Exhibit J

Dr. Evadne Marcolini Deposition

Vargas v. Cook County
18 CV 1865
Exhibits to Defendants Statement of Facts

Vargas

Marcolini Evadne

3/15/2021

Condensed Transcript

Prepared by:

Bill Ragen
CCSAO

Tuesday, August 31, 2021

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

LETICIA VARGAS, Administrator
of the Estate of Angel Cruz,
Plaintiff,

-vs- No. 18-cv-1865
Judge Steven Seeger
SHERIFF OF COOK COUNTY,
COUNTY OF COOK, et al.,
Defendants.

DEPOSITION OF EVADNE MARCOLINI, M.D.
MARCH 15, 2021
3:00 P.M.

Shelley L. Marvin: CSR# 84-003926

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APPEARANCES:

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EXHIBITS:

Deposition of EVADNE MARCOLINI, M.D., taken on behalf of the Defendants via Zoom videoconference at 3:00 P.M. on March 15, 2021, before Shelley Marvin, CSR in and for the State of Illinois, CSR License No. 84-003926.

Deposition taken pursuant to the evidentiary provisions of the Illinois Code of Civil Procedure and the Rules of the Supreme Court promulgated pursuant thereto.

(Whereupon the deposition commenced at 3:01 P.M.)

EVADNE MARCOLINI, M.D.,
the deponent herein, called as a witness, after having been first duly sworn, was examined and testified as follows:

MR. RAGEN: Usually there's like a little preamble that all the parties agree to do this deposition remotely in accordance with the, you know, State and Federal Rules. So without that, Ken, do you agree that this dep can be performed remotely rather than in-person?

MR. FLAXMAN: Absolutely.

MR. RAGEN: Okay. Great, John, how about you?

MR. POWER: (Indicating thumbs up.)

MR. RAGEN: I saw a thumbs up, but didn't hear any words.

MR. POWER: Yeah, sorry. I was frozen. Yes.

MR. RAGEN: Let the record reflect that Ken Flaxman, on behalf of the Plaintiff, and John Power, on behalf of the Sheriff, and William Ragen on behalf of the County and a number of individually named Defendants, have agreed to

proceed remotely for this deposition.

EXAMINATION

BY MR. RAGEN:

Q. Dr. Marcolini, how are you?

A. I'm good. I'm just took my scrub hat off and ran from my shift, so I'm a little disappointed in my hair, but I think we'll get past that.

Q. Well, I'm not disappointed in your hair. It looks great to me. Thanks for being here.

So I don't do too many ground rules. But one is that from time to time I'm going to ask a question that you will not understand. Will you tell me if you do not understand my question?

A. Yes.

Q. If you answer a question that I ask, I will assume that you understood it. Is that fair?

A. Yes.

(Whereupon Deposition Exhibit 1 was marked for identification.)

BY MR. RAGEN:

Q. Okay. So we'll mark as Exhibit 1 -- and it's a little different because it's all electronic -- but I take it you have your opinions that you drafted in this case with you?

A. I do.

Q. Okay. And it appears to be the six-page document dated February 16th, 2020?

A. It -- I don't have the specific date on it, but it is six pages. Yes, dated February 16th, yes.

Q. Okay. And then that'll be Exhibit 1.

MR. RAGEN: Let me write this all down because if I don't do this systematically, I forget, and then Shelley's going to hate me forever and I don't want that. For the record, Shelley's the court reporter. Exhibit 1 will be your six-page report.

(Whereupon Deposition Exhibit 2 was marked for identification.)

BY MR. RAGEN:

Q. Exhibit 2 will be -- you provided a list of cases you've been involved with, whether they be trial testimony and deposition or just deposition.

A. Yes.

Q. Do you have that in front of you?

A. I do.

Q. Okay. It appears to be a one-page document with three entries for trial and four

entries for deposition. Does that appear correct?

A. Oh, yes.

Q. Okay.

A. Yes.

(Whereupon Deposition Exhibit 3 was marked for identification.)

BY MR. RAGEN:

Q. And then what I'll mark Exhibit 3 is your C.V., which is a 26-page document. Do you have that?

A. I do.

Q. Okay. Do you know if you have the version that was -- and again, this is a little bit speculative. But do you have your version in front of you?

A. I do.

Q. Okay. Is yours 26 pages?

A. Yes, it should be 26 if there's one more page. Yes, it is 26 --

Q. Okay.

A. -- pages, yes.

Q. And usually if you're going to update a C.V., you're not going to update things in the past. So the most likely things to be updated would be lectures or articles you wrote, right?

A. Correct.

Q. Okay. So if you look at the articles, which can be found on page 7, do you see that?

A. Yes.

Q. Is the most recent one the -- oh, wait. Are these chronological?

A. It's the latest -- it's the oldest first.

Q. Okay. So that's good. Then you don't have to keep changing the format. You can just go to the end. So if you go to the end, the most recent one is an article entitled, "The Timely Topic For Emergency Medicine," authored by Guth, Luber, yourself for the Journal of American College of Emergency Physicians?

A. Yes.

Q. Is that the most recent publication you have?

A. That is.

Q. Okay. I'm not -- we'll go through this a little, like a fair amount. But if some -- if we go through something that -- well, yeah, we'll just go through it. If we have a different version, which we probably shouldn't -- well, do you know if the version you're pulling up, is that

from your desk or from the Plaintiff's attorneys e-mailing it back to you? Do you know?
A. My C.V.?
Q. Yeah.
A. My C.V. would be the one that's most current that I sent to them.
Q. Okay, good. So this is the one that you sent to them?
A. Correct.
Q. Okay, great. So then it's -- you know, you update your C.V. probably whenever anything relevant comes up, so I'm glad to know we have the same version. And then that will be Exhibit 3.
(Whereupon Deposition Exhibit 4 was marked for identification.)
BY MR. RAGEN:
Q. And then what I'll do Exhibit 4, there is a document that's one page that is entitled Materials Used By Expert. Do you have that?
A. I do.
Q. Okay. Is that something you prepared?
A. No. That was prepared by the attorneys.
Q. Okay. And does that appear to include all the materials that you used in review of this case?

A. It does indeed.
Q. If in the future we go through this deposition and you think oh, yeah, there's some other materials I reviewed that were relevant for the basis of my opinions, let me know. Okay?
A. Okay.
(Whereupon Deposition Exhibit 5 was marked for identification.)
BY MR. RAGEN:
Q. All right. And finally, Exhibit 5, there's a Declaration, Section 1746 Declaration. Do you have that?
A. I do.
Q. Okay. Is that your signature?
A. It is.
Q. Okay, great. So we'll just start. One question, did you ever read the -- do you know of a Daphne Glindmeyer?
A. Do I know of a Daphne Glindmeyer?
Q. Yes.
A. No.
Q. Okay. So I take it you've never read Dr. Daphne Glindmeyer's report; is that fair?
A. No.
Q. Is that correct?

A. Yes, that is correct.
Q. Again, that's one of my many problems; I ask a lot of double negatives. So I'll try not to, but I'll still do it anyway. So I'll apologize in advance right now.
So for undergraduate you went to Wheaton College?
A. Yes.
Q. And you graduated in 1983 --
A. Yes.
Q. -- with a Bachelor of Arts in economics and business?
A. Yes.
Q. Okay. And then in 2004, you obtained your medical degree from the University of Vermont?
A. Yes.
Q. So that would have been from roughly like 2000 to 2004, you were in medical school?
A. Yes.
Q. And then the first two years of that would be didactic learning and the last two years would be more practical learning?
A. Yes.
Q. And all of that learning was done in

furtherance of obtaining a medical degree?
A. Yes.
Q. You performed a residency, correct?
A. I completed a residency, yes.
Q. And what years did you do your residency?
A. 2004 to 2007.
Q. Can you tell us about what your residency entailed?
A. It was emergency medicine residency. So it was the clinical care and decision-making and taking care of patients in the emergency department. And there also were other rotations, including cardiology, internal medicine, surgery.
Q. Infectious disease?
A. I don't know if I did a specific rotation in infectious disease, but we certainly learned about that in all the different rotations.
Q. For the setup of that residency, would the rotation year be the first as other programs are? Or can you tell me what it would have been?
A. When what would have been?
Q. So for example, like you were in residency from, you know, probably June of 2004 to June 2007; is that fair?

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A. Residency would have gone from July 2004 to June of 2007.
Q. Right. And I guess my question is you mentioned some of the rotations. Do you know if they would have been front loaded for when you were a PGY-1 or would it have been later? Or do you remember?
A. Which rotations?
Q. Any of them besides the emergency -- you know, obviously, your residency was specializing to become an emergency medicine physician, correct?
A. Correct.
Q. And before that time, in medical school, no one really specializes -- or strike that.
When you were in medical school, you weren't specializing in one area of medicine versus the other; is that correct?
A. Correct.
Q. Okay. So your residency was designed to have you learn about the -- about emergency medicine, fair?
A. Yes.
Q. Okay. And then as part of the -- and perhaps the reason you do rotations is because the

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emergency medicine -- like emergency department will deal with other departments?
A. Well, we deal with other departments, and we also take care of all the patients who come into the hospital. That's the -- that's the entryway to the hospital, is through the emergency department for most patients. So we see all the problems that come through, whether it's cardiac, internal medicine, OB/GYN, et cetera. So we need to know a lot about a lot of different specialties.
Q. Right. Okay. But I guess this is a long way of just asking, can you tell me when your rotations would have been within those three years?
A. Oh, no. Probably not. That's a while ago.
Q. Okay, yeah. And so we -- so what were the rotations you can recall having done?
A. Aside from emergency medicine, cardiology. Of course, OB/GYN. I did a rotation in toxicology, a rotation -- an away rotation in trauma. I did rotations in surgery, pediatrics. And I'm sure I'm forgetting something, but those are the ones that I can remember.

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Q. And when you were doing those rotations, were you on staff at the hospital?
A. As a resident, we had a provisional license. So we weren't technically on staff, but we -- we had a provisional license.
Q. And that provisional license would have allowed you to practice in all those different rotations, as per the typical residency program for the emergency medicine at a Maine medical center, correct?
A. It allowed me to practice under the direct supervision of board certified physicians.
Q. Okay. And then the positions would be either a medical doctor or doctor of osteopathy, correct?
A. Yes.
Q. Okay. And in all those rotations, you would have been practicing under the supervision of a physician as a medical doctor, correct?
A. True.
Q. Okay. And then the next year, you did a post-doctor fellow in surgical critical care?
A. I did.
Q. Okay. And can you tell me about that program?

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A. This was a one-year surgical critical care fellowship at the Adams Cowley Shock Trauma Center where we focused on the critically ill trauma patients.
Q. Okay, great. I have to decide how much to go through here. So currently, what -- can you describe your practice currently?
A. My current practice, my clinical practice is 50 percent emergency medicine and 50 percent neuro critical care. So I practice in the emergency department and I practice in the neuro ICU.
Q. Okay. And for how long has that setup been the case?
A. When I graduated from fellowship, I was hired at the Shock Trauma Center, and I had 50 percent emergency medicine at University of Maryland and 50 percent surgical critical care. I worked there for two years. And I then transferred up to Yale, where I worked initially 50 percent EM and 50 percent surgical critical care.
But soon after arriving there, they asked me if I would help to build and develop a neuro critical care unit, which I did. So for a

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time, I was working 50 percent emergency medicine and then a combination of neuro critical care and surgical critical care. So I divided myself three ways.

Eventually I dropped the surgical critical care and became 50 percent EM, 50 percent neuro critical care. And since then that's what I've done.

Q. Okay. And in all those -- since, you know, you finished your fellowship, whether it be in the emergency medicine, the neuro critical care or in the surgical critical care, you've been practicing as a medical doctor, correct?

A. Correct.

Q. Okay. I'm looking at all the faculty positions you've held. We've talked at some length about all of those, this page 1 and 2 of your C.V. Do you see that?

A. I see it.

Q. Okay. Is there anything terribly relevant to add at this point?

A. Not from my perspective.

Q. Okay. And other positions and major administrative positions held, it shows that from 2010 to 2014, you were the trauma liaison for the

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Department of Emergency Medicine?

A. Yes.

Q. And 2014 to 2018, you were the medical director of the SkyHealth Critical Care Aeromedical Service?

A. Yes.

Q. And that's through Yale?

A. Yes.

Q. Okay. Your honors and awards, the ones you listed here are 2001 to 2018. Do you see that?

A. Yes.

Q. Are those all the honors and awards that would be relevant to -- potentially relevant to the care -- to the testimony you're rendering here today?

A. Yes.

Q. Okay. And they're all as a medical doctor?

A. Yes. Um, yes. Um, wait.

Q. Go ahead.

A. When you say in there all as a medical doctor, in 2001, I was a medical student.

Q. Okay.

A. In 2003, I was a medical student.

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Q. Right.

A. So I don't know if you're discriminating that, but just to clarify.

Q. So for either way, it would be as a medical director -- sorry, strike that. For either way, these honors and awards would have been as a medical -- as an M.D. or in furtherance of obtaining your M.D., correct?

A. Correct.

Q. Okay. And then your keywords area of interest, that -- does that show your, you know -- besides of all those things you're otherwise qualified, what you have the most interest in as a medical doctor?

A. So this keywords areas of interest is particular to the Geisel C.V. format.

Q. Okay.

A. When I structured this C.V., they want -- they want you to include this keywords areas of interest. So this is structured to reflect my trajectory from my first year as an attending through now to support the promotion to associate professor and then to full professor. So it certainly is a focus, but not complete.

Q. Okay. On pages 3 and 4, you have your

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professional service. Do you see that? Actually, 3, 4 and 5.

A. Yes.

Q. And do you hold all these positions as a medical doctor?

A. Yes.

Q. And public service, are any of the public service -- they seem awesome. I don't mean to discredit them. But are any of the public service items listed in your C.V. relevant to the opinions you will be rendering today?

