

# PRACTICE TIPS: Opening Statement in a Medical Malpractice Case, *Estate of Gerald Sallis, Jr vs. West Suburban Medical Center et al*

by Sarah F. King

On August 16, 2014, Ms. Sallis awoke in the morning to feel her baby moving. She was 38 weeks pregnant with her first son, Gerald Sallis, Jr. After eating breakfast, she became concerned when she didn't feel Gerald's usual kicks and movements. Since her husband was away for his monthly training with the army reserve, Ms. Sallis called her sister to bring her to the hospital. When she arrived at West Suburban Medical Center, Ms. Sallis reported to the defendant nurse, Shelia Walker, R.N., that she was experiencing decreased fetal movement. Nurse Walker placed Ms. Sallis on an external fetal monitor for a scheduled nonstress test. From the moment the monitor was placed, the fetal heart rate tracing was nonreactive (no accelerations) and non-reassuring, with minimal to absent variability. Baby Gerald was in trouble.

Given Ms. Sallis' underlying diagnosis of preeclampsia, immediate C-section delivery was required for the safety of mother and baby. Despite these concerning findings, there was no evidence that Nurse Walker reported the tracing to any physician for over four hours. Instead Nurse Walker took Ms. Sallis off the monitor after an hour and sent her for a biophysical profile (BPP), without ever speaking to a physician.

The defendant ultrasonographer, Olexandra Kolenskyj, delayed in performing the ultrasound and unnecessarily extended the length of the test. As a result, Ms. Sallis was off the monitor for over two hours. At the conclusion of the ultrasound, Ms. Kolenskyj found that the baby was not moving and had no muscle tone. She scored the

test as a 4/8, which is a critical result. Despite these further concerning findings, there was no evidence that Ms. Kolenskyj reported the 4/8 BPP to a radiologist for over two hours.

When Ms. Sallis was finally put back on the monitor, the fetal heart rate had dropped, and the variability was absent. Shortly thereafter, baby Gerald suffered a terminal bradycardia with heart rates dropping from 120 into the 90's and 60's. A physician was finally called over five hours after Ms. Sallis' admission, and an emergency C-section was initiated. When Gerald Sallis Jr. was born, he required a prolonged resuscitation. His Apgar scores were 1/1/1, all consistent with severe hypoxic ischemic encephalopathy and a baby with impaired brainstem responses from ischemic injury.

*Sallis v. West Suburban Medical Center* was a complex and hard fought medical negligence case concerning the devastating injuries suffered by Gerald Sallis, Jr. Discovery was conducted over the course of three years. Both written and oral discovery were extensive. Ultimately, the plaintiffs disclosed twelve retained experts. In response, the defense disclosed ten.

The case was assigned to Judge Robert E. Senechalle, Jr. for a jury trial which began on October 3, 2019. The case was tried by Keith A. Hebeisen, Bradley M. Cosgrove, Sarah F. King, and Charles R. Haskins of Clifford Law Offices. After a month-long trial, on November 5, 2019, the jury returned a unanimous total verdict of \$100,673,368.23 vs. West Suburban Medical Center, Shelia Walker, R.N., Olexandra Kolenskyj, Nathalie Mc-

Cammon-Chase and a not guilty verdict against defendants Dr. Gast and Metropolitan Advanced Radiological Services. The verdict was itemized as follows.

## Itemization

Disfigurement:  
\$3,750,000  
The loss of a normal life past:  
\$5,000,000  
The loss of a normal life future:  
\$27,000,000  
Pain and suffering past:  
\$5,000,000  
Pain and suffering future:  
\$5,500,000  
Emotional distress past:  
\$500,000  
Emotional distress future:  
\$2,500,000  
Future medical care:  
\$45,200,000  
Past Medical:  
\$673,368.23  
Lost earnings:  
\$1,150,000  
Shortened Life Expectancy:  
\$4,400,000

## Opening Statement

**Ms. King:** Thank you, your Honor. This case is about a little boy named Gerald Sallis. Gerald was severely and permanently injured on the day that he was born. His mother walked into the hospital that day, and she said that something was wrong. She wasn't feeling her baby moving as much as he normally did.

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She had a test scheduled that day, and eventually the nurse put her on a heart monitor for the baby, and that monitor showed that the baby wasn't moving either and that its heart rate wasn't normal. He needed help. He needed delivery. It would be over four hours before that nurse got any doctor to see her patients. It would be over four hours before that nurse told any doctor about the result of the heart monitor.

Tequila Sallis was also sent down for an ultrasound by that nurse, and the ultrasound also showed that the baby was not moving. He needed help, but he was still breathing. He needed immediate delivery. The ultrasound sonographer that did that ultrasound and found the critical result showing that the baby was not moving, but was still breathing, never reported that to any labor and delivery provider. You will hear that it was not until after Gerald Sallis was born before any labor and delivery provider ever knew about the result of the ultrasound, and at that point, it was

too late.

When we started looking into this matter and started gathering all of the evidence that you're going to hear throughout this trial, we worked diligently to try to figure out the answer to the question: how could it be that for over four hours, a physician didn't see this patient in light of this critical result and emergency? How could it be that an ultrasound sonographer never reported the result of a critical ultrasound showing the baby wasn't moving to the labor and delivery providers?

And what we found out and what we were met with, was finger pointing between every single one of the defendants. The nurse, Shelia Walker claims that she did call the doctor, but the doctor didn't pick up. You will not see a single piece of evidence in this case showing that Shelia Walker called or attempted to call Dr. McCammon at any time before 3:00 p.m. Not a medical record. Not a phone record.

To the contrary, there is no documentation of a phone call or any nurse/physician contact regarding this patient

prior to 3:00 p.m. Dr. McCammon will deny that she received any phone call or any contact regarding this patient prior to 3:00 p.m. And you're going to hear, importantly, that if she had been contacted that morning when Tequila Sallis walked in the hospital and told about what was going on with the heart monitor, she would have come to the hospital immediately, and she would have delivered Gerald Sallis by emergency C-section within thirty minutes of being there.

The ultrasound sonographer that I referred to earlier, her name is Olexandra Kolenskyj. She has no memory of this day, but she claims that based on her custom and practice, she would have reported this critical result that the baby wasn't moving to the radiologist, Dr. Gast, immediately because she understood that this was a critical result. Again, you will not see a single piece of evidence showing that Olexandra Kolenskyj reported this to Dr. Gast immediately. To the contrary, you are going to see a form she was supposed to fill out to document that she reported this

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to labor and delivery or Dr. Gast, and that form is blank.

Dr. Gast does have a memory of this day, and he will deny being given the results of this test immediately. He will tell you that it was over an hour before he was given any heads up that there was a critical result and read this report. You will hear that if Dr. Gast had been told immediately of this critical result, he would have read the study immediately because he understands that means that the baby could be experiencing asphyxia or a lack of oxygen in the womb.

All of these breakdowns of communication between the defendants and acts of professional negligence led to Gerald Sallis staying in his mother's womb for over four hours and then five hours before he was delivered. And during that time period, he depleted what we call his oxygen reserve, and his heart rate went from 150 to 120 to 90 to 60 and eventually when he was born by emergency C-section to 20. He experienced what we call a terminal bradycardia that deprived his brain of

oxygen.

It wasn't until Shelia Walker, the nurse's supervisor saw the heart rate and called one of the on-call physicians to come help Gerald that an emergency C-section was called. Dr. McCammon was called, and within seventeen minutes after that call, Gerald was delivered.

Gerald was born limp and not breathing. He required chest compressions to get his heart rate back up to where it had been when his mom walked in the door five hours earlier. He was diagnosed with a brain injury from lack of oxygen, and he was transferred to Lurie Children's Hospital for treatment where he remained admitted for three months.

He was discharged with a diagnosis of birth asphyxia, or a lack of oxygen at birth, which caused severe brain injury, which we call HIE, or hypoxic-ischemic encephalopathy, and that's the condition that he lives with today.

I want to take a minute to reintroduce myself to all of you. Some of you yesterday got to meet me and some of

you the day before. I want to thank you very quickly for your patience with this process. I know it was a long road to get here just through the jury selection process, and we ask a lot of prying questions in your life. So thank you for answering those so candidly.

This is a very important case to everyone in this courtroom, but specifically to Gerald because it involves his care in the future, the resources that he needs for his future. I have the privilege of representing Gerald Sallis and his mother, Tequila Sallis, who is here with us. I do that along with my trial partners, who you also had a chance to meet, but I've blocked with the TV, Keith Hebeisen, Bradley Cosgrove and Chuck Haskins from Clifford Law Offices.

I also want to introduce you to one person that you didn't get to meet during jury selection. She's here with us today, Katie McClanahan, and she is from CIBC Bank. Some of you were here for a discussion the other day about why the bank is involved in this action, and

*practice tips continued on page 58*

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some of you weren't. So I'm just going to give you a little insight into that issue.

So the bank has been appointed by the probate court of the Circuit Court of Cook County in this case as the administrator of Gerald Sallis's estate. This does not mean that they have any control over Gerald as his person. His mom still has full custody of him and makes all of his medical decisions. However, CIBC's role here is very important.

The bank is here for one purpose, and that purpose is dependent on this trial. If there is a verdict in Gerald's favor, the bank will be in charge of any money that is awarded to Gerald and will manage that money and safeguard it for him. If there is not a verdict in favor of Gerald, the estate will be closed, and there will be no money.

So as the judge indicated, opening statements are a chance for me to give you a preview of the some of the evidence that you're going to see throughout the case and some of the concepts that you're going to learn about. What you're going to learn about in this case is going to come a lot from the witness stand, both the witnesses that are involved and actually what went on on the day of Gerald's delivery, and some expert witnesses that are going to come in to help you understand some of the issues around labor and delivery and what happens when a baby is deprived of oxygen. It's also going to come heavily from the documents that you'll see, which I'm going to show you some of these today.

Trials don't necessarily happen in a chronological order, so what I get to do today is to present the evidence to you in a chronological order so that when you hear it kind of in pieces as we go on in these couple weeks, you can plug it into the timeline and make sure that it makes sense to you.

So where we have to start a little bit, because it's my job to make sure you have the tools to make this deci-

sion for Gerald, is that at the very beginning, which is the very beginning of pregnancy for all women. So we get prenatal data about what happens during pregnancy from office visits that moms go to with their primary care physicians or with their obstetricians, from ultrasounds that are done during pregnancy and from something called nonstress tests that we'll talk about.

Each of these types of tests measure different things that we want to keep track of when a woman has a baby. We want to make sure there's fetal movement present, that the baby is growing appropriately, that their heart rate is something called reactive and reassuring, that they have a good heart rate, that it has moderate variability, which I'll talk about in a minute, that there's no decelerations in the baby's heart rate and that there are something called accelerations present.

All of that data is recorded in the records. So for a prenatal visit, it's going to be recorded in the records of Dr. McCammon-Chase. Dr. McCammon-Chase was Tequila's provider. So she's a family medicine physician that has extra training in obstetrics so that she can manage moms when they're pregnant, and she delivers their babies.

When we look at her records, the really important things to pay attention to are every single visit that Tequila had will have a box at the top, and every single visit fundal height, fetal heart rate and fetal movement were measured. So this is an example from the very beginning of the pregnancy in March. Fundal height is how big mom's stomach is getting.

So I have a model I'm going to use. It's Plaintiff's Exhibit 323. It's just a cut-away of the baby in mom's tummy. Some of you may have had this experience before if you had your own kids, but as your belly grows outwards during your prenatal visits, they'll actually measure how big your belly is getting. That's your fundal height to make sure it's appropriate, and that tells us that the baby is growing appropriately in-

side mom.

