KAH/tls 16-0047

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

CIBC BANK USA, Guardian of the Estate of GERALD SALLIS, JR., a Minor, TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually, Plaintiffs,	)	
v.	)	No. 16 L 003989
VHS WEST SUBURBAN MEDICAL CENTER, INC. d/b/a WEST SUBURBAN MEDICAL CENTER, a Corporation, SHELIA WALKER, R.N., OLEXANDRA KOLENSKYJ, NATHALIE McCAMMON-CHASE, M.D, McCAMMON-CHASE TOTAL WELLNESS CENTER, INC., an Illinois Corporation, THOMAS GAST, M.D., and METROPOLITAN ADVANCED RADIOLOGICAL SERVICES, Defendants.	)	

THIRD AMENDED COMPLAINT AT LAW

Plaintiffs, CIBC BANK USA, Guardian of the Estate of GERALD SALLIS, JR., a Minor, TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually, by their attorneys, CLIFFORD LAW OFFICES, P.C., complaining of Defendants, VHS WEST SUBURBAN MEDICAL CENTER, INC., d/b/a WEST SUBURBAN MEDICAL CENTER (hereinafter "WEST SUBURBAN MEDICAL CENTER"), a Corporation, SHELIA WALKER, R.N. (hereinafter "WALKER"), OLEXANDRA KOLENSKYJ (hereinafter "KOLENSKYJ"), NATHALIE McCAMMON-CHASE, M.D. (hereinafter "McCAMMON"), McCAMMON-CHASE TOTAL WELLNESS CENTER, INC. (hereinafter "TOTAL WELLNESS CENTER"), an Illinois Corporation, THOMAS GAST, M.D. (hereinafter "GAST"), METROPOLITAN

ADVANCED RADIOLOGICAL SERVICES (hereinafter "METROPOLITAN"), and each of them, state as follows:

COUNT I – MEDICAL NEGLIGENCE – MINOR PLAINTIFF

1. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, was a healthcare corporation providing complete medical care to patients admitted therein, including obstetrical and radiological care.

2. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, held itself out as a provider of complete obstetrical and radiological care.

3. On August 16, 2014, and at all times mentioned herein, Defendant, WALKER, was a registered nurse duly licensed to practice nursing in the State of Illinois.

4. On August 12, 2014, and at all times mentioned herein, Defendant, WALKER, was a duly-authorized agent and employee of Defendant, WEST SUBURAN MEDICAL CENTER, acting within the scope of her agency and/or employment.

5. On August 16, 2014, and at all times mentioned herein, Defendant, KOLENSKYJ, was an ultrasound technician in the State of Illinois.

6. On August 16, 2014, and at all times mentioned herein, Defendant, KOLENSKYJ, was a duly-authorized agent and employee of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of her agency and employment.

7. On August 9, 2014, and at all times mentioned herein, Defendant, McCAMMON, was a physician duly licensed to practice medicine in the State of Illinois.

8. On August 9, 2014, and at all times mentioned herein, Defendant, TOTAL WELLNESS CENTER, was a duly licensed healthcare corporation providing complete obstetrical care to patients.

9. On August 9, 2014, and at all times mentioned herein, Defendant, McCAMMON, was a duly-authorized agent and/or employee of Defendant, TOTAL WELLNESS CENTER, acting within the scope of her agency and/or employment.

10. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, never informed Plaintiff, TEQUILA SALLIS, that Defendant, McCAMMON, was not an agent or employee of Defendant, WEST SUBURBAN MEDICAL CENTER.

11. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, never informed Plaintiff, TEQUILA SALLIS, that Defendant, TOTAL WELLNESS CENTER, was not an agent of Defendant, WEST SUBURBAN MEDICAL CENTER.

12. On August 9, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, did not know that that Defendant, McCAMMON, was not an agent or employee of Defendant, WEST SUBURBAN MEDICAL CENTER.

13. On August 9, 2014, and at all times mentioned herein, PLAINTIFF, TEQUILA SALLIS, relied upon Defendant, WEST SUBURBAN MEDICAL CENTER, for complete obstetrical and radiological care.

14. On August 9, 2014, and at all times mentioned herein, Defendant, McCAMMON, was a duly-authorized apparent agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of her apparent agency.

15. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, had the right to control the actions of Defendant, McCAMMON.

16. On August 9, 2014, and at all times mentioned herein, Defendant, McCAMMON, was a duly-authorized agent and/or employee of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of her agency and/or employment.

17. On August 12, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, did not know that that Defendant, TOTAL WELLNESS CENTER, was not an agent of Defendant, WEST SUBURBAN MEDICAL CENTER.

18. On August 9, 2014, and at all times mentioned herein, Defendant, TOTAL WELLNESS CENTER, was a duly-authorized apparent agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of its apparent agency.

19. On August 9, 2014, and at all times mentioned herein, Defendant, TOTAL WELLNESS CENTER was a duly-authorized agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of its agency.

20. On August 16, 2014, and at all times mentioned herein, Defendant, GAST, was a physician duly licensed to practice medicine in the State of Illinois specializing in radiology.

21. On August 16, 2014, and at all times mentioned herein, Defendant, METROPOLITAN, was a duly licensed healthcare corporation providing complete radiological care to patients.

22. On August 16, 2014, and at all times mentioned herein, Defendant, GAST, was a duly-authorized agent and/or employee of Defendant, METROPOLITAN, acting within the scope of his agency and/or employment.

23. On August 16, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, never informed Plaintiff, TEQUILA SALLIS, that Defendant, GAST, was not an agent or employee of Defendant, WEST SUBURBAN MEDICAL CENTER.

24. On August 16, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, never informed Plaintiff, TEQUILA SALLIS, that Defendant, METROPOLITAN, was not an agent of Defendant, WEST SUBURBAN MEDICAL CENTER.

25. On August 16, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, did not know that that Defendant, GAST, was not an agent or employee of Defendant, WEST SUBURBAN MEDICAL CENTER.

26. On August 9, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, relied upon Defendant, WEST SUBURBAN MEDICAL CENTER, for complete obstetrical and radiological care.

27. On August 16, 2014, and at all times mentioned herein, Defendant, GAST, was a duly-authorized apparent agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of his apparent agency.

28. On August 16, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, had the right to control the actions of Defendant, GAST.

29. On August 16, 2014, and at all times mentioned herein, Defendant, GAST, was a duly-authorized agent and/or employee of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of his agency and/or employment.

30. On August 16, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, did not know that that Defendant, METROPOLITAN, was not an agent of Defendant, WEST SUBURBAN MEDICAL CENTER.

31. On August 16, 2014, and at all times mentioned herein, Defendant, METROPOLITAN, was a duly-authorized apparent agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of its apparent agency.

32. On August 16, 2014, and at all times mentioned herein, Defendant, METROPOLITAN, was a duly-authorized agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of its agency.

33. On August 9, 2014, Plaintiff, TEQUILA SALLIS, then 37 3/7 weeks pregnant, presented to Defendant, WEST SUBURBAN MEDICAL CENTER, for an ultrasound biophysical profile.

34. On August 9, 2014, Defendant, McCAMMON, was informed of Plaintiff, TEQUILA SALLIS' condition.

35. On August 10, 2014, Plaintiff, TEQULA SALLIS, was discharged from WEST SUBURBAN MEDICAL CENTER by Defendant, McCAMMON.

36. On August 12, 2014, Plaintiff, TEQUILA SALLIS, again presented to Defendant, MEDICAL CENTER.

37. On August 12, 2014, Plaintiff, TEQUILA SALLIS, was placed on an external fetal heart monitor, which showed fetal heart rate decelerations to the 90s.

38. On August 12, 2014, Defendant, McCAMMON, spoke with Plaintiff, TEQUILA SALLIS, by telephone.

39. On August 12, 2014, Defendant, McCAMMON, did not evaluate Plaintiff, TEQUILA SALLIS, in the hospital.

40. On August 12, 2014, Defendant, McCAMMON, did not induce labor.

41. On August 16, 2014, Plaintiff, TEQUILA SALLIS, presented to Defendant, WEST SUBURBAN MEDICAL CENTER, for a scheduled non-stress test.

42. On August 16, 2014, Plaintiff, TEQUILA SALLIS, was assigned by Defendant, WEST SUBURBAN MEDICAL CENTER, to the obstetrical nursing care of Defendant, WALKER.

43. On August 16, 2014, Defendant, WALKER, placed an external fetal heart monitor at approximately 11:20am.

44. On August 16, 2014, Defendant, WALKER, did not inform Defendant, McCAMMON, of the admission of Plaintiff, TEQUILA SALLIS, or the initial fetal heart monitor tracings.

45. On August 16, 2014, at approximately 12:20 p.m., Defendant, WALKER, discontinued fetal monitoring.

46. On August 16, 2014, at approximately 1:45 p.m., Defendant, KOLENSKYJ, completed a BPP on Plaintiff, TEQUILA SALLIS, which was scored as 4/8 and some time thereafter communicated the results to Defendant, GAST.

47. On August 16, 2014, at approximately 3:27 p.m., Defendant, GAST, reported the results of the BPP to the floor.

48. On August 16, 2014, at approximately 3:21 p.m., Defendant, WALKER, re-applied the external fetal monitor to Plaintiff, TEQUILA SALLIS.

49. On August 16, 2014, at approximately 3:35 p.m., a Category III fetal heart rate tracing was present.

50. On August 16, 2014, at approximately 4:20 p.m., the minor Plaintiff, GERALD SALLIS Jr., was delivered by crash C-section, by Defendant, McCAMMON, with the active assistance and aid of various other agents and employees of Defendant, WEST SUBURBAN MEDICAL CENTER.

51. On August 9, 2014, and at all times mentioned herein, Defendant, WALKER, had the duty to possess and use the knowledge, skill, and care ordinarily used by a reasonably careful nurse under similar circumstances.

52. On August 16, 2014, Defendant, WALKER, was professionally negligent in one or more of the following ways:

a) failed to call Dr. McCammon-Chase at 11:00 and continuing thereafter; and/or

b) failed to monitor fetal heart tones from 11:00-11:22; and/or

c) failed to report Ms. Sallis' report of decreased fetal movement to physician beginning at 11:00 and continuing thereafter; and/or

d) failed to obtain timely physician assessment by an available physician beginning at 11:00 and continuing thereafter; and/or

e) failed to activate the chain of command to obtain timely physician assessment beginning at 11:00 and continuing thereafter; and/or

f) failed to advocate for C-section delivery beginning at 11:22 and continuing thereafter; and/or

g) failed to activate the chain of command to obtain C-section delivery beginning at 11:22 and continuing thereafter; and/or

h) failed to report Ms. Sallis' non-reactive NST to a physician; and/or

i) failed to notify a physician of the abnormal urine protein; and/or

j) failed to recognize an obstetrical emergency and advocate for immediate intervention; and/or

k) withheld information from Dr. McCammon-Chase regarding the status of Ms. Sallis and her baby; and/or

l) failed to document alleged notification attempts to Dr. McCammon-Chase; and/or

m) failed to notify the ultrasound technologist of the non-reactive NST; and/or

n) failed to monitor fetal heart tones from 14:00-15:23.

53. As a direct and proximate result of the aforementioned negligent acts or omissions of the Defendant, WALKER, Plaintiff, GERALD SALLIS, JR., a Minor, sustained injuries of a personal, permanent, and pecuniary nature.

54. On August 16, 2014, and at all times mentioned herein, Defendant, KOLENSKYJ, had the duty to possess and use the knowledge, skill, and care ordinarily used by a reasonably careful ultrasound technician under similar circumstances.

55. On August 16, 2014, Defendant, KOLENSKYJ, was professionally negligent in one or more of the following ways:

a) failed to perform a STAT BPP within 30 minutes of the request; and/or

b) failed to inform Dr. Gast of a request for a STAT BPP; and/or

c) failed to activate the chain of command to advocate for completion of a STAT BPP; within 30 minutes of the request; and/or

d) delayed the performance of STAT BPP for 1 hour and 18 minutes; and/or

e) performed a BPP scan that lasted 71 minutes; and/or

f) failed to obtain the results of the non-stress test; and/or

g) utilized improper techniques to "stimulate" the fetus which unnecessarily and further delayed the exam; and/or

h) failed to call Dr. Gast for immediate consultation during the BPP exam; and/or

i) failed to recognize an emergency and act on a critical result; and/or

j) failed to notify Ms. Sallis' labor and delivery providers of the BPP result; and/or

k) failed to advocate for immediate evaluation of Ms. Sallis and her fetus based on the results of the BPP, including by activation of the chain of command, if necessary; and/or

l) withheld the BPP result from Nurse Walker; and/or

m) failed to prioritize the study as STAT; and/or

n) failed to timely report the results of the BPP exam to Dr. Gast; and/or

o) failed to document notification of Dr. Gast; and/or

p) failed to follow-up to ensure a timely official read.

56. As a direct and proximate result of the aforementioned negligent acts or omissions of the Defendant, KOLENSKYJ, Plaintiff, GERALD SALLIS, Jr., a Minor, sustained injuries of a personal, permanent, and pecuniary nature.

57. On August 9, 2014, and at all times mentioned herein, Defendant, McCAMMON, had the duty to possess and use the knowledge, skill, and care ordinarily used by a reasonably careful physician under similar circumstances.

58. On August 9, 2014, and thereafter, Defendant, McCAMMON, was professionally negligent in one or more of the following ways:

a) failed to induce labor in Ms. Sallis; and/or

b) failed to deliver Gerald Sallis; and/or

c) failed to inform Ms. Sallis of the risks of continuing pregnancy; and/or

d) negligently discharged her patients.

59. On August 12, 2014, and thereafter, Defendant, McCAMMON, was professionally negligent in one or more of in the following ways:

a) failed to order continuous monitoring of Ms. Sallis' blood pressure; and/or

b) failed to induce labor in Ms. Sallis; and/or

c) failed to deliver Gerald Sallis; and/or

d) failed to inform Ms. Sallis of the risks of continuing pregnancy; and/or

e) negligently discharged her patients.

60. On August 16, 2014, Defendant, McCAMMON, was professionally negligent in one or more of the following ways:

a) if the testimony of Nurse Walker is true, failed to return a telephone call/voicemail from Nurse Walker; and/or

b) failed to gather information about her patients' conditions; and/or

c) failed to come to the hospital to evaluate her patient; and/or

d) failed to order an emergency bedside evaluation of her patients by an available physician; and/or

e) failed to order an emergency C-section.

61. As a direct and proximate result of the aforementioned negligent acts or omissions of the Defendant, McCAMMON, Plaintiff, GERALD SALLIS, Jr., a Minor, sustained injuries of a personal, permanent, and pecuniary nature.

62. On August 16, 2014, and at all times mentioned herein, Defendant, GAST, had the duty to possess and use the knowledge, skill, and care ordinarily used by a reasonably careful radiologist under similar circumstances.

63. On August 16, 2014, Defendant, GAST, was professionally negligent in one or more of the following ways:

a. failed to timely review the BPP exam; and/or

b. failed to timely report the results of the BPP exam to the bedside provider; and/or

c. failed to advocate for immediate evaluation of Ms. Sallis and her fetus based on the results of the BPP, including by activation of the chain of command, if necessary; and/or

64. As a direct and proximate result of the aforementioned negligent acts or omissions of the Defendant, GAST, Plaintiff, GERALD SALLIS, Jr., a Minor, sustained injuries of a personal, permanent, and pecuniary nature.

65. Attached to this Third Amended Complaint at Law are the affidavit of one of Plaintiffs' attorneys and the written health care providers' reports and/or 213 disclosures of Baha Sibai, M.D., Heidi M. Shinn, R.N., B.S.N., Samantha N. Sawyer, MHA, RDMS, RDCS, and Peter M. Doubilet, M.D., Ph.D., required by 735 ILCS 5/2-622 which are incorporated herein.

66. CIBC BANK USA is the duly-appointed Guardian of GERALD SALLIS, JR., a Minor, and brings this matter on behalf of the minor.

WHEREFORE, Plaintiffs, CIBC BANK USA, Guardian of the Estate of GERALD SALLIS, JR., a Minor, demand judgment against Defendants, VHS WEST SUBURBAN MEDICAL CENTER, INC., d/b/a WEST SUBURBAN MEDICAL CENTER, a Corporation, SHELIA WALKER, R.N., OLEXANDRA KOLENSKYJ, NATHALIE McCAMMON-CHASE, M.D., McCAMMON-CHASE TOTAL WELLNESS CENTER, INC., an Illinois Corporation, THOMAS GAST, M.D., and METROPOLITAN ADVANCED RADIOLOGICAL SERVICES, and each of them, in an amount in excess of FIFTY THOUSAND DOLLARS ($50,000.00).

COUNT II – MEDICAL NEGLIGENCE – FAMILY EXPENSE ACT

1-65. Plaintiffs, TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually, re-allege Paragraphs 1 through 66 of Count I of this Third Amended Complaint, as if fully set forth herein.

66. On August 9, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, was the mother of Plaintiff, GERALD SALLIS, Jr., a Minor.

67. On August 9, 2014, and at all times mentioned herein, Plaintiff, GERALD SALLIS, was the father of Plaintiff, GERALD SALLIS, Jr., a Minor.

68. As a direct and proximate result of one or more of the aforesaid negligent acts or omissions of Defendants, WEST SUBURBAN MEDICAL CENTER, WALKER, KOLENSKYJ, McCAMMON, TOTAL WELLNESS CENTER, GAST, and METROPOLITAN, Plaintiffs, TEQUILA and GERALD, as the parents of GERALD, JR., a Minor, became obligated for various hospital and medical expenses under the Family Expense Act, 750 ILCS 65/15 and bring this action to recover said expenses.

COUNT III – INSTITUTIONAL NEGLIGENCE – MINOR PLAINTIFF

1. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, was a healthcare corporation providing complete medical care to patients admitted therein, including obstetrical and radiological care.

2. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, held itself out as a provider of complete obstetrical and radiological care.

3. On August 16, 2014, and at all times mentioned herein, Defendant, WALKER, was a registered nurse duly licensed to practice nursing in the State of Illinois.

4. On August 12, 2014, and at all times mentioned herein, Defendant, WALKER, was a duly-authorized agent and employee of Defendant, WEST SUBURAN MEDICAL CENTER, acting within the scope of her agency and/or employment.