A. No.

Q. Okay. And the teaching awards that you've obtained, it appears you get them every three to four years, on page 6?

A. It appears I got three.

Q. Well, yeah. But you're going to get another one?

A. Four years apart.

Q. You're not done yet, are you?

A. No.

Q. So there's probably going to be one. But in any event, those three teaching awards, what type of teaching were you providing?

A. So for the teaching award from

University of Maryland, that was teaching to the emergency department residents, medical students and fellows. The National Junior Faculty Award is, again, teaching to emergency medicine residents, nurse practitioners, PAs, medical students and fellows. And then the Excellence in Teaching from Yale University Interdisciplinary Center for Bioethics is teaching to international and national students who go to a bioethics seminar every summer. And I teach two seminar courses each year at this bioethics seminar. One of them is in the ethics of emergency medicine. One of them is in the ethics of neurology or the neurology of ethics.

Q. Okay. And then you provide a nice summary of your teaching activities. Do you see that?

A. Uh-huh. Yes, I do.

Q. So it shows that you're performing bedside and formal didactic teaching of medical students, residents, fellows, advanced practice providers and emergency medicine, surgical care and neurosurgical critical care, correct?

A. Yes.

Q. So like medical students, that's people

that will be obtaining an M.D., correct?

A. Yes.

Q. And residents are people that have an M.D. or a D.O. and are attempting to -- well, they're going through their residency, correct?

A. Correct.

Q. And fellows are people with MDs or DOs that are getting more advanced training, correct?

A. Correct.

Q. And advanced practice providers, that would be like physician assistants or other types of -- kind of hybrid providers that are practicing under the supervision of a medical doctor or DO?

A. Advanced practice includes nurse practitioners and PAs that practice mostly under the supervision of a physician. In some states, as you probably know, they are gaining independent practice in some areas. But the ones that I teach are all working under the supervision -- direct supervision of a physician.

Q. Okay. I'm looking at your research and scholarly activities. Are there any articles or research support that's specifically relevant to the opinions you're rendering today?

A. No.

Q. Okay. Same thing for the non-peer reviewed publications, do any of those have any specific relevance to your opinions that we're going to talk about today?

A. No.

Q. Okay. You've written some chapters for books or written books. You find that on pages 11 and 12 of your C.V.

A. Yes.

Q. Are any of those particularly or specifically relevant to the opinions we're going to discuss today?

A. No, they're not.

Q. Okay. You have invited presentations here, whether they be international or regional. Are any of these, which are found on pages 13 through 26, do you want to do a quick scan to see if they're relevant to the opinions you're going to give today? I'd appreciate it.

A. (Reviewing) From my quick scan, no, they do not appear to be.

Q. If we, in the end, that we -- in all fairness, I asked you to review, you know, 13 pages. If we -- you know, we're going to go through a number of questions. And if that answer

would change, like oh, I remember, you know, we talked about X, DVTs or Heparin or whatever, and it would be related to one of these invited presentations, will you let me know?

A. Yes.

Q. Okay. You are board certified in emergency medicine and critical care?

A. I'm board certified in emergency medicine and neuro critical care.

Q. Okay, yeah, I see that. Sorry.

A. Uh-huh.

Q. And you were board certified in emergency medicine in 2008 and recertified in 2019?

A. Correct.

Q. Is there any reason why -- well, is there a 10-year recertification? Or is it 11 for emergency medicine?

A. It's 10 years for emergency medicine, and they just changed it to a five-year process.

Q. Yay.

A. Hmm.

Q. So was there -- from the 10-year perspective from 2008 to 200 -- was there a period when you were not board certified in emergency

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medicine between like 2008 to 2019?
A. No.
Q. So the first chance you -- the first time you were required to recertify for the American Board of Emergency Medicine, you did so in 2019, correct?
A. Correct.
Q. And you passed your boards on the first try?
A. The boards for -- yes, I passed my boards for emergency medicine on the first try. And for neuro critical care, I passed on the second try.
Q. Okay. Thank you. And then you became board certified in neuro critical care in 2011, correct?
A. Yes.
Q. And that recertification should be coming up soon?
A. It should be coming up soon. We're actually moving to an ABMS board certification process.
Q. What's ABMS stand for?
A. The American Board of Medical Subspecialties or Medical Specialties.

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Q. So then what impact does that have to do on a typical 10-year recertification timeframe?
A. So for -- for the first, yes, my recertification should come up in '21, '22. And I will have to choose whether I'm going to continue to be board certified with UCNS or go with ABMS. I will probably go with both.
Q. Okay. What journals do you subscribe to?
A. I receive the American -- the Annals of Emergency Medicine. I receive the Journal of Emergency Medicine and the American Journal of Emergency Medicine.
Q. Okay. And there's, I'm sure, other ones you review from time to time, correct?
A. Yes.
Q. And there's other ones you publish in from time to time?
A. Yes.
Q. Okay. Were those the three that you look at most frequently, correct?
A. Correct.
Q. Okay. And all those are emergency medicine journals, correct?
A. Yes.

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Q. Okay. Do you read any journals or keep up-to-date on any psychiatric journals?
A. Not specifically.
Q. Okay. We've covered your C.V. at some length, correct?
A. Yes.
Q. Have we covered all the training, experience, your teaching, at least from like a big picture standpoint, that's contained in your C.V.?
A. I'm not sure what you're asking.
Q. So was there anything in terms of training that you've obtained that's not listed in your C.V.?
A. Probably not. My ATLS is in there. I mean, over the years, we all do -- we, being emergency physicians, do training in American Trauma Life Support. We do training in ENLS, Emergency Neurologic -- ENLS, Emergency Neurologic -- something problems. I can't think of what it stands for. But there are other courses that we go through or maybe review courses. I can't tell you that everything that I've done is on this C.V.
Q. Okay.
A. I'm not sure what specifically you're

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looking for.
Q. Well, in terms of the training you receive, like those two things you mentioned that perhaps aren't on your C.V., would they be training you received as a medical doctor?
A. Yes.
Q. Okay. And all of your experience as a healthcare professional, is that listed in your C.V. in terms of practicing or teaching?
A. The greater part of it, yes.
Q. Okay. If there's something that we go through in this deposition and that's in terms of teaching that's not, you know, listed in your C.V., but it comes up and becomes relevant, would you let me know?
A. Yes.
Q. Okay. And all of the -- strike that. When were you first retained by Mr. Flaxman?
A. That was, I believe, in December of 2020.
Q. Okay. Looking at -- now turning to Exhibit 4, that's the page which lists all of the materials used by you. Do you see that?
A. I do.
Q. Okay. And you were able to render --

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your opinions are based on what you reviewed from these materials, correct?
A. Correct.
Q. Were you able -- was there -- were you lacking any materials? Were there any materials that you wish you would have received, but didn't receive?
A. Not that I can think of.
Q. Okay. And going through those materials, you received an autopsy report by Dr. Sozio?
A. I did.
Q. You received the Countryside Police records?
A. Yes.
Q. The Cook County Jail medical records?
A. Yes.
Q. Deposition of Helen Kanel?
A. Yes.
Q. Deposition of David Kelner?
A. Yes.
Q. Deposition of Cherri Krzyzowski?
A. Yes.
Q. Deposition of Elizabeth Lassen?
A. Yes.

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Q. Deposition of Steve Paschos?
A. Yes.
Q. Deposition of Ravi Yalamanchi?
A. Yes.
Q. Deposition of Hythem Zayed?
A. Yes.
MR. RAGEN: And for Shelley's perspective, because she can't see it, Ravi Yalamanchi is spelled R-a-v-i, Y-a-l-a-m-a-n-c-h-i. And Hythem Zayed is H-y-t-h-e-m, Z-a-y-e-d. And you don't have to answer that. That's just for Shelley.
BY MR. RAGEN:
Q. Then you reviewed the Hinsdale Hospital records, correct?
A. Yes.
Q. The jail restraint policies?
A. Yes.
Q. And those are the policies that pertained to Cermak Health Services?
A. Yes.
Q. Okay. So when you say Cermak Health Services, do you understand that, generally speaking, to be consistent with Cook County Jail?
A. Yes.

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Q. Okay. You may or may not know the distinction between the two. In my understanding, Cermak Health Services is a part of -- it's one entity within -- well, strike that.
You reviewed the Medical Examiner's report?
A. Yes.
Q. The root cause analysis?
A. Yes.
Q. The St. Anthony Hospital records?
A. Yes.
Q. And is that two Sheriff's incident reports or just one typed twice?
A. It's one.
Q. Okay. So we've covered all the materials that you reviewed in connection with rendering opinions in this case, correct?
A. Yes.
Q. Okay. Can you tell me the individuals you believe deviated from the standard of care in caring for Mr. Cruz?
A. Yes. I'm going to refer to my statement, my opinion.
Q. Sure. Yeah, of course.
A. So this would include --

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Q. Sorry about that. So the individuals you believe deviated from the standard of care?
A. Yes. Dr. Paschos.
Q. Okay.
A. Nurse Chatman. Nurse Manlastas. Nurse Krzyzowski.
Q. Do you believe Dr. Zayed deviated from the standard of care?
A. Now, Dr. Zayed was at Hinsdale Hospital, correct?
Q. They're your opinions.
A. I'm asking you if this is the Dr. Zayed you're referring to.
Q. Well, they're the doctors -- I had you review his deposition. In reviewing his deposition, do you -- and he was practicing at Hinsdale Hospital. At least from my understanding. I wasn't there either. But --
A. No, I don't believe Dr. Zayed deviated from the standard of care.
Q. Okay. Same thing with Dr. Yalamanchi, who provided care at Hinsdale Hospital, do you believe she deviated from the standard of care?
A. No, I do not.
Q. Okay. Does the standard of care for

Drs. Paschos, Zayed or Yalamanchi differ in any way?
A. No.
Q. Okay. Did you render an opinion that Nurse Aiste Barkauskaite deviated from the standard of care?
A. I don't know -- I don't recall a nurse of that name. I can't pronounce it.
Q. Okay. Same thing with a Nurse Meghan Weger, did you develop an opinion that Nurse Meghan Weger deviated from the standard of care?
A. I don't recall a Nurse Meghan Weger.
Q. Okay. Same thing for a Tiago Soltes. This will be the last one, I think. Do you have anything that Nurse Tiago Soltes has deviated from the standard of care?
A. I don't recall Nurse Tiago Soltes.
Q. Okay. It sounds like you don't -- the names Aiste Barkauskaite, Tiago Soltes, and Meghan Weger, they don't ring a bell to you as you sit here today, correct?
A. Not right now, no.
Q. Is it true that the standard of care -- like so, for example, medical literature by and large is instructive on a physician's

understanding of the standard of care, but usually literature does not create the standard of care; is that correct?
MR. FLAXMAN: Let me object to the form of the question.
MR. RAGEN: As vague?
MR. FLAXMAN: It doesn't make a whole lot of sense as to what you're asking.
MR. RAGEN: I was going to say I would object to that question as vague, so I'll ask a different one.
BY MR. RAGEN:
Q. This is a general concept. But we'll go -- can you define what the standard of care is?
A. The standard of care is the standard by which a physician -- if we're talking about a standard -- a standard by which a physician provides evaluation, assessment and care for a patient that is accepted by the -- by the general medical community and medical experts.
Q. Okay. If I were to define it as what a reasonably careful physician would do under the same or similar circumstances, would that be consistent with your understanding?
A. That would.

Q. Okay. Is the standard of care a national standard?
A. It is a -- it is a national, at least a national standard, if not international.
Q. Okay. Right. I mean, true. So within the United States of America --
A. Uh-huh.
Q. -- the standard of care for a reasonably careful physician won't differ from state to state, generally speaking, right?
A. Correct.
Q. And certain states may have heightened requirements on certain subjects; but that would be the exception, correct?
A. Can you repeat that question?
Q. Well, I didn't want to like box you in. Because there are certain requirements, let's just say, that exist in California, you know, that in terms of like psychiatry that don't exist in Louisiana, just so basically -- so I'll -- strike that.
Your understanding is that the standard of care for a reasonable careful physician is the same throughout the U.S., correct?
A. Correct.

Q. Okay. Would you agree that a number of different materials can assist you in developing the standard of care, meaning the care -- I mean, the training you received as a resident and a fellow is helpful in developing your understanding of the standard of care of a reasonably careful physician?
A. Yes.
Q. Medical literature, that also will be instructive in developing the standard of care of a reasonably careful physician?
A. Yes.
Q. Policies and procedures, are those, you know, informative in terms of developing what the standard of care -- what a reasonably careful physician should do under the same or similar circumstances?
MR. FLAXMAN: Let me object to the form of the question because it's unclear whose policies and procedures you're talking about.
MR. RAGEN: I'm speaking generally.
MR. FLAXMAN: I'm going to take a break and shut up my dog.
MR. RAGEN: Okay. Let's take a quick break.

(Whereupon a brief break was taken.)
BY MR. RAGEN:
Q. So medical -- so let's go back to medical literature. We were just on policies and procedures. Would you agree in developing -- so for example, you've written a number of peer reviewed medical articles, correct?
A. Yes.
Q. Okay. And from time to time -- well, some of these articles compare two different treatment modalities; is that correct?
A. Yes.
Q. Okay. When you are employing -- when you are looking at two different treatment modalities and you're writing an article about which is perhaps more efficacious, isn't it true that you would not select a treatment modality that would be a deviation from the standard of care; is that correct?
A. Well, when you're writing about two treatment modalities and comparing them, you might be writing about a novel treatment that's new and that's why you're comparing it to something that has been the standard of care.
Q. Right.

