia and blood transfusion issue?

A. No.

Q. When you said that they wanted him to go away, who are you referring to?

MR. ABBINGTON: Everybody. Sorry.

THE WITNESS: I mean, I think he made them uncomfortable with all of his questions. So when I say they wanted him to go away, I think they just wanted him to stop asking so many questions that they didn't have answers to.

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BY MS. ROSENTHAL:

Q. Did MayRose suffer from a brain bleed in the NICU?

A. Yes, that is what I was told.

Q. When did that happen?

A. It was at the very end, just before discharge they told me that -- for the first time -- that there was a small one.

Q. Who told you about that?

A. One of the two doctors.

Q. Did they explain what that meant?

A. They said that it might not mean anything, that that also is something that commonly happens and that because it was very minor, that it probably wouldn't mean anything unless it worsened. And so they told me to make sure that within a specified period of time I got a followup MRI to see if it stopped or it worsened.

Q. While MayRose was in the NICU, did anyone discuss with you her prognosis in general?

A. Well, yes. That is kind of a really broad question. But I mean they told me she would need therapy, that I should continue with the therapy they began in the NICU, and that she might be a little delayed, having been premature. That preemies are

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subject to infection, and so to do my best to make sure everybody washed their hands before touching her and to keep her away from sick people.

But the day of discharge is what I remember the most. Because Brian and I were so freaked out about the concept of whether she was really ready to go home, we kept saying, Are you sure? After having this long stay, it was like so many months of one thing, just felt like one negative thing after another, so I just remember saying, Are you sure, are you positive that you should be sending her home? And that was when he said, We only send home healthy babies.

And so it made me feel like, other than the therapy that she needed, and the fact that, you know, there might be a bleed, that couldn't be -- that nothing could really -- that it wasn't, you know, at a level where anything should be done about it. But other than those two things, and there was one other thing, we needed a sweat test for something that I already knew she didn't have, might have been the cystie fibrosis, because I had already found out I was not a carrier, but they wanted us to get a sweat test, so I knew I needed to do that. But other than that, that was pretty much, you know, they made us feel like we were taking home a healthy baby.

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Q. I want to talk about prior to the day of discharge and what they told you about her prognosis as a premature baby. You said they said she may be delayed because she was premature. Who told you specifically about that?

A. I think it was one of the therapists.

Q. What were you told about potential delays she may have?

A. Just that she wouldn't -- she might not meet the mile markers as quickly as -- at the same time as kids who weren't premature. Because she was going to be older than she should have been, since she was born three months early. So when she was six months, she probably would only be meeting mile markers of like a three month old. That the key was to try to get her up to speed before she was two, because she wouldn't be officially delayed, quote/unquote, as long as she caught up before age two.

Q. Prior to the day of discharge, what were you told about preemies being subject to infection?

A. I don't know about prior to the day of discharge, but I definitely know that I was told that preemies are, you know, subject to infection much more so than regular children, that RSP(sic)was a concern, so we needed to follow up with the lung doctor and get some kind of medicine, shots to try to prevent that from becoming an issue for her.

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And I was told that preemies often don't express the symptoms of a cold like other babies, that sometimes crying can mean that she is not feeling well. And then just about really good, you know, hand washing practices and anti-bacterial soap and cleaner and things like that. So the key was to try to keep her as germ free as I could. That was what they, you know, said that I should try to do.

Q. Was it generally Dr. Blahnik and Dr. Piroozi that would tell you these things about MayRose and her prognosis or was there any other health care provider at Sunrise that you remember telling you these kind of things?

A. On the day of discharge I kind of remember a variety of people telling us a variety of things. You know, the nurse who was working with us to be discharged told us different things. The therapist told us different things. I mean, everybody told us things about, you know, the future.

Q. On the day of discharge which doctor do you remember speaking to?

A. It was one of the two. I just don't remember which one it was.

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Q. Do you remember though it was only one of them that day, not both?

A. I couldn't even tell you that.

Q. Was the conversation that you had with the doctor about, We only discharge healthy babies, was that, you believe, either Dr. Blahnik or Dr. Piroozi?

A. If the two of them were here right now, I could look at them and tell you which one it was. But I just don't remember via name which one it was, although there is no doubt in my mind that Brian remembers because he is just better with names than I am.

Q. So when MayRose was getting ready to discharge, what were the doctors telling you about why she was ready to go home?

A. Well, I remember feeling it was a bit strange because it felt like we were struggling, we were going -- we were surmounting obstacle after obstacle after obstacle for two and a half months. And then -- and the last one being shortly prior to the reconnection of the colostomy bag, and that was a really scary one because that is when different antibiotics weren't working.

Then it just seemed like, boom, all of a sudden they just said, She is doing good. And if she

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keeps doing good for the next however many days, we are going to discharge her. And I remember wondering if it had something to do with the date that she was supposed to be born, and if that was what they were shooting for. It just felt abrupt to me because we had just gone through so many changes with her while we were in there, that is why I was asking the question, Are you sure. Because I, you know, Are you sure you don't need more time, you know, you are turning this responsibility over to me now and I just want to make sure she is ready. That is when he gave me the reassuring healthy baby response.

Q. Do you remember any discussions on the day of discharge about MayRose's anemia of prematurity?

A. No, I don't remember that specifically.

Q. Did someone at Sunrise Hospital give you the discharge summary?

A. Yes.

Q. Who gave you the discharge summary?

A. I don't remember.

Q. Do you know if was a doctor or nurse?

A. That I don't remember.

Q. Do you know if it was a man or woman?

A. I really don't remember who gave me the summary.

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Q. Do you remember what the person -- if they said anything when they gave you the summary?

A. Yes. I remember them telling me what my responsibilities were, so I remember they told me that I needed to schedule a followup MRI for the bleed, that I needed to get a -- schedule the sweat test, that I needed to follow up with the eye doctor, and I needed to follow up with the surgeon. And that I should follow up with the therapist, and that I needed to make an appointment with Dr. Conti within a couple of days after discharge. That I needed to make sure to hand him a copy of the discharge summary because even though they were sending over one, that they liked to have parents hand it to the doctor.

And that if she was crying a lot, that I should seek medical attention because sometimes that can mean she is sick. And sometimes that that is the only symptoms that preemies show. And then to do my best to keep her away from germs, make sure I did good hand washing and that anyone touching her wash their hands first. And if somebody, if one of us was sick, that we should wear a mask, or and, you know, or if anyone has to be around her that is sick, they should wear a mask.

Q. The person who gave you the discharge summary, did they give you one copy or multiple copies?

A. One copy that I remember. They may have given me -- I know that they gave me one for Dr. Conti. What I don't know is if they gave me two, one for him and one for me. That I don't recall.

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Q. Do you ever remember making a copy of the discharge summary yourself?

A. Well, later.

Q. But prior from the time of the discharge until you saw Dr. Conti?

A. No.

Q. In a discovery request for production we asked you to produce the discharge summary that you gave to Dr. Conti. Is that a copy of what you were actually given at Sunrise Hospital or is that just from the medical records, do you know?

A. Oh. I couldn't -- I have no idea.

Q. Have you ever given your attorney an actual copy of the discharge summary that you were given at Sunrise Hospital?

A. I just could not tell you if -- I mean, I'm generally pretty good at -- I was generally pretty good at keeping the paperwork that I was given. But at some point in time I did start requesting records, so it could be either/or, I just don't know.

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Q. At some point did you give all the paperwork that you had to your attorney?

A. Yes.

Q. So you had this conversation on the day of discharge and all of those things you just described to me about the tests that you needed to get done. Was this one conversation with a single person or did you have multiple conversations with different people?

A. I had multiple conversations with different people.

Q. Do you remember anything in particular the doctor telling you about the discharge summary?

A. What my responsibilities were. I know the doctor told me, get the MRI, schedule the MRI because that was something that I needed to do, not Dr. Conti. Schedule the sweat test, once again, that was something that I needed to do. So it was like he told me what I needed to do.

And then in terms of what Dr. Conti was supposed to do, he didn't say anything about that, but he said, Hand this discharge summary to him, so that he definitely had a copy of it.

Q. Did you read the discharge summary when you were handed it that day at Sunrise Hospital?

A. Probably.

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Q. Did you ask any specific questions about the discharge summary?
A. I don't believe I did.
Q. Do you remember anyone that day talking to you specifically about the blood work that was requested in the discharge summary?
A. Absolutely not. They did not talk to me about that at all. Everything that they talked to me about what was they expected me to do, and I presume that is why, because they wanted to emphasize what I was supposed to do.
Q. You said that MayRose was discharged on a multivitamin; is that right?
A. That is my recollection.
Q. Do you know what that was for?
A. Just what all babies are supposed to get was my understanding.
Q. Did anyone tell you it was -- whether it had anything to do with her anemia of prematurity?
A. That, I don't remember. I know that at some point -- I don't remember if it was -- if she had an iron prescription upon discharge or if that came later. That part, I don't remember. But no, it just -- I don't remember anyone saying to me, This is because of her anemia of prematurity.

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Q. Have you ever reviewed the Sunrise Hospital medical records?
A. I have.
Q. When did you review them?
A. Years ago, I think.
Q. Was it after MayRose's discharge?
A. Oh, definitely after that, way after that.
Q. After her crash?
A. Way after that.
Q. Was it during the time she was still treating with Dr. Conti or after?
A. I think she was still treating with him because it was during -- it probably was closely connected in time to our last visit with him. Because that was the first time I read the discharge summary and knew what a CBC meant. And figured out that -- and started figuring out that it hadn't happened.
Q. So did you request the Sunrise Hospital records yourself?
A. Yeah, I started -- I mean, initially there was -- and once again the time frame is a bit challenging. But at first I started requesting records because she had so many medical providers here in Las Vegas, and I was trying to -- and they weren't communicating with each other. And so I tried to get

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them all put on a website, so that they could just pull up the website, access her medical records, and keep track of what was going on. Because they don't have a centralized recordkeeping system here in Las Vegas.
So initially I don't think I was collecting the records because I knew that something had gone wrong. It wasn't -- and I can't remember exactly what triggered my knowledge that something problematic had happened -- well, that she had never -- that she was supposed to get a CBC, but it was around that time period.
It was like the -- because prior to her diagnosis of Diamond Blackfan anemia, I had no idea what a CBC was or a retic count or any of that. And it wasn't until she started getting regular CBCs to check her blood counts and then getting transfused, that I started learning, okay, this is a CBC, this is a reticulocyte count, blah, blah, blah. At some point I ended up rereading the discharge summary, and seeing that he was supposed to do a CBC/retic thing, it was only at that time that I understood what it was that he was supposed to do and never did.
And he never told me. When I went back to him after being discharged from Denver Children's Hospital, he did not tell me that they were supposed to

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do a test, and that they didn't.
Q. So when you say you reread the discharge summary and realized he was asked to do a CBC, that was during the time you were still treating with Dr. Conti or after?
A. Right, when I learned that, we didn't go back.
Q. Then you said that Dr. Conti never told you after discharge from Denver Children's that he was asked to do a CBC. What do you mean by that?
A. Well, he must have known by that point in time that he had failed to do a CBC that he was supposed to do. And yet -- and that that was something material, that was a material omission that he did not disclose to me when I started coming back to him for treating MayRose. I mean, I can't imagine that he would think that I wouldn't want to know that.
Q. Why do you say that Dr. Conti, he must have known that? What makes you think he must have known that?
A. Must have known that he failed in that regard?
Q. Uh-huh.
A. Because I learned later, and I didn't learn any of this until after her collapse, but I learned

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later that when I took MayRose to Foothills days before her collapse, and I said that I was worried she might have the flu, Dr. Weber sent us downstairs to a lab to get testing done, and I thought that the testing was a flu test at that time. But I later learned that it was -- that she had finally ordered the CBC that apparently was supposed to have been ordered a long time ago. So and I don't remember exactly when all of this -- when I learned all of this. But I can't imagine Dr. Weber not discussing that with Dr. Conti after they learned that my daughter had collapsed with a 1.5 hemoglobin because I called Dr. Conti from Summerlin Hospital and was on the phone with him several times while she was there, you know, asking him to come by, telling him what was going on, you know, wanting him to contribute to her care there.

Q. Did Dr. Conti ever come by Summerlin Hospital?

A. I never saw him there.

Q. Did anyone ever tell you that Dr. Weber ordered the CBC because it was ordered in the discharge summary?

A. No.

Q. Is that just your own opinion of what must have happened?

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A. It is.

Q. Back up a minute. From the time that you were discharged from Sunrise on August 2, 2008, to when you went to see Dr. Conti, did you see any health care providers in that time?

A. In the three-day period, I think he was the first one.

Q. So what happened when you went to Foothills Pediatrics on August 5?

A. Well, Brian and I took her and I handed him the paperwork, I told him about how I was supposed to get an MRI ordered and a sweat test ordered. And he told me his staff would help me with that, which they did. And then I told him about our entire traumatizing experience from day one with the thick nuchal fold all the way to the discharge. And Brian talked, we both told him about how challenging the entire experience had been, and I believe the word posttraumatic stress syndrome was used because we were just so still very freaked out about the concept of this little girl being followed, considering all the challenges she had had. And he talked about the thalassemia, because he always did. And we just talked about the whole thing from beginning to end.

And I remember apologizing because I knew he had other patients to see, but it was really important to me, you know, to convey, hey, this girl has been through a whole bunch of stuff, so we need to be careful with her. And he was like, you know, we will bring you back regularly, we will keep on top of her, and he was very reassuring.

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Q. How is it that you chose Dr. Conti as your pediatrician?

A. One of my coworkers, who is now a judge, referred him to me. When I was looking around, asking questions about the local pediatricians, I found out he had been like 2006 Best Pediatrician or something like that, and she highly recommended him.

Q. Who was your coworker that recommended him?

A. Linda Bell.

Q. When you got to Foothills Pediatrics, did you talk to the front office staff? Can you explain how the check-in process went?

A. We just gave them our insurance card and my license and insurance card, then we sat in the -- we sat in the well-side, waiting to be seen. Then they called us back, a nurse weighed her, and measured her head, then put us in a room to wait for Dr. Conti.

Q. What office did you go to on August 5, 2008?

A. I believe it was the one at St. Rose, that is my recollection. Although there is one in Summerlin too that we sometimes would go to, and there is one in the southwest that we sometimes would go to. But I think it was St. Rose.

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Q. On your first visit on August 5, 2008, do you remember filling out a history form?

A. Certainly possible.

Q. Other than the nurse and the front office people, did you speak to anyone else or interact with anyone else at Foothills Pediatrics before Dr. Conti saw you?

A. I don't believe so.

Q. So you said you physically handed Dr. Conti the discharge instructions?

A. I did.

Q. You hadn't given them to Foothills Pediatrics prior to that?

A. I don't believe -- I don't recall that being the case. And the reason I don't recall that being the case is because they were so specific, hand it to the doctor. And I tried to follow their instructions to the T. And so that was, I mean, I bought hand cleaner for every room in my house, everywhere somebody could sit there was a bottle of hand cleaner. I bought masks for people to wear, and, you know, and I just -- I was

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so worried that I just did everything they told me to do and that included handing a copy to him.

Q. You said earlier that the people at Sunrise told you they were also sending Dr. Conti a copy of the discharge summary?

A. Yes.

Q. Do you have any knowledge whether that actually was ever sent?

A. I don't have knowledge about that.

Q. So at your appointment with Dr. Conti on that date, you said you talked to him specifically about the MRI and the sweat test that you needed to schedule?

