IN THE STATE COURT OF COBB COUNTY
STATE OF GEORGIA

Tenika Storey, Individually and as Representative of the Estate of Waymon Marcel Storey (Deceased),

Plaintiff,

— *versus* —

Wellstar Health System, Inc,

Wellstar Medical Group, LLC,

Kennestone Hospital, Inc,

Atlanta Medical Center, Inc,

South Fulton Emergency Physicians, LLC,

Richisa Salazar, MD (f/k/a Richisa Hamilton),

Philip Ramsay, MD,

Vernon Henderson, MD,

Estate of Vernon Henderson,

Morning Strickland, RN,

Jessica Astrella, RN (f/k/a Jessica Kainer), and

John/Jane Does 1-10,

Defendants.

CIVIL ACTION

FILE NO. _____

JURY TRIAL DEMANDED

PLAINTIFF'S COMPLAINT FOR DAMAGES

Nature of This Action

1. This medical-malpractice and ordinary-negligence action arises out of care provided to 53-year-old Waymon Storey at Wellstar Atlanta Medical Center, in Atlanta, Georgia (the "Hospital" or "AMC"), on December 23, 2021.

2. This action is brought by Mr. Storey's surviving spouse, Mrs. Tenika Storey, individually and on behalf of Mr. Storey's estate.

3. As representative of her husband's estate, Mrs. Storey asserts a claim for the harm her husband suffered as a result of the alleged negligence.

4. Mrs. Storey also asserts a wrongful-death claim pursuant to OCGA Title 51, Chapter 4, on behalf of all wrongful-death beneficiaries.

5. Pursuant to OCGA § 9-11-9.1, the affidavits of Emergency Physician Keith Borg, MD; Trauma Surgeon Rohit Sharma, MD; Nurse Chrissy White, RN; and Internist Jonathan Schwartz, MD, MBA, are attached as Exhibits 1-4,

respectively. This complaint incorporates the opinions and allegations in those affidavits.

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

Factual Summary

7. This is a simple and straightforward case. The care at issue occurred over a short period of time, involved a designated team of emergency room providers, and is documented in a small set of medical records.

8. This is also tragic and heartbreaking case.

9. Two days before Christmas, Waymon Storey was at home with his wife enjoying his first day of vacation.

10. Mr. Storey left the house to run errands for his family—deposit a check, buy allergy medicine and coffee, and purchase a "crushed ice" at Sonic for his wife.

11. He never returned.

12. At a major intersection in Lake City, after running a red light, another car rammed into Mr. Storey's vehicle.

13. Despite rolling over twice, Mr. Storey had no life-threatening injuries.

14. In fact, the main concern was his chest trauma, which made it difficult for him to breathe and which therefore lowered his oxygen-saturation to critical levels.

15. The medically indicated care Mr. Storey needed was thus obvious and clear: assisted ventilation with a protected airway.

16. Yet, when Mr. Storey arrived at the Hospital ED by ambulance, Dr. Richisa Salazar did not even recognize the impending risk of respiratory failure, much less provide the indicated care.

17. Then, when Mr. Storey predictably fell into hypoxic arrest, the trauma team failed to secure his airway emergently—either by intubating him or by placing a surgical airway with a cricothyrotomy.

18. Such is the tragedy of this case: While Mrs. Storey was still waiting at home for his return, Mr. Storey died gradually of oxygen-deprivation—at a major trauma center, in the care of healthcare providers.

19. Perpetuating the indifference and indignity he faced at death, the Hospital then failed to preserve Mr. Storey's body.

20. As the Hospital has admitted: Mr. Storey's body "was transported to the hospital morgue on the evening of 12/23 but **was not able to be placed in refrigeration and instead was placed on a table in the autopsy suite at room temperature** . . . until the evening of 12/26."

21. This, then, is the heartbreak of this case: While the Storey family spent Christmas at home without their husband and father, Mr. Storey's body lay abandoned and decomposing on a table in the Hospital morgue.

22. On New Year's Eve, the Storey family held a memorial service with an open casket. Ten months later, Wellstar Atlanta Medical Center closed.

Parties, Jurisdiction, and Venue

23. **Plaintiff TENIKA STOREY** is a citizen and resident of Georgia. Plaintiff submits to the personal jurisdiction and venue of this Court.

24. **Defendant WELLSTAR HEALTH SYSTEM, INC. ("Wellstar Health")** is a Georgia nonprofit corporation. Registered agent: Leo Reichert. Physical address and principal office address: 793 Sawyer Road, Marietta, GA 30062, in Cobb County.

25. Wellstar Health is subject to the personal jurisdiction of this Court.

26. Wellstar Health is subject to the subject-matter jurisdiction of this Court in this case.

27. Wellstar Health is directly subject to venue in this Court, because Wellstar Health maintains its registered office in Cobb County.[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.

28. Pursuant to OCGA § 9-10-31, Wellstar Health is also subject to venue in this Court, because at least one of its co-defendants is directly subject to venue here.

29. Wellstar Health has been properly served with this complaint.

30. Wellstar Health has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

31. At all times relevant to this complaint, Wellstar Health was the employer or other principal of one or more of the individual defendants in this action.

32. At all times relevant to this complaint, Wellstar Health operated Wellstar Atlanta Medical Center ("Hospital" or "AMC"), which was located at 303 Parkway Drive NE, Atlanta, GA 30312.

33. At all times relevant to this complaint, Wellstar Health was the parent corporation of the Hospital.

34. Wellstar Health thus provided overall coordination (including governance) to the Hospital.

35. **Defendant WELLSTAR MEDICAL GROUP, LLC ("Wellstar Medical")** is a Georgia nonprofit corporation. Registered agent: Leo Reichert. Physical address and principal office address: 793 Sawyer Road, Marietta, GA 30062, in Cobb County.

36. Wellstar Medical is subject to the personal jurisdiction of this Court.

37. Wellstar Medical is subject to the subject-matter jurisdiction of this Court in this case.

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."

38. Wellstar Medical is directly subject to venue in this Court, because Wellstar Medical maintains its registered office in Cobb County.

39. Pursuant to OCGA § 9-10-31, Wellstar Medical is also subject to venue in this Court, because at least one of its co-defendants is directly subject to venue here.

40. Wellstar Medical has been properly served with this complaint.

41. Wellstar Medical has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

42. At all times relevant to this complaint, Wellstar Medical was the employer or other principal of one or more of the individual defendants in this action.

43. **Defendant KENNESTONE HOSPITAL, INC. ("Kennestone")** is a Georgia nonprofit corporation. Registered agent: Leo Reichert. Physical address and principal office address: 793 Sawyer Road, Marietta, GA 30062, in Cobb County.[2]

44. Kennestone is subject to the personal jurisdiction of this Court.

45. Kennestone is subject to the subject-matter jurisdiction of this Court in this case.

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[2] In December 2021, Wellstar Atlanta Medical Center, Inc. ("WAMC") was a Georgia nonprofit corporation. Registered agent: Leo Reichert. Physical address and principal office address: 793 Sawyer Road, Marietta, GA 30062, in Cobb County. On October 1, 2022, WAMC merged with and into Kennestone Hospital, Inc. Kennestone was the Surviving Corporation. WAMC and Kennestone are therefore the same entity for legal purposes. Herein, all references to "Kennestone" or "WAMC" refer to both entities.

