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

VIDEOTAPED DEPOSITION OF JILL BALDWIN, APRN

LOUISVILLE, KENTUCKY

MAY 14, 2025

PAUL A. KLAPHEKE, CCR

CERTIFIED COURT REPORTER

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

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APPEARANCES

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Also Present: Mable Barnes - Videographer

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WITNESS: Jill Baldwin, APRN

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EXHIBITS

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

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

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

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

MR. KINNEY: Martin Kinney for the Plaintiff.

MR. MONHOLLEN: Phil Monhollen here for the Defendant.

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

DIRECT EXAMINATION

BY MR. KINNEY:

Q. Good morning.

A. Good morning.

Q. Would you state your full name?

A. Jill Baldwin.

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

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

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

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

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

A. Out of my home.

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

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

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

A. Yes.

Q. And tell me a bit about that.

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

Do you need these resumes?

Q. I have them.

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

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

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

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

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

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

A. We have.

Q. How many cases have we worked on together?

A. Two.

Q. And I remember the Bryant case. Any other cases?

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

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

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

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

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

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

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

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

THE WITNESS: Thank you.

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

A. It's not.

Q. It's not? All right.

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

A. It is.

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

A. Yes --

Q. For like how --

A. Many times.

Q. -- for like how --

A. In the emergency department, many times.

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

A. Presentations?

Q. Yeah.

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

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

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

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

a total of, I think, 16 years in the ER.
Q. During the -- the stint from 2001 to 2005, would you ever serve as a charge nurse?
A. I would have been the nurse practitioner seeing patients at that time and would have received -- you know, had communication with the charge nurse and nursing staff.
Q. Okay. And did Midwest Medical Management have a policy that was specific to the handling of critical results for the laboratory?
A. In regard to what role?
Q. Just in general, as much as we have here.
Was there a policy in place?
A. There's not a policy that I'm aware of. I received information from nursing staff regarding critical labs and --
Q. I'm talking about a written policy.
Was there a written policy?
A. Not that I'm aware of.
Q. Okay. And what about from 2011 to 2021, during that stint, was -- did that -- did either Louisville Emergency Medical Associates or Southern Emergency Medical Specialists have any type of policy that would apply to the handling of

critical results?
A. I don't recall a specific policy. I can tell you that we use the Inbox and Epic on a regular basis, and we're required to go through it at the beginning of our shift.
Q. My question was very specific.
Was there a --
A. Yeah.
Q. -- written policy in place for the handling of critical results at the -- either at Louisville Emergency Medical Associates or Southern Emergency Medical Specialists, while you worked there from 2010 to 2021?
A. I'm assuming the hospital had a policy. I don't recall seeing it.
Q. Okay. So the hospital would have had the policy?
A. Correct.
Q. And were you required to be familiar with those policies?
A. I wasn't an employee of the hospital.
Q. That's not my question.
Were you --
A. No, because I would not have been an employee of the hospital.

Q. So the -- the critical result policy, to the -- to the extent it existed, either -- well, during 2000-2021 at those hospitals where you were working, you weren't required to be familiar with those policies, nor were you required to follow those policies?
A. I was medical staff at that point, and so I would have interacted with the nursing staff who would have had policies that they answered to at the hospital level.
Q. So the nurses you worked with would have been responsible for understanding and following the critical result policy that was in place at those hospitals?
A. That's my understanding, yes.
Q. Okay. And what was that policy?
A. The policy was that they would receive notification of critical lab work from the emergency department, and they would bring it directly to a provider. And at that point, we were responsible for opening the chart, assessing the situation and making a decision about care for that patient.
Q. I -- you may have misspoke, you may not have, you said the notification would come from

the emergency department.
Wouldn't the notification --
A. Oh.
Q. -- of a critical result come from the laboratory, ma'am?
A. I'm sorry. Ask that again. If I misspoke, I need to clarify.
Q. All right. I asked you what the policy was for handling critical results at the hospitals you worked at from 2010 to 2021.
A. In regards to myself in that role, or in regards to that specific hospital?
Q. The policy that was in place at those hospitals that applied to the nursing staff that you worked with?
A. Yes. I had earlier explained that the nurses respond to the policy.
Q. What is the policy, that's all I'm asking?
A. I didn't work for the hospital. I don't know --
Q. I didn't ask you that.
A. -- exactly what their policy is.
Q. So you didn't know what the policy was?

A. I'm not -- no. I'm working in a clinical position at that point.
Q. Okay. So you don't know what the nurse -- what the hospital had in place in terms of what the nursing staff was to do with critical results that were conveyed to them, you have no idea?
A. No. It was 2010. No. It was 15 years ago.
Q. No, it's not.
2010 to 2021?
A. Right, but I'm saying no.
Q. So you don't remember?
A. No, I -- no, I didn't remember seeing that policy, no. I know what happens procedurally in the department.
Q. And then we talked a bit about the 11-bed facility you worked at from 2001 to 2005.
Do you know if there was a written policy for that hospital that -- where you were working?
A. I don't recall seeing a policy. And again, that -- that would have been quite a while ago.
Q. Okay. Were the nurses –- well, you

help me with this.
A. Okay.
Q. What -- what was your understanding of how the critical results were to be handled at this hospital that you worked at from 2010 to 2021?
A. The critical results were called to the emergency department, to the nursing staff, who brought the information to us as clinical providers. And then it was our responsibility to follow through on those critical labs by opening the chart, assessing the situation and making decisions.
Q. All right. Was -- the -- the call that came from the lab, was the lab required to document that they made the call, the time they made the call and to whom they spoke?
A. I'm not in charge of the lab, but I think –-
Q. If you know, yes, or you don't?
A. Yeah. No -- no, I don't --
Q. Okay.
A. -- know. I assume Lincoln Dempsey said that -- yeah.
Q. I'm not talking about Lincoln Dempsey. We're talking about 2010 to 2001 -- 2021, when you

worked at this –-
A. Oh, so we're sticking just with that?
Yeah, I don't know.
Q. And then at that -– and -- and I'm sorry, the hospitals that you were covering during that period, you said was –- was it Norton Brownsboro?
A. Norton Brownsboro, Norton Audubon and Norton Downtown, ultimately with SEMS, yes.
Q. Okay. The written policy that was in place at the Norton facilities where you covered as a nurse practitioner in the emergency department, did it require the nurses that received the report from the laboratory of a critical result, were they required to note in the patient's chart the time they received it, the information they received and what they did with it?
A. Typically, no, that did not occur. They brought it directly to the provider. If a patient –- so we're talking about patients, which you have to be considerate of whether or not the patient was in the emergency room at the time or whether or not they had been discharged.
Q. My question's very specific, and --
A. And it's not a specific answer,

because you have to consider where the location of the patient is at the time you received the critical value.
Q. So you're saying that sometimes the nurses would be required to document, sometimes they would not, it would depend upon where the patient was?
A. That is the procedure that typically took place, yes. If the patient was in the emergency room at the time, the nursing staff would document it. If it was someone who had been discharged and they're bringing critical values to the -- the staff, I don't know that the nursing staff is required to get back in and make a note on that. I don't see that as common practice once the patient had been discharged.
Q. Yeah.
You agree that the policies that were in place at Muhlenberg Community Hospital, did require that the nursing staff make documentation in terms of what happened with the critical result, true?
A. No. I need to pull that policy and take a look. One moment, please.
Q. Well, we can hand -- I've got it here,

ma'am.
A. Okay. This is a clean copy that I'm looking at here.
So in regards to the nursing policy that says notification of physician -- one moment. This policy is really sort of specific to a policy -- to a patient that's in-house. If you look at number 2, it says, "notification of a physician shall be done only after a thorough assessment of the patient has been completed".
Q. Which policy are you looking at?
A. I am looking at notification nursing policy.
Q. Right.
We're talking about the critical values policy, ma'am.
A. Okay.
Q. All right. And do you see that under the critical value policy that was in place at the time that Jase Foster was a patient at Muhlenberg Hospital, that the critical value policy does in fact require documentation of the notification? That would be item number 3 under Procedure.
Do you see that?
A. I do see that.