A. Yes.

Q. He said his staff would help schedule that?

A. Yes.

Q. Was there anything else specifically you remember talking to him about that is in the discharge summary?

A. No. Because those two things were things that I was supposed to do.

Q. Do you remember having any discussions with him that day about the diagnosis of anemia of prematurity?

A. I don't specifically remember that. I just remember us telling him the entire history. So I would

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be surprised if we left that out, since, you know, her blood transfusions were part of her history.

Q. Do you remember specifically talking to him about her blood transfusions?

A. I remember talking to him about everything that we experienced. It took a long time, and I just remember feeling apologetic because he actually did sit there and listen. And I knew he had other people to go see.

Q. Do you remember Dr. Conti saying anything or asking anything about anemia of prematurity or MayRose's blood transfusions?

A. I don't remember him asking us much of anything other than standard questions, and I say standard because they were the same questions that he used to ask me when my son was born.

Q. So what are those standard questions that you recall?

A. Did I -- how is her tummy feeling, how is her -- is she eating well, is she pooping, how many diapers, is she urinating, how many diapers a day, those kinds of questions.

Q. Were you the one who called Dr. Conti's office to make the appointment that day for August 5?

A. Yes.

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Q. Do you remember anything specific about that conversation?

A. No. I'm sure I would have said that we were just discharged, we are supposed to meet in three days, because otherwise I don't think they would have gotten us in so quickly.

Q. MayRose came home to your house after the NICU?

A. Yes.

Q. She was there with you and Tristin?

A. Yes.

Q. Did Dr. Conti's office help you schedule the MRI and the sweat test?

A. Yes.

Q. Do you remember when you had those performed?

A. They were within the time frame. The MRI was supposed to be done in, I think it was in 30 -- whatever the time frame that was on the discharge summary, it was scheduled within that time frame. The sweat test, I don't think there was a time frame, but we just got it done their first available appointment.

Q. When you handed Dr. Conti the discharge instructions, did he look at them, did he put them aside? What did he do with them when you handed them to him?

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A. He may have glanced at them, but most of the visit was him listening to our traumatic experience.

Q. Do you remember if you ever wrote anything on the discharge summary you gave Dr. Conti?

A. I don't remember.

Q. Do you remember if when you received the discharge summary from Sunrise Hospital there was anything written on it?

A. I don't remember.

Q. I'm going to show you what is Bate stamped Foothills Pediatrics 0341 through 0345, it is the discharge summary in Dr. Conti's chart. In the upper right hand corner it looks like it is written Peds copy.

Is that your handwriting?

A. No.

Q. Do you know whose handwriting it is?

A. I don't know.

Q. Do you remember if it had that on it when you gave it to Dr. Conti?

A. It must have, which makes me -- when you asked me whether I had two copies, and I wasn't sure, I wouldn't be surprised that I did because this was probably the one that I was supposed to hand to him. But no, I didn't write that, and I don't know who did

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write it.
Q. Okay. You said when you handed the discharge summary to him, he may have glanced at it. Do you remember him asking any questions about anything in the discharge summary?
A. I don't recall that happening.
Q. Other than the general questions about how she is pooping, eating, do you remember him asking you any other particular questions about her time in the NICU?
A. No, but we talked about it the whole time, so he probably didn't, he probably felt like we had exhausted the topic by the time we finished talking. But no, he didn't.
Q. Did he ever talk about any plan to order any blood work for MayRose?
A. I don't recall him talking about a plan to do anything. Other than that we -- that he understood our concerns and our fears and that he would keep a close watch on her, and just in general him trying to soothe us, soothe our fears.
Q. One of the things requested in the discharge summary is a head ultrasound, and you said that that was one of your responsibilities?
A. Yes.

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Q. But you ended up having an MRI done; is that right?
A. I'm not sure. But that is what I was talking about. I do tend to conflate the words MRI, head ultrasound.
Q. Do you remember Dr. Conti ever talking to you about, since he helped you schedule the test, about whether to order an ultrasound or an MRI?
A. No.
Q. Do you remember him telling you anything specific about scheduling the sweat test?
A. Him telling me anything specific about it, no.
Q. Did he discuss why they would have requested a sweat test for MayRose?
A. I don't remember him asking me about that. Yeah, I don't remember him asking me about that.
Q. Did you have a discussion with Dr. Conti on August 5, 2008 regarding the request for OT and PT followups in the discharge summary?
A. No, because that I already knew how to do. We stayed with the people who were seeing her originally initially. So I had already scheduled appointments, either I had scheduled those, or I was in the process of scheduling them, but I already had the

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numbers to do that, unlike the MRI people and the sweat test people.
Q. Was there ever a time during the time you treated with Dr. Conti that you asked him to order a test and he said no?
A. I don't think I ever asked -- I can't remember asking him to order a test prior to her collapse.
Q. But you told him about the need for a sweat test and a head ultrasound and he accommodated that and helped you schedule those; is that right?
A. Right. I told him about those, yes, because I knew I was supposed to do it, and I wasn't sure how, and he helped me.
Q. Was there ever a time when MayRose was treating with Dr. Conti where you said to Dr. Conti, You know, I think I'd like her to have this test or someone told me she needs this test and he said he wouldn't schedule that test?
A. I don't think I ever talked to him about him scheduling tests. I talked to him about tests I needed to schedule. I don't recall ever having a conversation with him about him scheduling tests because at that time I just wasn't medically sophisticated enough to know what tests he should be doing. I just knew those

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two things I was supposed to make happen.
Q. During MayRose's treatment with Dr. Conti, was Dr. Conti helping you to organize the referrals that MayRose needed?
A. To some extent, yes.
Q. Was there ever a time that you asked him for a referral to a particular doctor and he said he wouldn't provide the referral?
A. No, not that I recall. I've never -- I don't recall him saying no to any referral requests that I made.
Q. Other than the visit on August 5 with Dr. Conti and the visit with Dr. Weber, are there any visits at Foothills Pediatrics between that time that you remember clearly?
A. That I remember clearly? I know that I don't remember many of them clearly, they are all very fuzzy. Because most of them were just well-checks, and then him looking at her and saying, Oh, she is well. There were a couple where I was a little worried. I remember one, going to one with Brian because she had been -- my son had been sick, and I was worried because I was so hyperconscious about germs, that she might have picked something up, and so I told them about that. And I was, you know, I was pretty specific about the concept

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that she doesn't show symptoms, because she might not show symptoms because she is a preemie, but my son is showing symptoms, so she might be sick. And I know he was there for one of the -- the first time -- for one of the times that that happened. And then the last time that that happened was shortly before the discharge -- I mean, the discharge -- the admission.

Q. Was anyone else at the appointment on August 5, 2008 other than yourself and Brian?

A. Wait a minute -- on August 5, no.

Q. Did Dr. Conti tell you on August 5 any possible prognosis for MayRose as a premature baby?

A. No.

Q. Anything else you remember about that visit at Foothills Pediatrics on August 5, 2008 that we haven't talked about?

A. No.

Q. The records show the next time you saw Dr. Conti at Foothills Pediatrics was September 9, 2008. Do you have any independent recollection of that visit?

A. No. I do know though that I had to ask another time about the head examination because it didn't get scheduled immediately, I had to ask a second time.

Q. Let's go off the record for just a minute.

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(Whereupon, a recess was taken from 1:29 to 1:45.)

BY MS. ROSENTHAL:

Q. At the time of MayRose's visit with Dr. Conti on August 5, 2008, outside of what had happened in the NICU and how traumatic it had been, did you have any concerns particularly at that time about her condition?

A. No, just that they were all generalized connected to the experience we had had at the NICU.

Q. From August 5, when you saw Dr. Conti to the next time you saw Dr. Conti, did you notice any decline in her condition or any change in her condition?

A. It is hard for me to say which dates. Generally there wasn't a decline that I noticed in her condition or a change in her condition in general. For a couple -- there were a couple of instances where I was worried, but I wouldn't be able to tell you which visits that was connected with.

Q. When you were worried about her condition, did you take her to Dr. Conti's office?

A. Always.

Q. Was there ever any change in her condition that concerned you that you didn't report to Dr. Conti?

A. No.

Q. Or another doctor at Foothills Pediatrics?

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A. No.

Q. The records reflect that you next saw Dr. Conti on September 9, 2008 at Foothills Pediatrics for a well-check. Do you remember anything in particular about that visit?

A. I don't remember anything in particular about the dates.

Q. Do you remember a visit where Dr. Conti made a referral for you to speech therapy, physical therapy, and occupational therapy?

A. There came a time and I decided I wanted to change from Sunrise and to go to places closer to where we lived, so that probably was that time frame.

Q. The records show that the next time you saw Dr. Conti was on September 30, 2008. Do you remember anything in particular about that visit?

A. Once again, the date is not triggering a memory.

Q. The complaint says cough and congestion. Would that be a time where you were concerned about her condition and brought her into the doctor?

A. That would be correct.

Q. Do you remember anything about what happened at that visit for her cough and congestion and what Dr. Conti told you?

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A. September, probably it would be about the time that we were looking at potential RSV related scenarios would be my best guess in connection with the date. I know that happened at some date, I'm just not sure if it was that particular date where we then were doing the Albuterol and setting her up to receive monthly injections to avoid getting RSV.

Q. The records show you saw Dr. Conti on September 30, and then you had another visit on October 1st. Do you remember that, having two visits very close in time, within a few days?

A. Yes, I think we had a well-visit scheduled, but I was worried, so I didn't want to wait until the next day.

Q. Do you remember Dr. Conti expressing any concerns about MayRose at either of those visits, the two that were close in time?

A. Not specifically.

Q. Does it seem right to you that you saw Dr. Conti approximately four times before MayRose's crash, not another doctor in his office but Dr. Conti specifically?

A. It is possible.

Q. At any of those visits with Dr. Conti, do you remember specifically talking about MayRose's anemia of

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prematurity?
A. I don't remember that specifically. I do remember that at some point I think her regular multivitamin might have been switched to a multivitamin with iron in connection with that issue, but I'm not completely certain about that.
Q. Do you believe it was switched because of a discussion regarding anemia or --
A. Well, it would have been due to a discussion regarding anemia, that would have been why iron was added, if I'm remembering correctly that iron was added.
Q. That conversation was with Dr. Conti do you believe or do you know?
A. I don't know.
Q. During the time you saw Dr. Conti from August 5 to the last visit with him prior to MayRose's crash was October 1st, 2008, did you notice any changes in MayRose's condition that you didn't report to Dr. Conti?
A. No.
Q. During that time period from August 5, 2008 to October 1st, 2008 did you ever notice MayRose to look pale?
A. No, but then she -- as a black baby, she

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wouldn't look pale. She would -- I've since learned what to look out for, but it is different from being pale.
Q. As her mother, during that time period you never noticed a change in her condition that you thought she looked different?
A. No. And black people go from, you know, like with the summer sun to a little yellower complexion as you get to September, October, and we both have yellow tones in our skin. So it wasn't a remarkable thing to me that she had yellow tones, and it wasn't until we started -- after she was diagnosed with Diamond Blackfan anemia and we started doing regular transfusions, that I started learning things like her eyelids can give telltale signs, as a black child, and like her lips might not be as reddish. So it is kind of different from looking pale.
Q. From August 5, 2008 to when you last saw Dr. Conti on October 1st, 2008, did you notice that her skin began to take on yellow tones?
A. Not from a remarkable perspective. I mean, I really didn't notice it as being anything out of the ordinary.
Q. Did you report to Dr. Conti that her skin may have taken on yellow tones?

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A. No. It wasn't remarkable.
Q. Did you notice --
A. At least to me.
Q. I only want to know what you thought.
A. I mean, you know --
Q. Did you ever notice MayRose, from August 5, 2008 to October 1, 2008, whether MayRose had a rapid heartbeat? Did you ever notice that?
A. No.
Q. Did you ever notice from August 5, 2008 to October 1, 2008 that MayRose had rapid breathing?
A. No.
Q. You didn't notice it?
A. No, there was no rapid breathing issue that I was aware of.
Q. It is fair to say any change in her condition that you were concerned about you would have reported to Dr. Conti; is that right?
A. That's correct.
Q. Do you remember going to Foothills Pediatrics on October 18, 2008 and seeing someone other than Dr. Conti?
A. Probably.
Q. Do you remember what that visit was about?
A. Let's see, October 18, was that the flu

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question visit?
Q. Yes, I know it talks about vomiting.
A. Yeah, I do remember that.
Q. Can you tell me about that visit?
A. Brian and I went to that one. And I remember that my son had thrown up, and I was worried because I didn't know if his throwing up was just a regular, you know, upset stomach, nonflu related, or if it might be the flu. And once again, because I had been told that preemies don't show symptoms of being sick except for maybe crying, I was worried that she might, you know, have the flu since someone in my household might have it. So just because it was a possibility, I took her in to get checked out. And also I think she was spitting up and she had had reflux. But I wasn't sure, you know, whether she might be sick. So I figured, well, better to take her in than not.
Q. Do you know who you saw at Foothills Pediatrics that day?
A. It was the Asian doctor there. I think she might have been a physician's assistant as opposed to a doctor, I think she might be a doctor from her own country or something like that, but I'm not completely sure. But I saw her, we saw her.
Q. Do you remember what day of the week that was

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that you took MayRose in?
A. I don't.
Q. Do you remember what office you went to?
A. I want to say St. Rose, although I'm not 100 percent sure. That tended to be the place where you could get in for sick visits more easily than the other location.
Q. Did you generally go to the Summerlin office at Foothills Pediatrics for well-checks?
A. Generally I tried to go to Summerlin because that was closest to my house for well-checks.
Q. Do you remember saying in the paperwork when you took MayRose to Foothills Pediatrics about where you wanted her chart kept?
A. I don't remember.
Q. Do you remember if the doctor who saw MayRose that day when you were concerned about your son's throwing up, whether she had MayRose's chart, any kind of chart to look at?
A. I had no knowledge of their charting procedures whatsoever.
Q. You don't remember that day whether or not that doctor had anything, any kind of paperwork she was looking at?
A. I have no knowledge about that whatsoever,

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none.
Q. Do you remember what questions that doctor asked you?
A. Not really.
Q. Do you remember what the doctor's impression was of what was wrong with MayRose that day, what she told you?
A. I really don't remember. The only thing I do remember is that I left feeling like there wasn't anything of significance wrong, that she looked good.
Q. Did you have any concern about that assessment or were you okay with that assessment?
A. I believed them.
Q. Do you remember the next time you took MayRose to the doctor at Foothills Pediatrics after that visit?
A. Yes.
Q. When was that?
A. Shortly before her crash.
Q. From the time you took MayRose and you saw the Asian doctor to when you took her shortly before her collapse, did you notice any change in her condition?
A. She was crying more. It wasn't constant crying, but she seemed not so happy. And we wondered

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if she was maybe having gas, I was still worried about the flu.
Q. At the prior visit with the Asian doctor, did you express to her at that visit all the concerns you had about MayRose's condition at that time?
A. Yes.
Q. Had you noticed any change in MayRose's condition from her prior visit with Dr. Conti to that day?
A. I think she was fussing more. I know there were certain things that towards the end we were wondering about. We were wondering whether she was having gas, whether she might be constipated, whether she was experiencing reflux that was bothering her. And then when my son threw up, whether she might have the flu. So around that time period it was a time period of her fussing more and us saying, Could it be this, could it be that, you know, I'm worried about this, I'm worried about that. I don't remember specifically what all I said to the doctor on the appointment before the last one, but I know I talked about the flu. And I think we may have talked about constipation. I know at some point they changed her food because they were thinking she was maybe getting gas from the type of baby food she was drinking. But the whole time it

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was -- the response was kind of normal baby stuff, you know, let's try a different formula, let's give her some Gas-X. So each time I would raise my concerns, it was like a normal, organic type answer, and I left feeling like, okay, well, this is normal baby stuff.
Q. Do you have any recollection of specifically talking to the Asian doctor about MayRose's anemia of prematurity or the blood transfusions in the NICU?
A. I don't, but I do remember that whenever we were prescribed the iron, I know it came up at that time. But I just don't remember which time we were prescribed the iron.
Q. Do you remember when you took MayRose to the Asian doctor, do you remember speaking to anyone else at Foothills Pediatrics that day?
A. I don't remember. I mean, I always would talk to the person who came -- when we first came in the door because you had to register. And there would always be a nurse who weighed her, and took her vitals, and things of that -- her blood pressure and her length, and her head circumference, that was standard practice.
Q. Around the time that you took MayRose to see the Asian doctor at Foothills Pediatrics, do you remember taking MayRose to see her surgeon who did her

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bowel surgery in the NICU?
A. I don't remember if it was around that time or not, but I do remember taking her to see the surgeon.
Q. Do you remember anything in particular about that appointment with the surgeon?
A. No, just that she seemed to be doing well.
Q. Did the surgeon express any concerns that he had for MayRose at that time?
A. Well, I remember, yeah, I remember one thing. I told him I thought she was having trouble with gas and I asked if that might be related. And he told me she might just be a stinky baby. You know, that was just such an amusing comment it stuck in my mind. She might just be a stinky baby.
Q. Do you remember talking to the surgeon at all about her anemia of prematurity?
A. No.
Q. So when you took MayRose to the Foothills Pediatrics the last time before her crash, you said that after the visit prior she had become more fussy?
A. Right, she had become more fussy.
Q. So was that the only reason you took her that day or what caused you to take her to the doctor that day?

