

**IN THE SUPREME COURT OF OHIO**

|                                |   |                                    |
|--------------------------------|---|------------------------------------|
| Beverly Clayton, C.N.P., R.N., | : | Case No. 2014-1092                 |
|                                | : |                                    |
| Appellant,                     | : | On Appeal from the Franklin County |
|                                | : | Court of Appeals,                  |
| v.                             | : | Tenth Appellate District           |
|                                | : |                                    |
| Ohio Board of Nursing          | : | Court of Appeals                   |
|                                | : | Case No. 13-AP-726                 |
| Appellee.                      | : |                                    |

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**APPELLANT'S MERIT BRIEF**

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**Proposition of Law**

**In an administrative evidentiary hearing held before a Hearing Examiner (H.E.) of the Ohio Board of Nursing (OBN) involving alleged nursing practice violations against the license of Appellant Nurse, it is reversible error, contrary to law and in violation of Due Process of Law for the Hearing Examiner to prohibit and deny Appellant Nurse the right to obtain by hearing subpoena and present in the hearing evidence highly relevant and material to her defense against the charges and to her defense in mitigation of sanctions.**

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## STATEMENT OF FACTS

This appeal arises out of a timely filed administrative appeal to the Franklin County Common Pleas Court of an Adjudication Order of Appellee Ohio Board of Nursing brought by Appellant/Respondent Nurse Beverly Clayton. The lower court affirmed the Adjudication Order of Appellee Ohio Board of Nursing. (Appx. at 79) Appellant/Respondent Beverly Clayton timely perfected her appeal to the Tenth District Court of Appeals for Franklin County. This Ohio Supreme Court, upon reconsideration, granted merits review of the decision and Opinion of the Court of Appeals. (Appx. at 5)

Appellant Beverly Clayton became an RN in 1987. At the present time, Appellant is also an MSN (Master of Science in Nursing), APN (Advanced Practice Nurse with prescription-writing authority), CCRN (Critical Care Registered Nurse), CMC (Cardiac Medicine Certification) as well as a respiratory therapist(T.77). She is a well-educated, intelligent, highly credentialed professional nurse with 25 years of experience without any prior practice violations.

The incident in question occurred during her Intensive Care Unit (ICU) shift at Mercy Hospital Western Hills in Cincinnati from 7:00 p.m. on August 27, 2009 to 7:00 a.m. on August 28, 2009, the night shift. (T. 78-9)

It is our contention that Appellant Beverly Clayton is the unfortunate victim of a shockingly understaffed and inadequate medical administration headquartered in Cincinnati, which invites inevitable errors and oversights. We urged below that she was made an unjustified scapegoat for the gross shortcomings of a deficient system driven by profit rather than patient care. We were denied the right to obtain and present evidence highly relevant to our defenses to the nursing practice charges and to our proof of substantial mitigation. *As will be discussed in more detail hereafter, during this overcrowded, understaffed ICU night shift, Appellant*

*Beverly Clayton had the duties of three jobs: she was the Charge Nurse, she was the Unit Secretary and she was a Staff Nurse with two patients directly assigned to her, including the patient in issue, Patient 1. The two other nurses who started the shift with her were both so inexperienced and useless that neither of them was able to insert i.v.'s into their own 4 patients. All of these 6 critically ill patients at the outset of the shift effectively came under the care and responsibility of Appellant, in addition to her two other roles of Charge Nurse and Unit Secretary.*

Patient 1 (Appellant's patient in issue) was an 80-year-old male, a 70-year smoker (T. 151), who entered the Emergency Room of Mercy Hospital at 4:00 p.m. on August 27, 2009 from a nursing home with a history of 4 days of shortness of breath. (State's (OBN/s) Exh. 5, p.6) He was diagnosed with renal (kidney) failure, anuria (no urine output), congestive heart failure (CHF), pneumonia, tachycardia, cardiac afibrillation, COPD (chronic obstructive pulmonary disease) and was DNR-CC (Do Not Resuscitate – Comfort Care). (State's (OBN)'s Exh. 5, p.3; Exh. 12, second page; T. 92-3) His chances of survival were “very slim”, at the very best a matter of “days” (T. 542) or for a day or two, irrespective of whatever care or treatment he received. (T. 205-6) He was “critically ill with a poor prognosis” with a poor chance of “leaving the hospital alive”. (T. 699-701) Although he was admitted to the ICU, his family prohibited his being intubated (put on a ventilator). Without being intubated, “it was going to be difficult to get him through this”, according to the attending physician, Dr. Bowers. (T. 701) Dr. Bowers further testified that if everything she ordered was done for Patient 1, “absolutely” and “without a doubt” he could have been near death by the end of Respondent's shift at 7:00 a.m. on August 28, 2009. (T. 750) The fact is that when Patient 1 came under the care of Respondent in the ICU, he was an acutely terminal patient about to expire and upon arrival in the ER, without additional