A. So...
Q. And that literature might improve the standard of care and change it in a certain way. I mean, I know it's a vague question. I guess my point is when people write medical -- when people draft articles for peer reviewed publications, they generally do not pick modalities -- treatment modalities that per se are deviations from the standard of care?
A. Well --
Q. Is that true?
A. Well, when you write an article that you're trying to show that one therapy is either inferior to, equal to, or superior to another therapy, sometimes the therapy that you're writing about or that you're researching or studying is not part of the standard of care. And that's how we develop new therapies, is by asking the question, you know.
Q. Right. So let's just say that. So you talk about a situation where you're going to look at two or three different treatment modalities, right? Through the research, you realize treatment modality A is the best and then that would make B and C no longer part of -- no longer

a treatment modality that would be within the standard of care. Okay?
Assuming that hypothetical, when you were providing the treatment -- when you were treating patients to determine whether A, B and C were more effective, it's not like at that point in time B and C were provided that treatment was a deviation from the standard of care for those patients; is that fair?
MR. FLAXMAN: Let me object to the form of the question. It's difficult to figure out what your question is.
BY MR. RAGEN:
Q. Did you understand it, Dr. Marcolini?
A. I agree, it's challenging to understand the specific question.
Q. Okay. Would you agree that -- do you -- what hospitals are you credentialed to provide treatment at currently?
A. Currently, Dartmouth-Hitchcock Medical Center and Alice Peck Day Hospital.
Q. How do you spell that?
A. Alice is as in the name Alice, A-l-i-c-e, and Peck is P-e-c-k, and then Day is D-a-y.

Q. Do those hospitals have policies and procedures concerning restraining a patient?
A. Yes.
Q. And did they back in March 2016?
A. Yes.
Q. Are you familiar with those policies and procedures from what they were in March 2016?
A. No.
Q. You'd have to look at the policy and procedures from both Dartmouth and Alice Peck to be certain what those policies and procedures say?
A. Correct.
Q. Were those policies and procedures -- are you familiar with the policies and procedures at Dartmouth and Alice Peck concerning restraints that are active today?
A. Yes.
Q. Are they the same policy and procedure?
A. So I know the policies at Dartmouth-Hitchcock. I am credentialed at Alice Peck Day Hospital because during Covid, we all became credentialed at that hospital in case we've needed to work there, as well. I've never worked there, so I'm not distinctly familiar with those policies. But inasmuch as we're affiliated, these

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are affiliated, this is an affiliated hospital with Dartmouth, I imagine it would be the same.
Q. The exact same?
A. I imagine it would be the same. I do not -- do not have specific knowledge of the Alice Peck Day protocols.
Q. Okay. Do you have the Hinsdale Hospital policies and procedures on restraints?
A. Let me see. I don't know if I have the Hinsdale policies. I'm looking through the chart for them. But if you have access to that, I don't know that I have them or not.
Q. Okay. But either way, since you can't recall obtaining them and you can't recall what they look like, I would take it it's true that they're not -- you're not using those Hinsdale Hospital policies and procedures to render -- to develop your opinions in this case; is that correct?
A. Well, the Hinsdale Hospital policies would be what they were operating under at Hinsdale Hospital. So specifically, no.
Q. Right. So I'm sorry, so seeing as you can't recall having the Hinsdale Hospital policies and procedures, I take it it's not part of the

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opinions that you've rendered in this case; is that correct?
MR. FLAXMAN: I'll object to the form of the question. It's not that what is not part of the opinions?
MR. RAGEN: Okay, I'll ask it open-ended.
BY MR. RAGEN:
Q. Are the Hinsdale Hospital policies and procedures, do they assist you in developing your opinions in this case?
A. So I don't recall specifically where the Hinsdale Hospital policies and procedures are. I don't know if they're specifically a part of my opinion.
Q. Right. But I mean, they're your opinions, right?
A. Yes.
Q. You're the one that wrote them and they're in your brain?
A. Yes.
Q. Is there anything that's in your six-page document that you use -- that you form the basis on by and through the Hinsdale Hospital policies and procedures?

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A. No.
Q. Okay. If we go through them and you determine oh, yes, this particular instance of -- you know, this finding or this conclusion is, in part, based on the Hinsdale Hospital policies and procedures, would you let me know?
A. Yes.
Q. Okay. Isn't it true that the policies and procedures aren't always the same as the standard of care?
A. Which policies and procedures?
Q. Well, I'm just saying like so for the Cermak Health Services, you reviewed the policies and procedures that were in effect from 2016?
A. Yes.
Q. And is that the standard of care?
A. Are the policies -- I'm going to pull them up and look at them.
Q. So you're looking at them just to determine whether or not the policies are consistent with the standard of care, as you understand it, correct?
A. I'm looking through them just to see what you're specifically asking about.
Q. So my first question was general. Do

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policies and procedures of a hospital, do they create the standard of care?
A. No.
Q. Okay. And many times they're consistent with the standard of care; is that correct?
A. Hopefully they are consistent with standard of care.
Q. Right. Exactly. It's like that's the goal of your policies and procedures is to be consistent with the standard of care, correct?
A. Yes, yes.
Q. And your opinions, part of them are -- give you some examples. Like if you look at page 4 of your opinions, the last sentence -- well, I'll read the last couple sentences. Let me know if I'm reading correctly. During his entire stay at the jail -- strike that. I'm referring to -- I'm going to -- when it says his, I'm going to read in Mr. Cruz's name. Okay?
A. And where are you reading from? Page 4?
Q. Page 4, middle paragraph, halfway up starting, During.
A. Okay.
Q. During Mr. Cruz's entire stay at the jail, he was not prescribed nor given any

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medication to reduce the risk of clot formation. The fact that Angel was morbidly obese and kept in four point chest restraints for 17.5 hours created an increased risk of clot formation which is likely to lead to embolus formation with clot traveling downstream to the lungs and causing pulmonary embolus, which was the cause of Angel's untimely death. Not giving him medication or executing appropriate limb release, either of which could mitigate the risk of clot formation, does not reach the standard of care and is medically unreasonable. Do you see that?

A. Yes.

Q. And that's your opinion?

A. Yes.

Q. And that's a standard of care opinion that you have?

A. Yes.

Q. And whether or not Stroger's policy and procedure are like dead on with this, your opinion to the standard of care is what the standard of care is, correct?

MR. FLAXMAN: Let me object to the form of the question. It's sort of -- it assumes facts -- or it asks -- it's compound as to whether or

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not. And it's also got Stroger, which I don't think we've introduced into the case yet.

BY MR. RAGEN:

Q. Can you answer the question, Dr. Marcolini, or not?

A. I'm unclear as to what you're really asking.

Q. So what I'm really asking is -- so we established, generally speaking, that policies and procedures don't create the standard of care; but that, generally speaking, they should be consistent with the standard of care, correct?

A. Generally speaking, we'd hope that they're consistent with standard of care, yes.

Q. Did you see -- did you review the Cermak policies and procedures concerning restraints?

A. I did.

Q. And did that seem to be acceptable, appropriate and reasonable?

A. They did seem to be appropriate and reasonable.

Q. Okay. And they would help guide healthcare practitioners providing care at Cermak to restrain patients at the jail, right?

A. Yes.

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Q. And there's nothing in those policies and procedures that struck you as deficient; is that correct?

A. I wasn't reading the policies and procedures to look for deficiencies. So I'd have to review them more closely to look for deficiencies. What specifically are you asking about?

Q. When you read them, did any deficiencies to the policies and procedures stand out, the Cermak policies and procedures from March 2016?

A. Nothing stood out to me --

Q. Okay.

A. -- in particular.

Q. If when we go through this deposition, you know, we're referring to policies and procedures and you say oh, yeah, this part of the policy and procedure is not good, would you let me know?

A. Yes.

Q. And if we go through some of the policies and procedures of Cermak in this deposition and you say oh, this part would be a deviation from the standard of care, would you let me know?

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A. Yes.

Q. And if we go through the deposition and we're going through the Cermak Health Services policies and procedures and you say, you know, this would be unreasonable, would you let me know?

A. Yes.

Q. Would you agree that reasonable care is consistent with the standard of care?

A. Reasonable care should be consistent with the standard of care, yes.

Q. Okay. If we go through your deposition and we come to a circumstance where we're talking about something that would be unreasonable care, but still fall within the -- would still comply with the standard of care, would you let me know?

A. Unreasonable?

Q. Yeah. So like for example, I was asking whether if the care is deemed reasonable, generally speaking. That would be synonymous with complying with the standard of care, correct?

A. The reasonable care, yes, generally complies with the standard of care.

Q. So if we go through your deposition and there's a difference, you have to draw a distinction like, you know, Dr. Paschos doing this

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complied with the standard of care, but it wasn't reasonable, I don't think that's going to happen, but if it does happen, would you let me know?
A. If he complied with the standard of care, but it was not reasonable?
Q. Yeah.
A. Okay.
Q. You doubt that's going to happen, right?
A. I don't know. I'm -- by the definitions that we've spoken about, I'm not sure what you're getting at. It's --
Q. Yeah, I just want to know, for you, there's not much of a distinction between complying with the standard of care and providing reasonable care, correct?
A. There shouldn't be.
Q. Okay. If we go through this deposition and you find that there should be a distinction between the two, will you let me know?
A. Yes.
Q. Okay. Can you tell me what Heparin is?
A. Heparin is an anticoagulant medication.
Q. Does the standard of care require that Mr. Cruz receive Heparin while he was restrained?
A. While Mr. Cruz was restrained, he should

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have received limb release as per the protocol. He could have received Heparin, and that would have been appropriate. And he did receive Heparin, as you know, at Hinsdale Hospital. So...
Q. I don't know that.
A. Okay.
Q. When did he first receive Heparin -- well, strike that.
Could the standard of care be met if -- I'll just say -- strike that. If all the -- okay.
So what you were saying in terms of -- your opinion is that Mr. Cruz developed DVTs and then developed a pulmonary embolus, correct?
A. Yes.
Q. And your opinion is that the DVTs were caused by either the failure to administer Heparin or the failure to move his limbs, which would have increased his mobility, correct?
A. The DVT was likely caused by immobility.
Q. Okay.
A. Immobility is when he was restrained.
Q. Right.
A. It could have been prevented by limb release. And it could have been prevented by Heparin. If they had been present, they could

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have prevented it from propagating by either limb release or Heparin.
Q. Okay. The two modalities that could have been employed to stop Mr. Cruz from developing DVTs were limb release and Heparin, correct?
A. Those are two modalities, yes.
Q. Are there any other modalities that you say should have been employed to reduce the chance Mr. Cruz would have developed DVTs?
A. Well, if he had been able to ambulate, that would have been something that could have prevented him from having DVT that propagated.
Q. Okay. But when you're restraining him, you're not going to have him ambulate, right?
A. Exactly.
Q. So in the period of restraint, the two modalities that you opined could have been employed to avoid a DVT are limb release and Heparin, correct?
A. Those are the two that could have reasonably been employed.
Q. Okay. While he was restrained, right?
A. Yes.
Q. Okay. And he was restrained both at

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Hinsdale and at Cermak Health Services, correct?
A. Correct.
Q. Who put in the order to restrain him at Hinsdale Hospital?
A. Let's see. The resident physician, but I don't know his name.
Q. Do you have the medical records in front of you?
A. I can pull them up.
Q. Yeah, please do. Let the record reflect it's 4:11.
If you could look at the records to determine who put the order to restrain Mr. Cruz, that would be great.
A. (Reviewing) It looks as if the ordering physician for the restraints on 3/13 at 043 was ordered by Dr. Yalamanchi.
Q. Okay. What page are you looking at?
A. I'm on page 101.
Q. Is that on the L. Vargas numerating -- numerical system or the so and so of 294?
A. I have 101 of 362.
Q. Oh, okay.
A. On the chart itself, it says page 100 of 360.

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Q. Man, I have a different record. So what time was it? March 12th at 0 --
A. No. March 13th at 043.
Q. What is the subject heading of the order?
A. I says CPOE orders. And you know, this is --
Q. Yeah, I can probably get there. I see it. So okay. So Dr. Yalamanchi initiated the need for restraint, correct?
A. Dr. Yalamanchi --
Q. Orders restraints?
A. -- ordered the restraints, yes.
Q. So Dr. Yalamanchi ordered restraints at 12:43 A.M. on March 13th, correct?
A. Yes.
Q. And do you believe -- does the standard of care -- why would a patient be restrained? Do you know?
A. Patients are typically restrained because they're violent, either to self or to others, and not redirectible by other means.
Q. Okay. Is it important to document whether the person is a danger to themselves or others in initiating restraints?

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A. It's informative to document that.
Q. Does the standard of care require that the physician indicate whether the patient's a danger to themselves or others in employing restraints?
A. I don't know if the standard of care requires that.
Q. Okay. In this case, your testimony is that on March 13th at 12:43 A.M., Mr. Cruz had obtained Heparin at that time?
A. Wait, we are saying that he was put in restraints.
Q. Yeah, yeah. So we're talking about that time. On March 13th at 12:43 A.M., that's the time the restraints are initiated, from your review of the records, correct?
A. Yes.
Q. At that point in time, had Mr. Cruz obtained Heparin?
A. I don't know.
Q. Okay.
A. I'm going to have to --
Q. Would that be relevant to your opinions; whether or not he had received a dose of Heparin at that time?

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A. No.
Q. Okay. And why not?
A. Because -- because he's being put in restraints. So why would I -- if that's the first time he's being put in restraints --
Q. Right.
A. -- my opinion then, it's not -- I'm not sure what you're asking again. Sorry.
Q. Yeah, that's okay. You had mentioned that giving some type of anticoagulant would be one of the modalities to decrease the chance that Mr. Cruz would develop a DVT, correct?
A. Yes.
Q. Especially when -- and especially in the setting of being restrained, correct?
A. Correct.
Q. Okay. And so do you know, do you know when the first order at Hinsdale Hospital was for Mr. Cruz to obtain Heparin?
A. Not off the top of my head. I can look through the chart and find it.
Q. I can find it for you. Well, see, my chart, I -- I don't know, would you be able to e-mail your chart to Ken, who could e-mail it to me?

