

COMMONWEALTH OF KENTUCKY  
MUHLENBERG CIRCUIT COURT  
CIVIL ACTION NO.: 20-CI-00370

KRYSTAL GEARY, Mother and Guardian

JASE AYDEN RAY FOSTER

PLAINTIFFS

vs.

THE COMMUNITY HOSPITAL, INC.

a/k/a OWENSBORO HEALTH

MUHLENBERG COMMUNITY HOSPITAL

DEFENDANTS

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VIDEOTAPED DEPOSITION OF JILL BALDWIN, APRN

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LOUISVILLE, KENTUCKY

MAY 14, 2025

PAUL A. KLAPHEKE, CCR

CERTIFIED COURT REPORTER

1 THE DEPOSITION of JILL BALDWIN, APRN,  
 2 taken pursuant to notice, on May 14th, 2025, in the  
 3 offices of Sheffer & Monhollen, 500 W. Jefferson  
 4 Street, Suite 1240, Louisville, Kentucky, said  
 5 deposition being taken on oral examination, to be  
 6 used in accordance with Kentucky Rules of Civil  
 7 Procedure.

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11 APPEARANCES

12  
 13  
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23 Also Present: Mable Barnes - Videographer  
 24  
 25 - - -

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1 THE VIDEOGRAPHER: We are on video  
 2 record, here to take the deposition of Jill  
 3 Baldwin, APRN, in the matter of Crystal Geary, et  
 4 al. Versus the Community Hospital, Inc., et al.,  
 5 in the Muhl -- Muhlenberg Circuit Court, excuse me,  
 6 Action No. 20-CI-00370.

7 Today's date is May the 14th, 2025.  
 8 The time now is 9.35 a.m.

9 I am Mabel Barnes, the video  
 10 technician. The court reporter is Paul Klapheke.

11 Will the attorneys introduce  
 12 themselves and state whom they represent, please?

13 MR. KINNEY: Martin Kinney for the  
 14 Plaintiff.

15 MR. MONHOLLEN: Phil Monhollen here  
 16 for the Defendant.

17 JILL BALDWIN, APRN, the said witness,  
 18 having been first duly sworn, was examined and  
 19 testified as follows:

20 DIRECT EXAMINATION

21 BY MR. KINNEY:

22 Q. Good morning.

23 A. Good morning.

24 Q. Would you state your full name?

25 A. Jill Baldwin.

1 Q. Ms. Baldwin, what is your home  
 2 address?

3 A. My home address currently is 12914  
 4 Observation Circle, #102, Louisville, Kentucky  
 5 40243.

6 Q. And do you have a separate address for  
 7 your business location?

8 A. I have not. I've moved since I took  
 9 this case, so that's why you're seeing two  
 10 different addresses.

11 Q. So where do you do your work as an  
 12 expert? Is it out of your home?

13 A. Out of my home.

14 Q. Okay. And was it different at one  
 15 time?

16 A. I've always worked out of my home, but  
 17 I'm in a different location now.

18 Q. And are you also working as a nurse  
 19 practitioner, as well?

20 A. Yes.

21 Q. And tell me a bit about that.

22 A. I work at two different locations. I  
 23 currently am -- am a family nurse practitioner.

24 Do you need these resumes?

25 Q. I have them.

1 A. Okay. I don't know if I sent him an  
2 updated one or not.

3 So I work in two locations.  
4 I currently work two days a week as a family nurse  
5 practitioner in LaGrange, Kentucky, where I  
6 provide primary care for uninsured families.

7 And then I also cover a solo private  
8 physician practice, it's a direct primary care  
9 practice, at Genesis One Health, and that's  
10 as-needed work. Sometimes I cover a day a month,  
11 sometimes I cover a week or more, take call.  
12 It depends on what the provider needs.

13 Q. In terms of your business, is the bulk  
14 of your time spent working as an expert?

15 A. No. No. My time is about 70 percent  
16 clinical, 30 percent expert.

17 Q. Okay. So you and I have met before?

18 A. We have.

19 Q. How many cases have we worked on  
20 together?

21 A. Two.

22 Q. And I remember the Bryant case.

23 Any other cases?

24 A. Right. So the Bryant case was the  
25 first case, and then the other case was a wound

1 care case, I believe, out of an LTAC in Evansville.  
2 I didn't find any merit in that case. I think you  
3 chose not to take it.

4 Q. I think that's the case where you  
5 shared some literature with me.

6 A. Yeah. I explained to you why this  
7 wound care in the middle of COVID. And then you  
8 subsequently referred me to Mike Kelly, I believe,  
9 who also, his case, I found some merit in, but that  
10 case has since settled.

11 Q. Okay. Have you seen the deposition  
12 notice for your deposition today?

13 A. I have. I don't have a copy with  
14 me.

15 MR. KINNEY: Okay. I'll share a copy  
16 with you. We'll mark it as Exhibit 1 to the  
17 deposition.

18 (Whereupon, Exhibit No. 1 was marked  
19 for identification.)

20 THE WITNESS: Thank you.

21 Q. Now, the CV that I have may not be  
22 current. I know you just passed out a CV to  
23 everyone.

24 A. It's not.

1 Q. It's not? All right.

2 A. I think that the picture's updated,  
3 frankly. I think it's all that's different on that  
4 CV, and the address.

5 MR. KINNEY: All right. We'll --  
6 we'll mark and file as Exhibit 2, your CV.

7 (Whereupon, Exhibit No. 2 was marked  
8 for identification.)

9 Q. And you said the only difference  
10 between the one I have and this one would be the  
11 photograph on the first page?

12 A. I think so. I haven't changed  
13 positions, employment, since then.

14 Q. You have a list of presentations on  
15 your CV.

16 Do any of these presentations apply to  
17 the issues in this case?

18 A. Yes.

19 So, number 1 is listed as a current  
20 update for essential ER management of  
21 stroke, pulmonary embolism, myocardial infarction  
22 and sepsis. That was presented in '21 to the  
23 American Academy of Legal Nurse Consultants Annual  
24 Conference. That directly deals with the issue of  
25 sepsis.

1 Q. Does it deal with the handling of a  
2 critical result and the conveyance of that result  
3 from the laboratory to the appropriate part of  
4 the hospital?

5 A. No. But it does deal with the  
6 standards of care regarding medical services  
7 offered in the emergency department to patients of  
8 suspected sepsis.

9 Q. In terms of patients with suspected  
10 sepsis or with a potential infection, is it  
11 standard to order a blood culture?

12 A. It is.

13 Q. And have you in your work in the  
14 emergency departments in your -- I think in your  
15 background, have you ordered such tests?

16 A. Yes --

17 Q. For like how --

18 A. Many times.

19 Q. -- for like how --

20 A. In the emergency department, many  
21 times.

22 Q. What about the other articles that may  
23 have applications? I meant presentations.

24 A. Presentations?

25 Q. Yeah.

1 A. Yes, I think that's the only one that  
 2 would apply to my opinion today.  
 3 Q. Okay. And then in terms of your  
 4 teaching, you're not currently teaching?  
 5 A. I'm not. On occasion, I will  
 6 have nurse practitioner students at the clinic, in  
 7 the clinical site, my colleague and I, but as far  
 8 as being in a clinical -- sorry, in a -- in a  
 9 professorship or didactic position, I am not.  
 10 Q. In terms of your teaching background,  
 11 have you ever provided teaching to your students  
 12 with regard to the handling of critical results and  
 13 the manner in which they should be conveyed from  
 14 the laboratory to the appropriate part of the  
 15 hospital?  
 16 A. I am showing the clinical setting.  
 17 At that time, I've had discussions with students  
 18 about how handle -- how to handle critical labs,  
 19 but different procedures are at different  
 20 facilities.  
 21 Q. I'm not sure we got all of your  
 22 answer, but you said yes, you would -- would talk  
 23 about clinical laboratory results with your  
 24 students?  
 25 A. If they're in the clinical setting and

1 A. I'm not suggesting that. I'm  
 2 suggesting that the ER is a different environment  
 3 than a medical-surgical unit, where I taught.  
 4 Q. We're going to be talking about  
 5 policies here.  
 6 You recognize that the two policies  
 7 that we're going to talk about both emphasize the  
 8 importance of documentation?  
 9 A. I understand it's included in the  
 10 policy, yes.  
 11 Q. And are you going to be taking the  
 12 position in this case that it's not a requirement  
 13 that nursing personnel document the time they  
 14 receive a critical result, what they do with their  
 15 critical result, and what time that they conveyed  
 16 that critical result to the appropriate person?  
 17 A. No, I'm not going to say that  
 18 documentation isn't important.  
 19 Q. Okay. So we agree it's important?  
 20 A. Documentation is important, yes.  
 21 Q. All right. Any articles that you've  
 22 authored, that would be pertinent or would have  
 23 application to the issues in our case?  
 24 A. No, I do not have publications.  
 25 Q. Okay. When we talk about your work in

1 they have a patient who had a critically --  
 2 critical result value, we would talk about how to  
 3 handle that or what to do with it. As far as the  
 4 procedure in that particular facility where I was  
 5 doing clinicals with students, no.  
 6 Q. Can we agree that a -- a positive  
 7 blood culture is a critical result?  
 8 A. We can.  
 9 Q. And is that potentially life  
 10 threatening?  
 11 A. It can be.  
 12 Q. And in terms of how you would instruct  
 13 your students in the handling of such a result,  
 14 would you be instructing them of the importance to  
 15 document what they do with the result?  
 16 A. When the patient is -- when the  
 17 patient is in inpatient and they're caring for that  
 18 patient at that moment, then it ends up in the  
 19 record, yes. I would have been on like a  
 20 medical-surgical unit with nursing staff, not in  
 21 the ER.  
 22 Q. Are you suggesting that personnel in  
 23 the emergency department are not responsible for  
 24 documenting what they do in terms of the handling  
 25 of a critical result?

1 the emergency room, it looks like there's overlap.  
 2 Was this with the same entity, or were  
 3 these two different entities that you were working  
 4 in the emergency department for?  
 5 A. Yes. I wasn't exactly sure how to  
 6 explain them on the CV. So I began working with  
 7 Louisville Emergency Medical Associates, and we  
 8 covered Norton Brownsboro and Norton Downtown. We  
 9 subsequent -- subsequently were absorbed into SEMS,  
 10 Southern Emergency Medical Services, which is the  
 11 one right above it, pretty quickly into my  
 12 employment with them.  
 13 So actually -- yeah. So it says 2011  
 14 is about the time we were absorbed into SEMS. So  
 15 that's why I tried to include both of those, but  
 16 didn't really know how to make that clear.  
 17 Q. All right. But to say it back to you,  
 18 from 2010 to 2021, you were working in an emergency  
 19 room setting as a nurse practitioner?  
 20 A. Yes. And I was also doing that in  
 21 2001 to 2005, with Midwest Medical Management in  
 22 Shelbyville, Indiana. And that emergency room is  
 23 very similar to the ER we're talking about today.  
 24 It's an ER with 11 beds, and there was 1 physician  
 25 and 1 nurse -- or 1 nurse practitioner on duty. So

1 a total of, I think, 16 years in the ER.

2 Q. During the -- the stint from 2001 to  
3 2005, would you ever serve as a charge nurse?

4 A. I would have been the nurse  
5 practitioner seeing patients at that time and would  
6 have received -- you know, had communication with  
7 the charge nurse and nursing staff.

8 Q. Okay. And did Midwest Medical  
9 Management have a policy that was specific to the  
10 handling of critical results for the laboratory?

11 A. In regard to what role?

12 Q. Just in general, as much as we have  
13 here.

14 Was there a policy in place?

15 A. There's not a policy that I'm aware  
16 of. I received information from nursing staff  
17 regarding critical labs and --

18 Q. I'm talking about a written policy.

19 Was there a written policy?

20 A. Not that I'm aware of.

21 Q. Okay. And what about from 2011 to  
22 2021, during that stint, was -- did that -- did  
23 either Louisville Emergency Medical Associates or  
24 Southern Emergency Medical Specialists have any  
25 type of policy that would apply to the handling of

1 critical results?

2 A. I don't recall a specific policy. I  
3 can tell you that we use the Inbox and Epic on a  
4 regular basis, and we're required to go through it  
5 at the beginning of our shift.

6 Q. My question was very specific.

7 Was there a --

8 A. Yeah.

9 Q. -- written policy in place for the  
10 handling of critical results at the -- either at  
11 Louisville Emergency Medical Associates or Southern  
12 Emergency Medical Specialists, while you worked  
13 there from 2010 to 2021?

14 A. I'm assuming the hospital had a  
15 policy. I don't recall seeing it.

16 Q. Okay. So the hospital would have had  
17 the policy?

18 A. Correct.

19 Q. And were you required to be familiar  
20 with those policies?

21 A. I wasn't an employee of the hospital.

22 Q. That's not my question.

23 Were you --

24 A. No, because I would not have been an  
25 employee of the hospital.

1 Q. So the -- the critical result policy,  
2 to the -- to the extent it existed, either -- well,  
3 during 2000-2021 at those hospitals where you were  
4 working, you weren't required to be familiar with  
5 those policies, nor were you required to follow  
6 those policies?

7 A. I was medical staff at that point, and  
8 so I would have interacted with the nursing staff  
9 who would have had policies that they answered to  
10 at the hospital level.

11 Q. So the nurses you worked with would  
12 have been responsible for understanding and  
13 following the critical result policy that was in  
14 place at those hospitals?

15 A. That's my understanding, yes.

16 Q. Okay. And what was that policy?

17 A. The policy was that they would receive  
18 notification of critical lab work from the  
19 emergency department, and they would bring it  
20 directly to a provider. And at that point, we were  
21 responsible for opening the chart, assessing the  
22 situation and making a decision about care for that  
23 patient.

24 Q. I -- you may have misspoke, you may  
25 not have, you said the notification would come from

1 the emergency department.

2 Wouldn't the notification --

3 A. Oh.

4 Q. -- of a critical result come from the  
5 laboratory, ma'am?

6 A. I'm sorry. Ask that again. If I  
7 misspoke, I need to clarify.

8 Q. All right. I asked you what the  
9 policy was for handling critical results at the  
10 hospitals you worked at from 2010 to 2021.

11 A. In regards to myself in that role, or  
12 in regards to that specific hospital?

13 Q. The policy that was in place at those  
14 hospitals that applied to the nursing staff that  
15 you worked with?

16 A. Yes. I had earlier explained that the  
17 nurses respond to the policy.

18 Q. What is the policy, that's all I'm  
19 asking?

20 A. I didn't work for the hospital. I  
21 don't know --

22 Q. I didn't ask you that.

23 A. -- exactly what their policy is.

24 Q. So you didn't know what the policy  
25 was?

1 A. I'm not -- no. I'm working in a  
2 clinical position at that point.

3 Q. Okay. So you don't know what the  
4 nurse -- what the hospital had in place in terms of  
5 what the nursing staff was to do with critical  
6 results that were conveyed to them, you have no  
7 idea?

8 A. No. It was 2010. No. It was 15  
9 years ago.

10 Q. No, it's not.  
11 2010 to 2021?

12 A. Right, but I'm saying no.

13 Q. So you don't remember?

14 A. No, I -- no, I didn't remember seeing  
15 that policy, no. I know what happens  
16 procedurally in the department.

17 Q. And then we talked a bit about the  
18 11-bed facility you worked at from 2001 to 2005.

19 Do you know if there was a written  
20 policy for that hospital that -- where you were  
21 working?

22 A. I don't recall seeing a policy. And  
23 again, that -- that would have been quite a while  
24 ago.

25 Q. Okay. Were the nurses -- well, you

1 help me with this.

2 A. Okay.

3 Q. What -- what was your understanding of  
4 how the critical results were to be handled at this  
5 hospital that you worked at from 2010 to 2021?

6 A. The critical results were called to  
7 the emergency department, to the nursing staff, who  
8 brought the information to us as clinical  
9 providers. And then it was our responsibility to  
10 follow through on those critical labs by opening  
11 the chart, assessing the situation and making  
12 decisions.

13 Q. All right. Was -- the -- the call  
14 that came from the lab, was the lab required to  
15 document that they made the call, the time they  
16 made the call and to whom they spoke?

17 A. I'm not in charge of the lab, but I  
18 think --

19 Q. If you know, yes, or you don't?

20 A. Yeah. No -- no, I don't --

21 Q. Okay.

22 A. -- know. I assume Lincoln Dempsey  
23 said that -- yeah.

24 Q. I'm not talking about Lincoln Dempsey.

25 We're talking about 2010 to 2001 -- 2021, when you

1 worked at this --

2 A. Oh, so we're sticking just with that?

3 Yeah, I don't know.

4 Q. And then at that -- and -- and I'm  
5 sorry, the hospitals that you were covering during  
6 that period, you said was -- was it Norton  
7 Brownsboro?

8 A. Norton Brownsboro, Norton Audubon and  
9 Norton Downtown, ultimately with SEMS, yes.

10 Q. Okay. The written policy that was in  
11 place at the Norton facilities where you covered as  
12 a nurse practitioner in the emergency department,  
13 did it require the nurses that received the report  
14 from the laboratory of a critical result, were they  
15 required to note in the patient's chart the time  
16 they received it, the information they received and  
17 what they did with it?

18 A. Typically, no, that did not occur.  
19 They brought it directly to the provider. If a  
20 patient -- so we're talking about patients,  
21 which you have to be considerate of whether or not  
22 the patient was in the emergency room at the  
23 time or whether or not they had been discharged.

24 Q. My question's very specific, and --

25 A. And it's not a specific answer,

1 because you have to consider where the location of  
2 the patient is at the time you received the  
3 critical value.

4 Q. So you're saying that sometimes the  
5 nurses would be required to document, sometimes  
6 they would not, it would depend upon where the  
7 patient was?

8 A. That is the procedure that typically  
9 took place, yes. If the patient was in the  
10 emergency room at the time, the nursing staff would  
11 document it. If it was someone who had been  
12 discharged and they're bringing critical values to  
13 the -- the staff, I don't know that the nursing  
14 staff is required to get back in and make a note on  
15 that. I don't see that as common practice once the  
16 patient had been discharged.

17 Q. Yeah.

18 You agree that the policies that were  
19 in place at Muhlenberg Community Hospital, did  
20 require that the nursing staff make documentation  
21 in terms of what happened with the critical result,  
22 true?

23 A. No. I need to pull that policy and  
24 take a look. One moment, please.

25 Q. Well, we can hand -- I've got it here,

1 ma'am.  
 2 A. Okay. This is a clean copy that I'm  
 3 looking at here.  
 4 So in regards to the nursing policy  
 5 that says notification of physician -- one moment.  
 6 This policy is really sort of specific to a  
 7 policy -- to a patient that's in-house. If you  
 8 look at number 2, it says, "notification of a  
 9 physician shall be done only after a thorough  
 10 assessment of the patient has been completed".  
 11 Q. Which policy are you looking at?  
 12 A. I am looking at notification nursing  
 13 policy.  
 14 Q. Right.  
 15 We're talking about the critical  
 16 values policy, ma'am.  
 17 A. Okay.  
 18 Q. All right. And do you see that under  
 19 the critical value policy that was in place at the  
 20 time that Jase Foster was a patient at Muhlenberg  
 21 Hospital, that the critical value policy does in  
 22 fact require documentation of the notification?  
 23 That would be item number 3 under Procedure.  
 24 Do you see that?  
 25 A. I do see that.