measures, was going to die “within a very short period of time”. (T. 681) Nevertheless, contrary to all of the expert medical testimony from both the Appellee State’s (OBN’s) and Appellant’s experts, the Hearing Examiner concluded that “Respondent’s [Appellant’s] failure to practice with acceptable and prevailing standards of safe nursing care in Ohio, as noted above, did not directly result in Patient 1’s demise but did lower his chance of surviving”. (H.E. Rpt. & Rec., p. 45, par. 17, Appx. at 24, 68) ***In fact, the evidence is undisputed that Patient 1 had no chance of “surviving” in any meaningful sense.*** This does not mean that he wasn’t entitled to safe and competent quality care. But in a grossly understaffed, overburdened and inadequate ICU, care and attention must be prioritized, since the attendant deficiencies in the system (for which Appellant was not responsible) created inherent danger and lack of safety for all patients in the ICU.

Appellant was charged by the Board with the following nursing practice violations:

Patient #1 was admitted to the ICU from the Emergency Department at approximately 1850 on August 27, 2009, with diagnoses of pneumonia and congestive heart failure. You admitted that during your shift, you did not receive report from Patient #1’s ICU nurse on the previous shift, and you never checked Patient #1’s physician’s orders. You continued to administer IV saline to Patient #1 during your shift despite the fact that a physician had ordered a saline lock. You failed to obtain pulmonary and cardiac consults despite a physician’s order to do so. You failed to initiate a Cardizem drip despite a physician’s order to do so. You failed to notify a physician of Patient #1’s decline, including decreasing blood pressure, rapid pulse and respirations, and low urine output, until approximately 4 am the next morning. Patient #1 died at approximately 11:17 a.m. on August 28, 2009. (State’s Exh. 1, p. 1, Appx. at 21, Notice of Opportunity for Hearing)

Some of these charges were unsupported by evidence and were not adopted as findings by the Hearing Examiner. For example, there is no proof whatsoever that Appellant continuously ran saline into Patient 1’s body at the rate of 200 c.c.’s per hour throughout the shift without a saline lock. (Mr. Terry Gallagher, Appellant’s Expert, T. 537)(Keegan, State’s OBN’s Expert, T.

372-3) There were sound emergency medical reasons for significant bolus infusions of fluids when Patient 1's blood pressure began to decline precipitously, (an urgent life-saving necessity), which was done by Appellant in the presence of the hospitalist, notwithstanding the saline lock order of the attending physician 12 hours earlier in the Emergency Room. And the finding of the Hearing Examiner that Appellant should have called in the hospitalist for Patient No. 1 at 2:00 a.m. or 3:00 a.m. instead of 4:00 a.m. is, in our view, an unfair conclusion of a Nursing Practice Act Violation for something well within the realm of reasonable medical nursing discretion under extreme pressures that night in the ICU. We submit that a reading of the Hearing Examiner's lengthy Report and Recommendation (Appx. at 24) reveals that the Hearing Examiner did not understand or appreciate the medical issues.

Other charges were found to be established by the Hearing Examiner, such as failure to locate the handwritten Physician Orders of the attending physician in the ER, Dr. Bowers, which led to failure to obtain the cardiac and pulmonary consults and to initiate a Cardizem "drip", and failure to call the night hospitalist, Dr. Chaudhry, sooner than 4:00 a.m. to see Patient 1. (H.E. Rpt. & Rec., Appx. at 24, 65-68, pp. 42-45, pars. 9-10, 13-17) The Hearing Examiner made an additional finding --- ***not charged in the Notice of Opportunity for Hearing*** --- that Appellant gave Patient 1 an emergency bolus of saline when his blood pressure dropped sharply without an order from the hospitalist, Dr. Chaudhry. (*id.*, p. 43, par. 11) Among Appellant's defenses to these charges was a simple and straightforward explanation: under the circumstances that existed in the ICU during Appellant's entire shift, it was impossible for her to comply with all of the handwritten physician orders for Patient 1 without jeopardizing the lives of several other patients in the overcrowded, incompetently staffed and understaffed ICU. (Appellant relied on the Physician Orders entered into the computer, which is reasonable for an ICU nurse to rely upon.