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

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

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

Q. All right. So fair to say that the policy, the critical value policy, that we're talking about now, fails to address what should be done when a blood culture result comes back for a patient that was seen in the emergency department that's no longer in the hospital, fair?
A. The critical values?
Q. Yes, ma'am.
A. No, I don't see that. But it also says --
Q. So it does not -- it does -- it does deal with it, is that correct?
A. It does not deal with it.
Q. Are you critical of this policy for not addressing what should be done under those circumstances, specifically when a critical result comes back for a patient who was seen in the emergency department, who's no longer in the hospital?
A. No, I'm not critical of this policy.
Q. Should there be a separate policy for what should be done with a critical result that comes back for a patient that was seen in the emergency department, but is no longer present in the hospital?

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

A. It's in paper form, and I have multiple copies in this stack.
Q. All right. Can I have my copy?
A. Sure.
Do you need one for her (indicating)? No?
So that's the first set of notes that has to deal with the medical records themselves, and this is the second set of notes that has my opinion on the 15 depositions that I read.
Q. Well, we're -- we're back to the notes section of the request.
I -- I was asking --
A. This is part of my file.
Q. I understand that.
A. Okay.
Q. I'm asking what you were provided, not what you generated.
Did you bring that?
A. As far as the medical records and all the depositions? No, I do not have a copy of that with me today. I thought you were asking about the -- about what was in my file.
Q. So going back, you were not provided a

copy of the notice before today?
A. I was provided a copy.
Q. All right.
A. I don't have it in my -- I don't bring a copy with me.
Q. And -- and did the notice, in fact, require you to bring your entire file on this matter, including, but not limited to, billing information, notes, memorandum, personnel files, all materials sent to you, all materials used by and relied upon by you, all correspondence and other writings related to this matter? Were you requested to bring that?
A. Yes, I was requested to bring that.
Q. And have you done that?
A. I have not copied the five things on my computer, but I don't bring a hard -- a hard copy of any of it.
Q. So how am I going to know what you were provided in order to understand what you reviewed in order to come up with your opinions?
A. Well, I'll have to tell you, and you're going to have a copy of the notes that I took throughout my review.
Q. So the -- the two groups of documents

provided to me would be the totality of your notes in this case?
A. If you have both of those, yes, those would be the notes that I made in this case.
Q. Okay. And help me again.
The first section, which is in purple ink, which will mark as Exhibit 3, would be notes coming from what you reviewed?
A. From the medical record, yes.
(Whereupon, Exhibit No. 3 was marked for identification.)
Q. Right.
And then the second group, which we'll mark as Exhibit 4, would be the opinions that you generated in this case?
A. And the pages behind -- subsequent pages are notes I took on the depositions.
(Whereupon, Exhibit No. 4 was marked for identification.)
THE WITNESS: I'm sorry, I'm just putting this down here, I don't like stuff in front of me.
Q. What depositions have you been provided in this case?
A. I was provided the depositions of

Doctor Coomes, Doctor Malik, P.A., Tauil, the grandparents, Crystal Geary, Kim Lasder, Lincoln Dempsey, Registered Nurse Jessica Tedders, Emily Knight, and the experts, Doctor Goodspeed, Doctor Nicks, Doctor Patel, Doctor Wright. Let me make sure I didn't miss any.
Tabitha Taylor, McCrary, the P.A. McCrary. And I think I already said Doctor Coomes. Those are the ones that I read.
Q. This just came to my mind.
You're -- you're not going to be offering causation opinions, are you?
A. I do have another opinion in this situation of where the standard was --
Q. Are you going to offer causation opinions as to whether or not -- well, just specifically, are you going to offer causation opinions, or are you going to talk about standard of care?
A. I'm talking about standard of care.
Q. Right.
So I didn't see a causation opinion in your disclosure.
Are you going to be offering one?
A. No.

Q. Okay. Your expert disclosure in this case was dated May 1st, 2024.
Are you aware of that?
A. I didn't pay attention to the date, but I'm not -- you know, it was early on.
Q. All right. Well, I'll represent to you that your disclosure was dated May 1st, 2024.
Subsequent to your disclosure, two depositions were taken that -- well, more than two, but two that I think are very important. One was the emergency department director, Dr. Coomes.
And you've read that, right?
A. I have.
Q. And the other was the charge nurse at -- on the day in question, that would be Emily Knight, right?
A. Correct.
Q. Those depositions were taken after your disclosure.
Have you changed your opinions based upon the testimony of Dr. Coomes and Ms. Knight?
A. No. My opinion has stayed the same regardless of the depositions, from my original reading of the medical record.
Q. You saw nothing in the depositions of

Dr. Coomes or Nurse Knight that conflicted with the opinions that were within your disclosure, correct?
A. No. I think they conflicted with one another, but it ultimately didn't change my opinion.
Q. What do you mean they conflicted with one another?
A. Well, Dr. Coomes insists that the critical value is the responsibility of the charge nurse. And the charge nurse says it is not. And in my experience in 16 years, I can tell you in practice, it is not.
Q. All right. We identified what depositions you've looked at.
A. Uh-huh.
Q. And to the extent you made notes, they'd be contained on either Exhibit 3 or Exhibit 4?
A. Yes.
Q. Okay. And then what medical records have you reviewed in this case?
A. I have looked at Owensboro Health -- or I'm -- I'm considering the file -- one moment -- I'm considering the file that was sent to me. There's a file with OHI, which was the

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

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

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

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

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

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

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

Q. Okay. So --

A. That was part of the discovery under

plaintiff.

Q. Okay.

A. Yes.

Q. So that would be important?

A. Yes.

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

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

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

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

Q. I would.

A. Okay.

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

A. Sure.

Q. -- okay?

A. Uh-huh.

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

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

A. No.

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

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

Q. Is that with purple and also with black?

A. Pencil. Yes. Yes.

Q. Okay. And where does the chronology begin?

A. At the very bottom where it says blood

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

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

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

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

A. -- thing I've put together.

Q. So we --

A. Sure.

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

A. Correct.

Q. And that's part of your timeline?

A. Yeah.

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

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

A. Lincoln Dempsey had called the emergency department.

Q. Lincoln Dempsey called the emergency department, or the laboratory called Lincoln Dempsey?
A. No. The laboratory called Lincoln Dempsey, and Lincoln Dempsey called the emergency department.
Q. Well, what happened at 14:36? What's that document?
A. When it was called to the ER, I believe.
Q. Who charted that?
A. It was in the deposition.
Q. Where in the record is it charted that a phone call was made by Lincoln Dempsey to the emergency department at 14:36?
A. I would have to go back and look through the record. I don't have the date.
Q. Let me suggest to you that the phone call you're referencing is a phone call from Kim Lasder, the chemistry -- chemistry supervisor, to the infection control person, Lincoln Dempsey, which occurred at 2:36 p.m.
Is that what you're referencing?
A. Possibly, because I have called -- yeah, Kim Lasder called Lincoln Dempsey with the

errors.
Q. So your timeline, as written, is incorrect, what you meant to say was called to Lincoln Dempsey, is that correct?
A. Lincoln Dempsey. One moment. I would have to go back and look at that exact in the -- in the records.
But it was -- yes, it was a call from Kim Lasder to Lincoln Dempsey.
Q. I just want to be clear.
That phone call you documented was at 2:36 p.m. on the 6th?
A. That's what I have written here.
Q. Okay. And we know that because Ms. Lasder, in fact, documented in the chart when she conveyed the critical result of that blood culture to Lincoln Dempsey?
A. Correct.
Q. All right. The policy we talked about earlier, about critical values, does it in -- anywhere in this document talk about communicating a critical result to infection control?
A. It does not, but policy does not always dictate procedure.
Q. Okay. Did you -- you said you saw Dr.