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MR. RAGEN: And I think, Ken, a little bit of what it was was Hinsdale has two versions of the chart. And I'll let Frank or John chime in because my version of the Hinsdale Hospital records is 294 pages. So I just want to make sure we have the same version.
A. Can I e-mail mine?
Q. Yeah. Don't e-mail it to me, though. E-mail it to Ken. Or is Joel still here?
MR. FLAXMAN: No, Joel's not here.
MR. RAGEN: Okay. And we can keep going. But once Ken gets it, because the thing is I don't want -- you shouldn't have to be involved in like the annoying lawyerly part of whether the document is the right -- the same one.
THE WITNESS: No worries.
MR. RAGEN: Yeah, yeah, yeah. All right.
BY MR. RAGEN:
Q. So talking about the standard of care, so at 12:43, March 13th, Mr. Cruz was restrained, correct?
A. 12:43, March 13th, yes, he was restrained.
Q. And then would the standard of care

require that he be given Heparin one way or the other in connection with being restrained on March 13th at 12:43 A.M.?
A. Sorry, I was sending the e-mail. Can you repeat that question?
Q. Sure. Are you done sending the e-mail?
A. Yeah, I just sent it.
Q. You're probably a better multi-tasker than me. I can't do that.
So going back to March 13th at 12:43 A.M., okay?
A. Yes.
Q. We established that that's the time Mr. Cruz was placed into restraints, correct?
A. Yes.
Q. Does the standard of care require that he be given Heparin at any time in the near future in association with him being restrained at 12:43 A.M. on March 13th?
A. So there's -- there's a clarification here that I'm going to explain to answer this question.
If somebody's being placed in restraints and you anticipate that it's not going to be for a long time, then you don't necessarily put them in

restraints based on -- I'm sorry, you don't necessarily give them Heparin based on placing them in restraints.
Q. Okay.
A. So it's when you have prolonged or, you know, when you anticipate prolonged or when the patient is even admitted. I have patients who are in the ICU who are not in restraints, but who are admitted and they are receiving Heparin. It's the -- it's the immobility.
Q. Sure. Is there any indication of how long Dr. Yalamanchi anticipated Mr. Cruz to be placed into restraints?
A. No.
Q. Did you see anything in the records that Dr. Yalamanchi said oh, he's an imminent harm to staff, so, you know, we're going to need him to be restrained just for a short period of time? Did you see a note like that one way or another?
A. No, I don't recall seeing that.
Q. Did you recall seeing any note from Dr. Yalamanchi in the chart?
A. Boy, going from my memory, I'd have to look through the chart.
Q. Well, take a look at the chart and see

if you see any note from Dr. Yalamanchi. Let the record reflect this is 4:23 at this time you're going to start looking.
A. I don't see a note specifically written by Dr. Yalamanchi.
Q. Okay. So isn't it fair to say that we have no indication of how long Dr. Yalamanchi thought Mr. Cruz would be placed in restraints on at 12:43 A.M. on March 13th; is that fair?
A. That's fair.
Q. I didn't see anything in his deposition that, you know, qualified the timeframe for which Dr. Yalamanchi expected Mr. Cruz to be placed in restraints one way or the other. Do you recall anything from --
A. I don't.
Q. -- Dr. Yalamanchi's dep?
A. I don't recall.
Q. And wouldn't that be consistent with just general like medicine and placing in restraints? Like, no one knows how long a patient's going to be in restraints. They're hopeful it's going to be short, but you really don't know. Isn't that usually fair?
A. You -- you don't -- you never

specifically or never 100 percent know. But you can have an idea.
Q. Okay. So what timeframe do you think would be the time when you should really start thinking about giving Heparin?
A. When you have -- I would say when you renew the restraints at the four-hour mark --
Q. Yep.
A. -- it's reasonable to consider.
Q. Right. Would the standard of care require that the Heparin be administered at the four-hour renew period?
A. So the standard of care requires that you consider the fact that the patient is immobilized and you know as a physician that there's a possibility of clot formation and with that possibility of clot breaking off heading to the lungs and you consider how can I prevent this from happening. And you either provide mobility, which is what the limb release is for, or you use something such as Heparin.
Q. Okay. But if you don't do either of those, you're deviating from the standard of care; is that correct?
A. If you don't do either of those, you're

not considering that potential and you're not -- you're not acting on it.
Q. Okay. So I'll ask the question again. If a patient who has been in restraints for four hours is not obtaining consistent range of motion exercises and then is not administered Heparin, would that be a deviation from the standard of care?
A. So I'm struggling a little bit, just pardon me, with your four-hour mark.
Q. Okay. Yeah, because -- that's the four-hour mark I'm using because you said that's when a physician should consider using Heparin, correct?
A. Correct.
Q. Okay.
A. Correct. There may be reasons why you can't use Heparin or you can't do the, you know, the limb release.
Q. Are you familiar with how often range of motion exercises were employed at Hinsdale Hospital when Mr. Cruz was being restrained?
A. I would have to look back through the chart.
Q. Yeah, I mean, they're not in your

opinions. They're not in your six-page report, correct?
A. Correct.
Q. Would it be important to your opinions that Dr. Zayed or Yalamanchi did or did not deviate from the standard of care?
A. No, because my opinions are based on Drs. -- Dr. Paschos and the folks at the jail.
Q. Right. But we agree that the standard of care of a physician doesn't change, right?
A. Correct.
Q. Okay. Are you implying that you have no -- do you think that Dr. Yalamanchi complied with the standard of care in her treatment of Mr. Cruz?
A. In which respect?
MR. FLAXMAN: Let me object to the question which assumes that she has an opinion, which is not in evidence.
BY MR. RAGEN:
Q. Do you have an opinion one way or the other whether Dr. Yalamanchi complied with the standard of care in her treatment of Mr. Cruz?
A. No, I don't.
Q. Okay. Is there -- would the standard of care between March 12th to 14th of 2016 differ

than from March 15th or 20th, 2016?
MR. FLAXMAN: Let me object to the form of the question. The standard of care relative to what? It's a specific condition or treatment or actions?
A. I agree. Can you be more specific with the question?
Q. Would the standard of care of a reasonably careful physician provided to a patient like Mr. Cruz, would it differ between March -- these two timeframes: Timeframe A, March 12th to 14th of 2016 versus Timeframe B, March 15th to March 20th, 2016?
A. So the standard of care of what?
Q. Of a reasonably careful --
A. Which standard of care are you specifically asking about?
Q. The standard of care of a reasonably careful physician. It would be the same, right? There's nothing about the dates that changes it?
A. No. I -- the standard of care, as we earlier said, as we earlier said, it's a national standard of care. It doesn't change until -- until there's new evidence or new science that comes out.

So what I'm saying is the standard of care applies to a patient in the situation with the patient's history and everything that's going on. So the standard of care, if the patient -- if something changes, if the situation changes might be different. Standard of care is, as I think you said, what a reasonable physician would do.
Q. Right. Okay. But there's nothing about -- okay. So are you competent to render opinion as to whether Dr. Yalamanchi complied or deviated from the standard of care in providing treatment to Mr. Cruz?
A. I'm not opining on Dr. Yalamanchi.
Q. Could you?
A. I would have to re-read the records again with a focus to do that.
Q. Do you have an opinion as to whether Mr. Cruz's DVT could have -- well, strike that.
All right. Let's just talk about 12:43 A.M. March 13th, 2016. Okay?
A. Yes.
Q. Dr. Yalamanchi ordered that Mr. Cruz be placed in restraints, correct?
A. Yes.
Q. Does the standard of care require that

Dr. Yalamanchi see Mr. Cruz at any point in time on or around March 13, 2016 at 12:43 A.M.?
A. Well, she could see Mr. Cruz or she could be getting a sign out from another physician or from a nurse describing the case. Either way.
Q. I want you to assume that -- so when was Mr. Cruz let out of restraints in Hinsdale Hospital?
A. Let's see. On March 14th.
Q. What are you looking at?
A. My opinion.
Q. What page?
A. Page 2. He was taken to Countryside Police Department on the 14th of March.
Q. So I'm sorry, I guess I didn't -- I'm just wondering when your understanding is that Mr. Cruz was released from restraints at Hinsdale Hospital? What time? What date?
A. Well, the March 14th is when he went to Countryside. So let me go through the chart and find that.
Q. Let the record reflect it's 4:34 when she starts looking.
A. So you want to know -- you want to know when he was discharged?

Q. No. No, no, no.
A. Sorry. I'm just looking through his chart trying to find clues as to how I can find out the answer for what you want.
Q. So basically it's -- you know, my whole point is you're providing opinions as to physicians at the jail who did the same thing as physicians at Hinsdale. And I'm just going to see if you have an opinion as to those physicians at Hinsdale. Okay?
MR. FLAXMAN: Well, let me object to that because she said she doesn't have opinions about people at Hinsdale. You're trying to sit here now and ask her to formulate new opinions, which is improper and is going to take a lot of time. And she's telling you she needs to study the records.
MR. RAGEN: Okay. How about this?
BY MR. RAGEN:
Q. Dr. Marcolini, let's just get a little foundation here. I want you to assume that at Hinsdale Hospital, okay, Mr. Cruz didn't get Heparin for the majority of the time he was restrained and also that range of motion exercises were not performed for the majority of time. I

just want you to assume that. Okay?
MR. FLAXMAN: I want to object to that question because it's imprecise what you mean about getting Heparin for a majority of the time that he was restrained.
MR. RAGEN: I haven't asked the question yet, Ken. Let me get the question out.
I want you to make those two assumptions, okay?
MR. FLAXMAN: That assumption is incomprehensible. I don't know and nobody knows what getting Heparin for the majority of the time while you're in restraints. Heparin, I think the record will show, is administered in certain doses every couple hours. Your question -- you should get your own expert if you want opinions about Hinsdale Hospital. You shouldn't ask Dr. Marcolini to sit here now and give you new opinions.
MR. CATANIA: I object to the objection.
BY MR. RAGEN:
Q. These are the assumptions I would like you to make, okay, and then I'll ask the question. I want you to assume that Mr. Cruz was in restraints at Hinsdale Hospital for over seven

hours and that for at least six of the hours, he didn't get Heparin, and that for at least two occasions there were not range of motion exercises performed. Would that be relevant to determine whether or not a DVT could have formed at Hinsdale Hospital?
MR. FLAXMAN: Let me object to the question. We don't have a DVT that formed at Hinsdale Hospital. There's no evidence of that. Nobody's suggested that. And your hypothetical talked about not getting range of motion exercises on at least two occasions. Nobody knows what that means.
By MR. RAGEN:
Q. Can you answer the question, Dr. Marcolini?
A. I'm uncomfortable answering your question because you're asking me to make an assumption and you're referring to events that have a factual basis. And I agree, it's -- this seems -- this seems unusual to ask me to make an assumption about something and --
Q. I was going to speed it up, but we'll just do it the slow way.
A. So it's challenging.

Q. Okay. In your report, you see it on page 2 --
A. Yes.
Q. -- you write that during his stay at Hinsdale Hospital, Mr. Cruz was placed in four-point restraints on March 13, 2016 from 1:24 A.M. until 10:05 A.M., do you see that?
A. I do.
Q. Do you have any reason to disagree with your report?
A. No.
Q. Okay. Looking at the medical record, it looks like the first time he was given Heparin was -- I'm going to share this. And if you need to look somewhere else in the record, that's fine. But I'm going to show you what I believe to be when he first received Heparin, okay?
Right now, before we look at this record, do you know when he first got Heparin, Mr. Cruz, at Hinsdale Hospital?
A. No, I don't recall when he first got Heparin.
Q. Okay. Okay. This is the medical record that I'm going to be marking as Exhibit --
THE COURT REPORTER: 6.

MR. RAGEN: Thank you.
(Whereupon Deposition Exhibit 6 was marked for identification.)
BY MR. RAGEN:
Q. Okay. I'm looking at what is page 120 of 294, okay?
A. Okay.
Q. See that?
A. I do.
Q. Does this appear to be a copy of the Hinsdale Hospital medical records?
A. Yes.
Q. Okay. This, to me, establishes that there was a dose of Heparin on March 12, 2016 at 2000 hours that was not given. Do you see that?
A. I do.
Q. And that was charted by Nurse Aiste Barkauskaite on March 12, 2016 at 2210. Do you see that?
A. I do.
Q. And the next note says that on March 13, 2016, that a dose of Heparin was administered. Do you see that?
A. Yes.
Q. Do you have any -- is there anything

else that would suggest that Mr. Cruz obtained Heparin prior to March 13, 2016 at 9:14 A.M.?
A. You're asking me if I know if he received any Heparin prior to that?
Q. Yes.
A. From my recall, I can't tell you. You're showing me when he did receive Heparin. In all honesty, I don't know if he did receive Heparin prior to that.
Q. Okay. Well, then look at the medical records and tell me if he did receive Heparin prior to March 13, 2016 at 9:15 A.M. Okay?
A. (Reviewing) So using the search tool looking for Heparin, I cannot find anything that states that he got Heparin before then.
Q. And that's before 9:19 A.M. on March 13th, correct?
A. I forgot the time. But before.
Q. Whatever time's in the record?
A. Yeah. Nine something, yeah.
Q. Okay. So that took five minutes, but that's okay. So that's one part of it.
MR. FLAXMAN: Can we have that time stated in the record?
MR. RAGEN: That's fine. Remember your

objections are supposed to be limited to not speaking.
MR. FLAXMAN: I'm not speaking. Could you state the time rather than just saying whatever you said before?
BY MR. RAGEN:
Q. Okay. And are you aware of the --
MR. FLAXMAN: Hold on. You're not going to honor my request to clean up the record so we can know what you guys have been talking about in the last question?
MR. RAGEN: What's your question, Ken?
MR. FLAXMAN: You said that Heparin was given at a particular time, and you never said the time when you finally got an answer to the question. What time was it?
MR. RAGEN: I got it. It's -- I'll back up.
BY MR. RAGEN:
Q. So you see I'm sharing the screen, Dr. Marcolini?
A. I do.
Q. So what time does it show that Mr. Cruz was administered Heparin?
A. 9:14.