(T. 578-9; T. 725)). Indeed, it is typically the task of an ICU unit secretary to “look at a set of Physician Orders and enter orders into the computer”. (Keegan, State’s Expert Nurse, VP for Nursing at Mercy Hospital Western Hills (T. 351)) In this regard, Appellant was being prosecuted by the Board for failure to do the duties of a Unit Secretary (i.e. finding the Emergency Room Physicians handwritten orders never put into the computer or calling in consulting outside specialists in the middle of the night). If Appellant Beverly Clayton had disregarded the life-saving care needs of the other patients who required it in favor of dotting every “i” and crossing every “t” for the terminally ill “Do Not Resuscitate” Patient 1, she risked being charged with violations for causing the *avoidable* deaths of some of the other patients, whom we shall call (though their names and medical records are unknown) 2 through 8. It is our position that no nurse’s license should be sanctioned for failure to do the impossible. Moreover, even if, *arguendo*, a nurse failed to do the impossible, such evidence clearly goes to the issue of mitigation of sanctions as well. ***The admissibility of relevant mitigation evidence is just as important as the admission of relevant exoneration evidence.*** The Hearing Examiner rejected our claim of mitigation but, in doing so, ***adamantly denied every pre-hearing Motion of Appellant to obtain this evidence, and quashed every hearing subpoena to obtain this evidence which Appellant requested,*** (Respondent’s Opposition to OBN’s Motion to Limit [Respondent’s] Subpoena Request, Appx. at 100), and in the hearing ***precluded every attempt of Appellant (over Appellant’s objections and proffers of proof) to obtain or admit into evidence any testimony whatsoever concerning the status, needs, conditions, or life-threatening medical emergencies of the 7 other ICU patients during Appellant’s shift.*** (Respondent’s Requests for Issuance of Subpoenas, filed 9-20, 9-26 and 10-13-11 (Appx. at 88, 92, 125); JE filed 10-28-11,

p. 4, Appx. at 147; JE filed 11-2-11, p. 3, pt. 2, Appx. at 152; T. 559, ll. 23-25, T. 560-62, ll. 1-3).

The testimony of Nurse Gallagher, RN, BSN, Appellant's expert (the only expert who has almost exclusively worked (and currently works) in multiple types of ICU's for the past decade, (Appx. at 118; T. 529-30)), vividly demonstrates the preservation of this claimed prejudicial error, including Appellant's offer of proof:

Q. The chaos that was referenced previously in other testimony, some of which you heard, related only to the change of shift time. Do you have any reason to believe that there was an overwhelming or chaotic situation, you pick the adjective, between 7 a.m. and 7 p.m. during her shift -- 7 p.m. to 7 a.m. sorry.

A. From the notes from Mary Nutt, who herself admits that there was lack of experience, a busy night, she said something else, it appears to me that it was total chaos; numerous admissions during that period of time with inexperienced staff. I believe that it was an absolutely insane night the entire night. *However, without the other documentation that we requested, we don't have anything that says we had to run over here. There's another rapid response; here's another admission; here's another admission; here's another admission. I believe that that kind of thing went on that entire time.*

Q. What are you referring to?

A. *I'm referring to Beverly having to run from room to room to room putting out fires because this person is having trouble doing this and that person is having trouble doing that, and/or the supervisor's on the phone sending me another admission when I have no nurses to accept transfer of care for that admission.*

Q. Okay. Are there any kinds of, any sources of information that you did not have available which would have shed more light on this?

MR. APPEL: Objection.

HEARING EXAMINER STEHURA: Well, consistent with the other orders that is subject to the ruling that I have made previously in this matter.

MR. SINDELL: So you're sustaining that objection?

HEARING EXAMINER STEHURA: Sustained. Yes.

MR. SINDELL: *I will make an offer of proof that if permitted to answer that question, this witness would testify that the records of the other patients in the emergency room are essential to a full understanding of the chaos that he is describing.* And as an offer of proof, he will further testify and in his written report to that effect, preliminary report, that *if he had those records, he would be able to describe in better detail one way or the other, frankly, what the chaos was that impinged upon my client.*

HEARING EXAMINER STEHURA: Move on. You made your record. (Emphasis added)(Nurse Gallagher, T. 559-562)

Without the knowledge of the circumstances of the other patients in the ICU, (along with other factors detailed hereafter), there was no way for the Hearing Examiner or any expert (or even any witness for that matter) to determine what the totality of demands, pressures, priorities and time constraints were imposed upon Respondent. State's Expert Nurse Keegan had no knowledge or idea of how overwhelming it was for Respondent. (T. 360) Respondent's Expert Nurse Gallagher could not render a fully grounded expert opinion because the Hearing Examiner refused to allow this crucial evidence to be obtained or admitted. As a result of the absence of this determinative evidence, the Hearing Examiner rendered a finding on mitigation (which finding is also applicable to exoneration as well) based upon grotesquely incomplete facts, and thus rejected Appellant's defense with rank speculation:

I find that the nature of providing registered nursing care in an ICU setting may at times be chaotic; *however, none of the factors alleged by Respondent was necessarily unusual for an ICU setting.* (Emphasis added)(H.E. Rpt. & Rec., Appx. at 45, par. 18, Findings of Fact)

*We ask: how can the Hearing Examiner or the Board conclude that “none of the factors alleged by Respondent was necessarily unusual for an ICU setting” without considering the most relevant evidence of what those factors were?*

The best evidence of what was “unusual” and how “unusual” the demands and pressures on Appellant were during her ICU shift that night would clearly be the records and charts of the

other 7-8 patients. These records were made at or near the times of the medical events for these other patients as those events actually occurred. The trial court below opined that multiple witnesses should have been inconvenienced and called (the hearing lasted 4 days) to testify without records about what details they remembered about those other patients on one shift in the ICU two and a half years earlier! It was the trial court's view that producing the records was unnecessary; how was our expert supposed to write a report or testify to an opinion based upon the dubious recollections of witnesses whose testimony our expert could never hear until the hearing itself? Not even the Hearing Examiner suggested such an absurd justification for precluding Appellant from requiring the production of those records. The trial court was so apparently hellbent on finding any way possible to avoid concluding that the Hearing Examiner abused his discretion, that the best the trial court could come up with was this ridiculous notion: that people should *preferably* testify from memory about detailed medical events and treatment for 7-8 patients which occurred on a single ICU night shift two and a half years earlier without reference to the contemporaneous medical records and charts which detailed those events and treatment at the time they occurred.