46. Kennestone is directly subject to venue in this Court, because Kennestone maintains its registered office in Cobb County.

47. Pursuant to OCGA § 9-10-31, Kennestone is also subject to venue in this Court, because at least one of its co-defendants is directly subject to venue here.

48. Kennestone has been properly served with this complaint.

49. Kennestone has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

50. At all times relevant to this complaint, Kennestone was the employer or other principal of one or more of the individual defendants in this action.

51. At all times relevant to this complaint, Kennestone operated the Hospital.

52. At all times relevant to this complaint, Kennestone was the parent corporation of the Hospital.

53. Kennestone thus provided overall coordination (including governance) to the Hospital.

54. **Defendant ATLANTA MEDICAL CENTER, INC. ("Atlanta Medical")** is a Georgia corporation. Registered agent: C T Corporation System. Physical address: 289 S Culver Street, Lawrenceville, GA 30046 in Gwinnett County. Principal office address: 14201 Dallas Parkway, Dallas, TX 75254.

55. Atlanta Medical is subject to the personal jurisdiction of this Court.

56. Atlanta Medical is subject to the subject-matter jurisdiction of this Court in this case.

57. Pursuant to OCGA § 9-10-31, Atlanta Medical is subject to venue in this Court, because at least one of its co-defendants is directly subject to venue here.

58. Atlanta Medical has been properly served with this complaint.

59. Atlanta Medical has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

60. At all times relevant to this complaint, Atlanta Medical was the employer or other principal of one or more of the individual defendants in this action.

61. At all times relevant to this complaint, Atlanta Medical operated the Hospital.

62. At all times relevant to this complaint, Atlanta Medical was the parent corporation of the Hospital.

63. Atlanta Medical thus provided overall coordination (including governance) to the Hospital.

64. **Defendant SOUTH FULTON EMERGENCY PHYSICIANS, LLC ("South Fulton Emergency")** is a Georgia nonprofit corporation. Registered agent: CSC of Cobb County, Inc. Physical address: 192 Anderson Street SE, Suite 125, Marietta, GA, 30060, in Cobb County. Principal office address: 5665 New Northside Drive, Suite 320, Atlanta, GA 30328, in Fulton County.

65. South Fulton Emergency is subject to the personal jurisdiction of this Court.

66. South Fulton Emergency is subject to the subject-matter jurisdiction of this Court in this case.

67. South Fulton Emergency is directly subject to venue in this Court, because South Fulton Emergency maintains its registered office in Cobb County.

68. Pursuant to OCGA § 9-10-31, South Fulton Emergency is also subject to venue in this Court, because at least one of its co-defendants is directly subject to venue here.

69. South Fulton Emergency has been properly served with this complaint.

70. South Fulton Emergency has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

71. At all times relevant to this complaint, South Fulton Emergency was the employer or other principal of one or more of the individual defendants in this action.

72. Herein, the Defendants identified in the preceding paragraphs may be referred to collectively as the **"Corporate Defendants."**

73. Herein, the Defendants identified in the following paragraphs may be referred to collectively as the **"Individual Defendants."**

74. **Defendant RICHISA SALAZAR, MD (formerly known as Richisa Hamilton)**, is a citizen and resident of Georgia. She resides at 2178 Waldrop Road, Marietta, GA, in Cobb County.

75. Dr. Salazar is subject to the personal jurisdiction of this Court.

76. Dr. Salazar is subject to the subject-matter jurisdiction of this Court in this case.

77. Dr. Salazar is directly subject to venue in this Court, because she is a resident of Cobb County.

78. Pursuant to OCGA § 9-10-31, Dr. Salazar is also subject to venue in this Court, because at least one of her co-defendants is directly subject to venue here.

79. Dr. Salazar has been properly served with this complaint.

80. Dr. Salazar has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

81. At all times relevant to this complaint, Dr. Salazar acted as an employee or other agent of one or more of the Corporate Defendants: Wellstar Health, Wellstar Medical, Kennestone, Atlanta Medical, and/or South Fulton Emergency.

82. As Dr. Salazar's employer(s) or other principal(s) at the time of her negligence, one or more of the Corporate Defendants is/are vicariously liable for her

negligence, because she was acting within the scope of her employment or other agency at that time.

83. If another entity was the employer or other principal of Dr. Salazar during that time, 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.

84. **Defendant PHILIP RAMSAY, MD,** is a citizen and resident of Georgia. He resides at 1630 W Sussex Road NE, Atlanta, GA 30306, in Fulton County.

85. Dr. Ramsay is subject to the personal jurisdiction of this Court.

86. Dr. Ramsay is subject to the subject-matter jurisdiction of this Court in this case.

87. Pursuant to OCGA § 9-10-31, Dr. Ramsay is subject to venue in this Court, because at least one of his co-defendants is directly subject to venue here.

88. Dr. Ramsay has been properly served with this complaint.

89. Dr. Ramsay has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

90. At all times relevant to this complaint, Dr. Ramsay acted as an employee or other agent of one or more of the Corporate Defendants: Wellstar Health, Wellstar Medical, Kennestone, Atlanta Medical, and/or South Fulton Emergency.

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

92. If another entity was the employer or other principal of Dr. Ramsay during that time, 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.

93. **Defendant VERNON HENDERSON, MD,** is a citizen and resident of Georgia.[3] He resides at 2134 Spencers Way, Stone Mountain, GA 30306, in DeKalb County.

94. Dr. Henderson is subject to the personal jurisdiction of this Court.

95. Dr. Henderson is subject to the subject-matter jurisdiction of this Court in this case.

96. Pursuant to OCGA § 9-10-31, Dr. Henderson is subject to venue in this Court, because at least one of his co-defendants is directly subject to venue here.

97. Dr. Henderson has been properly served with this complaint.

98. Dr. Henderson has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

99. At all times relevant to this complaint, Dr. Henderson acted as an employee or other agent of one or more of the Corporate Defendants: Wellstar Health, Wellstar Medical, Kennestone, Atlanta Medical, and/or South Fulton Emergency.

100. As Dr. Henderson's employer(s) or other principal(s) at the time of his negligence, one or more of the Corporate Defendants is/are vicariously liable

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[3] Plaintiff hereby intends to name the "Dr. Henderson" identified in Hospital records as being involved treating Waymon Storey on December 23, 2021. Upon information and belief, that physician was Dr. Vernon Henderson. If the "Dr. Henderson" identified in Hospital records was actually another person, that person is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against him. In that case, Plaintiff will also dismiss the allegations and claims herein asserted against Dr. Vernon Henderson and his Estate.

for his negligence, because he was acting within the scope of his employment or agency at that time.