Q. 9:14 A.M. on March --
A. Yeah, I believe you said 9:19. That's why I was unclear. So it was 9:14.
Q. And the only ambiguity, if you look at that, right, there's a date administered and date charted, right?
A. Yes.
Q. And those have a five-minute difference, correct?
A. Yes.
Q. Let's go with the earliest one. On March 13, 2016 at 9:14 A.M., okay?
A. Yes.
Q. You have no -- that's the first time you believe Heparin was administered to Mr. Cruz, correct?
A. According to this charting and that I can't find anything in my brief search, yes.
Q. Okay. So you have no reason to disagree with the fact that Mr. Cruz first obtained Heparin on March 13, 2016 at 9:14 A.M., correct?
A. Correct.
Q. Okay. And based on your own report, you say that he was placed in four-point restraints from 1:24 A.M. to 10:05 A.M., correct?

A. Yes.
Q. Okay. And earlier, we established that Dr. Yalamanchi placed the order for restraints on March 13, 2016 at 12:43 A.M., right?
A. Yes.
Q. Okay. So would you agree that the medical record reflects that there was a, at least, six-hour window where Mr. Cruz did not receive Heparin while restrained at Hinsdale Hospital?
A. Let's see. Yes.
Q. Okay. Now, for the Hinsdale Hospital, did you look at the types of range of motion exercises that were employed at Hinsdale Hospital?
A. I don't recall.
Q. Could they be relevant to your opinion as to whether or not a DVT formed while Mr. Cruz was at Hinsdale Hospital?
MR. FLAXMAN: Let me object to the question. It assumes she has an opinion about that.
MR. RAGEN: Okay.
BY MR. RAGEN:
Q. Do you have an opinion one way or the other whether Mr. Cruz developed a DVT at Hinsdale

Hospital?
A. Absolutely not. There's no way that we can know when a DVT was formed.
Q. Okay. But your opinions are that if you don't employ either two modalities, which are giving an anticoagulant like Heparin or immobilizing a patient, you increase the risk of developing a DVT, true?
A. Yes.
Q. Okay. And --
A. Under the heading of immobility.
Q. Right. And it's true that we can't say more probably true than not that the clot, the DVT that ended up killing Mr. Cruz was formed at Hinsdale Hospital; isn't that true?
A. State that again.
Q. Okay. Isn't it true that we can't say more probably true than not that the DVT that became a PE that killed Mr. Cruz originated at Hinsdale Hospital? Isn't that true?
A. I think you're doing that double negative thing again. But -- but...
Q. Can we rule out that -- so your cause of death is that a DVT -- DVT were formed, right, deep vein thrombi were formed and that caused a

pulmonary embolus to Mr. Cruz, right?
A. Yes.
Q. Okay. And it's certainly possible that those DVTs developed at Hinsdale Hospital, true?
A. It's possible.
Q. Okay. Because he was restrained at Hinsdale Hospital, true?
A. He was.
Q. He did not receive Heparin for a period of at least six hours while at Hinsdale Hospital, true?
A. True. If -- what you showed me is all that we have. I have not reviewed the record for that question.
Q. Well, Mr. Flaxman, when it's his turn to do Redirect, he can correct any facts that I'm -- that you're unwilling -- that you're unable to make right now. And I believe the deposition -- let me finish the question -- the depositions themselves will show that.
So you have no reason to disagree with the fact that Mr. Cruz was restrained at Hinsdale and did not receive Heparin for at least six hours, correct?
MR. FLAXMAN: Objection, it's a compound

question. I also object to your statement before that. Nobody -- neither one of us was at Hinsdale Hospital. Nobody here was at Hinsdale Hospital. If you want to know what happened at Hinsdale Hospital, you should ask somebody who was there who could talk about the records rather try to get it through the back door from Plaintiff's expert.

MR. CATANIA: Object to the objection.

BY MR. RAGEN:

Q. Have you read Nurse Aiste Barkauskaite's deposition?

A. No.

Q. Okay. Could her deposition be relevant to you forming opinion as to when a DVT was more likely to have been formed?

MR. FLAXMAN: Objection, speculation.

A. The question of when the DVT was formed does not influence my opinion.

Q. Okay. Are you -- you're testifying that Dr. Paschos -- strike that.

You're testifying that Cermak Health Services, the care that was provided there, created an increased risk that Mr. Cruz would develop a DVT, correct?

A. Yes.

Q. Okay. Do you have an opinion one way or the other whether the care that occurred at Hinsdale Hospital created an increased risk that Mr. Cruz would develop a DVT?

A. No.

Q. How long -- so do you have an opinion one way or the other, so -- no, I'm going to ask this specific question.

Can you say more probably true than not that the DVT that became the pulmonary embolism that killed Mr. Cruz was formed while he was at the Cook County Jail?

A. Again, we can't know when the DVT was formed.

Q. Okay. So it's true that you can't render an opinion that it's more probably true than not that the DVT that became a PE that killed Mr. Cruz was formed while he was at the Cook County Jail; is that true?

A. What I can say is that whenever the DVT was formed, the care that was provided at the Cook County Jail did not mitigate the risk of either formation of a DVT or propagation of an already formed DVT.

In either case, it's irrelevant when

because we can't know. Nobody can ever know when a DVT was formed unless you get imaging just prior to and just after it was formed. So -- so irrespective, the care that was rendered at the Cook County Jail did not mitigate the risk of propagation, did not mitigate the risk of formation. And that's -- that's the deviation from the standard of care.

MR. RAGEN: Shelley, could I have my question read back?

(Whereupon the requested portion of the record was read by the court reporter.)

A. Can you repeat that in not -- without double negatives? Can you make that question --

Q. I'll try. I'll try.

A. I realize that you're trying not to do that. But I want to make sure that what I say is accurate. It's very important that I -- that I am accurate, which is why I'm being very careful with my words.

Q. That's fine.

A. I don't want to misspeak.

Q. Agreed. And you know, this is -- and I wasn't inferring that you were evading the question. So to your question, on Redirect, I

will ask it -- try to ask it not with double negatives.

Is it more probably true than not that the DVT that became a PE that killed Mr. Cruz developed at Cermak Health Services?

A. It's more likely -- more likely than not true that it did develop at Cermak.

Q. Okay. And you're saying that because the -- there were -- the failure to mitigate those two things, that mobility exercises were not performed as regularly as you would like them and Heparin was not administered, true?

A. I'm saying that because Angel was immobilized for 17-1/2 hours. And in that time, he did not receive limb release and he did not receive Heparin. It's the -- it's the immobilization that contributed and that would cause this. And we have ways of mitigating that risk, and they were not employed.

Q. So would you say the more frequently range of motion exercises were employed, the better?

A. Yes.

Q. Okay. Do you have -- and so you just compared -- you just told me it's more probably

true than not that the DVT that killed Mr. Cruz via pulmonary embolism, it's more probably true than not that that originated while he was within the Cook County Jail; is that true?

A. If I had to make a guess and say what's more likely, yes, because of his prolonged immobilization and the lack of any mitigation of the risk.

Q. Now, to make that comparison, wouldn't it be helpful to know how much of the mitigating risks were performed at Hinsdale Hospital?

A. You know, you are asking me about something that happened at Hinsdale Hospital. It doesn't really matter, because if he was -- if he was restrained for 17-1/2 hours and not given the limb release that is specifically designed to mitigate the risk of either development or propagation of a clot, that stands alone. And it doesn't matter.

If -- let's just say this: If the clot, if we had some kind of a magic view and we knew that the clot formed while he was at Hinsdale Hospital, the actions at Cermak would have been actions to mitigate the risk of that propagating.

You could have a clot in your leg right

now and the fact that you have a clot in your leg right now is not going to kill you because you're up and you're walking around and you're active and you're squeezing your muscles and endogenous TPA is breaking down clot all the time.

So it doesn't matter to me what happened to you yesterday. What happened to you yesterday may have formed the clot. My job, if you're my patient right now, is to prevent that clot from propagating or prevent a clot from forming if I'm going to keep you immobilized. I just -- does that make sense?

Q. We just talked about whether the DVT that ended up killing Mr. Cruz, whether you could say when it was formed. And you just told me it's more probably true than not that it was formed when he was at Cook County Jail, right?

A. I did.

Q. Okay. And so for comparing, is it possible that the DVT that ended up killing Mr. Cruz was formed when he was at Hinsdale Hospital?

A. So you said if we're comparing. I'm not comparing.

Q. I'm asking you to compare.

A. Well, I'm telling you it's irrelevant to compare. I'm telling you that you asked me if it's more likely than not that the clot was formed at Cermak. And I said since he was -- since he was immobilized for 17-1/2 hours without any risk mitigation, then yeah, if you ask me to make an estimation is it more likely than not, yes, it's more likely than not. I have no way of knowing absolutely when that clot was formed.

Q. That's true. But in order to make that more likely than not assessment, wouldn't it be relevant to know how much the two mechanisms to avoid clot formation, which are anticoagulant and mobilizing the patient, were employed with Heparin; isn't that true?

MR. FLAXMAN: Object to the form of the question, which assumes facts that are contrary to the record.

BY MR. RAGEN:

Q. Can you answer the question?

A. I think you misspoke when you said something about Heparin. Can we read back the question?

Q. Okay. You -- strike that. We'll just plug along.

Can you tell me how often Mr. Cruz was mobilized while he was restrained at Hinsdale Hospital?

MR. FLAXMAN: Let me object to that. Immobilized or mobilized? What does mobilized mean in this context?

BY MR. RAGEN:

Q. Can you answer the question, Dr. Marcolini?

A. No, I cannot tell you.

Q. Okay. But you can answer the question, right? The question --

A. The question? Which question are we talking about right now?

Q. All right. So we just established the anticoagulant -- we talked about that you have two modalities to avoid the formation of a clot, right?

A. Formation or propagation, yes.

Q. We're talking about formation, right? We talked about there are two ways to avoid formation of a clot?

A. Yes.

Q. One is an anticoagulant, like Heparin. And the other one is making sure the restrained

patient is mobilized. Correct?
A. Yes.
Q. Okay. Can you tell me how the healthcare practitioners at Hinsdale Hospital mobilized Mr. Cruz?
A. No, I can't.
Q. Okay. Would that information more likely than not be in the records?
A. I don't know. Again, I -- again, I would have to go through the chart to look for that evidence. That's not what I based my opinion on. And it's not -- it's -- the important part of this case is that Angel Cruz was in the care of a physician and was immobilized for 17-1/2 hours. And in those 17-1/2 hours, the physician and the nurses were responsible for understanding that immobilization increases a risk of development and/or propagation of clot and that can be life-threatening.
Q. Okay.
A. That's the important part of this.
Q. I understand. Your answer, though --
MR. FLAXMAN: I think you have to let her answer your question, sir.
MR. RAGEN: I did. You were finished,

right?
A. The important -- and I was saying and that's the important part of this. And that's the basis of my opinion.
Q. So --
A. Are you asking -- you're asking me to compare the care at Cermak to the care at Hinsdale. I didn't do that. That's not what I based my opinion on.
Q. There's nothing there to stop you from rendering an opinion as to the doctors or nurses at Hinsdale; is that correct?
A. There is nothing that stops me. But as I answered before, the -- it wouldn't matter. If they had or hadn't, that clot developed. We know that. And in the 17-1/2 hours that Angel Cruz was immobilized, that's -- that's when the clot either developed or propagated. Irrespective, it embolized, it went to the lungs, and it killed him.
Q. Do you -- would you say that it's irrelevant that he was immobilized while at Hinsdale Hospital?
A. Irrelevant to what?
Q. Your opinions.

A. So in answer to your question, if he had been immobilized and treated appropriately, or inappropriately, the focus for me and my opinion is that he was inappropriately treated at the jail and that inappropriate -- that standard of deviation -- deviation from the standard of care is what caused embolus to go to the lungs.
Q. So but the one thing is could the -- could the care -- so it's possible that if you reviewed Hinsdale Hospital's chart and were given the time, it's possible that you would conclude that the care there did not meet the standard of care; is that true?
A. It's possible.
Q. And is it possible that if that opinion was made, that would have an impact on the causation of Mr. Cruz's death?
A. No.
Q. Okay. Let's talk about your report a little bit. Going to page -- when you say a propagation, explain propagation to me.
A. Oh, sure. When a clot is formed in the bloodstream, it typically is formed in a vessel, on a blood vessel. And mostly -- it can form in arteries, but it usually forms in veins. And when

that clot forms, it's formed by platelets. Platelets clump, they get sticky. They typically go to the site of either an injury to the blood vessel, which is why we have this mechanism, or to the site of a slowing of blood flow in the blood vessel or stasis, as we call it. Or they can be formed because of something pathological, like a disruption or a blood dyscrasia. So those platelets form, they go to the site, and they are at that site.
Now, if there's nothing done to stop the formation, a group of platelets is like a snowball going downhill. Platelets attract more platelets. And as you get more platelets showing up, the clot gets larger. It propagates, so it becomes longer within the blood vessel.
The larger the clot becomes, the more risk there is of part of that clot breaking off, heading downstream, as it were, and in the venous downstream is heading back toward the heart, into the right side of the heart, and then it goes into the lungs. And that's where the vessels get smaller, and these clots or clot get stuck in the smaller vessels.
So as they get stuck in those smaller

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vessels, now that traveling clot, it gets stuck somewhere and now it's going to start propagating.
Q. And so talking a little bit about clot burden. Would you say it's -- like sometimes people can survive a pulmonary embolism, sometimes they can't; isn't that true?
A. That is true.
Q. And the amount of the clot burden is instructive as to the chance of survivability; isn't that true?
A. It's the amount and location.
Q. Right. Okay. And those are the two main factors that determine whether or not a person can survive a PE, right?
A. Yes. It's the clot burden, which is the amount, and location, and the person's ability to mount a response to that.
Q. Do you have an opinion as to the severity of Mr. Cruz's clot burden?
A. It was severe enough to kill him.
Q. Right. Are there certain times where the clot burden is so high that no matter what methods are employed to save a patient's life, the patient will still die?
A. It depends on the patient's underlying

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condition and it depends on when that clot is discovered.
Q. Are there certain pulmonary emboli that are so big that they aren't survivable?
A. Well, no, because we have -- we have treatments. We have interventional treatments. We have interventional clot busters. And we also have endovascular procedures to remove clot.
Q. Okay. Let's talk about the treatment modalities. What would be the medications you could administer?
A. Heparin --
Q. Yep.
A. -- would be the first one.
Q. Uh-huh.
A. TPA.
Q. Okay.
A. Tissue plasminogen activator --
Q. Yeah.
A. -- can be employed. Those are basically the medications that you would deploy if and when you find the clot, or discover, or even to think that somebody has a clot.
Q. Right.
A. There's also Lovenox, which is a

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different form of Heparin.
Q. Right. One's unfractionated, one's fractionated?
A. Correct.
Q. When was a pulmonary embolism first diagnosed with Mr. Cruz?
A. I believe, at autopsy.
Q. Okay. Was a pulmonary embolism ever diagnosed while he was at Cook County Jail?
A. No.
Q. On pages five and six of your opinions, do you see that?
A. I do.
Q. Is that where you talk about how Mr. Cruz, if he was properly assessed, signs of a pulmonary embolism could have been detected?
A. Let me get my wording there. Where are you looking?
Q. Well, I'm just trying to -- the last two paragraphs on 5 and then, you know, through 6.
A. Okay.
Q. Is this a part of your opinions where you talk about how Mr. Cruz, if he was assessed properly, a pulmonary embolism could have been diagnosed?