The next thing that they'll measure is fetal heart rate. This can be done by actually listening to mom's stomach, or mom can be put on a heart monitor where it's going to show the baby's heart rate, and we're going to look at a lot of those.

And then fetal movement, and this is such an important piece of data that prenatal providers rely on. The only person who knows if their baby is moving is mom, right? She's the only person who's going to know. So one of the things they ask mom every single time she's at the hospital, every single time she's at a prenatal visit is are you feeling the baby move? How often are you feeling the baby move? She is the historian of that information because when babies move, that means they're healthy and they're well-oxygenated. That's a term you're going to hear a lot meaning they're getting enough oxygen to be able to accelerate their heart rate and move around.

So instead of going through every single visit today with the record up here, which we are going to do through the course of the trial, I created a summary for you to show you every single one of the prenatal visits and the data from those visits starting in March and moving through August. This exhibit will be used with a lot of the witnesses in the case so that we can keep track of that data together.

So March is the visit I just showed you that showed that Gerald's heart rate was 150. A baby's heart rate is a lot faster than ours. So a baby's heart rate is anywhere from 110 to 160. That's a normal heart rate. Anything under that is considered a low heart rate and can be a bradycardia and a sign that the baby's brain is not getting enough oxygen.

Gerald's heart rate through the entire pregnancy you're going to see is somewhere around 140 to 160. So he had an excellent heart rate through the entire pregnancy. Tequila reported fetal movement and her belly was grow-





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ing at an appropriate rate.

April 25th is her next prenatal visit. Again, Gerald's heart rate is 152, positive fetal movement, great fundal height. May 30th, great heart rate, fetal movement present, normal fundal height. Same for June 6th, June 10th, June 28th, July 12th, July 19th, August 9th. So as you can see, Gerald's heart rate and his growth was doing great based on the prenatal visit data.

The next piece of information that we look to to see how babies are growing and how they're doing inside mom are ultrasounds, and there's two types of ultrasounds we're going to talk about. There's normal ultrasounds that you get like when you find out you're pregnant and you get a picture of your baby that you put on your fridge or you send it to all your relatives. That's just a normal ultrasound. That's usually done in the second trimester. It's called a fetal anatomy survey.

The reason that we do fetal anatomy surveys in the second trimester is

because there's a lot more room to look around with the camera. So the baby is a lot smaller. You have more room to measure things. Once the baby gets to the third trimester. It gets pretty tight in there, and it's a lot harder to take pictures of all the things we need to. So the second trimester ultrasound is the one we heavily rely on to show the baby's heart and lungs are developing appropriately and that their head and their entire body are, and a series of measurements are taken.

This is Gerald Sallis's, one of the pictures from Gerald Sallis's fetal anatomy scan. His fetal anatomy scan was perfectly normal. He was growing at a great rate. He was right in the middle of the road for his fetal weight and fetal length, which was good.

And another thing that they measure during this fetal anatomy survey is the baby's head. So I'm not sure if any of you have had this experience, but there's something called head circumference, which is basically how big is your head around. So if we all wanted

to measure our head circumference, we'd take a tape measure, and we would wrap it around our head like this.

We have to make sure we're right in the middle of head, though, because not all of us are shaped like circles. Our heads at the top can be bigger or smaller and the same with the bottom. So to get an accurate head circumference, you have to measure right in the middle.

When a baby is in its mom's stomach, we can't take a tape measure and measure his head. So what they do is they take an actual picture of the baby's head, but it has to be right at the level of the middle of the brain, and then they draw a circle around it, and they measure the fetal head circumference. It's not as accurate as when you do it when the baby is out of the mom. So there's a pretty wide variability, but it can give you some really good information.

You're going to hear a little bit about head circumferences. The important thing is there are two land-

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marks you look for when you're measuring them, something called the thalami here and the CSP. When you see those two things, that means you're in the middle of the brain, and you get an accurate head circumference. Without those two landmarks, you can't accurately rely on that data.

Gerald's head circumference was normal on his fetal anatomy scan. The next time it was done where you can see both of those landmarks was much later in the pregnancy, actually on the date that he was delivered, and that showed that Gerald Sallis's head circumference was normal based on charts that we use to track fetal head circumferences when they were taken with those two landmark positions.

I told you there were going to be two types of ultrasounds that you're going to hear about. So we talked about the fetal anatomy survey. The second type of ultrasound you're going to hear about is something called a biophysical profile. Now, we refer to that as a BPP for short, and a BPP is very differ-

ent than a fetal anatomy scan. So what we're not concerned about looking for in a BPP is growth of the baby. What we're concentrated on during a biophysical profile is these elements, the baby's movement, tone, breathing and how much amniotic fluid there is.

So movement is simple. We all know that. We want to see the baby move during a period of time, and that period of time is designated as thirty minutes. The reason that biophysical profiles are done over thirty minutes is because you need to see each of these elements over thirty minutes so that you can say the baby doesn't need help, doesn't need to come out yet. He's doing well in his mom's stomach. Tone is a little different than movement. So tone is like if you're sitting here flexed, can you flex your muscles. If you have tone, you're not limp. So movement, tone and then fetal breathing.

Babies don't actually breathe like you and I. They don't breathe oxygen, so there's no breathing in and out of their mouth of oxygen. How they get

all their oxygen in their mom's stomach is through the placenta and through their umbilical cord, but they're very smart. They're going to need to breathe very soon. So what babies do in utero is they practice breathing. So you will actually see babies' lips move when you take an ultrasound, and you'll see Doppler studies, which show stuff coming in and out of the baby's nose. And the reason they're doing that is they're literally practicing the motion of breathing. So when they come out and they're born, it's not the first time that they're doing it.

They also need to expand their lungs up and down and get their lungs ready to make that motion. It can't be the first time they do that. So we definitely want to see babies moving their lips and moving their nose and getting prepared to breathe when they're in their mom's stomach within that thirty-minute period. And then amniotic fluid, this is just simply a measure that there is enough amniotic fluid protect-

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ing the baby and surrounding the baby.

Over the course of Tequila Sallis's pregnancy, Gerald had multiple biophysical profiles, again, data to show that he was doing great. So on July 14th, he had one. His score was perfect, eight out of eight. What the ultrasonographer will do is they take pictures or videos of each one of these things that they find. So they found movement. This is a picture of that breathing. You see that color right up there. That's showing that something is going in and out. It's called a Doppler. So that's how we can tell that the baby is breathing. And then tone, we'll take a picture of the baby's flexion.

Again, a perfect eight out of eight on July 14th. Another biophysical profile on July 28th with a perfect eight out of eight, on August 5th, a normal perfect eight out of eight, and you'll note that the people who interpret these studies, first is a sonographer and then is a radiologist. The radiologist not only records the score but reports that the score of eight out of eight means this

baby is not having trouble with oxygen. He's doing well inside his mom's stomach. So that's why when they say not at risk for asphyxia, this baby has a perfect score and is not at risk right now for anything with his oxygenation. He does not need to come out yet. August 9th, again, Gerald had a perfect eight out of eight score.

The last test that I showed you on that first slide is something called a nonstress test. This is a test you're going to hear the most about in this case. So a nonstress test is a type of fetal heart monitoring. So if you've had an EKG or if you've ever seen a family member get their heart monitored on something called telemetry if they were in a hospital, that's a way we measure adults' heart rates. So we look at it. We actually get a printout of what their heart rate is doing. Their heart rate is going up and down. It shows us exactly how fast their heart is beating.

With babies, that's done a little bit differently. So again, we have to do it through mom's stomach. What we do is mom comes into the hospital or to

an outpatient office. She lays down on the bed, and a strap is strapped onto her belly. And on that strap is a round device about this big, and it sits on her belly, and it measures the fetal heart rate through her belly. And then it prints out for us either on the screen or on a hard copy the actual rate and the look of the fetal heart rate.

The nonstress test is going to have specific type of monitoring, so it is a test. It's a way that we test over a twenty-minute period of time that the baby is getting appropriate amount of oxygen and is specifically moving around. So what we want to see during a nonstress test is something called accelerations, which I'm going to explain to you. If you and I were to get up right now and jog around for a second and then take our heart rate, it would have spiked up a little bit. That's our heart rate accelerating because we're moving. We're doing something.

Babies do the exact same thing when they're in their mom's stomach. The baby moves around. You're going

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to see a spike up in the heart rate, and that's a great sign. Again, that confirms for you that the baby is moving. In order to move around like that just like if you and I got up and jogged around, we might start breathing a little heavy, right? We'd need a little more oxygen. So the fact that we're able to do that shows that we're able to get more oxygen.

So a nonstress test tells you two things. The baby is moving, and the baby has enough oxygen to do that. So it's an assurance that there is good fetal well-being.

What we're testing out with a nonstress test is this fetal oxygen reserve. I kind of talked about that and alluded to it a little bit earlier. So like I said, a baby gets all of its oxygen through the umbilical cord, and it goes through the placenta. The placenta -- I'll pull this baby out for a minute while this is showing. Just like we see here, it sits right on top. Sometimes it's on the bottom of mom's stomach, and it works

kind of the same way that our lungs work. There's an oxygen exchange that takes place in the placenta so that the babies -- the blood that goes into the baby can have oxygen in it, and then the baby can send blood without oxygen back out to the mom to get more oxygen, and that exchange happens in the placenta.

The baby in the womb and in the placenta keeps something called a fetal oxygen reserve. So if you and I were to not get oxygen for a certain amount of time, very, very quickly we would start to become injured. Babies get a little extra protection, and they get that from their mom because their mom has a lot of oxygen, and that's called their fetal oxygen reserve. So they can go a little longer, and they can have things happen to their mom, and we can still help and get in there and have intervention.

That's why these tests that I'm talking about are done over a twenty-minute period of time or thirty-minute period of time so we can see if there's an issue and intervene before the baby de-

pletes its oxygen reserve. So we never want this oxygen tank to get completely low. The baby will have signs if it's getting low, and that's what we look for on the biophysical profile or the nonstress test.

So I'm going to show you an example of a nonstress test for Gerald Sallis on August 12th. We're going to go through all of them, but this is that fetal heart rate monitor that I was talking about. So this is a printout of Gerald's actual heart rate from the 12th. This is the beginning of his nonstress test. The date is always going to be over here, and then there's a series of numbers here, and that's actually the heart rate, so starting at 30 and going up to 210.

The line is going to hover over a certain place. We're going to talk about that, that being baseline, and what we're looking for in a nonstress test, like I said, is accelerations, so showing that baby moving using oxygen and something called variability. When that happens, the baby passes the test. It's

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called reactive and reassuring. It's a pass on the nonstress test, and that shows us the baby has adequate oxygenation and a normal nervous system function meaning it can make those movements. It's got enough oxygen.

Baseline, like I said, is between 110 and 160. So we highlighted it here in blue that normal baseline. So we want that baby's baseline to be somewhere hovering around in there, and really to evaluate a baseline by almost drawing a straight line through it and seeing where the baseline is about here. So here we would say 145 to 150 is the baseline. We can give a range for that.

Then accelerations, like I said, are when the heart rate starts to accelerate. So these two yellow circles here, this is Gerald's heart rate accelerating, accelerating up fifteen beats and then down. So this is a sign that Gerald is moving when this test happened. You need at least two of those to pass the test over the twenty-minute period. That tells us the baby is moving an appropriate amount if that happens two times.

The last thing that we're looking at is something called variability. So your heart rate doesn't stay at one rate for the whole time. Our heart rates don't. Babies' heart rates don't. What your heart rate will do when you see printouts of heart rate is it goes up and down, and it fluctuates, and that's a good thing. Nobody wants your heart rate to be at one constant rate. You want it to be fluctuating or varying. That's where this term comes from, variability.