5. On August 16, 2014, and at all times mentioned herein, Defendant, KOLENSKYJ, was an ultrasound technician in the State of Illinois.

6. On August 16, 2014, and at all times mentioned herein, Defendant, KOLENSKYJ, was a duly-authorized agent and employee of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of her agency and employment.

7. On August 9, 2014, and at all times mentioned herein, Defendant, McCAMMON, was a physician duly licensed to practice medicine in the State of Illinois.

8. On August 9, 2014, and at all times mentioned herein, Defendant, TOTAL WELLNESS CENTER, was a duly licensed healthcare corporation providing complete obstetrical care to patients.

9. On August 9, 2014, and at all times mentioned herein, Defendant, McCAMMON, was a duly-authorized agent and/or employee of Defendant, TOTAL WELLNESS CENTER, acting within the scope of her agency and/or employment.

10. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, never informed Plaintiff, TEQUILA SALLIS, that Defendant, McCAMMON, was not an agent or employee of Defendant, WEST SUBURBAN MEDICAL CENTER.

11. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, never informed Plaintiff, TEQUILA SALLIS, that

Defendant, TOTAL WELLNESS CENTER, was not an agent of Defendant, WEST SUBURBAN MEDICAL CENTER.

12. On August 9, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, did not know that that Defendant, McCAMMON, was not an agent or employee of Defendant, WEST SUBURBAN MEDICAL CENTER.

13. On August 9, 2014, and at all times mentioned herein, PLAINTIFF, TEQUILA SALLIS, relied upon Defendant, WEST SUBURBAN MEDICAL CENTER, for complete obstetrical and radiological care.

14. On August 9, 2014, and at all times mentioned herein, Defendant, McCAMMON, was a duly-authorized apparent agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of her apparent agency.

15. On August 9, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, had the right to control the actions of Defendant, McCAMMON.

16. On August 9, 2014, and at all times mentioned herein, Defendant, McCAMMON, was a duly-authorized agent and/or employee of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of her agency and/or employment.

17. On August 12, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, did not know that that Defendant, TOTAL WELLNESS CENTER, was not an agent of Defendant, WEST SUBURBAN MEDICAL CENTER.

18. On August 9, 2014, and at all times mentioned herein, Defendant, TOTAL WELLNESS CENTER, was a duly-authorized apparent agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of its apparent agency.

19. On August 9, 2014, and at all times mentioned herein, Defendant, TOTAL WELLNESS CENTER was a duly-authorized agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of its agency.

20. On August 16, 2014, and at all times mentioned herein, Defendant, GAST, was a physician duly licensed to practice medicine in the State of Illinois specializing in radiology.

21. On August 16, 2014, and at all times mentioned herein, Defendant, METROPOLITAN, was a duly licensed healthcare corporation providing complete radiological care to patients.

22. On August 16, 2014, and at all times mentioned herein, Defendant, GAST, was a duly-authorized agent and/or employee of Defendant, METROPOLITAN, acting within the scope of his agency and/or employment.

23. On August 16, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, never informed Plaintiff, TEQUILA SALLIS, that Defendant, GAST, was not an agent or employee of Defendant, WEST SUBURBAN MEDICAL CENTER.

24. On August 16, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, never informed Plaintiff, TEQUILA SALLIS, that Defendant, METROPOLITAN, was not an agent of Defendant, WEST SUBURBAN MEDICAL CENTER.

25. On August 16, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, did not know that that Defendant, GAST, was not an agent or employee of Defendant, WEST SUBURBAN MEDICAL CENTER.

26. On August 9, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, relied upon Defendant, WEST SUBURBAN MEDICAL CENTER, for complete obstetrical and radiological care.

27. On August 16, 2014, and at all times mentioned herein, Defendant, GAST, was a duly-authorized apparent agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of his apparent agency.

28. On August 16, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN MEDICAL CENTER, had the right to control the actions of Defendant, GAST.

29. On August 16, 2014, and at all times mentioned herein, Defendant, GAST, was a duly-authorized agent and/or employee of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of his agency and/or employment.

30. On August 16, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, did not know that that Defendant, METROPOLITAN, was not an agent of Defendant, WEST SUBURBAN MEDICAL CENTER.

31. On August 16, 2014, and at all times mentioned herein, Defendant, METROPOLITAN, was a duly-authorized apparent agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of its apparent agency.

32. On August 16, 2014, and at all times mentioned herein, Defendant, METROPOLITAN, was a duly-authorized agent of Defendant, WEST SUBURBAN MEDICAL CENTER, acting within the scope of its agency.

33. On August 9, 2014, Plaintiff, TEQUILA SALLIS, then 37 3/7 weeks pregnant, presented to Defendant, WEST SUBURBAN MEDICAL CENTER, for an ultrasound biophysical profile.

34. On August 9, 2014, Defendant, McCAMMON, was informed of Plaintiff, TEQUILA SALLIS' condition.

35. On August 10, 2014, Plaintiff, TEQULA SALLIS, was discharged from WEST SUBURBAN MEDICAL CENTER by Defendant, McCAMMON.

36. On August 12, 2014, Plaintiff, TEQUILA SALLIS, again presented to Defendant, MEDICAL CENTER.

37. On August 12, 2014, Plaintiff, TEQUILA SALLIS, was placed on an external fetal heart monitor, which showed fetal heart rate decelerations to the 90s.

38. On August 12, 2014, Defendant, McCAMMON, spoke with Plaintiff, TEQUILA SALLIS, by telephone.

39. On August 12, 2014, Defendant, McCAMMON, did not evaluate Plaintiff, TEQUILA SALLIS, in the hospital.

40. On August 12, 2014, Defendant, McCAMMON, did not induce labor.

41. On August 16, 2014, Plaintiff, TEQUILA SALLIS, presented to Defendant, WEST SUBURBAN MEDICAL CENTER, for a scheduled non-stress test.

42. On August 16, 2014, Plaintiff, TEQUILA SALLIS, was assigned by Defendant, WEST SUBURBAN MEDICAL CENTER, to the obstetrical nursing care of Defendant, WALKER.

43. On August 16, 2014, Defendant, WALKER, placed an external fetal heart monitor at approximately 11:20am.

44. On August 16, 2014, Defendant, WALKER, did not inform Defendant, McCAMMON, of the admission of Plaintiff, TEQUILA SALLIS, or the initial fetal heart monitor tracings.

45. On August 16, 2014, at approximately 12:20 p.m., Defendant, WALKER, discontinued fetal monitoring.

46. On August 16, 2014, at approximately 1:45 p.m., Defendant, KOLENSKYJ, completed a BPP on Plaintiff, TEQUILA SALLIS, which was scored as 4/8 and some time thereafter communicated the results to Defendant, GAST.

47. On August 16, 2014, according to Defendant, KOLENSKYJ, there was in place and in full force and effect a policy and procedure at Defendant, WEST SUBURBAN, prohibiting ultrasound technologists from communicating biophysical profile results to labor and delivery providers.

48. Before August 16, 2014, Defendant, KOLENSKYJ, was instructed she was prohibited from communicating results of biophysical profiles to labor and delivery providers.

49. On August 16, 2014, at approximately 3:27 p.m., Defendant, GAST, reported the results of the BPP to the floor.

50. On August 16, 2014, at approximately 3:21 p.m., Defendant, WALKER, re-applied the external fetal monitor to Plaintiff, TEQUILA SALLIS.

51. On August 16, 2014, at approximately 3:35 p.m., a Category III fetal heart rate tracing was present.

52. On August 16, 2014, at approximately 4:20 p.m., the minor Plaintiff, GERALD SALLIS Jr., was delivered by crash C-section, by Defendant, McCAMMON, with the active assistance and aid of various other agents and employees of Defendant, WEST SUBURBAN MEDICAL CENTER.

53. On August 16, 2014, and at all times mentioned herein, Defendant, WEST SUBURBAN, had a duty to possess and apply the knowledge and skill used by reasonably careful health care institutions under the same or similar circumstances.

54. On August 16, 2014, Defendant, WEST SUBURBAN, was institutionally negligent in one or more of the following ways:

a. establishing a policy, procedure and/or protocol prohibiting technologists from communicating BPP results to labor and delivery providers; and/or

b. training/instructing technologists that they were prohibited from communicating the results of a BPP to labor and delivery providers.

55. As a direct and proximate result of the aforementioned negligent acts or omissions of the Defendant, WEST SUBURBAN, Plaintiff, GERALD SALLIS, Jr., a Minor, sustained injuries of a personal, permanent, and pecuniary nature.

56. Attached to this Third Amended Complaint at Law are the affidavit of one of Plaintiffs' attorneys and the written health care providers' reports and/or 213 disclosures of Baha Sibai, M.D., Heidi M. Shinn, R.N., B.S.N., Samantha N. Sawyer, MHA, RDMS, RDCS, and Peter M. Doubilet, M.D., Ph.D., required by 735 ILCS 5/2-622 which are incorporated herein.

57. CIBC BANK USA is the duly-appointed Guardian of GERALD SALLIS, JR., a Minor, and brings this matter on behalf of the minor.

WHEREFORE, Plaintiffs, CIBC BANK USA, Guardian of the Estate of GERALD SALLIS, JR., a Minor, demand judgment against Defendants, VHS WEST SUBURBAN MEDICAL CENTER, INC., d/b/a WEST SUBURBAN MEDICAL CENTER, a Corporation, in an amount in excess of FIFTY THOUSAND DOLLARS ($50,000.00).

COUNT IV – MEDICAL NEGLIGENCE – FAMILY EXPENSE ACT

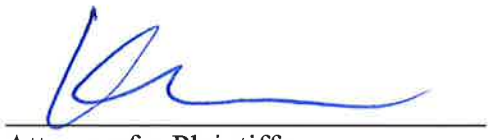
1-56. Plaintiffs, TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually, re-allege Paragraphs 1 through 56 of Count III of this Third Amended Complaint, as if fully set forth herein.

57. On August 9, 2014, and at all times mentioned herein, Plaintiff, TEQUILA SALLIS, was the mother of Plaintiff, GERALD SALLIS, Jr., a Minor.

58. On August 9, 2014, and at all times mentioned herein, Plaintiff, GERALD SALLIS, was the father of Plaintiff, GERALD SALLIS, Jr., a Minor.

59. As a direct and proximate result of one or more of the aforesaid negligent acts or omissions of Defendants, WEST SUBURBAN MEDICAL CENTER, Plaintiffs, TEQUILA and GERALD, as the parents of GERALD, JR., a Minor, became obligated for various hospital and medical expenses under the Family Expense Act, 750 ILCS 65/15 and bring this action to recover said expenses.

WHEREFORE, Plaintiffs, TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually, demand judgment against Defendants, VHS WEST SUBURBAN MEDICAL CENTER, INC., d/b/a WEST SUBURBAN MEDICAL CENTER, a Corporation, in an amount in excess of FIFTY THOUSAND DOLLARS ($50,000.00).



Attorney for Plaintiffs

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Firm No. 32640

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - PROBATE DIVISION

Estate of

GERALD SALLIS, J.R.
Minor

No. 2019 P 6711

8/16/19

ORDER APPOINTING GUARDIAN OF MINOR

On the verified petition of TEQUILA SALLIS for appointment of a guardian, due notice having been WAIVED (given) (waived), the court having considered the evidence,

IT IS ORDERED that:

1. CIBC BANK USA is appointed the guardian of the ESTATE (estate) ☑ 4256 (person) ☐ 4225 (estate and person) ☐ 4257 of the following minor:

GERALD SALLIS, JR.;

2. The bond of the guardian is WAIVED (approved 4611) (waived 4621);

3. Letters of guardianship shall issue;

*4. The guardian of the estate shall file an inventory in Room 1814, Richard J. Daley Center on November 12, 2019, _____ at ~~10:00 a.m.~~ 1:00 PM (4250)

*5. The guardian of the estate shall deposit the minor's funds in an account in the name of the minor, subject to withdrawal only on order of court or upon the attainment of majority, in an institution qualified to receive the deposit. The guardian shall file a report of receipts and disbursements, together with vouchers, on _____, _____, in Room _____ at _____.M. Upon approval of the report, the guardian and surety shall be discharged and the estate closed. (4220) (4251)

Status set for November 12, 2019 at ~~10:00 a.m.~~ 1:00 PM

COPY

ENTERED
Carolyn Quinn-1880
OCT 01 2019
DOROTHY BROWN
CLERK OF THE CIRCUIT COURT

ENTER: _____ 10/1/19
Judge Judge's No.

Atty. No.: 32640
Name: KEITH A. HEBEISEN
Firm Name: CLIFFORD LAW OFFICES, P.C.
Atty. for Petitioner:
Address: 120 N. LASALLE STE. 3100
City/State/Zip: CHICAGO, IL 60602
Telephone: (312)899-9090

*Strike if not applicable

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

CIBC BANK USA, Guardian of the Estate of GERALD SALLIS, JR., a Minor, TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually,	)	
Plaintiffs,	)	
v.	)	No. 16 L 003989
VHS WEST SUBURBAN MEDICAL CENTER, INC. d/b/a WEST SUBURBAN MEDICAL CENTER, a Corporation, SHELIA WALKER, R.N., OLEXANDRA KOLENSKYJ, NATHALIE McCAMMON-CHASE, M.D, McCAMMON-CHASE TOTAL WELLNESS CENTER, INC., an Illinois Corporation, THOMAS GAST, M.D., and METROPOLITAN ADVANCED RADIOLOGICAL SERVICES,	)	
Defendants.	)	

PLAINTIFFS' ATTORNEY AFFIDAVIT PURSUANT TO 735 ILCS 5/2-622(a)(1)&(d)

KEITH A. HEBEISEN states as follows:

1. I am one of the attorneys with responsibility for this matter on behalf of the Plaintiffs.

2. I have consulted and reviewed the facts of this case with health professionals whom I reasonably believe: (i) are knowledgeable in the relevant issues involved in this particular action; (ii) practice or have practiced within the last six (6) years or teach or have taught within the last six (6) years in the same area of health care or medicine that is at issue in this particular action; and (iii) are qualified by experience or demonstrated competence in the subject of this case.

3. The reviewing health professionals have determined in written reports after review of the medical records and other relevant material involved in this particular action that there is a reasonable and meritorious cause for the filing of this action against VHS WEST SUBURBAN MEDICAL CENTER, INC. d/b/a WEST SUBURBAN MEDICAL CENTER, a Corporation, SHELIA WALKER, R.N., OLEXANDRA KOLENSKYJ, NATHALIE McCAMMON-CHASE,

M.D, McCAMMON-CHASE TOTAL WELLNESS CENTER, INC., an Illinois Corporation, THOMAS GAST, M.D., and METROPOLITAN ADVANCED RADIOLOGICAL SERVICES.

4. In addition, I certify that it is the opinion of the reviewing health professionals after review of the medical records and other relevant material involved in this particular action that a reasonable health professional would have informed the patient of the risks of continuing her pregnancy, and the alternative treatment options, including but not limited to the induction of labor.

5. I have concluded on the basis of the reviewing health professionals' review and consultation that there is a reasonable and meritorious cause for filing of this action against VHS WEST SUBURBAN MEDICAL CENTER, INC. d/b/a WEST SUBURBAN MEDICAL CENTER, a Corporation, SHELIA WALKER, R.N., OLEXANDRA KOLENSKYJ, NATHALIE McCAMMON-CHASE, M.D, McCAMMON-CHASE TOTAL WELLNESS CENTER, INC., an Illinois Corporation, THOMAS GAST, M.D., and METROPOLITAN ADVANCED RADIOLOGICAL SERVICES.

6. Copies of the written reports and/or 213 disclosures of Baha Sibai, M.D., Heidi M. Shinn, R.N., B.S.N., Samantha N. Sawyer, MHA, RDMS, RDCS, and Peter M. Doubilet, M.D., Ph.D.are attached.

FURTHER AFFIANT SAYETH NOT.

Attorney for Plaintiffs

[X] Under penalties as provided by law pursuant to 735 ILCS 5/1-109 of the Code of Civil Procedure, I certify that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that I verily believe the same to be true.

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Bradley M. Cosgrove
Sarah F. King
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SFK/ah 16-0047

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

GERALD SALLIS, JR., a Minor, by his Parents and Next Friends, TEQUILA SALLIS and GERALD SALLIS, and TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually,	)	
Plaintiffs,	)	
v.	)	No. 16 L 003989
NATHALIE McCAMMON-CHASE, M.D., et al.,	)	
Defendants.	)	

PLAINTIFFS' RULE 213(f)(3) DISCLOSURE OF BAHA SIBAI, M.D.

GERALD SALLIS, JR., a Minor, by his Parents and Next Friends, TEQUILA SALLIS and GERALD SALLIS, and TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually, by their attorneys, CLIFFORD LAW OFFICES, P.C., make the following disclosure pursuant Illinois Supreme Court Rule 213(f)(3):

Baha M. Sibai, M.D.
5314 Fairdale Lane
Houston, TX 77056

1. Dr. Sibai is a licensed physician specializing in obstetrics and gynecology and maternal-fetal medicine. Attached to this disclosure is an up-to-date copy of Dr. Sibai's curriculum vitae further outlining his qualifications, education, training, experience and publications.

2. Dr. Sibai defines professional negligence as the failure to do something that a reasonably careful obstetrician would do, or the doing of something that a reasonably careful obstetrician would not do under similar circumstances. As used herein, "was professionally

negligent" is synonymous with "breached the standard of care," "deviated from the standard of care," "failed to possess and apply the knowledge and use the skill and care ordinarily used by a reasonably careful obstetrician under similar circumstances," "failed to do something a reasonably careful obstetrician would do" and "doing something a reasonably careful obstetrician would not do."

3. Dr. Sibai will be called to testify on issues of standard of care, proximate cause and damages. Dr. Sibai will testify regarding general medical concepts and logical corollaries relevant to his opinions. Additionally, Dr. Sibai is expected to testify, to a reasonable degree of medical certainty as to what is more probably true than not true to the following:

4. On December 23, 2013, in her 5th week of pregnancy, Tequila Sallis presented to Nathalie McCammon-Chase, M.D. at the McCammon-Chase Total Wellness Center in Oak Park, Illinois for her first pre-natal visit. Mrs. Sallis weighed 145 lbs, up four pounds from her pregravid weight of 141 lbs. Pre-natal labs were performed and ultrasounds were ordered for size and dates. Mrs. Sallis's estimated date of delivery was August 27, 2014. Ms. Sallis had an EDD of 8/28/14 by prenatal ultrasound at 6 4/7 weeks.