The Court of Appeals below rejected Appellant's claim of prejudicial error, as follows:

¶ 29: Here, Clayton sought the medical records of the other ICU patients in order to show the care required by and provided to those patients during her shift. Clayton wanted that information so she could point to circumstances involving those patients that demanded her intervention. The hearing examiner denied Clayton's subpoena request to avoid infringing on the privacy and confidentiality protections afforded to the other patients and because the information Clayton sought could be obtained through other sources.

¶ 30: *Although the hearing examiner refused to issue a subpoena for the other patients' medical records*, he granted Clayton's request to issue subpoenas to two ICU nurses who worked the overnight shift on August 27 and 28, 2009. *Those nurses could have testified regarding what occurred during the shift, including the assistance Clayton had to provide to other patients.* Clayton, however did not call either nurse to testify. The hearing examiner also allowed

Clayton to testify regarding the care she provided to other patients. Clayton stated that she “put [ ] I.V.s in for nurses that [could] not do that themselves” and “start[ed] Amiodarone drips for another patient where a nurse did not know what [an] Amiodarone drip was” (Tr. 81). Because the hearing examiner afforded Clayton the opportunity to present witness testimony regarding the needs of the other patient’s Clayton cannot now demonstrate prejudice due to the nondisclosure of the other patients’ medical records.

¶ 31: In a last ditch effort to show prejudice, Clayton argues that witnesses’ memories fade, and the medical records would have been necessary to refresh those memories. ***If Clayton had established at the hearing deficiencies in her or the other nurses’ memories, this argument might have succeeded.*** However, Clayton failed to establish any such deficiencies. Accordingly, we conclude that no prejudice resulted from the hearing examiner’s failure to issue the subpoena in question, and we overrule Clayton’s first assignment of error. (Emphasis Added) (Court of Appeals Opinion, Appx. at 14)

The Court of Appeals essentially held that Appellant should have first called nurses as witnesses in the evidentiary hearing to ask what they recalled, ***without the records***, about a one night shift on an ICU ***two and a half years earlier*** --- off the top of their heads.

Let’s assume, hypothetically, that these nurses claimed to have some recollections. Without access to the relevant contemporaneous medical records, is this the kind of testimony any court would or should consider “reliable” evidence? Particularly when the best evidence would be the recordation of the events at the time of their occurrence? Wouldn’t testimony refreshed by contemporaneous records be consistent with “reliability”? Wouldn’t the availability of those records to Appellant’s counsel permit counsel to ask more relevant and focused questions clarifying and detailing the overall circumstances that night in the ICU? What could counsel ask such nurses to attempt to “recall” without contemporaneous records concerning the other patients from a point in time two and a half years earlier? What were the acuties and specific needs of each of them? How could even Appellant, without access to those records, be expected to recall on her own the necessary details to present her own testimony in her defense?

Can this Court imagine the determination of any medical questions in any medical case of any kind based upon testimony without reference to the relevant contemporaneous medical records?

Let's hypothesize the other way. What omissions (if even known) or inability of a nurse to recall would be sufficient to "justify" the production of one night of records for patients in an ICU two and a half years earlier?

Then there is a practical problem imposed by the "no discovery" rule governing an administrative evidentiary hearing. Without records available to Appellant's expert witness, before the expert writes a report or testifies in the hearing, how is the expert supposed to incorporate the "recollections" of nurses into his opinion about the degree of chaos and the clear extent of the excessive systemic pressures impinging on Appellant? Is the expert supposed to sit and listen to nurses trying to recall without the medical records patient details during a single night on the ICU two and a half years earlier? Should the evidentiary hearing be adjourned or delayed while the court reporter types up their testimony of "recollections" without reference to records? If the records were produced after the nurses testify that they cannot recall significant details from 2 ½ years earlier, is Appellant's expert supposed to sit there on the spot and digest the records and then testify? Having already testified, (if that is the case), is the expert supposed to come back to the hearing to testify further about these matters, now taking into account records just produced and received? Should the hearing be continued so Appellant's expert can read and digest the newly produced records? Write a supplemental report and then testify further in a reconvened hearing? With the newly produced records, are the nurses supposed to return to testify about their now "refreshed" recollections?