We assess variability by looking at how much is your heart rate going up and down, and that again, is a sign that you are moving around and you have good oxygen. This concept actually is very common sensical. I know these terms sometimes are very medical, but it's common sense, and that's something that we ask you guys to bring here today.

So common sense tells you if you had low oxygen, so all of us will, this will not happen, but if all of us got trapped in an elevator together and there was a lack of oxygen, and we

were concerned that oxygen was going to run out when we were all in that room together, we wouldn't start running around. We would sit. We would stop moving, and we would try to conserve our oxygen. And our heart rates would not accelerate anymore, and your heart rate will start to flatten out. It will not be as variable. You're not running around because you're not getting an appropriate amount of oxygen.

Babies do the exact same thing. If babies are running out of oxygen or their oxygen is running low or they feel like their oxygen reserve is being depleted, their body tells them stop moving, conserve oxygen, and then that's reflected on their heart rate. That's what we're looking at when we look at how variable is a baby's heart rate.

There are categories of variability. So there's marked, moderate, minimal and absent. Moderate is normal. It's a nice moderate squiggly line over the baby. Minimal and absent are decreased. So when you look and you

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see a baby's heart rate not having that squigglyness, that's a sign there can be decreased oxygen to the baby and decreased blood flow to the baby's brain is the risk.

We're not going to talk as much about marked variability in this case. That's when it's too active. There's too much variability. That's also abnormal. So we're going to concentrate on moderate, minimal and absent.

When a baby's heart rate shows decreased variability, so not enough squigglyness over that line, it's a sign again that the baby can have decreased oxygen. So decreased variability, decreased oxygen.

This is an example of passing and failing the test. So this is the nonstress test from the 12th we talked about. All the elements are present. There's great variability. It's moderate variability. There's the presence of accelerations over a twenty-minute period and checked off that baby passed the test.

The bottom strip here that you're looking at, that is minimal to absent

variability with no accelerations. So this would be a failed nonstress test. That's called nonreactive and nonreassuring. And in a baby like Gerald Sallis, that is an emergency.

A drop in variability can show a drop in blood flow to the brain, which can show a drop in oxygen to the brain, which is called hypoxia or ischemia, and death of brain cells can be the ultimate risk of having not enough oxygen to your brain. So this is both for adults and babies, but specifically when we're looking at babies' variability, this is the risk that has to be recognized by health care providers when they see decreased variability.

That's why the rule is if a nurse administers this test, this nonstress test, and it is a fail called a nonreactive nonstress test, the standard of care you're going to hear requires direct nurse to physician communication of that failed nonstress test because that patient needs immediate evaluation by a doctor because only doctors can determine what to do. And in a term baby, like you're going to hear Gerald Sallis was

term when this happened, meaning he was fully grown and can be born, the doctor might do something called an emergency C-section to help the baby and get the baby out, because if the baby is fully grown and has run out of oxygen in its mom's stomach, it needs to come out here with all of us and start breathing oxygen out here.

This is the stress test again from August 12, moderate variability, accelerations, fetal movement, no decelerations, and it was reactive and reassuring. It tells us -- Gerald Sallis was born on the 16th. This is a nonstress test from just a few days before he was born showing us that Gerald Sallis was oxygenating well and was very healthy. I'm not going to put up for you every single one of these nonstress tests today. You're going to see them over the course of the whole trial.

So I did the same thing that I did with the prenatal visits and mapped out for you every single nonstress test and biophysical profile and ultrasound that Gerald Sallis had over the course

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of his mom's pregnancy. So starting in January, January 11th was a normal ultrasound, and that's where it was confirmed that Tequila was actually pregnant. That's her first ultrasound.

On April 9th, there was that fetal anatomy scan we already talked about where everything was normal and showed that Gerald was appropriately growing. July 14th Tequila had a nonstress test that showed all of those things we're talking about. Gerald passed the nonstress test. She also had a biophysical profile that was eight out of eight confirming Gerald is well-oxygenated.

On the 15th, again, a nonstress test that showed that Gerald had a great heart rate with accelerations present. He was moving around and a normal ultrasound.

July 21st, again, a normal nonstress test. July 28th, a normal nonstress test and an eight out of eight biophysical profile. August 5th, normal nonstress test, eight out of eight biophysical profile. August 9th, normal nonstress test,

eight out of eight biophysical profile. August 10th, normal nonstress test. August 12th, that's the one I showed you, this example, normal nonstress test showing Gerald is oxygenating well.

And that brings us up to August 16th. On August 16th at 10:00 a.m., you'll hear from Tequila Sallis that Gerald was moving. And after she ate breakfast, that's when she first started feeling that he wasn't moving as much, and she went to the hospital.

You might be asking yourself well, maybe I had a baby or my family member had a baby, and I didn't have that many appointments. Ms. King showed me a lot of clicking for this whole slide, and there's a lot of appointments and a lot of monitoring. And one of the reasons that Tequila was asked to and she did come in for a lot of appointments is because during the course of her pregnancy, she got diagnosed with something called gestational diabetes.

We asked you guys a little bit about that during jury selection because we knew it was going to come up in this tri-

al just to see what your experience was. You're going to hear a bit about gestational diabetes. So importantly, gestational diabetes is not something that happens to people who have diabetes in normal life when they're not pregnant. It can, but generally, it doesn't. It's actually a pregnancy-specific condition that happens.

The reason it happens is because having a baby means you've got somebody else using all your stuff. That's the most lay way that I can put that. So you're providing extra food, extra oxygen, extra blood to something that's inside of you. What that can do is it can cause your glucose regulation to get thrown off. The baby needs to regulate its sugars, too, and so do you, and sometimes that triggers in the mom gestational diabetes.

This is a very common condition. It actually happens in one out of ten women. So the statistic is ten percent of all pregnancies can have this, and it actually is more likely in African-American women for one reason or another. So they're specifically watched for this



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condition if it comes up.

The good news is with proper medication, diet and sometimes insulin, pregnancies are safely regulated, and babies come out safe and healthy all the time here in the United States. Tequila Sallis was very committed to the process. So she showed up to every single appointment that she was scheduled for regarding her biophysical profiles and her nonstress test and her prenatal care that she had with Dr. McCammon to check in on her blood glucoses and her sugar.

So you might be asking yourself this is a lot of information Ms. King just gave me. So what actually happened here? So I want to turn your attention now to what you're going to hear about the dates that are in play in this case. So where are we actually focusing our attention because the prenatal period is not at issue. Gerald was healthy all the way up until August 16th. So what we want to dig down deeper in is looking at what happened on August 9th, 10th, 12th, and then we're going to turn to what happened on the 16th.

So on August 9th, Tequila Sallis presented to Dr. McCammon-Chase's office. She had a normally scheduled prenatal visit that day. She had, as you've seen, many of these over her pregnancy. Dr. McCammon-Chase was a little concerned because Tequila had a little bit of a high blood pressure, and she had protein in her urine. Those two things can be a sign that you can be developing something called preeclampsia. I think a couple of you shared with us that you had family members develop this or you had heard of this before.

So again, women have to do a lot when they're pregnant. They have to provide a whole bunch of nutrients, blood, and their heart has to support a whole other being inside of them. And one of those pregnancy-related conditions that can creep up is preeclampsia. Simply put, it's hypertension or high blood pressure during your pregnancy.

Similar to gestational diabetes, it does mean you have high blood pressure in your normal life. It's just something that can happen when you're pregnant. And the reason why we think this

happens is because something is telling the mom's body that the baby needs more blood, and so the mom raises her blood pressure in order to get the baby more oxygen. And that's fine, but mom can only keep up with that demand for so long.

So preeclampsia is actually the most dangerous to the mom, and the reason we deliver babies generally after thirty-seven weeks when moms are diagnosed with preeclampsia is because we don't want mom's blood pressure to stay high for another three weeks because if you have high blood pressure, it can hurt your kidneys. That's the main reason we're concerned about preeclampsia for moms. And if your blood pressure gets high enough, it can cause mom to have a seizure. So this is actually a dangerous condition for mom.

The reason protein in your urine would be a sign that you were developing preeclampsia or you had preeclampsia is because when your kidneys are functioning correctly, you really

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shouldn't have a lot of protein in your urine. So your kidneys are that organ that cleans everything out. If your kidneys start to have some sort of damage or are under too much pressure, they'll leak protein into your urine, and we test that. That is a sign again that potentially you could have this condition called preeclampsia.

So on August 9th when Dr. McCammon was concerned that Tequila might be developing this, she sent her to the hospital to get monitored. Tequila went to the hospital, got checked in, and she was going to be there for a twenty-three-hour period of time. The reason for that is that we need to collect women's urine over a twenty-four-hour period of time, and then we test how much protein is in it because we don't want just one what's called a dipstick test because that could just be one result.

So we take all of the urine, and then we average out how much protein is in it. It's called a twenty-four hour urine collection. It's not particularly pleasant for moms, but Tequila Sallis was there to do it because she knew she needed to figure out whether she had this condition, and so did Dr. McCammon. And when they tested Tequila's urine and they averaged it over a period of time, you should have somewhere between ten to twenty. That's the result, that level of protein in her urine, and Tequila had 826. So that shows that she had proteinuria, which is a sign of preeclampsia.

Additionally, her blood pressures were checked, and she had some high blood pressure, so diagnostic criteria or sort of those checklists that doctors use in order to diagnose somebody with something. For preeclampsia, the diagnostic criteria are high blood pressure two occasions apart over four hours and proteinuria. Those are the most classic diagnostic criteria for preeclampsia.

And on this hospitalization, August 9th and 10th, Tequila Sallis checked

both of those boxes. So she was diagnosed -- this is her blood pressures that day that spiked up. She was diagnosed with preeclampsia or what Dr. McCammon referred to as emergent preeclampsia on the 9th and the 10th after she was discharged. And I'll show you her discharge instruction.

The important thing here is that Gerald Sallis was doing fine. So this whole time that Tequila was getting checked out, Gerald Sallis was also getting monitored. And like I showed you on all his heart monitors, Gerald was moving around a lot actually. He had great variability in his heart rate. It stayed at a good level, consistent rate. There were no decelerations, and Tequila reported great fetal movement during the hospitalization. So everything with Gerald was fine.

This is the discharge note that was written by Dr. McCammon showing that she had diagnosed, at this point, Tequila Sallis with preeclampsia mild, and she stated has ruled in for preeclampsia. So that's what doctors do. They rule people in or they rule people out for certain conditions, and at this point, Tequila Sallis had been ruled in for preeclampsia.

Importantly on this visit, you will not see at any point a single document that says that Tequila Sallis refused any type of treatment or refused anything that was offered to her, including any type of delivery. There is no note that says patient refused an induction or refused a C-section or anything like that. Tequila was going along with the recommendations of her providers, which at this point by Dr. McCammon was to continue the pregnancy because Gerald was doing fine and not to deliver.

Tequila was over thirty-seven weeks at this point. She was thirty-seven weeks and three days, so the standard of care says you can deliver the baby at this point with preeclampsia for the mother's safety. This is a plan of care that Dr. McCammon put in place, and it was communicated to the patient. The plan of care was explained

that Tequila was not going to be delivered that day. She was going to come back on the 13th to have another one of those ultrasounds and another non-stress test.

Any questions she had were answered, and then she was given a discharge sheet, which she was given after every hospitalization instructing her what to do next. So on the discharge instructions, she was scheduled for a BPP and a nonstress test on August 13th.

Before we can get to August 13th, Tequila Sallis on the 12th started having some fluid between her legs, and she was a little concerned. She thought maybe her water had broken. So she reached out to Dr. McCammon and told Dr. McCammon about it. She wasn't having any contractions, but she was having a wetness between her legs. Dr. McCammon told her if it kept happening that she needed to go to the hospital to get checked out, and so that's what Tequila Sallis did.