1 Q. But you don't think --  
 2 A. However --  
 3 Q. -- but you don't think that's  
 4 necessary to document?  
 5 A. What you need to understand when you  
 6 look at this policy is, right, it asks you to  
 7 document. It would have been easier had she  
 8 documented that situation, and it is part of the  
 9 policy.  
 10 Q. So you agree that the policy does  
 11 require nursing staff to make documentation of the  
 12 receipt of a critical result as to when they  
 13 received it and what they did with it, correct?  
 14 A. Well, what I'm saying is these --  
 15 Q. Is that what you said?  
 16 A. One moment, please. These policies  
 17 are hooked together, okay? So see nursing policy  
 18 and procedure notification of physician is included  
 19 in the policy for critical values. So these  
 20 policies go together.  
 21 Q. But My question was pretty  
 22 straightforward.  
 23 Does the critical value policy that  
 24 was in place at the time that Jase Foster was a  
 25 patient at the Muhlenberg Hospital, require nursing

1 staff to document what they did and when -- and  
 2 when they did it with regard to a critical result,  
 3 yes or no?  
 4 A. The policy says they recommend  
 5 documentation. But you cannot ignore the  
 6 notification of physician policy, because it's  
 7 written in this first policy. And the difference  
 8 is, you've got inpatient versus outpatient. Yes,  
 9 we would prefer that everyone document everything  
 10 all the time, but we also know that that does not  
 11 always happen and it's not always because of the  
 12 way procedures are followed.  
 13 Q. And -- and to be clear, this other  
 14 policy that you're referring to, would it be the  
 15 notification of physician policy?  
 16 A. Yes, the one that's in bold in  
 17 the middle of the critical value policy.  
 18 Q. I -- I have two policies, ma'am.  
 19 I don't -- what -- what are you  
 20 talking about? We've got the critical value policy  
 21 and we've got the notification of physician policy.  
 22 A. On this policy, under Identification  
 23 of Critical Value Results, if you go mid through  
 24 the page, the bold underlined sentence says "any  
 25 critical result must be called to the physician

1 within 30 minutes of the time the report is  
 2 received. See nursing policy and procedure  
 3 notification of physician". So these policies go  
 4 together.  
 5 Q. And just to be clear and so the jury  
 6 understands it, we'll be getting back to this.  
 7 But the policy and procedure, which is  
 8 the subject notification to physician, does require  
 9 under number 3, "all aspects of the notification  
 10 process and patient assessments shall be documented  
 11 in the medical record".  
 12 Does it not say that?  
 13 A. It does say that.  
 14 Q. Okay. But you don't think it was  
 15 necessary for the nursing staff in this case to  
 16 document what they did with the critical result,  
 17 fair?  
 18 A. It's not that it's not necessary. I'm  
 19 here to tell you procedurally when a patient is an  
 20 outpatient who's been discharged to the outside  
 21 world, this policy doesn't address that issue  
 22 (indicating).  
 23 And in fact, it says, "these  
 24 guidelines are not inclusive, nor is this policy  
 25 limited to the items stated".

1 Q. All right. So fair to say that the  
2 policy, the critical value policy, that we're  
3 talking about now, fails to address what should be  
4 done when a blood culture result comes back for a  
5 patient that was seen in the emergency department  
6 that's no longer in the hospital, fair?  
7 A. The critical values?  
8 Q. Yes, ma'am.  
9 A. No, I don't see that. But it also  
10 says --  
11 Q. So it does not -- it does -- it does  
12 deal with it, is that correct?  
13 A. It does not deal with it.  
14 Q. Are you critical of this policy for  
15 not addressing what should be done under those  
16 circumstances, specifically when a critical result  
17 comes back for a patient who was seen in the  
18 emergency department, who's no longer in the  
19 hospital?  
20 A. No, I'm not critical of this policy.  
21 Q. Should there be a separate policy for  
22 what should be done with a critical result that  
23 comes back for a patient that was seen in the  
24 emergency department, but is no longer present in  
25 the hospital?

1 A. No. I don't know that you need a  
2 separate one for that.  
3 And in fact, the one that says -- that  
4 is attached to this critical value, that says  
5 notification to physician, when you go to the back  
6 page, "note, these guidelines are not inclusive,  
7 nor is this policy limited to the items stated".  
8 The policy doesn't tell people how to practice  
9 nursing and medicine.  
10 Q. All right. We'll go back to Exhibit  
11 1, which was the notice.  
12 We talked about your CV, we talked  
13 about, you know, publications applied. And then  
14 number 2 is, you were requested to bring your  
15 entire file today, including --  
16 A. Uh-huh.  
17 Q. -- everything that would relate to the  
18 case.  
19 Have you done that?  
20 A. I have.  
21 Q. And is it in paper form, or is it  
22 on --  
23 A. It's in paper form, and I have  
24 multiple copies here.  
25 Q. I'm sorry?

1 A. It's in paper form, and I have  
2 multiple copies in this stack.  
3 Q. All right. Can I have my  
4 copy?  
5 A. Sure.  
6 Do you need one for her (indicating)?  
7 No?  
8 So that's the first set of notes that  
9 has to deal with the medical records themselves,  
10 and this is the second set of notes that has my  
11 opinion on the 15 depositions that I read.  
12 Q. Well, we're -- we're back to the notes  
13 section of the request.  
14 I -- I was asking --  
15 A. This is part of my file.  
16 Q. I understand that.  
17 A. Okay.  
18 Q. I'm asking what you were provided, not  
19 what you generated.  
20 Did you bring that?  
21 A. As far as the medical records and all  
22 the depositions? No, I do not have a copy of that  
23 with me today. I thought you were asking about the  
24 -- about what was in my file.  
25 Q. So going back, you were not provided a

1 copy of the notice before today?  
2 A. I was provided a copy.  
3 Q. All right.  
4 A. I don't have it in my -- I don't bring  
5 a copy with me.  
6 Q. And -- and did the notice, in fact,  
7 require you to bring your entire file on this  
8 matter, including, but not limited to, billing  
9 information, notes, memorandum, personnel files,  
10 all materials sent to you, all materials used by  
11 and relied upon by you, all correspondence and  
12 other writings related to this matter? Were you  
13 requested to bring that?  
14 A. Yes, I was requested to bring that.  
15 Q. And have you done that?  
16 A. I have not copied the five things on  
17 my computer, but I don't bring a hard -- a hard  
18 copy of any of it.  
19 Q. So how am I going to know what you  
20 were provided in order to understand what you  
21 reviewed in order to come up with your opinions?  
22 A. Well, I'll have to tell you, and  
23 you're going to have a copy of the notes that I  
24 took throughout my review.  
25 Q. So the -- the two groups of documents

1 provided to me would be the totality of your notes  
2 in this case?

3 A. If you have both of those, yes, those  
4 would be the notes that I made in this case.

5 Q. Okay. And help me again.  
6 The first section, which is in purple  
7 ink, which will mark as Exhibit 3, would be notes  
8 coming from what you reviewed?

9 A. From the medical record, yes.  
10 (Whereupon, Exhibit No. 3 was marked  
11 for identification.)

12 Q. Right.  
13 And then the second group, which we'll  
14 mark as Exhibit 4, would be the opinions that you  
15 generated in this case?

16 A. And the pages behind -- subsequent  
17 pages are notes I took on the depositions.  
18 (Whereupon, Exhibit No. 4 was marked  
19 for identification.)

20 THE WITNESS: I'm sorry, I'm just  
21 putting this down here, I don't like stuff in front  
22 of me.

23 Q. What depositions have you been  
24 provided in this case?

25 A. I was provided the depositions of

1 Q. Okay. Your expert disclosure in this  
2 case was dated May 1st, 2024.

3 Are you aware of that?

4 A. I didn't pay attention to the date,  
5 but I'm not -- you know, it was early on.

6 Q. All right. Well, I'll represent to  
7 you that your disclosure was dated May 1st, 2024.

8 Subsequent to your disclosure, two  
9 depositions were taken that -- well, more than two,  
10 but two that I think are very important. One was  
11 the emergency department director, Dr. Coomes.

12 And you've read that, right?

13 A. I have.

14 Q. And the other was the charge nurse  
15 at -- on the day in question, that would be Emily  
16 Knight, right?

17 A. Correct.

18 Q. Those depositions were taken after  
19 your disclosure.

20 Have you changed your opinions based  
21 upon the testimony of Dr. Coomes and Ms. Knight?

22 A. No. My opinion has stayed the same  
23 regardless of the depositions, from my original  
24 reading of the medical record.

25 Q. You saw nothing in the depositions of

1 Doctor Coomes, Doctor Malik, P.A., Tauil, the  
2 grandparents, Crystal Geary, Kim Lasder, Lincoln  
3 Dempsey, Registered Nurse Jessica Tedders, Emily  
4 Knight, and the experts, Doctor Goodspeed, Doctor  
5 Nicks, Doctor Patel, Doctor Wright. Let me make  
6 sure I didn't miss any.

7 Tabitha Taylor, McCrary, the P.A.  
8 McCrary. And I think I already said Doctor Coomes.  
9 Those are the ones that I read.

10 Q. This just came to my mind.

11 You're -- you're not going to be  
12 offering causation opinions, are you?

13 A. I do have another opinion in this  
14 situation of where the standard was --

15 Q. Are you going to offer causation  
16 opinions as to whether or not -- well, just  
17 specifically, are you going to offer causation  
18 opinions, or are you going to talk about standard  
19 of care?

20 A. I'm talking about standard of care.

21 Q. Right.  
22 So I didn't see a causation opinion in  
23 your disclosure.

24 Are you going to be offering one?

25 A. No.

1 Dr. Coomes or Nurse Knight that conflicted with the  
2 opinions that were within your disclosure, correct?

3 A. No. I think they conflicted with one  
4 another, but it ultimately didn't change my  
5 opinion.

6 Q. What do you mean they conflicted with  
7 one another?

8 A. Well, Dr. Coomes insists that the  
9 critical value is the responsibility of the charge  
10 nurse. And the charge nurse says it is not. And  
11 in my experience in 16 years, I can tell you in  
12 practice, it is not.

13 Q. All right. We identified what  
14 depositions you've looked at.

15 A. Uh-huh.

16 Q. And to the extent you made notes,  
17 they'd be contained on either Exhibit 3 or Exhibit  
18 4?

19 A. Yes.

20 Q. Okay. And then what medical records  
21 have you reviewed in this case?

22 A. I have looked at Owensboro  
23 Health -- or I'm -- I'm considering the file -- one  
24 moment -- I'm considering the file that was sent to  
25 me. There's a file with OHI, which was the

1 records of Tabitha Taylor's care. There was one  
2 from the visits from Muhlenberg Emergency Room  
3 Hospital, both of those. There were urgent care  
4 records. I read the summaries for Norton  
5 Children's and Frazier Rehab, and briefly looked at  
6 the physical therapy visits at Lincoln Memorial.

7 Q. But in terms of your opinions, what  
8 records would be germane to your opinions would be  
9 the records from the Muhlenberg Community Hospital,  
10 correct?

11 A. Correct. The Muhlenberg  
12 Community Hospital is where I spent the majority of  
13 my time, yes.

14 Q. Other than depositions and  
15 medical records, what else was provided to you by  
16 counsel, to help you formulate your opinions?

17 A. I think that's the majority of the  
18 information that I received.

19 Q. Okay. Well, I left out, but I would  
20 think it would be germane, the policies that were  
21 in place at -- at Muhlenberg?

22 A. Oh, yeah, that was part of -- yes.  
23 I'm sorry.

24 Q. Okay. So --

25 A. That was part of the discovery under

1 plaintiff.

2 Q. Okay.

3 A. Yes.

4 Q. So that would be important?

5 A. Yes.

6 Q. Anything else that you provided, that  
7 you think is relevant or supports your opinions in  
8 this case?

9 A. I can't think of anything at this  
10 time.

11 Q. Okay. And did you bring with you the  
12 correspondence you've had with counsel concerning  
13 this case?

14 A. I do not have the correspondence with  
15 counsel. There was nothing in there except, you  
16 know, sending me depositions or dates to talk or  
17 whatever. There's nothing substantive in that, but  
18 I can provide that if you would like.

19 Q. I would.

20 A. Okay.

21 Q. So let's -- let's do this, when we  
22 finish, the reporter will work it out with you, but  
23 we'll mark as Exhibit 5 all correspondence between  
24 you and counsel related to the Jase Foster  
25 matter --

1 A. Sure.

2 Q. -- okay?

3 A. Uh-huh.

4 (Subsequent to the taking of the  
5 deposition, documents were provided and marked  
6 Exhibit No. 5 for identification.)

7 Q. Have you -- are you going to rely upon  
8 any literature in this case, to support your  
9 opinions?

10 A. No.

11 Q. Okay. Have you prepared any timelines  
12 related to what happened in this matter?

13 A. Not a specific, official timeline.  
14 However, if you look at my notes for the medical  
15 records, which is in purple -- 1, 2, 3, 4 -- page  
16 5, in pencil, you will see a timeline with dates  
17 and times of the blood culture results that I had  
18 just put together based on reading the records.  
19 It's page 5, I believe.

20 Q. Is that with purple and also with  
21 black?

22 A. Pencil. Yes. Yes.

23 Q. Okay. And where does the chronology  
24 begin?

25 A. At the very bottom where it says blood

1 culture, circled. Drawn, 9/5/19 at 20:07, called  
2 to ER on 9/6/19 at 14:36. Kim Lasder called Linson  
3 -- Lincoln Dempsey, who called Jessica Tedders in  
4 the ER on 9/6, who spoke with P.A. Taulil.

5 Q. Well, let's -- let's stop and --

6 A. Yeah. So that's -- that's just the  
7 timeline that I was showing you. That's the  
8 only --

9 Q. All right. Well, I -- I --

10 A. -- thing I've put together.

11 Q. So we --

12 A. Sure.

13 Q. -- we can agree that the blood culture  
14 was performed on the 5th?

15 A. Correct.

16 Q. And that's part of your timeline?

17 A. Yeah.

18 Q. All right. And then you say the --  
19 there was a phone call to the emergency department  
20 at 14:36. I didn't see that.

21 So what are you telling us? Who  
22 called the emergency department at 14:36 on the 6th  
23 of September, 2019?

24 A. Lincoln Dempsey had called the  
25 emergency department.

1 Q. Lincoln Dempsey called the emergency  
2 department, or the laboratory called Lincoln  
3 Dempsey?

4 A. No. The laboratory called Lincoln  
5 Dempsey, and Lincoln Dempsey called the emergency  
6 department.

7 Q. Well, what happened at 14:36? What's  
8 that document?

9 A. When it was called to the ER, I  
10 believe.

11 Q. Who charted that?

12 A. It was in the deposition.

13 Q. Where in the record is it charted that  
14 a phone call was made by Lincoln Dempsey to the  
15 emergency department at 14:36?

16 A. I would have to go back and look  
17 through the record. I don't have the date.

18 Q. Let me suggest to you that the phone  
19 call you're referencing is a phone call from Kim  
20 Lasder, the chemistry -- chemistry supervisor, to  
21 the infection control person, Lincoln Dempsey,  
22 which occurred at 2:36 p.m.

23 Is that what you're referencing?

24 A. Possibly, because I have called --  
25 yeah, Kim Lasder called Lincoln Dempsey with the

1 Reich's deposition, right?

2 A. I did see Dr. Reich's deposition. I  
3 think that was -- I just got that one.

4 Q. Did you see where he testified that  
5 he's never seen a situation where the communication  
6 begins from the laboratory to infection control?

7 A. I understand that, and I can --

8 Q. I'm just saying, did you see that?

9 A. I don't recall seeing that. But I  
10 under -- if you're telling me that's what he  
11 said --

12 Q. Did you read the deposition?

13 A. I did read the deposition.

14 Q. All right. Did you read in there  
15 where he said he's never seen that before?

16 A. I don't recall reading that in his  
17 deposition.

18 Q. Did he testify that that's not the way  
19 it's done at his hospital?

20 A. I don't recall if he said that or not.

21 Q. His deposition was just taken. I  
22 mean, and you said you read it.

23 A. I understand. I also read 14 other  
24 depositions in this process.

25 Q. So you hadn't read any depositions

1 errors.

2 Q. So your timeline, as written, is  
3 incorrect, what you meant to say was called to  
4 Lincoln Dempsey, is that correct?

5 A. Lincoln Dempsey. One moment. I would  
6 have to go back and look at that exact in the -- in  
7 the records.

8 But it was -- yes, it was a call from  
9 Kim Lasder to Lincoln Dempsey.

10 Q. I just want to be clear.

11 That phone call you documented was at  
12 2:36 p.m. on the 6th?

13 A. That's what I have written here.

14 Q. Okay. And we know that because Ms.  
15 Lasder, in fact, documented in the chart when she  
16 conveyed the critical result of that blood culture  
17 to Lincoln Dempsey?

18 A. Correct.

19 Q. All right. The policy we talked about  
20 earlier, about critical values, does it in --  
21 anywhere in this document talk about communicating  
22 a critical result to infection control?

23 A. It does not, but policy does not  
24 always dictate procedure.

25 Q. Okay. Did you -- you said you saw Dr.

1 until you got Dr. Reich's deposition?

2 A. No, that's not true.

3 Q. Well, What are you saying to me? I --  
4 the deposition was taken like a month ago.

5 I mean, did you just not get it?

6 A. I read that deposition, and I don't  
7 recall what he said.

8 Q. Don't you think it's important to  
9 know what the pediatric infectious disease expert  
10 for the defense has to say about what happens at  
11 his hospital?

12 A. No.

13 Q. It's not important?

14 A. It's not important, because --

15 Q. Okay.

16 A. Yeah.

17 Q. So in your experience --

18 A. Hospitals all operate very  
19 differently.

20 Q. -- in your experience, would you ever  
21 get phone calls from infection control about a  
22 patient that was seen in the emergency department?

23 A. No. I would get a note from the  
24 nurse.

25 Q. Get a note from the nurse, okay.

1           Would the nurse ever get that  
2 information from the infection control?  
3           A. She would get it from the lab. Now,  
4 what --  
5           Q. She'd get it from the lab?  
6           A. Right. Well, I don't know if it's  
7 from the lab or infection control. Again,  
8 different hospitals work in different ways.  
9           Q. Do you agree with Dr. Reich that  
10 putting in a step where infection control is  
11 communicated with adds an extra step that leads to  
12 the potential for a mistake? Did you read that?  
13           A. I agree that adding layers can add to  
14 mistakes, but I can also tell you that the process  
15 that Jessica Tedders describes has happened in all  
16 six ERs that I've worked in in the last 16 years,  
17 this is the normal procedure that occurs in an ER.  
18           Q. Had Jessica Tedders ever handled the  
19 conveyance of a clinical result to anybody in the  
20 emergency department, prior to September 6, 2019?  
21           A. No. I think she stated this was  
22 like --  
23           Q. Has she ever done it, yes or no?  
24           A. No. I -- I think she says this was  
25 her first one.