Perhaps with contemporaneous records it would not be necessary to call nurses to testify at all. The experts for both sides might well have been able to reach reliable conclusions about

the circumstances obtaining that night in the ICU based only upon a review of contemporaneous records. This is often the case in litigation of medical issues.

And why (other than the “no discovery” rule) should the Respondent (Appellant) nurse not have the relevant records in sufficient time in advance of the hearing to prepare? The “no discovery” rule is only a deprivation applied to the nurse charged with license violations. The Board of Nursing, without any notice to Respondent nurse or his/her counsel, can subpoena any records or witnesses they wish months in advance of the evidentiary hearing under its authority to “investigate”, without any obligation to ever produce those records to opposing counsel (unless they choose to some or all of them as Exhibits in the evidentiary hearing). This is because of the Board’s statutory claims of “privilege” and “confidentiality” with respect to any documents obtained through its investigatory powers and procedures. And even then, the production to opposing counsel for the Appellant/Respondent nurse occurs shortly before the hearing, often after the due date for the production of expert reports. Moreover, any subpoenas issued by Appellant/Respondent may not request production prior to the date of the evidentiary hearing itself. How can any attorney or Appellant/Respondent nurse properly prepare to go forward with a defense in a hearing when the records he or she subpoenaed are first received the minute the hearing begins? The Board and its attorneys and witnesses have access to medical records and witness depositions obtained by “investigation” subpoena without notice to Appellant/Respondent or his/her counsel for many months prior to the beginning of the evidentiary hearing. This entire system is unconstitutionally skewed in favor of the Board in matters of license violations affecting the reputations, lifetime careers and economic survival of countless professionals who come under the provisions of O.R.C. §119.09. (Appx. at 159)

In Appellant's case, Appellant's counsel received the records for Patient 1 (slightly earlier than ordered by voluntary choice of opposing counsel for the Appellee State/Board) because Appellant's counsel complained that Appellant could not obtain an expert opinion or an expert report or even adequately prepare for the hearing without giving the expert to review, at a bare minimum, the contemporaneous medical records pertaining to the Patient 1 in question. Such a failure to have access even to those records, in sufficient time, would have constituted a blatant violation of Due Process of Law. Receiving the records of Patient 1 for the first time 3 or 4 weeks before the hearing created a desperate scramble for Appellant and her counsel to begin to figure out the names of certain (but not all) potential witnesses and further obtain the required expert report.

In short, calling nurses to testify without contemporaneous medical records about one night in an ICU 2 ½ years earlier is a vain act; it is a ridiculous basis to justify a refusal by a Hearing Examiner to permit Appellant to subpoena 7 or 8 patient records for the ICU night shift in question. *This Court is faced with a record in this case which does not contain a single contemporaneous medical document on the acuties and circumstances of the other 7 or 8 patients who were in the ICU during the night shift in question.* We do not know if the Board had those records in its possession or not. The obtaining of those records by the Board, if during its investigation, makes them "privileged" and "confidential". The Board may have chosen not to produce them because they didn't want to use them in their own case. Why? Because they perhaps support Appellant's defense? We'll never know unless they are produced.

No Appellant/Respondent nurse or physician in a license hearing should be required to call nurse witnesses to testify from off-the-top-of-the-head recollections about events 2 ½ years earlier *as a foundation or predicate for obtaining the production of contemporaneously made*

*medical records which are highly relevant to exoneration and/or mitigation defenses of an Appellant/Respondent nurse or physician.*

We submit that the refusal to ever permit Appellant in this case (or the Board in its consideration of the evidentiary hearing, the Common Pleas Court, the Court of Appeals, or this Ohio Supreme Court) to see, study, consider, obtain, use or offer in evidence these contemporaneous medical records was a gross abuse of discretion on the part of the Hearing Examiner, as well as a deprivation of Appellant's right to Due Process of Law, amounting to reversible prejudicial error on the part of the lower courts in this case.

The hospital, *upon Appellant's request*, was able to add only one more nurse after there was a sudden influx of several new patients. (T. 416-17; T. 564-5)

The reasons given by the Hearing Examiner (not by the trial court) for denying Appellant the right to subpoena for the hearing the medical charts of the other ICU patients during Appellant's shift (of course, with patient names, addresses and social security numbers redacted and numerical designations substituted), include that the evidence Appellant was seeking is: *"...either likely irrelevant, beyond the scope of the charges against Respondent in this matter, outweighed by the privacy and confidentiality protection afforded to others..."* (JE, filed 10-28-11, Appx. at 150, Motion to Limit Subpoenas Granted; JE filed 11-2-11, Appx. at 154, par. 2) These reasons are patently vacuous: such evidence is hardly "irrelevant" or "beyond the scope of the charges" and, in fact, is of overriding importance to Appellant's exoneration and mitigation claims. Moreover, the redaction of patient names, addresses, family references and social security numbers clearly protects the privacy and confidentiality rights of those patients (and, moreover, these records could be filed under seal). Finally, and again, the best evidence of the

circumstances in the ICU on August 27-28, 2009 are these medical records themselves, not the unrefreshed recollections of persons present on a single one-night shift over two years earlier.