101. If another entity acted as the employer or other principal of Dr. Henderson during that time, 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.

102. **Defendant ESTATE OF VERNON HENDERSON** is hereby named as a Defendant in the alternative to Dr. Henderson, based on the allegations herein pled against Dr. Henderson.

103. Upon information and belief, Dr. Vernon Henderson passed away prior to the filing of this lawsuit, likely on or about February 22, 2023.

104. Upon information and belief, Susan Henderson, Dr. Henderson's surviving spouse, serves as the representative of the Estate of Vernon Henderson.

105. Susan Henderson resides at 2134 Spencers Way, Stone Mountain, GA 30306, in DeKalb County.

106. The Estate of Vernon Henderson is subject to the personal jurisdiction of this Court.

107. The Estate of Vernon Henderson is subject to the subject-matter jurisdiction of this Court in this case.

108. Pursuant to OCGA § 9-10-31, the Estate of Vernon Henderson is subject to venue in this Court, because at least one of its co-defendants is directly subject to venue here.

109. The Estate of Vernon Henderson has been properly served with this complaint.

110. The Estate of Vernon Henderson has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

111. **Defendant MORNING STRICKLAND, RN,** is a citizen and resident of Georgia. She resides at 1423 Hartford Avenue SW, Atlanta, GA 30310, in Fulton County.

112. Nurse Strickland is subject to the personal jurisdiction of this Court.

113. Nurse Strickland is subject to the subject-matter jurisdiction of this Court in this case.

114. Pursuant to OCGA § 9-10-31, Nurse Strickland is subject to venue in this Court, because at least one of her co-defendants is directly subject to venue here.

115. Nurse Strickland has been properly served with this complaint.

116. Nurse Strickland has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

117. At all times relevant to this complaint, Nurse Strickland acted as an employee or other agent of one of more of the Corporate Defendants: Wellstar Health, Wellstar Medical, Kennestone, Atlanta Medical, and/or South Fulton Emergency.

118. As Nurse Strickland's employer(s) or other principal(s) at the time of her negligence, one or more of the Corporate Defendants is/are vicariously liable for her negligence, because she was acting within the scope of her employment or other agency at that time.

119. If another entity acted as the employer or other principal of Nurse Strickland during that time, 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.

120. **Defendant JESSICA ASTRELLA, RN (formerly known as Jessica Kainer),** is a citizen and resident of Georgia. She resides 619 Stoneview Drive, Canton, GA 30115, in Cherokee County.

121. Nurse Astrella is subject to the personal jurisdiction of this Court.

122. Nurse Astrella is subject to the subject-matter jurisdiction of this Court in this case.

123. Pursuant to OCGA § 9-10-31, Nurse Astrella is subject to venue in this Court, because at least one of her co-defendants is directly subject to venue here.

124. Nurse Astrella has been properly served with this complaint.

125. Nurse Astrella has no defense to this lawsuit based on undue delay—whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

126. At all times relevant to this complaint, Nurse Astrella acted as an employee or other agent of one or more of the Corporate Defendants.

127. As Nurse Astrella's employer(s) or other principal(s) at the time of her negligence, one or more of the Corporate Defendants is/are vicariously liable for her negligence, because she was acting within the scope of her employment or other agency at that time.

128. If another entity acted as the employer or other principal of Nurse Astrella during that time, 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.

129. **JOHN/JANE DOES 1-10** are those yet-unidentified natural and legal persons who may be wholly or partly liable for the damages alleged here.

130. Once served with process, John/Jane Does 1-10 are subject to the jurisdiction and venue of this Court.

General Notice of Claims

131. Pursuant to OCGA § 9-11-18 and OCGA § 9-11-9.1, Plaintiff hereby provides general and sufficient notice of her claims against the Defendants.

Professional Negligence: Dr. Salazar and Corporate Defendants

132. At all times relevant hereto, Dr. Richisa Salazar (formerly known as Dr. Richisa Hamilton) was a physician engaged in the practice of medicine in the State of Georgia.

133. On December 23, 2021, Dr. Salazar entered into a physician-patient relationship with Waymon Storey.

134. Dr. Salazar thus had a duty to provide care to Mr. Storey within the applicable standard of care.

135. Dr. Salazar failed to comply with the applicable standard of care in the care she provided to Mr. Storey.

136. At all times relevant hereto, Dr. Salazar was an employee or other agent of one or more of the Corporate Defendants, and was acting within the course and scope of her employment or other agency.

137. One or more of the Corporate Defendants are therefore liable for Dr. Salazar's failures to comply with the applicable standard of care.

Professional Negligence: Dr. Ramsay and Corporate Defendants

138. At all times relevant hereto, Dr. Philip Ramsay was a physician engaged in the practice of medicine in the State of Georgia.

139. On December 23, 2021, Dr. Ramsay entered into a physician-patient relationship with Waymon Storey.

140. Dr. Ramsay thus had a duty to provide care to Mr. Storey within the applicable standard of care.

141. Dr. Ramsay failed to comply with the applicable standard of care in the care he provided to Mr. Storey.

142. At all times relevant hereto, Dr. Ramsay was an employee or other agent of one or more of the Corporate Defendants, and was acting within the course and scope of his employment or other agency.

143. One or more of the Corporate Defendants are therefore liable for Dr. Ramsay's failures to comply with the applicable standard of care.

Professional Negligence: Dr. Henderson and Corporate Defendants

144. At all times relevant hereto, Dr. Vernon Henderson was a physician engaged in the practice of medicine in the State of Georgia.

145. On December 23, 2021, Dr. Henderson entered into a physician-patient relationship with Waymon Storey.

146. Dr. Henderson thus had a duty to provide care to Mr. Storey within the applicable standard of care.

147. Dr. Henderson failed to comply with the applicable standard of care in the care he provided to Mr. Storey.

148. At all times relevant hereto, Dr. Henderson was an employee or other agent of one or more of the Corporate Defendants, and was acting within the course and scope of his employment or other agency.

149. One or more of the Corporate Defendants are therefore liable for Dr. Henderson's failures to comply with the applicable standard of care.

Professional Negligence: Nurse Strickland and Corporate Defendants

150. At all times relevant hereto, Nurse Morning Strickland was a registered nurse engaged in the practice of nursing in the State of Georgia.

151. On December 23, 2021, Nurse Strickland entered into a nurse-patient relationship with Waymon Storey.

152. Nurse Strickland thus had a duty to provide care to Mr. Storey within the applicable standard of care.

153. Nurse Strickland failed to comply with the applicable standard of care in the care she provided to Mr. Storey.

154. At all times relevant hereto, Nurse Strickland was an employee or other agent of one or more of the Corporate Defendants, and was acting within the course and scope of her employment or other agency.

155. One or more of the Corporate Defendants are therefore liable for Nurse Strickland's failures to comply with the applicable standard of care.