1           Q. Has she been trained on it, what to  
2 do?  
3           A. She's a registered nurse. Now, what  
4 she's been trained on or not, I don't know. It was  
5 part of the policies and procedures. But this is  
6 part of nursing practice, and it's not dictated  
7 necessarily by policy.  
8           Q. Was Jessica Tedders a nurse-in-  
9 training when she received a phone call from  
10 Lincoln Dempsey?  
11           A. I don't know what nurse-in-training  
12 means.  
13           Q. Okay. That's fair.  
14           A. Nurse-in-training --  
15           Q. What time --  
16           A. -- is not -- I'd like to finish my  
17 statement. Nurse-in-training is not a phrase I've  
18 ever heard in 31 years, and I've taught it to  
19 nursing programs.  
20           She was a licensed registered nurse,  
21 who passed the NCLEX, who was orienting to a  
22 new job, just like anyone else in any other  
23 position oriented to a new job. She was a licensed  
24 registered nurse. She was not a nurse-in-training.  
25 I need to clarify that.

1           Q. All right. Did the personnel at  
2 Muhlenberg Community Hospital refer to her as a  
3 nurse-in-training?  
4           A. That, I don't recall. I recall --  
5           Q. Did she testify she was a  
6 nurse-in-training?  
7           A. She was a nurse-in-orientation.  
8           Q. Okay.  
9           A. I don't know what a nurse-in-training  
10 actually is.  
11           Q. With your emergency department  
12 experience, when a new nurse would come on board,  
13 was there anybody that would be supervising that  
14 new nurse to help them with any questions that they  
15 had?  
16           A. They would typically -- typically be  
17 assigned to a nurse who's working the shift with  
18 them in case they had questions or needed support.  
19           Q. Okay. So if Jessica Tedders had  
20 questions about what she should do with the  
21 critical result that was conveyed to her on  
22 September 6th, who was she supposed to speak to?  
23           A. If she had questions, she would have  
24 gone to the person who was supervising her at the  
25 time. However, she stated in her deposition that

1 she understood the policy, and therefore, didn't  
2 need to go to Emily Knight.  
3           Q. I guess my -- my question was, who was  
4 she supposed to go to if she had a question, and I  
5 understand your answer.  
6           But the answer is Emily Knight?  
7           A. Yes, she would have gone to Emily  
8 Knight had she had a question.  
9           Q. And Emily Knight was the charge nurse?  
10           A. Yes, she was.  
11           Q. Okay. And are you saying that the way  
12 Emily Knight described what should be done and the  
13 way Jessica Tedders did it is, in fact, the same?  
14           A. Yes.  
15           Q. Really?  
16           A. Yes. Emily Knight says that the nurse  
17 receives --  
18           Q. No, no. Let's just -- just hold on a  
19 minute. Let me just ask you a few things about  
20 that.  
21           A. Sure.  
22           Q. Did -- did Jessica Tedders testify  
23 that she had taken a written note, Post-it note,  
24 with the information about the critical result to  
25 P.A. Tauil?

1 A. She did testify that.  
 2 Q. And did she get instructions of what  
 3 to do with that critical result when she  
 4 communicated with Jessica Tauli?  
 5 A. She absolutely did, she was told to  
 6 put it on the -- right there with the --  
 7 Q. Did she get instructions about what  
 8 action she was supposed to do with that critical  
 9 result when she spoke to Jessica Tauli?  
 10 A. She did.  
 11 Q. All right.  
 12 A. She reported that she was told to  
 13 leave it on the desk for Dr. Malik, and that the  
 14 P.A. and the physician would take care of it. She  
 15 did wait for instructions and she did do as she was  
 16 told.  
 17 Q. And did she ever follow up with Ms.  
 18 Tauli or Dr. Malik about what was supposed to  
 19 happen in terms of who was to be communicated with  
 20 about that critical result, did she ever do that?  
 21 A. She gave the information. It's the  
 22 medical provider's responsibility at that point to  
 23 follow through on that critical lab value.  
 24 Q. Did the charge nurse, Emily Knight,  
 25 testify that it was the responsibility of the

1 nurse, communicating either with the P.A. or the  
 2 doctor, to stay there until they got the  
 3 information about who they were to contact and what  
 4 they were supposed to do with that  
 5 information, did she testify to that?  
 6 A. She did testify to that. And Jessica  
 7 did exactly that. She was told by a provider in  
 8 the emergency department, who she went to  
 9 immediately, to take the note and set it there so  
 10 the doctor and the P.A. can take care of it. She  
 11 was told what to do with it and she did exactly  
 12 that.  
 13 Q. Fair to say that Ms. Tedders never  
 14 received any instruction about whether the family  
 15 should be contacted, that is the family of Jase  
 16 Foster, or the laboratory -- whether the pharmacy  
 17 should be contacted, all she got was place a  
 18 Post-it note on Dr. Malik's desk, right?  
 19 A. Correct, and she followed those  
 20 instructions.  
 21 Q. And did Emily Knight testify that if  
 22 she understood that the nurse did not get  
 23 specific instructions about what to do, she was  
 24 required to go back to the provider and get  
 25 those instructions, is that what she testified to?

1 MR. MONHOLLEN: Object to the form.  
 2 But go ahead --  
 3 A. Yeah.  
 4 MR. MONHOLLEN: -- you can answer.  
 5 A. I don't recall that or not. But  
 6 that's not how it occurs. It is impossible for  
 7 someone to stand there and wait for any -- for  
 8 instructions, to follow somebody around for an  
 9 hour. And once the message is given to the  
 10 physician to manage that critical value, it's not  
 11 the responsibility of the nurse to go back and say,  
 12 hey, by the way, did you get -- what do you want to  
 13 do about that? She's already passed that on.  
 14 Particularly in a situation where the  
 15 patient has already been discharged from the  
 16 emergency department, and the nurse has no control  
 17 over the decision-making at that point. Because  
 18 it's the responsibility of the physician to review  
 19 the critical value, make a decision, and come back  
 20 to the nurse when there's something that they would  
 21 like them to do.  
 22 Q. Did Emily Knight testify that she  
 23 would view a -- a positive blood culture, which is  
 24 a critical result, as a potential life-threatening  
 25 situation, did she testify to that?

1 A. I don't have that in my notes, but  
 2 probably because I --  
 3 Q. So you don't remember?  
 4 A. Right. Plus I agree --  
 5 Q. Did she testify it was important to  
 6 convey that information to one of the providers in  
 7 the emergency department within 30 minutes of  
 8 receipt?  
 9 A. Yes.  
 10 Q. Did she testify that the practice that  
 11 she followed was that she would wait for the  
 12 provider to make a decision and then she would be  
 13 instructed about who was to call, did she testify  
 14 to that?  
 15 A. Martin, my answer is not going to  
 16 change. Jessica was given --  
 17 Q. Did she -- did she testify -- did  
 18 she --  
 19 A. -- instruction and she did exact --  
 20 Q. I'm not talking about Jessica.  
 21 A. Yes. Yes, she did --  
 22 Q. Okay.  
 23 A. -- wait for instructions, which  
 24 Jessica received.  
 25 Q. And then did she testify that I would

1 stand there and wait until I got instructions?  
 2 A. Which Jessica did, yes, she did  
 3 testify to that.  
 4 Q. And did she testify that if a nurse  
 5 doesn't get specific instructions about what to do  
 6 with a critical result, she would tell the nurse to  
 7 go back to the provider to get those instructions?  
 8 A. I don't have that written, but it's  
 9 not the nurse's responsibility to check up on the  
 10 work of the provider.  
 11 Q. Back to your timeline.  
 12 So we -- we found one mistake, which  
 13 was the phone call from lab was not to the  
 14 emergency department, but it was to Lincoln  
 15 Dempsey?  
 16 A. To Lincoln Dempsey, yes.  
 17 Q. Is Lincoln Dempsey -- well, strike  
 18 that.  
 19 What time did Lincoln Dempsey call  
 20 down to the emergency department, can you tell us  
 21 that?  
 22 A. I don't know what time he called.  
 23 Q. Who did Lincoln Dempsey contact in the  
 24 emergency department?  
 25 A. Ultimately, Registered Nurse Jessica

1 Tedders.  
 2 Q. Is that what he testified to?  
 3 A. No. He testified talking to Tiffany  
 4 Johnson.  
 5 Q. Okay. Did Lincoln Dempsey anywhere in  
 6 the chart, document the time he made the phone call  
 7 to the emergency department and to whom he spoke  
 8 with?  
 9 A. Not that I could see, no.  
 10 Q. Are you critical of Lincoln Dempsey  
 11 for not doing that?  
 12 A. I'm not in charge of the lab, so I  
 13 don't have an opinion on what Lincoln Dempsey did.  
 14 Q. Okay. And what time did Nurse Tedders  
 15 receive that phone call from Lincoln Dempsey, do  
 16 you know?  
 17 A. I don't know exactly.  
 18 Q. What information was conveyed to her  
 19 by Lincoln Dempsey, did she chart that?  
 20 A. No, but she's able to say that she  
 21 wrote it down and she read it back, so --  
 22 Q. We don't know what time she got it,  
 23 she didn't chart what information she got.  
 24 Did she chart with whom she spoke to  
 25 about that information, did she chart that?

1 A. No. The patient --  
 2 Q. Did she chart --  
 3 A. -- was no longer in the ER.  
 4 Q. -- did -- did she chart what  
 5 information or instructions she received from that  
 6 provider, about what to do with the critical  
 7 results she received? I'm just asking if she  
 8 charted it.  
 9 A. No, there's no charting. The  
 10 patient's not in the ER.  
 11 Q. And then your timeline goes to the 7th  
 12 of September.  
 13 It's -- I think that's referencing the  
 14 ER visit at Owensboro?  
 15 A. Yeah. It says the -- the preliminary  
 16 or the initial finding was included in the computer  
 17 on 9 -- by 9/7/19 at 13:39, is what I have. And  
 18 then above, it says that could have been seen  
 19 Doctor -- by Doctor Coomes when he was returned to  
 20 the ER on the 7th.  
 21 Q. So I want to understand it again.  
 22 So the Owensboro record would reflect  
 23 that the result of the blood culture would have  
 24 been conveyed to the Owensboro Hospital at 13:39 on  
 25 the 7th?

1 A. I have preliminary computer, meaning  
 2 you could have found it in the computer, on 9/7,  
 3 13:39, is what I have, meaning like it would have  
 4 been uploaded in the lab at Meditech or whatever.  
 5 Q. Okay.  
 6 A. And so at that point, it could have  
 7 been found.  
 8 Q. Found by whom?  
 9 A. Doctor Coomes, when he saw the chart  
 10 on the 7th.  
 11 Q. So What about the personnel, hospital  
 12 personnel, at Muhlenberg Community Hospital, could  
 13 they have found it on the 7th? Could they have  
 14 found it on the 6th?  
 15 A. Referring to who, anybody?  
 16 Q. Yeah.  
 17 A. Well, whatever time it would have been  
 18 put into the computer would have shown up in the  
 19 physician E -- E -- inbox in Epic. So --  
 20 Q. Well, did not --  
 21 A. -- I don't know.  
 22 Q. -- didn't Kim Lasder chart at 9/6/19,  
 23 that there was a positive blood culture for Jase  
 24 Foster and it was conveyed at 14:36 to Lincoln  
 25 Dempsey, did she not chart that?

1 A. She did that. That's on page --  
 2 Q. So that was in the --  
 3 A. -- 240.  
 4 Q. -- chart as of -- on the 6th as of  
 5 2:36 p.m.?  
 6 A. Correct. However, once the patient's  
 7 been discharged, the staff is not going back and  
 8 reviewing what Kim Lasder wrote the day before,  
 9 once the patient's discharged. You don't go back  
 10 and look at that after the fact the patient is  
 11 gone. You would recognize that once the patient  
 12 presents and the chart is opened up again, or  
 13 you've been notified of a critical value. That's  
 14 not something that the nursing staff would go back  
 15 and look at.  
 16 Q. My question was, was it in the chart  
 17 on the 6th as of 2:36 p.m., yes or no? I think the  
 18 answer is yes, ma'am.  
 19 A. Well, yeah, it's in the -- yes.  
 20 Q. Thank you.  
 21 And then the last part of your  
 22 timeline -- well, not the last. It then shows a  
 23 final result of the blood culture would have been  
 24 available at 8:40 a.m. on the 8th?  
 25 A. Uh-huh.

1 Q. Yes?  
 2 A. Yes.  
 3 Q. And to whom was the final result  
 4 conveyed at 8:40 a.m. on the 8th?  
 5 A. I don't know that the final result was  
 6 conveyed. They called the original, like the  
 7 preliminary.  
 8 Q. Are you -- are you testifying that the  
 9 final result wasn't conveyed to anybody?  
 10 A. I don't know that the final result was  
 11 called back to the ER, no.  
 12 Q. Should it have?  
 13 A. Not necessarily. They were already  
 14 told that there were bacteria growing the day after  
 15 the child was in the emergency department.  
 16 Q. Do you agree with Dr. Coomes that the  
 17 blood culture result for Jase Foster fell through  
 18 the cracks?  
 19 A. From the emergency room staff, I do,  
 20 meaning -- no. Excuse me. By the emergency room  
 21 providers, yes, they did not meet the standard of  
 22 care in this case.  
 23 Q. And I'm assuming you're saying  
 24 providers being Taul and Malik?  
 25 A. Yes.

1 Q. What about --  
 2 A. And Coomes on the 7th, and McCrary on  
 3 the 8th.  
 4 Q. All right. Back to your -- the  
 5 notice. We talked about timelines.  
 6 Any summaries would be set forth in  
 7 Exhibits 3 and 4, your notes?  
 8 A. Uh-huh. Yes.  
 9 Q. You were asked to bring a list of  
 10 cases that you reviewed as an expert. We talked  
 11 about one -- or two. You looked for me, one -- you  
 12 said yes, one -- you said no in terms of whether  
 13 there was a case.  
 14 How many current cases do you have?  
 15 A. I think I maybe have 15 open right  
 16 now.  
 17 Q. And how many plaintiff, how many  
 18 defense?  
 19 A. I don't know the exact -- I'm  
 20 typically 50/50, at the most 60/40, plaintiff. So  
 21 it's -- it's somewhere in there.  
 22 Q. Other than your notes, have you  
 23 authored a report in this case?  
 24 A. No.  
 25 Q. Did you play any role in the drafting

1 of your disclosure?  
 2 A. We discussed it, but it was written by  
 3 Mr. Monhollen.  
 4 Q. Right.  
 5 Did you write the disclosure?  
 6 A. No, I did not write any -- any --  
 7 Q. Is any part of your input contained in  
 8 that disclosure?  
 9 A. That I actually typed on the page?  
 10 Q. Yes.  
 11 A. No.  
 12 Q. Okay. Have you ever testified in  
 13 court?  
 14 A. I have. It was a missed sepsis case  
 15 in the emergency department.  
 16 Q. A missed sepsis case?  
 17 A. Uh-huh.  
 18 Q. And where was that case?  
 19 A. That case was in -- I have the list of  
 20 my deposition and trial here. It was in  
 21 Philadelphia.  
 22 Q. Oh, I didn't know you had that. Could  
 23 I see --  
 24 A. Yeah. I don't have a list of all my  
 25 cases, but this is the depositions I've had, and

1 the trial's on the last page.  
 2 Q. Can I have this to make a copy?  
 3 A. You can.  
 4 MR. KINNEY: Okay. We'll mark and  
 5 file this as Exhibit 5.  
 6 THE COURT REPORTER: 5 is -- is her --  
 7 THE WITNESS: Yeah.  
 8 THE COURT REPORTER: --  
 9 correspondence.  
 10 THE WITNESS: It's going to be 6.  
 11 MR. KINNEY: Oh, that's right, 6.  
 12 Okay.  
 13 (Whereupon, Exhibit No. 6 was marked  
 14 for identification.)  
 15 THE WITNESS: Yeah, that trial was  
 16 really weird, like I was the first expert up for  
 17 the plain --  
 18 MR. MONHOLLEN: Hold -- hold on.  
 19 THE WITNESS: Yeah.  
 20 MR. MONHOLLEN: I'll make a copy for  
 21 everybody at a break, so...  
 22 Q. I'm sorry. Go ahead.  
 23 A. No. I was just saying I had never  
 24 been to trial before, and it was kind of weird, I  
 25 was first plaintiff expert up, and I was the only

1 one, and like they settled the next day, it was  
 2 very weird. Anyway.  
 3 Q. So back to the list that I just marked  
 4 as Exhibit --  
 5 A. 6.  
 6 Q. -- 6 to your deposition.  
 7 A. Uh-huh.  
 8 Q. I think you said it -- it's not  
 9 complete, it's partial?  
 10 A. No. I'm sorry. This list of  
 11 depositions that you just saw, it's on 6, is  
 12 complete.  
 13 Q. Okay.  
 14 A. I don't have a list of like every  
 15 case I've ever looked at.  
 16 Q. Okay.  
 17 A. That's -- that's just what I was  
 18 trying to clarify.  
 19 Q. So what we have is a list that would  
 20 be all the depositions, as well as all the trial  
 21 testimony?  
 22 A. Correct.  
 23 Q. Okay. And I think we already touched  
 24 on this, you didn't do any literature search in  
 25 this matter?