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A. I just was really worried. I felt like, you know, something was bothering her, and whatever it was, you know, I just wanted them to try to get down to the bottom of it. And but mostly I was worried about the flu because of the throw-up that had occurred with my son and because I had been told that, you know, we wouldn't -- she wouldn't necessarily get a temperature if she had the flu. So even though I had previously asked about the flu and they were talking about formula and normal baby stuff, once again I was just like, are you sure. And that is why she sent us down to the lab. I thought she was doing a flu test because I was just so concerned that she might have the flu.
Q. So do you remember what office you went to at that last visit?
A. Yes, that was in Summerlin.
Q. Does it seem correct that that visit was on October 24, 2008?
A. That seems correct.
Q. Do you remember what time of day you went to the office?
A. I think it was in maybe mid morningish, early afternoonish, somewhere around there.
Q. Did you take MayRose to the doctor that day?
A. It was me and Tobi Whittaker.

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Q. You were physically at the doctor's office that day?
A. Yes. Well, I believe so. I know I was physically at the lab. I can't remember if I did it via telephone with Tobi and then arrived a little later, that might have been what happened. In fact, I think that is what happened because I was -- I remember being on the telephone, I'm almost here, so you can tell me this in person. And arriving in the office. So I was there, but initially it started via telephone.
Q. So before the appointment finished, you were in the office?
A. Yes.
Q. In the exam room with Dr. Weber and MayRose; is that right?
A. I was in the office. I don't remember if I made it to the exam room or if I just made it to the front of the office or what. But I do know I talked to Dr. Weber and met her that day.
Q. Do you know what Dr. Weber looks like?
A. I don't really remember. I think I only -- I don't remember seeing her more than that time.
Q. Can you tell me specifically what you remember telling Dr. Weber that your concerns were that day?

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A. Well, again, I told her about how my son had thrown up and how I was really worried about the idea of the flu because I had been told that preemies don't always show symptoms except for crying. She had been really fussy and while it might just be gas, I'm still a bit worried.
And that is when she sent us, she did a few things, like she gave us something, some samples to take home with us of potential medications or of medications, but I just don't remember what they were for. And meanwhile she sent us down to the lab. And interestingly enough it was the wrong lab. They had my correct lab information on file, but she sent us to the wrong lab. So we checked in and we were there for like an hour and a half, I mean, just some ridiculously long amount of time waiting to be called, just to be called up to the front. And when they called us up to the front, they told us that it was the wrong lab.
Q. So is it correct that you don't remember being present for any part of Dr. Weber's actual exam?
A. Right, I wasn't in the room, I was just present via telephone when they were there.
Q. So what do you remember Dr. Weber saying during that visit?
A. Whatever she gave us during that visit,

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because over a series of times different things were tried. So I don't remember what the very last thing was that she tried. It could have been gas medicine, it could have been reflux medicine, it could have been another change in baby formula, or some combination. But it was something along those lines.

Q. You said that you told her you were concerned that maybe MayRose had the flu?

A. Yes.

Q. Do you remember what her response to that was?

A. Well, I know that it wasn't that she thought she had the flu.

Q. How you do you know that?

A. Because she didn't tell us to do anything about the flu. I felt that the only response she had in connection to my concerns about the flu was sending us down to the lab, and that was just my own conclusion, because to me that was what I was talking about, so the fact she sent us down for a lab test was in response to what I was talking about. I remember talking to myself, that is just great, by the time we get the results of whether this is the flu, you know, she could be over the flu, from what I remember about flu tests.

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Q. Has anyone ever told you that your conclusion that your reported concerns about the flu and Dr. Weber ordering lab work because what you presumed, based on your complaints about the flu, has anyone ever told you your assumption was wrong?

A. Nobody told me that. It was only when she collapsed, that when my daughter collapsed, the day that we were in the hospital, I remember calling the lab to see what the results were. And because I was thinking it was for the flu, and I was just trying to gather whatever data might be helpful. And I remember them -- that was when they told me that the results don't come in for three working days unless the physician puts a rush on it. And that the physician had not put a rush on it.

And then I don't recall if that was when I found out that it was a blood test or if it was when I called the next time when we were at Denver Children's. But I think I found out that first call because then when we were in Denver Children's, I tried -- I worked on getting them to fax the results to Denver Children's. So by that time I knew it was a CBC, but I think that is how I learned, when I called them in an attempt to find out the results of her flu test, that it turned out not to be a flu test.

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Q. What do you believe a flu test would be?

A. Well, that is a good point. Truth be told, I don't really know what a flu test is. So if a CBC is the same as a flu test, I guess I wouldn't know that.

Q. Have you ever asked Tobi if Dr. Weber looked at any papers while she was examining MayRose that day?

A. No, I've never asked Tobi that.

Q. Has Tobi ever offered that information?

A. No.

Q. Has Tobi ever, since the time of that visit and since MayRose's crash, ever told you any more about that visit with Dr. Weber?

A. No. Because I was listening the whole time on telephone, so, no.

Q. You said earlier they had your correct lab information in the file. Who do you mean by they, Foothills Pediatrics? You said that Dr. Weber sent you to get the lab and it was at the wrong lab?

A. Correct.

Q. But they had the correct lab on file?

A. Right. They knew which insurance accepted which labs and because that had -- that was like some kind of issue that everybody was aware of at that time. And, in fact, the lab person, when we got called up, she asked me, Why did they send you down here? They know we don't take this insurance.

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Q. Did Dr. Weber specifically tell you to go down to Quest or someone in the office?

A. She specifically told us to go downstairs and get the labs drawn. She said go straight downstairs and get the labs drawn. So we went straight downstairs to get them drawn.

Q. So you arrived at Foothills Pediatrics just at the end of the appointment?

A. At the end, yes.

Q. So then you went straight downstairs to Quest to get the labs?

A. That's right, straight downstairs to Quest to get the labs and sat around for an extended period of time.

Q. Did Tobi go with you?

A. Yes.

Q. You sat there for an hour and a half you said?

A. Thereabouts. It was just a long time.

Q. Had they taken your paperwork first and then you sat there for half an hour or did it take them an hour and a half to even call you up to look at your paperwork?

A. To call us up. We signed in and the room was

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packed. All we did was sign her name and waited and waited and waited to be called up. And when we finally were called up, we handed the paperwork and I handed my Blue Cross Blue Shield card, and that is when she told me, she said, Why did they send you down here.

Q. Where did the person tell you to go?

A. I don't remember exactly. She gave us two cross streets. Because at that point I said, Well, do you know where the right lab is for us? And she gave us two cross streets out in Summerlin. And we drove there, but where she sent us, there wasn't any kind of lab. And so at that point I ended up calling. So I don't remember exactly the cross streets that she sent us to.

Q. On October 24, did you ever call back Foothills Pediatrics and tell them, You sent us to the wrong lab and where are we supposed to go?

A. No.

Q. So when you got to the two cross streets and there wasn't a lab and you said you called, who did you call?

A. The correct lab people that we were looking for.

Q. What was the correct lab?

A. Either LabCorp or Quest, it was those two

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that we were dealing with, so one of them was the wrong one and one of them was the right one.

Q. When you called LabCorp, what did they tell you?

A. They told us that they were closing and that we needed to schedule an appointment. So we scheduled an appointment, and that was where we -- that was when we went and got her blood drawn, and they drew a sample, but apparently it was not a good sample. Because when I ultimately had them transfer the sample to Denver Children's Hospital, it turned out that the sample they drew was insufficient for any analysis.

Q. So you said that you scheduled an appointment; is that right?

A. That's correct.

Q. And you scheduled that appointment on October 24; is that right?

A. The day that I actually scheduled -- no, it wasn't for that -- that was the day we saw -- that we actually went to the doctor's office, right?

Q. Right.

A. No, on that day we called them and they told us that we wouldn't be able to get her in that day, and that the first opening they had was first thing, I believe, Tuesday morning.

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Q. After you made the appointment, was there any further problem in getting her in to get the blood work done? Was there any other delay?

A. No.

Q. So by the time -- by the end of the day on October 24 when you saw Dr. Weber, you had gone to the wrong lab and then tried to find the right lab, then called and then made an appointment for the next week?

A. Right.

Q. All in the same day?

A. Right.

Q. When you went to your appointment, there was no problem getting you in at that time, right?

A. No, the time they gave us was sufficient, was the time they called us in.

Q. From the time that you left Foothills Pediatrics on October 24 to when you took MayRose to the emergency room, did you notice any change in her condition?

A. The evening that I took her to the emergency room was when I noticed a significant change in her condition.

Q. What change did you notice?

A. It was nighttime and it was very, very late or very, very early in the morning, and she started

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crying. And I did all the normal things when she starts crying, you know, changing the diaper, breastfeeding, holding her, and rocking her. And then I swaddled her, and I was in the rocking chair that Brian had built for us and we were just rocking back and forth. And I was holding her and I was thinking to myself, Man, you know, she is still crying and normally this makes her stop crying.

And then all of a sudden she -- she just -- her gaze just went glassy and her breathing just sounded strange to me, it just kind of slowed a bit. And it just -- it didn't look right at all to me.

And, you know, half of me was thinking, I keep bringing this baby in, and they keep saying she is fine, you know, I'm just obviously this hyper mother who is worried about this child, and they keep telling me there is nothing wrong. But I'll tell you what, I don't care because I am -- I just don't like this. So they are just going to have to tell me again that I don't know what I'm talking about.

And I just grabbed my son, jumped in the car, because I'm one exit away, I didn't even put her down, I just -- I just was not liking it at all. And I just drove straight there, took me about two minutes, and jumped out of the car, two second calculation as to

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whether it would be faster to open the stroller and put my two year old in there or make him run, opened the stroller because a two year old wouldn't have -- I'm holding her and pushing him and running and the parking lot was dark, they were doing reconstruction.

So that was when I noticed that something just wasn't right. And when I brought her in, I just handed her to an official, and I was like, She is not breathing right and he just took her back.

Q. From the time you saw Dr. Weber on October 24, you said one of your complaints at that time was she was fussy, crying a lot?

A. Right, right.

Q. From that time until you took her to the ER, had her fussiness increased, decreased, stayed about the same?

A. The night of her collapse it increased. And that was, you know, it was like for about an hour I was doing all the different things that I would normally do that would make her fussiness better, and it wasn't getting better, and then she collapsed. But prior to that, what would happen is she would be fussy for like maybe five or ten minutes, and then you would do something, she would stop being fussy.

Q. From the time you left the appointment with

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Dr. Weber to when you took her to the ER, did you ever call Foothills Pediatrics to report any change in her condition or any concerns that you had?

A. When I took her to the ER.

Q. Between the time --

A. Oh, before I took her to the ER.

Q. To when you took her to the ER.

A. No, because she was behaving the same for the most part. The increase was when I took her to see Dr. Weber. And that increase stayed about the same for those few days in between until that evening.

Q. From the time you left Dr. Weber's office to the time that you had the blood work drawn, did you ever call Foothills Pediatrics and report any of the problems with getting the blood work drawn?

A. No.

Q. Did Dr. Weber ever tell you she was ordering the test requested in the discharge summary?

A. No, absolutely not.

Q. Do you remember if -- did you ever ask where to go for the labs or did your nanny ever ask that while you were in the office with Dr. Weber?

A. I'm sorry?

Q. Did you or the nanny ever ask Dr. Weber where you should go to have the labs drawn or did she --

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A. She just said go downstairs, there is one right downstairs, just go right downstairs after you leave and get these drawn. So --

Q. Did Dr. Weber ever talk about the possibility of MayRose having an infection?

A. I don't recall her doing that. Once again, it was about normal changes we could make.

Q. Do you remember specifically having a conversation with Dr. Weber about MayRose's anemia of prematurity or her blood transfusions?

A. No, I don't specifically remember that. Once again, the person that I would have done that with post discharge, NICU discharge would have been the person who did the iron prescription.

Q. Is there anything about MayRose's treatment at Foothills Pediatrics --

A. Except for the conversation I had with Dr. Conti immediately after that first thing, we talked about everything.

Q. Have we talked about everything in particular that you remember happening at Foothills Pediatrics prior to MayRose's crash?

A. Pretty much. I mean, there are things that you probably could say that would trigger my recollection about various events. But it sounds about

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right.

Q. At the time it happened, I don't want to know about now, but at that time it happened, did you have any concerns about the treatment MayRose received at Foothills Pediatrics prior to her crash?

A. I thought it was a little odd that she was -- that there was so much of the standard stuff that had occurred with my son that was occurring with her, despite that she was a preemie and I would usually have -- I mean, I -- it just seemed a little odd that as a preemie it wouldn't be more than the usual checkups. However, because they occurred very frequently, I figured, okay, well, this must be the way they account for prematurity. So that was really the only thing that I thought was odd.

Q. Did you have any other concerns about MayRose's care at Foothills Pediatrics prior to her crash?

A. No.

Q. So when you got her to the emergency room on October 29 and handed her to somebody, what happened next?

A. Well, I went and got the stroller that I had tossed aside because I couldn't -- the door was roped off, terrific. I had to take my son out of the

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stroller, push her under the roped-off door, climb over the rope, open the door, and go in. It was a matter of seconds, but it just was crazy.

So what is the first thing I remember doing, well, they rushed her in the back and we were just standing there, and so I went and got the stroller.