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A. I didn't say that if he was assessed properly that a pulmonary embolism could be diagnosed, did I? Are you reading that somewhere?
Q. No. The thing is it's not -- I get to ask you questions about your opinions.
A. Yeah, okay.
Q. So is it true -- let's just talk about Nurse Krzyzowski, okay?
A. Okay.
Q. Do you believe that Nurse Krzyzowski deviated from the standard of care?
A. Yes.
Q. Okay. And that has to do with her care and treatment of Mr. Cruz on or around 2:35 A.M. on March --
A. Yes.
Q. -- on the date of his death, correct?
A. Correct.
Q. Okay. And your opinions as to Nurse Krzyzowski is that she did not do a proper assessment; is that correct?
A. She took ten minutes to respond to somebody who was crying out for help.
Q. Right. So I'm just going through your opinions. If you look at the last paragraph, you

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indicate, If the assessment described above had been done, Angel could have received treatment for his pulmonary embolus, true?
A. Yes.
Q. So what you're saying is if Nurse Krzyzowski would have done the proper assessment, she would have discovered that Mr. Cruz was suffering from a pulmonary embolism, true?
A. No, no.
Q. What are you saying?
A. That's not what I'm saying. What I'm saying is that at 2:35, when Deputy Anderson told Nurse Krzyzowski that Angel was yelling, "Help me, help me," she waited ten minutes and then responded and found him, you know, he had labored breathing and calling for help.
Now, when somebody's in distress and they're calling for help, as a healthcare practitioner, irrespective of whether you're a nurse or a physician, you go to that patient and you ask what's wrong? You find out what's wrong. And if somebody's having difficulty breathing, one of the first questions is do they have an airway, is the airway obstructed, you know, is he choking on something, does he have a foreign body in his

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airway.
And then when that's cleared and you don't have a foreign body and he's not choking, you ask is he breathing adequately. And if he has labored breathing and he's asking for help, then you want to ask yourself why is he having labored breathing? Why is he asking for help? What's his oxygenation?
So you get a pulse oximeter, you put it on the finger and you find out what the oxygenation is. If the oxygenation is not adequate, then you apply oxygen and you move down, you know, what is a pretty standard algorithm for taking care of a patient who's in respiratory distress or somebody with labored breathing.
And had Nurse Krzyzowski done that, she would have found that he did have some labored breathing and he probably did have some oxygenation problems. And that -- if that assessment would have been done, then she would have put oxygen on, called EMS, gotten them there. They would have even more tools to work with, and gotten him oxygen, an IV with IV fluid, and supported him, gotten him to the hospital where, at the hospital, they could put an ultrasound

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probe on the chest to see that his right ventricle is larger than his left, which belies an obstructive phenomenon, which would indicate something is going on in the lungs possibly and consider that he may be having a pulmonary embolus.
And so what I'm saying in that sentence that you read, if the assessment described above had been done, Angel could have received treatment for his pulmonary embolus, that means --
Q. Right.
A. -- that the nurse would have alerted the EMS system and they would have gotten Angel Cruz to the hospital while he was still alive and still had a chance to be resuscitated.
Q. Gotcha. So just to encapsulate what you're saying Nurse Krzyzowski did is she performed no assessment, correct?
A. I don't think she did perform an assessment. She didn't even go into the room --
Q. Right. So --
A. -- until ten minutes later and he was collapsed.
Q. I guess -- so you have to answer my question.

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A. Yes.
Q. Are you saying Nurse Krzyzowski's deviation from the standard of care is her failing to perform an assessment? Yes or no?
A. Yes.
Q. Okay. Is there any difference between assessment or examination? Did Nurse Krzyzowski perform any examination of Mr. Cruz at that time?
A. Not until she went to the room and found him collapsed.
Q. Right. What you're saying is her failure to perform an assessment or an examination, that's the deviation from the standard of care, correct?
A. I'm saying her failure to respond to a patient's cry for help, to delay her response to that, and not to, you know, respond to that cry for help until ten minutes later. And when she, you know --
Q. Do you -- do you think that -- let's just -- you talked about all the ways that Mr. Cruz maybe would have benefitted from a different treatment scenario. Okay?
A. Yeah.
Q. The fact that he didn't get any of that

treatment scenario, you're saying is that because Ms. Krzyzowski did not perform the assessment as you indicated she should have, correct?

MR. FLAXMAN: Let me object to the form of the question. And it's not a yes or no question with that "correct" at the end. That's sneaky, and you shouldn't do that.

MR. RAGEN: Can you read the question back, please?

(Whereupon the requested portion of the record was read by the court reporter.)

A. Can you reword the question?

Q. Sure. It's true that Nurse Krzyzowski failed to perform a proper assessment of Mr. Cruz's condition on around 2:35 A.M., correct?

A. It is true.

Q. Okay. Do you think -- let's just talk about Mr. Cruz and the chance that he could have survived this pulmonary embolism. You've read the Medical Examiner's report, correct?

A. I did.

Q. And how -- how high was his clot burden?

A. I don't recall off the top of my head.

Q. Okay. Do you think Mr. Cruz could have survived if he never was given either an

anticoagulant or tissue plasminogen activator? Can you say one way or another?

A. Could he have -- you're asking could he have survived?

Q. Right, if he never got Heparin or tissue plasminogen inactivator?

A. You mean if he had gotten to the hospital and never got those?

Q. Yeah, I mean, never. Right? So what I'm saying is you talked about how you can give someone oxygen, right, and IV fluids?

A. Yeah, yeah.

Q. That's one of the ways you can help a patient who is incurring a pulmonary embolism survive it, true?

A. Yes.

Q. Okay. Those are two methodologies, right?

A. Yes.

Q. What are the other ones you'd do? You can perform a surgery, right?

A. Yes.

Q. Okay. Or you can provide medication, right?

A. Yes.

Q. What are the other ways you could treat a pulmonary embolism?

A. To treat a pulmonary embolus, you can, as you suggested, provide Heparin. You can try unfractionated Heparin or Lovenox. You can perform an endovascular procedure.

Q. Right. Surgery, yeah. What I'm saying is did I talk about all --

MR. FLAXMAN: Hold it, hold it. You can't do that. She's answering your question and you're interrupting her. Please stop doing that.

MR. RAGEN: I only have three and a half hours. And I don't think Dr. Marcolini's trying to be evasive, but I just have a time constraint.

MR. FLAXMAN: You can have as much time constraints as you want, but don't interrupt her when she's answering.

MR. RAGEN: I can have as much what as I want?

MR. FLAXMAN: You should patiently wait for her to be finished, then you should ask another question. That's the way we work in the Federal Rules of Civil Procedure. We don't interrupt people.

BY MR. RAGEN:

Q. I'm sorry, are you finished, Dr. Marcolini?

A. No. The treatment modalities are Heparin, Lovenox, endovascular thrombectomy, intraarterial Heparin, TPA, or intraarterial TPA.

Q. Right. And those, all those are either surgical or medication, right?

A. True.

Q. Okay. So outside of giving the patient oxygen, giving them IV fluids, or those medical or surgical interventions you talked about, have we talked about all the different treatment modalities that could have been used on Mr. Cruz?

A. Oxygen, IV fluid, supportive care, Heparin, yeah. Those are -- those are the treatment modalities that he needed until he coded. Then he needed CPR.

Q. Right. And when did he code?

A. He coded while he was still at the jail.

Q. What time was it?

A. Let's see. I don't know. I'd have to look that up.

Q. Please do.

A. Okay.

Q. If it's important to your opinion. If it's not, that's fine.
A. I could tell you it was sometime after 2:35. So in Nurse Krzyzowski's progress note, she says that at 2:40 A.M., patient was verbalizing, "Help me." She -- and she told the patient to lie down and she would get some medications. She prepared the medications. He was lying down. He had a pulse. He was breathing. Code Blue was called -- I don't have a time here -- sometime after 2:40. Hang on.
Q. How long do you think you've been looking for this, would you say?
A. I don't know. A few minutes anyway.
Q. Okay.
A. As you know, these medical records are not designed for me to find an answer that I'm looking for. So I'm doing my best to try to find it. But I'm sorry.
Q. I know. Is it important to know for your opinions when Mr. Cruz coded?
A. No.
Q. Okay. Okay. Moving on, is it true that have you ever -- did you receive an undergraduate degree in nursing?

A. No.
Q. Are you licensed as a registered nurse?
A. No.
Q. Are you licensed as an LPN?
A. No.
Q. Did you -- when you went to medical school, did you receive training as a nurse?
A. No.
Q. In your residency, did you receive training as a nurse?
A. No.
Q. In your fellowship, did you receive training as a nurse?
A. No.
Q. You have certain continuing medical education obligations that we discussed, in part, correct?
A. I'm sorry, do I have?
Q. Like CMEs, right?
A. Yes.
Q. You do CME, correct?
A. I do.
Q. And that's as a medical doctor, right?
A. True.
Q. Are you aware of what the continuing

educational requirements are for nursing?
A. Yes.
Q. What are they?
A. They are continuing education. They have -- you know, it's that they have to acquire and they have to have certain -- I teach -- I teach nurses, so I realize that they have to have requirements. They have to have pharmacology as a certain percentage of their requirements, and they have to get documentation of that.
Q. Would you say that you've received a higher level of training than nurses?
A. Yes.
Q. Okay. Would you think a reasonably careful nurse would have to have as much education as you to be a competent nurse providing care in Illinois?
A. No.
Q. Okay. If you wanted to become a nurse at either of the hospitals you are credentialed at, could you?
A. No.
Q. Okay.
A. Not unless I went to nursing school and went through their curriculum.

Q. And became licensed, right?
A. True.
Q. And obtained the training that a nurse would get in nursing school, right?
A. Yes.
Q. In any of the other cases that you testified, did you testify to the nursing standard of care?
A. In any of the other cases that I testified?
Q. Yep.
A. Let's see. Not that I recall.
Q. Okay. We talked about the policies and procedures that were -- you know, about restraints at the hospitals you practiced at. Do you remember that?
A. Yes.
Q. Are the policies and procedures of those hospitals, are they confidential or privileged in any way, do you know?
A. I don't know.
Q. Okay. If they are not confidential and privileged, would you mind providing a copy of the policy that was in effect in March 2016 at the hospitals you were providing care at?

A. Well, I wasn't working at my current hospital in 2016.
Q. Were you practicing medicine in any hospital in 2016?
A. Yes.
Q. Would you mind providing a copy of the policy and procedure on restraints in March of 2016?
MR. FLAXMAN: From where?
MR. RAGEN: Whatever hospital you were practicing at in March of 2016.
MR. FLAXMAN: Is that proper to ask her to go out and get documents that she didn't rely on that you want to do fact discovery on?
MR. RAGEN: I just asked her if she'd mind. She could say no or yes.
MR. FLAXMAN: I think that's an improper question, if you would mind. How is that, you know, relevant? You can answer, but we'll object to the form of the question.
A. I -- I -- I don't -- yes, I would mind. I was working at Yale New Haven Hospital in 2016, and I don't work there anymore. So I think it would be inappropriate for me to ask for policies and procedures to apply them to a case that they

have nothing to do with.
Q. Okay. Labored breathing, that's a non-specific finding; would you agree?
A. Yes.
Q. Can labored breathing be associated with indigestion?
A. Not usually.
Q. Angina?
A. Yes.
Q. Exertion?
A. Yes.
Q. Can psychotic patients who don't have pulmonary embolism, can they have labored breathing?
A. Yes.
Q. Congestive heart failure, can patients with congestive heart failure have labored breathing?
A. Yes.
Q. Patients who have stroke, can they have labored breathing?
A. Yes.
Q. Are there many other medical conditions that could cause labored breathing?
A. There are others.