The circumstances of Appellant's night shift which were admitted into evidence clearly demonstrate an unremitting excess of responsibility and pressure imposed disproportionately upon one isolated nurse, Appellant Beverly Clayton. Had the most revealing evidence been obtained and admitted in evidence, namely, *the actual conditions, emergencies and needs of all of the critically ill ICU patients*, the evidence of exoneration, impossibility and strong mitigating factors would be overwhelming.<sup>1</sup>

*What we do know about the circumstances during appellant's night shift is as follows:*

*Appellant Beverly Clayton, throughout her entire night shift, served three simultaneous roles, that of Charge Nurse, Unit Secretary and Direct Care Nurse. This is an unreasonable, unsafe burden to place on one single ICU nurse, as all expert witnesses (Keegan, Klenke and Gallagher) for both parties testified.*

The role of Charge Nurse includes the duties of locating records, answering phone calls, making patient assignments for new admissions and *assisting other nurses with their patients*. (T. 81-2; T.237-8; T. 298 and T. 567-8).

*The vital and indispensable role of Unit Secretary includes the duties of compiling the patient charts (T. 573), locating physician orders, including calling physicians, if necessary, to*

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<sup>1</sup> The Appellee Board can secretly subpoena this potentially exculpatory evidence and prevent our obtaining it from the Board under a claim of the statutory investigation privilege. Without seeing this material, we have no way to assess it, other than by indirect possible intimations based upon other collateral factors. What we can say is that from the very outset of our efforts to require the production of these patient records, we were met with vociferous, consistent and aggressive opposition from Appellee OBN to our obtaining this information by request, motion, deposition or hearing subpoena. Why would the OBN so vigorously oppose our obtaining these other ICU patients' records by our hearing subpoenas directed to Mercy Hospital? Is winning more important than truth?

*establish or hunt down the Physician Orders (T. 573-4) and entering them from the written chart into the computer, (T. 351 and T. 565), taking phone calls from physicians, family members, clinical administrators, and other departments, such as the lab (T.354; T. 351-2), ordering supplies, (T. 351) entering lab orders and tests into the computer (T. 351), passing messages to the correct person (T. 353), determining physician orders for consults and calling these physician to come to the ICU for those consults, checking physician medication orders against pharmacy orders (T. 246-7; T. 303, T. 351 and T. 379), and locating and contacting off-duty nurses to obtain missing patient details not reported during shift changes (T. 306, T. 573-4).*

Finally, in addition to the role of Charge Nurse and the role of Unit Secretary, Appellant Beverly Clayton also had the role of a Direct Care Nurse with assignment responsibilities for two patients, one of whom was Patient 1.

The duties of these three roles were to be simultaneously performed by Appellant in circumstances in which the two other ICU nurses, each one with 2 to 3 direct care patients of their own (T. 564-5), were so inexperienced that they should never have been assigned to ICU nurse duty, according to the Appellee Board's expert witness, Nurse Joyce Keegan, an executive administrative employee of Mercy Hospital (T. 341); *these two nurses lacked the knowledge and ability to set up IV's, insert the IV's, insert the IV lines and needles into their own patients and start up the IV's* (T. 81-2), resulting in Appellant Beverly Clayton having to effectively undertake direct patient care responsibility for *a total of 6 ICU patients, rather than just the two assigned to her* (T. 82). State's Expert Nurse Klenke agreed. (T. 237).

With respect to Patient 1 (at issue in this case), he was transferred from the ER to the ICU before Appellee began her shift at 7 p.m. (T. 304, Exh. 5, p. 4; T. 314, Exh. 12, p. 2) and was

dropped off in the ICU by the transferring ER Nurse *and left alone, unattended by and unassigned to anyone* (T. 536) for over an hour (during which time he could have died (T. 272)), without any change-of-shift report from the outgoing charge nurse, Tina Forte, to Appellee Beverly Clayton (H.E. Rpt. & Rec., Appx. at 64, par. 6), and without reporting any physician orders to any ICU Nurse (T. 501-2, 508-9).

A sudden influx of new ICU admissions occurred in the first several hours of Appellant's shift (T. 564-5). When Respondent called her supervisor to request more assistance (T. 416-17), only one additional nurse was sent to the ICU at 11:00 p.m. A nationally recognized understaffing nurse-patient ICU ratio of 1:3 (T. 563-4) existed during the first four hours of Appellant's shift (a total of 8 patients including Patient 1 (T. 553-5) with 3 nurses, two of whom were unqualified for ICU service). *Moreover, the hospital had no policy on appropriate ICU nurse-patient ratios* (T. 332).