Q. When was the first time a health care provider came out to talk to you about her condition?

A. Man, I don't remember. I remember calling Brian at some crazy hour in the morning, sitting in the room with my son.

Q. When the health care provider came to talk to you, what did they tell you was wrong with MayRose?

A. They said she had a double pneumonia and the flu. And that she had gone into shock. But that she was stabilized, that they had stabilized her. I remember that much.

Q. Do you remember who that health care provider was that told you that information?

A. No, not at all.

Q. When is the first time you saw MayRose next at Summerlin Hospital?

A. They had put her, I think, in a room by the time I got to see her. I don't recall seeing her before they had taken her out of the emergency area and

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put her in a room.

Q. Did the health care provider who told you she had double pneumonia and the flu and was in shock, did they tell you what caused the shock?

A. They didn't tell me at that point what caused anything. They were just talking about her current condition and what we had ahead of us for getting her better.

Q. When was the first time at Summerlin Hospital any health care provider talked to you about MayRose's blood work results?

A. Well, somebody said to me they were amazed that she was still alive because she had a 1.5 hemoglobin, and at that point I had no idea what a 1.5 hemoglobin meant. But I understood the they were amazed that she was still alive part of it.

They explained normally if you or I had a hemoglobin that low, we would be dead. So I remember that.

Q. When was the first time anyone ever explained to you or talked to you about what a 1.5 hemoglobin meant?

A. That is when we got back to the whole thalassemia thing. They ended up calling in a consult with hematology to find out why her blood count had

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dropped so significantly. And that was, you know, that was when I remember having that discussion with the hematologist, the consulting hematologist.

Q. Was the hematologist the one who said he was surprised she was alive?

A. Somebody else told me that.

Q. Do you remember who the person was that told you that?

A. No.

Q. Do you remember the name of the hematologist that was called?

A. It was Dr. Rashid and her partner. I see Dr. Rashid all the time now, I can't remember her partner's name, but both of them treated her.

Q. What did Dr. Rashid tell you the first time she spoke to you?

A. I don't know about the first time she spoke to me. I do know we had a series of conversations about thalassemia and for the first time it was like -- for the first time ever somebody started paying attention to Brian and his thalassemia talk. So we talked a lot about that again and we got tested, we both got tested, and all this stuff.

Q. What was Dr. Rashid asking or wanting to know about the thalassemia?

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A. Well, she was asking -- I mean, she probably didn't even just ask. He probably just started talking about it again, and then she followed up this time, you know, somebody finally said, Oh, let's look into this thalassemia because we are not sure what the reason for the drop in hemoglobin is.

Q. Did you have any conversations with Dr. Rashid about MayRose's diagnosis of anemia of prematurity?

A. I know we talked about that. I mean, I just remember there was lot of brainstorming at that time of what might have been the cause of her drop in numbers. It wasn't like this immediate dawning on everyone that there was some anemia related issue because the first thing they were trying to do was to get the influenza and the double pneumonia under control. So the very beginning, the focus was draining the lungs and getting her healthy, helping her overcome that stuff. So that wasn't really the initial focus.

Then eventually, and this was over a month long period, then eventually as she began to really stay stabilized for a while and get off the breathing machines and all that, then we started discussions about the blood, the low blood counts.

Q. In those discussions about the low blood

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count, what were some of the ideas that were brainstormed about the cause?

A. Well, I -- it was about the different things that could cause a low red blood count. And at that time she had a low -- or she had -- her white, there was something off about her white count too. So they were looking into that. You know, it was just discussions about different potential blood disorders. I once again talked about my own anemia and my mother's anemia, just talking about how we might, our own genetic -- our own genetics might be contributing to the problem.

Q. Was Diamond Blackfan anemia ever discussed at Summerlin Hospital?

A. No.

Q. Was Dr. Rashid the hematologist in charge of MayRose from that point on?

A. No.

Q. At what point did another hematologist come in?

A. Well, when MayRose stabilized, she was -- she was behaving strangely. And the -- another brain -- they had a done a brain scan when she first came in, and that was normal. They did another one, and the people, the neurologist -- my aunt and uncle were

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visiting, and the neurologist went in and started talking to them about the results of my daughter's abnormal brain scan. They knew nothing about anything, they were just there visiting. And my aunt stopped her and said, We are not the right people to be talking to about this. And then she left. And then I came in, and she -- my first inkling was her saying, Oh I don't know what they were talking about. So anyway, I find out, serious damage to the brain.

And we had to find a rehab place. We found Denver Children's as being one of the best in the country, and so we took her there. And when we arrived there, they checked her blood again, and they were surprised to see that, again, her blood was -- her counts were low. And so then a team of hematologists there started looking into them again, and I told them about the blood work they had done for us and the whole thalassemia thing -- Brian would be proud -- and my anemia thing all over again. So anyway they actually started looking at her Sunrise records and that was the first time I learned that she had had a low retic count when she was born and that there had been another low retic count.

And they did a bone marrow check and they said to me, She hasn't been producing retics since she

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was born. How is that? Then they started looking deeper into it. And during that process they said to me, We think that she has Diamond Blackfan anemia. They ruled out a whole bunch of other stuff, including interestingly enough, the thalassemia. And found that and made that tentative diagnosis. But they didn't do genetic testing at that point. So they said there is genetic tests available to confirm it. So that is how we learned.

Q. At Summerlin Hospital Dr. Rashid was the only hematologist that was involved on the case at that point?

A. I think her partner participated too.

Q. But that group?

A. That group, I believe so.

Q. So when did the discussion happen when she had the second brain scan and you became aware of the brain damage? When was that, how far into her hospitalization?

A. It was like towards the end when we thought we were out of the water and safe and everything was fine or going to be fine. We thought she had survived, and it was looking good. And then it turned out that we knew something -- we thought she was having withdrawal from the methadone because they had -- not

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from the methadone, from the -- they had been giving her some kind of drugs to keep her quiet and we thought that she was experiencing withdrawal from those drugs. So they prescribed methadone, and then it turned out that it wasn't that, it was neurological.

Q. So you said a neurologist came in and started talking to your aunt and uncle?

A. Yes, she did.

Q. Is that the same aunt and uncle you mentioned previously?

A. Yes.

Q. Do you remember the name of the neurologist?

A. No. She had a thick accent, I don't remember her name.

Q. But then the neurologist told you the results of the MRI or brain scan?

A. Well, in like a day or two. They called her -- or I don't know. Anyway, they called her back and I think, yeah, she was the one who ultimately told me, she showed it to me on the computer and told me.

Q. So from the time that she told your aunt and uncle about the brain damage to when she actually told you was a couple of days?

A. I'm not sure. You know, I just -- I remember them saying she would be back the next day or the next

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two days. But I think maybe I was very adamant about her coming back sooner. So it might be stuck in my mind the one or two day thing, but she might have actually come back sooner than that. But there was a period of time where I knew something might be wrong, but I didn't know what because she wasn't there.

Q. What did she tell you when she spoke to you about MayRose's condition?

A. She said it was diffuse brain damage and it was everywhere.

Q. What else did she tell you?

A. Something about calcifications in the brain and it wasn't one specific spot, it was all over the place.

Q. Did she tell you what had caused the brain damage?

A. I don't believe she -- just said -- no.

Q. Did she tell you any of the possibilities of what may have caused the brain damage?

A. I don't think she told me, she told me. I think I read later what she said. But I don't remember her actually talking about causes. I remember we were just talking about results and the future and what I could do to make this better, if anything.

Q. So what did she tell you about the prognosis

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for the future?

A. That it was irreversible. And that I couldn't understand how she could go from having a normal scan on admission to having an abnormal scan, so she talked a little bit about how that happened. She was very medical about it, she was saying, you know -- I was more focused on what could I do to make this better, and that is when I started calling neuropsychologists I knew, trying to find out where I could take my daughter.

Q. What did the neurologist tell you about how she could go from a normal scan to an abnormal scan?

A. She said that sometimes it doesn't show up right away.

Q. What doesn't show up right away?

A. Damage that could be in the process, but it doesn't show up immediately on the scan or something like that.

Q. Did any health care provider at Summerlin Hospital tell you what they believed caused the brain damage?

A. Nobody told me, told me. I know that eventually they wrote stuff down about it, and it didn't -- at that point in time it didn't even occur to me to ask because at that point I didn't care what

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caused it. I cared what we could do about it, that is all I wanted to know, what could be done about it.

Q. What treatment was MayRose receiving at Summerlin Hospital for the low hemoglobin of 1.5?

A. She was transfused.

Q. Do you remember approximately how many times?

A. That I don't remember at all.

Q. Do you remember any specific conversations with health care providers at Summerlin Hospital where there was any discussion of what happened at the NICU at Sunrise Hospital with her anemia and transfusions?

A. I'm sure we told them about our long time in the NICU because that we just carried with us. So every time there was a new person, we would always tell the new person about the long tortured history, from the thick nuchal fold, to discharge at NICU, that was -- the first visit was when we did that then with each new person. So I know that happened there.

But you know, at that point in time they knew what needed to be done for her double pneumonia and her flu. So that was what they were focused on until -- for most of that time there, it was getting her over the double pneumonia and getting her over the flu. You know, the consult with hematology just came later in the process. It just wasn't their main focus, it was

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getting her well.

Q. So when you took her to Summerlin Hospital and you explained the symptoms she was having and they examined her, is it fair to say your impression was they were more concerned about the infections and the pneumonia at that point than the hemoglobin of 1.5?

A. Well, and transfusing her, they immediately transfused her with the 1.5.

Q. But after they transfused her and brought up her hemoglobin, then they continued to focus on the pneumonia --

A. And the draining her lungs and getting -- helping her get over the flu.

Q. Did anyone at Summerlin Hospital ever tell you how severe they felt her Influenza B was?

A. No.

Q. Other than the neurologist you spoke to, did anyone at Summerlin Hospital talk to you about the brain damage?

A. No. I remember everybody staring at me, oh, this poor woman.

Q. Any health care providers at Summerlin Hospital that you remember specifically talking to you other than Dr. Rashid and the neurologist?

A. Well, I talked to people about finding the

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best inpatient rehab because I just couldn't comprehend the concept there was nothing that could be done. I mean, it just -- that there is no reversing brain damage. So I know I kept saying, Well, you know, who is the top neurologist in the country, I want to take her to the top neurologist? Where do I go to find them. You know, it took a while, you know, a couple of days for people to convince me that the top neurologist wouldn't be able to do anything for her, that at this point it was rehabilitation.

So that was kind of how it went, the conversations were me looking for who can fix this, them telling me nobody can fix it, we can only treat it. And then me accepting that finally and finding out where the best place to treat it was. That is it, that is what we talked about.

Q. Just a couple of questions, then we will take a break. You eventually went to Denver Children's Hospital. But was there a discussion about going to Boston or UCLA?

A. Yeah, there was discussions about all the different top locations and their pros and cons.

Q. I think I read in the medical records that your first choice was Boston; is that right?

A. Well, I was -- I knew that some of the top

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neurologists were in Boston, and so I was leaning towards Boston when I was still not trying to believe that a neurologist couldn't help reverse the brain damage or that maybe somehow these neurologists had gotten it wrong and they could do something for it to be better. So, yeah, that is when I was talking about Boston.

But when it finally sank in, not just with those people, but with experts I know from my own profession, about what the next step was, then it became a different discussion. It became about what is the best children's rehab facility.

Q. How did you eventually decide on Denver?

A. Because a couple of neuropsychologists that I trust said if it was their kid, that is where they would take them. And then I went online, I started doing research about scores, and saw that the scores were some of the highest scores in the country. And then I confirmed with her treating doctors at Summerlin that it was one of the best. So after that and discussing it with Brian, I just decided that made the most sense.

Q. Let's take a break for a moment.

(Whereupon, a recess was taken from 2:55 to 3:05.)

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BY MS. ROSENTHAL:

Q. So after Summerlin you took MayRose to Denver Children's Hospital for rehabilitation; is that correct?

A. I did.

Q. Okay, you kind of explained how they started to figure out that maybe she had Diamond Blackfan. My understanding was they did some blood work, and they got the records from Sunrise and realized that the two retic tests showed she wasn't producing --

A. Retics.

Q. We talked about earlier when you were in Summerlin you called the lab where MayRose had her blood drawn just prior to her crash; is that right?

A. Just after her crash. I was waiting around at Summerlin the date of her crash, trying to figure -- waiting to hear something. And when it became -- because we went in the wee hours of the morning, and when it became regular hours, I called the lab to find out the results of the test.

Q. What is it they told you again?

A. They told me that it took three working days to get the results of the test.

Q. When was it that you found out that they hadn't obtained an adequate sample?

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A. That was in Denver Children's.

Q. Are you aware if anyone at Denver Children's ever contacted that lab regarding that blood work?

A. I remember there was an attempt made, but ultimately I had to do it, I had to have them fax the results or I don't know. Between the two of us, we had to work together to get the results. And it was faxed to them.

Q. Did you ever contact Dr. Conti's office about helping you get those results back to them?

A. I may have, I don't remember.

Q. Do you remember approximately what month that was when you were trying to get those results faxed?

A. December.

Q. So at Denver Children's Hospital were they ever able to make a definitive diagnosis of Diamond Blackfan or was that just a suspicion still during your first visit?

A. It was as definitive as it was going to get without genetic testing. Before they had genetic testing, that would have been the definitive diagnosis. But once they started narrowing down the genes involved and began being able to test for those specific genes, they stopped -- they changed the definitive diagnoses to genetically confirm the diagnosis.

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Q. Off the record.
(Off-record discussion held.)
BY MS. ROSENTHAL:
Q. So you said it was as a definitive diagnosis as you could get without genetic testing, right?
A. Yes, yes.
Q. Were they planning on doing genetic testing?
A. They told me the place to get it was at Schneider Children's, that they were where the registry was, and that was where I should go to get that done.
Q. Did you go to Schneider Children's to have that done?
A. I did.
Q. When did you go there?
A. In the spring.
Q. When did you first get the results of the genetic testing?
A. It was a few months later, it took a while. Because they had to collect enough samples to send it in, not just from us but from other people.
Q. So based on your understanding of what the physicians at Denver Children's were telling you, what, in particular, do you believe was leading them to think she had Diamond Blackfan? Was it the retic count or was it something else?

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A. It was when they did the bone marrow test and they saw that her bone marrow, that the retic count was so low, that it looked like she wasn't producing them. And then they collected what records they could from Sunrise, and they saw that she had never -- that it had been low both times that she was tested, whereas the rest of the white count and the other portion of the blood, I think it is plasma or -- I don't know, I get confused with that because we don't have a problem with that -- but the other areas of the blood were fine. So based upon that, and based upon ruling out some of the other possibilities, they made their assessment.
Q. So what did the doctors at Denver Children's tell you about the prognosis of your child with Diamond Blackfan?
A. I don't remember what they told me, if anything. I'm sure I went on the internet and started looking it up. And we were really there for rehab, so that part was actually a side part, it wasn't our primary focus there. We were mostly there doing rehab and interacting with the people about the brain injury. I think most of what I learned was through the website, contacting the registry people, and the different organizations who cater to Diamond Blackfan anemia patients.