5. Dr. Sibai has reviewed Ms. Sallis' prenatal course. He is expected to testify to the following pertinent aspects of her prenatal care:

- Ms. Sallis had a presumed yeast infection at 14 weeks which was treated with Diflucan and resolved. Further testing was negative. [McCammon 25] [WS 874].
- Ms. Sallis had a positive screen for HSV antibodies at 17 weeks and prescribed Valtrex. There are no reported outbreaks. [WS 841, 845, 869, McCammon 26]. HSV 1 & HSV 2 IgM Screens were negative. [WS 870].
- Ms. Sallis was GBS negative. [WS 868].
- There is no evidence of smoking, alcohol intake or recreational drug use.

- On 6/6/14 at 28 weeks gestation Ms. Sallis was diagnosed with gestational diabetes based on the results of a 3hrGTT measuring 150. She was instructed on tracking her glucose with the use of a Glucometer. (See Glucose summary). Her glucose remained controlled with Glipizide. She was switched to Levemir with Lispro sliding scale coverage. On 7/14/14 her A1C was 7.17. On 7/18/14 she was referred to Terri Washington, D.O. for a gestational diabetes consult. Her recent labs were: Glucose 180 1.5 hr pp. 7/15/14: Hbg 11.7, A1C 7.1 [4.5-6.5]; BS 175 [83-154] Glu 198. Alb 2.1 [3.5-5.0] Total protein 5.6 [6.4-8.3]. She was instructed to increase her insulin if running high, checking before and after meals. Levemir was increased to 26 units once daily, Novolog 7 units 3x day. Following this adjustment, it appears blood glucose levels remained between 146 -94 up to the day of delivery.

- Prenatal ultrasounds documented appropriate fetal heart rate and appropriate interval growth of the embryo. Amniotic fluid index was normal until 33 weeks gestation. On 7/14/14 an ultrasound was concerning for a low AFI of 7.4cm (5^{th} percentile). She was admitted to labor and delivery for rehydration. By 7/15/14 AFI increased to > 9.8cm. She was discharged on 7/16/4 with acceptable fluid levels. Fetal heart rate during admission remained reactive and reassuring. Weekly follow-up non-stress testing and BPP showed SFI remained normal. AFI on the day of delivery was 12.3 cm. (See ultrasound summary). At the time of delivery. Ms. Sallis' gestational diabetes did not appear to have any negative impact on the infant as he was of normal size and weight at the time of delivery.

- In her third trimester Ms. Sallis developed gestational hypertension which subsequently developed into preeclampsia. At 35 weeks she developed hypertension which was accompanied by bilateral edema in her feet and significant weight gain in 1 week. (See hypertension summary). At 36 weeks she developed a severe headache in addition to hypertension and edema. At 37 weeks 3 days she had evidence of proteinuria on dipstick and in a 24-hour dipstick. As discussed further below, Dr. Sibai is expected to testify that at 37 weeks, the standard of care required delivery for the safety of both mother and baby. In women with gestational hypertension or preeclampsia without severe features at or beyond 37 0/7 weeks of gestation, delivery rather than expectant management upon diagnosis is recommended. Per the 2014 American Congress of Obstetricians and Gynecologists (ACOG) standards, by August 9, 2014, Ms. Sallis should have been admitted and induced for preeclampsia.

6. On August 9, 2014, Ms. Sallis presented to Dr. McCammon-Chase for an obstetrical follow-up appointment. Her estimated gestational age was 37 and 3/7 weeks. Upon exam by Dr. McCammon she was found the have the following:

> **Prenatal Visit**: Wt. 212 (+6) + Contractions FH 46 FHR 150 + FM
> Edema: Lower Extremity
> **B/P 140/90**
> Prot/Glu: 400/-

Having a hard time sleeping. Slight cold. Feeling contractions on and off when Pt. wipes very light pink. Glucose level 123

1) SIUP: c/o occasional on & off headaches. Occasional on and off contractions at night (+) 1 edema to lower extremities moderate protein in urine 140/98 (preeclampsia sx) SVE 1/20%/-4
2) GDM: Continue schedule insulin Glucose123 pending NST today
Referred to triage for R/O Preeclampsia

Urinalysis:
Urobilinogen:.2
Protein: MODERATE
PH: 7.5
Sp.Gr.1.015
Yellow
Cloudy

[McCammon 31, 59].

7. Dr. McCammon-Chase referred Ms. Sallis to triage at West Suburban Medical Center "for r/o preeclampsia." [McCammon 31]. Ms. Sallis presented to the hospital and at 11:36AM underwent a biophysical profile. The BPP result was a perfect score of 8/8 for positive fetal breathing, fetal movement, fetal tone, and amniotic fluid volume. [WS 486]. Dr. Sibai is expected to testify that the 8/9/14 BPP results rules out a prior injury and confirm that baby Gerald was a well-oxygenated and non-acidemic fetus. Dr. Sibai will testify that the BPP result confirms that both mom and baby were both good candidates for induction.

8. Her membranes were intact. The fetal heart rate baseline was 155 with moderate variability [WS 453]

9. A twenty-four hour urine collection for protein was begun at 12:00PM. [WS 87]. At 12:20PM a fetal heart monitor was placed. [WS 506].

10. At 12:32PM Ms. Sallis' blood pressure was 146/84 and she complained of a slight headache. Ms. Sallis continued to complain of intermittent headaches throughout the afternoon. [WS 87, 88].

11. At 1:45PM, Dr. McCammon-Chase issued a telephone order to admit Ms. Sallis for twenty-three hour observation. [WS 457]. Ms. Sallis was admitted on continuous fetal monitoring. [WS 459]. At 5:22PM, Nurse Cano reviewed the strip and found there to be no change in the baseline fetal heartrate of 135. Variability was marked with more than twenty-five beats per minute, accelerations 15x15, and no decelerations. Nurse Cano noted the strip to be a Category I. [WS 88-89].

12. At 6:40PM Nurse Cano again reviewed the strip and noted a fetal baseline heartrate of 130 with no baseline change. There was moderate variability with 6-25 beats per minute, 15x14 accelerations, and no decelerations noted. [WS 89]. At 7:57PM Nurse Morton reviewed the strip and noted a fetal baseline heartrate of 145. Moderate variability was also noted with 15x15 accelerations and no decelerations. The strip was again marked as a Category I. [WS 90].

13. On August 10th at 12:27AM Ms. Sallis' blood pressure was 137/81. She complained of a dull pain in her abdomen, head, and right flank. Nurse Morton reviewed the strip and noted a fetal baseline heartrate of 140 with moderate variability, 15x15 accelerations, and no decelerations. The strip was marked as Category I. [WS 90-91].

14. At 1:27AM Nurse Morton reviewed the strip and noted a fetal baseline heartrate of 140 with moderate variability, 15x15 accelerations, and no decelerations. The strip was marked as a Category I. At 4:18AM Ms. Sallis' blood pressure was 142/64. [WS 91].

15. At 4:36AM Nurse Morton reviewed the strip and noted uterine contractions lasting 60-80 second with a frequency of x2 (minute). The fetal baseline heartrate was 145 with moderate variability, prolonged accelerations, and late decelerations. Nurse Morton marked the strip as a Category II. [WS 91-92].

16. At 5:29AM Nurse Morton again reviewed the strip and noted a fetal baseline heartrate of 145 with moderate variability, 15x15 accelerations, and no decelerations. The strip was marked as Category I. [WS 92].

17. At 7:20AM the electronic fetal monitor was turned off. Nurse Cano noted that the twenty-four hour urine collection continued. At 8:18AM Ms. Sallis' blood pressure was 139/65. At 8:28AM, Nurse Cano noted that the patient reported irregular contractions but denied any discomfort. [WS 92-93].

18. At 9:12AM the electronic fetal monitor was turned back on. At this time Ms. Sallis' blood pressure was 137/82. At 9:28AM Nurse Cano noted the fetal baseline heartrate to be 140 with no baseline change. There was moderate variability with 15x15 accelerations and no decelerations. The strip was marked as Category I. At 10:39AM Nurse Cano again reviewed the strip and it remained the same. [WS 94-95].

19. At 11:05AM a bedside blood glucose was done with a 166 result. It was repeated with a result of 239, and a third time with a 166 result. Dr. McCammon-Chase was paged. [WS 95].

20. At 2:54PM Ms. Sallis' blood pressure was 141/83. At 3:20PM, the electronic fetal monitoring was discontinued, due to the "reactive" NST. Dr. McCammon-Chase was notified of the twenty-four hour urine collection result of 826. [WS 95, 483].

21. Dr. McCammon-Chase noted that Ms. Sallis had "ruled-in for preeclampsia." The plan was to resume antenatal testing on August 13th with a biophysical profile and NST. Ms. Sallis requested that Dr. McCammon-Chase keep her for an induction that day but Dr. McCammon-Chase refused. [Sallis 25, 77]. Dr. McCammon-Chase told Ms. Sallis she wanted her to go further into the pregnancy. [Sallis 77]. She was told there was no medical reason to induce, so according

to Ms. Sallis, "she told me no." [Sallis 78]. There was no discussion about the risks associated with continuing the pregnancy. [Sallis 79]. Dr. McCammon-Chase discharged Ms. Sallis home with instructions to return on the 14th as planned. [WS 455].

August 9, 2014: Failure to Induce& Negligently Discharged Her Patients

22. Dr. Sibai is expected to testify that beginning on August 9, the standard of care required Ms. Sallis to be admitted and induced. Ms. Sallis was suffering from elevated blood pressure measurements greater than or equal to 140 mmHg. She had a critical finding of proteinuria with a 24-hour urine collection and she had developed headaches. Per current and past ACOG guidelines for management of preeclampsia in pregnancy, the standard of care required delivery.

23. Furthermore, Dr. Sibai will testify that there was no medical reason to delay delivery. Baby Gerald was healthy and of appropriate size and growth. Additionally, the patient was requesting induction. Dr. McCammon-Chase's decision to "go further in the pregnancy" was negligent and demonstrates a lack of knowledge and/or understanding of her patients' conditions. The risk to mother and baby of continuing this pregnancy far outweighed any possible benefit. Moreover, if Dr. McCammon-Chase was going to instruct Ms. Sallis to continue the pregnancy in violation of the standard of care and ACOG guidelines, she was required to fully explain the risk of this course of action and allow Ms. Sallis to make a fully informed choice regarding the care of her and her baby. The failure of Dr. McCammon-Chase to induce Ms. Sallis and to inform her of the risks of continuing her pregnancy was professional negligence.

24. On August 12th at 13:00 Ms. Sallis presented once again to OB triage at West Suburban Medical Center. She was 37 6/7 weeks pregnant. She reported experiencing a gush of clear fluid/mucus and was instructed by Dr. McCammon-Chase to go to the hospital. Ms. Sallis complained of occasional contractions. Her blood pressure was 136/90. [WS 95-96]. A urine

dipstick showed a +2 protein (100 mg/1). [WS 676]. Dr. McCammon-Chase failed to order a timed collection or continuous BP monitoring.

25. Ms. Sallis was placed on a fetal heart monitor around 13:36. Fetal heart tones remained reassuring throughout the hospitalization although portions of the tracing are spotty and difficult to interpret. Dr. Sibai is expected to testify that the fetal tracing confirms that as of August 12, Gerald Sallis was a well-oxygenated non-acidemic fetus. Dr. Sibai will testify that based on the fetal tracing both mom and baby were both good candidates for induction.

26. Dr. McCammon-Chase was paged and arrived at 14:50 to assess Ms. Sallis. Dr. McCammon-Chase noted that Ms. Sallis was "at term with GDM and mild preeclampsia." [WS 673]. Ms. Sallis again requested an induction and Dr. McCammon-Chase refused. [Sallis 28]. Dr. McCammon-Chase informed Ms. Sallis that she believed she could go "a couple more days" and that she wanted her "to get as close to 40 weeks as possible." [Sallis 28, 81]. There was no discussion about the risks of continuing the pregnancy or delivering. [Sallis 78, 80-81]. Ms. Sallis recalls Dr. McCammon-Chase informing her that the preeclampsia was likely the cause of her headaches and extensive swelling. [Sallis 81].

27. Induction of labor was decided upon "due to IDGDM (Insulin Dependent Gestational Diabetes Mellitus) and emerging preeclampsia." An NST was scheduled for August 16th and induction for August 18th. Ms. Sallis was then discharged home. [WS 96].

August 12, 2014: Failure to Monitor, Failure to Induce, Negligently Discharged Her Patients.

28. Dr. Sibai is expected to testify on August 12, the standard of care required Ms. Sallis to be admitted and induced. Ms. Sallis continued to have findings of proteinuria by urine dipstick. Additionally, she had an elevated diastolic pressure of 90. More likely than not Ms. Sallis had continuously elevated pressures throughout her hospitalization, however, she was

unmonitored. In a woman with diagnosed preeclampsia and proteinuria, the standard of care requires continuous blood pressure monitoring throughout admission.

29. Dr. Sibai is expected to testify that based on her history, suspected SROM, elevated diastolic BP and proteinuria, per current and past ACOG guidelines for management of preeclampsia in pregnancy, the standard of care required delivery. Dr. Sibai will testify that there was no medical reason to delay delivery. Baby Gerald was a healthy baby of appropriate size and growth. Additionally, the patient again requested induction. Dr. McCammon-Chase's decision to delay delivery "a couple more days" and "to get as close to 40 weeks as possible" was negligent and demonstrates a lack of knowledge regarding her patient's condition. The risk to mother and baby of continuing this pregnancy far outweighed any possible benefit of continuing the pregnancy "a couple more days." Moreover, if Dr. McCammon-Chase was going to instruct Ms. Sallis to continue the pregnancy in violation of the standard of care and ACOG guidelines, she was required to fully explain the risk of this course of action and allow Ms. Sallis to make a fully informed choice regarding her and her baby's care. The failure of Dr. McCammon-Chase to order continuous blood pressure monitoring, admit Ms. Sallis and deliver her baby was professional negligence.

30. On August 16th, Ms. Sallis awoke at 9:30am. She reported that she awoke due to fetal movement. Once she awoke she went to eat breakfast. At the time she ate Gerald was moving. [Sallis 104]. Overall Ms. Sallis described Gerald as a very active fetus throughout the pregnancy. [Sallis 143]. Approximately 20 minutes after finishing breakfast –at or around 10 am- Ms. Sallis reported that Gerald was no longer moving. [Sallis 104]. Ms. Sallis phoned her sister Christian at approx. 10:00 to bring her to the hospital. [Snow 32-33]. When they arrived at the hospital (West

Suburban) a little before 11:00AM and were walking towards the elevators, Ms. Sallis stated that she felt Gerald moving around a little bit. [Snow 33].

31. At 11:00AM Ms. Sallis arrived at OB Triage. She signed into the OB triage log and signed consents. [WS 195, Triage Log]. When she arrived. she reported to the nurse at the triage desk (identified as Shelia Walker, R.N.) that her baby was not moving. [Sallis 144-145]. At the time Ms. Sallis arrived she was Nurse Walker's only patient. [Walker 29]. Ms. Sallis testified that when she arrived in OB triage and reported that her baby was not moving, Nurse Walker sent her downstairs to the radiology department for an ultrasound. [Sallis 33-35; Snow 34]. In contrast, Nurse Walker testified that Ms. Sallis went directly to the radiology suite when she arrived at West Suburban and then came up to OB triage once she found out ultrasound was unavailable. [Walker 55]. Nurse Walker testified that Ms. Sallis did not want to wait for ultrasound and wanted to have her baby monitored while she was waiting. [Walker 56]. Nurse Walker documented at 11:23 "Received pt. await for BPP. U/S unavailable at present time, pt states was told too be seen in 1 hr." [WS 97]. This entry wasn't entered into the medical record und 18:05, almost two hours after the baby was delivered - (late entry @ 18:05) [WS 520].

32. Regardless, by 11:22 Ms. Sallis was on a fetal monitor. Within minutes of the tracing coming on-line it was clear this was a possible obstetrical emergency requiring intervention by emergency C-section. Dr. Sibai is expected to testify that at 11:00 the standard of care required communication to a physician of Ms. Sallis' presence at the hospital and reports of decreased fetal movement. She should have been placed immediately on a fetal heart monitor and fetal stimulation attempted. More likely than not had Ms. Sallis been placed on a monitor at 11:00 the tracing would have looked substantially similar to how it looked at 11:22, with minimal to absent variability. Had a reasonably careful obstetrician and/or MCH provider trained to provide obstetrical care been

notified and performed a bedside evaluation of mother, baby and the fetal monitor strip, more likely than not an emergency C-section would have been called and completed by 11:30AM. Dr. Sibai will testify that if Gerald Sallis been delivered by 11:30AM, more likely than not he would have been born uninjured. Instead, over 5 hours of delays ensued before delivery.

33. Nurse Walker testified to the following regarding the initial tracing:

- The fetal monitor strips from 11:20 to 11:36 showed minimal to absent variability. [Walker 58].
- She asked Ms. Sallis if this was normally her non-stress test and Ms. Sallis stated the baby was sleeping and he would probably wake up a little later. [Walker 14].
- Walker called Dr. McCammon-Chase to notify her of the strips within ten minutes of Ms. Sallis being on the monitor. [Walker 14]. Nurse Walker testified that when she made this call she did not actually speak with the doctor but left a message on her answering service. Her message would have stated that she was calling in reference to Tequila Sallis for her NST and wanted to give Dr. McCammon-Chase information based on her fetal strip and urine protein test. She left no other details in the message. [Walker 14-15].
- After leaving a message she went back to the unit. She noticed that the baby had not woken up yet so she changed Ms. Sallis' position and gave her something to drink. She called ultrasound to find out how long it would be until the tech would be available. [Walker 15].
- She made a second call to Dr. McCammon-Chase after she called ultrasound to find out how long it would be until the BPP could be performed. Dr. McCammon-Chase' voicemail picked up. Dr. McCammon-Chase's voice came on and gave her information and then it said the voicemail was full. [Walker 16-17].
- Nurse Walker admitted that she did not document any of these alleged phone calls in the medical record. [Walker 60].
- Dr. McCammon-Chase testified that on August 16, she was at home all day doing chores and laundry. [McCammon 26-27, 29-30]. She testified that she did not receive any calls from Nurse Walker until 15:00. [McCammon 29]. Dr. McCammon lives 5 to 7 minutes from West Suburban. [McCammon 25].