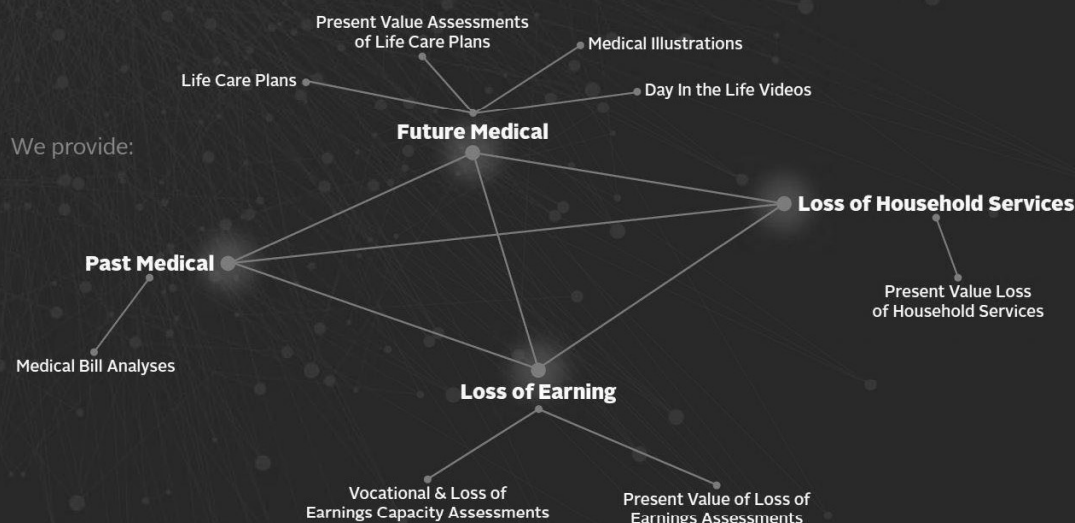
And when she got to the hospital, again, they put Gerald on a monitor, but they did a couple things to make sure that Tequila Sallis's water hadn't broken. So they actually checked her. They can tell whether that amniotic fluid sac that the baby is surrounded in is completely intact. They checked that. They can actually also swipe the fluid and figure out what it is.

So again, a little embarrassing, but sometimes when women are pregnant, they can have a little urine leakage towards the end of the pregnancy just because the baby is getting so big, and that's what was determined that this was. This was not Tequila Sallis's water breaking. She had a little urine leakage over the course of that day, but everything was safe to continue.

Again, Dr. McCammon confirmed that she was diagnosing this patient with preeclampsia, and the patient was over thirty-seven weeks. So by standard, this patient could be delivered. Again, there was no --there's no note. You will see



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absolutely no evidence that Tequila Sallis in any way refused any treatment or refused to be delivered this day. In fact, to the contrary, you're going to see that the plan was at this point to deliver her on the 18th.

So a plan was put in place scheduled for an induction of labor, that's what IOL stands for, on August 18th, and then she's going to come back on the 16th just for a nonstress test to check Gerald's heart rate one more time before the induction. Dr. McCammon was comfortable with this plan of care. Tequila was comfortable with this plan of care, and importantly, Gerald was comfortable with this plan of care at this point. So Gerald's heart rate during the 12th, as I showed you on the nonstress test, was great. He continued to have a reactive and reassuring fetal monitor strip.

At the end of this visit to the hospital, Tequila was again given a set of instructions just like you and I are given when we leave the doctor's office. These are the discharge instructions

that were given to her on the 12th. On the 12th, she was told she was now scheduled for the NST on the 16th. Then she was going to do an induction of labor meaning she was going to have the baby on the 18th. She was given that time to show up at the hospital at 8:00 a.m. And then her appointment for the 13th, since she had just been there the day before, was cancelled, and she was told to come back on the 16th. So turning our attention to the 16th, these are the defendants in this matter, and this is just to help you keep track of who's who since I told you at the beginning there's a lot of finger pointing going on between the defendants. So Dr. McCammon-Chase was the prenatal provider we've been talking about. Nurse Shelia Walker is the nurse that was responsible for Tequila's care on the 16th when she checked into the hospital. We're going to talk a lot about her.

The technician that performed the ultrasound, that's Olexandra Kolenskyj. She performed the biophysical profile that showed Gerald wasn't moving, and

Dr. Gast who is the radiologist who ultimately interpreted the biophysical profile much later.

So what happened on August 16th of 2014? Tequila Sallis woke up, and you're going to hear that she woke up because Gerald kicked her awake, and he did that often. He was a very active baby, especially when he heard music or in the morning when he wanted Tequila to wake up. So she reluctantly got up. She was home alone that day because her husband, her former husband, Gerald Sallis, Sr., was away, and he's part of the Army Reserve. So he was away for training.

So she got up. She was kicked awake by Gerald. She felt hungry. She went into the kitchen, and she made herself breakfast. She ate breakfast. Then about thirty minutes after she ate breakfast around 10:00 or a little thereafter, she felt like something was different. She felt like Gerald wasn't moving as much as he normally did in the morning.

So she picked up the phone, and she called her sister. She already had an

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appointment that day we saw for 11:00 a.m. for the nonstress test. So she called her sister, Chrissy, and she said can you drive me to the hospital now? I want to go in. I have this appointment. I'm not feeling the baby move as much.

So Chrissy came and picked Tequila up, and they arrived at the hospital at 11:00 a.m. And we know that they arrived at the hospital, and then they went and checked into what's called the OB triage unit. So West Suburban has a -- the 6th floor is everything to do with moms and babies. So on the 6th floor, there are operating rooms for C-sections, there's laboring rooms for normal vaginal births, and there's an OB triage area right in the middle for if you're coming in for some kind of test or some kind of unscheduled problem. And then there's the mother/baby part where after you have your baby, you go for your postpartum care.

There's a book called the triage outpatient log that will show when the patient gets there and what she's there for, and the patient checks in to the floor. So at 11:00 a.m., Tequila Sallis

checked in to the triage unit, and she was there for that nonstress test. She was put into OB triage room No. 2. That's where most of this goes down.

In OB Triage Room 2, her nurse that day was Shelia Walker. When she was brought into the room, Tequila told Nurse Walker that she was not feeling the baby as much as she normally did. Nurse Walker remembers her saying that it was like the baby was sleeping. Either way it was communicated to Nurse Walker that the baby wasn't moving as much as he normally does. So Nurse Walker sent Tequila down to ultrasound first.

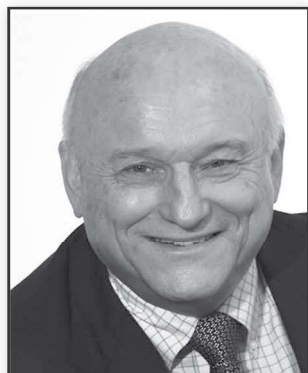
One of the important things that we learned in this case is that -- I'm showing you now what is a record of the census or the schedule that day, what nurses were assigned to what shifts and what patients they had. Shelia Walker was the only triage nurse for this day, and you're going to hear her testimony confirming that at this point in time at 11:00 a.m., Tequila Sallis was her only patient. So it was the only patient she had to take care

of at that time.

You'll also see something called the delivery nursing registry, which shows what else was going on on the unit during that time, specifically whether there were any other babies being born. And when you look at the log, the last baby that had been born was at 10:41 a.m. that day, and before that, at 10:11 by Dr. Tong. And the next one we're going to see is Tequila Sallis. So there were no other babies being delivered during that time. So Tequila was Nurse Walker's only patient, and there were no other labors or deliveries going on at that time.

Shelia Walker sent Tequila Sallis down to the ultrasound unit, and she wanted her to get a biophysical profile. And you'll hear from the witness stand Shelia Walker will say that she ordered the biophysical profile stat. And when Tequila got down to the ultrasound unit, she was told that they weren't available and that she was going to have to wait over an hour for the ultrasound. So she came right back up to the floor

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with her sister, and she went back into OB Triage Room 2, and she told Nurse Walker they told me I was going to have to wait an hour. She reported that to Nurse Walker, and it's documented in the chart.

Nurse Walker called down to the ultrasound unit and spoke with Sandy Kolensky and asked what's going on. Why is it going to be an hour? And she was told that they were swamped and that they could see the patient in an hour and a half.

At that point at 11:22, this is when Shelia Walker finally put Tequila Sallis on a heart monitor. When Tequila was put on the heart monitor, this is what Gerald Sallis's heart rate looked like. There were no accelerations present, and there was minimal to absent variability. This is a failed nonstress test, and in a patient like Tequila Sallis that has preeclampsia and has a full-term baby, this is an obstetrical emergency.

The nonstress test continued starting at 11:22 and through 11:37, and it was completed by 11:42. That would be twenty minutes later. Gerald Sallis's heart rate remained nonreactive, nonreassuring the entire time. There is no dispute about that. This is not a case about what does this heart rate show. Shelia Walker will admit on the witness stand that this is a nonreactive nonstress test, that there is minimal to absent variability and that there are no accelerations.

If we look back at some of the data that I showed you before, the heart rate from the 16th of Gerald Sallis is in very stark contrast to what had been happening this entire pregnancy. So you can see the variability is very decreased when we compare it to the nonstress test on the 9th and the 12th. For a reasonably careful nurse, this tells you you have to get a physician. You have to get a physician. It is not enough to try to call a physician or leave a voicemail for a physician. You have to get a physician and notify them of this obstetrical emergency.

When we tried to answer that question and ask Shelia Walker that question about what happened here, how could it be that there are four hours that passed after this test right here in the morning? How did this happen? This is where that finger pointing and that conflict you're going to hear about throughout this trial begins.

Nurse Walker claims that she did call Dr. McCammon-Chase after only ten minutes of Tequila Sallis being on the strip because she was that concerned, and she said she left a voicemail on Dr. McCammon's cell phone. Dr. McCammon denies that she received this call, and she will testify that the first time she ever heard about the results of this test were around 4:00 or 1600. A lot of medical providers in the records will use military time, so I tried to put both of them up for you.

You will not see a single record showing this alleged phone call. It doesn't exist. There is no documentation in the chart. We asked for it. We asked for additional documents to make sure. We asked for phone records from the hospital to see if this phone log existed at all. There is zero record of this call.

The thing that Nurse Walker and Dr. McCammon will agree on is that the standard of care required physician notification by 11:44 when that nonstress test was failed. There, again, is no dispute about that. Similar to the strip, there's no dispute about interpreting the strip. Dr. McCammon will testify that she would have expected a call, and Shelia Walker will acknowledge and admit that she understands the standard of care would have required physician notification.

Instead of physician notification, the fetal monitor was left on, and the test was continued from 11:46 to 11:54, onward from 11:54 to 12:02. During this time, Shelia Walker will say she did some things to try to see if the baby was sleeping. She moved the mom around, and she gave Tequila Sallis something to drink, some kind of juice

to see if she can perk the baby up and see if this was just the baby is sleeping. Nothing changed. The heart rate remained minimal to absent variability with no acceleration. This continued to be an emergency.

When the test continued, we wanted to find out how could it be now that the test continued when we tried to wake the baby up? How can it be hours and hours and hours before there was any physician notification or physician contact? How could it be that a physician never even sees this patient until 3:00 in the afternoon sometime?

Again, Nurse Walker says she tried to call again, but this time Dr. McCammon's voicemail was full. There is no record of her attempting to call again. There is no note in the medical chart that she attempted to call and couldn't reach the patient, no documentation of this. Dr. McCammon again denies that this occurred and will tell you the first time she heard about the results of this test were somewhere around 1600, which is 4:00 p.m. later that day.