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Q. What are MayRose's health care providers telling you about her progress now with Diamond Blackfan?
A. Well, I know that the life span of the kids with Diamond Blackfan has doubled over the past ten years now that two things have happened. One, you have a drug that enables iron chelation to occur just by taking that drug every day. And two, because they have identified genes that are the cause, the genetic defects that are the cause, so there is all kinds of advances that has doubled the life span of people with her illness.
I know that she did not respond well to the steroid treatment -- well, she just didn't respond to the steroid treatment. So some kids can take steroids and don't need blood transfusions. She is not one of those kids.
And amazingly enough, after all of this, Brian and I went together to her hematologist to discuss the possibility of another addition who might be a match for bone marrow. Unfortunately, because of her brain damage, she is not a good candidate for a bone marrow transplant. So --
Q. Why does her brain damage make her not a good candidate for a bone marrow transplant?

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A. It has something to do with her lack of mobility and her inability to tell us what she is experiencing. Those two factors would prevent a quick recovery and effective monitoring. There may be more, that is what I remember. And he said that he wouldn't do it unless she had reached a life-threatening stage where that was her last option.
Q. When did you and Brian discuss possibly having another child?
A. We didn't actually -- I mean, we discussed the concept of this being a way to have another donor. We discussed it with the doctor. So I just -- we definitely -- you know, obviously that is a -- a challenging concept, but we are just so committed to trying to figure out something for her. So that would have been when the steroids didn't work and the doctor was talking to us about what other options we had. And I believe that was earlier this year, oh, maybe late Februaryish of this year.
Q. When you went to Schneider Children's Hospital, was the only care that she received there related to her Diamond Blackfan, getting her in the registry, genetic testing?
A. Yeah.
Q. She hasn't been there for treatment for other

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things?
A. No, she has not.
Q. After MayRose was released from Summerlin Hospital, you continued to have her treat with Dr. Conti; is that right?
A. After her release from Denver Children's Hospital.
Q. Okay. But when she was released from Summerlin Hospital, would you consider Dr. Conti was still her pediatrician at that time?
A. I did consider him to be her pediatrician, although we didn't see him though, but I considered him to be her pediatrician, yes.
Q. You went from Summerlin to Denver, then came back to Las Vegas?
A. Yes.
Q. Then continued to treat with Dr. Conti as issues came up?
A. Yes.
Q. At what point did you start to have concerns about Dr. Conti's care and treatment of MayRose?
A. When I learned that he failed to give her the CBC test.
Q. And you said earlier, once you learned that, you no longer took MayRose back there?

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A. That's correct.
Q. You learned he failed to order the CBC because you had requested the records and reviewed them yourself; is that fair?
A. I believe it was around the time that I was putting her records in a centralized location for all of her people to look at them. It was around that time period. That is why I was initially going through the records.
Q. Up until the time that you learned Dr. Conti did not order the CBC, did you have any concerns about the care and treatment he was giving MayRose?
A. No.
Q. Did you have any concerns about the care and treatment any other physician at Foothills Pediatrics gave MayRose up until the time you learned about the blood work?
A. No. I was becoming a little frustrated with the concept of there being no centralized recordkeeping.
Q. Were you frustrated with Dr. Conti for that or just in general?
A. In general because I was asking people to send him faxes and keep him updated, and it just was very difficult to get people to do that.

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Q. What pediatrician did you start after seeing Dr. Conti?
A. Well, momentarily Dr. Robertson. And I went there kind of for a consultation and to discuss with him the central recordkeeping concerns that I had. Because by then she just had so many doctors and therapists, it was just an insane number, and I told him that I really needed somebody who could coordinate all that. He said to me that it was a monumental task to coordinate all and that I would be better off taking her to a place like CHLA that had centralized recordkeeping. And that is how we ended up going there, transferring all her care there.
Q. That was on Dr. Robertson's recommendation?
A. Uh-huh.
Q. So who then became MayRose's pediatrician after that?
A. Dr. Burgamy.
Q. That is at the Children's Hospital in Los Angeles?
A. Yes, she is.
Q. What kind of treatment is MayRose getting at Los Angeles Children's Hospital?
A. All of the specialties listed in the interrogatories are -- I mean, I'm sure I'll leave one

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out if I'm going by memory. But she has an endocrinologist, a urologist, a neurologist, a hematologist, she has therapists there, she has an ophthalmologist there, just about every organ she has someone that is either treating her or monitoring her. A gastrointestinal person.
Q. There is no facility in Las Vegas that has all the specialists that she could see?
A. No, no centralized, no one group with all those specialties, and no location for access to all of the medical records. No centralized recordkeeping here.
Physiatrists, I didn't even know what that was, it sounded like a foot doctor or whatever.
Q. I want to go through your day-to-day routine with MayRose, and I want you to describe for me from when you get up in the morning or from midnight to midnight what happens with MayRose on a day-to-day basis.
A. Well, depending upon where her meds -- what meds she is taking at any given time. We start the day with -- currently we start the day with Lansoprazole, and as long as that goes smoothly, then we move on to the next group of medication. If her tummy is bothering her and she doesn't keep that down well, then

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I will give her some nausea medication.
After that we move on to Clonazepam, Neurontin, Neuroptin, and Baclofen. And that will be with some yogurt, try to get her to eat some yogurt for good gastrointestinal movement. And meanwhile I get my son ready for school, I get ready for work, the nanny comes, she helps getting May ready for the day with grooming, things like that.
Sometimes I stay for the therapist, her occupational therapist comes on Monday mornings, her physical therapist comes to the house Tuesdays and Friday mornings, depending upon my workload. That determines whether I stay. Then Monday through Friday usually I go to work at which point the nanny will take over. And she has to take her on Wednesdays, she -- on Tuesday she takes her to the speech therapist, on Wednesdays she takes her to the hippotherapist, horseback form of therapy to build trunk muscles. Sometimes she goes to Dr. Raja, who is a local neurologist who works with Dr. Sanger in Los Angeles. And on occasion she goes to Dr. Rashid, who works with Dr. Hofstra, they are both hematologists, he is in Los Angeles.
She has to get her iron chelation medicine in the early afternoon. Then we try to feed her if she is

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willing. Oh, she gets bolus feeds through her feeding tube three times a day. She wears -- we put her braces on, we put her hand splints on. We put her glasses on.
She spends time in her black box because she has cortical visual impairment, so even though her eyes are healthy, her brain doesn't process what it is seeing. So sometimes that takes the effect of like looking through a slice of Swiss cheese or sometimes it is like looking through cellophane. So we have a black box where she can reach and grab things and she knows the familiar area of it, so it helps with her occupational therapy and reaching and trying to hold on to things.
We put her in her stander, we try to get her to stay in there as long as possible because to avoid osteoporosis, she needs to be in there for two hours a day, which is impossible to get a three year old to stand in a stander for two hours a day. But we keep her in there and entertained as long as possible and she has made it for like an hour and 15, so she is doing her best.
We put her on the floor on a mat so she can do tummy time, roll over and try to push up, and lately she has been getting her knees under her a bit so who knows. She is very motivated, so she might get the

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crawling concept one day hopefully. But her muscles are weak and we have to do exercises to build their strength.
And then she gets more medicine at around 2:30, and then another bolus feeding at around 5:00, around 5:30. More Lansoprazole at around 7:00 and then more of the other medicine at 8:00.
Then finally at 9:30 she has Senna to stimulate the pooping, to make sure everything goes through properly. We have a little timer that reminds us, because she needs medicine at so many different times a day that goes off each time she needs medicine.
We put her on -- we have a horse simulator, so we put her on the horse simulator every day. We have little black and white cubes to help her work on her vision. And plus we have certain colors all around that she focuses on, once again, to help work on her vision. We do a lot of mirroring of her language to help her develop her language skills. And that is all stuff that is daily. We actually have a little written calendar for -- not a calendar, but like a daily thing -- chart to check off to make sure we have done something and to coordinate it, both with the medication and with the activities.
Q. What is the daily chart check off written on,

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is it typewritten?
A. I have a typewritten thing and I put it in a -- there is a plastic thing over it so we can wipe it off at the end of the week and we start again. So it is an erasable marker we use.
Q. Can you make a copy of that and produce that?
A. Yes.
Q. So when you go to work, what time do you go to work each day approximately?
A. It depends. I arrive at work anywhere from 9:00 to 10:30, depending on what is going on.
Q. You get home I think you said at approximately 6:30ish?
A. Anywhere from 6:30 to 8:00, depending on what is going on. I left off the part where we hook her to continuous feeds all night, we have a pump and we also have to clean her G-tube, keep her G-tube clean. We have got to brush her teeth after each meal. Unfortunately, despite that, because of the stomach acids going on with her G-tube, she is developing cavities, so she has to get those taken care of under anesthesia. That is coming up. And also, you know, she just has osteoporosis in general, it is just part of I guess not working the bones properly, her chewing is not that skilled.

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Q. So in the morning you help her with her breakfast and her initial medications, right, then the nanny comes and helps take over and is with her the remainder of the day unless you stay for a therapy; is that right?

A. She is with her until around 2:30, 2:45 and then the sitter comes. And then of course I do the full routine Saturday and Sundays and when we are away. And we are away at least once every three weeks because she gets transfusions once every three weeks at LA Children's Hospital because Sunrise can't get it together with the concept that she needs fresh blood. Whereas LA Children's Hospital knows, it is all set up and it is prearranged, and they make sure that the patients who have chronic transfusions are given fresh blood.

Q. As far as doctors' appointments, not therapy, but doctors, are the only doctors she is currently seeing in Las Vegas Dr. Raja and Dr. Rashid occasionally?

A. Yes. If there is like -- it hasn't happened, but if there is some kind of emergency, I know I can take her to Dr. Robertson, who continues to be my son's pediatrician. Although generally if there is an emergency, I call Dr. Rashid and she arranges for what

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should be done.

Q. So currently as far as doctors' appointments, you have occasional appointments with Dr. Raja. How often are you seeing him?

A. Maybe once every couple of months.

Q. How often do you see Dr. Rashid?

A. That has changed since I started getting the transfusions at CHLA. So it is kind of hard to say the exact. We haven't settled into an updated routine since I started going to CHLA for the transfusions which was after her discharge in July. I think we transfused once here, but -- no, actually I think we transfused once in between. There were two hospitalizations, so I think it was in between and then we started transfusions solely at CHLA.

Q. So you see Dr. Raja and Dr. Rashid here. Other than that, she goes once every three weeks to CHLA for transfusions?

A. Yes.

Q. And is it while you are there you take care of any other medical appointments she needs?

A. Sometimes we can't do it during that period, sometimes we have to go outside that time period.

Q. But generally when you go for transfusions, what doctors do you see while you are there at CHLA?

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A. All of them at different times. So it is just different routines for different doctors. Like some of them are just twice a year, those are the ones just monitoring her. Whereas GI is more frequent, neurology it is like every three months, physiatry may be every four months. It just varies.

Q. I want to talk about the specific therapies she is currently in. She is in occupational therapy?

A. Uh-huh.

Q. Where does she get that?

A. Shannon Holman is her primary occupational therapist although she does have someone monitoring her at CHLA.

Q. How often does she go for occupational therapy?

A. Once a week here in the home. And generally once every three weeks at CHLA. That is the current regimen. It has changed over time because for a while ISS was involved in providing preschool services.

Q. How often does MayRose receive physical therapy?

A. Twice a week. And actually the hippotherapy is a form of occupational therapy, so that is once a week as well.

Q. Where does she get hippotherapy?

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A. Dream Therapies.

Q. The physical therapy is twice a week on what days?

A. Tuesday and Fridays.

Q. Who provides that?

A. Beth.

Q. Beth Ford?

A. Yes.

Q. What other therapies is she in?

A. Speech therapy with Julie.

Q. Do you know Julie's last name?

A. It is escaping me for the moment. But she is on the interrogatories. Then she has osteopathic therapy once a month with Dr. Galen, Clair Galen.

Q. How often does she have speech therapy?

A. Once a week.

Q. Osteopathic therapy is once a month with Dr. Galen. Any other therapies she is currently in?

A. No.

Q. Are there any other doctors' appointments or therapies other than what we just outlined that are part of your regular routine at this point?

A. No, not that I can think of.

Q. What percentage of MayRose's doctors' appointments do you go to at this point?

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A. I do the overwhelming majority of her doctors' appointments because the overwhelming majority of them are at CHLA, so I'm the one who takes her there. Whereas -- go ahead.

Q. If she has doctors' appointments in Las Vegas, do you generally take her or does the nanny take her?

A. If it is routine, the nanny takes her generally. I took her to the last one with Dr. Raja, but that wasn't routine. She was getting a Botox injection in her legs to help avoid hip displacement.

Q. Prior to transferring her care to CHLA, did the nanny end up taking her to more appointments or would you take her to the majority?

A. The nanny would take her to the routine ones that I could listen to over the phone when there wasn't anything -- when I wasn't concerned that anything was wrong. But if I thought -- if I was concerned about something being wrong, then I would take her. And I should say that there wasn't anything wrong out of the ordinary. If there is something out of the ordinary, I would take her.

Q. Since MayRose's birth, I just want to make sure I have all the hospitals she has treated with. She has treated at Sunrise, Summerlin, Denver

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Children's, Schneider Hospital and CHLA?

A. Yes, she didn't actually treat at Schneider's, but she was a part of the registry located at Schneider's. I think they might be separate from Schneider's, but they are located in Schneider's.

Q. When MayRose is hospitalized now, what is the general reason she is usually hospitalized for now?

A. Now at this point? Well, she had gone an entire year, and then it was because she was having dysmotility issues, which caused constipation and vomiting.

Q. What caused those problems, did the doctors tell you?

A. Well, they ruled out adhesions in connection with her perforation surgery, and they said that it is a possibility that her brain just isn't telling the poop where to go properly. But they don't know for sure.

Q. Let me go over one of your interrogatory responses and I want to look at Response No. 5 to Interrogatory 5 of the responses to Dr. Conti's first interrogatories of MayRose Hurst. I asked for people who have knowledge of the facts in the case and you have listed a list of all her treatment providers since she was born, I believe; is that right?

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A. All the ones I could think of that I had, you know, knowledge of that I could recall.

Q. I just want to go through this list and I want you to tell me -- I'll ask the questions about each one, but I want to make sure I understand what care these people have all provided and if they will be providing care in the future. The first one is a dentist, John Morzov. Is he currently treating MayRose?

A. I believe that -- I'm not a hundred percent certain at this point, but it is his group. Because I'm not sure that he is going to be the one that puts her under and fills the cavities, but that is happening shortly. So I just am not a hundred percent sure if it is him.

Q. Explain again why she is getting cavities.

A. Because her G-tube results in food going to her stomach and producing saliva in her mouth that normally would be used to help break down food or something along those lines. And yet because she is not eating when this happens, it is just breaking down her teeth.

Q. When did MayRose get her G-tube?

A. I believe it was July.

Q. Of 2011?

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A. Yeah, it was recently.

Q. Then you have endocrinologist, Dr. Pisit. Is she currently treating with him?

A. Yes.

Q. What does he do for MayRose?

A. He monitors her osteoporosis.

Q. How often does she see him?

A. A couple times a year.

Q. You have gastroenterologist, Dr. Collins?

A. Just she left their practice, so we are going to start seeing a new person.

Q. Who are you going to start seeing?

A. I can look at my calendar and tell you.

Q. How often does MayRose see the gastroenterologist?

A. It has varied. But it is definitely several times a year. I still have her. I probably wrote it in my book, so I have her down.