There was considerable testimony from both experts, Appellee OBN Nurse Joyce Keegan and Appellant Nurse Terry Gallagher, that the absence of a separate full-time Charge Nurse *and, in particular, a full-time Unit Secretary in the night shift* was a critical deficiency. According to Nurse Gallagher, there was no justification to be without a Unit Secretary in the ICU at night and the absence of a Unit Secretary contributed "hugely" to the overall chaos (T. 566-7); Nurse Keegan, the OBN expert, testified that staffing requirements in the ICU are the same whether during the day or night shift (T. 346), that on the day shift in the ICU, the Unit Secretary is a full-time job for a 12-hour shift, and that the absence of any Unit Secretary on the night shift could be a deficiency. (T. 355) *Nurse Keegan further testified that one of the duties of the ICU Unit Secretary was to enter Physician Orders into the computer and answer the phone.* (T. 351) *In other words, the undisputed evidence clearly demonstrates that many of the alleged*

*performance failures claimed against Appellant Beverly Clayton were functions which are normally done by the Unit Secretary. These functions include finding the Physician Orders (in this case from the ER), contacting the physicians ordered to do the consults, entering Physician Orders into the computer (which was primarily the source of orders used by Respondent Beverly Clayton and other ICU Nurses during her shift), checking the Pharmacy Orders to determine if they conform to the Physician Orders, calling the off-duty charge nurse on the preceding shift to fill in any missing details in the change-of-shift report, arranging the medical chart of the newly admitted ICU patients, et cetera.* (*supra*, pp. 13-14) As Appellant's Expert Nurse Gallagher testified, "Secretaries are worth their weight in gold." (T. 574).

The sanctions recommended by the Hearing Examiner and those slightly reduced and ultimately adopted by the Board in the Adjudication Order (Appx. at 79) were, in our view, harsh, extreme and unwarranted:

Respondent Beverly Clayton was ordered to suffer a complete unstayed suspension for one year before she could even apply for reinstatement. Her suspension is indefinite; after reinstatement, her suspension must continue for not less than 2 more years subject to a stay based upon certain probationary terms. Those terms include temporary practice restrictions prohibiting her from working independently in any facility or home on her own without on-site supervision or to serve in any management or supervisory capacity with respect to other nurses or nursing responsibilities, or supervising and evaluating any nursing practice. "Any period during which Ms. Clayton does not work in a position for which a nursing license is required shall not count toward fulfilling the probationary period imposed by this Order." (As to aforementioned quote, Adjudication Order, Appx. at 79, 83 and otherwise, throughout entire Adjudication Order). There

are also numerous other onerous terms. *As of the date of the filing of this Appellant's Brief, Appellant Beverly Clayton has not yet been reinstated.*

*We submit that these are draconian punishments.* What employer is going to hire (and submit quarterly performance reports about) an RN/NP (particularly a Nurse Practitioner) who cannot exercise any supervisory or evaluation authority, particularly in this tight employment market? Without a job requiring the use of her license, Appellant Beverly Clayton will be unable to work off with "good time" her *minimum* 2 required probationary years, after having served a full one-year *unstayed* suspension, *after* her yet-to-occur reinstatement. What employer in this current economy is going to hire an RN or NP with this kind of baggage? What will the impact be on her career of an entire year of unstayed suspension? Appellant was completely unemployed for a period of time and only intermittently employed thereafter. What impact on her future career will this permanent public record of discipline have? These excessive sanctions should cause this Court to seriously re-examine its now over 50-year old decision in *Henry's Café, Inc. v. Board of Liquor Control* (1959), 170 Ohio St. 233.

And, most importantly, the issue in this appeal is: should these violations and sanctions be imposed *without giving Appellant the opportunity to obtain, review and produce in her hearing the most critical evidence available in support of her defense?*

Appellant's highly qualified expert (entirely ignored in every opinion and finding below) repeatedly testified most compellingly, even though deprived of the most important evidence which could further and mightily substantiate Appellant's exculpation and mitigation:

It appears to me that it was total chaos; numerous admissions during that period of time with inexperienced staff. [Direct Care Nurses unable to set up and insert IV's.] I believe that it was an absolutely insane night the entire night. *However, without the other documentation that we requested, we don't have anything...* (Emphasis added) (T. 560-1)

.....

I would hold the nursing supervisor and the hospital administration at fault for not having sufficient numbers of staff available and/or well trained that night. One person can only be in so many places at a time, and *we asked of Beverly Clayton to do things that are far above what is reasonable and prudent.* (Emphasis added)(T. 571)

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I believe she was forced into a situation where *errors were set up to occur; we set her up to fail.* (Emphasis added)(T. 572)

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You had a *systemic breakdown of the entire system that night.* You had miscommunication starting from the ER to the ICU. You had a rapid response where the [previous charge] nurse [Tina Forte] did not report off or transfer her care [to Beverly Clayton].

