IN THE STATE COURT OF DEKALB COUNTY
STATE OF GEORGIA

BRENDA MAINOR AND THOMAS MAINOR, INDIVIDUALLY AND AS REPRESENTATIVES OF THE ESTATE OF SEQUOYAH MAINOR (DECEASED),

PLAINTIFFS,

— *VERSUS* —

CHILDREN'S HEALTHCARE OF ATLANTA, INC,

EMORY UNIVERSITY,

THE EMORY CLINIC, INC,

EMORY HEALTHCARE, INC,

EMORY PHYSICIANS GROUP, LLC,

MICHAEL GREENWALD, MD,

GABRIEL RIBEIRO DE MATOS SILVEIRA, RN, AND

JOHN/JANE DOES 1-10,

DEFENDANTS.

CIVIL ACTION

FILE NO. 23A02643

JURY TRIAL DEMANDED

PLAINTIFFS' COMPLAINT FOR DAMAGES

Nature of the Action

1. This medical malpractice action arises out of healthcare negligently provided to Plaintiffs' daughter, 15-year-old Sequoyah Mainor, on June 20, 2021, resulting in her wrongful death.

2. Plaintiffs hereby assert claims of professional negligence against each Defendant, either directly or vicariously.

3. Plaintiffs also assert claims of ordinary negligence against the corporate Defendants, based on the conduct of their administrators.

4. Plaintiffs demand a jury trial on all issues.

5. Herein, "standard of care" means that degree of care and skill ordinarily employed by the medical profession generally under similar conditions and like circumstances as pertained to Defendants' conduct here.

6. Pursuant to OCGA § 9-11-9.1, the affidavits of Keith Borg, MD, and Chrissy White, RN, are attached as Exhibits 1 and 2, respectively. This Complaint incorporates the opinions and assertions found in those affidavits.

7. Plaintiffs stipulate that Defendants need not respond to:

   - anything contained in the exhibits or attachments to this Complaint,
   - statements in this Complaint that are not made in enumerated allegations, including footnotes, except where an enumerated allegation explicitly incorporates accompanying matter,
   - citations to Bates-stamped pages of records, and
   - graphics or screenshots that accompany enumerated allegations, which graphics and screenshots are included only to make it as easy as possible to respond to the allegations, but are not part of them.

Parties, Jurisdiction, and Venue

8. **Plaintiffs BRENDA MAINOR** and **THOMAS MAINOR** are citizens and residents of Georgia. They submit to the personal jurisdiction and venue of this Court.

9. **Defendant CHILDREN'S HEALTHCARE OF ATLANTA, INC. ("CHOA")** is a Georgia nonprofit corporation. Its Registered Agent is CSC of Cobb County, Inc. Its physical address is 192 Anderson Street, Suite 125, Marietta, GA 30060, in Cobb County. Its principal office address is 1575 Northeast Expressway, Atlanta, GA 30329, in DeKalb County.

10. **CHOA** is subject to the personal jurisdiction of this Court.

11. **CHOA** is subject to the subject-matter jurisdiction of this Court in this case.

12. **CHOA** is directly subject to venue in this Court.[1]

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[1] OCGA §§ 14-2-510 and 14-3-510 provide identical venue provisions for regular business corporations and for nonprofit corporations:

> "Each domestic corporation and each foreign corporation authorized to transact business in this state shall be deemed to reside and to be subject to venue as follows: (1) In civil proceedings generally, in the county of this state where the corporation maintains its registered office . . .. (3) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated, if the corporation has an office and transacts business in that county; (4) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated."

These same venue provisions apply to Professional Corporations, because PCs are organized under the general "Business Corporation" provisions of the Georgia Code. *See* OCGA § 14-7-3.

These venue provisions also apply to Limited Liability Companies, *see* OCGA § 14-11-1108, and to foreign limited liability partnerships, *see* OCGA § 14-8-46.

OCGA 9-10-31 provides that, "joint tort-feasors, obligors, or promisors, or joint contractors or copartners, residing in different counties, may be subject to an action as such in the same action in any county in which one or more of the defendants reside."

13. **CHOA** has been properly served with this Complaint.

14. **CHOA** has no defense to this lawsuit based on undue delay in bringing suit—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

15. At all times relevant to this Complaint, **CHOA** was the employer or other principal of Dr. Michael Greenwald, Nurse Gabriel Ribeiro de Matos Silveira, Nurse Elizabeth Wright, and other persons who provided care to Sequoyah.

16. If any other entity was the employer or other principal of any of those persons during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

17. At all times relevant to this Complaint, **CHOA** owned, controlled, managed, and administered multiple healthcare facilities, including Children's Egleston Hospital, 1405 Clifton Road, Atlanta, GA 30322 (the "Hospital"), also known as "Children's Healthcare of Atlanta – Egleston Hospital."

18. At all times relevant to this Complaint, **CHOA** also did business as Children's Egleston Hospital and/or Children's Healthcare of Atlanta – Egleston Hospital.

19. **Defendant EMORY UNIVERSITY** is a Georgia nonprofit corporation. Its Registered Agent is Amy Adelman. Its physical address is Emory University, 201 Dowman Drive, 312 Administration Building, Atlanta, GA 30322, in DeKalb County. Its principal office address is 505 Kilgo Circle NE, 300 Convocation Hall, Atlanta, GA 30322.

20. **EMORY UNIVERSITY** is subject to the personal jurisdiction of this Court.

21. **EMORY UNIVERSITY** is subject to the subject-matter jurisdiction of this Court in this case.

22. **EMORY UNIVERSITY** is directly subject to venue in this Court.

23. **EMORY UNIVERSITY** has been properly served with this Complaint.

24. **EMORY UNIVERSITY** has no defense to this lawsuit based on undue delay in bringing suit—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

25. At all times relevant to this Complaint, **EMORY UNIVERSITY** was the employer or other principal of Dr. Michael Greenwald, Nurse Gabriel Ribeiro de Matos Silveira, Nurse Elizabeth Wright, and other persons who provided care to Sequoyah Mainor.

26. If any other entity was the employer or other principal of any of these persons during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

27. **Defendant THE EMORY CLINIC, INC. ("Emory Clinic")** is a Georgia nonprofit corporation. Its Registered Agent is Amy Adelman. Its physical address is Emory University, 201 Dowman Drive, 312 Administration Building, Atlanta, GA 30322, in DeKalb County. Its principal office address is 1365 Clifton Rd NE, Atlanta, GA 30322-1013.

28. **EMORY CLINIC** is subject to the personal jurisdiction of this Court.

29. **EMORY CLINIC** is subject to the subject-matter jurisdiction of this Court in this case.

30. **EMORY CLINIC** is directly subject to venue in this Court.

31. **EMORY CLINIC** has been properly served with this Complaint.

32. **EMORY CLINIC** has no defense to this lawsuit based on undue delay in bringing suit—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

33. At all times relevant to this Complaint, **EMORY CLINIC** was the employer or other principal of Dr. Michael Greenwald, Nurse Gabriel Ribeiro de Matos Silveira, Nurse Elizabeth Wright, and other persons who provided care to Sequoyah Mainor.

34. If any other entity was the employer or other principal of any of these persons during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

35. **Defendant EMORY HEALTHCARE, INC. ("Emory Healthcare")** is a Georgia nonprofit corporation. Its Registered Agent is Amy Adelman. Its physical address is 201 Dowman Drive, 312 Administration Building, Atlanta, GA 30322, in DeKalb County. Its principal office address is 201 Dowman Drive NE, 101 Administration Building, Atlanta, GA 30322-1018, in DeKalb County.

36. **EMORY HEALTHCARE** is subject to the personal jurisdiction of this Court.

37. **EMORY HEALTHCARE** is subject to the subject-matter jurisdiction of this Court in this case.

38. **EMORY HEALTHCARE** is directly subject to venue in this Court.

39. **EMORY HEALTHCARE** has been properly served with this Complaint.

40. **EMORY HEALTHCARE** has no defense to this lawsuit based on undue delay in bringing suit—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

41. At all times relevant to this Complaint, **EMORY HEALTHCARE** was the employer or other principal of Dr. Michael Greenwald, Nurse Gabriel Ribeiro de Matos Silveira, Nurse Elizabeth Wright, and other persons who provided care to Sequoyah Mainor.

42. If any other entity was the employer or other principal of any of these persons during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

43. **Defendant EMORY PHYSICIANS GROUP, LLC ("Emory Physicians")** is a Georgia limited liability company. Its Registered Agent is Amy Adelman. Its physical address is Emory University, 201 Dowman Drive, 312

Administration Building, Atlanta, GA 30322, in DeKalb County. Its principal office address is 201 Dowman Drive, 401 Administration Building, Atlanta, GA 30322, in DeKalb County.

44. **EMORY PHYSICIANS** is subject to the personal jurisdiction of this Court.

45. **EMORY PHYSICIANS** is subject to the subject-matter jurisdiction of this Court in this case.

46. **EMORY PHYSICIANS** is directly subject to venue in this Court.

47. **EMORY PHYSICIANS** has been properly served with this Complaint.

48. **EMORY PHYSICIANS** has no defense to this lawsuit based on undue delay in bringing suit—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

49. At all times relevant to this Complaint, **EMORY PHYSICIANS** was the employer or other principal of Dr. Michael Greenwald, Nurse Gabriel Ribeiro de Matos Silveira, Nurse Elizabeth Wright, and other persons who provided care to Sequoyah Mainor.

50. If any other entity was the employer or other principal of any of these persons during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

51. Herein, "**Emory Defendants"** refers to Defendants Emory University, Emory Clinic, Emory Healthcare, and Emory Physicians, collectively.

52. Herein, "**Corporate Defendants**" refers to CHOA and the Emory Defendants, collectively.

53. **Defendant MICHAEL GREENWALD, MD ("Dr. Greenwald")** is a resident of Georgia. He resides at 5016 Redcliff Ct, Dunwoody, GA 30338-5331, in DeKalb County.

54. **DR. GREENWALD** is subject to the personal jurisdiction of this Court.

55. **DR. GREENWALD** is subject to the subject-matter jurisdiction of this Court in this case.

56. Pursuant to OCGA § 9-10-31, **DR. GREENWALD** is subject to venue in this Court, because he resides in DeKalb County and because at least one of his co-defendants is directly subject to venue here.

57. **DR. GREENWALD** has been properly served with this Complaint.

58. **DR. GREENWALD** has no defense to this lawsuit based on undue delay in bringing suit—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

59. At all times relevant to this Complaint, **DR. GREENWALD** owed professional duties of care to Sequoyah Mainor—duties Dr. Greenwald breached, causing Sequoyah harm.

60. At all times relevant to this Complaint, **DR. GREENWALD** acted as an employee or other agent of CHOA and/or one or more of the Emory Defendants. As Dr. Greenwald's employer(s) or other principal(s) at the time of his negligence, CHOA and/or one or more of the Emory Defendants are vicariously liable for his negligence, because he was acting within the scope of his employment or agency at that time.

61. **Defendant GABRIEL RIBEIRO DE MATOS SILVEIRA ("Nurse Ribeiro" or "Nurse Silveira")** is a Georgia resident. He resides at 185 Montag Cir NE, Unit 338, Atlanta, GA 30307.

62. **NURSE RIBEIRO** is subject to the personal jurisdiction of this Court.

63. **NURSE RIBEIRO** is subject to the subject-matter jurisdiction of this Court in this case.

64. Pursuant to OCGA § 9-10-31, **NURSE RIBEIRO** is subject to venue in this Court, because at least one of his co-defendants is directly subject to venue here.

65. **NURSE RIBEIRO** has been properly served with this Complaint.

66. **NURSE RIBEIRO** has no defense to this lawsuit based on undue delay in bringing suit—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

67. At all times relevant to this Complaint, **NURSE RIBEIRO** owed professional duties of care to Sequoyah Mainor—duties he breached, causing Sequoyah harm.

68. At all times relevant to this Complaint, **NURSE RIBEIRO** acted as an employee or other agent of CHOA and/or one or more of the Emory Defendants. As Nurse Ribeiro's employer(s) or other principal(s) at the time of his negligence, CHOA and/or one or more of the Emory Defendants are vicariously liable for his negligence, because he was acting within the scope of his employment or agency at that time.

69. **JOHN/JANE DOES 1-10** are yet-unidentified natural and legal persons who may be liable for damages alleged here. Once served with process, John/Jane Does 1-10 are subject to the jurisdiction and venue of this Court.

Professional Malpractice: General Notice of Claim

70. Plaintiffs here incorporate by reference all paragraphs of this Complaint.

71. On June 20, 2021, Dr. Greenwald owed professional duties of care to Sequoyah Mainor — duties he breached, causing Sequoyah harm.

72. At all times relevant to this Complaint, Dr. Greenwald acted as an employee or other agent of one or more of the Corporate Defendants.

73. As Dr. Greenwald's employer(s) or other principal(s) at the time of his negligence, one or more of Corporate Defendants are vicariously liable for his negligence, because Dr. Greenwald was acting within the scope of his employment or agency at that time.

74. On June 20, 2021, Nurse Ribeiro owed professional duties of care to Sequoyah Mainor — duties he breached, causing Sequoyah harm.

75. At all times relevant to this Complaint, Nurse Ribeiro acted as an employee or other agent of one or more of the Corporate Defendants.

76. As Nurse Ribeiro's employer(s) or other principal(s) at the time of his negligence, one or more of the Corporate Defendants are vicariously liable for his negligence, because Nurse Ribeiro was acting within the scope of his employment or agency at that time.

77. At all times relevant to this Complaint, other nurses at the Hospital acted as employees or other agents of one or more of the Corporate Defendants.

78. As the employer(s) or other principal(s) of these nurses at the time of their negligence, one or more of the Corporate Defendants are vicariously liable for these nurses' negligence, because these nurses were acting within the scope of their employment or agency at that time.

Professional Malpractice: Detailed Notice of Claim

Defendants need not respond to statements or other matter (e.g., citations. screenshots) not made in enumerated paragraphs.

The above "General Notice" allegations suffice to state a claim. In keeping with the overriding goal of the Civil Practice Act ("to secure the just, speedy, and inexpensive determination of every action"), the detailed allegations below are presented to provide further notice, narrow disputes, and simplify discovery and trial.

Nevertheless, Plaintiffs do not waive Georgia's notice-pleading requirements, or assume any obligation to provide more than the general notice required by law.

Treatment of Sequoyah Mainor

Sequoyah Arrives at ER with Signs of Severe Constipation

79. On Sunday, June 20, 2021, at 1417 hrs, Sequoyah Mainor arrived at the Hospital's Emergency Department (the "ED" or "ER"). CHA 5.

80. Sequoyah walked in under her own powers, accompanied by her grandmother. CHA 5, CHA 21, CHA 13.

81. During her three-hour stay in the ER, Sequoyah received care from Dr. Greenwald, Nurse Ribeiro, and Nurse Rafia Khan, among others. CHA 18.

82. Dr. Greenwald was Sequoyah's attending physician. CHA 18.

Treatment Team

Provider	Role	From	To
Greenwald, Michael H, MD	**Attending Provider**	**06/20/21 1441**	**--**
Khan, Rafia, RN	**Registered Nurse**	**06/20/21 1451**	**06/20/21 1502**
Ribeiro de Matos Silveira, Gabriel, RN	**Registered Nurse**	**06/20/21 1502**	**--**

CHA 18.

83. Other Hospital clinicians also provided care to Sequoyah at the ER, as demonstrated below and in her medical records.

84. At about 1421 hrs, Nurse Sheila K. Vinas performed a triage evaluation of Sequoyah. CHA 8, CHA 17.

85. Nurse Vinas's findings were all normal. CHA 8.

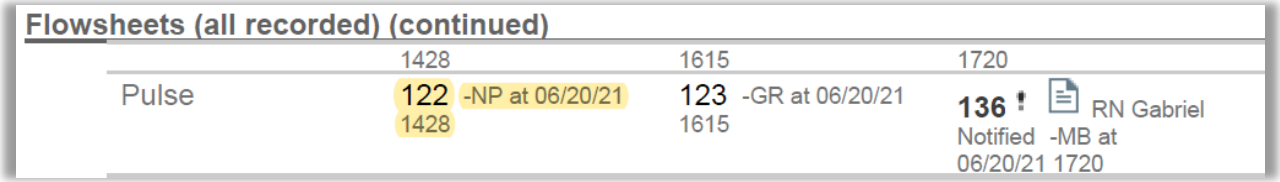
Triage Evaluation - Sun June 20, 2021

Row Name	1421
Airway patent, No adjuncts	Yes -SV at 06/20/21 1421
Respiratory effort is easy	Yes -SV at 06/20/21 1421
Skin color pink, no obvious bleeding	Yes -SV at 06/20/21 1421
Disability WDL	Yes -SV at 06/20/21 1421
WDL Disability	Awake & Alert -SV at 06/20/21 1421

CHA 8.