Q. The hematologist you have listed as Dr. Hofstra?

A. Yes.

Q. Dr. Davidson?

A. Dr. Davidson hasn't really been involved. It is really just Dr. Hofstra.

Q. She sees Dr. Hofstra once every three weeks?

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A. We don't necessarily see him each and every time we go there, but we see him pretty regularly.
Q. You have a nephrologist, Dr. Grushkin?
A. Right.
Q. How often does MayRose see him?
A. He monitors her. That is a couple times a year.
Q. What was he monitoring her for?
A. I guess urinary issues. She is, because of all the medication she is on, he monitors what it is doing to her, I guess, her bladder. And breaking it down.
Q. Her neurologist is Dr. Sanger?
A. Yes.
Q. How often does she see him?
A. We see him, I guess, once every -- well, see his assistant every three months, and then we see him the next three months. So we see one or the other every three months, either him or his assistant and her name is Diane, his assistant.
Q. You have an orthopedic, Dr. Myung, M-Y-U-N-G?
A. Yes.
Q. How often does she see that doctor?
A. That is a couple times a year.
Q. What does he see her for?

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A. Well, she is at risk for scoliosis and at risk for hip displacement, so she monitors those areas via x-ray and she has leg braces, so she prescribes bracing.
Q. Orthotics, Mr. Wayne Eguchi?
A. He does the -- prepares the braces.
Q. What braces does she have?
A. The leg braces.
Q. You mentioned hand splints?
A. She has hand splints and those are prescribed by the OT.
Q. Ophthalmology is Dr. Buffen?
A. Yes.
Q. How often does MayRose see him?
A. Only a couple times a year.
Q. Urology is Andy Change?
A. Yeah. Interestingly enough he, I guess, is the surgery half of the nephrologist. So he is only -- he is really only going to get involved once it looks like surgical intervention might be necessary.
Q. Her pediatrician is Dr. Bergamy?
A. Uh-huh.
Q. Do you regularly see her every three weeks or --
A. We see her like once every couple of months.

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Q. Surgeon is Dr. James Klein?
A. Yes.
Q. What surgery did he perform?
A. He put her cork in and he put her G-tube in.
Q. Then you have her occupational therapist that she sees how often in Los Angeles?
A. Every three weeks we schedule OT and PT in Los Angeles. And I think you missed the physiatrist. I don't know if that was on purpose.
Q. No, you are right. And the physiatrist, Dr. Craig?
A. Yeah. We see him about three to four times a year.
Q. Then if you go to Section D there is the people who MayRose currently treats with in Las Vegas, which I believe we went over --
A. Yes.
Q. -- except for Dr. Grant, the ophthalmologist. How often does MayRose see him?
A. You know, Dr. Grant, we kind of went back and forth between Dr. Grant and Dr. Buffen, so we have kind of been working with both. But I finally decided on Dr. Buffen just once again because of the centralized recordkeeping issue.
Q. So you have no plans to see Dr. Grant?

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A. Right.
Q. Where do you have MayRose's prescriptions filled at?
A. Almost all of them are Walgreens in Summerlin except for her Exjade, which has to be mailed to us because it is a specialized medication. She has a prescription for the food that she eats through the G-tube that comes through Walgreens Option Care, the formula.
Q. You mentioned earlier that MayRose received services from ISS?
A. Yes.
Q. She is no longer receiving those services; is that right?
A. That's correct, she aged out of them.
Q. Then Section F lists all the people she has seen in the past; is that right?
A. Everyone that I could remember.
Q. Other than your nanny, do you have any other health care providers that help take care of MayRose?
A. Also, well, for a period Brian's cousin Carolyn Reed watched her while we were in between babysitters. And we had a prior babysitter, there were a couple of prior babysitters before we settled on the current one. And I'm just trying to remember their

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names, but they are escaping me. I'm not really sure how much they could contribute, but --

Q. You can find out?

A. I can definitely find their names somewhere. The two that we currently have have been with us the longest, and Tobi has been with us the entire time from day one, discharge. So she is the person that actually does appointments and therapy and stuff like that, whereas the babysitter not so much.

Q. Assuming that MayRose had been born without any problems, what was your plan as far as going back to work and child care for her?

A. I would have done the same thing I did with my son, which was the first two years with a nanny and then put her in to half-day day care, then transition her to full-day day care. I had done that with my son. But then when it became obvious that -- when the whole health care, the germ-free environment became an instruction, I took him out of day care.

Q. Has any health care provider ever told you that if Dr. Conti had ordered the blood work requested in the discharge summary within a month of discharge, that it would have made a difference?

A. Well, Diane in Dr. Sanger's office, the neurologist's office expressed that his failure to do

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so was -- I can't remember the adjective she used, but it was very negative.

Q. Can you describe that conversation with her? How did that come up?

A. Well, I told her about how she had been discharged and had never produced retics and nobody noticed that that was significant, and that the pediatrician was supposed to do a CBC and it didn't get done, and then three weeks later she collapsed with a 1.5 hemoglobin and suffered brain damage. And she just found that to be extremely problematic, and she expressed that to me.

Q. Was that appointment with Dr. Sanger when you had that conversation?

A. It was during one of the appointments.

Q. Do you remember approximately when?

A. Early on. One of our first couple of appointments.

Q. You started seeing Dr. Sanger when, do you remember?

A. I believe it was in January maybe of last year. I believe it was probably January of last year, but I'm not a hundred percent certain.

Q. Other than that conversation, have you had any other conversations with a health care provider

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where they were critical of the care Dr. Conti provided to MayRose?

A. Well, Dr. Robertson asked me if I was going to sue him.

Q. Tell me about that conversation.

A. I told him the same thing that I just told you I told the neurologist, and he, Dr. Robertson, is both a doctor and a lawyer, and he asked me if I was going to sue him. That is when I had just switched, I had just found out about the CBC not being done and had just switched over to him. And that was it.

Q. What was your response to the question if you were going to sue him?

A. I said I didn't know because I was trying to figure out the full extent of what transpired at that point. Prior to that, my sole focus was on what I could do to just improve her condition, and for a long time I was unwilling to accept there wasn't anything that could be done. So I did everything I could possibly, you know, take her to an acupuncturist, and, you know, that was ridiculous, we only went once, do that, everything else, the osteopath, the therapy, everything. And I just was hoping that maybe the person at Denver Children's who said her prognosis was, Well, maybe one day she will walk and talk, I was

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hoping that she just didn't know what she was talking about, of course she would walk and talk, and we would be over this and wouldn't be worried about the rest of her life because she would be fine.

But once it became clear she wasn't going to be fine, then it also became clear I had a responsibility to her to see about her welfare for the rest of her life since, who knows, I'm 42, who knows how long I'll be around. Hopefully long. But you never know.

Q. Have we talked about all the complaints and criticisms you have of Dr. Conti?

A. Huh?

Q. Have we talked about all the complaints and criticisms you have of Dr. Conti?

A. Yeah. I'm very saddened by the entire situation. You know, Dr. Conti was a nice person and you know, truth is, I partly feel bad for him. I mean, I think his practice just got too busy to pay attention to the special needs of children. You know, maybe if she had been -- I'm sure if she had been a normal baby like my son, it would have been fine. But he needed to do what Dr. Robertson did and say, Look, I don't have the ability to monitor her needs or something. I don't know. It is sad.

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Q. When you would go to Foothills Pediatrics, did you feel like the practice was too busy?
A. Well, he had tons of patients and I felt like he was doing a dance from room to room to room. But he was always very upbeat and he made you laugh, he would flatter the mothers, thought that was a good technique on his part, you know, had all these mothers being flattered. And but, yeah, his practice was very busy.
Q. If I understood your earlier testimony, you said that when you took MayRose the first time, he sat and listened to you the whole time?
A. The very first time he listened to us, mostly because we wouldn't shut up. I mean, we just kept going on and on and on. After that, you know, it kind of -- the amount of time decreased that he spent with us.
Q. Have we gone over all the complaints you have of any employee or physician of Foothills Pediatrics?
A. Well, you know, obviously I'm no medical doctor, so from just my personal observation, you know, obviously when I kept saying I think she has the flu, I think she has the flu, somebody should have recognized that she was a premature baby, who maybe out of precaution you do something more than just treat her like a regular baby. So I think that in combination

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with just completely failing to do the test he was supposed to do, there should have been some protocol in place for a preemie and for, you know, the fact they don't display the same symptoms of being sick. And they clearly didn't have that protocol in place, despite the fact I had gone there a couple of times and said, I'm worried about the flu.
Q. Has anyone ever told you there should have been a protocol in place for preemies at Foothills Pediatrics?
A. I don't think so. I think these are just my personal observations as a nonmedical professional.
Q. Other than Dr. Robertson and Dr. Sanger's assistant, have you ever spoken with any of your other health care providers regarding the medical care and treatment Dr. Conti provided MayRose?
A. I'm sure I have mentioned this to everybody because, I mean, I don't know to what -- I mean, there is different parts of the scenario that apply to different providers. But I mean I've definitely talked about different parts of it to different doctors.
Q. Other than Dr. Sanger's assistant, has any health care provider specifically criticized the care Dr. Conti or Foothills Pediatrics provided MayRose?
A. No, not that I recall, other than

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Dr. Robertson asking me if I was going to sue him and yeah.
Q. How much have you incurred in medical expenses for MayRose?
A. I have no idea.
Q. Do you know how much you have received in bills from medical providers?
A. I have no idea.
Q. Have you ever paid any medical bills for MayRose to date?
A. I have paid a ton of medical bills, and there is even more that I haven't paid that I just --
Q. Do you know how much you have paid out-of-pocket so far?
A. Well, I know that I have -- no, I really have no idea, thousands of dollars, but, I mean --
Q. You have records or something to show --
A. Yeah, I mean, all the records are there that -- the insurance has all the records, each doctor has all the records.
Q. Has anyone else paid for any of MayRose's medical expenses?
A. Brian has reimbursed me for some of what I have paid. There was that one $1,000 anonymous donation, my aunt and uncle paid for one medical bill,

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like $100 or something like that. And then a coworker gave me about 50 for medical.
Q. In your discovery responses you said you had applied for the Katie Beckett program?
A. I did.
Q. When did you apply for that?
A. Oh, maybe about a half year ago.
Q. You said in this discovery that MayRose was accepted into that program?
A. She was.
Q. But you decided not to enroll. Why was that?
A. Because they assessed me, it is a welfare program, it turned out that I was going to have to pay 200 and I think it was 93 dollars a month for my daughter to be on welfare, which I was willing to pay because it still seemed like maybe it would be less than ultimately every -- you know, the other expenses.
But then it turned out that none of her therapists were going to -- would take it, and then they assessed Brian as having to pay I think it was $1700 a month. So between the two of us we were going to have to pay $2000 a month for our child to be on welfare. So obviously that made no sense at all.
Q. There was a period of time where some of her medical expenses were paid by that program?

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A. A few copays.
Q. That is a Medicaid program; is that right?
A. Yeah. So like maybe for a month or two of copays, that was it.
Q. Has MayRose ever received any disability payments?
A. No, that was it.
Q. So none of her -- other than that one Medicaid program, has any of her other treatment been covered by any kind of Medicaid program?
A. No, everything else is based on my income solely, and I didn't qualify for anything else. That was also based on her medical needs, so it wasn't just my income. So that is why she -- that was the only thing she qualified for. I applied for disability and they turned me down.
Q. When did you apply for disability?
A. Around the same time, I applied for them both at the same time.
Q. Is that Social Security Disability?
A. I believe so.
Q. Did they give a reason for their denial?
A. My income.
Q. Are you claiming any child expenses as a damage in this lawsuit?

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A. I'm not sure exactly what we are claiming. Logically it would make sense, but I don't know ultimately, leaving that up to the attorney.
Q. My understanding of your responses is you are not claiming any damages for yourself, personally, for physical or emotional injuries?
A. No.
Q. But that you would be claiming out-of-pocket expenses for MayRose; is that correct?
A. Yes, yes.
Q. So travel expenses would be out-of-pocket expenses that you incurred; is that right?
A. I definitely incur travel for medical reasons, that is every three weeks at bare minimum.
Q. How much does it cost you to travel to Los Angeles every three weeks?
A. Depending upon gas prices. Because we take a car, it can be like, I don't know, it is a full tank to get down there, that is like maybe 60 bucks, full tank to get back. So like 120. And then depending, usually stay at the Ronald McDonald House, that is $20 a night. Then all the different --
Q. Are you claiming damages in this lawsuit for the medical expenses MayRose has incurred related to the Diamond Blackfan treatment?

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A. Not solely, nothing that is solely due to Diamond Blackfan anemia, no, only to the extent that it has been exacerbated by the brain damage.
Q. How has Diamond Blackfan been exacerbated by the brain damage?
A. That is going to take an expert opinion. I don't really --
Q. Has any health care provider ever told you the brain injury has exacerbated the Diamond Blackfan?
A. Well, to the extent No. 1, she can't get a bone marrow transplant, she is not a good candidate for that, so that is -- that changes her quality of her treatment for Diamond Blackfan anemia. Also, her difficulties with taking food and liquids was one of the reasons why they needed to do the G-tube because she wasn't keeping down the Exjade, which is the iron chelation therapy which is what gets rid of the excess iron due to the multiple blood transfusions. If you can't do that, the organs start shutting down. That is usually what kills Diamond Blackfan anemia people. So the G-tube, even though we were getting her to eat, she was healthy, it was tough, it was really hard, but we were doing it. But the part where she was not getting all the Exjade she needed really weighed heavily for a G-tube.

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Q. The travel when you went to Schneider Hospital in New York, that was related solely to diagnosis of Diamond Blackfan, right?
A. Completely.
Q. Do you remember when you first decided to consult an attorney in this case?
A. Yes.
Q. When was that?
A. Well, I went -- it was around the time that I was pulling all of her records together, and at that point I had learned more about the whole -- what a CBC was, I mean, not learned more, I actually learned what a CBC was because we were getting them regularly. And I just had more medical knowledge at that point because of everything we had gone through at Summerlin Hospital and then at Denver Children's, and then with the followups with Dr. Rashid.
So when I was reading through the records that I was collecting for the purpose of a centralized database, they included the discharge summary, it had a completely different significance to me than when I had read the discharge summary when I first got it. Like I said, for the first time I realized when I read he was supposed to do a CBC, I was like, Oh, my gosh, this is the test she is getting regularly, this is the test

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that shows that the hemoglobin -- what the hemoglobin levels are. If we had done that in a month, we would have known they were dropping.

And so that was the first time that I realized that he had been told to do that test. I didn't realize it prior to then.

And I can tell I'm getting tired because I'm not even sure I just answered your question.

Q. Do you remember when, what month and year you first consulted an attorney?

A. Okay, it was around that time that I started saying, you know -- and it was around that time that the full scope of her medical needs and the fact that they were going to probably be for the rest of her life was hitting me, that, you know, there wasn't any miracle cure, I was going to have a disabled child. You know, it all kind of came together.

So I went and I talked with someone locally. Meanwhile, I ended up going to this seminar in Texas on traumatic brain injury pulled together by the Sarah Jane Brain Foundation, and I learned about how they had pulled together lawyers all over the country, along with all kind of other medical professionals, experts in their field, and all of this. And that was how -- and I talked to them about my scenario, various people

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there, and that was how I ended up hiring my current attorney. I found out about them and hired them.

Q. When did you first -- when did you contact someone locally here?

A. It was all around the same time, but I'm afraid that the dates are not etched in my mind, I couldn't tell you exactly when.

Q. What year was it?

A. Gosh, all right --

Q. The records show your last visit with Dr. Conti was in July of 2009.

A. Good, because I was thinking around 2009. It does help because that is around the time period that it was kind of all happening.