Q. Yeah. More than five, but less than a thousand, true?
A. Sure.
Q. What are the signs -- can DVTs present clinically?
A. Yes.
Q. And how would they present?
A. You can have signs that are associated with DVT such as leg swelling or tenderness in the calf.
Q. Can redness of the lower extremities be a sign of a DVT?
A. It can, but it's not typically.
Q. Can DVTs in the lower extremities present with lower extremity pain?
A. Yes.
Q. Okay. Can DVTs present with lower extremity itchiness?
A. Not that I know of.
Q. So the main characteristics of a DVT that is observable clinically would be redness, swelling and pain, correct?
A. Could be swelling, pain, and tenderness, tachycardia, shortness of breath.
Q. Okay. But let's just say talking about

the main three where you're looking at an extremity. You said tenderness, pain, and what was the other one?
A. I said swelling.
Q. Okay, yeah.
A. And pain and tenderness.
Q. Swelling, pain and tenderness. Okay. And would you include redness as a clinical observable sign of DVT or not?
A. Not typically.
Q. Okay. So looking at those three, you did include swelling, pain and tenderness, if you observed those in the lower extremity, would there be a high likelihood that you'd be -- would you be very suspicious of a DVT?
A. I would be suspicious of a DVT in the right clinical setting.
Q. Right. Did you see that Mr. Cruz exhibited any three of those symptoms?
A. I did not see -- it is not documented that he exhibited any of those symptoms.
Q. Whether at Hinsdale or Cermak, correct?
A. No. But I should add that Mr. Cruz was -- was noted to have an altered mental status and to be psychotic, and he certainly wasn't focusing

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on whether or not his calf was swollen. He was much more agitated than that. He could have overlooked any kind of complaint.
Q. Did you see anywhere in the medical record that they cleaned him off because he had defecated on himself?
A. I do recall seeing that somewhere.
Q. And is it possible that in the process of cleaning off defecation, they might be looking at his lower extremities?
MR. FLAXMAN: Let me object to the form of the question. Who's to say? Is that a correctional officer or a nurse or a doctor? Objection.
MR. RAGEN: Just keep your objections to not speaking, sir.
MR. FLAXMAN: Who's the they?
BY MR. RAGEN:
Q. Can you answer the question, Dr. Marcolini?
A. So can you repeat the question?
Q. You indicated that you saw in the medical records that at certain times, he defecated on himself and was cleaned, correct?
A. I think I recall that, yes, he was

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cleaned.
Q. Okay. And in that process, in the cleaning of someone who had defecated on themselves, is it possible that if signs of a DVT such as swelling, pain or tenderness existed, they could have been observed?
MR. FLAXMAN: Object to the form of the question. Who's the they?
A. First of all, if -- if you are -- if you're considering the -- if you're considering the diagnosis of DVT and you're thinking about the lower extremity and the assessment of that lower extremity, it can be very subtle. And what we haven't talked about is that you can have a DVT and have none of those. You could have a DVT and not have swelling, not have pain, not have tenderness.
Q. For sure. What percentage of the time do DVTs present with observable signs versus not generally?
A. I don't know. I don't know.
Q. Are you familiar with the term Braden assessment?
A. Sorry, with what term?
Q. Braden assessment?

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A. I have heard it. I can't tell you what it is.
Q. Okay. Is that something that a nurse would typically do?
A. I can't tell you what it is, so I don't know if I can answer that question.
Q. And we covered this, but I just want to make sure. Right now, as you sit here, I had to ask you about your opinions and you're telling me what you're basing them on. Is the extent of Mr. Cruz's -- are you basing any of your opinions on the severity or non-severity of Mr. Cruz's clot burden?
A. The severity of his clot burden was obviously severe enough to kill him. So --
Q. Right. But the thing is we established --
MR. FLAXMAN: Hold on, hold on, you're interrupting her again. She's answering your question.
MR. RAGEN: I'm sorry.
MR. FLAXMAN: Let her answer.
BY MR. RAGEN:
Q. Dr. Marcolini, I thought you were done. I didn't mean to interrupt.

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A. That's okay. I didn't think you did. What I'm saying is I'm not clear on specifically what you're asking.
Q. Right, okay. The survivability of a pulmonary embolus, right, some are more survivable than others; would you agree?
A. Yes.
Q. And if a person has a very, very, very tiny clot and there's one of them, that's more survivable than if the patient has bilateral clots and they're big and they're multiple; is that true generally?
A. Yes, true.
Q. Okay. Do you have an opinion as to the extent of Mr. Cruz's clot burden that was seen on autopsy one way or the other?
A. I was -- my opinion is that it was severe enough to cause his death.
Q. Okay. Do you have an opinion as to whether it was so severe that no matter what treatment modalities were administered after 2:35 A.M., he could have survived one way or the other?
A. I do -- I'm trying to answer this in the right form.

Q. So go ahead. Shelley, can you -- sorry I didn't mean to interrupt. You can answer, if you can.
A. He -- irrespective of the clot burden, it is absolutely possible that he could have survived it.
Q. Right. Is the other side true, that even if all the treatment modalities were administered, it's possible he could have died also?
A. It depends on when it was discovered. Because part of the physiology of this is that when the clot -- when the clot reaches the lungs and causes this obstruction, the heart is working against it. The heart is working as hard as it can to pump the blood through the lungs. And if there's clot burden in the lungs, it makes the heart's job that much harder. And when the heart works so hard and can't get the blood through the lungs, now you run into heart failure. And it's the heart failure that actually -- that actually manifests and the patient dies because the heart fails.
And if you get into that cycle early on, you can even have somebody who's got -- who's got

compromise to the heart and still you can -- they can survive, because we can fix that. We can support the heart with fluids, with medications, with vasoactive medications at the same time that we're getting that clot out of the lung. So it really depends on where you catch it in the cycle.
Q. And so the timing is important in the cycle where you catch it, correct?
A. Yes.
Q. Okay. Is it important -- well, okay, let me know -- tell me if you can answer this question one way or another. Are all -- so like sometimes pulmonary embolism causes death, true?
A. True.
Q. Are there certain pulmonary embolisms that are unsurvivable, despite all treatments being provided within the standard of care?
A. It depends on the condition of the patient and when you catch that.
MR. RAGEN: Sorry, can you ask the question back, Shelley?
(Whereupon the requested portion of the record was read by the court reporter.)
A. It depends on the condition of the patient and when you catch the pulmonary embolism.

Q. Okay. I'm going to ask to see if you can answer the question yes or no. And if you can't answer it yes or no, that's fine too.
MR. RAGEN: Can you read the question back, Shelley?
(Whereupon the requested portion of the record was read by the court reporter.)
A. I can't answer that yes or no.
Q. Okay.
A. I can answer it the way I did answer it.
Q. No, I understand for sure. And part of what it depends on is how big the clot burden is, true?
A. No. What it depends on is the condition of the patient and the cardiovascular system that's working against that clot. So see, it's -- the clot is there and the clot provides an obstruction to the heart pumping. So when you -- when you have that obstruction to the heart pumping, now the heart has to work harder and work overtime.
So the heart working hard not -- not able to work that hard and failing causes the cardiac arrest. The cardiac arrest is traced back to the heart working so hard because there's a

pulmonary embolus.
Q. Does it matter how many clots make it to the lung one way or the other?
A. It can be multiple clots or it can be one large clot or two large clots. It depends on the clot burden and how hard it is for the heart to pump against that.
Q. Right. And so the bigger the clot burden, the harder it is -- the more likely the patient's not going to survive; is that true?
A. The bigger the clot burden in conjunction with the condition of the heart and the, you know, the work -- the work that, you know, also hydration and how much, you know, how much support the heart has, how much ability the heart has to do the job that it has to do.
Q. And the clot burden is a relevant factor; would you agree?
A. It is one relevant factor.
Q. Okay. How often do you employ restraints on patients?
A. Not very often.
Q. When was the last time you employed restraints on a patient?
A. Last time was probably ten days ago, in

the ICU.
Q. Okay. And then in a given year, how many times do you employ restraints on a patient?
A. Ten to twenty.
Q. Okay. Did you -- I looked at all the materials you listed here. Did you watch any videos?
A. I did.
Q. Which videos did you watch?
A. The videos of the -- of the jail -- sorry, videos of the jail where he was -- where Angel was being held.
Q. How many videos?
A. It was one prolonged video.
Q. Okay. And that instructed you to conclude that the restraints could not have been performed for ten minutes?
A. Yes.
Q. Okay. If restraints weren't employed at Hinsdale Hospital for ten minutes, would that be a deviation from the standard of care when Mr. Cruz was restrained at Hinsdale Hospital?
MR. FLAXMAN: Objection, asked and answered.
A. I agree.

Q. It would be a deviation, correct?
A. No, I agree it was already asked and answered. And I'm -- I'm not -- if you want me to opine on the Hinsdale Hospital care, I can go back to the chart and spend some hours doing that. But it's not where my focus is.
Q. No, I know. But my question is just real simple. If -- if at Hinsdale Hospital restraints were employed every two hours and for over ten minutes and all four limbs were mobilized, would that comply with the standard of care?
A. Yes.
Q. Okay. If range of motion exercises were not done for a period of over ten minutes at Hinsdale Hospital, would that deviate from the standard of care?
A. Depends on why they weren't done.
Q. Okay. And why would it depend?
A. Sorry?
Q. Well, why would it depend?
A. If the patient is violent and they can't get near the patient, then you have to -- you have to take into account safety of the nurses, techs, and security guards. I mean, there are many

reasons. Again, if you want to get specific about Hinsdale Hospital, we could go there. But I'm not prepared to answer specific questions about the Hinsdale Hospital care.
Q. On page 4 of your opinions -- can you turn there?
A. Yes.
Q. Looking at the middle -- page 4, in the middle paragraph, it says, During his stay at Hinsdale Hospital, he was appropriately administered Heparin to mitigate the risk of deep vein clot formation.
A. Yes.
Q. Do you hold that opinion?
A. Yes.
Q. When was he first administered Heparin?
MR. FLAXMAN: Object to the form of the question. Where?
MR. RAGEN: At Hinsdale Hospital.
MR. FLAXMAN: Objection now is asked and answered. You went through those records.
MR. RAGEN: I know. But she's saying she doesn't have an opinion about Hinsdale Hospital. But then in her report, she has an opinion about Hinsdale Hospital. She calls it

appropriate.
MR. FLAXMAN: I mean, are you going to argue with her or are you going to ask her questions?
A. In this statement, he was appropriately administered Heparin, meaning it was appropriate to administer Heparin to Angel to mitigate the risk of deep venous clot formation.
Q. When you say appropriate, that means reasonable, right?
A. It was reasonable to administer that, yes.
Q. Right. And did he -- do you know if he had a period when he was restrained and was not Heparinized? Do you know one way or another?
A. Not without going back and reading through the records again. But I see your question. I see why you're asking it. The wording of that sentence, During his stay at Hinsdale Hospital, he was properly administered Heparin.
That, what I mean with that statement is that during his stay at Hinsdale Hospital, it was appropriate to give him Heparin.
Q. Okay. But you're not saying whether the

care was appropriate one way or the other?
MR. FLAXMAN: Again -- again, you cut her off. She was answering. She had more to say and you cut her off. Please don't do that.
MR. RAGEN: By the way, what I'll say for the record, because you're doing this for the written record.
BY MR. RAGEN:
Q. Dr. Marcolini, it seemed like you were done with your answer. Is that true?
A. I'm sorry, let's just start again. Let me say my sentences. When I make that statement, During his stay at Hinsdale Hospital, he was appropriately administered Heparin, what I mean is it was appropriate for them to administer Heparin. He was appropriately administered Heparin. But I'm not making a statement as to the way that they administered it or the frequency or dosing or any of that.
So I can see -- I can understand your confusion with that sentence. But hopefully I've cleared it up.
Q. Did you finish your answer?
A. Yes.
Q. Okay. And I'm trying not to cut you

off. Would you agree?
A. Understood.
Q. Well, would you agree?
A. Yes.
Q. I would say, in all fairness for the record, there probably were two to three to maybe four times when I cut you off, right?
A. I haven't been counting.
Q. But my cutting you off is not obstructing with you getting your opinions out, is it?
MR. FLAXMAN: Let me object to that. That's a -- beyond the scope of the expert deposition.
BY MR. RAGEN:
Q. Dr. Marcolini, do you feel that I'm cutting you off too frequently?
A. No. We can just move forward.
Q. Yeah, thank you. The reason I say that is because when we go back and show the Judge this transcript, Mr. Flaxman keeps saying on the record that I'm interrupting you when, in my opinion, I'm not.
A. I should say, though, that you have interrupted when he -- when he has brought it up,

you have interrupted. But I think we can move forward.
Q. Right. And -- is the time period that he was restrained at Hinsdale irrelevant to how many emboli formed in his DV -- in his lower extremities?
A. I don't know how to answer that question.
Q. Okay. The amount of time that he was restrained at Cermak and how mobile or immobile he was is relevant to your opinions as to that Mr. Cruz formed a DVT; is that true?
A. It is true that the time that he was immobilized without risk mitigation is relevant to the formation or propagation of DVT.
Q. Okay. So that last answer, does it matter whether or not that occurred at Hinsdale or Cermak?
A. No.
Q. Can Geodon cause an increase -- can the overprescription of Geodon cause an increased risk of developing a DVT?
A. I don't know. I'd have to look that up.
Q. Looking at page 3 of your opinions, do you see them?

A. I do.
Q. See the bullet points that are there?
A. Yes.
Q. So when reading, The following was required by the jail's policy to be done by a nurse after and while a detainee is placed in restraints, do you see that?
A. Yes.
Q. And there is five bullet points?
A. Yes.
Q. Is this the standard of care?
A. Yes.
Q. Would this be the standard of care applicable to any -- and this corresponds to a nurse, correct?
MR. FLAXMAN: Object to the form of the question. Corresponds.
MR. RAGEN: You may answer.
A. It can be done by a nurse or a physician. It can be done by anybody taking care of the patient.
Q. Okay. So look at your opinion, though, on page 3. It says --
A. Yeah.
Q. I'm sorry, did I cut you off?