At this point, Nurse Walker, you're also going to hear, acknowledges that she was very concerned about this fetal well-being. She was concerned about Gerald, and as a nurse, she knew that one of the things on the list that could be going on with Gerald was hypoxia, a lack of oxygen. She understands all of this stuff I just explained to you that a baby's heart rate will flatten out, that a baby's heart rate will stop having accelerations if they're having a hypoxic environment, and they're starting to deduct from that oxygen reserve. She knows that, and she also knows physician notification is required.

This is the request we sent to the hospital that you're going to see a little bit about asking for give us the phone records. Please give us the phone records if you say you attempted to call. And the response you're going to hear that we got from the hospital was the phone records aren't relevant first and that the second part of the response is





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there are no phone records. We asked for the phone that Nurse Walker carried. We asked for the phone for the whole unit during this relevant time period.

But setting aside the phone records, setting aside the alleged call, let's set all of that aside for one minute. I've been using a very specific term that you're going to hear over the course of this trial about notifying a physician and having a physician come to the bedside because the standard of care didn't just require a phone call and a voicemail. It required Nurse Walker to get a doctor in the room for this patient.

So what's very important for you to take note of, especially when you hear it from the witness stand, and Shelia Walker is going to be the first one to tell you this, there was not one, not two, not three, four doctors available at West Suburban that day, four doctors available that could have helped Shelia Walker. There was Dr. Tong. He was the obstetrician that was on call. You saw in the delivery summary; he

had just delivered a baby on the unit at 10:00 a.m. that day.

There was Dr. Lamaster. He's what we call a maternal health child fellow. He is trained to perform C-sections similar to Dr. McCammon. They went through the same program together. There is a Dr. Thomas, who is a family practice physician, and then there is a Dr. Torres, who was another MCH fellow trained to perform C-sections. Each of these physicians was available in multiple ways for Shelia Walker. She could have called them. They all had cell phones. She could have paged them. She could have paged them overhead at the hospital.

And then there's always the old-fashioned way. She could have walked down the hall on the exact same floor that she was on and gone up to any one of these physicians and said I have an emergency. I have a baby that has a nonreactive nonstress test. I cannot get ahold of Dr. McCammon. I need you to come into the room and see the patient.

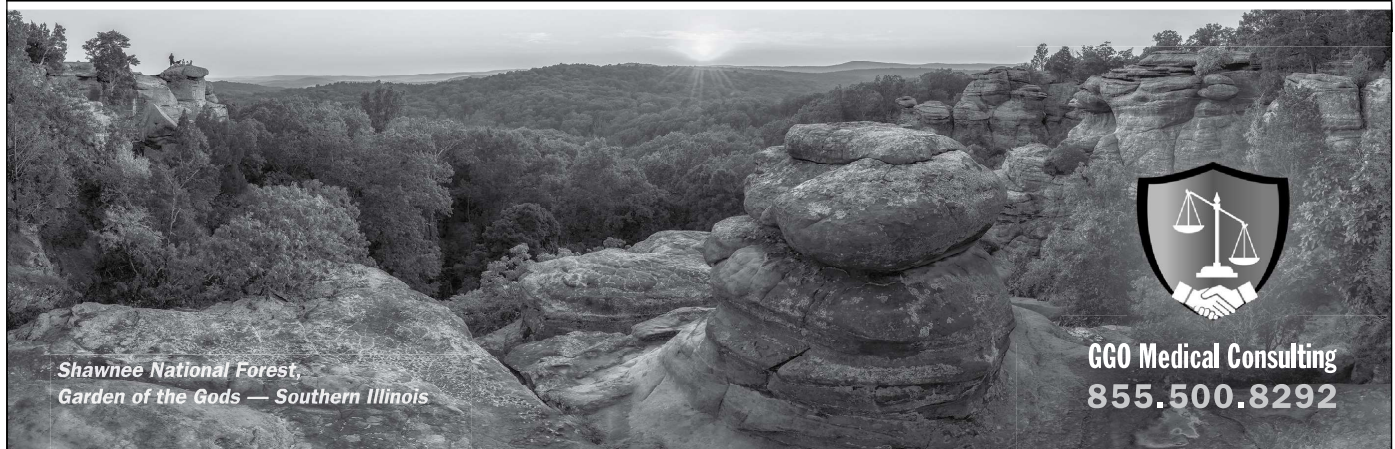
And the reason we have the sched-

ules up here is these show what doctors were scheduled and what doctors were on unit, but they also show that at West Suburban, that's what the intention was. They had doctors on call and available for patients that came into the hospital.

Instead of finding any of these four doctors, Nurse Walker told no physician about this and got no physician in the room, and the test continued. 12:03 to 12:10 Gerald stayed on the monitor. His heart rate was minimal to absent variability, nonreactive, nonreassuring, no acceleration. 12:11 to 12:19, nonreactive, nonreassuring, no accelerations.

At this point, Shelia Walker made the decision to take Tequila Sallis off the monitor, and you're going to hear a lot of testimony about that. In a patient who has this test that is showing that the baby needs help, that the baby is in danger, that the baby is telling us I need to come out, I need oxygen, you do not take that mom off the monitor. You get a physician in the room, and you leave them on the monitor until you're

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taking the patient away for an emergency C-section, but Shelia Walker decided to take this patient off the monitor and send her down to ultrasound for that ultrasound that she had been waiting for.

We're going to turn our attention a little more to the other defendant I talked about earlier, Olexandra Kolenskyj. So like I said, at 12:20 is when Nurse Walker took Tequila Sallis off the monitor, which she shouldn't have been, and no physician had been notified, and she sent her down to ultrasound.

At this point, Tequila's sister, Christy, had to leave to go to work, and her cousin, Syesha had come to accompany her at the hospital. So Syesha and Tequila went downstairs to the ultrasound department. Like I told you, mother/baby issues are on the 6th floor at West Suburban. Ultrasound is on the first floor. So they took the elevator down to the first floor, and they checked into the radiology department, and they had to wait.

They were told that it was going to be a couple minutes before Sandy Kolenskyj could get to them. And I said Sandy just then. Her name is Olexandra Kolenskyj. She does go by the name of Sandy sometimes. She is the ultrasound technician. So Syesha and Tequila waited, and then they were brought back for the test by the technician herself, Olexandra Kolenskyj.

The test that was being performed was that biophysical profile-type ultrasound that I told you about earlier where it's specifically looking for movement, tone, fetal breathing and appropriate amniotic fluid. Again, this test had been ordered stat by Nurse Walker. She is going to tell you that she orders these tests stat because she wants to get the technologist's attention. Yet, it had been over an hour and a half before this test was performed.

We can tell how long this test took by looking at the time on the images themselves. So when you look at an ultrasound or you look at an x-ray, any type of imaging study, what you're go-

ing to see is the actual time that the image was snapshotted and saved. So over here we've highlighted this image was taken at 1247:05 seconds on August 16, 2014. That is the first image that was taken in the biophysical profile.

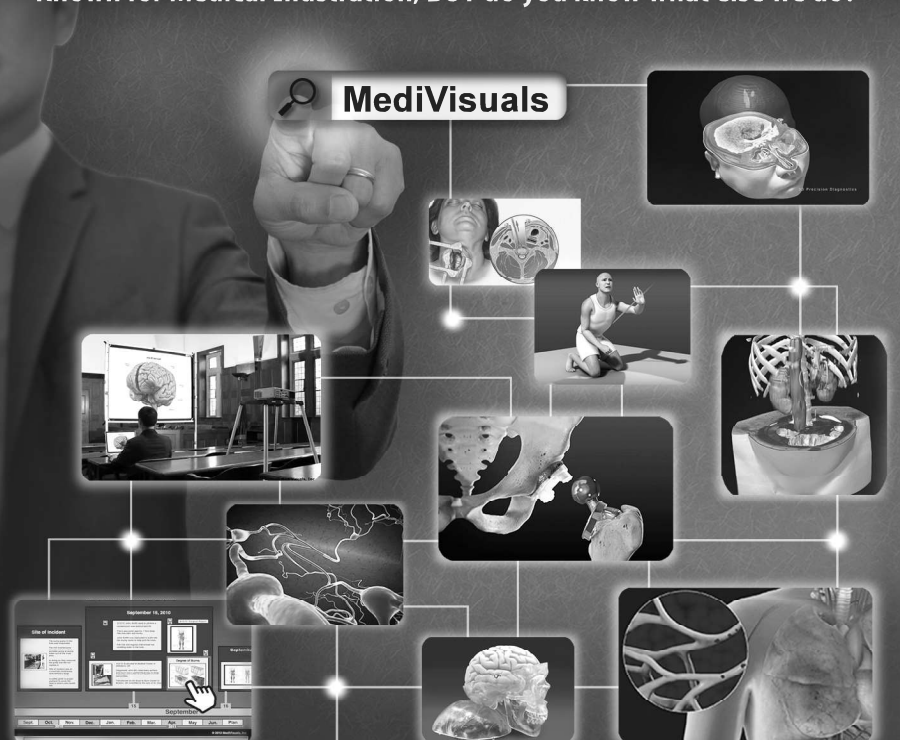
So we know that at that point, Tequila Sallis was on the ultrasound table and that Sandy Kolenskyj had the ultrasound wand in her hand and was moving it around her belly in order to take that picture. We can also tell when the study ends by looking at the last image when the results were inputted into the system itself. The last image is going to look the same, August 16, 2014, and then it says 1356:51 with the results of the biophysical profile entered in the computer by Olexandra Kolenskyj. BPP begins at 12:47 with that first image. It ends at 1356 with that last image when she inputs her findings.


If you remember back just a little bit maybe about an hour ago, I told you that the reasons that we have certain time frames for both the nonstress test

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and the biophysical profile is because we want to see certain things within those time frames. We want the baby to move and show tone within a thirty-minute period of time because if it's longer than that, again, that can show us that something is going wrong with the baby.

So you're going to hear that the standard of care requires the technician to end the test at thirty minutes. If it's a failed test, they need to send the patient right back to labor and delivery because you don't want to extend the test. That's nothing to be gained from extending the test except risk to the baby if the baby is experiencing a lack of oxygen and that's why they're not moving.

You're going to hear that Olexandra Kolenskyj extended this test. It lasted much longer than it was supposed to. It lasted over an hour, and she did that because she had Tequila get up and go to the bathroom at one point. She took some growth measurements during the study, and all of that is fine,

but this is a specific test for a specific reason. This is potentially an obstetrical emergency. Gerald is not moving. You don't take an hour to do this kind of test in that situation.

At the end of the test, Olexandra Kolenskyj handwrote her note. She entered in the computer and she handwrote on this biophysical profile sheet her findings of the test, and these are those categories we talked about, breathing, movement, tone and amniotic fluid. She took a picture of Gerald Sallis breathing. That's how we know he was still breathing in utero, that he was still making those breathing movements with his mouth and nose. She placed the Doppler, and you'll see the picture that she took of his breathing.

She gave Gerald a zero for fetal movement. You're going to hear Tequila Sallis and her cousin talk about what happened in the ultrasound suite. That's what we call where you get your ultrasound done, the ultrasound suite. Olexandra Kolenskyj took the ultrasound probe and her hand, and she was pushing on Tequila's stomach fairly

hard. We're not critical of her for this, but she was trying to elicit a movement from Gerald, and she still couldn't.

And that's when Tequila became very concerned. She had not been told anything about the nonstress test by Nurse Walker. She had trusted that she was at the hospital for the test. She had reported to Nurse Walker her findings and that Nurse Walker would take care of monitoring her baby calling the appropriate physicians. Tequila Sallis is not a doctor. She relies on the nurses at the hospital to do their job.

