UNIVERSITY OF ILLINOIS
AT CHICAGO

UIC O'Hare Medical Center
Chicago O'Hare International Airport
P.O. Box 66508
Chicago, Illinois 60666-0508

February 18, 1997

Ms Donna 'Taylor-Kolis
Attorney at Law
1015 Euclid Avenue
Cleveland, OH 441 15

RE: Daniel Lavely

Dear Ms. Taylor:

As we discussed on the phone today, I have finished my review of'the Lavely file A summary and my opinions follow As more information is made available to me, I reserve my right to clarify these opinions

Mr Lavely was 25 years old when he was brought to the emergency room at Fireland's Community Hospital on 4/22/96 I-Ie had a history of mental retardation and schizophrenia The chief'complaint was bleeding from his mouth. The caretaker apparently told the emergency physician that the patient possibly had self-induced trauma to his pharynx in an attempt to vomit. He had been known to do this in the past The patient also had a cough

On physical exam, the vitals were all essentially normal. Examination of the pharynx showed evidence of trauma on the soft palate No other abnormalities were found When questioned, the patient told the physician that he liad gagged himself in an effort to vomit

Mr Lavely was discharged home on Bactrim DS for bronchitis He was told to gargle with salt water for the lesions in his mouth

The next dav Mi Lavely was admitted tu the psychiatiic unit at Fireland's Community Hospital because he was reported to be in a decompensated psychotic state On the nursing assessment form at I 00 pm, the patient was noted to have gray skin and "blowing and snoreous respiiations " Vital signs showed an increased respiratory rate of 60/minute and a temperature of 92 3 degrees

It appears that personnel from the psychiatric unit contacted Dr H J Lee, who ordered stat labs and a chest x-ray. The chest x-ray showed a "significant pulmonary infiltrate at the right lung field " His WBC was elevated to 23 99 It did not appear that the patient was examined by Dr Lee, but he did arrange to have Mi Lavely transferred to a medical floor under the care of Dr Ahluwalia It is also not cleat- whether Dr Lee called Dr Aliluwalia himself According to the progress notes, Dr Ahluwalia was contacted by the nursing staff at 3 00 pm

Mr Lavely arrived on the medical floor about 3 50 pm There he was anxious and tachypneic (respiratory rate at 58/min) I-lis pulse oximetry was 53% (normal is > 94%) and his respirations were described as labored Dr Ahluwalia was again contacted at 4 00 pm. Arterial blood gasses were ordered and the patient was placed on oxygen, initially only at 2 liters/minute via cannula. The patient's respiratory status remained labored and he was ordered to be transferred to the Intensive Care Unit (ICU) at about 4 50 pm. Shortly thereafter he went into respiratory arrest and resuscitation was unsuccessful.

Based on my preliminary review of the records, I believe the care rendered on 4/23/96 was substandard and did not meet accepted standards. The patient arrived on the psychiatric unit at approximately 1 00 pm, clearly in distress. It was not until almost 4 00 pm that he was transferred to a medical floor Considering the patient's unstable condition, this transfer to the medical floor was inappropriate He should have been placed on 100% oxygen and immediately transferred to the ICU where his respiratory difficulties could have been aggressively treated. Within a reasonable degree of medical certainly, these delays in getting the patient transferred to the appropriate unit were a proximate cause in his death. Had aggressive treatment of the pneumonia and related respiratory difficulties been initiated earlier, more likely than not, the patient would have survived without sequela.

If you have any questions, do not hesitate to give me a call. Please let me know if I can be of further assistance.

Sincerely,

John L Zautcke, MD

John L Zautcke, MD

March **29,** 2000

Ms. Donna Taylor-Kolis
Third Floor - Standard Building
1370 Ontario Street
Cleveland, OH **441 13-1701**

RE: Daniel Lavely

Dear Donna:

As we discussed on the phone, I have reviewed the deposition of Dr. J. Lee. From his depositions, medical records, and other nurse depositions, it appears to me that Dr. Lee did not violate applicable standards of care. When it was reported to him that **Mr.** Lavely was experiencing some respiratory difficulty, he ordered appropriate tests and requested a consultation from Dr. Ahluwalia. Since he was not even at the hospital, there was nothing more that he should or could have done. Therefore, it is my recommendation that he be dropped as a defendant from the lawsuit. Let me know if you have any further questions. **As** usual, please use my home phone and address for all correspondence.

Sincerely,

John L. Zautcke, MD

UNIVERSITY OF ILLINOIS
AT CHICAGO

Department of Emergency Medicine (MC 722)
UIC Medical Center
1740 West Taylor Street, Suite 1600
Chicago, Illinois 60612-7233

July 22, 1998

Ms. Donna Taylor-Kolis
Third Floor - Standard Building
1370 Ontario Street
Cleveland, OH 44113

RE: Daniel Lavely

Dear Ms. Taylor:

I have received and reviewed the deposition of Dr. Shavinder Ahluwalia. As a supplement to my original report, I still believe that Dr. Ahluwalia deviated from accepted standards and that these actions contributed to the death of Mr. Lavely. Specifically, when notified at about 4 pm that the patient's pulse oximetry was only 53%, Dr. Ahluwalia should have had the patient placed on 100% oxygen by non-rebreather mask and had him immediately transferred to the intensive care unit. Because of the likely need for an emergent intubation, she (or a designee) should have immediately gone to evaluate the patient in person instead of trying to manage a life threatening disease process over the phone. In a young patient like Mr. Lavely, pneumonia is a very treatable disease. With aggressive treatment, more likely than not, I believe he would have survived the hospitalization without sequela.