Reich's deposition, right?
A. I did see Dr. Reich's deposition. I think that was -- I just got that one.
Q. Did you see where he testified that he's never seen a situation where the communication begins from the laboratory to infection control?
A. I understand that, and I can --
Q. I'm just saying, did you see that?
A. I don't recall seeing that. But I under -- if you're telling me that's what he said --
Q. Did you read the deposition?
A. I did read the deposition.
Q. All right. Did you read in there where he said he's never seen that before?
A. I don't recall reading that in his deposition.
Q. Did he testify that that's not the way it's done at his hospital?
A. I don't recall if he said that or not.
Q. His deposition was just taken. I mean, and you said you read it.
A. I understand. I also read 14 other depositions in this process.
Q. So you hadn't read any depositions

until you got Dr. Reich's deposition?
A. No, that's not true.
Q. Well, What are you saying to me? I -- the deposition was taken like a month ago.
I mean, did you just not get it?
A. I read that deposition, and I don't recall what he said.
Q. Don't you think it's important to know what the pediatric infectious disease expert for the defense has to say about what happens at his hospital?
A. No.
Q. It's not important?
A. It's not important, because --
Q. Okay.
A. Yeah.
Q. So in your experience --
A. Hospitals all operate very differently.
Q. -- in your experience, would you ever get phone calls from infection control about a patient that was seen in the emergency department?
A. No. I would get a note from the nurse.
Q. Get a note from the nurse, okay.

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

Q. Has she been trained on it, what to do?
A. She's a registered nurse. Now, what she's been trained on or not, I don't know. It was part of the policies and procedures. But this is part of nursing practice, and it's not dictated necessarily by policy.
Q. Was Jessica Tedders a nurse-in-training when she received a phone call from Lincoln Dempsey?
A. I don't know what nurse-in-training means.
Q. Okay. That's fair.
A. Nurse-in-training --
Q. What time --
A. -- is not -- I'd like to finish my statement. Nurse-in-training is not a phrase I've ever heard in 31 years, and I've taught it to nursing programs.
She was a licensed registered nurse, who passed the NCLEX, who was orienting to a new job, just like anyone else in any other position oriented to a new job. She was a licensed registered nurse. She was not a nurse-in-training. I need to clarify that.

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

she understood the policy, and therefore, didn't need to go to Emily Knight.
Q. I guess my -- my question was, who was she supposed to go to if she had a question, and I understand your answer.
But the answer is Emily Knight?
A. Yes, she would have gone to Emily Knight had she had a question.
Q. And Emily Knight was the charge nurse?
A. Yes, she was.
Q. Okay. And are you saying that the way Emily Knight described what should be done and the way Jessica Tedders did it is, in fact, the same?
A. Yes.
Q. Really?
A. Yes. Emily Knight says that the nurse receives --
Q. No, no. Let's just -- just hold on a minute. Let me just ask you a few things about that.
A. Sure.
Q. Did -- did Jessica Tedders testify that she had taken a written note, Post-it note, with the information about the critical result to P.A. Tauil?

A. She did testify that.
Q. And did she get instructions of what to do with that critical result when she communicated with Jessica Tauil?
A. She absolutely did, she was told to put it on the -- right there with the --
Q. Did she get instructions about what action she was supposed to do with that critical result when she spoke to Jessica Tauil?
A. She did.
Q. All right.
A. She reported that she was told to leave it on the desk for Dr. Malik, and that the P.A. and the physician would take care of it. She did wait for instructions and she did do as she was told.
Q. And did she ever follow up with Ms. Tauil or Dr. Malik about what was supposed to happen in terms of who was to be communicated with about that critical result, did she ever do that?
A. She gave the information. It's the medical provider's responsibility at that point to follow through on that critical lab value.
Q. Did the charge nurse, Emily Knight, testify that it was the responsibility of the

nurse, communicating either with the P.A. or the doctor, to stay there until they got the information about who they were to contact and what they were supposed to do with that information, did she testify to that?
A. She did testify to that. And Jessica did exactly that. She was told by a provider in the emergency department, who she went to immediately, to take the note and set it there so the doctor and the P.A. can take care of it. She was told what to do with it and she did exactly that.
Q. Fair to say that Ms. Tedders never received any instruction about whether the family should be contacted, that is the family of Jase Foster, or the laboratory -- whether the pharmacy should be contacted, all she got was place a Post-it note on Dr. Malik's desk, right?
A. Correct, and she followed those instructions.
Q. And did Emily Knight testify that if she understood that the nurse did not get specific instructions about what to do, she was required to go back to the provider and get those instructions, is that what she testified to?

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

A. I don't have that in my notes, but probably because I --
Q. So you don't remember?
A. Right. Plus I agree --
Q. Did she testify it was important to convey that information to one of the providers in the emergency department within 30 minutes of receipt?
A. Yes.
Q. Did she testify that the practice that she followed was that she would wait for the provider to make a decision and then she would be instructed about who was to call, did she testify to that?
A. Martin, my answer is not going to change. Jessica was given --
Q. Did she -- did she testify -- did she --
A. -- instruction and she did exact --
Q. I'm not talking about Jessica.
A. Yes. Yes, she did --
Q. Okay.
A. -- wait for instructions, which Jessica received.
Q. And then did she testify that I would

stand there and wait until I got instructions?
A. Which Jessica did, yes, she did testify to that.
Q. And did she testify that if a nurse doesn't get specific instructions about what to do with a critical result, she would tell the nurse to go back to the provider to get those instructions?
A. I don't have that written, but it's not the nurse's responsibility to check up on the work of the provider.
Q. Back to your timeline.
So we -- we found one mistake, which was the phone call from lab was not to the emergency department, but it was to Lincoln Dempsey?
A. To Lincoln Dempsey, yes.
Q. Is Lincoln Dempsey -- well, strike that.
What time did Lincoln Dempsey call down to the emergency department, can you tell us that?
A. I don't know what time he called.
Q. Who did Lincoln Dempsey contact in the emergency department?
A. Ultimately, Registered Nurse Jessica

Tedders.
Q. Is that what he testified to?
A. No. He testified talking to Tiffany Johnson.
Q. Okay. Did Lincoln Dempsey anywhere in the chart, document the time he made the phone call to the emergency department and to whom he spoke with?
A. Not that I could see, no.
Q. Are you critical of Lincoln Dempsey for not doing that?
A. I'm not in charge of the lab, so I don't have an opinion on what Lincoln Dempsey did.
Q. Okay. And what time did Nurse Tedders receive that phone call from Lincoln Dempsey, do you know?
A. I don't know exactly.
Q. What information was conveyed to her by Lincoln Dempsey, did she chart that?
A. No, but she's able to say that she wrote it down and she read it back, so --
Q. We don't know what time she got it, she didn't chart what information she got.
Did she chart with whom she spoke to about that information, did she chart that?