Professional Negligence: Nurse Astrella and Corporate Defendants

156. At all times relevant hereto, Nurse Jessica Astrella (formerly known as Jessica Kainer) was a registered nurse engaged in the practice of nursing in the State of Georgia.

157. On December 23, 2021, Nurse Astrella entered into a nurse-patient relationship with Waymon Storey.

158. Nurse Astrella thus had a duty to provide care to Mr. Storey within the applicable standard of care.

159. Nurse Astrella failed to comply with the applicable standard of care in the care she provided to Mr. Storey.

160. At all times relevant hereto, Nurse Astrella was an employee or other agent of one or more of the Corporate Defendants, and was acting within the course and scope of her employment or other agency.

161. One or more of the Corporate Defendants are therefore liable for Nurse Astrella's failures to comply with the applicable standard of care.

OCGA § 9-11-9.1 Affidavit Requirements

162. Pursuant to OCGA § 9-11-9.1, the affidavit of Emergency Medicine Physician Keith Borg, an expert witness competent to testify as to the standard of care required of Dr. Salazar, is attached as Exhibit 1.

163. Pursuant to OCGA § 9-11-9.1, the affidavit of Surgeon Rohit Sharma, an expert witness competent to testify as to the standard of care required of Dr. Ramsay, Dr. Henderson, and other trauma surgeons, is attached as Exhibit 2.

164. Pursuant to OCGA § 9-11-9.1, the affidavit of Nurse Chrissy White, an expert witness competent to testify as to the standard of care required of Nurse Strickland, Nurse Astrella, and other nurses, is attached as Exhibit 3.

165. Pursuant to OCGA § 9-11-9.1, the affidavit of Internist Jonathan Schwartz, a witness competent to testify as to a standard of care required of the Individual Defendants and other providers, is attached as Exhibit 4.

Administrative Negligence: Corporate Defendants

166. Plaintiff here incorporates by reference all paragraphs of this complaint.

167. Each of the Corporate Defendants owed ordinary duties of care to Waymon Storey.

168. Each of the Corporate Defendants breached those duties.

169. Each of the Corporate Defendants are directly liable for the breach of those duties.

170. Each of the Corporate Defendants breached those duties through the acts and omissions of administrators not licensed for the professions listed in OCGA § 9-11-9.1(g).

171. Each of the Corporate Defendants breached those duties through the acts and omissions of professional staff performing purely administrative tasks.

172. Negligent administration by Corporate Defendants created unnecessary and unreasonable potential for medical error by providers involved in the care of Waymon Storey.

173. Negligently administered systems and organizational cultures facilitated, rather than prevented, individual medical error.

174. By violating its duties of ordinary care, each of the Corporate Defendants harmed Waymon Storey.

175. The administrators directly responsible for the negligent administration were employees or servants, or actual or ostensible agents, of one or more of the Corporate Defendants.

176. The Corporate Defendants are thus vicariously liable for the ordinary negligence of those administrators.

177. As the direct and proximate result of the negligence alleged herein, Waymon Storey experienced pain, suffering, injury, and death.

178. As the direct and proximate result of the negligence alleged herein, Plaintiff and her family experienced pain, suffering, severe emotional distress, and other damages.

179. Plaintiff is thus entitled to survival and wrongful-death damages in excess of $10,000, in an amount to be proved at trial.

180. Wherefore, Plaintiff respectfully demands judgments against the Defendants for money damages in an amount in excess of $10,000, together with the costs of this action and such other and further relief as is just and proper.

Note on Notice Pleading

Herein, statements not in enumerated paragraphs require no response from Defendants.

The above "General Notice" suffices to plead this case. In keeping with the overriding goal of the Civil Practice Act ("to secure the just, speedy, and inexpensive determination of every action"),[4] the detailed allegations below are presented to provide further notice, narrow disputes, and simplify discovery and trial.

Nevertheless, Plaintiff does not waive Georgia's notice-pleading requirements, or assume any obligation to provide more than the general notice required by law.[5]

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[4] *See* OCGA § 9-11-1.

[5] *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).

Additional Notice of Claims

Professional Negligence

Claim 1 – Failure to Recognize Significance of Trauma

181. Plaintiff here incorporates by reference all paragraphs of this complaint.

182. Under the circumstances present in this case, the standard of care requires an ED physician to recognize the severity of the patient's chest trauma and its implications for the patient's ability to maintain ventilation.

183. Specifically, the standard of care requires an ED physician to recognize that the patient's chest trauma has already impaired the patient's ability to ventilate and may soon result in respiratory failure.

184. On December 23, 2021, Dr. Richisa Salazar violated these requirements, by failing to recognize that Mr. Storey had suffered serious chest injuries in a rollover car accident and that the trauma had already impaired his ability to maintain ventilation and could soon result in respiratory failure.

185. Because Dr. Salazar failed to recognize the extent and significance of Mr. Storey's chest trauma, Dr. Salazar also failed to include chest trauma, hypoventilation, or hypoxia among her differential diagnoses.

186. Dr. Salazar then also failed to obtain a chest x-ray, which would have assisted in identifying the extent of Mr. Storey's chest injuries.

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

    a. Mr. Storey had just survived a rollover car accident, requiring extrication from a 2-foot vehicular intrusion.

    b. Mr. Storey presented to the ED with obvious traumatic injuries, including visible bone depressions over his sternum and ribs.

c. Mr. Storey presented to the ED with severe hypoxemia—with a critically low oxygen-saturation level.

d. Mr. Storey's oxygen reserves were thus likely depleted by the time he arrived.

e. Mr. Storey had other independent and observable risk-factors for hypoventilation and hypoxia, including his weight and body-mass index.

f. Mr. Storey had a lower tolerance for hypoxia, given such risk-factors.

g. On route to the Hospital, Mr. Storey repeatedly asked EMS to be sat up, suggesting he had positional hypoxia.

h. Consistent with his worsening hypoxia and respiratory effort, Mr. Storey presented to the ED in severe pain and distress.

i. Once at the ED, Mr. Storey's hypoxia did not improve "despite non rebreather mask application."

j. Instead, as his "dyspnea progressed," Mr. Storey's mental status "rapidly declined," from a GCS-score of 15 to 3.

k. As his hypoxia worsened, the trauma team gave Mr. Storey an antipsychotic.

188. With such evidence, an ED physician should readily recognize that the patient's chest trauma has put him at impending risk of losing his ability to breathe.

189. Nothing is more basic to the job of an ED physician than recognizing that a patient is losing the ability to breathe.

190. In fact, in a healthcare provider's encounter with a trauma patient, the provider must immediately assess the patient's ABCs—airway, breathing, and circulation.

191. By failing to recognize that Mr. Storey was losing his ability to breathe, Dr. Salazar deviated from the standard of care.

192. In fact, she deviated grossly from that standard of care.

193. By failing to recognize something as basic as a patient's failing ability to breathe, Dr. Salazar also failed to exercise even slight diligence as an ED physician.

194. Had she exercised even slight diligence, Dr. Salazar would have readily recognized that Mr. Storey's chest trauma had already put him at impending risk of losing his ability to maintain ventilation.