86. At 1425 hrs, Technician Nepefteria F. Poythress took Sequoyah's vitals. CHA 12, CHA 17

87. At 1428 hrs, Sequoyah was tachycardic, with a heartrate of 122. CHA 16.

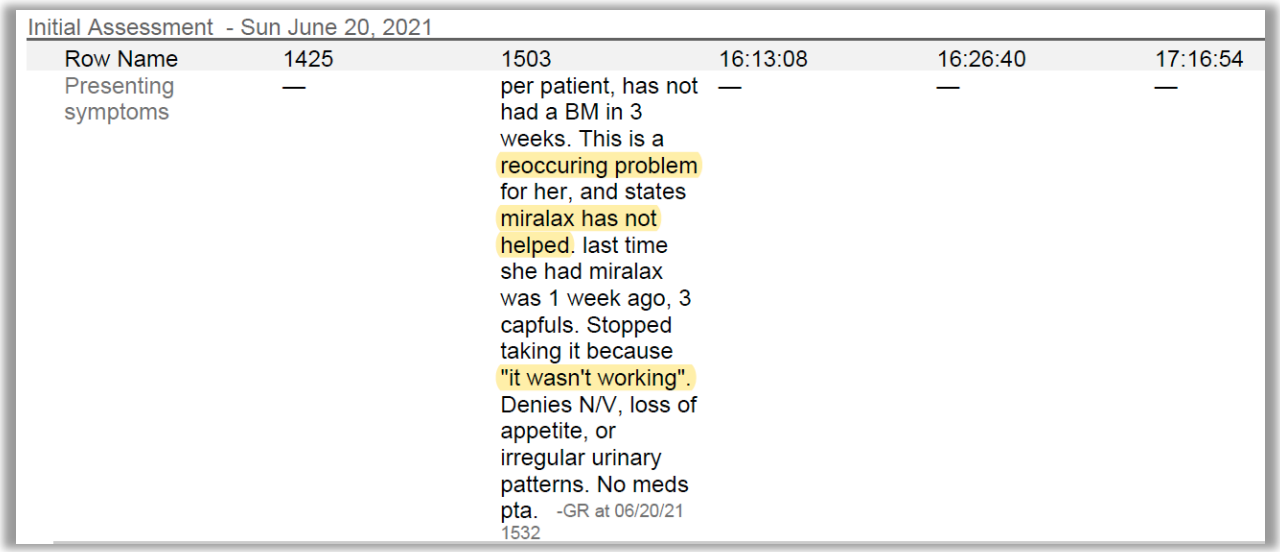


CHA 16.

88. At 1503 hrs, Nurse Gabriel Ribeiro started an initial assessment of Sequoyah. CHA 10.

89. Sequoyah's presenting problem was severe constipation: not having a bowel movement "in 3 weeks"—"a reocurring problem for her." CHA 10.

90. Sequoyah explained she had stopped taking Miralax because "it wasn't working" and had "not helped." CHA 10.



CHA 10.

91. During Nurse Ribeiro's exam, Sequoyah's abdomen was distended, firm, and round—all signs of severe constipation and possible bowel obstruction. *See* CHA 9, CHA 11.

Abdomen Exam Exceptions	—	Distended;Firm;Round -GR at 06/20/21 1532	—

CHA 11.

92. Sequoyah also had abdominal pain she rated a 2 out of 10. CHA 11.

Pain Intensity Rating	—	2 -GR at 06/20/21 1532
Other Pain Documentation	—	abdominal pain -GR at 06/20/21 1532

CHA 11.

93. Nurse Ribeiro concluded that Sequoyah had "constipation." CHA 10.

Gastrointestinal	—	**WDL except as noted- complete CDS !** -GR at 06/20/21 1532	—
GI Exceptions	—	Constipation -GR at 06/20/21 1532	—

CHA 10.

94. Sequoyah was otherwise normal. *See* CHA 10-11.

95. Sequoyah was otherwise a "healthy child." CHA 264.

96. At 1532 hrs, Nurse Ribeiro concluded the initial assessment. CHA 11.

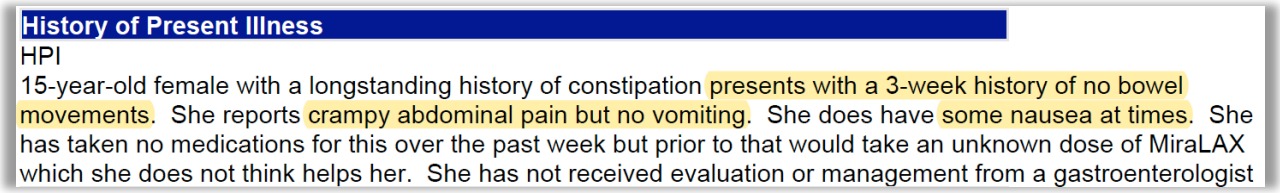
Dr. Greenwald Diagnoses Sequoyah with Constipation

97. After 1523 hrs, Dr. Greenwald examined Sequoyah. *See* CHA 18-20.

98. Sequoyah presented "with a 3-week history of no bowel movements." CHA 18.

99. Sequoyah reported "crampy abdominal pain." CHA 18.

100. Sequoyah had "nausea at times" but "no vomiting." CHA 18.



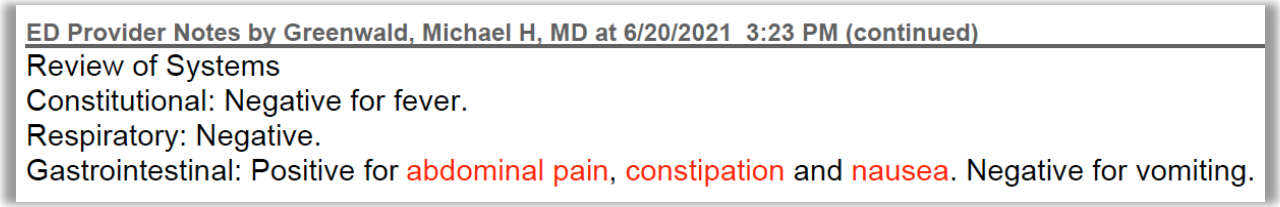
History of Present Illness

HPI

15-year-old female with a longstanding history of constipation presents with a 3-week history of no bowel movements. She reports crampy abdominal pain but no vomiting. She does have some nausea at times. She has taken no medications for this over the past week but prior to that would take an unknown dose of MiraLAX which she does not think helps her. She has not received evaluation or management from a gastroenterologist

CHA 18.

101. Sequoyah's gastrointestinal system was thus "positive for abdominal pain, constipation and nausea" and "negative for vomiting." CHA 18-19.



ED Provider Notes by Greenwald, Michael H, MD at 6/20/2021 3:23 PM (continued)

Review of Systems

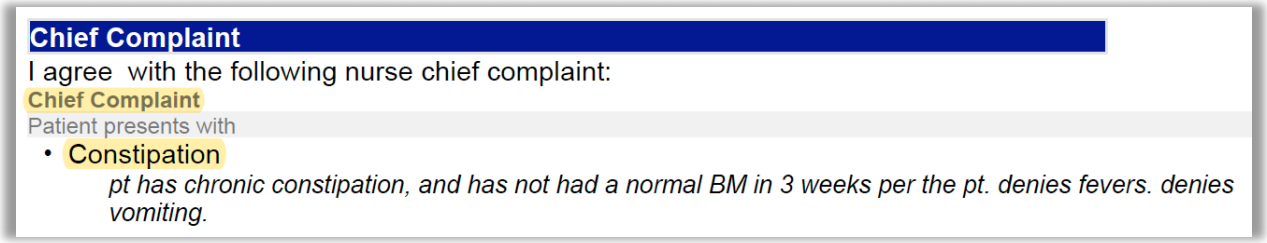
Constitutional: Negative for fever.

Respiratory: Negative.

Gastrointestinal: Positive for abdominal pain, constipation and nausea. Negative for vomiting.

CHA 19.

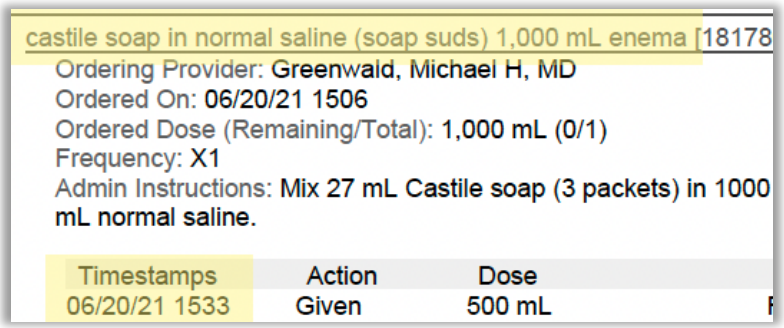
102. Dr. Greenwald agreed with Nurse Ribeiro's diagnosis of "constipation" as Sequoyah's "chief complaint." CHA 18.



CHA 18.

Dr. Greenwald Orders Enema, Which Fails

103. At 1506 hrs, while Nurse Ribeiro was conducting his initial assessment of Sequoyah, Dr. Greenwald ordered a 1,000 mL soap suds enema. CHA 4.



CHA 4.

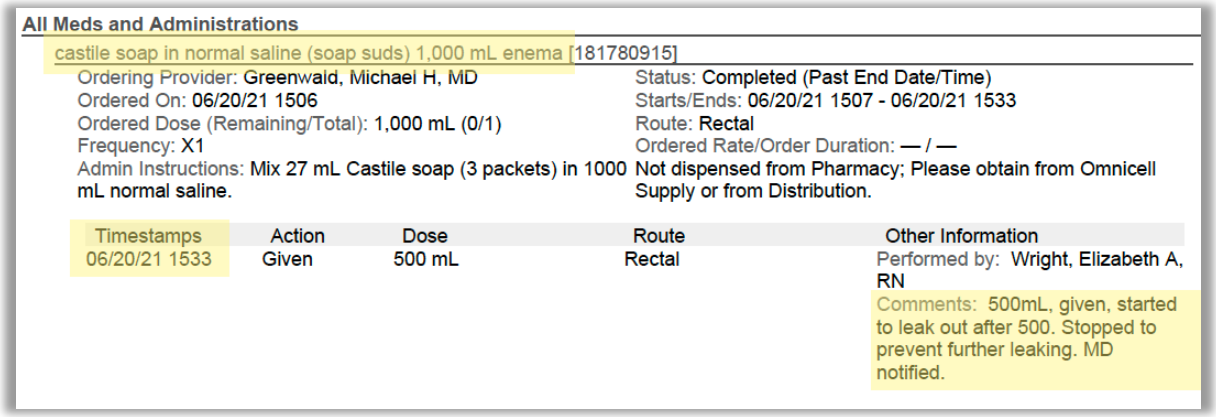
104. At 1526 hrs, upon an order by Dr. Greenwald, Nurse Ribeiro gave Sequoyah six milligrams of Zofran. CHA 24.

105. Zofran prevents nausea and vomiting. A common side-effect of Zofran is constipation.

106. At 1533 hrs, Nurse Elizabeth Wright started the enema. CHA 4.

107. The enema, however, "started to leak out after 500 [mL]." CHA 4.

108. As a result, Nurse Wright "stopped to prevent further leaking." CHA 4.



All Meds and Administrations

castile soap in normal saline (soap suds) 1,000 mL enema [181780915]

Ordering Provider: Greenwald, Michael H, MD
Ordered On: 06/20/21 1506
Ordered Dose (Remaining/Total): 1,000 mL (0/1)
Frequency: X1
Admin Instructions: Mix 27 mL Castile soap (3 packets) in 1000 mL normal saline.

Status: Completed (Past End Date/Time)
Starts/Ends: 06/20/21 1507 - 06/20/21 1533
Route: Rectal
Ordered Rate/Order Duration: — / —
Not dispensed from Pharmacy; Please obtain from Omnicell Supply or from Distribution.

Timestamps	Action	Dose	Route	Other Information
06/20/21 1533	Given	500 mL	Rectal	Performed by: Wright, Elizabeth A, RN Comments: 500mL, given, started to leak out after 500. Stopped to prevent further leaking. MD notified.

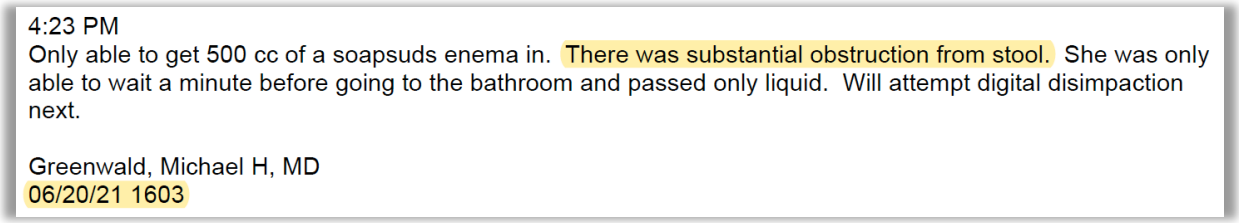
CHA 4.

109. Nurse Wright then informed Dr. Greenwald of the failed enema. CHA 4.

Dr. Greenwald Suspects Sequoyah Has Bowel Obstruction

110. At about 1603 hrs, Dr. Greenwald entered notes concerning the aborted enema. CHA 21.

111. After Nurse Wright was "only able to get 500 cc of a soapsuds enema in," Dr. Greenwald recognized that Sequoyah's bowel had **"substantial obstruction from stool."** CHA 21.



4:23 PM
Only able to get 500 cc of a soapsuds enema in. There was substantial obstruction from stool. She was only able to wait a minute before going to the bathroom and passed only liquid. Will attempt digital disimpaction next.

Greenwald, Michael H, MD
06/20/21 1603

CHA 21.

112. In fact, after the failed enema, Sequoyah "passed only liquid." CHA 21.

113. At minimum, Dr. Greenwald *suspected* that Sequoyah had "substantial obstruction from stool."

114. As a result, Dr. Greenwald decided to "attempt digital disimpaction next." CHA 21.

115. At 1605 hrs, Dr. Greenwald met "face to face" with Nurse Ribeiro. CHA 11.

Provider Communication - Sun June 20, 2021

Row Name	1605	1642	17:16:11
Reason for Communication	Other (comment) -GR at 06/20/21 1644	Other (comment) -GR at 06/20/21 1645	Other (comment) -GR at 06/20/21 1716
Provider Name	Greenwald -GR at 06/20/21 1644	Greenwald -GR at 06/20/21 1645	Greenwald -GR at 06/20/21 1716
Provider Role	Attending physician -GR at 06/20/21 1644	Attending physician -GR at 06/20/21 1645	Attending physician -GR at 06/20/21 1716
Method of Communication	Face to face -GR at 06/20/21 1644	Face to face -GR at 06/20/21 1645	Face to face -GR at 06/20/21 1716
Response	— MD notified that patient had some BM. No solid BM at this time. Provider will order versed to help with digitial stimulation. -GR at 06/20/21 1644	Other (comment) MD notified RN that digital stimulation was unsuccesful. MD believes only option left is to send patient home with miralax. -GR at 06/20/21 1645	No new orders MD notified that patient's HR was in 130s while laying down and in pain. Other VS stable. MD ok to send patient home at this time. -GR at 06/20/21 1716
Notification Time	1605 -GR at 06/20/21 1644	1642 -GR at 06/20/21 1645	1716 -GR at 06/20/21 1716

CHA 11.

116. Nurse Ribeiro informed Dr. Greenwald that Sequoyah had "some BM" but "no solid BM at this time." CHA 11.

117. Following the conversation, Dr. Greenwald decided to "order versed to help with digital stimulation." CHA 11.

118. At 1610 hrs, Dr. Greenwald entered the order for Versed. CHA 24.

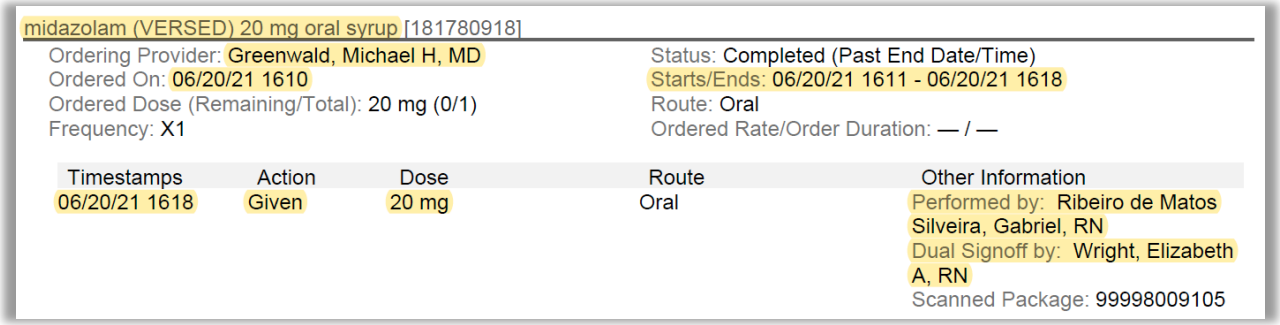
midazolam (VERSED) 20 mg oral syrup [181780918]

Electronically signed by: **Greenwald, Michael H, MD on 06/20/21 1610** Status: **Completed**
Ordering user: Greenwald, Michael H, MD 06/20/21 1610 Ordering provider: Greenwald, Michael H, MD
Authorized by: Greenwald, Michael H, MD Ordering mode: Standard
Frequency: Once 06/20/21 1611 - 1 occurrence Package: 99998009105
Medication Dose: 20 mg

CHA 24.

119. At 1618 hrs, Nurse Ribeiro completed the administration of Versed. CHA 4.

120. Nurse Wright was the "dual signoff" to the administration. CHA 4.


midazolam (VERSED) 20 mg oral syrup [1817809 18]

Ordering Provider: Greenwald, Michael H, MD
Ordered On: 06/20/21 1610
Ordered Dose (Remaining/Total): 20 mg (0/1)
Frequency: X1

Status: Completed (Past End Date/Time)
Starts/Ends: 06/20/21 1611 - 06/20/21 1618
Route: Oral
Ordered Rate/Order Duration: — / —

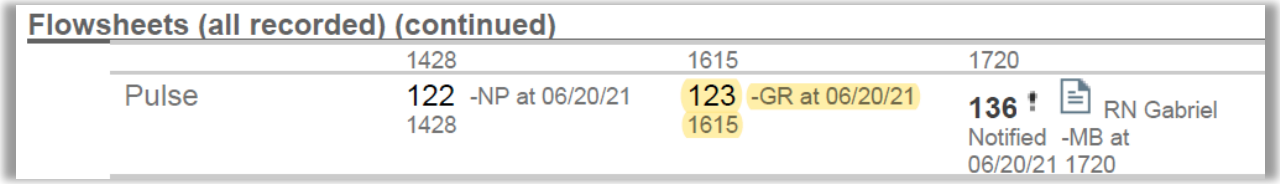
Timestamps	Action	Dose	Route	Other Information
06/20/21 1618	Given	20 mg	Oral	Performed by: Ribeiro de Matos Silveira, Gabriel, RN Dual Signoff by: Wright, Elizabeth A, RN Scanned Package: 99998009105

CHA 4.