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

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

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

Q. Yes?
A. Yes.
Q. And to whom was the final result conveyed at 8:40 a.m. on the 8th?
A. I don't know that the final result was conveyed. They called the original, like the preliminary.
Q. Are you -- are you testifying that the final result wasn't conveyed to anybody?
A. I don't know that the final result was called back to the ER, no.
Q. Should it have?
A. Not necessarily. They were already told that there were bacteria growing the day after the child was in the emergency department.
Q. Do you agree with Dr. Coomes that the blood culture result for Jase Foster fell through the cracks?
A. From the emergency room staff, I do, meaning -- no. Excuse me. By the emergency room providers, yes, they did not meet the standard of care in this case.
Q. And I'm assuming you're saying providers being Tauil and Malik?
A. Yes.

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

of your disclosure?
A. We discussed it, but it was written by Mr. Monhollen.
Q. Right.
Did you write the disclosure?
A. No, I did not write any -- any --
Q. Is any part of your input contained in that disclosure?
A. That I actually typed on the page?
Q. Yes.
A. No.
Q. Okay. Have you ever testified in court?
A. I have. It was a missed sepsis case in the emergency department.
Q. A missed sepsis case?
A. Uh-huh.
Q. And where was that case?
A. That case was in -- I have the list of my deposition and trial here. It was in Philadelphia.
Q. Oh, I didn't know you had that. Could I see --
A. Yeah. I don't have a list of all my cases, but this is the depositions I've had, and

the trial's on the last page.
Q. Can I have this to make a copy?
A. You can.
MR. KINNEY: Okay. We'll mark and file this as Exhibit 5.
THE COURT REPORTER: 5 is -- is her --
THE WITNESS: Yeah.
THE COURT REPORTER: -- correspondence.
THE WITNESS: It's going to be 6.
MR. KINNEY: Oh, that's right, 6. Okay.
(Whereupon, Exhibit No. 6 was marked for identification.)
THE WITNESS: Yeah, that trial was really weird, like I was the first expert up for the plain --
MR. MONHOLLEN: Hold -- hold on.
THE WITNESS: Yeah.
MR. MONHOLLEN: I'll make a copy for everybody at a break, so...
Q. I'm sorry. Go ahead.
A. No. I was just saying I had never been to trial before, and it was kind of weird, I was first plaintiff expert up, and I was the only

one, and like they settled the next day, it was very weird. Anyway.
Q. So back to the list that I just marked as Exhibit --
A. 6.
Q. -- 6 to your deposition.
A. Uh-huh.
Q. I think you said it -- it's not complete, it's partial?
A. No. I'm sorry. This list of depositions that you just saw, it's on 6, is complete.
Q. Okay.
A. I don't have a list of like every case I've ever looked at.
Q. Okay.
A. That's -- that's just what I was trying to clarify.
Q. So what we have is a list that would be all the depositions, as well as all the trial testimony?
A. Correct.
Q. Okay. And I think we already touched on this, you didn't do any literature search in this matter?

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

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

but failed to convey that information to the patient?
A. Correct.
Q. In this case, in reading the deposition of Doctor -- or excuse me, of P.A. Tauil --
A. Uh-huh.
Q. -- did she testify that she was made aware of the critical result for Jase Foster?
A. As I recall, she didn't remember anything that day.
Q. Did she testify whether she was given that information?
A. She doesn't remember.
Q. All right. And is there any documentation anywhere, that that information was, in fact, conveyed -- conveyed to P.A. Tauil?
A. Just in the testimony of Jessica Tedders.
Q. And we wouldn't be having this discussion if Jessica Tedders had simply documented the time she got the report and what she did with it, correct?
A. Actually, Martin, we wouldn't be having this discussion had the medical staff done

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

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

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

Q. I'm sorry.
Was that a critical result that was being conveyed?
A. It was a critical result missed by medical staff.
Q. And the critical result was what?
A. Missed by medical staff.
Q. What was the critical result?
A. They didn't know how to read a CBC. They didn't understand that this patient had infection brewing because they didn't know what to do with the differential dia -- the differential on the CBC, and they missed brewing sepsis.
Q. And you're -- you're --
A. Let's see.
Q. -- you're saying that that -- you believe that has bearing on this case?
A. It's exactly what the physicians did in the emergency room with Jase Foster, they did the exact same thing.
Q. And tell me again what they did.
A. They missed the infection that was already going on in Jase Foster on 9/5. The doctor, Doctor Argotte, wrote his CBC was normal. His CBC was not normal, it absolutely was not.

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

And so --
A. Sure.
Q. -- the critical result would have been the CDC?
A. Correct.
Q. And who failed to convey the CDC results in that matter?
A. The nurse practitioner didn't interpret it correctly.
Q. Oh, so an interpretation? It's not a -- how to handle it, but they just didn't understand it?
A. They didn't understand it, so therefore, they didn't contact the patient --
Q. Okay.
A. -- to go to the ER.
Q. All right.
A. Yeah.
Q. Were there -- Were there policies that were pertinent in that case, that -- or was this just a matter of a doctor or a P.A. not appreciating the significance of some abnormal findings on the CBC?
A. Yeah, it was the medical personnel not doing their job.

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

Q. From '93 to '98, did you work in an emergency department setting?
A. '93 to '98.
Q. You've already testified you didn't begin until 2001. I just wanted to be clear.
A. No. I was in family practice at that time.
Q. Okay. So you began your -- your professional work in a family practice setting and then migrated into an emergency department role, fair?
A. I did. I did several things during that time. I taught at a university. I did independent coverage of practices in Shelbyville, Indiana, and I worked in the ER. I was juggling a number of things at that time.
Q. Your certification has been in good standing since you became a certified family nurse practitioner?
A. Yes.
Q. Is there any certification that would apply specifically to working as a nurse practitioner in an emergency department?
A. When I went to school, they didn't have a certification or a board process for nurse

practitioners in the ER. It exists now.
Q. Right.
Do you -- do you have that?
A. I don't. I could probably teach in that program. I -- I see no need --
Q. And when --
A. -- to go get it.
Q. -- and when did that certification become available?
A. You know, I don't even know.
Q. Okay. But you -- you don't have it?
A. I don't have it. I don't need it.
Q. Do you intend to work in an emergency department setting in the future?
A. I don't know. I don't believe so, but --
Q. Okay.
A. -- things change all the time.
Q. So let's talk about Jill Baldwin as a -- in your professional life.
Your typical week would be two days in a family practice clinic?
A. Uh-huh.
Q. In addition, one or more, a few days, a month working for another family practice?