Q. Okay. So who was the local attorney who you contacted?

A. I don't remember his name, but I know Brian will.

Q. Do you know who E. Robert Spear is?

A. That may well have been the local attorney, I just don't remember. Initially I was looking into the local person, but I just didn't spend much time interacting with him.

Q. Do you remember what month you went to the conference in Texas?

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A. No. It was hot, so --

Q. That was in 2009?

A. Yes.

Q. How was it that you were introduced to your current attorney from that conference?

A. Well, I know they were on the list. And I know I talked to various people there about the reputations of the different attorneys and their specialties and things of that nature. And that was how I selected this firm.

Q. So other than the local attorney, your current counsel is the only one you consulted?

A. Yes. Also the local attorney was going to take it, but I decided that I wanted to go with this firm instead.

Q. Why did you make that decision?

A. Because I felt they had more experience with these types of matters.

Q. Do you know who Mr. Monks was?

A. Yes.

Q. Who was he?

A. He was local counsel, who is now deceased. He was associated or affiliated or -- he was the local counsel that my current attorneys associated themselves with.

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Q. Do you know how they were introduced to Mr. Monks?

A. Yes, I introduced them.

Q. How do you know Mr. Monks?

A. He was an old friend of Brian's.

Q. But he wasn't the local attorney that you talked to initially?

A. No.

Q. Have you ever spoken to any of your experts in this case?

A. No.

Q. After you initially received the discharge summary at Sunrise Hospital, was the next time you reviewed it when you requested the records to put them together kind of in a central repository, that is the next time you reviewed that summary; is that right?

A. Yeah, after, I mean, yeah.

Q. Have you done any research yourself on Diamond Blackfan anemia?

A. Yes.

Q. As part of your research, have you learned that children with Diamond Blackfan generally have any physical -- sometimes physical anomalies?

A. I'm not sure what you mean by physical anomalies.

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Q. Parts of their bodies that aren't developed normally, that look different.
A. I think I did read something about that.
Q. Did you consider MayRose to have any physical anomalies?
A. No.
Q. No, you wouldn't, you don't think that?
A. No, I don't think she outwardly appears to have any physical anomalies.
Q. When you go to doctors' appointments, do you generally write notes of what happens?
A. Not generally, no.
Q. If you go with someone else, does the nanny or whoever else take notes for you?
A. No, because -- no.
Q. Do you have any photographs of MayRose taken from the time period of her discharge from Sunrise Hospital to the time of her crash in October?
A. Yes.
Q. You could produce those if we asked for them?
A. I can.
Q. Do you have any videos of MayRose during that time period?
A. I don't think I have any videos. But I have about a trillion pictures.

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Q. Do you have photographs --
A. Figuratively speaking.
Q. -- do you have photographs or videos taken since the time of her crash that you allege show the injuries she is currently suffering from?
A. Yes.
Q. Can you produce those?
A. Yes.
Q. MayRose is currently unable to sit up on her own; is that correct?
A. That's correct.
Q. She is not crawling?
A. She is not.
Q. She is fed through a G-tube?
A. Yes.
Q. Is she able to feed herself at all or --
A. We do feed her orally as well, but for pleasure and exercise as opposed to for nutrition, and some days go better than other days.
Q. How much do you pay out-of-pocket for each of MayRose's therapies?
A. Well, her hippotherapy is $125 a session, and she goes to that weekly. Her OT and PT sessions are $65 a session, and she does those three times a week. Everything else consists of copays. Those three just

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don't accept my insurance. Ycah, pretty much everything else is copays.
Q. So 125 for hippo, and then 65 each for occupational therapy and physical therapy?
A. Uh-huh.
Q. Was MayRose on Neupogen at some point?
A. She was -- I think that is the steroid, does that sound right to you? No, actually that is the thing that helps her white blood count, I think she was taking that regularly for a while. But that was during her first -- during the first year after her collapse. But she does not take that anymore.
Q. Do you know why the decision was made to discontinue that?
A. Well, yes. Because she doesn't have a problem with white blood cells. And I believe the Neupogen was to stimulate the white blood cells. We only put her on it for a little while because she was having a scenario about once a month where her -- or once every two months where her white blood count would drop. And then she would be hospitalized. And so we were -- during that first year we were hospitalized a lot. And so for a short period of time Dr. Rashid decided maybe we should just keep her on Neupogen for a little while to see if that helped keep her out of the

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hospital. But after that rocky time period, we didn't have any more problems with her white blood counts. So they discontinued the Neupogen.
Q. Does your nanny ever travel with you?
A. My nanny does not, no.
Q. Does anyone other than you and your son ever go to Los Angeles with MayRose?
A. A couple of times I have had my babysitter come with me.
Q. Do you pay her for that time?
A. Yes.
Q. Why would she come with you?
A. Well, during the last hospitalization it was tough with a five year old and a three year old and me. And so she came down for a week of that six-week period to assist for a little bit. And then since that time period there were a couple of times where I had to interview witnesses in connection with a case that I was on, so I asked her to come down so she could watch the kids those extra couple of days I was staying. So I stayed more days to interview witnesses, and I asked her to come down for that time period. It is tough, going down there every three weeks with a three year old and a five year old. So sometimes it is just helpful to have another person.

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Q. When you go down there just for normal visits, how long are you there?
A. You know, we just haven't gotten a complete normal scenario down yet. Because we had a whole week of followup appointments after her July discharge -- or was it a June discharge, I don't know -- but anyway, of that six-week time period, we were home for a couple of weeks, then we had a week of appointments, and then we have been doing every three weeks. We have done that maybe three times so far.
Q. Has a health care provider told you how long, once you get into the routine, how long you will be there each time?
A. Well, I'm shooting for Thursdays and Fridays in general. Unfortunately, sometimes that is not doable because some health care providers don't have hours during that time period. Then we have to add days. But mostly I'm trying to do that.
Q. Let's take a break or I'll pass the witness and let them ask their questions.
(Whereupon, a recess was taken from 4:30 to 4:33.)
EXAMINATION
BY MR. COTTON:
Q. Maybe I didn't hear you correctly, Tiffani,

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you have no recollection of who your OB-GYN was?
A. I just don't remember her name. I have it listed.
Q. She was at Women's Specialty Care?
A. I believe so.
Q. You don't remember her name at all?
A. I saw her like maybe three times three years ago.
Q. That is what I was going to ask you. I think the child was born around 29 weeks, 28, 29 weeks?
A. Yes.
Q. How many times before that time period did you actually see that OB-GYN?
A. Maybe twice because -- not very many because as soon as I found out about -- as soon as she found out about the thick nuchal fold, she sent us to a specialist, and it was the specialist I saw after that.
Q. Was the first specialist you saw the people at the Center for Maternal Fetal Medicine?
A. No, that, I believe, was the second specialist, and that is the one that actually treated me.
Q. Do you believe that the first person you saw as a specialist was somebody from Desert Perinatology?
A. That is probably right.

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Q. So the OB-GYN referred you first to somebody you think at Desert Perinatology --
A. Right.
Q. -- and then you ultimately ended up at the Center for Maternal Fetal Medicine?
A. That's correct.
Q. Why did Desert Perinatology transfer you down there?
A. Because they could not -- there was a test that could be done right away for the chromosomal defect, but he couldn't do it. And but she could.
Q. But you don't remember the name of the person at Desert Perinatology?
A. No, it was a man, and I wouldn't be surprised if Brian remembers, but I don't remember.
Q. Generally I know that perinatologists don't deliver children. Did a perinatologist deliver your child or did an OB-GYN?
A. An OB-GYN.
Q. Is that the one whose name you can't remember?
A. No, hers, Dr. Kendricks, she was on staff or she was the person -- the OB-GYN on call at Sunrise.
Q. So Dr. Kendricks was the one that actually delivered MayRose?

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A. I believe that was her name, yes, Dr. Kendricks.
Q. Was the delivery a planned delivery or an emergent delivery?
A. Both. It was -- there were -- I was there in the hospital for a few days, two or three days, and a decision was made that before she had any more moments of distress, while she was still strong, we should deliver her.
Q. Who made that decision with you, Dr. Kendricks or some other doctor?
A. Dr. Kendricks.
Q. Was a perinatologist called in on a consult?
A. Yes.
Q. Do you remember the name of the person?
A. No, it was a guy. It wasn't the one who normally treated me, who was a woman.
Q. Dr. Iriye or Wilson Huang, does that sound familiar at all?
A. I really don't remember. I don't think I had met him.
Q. Now shortly after the little girl was born, she was hospitalized on May 14. Do you have any independent recollection of meeting my client, Dr. Blahnik at that point?

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A. No.
Q. Let me ask you this, may save some time. As you sit here today, can you recall any specific conversation you had with Dr. Blahnik at all?
A. No.
Q. Can you recall specifically any conversation you ever had with Dr. Piroozi?
A. I really can't recall -- I can recall conversations I had, I just can't recall which one it was with.
Q. The reason I'm asking, there were other doctors, neonatologists besides Dr. Blahnik and Dr. Piroozi involved in the care of your little girl, you know that?
A. I do know that.
Q. These conversations were related to us earlier on counsel's exam, you don't know which one of those doctors said those things?
A. Well, I know that I repeated myself a lot, but I'm not going to be able to definitively say I said this to this person at this moment in time because my memory doesn't work that way. But I just recall the topics and it came up often.
Q. But as to any of the statements you related to us, you don't recall one way or the other whether it

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was Dr. Blahnik, Dr. Piroozi, or somebody else?
A. No.
Q. Now it wasn't some secret to you while the little girl was in the hospital from May 14 until August 2nd she was anemic, correct?
A. Correct.
Q. The doctors didn't hide that from you?
A. No.
Q. You knew she was getting regular transfusions?
A. Yes.
Q. In the roughly month or so before her discharge, were you advised by the doctors that her hematocrit and hemoglobin levels were relatively normal?
A. There is a possibility.
Q. Well, did doctors at any point in time up to discharge advise you in the last month that she was there they never dropped below normal?
A. I don't recall because that really wasn't the focus of my discussions with them because I believed them when they said it was routine anemia of prematurity. So I was more focused on things like her white blood count when it got high, and she needed antibiotics and things like that.

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Q. Again, you are not a doctor to know whether that was significant or not, right?
A. That's correct, I am not a doctor.
Q. Now on discharge you were given the discharge summary we looked at earlier today, correct?
A. Correct.
Q. You read it?
A. I did.
Q. Again, did you go over any of the items in here that were supposed to be followed up on with Dr. Conti in the first visit you had with him?
A. Only the ones that I was supposed to do.
Q. You just assumed he was going to do the others?
A. Yeah. I thought that was why I was handing him the -- why it was so important to hand him the forms, so that he would know what he had to do, and I talked to him about what I was supposed to do.
Q. Now when your daughter went back into the hospital on October of 2008, towards late October of 2008 over at Summerlin, who was her admitting doctor there, do you remember?
A. I know one of her treating doctors was Dr. Frank, but I don't remember who her admitting doctor was. It may have been -- actually I think he

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was Asian. But I don't remember his name. I don't remember.
Q. Now it appears from the records that the admitting diagnosis was apnea, severe anemic shock, respiratory failure, bradycardia, and rule out sepsis. Do you remember them raising those concerns with you?
A. I remember reading that. I remember, and that was later, but I remember talking to them about double pneumonia or -- yeah, double pneumonia and influenza.
Q. Did either Dr. Weber or Dr. Conti follow MayRose in the hospital at this hospitalization?
A. I called Dr. Conti and I talked to him a couple of times, and he told me that he was going to keep on top of it. Whether he did, I have no idea.
Q. To your knowledge was her care taken care of by a pediatric hospitalist as opposed to Dr. Conti?
A. I'm sorry?
Q. Was there a separate doctor that was day-to-day managing her care while she was in the hospital?
A. Well, I believe that the intensive care doctors were managing her care.
Q. Pediatric intensive care?
A. That was my understanding.

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Q. At some point in time did somebody in pediatric intensive care tell you that the little girl had been diagnosed with Diamond Blackfan?
A. Oh, no.
Q. During that entire hospitalization did anybody come to that diagnosis?
A. No. It wasn't until towards the end that -- maybe towards the middle to end that they started even really talking about it. And we were told that it was going to take a little bit of time to actually diagnose what was going on with the blood count and since we were going to -- but that since she didn't need to continue to be admitted, it was going to be followed up on upon her discharge. However, we went straight to Denver Children's and so it ended up being followed up on there as opposed to by Dr. Rashid.
Q. How long was MayRose in the hospital on this October 29 hospitalization?
A. For the entire month of November.
Q. Past Thanksgiving?
A. I believe so, yeah.
Q. Did you guys go right away up to Denver Children's Hospital?
A. We did immediately.
Q. How long was she in Denver Children's

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Hospital?
A. For about three weeks.
Q. During that three-week period of time, December, January -- December basically, right?
A. Yes.
Q. Did someone there diagnose Diamond Blackfan syndrome?
A. They tentatively diagnosed it.
Q. Do you remember the first person, doctor who told you that that is what they thought it was?
A. It might have been Dr. Sullivan, I think he was in charge, but there was a whole team of doctors involved, so I'm not completely certain who the first person was who told me.
Q. So I have it correctly then, during that entire hospitalization of about a month at Summerlin Hospital, nobody there diagnosed Diamond Blackfan?
A. They weren't even looking at that part.
Q. My question is did anybody ever tell you there that they had diagnosed Diamond Blackfan?
A. No.
Q. In terms of treatment of MayRose's Diamond Blackfan syndrome, the only doctors who are actually treating her for that were the ones at LA Children's?
A. No.

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Q. You have somebody here that is treating --
A. Dr. Rashid.
Q. Other than Dr. Rashid and the people at LA Children's, anyone else treating her for that syndrome?
A. No.
Q. Have any of the doctors -- I don't like to ask this question -- but have any of the doctors treating MayRose indicated to you anything at all about what her life expectancy might be?
A. No. I've read about that sort of thing, but nobody has.
Q. None of the doctors have said a thing about it?
A. No.
Q. I think that is all I've got.
(At 4:46 Ms. Urdaz began her examination.)
EXAMINATION
BY MS. URDAZ:
Q. I introduced myself earlier, my name is Jonquil Urdaz, I represent Sunrise Hospital. Is it okay if I call you Tiffani?
A. Yes.
Q. I promise to be brief.
A. Okay.

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Q. For this lawsuit do you have any allegations against any of the nurses or staff at Sunrise Hospital?
A. No.
Q. Do you have any criticisms of the care they provided?
A. I am unaware of any problems involving them.
Q. Okay. Have you been back to Sunrise Hospital since the discharge on August 2, 2008?
A. Yes.
Q. How many times have you gone back approximately?
A. We -- oh, a lot.
Q. Would you say more than ten?
A. Yes.
Q. More than 20?
A. Probably, because we were getting outpatient transfusions there. So we have been back a lot.
Q. When you first went in to Sunrise Hospital that ended up meaning you were going to deliver MayRose, do you recall going through the admission forms when you were admitted that day?
A. I do not. But I know that I signed a whole bunch of forms when I was admitted that day.
Q. Did you review those forms at that point in time when you were signing them?

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A. Probably not. But -- you know, initially when I went there, I wasn't being admitted. So I'm not sure -- I'm not sure that I signed a whole bunch of admission forms when I first arrived. But I'm sure at some point I did sign forms. If I read them, I don't remember now. Sometimes -- sometimes I do and sometimes they look standard and I don't.