121. Versed is an anti-anxiety medication.

Dr. Greenwald Confirms Sequoyah Has Bowel Obstruction

122. At 1615 hrs, Sequoyah remained tachycardic, with a heartrate of 123. CHA 16.


Flowsheets (all recorded) (continued)

	1428	1615	1720
Pulse	122 -NP at 06/20/21 1428	123 -GR at 06/20/21 1615	136 ! RN Gabriel Notified -MB at 06/20/21 1720

CHA 16.

123. At 1615 hrs, Sequoyah's abdominal pain rose to a 10, and was flagged by the EMR system. CHA 11.

124. At 1627 hrs, Sequoyah's abdominal pain remained a 10, and was again flagged by the EMR system. CHA 11.

Pain Intensity Rating	—	2 -GR at 06/20/21 1532	10 ! -GR at 06/20/21 1615	10 ! -GR at 06/20/21 1627	10 ! -GR at 06/20/21 1719
Other Pain Documentation	—	abdominal pain - GR at 06/20/21 1532	abdominal pain (post enema) -GR at 06/20/21 1615	abdominal pain (post enema) -GR at 06/20/21 1627	abdominal pain post enema -GR at 06/20/21 1719

CHA 11.

125. By approximately 1642 hrs, Dr. Greenwald completed the attempt at digital disimpaction. CHA 11, CHA 21.

126. The "digital disimpaction attempt" proved "unsuccessful." CHA 21.

127. Dr. Greenwald found a **"large amount of stool high in the rectum,"** but was unable to **"get around to pull anything out."** CHA 21.

4:46 PM
Digital disimpaction attempt unsuccessful. There was large amount of stool high in the rectum but could not get around to pull anything out. Will advise on outpatient management.

Greenwald, Michael H, MD
06/20/21 1646

CHA 21.

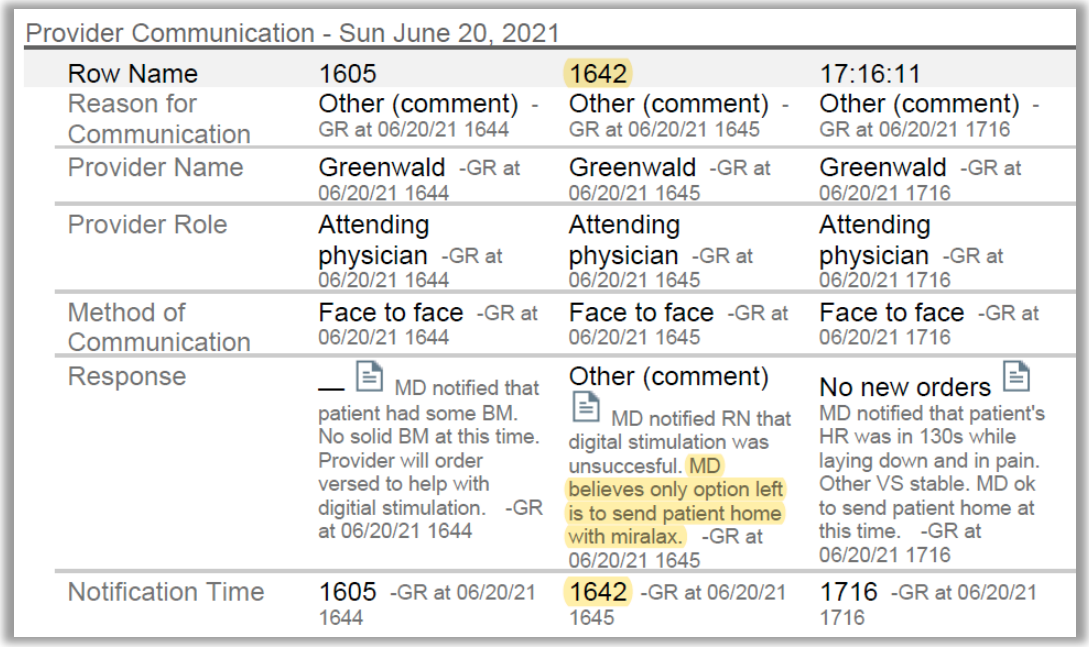
128. Dr. Greenwald thus confirmed the obstruction in Sequoyah's bowel.

Dr. Greenwald Declares Discharge "Only Option Left"

129. At 1642 hrs, Dr. Greenwald and Nurse Ribeiro had a second "face to face" conversation. CHA 11.

130. During the conversation, Dr. Greenwald notified Nurse Ribeiro "that digital stimulation was unsuccessful." CHA 11.

131. Dr. Greenwald also declared that the **"only option left [was] to send patient home with miralax."** CHA 11.



Provider Communication - Sun June 20, 2021

Row Name	1605	1642	17:16:11
Reason for Communication	Other (comment) - GR at 06/20/21 1644	Other (comment) - GR at 06/20/21 1645	Other (comment) - GR at 06/20/21 1716
Provider Name	Greenwald -GR at 06/20/21 1644	Greenwald -GR at 06/20/21 1645	Greenwald -GR at 06/20/21 1716
Provider Role	Attending physician -GR at 06/20/21 1644	Attending physician -GR at 06/20/21 1645	Attending physician -GR at 06/20/21 1716
Method of Communication	Face to face -GR at 06/20/21 1644	Face to face -GR at 06/20/21 1645	Face to face -GR at 06/20/21 1716
Response	— MD notified that patient had some BM. No solid BM at this time. Provider will order versed to help with digitial stimulation. -GR at 06/20/21 1644	Other (comment) MD notified RN that digital stimulation was unsuccesful. MD believes only option left is to send patient home with miralax. -GR at 06/20/21 1645	No new orders MD notified that patient's HR was in 130s while laying down and in pain. Other VS stable. MD ok to send patient home at this time. -GR at 06/20/21 1716
Notification Time	1605 -GR at 06/20/21 1644	1642 -GR at 06/20/21 1645	1716 -GR at 06/20/21 1716

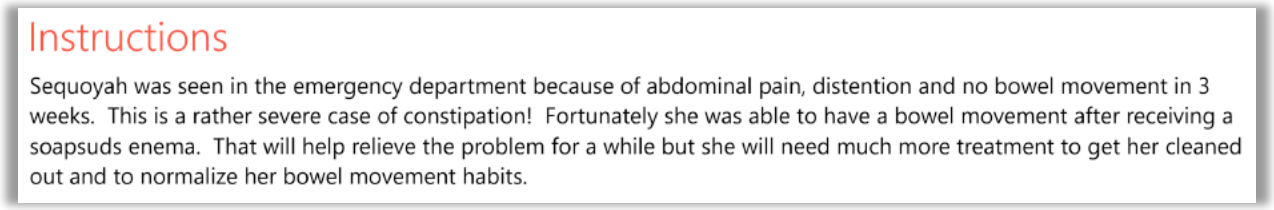
CHA 11.

132. Accordingly, Dr. Greenwald decided to "advise on outpatient management." CHA 21.

Dr. Greenwald Instructs Sequoyah to Start Aggressive Regimen of Miralax That Day, and See Pediatrician or Gastroenterologist "Within 2 Weeks"

133. Apparently at 1647 hrs, Dr. Greenwald entered discharge instructions for Sequoyah and her family. CHA 21.

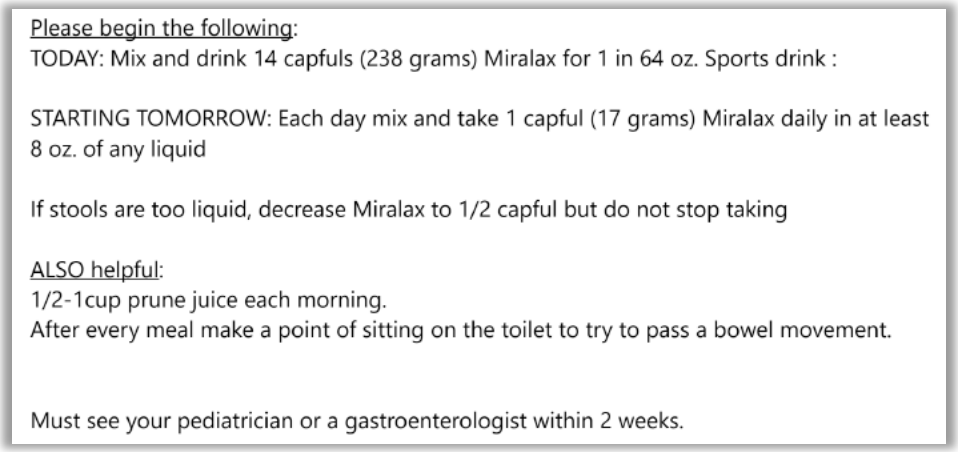
134. Although Dr. Greenwald recognized that Sequoyah had a "rather severe case of constipation," and needed "much more treatment to get her cleaned out," Dr. Greenwald sent her home—with two instructions. CHA 25.



CHA 25.

135. *First*, Dr. Greenwald directed Sequoyah to take an aggressive regimen of Miralax: an initial 14-capfuls (238-gram) cleanout dose that same day, and a 1-capful (17-gram) dose daily thereafter. CHA 25.

136. *Second*, Dr. Greenwald directed Sequoyah to see her "pediatrician or a gastroenterologist within 2 weeks." CHA 25.



CHA 25.

137. Dr. Greenwald provided Sequoyah no instruction on returning to the ER—even if her pain, tachycardia, or other symptoms worsened, or even if she experienced new symptoms, like vomiting.

138. According to a narrative Dr. Greenwald entered at 1704 hrs, Sequoyah "passed a small amount of stool" at that time—after he had already decided to send her home. CHA 21.

5:04 PM
Passed a small amount of stool after the digital disimpaction attempt. Reviewed discharge instructions with grandmother and answer questions.

Greenwald, Michael H, MD
06/20/21 1704

139. At 1707 hrs, Dr. Greenwald's discharge instructions for Sequoyah were printed. CHA 25.

Though Sequoyah Has Deteriorated, Nurse Ribeiro Sends Her Home for "Self Care"—without Advocating for Escalation of Care

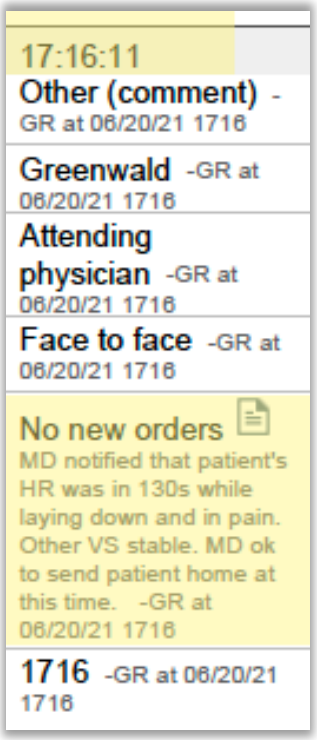
140. At 1716 hrs, just minutes before she was sent home, Sequoyah's abdominal pain remained a 10. CHA 11.

141. The pain score was again flagged by the EMR system—the third time in about 64 minutes. CHA 11.

Pain Intensity Rating	—	2 -GR at 06/20/21 1532	10 ! -GR at 06/20/21 1615	10 ! -GR at 06/20/21 1627	10 ! -GR at 06/20/21 1719
Other Pain Documentation	—	abdominal pain -GR at 06/20/21 1532	abdominal pain (post enema) -GR at 06/20/21 1615	abdominal pain (post enema) -GR at 06/20/21 1627	abdominal pain post enema -GR at 06/20/21 1719

142. At 1716 hrs, Nurse Ribeiro and Dr. Greenwald had a third "face to face" conversation. CHA 11.

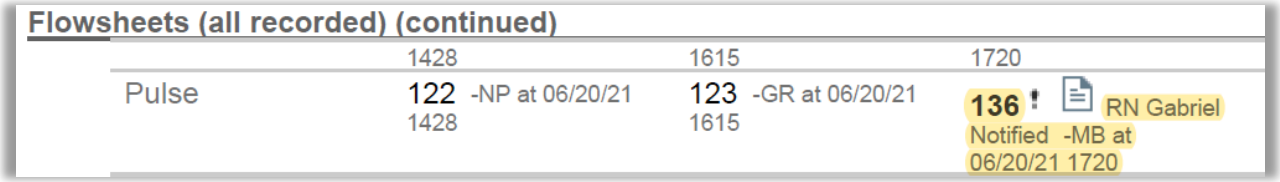
143. Nurse Ribeiro notified Dr. Greenwald that Sequoyah's heartrate was now "in 130s while laying down and in pain." CHA 11.



144. At 1719 hrs, Nurse Ribeiro reviewed the After Visit Summary (which included Dr. Greenwald's discharge instructions) with Sequoyah and her grandmother, who "verbalized understanding." CHA 13.

145. At 1720 hrs, Sequoyah's tachycardia remained in the 130s, now at 136—a heartrate that was flagged by the EMR system. CHA 12.

146. At that time, Technician Mary Frances Butler brought the EMR alert to Nurse Ribeiro's attention. CHA 16.



CHA 16.

147. Shortly thereafter, Nurse Ribeiro saw Sequoyah off in a wheelchair. CHA 13.

148. During the three hours Sequoyah was at the ER, the severity of her pain rose from a 2 to a 10—the most excruciating level of pain.

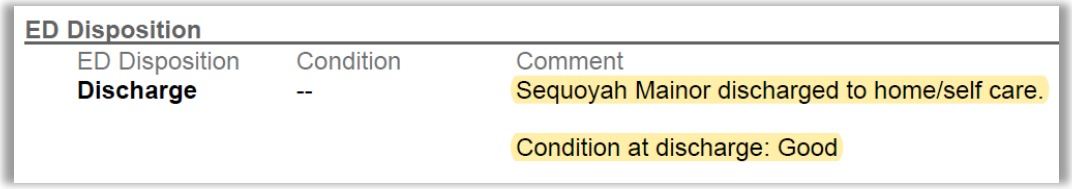
149. During those three hours, her tachycardia rose from 122 to at least 136.

150. During those three hours, Sequoyah became unable to walk on her own.

151. In short, while in the Hospital's care, Sequoyah deteriorated.

152. Nevertheless, without any pushback from Nurse Ribeiro, Nurse Wright, or other nurses, Dr. Greenwald instructed Nurse Ribeiro that it was "okay to send patient home at this time." CHA 11.

153. At about 1720 hrs, the Hospital sent Sequoyah "home" for "self care." CHA 5.



ED Disposition

ED Disposition	Condition	Comment
Discharge	--	Sequoyah Mainor discharged to home/self care.
		Condition at discharge: Good

CHA 5.

154. Thus, disregarding Sequoyah's deterioration and the EMR alerts, Nurse Ribeiro sent Sequoyah home.

155. Nurse Ribeiro executed Dr. Greenwald's discharge order, without advocating on Sequoyah's behalf for escalation of care—either with Dr. Greenwald himself or with anyone up the Hospital's chain-of-command.

156. Though Sequoyah was tachycardic, in excruciating pain, and in a wheelchair, the ED documented her "condition at discharge" as "good." CHA 5.

After Taking Miralax and Vomiting Blood, Sequoyah Returns "in Extremis"

157. After the discharge, Sequoyah continued to complain of nausea and abdominal pain.

158. After the discharge, Sequoyah did not have any bowel movements.

159. By the next morning, now June 21, 2021, Sequoyah had taken the cleanout dose of Miralax that Dr. Greenwald had prescribed.

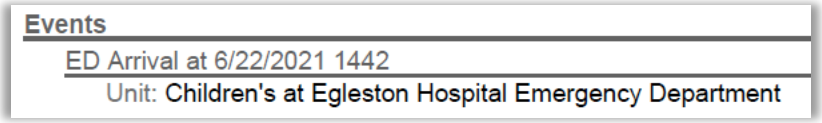
160. Sequoyah took most of cleanout dose the night of June 20, but fell asleep before finishing. She thus took the rest of the dose the morning of June 21.

161. Sequoyah then slept much of the day.

162. On June 22, 2021, when Sequoyah started vomiting blood and complained of intensifying pain, her family called 911.

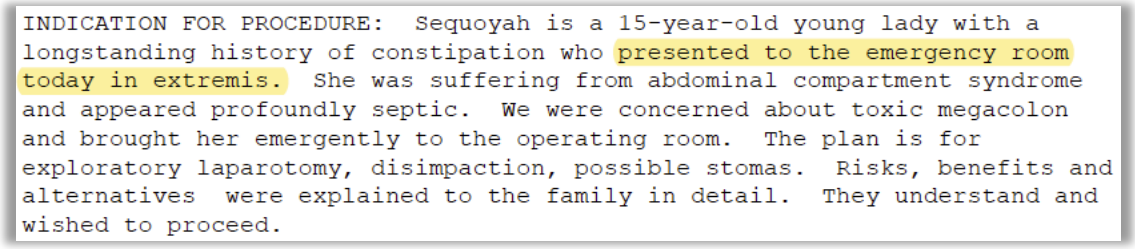
163. By the time the ambulance came, Sequoyah was having trouble breathing, had difficulty speaking, and was screaming with pain.

