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NEWS

How the Barnes Law Group Secured a \$10M Med Mal Verdict in Fulton County

According to plaintiff's counsel Mark Meliski, the defense's strategy posed one of the greatest challenges throughout the litigation process—especially once their codefendant admitted negligence a couple of weeks before trial.

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Medical Malpractice



Alex Anteau



What You Need to Know

- The plaintiffs are the family of a woman who died at Piedmont Hospital when a feeding tube was inserted into her lung instead of her stomach.
- The hospital argued that because a co-defendant radiologist admitted negligence, it was not at fault.
- However, plaintiffs said a combination of favorable facts, good lawyering and credible witnesses swayed the jury in their favor.

Former Georgia Gov. [Roy Barnes](#) and co-counsel [Mark Meliski](#) and [John Bartholomew](#) of the Barnes Law Group recently secured a \$10 million medical malpractice verdict in the State Court of Fulton County against Piedmont Hospital, represented by [David Ladner](#) and [Alan Payne](#) of Bendin Sumrall & Ladner.

According to Meliski, the jury responded to:

- Plaintiff's expert witnesses who were effective teachers.
- A defense expert who was evasive on cross-examination.
- An effective closing argument.
- Facts favorable to the plaintiffs.

"[The defense] dealt with bad facts as well as any lawyer could—I was very impressed by how they addressed the issues in the case," Meliski said. "As lawyers, we never get to dictate the facts that come through the door. All we get to dictate is how they're presented to a jury. ... [They] limited their exposure as much as they could by being effective in how they presented evidence to the jury."

According to Meliski, the defense's strategy posed one of the greatest challenges throughout the litigation process—especially once their co-defendant, radiologist Louis Jacobs, represented by [John Hall Jr.](#) and [Beth Kanik](#) of Hall Booth Smith, admitted negligence a couple of weeks before trial.

"It wasn't a surprise to us that [he] did that, but one of the largest challenges we had to overcome was navigating how that played with a codefendant in the case pointing the finger at [another] defendant who has admitted negligence to try and lessen their culpability," he said.

The plaintiffs were the family of retired pediatric ICU nurse Vadona Sorenson, who was 68 when she was admitted to Atlanta's Piedmont Hospital on Sept. 8, 2018, with suspected bronchitis. She had other health conditions and her overall health worsened after she arrived until she was intubated and transferred to the ICU.

A couple of weeks later, on Sept. 25, Sorenson was eventually extubated as she prepared to transfer to the regular floor. However, afterward, a speech and language pathologist determined she wasn't quite ready for solid food yet and that she needed to have the feeding tube reinserted. That's where the trouble began.

[Read the pretrial order.](#)

Instead of placing the feeding tube down Sorenson's esophagus and into her stomach, her nurse, Kara Lehman, unknowingly inserted it in Sorenson's trachea and punctured her lung. At this point, Meliski said there was still "an opportunity for the nurse who placed the tube to recognize she'd placed it into the lung." This didn't happen and two hours later, Jacobs misread an X-ray taken of the tube placement. As a result, the misplacement wasn't discovered for another six and a half hours, during which time Sorenson slowly suffocated, eventually falling into a coma she didn't recover from.

Another challenge, according to Meliski, was how the hospital treated its own policies. He said that the hospital had a set of policies that laid out the ways nurses should verify the placement of feeding tubes. While Lehman used one of these methods (she was supposed to use two of the methods outlined in the policy), the second test she performed, known as auscultation, or listening for air in the stomach, was not one of those options and also "notoriously unreliable to determine the placement of a feeding tube," he said.

"Piedmont's own policy and our contention was that if she had followed the policy, she likely would have discovered the tube was placed in the lung and could have stopped all this very early," Meliski said. However, at trial, he said that the hospital maintained that this was not a policy, but rather a guide—the jury disagreed.

Meliski said throughout the trial, the plaintiffs' throughline was the hospital's refusal to accept responsibility for something going wrong.

"It really played into the radiologist in the case conceding he violated the standard of care, coming to trial, and testifying appropriately [and] the jury understood he was accepting responsibility, whereas Piedmont took the opposite track," Meliski said.

Meliski said he gave the first portion of the plaintiff's closing argument and Barnes finished the case with their ask. While Meliski would not say what the amount was, he said Barnes anchored the damages to "the value of life."

“When you think about these cases before a jury, you look at what [the deceased] is missing out on, even if it’s only five or 10 years,” Meliski said. He added the plaintiff’s counsel focused on the pain and suffering Sorenson endured leading up to her death in the hospital and emphasized her relationship with her children and grandchildren.

Lander declined to comment, citing pending litigation. Hall and Kanik did not respond to requests for comment.

The case is *Sorenson v. Piedmont Hospital*, in the State Court of Fulton County.

Read the verdict sheet below.

	<input checked="" type="radio"/>	YES	<input type="radio"/>	NO
ii.		Dr. Louis Jacobs? (CIRCLE ONE)		
	<input checked="" type="radio"/>	YES	<input type="radio"/>	NO
B. Was Vandona Sorenson’s death proximately caused by violation of the standard of care by:				
i.		Piedmont Hospital, Inc.? (CIRCLE ONE)		
	<input checked="" type="radio"/>	YES	<input type="radio"/>	NO
ii.		Dr. Louis Jacobs? (CIRCLE ONE)		
	<input checked="" type="radio"/>	YES	<input type="radio"/>	NO
<u>Instruction:</u> If you circled NO for ALL sections of Question Two, STOP, sign the Verdict Form at the end of this document and announce you have a verdict. Otherwise, continue to Question Three.				
Page 2 / 3				

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