A. Yeah. Sometimes I cover the whole week for her. Like I'm covering all next week and then I have three more weeks scheduled so far this year.
Q. I mean, we're -- it's Wednesday.
I mean, what -- what did you do on Monday this week?
A. I worked.
Q. In the family practice?
A. Yeah. Mondays and Tuesdays, I'm in LaGrange.
Q. Okay. And then if you were to break down your work between expert work and working in your field as a nurse practitioner, what's the breakdown?
A. It's probably 70/30 clinical.
Q. Okay. Do you have a -- is there a physician that you're responsible to as a nurse practitioner?
A. No, not in the state of Kentucky. I'm an independent provider.
Q. Okay. Are you a member of any professional organizations?
A. Yes, I'm a member of the American Academy of Nurse Practitioners, the Kentucky

Association of Nurse Practitioners and Nurse Midwives. I was a member of the AALNC, and I forgot to renew and still haven't done it. And I'm a member of Institute for Functional Medicine. That needs to be included on there, but I haven't -- I haven't included that yet.
Q. Have you ever been a -- a defendant in a medical malpractice lawsuit?
A. No, I have not been sued.
Q. Have you ever had any complaints filed against you with the licensure board?
A. No.
Q. And your license would be a license for Kentucky, is that correct?
A. Correct.
Q. Any other states?
A. They're all inactive at this point. My original license would have come from Ohio and then Indiana and Kentucky, but I no longer carry Ohio and Indiana.
Q. Okay. Any experience in Muhlenberg County? Have you ever been there?
A. No.
Q. You've not been to the Muhlenberg Community Hospital?

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

I'm not sure what you're talking about. So --
A. Oh, I -- I'm sorry. It's Expert Institute. And I thought you found me through Expert Institute. I was just trying to describe the service since I couldn't recall the name at the moment.
Q. Okay. So do you --
A. Expert Institute.
Q. -- do you pay to be part of the Expert Institute --
A. No.
Q. -- family?
A. No.
Q. What about SEEK, are you part of that?
A. Yes. I do pay for a spot in their electronic and the paper directory.
Q. Okay. Any -- any other expert groups that you're associated with?
A. No.
Q. All right. Ever work with Mr. Monhollen before?
A. No. I've worked with Mr. Sheffer and Mr. Tackett.
Q. All right. Question: "Have you ever worked with Mr. Monhollen?" Answer: "No".

A. No.
Q. Have you worked with his firm before?
A. Yes.
Q. And that would include both Mr. Sheffer, as well as one of his other attorneys?
A. Mr. Tackett.
Q. Okay. And how many cases have you worked on with Mr. Sheffer?
A. Two, I think.
Q. All right. Any of those current?
A. I don't think so.
Q. Any of those part of the depositions that you provided to us the last time?
A. No. This is the only deposition I've done with this law office.
Q. And in those two cases, Mr. -- Mr. Sheffer would have been for the defense?
A. Yes.
Q. And then Mr. Tackett, how many cases with him?
A. One.
Q. And would that be part of the list of depositions that you provided to us?
A. I've not been deposed with anybody --

Q. Okay.
A. -- in this office other than today.
Q. And was that a defense case, as well?
A. It was.
Q. Okay. When were you first contacted?
A. End of February, beginning of March in '24.
Q. So February, March of 2024?
A. Yes.
Q. And that would have been a few months before your disclosure was filed in this case?
A. Correct.
Q. All right. And you weren't familiar with Mr. -- or you weren't familiar with Mr. Monhollen before he contacted you? You knew his firm, but you didn't know him?
A. Correct.
Q. And was it Mr. Monhollen who, in fact, contacted you?
A. I believe Laura Morgan contacted me.
Q. All right. And does she work with Mr. Monhollen?
A. She does. I don't know if she's the legal assistant, I -- I don't exactly know what her job title is.

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

sorry, the Plaintiff's experts.
And I'm guessing that you -- which you haven't disclosed to us, but you probably also got Plaintiff's expert disclosure.
Did you get that?
A. Yeah, I'm -- I'm assuming that I did. Like I said, I didn't --
Q. Well, you didn't --
A. -- write them down.
Q. -- you didn't mention that, though.
Was that not important? So when you first got the case, you knew already who the Plaintiff's experts were and what their opinions are, correct?
A. Well, I would have had to have received it if it's in my disclosure, but I don't actually recall what date that I received it.
Q. Is it typical that you would get an expert disclosure in a case that you're asked to give an independent review on?
A. I get expert disclosures -- disclosures all the time. Depositions come in in different ways in every case.
Q. So you get expert disclosures all the time before you've even reviewed the material in a

case?
A. No. What I'm saying to you is, I receive expert depositions along the line with all the other depositions, and I don't keep track of when I receive what, and every case --
Q. I didn't say depositions.
A. -- is different.
Q. I said expert disclosures.
And I'm -- and you've --
A. Oh.
Q. -- testified you got the disclosure in this case, and it sounds like you got it early on, because it's referenced in your -- your expert disclosure.
Is it typical for you to get the expert disclosure when you're being asked to do an independent review of a new case?
A. You know, I don't know. I mean, I don't -- every case comes in with different information in a different order.
Q. So did you review the Plaintiff's expert disclosure before you formulated your opinions in this case?
A. If it says that I had -- one moment. I think the disclosure mentions Dr. Goodspeed. And

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

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

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

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

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

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

How many hours would be focused on deposition prep?

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

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

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

Q. Okay.

A. -- phone consultation in there somewhere.

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

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

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

A. One moment.

Q. Is it contained in your disclosure?

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

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

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

Q. So --

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

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

A. Most likely.

Q. Most likely.

Why isn't it in here?

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

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

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

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

A. I have told him that opinion, yes.

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

A. I did review my disclosure.

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

A. Yes.

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

A. Apparently, I didn't.

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

A. I don't know.

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

A. May or may not have.

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

A. No.

Q. You thought it was important?

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

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

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

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

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

Q. Okay. Thank you.

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

A. Correct.

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

A. A number of times, yes.

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

A. I'm sure I have, yes.

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

A. Yes.

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

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

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

A. If it's a patient discharged from the

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

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

A. Yes.

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

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

Q. I understand that.

A. Yeah.

Q. Isn't that what --

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

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

positive blood culture, correct?

A. Yes.

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

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

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

I said some of the times.

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

Q. It isn't, I understand that.

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

A. Probably, yes.

Q. Probably or not?

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

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

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

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

A. Yes.

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

A. Yes.

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

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

Q. And you would?

A. Yes.

Q. Okay.

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

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

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

Did you make a comment?

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

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

A. Thank you.

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

Am I incorrect?

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

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

A. No. Those are my opinions.

And then page 2 -- the next three

pages are notes from depositions.
Q. Okay. So you've got summaries of what you thought was important for Emily Knight, Jessica Tedders?
A. Yeah, just comments or things that they -- they said, that -- that I thought might be important for today's discussion.
Q. Okay. Then Kim --
A. Lasder.
Q. -- Kim Lasder, Lincoln Dempsey, Malik McCrary.
And can you tell us and the jury when you generated Exhibit 4, which are the opinions and notes?
A. Some of this was generated as I went through, some of it was generated in the last week. Some of the depositions, I read twice. So sometimes you'll see added notes or things to that.
Q. In fact, didn't most of Exhibit 4 -- is this something you just recently generated?
A. No. Actually, I had some notes scribbled in here, and when I reread it, I carried that over and added to it. So some of these notes were in here already, and some of them were not.
Q. Well, when did you summarize what you