So when this first happened, it was the first time that Tequila Sallis was very upset that something could be wrong with her baby and that he wasn't moving. Technologist Kolenskyj also assessed fetal tone, and it showed that Gerald didn't have fetal tone. He didn't have that stretching of the muscle that we like to see. So the only positive findings were the fetal breathing and the amniotic fluid, and that's recorded as a four out of eight score. That is a failed score in a biophysical profile.

Olexandra Kolenskyj noted the

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score in her comment section with an exclamation point, and then there is a specific section on the form for her to fill out and check yes or no. Was labor and delivery or doctor given the test results? This is blank. She signed her initials, O.K., and left this blank. You are not going to see any other form that shows that she gave these results to anybody on labor and delivery. This is the only form, and it's left completely blank.

The first time that Dr. Gast, the radiologist that was involved in this case and is here with us today, opened this study was not until 1514. So if the test is completed at 1356, 1514 is a little over an hour later. It's the first time that he opens the study, and he did so because he saw it on his list called a worksheet of studies that will pop up for him, and that's the first time that he even knew that this test exists. And he has a memory of over an hour after the test was performed Olexandra Kolenksyj walking into the radiology suite where he reads studies and telling him I think you need to look at this biophysi-

cal profile. That is the first moment in time. He was not told immediately after the test was done.

You're going to hear Dr. Gast testify, and you're going to hear him testify as to his expectation about the communication here, that it should be communicated immediately. And if it had been communicated immediately, he would have read the test immediately, but he's here today because Olexandra Kolenksyj claims based on no memory, but based on her custom and practice that she would have reported this to him even though she has no documentation to prove that. This is another one of those finger-pointing conflicts we have between the defendants here.

Similar to the nonstress test, there is not going to be any dispute about the interpretation of the biophysical profile. Everyone in this courtroom is going to agree that result is what it was. It was a four out of eight. It was an emergency. There was no movement and no tone, but there was fetal breathing and that Gerald needed help, and the labor and delivery providers are the people

that needed to know about that result.

After the test was completed at 1356, Tequila and her cousin were instructed to go back upstairs to the 6th floor and back to OR triage room No. 2. I'm sorry. Triage room No. 2, the same room she had been in before. They had actually left their purses in that room. They left everything in that room, and they came back to the floor.

Shelia Walker was there, and at 1425, she came in the room, and she greeted Tequila and her cousin, and she took a finger prick of Tequila's finger to test her glucose, and that was done at 1425. So we know Shelia Walker was in the room with Tequila Sallis at 1425 in triage room No. 2 in order to test her blood glucose.

This is the result of the blood glucose. This is how we know what time it was at, 1425. So that's how we can put Nurse Walker and Tequila Sallis back in the room together by 1425. So we know what Nurse Walker is doing at this time. Even though she was in the room with Tequila Sallis, she did

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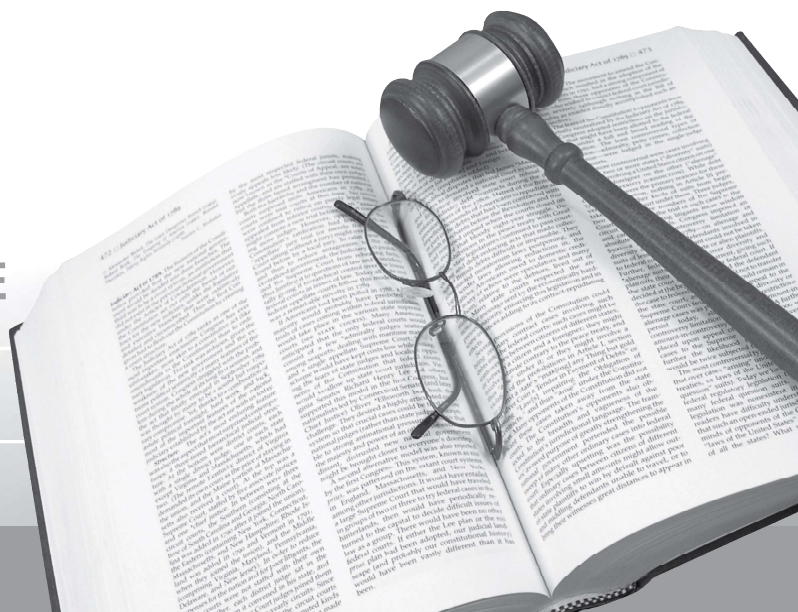
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not place her back on the monitor. So from 1425 when we know she's in the room with her all the way until 1523, Tequila Sallis sat in triage room No. 2 completely off the monitor.

At 1500, there's a very important note that Shelia Walker did write in the chart, and she wrote that the patient was back from ultrasound, and there were no results that she could find. So she called Sandy. She called her on the phone. The patient is back. She's done her glucose. She's sitting there monitoring her. She called Sandy to ask her where the results are, and Sandy did not tell her the results. She withheld the results of the four out of eight from the nurse.

How could this be? And this is a question I want you to listen very carefully to what happened here throughout the trial. How could it be that when you're asked about the result, a critical result that you have in your hand, you put it in your hand at 1356, you knew the baby wasn't moving, how could you withhold that from a nurse? Sandy Kolenskyj says she withheld it because the hospital told her she wasn't allowed to give that result to Nurse Walker, that the hospital had a policy that she wasn't allowed to share that information with labor and delivery. She could only share it with the radiologist. There is no written policy that says this because we asked for it. It's an oral policy that she's not allowed to share that.

A couple points here. If there truly is a policy that tells the technologist they're not allowed to give a critical result to a nurse when directly asked, that is an unsafe policy, and that is on the hospital. But think about whether there is a policy because like I showed you before, if there truly was a policy that didn't allow technologists to share information with labor and delivery, why on the form would it say have you shared this information with labor and delivery, please check yes or no?

You're also going to see past biophysical profiles and reports from past

biophysical profiles that are very contrary to Olexandra Kolenskyj's testimony. In the biophysical profile report from July 14th, that I showed you that one biophysical profile, it specifically mentions that the technologist directly discussed findings with labor and delivery.

1500 and 1508 are the first time that there is any documented evidence of contact that Shelia Walker has with a physician. So she writes in the chart that she paged Dr. McCammon and that she was on the phone with her around 1508. This is what she charts. So this is the first time that the chart tells us that Shelia Walker and a physician were in contact with one another about this patient and that she discussed with Dr. McCammon the results of a protein urine test, so the test where they did a dipstick and tested Tequila's protein in her urine again, and the reports of the decreased fetal movement that Tequila had walked in the door with that morning at 11:00 a.m.

She does not document that she in any way told -- that Nurse Walker in any way told Dr. McCammon about the failed nonstress test. She doesn't document that she told her about that test. Dr. McCammon says during this first phone call, she was not told about the nonreactive nonstress test. She was told about protein in the urine, and she was told about her glucose. She was told about the decreased fetal movement, but she wasn't told the patient had failed the nonstress test.

This is another conflict of pointing the finger between Nurse Walker and Dr. McCammon. Nurse Walker claims she did tell her the results of the nonstress test at 1508 during that first phone call. Dr. McCammon denies that and says if she had been told, she would have come right away, and she would have done an emergency C-section, but she didn't. She put orders in for the patient to be admitted and said she would be there soon. And the orders that she put in were for an induction, not a C-section.

And Dr. McCammon confirmed she would have never put orders in for an induction if she had been told that a patient had a nonreactive nonstress test because it's not safe. If a baby is having a decreased variability in their heart rate, you're not going to put them through labor. Labor is like a marathon for a baby. If they're already having a problem, you don't put them through labor. That's why the answer, under the standard of care, is a C-section because that baby needs to be out within thirty minutes, an emergency C-section.

At 1523, Tequila was finally put back on the monitor. So remember she's been off the monitor this whole time. After this phone call occurred, Nurse Walker put Tequila back on the monitor, and this particular monitor strip shows before she's taken off the monitor, so this half of the strip is where it ended at 12:19 right here on this line, and this is where it started back up. So the two connect when you print out the strip.

So all that period of time you saw between that was blank, we connect them together. This is 12:19. This is 1522. That's important because it shows you what's happened over time as this patient has been off the monitor. And when Tequila was put back on the monitor, there were some more concerning findings about Gerald's heart rate. In that period of time, his baseline, which had previously been around 150, had dropped down to around 120. Also, the variability that used to be minimal to absent was now absent.

So if this is the variability at 12:19 when we have a little bit of fluctuation in that line, you can barely see the difference here between the heart rate and the line. That's called absent variability, no detectable variability.

These are a sign that over this period of time, Gerald had depleted his fetal oxygen reserve. He came in with a heart rate of 150 and some variability. Over the period of time that he sat





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and waited for help and waited for a C-section, he had deducted from that oxygen reserve to a point where he no longer had anything left. And when you no longer have anything left, your heart stops working. The line on the page gets flatter. The heart rate starts to go down, and this is what we call the beginning of a terminal bradycardia.

You're going to hear from an expert in this case named Dr. Sibai. He's a maternal-fetal medicine specialist. He has a term for this that he uses. He uses it when he teaches. He uses it when he cautions physicians when they're dealing with a situation like this. When you see a baby's heart rate start to do this, it is a sign they've depleted their fetal oxygen reserve, and it's called a staircase to death.

Ultimately when we get to the C-section in this case, you're going to see that Gerald Sallis was delivered within seventeen minutes once it was called. It's called decision to incision time. So if necessary, Gerald Sallis could have been delivered within seventeen min-

utes over any course of this day.

At 1538, there's that continued drop in the baseline up until 1533, absent variability. And then at 1538, what happens is the heart rate drops even further down to 90 and then ultimately to 60. This is that terminal bradycardia. If a baby's heart rate is supposed to be somewhere between 110 and 160, when it gets down to 90 and 60 and all the oxygen is gone, that baby experiences an acute and profound injury to their brain. They can sustain some hypoxia using their fetal oxygen reserve, but this level of hypoxia causes acute profound brain injury.

At this point was the first point in time that Nurse Shelia Walker notified her supervisor that something might be going on. Her name is Tina DeVito. She is the charge nurse that was there that day, just one of the many resources that was available to Shelia Walker to get Gerald help.

She finally contacted her, and when Nurse DeVito saw this heart rate and saw what had been going on during the day, she immediately called the mater-

nal child health team. That is that team of people I showed you earlier that was available on the floor that day to help with any patient that needed help. She called them, and they were in the room at 1549, Dr. Thomas and Dr. Torres.

Dr. Thomas and Dr. Torres then called Dr. Lamaster. They gave Tequila Sallis an oxygen mask. They tried rolling her from side to side. And when Dr. Lamaster got in the room at 1551, he knew this patient needed an emergency C-section stat.

Dr. McCammon was called at 1554, told that the patient was being taken for an emergency C-section. Dr. McCammon lives minutes from the hospital. She was able to get to the hospital when Dr. Lamaster was rushing Tequila to the OR room, and she says she basically took the scalpel out of Dr. Lamaster's hand and performed the C-section herself, which is exactly what she would have been done if she had been called way earlier in the day around 11:00 a.m.

Gerald Sallis was born at 4:20 in the afternoon. So the C-section was called



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at 1600. The incision time is 1617, and then he was actually brought out into the world at 1620 or 4:20.

When we look at Gerald's condition when he was born, we can determine a couple things of what happened to him. We can tell about the timing of the brain injury, and we can also tell what things he needed to be treated with in order to survive.

When Gerald was born, he was bradycardic. So that low heart rate that we saw, that continues until he's taken out, and when he's taken out, his heart rate is in the 20s. He was not breathing on his own. He was limp and pale and not moving. He needed chest compressions by a specialized neonatal team in order to bring his heart rate back up. He needed to be intubated since he couldn't breathe on his own, and he had something called severe metabolic acidosis, which you're going to hear a lot about.