1 A. I didn't.  
 2 Q. Okay. Is there any go-to literature  
 3 source that you access if you have questions?  
 4 A. You know, typically, I use DynaMed.  
 5 Q. DynaMed?  
 6 A. DynaMed in the clinical setting.  
 7 Q. Okay. Anything else?  
 8 A. I can use UpToDate, but I have access  
 9 at one place for UpToDate and my DynaMed. I can  
 10 access it both places.  
 11 MR. KINNEY: Okay. Let's take a break  
 12 just for a second.  
 13 THE VIDEOGRAPHER: We are going off  
 14 record. The time is 10:27 a.m.  
 15 (Whereupon, there was a brief recess.)  
 16 THE VIDEOGRAPHER: We are on record.  
 17 The time is 10:35 a.m.  
 18 Q. Ms. Baldwin, I wanted to talk to you  
 19 just a bit about the list of depositions --  
 20 A. Uh-huh.  
 21 Q. -- that you provided to us.  
 22 Do any of these cases deal with the  
 23 issue of the handling of a critical result and the  
 24 manner in which it's conveyed?  
 25 A. Let me see. Yes, the very first one,

1 June 21, Joseph Gorman, the provider and the  
 2 emergency department failed to notify Mr. Gorman  
 3 that he had abnormal incidental findings on the CAT  
 4 scan of his abdomen and subsequently was diagnosed  
 5 with stage four renal carcinoma the following year.  
 6 Q. If I heard you, there was a -- in that  
 7 case, the Gorman case, information was available at  
 8 the hospital, but it was never communicated to the  
 9 patient, is that right?  
 10 A. The patient, nor did they write like  
 11 you need to follow up with your doctor or here's  
 12 a -- they didn't put it as a diagnosis, and he had  
 13 a right to know his incidental finding.  
 14 Q. Okay. And you were critical of the  
 15 hospital personnel that failed to notify the family  
 16 of that critical result?  
 17 A. I was critical of the medical provider  
 18 whose job it was to notify him of that result.  
 19 Q. And in that particular case, who was  
 20 the provider you were critical of?  
 21 A. A nurse practitioner.  
 22 Q. Okay.  
 23 A. That one was missed.  
 24 Q. So the -- the nurse practitioner,  
 25 there was no question, had the information, but --

1 but failed to convey that information to the  
 2 patient?  
 3 A. Correct.  
 4 Q. In this case, in reading the  
 5 deposition of Doctor -- or excuse me, of P.A.  
 6 Tauil --  
 7 A. Uh-huh.  
 8 Q. -- did she testify that she was made  
 9 aware of the critical result for Jase Foster?  
 10 A. As I recall, she didn't remember  
 11 anything that day.  
 12 Q. Did she testify whether she was given  
 13 that information?  
 14 A. She doesn't remember.  
 15 Q. All right. And is there any  
 16 documentation anywhere, that that information was,  
 17 in fact, conveyed -- conveyed to P.A. Tauil?  
 18 A. Just in the testimony of Jessica  
 19 Tedders.  
 20 Q. And we wouldn't be having this  
 21 discussion if Jessica Tedders had simply documented  
 22 the time she got the report and what she did with  
 23 it, correct?  
 24 A. Actually, Martin, we wouldn't be  
 25 having this discussion had the medical staff done

1 their job on 9/5. In fact, if you look at my  
 2 notes, on page 3, it says under my -- I wrote down  
 3 the X-ray, missed before blood culture preliminary  
 4 results were even called.  
 5 So had the medical staff done their  
 6 job --  
 7 Q. Whoa, whoa, whoa, whoa, whoa, whoa.  
 8 What --  
 9 A. Please let me finish.  
 10 Q. I just want to know where you're -- I  
 11 just want to know what you're talking -- looking  
 12 at.  
 13 A. Page 3.  
 14 Q. Of what?  
 15 A. Of my medical records.  
 16 Q. Exhibit 3 or 4?  
 17 A. Exhibit 3.  
 18 Q. Page 3?  
 19 A. Yep.  
 20 Q. All right. And this is that begins  
 21 9/5 ankle X-ray?  
 22 A. Ankle X-ray. It's the results of the  
 23 X-ray written out there. And then you'll see I  
 24 wrote, "missed before blood culture preliminary  
 25 results were called". This child should have been

1 admitted to the hospital by the medical staff.  
 2 They did not meet the standard of care in regards  
 3 to Jase Foster, absolutely not. This was  
 4 extremely clear. And I'm very surprised, actually,  
 5 that the pediatric infectious disease experts,  
 6 neither one -- well, one of them brought it up and  
 7 said yes, he should have been admitted.  
 8 But when you go back and look at this  
 9 visit from 9/5, it is very clear this child is  
 10 suspected sepsis, headed towards sepsis and clearly  
 11 told by the radiologist where it was.  
 12 In fact, let me find which --  
 13 Q. Ma'am, my question to you is very  
 14 specific. And we can -- we'll go down that road.  
 15 A. Sure.  
 16 Q. But you agree that Nurse Tedders made  
 17 no documentation about this critical result, that  
 18 is when she got it, what she did with it and when  
 19 she conveyed it, correct?  
 20 A. No. And the normal procedure when the  
 21 patient has been discharged --  
 22 Q. That's -- the answer is yes or no.  
 23 Yes or --  
 24 A. I need to be able to finish. It's not  
 25 a yes or no answer. There's more to it than that,

1 it's not a simple yes or no.  
 2 Q. Well, finish your answer.  
 3 A. My answer is, the patient was already  
 4 outside of the hospital. It's not like she was  
 5 caring for this patient at the time and forgot to  
 6 document it. He was discharged. And the procedure  
 7 that she describes in her testimony is exactly what  
 8 occurs all the time.  
 9 Martin, I have gotten notes on my  
 10 keyboard, taped to my monitor. I've had staff  
 11 shove critical results under a bathroom door and in  
 12 an office when I was indisposed.  
 13 What Jessica Tedders describes is the  
 14 procedure that happens every day in the four ERs  
 15 that I have worked in here in Louisville.  
 16 Q. Any other of the cases that you gave  
 17 depositions where similar issues would be involved?  
 18 A. The issue -- the one on 9/28/22, Diana  
 19 and Mark Sullivan v. Mountain View Family Health  
 20 Care, is a situation where an outpatient provider  
 21 did not know how to read a CBC, subsequently  
 22 missed a cellulitis in a patient's lower extremity,  
 23 patient later presented to the emergency  
 24 room, had multiple surgeries and had his leg  
 25 amputated. So that's similar for today's case.

1 Q. I'm sorry.  
 2 Was that a critical result that was  
 3 being conveyed?  
 4 A. It was a critical result missed by  
 5 medical staff.  
 6 Q. And the critical result was what?  
 7 A. Missed by medical staff.  
 8 Q. What was the critical result?  
 9 A. They didn't know how to read a CBC.  
 10 They didn't understand that this patient had  
 11 infection brewing because they didn't know what to  
 12 do with the differential dia -- the differential on  
 13 the CBC, and they missed brewing sepsis.  
 14 Q. And you're -- you're --  
 15 A. Let's see.  
 16 Q. -- you're saying that that -- you  
 17 believe that has bearing on this case?  
 18 A. It's exactly what the physicians  
 19 did in the emergency room with Jase Foster, they  
 20 did the exact same thing.  
 21 Q. And tell me again what they did.  
 22 A. They missed the infection that was  
 23 already going on in Jase Foster on 9/5. The  
 24 doctor, Doctor Argotte, wrote his CBC was normal.  
 25 His CBC was not normal, it absolutely was not.

1 And if you look at page 2 of my notes,  
 2 of the purple, I have CBC, white count, 8.9.  
 3 Granulocyte, 77.2, which are elevated. Immature  
 4 granulocytes, 2.4, elevated. That's what's called  
 5 a left shift.  
 6 So granulocytes are a specific type of  
 7 white blood cell that are used to fight infection,  
 8 and when they're elevated, the body is fighting  
 9 infection. And immature granulocytes is the body's  
 10 ability to try to create more white blood cells to  
 11 fight an infection that is currently  
 12 existing.  
 13 He's tachycardic, he has a fever, he's  
 14 had a change in his status, he's had temperatures  
 15 of three days while he was on amoxicillin.  
 16 And then when you look at the X-ray,  
 17 it says, "sub-Q stranding and soft tissue swelling  
 18 along the distal aspect of the fibula and overlying  
 19 the foot. Cellulitis is a possibility. Clinical  
 20 correlation is needed". The doc that saw this  
 21 person on the 5th missed it. And had he been put  
 22 in the hospital like he was supposed to, this blood  
 23 culture stuff would not have mattered at all.  
 24 Q. I'm still talking about Diana and Mark  
 25 Sullivan.

1 And so --  
 2 A. Sure.  
 3 Q. -- the critical result would have been  
 4 the CDC?  
 5 A. Correct.  
 6 Q. And who failed to convey the CDC  
 7 results in that matter?  
 8 A. The nurse practitioner didn't  
 9 interpret it correctly.  
 10 Q. Oh, so an interpretation? It's not  
 11 a -- how to handle it, but they just didn't  
 12 understand it?  
 13 A. They didn't understand it, so  
 14 therefore, they didn't contact the patient --  
 15 Q. Okay.  
 16 A. -- to go to the ER.  
 17 Q. All right.  
 18 A. Yeah.  
 19 Q. Were there -- Were there policies that  
 20 were pertinent in that case, that -- or was this  
 21 just a matter of a doctor or a P.A. not  
 22 appreciating the significance of some abnormal  
 23 findings on the CBC?  
 24 A. Yeah, it was the medical personnel not  
 25 doing their job.

1 Q. Okay. So that -- okay. Anything else  
 2 that would relate to our case?  
 3 A. Let me see.  
 4 There's one more where there was a  
 5 missed -- in that regard to policy and procedure.  
 6 I'm trying to find it. It was here in Kentucky. I  
 7 can't find it now.  
 8 It's a case where compartment syndrome  
 9 was missed by the provider, with the swelling and  
 10 the complaints of pain. It wasn't dealt with, and  
 11 the patient ultimately lost her finger. So she had  
 12 compartment syndrome like Jase Foster ultimately  
 13 had.  
 14 But I don't -- I can't identify it.  
 15 It was the one in Kentucky.  
 16 Q. Okay. All right. Your CV would set  
 17 out your educational background?  
 18 A. Yes.  
 19 Q. It sets forth all of your employment  
 20 background?  
 21 A. Yes.  
 22 Q. You've been board certified as a  
 23 family nurse practitioner since 1998?  
 24 A. Yes. I graduated in '97 and passed my  
 25 boards in '98, yeah.

1 Q. From '93 to '98, did you work in an  
2 emergency department setting?

3 A. '93 to '98.

4 Q. You've already testified you didn't  
5 begin until 2001. I just wanted to be clear.

6 A. No. I was in family practice at that  
7 time.

8 Q. Okay. So you began your -- your  
9 professional work in a family practice setting and  
10 then migrated into an emergency department role,  
11 fair?

12 A. I did. I did several things during  
13 that time. I taught at a university. I did  
14 independent coverage of practices in Shelbyville,  
15 Indiana, and I worked in the ER. I was juggling a  
16 number of things at that time.

17 Q. Your certification has been in good  
18 standing since you became a certified family nurse  
19 practitioner?

20 A. Yes.

21 Q. Is there any certification that would  
22 apply specifically to working as a nurse  
23 practitioner in an emergency department?

24 A. When I went to school, they didn't  
25 have a certification or a board process for nurse

1 practitioners in the ER. It exists now.

2 Q. Right.

3 Do you -- do you have that?

4 A. I don't. I could probably teach in  
5 that program. I -- I see no need --

6 Q. And when --

7 A. -- to go get it.

8 Q. -- and when did that certification  
9 become available?

10 A. You know, I don't even know.

11 Q. Okay. But you -- you don't have it?

12 A. I don't have it. I don't need it.

13 Q. Do you intend to work in an emergency  
14 department setting in the future?

15 A. I don't know. I don't believe so,  
16 but --

17 Q. Okay.

18 A. -- things change all the time.

19 Q. So let's talk about Jill Baldwin as  
20 a -- in your professional life.

21 Your typical week would be two days in  
22 a family practice clinic?

23 A. Uh-huh.

24 Q. In addition, one or more, a few days,  
25 a month working for another family practice?

1 A. Yeah. Sometimes I cover the whole  
2 week for her. Like I'm covering all next week and  
3 then I have three more weeks scheduled so far this  
4 year.

5 Q. I mean, we're -- it's Wednesday.

6 I mean, what -- what did you do on  
7 Monday this week?

8 A. I worked.

9 Q. In the family practice?

10 A. Yeah. Mondays and Tuesdays, I'm in  
11 LaGrange.

12 Q. Okay. And then if you were to break  
13 down your work between expert work and working in  
14 your field as a nurse practitioner, what's the  
15 breakdown?

16 A. It's probably 70/30 clinical.

17 Q. Okay. Do you have a -- is there a  
18 physician that you're responsible to as a nurse  
19 practitioner?

20 A. No, not in the state of Kentucky. I'm  
21 an independent provider.

22 Q. Okay. Are you a member of any  
23 professional organizations?

24 A. Yes, I'm a member of the American  
25 Academy of Nurse Practitioners, the Kentucky

1 Association of Nurse Practitioners and Nurse  
2 Midwives. I was a member of the AALNC, and I  
3 forgot to renew and still haven't done it.  
4 And I'm a member of Institute for Functional  
5 Medicine. That needs to be included on there, but  
6 I haven't -- I haven't included that yet.

7 Q. Have you ever been a -- a defendant in  
8 a medical malpractice lawsuit?

9 A. No, I have not been sued.

10 Q. Have you ever had any complaints filed  
11 against you with the licensure board?

12 A. No.

13 Q. And your license would be  
14 a license for Kentucky, is that correct?

15 A. Correct.

16 Q. Any other states?

17 A. They're all inactive at this  
18 point. My original license would have come from  
19 Ohio and then Indiana and Kentucky, but I no longer  
20 carry Ohio and Indiana.

21 Q. Okay. Any experience in Muhlenberg  
22 County? Have you ever been there?

23 A. No.

24 Q. You've not been to the Muhlenberg  
25 Community Hospital?

1 A. I have not. It sounded extremely  
2 similar to the one that I worked at in 2001 and  
3 2005, though.  
4 Q. In terms of your focus of your  
5 practice, I -- I would say it would be both family  
6 medicine, as well as emergency medicine?  
7 A. In general, yes, I -- I do cases for  
8 both family practice and ER.  
9 Q. Do you maintain a website advertising  
10 your services?  
11 A. I don't.  
12 Q. My memory is that you do have --  
13 have -- have affiliated with some of these expert  
14 groups, have you not?  
15 A. Uh-huh.  
16 Q. Which ones?  
17 A. Yeah. I think you found me on -- oh,  
18 no -- Expert -- it just went out of my mind. It --  
19 I'm in their database. And I understand that  
20 attorneys pay to have access to the database, and  
21 it's where you found me. Expert something, I can't  
22 remember the name of it.  
23 I am also in the directory for SEEK.  
24 Q. I -- I will represent to you I did not  
25 pay anybody for a reference or finding your name.

1 I'm not sure what you're talking about. So --  
2 A. Oh, I -- I'm sorry. It's Expert  
3 Institute. And I thought you found me through  
4 Expert Institute. I was just trying to describe  
5 the service since I couldn't recall the name at the  
6 moment.  
7 Q. Okay. So do you --  
8 A. Expert Institute.  
9 Q. -- do you pay to be part of the Expert  
10 Institute --  
11 A. No.  
12 Q. -- family?  
13 A. No.  
14 Q. What about SEEK, are you part of that?  
15 A. Yes. I do pay for a spot in their  
16 electronic and the paper directory.  
17 Q. Okay. Any -- any other expert groups  
18 that you're associated with?  
19 A. No.  
20 Q. All right. Ever work with Mr.  
21 Monhollen before?  
22 A. No. I've worked with Mr. Sheffer and  
23 Mr. Tackett.  
24 Q. All right. Question: "Have you ever  
25 worked with Mr. Monhollen?" Answer: "No".

1 A. No.  
2 Q. Have you worked with his firm  
3 before?  
4 A. Yes.  
5 Q. And that would include both Mr.  
6 Sheffer, as well as one of his other attorneys?  
7 A. Mr. Tackett.  
8 Q. Okay. And how many cases have you  
9 worked on with Mr. Sheffer?  
10 A. Two, I think.  
11 Q. All right. Any of those current?  
12 A. I don't think so.  
13 Q. Any of those part of the depositions  
14 that you provided to us the last time?  
15 A. No. This is the only deposition I've  
16 done with this law office.  
17 Q. And in those two cases, Mr. -- Mr.  
18 Sheffer would have been for the defense?  
19 A. Yes.  
20 Q. And then Mr. Tackett, how many cases  
21 with him?  
22 A. One.  
23 Q. And would that be part of the list of  
24 depositions that you provided to us?  
25 A. I've not been deposed with anybody --

1 Q. Okay.  
2 A. -- in this office other than today.  
3 Q. And was that a defense case, as well?  
4 A. It was.  
5 Q. Okay. When were you first contacted?  
6 A. End of February, beginning of March in  
7 '24.  
8 Q. So February, March of 2024?  
9 A. Yes.  
10 Q. And that would have been a few months  
11 before your disclosure was filed in this case?  
12 A. Correct.  
13 Q. All right. And you weren't familiar  
14 with Mr. -- or you weren't familiar with Mr.  
15 Monhollen before he contacted you? You knew his  
16 firm, but you didn't know him?  
17 A. Correct.  
18 Q. And was it Mr. Monhollen who, in fact,  
19 contacted you?  
20 A. I believe Laura Morgan contacted me.  
21 Q. All right. And does she work with Mr.  
22 Monhollen?  
23 A. She does. I don't know if she's the  
24 legal assistant, I -- I don't exactly know what her  
25 job title is.

1 Q. And what did she ask you to do?  
 2 A. If I would be willing to look at a  
 3 case for them.  
 4 Q. All right. Anything else that she  
 5 told you?  
 6 A. No. Just that it was probably a  
 7 pediatric ER case, but that's -- that's it.  
 8 Q. And before you reviewed any material,  
 9 did you also speak with -- speak with Mr.  
 10 Monhollen?  
 11 A. I don't -- no, I don't believe so.  
 12 Q. Okay. And in terms of what you  
 13 received, we've already gone over that.  
 14 I'm guessing that initially -- and I  
 15 shouldn't guess anything -- but initially, you  
 16 would have gotten depositions and medical records?  
 17 A. Well, I would have gotten all of the  
 18 medical -- the medical records. I don't know how  
 19 many depositions that I had initially. I didn't  
 20 write an order or write down when I actually got  
 21 them. I probably had the grandparents, maybe.  
 22 Generally, I try to form my opinion  
 23 out of the medical -- the medical chart initially.  
 24 Q. Well, in your disclosures, you  
 25 specifically referenced the defense -- I'm -- I'm

1 case?  
 2 A. No. What I'm saying to you is, I  
 3 receive expert depositions along the line  
 4 with all the other depositions, and I don't keep  
 5 track of when I receive what, and every case --  
 6 Q. I didn't say depositions.  
 7 A. -- is different.  
 8 Q. I said expert disclosures.  
 9 And I'm -- and you've --  
 10 A. Oh.  
 11 Q. -- testified you got the disclosure in  
 12 this case, and it sounds like you got it early on,  
 13 because it's referenced in your -- your expert  
 14 disclosure.  
 15 Is it typical for you to get the  
 16 expert disclosure when you're being asked to do an  
 17 independent review of a new case?  
 18 A. You know, I don't know. I mean, I  
 19 don't -- every case comes in with different  
 20 information in a different order.  
 21 Q. So did you review the Plaintiff's  
 22 expert disclosure before you formulated your  
 23 opinions in this case?  
 24 A. If it says that I had -- one moment.  
 25 I think the disclosure mentions Dr. Goodspeed. And

1 sorry, the Plaintiff's experts.  
 2 And I'm guessing that you -- which you  
 3 haven't disclosed to us, but you probably also got  
 4 Plaintiff's expert disclosure.  
 5 Did you get that?  
 6 A. Yeah, I'm -- I'm assuming that I  
 7 did. Like I said, I didn't --  
 8 Q. Well, you didn't --  
 9 A. -- write them down.  
 10 Q. -- you didn't mention that, though.  
 11 Was that not important? So when you  
 12 first got the case, you knew already who the  
 13 Plaintiff's experts were and what their opinions  
 14 are, correct?  
 15 A. Well, I would have had to have  
 16 received it if it's in my disclosure, but I don't  
 17 actually recall what date that I received it.  
 18 Q. Is it typical that you would get an  
 19 expert disclosure in a case that you're asked to  
 20 give an independent review on?  
 21 A. I get expert disclosures --  
 22 disclosures all the time. Depositions come in in  
 23 different ways in every case.  
 24 Q. So you get expert disclosures all the  
 25 time before you've even reviewed the material in a

1 if it says that I read it, then I assume that I  
 2 did. But I don't recall, again, what order I read  
 3 anything in.  
 4 (Whereupon the witness's phone rang.)  
 5 Oh, my goodness. I'm sorry. I  
 6 thought I had turned that off. I'm trying to put  
 7 it in airplane mode. Believe it or not, that was  
 8 the car insurance company. Okay. Sorry about  
 9 that.  
 10 Q. Okay. In -- in your disclosure, you  
 11 specifically are referencing Dr. Goodspeed and your  
 12 opinion of Dr. Goodspeed. I'll represent to you  
 13 that Dr. Goodspeed's deposition had not taken place  
 14 as of May 1st, 2024.  
 15 So it's clear, is it not, that you had  
 16 been given the expert disclosure of the Plaintiffs  
 17 before you formulated your opinions?  
 18 A. Again, I don't recall in which order I  
 19 got this. I am --  
 20 Q. It's in the disclosure, ma'am.  
 21 Is it clear that you had read it  
 22 before you formulated your opinions and this  
 23 disclosure was provided --  
 24 A. Well --  
 25 Q. -- to me?