thought was important from the depositions?
A. The mean -- on the depositions, would have been -- like, again, some of it's when I first read it, and some of it's been in the last couple of weeks.
Q. Uh-huh.
Okay. We've talked before that you were given Dr. Reich's deposition.
A. Uh-huh.
Q. And you've testified that you did review it --
A. Correct.
Q. -- although you don't remember all of it.
Is that a fair statement?
A. It is. I don't remember verbatim, no.
Q. Do you recall Dr. Reich testifying that a hospital has a responsibility to train employees on the hospital policies?
A. I don't recall, but...
Q. Do you agree with that?
A. I would agree with that.
Q. And from the depositions that you've read in this case, did everybody understand what was supposed to happen with the blood culture

result, when a patient was no longer in the hospital, that had been seen in the emergency department?
A. I always think it was very clear throughout their deposition that they understood the steps in which it was going to happen, the -- the actual procedure.
Q. So you're going to testify in this case that the depositions of Dr. Coomes and Nurse Knight and Nurse Tedders, as well as the others, are all consistent in terms of what should happen with a clinical -- with a critical result?
A. I was not referring to Dr. Coomes. I was referring to the process that occurs between the lab infection control and the nurse in the ER. Those were pretty consistent in the way in which these steps occur.
Q. Who is Dr. Coomes?
A. Dr. Coomes is the medical director for that emergency department.
Q. Should he understand what should happen with a critical result that comes back for a patient that was seen in the emergency department, that's no longer there?
A. He should, but...

Q. He should.
You'd expect he would?
A. You would hope that he would. But it's through the other --
Q. And --
A. -- depositions they disagree with him, so --
Q. I understand that.
A. -- it doesn't say that he does.
Q. When you worked in the emergency department, did you ever work with the director of the emergency department?
A. Yes.
Q. And was the director somebody that was -- that you reported to?
A. Yes.
Q. If you had questions, was the director someone you could go to to get clarification, if you had questions?
A. Any of the physicians that were on staff while I was there --
Q. I'm talking about the director of the emergency department.
A. If he was on staff at the time, yes -- I mean, in the ER at that time, on the same

shift, I would.
Q. In terms of the -- the -- the hierarchy in the emergency department, would the director be on the top rung?
A. Yes.
Q. And he would be responsible for those that worked in the emergency department, correct?
A. He would be responsible for -- well, it depends. He's certainly responsible for his staff, and he's responsible for being the liaison between his staff and the hospital.
Q. Okay.
A. But I don't know that he's responsible for what the lab should be doing with critical results.
Q. And does he have responsibility over the training of the nursing personnel that -- that staff the emergency department at Muhlenberg Community Hospital?
A. No, he does not.
Q. And what do you base that on?
A. 16 years of being a nurse practitioner in the ER. He's over his own staff. If there's difficulty between his own staff and hospital staff, then it would be their responsibility to

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

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

you agree there's nothing in this policy that addresses the scenario I just discussed, other than you're referencing to a sentence that says this may not be all-inclusive?
A. Yes. The bottom of this policy says --
Q. I got you.
A. -- this guideline --
Q. I got you.
A. -- doesn't include everything.
Q. Right.
A. It's not possible --
Q. Right.
A. -- to include every single scenario.
Q. Okay. Dr. Reich also testified that it's imperative that hospital personnel know and understand the policy for critical results.
Do you agree with that?
A. I would agree --
MR. MONHOLLEN: Object to the form. Go ahead.
A. I would agree that they understand the way in which critical values should be handled.
MR. KINNEY: What was the objection?
MR. MONHOLLEN: That wasn't his quote.

THE WITNESS: Yeah.
MR. MONHOLLEN: I'm only objecting to the form because --
MR. KINNEY: It is a direct quote, "hospital personnel should know and understand policies for critical results".
MR. MONHOLLEN: You said imperative. That's not what he said.
MR. KINNEY: Well, let me restraight -- restate it.
Q. Do you agree with Dr. Reich's testimony that a hospital personnel should know and understand the policy for critical results?
A. I understand that they need to un -- yes, that, and the procedure in which it happens.
Q. Okay. In your disclosure, you state the following: "Nursing and laboratory staff followed the unwritten procedure for notification of a critical value in this laboratory, which has been in place for a number of years".
So, first of all, what is the unwritten procedure?
A. Okay. I'm sorry. Where are you at in this deposition -- I'm sorry. Where are you at in my disclosure? I apologize.

Q. You don't agree that you made that statement, "nursing and laboratory staff followed the unwritten procedure for notification of a critical value in the laboratory, which has been in place for a number of years"?
A. I would like to read below -- above and below the statement that you made so that --
Q. Sure.
A. -- I can get a context.
Q. I have it as the second page, second full paragraph, halfway down, that states, "furthermore, Ms. Baldwin is expected to testify that the Hospital Defendant met the standard of care in the policies and procedures that were in place at the time of the events, the handling of the presumably positive blood culture result and the process which was utilized in the transmission of such information from the laboratory to the emergency department. She will testify that the nursing and laboratory staff followed the unwritten procedure for notification of a critical value in the laboratory, which has been in place for a number of years".
A. Yes, I --
Q. Is that not a direct -- am I not

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

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

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

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

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

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

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

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

A. For unwritten procedure? No, not necessarily.

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

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

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

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

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

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

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

A. Yes, I would agree with that.

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

A. Yes.

Q. You read the depositions?

A. I understand. Everyone --

Q. Have you --

A. -- understands to report it immediately.

Q. Have you read the depositions?

A. I have read all of the depositions.

Q. Are they consistent?

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

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

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

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

A. I'm not.

Q. Are you critical of Ms. Lasder for

documenting what she did with that critical information?

A. I am not.

Q. That's appropriate, correct?

A. Correct.

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

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

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

A. According to this policy, yes.

Q. And he did not?

A. Not that I could see.

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

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

Q. He did, didn't he?

A. He did.

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

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

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

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

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

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

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

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

so-and-so's desk.
Q. Well, Ms. Tauil testified that she would handle it, didn't she, did she not testify to that, if she got this information, she would have handled it?
A. Well, she doesn't --
Q. Did she -- yes or no?
A. Everything is not a yes or no question.
Q. I know it's not with you.
A. She testified that she doesn't think that that would be -- she doesn't remember what she did, but she assumes she didn't, because that might not be her normal practice.
Q. My question is, does -- did Nurse Tauil testify that she would know -- that she would handle it and she would know what to do if given the information that a patient who was seen in the emergency department, who was no longer there, had a blood culture that came back positive, did she testify she would know what to do?
A. She would testify that she would know what to do.
Q. And did she testify that she would, in fact, handle it?

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

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

laboratory should have contacted about Jase Foster's positive blood culture result?
A. One moment. I don't recall exactly what he said.
Q. I know you don't.
Dr. Coomes testified that the lab should notify either the doctor or the charge nurse.
Do you have any memory of reading that?
A. Yes. He put the onus on the charge nurse, and that's just not how it plays out in everyday life.
Q. I'm not asking what you think.
I'm asking what the emergency room director at the Muhlenberg Community Hospital testified about what should happen with a critical result that came back much like in Jase Foster's situation?
A. Yes. I recall him saying it would be the responsibility of the charge nurse.
Q. Well, he testified the lab shouldn't be contacting Lincoln Dempsey, it should be contacting either the doctor or the charge nurse, did you see that?

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

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

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

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

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

situation, the charge nurse should be directly involved in the communicate -- in the communication, you agree with that, that's what he said, right?

A. No, I don't agree the charge nurse needs to be involved.

Q. I didn't say that.

I said about what he testified to.

A. Yes, he testified to that.

Q. Okay. Now, Emily Knight, as we know, was the charge nurse, right?

A. Yes.

Q. And did she agree that the charge nurse should play a role in the conveyance of a critical result that comes from the laboratory?