164. At 1442 hrs, about 46 hours after the premature discharge, Sequoyah was back at the Hospital ER. CHA 36.



CHA 36.

165. Sequoyah now presented "in extremis" (CHA 258)—in so extreme a condition that providers rushed her to the operating room for immediate treatment, bypassing assessments and diagnostic studies like a CT.

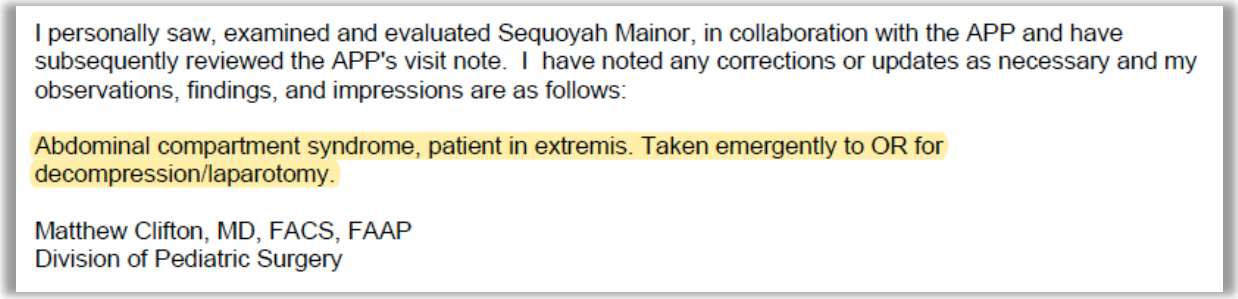


CHA 258.

Sequoyah Rushed to OR for Disimpaction, Laparotomy, and Possible Stomas

166. Upon arriving at the ER, Sequoyah "was emergently taken to the operating room for exploratory laparotomy." CHA 219, CHA 258.

167. Upon arriving at the ER, Sequoyah was "taken emergently to OR for decompression/laparotomy." CHA 223.



I personally saw, examined and evaluated Sequoyah Mainor, in collaboration with the APP and have subsequently reviewed the APP's visit note. I have noted any corrections or updates as necessary and my observations, findings, and impressions are as follows:

Abdominal compartment syndrome, patient in extremis. Taken emergently to OR for decompression/laparotomy.

Matthew Clifton, MD, FACS, FAAP
Division of Pediatric Surgery

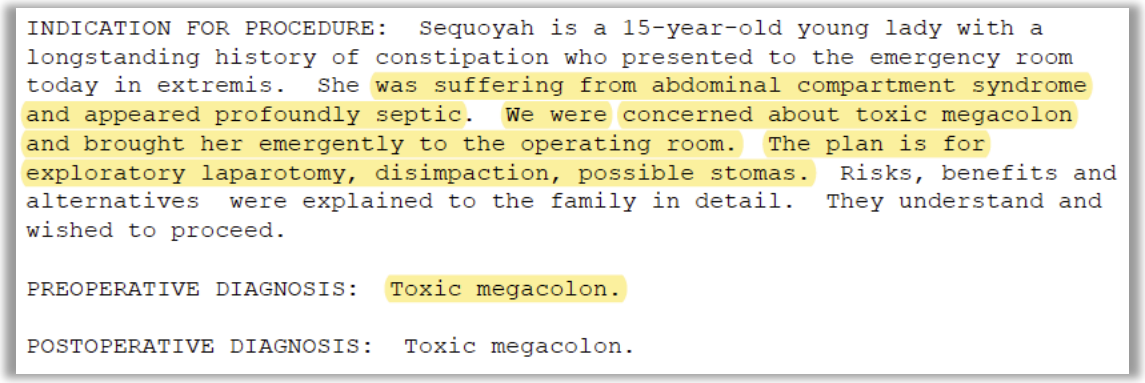
CHA 223.

168. Thus, the ER now immediately recognized that Sequoyah required emergent escalation of care for the presenting problem with which she had presented—and left—46 hours earlier: severe constipation with bowel obstruction.

169. As a surgical patient, Sequoyah came under the care of Pediatric Surgeon Michael S. Clifton and General Surgeon Katherine Fay. CHA 259.

170. Dr. Clifton and Dr. Fay recognized that Sequoyah "was suffering from abdominal compartment syndrome and appeared profoundly septic." CHA 258.

171. Dr. Clifton and Dr. Fay "were concerned about toxic megacolon"—their "preoperative diagnosis." CHA 258.



INDICATION FOR PROCEDURE: Sequoyah is a 15-year-old young lady with a longstanding history of constipation who presented to the emergency room today in extremis. She was suffering from abdominal compartment syndrome and appeared profoundly septic. We were concerned about toxic megacolon and brought her emergently to the operating room. The plan is for exploratory laparotomy, disimpaction, possible stomas. Risks, benefits and alternatives were explained to the family in detail. They understand and wished to proceed.

PREOPERATIVE DIAGNOSIS: Toxic megacolon.

POSTOPERATIVE DIAGNOSIS: Toxic megacolon.

CHA 258.

172. Their plan was to perform "exploratory laparotomy, disimpaction, possible stomas." CHA 258.

173. In suspecting that Sequoyah had compartment syndrome, sepsis, and megacolon and required possible stomas, Dr. Clifton and Dr. Fay immediately recognized that Sequoyah's untreated bowel obstruction had likely progressed to an acute life-threatening abdominal process requiring emergency surgery.

174. At 1512 hrs, Sequoyah was in the operating room and was started on anesthesia. CHA 63.

Belated Disimpaction Leads to Cardiac Arrest

175. In the operating room, Dr. Clifton and Dr. Fay immediately performed a successful disimpaction. CHA 259.

176. The disimpaction produced "a massive decompression from her abdomen." CHA 259.

FINDINGS: When the patient arrived in the OR, she appeared moribund, obtunded, non verbal. When we disimpacted the patient, we had a massive decompression from her abdomen and she subsequently coded. We then undertook about 45 minutes of CPR, including massive resuscitation working under the presumption of hyperkalemic and septic shock. We were able to cannulate her on ECMO and then once we did, we began our resuscitation. That, along with a very aggressive treatment of her hyperkalemia, allowed us to restore sinus rhythm. She had multiple defibrillation attempts because she was in ventricular tachycardia and ventricular fibrillation for quite some time. In order to get additional flow, my colleague, Dr. Shashidharan from cardiac surgery inserted an additional femoral venous and arterial cannula. When we opened the abdomen, we found that there was about a liter of blood in the abdomen already. The cecum and rectum appeared ischemic. The cecum had perforated and there was fecal contamination in the peritoneum. The rest of the colon was tremendously distended. She was left in intestinal discontinuity with an open abdomen and Vac-Pac dressing.

CHA 259.

177. Sequoyah then "coded"—that is, she "suffered cardiac arrest after manual disimpaction." CHA 259, CHA 219.

History of Present Illness

Patient was seen in ED two days ago for constipation and re-presented today with a rigid, tympanic abdomen. She was emergently taken to the operating room for exploratory laparotomy and suffered cardiac arrest after manual disimpaction. She received ECPR for approximately 45 minutes prior to going on ECMO. She then underwent a total colectomy and suffered significant blood loss with tens of units of blood products given. She was then transferred to the ICU for further management.

CHA 219.

178. Sequoyah "coded after manual disimpaction likely due to release of potassium and lactate from necrotic bowel." CHA 239.

179. In other words, the death of the tissue in her bowel released potassium and lactate, causing cardiac arrest.

Sequoyah Receives CPR for 45 Minutes, Followed by Massive Resuscitation

180. After Sequoyah coded, providers "undertook about 45 minutes of CPR, including massive resuscitation working under the presumption of hyperkalemic and septic shock." CHA 259.

181. Providers made "multiple defibrillation attempts because she was in ventricular tachycardia and ventricular fibrillation for quite some time." CHA 259.

> FINDINGS: When the patient arrived in the OR, she appeared moribund, obtunded, non verbal. When we disimpacted the patient, we had a massive decompression from her abdomen and she subsequently coded. We then undertook about 45 minutes of CPR, including massive resuscitation working under the presumption of hyperkalemic and septic shock. We were able to cannulate her on ECMO and then once we did, we began our resuscitation. That, along with a very aggressive treatment of her hyperkalemia, allowed us to restore sinus rhythm. She had multiple defibrillation attempts because she was in ventricular tachycardia and ventricular fibrillation for quite some time. In order to get additional flow, my colleague, Dr. Shashidharan from cardiac surgery inserted an additional femoral venous and arterial cannula. When we opened the abdomen, we found that there was about a liter of blood in the abdomen already. The cecum and rectum appeared ischemic. The cecum had perforated and there was fecal contamination in the peritoneum. The rest of the colon was tremendously distended. She was left in intestinal discontinuity with an open abdomen and Vac-Pac dressing.

CHA 259.

182. Sequoyah received CPR "for approximately 45 minutes prior to going on ECMO." CHA 219.

183. Once providers were able to cannulate Sequoyah on ECMO, they began resuscitation. CHA 259.

184. "In order to get additional flow, . . . Dr. Shashidharan from cardiac surgery inserted an additional femoral venous and arterial cannula." CHA 259.

185. "That, along with a very aggressive treatment of her hyperkalemia, allowed [providers] to restore sinus rhythm." CHA 259.

186. After Sequoyah coded, the Hospital called in Intensivist Michael L. Paden, who was at home. CHA 265-66.

187. Dr. Paden "was told about Sequoyah's arrest in the OR and that she had been put on ECMO and that massive bleeding was occurring." CHA 265.

188. Dr. Paden "came immediately to the hospital and directly to the operating room." CHA 265.

> I was called at home and told about Sequoyah's arrest in the OR and that she had been put on ECMO and that massive bleeding was occurring. I came immediately to the hospital and directly to the operating room. On arrival to the room, there were approximately 20 people actively from four different services involved in Sequoyah's resuscitation. Blood products were being pushed and Dr. Clifton working on re-establishing flow in a femoral arterial cannula.

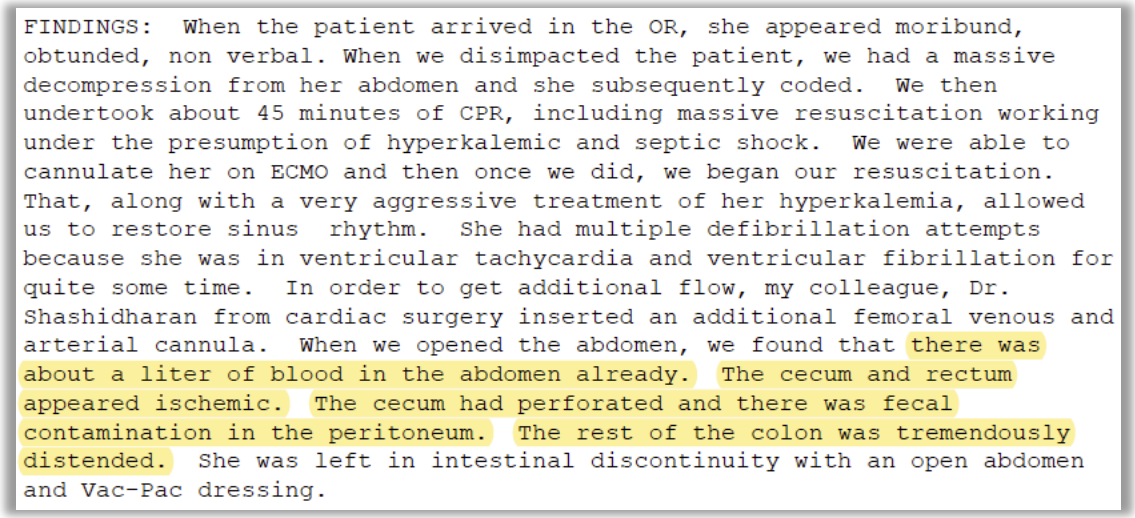
CHA 265.

189. When he arrived at the OR, "there were approximately 20 people actively from four different services involved in Sequoyah's resuscitation." CHA 265.

Dr. Clifton and Dr. Fay Find Bleeding in the Abdomen, Ischemic Bowel, Perforated Bowel, Fecal Contamination, and Tremendous Distention

190. At about 1623 hrs, Dr. Clifton and Dr. Fay finally started the laparotomy. CHA 64.

191. "When [they] opened the abdomen, [they] found that there was about a liter of blood in the abdomen already." CHA 259.



FINDINGS: When the patient arrived in the OR, she appeared moribund, obtunded, non verbal. When we disimpacted the patient, we had a massive decompression from her abdomen and she subsequently coded. We then undertook about 45 minutes of CPR, including massive resuscitation working under the presumption of hyperkalemic and septic shock. We were able to cannulate her on ECMO and then once we did, we began our resuscitation. That, along with a very aggressive treatment of her hyperkalemia, allowed us to restore sinus rhythm. She had multiple defibrillation attempts because she was in ventricular tachycardia and ventricular fibrillation for quite some time. In order to get additional flow, my colleague, Dr. Shashidharan from cardiac surgery inserted an additional femoral venous and arterial cannula. When we opened the abdomen, we found that there was about a liter of blood in the abdomen already. The cecum and rectum appeared ischemic. The cecum had perforated and there was fecal contamination in the peritoneum. The rest of the colon was tremendously distended. She was left in intestinal discontinuity with an open abdomen and Vac-Pac dressing.

CHA 259.

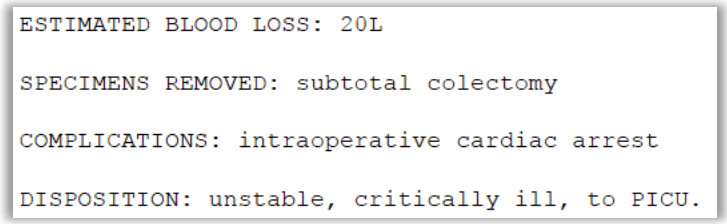
192. "The cecum and rectum appeared ischemic." CHA 259.

193. "The cecum had perforated and there was fecal contamination in the peritoneum." CHA 259.

194. The rest of Sequoyah's colon "was tremendously distended." CHA 259.

Dr. Clifton and Dr. Fay Remove Most or All of Sequoyah's Colon, Administer "Tens of Units of Blood Products"

195. Dr. Clifton and Dr. Fay then performed a "subtotal colectomy"—that is, they resected most of Sequoyah's colon. CHA 260, CHA 239.



ESTIMATED BLOOD LOSS: 20L

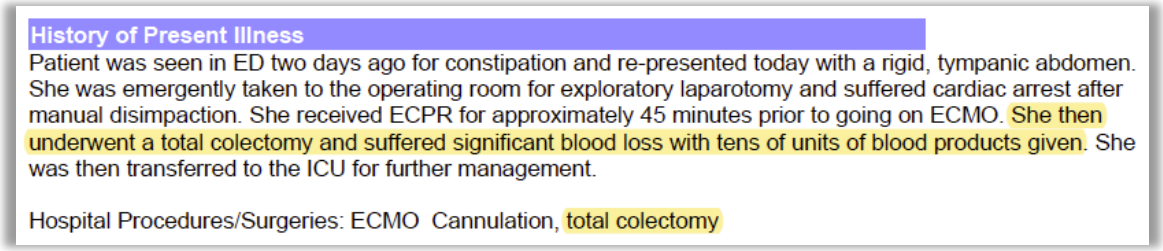
SPECIMENS REMOVED: subtotal colectomy

COMPLICATIONS: intraoperative cardiac arrest

DISPOSITION: unstable, critically ill, to PICU.

CHA 260.

196. In fact, they may have performed a "total colectomy"—the resection of her entire colon. CHA 219, CHA 92.



History of Present Illness

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Hospital Procedures/Surgeries: ECMO Cannulation, total colectomy

CHA 219.

197. During the surgery, "given her anticoagulation requirements on ECMO," Sequoyah "suffered significant blood loss," and was therefore given "tens of units of blood products." CHA 219-20.

Post-Colectomy, Sequoyah Remains "in Intestinal Discontinuity," with Open and Packed Abdomen

198. A few hours after Sequoyah went to the OR, likely soon after the colectomy, Dr. Clifton went out to the surgical waiting room and updated Brenda, Thomas, and their family on Sequoyah's status and outlook.

199. At the conclusion of the colectomy, Sequoyah "was left in intestinal discontinuity" (CHA 259)—meaning that Dr. Clifton and Dr. Fay did not reconnect the two ends of the bowel remaining after the resection.

200. At the conclusion of the colectomy, Sequoyah was also left with "an open abdomen and Vac-Pac dressing" (CHA 259)—meaning that Dr. Clifton and Dr. Fay did not close the surgical incision and packed Sequoyah's abdomen with dressing.

FINDINGS: When the patient arrived in the OR, she appeared moribund, obtunded, non verbal. When we disimpacted the patient, we had a massive decompression from her abdomen and she subsequently coded. We then undertook about 45 minutes of CPR, including massive resuscitation working under the presumption of hyperkalemic and septic shock. We were able to cannulate her on ECMO and then once we did, we began our resuscitation. That, along with a very aggressive treatment of her hyperkalemia, allowed us to restore sinus rhythm. She had multiple defibrillation attempts because she was in ventricular tachycardia and ventricular fibrillation for quite some time. In order to get additional flow, my colleague, Dr. Shashidharan from cardiac surgery inserted an additional femoral venous and arterial cannula. When we opened the abdomen, we found that there was about a liter of blood in the abdomen already. The cecum and rectum appeared ischemic. The cecum had perforated and there was fecal contamination in the peritoneum. The rest of the colon was tremendously distended. She was left in intestinal discontinuity with an open abdomen and Vac-Pac dressing.