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A. No, you didn't. Sorry, I probably cut you off.
Q. No, that's okay. It says, The following is required by the jail policy to be done by a nurse after and while a detainee is placed in restraints. Do you see that?
A. Yes.
Q. Okay. And those same requirements would apply to Hinsdale Hospital, correct?
A. This is the jail's policy. So this applies to the jail.
Q. Right. But I asked you if this is the standard of care of what a reasonably careful nurse should or shouldn't do.
A. Yes.
Q. Okay. So this is the standard of care of what a reasonably careful nurse should do, correct?
A. This is reasonable care. And it conforms with the standard of care of what a nurse should do for somebody who's in restraints.
Q. Okay. And whether that be on March 12th, 13th, 14th, 15th, 16th, 17th, 18th, 19th or 20th, correct?
A. True.

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Q. The same thing about the ten minutes of limb relief right underneath that, do you see that?
A. I do.
Q. And you're saying that the policy requiring ten minutes of limb relief, that is consistent with the standard of care, correct?
A. It is.
Q. Okay. And that would apply at any point in time between March 12th and March 20th, 2016, true?
A. True, when the patient is restrained.
Q. Right. Independent of the hospital, right?
A. Yeah.
Q. Looking at your opinion on page 4 --
A. Yes.
Q. -- paragraph on the bottom in the middle, you talk about -- we've talked about how the three common most factors contributing to blood clot formation known as Virchow's triad, muscle wall damage and hypercoagulability, right?
A. Yes.
Q. You've explained that, right?
A. Yes.

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Q. Okay. Then right after that, the sentence says -- well, I'll read it. If any of these components (stasis, muscle damage, hypercoagulability) is present for a prolonged period of time, treatment is indicated to prevent blood clot formation. Do you see that?
A. Yes.
Q. And then the next sentence says, This was done at the hospital in the form of Heparin. Do you see that?
A. Yes.
Q. Do you want to change that statement?
A. Why would I want to change my statement?
Q. Well, we talked at length a long time about --
MR. FLAXMAN: You're arguing with her now. You know, you asked her if she wanted to change. She said, Why would I want to do that? And now you're going to tell her, Well, you want to do it because A, B, C. Let's try to move on with questions rather than arguing with her.
BY MR. RAGEN:
Q. You told me that you don't have an opinion as to whether or not the treatment needed to prevent blood clot formation occurred at

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Hinsdale Hospital; isn't that true?
A. Well, what I told you was that I couldn't attest to the timing, the dosing, the specifics of it. But I do know that they administered Heparin. So...
Q. Okay. And so the standard of care requires that Heparin be considered at least as early as the four-hour continuation of restraints, right?
A. In general, I believe that if I'm renewing a restraint order, I'm starting to think about immobilization and clot formation or propagation.
Q. Are you ever consulted on patients?
A. Yes.
Q. Okay. And as -- does that -- let me know if I'm getting this right. An attending will say I need a certain specialist and they'll call for a consult, true?
A. True.
Q. And from time to time, you are called as one of those consultants, true?
A. Yes.
Q. Okay. Does the standard of care as a consultant require that you see the patient?

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A. If somebody calls me for a consult, they can run the consult by me and describe the case and say if, you know, I have X, Y and Z, and if I can't see the patient, I can still give them my opinion. If it's possible, it's best to see the patient.
Q. But you said that there's no requirement that if a -- so in this case, if a psychiatrist was called to consult on Mr. Cruz, would the standard of care require that that psychiatrist see Mr. Cruz at any point in time?
A. It depends on what the consult is for.
Q. What if it is to see an acute psychiatric patient?
A. If the consult is to see an acute psychiatrist -- psychiatric patient, then the physician should see the patient.
Q. And within what timeframe?
A. It depends on the acuity of the condition that they're being consulted for. Some consults are urgent or emergent, and some consults are not.
Q. So on the least level of urgency, what timeframe would you expect that order to be executed?

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A. It's -- there's not a timeframe. There's not a timeframe. It all really depends on what you're consulting for. Sometimes a consult is not going to happen 'til the next day. And that's understood and may be appropriate.
Q. Would you agree that if a psychiatrist was ordered in Mr. Cruz's case, that the standard of care required that psychiatrist to see Mr. Cruz within 24 hours?
A. What is the consult being ordered for?
Q. For like acute psychiatric observation.
A. So I'm not a psychiatrist, and it's hard for me, if not impossible, to determine how long is an appropriate time for a consult to occur. So I can't.
Q. Is that because you're unfamiliar with the standard of care as it applies to a reasonably careful psychiatrist?
A. In terms of psychiatry, I'm not a psychiatrist, so I can't opine on when it's appropriate for the psychiatrist to see the patient after he or she is consulted.
Q. Do you know whether or not a psychiatrist saw Mr. Cruz at Hinsdale Hospital?
A. Off the top of my head, I don't know.

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Q. Is that important to your opinions?
A. No.
Q. Do you know whether or not Mr. Cruz ever had a face-to-face assessment by a physician in connection with his being placed in restraints?
A. When? Where?
Q. At Hinsdale Hospital.
A. I can't recall.
Q. Would that be important to your opinions?
A. No.
Q. Are you aware of the relative risk of patients developing a DVT in terms of their age? You know what -- strike that. Let's go back.
Are there other risk factors for developing a DVT other than immobility and obesity?
A. Yes.
Q. Is congestive heart failure one?
A. Could be, yes.
Q. Smoking?
A. Yes.
Q. Does pregnancy create an increased risk in developing a DVT?
A. Yes.

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Q. Are patients that are postpartum, after delivering a baby, are they at increased risk of developing a DVT?
A. Yes.
Q. Cancer patients? Some cancer patients?
A. Yes.
Q. Not all, correct?
A. I consider anybody who has a malignancy or who has been diagnosed with a malignancy to be at increased risk of having a thrombus formation.
Q. Does old age by itself cause an increased risk of developing a DVT?
A. I don't know.
Q. Family history of, you know, stroke or embolic events, would that create an increased risk of DVT?
A. I believe so.
Q. Cardiomyopathy, would that create an increased risk of DVT?
A. Yes.
Q. Atrial fibrillation, would that create an increased risk of DVT?
A. Atrial fibrillation causes an increased risk of clot formation in the heart, but not necessarily an increased risk of DVT formation,

that I know of.
Q. Was that because it's so distal to the type of blood flow disturbance that it might not correlate to the development of clots?
A. Yes.
Q. Heart murmurs, same thing as atrial fib?
A. Heart murmurs, I don't consider as an increased risk for DVT.
Q. Lupus, would that create an increased risk of developing a DVT?
A. Yes.
Q. Antiphospholipid antibody syndrome?
A. Yes.
Q. What are the conditions -- like so Mr. Cruz had obesity and immobility as his risk factors for DVT, correct?
A. Yes.
Q. Were there any others?
A. Not that I know of.
Q. Okay. Do you have an opinion one way or another if being administered Geodon increased his risk for developing a DVT?
MR. FLAXMAN: Objection, asked and answered.
A. I don't know.

Q. Okay. What percentage of DVTs come from the lower extremities?
A. I don't know the answer to that.
Q. Are you aware of the relative risks of patients developing a risk in the following specific age categories? Under 40 versus over 65?
A. I don't know.
Q. Are you aware of the risk ethnicity plays in the development of DVTs?
A. No.
Q. Okay. Do you believe that ethnicity plays any role in the risk factors of a patient developing DVT?
A. I don't know.
Q. So -- and I'm not trying to -- I just want to understand your opinion. Like it's possible that ethnicity does play a role in whether a patient develops a DVT; you just can't tell me one way or the other, correct?
MR. FLAXMAN: Objection, objection to form of the question. It calls for speculation. Compound question.
A. I don't know whether ethnicity plays a role.
Q. Okay. The books I see behind you,

there's a number of books. Do you see them?
A. I do.
Q. Yeah. Are they all books related to your -- the care -- like, you know, your role as a medical doctor?
A. Let's see. Of the ones you can see, probably yes.
Q. Okay. How many of those are related to nursing care?
A. None.
Q. Do you know if there are any other experts retained by Plaintiff in this case?
A. I don't know of them.
Q. Do you know if they retained a nursing expert?
A. I don't know.
Q. Did you read Nurse Manlastas's deposition?
A. Let's see, did I read it? No.
Q. So you're not relying on any of Nurse Manlastas's deposition testimony for your opinions; is that true?
A. That's true.
Q. Did you read Ms. Chatman's deposition testimony?

A. No.
Q. And so it's true that you're not relying on any of her deposition testimony to form your opinions, true?
A. True.
Q. Are you relying -- strike that. In your -- whether that be in your -- are you relying on any specific medical literature to form your opinions here today?
A. No.
Q. Are there other things that could cause -- so in your opinion, was Mr. Cruz's labored breathing caused by pulmonary emboli or pulmonary embolus?
A. More likely than not, yes.
Q. Are there other medical conditions that could cause labored breathing?
A. Yes. We reviewed those earlier.
Q. Yeah, we talked about those, okay. When -- do you have an opinion as to when -- so DVTs and PEs are different, right?
A. Yes.
Q. Okay. DVTs can become PEs, correct?
A. A DVT can embolize and get lodged in the lungs, which makes it a PE. So it's the same

substrate, but the location is different.
Q. Do you have an opinion as to when Mr. Cruz's DVT first mobilized and became an embolus in or around the pulmonary anatomy?
A. No.
Q. Have we discussed -- and I think we have, right, because we went through your C.V. for quite a bit, right?
A. We did go through it.
Q. You're right, I was going to ask the question like have we discussed all the, you know, schooling, training, expertise, teaching that is relevant to your opinions today?
A. I believe so.
Q. Do you know whether or not Hinsdale Hospital has a psychiatric unit?
A. I can't remember if he was in the psychiatric unit or if a medicine bed. But I don't know.
Q. Okay. Does it make a difference to your opinion?
A. No.
Q. Do you know whether he, Mr. Cruz, was on a general floor or an ICU floor?
A. At Hinsdale Hospital?

Q. Yeah.
A. I believe he was on a general floor, but I can't be certain.
Q. Would it make a difference if he was on a general floor or ICU floor?
A. No.
Q. This is always good when you see me going through and crossing everything off. I have nothing further. Thanks.
MR. FLAXMAN: Frank or John?
MR. POWER: John. Yeah, I think I've got a few.
EXAMINATION
BY MR. POWER:
Q. Dr. Marcolini, my name is John Power. I'm one of the attorneys for the Sheriff's Office Defendants in this case. And actually that's a distinction I'm going to go to now.
Your opinions in your report address the medical care and the providers of medical care to the Plaintiff; is that right?
A. Yes.
Q. And you did not render any opinions about the conduct of any Sheriff's officers, did you?

A. No, I did not.
Q. And you did not render any opinions about the Sheriff's office as an entity, did you?
A. Not that I'm aware of, unless the physician and/or nurses work for the Sheriff's office. I don't know the lines of reporting.
Q. Okay. And if they don't, then you didn't render any opinions regarding the Sheriff's office?
A. Correct.
Q. And in your expert report, there were a couple of times you reference jail policies or jail protocols. I see, for example, on page 4 of your report -- or rather page 5. When you say jail policies or protocols, you're just referring to the policies or protocols followed by the medical personnel who worked in the jail; is that right?
A. Yes.
Q. And you're not claiming that those were Sheriff's policies or protocols; is that right?
A. I don't know who writes the protocols in the structure of the, you know, the medical unit there at the jail. So I would imagine that they are written in conjunction with the medical

personnel.
So I mean, I'm not judging policy. Judging the -- that they didn't follow the policy. I'm not sure if I'm answering your question.
Q. No, I think you are. And the people who didn't follow the policies were the medical personnel, not -- as opposed to the Sheriff's deputies?
A. Correct.
MR. POWER: Nothing further. Thank you.
MR. FLAXMAN: I have nothing further. Do you have any questions based on the Sheriff's questions, Mr. Ragen?
MR. RAGEN: No, I don't.
MR. FLAXMAN: All right. We will reserve signature. And if anybody orders it, we want a copy.
THE COURT REPORTER: Mr. Ragen, are you ordering?
MR. RAGEN: Yes, I would like to order, please.
MR. FLAXMAN: I'd like a copy, as well.
THE COURT REPORTER: Format, Mr. Ragen?
MR. RAGEN: Etran, please.
THE COURT REPORTER: Mr. Catania?

MR. CATANIA: Etran also, please.
(Whereupon the deposition concluded at 6:30 P.M.)

IN THE UNITED STATES DISTRICT COURT.
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

LETICIA VARGAS, Administrator of the Estate of Angel Cruz,
Plaintiff,

-vs- No. 18-cv-1865
Judge Steven Seeger
SHERIFF OF COOK COUNTY, COUNTY OF COOK, et al.,
Defendants.

This is to certify that I have read the transcript of my deposition taken in the above-entitled cause, and that the foregoing transcript taken on March 15, 2021, accurately states the questions asked and the answers given by me, with the exception of the corrections noted, if any, on the attached errata sheet(s).

EVADNE MARCOLINI, M.D.

Subscribed and Sworn before me this day of , 2021.

Notary Public

Return to:
Magna Legal Services
190 S. LaSalle Street
Suite 1220
Chicago, IL 60603

STATE OF ILLINOIS)
) SS
COUNTY OF McLEAN)

I, SHELLEY MARVIN, CSR in and for the State of Illinois, do hereby certify that EVADNE MARCOLINI, M.D., the deponent herein, was by me first duly sworn to tell the truth, the whole truth and nothing but the truth, in the aforementioned cause of action.

That the foregoing deposition was taken on behalf of the Defendants, on the 15th day of March, 2021.

That said deposition was taken down in stenograph notes, afterwards reduced to typewriting by me, and is a true and accurate transcription of the testimony; and that it was agreed by and between the witness and attorneys that said signature on said deposition would not be waived.

I do hereby certify that I am a disinterested person in this cause of action; that I am not a relative of any party or any attorney of record in this cause, or an attorney for any party herein, or otherwise interested in the event of this action, and am not in the employ of the attorneys for either party.

IN WITNESS WHEREOF, I have hereunto set my hand this 29th day of March, 2021.

SHELLEY MARVIN, CSR

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