It means that your organs have been deprived of oxygen over a period of time, and when your organs are deprived of oxygen, they leak out

acid into your body that we can test and measure how much is in there. And if you have an acute injury, your levels are going to be very high. And it's the job of the neonatologist to correct those levels to save you. And looking at metabolic acidosis and labs, and you're going to hear from a neonatologist named Dr. Null who is going to explain all of this to you, you can tell what needs to be done for a baby and also what has happened to a baby to make that occur.

And you're going to hear that this period of time from 11:00 until 1620 where Gerald Sallis depleted his fetal reserve is consistent with all of the measurements that were taken after he was born. It's consistent with the fact that he wasn't breathing, that he was pale and limp. The level of acid in his body, which is called a lactic acid trend, the pH of his blood and the things that he needed done for him when he was transferred.

Gerald was immediately diagnosed with a condition called HIE. That is a brain injury. So hypoxic-ischemic encephalopathy is an injury to your brain,

and that was confirmed in all the medical records that we have from right after Gerald was born from the neonatal team that first saw him when he was born all the way to every single provider that saw him at Lurie Children's Hospital. He has consistently had this diagnosis as the cause of his brain injury.

When he was transferred to Lurie Children's Hospital, the reason for the transfer was that something they do now for babies or anybody, they can actually do it in adults, that have a suspected brain injury is they do something called head cooling. And if it's suspected that your injury has just occurred, they have realized that they can help you if you meet certain criteria by cooling your head, and that prevents further injury to your brain.

So when you have a brain injury, it's similar to when if you stub your toe or you hit your thumb on something, right away you're not going to see what happens, but over time, that's going to get swollen and red. And what do you

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do? You put ice on it. It's the same concept for head cooling.

If we suspect you have acute brain injury, they put ice on your head. They want to decrease any further brain injury that may happen, and that happens at specialized hospitals for children, and in this case, it was Lurie Children's Hospital.

There's a number of criteria you have to meet within a six-hour period of time to qualify for that cooling, and all of those criteria show that it means you have had an acute event, and you can benefit from head cooling. You're going to hear that Gerald checked every one of those boxes for determination, that on this day, he had experienced asphyxia, and that's the reason why he was transferred for head cooling.

This is his diagnosis of severe HIE, and the transfer documentation for when he's transferred to Lurie Children's Hospital from West Suburban and his diagnosis of hypoxic-ischemic encephalopathy at Lurie Children's Hospital by a neurologist. It was noted

in his chart several times that he had very severe brain injury, severe HIE, and he's treated with selective head cooling.

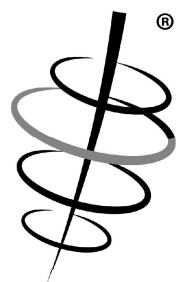
You're also going to hear a lot of evidence from people who specially treat babies who may have brain injuries, and they're called pediatric neurologists. You're going to hear from a pediatric neurologist from Children's Hospital of Philadelphia referred to as CHOP. Her name is Lauren Beslow, and Dr. Beslow treats babies that have brain injuries day in and day out. She treats babies that are on these head cooling protocols, and she helps them get out of the NICU. So she is the same specialty of doctor that Gerald was treated by at Lurie Children's Hospital.

You're also going to hear from a fetal neurologist, and you're going to hear from Dr. Null again, the neonatologist, who is going to look at the things that happened to Gerald afterwards and show you all of the evidence that allows us to say that this brain injury occurred from 11:00 in the morning through 1620 consistent with the

evidence we have of Gerald depleting his fetal oxygen reserve. Some of those things come from the tracings prior to August 16th, which we've already talked about, that everything was normal with Gerald prior to this day. They come from the normal biophysical profiles prior to the 16th. They come from the fetal movement reports of Tequila Sallis that the baby was moving that day up until right after she ate breakfast.

Gerald's Apgar scores, that's the score you get when he was born, were one, one, one meaning he's not doing the things he's supposed to be doing when he was born. That shows us that he's had an acute brain injury.

The severe metabolic acidosis that I talked about -- these are his Apgar scores. So he only got one point for heart rate, not breathing on his own, no tone, no reflexes, and he was pale. The severe metabolic acidosis that we talked about, which is what is going on in his blood, and that allows us to help time his injury and show that it's consistent with the fact that he had depleted his fetal oxygen reserve, those are going to



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be found in blood gas slips. So we're going to show you a lot of these slips of paper.

When they take blood from a baby, they put it in a machine, and it prints out this blood gas slip here, which shows certain things about the baby's blood. And when Gerald was admitted to the hospital, they continued to track these things over time, and the neonatologist is going to explain how these trends in the blood gases show us when Gerald's brain injury occurred.

We're also going to look at lactate trend, and then we're going to look to rule out things. So we always want -- what the providers at Lurie Children's Hospital did and what experts here are going to tell you they did is they look to make sure that nothing else could be the cause of Gerald's brain injury, that it was a hypoxic-ischemic encephalopathy, that it was birth asphyxia. One of the things we look at is to make sure that there's normal pathology. There wasn't anything else going on.

And the placental pathology report in this case shows that there's no

histologic abnormality. So there wasn't anything wrong that they could see with their eyes or under the microscope with the placenta that would show that this was in any way caused with an issue with the placenta.

Gerald met head cooling criteria like I talked about, confirming that he had this acute event, and he could benefit from being head cooled. We're going to hear about an absence of pulmonary hypertension. So if you have a problem with the baby that was going on for a long, long period of time, you develop something called pulmonary hypertension, and that shows us that the baby had been deprived of oxygen for days and days. Gerald did not have pulmonary hypertension.

And then we're going to look at the MRI findings in this case. So after they were done cooling Gerald's brain, they took a picture of his brain, and they did that when he was about four days old after he came off the head cooling protocol. And the MRI tells us what areas of Gerald's brain were injured.

Gerald had injury to the cortical

areas of his brain, which are the more outer parts of his brain, but he also had injury to what we call the deep gray structures of your brain, so those things that really control what we all can do without even thinking about it, walking, eating and talking, those kind of things.

And this is consistent, again, with what I talked about, a deprivation of oxygen over time that then goes into that bradycardia. It's called a prolonged deprivation of oxygen, so that 11:00 a.m. to 1538. And then when we see that bradycardia occur, that's an acute deprivation of oxygen. So this is -- you'll see evidence from the MRI itself. We'll actually put up the images for you to see. There's going to be a neuroradiologist that will come in and explain this to you and explain what areas of Gerald's brain is injured and what type of disabilities he has from the injury. He's also going to tell you how injuries to those areas of the brain occur.

And one of the things you're going to hear again and is going to be com-

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mon sense to you is that your brain, just like your body that we're going to talk about in a minute, tries to protect itself when it has a lack of oxygen. So the first part of your brain that's going to get injured if you're having a depletion in your oxygen reserve is that cortical area. It's going to try to hold onto the deeper gray part of your brain, that part that controls those things we don't think about. So that's going to get injured first.

Then if you have an acute event where you're completely deprived of oxygen just like at the end of Gerald's strip where we saw that he went into a terminal bradycardia, your body can't compensate for that. So then the deep part of your brain gets hurt, and that's what causes the severe disability.

We're going to look at pathology that shows that Gerald was not infected in any way. There was no sepsis. There's no issue in this case that there was any infection with this mom or baby.

Gerald started having seizures two hours after he was born, which is consistent with a severe brain injury. You're going to hear Dr. Beslow explain that after you have a brain injury like this, you can have seizures immediately up to six or twelve hours after you have a brain injury. And again, it's your brain starting to swell and starting to not be able to send the right signals.

Gerald is on medication to control his seizures today. He has been seizure-free thankfully since 2016, and he's well-controlled with medication. However, he is at life-long risk for having seizures.

We're also going to look at how Gerald's muscle tone came back. So like I told you, he was born limp, and then over time, he became hypertonic. So you're going to get a chance to meet Gerald, so you're going to witness this for yourself. Children with these type of brain injuries, their muscles are very tight. They have hypertonia because the injury that happened to their brain is not allowing their brain to tell their

body to do the right thing.

So as we all sit here today, we can relax our muscles. If we wanted to tense up, we can tense them up. When that part of your brain is hurt, you have spasticity. You're not able to control that. You're not able to even control what your muscles do when you don't want them to do something.

Over time, Gerald became hypertonic. This is, again, a sign of brain injury and also a sign of when brain injury occurred. So a child that goes from hypotonic to hypertonic has this type of brain injury that occurred over time starting with the deprivation of oxygen at 11:00 continuing on until the bradycardia.

I showed you a couple records here, but Gerald has never been diagnosed with anything other than HIE. So that is what he has. He has a hypoxic-ischemic brain injury. Any other diagnosis that you hear in this litigation that has not been something that Gerald was diagnosed with by clinicians,

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I want you to note that down and ask yourself where is the evidence of that. If anyone tries to get up here and tell you well, we think maybe it was this or we think maybe it was that, I want you to ask yourself this question. Why would everyone diagnose Gerald with hypoxic-ischemic encephalopathy due to a lack of oxygen, but then in a courtroom tell you that he had something else? That just doesn't make sense. That's not common sense.

Then lastly, when Gerald was discharged from Lurie Children's Hospital, he had a discharge diagnosis, and his discharge diagnosis was birth asphyxia. We're going to look at that record and look at why it was that Gerald's end diagnosis was birth asphyxia. And again, these pediatric neurologists are going to help us with that to put all of this together just the same way they did at Lurie in order to determine that Gerald was deprived of oxygen on the day that he was born.

This is the note of Gerald's diagnosis of birth asphyxia in his discharge

summary from Lurie Children's Hospital. Like I told you, he had to remain there for three months. And during that time, he was head cooled, and they tried to get Gerald to a point where he could go home.

A lot of things had happened during that time. Gerald had to breathe on his own. He had to be extubated. They tried to have Gerald eat on his own, but ultimately, he had to have a G-tube placed. I don't know if any of you are familiar with that, but basically Gerald cannot get enough food by mouth. He has to get his food through a tube that's connected directly to his stomach. He can eat for pleasure meaning if he wants to taste things, but because of the way his brain is affected, he cannot eat enough food to get nutrition without this G-tube. So that had to be placed when he was at Lurie Children's Hospital.

And then also Tequila Sallis had to be taught. She had to be taught how it was that her son was going to do these things that he couldn't do for himself. How was she going to help him? She

had to be taught how to feed him, how to prepare his food, how to hook a G-tube up. She had to be taught how to do I massage my son's muscles so he doesn't have contractures, so he doesn't have such spasticity so it hurts him?

I told you that when your brain gets injured, it tries to protect the deepest part. Your body does a similar thing. If you have a lack of oxygen and you're depleting your oxygen reserve, your body knows that there are two things that are the most important for its survival, your brain and your heart. And at all costs, your body is going to try to protect those two organs.

So what it's going to do as the oxygen gets low is it's going to grab oxygen from other organs in your body that it considers to be less important. For instance, you have two kidneys. It's going to grab some oxygen from there. You can get by with part of your liver. It's going to grab some oxygen from there. And it's going to try to preserve your heart rate as long as possible.

We know that Gerald's body tried to do that in this case, one, because ul-

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tunately, he had a bradycardia, and his heart gave up. Two, Gerald had evidence that his body had tried to grab oxygen from a lot of other organs. So he has damage to other parts of his body besides just his brain.

