Reckless assumptions and miscommunications by medical personnel lead to patient's untimely death

Young mother dies of head injury while medical personnel ignore test reports and withhold timely and critical care

In September 2010, a young mother was at a gas station when she suddenly fell over. While no one witnessed her fall, she did have a bruise on her head.

An ambulance arrived and took the woman to a nearby hospital where an emergency room doctor examined her. The ER examination diagnosed 26-year-old Connie Black (not her real name) as having a "seizure." Records indicated that the patient was minimally cooperative and that she had an abnormal "neuro exam." Because of the trauma and seizure, the emergency room doctor ordered a CT scan of the head and spine. This young mother had tattoos so the hospital jumped to the conclusion that this was a drug overdose.

What followed was the beginning of a series of miscommunications, mistaken assumptions, reckless decisions, and failures to provide proper professional care for a patient in distress – actions and inactions that eventually led to Connie's untimely and preventable death.

The hospital's radiologist reviewed the CT scan and concluded that there was "no evidence of any acute intracranial pathology," meaning nothing was broken. An electrocardiogram (ECG) was performed as well, which indicated abnormal findings recorded as "long QT," or slowed heart beat. Connie was mildly confused and lethargic. The ER doctor noted that Connie's mental status did not improve over several hours in the ER, and that she remained uncooperative. She was not able to walk. While still in the ER, she suffered nausea and vomited three times. Additional tests included a urine screening which tested positive for opiates and benzodiazepines. Of significance in her medical history, Connie had been in a car accident a few years earlier and had suffered a back injury. She had also been diagnosed with migraine headaches. Her family doctors had prescribed medications for both of these problems, and this medical data was provided to the doctors at the hospital, but the doctors and hospital chose to disbelieve her family.

The ER doctor correctly believed that Connie needed to be admitted to the hospital for observation. She was released from the ER in "good condition" and admitted to the hospital under the care of the hospital's internist. Despite the various abnormal findings from the ER examinations, the

internist did not examine Connie until the following morning, over 24 hours later.

Following a review of the ER chart, which included the negative CT report and the ER clinical examination, the internist presumed that Connie's problems were not urgent and possibly psychiatric in nature. He asked for a psychiatric consult, a neurology consult, and an MRI. The neurologist visited Connie the next morning. The neurologist never viewed the brain CT scans himself, relying instead on the radiologist's negative interpretations of the CT. That was a serious mistake because the CT scans of the head showed a skull fracture and brain bleed. He presumed there was no urgency to Connie's problems. Nonetheless, her clinical condition continued to deteriorate and she continued to have clear symptoms of a severe head injury.

The internist's order for the MRI was cancelled allegedly because of her level of agitation. The neurologist agreed to delay an MRI "due to her level of agitation." Connie's records reflect that she was given medications to sedate her, but apparently no consideration was given to sedating her sufficiently to conduct an MRI and find the answers to her condition.

All of the doctors dismissed clear symptoms of a head injury and, instead, presumed she was suffering from a drug overdose. Neither the doctors nor the nursing staff considered the fact that prescriptions for her back pain and migraines would support a positive urine screen and prompt further inquiry. This assumption and lack of attention would prove fatal to this young mother.

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She continued to experience agitation and stress. About 4:00 pm, nurses put her in four-point restraints to control her. The internist, unbelievably, had approved the order without any further evaluation of the patient. Oddly, hospital records noted that at 7:00 pm – three hours after the nurses had recorded that Connie was put in restraints – records stated "pt trying to get out of bed, found naked." She was medicated with Haldol, and her heart rate increased. She remained confused and disoriented, and was found out of bed, naked, again. She began to develop respiratory problems. The internist ordered a chest x-ray and had her transferred to ICU. Connie's blood pressure and oxygen level dropped, but her heart rate continued to increase. Rather belatedly, the internist ordered a cardiac consult. That consult showed severe cardiac damage.

On the morning of the fourth day in the hospital, the neurologist ordered another CT head scan. This scan reported ". . . widespread cerebral, cerebella, and brainstem edema . . . a high density epidural hematoma . . . widespread brain edema . . . contusions . . ." This was in stark contrast to the initial CT scan report of the radiologist who misread the CT scan and missed an injury that could have been timely treated, which would have prevented Connie's death. It was now, however, too late for catch-up actions. Connie was pronounced brain dead that afternoon.

Connie was a young, healthy, vibrant mother of a three-year-old son. Her untimely death left a family in tremendous grief and loss. SDSBS attorney **Greg Barnhart**, along with Michael Maher of Winter Park, represented the estate and her son in a wrongful death lawsuit. The case went to mediation and shortly thereafter, all parties except the internist reached a confidential settlement. His reluctance was short lived though. He later reached settlement with the plaintiffs for his full policy limits. ◆

Head injury was ignored, test reports were misread, and symptoms were dismissed . . .

. . . as medical personnel mistakenly jumped to the conclusion that the patient was either overdosed on drugs or in need of psychiatric care.

Speaking Opportunities

Chris Searcy participated in the Automobile Litigation Series webinar on November 15, 2013, hosted by the Florida Justice Association. His subject was "Closing Arguments." ◆

Sia Baker-Barnes was a panelist at the Palm Beach County Bar Association's Alternative Dispute Resolution Seminar held February 10, 2014. The panel's topic was "The Litigator's Perspective on Effective Mediators." Ms. Baker-Barnes also spoke at the American Association for Justice's annual convention held February 12, 2014, in New Orleans, Louisiana. Her topic was "Maximizing Damages in Personal Injury Cases." ◆

Brenda Fulmer was a moderator at the American Association for Justice's "Plaintiffs-Only Drug and Medical Device Conference" held December 2013 in Las Vegas, Nevada. Ms. Fulmer also participated in AAJ's Winter Conference held February 2014 in New Orleans, Louisiana. She was moderator for the presentation titled "Holding Corporation and Insurance Industries Accountable." ◆

Matt Schwencke spoke at the Florida Justice Association's Workhorse Convention on the topic of "Mental Pain and Suffering Damages" in negligence cases. The conference was held February 20, 2014, in Orlando, Florida. ◆

Kelly Hyman participated in the "Trial Lawyer MMA – Combining the Disciplines Conference" hosted by 360 Advocacy Institute in March 2014 at Aspen, Colorado. Ms. Hyman's subject was "Presentation – Setting the Stage: Isn't a Trial Just a Play?" ◆

Brian Denney and **Laurie Briggs** spoke October 9, 2013, at the Workers' Injury Law and Advocacy Group's annual convention held at The Breakers Hotel, Palm Beach, Florida. The subject of their presentation was witness deposition and trial testimony. ◆