1 A. -- yes. I already stated --  
 2 Q. Thank you.  
 3 A. -- if it's in the writing, I assume  
 4 that that's the order in which it occurred.  
 5 Q. And you're saying sometimes you get  
 6 expert disclosures from the other side before you  
 7 do an independent review, and sometimes you don't,  
 8 is that fair?  
 9 A. Correct.  
 10 Q. And -- okay, we'll leave -- we'll  
 11 leave it at that.  
 12 Have you spoken to anybody  
 13 specifically that works for Muhlenberg Community  
 14 Hospital?  
 15 A. No.  
 16 Q. Let's talk about your fees. One of  
 17 the things that was in the notice was you were to  
 18 bring to us -- or with you your -- your -- your fee  
 19 schedule and your -- your -- your statements in  
 20 terms of your charges.  
 21 Have you done that?  
 22 A. I've got invoices. I did not bring my  
 23 fee schedule. That was simply an oversight, and I  
 24 can get that sent in. But I have two invoices that  
 25 have been paid so far.

1 of travel.  
 2 Q. Did you find your two invoices?  
 3 A. I did. They're right here.  
 4 MR. KINNEY: Okay. We'll -- we'll  
 5 mark and file this as the next -- next exhibit, but  
 6 I'm thinking I'm up to No. 7.  
 7 Does that seem right to you, sir?  
 8 THE COURT REPORTER: That's right.  
 9 (Whereupon, Exhibit No. 7 was marked  
 10 for identification.)  
 11 Q. And Exhibit 7 is a two-page document  
 12 and is showing that prior to today --  
 13 A. There is an error on the second  
 14 invoice.  
 15 Q. Well, let's --  
 16 A. Yeah.  
 17 Q. -- do that in just a second.  
 18 So the first invoice dated 4/4/2024 is  
 19 for 12 and a quarter hours, right?  
 20 A. Correct.  
 21 Q. Okay. And then since that time, you  
 22 generated a second invoice.  
 23 And what was the mistake on there?  
 24 A. It's listed at 350 an hour instead of  
 25 400. That was my error.

1 Q. Okay. Well, I -- you -- you --  
 2 A. I'll add that to my list.  
 3 Q. I would -- well, I don't know that I  
 4 need it. I would hope that as we sit here today,  
 5 you know what your fee schedule is, right?  
 6 A. I do.  
 7 Q. All right. So what do you charge for  
 8 reviewing medical records and depositions?  
 9 A. 400 an hour across the board for all  
 10 services.  
 11 Q. Okay. And that would include today's  
 12 deposition?  
 13 A. It would.  
 14 Q. And that would include trial  
 15 testimony, if you're asked to testify in this  
 16 matter?  
 17 A. It would.  
 18 Q. And in terms of how you charge for  
 19 attending trial, would that be a flat fee, or is it  
 20 how many hours each day that you spend either in  
 21 transit or actually testifying?  
 22 A. If it's in Kentucky and I  
 23 don't spend the night, when I leave the house to  
 24 when I get home. If it's overnight, it's 4,000 or  
 25 billing basically for 10 hours, plus the expenses

1 Q. Okay.  
 2 A. So this was not billed --  
 3 Q. So the only change --  
 4 A. -- in full.  
 5 Q. -- the only change should be?  
 6 A. The hours -- or the -- the rate,  
 7 excuse me, the hourly rate on that bill.  
 8 Q. All right. So the hours are correct,  
 9 just the rate's incorrect?  
 10 A. Correct.  
 11 Q. And that invoice was as of 4/3/2025?  
 12 A. Correct.  
 13 Q. And -- let's break this down. You say  
 14 transcript review.  
 15 I assume that's referring to  
 16 deposition?  
 17 A. Correct.  
 18 Q. Which depositions did you review that  
 19 would be part of the invoice dated April 30th,  
 20 2025?  
 21 A. As I said earlier, I don't know the  
 22 order in which I reviewed the materials. I didn't  
 23 write that down. I just write a note of what I'm  
 24 generally doing and stick it on the invoice.  
 25 Q. Okay. And then it also says

1 deposition prep as part of the 3.25 hours that make  
2 up the second invoice.

3 How many hours would be focused on  
4 deposition prep?

5 A. Again, I didn't write the details  
6 down, other than I was reviewing materials.

7 Q. Okay. Would it include a conference  
8 with Mr. Monhollen?

9 A. Most likely, yes. There's a --

10 Q. Okay.

11 A. -- phone consultation in there  
12 somewhere.

13 Q. Okay. And then from 4/30 until  
14 today's date, which I think it's the 14th, that  
15 would be -- so for two weeks, have you had any  
16 additional time?

17 A. Yeah, I've probably had another 10  
18 hours in this case, or more, given the number of  
19 depositions that I had to go through.

20 Q. Okay. That aside, when you talked  
21 about September 5th and all these findings, can  
22 we -- fair to say it's not contained in your  
23 disclosure?

24 A. One moment.

25 Q. Is it contained in your disclosure?

1 A. I don't know that it's in my  
2 disclosure. No, I don't believe so.

3 Q. Okay. When did you come up with that  
4 opinion?

5 A. When I originally reviewed the records  
6 at -- on my notes.

7 Q. So --

8 A. Or it would have been a second -- a  
9 second roll through, because it's, unfortunately, a  
10 different color, but --

11 Q. As of May 1st, 2024, had you come to  
12 the opinion that a provider had deviated from  
13 the standard care for not appreciating the findings  
14 from an X-ray that was done on September 5th?

15 A. Most likely.

16 Q. Most likely.

17 Why isn't it in here?

18 A. I don't know. You'll have to discuss  
19 that with Mr. Monhollen.

20 Q. Did you have that opinion as of May  
21 1st, 2024?

22 A. Yeah. It's written on my notes from  
23 my original review.

24 Q. Okay. Did you talk with Mr. Monhollen  
25 about that opinion, as well?

1 A. I have told him that opinion, yes.

2 Q. Okay. And did you have a chance to  
3 review the disclosure before it was filed?

4 A. I did review my disclosure.

5 Q. And you saw that it wasn't contained  
6 in there, correct?

7 A. Yes.

8 Q. And did you raise that point with Mr.  
9 Monhollen?

10 A. Apparently, I didn't.

11 Q. You didn't, or you may have?

12 A. I don't know.

13 Q. So you -- you may or may not have?

14 A. May or may not have.

15 Q. Did Mr. Monhollen tell you that he  
16 didn't think that opinion was important to the  
17 case?

18 A. No.

19 Q. You thought it was important?

20 A. I do think it's important, but --

21 Q. But you didn't enclose it in your --  
22 in your disclosure?

23 A. -- but it's not in the disclosure.

24 Q. Have you authored a supplemental  
25 disclosure to set forth that opinion?

1 A. Not that I'm aware of, no.

2 Q. Okay. Thank you.

3 Ms. Baldwin, as we talked earlier,  
4 it's fairly common for a blood culture to be  
5 ordered for patients that are seen in the emergency  
6 department, true?

7 A. Correct.

8 Q. And you've done that before, correct?

9 A. A number of times, yes.

10 Q. And as a nurse practitioner, I'm  
11 guessing -- I shouldn't guess -- but have you ever  
12 received the results of a blood culture that you  
13 ordered, that demonstrated a positive finding?

14 A. I'm sure I have, yes.

15 Q. And you, as a nurse practitioner,  
16 given that information, would you act upon that?

17 A. Yes.

18 Q. And would you believe that a positive  
19 blood culture showing potential MRSA, is that  
20 something that you've seen before?

21 A. Yes, I've seen cultures with  
22 gram-positive cocci, yes.

23 Q. Okay. And what would you do if you  
24 got that information?

25 A. If it's a patient discharged from the

1 emergency department, I would open that chart, I  
2 would look at the situation, and then I would call  
3 the patient or ask one of the nurses to call the  
4 patient and have them return to the emergency  
5 department, particularly if it's a two year-old  
6 with ankle pain.

7 Q. So, fair to say on many occasions,  
8 you've had this happen?

9 A. Yes.

10 Q. And some of the time, you would get  
11 the information, review it, look at the chart for a  
12 patient not in the ED, and then you would instruct  
13 the nurse who had given you the information to  
14 contact the family, correct?

15 A. Say that again? For a patient who had  
16 been discharged from the emergency room? Or I  
17 would contact the patient myself.

18 Q. I understand that.

19 A. Yeah.

20 Q. Isn't that what --

21 A. I just want to be clear about my  
22 points, I'm just trying to get all my information  
23 out here.

24 Q. Ms. Baldwin, you testified that you've  
25 gotten these kinds of results before, that is a

1 positive blood culture, correct?

2 A. Yes.

3 Q. And you've testified that on some  
4 occasions, you would instruct the nurse, after  
5 looking at the charts for a patient not in the  
6 emergency department, and give the nurse  
7 instruction to contact the family, is that correct?

8 A. If I thought that was appropriate, or  
9 I would call the patient myself, but saying --

10 Q. I understand that. That wasn't my  
11 question.

12 I said some of the times.

13 A. It is not -- everything is not a yes  
14 or no answer.

15 Q. It isn't, I understand that.

16 I'm just talking about those occasions  
17 where you, in fact, instructed the nurse to do  
18 something, the instruction would be contact the  
19 family, right? You've done that?

20 A. Probably, yes.

21 Q. Probably or not?

22 A. I'm saying in 16 years in the ER, yes,  
23 there's a likely chance that that has happened.

24 Q. In fact, it's something that probably  
25 happened quite often, correct?

1 A. No. There was a lot of times, I would  
2 call that patient myself.

3 Q. Okay. Okay. So in your situation, in  
4 working in the Browns -- in the Norton facilities,  
5 given this information, often, you would  
6 make the contact yourself with the family?

7 A. Yes.

8 Q. But sometimes, you would instruct the  
9 nurse to do it?

10 A. Yes.

11 Q. And as a prudent nurse practitioner,  
12 would you chart when the patient's medical record  
13 that you had received this information and what you  
14 did with it?

15 A. Yes, I would have opened the chart.  
16 And in the EPIC system, there's a way to go back  
17 and make comments on the inbox where the  
18 information had been filed, as well, so you can go  
19 back and find it, and there is usually a place to  
20 document that.

21 Q. And you would?

22 A. Yes.

23 Q. Okay.

24 A. By the way, Martin, you can yell at me  
25 all you want, it's -- it's not going to get me to

1 change my -- raising your voice is not going to get  
2 me to change my answer. So I'd appreciate it if  
3 you spoke to me with respect.

4 Q. I'm sorry, I didn't hear what you  
5 said.

6 Did you make a comment?

7 A. I made a comment about you raising  
8 your voice to me. It's not going to change my  
9 answer. And I would just ask you to treat me with  
10 respect.

11 Q. And I didn't realize I was raising my  
12 voice with you, ma'am.

13 A. Thank you.

14 Q. In looking at your notes, and I may  
15 have missed it, Ms. Baldwin, but I didn't see  
16 any -- any references to your summaries of  
17 depositions that you read.

18 Am I incorrect?

19 A. There's two packets. This one, it  
20 starts with opinions at the top. This has notes  
21 about some of the depositions.

22 Q. All right. Are there notes about  
23 depositions on page 1?

24 A. No. Those are my opinions.

25 And then page 2 -- the next three

1 pages are notes from depositions.

2 Q. Okay. So you've got summaries of what  
3 you thought was important for Emily Knight, Jessica  
4 Tedders?

5 A. Yeah, just comments or things that  
6 they -- they said, that -- that I thought might be  
7 important for today's discussion.

8 Q. Okay. Then Kim --

9 A. Lasder.

10 Q. -- Kim Lasder, Lincoln Dempsey, Malik  
11 McCrary.

12 And can you tell us and the jury when  
13 you generated Exhibit 4, which are the opinions and  
14 notes?

15 A. Some of this was generated as I went  
16 through, some of it was generated in the last week.  
17 Some of the depositions, I read twice. So  
18 sometimes you'll see added notes or things to that.

19 Q. In fact, didn't most of Exhibit 4 --  
20 is this something you just recently generated?

21 A. No. Actually, I had some notes  
22 scribbled in here, and when I reread it, I carried  
23 that over and added to it. So some of these notes  
24 were in here already, and some of them were not.

25 Q. Well, when did you summarize what you

1 result, when a patient was no longer in the  
2 hospital, that had been seen in the emergency  
3 department?

4 A. I always think it was very clear  
5 throughout their deposition that they understood  
6 the steps in which it was going to happen, the --  
7 the actual procedure.

8 Q. So you're going to testify in this  
9 case that the depositions of Dr. Coomes and Nurse  
10 Knight and Nurse Tedders, as well as the others,  
11 are all consistent in terms of what should happen  
12 with a clinical -- with a critical result?

13 A. I was not referring to Dr. Coomes.  
14 I was referring to the process that occurs between  
15 the lab infection control and the nurse in the ER.  
16 Those were pretty consistent in the way in which  
17 these steps occur.

18 Q. Who is Dr. Coomes?

19 A. Dr. Coomes is the medical director for  
20 that emergency department.

21 Q. Should he understand what should  
22 happen with a critical result that comes back for a  
23 patient that was seen in the emergency department,  
24 that's no longer there?

25 A. He should, but...

1 thought was important from the depositions?

2 A. The mean -- on the depositions, would  
3 have been -- like, again, some of it's when I first  
4 read it, and some of it's been in the last couple  
5 of weeks.

6 Q. Uh-huh.

7 Okay. We've talked before that you  
8 were given Dr. Reich's deposition.

9 A. Uh-huh.

10 Q. And you've testified that you did  
11 review it --

12 A. Correct.

13 Q. -- although you don't remember all of  
14 it.

15 Is that a fair statement?

16 A. It is. I don't remember verbatim, no.

17 Q. Do you recall Dr. Reich testifying  
18 that a hospital has a responsibility to train  
19 employees on the hospital policies?

20 A. I don't recall, but...

21 Q. Do you agree with that?

22 A. I would agree with that.

23 Q. And from the depositions that you've  
24 read in this case, did everybody understand what  
25 was supposed to happen with the blood culture

1 Q. He should.

2 You'd expect he would?

3 A. You would hope that he would. But  
4 it's through the other --

5 Q. And --

6 A. -- depositions they disagree with him,  
7 so --

8 Q. I understand that.

9 A. -- it doesn't say that he does.

10 Q. When you worked in the emergency  
11 department, did you ever work with the director of  
12 the emergency department?

13 A. Yes.

14 Q. And was the director somebody that  
15 was -- that you reported to?

16 A. Yes.

17 Q. If you had questions, was the director  
18 someone you could go to to get clarification, if  
19 you had questions?

20 A. Any of the physicians that were on  
21 staff while I was there --

22 Q. I'm talking about the director of the  
23 emergency department.

24 A. If he was on staff at the time,  
25 yes -- I mean, in the ER at that time, on the same

1 shift, I would.  
 2 Q. In terms of the -- the -- the  
 3 hierarchy in the emergency department, would the  
 4 director be on the top rung?  
 5 A. Yes.  
 6 Q. And he would be responsible for those  
 7 that worked in the emergency department, correct?  
 8 A. He would be responsible for -- well,  
 9 it depends. He's certainly responsible for his  
 10 staff, and he's responsible for being the liaison  
 11 between his staff and the hospital.  
 12 Q. Okay.  
 13 A. But I don't know that he's responsible  
 14 for what the lab should be doing with critical  
 15 results.  
 16 Q. And does he have responsibility over  
 17 the training of the nursing personnel that -- that  
 18 staff the emergency department at Muhlenberg  
 19 Community Hospital?  
 20 A. No, he does not.  
 21 Q. And what do you base that on?  
 22 A. 16 years of being a nurse practitioner  
 23 in the ER. He's over his own staff. If there's  
 24 difficulty between his own staff and hospital  
 25 staff, then it would be their responsibility to

1 liaise on that. But the ER director, as far as I  
 2 know, in my experience, is responsible for his  
 3 staff or her staff.  
 4 Q. And that staff in this setting would  
 5 be who?  
 6 A. Staff in this setting would be Doctor  
 7 Malik, Doctor Tauil, people that were employees of  
 8 Envision at the time.  
 9 Q. Doctor Wright also testified -- I'm  
 10 going to ask if you agree with this -- "hospital  
 11 policies are in place to ensure patient safety and  
 12 to maintain quality care".  
 13 Do you agree with that?  
 14 MR. MONHOLLEN: Object to  
 15 the form. But you can answer.  
 16 A. I agree with policy, but there's a  
 17 difference between policy and procedure. Procedure  
 18 is not always outlined. Policy is a framework,  
 19 meaning --  
 20 Q. My question was very simple.  
 21 Do you agree or disagree that hospital  
 22 policies are in place to ensure patient safety and  
 23 to maintain quality care?  
 24 A. Yes, I believe that is one of the --  
 25 one of the responsibilities of policy, yes.