34. Dr. Sibai is expected to testify that if Nurse Walker did in fact leave Dr. McCammon-Chase a voicemail sometime around 11:32AM, the standard of care required Dr.

McCammon-Chase to call the hospital back as soon as possible to gather more information about her patients including what was shown on the fetal heart monitor and the patient's reports of decreased fetal movement. Upon learning that fetal heart rate variability was minimal to absent with reports of decreased fetal movement, the standard of care would have required Dr. McCammon-Chase to instruct the available OB team on the unit to move toward an emergency C-section while she made her way to the hospital.

35. Nurse Walker documented that at 11:27, "U/S called spoke with Sandy stts ask pt to wait will see pt in 1 1/2hrs." [WS 97]. Ms. Kolenskyj testified that she has no memory of her conversations with Nurse Walker. [Kolenskyj 56]. Nurse Walker testified as follows:

Q. So picking up after you said you called ultrasound to find out about the biophysical profile, what's the next thing that you remember?

A. When I spoke to the ultrasound person and she was telling me that she was in the ED and that she was unable at that time to come get the patient, so I monitored the patient for a little while longer. And I don't remember what happened after that. I would have to refer to my notes.

Q. Right now we're going through your memory, and then we'll get into your notes. The person that you spoke with from ultrasound, do you remember her name?

A. Sandy.

Q. And when you called, did you call the radiology department, or did you call a different number?

A. I spoke to her at 6967.

Q. And she was actually in the emergency room when you talked to her?

A. She picked up the phone. I have no idea where she was. She just stated that she was in the ED.

Q. So she told you that she was in the ER?

A. Yes. Uh-huh, but she couldn't have been if 6967 is the ultrasound number.

Q. So do you know one way or the other whether 6967 goes to a mobile phone or a land line?

A. I don't.

Q. But she told you either way she was in the ED, correct?

A. Uh-huh.

Q. Is that a yes?

A. Yes. I'm sorry. I apologize.

Q. Not a problem. Okay. Anything else you remember saying to Sandy during that conversation other than asking where she was?

A. That I needed an ultrasound and biophysical profile **stat.**

Q. And you used the word stat?

***

Q. In that conversation with Sandy, you used the word **stat**, and you communicated to her that it was an urgent request?

A. Yes.

[Walker 18-20]

36. At 11:44 the strip demonstrated more than a twenty-minute time frame of fetal monitoring which was nonreactive and showed minimal to absent variability. Nurse Walker admitted that this equated to a nonreactive nonstress test and that the standard of care required her to inform a physician of the nonreactive NST. [Walker 59]. She failed to do so.

37. From 11:44 to 11:52, Nurse Walker agreed that the fetal heart strip continued to be nonreactive. [Walker 62]. At this point Ms. Sallis had been on a monitor for 45 minutes with a non-reactive strip which showed minimal to absent variability. Nurse Walker testified that she did not consider this to be an emergency situation and still felt it appropriate to send Ms. Sallis down for a biophysical profile. [Walker 69-70].

38. At 12:20, Ms. Sallis was taken off the monitor and Nurse Walker noted that she was "down to US" (ultrasound). [WS 97]. Ms. Sallis was accompanied down to ultrasound by her cousin, Syesha Hampton, who had since arrived at the hospital. [Hampton 27]. Ms. Hampton recalls Tequila telling her that she had not felt the baby move since she arrived at the hospital. [Hampton 24].

39. When Ms. Hampton and Ms. Sallis arrived in ultrasound they waited. [Hampton 27-28]. They were told by the technician that they were understaffed and had to wait. [Hampton 27-28].

40. At 12:45, the ultrasound technologist, Ms. Kolenskyj, began performing the Biophysical Profile. [WS 962]. It does not appear from the record or testimony that Ms. Kolenskyj was provided or requested the results of the NST.

41. At 13:00, Nurse Walker documented the results of the urine protein test, which had an abnormal result of a +3 protein. [WS 778]. Nurse Walker testified that she performed the test on the urine herself and had the results of this test since 13:00. Nevertheless, the first time she notified anyone of this abnormal result was at 15:08 when she spoke with Dr. McCammon on the phone. [Walker 95].

42. From 12:45 through 13:56, Ms. Kolenskyj scanned Ms. Sallis. During the exam, Ms. Kolenskyj suggested the baby might be asleep and decided to "shove" or "thrust" the sides of Mrs. Sallis' stomach to facilitate movement. [Hampton 30]. Ms. Sallis described that Ms. Kolenskyj showed her that the baby was not moving. [Sallis 124]. Ms. Sallis testified that she was crying and visibly upset. Ms. Kolenskyj had her hold onto the railing of the hospital bed while she used the ultrasound doppler to push into her abdomen. [Sallis 124]. Thereafter, Ms. Kolenskyj had Ms. Sallis use the restroom during the exam and return to complete the exam. [Sallis 124].

43. At 13:56 Ms. Kolenskyj completed the exam and wrote the following findings on the BPP worksheet:

Fetal Breathing 2
Fetal Movements 0
Fetal Tone 0
Amniotic Fluid 2
Total BPP Score 4/6

Comments: Score 4/8 No movement and tone noted!

44. The BPP was completed at 13:56 [WS 950], with a failing score of 4/8. Two points were scored for fetal breathing and two for amniotic fluid, while zero points were scored for fetal movement and fetal tone. [WS 953]. At 13:45:51, the BPP results were also entered into the PACS system.

45. After the BPP exam Ms. Hampton pushed Ms. Sallis back to OB Triage in a wheelchair which was available outside of the radiology suite. [Sallis 42-43, 125]. At 14:25 Ms. Sallis had blood glucose testing with a result of 138. [WS 784]. According to Nurse Walker this result would have been obtained in OB triage at the bedside using a finger-stick with a lancet and checked in an Accu-Check machine. [Walker 84]. Nurse Walker admitted that Ms. Sallis was back in the OB Triage unit by 14:25. [Walker 86].

46. Dr. McCammon testified that she was called by Shelia Walker, RN around 15:00 and told that Ms. Sallis was back from ultrasound that she was going to put her back on the monitor. [McCammon 27, 30]. She does not recall any other information being conveyed about the baby's status or Ms. Sallis' condition. [McCammon-Chase 31-32]. In contrast, Nurse Walker documented that at 15:08 she discussed with Dr. McCammon-Chase the patient's urine drip and decreased fetal movement. [WS 97]. Nurse Walker testified that she told Dr. McCammon-Chase "some of the findings" from the strip earlier that morning. Nurse Walker testified she informed her that there

had was minimum variability now and there had been similar minimum variability in the morning. [Walker 22]. Dr. McCammon-Chase told her to admit Ms. Sallis to labor. [WS 97].

47. Dr. Sibai is expected to testify that at 15:00 when Dr. McCammon spoke with Nurse Walker for the first time, the standard of care required her to ask Nurse Walker about her patients' conditions including the previous fetal heart tracing findings, the results of the urine dip and pertinent patient complaints. At 15:00, whether it was because she was told or because she asked, Dr. McCammon should have had enough information to identify this as an obstetrical emergency and to instruct Nurse Walker to call the MCH obstetrical team available on the unit to evaluate the patient and move toward an emergency C-section. Had this occurred, more likely than not Gerald Sallis would have been born at or before 15:30, thereby avoiding the terminal bradycardia and permanent acute profound brain injury he suffered at and after 15:36.

48. According to the nursing flowsheet, at 15:00 Shelia Walker, RN called Ms. Kolenskyj asking for the BPP results and was told there were "No Results." [WS 97]. Ms. Kolenskyj claimed that the reason she withheld the results from Nurse Walker was because the rule at West Suburban stated she was not allowed to tell the nurse the results, only the radiologist. [Kolenskyj 61]. She believes she was only permitted to communicate with the radiologist. [Kolenskyj 62-63].

49. Dr. Sibai is expected to testify that open and timely communication between OB ultrasound providers and a patient's obstetrical team is imperative for patient safety. If one assumes the sworn testimony of Ms. Kolenskyj to be true, then West Suburban Hospital developed a system which placed its patients at risk of harm by establishing a policy, procedure and/or protocol prohibiting technologists from communicating BPP results to labor and delivery providers and/or

training/instructing technologist that they were prohibited from communicating the results of a BPP to labor and delivery providers.

50. At 15:23, Ms. Sallis was finally placed back on the monitor. [WS 527]. Any minimal variability that had previously been present was now absent. Dr. Sibai will testify regarding fetal oxygen reserves. Specifically, he will testify that by 15:36 the baby had depleted his fetal oxygen reserve while waiting for intervention for almost 5 hours. At 15:36 when his oxygen reserve had been completely depleted his heart rate became bradycardic and never recovered. [FHT 37].

51. Dr. McCammon testified that she was called a second time by Nurse Walker and told that the baby's heart had decreased down to the 80's or 90's and stayed down. She requested that they administer a dose of terbutaline and that she would meet them in the OR. [McCammon 27]. Dr. Sibai will testify that Dr. McCammon's order for terbutaline does not make sense. When Dr. McCammon-Chase received the second call from Nurse Walker indicating that the baby was experiencing a prolonged bradycardia, the standard of care required Dr. McCammon-Chase to instruct Nurse Walker to contact the MCH team on the unit and to move the patient for an emergency C-section. Additionally, nothing was preventing Dr. McCammon-Chase from speaking with the MCH providers herself to call for an emergency C-section. Dr. McCammon-Chase's failure to call for an immediate physician evaluation of her patients and an emergency C-section caused an additional 20 minute delay in the evaluation and delivery of baby Gerald.

52. At 15:38, Nurse Walker called for her charge nurse. At 15:42, the MCH team was called. [WS 97]. Dr. Thomas, Dr. Torres, and Dr. LaMaster were in the room by 15:51, and Dr. McCammon was also called at this time. [WS 98]. A crash c-section "for fetal bradycardia" was called at 16:00. [WS 184, 173].

53. At 16:20 Gerald was born by emergency C-section. A neonatology nurse practitioner, Karen Wolfe, was in the operating room for delivery, followed at 16:54 by an attending neonatologist, Narendra Pavuluri, M.D. The documented reason for neonatology attendance was emergency C-section for FHT of 60bpm without recovery. Birth weight was 3680g (75th percentile), length 49.5cm (50th percentile) and head circumference 33.5cm (20th - 40th percentile). These measurements are appropriate for gestational age, and there was no evidence of intrauterine growth restriction (IUGR). Apgars scores were 1, 1, and 1 at 1, 5, and 10 minutes, respectively, with points only for heart rate. [WSBaby 006]. He was noted to be limp/hypotonic and pale. Venous cord gas was 7.08 with base deficit 11. The fluid was clear at delivery and there was a nuchal cord. His initial heart rate was in the 20's. He required significant resuscitative measures including chest compressions, epinephrine x3 doses, intubation at 2 minutes of age, normal saline fluid bolus, and NaBicarb fluid bolus. Chest compressions were performed until 18 minutes of age, at which point his heart rate was maintained at >60. At 1709 phenobarbital 75mg IV x1 dose was ordered. At 18:25 seizures were noted by the neonatal nurse. [WSBaby 005]. He was started on antibiotics. He received additional saline and bicarbonate boluses for persistent lactic acidosis. Cord and postnatal blood gases showed significant perinatal depression, and were as follows:

Cord VBG at 16:52, pH 7.08, pCO2 71.1, pO2 52.9, bicarb 20.3 (BD-11), Lac 11.8
VBG at 16:56, pH 6.53, pCO2 129, pO2 61.3, bicarb 10.3 (BD -34.1), Lac 23
VBG at 17:03, pH 6.75, pCO2 81.3, pO2 59.1, bicarb 10.5(BD -29), Lac 25
VBG at 17:58, pH 7.06, pCO2 34.0, pO2 39.2, bicarb 9.1 (BD -21), Lac 24
VBG at 18:51, pH 7.20, pCO2 23.5, pO2 34.7, bicarb 8.8 (BD -18).
VBG at 23:15, pH 7.24, pCO2 33.2, pO2 29.7, bicarb 14.8 (BD -13) [p.717]

54. Dr. Pavuluri diagnosed severe HIE with seizures and initiated transfer to Lurie Children's Hospital. Dr Sibai is expected to testify regarding his agreement with the diagnosis by both Dr. Pavuluri [WSBaby 004] and baby Gerald's treating neontologist, Dr. Ritacco [Ritacco

Dep. 53] of severe hypoxic ischemic encephalopathy which was due acute perinatal asphyxia, most likely occurring in the 4-5 hours to minutes prior to delivery. [Ritacco 29, 80-81].

55. Additionally, Dr. Sibai will testify regarding the guidelines developed by the Task Force on Neonatal Encephalopathy and jointly published by American College of Pediatrics and the American College of Obstetricians and Gynecologist issuing body in 2014 for identification of an acute intrapartum event. In confirmed cases of neonatal encephalopathy, these guidelines assist in determining the likelihood that and acute intrapartum event was the cause. The more elements from each item that are met, the more increasingly likely an intrapartum hypoxia-ischemia was the cause. Dr. Sibai will testify that Gerald meets one or more elements and/or sub-elements from each category.

56. Additionally, Dr. Sibai will testify there is a complete absence of evidence of any other causes of baby Gerald's brain injury. There is no evidence of infection, no congenital condition caused or contributed to his injuries and there is not any indication of a remote or chronic insult to the brain. Dr. Sibai will testify that the sole medical cause of Baby Gerald's brain and multi-organ injury is HIE that occurred intrapartum, likely beginning 4-5 hours prior to birth culminating in a complete loss of fetal reserve and acute profound injury immediately prior to delivery.

57. Dr. Sibai will testify that had Gerald Sallis been delivered anytime between 8/9/14 or 8/12/14 he would be uninjured today. On 8/16/14, at 11: 22 AM there was evidence that baby Gerald was compensating for a partially hypoxic environment and needed to be delivered. The most likely explanation for the onset of this environment was complication from his mother's diagnosed preeclampsia. With every minute that passed thereafter, baby Gerald was more at risk for permanent and irreversible brain injury. Gerald's partial prolonged injury occurred on a

spectrum. The longer he was subjected to a hypoxic environment the less likely his brain injury would be completely reversible with appropriate treatment.

58. Initially, Gerald maintained a baseline fetal heart tone with reports of minimal variability. At 12:29 BPP films captures heart rate variability. At 13:20 and 13:29 there is evidence of fetal breathing movements. More likely than not had Gerald been delivered prior to 13:29 with appropriate care and treatment he would have been uninjured or minimally injured. Thereafter, when Gerald was placed back on the monitor at 15:23/15:24 any minimal variability that was previously present was absent. By 15:38 Gerald had depleted his fetal reserves and suffered an acute profound deprivation of oxygen manifested on the heart rate monitor as a terminal bradycardia. Thereafter, every minute that passed his organ injuries became more permanent and profound. More likely than not had Gerald been delivered prior to 15:38 he would not have suffered an acute profound injury to his brain and other organs.

59. Dr. Sibai has reviewed the disclosures of Plaintiffs' other experts including Nurse Shinn, ultrasound technologist Samantha Sawyer and Dr. Doubilet. The deviations from the nursing, radiology and ultrasound technology standard of care outlined in these reports delayed Gerald Sallis' delivery and were a proximate cause of his injuries. Dr. Sibai is expected to testify that had Nurse Walker complied with the standard of care, more likely than not Gerald Sallis would have been born earlier on August 16 and without (or with less) permanent injury to his brain and other organs. Dr. Sibai is expected to testify that had Olexandra Kolenskyj and Thomas Gast, M.D. complied with the standard of care, more likely than not Gerald Sallis would have been born earlier on August 16 and without (or with less) permanent injury to his brain and other organs.

60. In summary Dr. Sibai will testify to the following based on a reasonable degree of medical certainty:

61. On August 9, 2014, and thereafter, Nathalie McCammon-Chase, M.D., deviated from the standard of care in the following ways:

a) failed to induce labor in Ms. Sallis;
b) failed to deliver Gerald Sallis;
c) failed to inform Ms. Sallis of the risks of continuing pregnancy;
d) negligently discharged her patients.

62. On August 12, 2014, and thereafter, Nathalie McCammon-Chase, M.D., deviated from the standard of care in the following ways:

a) failed to order continuous monitoring of Ms. Sallis' blood pressure;
b) failed to induce labor in Ms. Sallis;
c) failed to deliver Gerald Sallis;
d) failed to inform Ms. Sallis of the risks of continuing pregnancy;
e) negligently discharged her patients.

63. On August 16, 2014, Nathalie McCammon-Chase, M.D., deviated from the standard of care in the following ways:

a) if the testimony of Nurse Walker is true, failed to return a telephone call/voicemail from Nurse Walker;
b) failed to gather information about her patients' conditions;
c) failed to come to the hospital to evaluate her patient;
d) failed to order an emergency bedside evaluation of her patients by an available physician; and
e) failed to order an emergency C-section.

64. Dr. Sibai is expected to testify regarding issues involving communication – specifically, what a physician is entitled to rely upon in communication from a nurse or ultrasound technologist. The standard of care for communication between members of an obstetrical team is well within his knowledge and experience.

65. Dr. Sibai is expected to testify that on August 16, 2014 Shelia Walker, R.N. was professionally negligent in the following ways:

a) if Dr. McCammon-Chase's testimony is true, failed to call Dr. McCammon-Chase at 11:00 and continuing thereafter;

b) failed to report Ms. Sallis' report of decreased fetal movement to a physician beginning at 11:00 and continuing thereafter;
c) failed to report Ms. Sallis' non-reactive NST to a physician;
d) failed to notify a physician of the abnormal urine protein;
e) withheld information from Dr. McCammon-Chase regarding the status of Ms. Sallis and her baby; and
f) failed to notify the ultrasound technologist of the non-reactive NST.

66. Dr. Sibai is expected to testify that on August 16, 2014, Olexandra Kolenskyj was professionally negligent in the following ways:

a) failed to notify Ms. Sallis' labor and delivery providers of the BPP result.