Q. Do you recall that day reviewing a consent to treatment form?

A. I'm sure I did.

Q. I'm going to mark as Defendants' Exhibit A the Conditions of Admission and Authorization For Medical Treatment, it is SH2578.

(Defendants' Exhibit A was marked.)

BY MS. URDAZ:

Q. Does that form look familiar to you at all?

A. Yes.

Q. Do you recall receiving that upon admission or being at Sunrise Hospital for treatment?

A. I highly doubt that I read it, but I most definitely signed it.

Q. That is your signature?

A. That is my signature.

Q. And that signature was to represent that you have reviewed and signed that document?

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A. That I -- yeah.

Q. You were consenting to treatment?

A. That I was consenting, yes, to treatment.

Q. And you were consenting to the authorization of the physicians who had privileges at the hospital to treat you; is that correct?

A. Correct.

Q. We talked quite a bit about your discharge from Sunrise Hospital, I believe on August 2, 2008?

A. Correct.

Q. And we reviewed the discharge summary that you were to give Dr. Conti, correct?

A. Correct.

Q. Do you recall a different form being given to you and reviewed with one of the nurses prior to discharge?

A. It sounds familiar. There may have been something about car seats, I don't know.

Q. Okay, and I will give you what I'm going to mark as Defendants' Exhibit B, it is SH2562. Why don't you go ahead and review that and see if it looks familiar to you.

(Defendants' Exhibit B was marked.)

THE WITNESS: It does look familiar to me.

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BY MS. URDAZ:

Q. If you can look at the last page, there is a signature on the bottom. Is that your signature?

A. That is my signature.

Q. Did you sign that under acknowledgment that you had been explained the discharge instructions?

A. I did.

Q. Do you recall receiving a copy of that to take home with you?

A. I believe I did.

Q. Was Mr. Abbington with you when they were going through the discharge instructions?

A. He was.

Q. Did you have an opportunity to ask any questions about what was within those discharge instructions?

A. I did.

Q. Okay, now I believe in the middle of the last page there is some instructions, what needs to be followed up on, the very last page in the middle in capital letters. Second to the last page, I'm sorry, right above your signature.

A. Yes.

Q. Do you recall that portion being reviewed with you by the nurse before you were discharged?

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A. Yes.

Q. Can you read out loud what that portion states?

A. OT/PT/ST one to two times a week for six months. Script given to parents. Sweat test at three months of age. CBC with differential, one month after discharge. Head J/S, one month after discharge.

Q. Were you given a prescription for that first part when they reviewed the discharge instructions with you?

A. Yes.

Q. Do you recall having any questions about any of those instructions?

A. I didn't.

Q. I don't think I have any -- oh, I do have one question. Does Tristin have anemia also?

A. No.

Q. That is good. If you will give that to the court reporter and I think I'm done.

MS. ROSENTHAL: Just a couple of questions, I'll be brief.

FURTHER EXAMINATION

BY MS. ROSENTHAL:

Q. Did any doctor at Foothills Pediatrics during the entire time you treated there ever mention

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performing a hemoglobin test in the office?
A. No.
Q. Did you ever try to contact Dr. Conti after you left his practice?
A. Only to get records.
Q. Other than to get medical records, there was no other contact with his practice?
A. I don't think so. Because I think I was trying to get -- actually, I may not have even contacted them for records. I think I got those -- I know I got those before I left. So I think that I've been -- still get bills from them. But I think that may have been it. I don't remember contacting, talking to them.
Q. You said you still get bills from Dr. Conti's office?
A. Uh-huh.
Q. Do you know how much you owe Dr. Conti's office, what the bills are for?
A. No, maybe $50 or something.
Q. That are still outstanding?
A. That bill is, yes.
Q. Did the babysitter, not the nanny, but did any of your babysitters ever go to any appointments with MayRose?

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A. Yes.
Q. Do you know which babysitter went to appointments?
A. Only with him at his office, only Tobi.
Q. But did your other babysitter, has she ever gone to any of MayRose's medical appointments, the other babysitter?
A. She has been to a few with me.
Q. Did the prior babysitters ever go to any of MayRose's medical appointments?
A. Hospitalizations, yes. And there were times when ISS therapists would come to the house that they would be there because they would sometimes come in the afternoon.
Q. Did Mr. Abbington see MayRose at any time from October 24, 2008, when she left Dr. Conti's office, to October 29 when she went to the hospital?
A. Yes.
Q. When did he see her during that time frame?
A. Regularly.
Q. It was over a weekend, so he would have seen her over the weekend?
A. It would normally be a weekend, yes.
Q. Did he mention any concerns he saw in her during that time period to you?

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A. He and I constantly discussed her status, and what was going on with her in visits. And, I mean, her health was of such a concern to us, we were always having discussions about it.
Q. Do you remember him saying to you, Hey, I'm really worried about whatever X that I'm observing in her right now?
A. He was always really worried about her. So it is hard for me to answer. I mean, you are asking me did he -- was there any outside-of-the-ordinary worry?
Q. Yes.
A. I don't think I recall him expressing an outside-of-the-ordinary worry. But Brian was always worried about her condition, her development, I mean, he just constantly worried, which, you know, after three months in NICU, that is just how he was.
Q. Did you create the MayRoseLili Foundation for blind infants, toddlers and preschoolers?
A. I did.
Q. Is that organization still in existence?
A. No, nobody wanted to participate. And then I ran out of -- I didn't really have any time. It was ambitious to try to -- unfortunately, there is nothing here like that in Las Vegas. The anchor center for blind children is in Colorado and for a while we were

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going back and forth to Denver Children's Hospital following up there until it just became impossible. And I haven't found a place like it, like the anchor center for blind toddlers here or even in Los Angeles. So --
Q. So did you actually set up the MayRoseLili Foundation or you were in the process and just never completed the process?
A. I set it up. I filed business papers, nonprofit organization, got a tax ID number, sent the link to everyone I could think of, and got lots of hits, but nobody who was interested in actually donating funds for it to get off the ground.
Q. You created a website, MayRosehurst.org?
A. Yes.
Q. Is all the information on that website something that you have created yourself?
A. Well, I pulled in a lot of information from surfing the internet on different conditions that she is suffering from.
Q. So you do your research on the internet and then you put it together how you want it, and you have created all the content that is on the website?
A. Yeah, most of it came from different other sites, just collected that information.

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Q. How often do you change the content on the website?

A. Not nearly as often as I originally anticipated. Because mainly the two functions of the website, the first one was to have a centralized recordkeeping database for her. So that was the primary motivation.

Then when I found out that the only care provider who would look at it was Dr. Raja, I gave up at that point. So now I just update it maybe once every six months or so. If there is a significant difference in medications, that tends to prompt me, significant change in medications, that tends to prompt me.

Q. So you first created this website in 2009 approximately?

A. Uh-huh.

Q. Do you remember what month? If your last appointment with Dr. Conti was in July of 2009, was it prior to that?

A. I don't remember at all. I just remember it was an ongoing process. I had this great idea I could coordinate everybody using a website, and it didn't really work. And around that time I was also trying, you know, to figure out what I was going to do about

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her cortical visual impairment, so I just combined both.

Q. When you make changes to the website, do you somehow keep -- save the previous version before you make the changes?

A. No.

Q. So you don't have any documentation of the different changes you have made throughout the course of this website?

A. No.

Q. You have a section in there that is for MayRose's medical records that is password protected?

A. Yes.

Q. What is the password?

A. Okay, I believe that it is 042769. However, if that turns out to be inaccurate, I do have it written down.

Q. You have a section on here where you can pay a medical bill for MayRose. And the only medical bill you said was ever paid was by your aunt and uncle?

A. Yeah.

Q. And you got a $1000 donation?

A. Uh-huh.

Q. I had looked at your website a while ago, and you used to have a section on there that was MayRose's

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Blog that is no longer on your website. Is there a reason you took that off?

A. No. 1, I could never figure out how to use it properly, that was first and foremost. And No. 2, I just -- once it became clear that the medical providers weren't going to use -- pay any attention to it, I lost the incentive to figure out how to update the blog. So I just deleted it, since I wasn't making any entries on it.

Q. You also used to have a section entitled therapy videos that is no longer there?

A. That was another area that turned out to be a challenge. I tried to upload therapy videos and I just couldn't get it reduced to the right -- you can only upload so many minutes of footage, and I couldn't figure out how to make it so that it was small enough to upload it. Then I tried to do YouTube and that didn't work, and once again because the care providers weren't using it anyway, I stopped trying to figure out how to do that.

Q. Do you still have those therapy videos then of MayRose?

A. I have a few, a couple. I had gotten an ADT system and the whole theory at one point was I was going to download her regular therapy sessions and

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upload them and since we still had providers here and providers there at CHLA, they would be able to look at them at CHLA. It was a great theory, I just wasn't sophisticated enough to do it. So I deleted it.

Q. Okay.

A. But the -- I changed my room around, I haven't figured out how to get the ADT working again, so I know there are some therapy sessions still on that, and I'm sure there is somebody who can access them, just not me right now. But they are available to be accessed. Then I just have a few from Denver Children's, I think, that might still be hanging around.

Q. That is all I have.

MS. URDAZ: I have a few quick followups, I promise.

(At 5:08 Ms. Urdaz began her further examination.)

FURTHER EXAMINATION

BY MS. URDAZ:

Q. During your hospitalization with MayRose from May to August of '08, did you have an understanding as to whether Dr. Blahnik and Dr. Piroozi were part of a doctors' group?

A. I had no understanding of that. I didn't

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have an understanding of that whole concept until after Summerlin, because the group at Summerlin Hospital doesn't accept -- didn't accept my insurance. And nobody -- that is not something they advertise, that you could actually go to a hospital that accepts your insurance, but that the care providers are not employees of the hospital, they could be contracted, and that their group might not accept your medical insurance. So that was the first -- so when I got a $15,000 bill from them, that was the first time I learned about contracting, and the fact that they are not employees of the hospital.

Q. Did you receive a separate bill from Blahnik and Piroozi from your stay at Sunrise Hospital, talking about MayRose's care?

A. I think I have a bill from them too. I know I have like a 2500-dollar bill from that time period. I have a ton of bills.

Q. I don't have anything else.

MS. CARMICHAEL: In Nevada do you declare your intention to read and sign on the record? We would like the opportunity to do that.

Would you mail the deposition directly to the deponent's address please.

(The deposition concluded at 5:09 p.m.)

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DECLARATION OF DEPONENT

I do solemnly swear under penalty of perjury under the laws of the State of Nevada that the foregoing is my deposition under oath; are the questions asked of me and my answers thereto; that I have read same and have made the necessary corrections, additions, or changes to my answers that I deem necessary. In witness thereof, I hereby subscribe my name this_____day of_____, 2___.

_____

TIFFANI HURST, Deponent

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CERTIFICATE OF REPORTER

The undersigned Certified Shorthand Reporter, licensed in the States of California and Nevada does hereby certify:

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed, said transcript being a true copy of my shorthand notes thereof.

That the dismantling of the original transcript will void the reporter's certificate.

I further declare that I have no interest in the outcome of the action.

In witness thereof, I have subscribed my name this 1st day of September, 2011.

_____

MARY DANE McCOY, CA CSR NO. 8216
NV CCR NO. 219

EXHIBIT B

NEONATAL ADMISSION HISTORY & PHYSICAL

Hurst, baby girl

Mother: Tiffani Hurst
Birth weight: **1280 gms (2 lbs, 13 oz)**
Singleton Gestation

Neonatologist: **Martin Blahnik, M.D.**
Admitting Physician:
Follow-up Physician:
Delivering Obstetrician:
Delivery date: 5/14/2008 time: 00:06

MATERNAL HISTORY

The infant was born at 28 6/7 weeks (by dates) to a 39 year old woman who was G 3 and P 2 (TAB 1) at the time of delivery. EDD was 7/31/2008

Prenatal Labs: Blood Type: **O** Rh: **pos** Antibody: **nonrespon** Hepatitis B: **negative**
Rubella status: **immune** RPR: **nonreactive** Length ROM: **Ruptured at delivery.**

GBS Status: **unknown**

Maternal diagnoses and procedures during the pregnancy, labor and delivery included:

Antepartum events: None noted. L&D events: Advanced Maternal Age (multiparous), Preterm labor with delivery, Terbutaline, Indocin, Steroids - complete course
Mom admitted 5/12 to the hospital. PTL w/ FHR decels and non-reassuring strip, AROM at the time of repeat C-section. AFI WNL. Pt admitted for flank pain / then non-reassuring FHR. Meds included PNV, beta-methasone, procardia, terbutaline, indocin, pitocin. Urine tox negative.

DELIVERY **Cesarean, unspecified**

Apgars 1 min: **03** 5 min: **06** 10 min: **07**

Resuscitation: 02, mask vent
Martin Blahnik, M.D. was called to the delivery room because of Preterm baby. Delivery analgesia used: spinal. Suctioning at delivery: bulb. The respiratory effort at birth was delayed 1 min. Delivery outcome: live birth admitted t ICN.
CPAP given for poor respiratory effort. Pulse ox increase on 60% 02 to low 80s, then higher on CPAP so that 02 wa weaned to less than 50% with good sats and improved respiratory effort after 5min.

ADMISSION HISTORY

ADMISSION EXAMINATION

Weight (g): 1280 (2 lbs, 13 oz) Length (cm): 37 Head circ (cm): 27.5
GA Exam: 28 6/7 wks AGA

VITAL SIGNS: Temperature: 36.8 Heart rate: 150 Respiratory rate: 30 Blood pressure: 40-40 / 18-20 Mean BP: 22-23 Oxygen saturation: 93
GENERAL: CPAP in place, immature infant, exam consistent with dates
SKIN: no icterus or rashes
HEAD: open, flat anterior fontanelle
EYES: normal shape and size
EARS: immature cartilage, normally set, no anomalies
NOSE & MOUTH: nares appear patent, intact palate
NECK & CLAVICLES: no masses, clavicles intact
LUNGS & CHEST: CTA with some grunting
CARDIAC: normal rate and rhythm, no murmurs, pulses equal in all 4 extremities
ABDOMEN & CORD: no hepatomegaly, 3 vessel cord
GENITALIA: immature female external genitalia, appropriate for age
BACK & SPINE: straight spine
LIMBS & HIPS: symmetric, moves all 4 limbs, 10 fingers and toes
NEUROLOGIC: appropriate strength and tone for gestational age

5/14/2008 00:30

NEONATAL ADMISSION HISTORY & PHYSICAL

SOCIAL HISTORY: Father at the delivery and in the NICU. Mom saw baby in the OR.

ASSESSMENTS & PLANS

ASSESSMENT: AGA 28 6/7 wks female born by C-section for repeat / PTL / non-reassuring FHT, stablized on CPAP, with grunting intubated and given one dose of surfactant before 1hr of age and immediately extubated.
ADMIT DIAGNOSES: Hypoglycemia (admit), Prematurity (admit), Respiratory distress (admit), Suspected sepsis (admit)
ADMIT PLAN: 1) CPAP post-extubation after 1x dose surfactant; 2) check CXR; 3) check ABG; 4) UAC / UVC placed; 5) first chem-strip 27, received D10 push 2cc/kg, check f/u; 6) total fluids 100cc/kg/day; 7) keep sats 85-92% 8) CBC, CRP, chemistries per routine; 9) amp / gent; 10) OB Dr. Dickens updated; 11) family updated

Martin Blahnik, M.D.