201. After the colectomy, Sequoyah "underwent an additional several hours long resuscitation in the OR, including the cannulation of the groin." CHA 260.

Sequoyah Goes to the ICU with "Grave Prognosis"

202. Sequoyah "was then transferred to the ICU for further management." CHA 219.

203. At the time of the transfer, Sequoyah was "critically ill, unstable, with a grave prognosis." CHA 266.

204. After transfer of care, Dr. Clifton and Dr. Paden "spoke to Sequoyah's parents and family members in the surgical waiting room." CHA 266.

205. Brenda and Thomas understood "how ill" Sequoyah was, and that "she may not survive." CHA 266.

Sequoyah Dies

206. In the ICU, Sequoyah came under the care of Intensivist Atul Vats, Intensivist Michael J. Ripple (a fellow), and Nurse Quinn E. Trahan. CHA 221, CHA 273.

207. Dr. Vats was now "the attending physician." CHA 240.

208. Sequoyah "continued to receive non-stop blood product replacement for the duration of her time in the ICU until her death." CHA 220.

209. "She had dwindling flows on ECMO despite nearly continuous blood product replacement." CHA 220.

210. Sequoyah also "remained in PEA for most of her time on VA ECMO in the ICU with minimal pulsatility on arterial tracing." CHA 220.

211. At 0200 hrs, now June 23, 2021, Sequoyah "had a clot in her ECMO pump requiring it to be cut out." CHA 220.

212. "At this time she had no pulsatility on her arterial line, no palpable pulses, no heart tones on auscultation, and a flat EKG tracing." CHA 220.

213. After discussing options with Sequoyah's parents, Dr. Vats decided "to leave her off ECMO" and forego "chest compressions." CHA 220, CHA 222.

214. "After it became clear that ECMO support was not sustainable" and that there would be "no [return of spontaneous circulation]," Sequoyah was "declared dead at 0227." CHA 222.

215. Dr. Vats declared Sequoyah dead after she was "asystolic"—that is, had flatlined—for 10 minutes. CHA 206.

216. In the time leading up to Sequoyah's death, Chaplain Kenneth Hammond "met with the parents, maternal grandmother, and other family members," to offer comfort and support. CHA 274.

217. Chaplain Hammond was therefore present when Dr. Vats informed Brenda and Thomas of Sequoyah's death. CHA 222.

218. Referring to Thomas's response to the news of his daughter's death, Chaplain Hammond later confided to Dr. Vats that "it was difficult to watch a grown man lose it." CHA 222.

219. Dr. Vats later reflected: "Frankly, he could have been referring to me. This was a tough night for all of us." CHA 222.

220. That night, Sequoyah Mainor was still 15 years old. CHA 219.

221. She was soon to be 16.

Professional Malpractice Claims

Count 1: Premature Closure

222. Plaintiffs here incorporate by reference all paragraphs of this Complaint.

223. Under the circumstances chronicled above for June 20, 2021, the standard of care requires an emergency medicine physician to provide escalation of care to treat the patient's presenting complaint—severe constipation with functional bowel obstruction.

224. The standard of care prohibits the ER physician from discharging the patient without providing such care.

225. These requirements apply with special force here, because the presenting complaint can lead to dangerous complications, as occurred here.

226. On June 20, 2021, Dr. Michael Greenwald violated these requirements, by discharging Sequoyah Mainor from the Hospital without providing escalation of care to treat her presenting complaint—severe constipation with functional bowel obstruction.

227. Dr. Greenwald thus prematurely closed Sequoyah's case.

228. These violations were all the more egregious for the following reasons:

a. Sequoyah presented with a "3-week history of no bowel movements" and "substantial obstruction from stool."

b. Dr. Greenwald recognized that Sequoyah's presenting complaint required treatment—that's why he tried enema and disimpaction in the first place.

c. The unsuccessful disimpaction confirmed both that Sequoyah had bowel obstruction and that the procedure failed to "pull anything out."

d. Like other hospital physicians, Dr. Greenwald had further clinical options readily available to investigate and treat the presenting complaint, including imaging, admission, consultation, and more-aggressive forms of disimpaction (including possible surgical interventions).

e. Nevertheless, inexplicably noting that his "only option" was to send her home, Dr. Greenwald discharged Sequoyah, prematurely closing her case without reason, explanation, or even further investigation.

229. By prematurely closing Sequoyah's case without providing the escalation of care she needed, Dr. Greenwald deviated from the standard of care.

230. In fact, Dr. Greenwald deviated grossly from the standard of care.

231. Emergency medicine physicians and other hospital physicians routinely provide effective treatment to patients who present with severe constipation with functional bowel obstruction.

232. A variety of escalating options are readily available to hospital physicians for that purpose.

233. In this case, Dr. Greenwald failed to provide Sequoyah such escalation of care. Instead, Dr. Greenwald sent Sequoyah home to self-care with an aggressive regimen of an oral laxative.

234. Had Dr. Greenwald provided Sequoyah the escalation of care her presenting complaint required, she would not have suffered the complications that forced

her to return to the ER in critical condition and that led to her painful and dramatic death.

235. Those complications included extreme colonic distention, bleeding into the abdomen, bowel ischemia, perforation of the cecum, fecal contamination in the peritoneum, sepsis, and death.

236. Dr. Greenwald's premature closure of Sequoyah's case thus caused her pain, suffering, injury, and death.

237. As Dr. Greenwald's employer or other principal at the time of his negligence, CHOA and/or one or more of the Emory Defendants are vicariously liable for Dr. Greenwald's negligence, because he was acting within the scope of his employment or agency at that time.

Count 2: Failure to Advocate

238. Plaintiffs here incorporate by reference all paragraphs of this Complaint.

239. Under the circumstances chronicled above for June 20, 2021, when the ER physician orders discharge of the patient without providing escalation of care, the standard of care requires each nurse caring for the patient to advocate for escalation of care with the ER physician, on behalf of the patient.

240. The standard of care prohibits the nurses from following the discharge order without so advocating for the patient first.

241. Insofar as nurses meet these requirements and the ER physician nevertheless overlooks or disregards the need to keep the patient in the hospital for escalation of care, the standard of care then requires each nurse to advocate for the patient up the hospital's chain-of-command.

242. These requirements apply with special force to the assigned nurse, charge nurse, nurse manager, and house supervisor, insofar as they become aware of the reasons or grounds for advocating on behalf of the patient.

243. These requirements apply with special force here, because the patient's presenting complaint can lead to fatal complications, as occurred here.

244. On June 20, 2021, nurses caring for Sequoyah Mainor at the Hospital (especially Nurse Ribeiro) violated these requirements, by failing to advocate on Sequoyah's behalf when Dr. Greenwald ordered her discharge without providing escalation of care to treat her presenting problem—severe constipation with functional bowel obstruction.

245. Those violations included:

a. The failure to advocate for diagnostic testing, including imaging studies, which would have confirmed the nature and extent of Sequoyah's constipation and bowel obstruction, and which would have guided the escalation of care.

b. The failure to advocate for a consultation with a specialist—a gastroenterologist or a surgeon—to guide and assist with the diagnosis and treatment of Sequoyah's presenting problem.

c. The failure to advocate for Sequoyah's admission for further observation, evaluation, and treatment. In fact, the nurses failed to advocate even for keeping Sequoyah in the Hospital under observation status.

d. The failure to advocate for escalating therapeutic intervention, including more-aggressive forms of disimpaction (including surgical interventions), by either the Dr. Greenwald or by a consulting specialist.

246. Instead, Nurse Ribeiro and other nurses executed Dr. Greenwald's discharge order without making any effort to advocate on Sequoyah behalf, either with Dr. Greenwald or with anyone up the chain-of-command.

247. These violations were all the more egregious for the following reasons:

a. During the three hours Sequoyah was at the ER on June 20, 2021, her clinical condition deteriorated:

i. her tachycardia rose from 122 to at least 136,

ii. her pain rose from a 2 to the worst possible pain—a 10 of 10, and

iii. after walking into the ER under her own powers, she was discharged in a wheelchair.

b. Sequoyah was thus significantly worse at the time of discharge, compared to the time of arrival.

c. Nurse Ribeiro himself found and noted that Sequoyah's abdomen was distended, firm, and round—all signs of severe constipation with possible bowel obstruction.

d. Nurse Wright herself performed the unsuccessful enema.

e. Dr. Greenwald notified Nurse Ribeiro that manual disimpaction had failed to clear "anything" from the bowel obstruction.

f. Dr. Greenwald nevertheless decided to discharge Sequoyah without escalation of care, based on the plainly faulty conclusion that discharge with a Miralax prescription was the "only option left."

g. Dr. Greenwald thus discharged Sequoyah with a known and dangerous case of bowel obstruction, as she was deteriorating.

248. By failing to advocate on Sequoyah's behalf when Dr. Greenwald ordered her premature discharge, Nurse Ribeiro, Nurse Wright, and possibly other nurses deviated from the standard of care.

249. In fact, under the circumstances outlined above, each nurse deviated grossly from the standard of care.

250. Hospitals routinely provide effective treatment to patients who present with severe constipation with functional bowel obstruction.

251. A variety of escalating therapeutic interventions are readily available for that purpose.

252. Here, as a threshold matter, had a nurse advocated to keep Sequoyah at the Hospital, Dr. Greenwald may have realized that sending her home with

Miralax was not the "only option left" and that Sequoyah rather could be kept and needed to be kept at the Hospital for escalation of care.

253. Here, had a nurse advocated to keep Sequoyah at the Hospital for escalation of care, the Hospital likely would have promptly provided her effective treatment for her presenting problem—without her becoming fatally or even critically ill. For example:

    a. Had a nurse advocated for imaging or other diagnostic studies, they would have provided additional evidence of Sequoyah's presenting problem, and would have guided the escalation of care Sequoyah needed. As a result, the Hospital would have promptly provided Sequoyah effective treatment—well before she became critically ill.

    b. Had a nurse advocated for a consultation with a specialist, the specialist would have promptly recommended or provided escalating therapeutic intervention, until a resolution of Sequoyah's presenting problem was achieved.

    c. Had a nurse advocated for admission, the unobserved deterioration Sequoyah experienced at home would have occurred at the Hospital. Directly observing such deterioration, the Hospital would have promptly provided Sequoyah the escalation of care she needed—well before she became critically ill. In fact, that would have occurred even if a nurse had advocated for keeping Sequoyah at the Hospital only for observation.

    d. Had a nurse advocated for escalating therapeutic intervention, the Hospital would have promptly provided such escalating intervention, until resolution of Sequoyah's presenting problem was achieved.

254. As a result, had even one nurse advocated for even one of these options, the Hospital would have promptly provided Sequoyah the escalation of care that was readily available and that she needed.

255. As a result, Sequoyah would not have experienced anywhere near the fatal or even critical illness that caused her return to the ER about 46 hours later.

256. Each failure to advocate by each nurse thus led to Sequoyah's pain, suffering, injury, and death.

257. As Nurse Gabriel Ribeiro's employer or other principal at the time of his negligence, CHOA and/or one or more of the Emory Defendants are vicariously liable for Nurse Ribeiro's negligence, because he was acting within the scope of his employment or agency at that time.

258. As Nurse Elizabeth Wright's employer or other principal at the time of her negligence, CHOA and/or one or more of the Emory Defendants are vicariously liable for her negligence, because she was acting within the scope of her employment or agency at that time.

259. As the employer or other principal at the time of their negligence, CHOA and/or one or more of the Emory Defendants are vicariously liable for the failure to advocate by other nurses who cared for Sequoyah at the Hospital on June 20, 2021, because those nurses were acting within the scope of their employment or agency at that time.

Negligent Administration: General Notice of Claim

260. Plaintiffs here incorporate by reference all paragraphs of this Complaint.

261. CHOA, as owner, manager, and/or administrator of the Hospital, owed Sequoyah Mainor and other patients ordinary duties of care.

262. CHOA breached those duties in Sequoyah's case.

263. CHOA breached those duties through the conduct of administrators not licensed for professions listed in OCGA 9-11-9.1(g).

264. CHOA also breached those duties through the conduct of professional staff performing purely administrative tasks.

265. Negligent administration by CHOA created unnecessary and unreasonable potential for error by physicians and nurses caring for Sequoyah Mainor.

266. That is, negligently administered systems and organizational cultures promoted and facilitated, rather than prevented, medical and nursing error.

267. By violating duties of ordinary care, CHOA harmed Sequoyah Mainor.

268. Each administrator directly responsible for acts or omissions of negligent administration was an actual or ostensible agent or otherwise a servant or employee of CHOA.[2]

269. CHOA is thus vicariously liable for those acts and omissions.

Negligent Administration: Detailed Notice of the Claim

Statements not in enumerated paragraphs require no response from Defendants.

The above "General Notice" suffices to state a claim. In keeping with the overriding goal of the Civil Practice Act ("to secure the just, speedy, and inexpensive determination of every action"),[3] the detailed allegations below are presented to provide further notice, narrow disputes, and simplify discovery and trial.

Nevertheless, Plaintiffs do not waive Georgia's notice-pleading requirements, or assume any obligation to provide more than the general notice required by law.[4]

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[2] Insofar as the negligent administrators were employees or other agents of other Corporate Defendants or of the Hospital itself, the allegations in Plaintiffs' Negligent Administration Claim are also directed at the other Corporate Defendants or at the Hospital itself.

[3] *See* OCGA 9-11-1.

[4] *See Atlanta Women's Specialists v. Trabue*, 310 Ga. 331 (2020) ("Georgia is a notice pleading jurisdiction. Generally, our Civil Practice Act (CPA) advances liberality of pleading. … [A] complaint need only provide fair notice of what the plaintiff's claim is and the grounds upon which it rests . … [The] objective of the CPA is to avoid technicalities and to require only a short and plain statement of the claim that will give the defendant fair notice of what the claim is and a general indication of the type of litigation involved; the discovery process bears the burden of filling in details.") (cleaned up).

Negligence, not Professional Malpractice

270. Georgia law recognizes that ordinary negligence in the form of negligent administration can contribute to a chain of events that includes harmful medical malpractice.[5]

271. Georgia law recognizes that both ordinary negligence and medical malpractice can exist and combine to cause harm — creating liability for both ordinary negligence and medical malpractice.

272. Any negligence by a person not licensed for a profession listed in OCGA 9-11-9.1(g) is ordinary negligence, not professional malpractice.

273. Georgia courts have not catalogued every purely administrative duty in a hospital.

274. Plaintiffs' Negligent Administration claim is not a claim for professional malpractice as defined in OCGA 9-11-9.1. Instead, it is a claim for negligence — that is, ordinary or simple negligence.

275. This claim is premised largely on the negligence of persons who are not licensed for professions listed in OCGA 9-11-9.1.

276. To the extent this claim is premised on the negligence of persons who *are* licensed for professions listed in OCGA 9-11-9.1, this claim addresses only acts that could permissibly be performed by people who are not so licensed.

277. To the extent trial and appellate courts ultimately determine that any particular conduct constituted professional malpractice as defined in OCGA

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[5] *See, e.g., Dent v. Memorial Hospital,* 270 Ga. 316 (1998) (reversing judgment in favor of hospital, because jury instructions did not make clear that both ordinary negligence and professional malpractice would authorize a verdict against the hospital); *Lowndes County Health v. Copeland,* 352 Ga. App. 233 (2019) (affirming verdict for both ordinary negligence and professional negligence against skilled nursing facility).

9-11-9.1, Plaintiffs stipulate that the conduct does not support a claim for ordinary negligence.

Non-Licensed Administrators

278. At all times relevant to this action, CHOA was responsible for managing, operating, and/or administering the Hospital.

279. The administrators of the Hospital included persons who were not licensed healthcare professionals and were not licensed for any profession listed in OCGA 9-11-9.1 ("Non-Licensed Administrators").

280. Non-Licensed Administrators at the Hospital had job responsibilities that impacted the safety of patients, including Sequoyah Mainor.

281. Non-Licensed Administrators at the Hospital negligently failed in their duties and thereby contributed to causing injury to Sequoyah Mainor.

282. The negligent administration by Non-Licensed Administrators included failures of monitoring, communication, supervision, training, staffing, and funding, and the failure to create and maintain a culture of safety.

Licensed Administrators Acting in Purely Administrative Capacity

283. The administrators of the Hospital included persons who *were* licensed healthcare professionals but who at times performed purely administrative duties ("Licensed Administrators").

284. Licensed Administrators had purely administrative job responsibilities that impacted the safety of patients, including Sequoyah Mainor.

285. Licensed Administrators negligently failed in purely administrative duties and thereby contributed to causing injury to Sequoyah Mainor.

286. The negligent administration by Licensed Administrators included failures of monitoring, communication, supervision, training, staffing, and funding, and the failure to create and maintain a culture of safety.

Healthcare Administration Generally

287. The way healthcare facilities are managed is not obvious or intuitive.

288. Even clinicians with years of experience in a healthcare facility may have limited knowledge of how that facility is administered.

289. Because most adults will have significant experience with healthcare as patients or consumers, they may have "gut" or "common sense" intuitions about healthcare administration that are strong, but wrong.

Principles of Healthcare Administration

Scale of Medical Error, and System Failures as a Cause

290. Preventable medical error is a leading cause of death in the United States.

291. The complexity of hospital care creates potential for medical errors of various kinds — for example, inattention, failures of communication, lack of preparedness, mistaken assumptions that someone else is addressing a problem, and others.

292. A central function of healthcare administration is to create systems and organizational cultures that facilitate detection and correction of medical errors before they cause serious harm.

293. Medical errors usually involve (a) error by a clinician directly involved in a patient's care, and (b) system failures that create unnecessary potential for error.