1 Q. And we can agree that there is nothing  
 2 in the hospital policy for the handling of critical  
 3 values that would address what to do with a patient  
 4 seen in the emergency department, that is no longer  
 5 in the hospital when the results come back, true?  
 6 A. Again, it doesn't say if the patient  
 7 has been discharged. But on the back of nursing  
 8 policy for two, it says, "note, these guidelines  
 9 are not inclusive, nor is this policy limited to  
 10 the items stated", which means this policy is not  
 11 meant to be all-inclusive for every situation.  
 12 Q. My question was very simple, ma'am.  
 13 Within the four --  
 14 A. And so was my answer, sir.  
 15 Q. -- within the four corners of the  
 16 critical value policy, does it address the scenario  
 17 where a patient has a blood culture done in the  
 18 emergency department, that comes back positive, but  
 19 they're no longer in the emergency department, yes  
 20 or no?  
 21 A. It makes note of that by saying this  
 22 can't possibly have everything. So they address  
 23 the issue, but it's not in here, because they write  
 24 this is not inclusive.  
 25 Q. I'm not sure about your answer, but

1 you agree there's nothing in this policy that  
 2 addresses the scenario I just discussed, other than  
 3 you're referencing to a sentence that says this may  
 4 not be all-inclusive?  
 5 A. Yes. The bottom of this policy  
 6 says --  
 7 Q. I got you.  
 8 A. -- this guideline --  
 9 Q. I got you.  
 10 A. -- doesn't include everything.  
 11 Q. Right.  
 12 A. It's not possible --  
 13 Q. Right.  
 14 A. -- to include every single scenario.  
 15 Q. Okay. Dr. Reich also testified that  
 16 it's imperative that hospital personnel know and  
 17 understand the policy for critical results.  
 18 Do you agree with that?  
 19 A. I would agree --  
 20 MR. MONHOLLEN: Object to the form.  
 21 Go ahead.  
 22 A. I would agree that they understand the  
 23 way in which critical values should be handled.  
 24 MR. KINNEY: What was the objection?  
 25 MR. MONHOLLEN: That wasn't his quote.

1 THE WITNESS: Yeah.  
 2 MR. MONHOLLEN: I'm only objecting to  
 3 the form because --  
 4 MR. KINNEY: It is a direct quote,  
 5 "hospital personnel should know and understand  
 6 policies for critical results".  
 7 MR. MONHOLLEN: You said imperative.  
 8 That's not what he said.  
 9 MR. KINNEY: Well, let me restraight  
 10 -- restate it.  
 11 Q. Do you agree with Dr. Reich's  
 12 testimony that a hospital personnel should know and  
 13 understand the policy for critical results?  
 14 A. I understand that they need to un --  
 15 yes, that, and the procedure in which it happens.  
 16 Q. Okay. In your disclosure, you state  
 17 the following: "Nursing and laboratory staff  
 18 followed the unwritten procedure for notification  
 19 of a critical value in this laboratory, which has  
 20 been in place for a number of years".  
 21 So, first of all, what is the  
 22 unwritten procedure?  
 23 A. Okay. I'm sorry. Where are you at in  
 24 this deposition -- I'm sorry. Where are you at in  
 25 my disclosure? I apologize.

1 Q. You don't agree that you made that  
 2 statement, "nursing and laboratory staff followed  
 3 the unwritten procedure for notification of a  
 4 critical value in the laboratory, which has been in  
 5 place for a number of years"?  
 6 A. I would like to read below -- above  
 7 and below the statement that you made so that --  
 8 Q. Sure.  
 9 A. -- I can get a context.  
 10 Q. I have it as the second page, second  
 11 full paragraph, halfway down, that states,  
 12 "furthermore, Ms. Baldwin is expected to testify  
 13 that the Hospital Defendant met the standard of  
 14 care in the policies and procedures that were in  
 15 place at the time of the events, the handling of  
 16 the presumably positive blood culture result and  
 17 the process which was utilized in the transmission  
 18 of such information from the laboratory to the  
 19 emergency department. She will testify that the  
 20 nursing and laboratory staff followed the unwritten  
 21 procedure for notification of a critical value in  
 22 the laboratory, which has been in place for a  
 23 number of years".  
 24 A. Yes, I --  
 25 Q. Is that not a direct -- am I not

1 quoting directly from your disclosure?  
 2 A. It is a direct quote. And I wanted to  
 3 understand the context, the paragraph that it was  
 4 in. And I would say yes, they testified to the  
 5 unwritten procedure of notification.  
 6 Q. Okay. What is the unwritten  
 7 procedure?  
 8 A. The unwritten procedure is that a  
 9 critical value is called from the lab -- it's a  
 10 blood culture, it's called from the lab to  
 11 infectious control. It is then called to a staff  
 12 member in the emergency department, who is  
 13 licensed, either a nurse or a medical provider. If  
 14 the nurse receives it, the medical provider is to  
 15 be notified.  
 16 And then the medical provider is to  
 17 make decisions on that case and what needs to  
 18 transpire for that patient's care, for patients  
 19 that are no longer in the hospital.  
 20 Q. Okay. And how long has this unwritten  
 21 policy been in place? You said it's been there for  
 22 years. So tell us how long it's been there.  
 23 A. The top of the policy says --  
 24 Q. The unwritten policy, ma'am?  
 25 A. I'm looking at the written policy.

1 Q. Unwritten policy that you reference in  
 2 your disclosure? You said it's been in place for a  
 3 number of years.  
 4 How long?  
 5 A. Well, part of it's been in place since  
 6 2008, the policy. The procedure, I don't know at  
 7 what point they started the procedure. But Kim  
 8 Lasder's been there 25 years, so, you know, she  
 9 might be the one --  
 10 Q. You made the statement --  
 11 A. Yeah.  
 12 Q. -- "she will testify that the nursing  
 13 and laboratory staff followed the unwritten  
 14 procedure for notification of a critical value in  
 15 the laboratory, which has been in place for a  
 16 number of years".  
 17 My first question was, what is it?  
 18 And you told me what it was.  
 19 And secondly, I asked, well, how  
 20 many years has it been in place? And your answer  
 21 is?  
 22 A. Well, as long as Lincoln Dempsey has  
 23 been employed there. I mean, that's the procedure  
 24 that he's discussed since his employment. And Kim  
 25 Lasder was there before him. So I don't have an

1 exact date. Because you don't document  
2 procedure all the time. Procedure can change. But  
3 unwritten -- procedure changes based on flow, based  
4 on number of patients you have come in. It's  
5 constantly evolving.

6 So I don't know that they have a  
7 specific date, because it's an unwritten procedure.

8 Q. This unwritten procedure that you  
9 speak about, is there any requirement that anybody  
10 in the chain of communication document what's being  
11 conveyed?

12 A. Typically, what happens when they've  
13 changed a -- sir, I'd like to finish my statement  
14 and tell you --

15 Q. Well, be specific to the case. We're  
16 talking about Muhlenberg Community Hospital and an  
17 unwritten procedure that you believe existed,  
18 and I've asked you how long. You have no idea.

19 I asked you whether there's a  
20 requirement for documentation. Your answer is  
21 what?

22 A. For unwritten procedure? No, not  
23 necessarily.

24 Q. So your testimony would be that this  
25 unwritten procedure did not require anybody to

1 document anything about this critical result as  
2 it's being conveyed from the laboratory to  
3 infection control, to a nurse, to a provider,  
4 nobody's required to document it, correct?

5 A. I'd like to answer that question.  
6 It's not a yes or no question.

7 The policy states, yeah, we would like  
8 to have it documented. In a perfect world,  
9 everyone documents things. The ER is not a perfect  
10 world. Procedures change constantly. We don't  
11 have it in writing what the current -- other than  
12 the depositions. You don't document procedure,  
13 necessarily.

14 And I can tell you, in my experience,  
15 once that information is given to the provider,  
16 it's the provider's responsibility.

17 Q. Fair to say -- well, we talked about  
18 the defense pediatric infectious disease  
19 expert, Dr. Wright, and he made the statement,  
20 "hospital personnel should know and understand  
21 policies for critical results".

22 You agree with that, right? Everybody  
23 should understand what should happen with a  
24 critical result in the emergency department,  
25 correct?

1 A. Yes, I would agree with that.

2 Q. There shouldn't be any confusion among  
3 everybody in that department about what should  
4 happen?

5 A. Yes.

6 Q. You read the depositions?

7 A. I understand. Everyone --

8 Q. Have you --

9 A. -- understands to report it  
10 immediately.

11 Q. Have you read the depositions?

12 A. I have read all of the depositions.

13 Q. Are they consistent?

14 A. As far as, yes, getting information to  
15 a physician, yes.

16 Q. What did Kim Lasder testify was the  
17 procedure that she would -- should follow if a  
18 patient's blood culture comes back positive and the  
19 patient's no longer in the emergency department?

20 A. Kim Lasder states that she's to call  
21 infectious -- infection control or Lincoln Dempsey.

22 Q. Okay. Are you critical of Kim Lasder  
23 in conveying that information to Lincoln Dempsey?

24 A. I'm not.

25 Q. Are you critical of Ms. Lasder for

1 documenting what she did with that critical  
2 information?

3 A. I am not.

4 Q. That's appropriate, correct?

5 A. Correct.

6 Q. And then what was Lincoln Dempsey's  
7 understanding of what he was supposed to do with  
8 that information?

9 A. His understanding was to relay it  
10 to -- excuse me -- the emergency department.

11 Q. All right. And is Lincoln Dempsey  
12 required under this unwritten policy, to note in  
13 the chart what he did with that information?

14 A. According to this policy, yes.

15 Q. And he did not?

16 A. Not that I could see.

17 Q. And we know from Mr. Dempsey's  
18 deposition that he misidentified the person that he  
19 contacted?

20 A. Yeah. That happens when you -- yeah.

21 Q. He did, didn't he?

22 A. He did.

23 Q. And that happens when -- when nurses  
24 and hospital staff fail to document what's  
25 happening in the real time, correct?

1 A. Or it happens when you're sitting in a  
 2 deposition and interact with a myriad of nurses  
 3 during the week.  
 4 Q. And then can Mr. Dempsey call anybody  
 5 in the emergency department, or should he be  
 6 speaking to a specific person?  
 7 A. Licensed -- he needs to talk to a  
 8 nurse or a medical provider.  
 9 Q. All right. And if you had a choice  
 10 between a nurse that had been working at that  
 11 hospital for less than three months, that was still  
 12 in training, versus the charge nurse, who would you  
 13 want that information conveyed to?  
 14 A. I would want the information conveyed  
 15 to me by anybody who received the message. Jessica  
 16 Tedders, again, is not a nurse-in-training. She's  
 17 orienting to a new area as a licensed registered  
 18 nurse.  
 19 And I don't care who hands it to  
 20 me, I just need somebody to hand it to me in a  
 21 timely fashion.  
 22 Q. I think we covered this, but from  
 23 your reading of Ms. Tedders's deposition, did she  
 24 have training at Muhlenberg Community Hospital  
 25 about what she was supposed to do if she got

1 A. Right, in this setting, yes -- or in  
 2 this particular ER, yes.  
 3 Q. Okay. Now, you understood that Ms.  
 4 Tedders was being supervised at the time that this  
 5 communication was -- occurred, correct?  
 6 A. It's not really a supervisory role.  
 7 It's this is the person you go to if you have  
 8 questions. The charge nurse or whoever the  
 9 supervisor is does not go back and check Jessica --  
 10 Jessica Tedders's work, her charting. It's not  
 11 that, because she's a licensed RN.  
 12 The person that she's assigned to  
 13 is available there if she has questions, but they  
 14 don't go back and check her work.  
 15 Q. If you were the supervisor for Ms.  
 16 Tedders back in September of 2019, and she came to  
 17 you about this, would you instruct her to document  
 18 what she did with this critical result?  
 19 A. I would have first told her to hand it  
 20 to --  
 21 Q. That wasn't my question. We'll get to  
 22 that.  
 23 But -- but did -- the question is,  
 24 would you instruct her to document in the chart  
 25 what she did with the critical result?

1 information about a critical result?  
 2 A. According to her, she understood the  
 3 policy.  
 4 Q. Did she get training? That's my  
 5 question.  
 6 A. She would have received training on  
 7 the procedure because she had been orienting for  
 8 almost 12 weeks. So, yes, she knew what to do with  
 9 that procedure.  
 10 Q. Who gave her that training?  
 11 A. It would have been the charge nurses  
 12 or the nurses that were supervising her during her  
 13 orientation.  
 14 Q. Had Ms. Tedders ever been responsible  
 15 or part of the chain of communication for a  
 16 critical result prior to September 6, 2019?  
 17 A. That, I don't know, because I don't --  
 18 Q. Well, she testified to it.  
 19 A. Right. This was the first one she  
 20 would have received in the emergency room. But I  
 21 don't know what her clinical experience was prior  
 22 to being oriented to her new position.  
 23 Q. So you don't know, but you agree that  
 24 that was the first time she got that information  
 25 while working in the emergency department setting?

1 A. When the patient is discharged from  
 2 the emergency department, you don't always have the  
 3 access, as a nurse, to go back and document that.  
 4 That's why it is upon the provider to take care of  
 5 it.  
 6 Q. You're going to represent to the jury  
 7 that there was no way for Ms. Tedders to document  
 8 in Jase Foster's chart, on September 6, 2019, what  
 9 she was doing, correct?  
 10 A. I'm going to tell the jury that yeah,  
 11 we would have preferred that it had been written.  
 12 But the unwritten procedure that occurs in  
 13 emergency departments every single day is exactly  
 14 what Jessica Tedders describes in her testimony.  
 15 Q. Was Ms. Lasder able to access Jase  
 16 Foster's record and document what she did with the  
 17 critical result?  
 18 A. I don't know if --  
 19 Q. You know it's in the chart, ma'am.  
 20 Is it not in the chart that she  
 21 documented --  
 22 A. Again, please speak to me with  
 23 respect.  
 24 Q. Did she document in the chart what she  
 25 did?

1 A. Could you repeat the question with  
 2 respect, please?  
 3 Q. Can you answer the question?  
 4 A. Please repeat the question.  
 5 Q. Did Ms. -- did Kim Lasder document in  
 6 Jase Foster's chart on September 6, 2019, that at  
 7 2.36 p.m., she communicated with Lincoln Dempsey  
 8 the results of a blood culture that came back  
 9 positive, did she do that?  
 10 A. She did. She also --  
 11 Q. So she had access -- so she had access  
 12 to the chart?  
 13 A. I'd like to finish this. She's a lab  
 14 employee, which is a very different role and  
 15 responsibility than Jessica Tedders's. And I can't  
 16 tell you what the job of the lab tech is, nor their  
 17 unwritten policies or procedures or any of that.  
 18 Yes, it was documented, but I don't  
 19 have an opinion on how the lab operates.  
 20 Q. But are you going to tell the jury  
 21 that there was no way for Jessica Tedders to enter  
 22 into the electronic medical record, what she did  
 23 with the critical result when she got it on  
 24 September 6, 2019?  
 25 A. I don't --

1 A. No. As the medical provider in the  
 2 emergency department, I would have taken that  
 3 Post-it note and done something about it at the  
 4 time it was handed to me.  
 5 Q. Makes no sense, does it?  
 6 A. Ms. Tauil doesn't recall whether she  
 7 did her job or not.  
 8 Q. Does it make sense to you --  
 9 A. It absolutely --  
 10 Q. -- that a nurse practitioner --  
 11 A. Yeah.  
 12 Q. -- would not be in a position  
 13 to be able to react to this information and to  
 14 instruct the nurse-in-training to contact the  
 15 family to get this boy into the hospital?  
 16 A. I am very confused on your question at  
 17 this point. What I can tell you is that routine  
 18 practice in the emergency department is nurses hand  
 19 me Post-it notes, scraps of paper, they put it on  
 20 my keyboard, my monitor, they shove it under the  
 21 bathroom door. It's happened constantly. And when  
 22 I -- when that happens, it -- I need to do  
 23 something about it, as the provider. I've been in  
 24 Ms. Tauil's shoes, and I actually do the job when  
 25 it's handed to me, I don't tell them to put it on

1 Q. Would she have, yes or no?  
 2 A. I don't know. I'm not in charge of  
 3 health information for Owensboro Hospital. But I'm  
 4 here to tell you what she describes in her  
 5 testimony occurs all the time in the emergency  
 6 department. What she describes is routine practice  
 7 in the ER. I have no idea. That's a health  
 8 information systems problem.  
 9 Q. Okay. And then she testified that she  
 10 went up to the P.A., Jessica Tauil, and gave her  
 11 a -- or had a Post-it note, correct?  
 12 A. Correct.  
 13 Q. And did she give it to Ms. Tauil?  
 14 A. She tried to give it to Ms. Tauil.  
 15 Q. Did Ms. Tauil take it?  
 16 A. No. Ms. Tauil gave her instructions  
 17 on what to do with that critical value, which  
 18 was put it there, and then Dr. Malik and she would  
 19 take care of it.  
 20 Q. Is that the way Jill Baldwin would  
 21 want the nurse to handle the conveyance of a  
 22 critical result for a patient that was seen in the  
 23 emergency department, that's no longer there, that  
 24 is to put a Post-it note on the desk of the ED  
 25 physician, is that what you would want them to do?

1 so-and-so's desk.  
 2 Q. Well, Ms. Tauil testified that she  
 3 would handle it, didn't she, did she not testify to  
 4 that, if she got this information, she would have  
 5 handled it?  
 6 A. Well, she doesn't --  
 7 Q. Did she -- yes or no?  
 8 A. Everything is not a yes or no  
 9 question.  
 10 Q. I know it's not with you.  
 11 A. She testified that she doesn't think  
 12 that that would be -- she doesn't remember what she  
 13 did, but she assumes she didn't, because that might  
 14 not be her normal practice.  
 15 Q. My question is, does -- did Nurse  
 16 Tauil testify that she would know -- that she would  
 17 handle it and she would know what to do if given  
 18 the information that a patient who was seen in the  
 19 emergency department, who was no longer there, had  
 20 a blood culture that came back positive, did she  
 21 testify she would know what to do?  
 22 A. She would testify that she would know  
 23 what to do.  
 24 Q. And did she testify that she would, in  
 25 fact, handle it?

1 A. She doesn't -- yes. However --  
 2 Q. She did.  
 3 Now --  
 4 MR. MONHOLLEN: She's got an however,  
 5 she's -- she's entitled to -- to finish her -- her  
 6 question.  
 7 A. However, she knew what to do with it,  
 8 and it wasn't done.  
 9 Q. Now, in this case, it sounds like, to  
 10 me, you're putting a lot more credence on the  
 11 testimony of the nurse-in-training, Jessica  
 12 Tedders, who didn't document anything in this  
 13 chart, versus the testimony of P.A. Tauil, correct?  
 14 A. I am. Because in my experience -- I  
 15 have been in the shoes of P.A. Tauil for 16 years,  
 16 and I can tell you the way that this happens, the  
 17 way that Jessica Tedders describes it is exactly  
 18 the way that it happens.  
 19 Q. Now, the top of the totem pole, Dr.  
 20 Coomes, ED director, been with the hospital 26  
 21 years.  
 22 A. Uh-huh.  
 23 Q. What was his testimony about whether a  
 24 nurse-in-training should be in the chain of  
 25 communication of a critical result?