67. Additionally, if one assumes the sworn testimony of Olexandra Kolenskyj to be true, Dr. Sibai will testify that on August 16, 2014, West Suburban Hospital was institutionally negligent in the following ways:

a) establishing a policy, procedure and/or protocol prohibiting technologist from communicating BPP results to labor and delivery providers;
b) training/instructing technologist that they were prohibited from communicating the results of a BPP to labor and delivery providers.

68. Dr. Sibai bases his opinions upon his training, experience, and review of the following:

- Dr. McCammon-Chase Office Records
- West Suburban Medical Center Records
- Lurie Children's Hospital Records
- Dr. Washington Records
- Imaging – West Suburban Hospital
- Imaging – Lurie Children's Hospital
- Deposition of Shelia Walker, RN
- Deposition of Thomas Gast, M.D.
- Deposition of Zachary LaMaster, D.O.
- Deposition of Nathalie McCammon-Chase, M.D.
- Deposition of Olexandra Kolenskyj
- Deposition of Tina Devito-Opsenica, RN
- Deposition of Linda Andrus, RN
- Deposition of Syesha Hampton
- Deposition of Tequila Sallis
- Deposition of Gerald Sallis
- P&P – Triage Assessment

- P&P – Placental Examination
- P&P – Fetal Heart Monitoring
- P&P – Chain of Command
- P&P – OB Code Emergencies
- P&P – Cesarean Birth & Preparation of Patient
- Triage Log
- L&D Log
- PACs Timeline
- BPP Worksheet & Requisition Form
- BPP Worksheet & Requisition Form
- Map of West Suburban Medical Center
- On-Call List
- Dr. McCammon-Chase Credentialing File

69. Dr. Sibai reserves the right to expand on these opinions based on the questioning of counsel at the time of his discovery deposition and will supplement her opinions based on the review of additional materials.

70. Once available, Dr. Sibai will review the disclosures and depositions of Defendants' 213(f)(3) witnesses. At trial, Dr. Sibai will testify regarding any and all disagreements with Defendants' disclosed witnesses.

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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

GERALD SALLIS, JR., a Minor, by his Parents and Next Friends, TEQUILA SALLIS and GERALD SALLIS, and TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually,	)	
Plaintiffs,	)	
v.	)	No. 16 L 003989
NATHALIE McCAMMON-CHASE, M.D., et al.,	)	
Defendants.	)	

PLAINTIFFS' RULE 213(f)(3) DISCLOSURE OF HEIDI M. SHINN, R.N., B.S.N.

GERALD SALLIS, JR., a Minor, by his Parents and Next Friends, TEQUILA SALLIS and GERALD SALLIS, and TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually, by their attorneys, CLIFFORD LAW OFFICES, P.C., make the following disclosure pursuant Illinois Supreme Court Rule 213(f)(3):

Heidi M. Shinn, RN, BSN
(Labor & Delivery Nursing)
3449 Farmers Delight Drive
Lewis Center, OH 43035

1. Heidi M. Shinn, RN, BSN is a licensed nurse specializing in obstetrical nursing. Attached to this disclosure is an up-to-date copy of Nurse Shinn's curriculum vitae further outlining her qualifications, education, training, experience and publications.

2. Nurse Shinn defines professional negligence as the failure to do something that a reasonably careful obstetrical nurse would do, or the doing of something that a reasonably careful obstetrical nurse would not do under similar circumstances. As used herein, "was professionally

negligent" is synonymous with "breached the standard of care," "deviated from the standard of care," "failed to possess and apply the knowledge and use the skill and care ordinarily used by a reasonably careful obstetrical nurse under similar circumstances," "failed to do something a reasonably careful obstetrical nurse would do" and "doing of something a reasonably careful obstetrical nurse would not do."

3. Nurse Shinn will be called to testify on issues of standard of care. Nurse Shinn will testify regarding general medical concepts and logical corollaries relevant to her opinions. Additionally, Nurse Shinn is expected to testify, to a reasonable degree of medical certainty as to what is more probably true than not true to the following:

4. Tequila Sallis' prenatal course was as follows:

- EDC of 8/28/14 by prenatal ultrasound at 6 4/7 weeks.
- Mother did suffer from a single presumed yeast infection at 14 weeks which was treated with Diflucan and resolved. Further testing was negative. [McCammon 25] [WS 874].
- Mother had a positive screen for HSV antibodies at 17 weeks and prescribed Valtrex. There are no reported outbreaks. [WS 841, 845, 869, McCammon 26]. HSV 1 & HSV 2 IgM Screens were negative. [WS 870].
- Mom was GBS negative. [WS 868].
- There is no evidence of smoking, alcohol intake or recreational drug use.
- On 6/6/14 at 28 weeks gestation she was diagnosed with gestational diabetes by her prenatal provider, Natalie McCammon, based on the results of a 3hrGTT measuring 150. She was instructed on tracking her glucose with the use of a Glucometer. (See glucose summary). Her glucose remained controlled with Glipizide. It appears she was switched to Levemir with Lispro sliding scale coverage. On 7/14/14 her A1C was 7.17. On 7/18/14 she was referred to Terri Washington, D.O. for a gestational diabetes consult. Her recent labs were: Glucose 180 1.5 hr pp. 7/15/14: Hbg 11.7, A1C 7.1 [4.5-6.5]; BS 175 [83-154] Glu 198. Alb 2.1 [3.5-5.0] Total protein 5.6 [6.4-8.3]. She was instructed to increase her insulin if running high, checking before and after meals. Levemir was increased to 26 units once daily, Novolog 7 units 3x day. Following this adjustment, it appears blood glucose levels remained between 146 -94 up to the day of delivery.

- Prenatal ultrasounds documented appropriate fetal heart rate and appropriate interval growth of the embryo. Amniotic fluid index was normal until 33 weeks gestation. On 7/14/14 an ultrasound was concerning for a low AFI of 7.4cm (5th percentile). She was admitted to labor and delivery for rehydration. By 7/15/14 AFI increased to > 9.8cm. She was discharged on 7/16/4 with acceptable fluid levels. Fetal heart rate during admission remained reactive and reassuring. Weekly follow-up non-stress testing and BPP showed SFI remained normal. AFI on the day of delivery was 12.3 cm. (See ultrasound summary).

5. On August 9, 2014, Ms. Sallis presented to her OBGYN Dr. McCammon-Chase for an obstetrical follow-up appointment. Her estimated gestational age was 37 and 3/7 weeks. Upon exam she was found to have moderate protein in her urine and her blood pressure was 140/90. She complained of on and off headaches and had swelling in her lower extremities. Dr. McCammon-Chase referred Ms. Sallis to triage at West Suburban Medical Center "for r/o preeclampsia." [McCammon 31].

6. At 11:36AM Ms. Sallis underwent a biophysical profile. The BPP result was a perfect score of 8/8 for positive fetal breathing, fetal movement, fetal tone, and amniotic fluid volume. [WS 486]. Her membranes were intact. The fetal heart rate baseline was 155 with moderate variability [WS 453]. A twenty-four hour urine collection for protein was begun at 12:00PM. [WS 87].

7. At 12:20PM a fetal heart monitor was placed. [WS 506].

8. At 12:32PM Ms. Sallis' blood pressure was 146/84 and she complained of a slight headache. Ms. Sallis continued to complain of intermittent headaches throughout the afternoon. [WS 87, 88].

9. At 1:45PM, Dr. McCammon-Chase issued a telephone order to admit Ms. Sallis for twenty-three hour observation. [WS 457]. Ms. Sallis was admitted on continuous fetal monitoring. [WS 459]. At 5:22PM, Nurse Cano reviewed the strip and found there to be no change in the baseline fetal heartrate of 135. Variability was marked with more than twenty-five beats per

minute, accelerations 15x15, and no decelerations. Nurse Cano noted the strip to be a Category I. [WS 88-89].

10. At 6:40PM Nurse Cano again reviewed the strip and noted a fetal baseline heartrate of 130 with no baseline change. There was moderate variability with 6-25 beats per minute, 15x14 accelerations, and no decelerations noted. [WS 89]. At 7:57PM Nurse Morton reviewed the strip and noted a fetal baseline heartrate of 145. Moderate variability was also noted with 15x15 accelerations and no decelerations. The strip was again marked as a Category I. [WS 90].

11. On August 10th at 12:27AM Ms. Sallis' blood pressure was 137/81. She complained of a dull pain in her abdomen, head, and right flank. Nurse Morton reviewed the strip and noted a fetal baseline heartrate of 140 with moderate variability, 15x15 accelerations, and no decelerations. The strip was marked as Category I. [WS 90-91].

12. At 1:27AM Nurse Morton reviewed the strip and noted a fetal baseline heartrate of 140 with moderate variability, 15x15 accelerations, and no decelerations. The strip was marked as a Category I. At 4:18AM Ms. Sallis' blood pressure was 142/64. [WS 91].

13. At 4:36AM Nurse Morton reviewed the strip and noted uterine contractions lasting 60-80 second with a frequency of x2 (minute). The fetal baseline heartrate was 145 with moderate variability, prolonged accelerations, and late decelerations. Nurse Morton marked the strip as a Category II. [WS 91-92].

14. At 5:29AM Nurse Morton again reviewed the strip and noted a fetal baseline heartrate of 145 with moderate variability, 15x15 accelerations, and no decelerations. The strip was marked as Category I. [WS 92].

15. At 7:20AM the electronic fetal monitor was turned off. Nurse Cano noted that the twenty-four hour urine collection continued. At 8:18AM Ms. Sallis' blood pressure was 139/65.

At 8:28AM, Nurse Cano noted that the patient reported irregular contractions but denied any discomfort. [WS 92-93].

16. At 9:12AM the electronic fetal monitor was turned back on. At this time Ms. Sallis' blood pressure was 137/82. At 9:28AM Nurse Cano noted the fetal baseline heartrate to be 140 with no baseline change. There was moderate variability with 15x15 accelerations and no decelerations. The strip was marked as Category I. At 10:39AM Nurse Cano again reviewed the strip and it remained the same. [WS 94-95].

17. At 11:05AM a bedside blood glucose was done with a 166 result. It was repeated with a result of 239, and a third time once again gave a 166 result. Dr. McCammon-Chase was paged. [WS 95].

18. At 2:54PM Ms. Sallis' blood pressure was 141/83. At 3:20PM, the electronic fetal monitoring was discontinued, due to the "reactive" NST. Dr. McCammon-Chase was notified of the twenty-four hour urine collection result of 826. [WS 95, 483].

19. Dr. McCammon-Chase noted that Ms. Sallis had "ruled-in for preeclampsia." The plan was to resume antenatal testing on August 13th with a biophysical profile and NST. Ms. Sallis requested that Dr. McCammon-Chase keep her for an induction that day but Dr. McCammon-Chase refused. [Sallis 25, 77]. Dr. McCammon-Chase told Ms. Sallis she wanted her to go further into the pregnancy. [Sallis 77]. She was told there was no medical reason to induce, so according to Ms. Sallis, "she told me no." [Sallis 78]. There was no discussion about the risks associated with continuing the pregnancy. [Sallis 79].

20. Dr. McCammon-Chase discharged Ms. Sallis home with instructions to return on the 14th as planned. [WS 455].

21. On August 12th at 13:00 Ms. Sallis presented once again to OB triage at West Suburban Medical Center. She reported experiencing a gush of clear fluid/mucus and was told by the doctor to come to the hospital. Ms. Sallis complained of occasional contractions. Her blood pressure was 136/90. [WS 95-96]. A urine dipstick showed a +2 protein (100 mg/1). [WS 676]. No timed collection or continuous BP monitoring was performed.

22. She was placed on a fetal heart monitor around 13:36. Fetal heart tones remained reactive and reassuring throughout the hospitalization. Dr. McCammon-Chase was paged and arrived at 14:50 to assess Ms. Sallis. Dr. McCammon-Chase noted that Ms. Sallis was "at term with GDM and mild preeclampsia." [WS 673]. Ms. Sallis again requested an induction and Dr. McCammon-Chase said no. [Sallis 28]. Dr. McCammon-Chase informed Ms. Sallis that she believed she could go "a couple more days" and that she wanted her "to get as close to 40 weeks as possible." [Sallis 28, 81]. There was no discussion about the risks of continuing the pregnancy or delivering. [Sallis 78, 80-81]. Ms. Sallis recalled Dr. McCammon-Chase informing her that the preeclampsia was likely the cause of her headaches and extensive swelling. [Sallis 81].

23. Induction of labor was decided upon "due to IDGDM (Insulin Dependent Gestational Diabetes Mellitus) and emerging preeclampsia." An NST was scheduled for August 16th and induction for August 18th. Ms. Sallis was then discharged home. [WS 96].

24. On August 16th, Ms. Sallis awoke at 9:30am. She reported that she awoke due to fetal movement. Once she awoke she went to eat breakfast. At the time she ate Gerald was moving. [Sallis 104]. Overall Ms. Sallis described Gerald as a very active fetus throughout the pregnancy. [Sallis 143]. Approximately 20 minutes after finishing breakfast –at or around 10 am- Ms. Sallis reported that Gerald was no longer moving. [Sallis 104]. Ms. Sallis phoned her sister Christian at approx. 10:00 to bring her to the hospital. [Snow 32-33]. When they arrived at the hospital (West

Suburban) a little before 11:00AM and were walking towards the elevators, Ms. Sallis stated that she felt Gerald moving around a little bit. [Snow 33].

25. At 11:00AM Ms. Sallis arrived at OB Triage. She signed into the OB triage log and signed consents. [WS 195, Triage Log]. When she arrived. she reported to the nurse at the triage desk (identified as Shelia Walker, R.N.) that her baby was not moving. [Sallis 144-145]. At the time Ms. Sallis arrived she was Nurse Walker's only patient. [Walker 29]. Ms. Sallis testified that when she arrived in OB triage and reported that her baby was not moving, Nurse Walker sent her downstairs to the radiology department for an ultrasound. [Sallis 33-35; Snow 34]. In contrast, Nurse Walker testified that Ms. Sallis went directly to the radiology suite when she arrived at West Suburban and then came up to OB triage once she found out ultrasound was unavailable. [Walker 55]. Nurse Walker testified that Ms. Sallis did not want to wait for ultrasound and wanted to have her baby monitored while she was waiting. [Walker 56]. Nurse Walker documented that at 11:23 "Received pt. await for BPP. U/S unavailable at present time, pt states was told too be seen in 1 hr." [WS 97]. This entry wasn't entered into the medical record until 18:05, almost two hours after the baby was delivered - (late entry @ 18:05) [WS 520].

26. Finally, by 11:22 Ms. Sallis was on a fetal monitor. Nurse Walker testified to the following regarding the initial tracing:

- The fetal monitor strips from 11:20 to 11:36 showed minimal to absent variability. [Walker 58].
- She asked Ms. Sallis if this was normally her non-stress test and Ms. Sallis stated the baby was sleeping and he would probably wake up a little later. [Walker 14].
- She called Dr. McCammon-Chase to notify her of the strips within ten minutes of Ms. Sallis being on the monitor. [Walker 14]. Nurse Walker testified that when she made this call she did not actually speak with the doctor but left a message on her answering service. Her message would have stated that she was calling in reference to Tequila Sallis for her NST and wanted to give Dr. McCammon-Chase

information based on her fetal strip and urine protein test. She left no other details in the message. [Walker 14-15].

- After leaving a message she went back to the unit. She noticed that the baby had not woken up yet so she changed Ms. Sallis' position and gave her something to drink. She called ultrasound to find out how long it would be until the tech would be available. [Walker 15].

- She made a second call to Dr. McCammon-Chase after she called ultrasound to find out how long it would be until the BPP could be performed. Dr. McCammon-Chase' voicemail picked up. Dr. McCammon-Chase's voice came on and gave her information and then it said the voicemail was full. [Walker 16-17].

- Nurse Walker admitted that she did not document any of these alleged phone calls in the medical record. [Walker 60].

27. Nurse Walker documented that at 11:27, "U/S called spoke with sandy stts ask pt to wait will see pt in 1 1/2hrs." [WS 97]. Ms. Kolenskyj testified that she has no memory of her conversations with Nurse Walker. [Kolenskyj 56]. Nurse Walker testified as follows:

Q. So picking up after you said you called ultrasound to find out about the biophysical profile, what's the next thing that you remember?

A. When I spoke to the ultrasound person and she was telling me that she was in the ED and that she was unable at that time to come get the patient, so I monitored the patient for a little while longer. And I don't remember what happened after that. I would have to refer to my notes.

Q. Right now we're going through your memory, and then we'll get into your notes. The person that you spoke with from ultrasound, do you remember her name?

A. Sandy.

Q. And when you called, did you call the radiology department, or did you call a different number?

A. I spoke to her at 6967.

Q. And she was actually in the emergency room when you talked to her?

A. She picked up the phone. I have no idea where she was. She just stated that she was in the ED.

Q. So she told you that she was in the ER?

A. Yes. Uh-huh, but she couldn't have been if 6967 is the ultrasound number.

Q. So do you know one way or the other whether 6967 goes to a mobile phone or a land line?

A. I don't.

Q. But she told you either way she was in the ED, correct?

A. Uh-huh.

Q. Is that a yes?

A. Yes. I'm sorry. I apologize.

Q. Not a problem. Okay. Anything else you remember saying to Sandy during that conversation other than asking where she was?

A. That I needed an ultrasound and biophysical profile **stat.**

Q. And you used the word stat?

***

Q. In that conversation with Sandy, you used the word **stat**, and you communicated to her that it was an urgent request?

A. Yes.

[Walker 18-20]

28. At 11:44 the strip demonstrated more than twenty-minutes of fetal monitoring which was nonreactive and showed minimal to absent variability. Nurse Walker admitted that this equated to a nonreactive nonstress test and that the standard of care required her to inform a physician of the nonreactive NST. [Walker 59]. She failed to do so.

29. From 11:44 to 11:52, Nurse Walker agreed that the fetal heart strip continued to be nonreactive. [Walker 62]. At this point Ms. Sallis had been on a monitor for 45 minutes with a non-reactive strip which showed minimal to absent variability. Nurse Walker testified that she did

not consider this to be an emergency situation and still felt it appropriate to send Ms. Sallis down for a biophysical profile. [Walker 69-70].