Management or Administration as a Distinct Discipline

294. Hospital administrators need education, training, and skills different from those required to be a physician or nurse. Hospital administrators must have management training, but need not have gone to medical or nursing school.

295. OCGA 9-11-9.1(g) does not include hospital administrators in the list of professionals to which OCGA 9-11-9.1 applies.

296. Non-Licensed Administrators — because they are not medical professionals — do not apply medical judgment in their work.

297. Where licensed medical professionals occupy administrative roles, some of their duties include administrative tasks that do not require being a licensed medical professional — for example, checking to make sure a certain policy has been communicated to hospital staff, or checking to make sure hospital staff has undergone certain training.

Non-Licensed Administrators and Patient Safety

298. Clinicians treating patients usually are not in a position to fix problems with the systems and organizational cultures in a hospital.

299. Hundreds or thousands of providers may practice in a given hospital. The individual providers practice within the systems and organizational cultures maintained by hospital administrators. The individual providers must rely on and are constrained by the work of hospital administrators.

300. Patient safety is not solely the responsibility of the individual providers treating a patient.

301. Hospital administrators acting in a purely administrative capacity also have responsibilities for protecting patient safety.

302. Negligence by Non-Licensed Administrators can and does foreseeably cause harm to patients. Within the healthcare industry, this principle is accepted and well understood by clinicians and non-clinicians alike.

Responsibilities of Hospital Administrators for Patient Safety

303. Federal regulations impose requirements on hospital administrators concerning patient safety.

304. The Joint Commission's accreditation standards impose requirements on hospital administrators concerning patient safety.

305. Pursuant to industry standards, Non-Licensed Administrators are responsible for the systems and organizational cultures of the hospital.

306. Non-Licensed Administrators must learn about and identify the common sources of medical error industry-wide, and must ensure that those general sources of error are addressed effectively in the administrators' own hospital.

307. Concerning policies or protocols for medical care, Non-Licensed Administrators have limited but important responsibilities.

308. Concerning policies or protocols for medical care, Non-Licensed Administrators are responsible for:

    a. making sure need-assessments are performed, to identify what policies or protocols should be created,

    b. making sure policies and protocols are communicated effectively to hospital staff (instead of merely papering the file),

    c. making sure training is given so that hospital staff understand how to apply the policies and protocols in practice,

    d. making clear that the policies and protocols must be followed (that is, that they are not bureaucratic formalities that staff can disregard),

e. monitoring and enforcing compliance, and

f. ensuring remedial actions are taken where compliance problems arise.

309. Non-Licensed Administrators must engage all hospital staff in actively seeking out problems in the hospital's system and culture — and in fixing the problems before they cause further harm.

310. Non-Licensed Administrators must ensure the hospital is actually implementing policies. Papering the file is not enough.

311. Non-Licensed Administrators have important responsibilities in a variety of specific areas. The following is a non-exhaustive list:

a. Culture of Safety

b. Quality Monitoring and Improvement

c. Staffing and Training

d. Communication, Transfers, and Hand-offs

e. Patient Rights and Grievance Process

f. Sentinel Events

Accountability for Hospital Administrators

312. Purely administrative negligence can contribute substantially to medical error that hurts patients.

313. It would be dangerous to exempt hospital administrators from accountability for their negligence.

314. Exempting hospital administrators from accountability for their own negligence would remove an important incentive for administrators to work diligently to create systems that protect patients.

Negligent Administration Claim

315. Through the negligent acts and omissions of administrators, CHOA breached duties of care it owed to Sequoyah Mainor, causing her pain, suffering, injury, and death.

316. The negligent care Sequoyah received gives rise to reasonable inferences of administrative negligence in the ways identified below, among others.

Example 1

317. Nurses play a vital role in patient care and safety.

318. Because of their presence at the bedside, nurses are said to be "the eyes and ears" of healthcare.

319. Because of their presence at bedside, nurses have their own independent duties to speak up and advocate for patient safety.

320. A nurse has a duty to speak up when he or she believes, or has reason to believe, that a patient is not receiving required or appropriate care.

321. Administrators owe patients a duty to create and maintain a culture of safety that supports and empowers nurses in voicing and escalating concerns about patient care, without fear of criticism or reprisal.

322. Insofar as administrators fail to create or maintain such a culture of safety, nurses are disempowered and discouraged from voicing and escalating legitimate concerns.

323. Insofar as administrators fail to create or maintain a culture of safety, nurses provide care to patients in an environment that condones apathy and indifference toward patient safety, and that therefore enables substandard care and even medical error.

324. Here, Nurse Ribeiro's failure to advocate for keeping Sequoyah at the Hospital for escalation of care suggests that Hospital administrators failed to create and maintain a culture of safety at the Hospital.

325. Because Hospital administrators failed to create and maintain such culture, Nurse Ribeiro and other nurses followed Dr. Greenwald's discharge order without raising concerns—without advocating for Sequoyah to be kept at the Hospital for escalation of care.

326. Had Nurse Ribeiro or another nurse voiced concerns to Dr. Greenwald, he likely would have reflected upon, reconsidered, and cancelled his discharge order, admitting Sequoyah for escalation of care instead.

327. In turn, with escalation of care, Sequoyah would have promptly received effective treatment for her presenting problem, without ever becoming critically ill.

328. The failure by administrators to maintain a culture of safety thus contributed to Sequoyah's pain, suffering, injury, and death.

Example 2

329. Administrators owe patients a duty to create, implement, promulgate, and enforce policies and procedures enabling and empowering nurses to escalate concerns about patient care up the chain-of-command.

330. Such policies and procedures must identify the persons on the chain-of-command, as well as the step-by-step process for escalating concerns.

331. Such policies and procedures must ensure that concerns are taken seriously and addressed promptly.

332. Here, Nurse Ribeiro's failure to escalate concerns about Sequoyah's premature discharge suggests that Hospital administrators failed to create, implement, promulgate, and/or enforce escalation policies and procedures.

333. Because Hospital administrators so failed, Nurse Ribeiro and other nurses followed Dr. Greenwald's discharge order without questioning it, instead of escalating concerns up the chain-of-command.

334. In turn, because nurses failed to escalate concerns, persons along the chain-of-command were unaware of Sequoyah's premature discharge.

335. Had even one of the nurses escalated a concern, at least one person along the chain-of-command would have addressed the concern with Dr. Greenwald, causing him to reflect upon, reconsider, and cancel his discharge order.

336. As a result, Dr. Greenwald would have admitted Sequoyah to the Hospital for escalation of care.

337. In turn, with escalation of care, Sequoyah would have promptly received effective treatment for her presenting problem—without ever becoming even critically ill.

338. The failure by Hospital administrators to create, implement, promulgate, and/or enforce escalation policies and procedures thus contributed to Sequoyah's pain, suffering, injury, and death.

Example 3

339. Administrators owe patients a duty to create, implement, promulgate, and enforce such other policies as are necessary to reasonably ensure patient safety, including policies on discharge instructions.

340. Administrators also owe patients a duty to provide education and training sufficient to ensure that providers understand, follow, and comply with policies.

341. Here, Dr. Greenwald's failure to send Sequoyah home with strict instructions for returning to the ER if she got worse suggests that Hospital administrators failed to create, implement, promulgate, and/or enforce a policy sufficient to ensure that patients were discharged for home-care safely.

342. Sequoyah's discharge also reveals that Hospital administrators provided insufficient education and training on any such discharge policy the Hospital had.

343. Because Hospital administrators failed to create, implement, promulgate, and/or enforce a policy sufficient to ensure safe discharge of patients, Dr. Greenwald discharged Sequoyah without any instructions for returning to the ER.

344. In turn, because Dr. Greenwald failed to provide her such instructions, Sequoyah did not return to the ER until she was critically ill.

345. In fact, his instructions gave Sequoyah false comfort, by directing her to see a pediatrician or gastroenterologist within two weeks.

346. Had Dr. Greenwald followed a policy on the safe discharge of patients, he would have instructed Sequoyah to return immediately upon getting worse.

347. In turn, with those instructions, Sequoyah would have promptly returned to the ER, and promptly received effective treatment for her presenting problem—without becoming even critically ill.

348. The failure by Hospital administrators to create, implement, promulgate, and/or enforce a policy concerning discharge instructions thus contributed to Sequoyah's pain, suffering, injury, and death.

349. Pursuant to OCGA Title 51, Chapter 4, Plaintiffs are entitled to recover from CHOA for the harm its negligent administration caused Sequoyah.

OCGA § 13-6-11 Claims

350. Plaintiffs here incorporate by reference all paragraphs of this Complaint.

351. Plaintiffs show and will show that Defendants have acted in bad faith, have been stubbornly litigious, and have caused Plaintiffs unnecessary trouble and expense.

352. Plaintiffs are thus entitled to their expenses of litigation pursuant to OCGA § 13-16-11, including reasonable attorneys fees.

Damages

353. Pursuant to OCGA Title 51, Chapter 4, Plaintiffs are entitled to recover from all Defendants for all damages caused by their negligence.

Survival Action - Estate Claim

354. Plaintiffs here incorporate by reference all paragraphs of this Complaint.

355. Plaintiffs are entitled to damages for their daughter Sequoyah's conscious pain and suffering after she was wrongfully discharged from the Hospital—over the hours and days she endured and gradually died from an untreated bowel obstruction and its deadly complications.

356. Plaintiffs are also entitled to damages for the existential terror Sequoyah experienced while deteriorating toward and finding herself in critical condition.

357. Plaintiffs are also entitled to damages for the existential terror Sequoyah experienced upon being taken emergently to the ER and the operating room for belated interventions by a battery of providers.

Wrongful-Death Action

358. Plaintiffs here incorporate by reference all paragraphs of this Complaint.

359. At the time of her death, Sequoyah Mainor was a 15-year-old teenager, with almost her entire life ahead of her.

360. Sequoyah grew up in Conyers, Georgia, with her parents and seven siblings.

361. Brenda worked at a temp agency and Thomas was a disabled veteran.

362. Sequoyah was especially close to her two younger brothers—Thomas, whom she called Pinocchio, and Frederick, whom she called Butterball.

363. Sequoyah loved taking care of Thomas and Frederick. She would tease Brenda that they were really her (Sequoyah's) kids.

364. At the time of her death, Sequoyah worked at a restaurant.

365. At the time of her death, because of the Covid-19 Pandemic, Sequoyah was being home-schooled.

366. Although she had been bullied at school because of her weight, Sequoyah was warming up to the idea of returning to school, to be with her peers.

367. Sequoyah had dreams and ambitions of a bright future.

368. Sequoyah's untimely death left a void in her family and in the hearts of all those who knew her and loved her.

369. Plaintiffs are entitled to damages for the full value of Sequoyah's life.

370. Plaintiffs are entitled to all wrongful-death damages recognized by Georgia law, including economic and noneconomic damages.

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371. As a direct and proximate result of the Defendants' conduct, Plaintiffs are entitled to recover from Defendants reasonable compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury, for all damages Plaintiffs and Sequoyah suffered, including physical, emotional, and economic injuries.

372. WHEREFORE, Plaintiffs demand a trial by jury and judgment against the Defendants as follows:

a. compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury;

b. all costs of this action;

c. expenses of litigation pursuant to OCGA 13-6-11;

d. punitive damages; and

e. such other and further relief as the Court deems just and proper.

June 15, 2023

Respectfully submitted,

/s/ *Lloyd N. Bell*
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Exhibit 1

AFFIDAVIT OF KEITH THOMAS BORG, MD, PHD, FACEP, REGARDING SEQUOYAH MAINOR

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, Keith Thomas Borg, MD, PhD, FACEP, who after first being duly sworn states as follows.

Introduction

1. This affidavit addresses medical negligence that occurred on June 20, 2021, when 15-year-old Sequoyah Mainor visited the Emergency Department of Children's Healthcare of Atlanta – Egleston Hospital ("CHOA" or "Hospital").

2. The process of creating this affidavit was as follows.

   a. Plaintiffs' counsel contacted me, outlined the basic facts of this case, and identified the issues they wanted me to analyze. I reserved judgment until I reviewed the relevant Hospital records myself.

   b. After reviewing the records, I formed my own views, reached my own conclusions, and then shared my conclusions with Plaintiffs' counsel.

   c. Plaintiffs' counsel then prepared a draft of this affidavit, based on my views and conclusions.

   d. I then reviewed and edited the draft, to make sure it correctly states my views and conclusions. I did not edit the affidavit for style.

3. This affidavit addresses matters that Plaintiffs' counsel have asked me to address. I have not attempted to identify all standard-of-care violations, state every causation opinion, or anticipate or address all issues that the Defense may raise or that may otherwise arise as the case unfolds.

4. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation, but I have not attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional detail.

5. I hold all opinions expressed below to a reasonable degree of medical certainty—that is, more likely than not. If additional information later becomes available, my views may change.

6. I use the phrase "standard of care" to refer to that degree of care and skill ordinarily exercised by members of the medical profession generally under the same or similar circumstances and like surrounding conditions as pertained to the providers I discuss here.

7. The purpose of this affidavit is to disclose to the Defendants, their lawyers, and their insurers opinions I plan to offer at trial—in enough detail that the Defense can evaluate them and thereby prepare to cross-examine me.

8. I understand that Plaintiffs' counsel may have consulted with other experts. If so, I would expect most other experts, possibly all, to reach conclusions that are similar to, if not the same as, mine.

9. If anyone on the Defense believes that I have not been given, or have overlooked or misconstrued, any relevant information, I invite the Defense to communicate with me by letter through Plaintiffs' counsel. The Defense need not wait to take my deposition to communicate with me.

10. I will consider all information the Defense brings to my attention. Insofar as such information warrants reconsideration of my views, I will reconsider them and will provide a supplemental affidavit to the extent necessary.

Evidence Considered

11. I have reviewed CHOA medical records for Sequoyah's visits to the Hospital on June 20 and 22, 2021, and the autopsy report for Sequoyah prepared by Forensic Medicine Associates, Inc.

Principal Opinions: Standard of Care

12. Summarized below are principal opinions I have developed thus far. In deposition or trial testimony, I may elaborate on these opinions, and in doing so, I may offer related, subsidiary, or incidental opinions. In addition, I may later develop and disclose additional principal opinions for this case.

Clinical Setting

13. The requirements of the standard of care identified below apply under the following circumstances present in this case.

a. a 15-year-old girl presents to the ER with these complaints:

    i. a "3-week history of no bowel movements,"

    ii. "abdominal pain,"

    iii. "some nausea at times," and

    iv. "a longstanding history of constipation,"

b. an ER nurse (here, Nurse Gabriel Ribeiro) finds that the girl's abdomen is firm and distended,

c. an ER physician (here, Dr. Michael Greenwald) also finds that the girl's abdomen is distended,

d. recognizing that the girl has severe constipation, the physician orders a 1,000 mL soap-suds enema,

e. after the enema fails, recognizing that the girl has "substantial obstruction from stool," the physician attempts digital disimpaction,

f. the attempt then confirms the obstruction, as the physician finds a "large amount of stool high in the rectum," but cannot "get around to pull anything out,"

g. as a result, the physician reports that the attempt "was unsuccessful,"

h. then, declaring that the "only option left is to send patient home with miralax," the physician discharges the girl from the hospital,

i. the girl then leaves the hospital even though:

    i. the physician notes that the girl still has "a rather severe case of constipation!"

    ii. the physician notes that the girl "will need much more treatment to get her cleaned out,"

    iii. the girl complains of the worst possible pain—a 10 of 10,

    iv. the girl's heartrate has risen to the 130s at the time of discharge, and

v.the girl leaves the hospital in a wheelchair because she cannot walk,

j. in his discharge instructions, the physician directs the girl to see her pediatrician or gastroenterologist "within 2 weeks,"

k. in his discharge instructions, the physician also directs the girl to take an aggressive regimen of Miralax: an initial 238-gram cleanout dose that same day, and 17 grams daily thereafter,

l. about 46 hours later, after taking the cleanout dose as instructed, the girl returns to the same ER in critical condition,

m. a different ER physician immediately sends the girl to the operating room, where a surgeon quickly disimpacts her bowel;

n. the girl then suffers cardiac arrest in the operating room,

o. surgeons then cannulate the girl for ECMO, resuscitate her, and perform an exploratory laparotomy,

p. the laparotomy reveals extreme colonic distention, bleeding into the abdomen, ischemia of the cecum and rectum, perforation of the cecum, and fecal contamination in the peritoneum, and

q. within hours, the girl dies despite heroic but belated efforts to resolve her presenting complaint and its complications.

Premature Closure

14. **Requirements:** Under the circumstances outlined in paragraph 13 above, the standard of care requires the ER physician to provide escalation of care to treat the patient's presenting complaint—severe constipation with functional bowel obstruction. The standard of care prohibits the ER physician from discharging the patient without providing such care.

    These requirements apply with special force here, because the presenting complaint can lead to dangerous complications, as occurred here.

15. **Violations:** On June 20, 2021, Dr. Michael Greenwald violated these requirements by discharging Sequoyah Mainor from CHOA without providing escalation of care to treat her presenting complaint—severe constipation with

functional bowel obstruction. Dr. Greenwald thus prematurely closed Sequoyah's case.

These violations were all the more egregious for the following reasons:

a. Sequoyah presented with a "3-week history of no bowel movements" and "substantial obstruction from stool."

b. Dr. Greenwald recognized that Sequoyah's presenting complaint required treatment—that's why he tried enema and disimpaction in the first place.

c. The unsuccessful disimpaction confirmed both that Sequoyah had bowel obstruction and that the procedure failed to "pull anything out."

d. Like other hospital physicians, Dr. Greenwald had further clinical options readily available to investigate and treat the presenting complaint, including imaging, admission, consultation, and more-aggressive forms of disimpaction (including possible surgical interventions).

e. Nevertheless, inexplicably noting that his "only option" was to send her home, Dr. Greenwald discharged Sequoyah, prematurely closing her case without reason, explanation, or even further investigation.