1 A. Ms. Tedders --  
 2 Q. Should they be or not?  
 3 A. Licensed Registered Nurse Jessica  
 4 Tedders has every right to be in charge of that  
 5 critical value. She's a licensed registered nurse  
 6 in her 12th week of orientation to a new job.  
 7 Q. That's not what I'm asking you, ma'am.  
 8 You know exactly what I'm asking.  
 9 Did Dr. Coomes --  
 10 A. No, I really -- I really don't.  
 11 Q. Did Dr. Coomes testify whether or not  
 12 a nurse-in-training should ever be in the chain of  
 13 communication with a critical result being conveyed  
 14 from the laboratory to the emergency department,  
 15 yes or no, did he testify about it?  
 16 A. He testified about a nurse-in-  
 17 training, but she's not a nurse-in-training. She's  
 18 a licensed registered nurse who passed her NCLEX  
 19 exam. She is not what was described in the  
 20 deposition, she's not a nurse-in-training. Your --  
 21 that phrase suggests she's a student nurse. She's  
 22 not a student nurse.  
 23 Q. Who did Dr. Coomes testify, who did  
 24 the emergency department director for the  
 25 Muhlenberg Community Hospital testify, the

1 laboratory should have contacted about Jase  
 2 Foster's positive blood culture result?  
 3 A. One moment. I don't recall exactly  
 4 what he said.  
 5 Q. I know you don't.  
 6 Dr. Coomes testified that the lab  
 7 should notify either the doctor or the charge  
 8 nurse.  
 9 Do you have any memory of reading  
 10 that?  
 11 A. Yes. He put the onus on the charge  
 12 nurse, and that's just not how it plays out in  
 13 everyday life.  
 14 Q. I'm not asking what you think.  
 15 I'm asking what the emergency room  
 16 director at the Muhlenberg Community Hospital  
 17 testified about what should happen with a critical  
 18 result that came back much like in Jase Foster's  
 19 situation?  
 20 A. Yes. I recall him saying it would be  
 21 the responsibility of the charge nurse.  
 22 Q. Well, he testified the lab shouldn't  
 23 be contacting Lincoln Dempsey, it should be  
 24 contacting either the doctor or the charge nurse,  
 25 did you see that?

1 A. I assume that I did, because -- yeah.  
 2 Q. Okay. And you're right, he put a lot  
 3 of onus onto the charge nurse, stating that the  
 4 charge nurse should always be the one involved with  
 5 this communication, correct?  
 6 A. Yes. And that's not how it happens.  
 7 Q. It's not happened where you've been.  
 8 But I'm talking about this situation  
 9 at Muhlenberg Community Hospital. You understand  
 10 where you've worked is not relevant? We're talking  
 11 about what the policies were, whether written or  
 12 unwritten, at the Muhlenberg Community Hospital,  
 13 right?  
 14 A. I think where I worked is pertinent.  
 15 I'm here today because of my education and my  
 16 experience. So what I have done is pertinent.  
 17 And I can tell you that the ER that I worked in in  
 18 Shelbyville, Indiana, was an ER with 11 beds, one  
 19 doc, one NP, very similar to the situation you have  
 20 here. It's a town of like 15,000 people. And I  
 21 think my experience does matter, and that's why I'm  
 22 here today.  
 23 Q. Did he talk about what he would expect  
 24 Lincoln Dempsey to do, if, in fact, he got the  
 25 information, did he talk about that?

1 A. I don't recall what he said, his  
2 opinion on Lincoln Dempsey.  
3 Q. Okay. No idea what he said?  
4 A. I didn't -- I don't recall.  
5 Q. Do you think it's important to  
6 understand the testimony of the emergency room  
7 director at the time that this happened, is that  
8 not of any import to you?  
9 A. It is important. However, it's  
10 contradictory to what the players in the lab and  
11 the nursing staff are telling us.  
12 Q. Well, as we sit here today, you have  
13 no idea or clue what Dr. Coomes testified to,  
14 correct?  
15 A. Actually, we can -- I'd like to pull  
16 up his deposition. I can --  
17 Q. I'm not going there. I'm asking --  
18 A. Okay.  
19 Q. -- about what you --  
20 A. I'm just saying if I can't remember, I  
21 have the option to pull the deposition, correct?  
22 Q. Didn't you just testify earlier  
23 that you reviewed all these depositions?  
24 A. I don't recall everything, and this  
25 isn't a memory test. So I could call -- pull up

1 his deposition, if you would like.  
2 Q. Well, he testified that if Lincoln  
3 Dempsey got that information, he had a choice of  
4 contacting the emergency department doctor, the  
5 emergency department P.A. or the emergency  
6 department charge nurse.  
7 Did you read that?  
8 A. I don't remember the exact words, but  
9 he did put the onus on the charge nurse, is what I  
10 recall. But again, I could get out the deposition,  
11 we can go through it and let me reread it.  
12 Q. And did he testify that a nurse-in-  
13 training should not be in the chain of  
14 communication, and that if they got that  
15 information, they should immediately relay it to  
16 the charge nurse and let her handle it?  
17 A. There wasn't a nurse-in-training in  
18 the line of communication. That person doesn't  
19 exist in the ER.  
20 Q. Well --  
21 A. There's not a nurse-in-training in  
22 that list.  
23 So yes, if a nurse-in-training is a  
24 student nurse, then no, you would not want them  
25 responsible for critical -- for critical lab

1 values.  
2 There was not a nurse-in-training in  
3 the line of communication. There was a licensed  
4 registered RN in the line of communication.  
5 Q. How do you know that Jessica Tedders  
6 prepared a Post-it note and put it on the desk of  
7 Doctor Malik?  
8 A. I am reading her testimony saying that  
9 she recalls that information, and it rings true  
10 with what I've experienced in 16 years.  
11 Q. But as we talked about, she didn't  
12 document anything about what she did with that  
13 information, did she?  
14 A. No. Just her testimony --  
15 Q. And did not --  
16 A. -- under oath.  
17 Q. And nowhere in that record do we see  
18 that she -- the time she got the call, that she  
19 prepared a Post-it note, that she communicated with  
20 Ms. Tauil and that she was told to place it on  
21 Doctor Malik's desk, nowhere, correct?  
22 A. We don't see that documented, no.  
23 Q. So if she's wrong, and if Ms. Tauil is  
24 right, you agree that Ms. Knight dropped the ball,  
25 right?

1 A. No, I don't.  
2 Q. What if Ms. Knight is not telling  
3 the truth and she never conveyed the information to  
4 either Ms. Tauil or Doctor Malik, if that's, in  
5 fact -- if that became -- if she admitted to that,  
6 that would -- your entire opinions would fall down,  
7 would they not?  
8 A. No. Because my opinion is this baby  
9 should have already been in the hospital  
10 on the 5th. And all of this --  
11 Q. I'm talking about the 6th --  
12 A. -- rigamarole doesn't matter.  
13 Q. -- I'm talking about the 6th, ma'am.  
14 A. Okay. Ask your question again,  
15 please.  
16 Q. If Ms. Tedders is not being truthful  
17 and that she never conveyed this information to Ms.  
18 Tauil or Doctor Malik, you'd be critical of her,  
19 wouldn't you?  
20 A. Yes, if she went under oath and said,  
21 well, I didn't give them that information and I  
22 threw that paper in the trash can, then yes, I  
23 would be critical of her.  
24 Q. Okay. And we talked about the ED  
25 director, Doctor Coomes, stating that, under this

1 situation, the charge nurse should be directly  
 2 involved in the communicate -- in the  
 3 communication, you agree with that, that's what he  
 4 said, right?  
 5 A. No, I don't agree the charge nurse  
 6 needs to be involved.  
 7 Q. I didn't say that.  
 8 I said about what he testified to.  
 9 A. Yes, he testified to that.  
 10 Q. Okay. Now, Emily Knight, as we know,  
 11 was the charge nurse, right?  
 12 A. Yes.  
 13 Q. And did she agree that the charge  
 14 nurse should play a role in the conveyance of a  
 15 critical result that comes from the laboratory?  
 16 A. No.  
 17 Q. Okay. So she disagrees, right?  
 18 A. Correct.  
 19 Q. So when we go back to Doctor Reich's  
 20 opinion that the hospital personnel in the  
 21 emergency department should know and understand the  
 22 policy for handling critical results, clearly,  
 23 there was a lack of understanding among Ms.  
 24 Tedders, Doctor Coomes and Nurse Knight about what  
 25 to do, correct?

1 A. I think -- no. I think Doctor Coomes  
 2 is mistaken in who he thinks. Emily Knight does  
 3 not say it goes to the charge nurse, and neither  
 4 did Jessica Tedders.  
 5 Q. Now, Ms. Knight testified that whoever  
 6 gets the call in the emergency department should  
 7 handle it, did you see that?  
 8 A. Correct.  
 9 Q. And she testified that she would think  
 10 that Ms. Tedders could handle it, but if she had  
 11 questions, she was to come to her, right?  
 12 A. Correct.  
 13 Q. Did Nurse Tedders ever speak with Ms.  
 14 Knight about what she should or -- do with the  
 15 critical result for Jase Foster?  
 16 A. No.  
 17 Q. Did Nurse Knight testify that it's  
 18 important to chart in the medical record what  
 19 happens with the critical result?  
 20 A. I don't recall exactly what she said,  
 21 but in general, that's the principle, yes.  
 22 Q. Okay. And that wasn't done here,  
 23 right?  
 24 A. It was not done in this situation.  
 25 Q. And then did she testify that it was

1 important that this information, which she  
 2 considered potentially life threatening, be -- be  
 3 given to a provider within 30 minutes?  
 4 A. Yes. She said immediately.  
 5 Q. Okay. And then what did she say she  
 6 would do when she conveyed that information to one  
 7 of the providers in the hospital?  
 8 A. Are you talking about Jessica Tedders?  
 9 Q. No. We're talking about Emily Knight.  
 10 A. Emily Knight -- yeah. Emily Knight  
 11 said she would stand there and get instruction.  
 12 Q. Okay. And you're saying that you  
 13 believe that Ms. Tedders fulfilled that  
 14 requirement, because she was told to put that piece  
 15 of paper on Doctor Malik's desk?  
 16 A. Yes. She got instruction, and she did  
 17 it.  
 18 Q. But you understand that Ms. Knight was  
 19 referring to what specifically was to happen, that  
 20 is, whether to call the pharmacy, whether to call  
 21 the family and whether to get that boy into the  
 22 hospital, you understand that, do you not?  
 23 A. I thought she was giving examples of  
 24 what the possibilities could have been of -- of the  
 25 instructions that she would receive from a medical

1 provider, that's what -- that's what I understood  
 2 that to be.  
 3 Q. And did she testify that the nurse, in  
 4 this situation Ms. Tedders, if she didn't get  
 5 specific instructions about what to do with that  
 6 critical result, she would tell Ms. Tedders to go  
 7 back to the provider to make sure it was followed  
 8 up on and she got the instruction, did she testify  
 9 to that?  
 10 A. I believe so. And I would say Ms.  
 11 Tedders did exactly that.  
 12 Q. Did Ms. Tedders ever go back and speak  
 13 to either Ms. Taul or Dr. Malik about the critical  
 14 result for Jase Foster on September 6, 2019, after  
 15 she supposedly put a Post-it note on Doctor Malik's  
 16 desk?  
 17 A. No. She notified the provider, and at  
 18 that point --  
 19 Q. Did -- the answer is no, she did not?  
 20 MR. MONHOLLEN: She -- she -- she can  
 21 finish.  
 22 Q. Well, but the -- you can finish.  
 23 But the answer is she did not,  
 24 correct? Did --  
 25 A. Did she go back and verify that the

1 clinical staff -- that the physician staff did  
 2 their job? No.  
 3 Q. Right.  
 4 A. It's not her job to --  
 5 Q. Right.  
 6 A. -- supervise the physician.  
 7 Q. She never did, did she?  
 8 A. It's not her job to supervise the  
 9 physician.  
 10 MR. KINNEY: All right. We're almost  
 11 done.  
 12 MR. MONHOLLEN: Can -- can we take  
 13 a --  
 14 MR. KINNEY: Sure.  
 15 MR. MONHOLLEN: -- short break?  
 16 THE WITNESS: Yeah.  
 17 THE VIDEOGRAPHER: We're going off  
 18 record. The time is 11:32 a.m.  
 19 (Whereupon, there was a brief recess.)  
 20 THE VIDEOGRAPHER: We are back on  
 21 record. The time is 11:50 a.m.  
 22 (Whereupon, Exhibit No. 8 was marked  
 23 for identification.)  
 24 Q. Okay. I'm going to hand you what I've  
 25 marked as Exhibit 8, which is something we've kind

1 of talked about, it's the critical value policy  
 2 that was in place at the time that this --  
 3 A. Yeah, I've got it here.  
 4 Q. -- matter happened.  
 5 You've read this before, right?  
 6 A. I have. I've got a copy in my file.  
 7 Q. Okay. Well, we're going to make it an  
 8 Exhibit to your deposition.  
 9 A. Okay.  
 10 Q. And we won't spend a lot of time, but  
 11 we've already talked about this does not --  
 12 A. Yeah.  
 13 Q. -- address our situation, correct?  
 14 A. Correct.  
 15 Q. But in terms of how Muhlenberg  
 16 Community Hospital views critical results, do you  
 17 see in the middle of the page, underlined in -- in  
 18 dark printing, it says, "any critical result must  
 19 be called to the physician within 30 minutes of the  
 20 time the report is received", do you see that?  
 21 A. I do see that.  
 22 Q. But the problem here is, I guess,  
 23 because the patient's not in the hospital, that  
 24 changed the situation?  
 25 A. Yeah. And I think really the end of

1 that statement says "see nursing policy and  
 2 procedure notification of physician". And then  
 3 they attach -- you know, then it goes on to the  
 4 next policy that I have here that says, "this  
 5 is the procedure that the nurse should use" --  
 6 Q. We're going to get to that one. I'm  
 7 just saying that --  
 8 A. Yeah, it's -- it's what it says here  
 9 in the middle.  
 10 Q. And in reading that, what physician  
 11 are they talking about should they communicate it  
 12 with, is it the one that ordered the test?  
 13 A. "It must be called to the physician  
 14 within" -- one moment. I don't know that it  
 15 specifically says which physician. The assumption  
 16 is, when you read this policy, it would have been  
 17 the ordering physician if --  
 18 Q. Okay. So your assumption, although  
 19 it's not clearly delineated, but this policy would  
 20 require that the physician that ordered the test be  
 21 communicated with within 30 minutes of the critical  
 22 result coming back, right?  
 23 A. Right. But it doesn't say who's  
 24 supposed to do that job. It just says it needs to  
 25 be done. It doesn't say the lab should call.

1 Q. Well, you --  
 2 A. This is a --  
 3 Q. -- you understand this is a policy  
 4 that applies to the laboratory, the nursing  
 5 department and radiology, right?  
 6 A. I understand that. But it doesn't  
 7 outline specifically who's to call the physician.  
 8 They just want it done within 30 minutes.  
 9 Q. So you're critical that it's not  
 10 specific as to who's making the phone call, if  
 11 it --  
 12 A. Well, I'm not -- I'm not critical of  
 13 the policy. I'm -- it's a framework, and it is  
 14 understood that they should be contacting the  
 15 physician in 30 minutes. It's just a general  
 16 framework policy.  
 17 Q. With regard to Jase Foster, was the  
 18 critical result ever conveyed to a physician, based  
 19 upon what you reviewed in the record?  
 20 A. It was conveyed, according to Jessica  
 21 Tedders, to the P.A., who was also responsible for  
 22 providing care.  
 23 Q. Listen to my question.  
 24 Was it ever given to -- was it ever  
 25 conveyed to a physician, based upon what you've

1 read in the record?  
 2 A. It was conveyed to a nurse in  
 3 the emergency department.  
 4 Q. Right.  
 5 Was it ever conveyed to a physician?  
 6 A. By the nurse.  
 7 Q. Did a physician ever receive this  
 8 critical result for Jase Foster?  
 9 A. According to Jessica Tedders, she  
 10 handed this note to the P.A., who's also  
 11 responsible for it, who said that she and Doctor  
 12 Malik would take care of it.  
 13 This doesn't say that --  
 14 Q. That's not my question, ma'am, and you  
 15 know it's not my question. I'm not -- I was asking  
 16 not whether it went to a P.A.  
 17 I was asking, did this information,  
 18 based on what you've read in the record, ever --  
 19 was it ever conveyed to a physician, from what  
 20 you've seen?  
 21 A. I don't know if it was conveyed to a  
 22 physician.  
 23 Q. All right. Are you critical that a  
 24 physician was not notified of this critical result  
 25 for Jase Foster?

1 A. I am not --  
 2 Q. Okay.  
 3 A. -- because --  
 4 Q. I understand.  
 5 MR. MONHOLLEN: She can finish.  
 6 MR. KINNEY: But it's going to be the  
 7 same thing.  
 8 Q. But go ahead.  
 9 A. It is, because you keep asking the  
 10 same question.  
 11 I'm not critical it didn't go directly  
 12 to Doctor Malik, because it went to a member of the  
 13 clinical staff, the medical staff at Envision, and  
 14 she was assured that that information would be  
 15 taken care of by that P.A. and physician.  
 16 I'm going to give you the same answer  
 17 every time. It's not going to change.  
 18 Q. And in terms of this policy, does it  
 19 specifically state that documentation of  
 20 notification of test results must be placed into  
 21 the electronic health record, does it state that?  
 22 A. Again, yes, it does.  
 23 Q. And it wasn't done --  
 24 A. And I think we already agreed that  
 25 this does --

1 Q. -- and it wasn't done here?  
 2 A. And you also stated that it is not  
 3 pertinent to this situation we find ourself in.  
 4 Martin, this policy doesn't determine standard of  
 5 care. This is the policy. This is a hospital  
 6 framework. It's -- it's -- it's not the standard.  
 7 Q. So Jill Baldwin is going to testify  
 8 that there was no requirement to document anything  
 9 about what happened with this critical result,  
 10 that's your testimony, is that correct?  
 11 A. No. I agreed that, number 3, it says,  
 12 "documentation and notification of test results,  
 13 including the time the notification was made, to be  
 14 docketed in the appropriate location of the EHR".  
 15 And I'm also saying that this policy  
 16 is not written to cover every single instance that  
 17 happens.  
 18 MR. KINNEY: And then Exhibit 9, which  
 19 you talked about, is notification of physicians.  
 20 We'll make that Exhibit 9.  
 21 THE WITNESS: Uh-huh.  
 22 (Whereupon, Exhibit No. 9 was marked  
 23 for identification.)  
 24 Q. And I think we talked -- touched on  
 25 that, as well, have we not?