195. Had Dr. Salazar met the standard of care, the trauma team likely would have provided Mr. Storey the ventilation and oxygenation he needed, well before his hypoxia could result in respiratory arrest, much less death.

196. Had Dr. Salazar recognized the extent of Mr. Storey's trauma and its clinical implications, she herself (or others on the trauma team) would have performed an earlier intubation, promptly after his arrival—in a more-controlled setting, with a high probability of obtaining a definitive airway.

197. With a definitive airway in place, the trauma team then would have easily provided Mr. Storey the ventilation that was required to reverse his hypoxia.

198. As a result, Mr. Storey likely would have returned to normoxia within minutes of his arrival— before he could experience respiratory arrest, much less death.

199. Dr. Salazar's failure to recognize the clinical significance of Mr. Storey's presentation was thus a cause of his respiratory arrest, cardiac arrest, and death.

200. Dr. Salazar's failure was also a cause of the pain and suffering Mr. Storey likely endured as he gradually died from oxygen-deprivation—in the hands of a trauma team, at a major trauma center.

Claim 2: Failure to Intubate Patient

201. Plaintiff here incorporates by reference all paragraphs of this complaint.

202. Under the circumstances present in this case, because the patient's ability to maintain ventilation is impaired before he arrives at the hospital, the standard of care requires an ED physician to perform an intubation on the patient promptly upon the patient's arrival.

203. In light of the patient's clinical presentation, the standard of care requires an ED physician to seize upon the potentially-narrow window of time to perform the intubation.

204. In this setting, early recognition and intervention increase the chance of success, while decreasing the risk that a crash intubation will be needed.

205. For these reasons, upon receiving a trauma alert while the patient is on route, the standard of care also requires an ED physician to prepare the trauma team to perform an early intubation promptly upon the patient's arrival.

206. On December 23, 2021, Dr. Salazar violated these requirements, by failing to intubate Mr. Storey promptly after he arrived at the Hospital ED.

207. Instead, because Dr. Salazar failed to intubate him promptly upon arrival, Mr. Storey decompensated further, forcing Dr. Salazar to attempt an emergent intubation in the uncontrolled setting of cardiac arrest.

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

    a. Mr. Storey had just survived a rollover car accident, requiring extrication from a 2-foot vehicular intrusion.

    b. Mr. Storey presented to the ED with obvious traumatic injuries, including visible bone depressions over his sternum and ribs.

    c. Mr. Storey's prehospital oxygen-saturation level was critically low.

    d. Mr. Storey's oxygen reserves were thus likely depleted by the time he arrived.

    e. Mr. Storey had other independent and observable risk-factors for hypoventilation and hypoxia, including his weight and body-mass index.

f. Mr. Storey had a lower tolerance for hypoxia, given such risk-factors.

g. Mr. Storey was in severe distress on route to the Hospital.

h. Nevertheless, Mr. Storey had a GCS score of 15 at the time of arrival.

i. Generally, a competent ED physician can perform an intubation rapidly, even on a difficult patient.

209. Nothing is more basic to the job of an ED physician than securing a patient's airway.

210. Because Dr. Salazar failed to intubate him promptly upon his arrival at the ED, Mr. Storey's ability to maintain ventilation diminished and failed, resulting in respiratory arrest.

211. By failing to intubate him promptly upon his arrival, Dr. Salazar thus deviated from the standard of care.

212. In fact, she deviated grossly from the standard of care.

213. By failing to intubate him promptly after his arrival, Dr. Salazar also failed to exercise even slight diligence as an ED physician.

214. Had Dr. Salazar exercised even slight diligence, she would have prepared to intubate Mr. Storey when he was on route to the Hospital, and she would have then started intubation upon his arrival.

215. The fact that his heart still had pulseless electrical activity (PEA) when it arrested strongly suggests that Mr. Storey had hypoxic cardiac arrest.

216. Had Dr. Salazar intubated Mr. Storey promptly upon his arrival, the trauma team would have quickly provided him the ventilation required to reverse his hypoxia.

217. As a result, Mr. Storey likely would have returned to normoxia within minutes of his arrival—before he could experience respiratory failure, much less hypoxic cardiac arrest and death.

218. Dr. Salazar's failure to intubate Mr. Storey promptly upon his arrival was thus a cause of his respiratory arrest, cardiac arrest, and death.

219. Dr. Salazar's failure was also a cause of the pain and suffering Mr. Storey likely endured as he gradually died from oxygen-deprivation—in a major trauma center, in the hands of a host of healthcare providers.

Claim 3: Failure to Use Supraglottic Device

220. Plaintiff here incorporates by reference all paragraphs of this complaint.

221. Under the circumstances present in this case, when intubation proves unsuccessful or difficult, the standard of care alternatively requires an ED physician to utilize a supraglottic device to establish an airway on the patient.

222. This requirement is critical when the patient has coded after an extended period of hypoxia, and when every minute that passes may therefore make a difference between life and death.

223. On December 23, 2021, Dr. Salazar violated this requirement, by failing to utilize a supraglottic device to establish an airway on Mr. Storey—even after intubation proved unsuccessful and difficult.

224. On December 23, 2021, Dr. Salazar violated this requirement, by attempting to intubate Mr. Storey "5 or more" times—even after intubation proved unsuccessful and difficult.

225. These violations are all the more egregious for the following reasons:

    a. A supraglottic device is a common, simple, and effective airway adjunct to establish a patient's airway in seconds.

    b. The anatomy of an obese patient can make intubation more challenging than normal.

    c. A supraglottic device is an alternative precisely for challenging intubations.

    d. By the time of the first unsuccessful intubation, Mr. Storey was already in respiratory arrest or imminently in respiratory arrest.

e. It was therefore essential to establish an airway as soon as possible, before the arrest could become irreversible.

226. Nothing is more basic to the job of an ED physician than establishing a patient's airway.

227. Here, because Dr. Salazar failed to utilize a supraglottic device, she failed to establish an airway during the time available to save Mr. Storey's life.

228. Dr. Salazar thus deviated from the standard of care.

229. In fact, she deviated grossly from the standard of care.

230. By failing to utilize a supraglottic device, Dr. Salazar also failed to exercise even slight diligence as an ED physician.

231. Had she exercised even slight diligence, Dr. Salazar would have promptly used a supraglottic device—right after intubation first failed or proved difficult.

232. Instead, Dr. Salazar attempted "5 or more" intubations over an extended period of time.

233. Had Dr. Salazar promptly utilized a supraglottic device, the trauma team likely would have ventilated and oxygenated Mr. Storey, reversing his hypoxia.

234. In turn, because Mr. Storey was in hypoxic arrest, the trauma team likely would have resuscitated Mr. Storey, preventing his death.