16. By prematurely closing Sequoyah's case without providing the escalation of care she needed, Dr. Greenwald deviated from the standard of care.

17. In fact, Dr. Greenwald deviated grossly from the standard of care.

Principal Opinions: Causation

18. ER and other hospital physicians routinely provide effective treatment to patients who present with severe constipation with functional bowel obstruction. A variety of escalating options are readily available to hospital physicians for that purpose.

19. In this case, Dr. Greenwald failed to provide Sequoyah such escalation of care. Instead, Dr. Greenwald sent Sequoyah home to self-care with an aggressive regimen of an oral laxative.

20. Had Dr. Greenwald provided Sequoyah the escalation of care her presenting complaint required, she would not have suffered the complications that forced

her return to CHOA in critical condition and that led to her painful and dramatic death.

21. Those complications included extreme colonic distention, bleeding into the abdomen, bowel ischemia, perforation of the cecum, fecal contamination in the peritoneum, and death.

22. Dr. Greenwald's premature closure of Sequoyah's case thus caused her pain, suffering, injury, and death.

Qualifications

23. I am more than 18 years old, suffer from no legal disabilities, and give this affidavit based on my own personal knowledge and belief.

24. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA § 24-7-702.

25. My curriculum vitae, which is attached as Exhibit A, provides further detail about my qualifications. I incorporate and rely on that information here.

26. The events at issue here occurred in June 2021.

27. I am qualified to provide expert testimony pursuant to OCGA 24-7-702.

    a. In June 2021, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing and/or teaching in the profession. Specifically, I was licensed by the State of South Carolina to practice as an emergency medicine physician, and I was practicing in South Carolina at that time. In June 2021, I was also licensed in Wyoming, Missouri, and Montana.

    b. In June 2021, I had actual professional knowledge and experience in the areas of practice or specialty which my opinions relate to—specifically, the tasks identified above on which I offer standard-of-care opinions.

       I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of practice or specialty of my profession for at least three of the five years prior to June 2021, with

sufficient frequency to establish an appropriate level of knowledge of the matters my opinions address.

Specifically, I was at that time, and I am today, an emergency medicine physician managing pediatric and adult patients with severe constipation and related complications in an emergency department setting, and for many years I have had great familiarity with each of the tasks on which I offer standard-of-care opinions here.

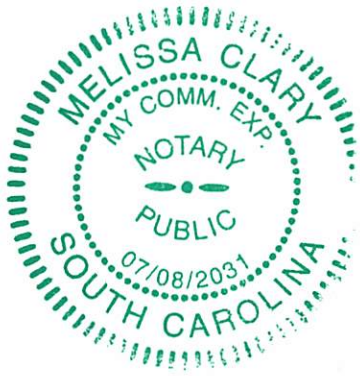
Keith T. Borg, MD, PhD, FACEP

SWORN TO AND SUBSCRIBED before me

May 5th, 2023

NOTARY PUBLIC

My Commission Expires: 07/08/2031



Curriculum Vitae

Keith Thomas Borg, MD, PhD, FACEP
Division of Emergency Medicine, Department of Medicine
Medical University of South Carolina
169 Ashley Ave, Charleston, SC 29425-3000
borgk@musc.edu

PROFESSIONAL EXPERIENCE

Assistant Professor 2009 – Present
Division of Emergency Medicine
Medical University of South Carolina, Charleston, SC

Assistant Professor 2006 – 2009
Director of Research
Division of Emergency Medicine
Medical University of South Carolina, Charleston, SC

Assistant Professor 20004 – 2009
Division of Emergency Medicine
Emory University, Atlanta, GA

EDUCATION

NINDS Clinical Trial Methods Course in Neurology 2010

Medical University of South Carolina 2009-2010
Coursework – Biostatistics, Epidemiology, KL2 Scholar

University of Cincinnati / University Hospital 2000-2004
Resident, Emergency Medicine

Medical University of South Carolina, Charleston, SC 1993-2000
MD, Medicine
PhD, Microbiology and Immunology
Thesis *Involvement of HIV-1 Splice Sites in the Cytoplasmic Accumulation of Viral RNA*

Macalester College, St. Paul, MN
BA, Biology (Honors), Japanese Studies (Minor) 1986-1990
Thesis *Collagenase Expression by Isolated Cardiac Myocytes Following Mechanical Stretch*

CERTIFICATION

American Board of Emergency Medicine 2005

APPOINTMENTS

Hospital Appointments

2006	Medical University of South Carolina Hospital
2006	MUSC Children's Hospital
2006- 2008	Charleston Memorial Hospital
2004-2006	Emory University Hospital
2004-2006	Grady Memorial Hospital
2004-2006	Hughes Spalding Pediatric Hospital
1999-2000	Fort Hamilton Hospital, Fort Hamilton, Ohio

Administrative Appointments

2012	Division Chief, Pediatric Emergency Medicine, Department of Pediatrics
2006-2009	Research Director MUSC
2004	Chief Resident Emergency Medicine, University of Cincinnati
2003-2004	Assistant Medical Director Cincinnati Hazard Materials Management

HONORS AND AWARDS

Emergency Medicine Residents Association Life Member Award, 2010
Fellow NINDS Clinical Trials Methods Course in Neurology 2010
MUSC Faculty Excellence Award Nominee 2009, 2010
Fellow of the American College of Emergency Physicians, 2007
Nominee Golden Apple Award, Medical University of South Carolina, 2006, 2008
Resident Advocacy award, Emory University Department of Emergency Medicine, 2006
Medical Student Teaching Award, University of Cincinnati College of Medicine, 2003
National Humanism in Medicine Award, 2000
SAEM Emergency Medicine Medical Student Award, 2000
National Student Research Forum, 1996, Second place poster presentation
MUSC Research Day, 1996 Second place poster presentation
MUSC Research Day, 1995 First place oral presentation

PROFESSIONAL ORGANIZATIONS

American College of Emergency Physicians (ACEP)
- Finance Committee Chair
- Special Task Force Advisory Group
  - Emergency Medicine Workforce 2007-2009
- Young Physician's Section Chair 2005-2006
  - Chair Elect 2004-5
- Young Physicians Delegate to the American Medical Association 2006-9
- Research Committee 2003-2004, 2006-8
- Tellers Committee 2001-2003
- Board Nominating Committee 2002-2003
- Finance Committee, 2001-2002, 2004-current
- Audit Committee 2006-current
- Scientific Review Committee 2006- current

PROFESSIONAL ORGANIZATIONS - continued

Emergency Medicine Residents Association, Board of Directors
Immediate Past President 2002-2003
President 2001-2002
President-Elect, Treasurer 2000-2001

National Health Professions Preparedness Consortiums' "Healthcare Leadership and Administrative Decision-Making in Response to WMD Incidents" Course – Representative from EMRA
Participant and reviewer October 2002

Emergency Medicine Foundation
Board of Directors *ex-officio* member 2008- 2010
Board of Directors 2001-2002

Society for Academic Emergency Medicine
Member 2000-current
Research Committee 2008-current

Shock Society
Member
Mentoring Committee 2007-current

American Medical Association
ACEP delegate to the Young Physicians Section 2006-2009
Alternate Delegate 1999-2000 Medical Student Section
Medical Student Section Board of Directors 1999-2000

South Carolina Medical Association
Student Representative to Board of Directors, 1998-99
Secretary-Treasurer, Medical University of South Carolina Chapter, 1994-95

JOURNAL REVIEWER

Emergency Medicine Practice 2003-current
Annals of Emergency Medicine 2003-current
Canadian Association Medical Journal 2004-2006

MAJOR TEACHING RESPONSIBILITIES

Bedside and Didactic teaching as faculty in the Division of Emergency Medicine and Division of Pediatric Emergency Medicine, Medical University of South Carolina, 2006-current

Bedside and Didactic teaching as faculty in the Department of Emergency Medicine, Emory University, 2004-2006

Bedside and Didactic teaching as Chief Resident in the Department of Emergency Medicine, University of Cincinnati, 2003-2004

Grand Rounds – Five hours of didactic weekly teaching coordinated by the Chief residents

HOSPITAL COMMITTEES

Ambulatory Electronic Medical Record Selection Advisory Committee 2010
Pediatric Trauma Focus Group 2009- current
Budget Committee MUSC Emergency Medicine 2008-2010
Emergency Medicine Research Committee, MUSC, 2006-current
Emergency Medicine Research Committee, Emory University, 2004-6
SOCRATES Mentoring group, MUSC, 2009-current
Sports Medicine Committee, MUSC, 2010

EVENT MEDICAL COVERAGE

Race Doctor, Tour of California 2006, 2007, 2008, 2009, 2010
Medical Director, US Professional Cycling Championships 2006, 2007, 2008, 2009, 2010
Medical Director, Tour De Georgia Bicycle Race 2005, 2006, 2007, 2008
Medical Director, Tour of Missouri Bicycle Race 2007, 2008, 2009
Medical Support, Peachtree Road Race 2004, 2005
Medical Support, ING Atlanta Marathon 2007
Medical Support, Cooper River Bridge Run 2007, 2008, 2010
Medical Support, Ironman Triathlon World Championships 2001, 2002
Other event coverage including NASCAR, Indianapolis 500 medical team, Lowcountry Roller Derby

PUBLICATIONS

Keith Borg, Megan Cifuni, Edward Jauch, Anbesaw Selassie, Epidemiology of Pediatric Traumatic Brain Injury in the State of SC, Manuscript in Preparation.

Anbesaw Selassie, **Keith Borg**. ICD 9 Codes in Surveillance of Pediatric Abusive Head Trauma, Manuscript in preparation.

Keith Borg, Edward Jauch, Kupchak P, Stanton EB, Sawadsky B, Serum levels of biochemical markers of traumatic brain injury: a preliminary study, Manuscript under review.

Hongkuan Fan, Alessandra Bitto, Basilia Zingarelli, Louis Luttrell, **Keith Borg**, Perry Halushka, Jim Cook. Beta-Arrestin 2 Negatively Regulates Sepsis-Induced Inflammation. Immunology. 130: 344-351. 2010.

Scott Stewart, Sarah Miles, Ashley Kuklentz and **Keith Borg**. Identification and□Risk-Stratification of Problem Alcohol Drinkers with Minor Trauma in the Emergency Department. Western Journal of Emergency Medicine. Western Journal of Emergency Medicine, 11:2: 133-17, 2010.

Francis Counselman, Catherine Marco, Vicki Patrick, David McKenzie, Luke Monck, Frederick C. Blum, **Keith Borg**, et al. A study of the workforce in emergency medicine: 2007. American Journal of Emergency Medicine. 27:6. 2009, 691-700.

Charlie M. Andrews, **Keith Borg** and Kate L. Heilpern
Correspondence in reply Laboratory Testing and Confirmation of Suspected Measles Infection Crucial in Countries That Have Eliminated Measles. Annals of Emergency Medicine□Volume 54, Issue 4, October 2009, 640.

Charlie Andrews, **Keith Borg**, Kate Heilpern, David Talan, Gregory Moran, Robert Pinner. Update on emerging infections: news from the Centers for Disease Control and Prevention. Update: Measles- United States, January-July 2008. Ann Emerg Med. *In Press*, 2009.

Fahmin Basher, Hongkuan Fan, Basilia Zingarelli, **Keith Borg**, Lou Lutrell, George Temple, Perry Halushka and James Cook. Beta- Arrestin 2: A negative regulator of Inflammatory responses in Polymorphonuclear Leukocytes. International Journal of Clinical and Experimental Medicine 1. 32-41, 2008.

Scott Stewart, **Keith Borg**, Peter Miller. Prevalence of Problem Drinking and Characteristics of a Single Question Screen. Journal of Emergency Medicine, 39, 2:291-295, 2008.

Keith Borg. To Test or Not to Test- HIV, Emergency Departments, and the New Centers for Disease Control and Prevention Guidelines. *Annals of Emergency Medicine*; 49(5), 573-4, 2007.

Katherine L Heilpern, **Keith Borg**. Update on emerging infections: news from the Centers for Disease Control and Prevention. Vibrio illness after Hurricane Katrina--multiple states, August-September 2005. Ann Emerg Med. March ;47:255-8, 2006.

Keith Borg and Arthur Pancioli, TIAs – An Emergency Medicine Approach, Emergency Medicine Clinics of North America, 20:597-608, 2002.

Keith Borg, Justin Favaro, Salvatore Arrigo and Michael Schmidt. Activation of a Cryptic Splice Donor in HIV-1. Journal of Biomedical Sciences. 6:1. 45-52. 1999.

Justin Favaro, **Keith Borg**, Salvatore Arrigo and Michael Schmidt. Effect of Rev on the Intranuclear Localization of HIV-1 Unspliced RNA. Virology 249:2. 286-96, 1998.

Keith Borg, Justin Favaro and Salvatore Arrigo. Involvement of Human Immunodeficiency Virus type-1 Splice Sites in the Cytoplasmic Accumulation of Viral RNA. Virology. 236:1. 95-103. 1997.

Keith Borg, William Burgess, Louis Terracio, Thomas Borg, Expression of Metalloproteases by Cardiac Myocytes and Fibroblasts In Vitro, Cardiovascular Pathology .6:5. 261-269. 1997.

Lia Campbell, **Keith Borg** and Salvatore Arrigo. Differential Effects of Intronic and Exonic Locations of the Human Immunodeficiency Virus Type 1 Rev-response Element.
Virology. 219:2. 423-31. 1996.

Lia Campbell, **Keith Borg**, Julia Haines, Randall Moon, Daniel Schoenberg and Salvatore Arrigo. Human Immunodeficiency Virus Type 1 Rev is Required In Vivo for Binding of Poly(A)-binding protein to Rev-dependent RNAs. Journal of Virology. 68:9. 5433-8. 1994.

Book Chapters

Andrew Ross, **Keith Borg,** Richard Ryan. Parasitic Disease; Wolfson A.B. ed. *The Clinical Practice of Emergency Medicine*. Fifth Edition, Lippincott, Williams and Wilkins, New York, 2009.

Keith Borg. *Self-Harm and Harm to Others.* Adams, Barton, Collings et.al.ed. Emergency Medicine, First Edition,Saunders Elsevier, Philaelphia, PA, 2008.

Keith Borg, Richard Ryan. Parasitic Disease; Wolfson A.B. ed. *The Clinical Practice of Emergency Medicine.* Fourth Edition, pp. 775-781. Lippincott, Williams and Wilkins, New York, 2005.

Abstracts

Ashley Kuklentz, **Keith Borg**, Scott Stewart and Sarah Miles. Is There a Rapid and Effective Tool to Differentiate between Hazardous Drinkers and Alcohol Dependent Patients in the Emergency Department? American College of Emergency Physicians Research Forum, October, 2008.

Susanne Hardy, Matthew Bitner, Ian Greenwald and **Keith Borg**. Injuries and Illness in a Professional Bicycling Stage Race. International College of Emergency Medicine, April 2008.

Keith Borg, Justin Favaro and Salvatore Arrigo. Activation of a Cryptic Splice Donor in HIV-1. National MD/PhD Student Conference, Oral Presentation, Aspen 1998.

Keith Borg, Justin Favaro and Salvatore Arrigo. Involvement of HIV-1 Splice Sites in the Cytoplasmic Accumulation of Viral RNAs. National MD/PhD Student Conference, Poster Presentation, Aspen July 1997.

Keith Borg, Justin Favaro and Salvatore Arrigo. Involvement of HIV-1 Splice Sites in the Cytoplasmic Accumulation of Viral RNAs. Cold Spring Harbor Retrovirus Meeting, May 1997.

Keith Borg and Salvatore Arrigo. Cis Repressor Sequences and the Regulation of HIV-1 Gene Expression. National Student Research Forum. April 1996, Galveston Texas.

Lia Campbell, **Keith Borg** and Salvatore Arrigo. HIV-1 Rev Relieves the "Masking" of the Poly(A) Tail: Second National Conference on Human Retroviruses and Related Infection. January 1995, Washington DC.

Selected Presentations

Traumatic Brain Injury in Cycling Stage Races, November 14, 2010, Colorado Springs, Colorado.
Invited Lecture at the Medicine in Cycling National Meeting

Care of the Patient with TBI in the Prehospital Setting October 13, 2010
Presentation for Charleston County EMS

Facial Trauma, Pediatric Resident Conference, October 5, 2010

The Difficult Airway, Pediatric Fellows Conference, July 21, 2010

Orientation to Emergency Medicine, Emergency Medicine Resident Lecture, June 29, 2010.

Common Sports Medicine Emergencies, Sports Medicine Spring Symposium, March 19, 2010.

Pediatric Airway, March 9, 2010. Pediatric Housestaff Didactic Lecture

Upper Extremity Injury and Radiology, January 2010, MUSC Emergency Medicine Didactic Lecture

Pediatric Trauma, March 2009, MUSC Emergency Medicine Didactic Lecture

Ouch! That's Gonna Leave a Mark! Critical Decisions and Diagnoses in the Management of Patients with Facial Trauma. ACEP Scientific Assembly, October 7, 2009.

Approach to Head Injury July 2009, MUSC Emergency Medicine Didactic Lecture.

Sports Medicine Emergencies, Sports Medicine Spring Symposium, March 2009.

Trauma Radiology – What You Can't Miss! Southeastern Emergency Medical Symposium March 2006.