A. No.

Q. Okay. So she disagrees, right?

A. Correct.

Q. So when we go back to Doctor Reich's opinion that the hospital personnel in the emergency department should know and understand the policy for handling critical results, clearly, there was a lack of understanding among Ms. Tedders, Doctor Coomes and Nurse Knight about what to do, correct?

A. I think -- no. I think Doctor Coomes is mistaken in who he thinks. Emily Knight does not say it goes to the charge nurse, and neither did Jessica Tedders.

Q. Now, Ms. Knight testified that whoever gets the call in the emergency department should handle it, did you see that?

A. Correct.

Q. And she testified that she would think that Ms. Tedders could handle it, but if she had questions, she was to come to her, right?

A. Correct.

Q. Did Nurse Tedders ever speak with Ms. Knight about what she should or -- do with the critical result for Jase Foster?

A. No.

Q. Did Nurse Knight testify that it's important to chart in the medical record what happens with the critical result?

A. I don't recall exactly what she said, but in general, that's the principle, yes.

Q. Okay. And that wasn't done here, right?

A. It was not done in this situation.

Q. And then did she testify that it was

important that this information, which she considered potentially life threatening, be -- be given to a provider within 30 minutes?

A. Yes. She said immediately.

Q. Okay. And then what did she say she would do when she conveyed that information to one of the providers in the hospital?

A. Are you talking about Jessica Tedders?

Q. No. We're talking about Emily Knight.

A. Emily Knight -- yeah. Emily Knight said she would stand there and get instruction.

Q. Okay. And you're saying that you believe that Ms. Tedders fulfilled that requirement, because she was told to put that piece of paper on Doctor Malik's desk?

A. Yes. She got instruction, and she did it.

Q. But you understand that Ms. Knight was referring to what specifically was to happen, that is, whether to call the pharmacy, whether to call the family and whether to get that boy into the hospital, you understand that, do you not?

A. I thought she was giving examples of what the possibilities could have been of -- of the instructions that she would receive from a medical

provider, that's what -- that's what I understood that to be.

Q. And did she testify that the nurse, in this situation Ms. Tedders, if she didn't get specific instructions about what to do with that critical result, she would tell Ms. Tedders to go back to the provider to make sure it was followed up on and she got the instruction, did she testify to that?

A. I believe so. And I would say Ms. Tedders did exactly that.

Q. Did Ms. Tedders ever go back and speak to either Ms. Tauil or Dr. Malik about the critical result for Jase Foster on September 6, 2019, after she supposedly put a Post-it note on Doctor Malik's desk?

A. No. She notified the provider, and at that point --

Q. Did -- the answer is no, she did not?

MR. MONHOLLEN: She -- she -- she can finish.

Q. Well, but the -- you can finish.

But the answer is she did not, correct? Did --

A. Did she go back and verify that the

clinical staff -- that the physician staff did their job? No.
Q. Right.
A. It's not her job to --
Q. Right.
A. -- supervise the physician.
Q. She never did, did she?
A. It's not her job to supervise the physician.
MR. KINNEY: All right. We're almost done.
MR. MONHOLLEN: Can -- can we take a --
MR. KINNEY: Sure.
MR. MONHOLLEN: -- short break?
THE WITNESS: Yeah.
THE VIDEOGRAPHER: We're going off record. The time is 11:32 a.m.
(Whereupon, there was a brief recess.)
THE VIDEOGRAPHER: We are back on record. The time is 11:50 a.m.
(Whereupon, Exhibit No. 8 was marked for identification.)
Q. Okay. I'm going to hand you what I've marked as Exhibit 8, which is something we've kind

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

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

Q. Well, you --
A. This is a --
Q. -- you understand this is a policy that applies to the laboratory, the nursing department and radiology, right?
A. I understand that. But it doesn't outline specifically who's to call the physician. They just want it done within 30 minutes.
Q. So you're critical that it's not specific as to who's making the phone call, if it --
A. Well, I'm not -- I'm not critical of the policy. I'm -- it's a framework, and it is understood that they should be contacting the physician in 30 minutes. It's just a general framework policy.
Q. With regard to Jase Foster, was the critical result ever conveyed to a physician, based upon what you reviewed in the record?
A. It was conveyed, according to Jessica Tedders, to the P.A., who was also responsible for providing care.
Q. Listen to my question.
Was it ever given to -- was it ever conveyed to a physician, based upon what you've

read in the record?
A. It was conveyed to a nurse in the emergency department.
Q. Right.
Was it ever conveyed to a physician?
A. By the nurse.
Q. Did a physician ever receive this critical result for Jase Foster?
A. According to Jessica Tedders, she handed this note to the P.A., who's also responsible for it, who said that she and Doctor Malik would take care of it.
This doesn't say that --
Q. That's not my question, ma'am, and you know it's not my question. I'm not -- I was asking not whether it went to a P.A.
I was asking, did this information, based on what you've read in the record, ever -- was it ever conveyed to a physician, from what you've seen?
A. I don't know if it was conveyed to a physician.
Q. All right. Are you critical that a physician was not notified of this critical result for Jase Foster?

A. I am not --
Q. Okay.
A. -- because --
Q. I understand.
MR. MONHOLLEN: She can finish.
MR. KINNEY: But it's going to be the same thing.
Q. But go ahead.
A. It is, because you keep asking the same question.
I'm not critical it didn't go directly to Doctor Malik, because it went to a member of the clinical staff, the medical staff at Envision, and she was assured that that information would be taken care of by that P.A. and physician.
I'm going to give you the same answer every time. It's not going to change.
Q. And in terms of this policy, does it specifically state that documentation of notification of test results must be placed into the electronic health record, does it state that?
A. Again, yes, it does.
Q. And it wasn't done --
A. And I think we already agreed that this does --

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

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

told them that, that's why it's important to document it?
A. No.
Q. Well, what do you tell them?
A. I don't stick by the not documented, not done rule, because I work in healthcare and I understand the -- the realistic situation.
The goal, yes, you would want them to document everything, right, you would want that to happen. But I also know in a realistic situation like the emergency room, that doesn't always happen.
Q. The second page has a section that applies to the emergency department, do you see that?
A. I do.
Q. And the last item says, "notification of physicians in time of the notification shall be documented on the patient's emergency room record", do you see that?
A. I do see that. You have to consider, though, that earlier, under this particular number, it says the RN would be assessing the patient, notify the emergency room physician. So this policy is written with the understanding that the

patient is actually in-house, but they're not. This patient is discharged, and that's why the statement, "no, these guidelines are not inclusive, nor is this probably limited to this item stated". That's why that's there, because this addresses patients in-house.
(Whereupon, Exhibit No. 10 was marked for identification.)
Q. And then the last exhibit is your disclosure. I've only pulled out that portion that relates to you I marked as Exhibit 10.
Is that, in fact, your disclosure?
A. Yes, this is my disclosure.
Q. And you've testified already that you didn't draft it?
A. Correct.
Q. And you didn't make any changes to it?
A. No --
Q. And --
A. -- not that I can recall.
Q. -- and there's been no amendments or revised disclosures setting forth any additional opinions?
A. No. I would like --
Q. And you understand that a disclosure

is supposed to identify all opinions you intend to offer at trial, correct?
A. Yes. And I would like to make a statement about that, I would like to say something in regards to that.
Q. We're waiting.
A. On the beginning of the page, at the first full paragraph on the second page, it says, "it is anticipated that Ms. Baldwin will testify generally regarding the different roles, responsibilities and scope of practice of a physician, mid-level practitioner and a nurse in emergency department setting. She will testify that the roles, responsibilities and scope of the practice of physician, mid-level practitioner and nurse differed greatly, and that it is the responsibility of the medical providers to address critical values in the emergency department". I did say that. It -- it is in this disclosure.
Q. What?
A. The part about -- earlier, we had a discussion --
Q. My question was, is a disclosure supposed to set forth all of the opinions you intend to offer at trial?