235. Dr. Salazar's failure to utilize a supraglottic device was thus a cause of Mr. Storey's death.

Claim 4: Failure to Place Surgical Airway

236. Plaintiff here incorporates by reference all paragraphs of this complaint.

237. Under the circumstances present in this case, when the ED physician is otherwise unable to establish an airway, the standard of care alternatively requires the ED physician to emergently place a surgical airway on the patient by performing a cricothyrotomy.

238. This requirement is critical when (a) the patient has received a sedative and paralytic, (b) the patient has arrested after an extended period of hypoxia, and (c) every minute may therefore represent the difference between life and death for the patient.

239. On December 23, 2021, Dr. Salazar violated this requirement, by failing to place a surgical airway on Mr. Storey, promptly after intubation failed.

240. Nothing is more basic to the job of an ED physician than securing a patient's airway.

241. Here, because Dr. Salazar failed to place a surgical airway, the trauma team failed to secure Mr. Storey's airway during the time available to save his life.

242. By failing to place a surgical airway, Dr. Salazar thus deviated from the standard of care.

243. In fact, she deviated grossly from the standard of care.

244. By failing to obtain a surgical airway, Dr. Salazar also failed to exercise even slight diligence as an ED physician.

245. Had she exercised even slight diligence, she would have emergently placed a surgical airway on Mr. Storey—immediately after intubation failed.

246. Instead, Dr. Salazar attempted intubation "5 or more" times.

247. Had Dr. Salazar promptly placed a surgical airway, the trauma team likely would have provided Mr. Storey the ventilation and oxygenation he needed, reversing the hypoxia that led to his cardiac arrest in the first place.

248. In turn, the trauma team likely would have resuscitated Mr. Storey, preventing his death.

249. Dr. Salazar's failure to place a surgical airway was thus a cause of Mr. Storey's death.

Claim 5: Failure to Secure Airway

250. Plaintiff here incorporates by reference all paragraphs of this complaint.

251. Under the circumstances present in this case, when the ED physician is unable to establish an airway promptly, the standard of care requires the on-call trauma surgeon and any other trauma surgeon at bedside to secure the patient's airway emergently, either by intubating the patient or by placing a surgical airway.

252. On December 23, 2021, insofar as they were on-call or at bedside, Dr. Phillip Ramsay, Dr. Vernon Henderson, and possibly other trauma surgeons violated these requirements, by failing to secure Mr. Storey's airway emergently, immediately after Dr. Richisa Salazar, the ED physician, was unable to do so.

253. Nothing is more fundamental to the job of a trauma surgeon than securing a patient's airway.

254. Here, the trauma surgeons failed to secure Mr. Storey's airway during the window of time available to save his life.

255. By failing to secure Mr. Storey's airway under those circumstances, these trauma surgeons deviated from the standard of care.

256. In fact, they deviated grossly from the standard of care.

257. By failing to secure Mr. Storey's airway, these surgeons also failed to exercise slight diligence as trauma surgeons.

258. Had they exercised slight diligence, these surgeons would have emergently secured Mr. Storey's airway—as soon as it became clear that Dr. Salazar was unable to do so.

259. Instead, Dr. Salazar attempted intubation "5 or more" times, even as and after the window to save Mr. Storey's life closed.

260. Had even one of these surgeons secured Mr. Storey's airway, Mr. Storey would have received the ventilation and oxygenation he needed, likely reversing the hypoxia that led to his cardiac arrest in the first place.

261. In turn, the trauma team likely would have resuscitated Mr. Storey, preventing his death.

262. Each failure to secure Mr. Storey's airway thus contributed to his death.

Claim 6: Failure to Monitor Vitals

263. Plaintiff here incorporates by reference all paragraphs of this complaint.

264. Under the circumstances present in this case, the standard of care requires a hospital nurse attending to the patient to monitor, report, and document the patient's vital signs—at least every 5 minutes for the first 30 minutes after the patient arrives.

265. The required vital signs include the patient's temperature, heart rate, respiratory rate, blood pressure, and oxygen saturation (SpO2 level).

266. The purpose of closely monitoring the patient is early detection of any clinical deterioration, to provide appropriate treatment or intervention without delay.

267. On December 23, 2021, according to Hospital records, Nurse Morning Strickland, Nurse Jessica Kainer, and possibly other nurses at the Hospital's ED each violated these requirements, by failing to monitor Mr. Storey's vitals as required, from the time of his arrival until he coded. Hospital nurses thus repeatedly violated the standard of care.

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

    a. Mr. Storey had just survived a rollover car accident, requiring extrication from a 2-foot vehicular intrusion.

    b. Mr. Storey presented to the ED with severe hypoxemia—with a critically low oxygen-saturation level.

c. Mr. Storey had other independent and observable risk-factors for hypoventilation and hypoxia, including his weight and body-mass index.

d. Mr. Storey was in severe pain and distress upon his arrival at the ED.

e. Mr. Storey had obvious traumatic injuries, including bone depressions in his sternum and ribs.

269. Because monitoring a patient's vitals enables early detection of clinical deterioration, nothing is more basic to the job of a nurse than monitoring a patient's vitals.

270. By failing to monitor Mr. Storey's vitals as required, Nurse Strickland, Nurse Kainer, and possibly other Hospital nurses deviated from the standard of care.

271. In fact, they deviated grossly from the standard of care.

272. By failing to monitor Mr. Storey's vitals as required, these nurses also failed to exercise even slight diligence.

273. Had they exercised even slight diligence, they would have monitored Mr. Storey's vitals as required.

274. Had Nurse Strickland, Nurse Kainer, or another Hospital nurse monitored, reported, and documented Mr. Storey's vitals as required, his vitals (especially his oxygen saturation and respiratory rate) likely would have alerted the trauma team that Mr. Storey's hypoxia was rapidly worsening.

275. So alerted, the trauma team then likely would have recognized that Mr. Storey's already-impaired ability to maintain ventilation was diminishing quickly.

276. As a result, the trauma team likely would have intubated Mr. Storey without delay—before his hypoxia resulted in respiratory arrest, much less death.

277. Each failure to monitor Mr. Storey's vitals thus contributed to his respiratory arrest, cardiac arrest, and death.

278. Each such failure was also a cause of the pain and suffering he likely experienced as he gradually died from oxygen-deprivation—in a major trauma center, in the hands of healthcare providers.

Claim 7: Failure to Document

279. Plaintiff here incorporates by reference all paragraphs of this complaint.

280. Under the circumstances present in this case, the standard of care requires the physicians, nurses, and other providers involved in the patient's care to enter clear, complete, and accurate records concerning the care provided to the patient.

281. Under these circumstances, the standard of care also requires the physicians and nurses to enter such records promptly.

282. These documentation requirements serve a clinical purpose beyond merely memorializing information.

283. Especially here, the required documentation informs and drives clinical decision-making, in a setting where fast and accurate communications are essential for patient care and safety.

284. These requirements, for example, help ensure that providers work in a coordinated and effective fashion.

285. In short, these requirements help optimize outcomes, prevent adverse long-term consequences, and safeguard patient safety.