Emory Emergency Department Resident Radiology Lecture Series 2005-2006

Glenn School Invited Lectureship in Hygiene and Trauma, March 2006

MENTORED STUDENTS AND RESIDENTS

Joe Mahoney, MUSC EM Resident 2007-2010
Garrick Messer, MUSC EM Resident 2008-2010
Jason Prystowsky, Emory University Chief Resident, 2004-6
Chris Klingenberg, Emory University Resident 2004-6
Christanne Hoffman, MUSC Medical Student 2008-9
Ginger Culyer, MUSC Medical Student 2007-8
Ashley Kuklentz, MUSC Medical Student 2007-10
Matthew Dettmer, MUSC Medical Student 2008-9
Susanne Hardy, Philadelphia College of Osteopathic Medicine Student, Atlanta Campus 2007-10
Megan Cifuni, MUSC Medical Student 2009-10
Katie Clark, MUSC Pediatric Dental Resident 2009-10

FUNDED RESEARCH

Current

KL2RR029880 — Borg (P.I.), Jauch (Mentor), Halushka (Mentor) — 07/01/09-06/30/12
South Carolina Clinical & Translational Research Institute (SCTR) Scholars
NIH — Effort: 75%
Oxidative Stress in Traumatic Brain Injury
This is a career development award focused on traumatic brain injury (TBI) translational research. Markers of oxidative stress are being studied in adult and pediatric patients with TBI. Isoprostane levels in cerebrospinal fluid are analyzed for correlation to injury severity and outcome.
Role on Project: Principal Investigator

Completed

Borg (P.I.) Robbins (Co-Iinvestigator) — 01/07/08–01/06/09
UCB, Inc
A Pilot Study Examining the Efficacy of Keppra (levetiracetam) in Acute Alcohol Related Seizure Control in the Emergency Department Setting

This is was an open label trial for the use of levetiracetam in the treatment of alcohol related seizures in the Emergency Department.
Role on Project: Principle Investigator

Emory Intramural Research Award — Borg (PI) , Del Rio (mentor) — 01/01/06-6/15/06
Rooms to Go Health Policy Grant — Effort: 5%
Point of Care Testing in the Emergency Department
This was a research award to establish research protocols for point of care HIV testing in Grady Memorial Hospital.
Role on Project: Principle Investigator

Exhibit 2

AFFIDAVIT OF CHRISSY ANJANEIK WHITE, RN, REGARDING SEQUOYAH MAINOR

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, Chrissy Anjaneik White, RN, who after first being duly sworn states as follows.

Introduction

1. This affidavit addresses nursing negligence that occurred on June 20, 2021, when 15-year-old Sequoyah Mainor visited the Emergency Department of Children's Healthcare of Atlanta – Egleston Hospital ("CHOA" or "Hospital").

2. The process of creating this affidavit was as follows.

   - Plaintiffs' counsel contacted me to inquire whether I would be interested in and available to review a case involving nursing care in a hospital's emergency department ("ED" or "ER").

   - Plaintiffs' counsel then sent me Sequoyah Mainor's records from CHOA for June 20, 2021, for me to review without additional information.

   - After reviewing those records independently, without knowing anything else about the case, I formed my own views, reached my own conclusions, and then shared my conclusions with Plaintiffs' counsel.

   - I subsequently reviewed Sequoyah's records from CHOA for June 22, 2021, as well as her autopsy report, all of which confirmed my views and conclusions.

   - Plaintiffs' counsel then prepared a draft of this affidavit, based on my views and conclusions.

   - I then reviewed and edited the draft, to make sure it correctly states my views and conclusions. I did not edit the affidavit for style.

3. This affidavit addresses matters that Plaintiffs' counsel have asked me to address. I have not attempted to identify all standard-of-care violations, state

every causation opinion, or anticipate or address all issues that the Defense may raise or that may otherwise arise as the case unfolds.

4. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation, but I have not attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional detail.

5. I hold all opinions expressed below to a reasonable degree of nursing certainty—that is, more likely than not. If additional information later becomes available, my views may change.

6. I use the phrase "standard of care" to refer to that degree of care and skill ordinarily exercised by members of the nursing profession generally under the same or similar circumstances and like surrounding conditions as pertained to the providers I discuss here.

7. The purpose of this affidavit is to disclose to the Defendants, their lawyers, and their insurers opinions I plan to offer at trial—in enough detail that the Defense can evaluate them and thereby prepare to cross-examine me.

8. I understand that Plaintiffs' counsel may have consulted with other experts. If so, I would expect most other experts, possibly all, to reach conclusions that are similar to, if not the same as, mine.

9. If anyone on the Defense believes that I have not been given, or have overlooked or misconstrued, any relevant information, I invite the Defense to communicate with me by letter through Plaintiffs' counsel. The Defense need not wait to take my deposition to communicate with me.

10. I will consider all information the Defense brings to my attention. Insofar as such information warrants reconsideration of my views, I will reconsider them and will provide a supplemental affidavit to the extent necessary.

Evidence Considered

11. I have reviewed CHOA medical records for Sequoyah Mainor's visits to CHOA on June 20 and 22, 2021, and the autopsy report for Sequoyah prepared by Forensic Medicine Associates, Inc.

Principal Opinions

12. Summarized below are principal opinions I have developed thus far, as well as the factual grounds for those opinions. In deposition or trial testimony, I may elaborate on these opinions, and in doing so, I may offer related, subsidiary, or incidental opinions. In addition, I may later develop and disclose additional principal opinions for this case.

Clinical Setting

13. The requirements of the standard of care identified below apply under the following circumstances present in this case.

- a 15-year-old girl presents to the ER with these complaints:
  i. a "3-week history of no bowel movements,"
  ii. "abdominal pain,"
  iii. "some nausea at times," and
  iv. "a longstanding history of constipation,"
- an ER nurse (here, Nurse Gabriel Ribeiro) finds that the girl's abdomen is firm, distended, and round,
- an ER physician (here, Dr. Michael Greenwald) also finds that the girl's abdomen is distended,
- recognizing that the girl has severe constipation, the physician orders a second nurse (here, Nurse Elizabeth Wright) to administer a 1,000 mL soap-suds enema,
- when the enema starts "to leak out after 500," the second nurse stops the enema "to prevent further leaking,"
- after the enema fails, recognizing that the girl has "substantial obstruction from stool," the physician attempts digital disimpaction,

- the attempt confirms the bowel obstruction, as the physician finds a "large amount of stool high in the rectum," but cannot "get around to pull anything out,"
- as a result, the physician informs the first nurse that "digital stimulation was unsuccessful,"
- then, declaring that the "only option left is to send patient home with miralax," the physician orders the girl's discharge from the hospital,
- about three hours after arriving, the girl then leaves the hospital even though:
    i. the girl still has "a rather severe case of constipation!"
    ii. the girl "will need much more treatment to get her cleaned out,"
    iii. the girl complains of the worst possible pain—a 10 of 10,
    iv. the girl's heartrate has risen to the 130s at the time of discharge, and
    v. although she was ambulatory at arrival, the girl exits the ER in a wheelchair,
- in his discharge instructions, the physician directs the girl to see her pediatrician or gastroenterologist "within 2 weeks,"
- in his discharge instructions, the physician also directs the girl to take an aggressive regimen of Miralax: an initial 238-gram cleanout dose that same day, and a 17-gram dose daily thereafter,
- about 46 hours later, after taking the cleanout dose, the girl returns to the same ER in critical condition,
- a different ER physician immediately sends the girl to the operating room, where a surgeon quickly disimpacts her bowel,
- the girl then suffers cardiac arrest in the operating room,
- surgeons then cannulate the girl for ECMO, resuscitate her, and perform an exploratory laparotomy,

- the laparotomy reveals extreme colonic distention, bleeding into the abdomen, ischemia of the cecum and rectum, perforation of the cecum, and fecal contamination in the peritoneum, and

- within hours, the girl dies despite heroic but belated efforts to resolve her presenting complaint and its complications.

Violations: Failure to Advocate for Patient

14. **Requirements:** Under the circumstances outlined in paragraph 13 above, when the ER physician orders discharge of the patient without providing escalation of care to treat the patient's presenting problem (severe constipation with functional bowel obstruction), the nursing standard of care requires each nurse caring for the patient to advocate for escalation of care with the ER physician, on behalf of the patient.

    The standard of care prohibits the nurses from following the discharge order without so advocating for the patient first.

    Insofar as nurses meet these requirements and the ER physician nevertheless overlooks or disregards the need to keep the patient in the hospital for escalation of care, the nursing standard of care then requires each nurse to advocate for the patient up the hospital's chain-of-command.

    These requirements apply with special force here, because the patient's presenting complaint can lead to fatal complications, as occurred here.

15. **Violations:** On June 20, 2021, CHOA nurses caring for Sequoyah Mainor at the Hospital violated these requirements, by failing to advocate on Sequoyah's behalf when Dr. Greenwald ordered her discharge without providing further escalation of care to treat her presenting problem—severe constipation with functional bowel obstruction. Those violations included:

    - The failure to advocate for diagnostic testing, including imaging studies, which would have confirmed the nature and extent of Sequoyah's constipation and bowel obstruction, and would have guided the escalation of care.

- The failure to advocate for a consultation with a specialist—a gastroenterologist or a surgeon—to guide and assist with the diagnosis and treatment of Sequoyah's presenting problem.

- The failure to advocate for Sequoyah's admission to CHOA for further observation, evaluation, and treatment. In fact, the nurses failed to advocate even for keeping Sequoyah in the Hospital under observation status.

- The failure to advocate for escalating therapeutic intervention, including more-aggressive forms of disimpaction (including surgical interventions), by either the ER physician or by a consulting specialist.

Instead, CHOA nurses executed Dr. Greenwald's discharge order, without making any effort to advocate on Sequoyah behalf, either with Dr. Greenwald or with anyone up the chain-of-command.

These violations were all the more egregious for the following reasons:

- During the three hours Sequoyah was at the CHOA ER on June 20, 2021, her clinical condition deteriorated:

    i. her tachycardia rose from 122 to the 136,

    ii. her pain rose from a 2 to the worst possible pain—a 10 of 10, and

    iii. after walking into the ER under her own powers, she was discharged in a wheelchair.

- Sequoyah was thus significantly worse at the time of discharge, compared to the time of arrival.

- Nurse Ribeiro himself found and noted that Sequoyah's abdomen was distended, firm, and round—all signs of severe constipation with possible bowel obstruction.

- Nurse Wright herself performed the unsuccessful enema.

- Dr. Greenwald notified Nurse Ribeiro that manual disimpaction had failed to clear "anything" from the bowel obstruction.

- Dr. Greenwald nevertheless decided to discharge Sequoyah without escalation of care, based on the plainly faulty conclusion that discharge with a Miralax prescription was the "only option left."

- Dr. Greenwald thus discharged Sequoyah with a known and dangerous case of bowel obstruction, as she was deteriorating.

16. By failing to advocate on Sequoyah's behalf when Dr. Greenwald ordered her discharge, the nurses caring for Sequoyah deviated from the standard of care.

17. In fact, under the circumstances outlined above, each nurse deviated grossly from the standard of care.

Causation

18. Hospitals routinely provide effective treatment to patients who present with severe constipation with functional bowel obstruction. A variety of escalating therapeutic interventions are readily available for that purpose.

19. Here, as a threshold matter, had a nurse advocated to keep Sequoyah at CHOA, Dr. Greenwald may have realized that sending her home with Miralax was not the "only option left" and that Sequoyah rather could be kept and needed to be kept at the Hospital for escalation of care.

20. Here, had a nurse advocated to keep Sequoyah at CHOA for escalation of care, CHOA likely would have promptly provided her effective treatment for her presenting problem—without her becoming fatally or even critically ill.

For example:

- Had a nurse advocated for imaging or other diagnostic studies, they would have provided additional evidence of Sequoyah's presenting problem, and would have guided the escalation of care Sequoyah needed. As a result, CHOA would have promptly provided Sequoyah effective treatment—well before she became critically ill.

- Had a nurse advocated for a consultation with a specialist, the specialist would have promptly recommended or provided escalating

therapeutic intervention, until a resolution of Sequoyah's presenting problem was achieved.

- Had a nurse advocated for admission, the unobserved deterioration Sequoyah experienced at home would have occurred at the Hospital. Directly observing such deterioration, CHOA would have promptly provided Sequoyah the escalation of care she needed—well before she became critically ill. In fact, that would have occurred even if a nurse had advocated for keeping Sequoyah at CHOA only for observation.

- Had a nurse advocated for escalating therapeutic intervention, CHOA would have promptly provided such escalating intervention, until resolution of Sequoyah's presenting problem was achieved.

21. As a result, had even one nurse advocated for even one of these options, CHOA would have promptly provided Sequoyah the escalation of care that was readily available and that she needed.

22. As a result, Sequoyah would not have experienced anywhere near the fatal or even critical illness that caused her return to CHOA 46 hours later.

23. Each failure to advocate by each nurse thus led to Sequoyah's pain, suffering, injury, and death.

Qualifications

24. I am more than 18 years old, suffer from no legal disabilities, and give this affidavit based on my own personal knowledge and belief.

25. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA § 24-7-702.

26. My curriculum vitae, which is attached as Exhibit A, provides further detail about my qualifications. I incorporate and rely on that information here.

27. The events at issue here occurred in June 2021.

28. I am qualified to provide expert testimony pursuant to OCGA 24-7-702.

- In June 2021, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing and/or teaching in the profession. Specifically, I was licensed by the State of Wyoming to practice as registered nurse, and I was practicing in Wyoming at that time.

- In June 2021, I had actual professional knowledge and experience in the areas of practice or specialty which my opinions relate to—specifically, the tasks identified above on which I offer standard-of-care opinions.

  I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of practice or specialty of my profession for at least three of the five years prior to June 2021, with sufficient frequency to establish an appropriate level of knowledge of the matters my opinions address.

  Specifically, I was at that time, and I am today, a registered nurse caring for pediatric and adult patients with severe constipation and related complications in an emergency department setting, and for many years I have had great familiarity with each of the tasks on which I offer standard-of-care opinions here.

Chrissy Anjaneik White

Chrissy Anjaneik White, RN

SWORN TO AND SUBSCRIBED before me

May 15th, 2023

Shaylee Ingalls

NOTARY PUBLIC

SHAYLEE INGALLS
NOTARY PUBLIC
STATE OF WYOMING
COMMISSION ID: 166703
MY COMMISSION EXPIRES: 03/07/2028

My Commission Expires: 03/07/2028

Chrissy Anjaneik White
307-840-1808
338 East Burrows Street
Sheridan, WY 82801
camadridwyo@gmail.com

Education

Associate of Applied Science in Nursing
Central Wyoming College
Riverton, WY

- Graduated May 2010
- Dual Associates degree in General Studies

High School Diploma
Riverton High School
Riverton, WY

- Graduated May 1998

Licensing

June 2010 to present

- Registered Nurse

July 2002 to December 2010

- Certified Nurses Aid

Work Experience

October 2018 to present
Registered Nurse-Emergency Room

Sheridan Memorial Hospital
1401 West 5th Street
Sheridan, WY 82801

- Emergency Room Charge Nurse
  - Supervision of emergency room nursing staff
  - Appropriate triage of emergency room patients
  - Coordination of emergency room activities with all units of the hospital
  - Implementation of transfers to other facilities via ground or air ambulance
- House Supervisor as needed
  - Appropriate nursing staffing for the hospital

    - Orchestrating activities from all departments in the hospital (admissions, surgeries, etc.)
    - Problem solving with the nursing staff for appropriate patient care
- Staff Nurse
    - Completing direct patient care and assessment while upholding the highest standards of care
    - Administration of medications and performance of medical procedures as ordered by a physician
    - Assessment, intervention, and observation of patients within the full spectrum of acuity
    - Accurate Documentation of all patient interventions
    - Sexual assault exams (adult/adolescent/pediatric)
        - Patient advocacy coordination and police reporting if requested
        - Biological evidence kit collection
        - Court testimony as needed

June 2010 to September 2018
Registered Nurse-Emergency Room

Sage West Riverton
2100 West Sunset Drive
Riverton, WY 82501

- Completing direct patient care and assessment while upholding the highest standards of care
- Administration of medications and performance of medical procedures as ordered by a physician
- Assessment, intervention, and observation of patients within the full spectrum of acuity
- Accurate documentation of all patient interventions
- Sexual Assault exams (adult/adolescent/pediatric)
    - Patient advocacy coordination
    - Coordinating with correct police jurisdiction (city, county, BIA, FBI)
    - Biological evidence kit collection
    - Court testimony as needed
- ACLS and PALS instructor

May 2009-June 2010
Certified Nursing Assistant

Sage West Riverton
2100 West Sunset Drive
Riverton, WY 82501

- Direct Patient Care on Medical Surgical Floor
- Direct Patient Care when floated to another department

- Vitals, Intake and Outputs every shift
- Assisting Nursing Staff with any procedures
- Accurate documentation of all activities

June 2002 to May 2009
Certified Nursing Assistant

Kindred Health Care-Wind River Healthcare and Rehabilitation Center
1002 Forest Drive
Riverton, WY 82501

- Assisting patient with Activities of Daily Living
- Bathing, dressing, feeding, etc.
- Vitals, Intakes and Outputs every shift
- Assisting Nurse with procedures
- Documentation of all activities

Certifications

- Advanced Coronary Life Saving (ACLS)
- Pediatric Advanced Life Saving (PALS)
- Trauma Nursing Core Course (TNCC)
- Emergency Nursing Pediatric Course (ENPC)

Additional Education

- Pediatric Sexual Assault Examiner Course
- Intimate Partner Violence Examiner Course
- Sexual Assault Nurse Examiner Course for Adults and Adolescents