30. At 12:20, Ms. Sallis was taken off the monitor and Nurse Walker noted that she was "down to US" (ultrasound). [WS 97]. Ms. Sallis was accompanied down to ultrasound by her cousin, Syesha Hampton, who had subsequently arrived at the hospital. [Hampton 27]. Ms. Hampton recalls Tequila telling her that she had not felt the baby move since she arrived at the hospital. [Hampton 24].

31. When Ms. Hampton and Ms. Sallis arrived to ultrasound they waited. [Hampton 27-28]. They were told by the technician that they were understaffed and had to wait. [Hampton 27-28].

32. At 12:45, the ultrasound technologist, Ms. Kolenskyj, began performing the Biophysical Profile. [WS 962]. It does not appear from the record or testimony that Ms. Kolenskyj was provided or requested the results of the NST.

33. At 13:00, Nurse Walker documented the results of the urine multistick protein test, which had an abnormal result of a +3 protein. [WS 778]. Nurse Walker testified that she performed the test on the urine herself and had the results of this test since 13:00. Nevertheless, the first time she notified anyone of this abnormal result was at 15:08 when she spoke with Dr. McCammon on the phone. [Walker 95].

34. From 12:45 through 13:56, Ms. Kolenskyj scanned Ms. Sallis. During the exam, Ms. Kolenskyj suggested the baby might be asleep and decided to "shove" or "thrust" the sides of Mrs. Sallis' stomach to facilitate movement. [Hampton 30]. Ms. Sallis described that Ms. Kolenskyj showed her that the baby was not moving. [Sallis 124]. Ms. Sallis testified that she was crying and visibly upset. Ms. Kolenskyj had her hold onto the railing of the hospital bed while

she used the ultrasound doppler to push into her abdomen. [Sallis 124]. Thereafter, Ms. Kolenskyj had Ms. Sallis use the restroom during the exam and return to complete the exam. [Sallis 124].

35. At 13:56 Ms. Kolenskyj completed the exam and wrote the following findings on the BPP worksheet:

> Fetal Breathing 2
> Fetal Movements 0
> Fetal Tone 0
> Amniotic Fluid 2
> Total BPP Score 4/6
>
> Comments: Score 4/8 No movement and tone noted!

36. The BPP was completed at 13:56 [WS 950], with a failing score of 4/8. Two points were scored for fetal breathing and two for amniotic fluid, while zero points were scored for fetal movement and fetal tone. [WS 953]. At 13:45:51, the BPP results were also entered into the PACs system.

37. After the BPP exam there was a wheelchair available outside of the radiology suite and Ms. Hampton pushed Ms. Sallis back to OB Triage. [Sallis 42-43, 125]. At 14:25 Ms. Sallis had blood glucose testing with a result of 138. [WS 784]. According to Nurse Walker this result would have been obtained in OB triage at the bedside using a finger-stick with the lancet and checked in an Accu-Check machine. [Walker 84]. Nurse Walker admitted that Ms. Sallis was back in the OB Triage unit by 14:25. [Walker 86].

38. Dr. McCammon testified that she was called by Shelia Walker, RN around 15:00 and told that Ms. Sallis was back from ultrasound that she was going to put her back on the monitor. [McCammon 27, 30]. She does not recall any other information being conveyed about the baby's status or Ms. Sallis' condition. [McCammon-Chase 31-32].

39. In contrast, Nurse Walker documented that at 15:08 she discussed with Dr. McCammon-Chase the patient's urine drip and decreased fetal movement. [WS 97]. Nurse Walker testified that she told Dr. McCammon-Chase "some of the findings" from the strip earlier that morning. Nurse Walker testified she informed her that there had was minimum variability now and there had been similar minimum variability in the morning. [Walker 22]. Dr. McCammon-Chase told her to admit Ms. Sallis to labor. [WS 97].

40. According to the nursing flowsheet, at 15:00 Shelia Walker, RN called Ms. Kolenskyj asking for the BPP results and was told there were "No Results." [WS 97]. Ms. Kolenskyj claimed that the reason she withheld the results from Nurse Walker was because the rule at West Suburban stated she was not allowed to tell the nurse the results, only the radiologist. [Kolenskyj 61]. She believes she was only permitted to communicate with the radiologist. [Kolenskyj 62-63].

41. At 15:23, Ms. Sallis was finally placed back on the monitor. [WS 527]. Any minimal variability that had previously been present was now absent. Nurse Shinn will testify regarding fetal oxygen reserves. Specifically, she will testify that by 15:36 the baby had depleted his fetal oxygen reserve while awaiting for intervention for almost 5 hours. His heart rate became bradycardic and never recovered. [FHT 37]. Nurse Walker testified that the tracing at this time was a Category III and agreed that it showed prolonged bradycardia. [Walker 104].

42. Dr. McCammon testified that she was called a second time by Nurse Walker and told that the baby's heart had decreased down to the 80's or 90's and stayed down. She requested that they administer a dose of terbutaline and that she would meet them in the OR. [McCammon 27].

43. At 15:38, Nurse Walker called for her charge nurse. At 15:42, the MCH team was called. [WS 97]. Dr. Thomas, Dr. Torres, and Dr. LaMaster were in the room by 15:51, and Dr. McCammon was also called at this time. [WS 98]. A crash c-section "for fetal bradycardia" was called at 16:00. [WS 184, 173].

44. At 16:20, Gerald Sallis was born by emergency C-section. He was noted to be limp/hypotonic and pale. Apgar scores were 1, 1, and 1 at 1, 5, and 10 minutes, respectively, with a point only for heart rate. In all, baby Gerald was born toneless, not breathing, and required mechanical ventilation to sustain life. He was transferred to Lurie Children's Hospital for whole body cooling and additional NICU care.

45. ***Fetal Monitoring Strips from 8/9/14-8/12/14***: Nurse Shinn has reviewed the fetal monitoring strips from Ms. Sallis' admissions at West Suburban Medical Center from August 9th through August 12th. She is expected to testify the strips are reactive and reassuring. From a nursing perspective, it is Nurse Shinn's opinion that baby Gerald was a normal, healthy fetus during the prenatal period.

46. ***Failure to Notify a Physician of Decreased Fetal Movement on Arrival and Obtain a Physician Assessment:*** There is no documented evidence that Nurse Walker spoke with any physician prior to the documented called with Dr. McCammon-Chase at 15:08. Nurse Shinn is expected to testify that Nurse Walker's failure to notify Dr. McCammon-Chase, or another available and qualified physician, of Ms. Sallis' report of decreased fetal movement upon arrival to OB Triage on August 16th and obtain a physician assessment for her patient was a violation of the standard of care. Nurse Walker should have been aware that Ms. Sallis was a high-risk obstetric patient based on her diagnosis of preeclampsia. She should have known that any report of decreased fetal movement in a term pregnancy is concerning and requires a physician assessment,

especially in a mother with a diagnosis of preeclampsia. Ms. Sallis' medical record was available to Nurse Walker in the West Suburban electronic medical record. Additionally, Ms. Sallis was a very reliable historian. Nurse Walker was required to take seriously Ms. Sallis' reports regarding her child's decreased fetal movements and her report of her diagnosis of preeclampsia. Dr. McCammon-Case herself testified that had Ms. Sallis reported decreased fetal movement upon arrival to the hospital, Nurse Walker was required by the standard of care to report that to her. [McCammon-Chase 65-66]. Nurse Shinn will testify that upon arrival to OB triage, the standard of care required Nurse Walker to notify a physician of Ms. Sallis' report and obtain a physician assessment as soon as possible. If Dr. McCammon-Chase was unresponsive or unavailable the standard of care required Nurse Walker to notify an available physician and advocate for physician assessment. Nurse Walker was required to take all steps necessary to obtain a physician assessment of her patient, including activating the chain of command.

47. ***Failure to Monitor Fetal Heart Tones 11:00-11:22***: In addition to notifying a physician of Ms. Sallis' reports of decreased fetal movement, the standard of care required Nurse Walker to immediately place Ms. Sallis on a monitor to evaluate the health and well-being of her child. Sending Ms. Sallis to ultrasound prior to placing her on a monitor was negligent and added further delay to this baby's assessment and delivery.

48. ***Failure to Report a Non-Reactive NST and Advocate for Bedside Evaluation and C-section:*** Nurse Shinn will testify that Nurse Walker's failure to inform Dr. McCammon-Chase or any other physician of Ms. Sallis' non-reactive NST on August 16th, obtain a physician assessment of this mom and baby and advocate for an emergency C-section were violations of the standard of care. Nurse Shinn agrees with Nurse Walker's admission that the strips from approximately 11:22 through 11:44 show minimal to absent variability and are non-reactive. Dr.

McCammon-Chase testified that she would expect to receive a phone call from the OB triage nurse if the patient's nonstress test was nonreactive. [McCammon-Chase 50]. Nurse Walker also testified that a nonreactive NST requires her, as the OB triage nurse, to notify a physician. [Walker 46]. Nurse Shinn is expected to testify that a finding of minimal to absent variability during a twenty-minute period requires physician notification, advocacy for immediate bedside evaluation and emergent C-section. There is no documented evidence that Nurse Walker notified any physician that Ms. Sallis was in the hospital until 15:08. Even assuming Nurse Walker did leave (or attempt to leave) Dr. McCammon a voicemail following the NST, when Nurse Walker was unable to reach Dr. McCammon-Chase the standard of care required immediate notification of another physician on the unit who could perform a bedside evaluation and a C-section if necessary. Nurse Walker was required to take all steps necessary to obtain a physician assessment of her patients, including activating the chain of command.

49. ***Failure to Report +3 Urine Protein to a Physician and Advocate for Bedside Evaluation and C-Section:*** Nurse Shinn will testify that a urine protein result of +3 is abnormal and requires immediate physician notification and evaluation. Nurse Shinn will explain that although it is abnormal enough on its own, this test result combined with the report of decreased fetal movement and the non-reactive NST are even more reason to ensure the result is reported immediately and the patient is evaluated by a physician. Nurse Walker admitted that a +3 result in a patient's urine is an urgent result that requires physician notification. [Walker 97]. Nurse Shinn will testify that Nurse Walker's failure to inform any physician of Ms. Sallis' urine protein for over two hours from the test result at 13:00 until her phone call with Dr. McCammon-Chase at 15:08 is negligence.

50. ***Failure to Document:*** Nurse Shinn will testify that documentation in the electronic medical record is a form of communication which impacts patient safety. As such, the standard of care requires documentation of any and all phone calls or notification attempts to the obstetrician. If one assumes that Nurse Walker did in fact place two phone calls to Dr. McCammon-Chase regarding the non-reactive NST, she was negligent in failing to document those calls.

51. ***Withholding Information:*** If one assumes the testimony of Nurse Walker to be true, on August 16, 2014 Nurse Walker first called Dr. McCammon-Chase and left a voicemail after the NST. Her failure to inform Dr. McCammon-Chase in the voicemail regarding the specifics of the on-going emergency, including but not limited to the results of the NST and the reports of decreased fetal movement was negligent. If one assumes the sworn testimony of Dr. McCammon-Chase to be true, on August 16, 2014 Nurse Walker first called around 14:00, after the time Ms. Sallis returned from ultrasound. At that time Nurse Walker was negligent in withholding information from Dr. McCammon-Chase regarding the condition of Ms. Sallis and her baby. Dr. McCammon-Chase testified that during that phone call she was only told that Ms. Sallis was back from ultrasound and she was going to be put back on the monitor. She does not recall Nurse Walker providing her with any additional information, such as the results of the NST, the reports of decreased fetal movement or the result of proteinuria. Nurse Shinn will testify that Nurse Walker's failure to provide a complete and accurate picture of the on-going obstetrical emergency was a violation of the standard of care.

52. ***Failure to Get Help From an Available Physician:*** Nurse Shinn is expected to testify that given Ms. Sallis' reports of decreased fetal movement and minimal to absent variability apparent on the fetal monitor, her failure to get help for her patients from an available physician

was a violation of the standard of care. The West Suburban Maternal Child Health (MCH) team consisting of Dr. LaMaster, Dr. Torres, Dr. Thomas, and Dr. Tong were either available on the unit or readily accessible on August 16, 2014. [Walker 38-42]. When Ms. Sallis presented with complaints of decreased fetal movement, Nurse Walker was required to ensure that her patients received a physician assessment. When fetal heart monitoring showed minimal to absent variability at 11:22, Nurse Walker was required to inform a physician from MCH team and activate the chain of command to advocate for an emergent physician evaluation and C-section. Nurse Shinn will testify that Nurse Walker's alleged decision to simply wait for Dr. McCammon-Chase to return her call was dangerous and placed the health and safety of Ms. Sallis and her baby in jeopardy. Nurse Walker admitted there was nothing preventing her from notifying any of these other physicians. [Walker 70]. Nurse Shinn is expected to testify that at the time Ms. Sallis arrive in OB triage and was put on the monitor, a reasonably careful labor and delivery nurse had a clear duty to notify any available physician of the situation and advocate for immediate intervention by C-section.

53. ***Failure to Recognize an Obstetrical Emergency and Advocate for a C-section:*** Nurse Shinn will testify that Ms. Sallis' high-risk status, history of preeclampsia, reports of decreased fetal movement, abnormal urine protein, and non-reactive NST upon admission at West Suburban were all signs of an obstetrical emergency which Nurse Walker failed to recognize and react to. Nurse Shinn will testify that a reasonably careful labor and delivery nurse should be capable of recognizing these signs and intervene. Nurse Walker's failure to recognize that her patients were in danger and failure to act are clear violations of the standard of care. As a labor and delivery nurse, Nurse Walker had a duty to advocate for her patient. Her decision to ignore

these obvious warning signs and allow Ms. Sallis and her baby to remain in a dangerous situation without intervention from a physician was negligent.

54. ***Failure to Monitor Fetal Heart Tones 14:25 -15:22:*** Ms. Sallis was back from ultrasound in the OB triage unit by 14:25. Nonetheless, she sat on the unit unmonitored for an hour. It was negligent not to place Ms. Sallis immediately back on a monitor when she returned from ultrasound.

55. ***Failure to Provide NST Information to the Ultrasound Technologist:*** A BPP consists of an NST result combined with four observations made by real-time ultrasonography. Technologists do not perform or interpret non-stress tests. If an NST has been completed prior to a BPP scan, the standard of care requires that those results be relayed to the ultrasound technologist by the labor and delivery nursing staff. Nurse Shinn will testify that Nurse Walker should have notified the ultrasound technologist of the non-reactive NST results before beginning the BPP. Nurse Shinn will explain that a non-reactive NST is extremely concerning and this information should have been shared with the technologist in order to ensure that the BPP was performed STAT and completed in a timely manner. It is Nurse Shinn's opinion that this lack of communication with the ultrasound technologist, particularly in such a high-risk patient, was a violation of the standard of care.

56. Nurse Shinn is expected to testify that on August 16, 2014, Nurse Walker's repeated failure to recognize, report and advocate for her patient's caused a delay of more than 5 hours in the delivery of this child.

57. In summary, Nurse Shinn is expected to testify that on August 16, 2014 Shelia Walker, R.N. was professionally negligent in the following ways:

a) failed to call Dr. McCammon-Chase at 11:00 and continuing thereafter;
b) failed to monitor fetal heart tones from 11:00-11:22;

c) failed to report Ms. Sallis' report of decreased fetal movement to physician beginning at 11:00 and continuing thereafter;
d) failed to obtain timely physician assessment by an available physician beginning at 11:00 and continuing thereafter;
e) failed to activate the chain of command to obtain timely physician assessment beginning at 11:00 and continuing thereafter;
f) failed to advocate for C-section delivery beginning at 11:22 and continuing thereafter;
g) failed to activate the chain of command to obtain C-section delivery beginning at 11:22 and continuing thereafter;
h) failed to report Ms. Sallis' non-reactive NST to a physician;
i) failed to notify a physician of the abnormal urine protein;
j) failed to recognize an obstetrical emergency and advocate for immediate intervention;
k) withheld information from Dr. McCammon-Chase regarding the status of Ms. Sallis and her baby;
l) failed to document alleged notification attempts to Dr. McCammon-Chase;
m) failed to notify the ultrasound technologist of the non-reactive NST; and
n) failed to monitor fetal heart tones from 14:00-15:23.

58. Nurse Shinn bases her opinions upon her training, experience, and review of the following:

- West Suburban Medical Records
- McCammon-Chase Wellness – Prenatal Records
- Triage Log
- L&D Log
- PACs Timeline
- BPP Worksheet & Requisition Form
- Map of West Suburban Medical Center
- On-Call List
- Nursing Schedule 8/12 & 8/16
- Deposition of Shelia Walker, RN
- Deposition of Thomas Gast, M.D.
- Deposition of Zachary LaMaster, D.O.
- Deposition of Nathalie McCammon-Chase, M.D.
- Deposition of Olexandra Kolenskyj
- Deposition of Tina Devito-Opsenica, RN
- Deposition of Linda Andrus, RN
- Deposition of Syesha Hampton
- Deposition of Tequila Sallis
- Deposition of Gerald Sallis
- P&P – Triage Assessment
- P&P – Placental Examination

- P&P – Fetal Heart Monitoring
- P&P – Chain of Command
- P&P – OB Code Emergencies
- P&P – Cesarean Birth & Preparation of Patient

59. Nurse Shinn reserves the right to expand on these opinions based on the questioning of counsel at the time of her discovery deposition and will supplement her opinions based on the review of additional materials.

60. Once available, Nurse Shinn will review the disclosures and depositions of Defendants' 213(f)(3) witnesses. At trial, Nurse Shinn will testify regarding any and all disagreements with Defendants' disclosed witnesses.