A. That's -- yes. However, earlier, the discussion was whether or not I had made a comment about the failure of the medical staff, and I'm saying it's -- it's right here in my disclosure.
Q. So you're saying the second full paragraph of your disclosure sets forth criticisms of the emergency room personnel?
A. Of the ER providers, yes.
Q. And -- and -- and specifically what are you referencing?
A. Let's see. I just -- second sentence, "testify to the roles -- "Ms. Baldwin will testify generally regarding medical providers's responses to preliminary positive blood culture results".
Q. I've read that.
I'm saying, where is the opinion in here where you're critical of the -- the emergency department providers?
A. I think it's part of the roles, responsibilities and scope of practice, that's all I'm saying.
Q. But you agree that the second paragraph does not contain any opinion, does it?
A. Contain what?
Q. Any opinion, no criticism?

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

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

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

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

whatever it is.
But my point is that that piece of paper or that Post-it note, I have absolutely had that experience of it being laid on my desk.
Q. Do you know whether the emergency department was chaotic on September 6, 2018?
A. I don't. But I can tell you that the issue over the Post-it note has happened before, because that --
Q. That wasn't my question.
A. Okay.
Q. You -- you just --
A. I don't know how many patients were in the emergency department at that time.
Q. And You've not been supplied that information?
A. I have not.
Q. But you said that often, emergency departments, as we all know, can be chaotic, right?
A. Yes.
Q. And things can fall through the cracks, right?
A. Yes.
Q. And that's why we want documentation, right?

A. Yes.
Q. And that's why we want consistency with an understanding among everybody about what's supposed to happen with something as important as a critical result demonstrating a positive blood culture, right?
A. The procedure, yes.
Q. Right.
A. My --
Q. And I'm taking it from what you're stating here, that your experience is Post-it notes is the common means of transmitting, your experience, critical information of a blood culture result that's positive, that your experience has been Post-it notes are -- are certainly an acceptable way and it's a way that you often see it conveyed, right?
A. I see it in a written form, yes.
Q. You said Post-it notes. So I'm just asking that.
A. Or pieces of paper. I didn't say just Post-it notes.
Q. Just --
A. I'm saying it's in writing somewhere along the line.

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

understand that the P.A.'s desk, the -- the ED doctor's desk and the charge nurse area, were all in close proximity?
A. Yes, that's been my experience.
Q. And how many doctors were working in the emergency department on September 6, 2019 when this information came into the emergency department?
A. My understanding was it was just one MD and one advanced practice provider.
Q. Well, my question was doctors.
And it was one, right?
A. Just one, yeah.
Q. And how many P.A.'s?
A. One advanced practice provider --
Q. Okay.
A. -- which is like P.A. or NP --
Q. And then --
A. -- it could be either one.
Q. -- and then you've got a charge nurse, and then you've got a nurse-in-training.
Anybody else working in there?
A. You have licensed registered nurses who are orienting to a new job, yes, and there are also techs.

Q. And you wouldn't expect anybody to follow up during that shift in this small work environment where they're seeing each other routinely throughout the day, to say hey, did you get that information about Jase Foster and follow up?
A. No. It is not the nurse's job to make sure --
Q. It's not the nurse's job.
Even though the charge nurse says it is, even though the ED director says it is, you say it's not --
MR. MONHOLLEN: Object to the form.
Q. -- right? Is that right?
A. Right. Once the information is passed on to a physician, it's their responsibility to deal with the issue.
Q. But you just testified there's no evidence that the physician ever got that information.
A. Other than her sworn testimony.
Q. Doctor Malik is a man.
A. I was referring to Ms. Tedders.
Q. That was just based on what you testified to, that the doctor was to be given the

information?
A. A medical provider in the ER who can deal with those critical lab values.
Q. I think we touched on this, but the -- just dealing with the Norton hospitals, and I may have asked this, I apologize, are you saying that they did not have a policy that would address our situation here, that is, a critical result that comes back for a patient who was seen in the emergency department, that's no longer there?
A. I don't know if there's a policy in writing, but I can tell you the staff understands to get it to one of the medical providers immediately.
Q. Ms. Baldwin, was Jase Foster's -- contacted about the blood culture result on September 6, 2019?
A. No.
Q. Ms. Baldwin, was the family of Jase Foster contacted about the blood culture result on September 7, 2019?
A. No. Unfortunately, Doctor Coomes didn't tell them that --
Q. Ms. Baldwin --

A. -- when they re-presented.
Q. -- was the family contacted on September 8th, 2019, about the positive blood culture result?
A. No. Unfortunately, Mr. -- when P.A. McCrary saw it and signed off on it, he did not contact the family.
Q. And how is it that it was discovered that the blood culture result, in fact, was positive for Jase Foster, if you know?
A. It was discovered on the 9th by Tabitha Taylor, when he showed up and did outpatient follow-up.
Q. And -- and what did she have to do to gain access to that information?
A. Look in the computer.
Q. Right.
I -- I may be done. Let me just have a moment to think.
A. Sure.
MR. KINNEY: If you want to walk out, that's fine.
THE VIDEOGRAPHER: We are going off record. The time is 12:11 p.m.
(Whereupon, there was a brief recess.)

THE VIDEOGRAPHER: We are back on record. The time is 12:17 p.m.
Q. Ms. Baldwin, let's go back to what happened on September 6, or at least what Ms. Tedders says happened, and take Nurse Tauil out of the picture.
A. Okay.
Q. Would you be critical of her if she had gotten this information from Lincoln Dempsey, wrote it down on a Post-it note, and simply put it on Doctor Malik's desk, would that be sufficient?
A. I don't know in that situation. It's -- it's something that's occurred with Doctor Malik before. He -- he talked about they put Post-it notes on my things, so he's aware that sometimes that does occur.
Preferably, you say to them hey, I got this blood culture result, et cetera.
Q. My -- my question, though, is, do you believe that she met -- that she would have met the standard of care if all she did was place a Post-it note on his desk?
A. I think there probably needs to be some sort of verbal --
Q. Okay.

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

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

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COMMONWEALTH OF KENTUCKY)
)SS
COUNTY OF JEFFERSON)

I, PAUL A. KLAPHEKE, a Notary Public within and for the Commonwealth and County aforesaid, certify that the foregoing is a true, correct and complete transcript of the deposition of JILL BALDWIN, APRN, taken at the time and place and for the purpose as set out in the caption hereof; that said witness was duly sworn before giving said testimony; that said testimony was taken down by me in stenotypy and was thereafter under my direction transcribed into computer-assisted transcription; that the appearances were as set out in the caption hereof; and that no request was made by counsel for any party that the deposition be submitted to the witness for reading and signature.

My commission expires August 6, 2027. Given under my hand as Notary Public this 20th day May, 2025.

NOTARY PUBLIC STATE-AT-LARGE

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