286. In December 2021, physicians and nurses who cared for Mr. Storey at the Hospital violated these requirements, by entering records that are unclear, incomplete, and incongruent.

287. For example, the records concerning oxygen delivery omit or confuse important facts, such as the time and the rate at which oxygen was administered.

288. Likewise, the records of the attempted intubations document at most two of the "5 or more" intubation attempts, without noting information about the other attempts.

289. The providers who violated these requirements include Dr. Richisa Salazar, Dr. Philip Ramsay, Nurse Morning Strickland, and Nurse Jessica Kainer, and may also include Dr. Naqeeb Faroqui, physicians identified in the records as "Dr. Henderson" and "Dr. Anderson," Nurse Wendy Tribble, Nurse Joshua Willis, RCP Jacob Byrd, and others.

290. The physicians and nurses also violated these documentation requirements, by failing to enter records promptly.

291. The deficiencies in these Hospital records are far from trivial or immaterial.

292. On the contrary, they are of a degree rarely seen in hospital records, particularly records from a major trauma center concerning a patient who died there.

293. These violations were thus a gross departure from the standard of care.

Additional Notice of Claims

Administrative Negligence

Negligence, Not Professional Malpractice

294. Georgia law recognizes that ordinary negligence in the form of negligent administration can contribute to a chain of events that includes harmful medical malpractice.[6]

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[6] *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*

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

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

297. Georgia courts have not catalogued every purely administrative task or duty that exists in a hospital.

298. Plaintiff's 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.

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

300. 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.

301. To the extent trial and appellate courts ultimately determine that any particular act constituted professional malpractice as defined in OCGA § 9-11-9.1, Plaintiff stipulates that the act does not support a claim for ordinary negligence.

Non-Licensed Administrators

302. At all times relevant to this action, one or more of the Corporate Defendants was responsible for managing, operating, and/or administering the Hospital.

Health v. Copeland, 352 Ga. App. 233 (2019) (affirming verdict for both ordinary negligence and professional negligence against skilled nursing facility).

303. 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").

304. Non-Licensed Administrators at the Hospital had responsibilities that impacted the safety of patients, including Waymon Storey.

305. Non-Licensed Administrators at the Hospital negligently failed in such duties, thereby causing harm to Waymon Storey and his family.

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

Licensed Administrators Acting in Purely Administrative Capacity

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

308. Licensed Administrators had purely administrative responsibilities that impacted the safety of patients, including Waymon Storey.

309. Licensed Administrators negligently failed in such purely administrative duties, thereby causing injury to Waymon Storey and his family.

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

Healthcare Administration Generally

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

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

313. 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

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

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

316. 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 to any patient.

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

Management or Administration as a Distinct Discipline

318. 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.

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

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

321. 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 have undergone certain training.

Non-Licensed Administrators and Patient Safety

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

323. 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.

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

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

326. 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

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

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

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

330. 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.

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

332. 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.

333. 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.

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

335. 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

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

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

338. 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.

Claim 8: Negligent Administration Claim

339. Through the negligent acts and omissions of administrators, one or more of the Corporate Defendants breached duties of care owed to Waymon Storey, causing him pain, suffering, injury, and death.

340. Through the negligent acts and omissions of administrators, one or more of the Corporate Defendants breached duties of care owed to Waymon Storey's family, causing them pain and suffering.

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

First Example of Negligent Administration

342. Plaintiff here incorporates by reference all paragraphs of this complaint.

343. Administrators owe patients and their families duties to treat patients with dignity and respect.

344. In December 2021, after negligence had caused Mr. Storey's death, Hospital administrators breached these additional duties, by failing to treat Mr. Storey's body with dignity and respect.

345. Instead of refrigerating his body as required by law, Hospital administrators permitted his body to decompose for over three days, at room temperature.

346. On December 23, 2021, after being examined by County Medical Examiner Will Anderson, Mr. Storey's body "was transported to the AMC hospital morgue for storage until transport to the Georgia Bureau of Investigation Headquarters Medical Examiner's Office for examination." CCA 3-4.

> The body was documented with photographs, which were uploaded to CODIMS. The body was transported to the AMC hospital morgue for storage until transport to the Georgia Bureau of Investigation Headquarters

> Medical Examiner's Office for examination. Next-of-kin in this case is the decedent's wife, Tenika Storey (678-790-9844). This MEI left the scene at 1848 hours.

CCA 3-4.

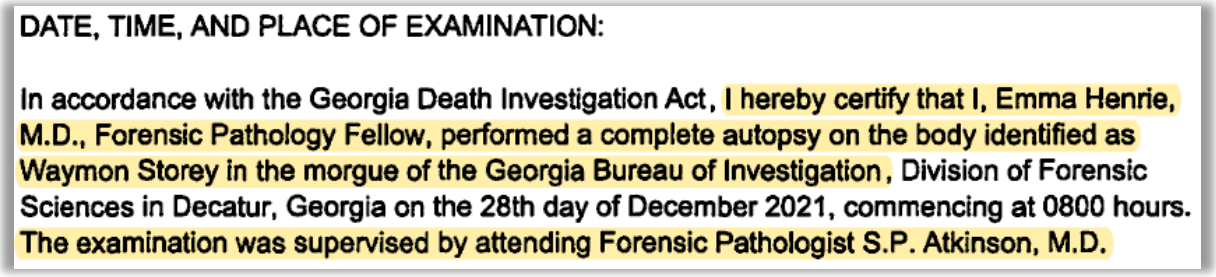
347. On December 27, 2021, at approximately 07:47, the GBI's Division of Forensic Sciences received Mr. Storey's body from the Hospital, as "evidence." GBA 1, GBA 5, CCA 5.

> **Case Individuals:**
> Victim: Waymon Marcel Storey
>
> **Evidence:**
> On 12/27/2021, the laboratory received the following evidence from the Clayton Co. Coroner.
> 2021-1040025-001 DECEDENT

GBA 1.

348. On December 28, 2021, under the supervision of Associate Medical Examiner Steven P. Atkinson, Forensic Pathology Fellow Emma Henrie, MD, "performed

a complete autopsy on the body identified as Waymon Storey in the morgue of the Georgia Bureau of Investigation." GBA 1, GBA 5.



DATE, TIME, AND PLACE OF EXAMINATION:

In accordance with the Georgia Death Investigation Act, I hereby certify that I, Emma Henrie, M.D., Forensic Pathology Fellow, performed a complete autopsy on the body identified as Waymon Storey in the morgue of the Georgia Bureau of Investigation, Division of Forensic Sciences in Decatur, Georgia on the 28th day of December 2021, commencing at 0800 hours. The examination was supervised by attending Forensic Pathologist S.P. Atkinson, M.D.

GBA 1.

Steven P. Atkinson, MD

Steven P. Atkinson
Associate Medical Examiner

Emma Henrie MD

Emma Henrie
Forensic Pathology Fellow

GBA 5.