Then you have more patients than are reasonable and prudent in a given situation. You have got a nursing supervisor that continues to send patients to an already overwhelmed ICU without coming down and offering assistance. No, you need to go to the top and work your way down on this one. (Emphasis added)(T. 584)<sup>2</sup>

## LEGAL ARGUMENT

### PROPOSITION OF LAW

**In an administrative evidentiary hearing held before a Hearing Examiner (H.E.) of the Ohio Board of Nursing (OBN) involving alleged nursing practice violations against the license of Appellant Nurse, it is reversible error, contrary to law and in violation of Due Process of Law for the Hearing Examiner to prohibit and deny Appellant Nurse the right to obtain by hearing subpoena and present in the hearing**

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<sup>2</sup> Well after the conclusion of the evidentiary hearing, it was reported that more than 500 Registered Nurses at Mercy Regional Medical Center in Lorain County (a Mercy Hospital affiliate governed by policies adopted by headquarters in Cincinnati which applied to Mercy Hospital Western Hills where Appellant worked in the ICU on August 27-28, 2009) issued a strike notice. The biggest concerns were unsafe staffing ratios and 12-hour shifts. One article quoted a Registered Nurse as stating “they’ve done studies that show that more mistakes are made at the end of a long shift.” (Both articles published October 8, 2012, Appx. at 86)

**evidence highly relevant and material to her defense against the charges and to her defense in mitigation of sanctions.**

Due Process of Law, as recognized in the Fourteenth Amendment to the United States Constitution and in Section 16, Article I of the Ohio Constitution is applicable to administrative license hearings in Ohio. *Natoli v. The Ohio State Dental Board*, 177 Ohio App. 3d 645 (C.A. 10<sup>th</sup> Dist., Franklin Cty., 2008)(at P18). In *Natoli*, the appellate court reversed the trial court's order affirming the Board's suspension of Dr. Natoli's license and remanded the case to the Board for a new hearing on the alleged violations. The Franklin County Court of Appeals found that the Board's Order was "not supported by reliable, probative, and substantial evidence due to the absence of certain evidence in the record" (at P25), and held that "In excluding Dr. Kramer's testimony, the hearing examiner divested Dr. Natoli of the opportunity to be heard in a meaningful manner". (at P21) It is important to note that this Court of Appeals recognized that some violations were validly established, being uncontested (i.e. infectious control violations), while others may not have been. The appellate court specifically held that "Depending upon the outcome of that hearing, the Board will impose a penalty for all the violations (if the Board again finds that Dr. Natoli violated the standard of care) or just the infection control violations (if the Board finds that Dr. Natoli did not violate the standard of care). If the trial court determines that reliable, probative, and substantial evidence does *not* exist, then it may vacate the Board's order in relevant part and remand the matter to the Board for it to sanction Dr. Natoli for the infection control violations only." (at P26)

Thus, new reconsideration of the penalty must be determined in our Clayton case at bar, depending upon which alleged violations, ***if any***, are validly proven and which ones are not, ***after the inclusion of the evidence which was improperly excluded.***

“In an administrative appeal, the court of common pleas weighs the evidence in the record and uses the results of its weighing of the evidence to determine whether the administrative order is 'unconstitutional, illegal, arbitrary, capricious, unreasonable, or unsupported by the preponderance of substantial, reliable, and probative evidence.” *Johnson v. State Medical Board of Ohio*, 147 Ohio Misc. 2d 121 (Franklin Cty. Common Pls. Ct., 2008)(at P23), citing various Ohio Supreme Court and intermediate appellate decisions. (*id.*, at P23) The *Johnson* court specifically summed up its holding as follows: “In short, the board acted contrary to the greater weight of the probative evidence in the record.” (at P56)

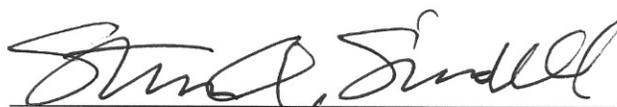
The position of Appellant, during the hospital’s investigation, during the Board’s investigation and in the hearing, was consistently asserted that when Appellant reviewed Patient 1’s chart, she did not see the Physician Orders from the ER and thus did not believe they were there at that time. Moreover, she did not have the time given the overwhelming chaos in the ICU (T. 359-60) to hunt down the handwritten Physician Orders (T. 300). Instead, she relied on the Physician Orders as they had been entered into the computer. (T. 83-4; T. 298; T. 342; T. 419-20; and previously quoted Gallagher testimony).

The exclusion of the evidence of the needs, conditions and emergencies of all ICU patients during Appellant’s shift impacts every allegation brought against Appellant Beverly Clayton, particularly the “secretarial” functions of arranging patient charts, locating Physician Orders and entering them into the computer, locating and arranging the physician consults, et cetera.

**CONCLUSION**

For all the reasons set forth in Appellant's Brief, the judgment of the Court of Appeals should be reversed, and the Administrative Order should be vacated.

RESPECTFULLY SUBMITTED,

A handwritten signature in black ink, appearing to read "Steven A. Sindell". The signature is written in a cursive style with a horizontal line underneath it.

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**CERTIFICATE OF SERVICE**

The undersigned counsel hereby certifies that a true and accurate copy of the foregoing Appellant's Merit Brief was served upon the following by Priority Mail with Tracking on January 30, 2015:

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