1 A. Yeah. This is information for  
 2 nurse -- pertaining to nursing services.  
 3 Q. And this would pertain to Nurse  
 4 Tedders, right, she's a nurse, right?  
 5 A. It would.  
 6 Q. And under number 3 of the policy, it  
 7 states, "all aspects of the notification process  
 8 and patient assessment shall be documented in the  
 9 medical record", do you see that?  
 10 A. Under number 3? I only have -- like  
 11 are you looking at -- where are you looking at,  
 12 Martin?  
 13 Q. Page 1 --  
 14 A. Oh, at the very beginning, Roman  
 15 numeral III?  
 16 Q. -- item number III, "all aspects of  
 17 the notification process and patient assessment  
 18 shall be documented in the medical record".  
 19 A. Yes, and I've agreed to that.  
 20 Q. In your work instructing nursing  
 21 students, don't you emphasize the importance of  
 22 documentation?  
 23 A. I would.  
 24 Q. And you tell them that if it's not  
 25 documented, then it didn't happen, have you ever

1 told them that, that's why it's important to  
2 document it?

3 A. No.

4 Q. Well, what do you tell them?

5 A. I don't stick by the not documented,  
6 not done rule, because I work in healthcare and  
7 I understand the -- the realistic situation.

8 The goal, yes, you would want them to  
9 document everything, right, you would want that to  
10 happen. But I also know in a realistic situation  
11 like the emergency room, that doesn't always  
12 happen.

13 Q. The second page has a section that  
14 applies to the emergency department, do you see  
15 that?

16 A. I do.

17 Q. And the last item says, "notification  
18 of physicians in time of the notification shall be  
19 documented on the patient's emergency room record",  
20 do you see that?

21 A. I do see that. You have to consider,  
22 though, that earlier, under this particular number,  
23 it says the RN would be assessing the patient,  
24 notify the emergency room physician. So this  
25 policy is written with the understanding that the

1 patient is actually in-house, but they're not.  
2 This patient is discharged, and that's why the  
3 statement, "no, these guidelines are not inclusive,  
4 nor is this probably limited to this item stated".  
5 That's why that's there, because this addresses  
6 patients in-house.

7 (Whereupon, Exhibit No. 10 was marked  
8 for identification.)

9 Q. And then the last exhibit is your  
10 disclosure. I've only pulled out that portion that  
11 relates to you I marked as Exhibit 10.

12 Is that, in fact, your disclosure?

13 A. Yes, this is my disclosure.

14 Q. And you've testified already that you  
15 didn't draft it?

16 A. Correct.

17 Q. And you didn't make any changes to it?

18 A. No --

19 Q. And --

20 A. -- not that I can recall.

21 Q. -- and there's been no amendments or  
22 revised disclosures setting forth any additional  
23 opinions?

24 A. No. I would like --

25 Q. And you understand that a disclosure

1 is supposed to identify all opinions you intend to  
2 offer at trial, correct?

3 A. Yes. And I would like to make a  
4 statement about that, I would like to say something  
5 in regards to that.

6 Q. We're waiting.

7 A. On the beginning of the page, at the  
8 first full paragraph on the second page, it says,  
9 "it is anticipated that Ms. Baldwin will testify  
10 generally regarding the different roles,  
11 responsibilities and scope of practice of a  
12 physician, mid-level practitioner and a nurse in  
13 emergency department setting. She will testify  
14 that the roles, responsibilities and scope of the  
15 practice of physician, mid-level practitioner and  
16 nurse differed greatly, and that it is the  
17 responsibility of the medical providers to address  
18 critical values in the emergency department". I  
19 did say that. It -- it is in this disclosure.

20 Q. What?

21 A. The part about -- earlier, we had a  
22 discussion --

23 Q. My question was, is a disclosure  
24 supposed to set forth all of the opinions you  
25 intend to offer at trial?

1 A. That's -- yes. However, earlier, the  
2 discussion was whether or not I had made a comment  
3 about the failure of the medical staff, and I'm  
4 saying it's -- it's right here in my disclosure.

5 Q. So you're saying the second full  
6 paragraph of your disclosure sets forth criticisms  
7 of the emergency room personnel?

8 A. Of the ER providers, yes.

9 Q. And -- and -- and specifically what  
10 are you referencing?

11 A. Let's see. I just -- second sentence,  
12 "testify to the roles -- "Ms. Baldwin will testify  
13 generally regarding medical providers's responses  
14 to preliminary positive blood culture results".

15 Q. I've read that.

16 I'm saying, where is the opinion in  
17 here where you're critical of the -- the emergency  
18 department providers?

19 A. I think it's part of the roles,  
20 responsibilities and scope of practice, that's all  
21 I'm saying.

22 Q. But you agree that the second  
23 paragraph does not contain any opinion, does it?

24 A. Contain what?

25 Q. Any opinion, no criticism?

1 A. I am saying that I would be testifying  
 2 to the role of those people. It's in today's  
 3 deposition.  
 4 Q. The first opinion that I see is on the  
 5 second page, beginning with "based upon review of  
 6 this matter", do you see that?  
 7 A. I do see that.  
 8 Q. Okay.  
 9 A. But I thought I was here today to give  
 10 opinions.  
 11 Q. You're here to address the opinions  
 12 set forth in your expert disclosure. And I'm  
 13 bringing you up now to the first opinion set forth  
 14 in your disclosure, and it says that "the nurse and  
 15 laboratory personnel met the applicable standard of  
 16 care and acted as reasonable nurses and laboratory  
 17 personnel under like or similar circumstances".  
 18 And I think we've covered that, have  
 19 we not?  
 20 A. Yeah. But it also says, "this  
 21 designation is in no way intended to limit the  
 22 expert witness testimony on these or other  
 23 subjects". That's on the last page in -- in my  
 24 disclosure. It says, "it doesn't include  
 25 everything".

1 leave the hospital before the results come back,  
 2 that's not unusual, is it?  
 3 A. No, that's not unusual.  
 4 Q. And we do want our ED department  
 5 personnel, including nursing staff, to be familiar  
 6 with what is to happen with a critical result  
 7 that comes back for a patient who is no longer in  
 8 the emergency department, we want them to be  
 9 consistent and have everybody have a full  
 10 understanding of what is to happen, right?  
 11 A. We want -- yes, we want consistency in  
 12 the procedure, yes.  
 13 Q. And you would agree with me that there  
 14 was not consistency between Ms. Tedders, Ms. Knight  
 15 and Doctor Coomes as to what was to happen, they  
 16 all had a different view of what should happen,  
 17 correct?  
 18 A. No, I don't agree with that.  
 19 Q. All right. We'll let that stand.  
 20 So I'm trying to understand. You said  
 21 that in your practice, you would often get critical  
 22 results conveyed to you by people pushing paper  
 23 underneath the bathroom door?  
 24 A. Not -- not often.  
 25 Q. That's what you testified to. And I

1 Q. Have we addressed your opinions  
 2 with regard to the nurse and laboratory personnel  
 3 met the applicable standard of care and acted as  
 4 reasonable nurses and laboratory personnel under  
 5 like or similar circumstances? My question is,  
 6 have we not addressed that?  
 7 A. Yes, I think I've made that clear.  
 8 Q. Okay. Are -- are you critical that  
 9 the hospital policy for critical results does not  
 10 address the situation that we have in this case,  
 11 yes or no?  
 12 A. I am not.  
 13 Q. Okay. Are you critical that there is  
 14 not a separate policy that speaks directly to the  
 15 circumstances here, where you have a patient that's  
 16 seen in the emergency department, a blood culture  
 17 is ordered and then the results come back positive  
 18 after the patient has left the hospital, are you  
 19 critical of there not being a policy to address  
 20 that situation?  
 21 A. I am not, because it is noted on the  
 22 policy that we have already reviewed.  
 23 Q. And you would agree that it's not  
 24 uncommon for patients to come into the emergency  
 25 department, have a blood culture done, and then

1 want to talk about that.  
 2 A. I didn't use the word often.  
 3 Q. You said that that was something that  
 4 happened in your practice.  
 5 A. No. I would like to clarify that. I  
 6 often --  
 7 Q. Did you not testify to that?  
 8 MR. MONHOLLEN: Well, let her clarify  
 9 what she said.  
 10 Q. Well, yes or no, and then you can  
 11 clarify. But I -- my understanding is you  
 12 testified that --  
 13 A. No, I did not say it was often shoved  
 14 under the bathroom door. I said I often receive  
 15 things on Post-it notes, pieces of paper, and then  
 16 I added this, you know, experience of having staff  
 17 shove it under the bathroom door.  
 18 Q. So was this at home, in the hospital,  
 19 where is this happening, where they're shoving  
 20 documents under the bathroom door?  
 21 A. This is in the emergency department.  
 22 And it's my example of saying this is how the ER  
 23 works, it is chaotic, and the goal is to get it to  
 24 the provider, and sometimes I have had nursing  
 25 staff do that. They track me down at lunch,

1 whatever it is.  
 2 But my point is that that piece of  
 3 paper or that Post-it note, I have absolutely had  
 4 that experience of it being laid on my desk.  
 5 Q. Do you know whether the emergency  
 6 department was chaotic on September 6, 2018?  
 7 A. I don't. But I can tell you that the  
 8 issue over the Post-it note has happened before,  
 9 because that --  
 10 Q. That wasn't my question.  
 11 A. Okay.  
 12 Q. You -- you just --  
 13 A. I don't know how many patients were in  
 14 the emergency department at that time.  
 15 Q. And You've not been supplied that  
 16 information?  
 17 A. I have not.  
 18 Q. But you said that often, emergency  
 19 departments, as we all know, can be chaotic, right?  
 20 A. Yes.  
 21 Q. And things can fall through the  
 22 cracks, right?  
 23 A. Yes.  
 24 Q. And that's why we want documentation,  
 25 right?

1 A. Yes.  
 2 Q. And that's why we want consistency  
 3 with an understanding among everybody about  
 4 what's supposed to happen with something as  
 5 important as a critical result demonstrating a  
 6 positive blood culture, right?  
 7 A. The procedure, yes.  
 8 Q. Right.  
 9 A. My --  
 10 Q. And I'm taking it from what you're  
 11 stating here, that your experience is Post-it notes  
 12 is the common means of transmitting, your  
 13 experience, critical information of a blood culture  
 14 result that's positive, that your experience has  
 15 been Post-it notes are -- are certainly an  
 16 acceptable way and it's a way that you often see it  
 17 conveyed, right?  
 18 A. I see it in a written form, yes.  
 19 Q. You said Post-it notes. So I'm just  
 20 asking that.  
 21 A. Or pieces of paper. I didn't say just  
 22 Post-it notes.  
 23 Q. Just --  
 24 A. I'm saying it's in writing somewhere  
 25 along the line.

1 Q. And when these papers are pushed under  
 2 the bathroom door, do you expect that somebody's  
 3 going to come back and make sure that you followed  
 4 up with -- with that piece of paper that went under  
 5 the door?  
 6 A. No. It's my job to be responsible for  
 7 the critical value that I was given.  
 8 Q. So you don't think it's a good idea to  
 9 have a -- a -- a procedure in place to make sure it  
 10 doesn't fall through the cracks, correct?  
 11 A. There is a procedure in place. Even  
 12 if it gets shoved under the bathroom door, the  
 13 procedure was to get the record -- the critical  
 14 value to the provider. It doesn't say you have to  
 15 do it in this exact format. The goal is get it to  
 16 the provider, even if it's shoved under a bathroom  
 17 door.  
 18 Q. You equated this hospital emergency  
 19 department to one you've worked with -- worked at  
 20 before, which was an 11-bed ED, right?  
 21 A. Correct.  
 22 Q. And you understand that an 11-bed ED  
 23 is a fairly small emergency department?  
 24 A. It is.  
 25 Q. That -- in this situation, did you

1 understand that the P.A.'s desk, the -- the ED  
 2 doctor's desk and the charge nurse area, were all  
 3 in close proximity?  
 4 A. Yes, that's been my experience.  
 5 Q. And how many doctors were working in  
 6 the emergency department on September 6, 2019  
 7 when this information came into the emergency  
 8 department?  
 9 A. My understanding was it was just  
 10 one MD and one advanced practice provider.  
 11 Q. Well, my question was doctors.  
 12 And it was one, right?  
 13 A. Just one, yeah.  
 14 Q. And how many P.A.'s?  
 15 A. One advanced practice provider --  
 16 Q. Okay.  
 17 A. -- which is like P.A. or NP --  
 18 Q. And then --  
 19 A. -- it could be either one.  
 20 Q. -- and then you've got a charge nurse,  
 21 and then you've got a nurse-in-training.  
 22 Anybody else working in there?  
 23 A. You have licensed registered nurses  
 24 who are orienting to a new job, yes, and  
 25 there are also techs.

1 Q. And you wouldn't expect anybody to  
2 follow up during that shift in this small work  
3 environment where they're seeing each other  
4 routinely throughout the day, to say hey, did you  
5 get that information about Jase Foster and follow  
6 up?

7 A. No. It is not the nurse's job  
8 to make sure --

9 Q. It's not the nurse's job.  
10 Even though the charge nurse says it  
11 is, even though the ED director says it is, you say  
12 it's not --

13 MR. MONHOLLEN: Object to the form.

14 Q. -- right? Is that right?

15 A. Right. Once the information is  
16 passed on to a physician, it's their responsibility  
17 to deal with the issue.

18 Q. But you just testified there's no  
19 evidence that the physician ever got that  
20 information.

21 A. Other than her sworn testimony.

22 Q. Doctor Malik is a man.

23 A. I was referring to Ms. Tedders.

24 Q. That was just based on what you  
25 testified to, that the doctor was to be given the

1 information?

2 A. A medical provider in the ER who can  
3 deal with those critical lab values.

4 Q. I think we touched on this, but the --  
5 just dealing with the Norton hospitals, and I may  
6 have asked this, I apologize, are you saying that  
7 they did not have a policy that would address our  
8 situation here, that is, a critical result that  
9 comes back for a patient who was seen in the  
10 emergency department, that's no longer  
11 there?

12 A. I don't know if there's a policy in  
13 writing, but I can tell you the staff understands  
14 to get it to one of the medical providers  
15 immediately.

16 Q. Ms. Baldwin, was Jase Foster's --  
17 contacted about the blood culture result on  
18 September 6, 2019?

19 A. No.

20 Q. Ms. Baldwin, was the family of Jase  
21 Foster contacted about the blood culture result on  
22 September 7, 2019?

23 A. No. Unfortunately, Doctor Coomes  
24 didn't tell them that --

25 Q. Ms. Baldwin --

1 A. -- when they re-presented.

2 Q. -- was the family contacted on  
3 September 8th, 2019, about the positive  
4 blood culture result?

5 A. No. Unfortunately, Mr. -- when P.A.  
6 McCrary saw it and signed off on it, he did not  
7 contact the family.

8 Q. And how is it that it was discovered  
9 that the blood culture result, in fact, was  
10 positive for Jase Foster, if you know?

11 A. It was discovered on the 9th by  
12 Tabitha Taylor, when he showed up and did  
13 outpatient follow-up.

14 Q. And -- and what did she have to do to  
15 gain access to that information?

16 A. Look in the computer.

17 Q. Right.

18 I -- I may be done. Let me just have  
19 a moment to think.

20 A. Sure.

21 MR. KINNEY: If you want to walk out,  
22 that's fine.

23 THE VIDEOGRAPHER: We are going off  
24 record. The time is 12:11 p.m.  
25 (Whereupon, there was a brief recess.)

1 THE VIDEOGRAPHER: We are back on  
2 record. The time is 12:17 p.m.

3 Q. Ms. Baldwin, let's go back to what  
4 happened on September 6, or at least what Ms.  
5 Tedders says happened, and take Nurse Tauil out of  
6 the picture.

7 A. Okay.

8 Q. Would you be critical of her if she  
9 had gotten this information from Lincoln Dempsey,  
10 wrote it down on a Post-it note, and simply put it  
11 on Doctor Malik's desk, would that be sufficient?

12 A. I don't know in that situation.  
13 It's -- it's something that's occurred with Doctor  
14 Malik before. He -- he talked about they put  
15 Post-it notes on my things, so he's aware that  
16 sometimes that does occur.

17 Preferably, you say to them hey, I got  
18 this blood culture result, et cetera.

19 Q. My -- my question, though, is, do you  
20 believe that she met -- that she would have met the  
21 standard of care if all she did was place a Post-it  
22 note on his desk?

23 A. I think there probably needs to be  
24 some sort of verbal --

25 Q. Okay.

1 A. -- acknowledgement in -- in writing  
 2 that -- that it was given.  
 3 Q. And so if that's what happened and she  
 4 put the note on there, would you say she would meet  
 5 the standard of care, if she then followed that up  
 6 with saying down later, hey, Doctor Malik, did you  
 7 see the Post-it note and have you done anything  
 8 with it, would that then satisfy --  
 9 A. Yeah, I -- I think that scenario  
 10 makes --  
 11 Q. That makes sense?  
 12 A. -- makes sense, yeah.  
 13 Q. Okay. Did Nurse Tedders, based on her  
 14 testimony, ever speak to Doctor Malik about Jase  
 15 Foster's critical result?  
 16 A. No.  
 17 MR. KINNEY: The -- I think that's all  
 18 I have. Thank you.  
 19 THE WITNESS: Okay.  
 20 THE VIDEOGRAPHER: This concludes the  
 21 deposition. The time is 12:19 p.m.  
 22 THE COURT REPORTER: While we're still  
 23 on the steno record --  
 24 THE WITNESS: I would like to review  
 25 mine, and I'd like a large.

1 COMMONWEALTH OF KENTUCKY)  
 2 )SS  
 3 COUNTY OF JEFFERSON )  
 4 I, PAUL A. KLAPHEKE, a Notary  
 5 Public within and for the Commonwealth and  
 6 County aforesaid, certify that the foregoing is  
 7 a true, correct and complete transcript of the  
 8 deposition of JILL BALDWIN, APRN, taken at the  
 9 time and place and for the purpose as set out  
 10 in the caption hereof; that said witness was  
 11 duly sworn before giving said testimony; that  
 12 said testimony was taken down by me in  
 13 stenotypy and was thereafter under my direction  
 14 transcribed into computer-assisted  
 15 transcription; that the appearances were as set  
 16 out in the caption hereof; and that no request  
 17 was made by counsel for any party that the  
 18 deposition be submitted to the witness for  
 19 reading and signature.  
 20 My commission expires August 6,  
 21 2027. Given under my hand as Notary Public  
 22 this 20th day May, 2025.  
 23  
 24 -----  
 25 NOTARY PUBLIC STATE-AT-LARGE

1 THE COURT REPORTER: Okay. Sir, while  
 2 we're still on the steno record, I need a copy of  
 3 your order.  
 4 MR. MONHOLLEN: A PDF, full and mini.  
 5 THE VIDEOGRAPHER: And do you need a  
 6 video?  
 7 MR. MONHOLLEN: Sure.  
 8 THE COURT REPORTER: And Martin, I  
 9 assume your order's on file, is that right?  
 10 MR. KINNEY: Order's on file.  
 11 THE COURT REPORTER: It should be, it  
 12 should be.  
 13 MR. KINNEY: I think it is.

- - -

A			
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