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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

GERALD SALLIS, JR., a Minor, by his Parents and Next Friends, TEQUILA SALLIS and GERALD SALLIS, and TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually,	)	
Plaintiffs,	)	
v.	)	No. 16 L 003989
NATHALIE McCAMMON-CHASE, M.D., et al.,	)	
Defendants.	)	

PLAINTIFFS' RULE 213(f)(3) DISCLOSURE OF SAMANTHA N. SAWYER, MHA, RDMS, RDCS

GERALD SALLIS, JR., a Minor, by his Parents and Next Friends, TEQUILA SALLIS and GERALD SALLIS, and TEQUILA SALLIS, Individually, and GERALD SALLIS, Individually, by their attorneys, CLIFFORD LAW OFFICES, P.C., make the following disclosure pursuant Illinois Supreme Court Rule 213(f)(3):

Samantha N. Sawyer, MHA, RDMS, RDCS
(Diagnostic Medical Sonography)
University of Southern Indiana
Health Professionals Building, Office #3064
8600 University Blvd.
Evansville, IN 47712

1. Samantha N. Sawyer, MHA, RDMS, RDCS is a licensed sonographer specializing in diagnostic medical sonography. Attached to this disclosure is an up-to-date copy of Ms. Sawyer's curriculum vitae further outlining her qualifications, education, training, experience and publications.

2. Ms. Sawyer defines professional negligence as the failure to do something that a reasonably careful ultrasound technologist would do, or the doing of something that a reasonably careful ultrasound technologist would not do under similar circumstances. As used herein, "was professionally negligent" is synonymous with "breached the standard of care," "deviated from the standard of care," "failed to possess and apply the knowledge and use the skill and care ordinarily used by a reasonably careful ultrasound technologist under similar circumstances," "failed to do something a reasonably careful ultrasound technologist would do" and "doing of something a reasonably careful ultrasound technologist would not do."

3. Ms. Sawyer will be called to testify on issues of standard of care. Ms. Sawyer will testify regarding general medical concepts and logical corollaries relevant to her opinions including but not limited to her interpretation of all relevant imaging and fetal biophysical profile testing. Additionally, Ms. Sawyer is expected to testify, to a reasonable degree of medical certainty, as follows:

4. On August 16, 2014, Tequila Sallis (then age 24) awoke at 9:30am. She reported that she awoke due to fetal movement. Once she awoke she went to each breakfast. At the time she ate Gerald was moving. [Sallis Dep. 104]. Overall Ms. Sallis described Gerald as a very active fetus throughout the pregnancy. [Sallis Dep. 143]. Approximately 20 minutes after finishing breakfast -at or around 10 am- Ms. Sallis reported that Gerald was no longer moving. [Sallis 104]. Ms. Sallis phoned her sister Christian at approx. 10:00 to bring her to the hospital. [Snow 32-33]. When they arrived at the hospital a little before 11:00AM and were walking towards the elevators Ms. Sallis stated that she felt Gerald moving around a little bit. [Snow 33].

5. At 11:00AM Ms. Sallis arrived at OB Triage and signed consents. [WS 195]. When she arrived she reported to the nurse at the triage desk, identified as Shelia Walker, R.N.,

that her baby was not moving. [Sallis 144-145]. At the time Ms. Sallis arrived she was Nurse Walker's only patient. [Walker 29]. Nurse Walker sent Tequila to downstairs to the radiology department for an ultrasound. [Sallis 33-35; Snow 34].

6. Ms. Sallis was accompanied to radiology by her sister Christian Snow. When Christian and Tequila got to the radiology suite, they were told by the receptionist that the tech was not available and wouldn't be for a while. [Snow 35]. Tequila testified that the receptionist/secretary told her they were swamped and that there was only one technologist and she was currently in the ER. [Sallis 34]. The receptionist sent Tequila back upstairs and said she would call when the ultrasound tech was ready. [Sallis 36].

7. According to the radiology records from the PACs McKesson system, at 11:13 the ultrasound technologist, Olexandra Kolenskyj (i.e. "Sandy") was performing a USV Doppler on a patient. [WS 962].

8. Ms. Sallis and Ms. Snow arrived back to OB triage and at 11:22 Nurse Walker placed Ms. Sallis on a fetal monitor. Nurse Walker testified that she subsequently called ultrasound to find out when an ultrasound could be done. According to the record, she spoke with "Sandy" in Ultrasound at 11:27 who stated that the patient will be seen in one and a half hours. [WS 97]. Ms. Kolenskyj testified that she has no memory of her conversations with Nurse Walker. Regarding this conversation, Nurse Walker testified as follows:

> Q. So picking up after you said you called ultrasound to find out about the biophysical profile, what's the next thing that you remember?
>
> A. When I spoke to the ultrasound person and she was telling me that she was in the ED and that she was unable at that time to come get the patient, so I monitored the patient for a little while longer. And I don't remember what happened after that. I would have to refer to my notes.

Q. Right now we're going through your memory, and then we'll get into your notes. The person that you spoke with from ultrasound, do you remember her name?

A. Sandy.

Q. And when you called, did you call the radiology department, or did you call a different number?

A. I spoke to her at 6967.

Q. And she was actually in the emergency room when you talked to her?

A. She picked up the phone. I have no idea where she was. She just stated that she was in the ED.

Q. So she told you that she was in the ER?

A. Yes. Uh-huh, but she couldn't have been if 6967 is the ultrasound number.

Q. So do you know one way or the other whether 6967 goes to a mobile phone or a land line?

A. I don't.

Q. But she told you either way she was in the ED, correct?

A. Uh-huh.

Q. Is that a yes?

A. Yes. I'm sorry. I apologize.

Q. Not a problem. Okay. Anything else you remember saying to Sandy during that conversation other than asking where she was?

A. That I needed an ultrasound and biophysical profile **stat.**

Q. And you used the word stat?

***

Q. In that conversation with Sandy, you used the word **stat**, and you communicated to her that it was an urgent request?

A. Yes.

[Walker 18-20]

9. According to the record, Sandy told Nurse Walker it would be 1 ½ hours until the patient could be seen. [WS 97].

10. According to the radiology records from the PACs McKesson system, at 11:27 Ms. Kolenskyj was not occupied.

11. Ms. Sallis was on a monitor for non-stress from 11:21 through around 12:22 when she was taken off the monitor. At 12:20, Nurse Walker noted that the patient was "down to US" (ultrasound). [WS 97]. Ms. Sallis was accompanied down to ultrasound by her cousin, Syesha Hampton, who had subsequently arrived at the hospital. [Hampton 27]. Ms. Hampton recalls Tequila telling her that she had not felt the baby move since she arrived at the hospital. [Hampton 24].

12. At 11:40, Ms. Kolenskyj performed a right upper quadrant (RUQ) ultrasound on a patient. [WS 962]. She testified that on average a RUQ ultrasound takes on average 10-25 minutes. [Kolenskyj 41]. Therefore, at most, Ms. Kolenskyj was finished scanning at 12:05.

13. When Ms. Hampton and Ms. Sallis got down to ultrasound they waited. [Hampton 27-28]. They were told by the technologist that they were understaffed and had to wait. [Hampton 27-28].

14. At 12:45, the ultrasound technologist, Ms. Kolenskyj, began performing the Biophysical Profile. [WS 962]. It does not appear from the record or testimony that Ms. Kolenskyj was provided or requested the results of the NST.

15. During the exam, Ms. Kolenskyj suggested the baby might be asleep and decided to "shove" or "thrust" the sides of Mrs. Sallis' stomach to facilitate movement. [Hampton 30]. Ms. Sallis described that Ms. Kolenskyj showed her that the baby was not moving. [Sallis 124]. Ms.

Sallis testified that she was crying and visibly upset. Ms. Kolenskyj had her hold onto the railing of the hospital bed while she used the ultrasound doppler to push into her abdomen. [Sallis 124]. Thereafter, Ms. Kolenskyj had Ms. Sallis use the restroom during the exam and return to complete the exam. [Sallis 124].

16. From 12:45 though 13:56, Ms. Kolenskyj scanned Ms. Sallis. Ms. Kolenskyj testified that standard protocol calls for a BPP to last 30 minutes. [Kolenskyj 73]. Within that time frame a technologist should accomplish observation, measurements, weight estimation and systolic/diastolic ratio. [Kolenskyj 73]. Ms. Kolenskyj gave no explanation why this exam took over an hour.

17. At 13:56 Ms. Kolenskyj completed the exam and wrote the following findings on the BPP worksheet:

Fetal Breathing 2
Fetal Movements 0
Fetal Tone 0
Amniotic Fluid 2
Total BPP Score 4/6

Comments: Score 4/8 No movement and tone noted!

18. At 13:45:51, the BPP results were also entered into the PACs system. Ms. Kolenskyj testified that in a situation where a BPP result is 4 out of 8 it would have been her practice to inform the radiologist on duty in person or over the phone immediately after the study is complete. [Kolenskyj 37].

19. The BPP was completed at 13:56 [WS 950], with a failing score of 4/8. Two points were scored for fetal breathing and two for amniotic fluid, while zero points were scored for fetal movement and fetal tone. [WS 953].

20. Ms. Kolenskyj does not have a specific memory of August 16th, however, she testified that it is her custom and practice as well as hospital protocol to alert the interpreting physician of the completed exam by both calling and walking into the room. [Kolenskyj 24]. According to Ms. Kolenskyj, the radiology viewing suite is on the same floor as the ultrasound suite. [Kolenskyj 67]. She also has a portable phone that she carried with her during her shift and the radiologist has a portable phone with them during their shift. [Kolenskyj 66-67]. She testified that in a situation where a BPP result is 4 out of 8 it would have been her practice to inform the radiologist on duty in person or over the phone immediately after the study is complete. [Kolenskyj 37]. Ms. Kolenskyj admitted that in the setting of a 4 out of 8 score on a BPP it is protocol to inform the radiologist right away when the exam is complete. [Kolenskyj 52].

21. According to the exam access report after the study was completed, Ms. Kolenskyj did the following between 14:09 and 14:14:

14:09	opened the BPP study
14:09	study updated
14:13-14:14	scanned documents modified
14:14	study reviewed
14:14	study closed
14:14	study opened
14:14	22 images deleted + study closed

22. At 14:37, Ms. Kolenskyj performed a transvaginal ultrasound on another patient. Ms. Kolenskyj testified that in her experience a transvaginal ultrasound takes about 15-20 minutes. [Kolenskyj 39].

23. According to the nursing flow-sheet, at 15:00 Shelia Walker, R.N. called Ms. Kolenskyj asking for the BPP results and was told there were "No Results." [WS 97]. Ms. Kolenskyj claimed that the reason she withheld the results from Nurse Walker was because the rule at West Suburban was that she was not allowed to tell the nurse the results, only the radiologist.

[Kolenskyj 61]. She believes she was only permitted to communicate with the radiologist. [Kolenskyj 62-63].

24. Thomas Gast, M.D. was the radiologist on-duty that day. According to the exam record access report, Dr. Gast first accessed the BPP study at 15:14. Dr. Gast recalls the events of August 16th. In contrast to Ms. Kolenskyj, Dr. Gast's recollection is that he was not told of the results by Ms. Kolenskyj until 15:14. Dr. Gast testified that he recalls Ms. Kolenskyj walking into the radiology reading room and verbally telling him that the results of the BPP study were 4 out of 8 and mentioning something about extending the test. [Gast 32]. He testified that he immediately opened the study, looked at the images, dictated the report and called the bedside nurse in labor and delivery to alert her to the results. [Gast 35-36]. Dr. Gast testified that he would have immediately communicated that this was a concerning score which needed OB/GYN follow-up. [Gast 18-19]. Dr. Gast does not remember the name of the nurse he called or the number he called. [Gast 10]. There is no record in the nursing flowsheets of a call. There is no mention in Dr. Gast's official report of a call. According to the PACs exam access report, Dr. Gast dictated his report and closed the study at 15:27. Dr. Gast testified that he would have expected Ms. Kolenskyj to inform him of the 4 out of 8 results as soon as possible. [Gast 37]. Dr. Gast testified that he does not know what Ms. Kolenskyj had been doing since 13:56 when she closed and uploaded the study. [Gast 36-37].

25. Ms. Sawyer will testify regarding what a reasonably careful and well qualified ultrasound technologist would have done in the course of responding to a request for a BPP, performing a BPP and reporting a BPP on a patient like Ms. Sallis.

26. ***Stat/Urgent Request for BPP***: When Ms. Kolenskyj received a STAT/Urgent request for a BPP from Nurse Walker the standard of care required performing the BPP within 30

minutes or sooner of the request for the patient's safety. Based on her review of the PACs McKesson radiology log, Ms. Sawyer will testify there does not appear to be any reason why Ms. Kolenskyj delayed even starting the exam for an hour and 18 minutes (11:27-12:45). Ms. Kolenskyj was negligent in failing to begin the BPP until 12:45 If a request for a STAT/Urgent BPP cannot be completed within 30 minutes of the request because the technologist is occupied or otherwise unavailable, the standard of care requires the technologist to immediately contact her supervising radiologist for assistance. If the radiologist is unavailable or non-responsive, the standard of care required the technologist to activate the chain of command to advocate for testing to be completed. In this case, that would have required Ms. Kolenskyj to contact Dr. Gast at or around 11:27 to inform him of the situation. If Dr. Gast was unavailable, Ms. Kolenskyj was required to call her supervising technologist, Larry Albaracin, to activate the chain of command. Ms. Kolenskyj was negligent in failing to call Dr. Gast and/or activating the chain of command following at request for a STAT/Urgent BPP if she was unable to complete the exam herself.

27. ***Timing of a BPP***: Guidelines for the completion of BPP call for observation within a 30-minute time-frame in order to properly assess fetal well-being. *See ACOG Practice Bulletin 145 Antepartum Fetal Surveillance*. Ms. Sawyer is familiar with the American College of Obstetricians and Gynecologists' Practice Bulletin on Antepartum Fetal Surveillance. "Extending" a BPP exam to 71 minutes is unnecessary and a blatant violation of the standard of care. Additionally, "extending" the scan beyond the standard 30-minute observation window has the potential to skew results. In the setting of a failing score, "extending" the exam delays intervention and puts the fetus at risk of harm. Ms. Kolenskyj negligently scanned this patient for 1 hour and 11 minutes (12:45-13:56). Had Ms. Kolenskyj been practicing within the standard of care, she

should have completed the exam within 30 minutes and immediately reported the results based on a 30-minute observation window.

28. ***NST Information:*** A BPP consists of an NST result combined with four observations made by real-time ultrasonography. Technologists do not perform or interpret non-stress tests. However, if an NST has been completed prior to a BPP scan, the standard of care requires that those results be relayed to the ultrasound technologist by the labor and delivery nursing staff. If the results are not relayed, the standard of care requires that the ultrasound technologist affirmatively inquire if the patient was being monitored and if the strips were reactive or non-reactive. Ms. Sawyer will testify that it is the technologist's duty to confirm the results of the NST prior to the BPP being performed. It is Ms. Sawyer's opinion that this lack of communication with the labor and delivery staff, particularly in such a high-risk patient, was a violation of the standard of care. Additionally, Ms. Sawyer will testify that a reasonably careful and well-qualified technologist knows that in the setting of a non-reactive NST and a request for a STAT/Urgent BPP, the scan should be succinct, not to exceed the 30-minute window, to ensure the patient be returned to labor and delivery for immediate intervention(s).

29. ***Shoving, Thrusting, Pushing and Instructing the Patient to Use the Restroom During Exam:*** Ms. Sawyer will testify that Ms. Kolenskyj's decision to "push," "shove," or "thrust" with the ultrasound doppler is poor practice for an ultrasound technologist. Ms. Sawyer will explain that a stimulation such as applying stomach pressure is not recommended for a BPP because the scan should reflect the baby's current state. Ms. Sawyer will also testify that the BPP should not be stopped unless the patient requests to stop the exam or there is a medical indication to do so. Ms. Sawyer will explain that by the third trimester bladder volume has no effect on the BPP results and an empty bladder adds no benefit to the exam. Ms. Sawyer will testify that

allowing the patient to go off the monitor and use the bathroom is poor practice, particularly in the midst of a time-sensitive emergency.

30. ***Consultation with Radiology During the Scan:*** Ultrasonography is often a collaborative process between technologists and radiologist. According to the deposition testimony, Dr. Gast was available to Ms. Kolenskyj for consultation. He was sitting in a radiology reading room just down the hall. Moreover, given her inability to obtain fetal movement and tone, Ms. Kolenskyj should have consulted with Dr. Gast during her exam.

31. ***Recognition of an Emergency***: Although the reviewing radiologist will ultimately complete the official report, a reasonably careful and well-qualified technologist is required to be able to recognize that a 4/8 BPP is a critical result and represents an emergency. Ms. Kolenskyj's failure to recognize the emergency nature of the BPP results in front of her and act on such a critical result was medical negligence.

32. ***Notification to Labor and Delivery Providers:*** Ms. Sawyer will testify that a reasonably careful and well qualified ultrasound technologist would have immediately notified the labor and delivery team during the BPP once no movement or tone was noted. Ms. Sawyer will explain that a BPP score of 4 indicates that immediate intervention may be warranted, and the ultrasound technologist must directly inform the patient's labor and delivery providers of the result by phone or in person. Ms. Kolenskyj's failure to independently report a 4/8 BPP directly to one of Ms. Sallis' labor and delivery providers was negligent.

33. ***Advocacy for Immediate Evaluation:*** In addition to notification, it is the duty of the technologist to advocate that the patient be escorted to labor and delivery immediately for evaluation. If a labor and delivery provider cannot be reached for notification or evaluation of the patient, the technologist must activate the chain of command to ensure the patient is evaluated.

Ms. Kolenskyj's failure to advocate for Ms. Sallis' immediate evaluation by a labor and delivery provider was negligent.

34. ***Withholding Information:*** Not only did Ms. Kolenskyj fail to independently report the 4/8 result to Ms. Sallis' labor and delivery providers, she actively withheld this information when she was contacted by Nurse Walker and directly asked for the results. Withholding a 4/8 result from a patient's labor and delivery provider is willful and wanton conduct.

35. ***Hospital Policy Preventing Notification of Labor and Delivery:*** Ms. Kolenskyj's claim that she was not permitted to inform Nurse Walker of the BPP results based on a hospital policy put in place in 2014 is very concerning. Ms. Sawyer has experience in the development and implementation of the hospital policies and procedures relating to ultrasound technologists. Assuming Ms. Kolenskyj was not lying under oath, West Suburban Hospital's implementation of a policy, protocol or training program which prohibited ultrasound technologists from reporting BPP results directly to labor and delivery providers, even when specifically asked, is negligent.