Let me know if you have further questions. Tomorrow and Friday you can reach me at 773-894-5100 until 3 pm. Talk to you soon.

Sincerely,

John Zautcke, MD

UIC

Phone (312) 996-7297

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Sincerely,

John Zautcke, MD

July 22, 1998

TO: Ms. Donna Taylor-Kolis

FR: John Zautcke, MD

RE: Daniel Lavely

The charge for my recent time and report is $250 for one hour of my time. Let me know if you have questions. As usual, please use my home phone and address for all correspondence:

1320 N. Clark Street #14-A
Chicago, IL 60614
(312) 337-4233

April 17, 2000

Ms. Donna Taylor-Kolis
Third Floor - Standard Building
1370 Ontario Street
Cleveland, OH 44113-1701

RE: Daniel Lavely

Dear Donna:

As we discussed on the phone, I have reviewed the medical records of Daniel Lavely for 4/22/96 - 4/23/96, the depositions of the nurses involved, the deposition of Dr. Lee, and the deposition of Dr. S. Ahluwalia. The pertinent historical and physical findings of Mr. Lavely have been summarized in my prior reports. Below is a summary of my opinions on the case.

As to the nurses involved, my opinion is that their care did not deviate from acceptable standards. They all did an acceptable job of assessing the patient, transferring the patient (twice), and keeping Drs. Lee and Ahluwalia appraised of the situation.

It is my opinion that the care of Dr. Ahluwalia did deviate from accepted standards. She was notified about Mr. Lavely by the 1 - South psychiatric nurses at approximately 3 pm on 4/23/96 and accepted the patient for transfer to 3 - North, a medical floor. According to the nursing note at 3 pm, the results of the chest x-ray were reported to Dr. Ahluwalia. According to the nurse's deposition, the condition of the patient as well as the patient's vital signs were reported as well. It was at this time that the patient's respiratory rate was 60/min, approximately three times the normal rate. This vital sign alone mandated that Dr. Ahluwalia (or her designee) see the patient immediately. It is clearly a sign of respiratory difficulty/distress in a patient known to have pneumonia and needed immediate attention. Besides the immediate physician assessment, the patient should also have been immediately placed on 100% oxygen and transported to the ICU. In her deposition, Dr. Ahluwalia said that she does not remember exactly what information was given to her, including the elevated respiratory rate. She did remember being told that the patient was short of breath and had pneumonia on the x-ray. It is my opinion also that, even if Dr. Ahluwalia wasn't told of the abnormal respiratory rate (which I believe she was), it was her responsibility to ask and find out everything she needed to know about the condition of the patient (including vital signs) in order to provide proper medical care.

After the patient was transferred to the medical floor, Dr. Ahluwalia continued to mismanage Mr. Lavely. Shortly after arriving there, it was even more apparent how sick the patient really was as evidenced by his pulse oximetry reading of *53%* (normal > 95%) and his anxiety. Dr. Ahluwalia was notified by a nurse of the pulse oximetry result at approximately 4pm. This again should have prompted her to have the patient immediately assessed by herself (or another physician). It was obvious that the patient was suffering from acute respiratory failure secondary to pneumonia and in need of immediate intubation. Instead of doing this, Dr. Ahluwalia merely increased the supplemental oxygen being given to the patient to 6 liters/min (–44% oxygen) and ordered arterial blood gasses (ABG's). Although ABG's are a reasonable order, it should already have been apparent to Dr. Ahluwalia that the patient was suffering from respiratory failure and in need of aggressive care. After the **ABG** result was reported, the patient should have been immediately given 100% oxygen and preparations made for intubation and transfer to the ICU. An immediate physician assessment at this time would have determined subsequent care - either the intubation needed to be done immediately in his room on the medical floor or it could have waited until he was transferred to the ICU.

The delays in physician assessment and subsequent transfer to the ICU were critical to the survival of the patient. It was clear at both 3 pm and 4 pm when Dr. Ahluwalia spoke to nursing personnel, that Mr. Lavely needed emergent assessment by a physician to manage his pneumonia and associated acute respiratory failure. Within a reasonable degree of medical certainty, I believe the patient would have survived without sequella if he was intubated and transferred to the ICU in a timely manner.

Let me know if you have any questions or if I can be of further assistance. **As** usual, please use my home phone and address for all correspondence.

Sincerely,

John L. Zautcke, MD

John L. Zautcke, MD, FACEP