Gerald had damage to his liver. His body tried to grab oxygen from there. He had damage to his kidneys. It tried to grab oxygen from there over those five hours, his lungs, and we know ultimately his brain. It also tried to grab oxygen from his glucose system, his own system that regulates how much glucose is in his body was dysregulated when he was born, and his coagulation system.

So you and I as we sit here today, our body is constantly making blood cells, making platelets, and that's all happening. A lot of it is happening in our bone marrow. There's a lot of oxygen that goes into that process. Your body knows I can get a transfusion. I'm going to take blood from there when I'm having a lack of oxygen to preserve my brain and heart. So again, this is part of the evidence that shows that what hap-

pened to Gerald happened over that period of time from 11:00 a.m. to 1620.

We're going to look at some imaging of Gerald's brain like I told you, and then we'll show you the lab results that show Gerald's other organs that were injured. Then we're going to talk about the medications that he's on to help him with those problems today.

This is Gerald. Gerald is now five years old, and he's got a lot of things going on, but at some point, Gerald made the decision himself to smile, and he does that a lot. He does it the most when his mom is around. So when you meet Gerald, you're going to meet him with Tequila, and they're both going to sit here. And they're going to talk to you, and they're going to explain to you what's going on with Gerald and what he needs.

Gerald doesn't not communicate, not stand and not eat. He just does it differently than we do. So one of the things we had to do in preparation for getting evidence to you in this case is we had a doctor visit Gerald and put together something called a life care

plan so that we can summarize for you all the things that Gerald is going to need over his life so he can continue to do the things that we all do without help.

That doctor's name is Dr. Gary Yarkony. He put together a report. He's going to come and testify, and we're going to show you everything that's in his report, a picture of everything that Gerald needs, every device he uses. We're going to explain why it is that he needs assistance from a nurse over time, why it is he needs medications for certain injuries, and we're going to talk about how Gerald gets his medications.

So Gerald needs life-long medical care, but every type of medication that Gerald gets goes through that G-tube. Every type of fluid he gets goes through that G-tube. So he doesn't take things orally like we do.

Important reason why I'm bringing that up is that it takes a lot of time. Where you and I can just grab a glass of water and drink it, putting liquid

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through a tube takes a lot of time. So when Gerald wakes up in the morning, having him drink, take his medication and have his breakfast can be a two-and-a-half-hour process for it to slowly go through the G-tube. It's in an IV bag that hangs on a rack, or it can hang on a backpack that's on the back of his chair.

When you have a G-tube, you're going to have somebody assist you with a G-tube. It has to be a nurse. It can't be an aide. It can't be a CNA or somebody that's considered a lower-level provider. It has to be a nurse because there's too much risk of infection. So if you're going to hire somebody to help you feed a child like this, it has to be an LPN or an RN.

We're going to talk about all the medical equipment that Gerald uses today, but one of the things Gerald is doing real well is he's growing. So every time you see Gerald, he is taller. He is bigger, and he has outgrown something. So he's certainly not in the same wheelchair today that he was in two years ago. He has a new one. He's not in the same stander he was two years ago.

As he grows, he needs different equipment that meet his growth needs. These are things like his wheelchairs and his standers. Also, you'll see Gerald wears braces on his arms to help keep his arms straight and his hands straight, and he wears braces on his legs, and he's going to need those his whole life.

This is a picture of Gerald in his

stander. So Gerald does stand. He just uses a stander to do it. He needs some help. He uses a stander at home. He uses it at Misericordia. He uses it at school. And when Gerald is in the stander, he is so happy because then he is tall like everybody else.

He's going to outgrow the stander. The plan that you're going to hear from Dr. Yarkony talks about with these types of devices he's going to need all the way up until he has fulfilled his whole life expectancy. And for a child-like Gerald, statistically he has another 71 years to live.

This was just a picture of Gerald at school in his stander. There's a social worker, you're going to hear from his teacher, who comes into school and plays music once a week. It's Gerald's favorite thing to have bells with his braces and in his stander so he can shake the bells along with all the other students when they come in.

This is Gerald in his new wheelchair. Again, I told you he outgrew his old one. This is a specialized chair for him. It allows him to be wheeled in and out, but it also allows him to be tipped back and forth, which can be helpful for Gerald's digestion so that we can adjust how he is. Gerald can't manage his own secretions like you and I can. He does a pretty good job, but every once in a while, if he's got something stuck, he needs a little help getting it out. And that's by tipping him or by mom burping him.

We're also going to talk about Gerald's therapy needs. So like I said,

Gerald does have abilities. He has a lot of abilities, and he's worked really hard to have these abilities. And the reason he has them today is because he's been in therapy since the day he was born. He's been in physical therapy, occupational therapy and speech therapy. So the things that Gerald can do he's worked hard for. And by continuing therapy throughout his life, he'll never lose those things that he's gained.

So Dr. Yarkony's plan talks about how often Gerald will need therapy. Right now he's getting his therapy in school. It can be supplemented with additional therapy, but once he ages out of school, he'll need private therapy.

Right now you're going to hear one of the things Gerald is working on the hardest in his therapy is using this device called a switch. So Gerald can communicate. He just does it using this device or using noises, sounds or facial expressions. So he's working on using a switch, and what it does is it can be hooked up to certain things. So it can be hooked up to, for instance, a computer that plays a song. It can be -- a voice can be recorded that says yes or no, and Gerald can hit the switch.

He's right at the beginning stages of using this switch. He does it with his hand when he has his braces on, or they're working on him using it with his head where he can turn and hit the switch as well to tell us and communicate to us things that he likes and things he doesn't like. And he's working on using the switch with all types of therapists, his speech therapist, his occupational therapist and his physical therapist to be able to do this with his arms.

This is Gerald in physical therapy. One of the important things for Gerald and one of the things Tequila was taught was that he needs to be taken out of his wheelchair, and he needs to be stretched and massaged a lot because the actual name of the condition that he has due to his HIE is spastic quadriplegia cerebral palsy. That is the

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name for the type of brain injury he has that affects his entire body.

In therapy, Gerald practices sitting. He practices rolling, and they massage his muscles to make sure he doesn't get contractures where his muscles are getting very tight.

There are disposable supplies that we talked about that Gerald needs every day. So he needs diapers. He needs wipes. He needs all the feeding bags and tubes that he uses to eat, and he needs those on a daily basis for the rest of his life.

There's additional medical care you're going to hear about that Gerald is going to need over time. He has to go to the doctor a lot. He will always have to go to the doctor a lot, and he will always have to be monitored in some way by a doctor and by certain specialists. Like I said, his injury is not just his brain injury. So he will be monitored by a neurologist, but he also will be monitored by people who deal with his kidneys, his liver and any other con-

dition that he has.

The one thing that we're going to talk a lot about is how can Gerald be cared for at this capacity for the rest of his life for 71 years, and that's a major part of the plan you're going to hear about, the nursing care that Gerald needs on a daily basis for the rest of his life, and it's expensive. You're going to hear for the price of nursing care, how it's trended over the past.

So you're going to hear from an economist in this case who is going to take this chart and these recommendations by Dr. Yarkony regarding nursing care, and he's going to tell you how much money does Gerald need today to continue to pay for nursing care for the rest of his life. I hadn't really thought about this, and it hadn't really been explained to me, but you guys are going to get sort of the same lesson in this as I did from the economist. We're going to talk about the price of milk fifty years ago used to be this and how inflation has had it go up over time. The same thing has happened for wages of

nurses, for medical equipment and for medical care.

So the thing we're going to teach you about from the witness stand and that you're going to hear is how do you take that consideration that twenty years from now, nursing care is going to cost more than it does today, that twenty years from now, that seventy years from now, durable medical equipment like Gerald's stander will cost more. So an economist is going to come in and do those numbers for you and teach you how you take these recommendations from local places about what care actually costs if you call on the phone and how you project that out into the future for Gerald.

It's broken up in this chart for his age. So currently we include in here when he's in school and when he's not in school because when he's in school, he has people there to help him already. So he doesn't need a nurse while he's there. For a child like Gerald, he's allowed to go to school up until age 21 or 22, and he is he at Park School in

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Then eventually as Gerald gets older, there's Gerald and Tequila, he's going to need more care, and eventually that care is going to be twenty-four-hour care. Like I said, that care has to be performed by a nurse. Tequila Sallis is Gerald's mom. She's always going to be there to help Gerald. And when he comes home to her, she's going to be there every day to be his mom, but she's just that. She needs a nurse there to help her every day with Gerald and to help her with all these things he needs so that she can be mom and not nurse.

When Gerald wakes up in the morning right now, he does have a nurse, and that's because he's currently living at Misericordia. You're going to hear that from the moment he was born up until he was age four, Tequila Sallis took care of him twenty-four hours a day seven days a week. And when Tequila and her husband divorced, you're going to hear from Tequila Sallis she had some decisions to make over time,

whether she could keep Gerald in the home by herself. And for the best interest of Gerald for right now, she was able to secure a spot for him at Misericordia for right now.

I say that because you're going to hear from Tequila Sallis, and you're going to hear from her relatives this was one of the toughest decisions she's ever had to make. She wants Gerald home more than anybody. And trust me, when you meet Gerald and you see him and Tequila together, Gerald wants to be home with his mom more than ever.

Tequila goes to Misericordia. She can be there with him. She can visit him at school when she does all those things. She can take him out of the facility and bring him home for holidays, but it's not like being there every day. She wants him home, and she needs help getting him home.

When you hear from the economist and you take all of these things into consideration in this case, all the things that Gerald is going to need for

the rest of his life, he is going to tell you that Gerald's price of his future care for the rest of Gerald's life for the next 71 years has a range from \$73 million to \$85 million. It's a large sum of money for a large sum of care and a long period of time. The economist and Dr. Yarkony and the pediatric neurologist are going to talk about why this level of care is necessary to keep Gerald safe and for him to keep progressing the way that he is today.

I'm going to end on this slide. This year was Gerald's first official day at kindergarten at Park School. At the beginning of the school year, this was Gerald's first kindergarten picture taken by Tequila. I wanted to share that with you.

Like I told you, you're going to meet Gerald in this case. We'll tell you when that day is coming, and Tequila will be here to introduce you to her son. Thank you very much, ladies and gentlemen, for your attention.

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**Sarah King** is a partner at Clifford Law Offices. Her litigation work has been highlighted by significant achievements of justice on behalf of injured women and children. Sarah obtained a \$22,900,000 settlement on behalf of a young boy injured at birth who is now permanently brain damaged and suffering with life altering physical disabilities as a result of obstetrical malpractice and a \$8,500,000 settlement on behalf the husband and children of a young mother who died following childbirth due to a failure of the medical providers to diagnose and treat bleeding from a placental

abruption.

Most recently, Sarah obtained a record \$101 million verdict on behalf of a baby boy who was brain damaged at birth when his external fetal monitoring strips were ignored for six hours. Experts on behalf of the plaintiff testified that he would have been born a normal baby if hospital nurses and other medical personnel would have alerted doctors to the abnormalities and performed an emergency C-section.

Sarah currently serves as President of the Board of Directors for Woman Everywhere: Partners in Service Project, a non-for-profit organization comprised of attorneys and judges dedicated to creating opportunities for women through education and community service. Additionally, Sarah is the Chair of the Illinois

Trial Lawyers Association Women's Caucus, a group she co-founded in June 2017 to encourage female leadership within the profession and to act as a resource for the mentorship of young female trial attorneys.

Since joining the firm in 2011, Clifford Law Offices has supported Sarah's dedication to the success of women in the legal profession and encourages her to spend time and firm resources mentoring young attorneys, leading women's organizations and achieving justice for women and children. Last year she was named one of Crain's Custom Media's Most Influential Women in Law in Chicago. Sarah is a graduate of Loyola University Chicago and DePaul University College of Law.

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