36. ***Status of a STAT Exam:*** Ms. Sawyer is familiar with the McKesson PACs system in place at West Suburban Hospital and will testify that the ultrasound technologist has both the duty and ability to change an order's priority status for a failing BPP score of 4/8. Ms. Sawyer will testify that a failing BPP score should marked as STAT in the McKesson PACs system in order to alert all radiologists with access to the system that the exam is urgent at the moment it is uploaded. According to Dr. Gast, had this study been marked as STAT in the system, it would have come up on his screen in the reading room as a STAT study. According to Dr. Gast, studies marked as STAT are read as soon as possible. [Gast 28].

37. ***Notification to the Reviewing Radiologist:*** Ms. Sawyer will testify that the standard of care requires a BPP result of 4/8 to be communicated directly to the interpreting

radiologist by phone or in person at the completion of the 30-minute exam. If one assumes the sworn testimony of Dr. Gast to be true, then on August 16, 2014, Ms. Kolenskyj was negligent in failing to inform Dr. Gast of the BPP result until at or around 15:14. If one assumes that Ms. Kolenskyj did in fact notify Dr. Gast immediately upon completion of the exam at 13:56, pursuant to her sworn testimony regarding her custom and practice, then her notification was delayed by her extended exam and other delays set forth above.

38. ***Documentation of Notification:*** Ms. Sawyer will testify that documentation in the electronic medical record is a form of communication which impacts patient safety. As such, the standard of care requires documentation of any and all notifications of results to the radiologist and the labor and delivery providers. If one assumes that Ms. Kolenskyj did in fact notify Dr. Gast of the results immediately upon completion of the exam at 13:56, pursuant to her sworn testimony regarding her custom and practice, she was negligent in failing to document the notification.

39. ***Follow-Up on Official Read:*** Ms. Sawyer will testify that it is the ultrasound technologist's duty to ensure that that there is an official read on a failing 4/8 BPP within thirty minutes of the exam's completion. If an official read has not been generated within thirty minutes, the standard of care requires the technologist to follow-up with the interpreting physician within thirty minutes. If the interpreting physician is not available, the standard of care requires the technologist to activate her chain of command to advocate for an official interpretation and report of the scan. If one assumes that Ms. Kolenskyj did in fact notify Dr. Gast of the results immediately upon completion of the exam at 13:56, pursuant to her sworn testimony regarding her custom and practice, she was negligent in failing to follow-up with Dr. Gast by 14:26 to ensure there had been an official read.

40. In summary, Ms. Sawyer is expected to testify that on August 16, 2014 Olexandra Kolenskyj was professionally negligent in the following ways:

a) failed to perform a STAT BPP within 30 minutes of the request;
b) failed to inform Dr. Gast of a request for a STAT BPP;
c) failed to activate the chain of command to advocate for completion of a STAT BPP; within 30 minutes of the request;
d) delayed the performance of STAT BPP for 1 hour and 18 minutes;
e) performed a BPP scan that lasted 71 minutes;
f) failed to obtain the results of the non-stress test;
g) utilized improper techniques to "stimulate" the fetus which unnecessarily and further delayed the exam;
h) failed to call Dr. Gast for immediate consultation during the BPP exam;
i) failed to recognize an emergency and act on a critical result;
j) failed to notify Ms. Sallis' labor and delivery providers of the BPP result;
k) failed to advocate for immediate evaluation of Ms. Sallis and her fetus based on the results of the BPP, including by activation of the chain of command, if necessary;
l) withheld the BPP result from Nurse Walker;
m) failed to prioritize the study as STAT;
n) failed to timely report the results of the BPP exam to Dr. Gast;
o) failed to document notification of Dr. Gast; and
p) failed to follow-up to ensure a timely official read.

41. Additionally, Ms. Sawyer is expected to testify that on August 16, 2014 West Suburban Hospital was institutionally negligent in the following ways:

a) establishing a policy, procedure and/or protocol prohibiting technologist from communicating BPP results to labor and delivery providers;

b) training/instructing technologist that they were prohibited from communicating the results of a BPP to labor and delivery providers.

42. Ms. Sawyer bases her opinions upon her training, experience, and review of the following:

- West Suburban Medical Records
- West Suburban Fetal Monitoring Strips
- Imaging (1 disc) West Suburban Medical Center
- Deposition of Shelia Walker, RN
- Deposition of Thomas Gast, M.D.
- Deposition of Olexandra Kolenskyj
- Deposition of Syesha Hampton

- Deposition of Tequila Sallis
- P&P – Accessing Reports
- P&P – Order Processing
- P&P – Performance of Radiological Exams
- P&P – Result Reporting
- Radiology/Tech Schedule
- PACS Access Report

43. Ms. Sawyer will supplement her opinions based on the review of additional materials including but not limited to her review of the complete West Suburban Audit trail and requested policies and procedures relating to obstetrical ultrasound.

44. Once available, Ms. Sawyer will review the disclosures and depositions of Defendants' 213(f)(3) witnesses. At trial, Ms. Sawyer will testify regarding any and all disagreements with Defendants' disclosed witnesses.

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May 1, 2019

Sarah F. King
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Re: Gerald Sallis, Jr. DOB: 8/16/2014

Dear Ms. King,

I am a physician specializing in radiology. I am familiar with the relevant literature and guidelines applicable to the subject matter in this case. I am qualified by experience and demonstrated competence in the subject of this case. I have reviewed the medical records of Gerald Sallis, Jr. and Tequila Sallis, including, but not limited to, records from West Suburban Medical Center, including all imaging, PACS exam access reports, requisition forms, radiology suite scheduling, policies and procedures and the depositions of Thomas Gast, M.D., Olexandra Kolenskyj, Shelia Walker, R.N., Tequila Sallis, Syesha Hampton, Christian Snow and Thomas LeMaster, M.D.

The opinions stated herein are based upon a reasonable degree of medical certainty based upon my training, experience and my review of the aforementioned materials. My opinions, based on a reasonable degree of medical certainty, are that Olexandra Kolenskyj and Thomas Gast, M.D. were professionally negligent in their involvement with a biophysical performed on Ms. Tequila Sallis on August 16, 2014. Additionally, West Suburban Hospital was institutionally negligent in its alleged protocol and training of technologists regarding the communication of BPP results.

My review and understanding of the pertinent facts are as follows:

On August 16, 2014, at 11:00AM, Ms. Sallis was approximately 39 weeks pregnant. She began experiencing decreased fetal movement and presented to West Suburban Medical Center OB Triage Unit.

At 11:00AM Ms. Sallis arrived at OB Triage and signed consents. [WS 195]. When she arrived, she reported to Shelia Walker, R.N., that her baby was not moving. [Sallis 144-145]. At the time Ms. Sallis arrived she was Nurse Walker's only patient. [Walker 29]. Ms. Sallis was sent to radiology for testing but returned to the family birthing unit after being told that the that the technologist was not available and wouldn't be for a while. [Snow 35]. Ms. Sallis testified that the receptionist/secretary told her they were swamped and that there was only one technologist

available who was currently in the ED. [Sallis 34]. Ms. Sallis was sent back upstairs and was told that the receptionist would call when the ultrasound technologist was ready. [Sallis 36]. According to the radiology schedule, the ultrasound suite was not occupied and Ms. Kolenskyj was not attending to another patient until 11:13AM, when Ms. Kolenskyj performed a venous doppler on another patient [WS 962].

At 11:22 am, Nurse Walker called radiology and spoke with Ms. Kolenskyj to find out when an ultrasound could be done. According to the radiology schedule, the ultrasound suite was not occupied and Ms. Kolenskyj was not attending to another patient at that time. Nonetheless, according to the nursing flowsheet, Ms. Kolenskyj informed Nurse Walker that the patient would need to wait 1 ½ hours to be seen. Ms. Kolenskyj testified that she has no memory of her conversations with Nurse Walker. Regarding this conversation, Nurse Walker testified that she informed Ms. Kolenskyj that her patient required a STAT BPP which was urgent. [Walker 18-20].

At 11:40, Ms. Kolenskyj performed an ultrasound of the right upper quadrant (RUQ) on another patient. In her experience a RUQ ultrasound on average takes 10-25 minutes. [Kolenskyj 41].

Approximately an hour later, Ms. Sallis was taken off the monitor and sent down to radiology. Ms. Kolenskyj did not begin performing the biophysical profile until 12:45. From 12:45 though 13:56, Ms. Kolenskyj scanned Ms. Sallis.

During the exam, Ms. Kolenskyj suggested the baby might be asleep and decided to "shove" or "thrust" the sides of Mrs. Sallis' stomach to facilitate movement. [Hampton 30]. Ms. Sallis described that Ms. Kolenskyj showed her that the baby was not moving. [Sallis 124]. Ms Sallis testified that she was crying and visibly upset. Ms. Kolenskyj had her hold onto the railing of the hospital bed while she used the ultrasound doppler to push into her abdomen. [Sallis 124]. Thereafter, Ms. Kolenskyj had Ms. Sallis use the restroom during the exam and return to complete the exam. [Sallis 124].

At 13:56 Ms. Kolenskyj completed the exam and wrote the following findings on the BPP worksheet:

Fetal Breathing 2
Fetal Movements 0
Fetal Tone 0
Amniotic Fluid 2
Total BPP Score 4/8

Comments: Score 4/8 No movement and tone noted!

At 13:45:51, the BPP results were also entered into the PACS system. Ms. Kolenskyj does not remember the events of August 16th. She testified that it is her custom and practice as well as hospital protocol to alert the interpreting physician of the completed exam by both calling and walking into the room. [Kolenskyj 24]. According to Ms. Kolenskyj, the radiology viewing suite is on the same floor as the ultrasound suite. [Kolenskyj 67]. She also has a portable phone that she carried with her during her shift and the radiologist has a portable phone with them during their shift. [Kolenskyj 66-67]. She testified that in a situation where a BPP result is 4 out of 8 it would have been her practice to inform the radiologist on duty in person or over the phone immediately

after the study is complete. [Kolenskyj 37]. Ms. Kolenskyj testified that in the setting of a 4 out of 8 score on a BPP it is protocol to inform the radiologist right away when the exam is complete. [Kolenskyj 52].

According to the exam access report after the study was completed, Ms. Kolenskyj did the following between 14:09 and 14:14:

14:09	opened the BPP study
14:09	study updated
14:13-14:14	scanned documents modified
14:14	study reviewed
14:14	study closed
14:14	study opened
14:14	22 images deleted + study closed

At 14:37, Ms. Kolenskyj performed a transvaginal ultrasound on another patient. Ms. Kolenskyj testified that in her experience a transvaginal ultrasound takes about 15-20 minutes. [Kolenskyj 39].

According to the nursing flow-sheet, at 15:00 Shelia Walker, RN called Ms. Kolenskyj asking for the BPP results and was told there were "No Results." Ms. Kolenskyj testified that the reason she withheld the results from Nurse Walker was because the rule at West Suburban was that she was not allowed to tell the nurse the results, only the radiologist. [Kolenskyj 61]. She believes she was only permitted to communicate with the radiologist. [Kolenskyj 62-63].

Thomas Gast, M.D. was the radiologist on-duty that day. According to the exam record access report, Dr. Gast first accessed the BPP study at 15:14. Dr. Gast recalls the events of August 16th. In contrast to Ms. Kolenskyj, Dr. Gast's recollection is contrary to Ms. Kolenskyj's testimony, and he believes he was not told of the results by Ms. Kolenskyj until 15:14. [Gast 36]. Dr. Gast testified that he recalls Ms. Kolenskyj walking into the radiology reading room and verbally telling him that the results of the BPP study were 4 out of 8 and mentioning something about extending the test. [Gast 32]. He testified that the he immediately opened the study, looked at the images, dictated the report and called the bedside nurse in labor and delivery to alert her to the results. [Gast 35-36]. Dr. Gast testified that he would have immediately communicated that this was a concerning score that needed OB/GYN follow-up. [Gast 18-19]. Dr. Gast does not remember the name of the nurse he called or the number he called. [Gast 10]. There is no record in the nursing flowsheets of a call. There is no mention in Dr. Gast's official report of a call. Nurse Shelia Walker testified that she never spoke with Dr. Gast regarding the results of the BPP. [Walker 132].

According to the PACS exam access report, Dr. Gast dictated his report and closed the study at 15:27. Dr. Gast testified that he would have expected Ms. Kolenskyj to inform him of the 4 out of 8 results as soon as possible. [Gast 37]. Dr. Gast testified that he does not know what Ms. Kolenskyj had been doing since 13:56 when she closed and uploaded the study. [Gast 36-37].

At 15:23, Ms. Sallis was placed back on the monitor. The tracing was a Category III due to absent variability. At 15:42 an MCH team was called. At 16:04, Ms. Sallis was taken to the OR for crash primary low transverse C-section. At 16:20, Gerald Jr. was delivered by Nathalie McCammon-

Chase, Zachary LaMaster, DO, FP, and Dr. Doroskova. Gerald's Apgars were 1/ 1/ 1. He was diagnosed with severe HIE and transferred to Lurie Children's Hospital for care.

A biophysical profile result of 4 out of 8 is an emergency. This result is an indication that the fetus needs immediate evaluation by a qualified provider. With a profile of a 4 out of 8, the standard of care requires an ultrasound technologist to immediately inform the on-duty radiologist and/or Ob/GYN/MFM and the patient's labor and delivery provider to report the results and request evaluation. Similarly, the standard of care requires a radiologist to inform a qualified provider of the result and request immediate evaluation of mom and baby.

The results of the BPP were known at 13:45. According to the testimony of Dr. Gast, the bedside provider was not notified of the results and the need for immediate evaluation until sometime between 15:14 and 15:27. It is my opinion that this was a negligent delay in the reporting of the emergent BPP results to a qualified health professional and a negligent delay in advocating for immediate evaluation.

With respect to the communication of the BPP results and the need for evaluation of mother and baby, my opinions are as follows:

If one assumes the sworn testimony of Dr. Gast to be true, then it is my opinion that on August 16, 2014, Olexandra Kolenskyj deviated from the standard of care in the following ways:

a) failed to call Dr. Gast for immediate consultation during the BPP exam;

b) failed to timely report the results of the BPP exam;

c) failed to advocate for immediate evaluation of Ms. Sallis and her fetus based on the results of the BPP, including by activation of the chain of command, if necessary; and

d) withheld the results of the BPP from the bedside nurse.

If one assumes that Ms. Kolenskyj did in fact notify Dr. Gast immediately, pursuant to her sworn testimony regarding her custom and practice, then it is my opinion that on August 16, 2014, Thomas Gast, M.D. deviated from the standard of care in the following ways:

a) failed to timely review the BPP exam;

b) failed to timely report the results of the BPP exam to the bedside provider;

c) failed to advocate for immediate evaluation of Ms. Sallis and her fetus based on the results of the BPP, including by activation of the chain of command, if necessary.

If one assumes the sworn testimony of Nurse Walker to be true that Dr. Gast never reported the results of the BPP to her, then it is my opinion that on August 16, 2014, Thomas Gast, M.D. deviated from the standard of care in the following ways:

a) failed to report the results of the BPP exam to the bedside provider; and

b) failed to advocate for immediate evaluation of Ms. Sallis and her fetus based on the results of the BPP, including by activation of the chain of command, if necessary.

Additionally, I am familiar with the communication and quality of ultrasound examination a physician is entitled to rely upon from an ultrasound technologist. The standard of care for communication between members of a radiological team is well within my knowledge and experience. Furthermore, I interpret BPPs and work with and train many ultrasound technologists in my day-to-day practice. I am familiar with the duties and responsibilities of ultrasound technologists and the extent of their communication with the interpreting physician, prioritizing and scheduling of exams.

I have reviewed the opinions of ultrasound technologist Samantha Sawyer and agree with her opinions that on August 16, 2014 Olexandra Kolenskyj was professionally negligent in the following ways:

a) failed to perform a STAT BPP within 30 minutes of the request;
b) failed to inform Dr. Gast of a request for a STAT BPP;
c) failed to activate the chain of command to advocate for completion of a STAT BPP; within 30 minutes of the request;
d) delayed the performance of STAT BPP for 1 hour and 18 minutes;
e) performed a BPP scan that lasted 71 minutes;
f) failed to obtain the results of the non-stress test;
g) utilized improper techniques to "stimulate" the fetus which unnecessarily and further delayed the exam;
h) failed to call Dr. Gast for immediate consultation during the BPP exam;
i) failed to recognize an emergency and act on a critical result;
j) failed to notify Ms. Sallis' labor and delivery providers of the BPP result;
k) failed to advocate for immediate evaluation of Ms. Sallis and her fetus based on the results of the BPP, including by activation of the chain of command, if necessary;
l) withheld the BPP result from Nurse Walker;
m) failed to prioritize the study as STAT;
n) failed to document notification of Dr. Gast; and
o) failed to follow-up to ensure a timely official read.

Additionally, if one assumes the sworn testimony of Olexandra Kolenskyj to be true, then it is my opinion that on August 16, 2014, West Suburban Hospital was institutionally negligent in the following ways:

a) establishing a policy, procedure and/or protocol prohibiting technologist from communicating BPP results to labor and delivery providers;

b) training/instructing technologist that they were prohibited from communicating the results of a BPP to labor and delivery providers.

Each and every negligent act and omission of Thomas Gast, M.D., Olexandra Kolenskyj and West Suburban Hospital outlined in my report and the disclosure of Samantha Sawyer was a proximate

cause of injury to Gerald Sallis, Jr. In a baby with a result concerning for possible asphyxia every minute counts. The failures of Thomas Gast, M.D., Olexandra Kolenskyj and West Suburban Hospital further delayed evaluation of Gerald Sallis by a qualified provider and further delayed necessary intervention. Beginning at the point of first contact – 11:22, Olexandra Kolensky and West Suburban Hospital contributed to the delay in evaluation and intervention by as much as 6 hours (11:22-15:14). If one assumes that Ms. Kolenskyj did in fact notify Dr. Gast immediately pursuant to her sworn testimony regarding her custom and practice, Thomas Gast, M.D. contributed to the delay in evaluation and intervention of Gerald Sallis by as much as 1 hour and 31 minutes (13:56-15:27).

My opinions are subject to modification pending review of further materials. My opinions are further subject to modification pending determinations by the finder of fact as to the truthfulness of the sworn testimony cited in this report.

Sincerely,

Peter M. Doubilet, MD, PhD

Peter M. Doubilet, M.D., Ph.D.