349. Mr. Storey's body was decomposed:

a. "Rigor had passed in the upper extremities." GBA 1.

b. "Green discoloration was present over the head and chest with skin slippage." GBA 1.

c. "Approximately 20 ml of red-brown decomposition fluid was in the right pleural cavity and approximately 50 ml of red-brown decomposition fluid was in the left pleural cavity." GBA 3.

d. Mr. Storey's body "was mild to moderately decomposed" as received from the Hospital. GBA 1, GBA 4.

e. "The foul odor of decomposition was also present." GBA 1.

EXTERNAL EXAMINATION:

The mild to moderately decomposed body was received in the supine position in a white plastic transport bag. Identification tags bearing the decedent's name and the moniker "Newcastle, Newcastle" were attached to the zipper and right first toe.

The body was that of a well-developed, obese (body mass index 39.4 kg/m2), Black male that weighed 315 pounds and was 73" in length which appeared the stated age of 53 years. There was a general decrease in body hair on the torso and extremities. The body had been refrigerated and was cold to the touch. Rigor had passed in the upper extremities. Green discoloration was present over the head and chest with skin slippage. The foul odor of decomposition was also present. Injuries to the body will be described below (See "Evidence of Injury").

GBA 1.

See "Evidence of Injury," above. The body was opened by the usual thoraco-abdominal incision and the chest plate was removed. Approximately 20 ml of red-brown decomposition fluid was in the right pleural cavity and approximately 50 ml of red-brown decomposition fluid was in the left pleural cavity. No adhesions were present in any of the body cavities. All body organs were present in the normal anatomical position. The subcutaneous fat layer of the abdominal wall was 3-1/2" thick.

GBA 3.

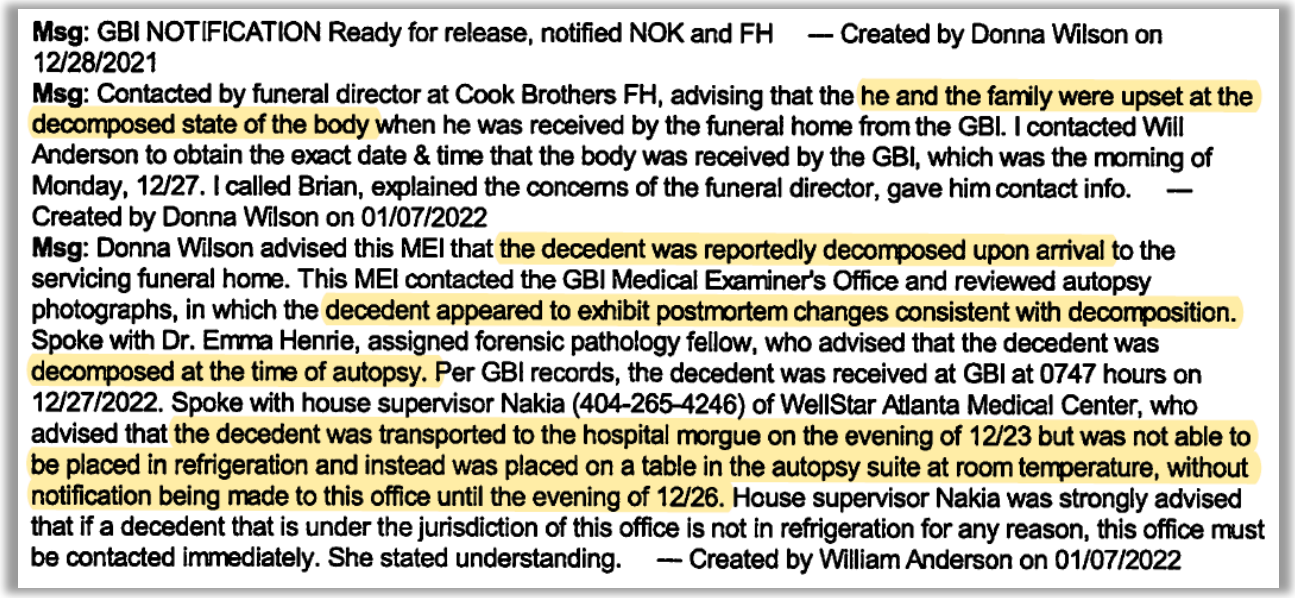
350. After Mr. Storey's body was subsequently transported to Cook Brothers Funeral Home, the funeral director called the GBI, "advising that he and the family were upset at the decomposed state of the body when he was received by the funeral home from the GBI." CCA 5.

351. In investigating that report, Mr. Anderson "contacted the GBI Medical Examiner's Office and reviewed autopsy photographs." CCA 5.

352. The photographs confirmed that "the decedent appeared to exhibit postmortem changes consistent with decomposition." CCA 5.

353. Dr. Henrie advised Mr. Anderson "that the decedent was decomposed at the time of autopsy." CCA 5.

354. Mr. Anderson then "spoke with house supervisor Nakia . . . of Wellstar Atlanta Medical Center." CCA 5.



Msg: GBI NOTIFICATION Ready for release, notified NOK and FH — Created by Donna Wilson on 12/28/2021
Msg: Contacted by funeral director at Cook Brothers FH, advising that the he and the family were upset at the decomposed state of the body when he was received by the funeral home from the GBI. I contacted Will Anderson to obtain the exact date & time that the body was received by the GBI, which was the morning of Monday, 12/27. I called Brian, explained the concerns of the funeral director, gave him contact info. — Created by Donna Wilson on 01/07/2022
Msg: Donna Wilson advised this MEI that the decedent was reportedly decomposed upon arrival to the servicing funeral home. This MEI contacted the GBI Medical Examiner's Office and reviewed autopsy photographs, in which the decedent appeared to exhibit postmortem changes consistent with decomposition. Spoke with Dr. Emma Henrie, assigned forensic pathology fellow, who advised that the decedent was decomposed at the time of autopsy. Per GBI records, the decedent was received at GBI at 0747 hours on 12/27/2022. Spoke with house supervisor Nakia (404-265-4246) of WellStar Atlanta Medical Center, who advised that the decedent was transported to the hospital morgue on the evening of 12/23 but was not able to be placed in refrigeration and instead was placed on a table in the autopsy suite at room temperature, without notification being made to this office until the evening of 12/26. House supervisor Nakia was strongly advised that if a decedent that is under the jurisdiction of this office is not in refrigeration for any reason, this office must be contacted immediately. She stated understanding. — Created by William Anderson on 01/07/2022

CCA 5.

355. Supervisor Nakia admitted "that the decedent was transported to the hospital morgue on the evening of 12/23 **but was not able to be placed in refrigeration and instead was placed on a table in the autopsy suite at room temperature** . . . until the evening of 12/26." CCA 5 (emphasis added).

356. Mr. Storey's body thus lay abandoned and decomposing on a table at Wellstar Atlanta Medical Center for over three full days. CCA 5.

Second Example of Negligent Administration

357. Plaintiff here incorporates by reference all paragraphs of this complaint.

358. Administrators owe patients and their families duties to create, implement, promulgate, and enforce protocols that are necessary to reasonably ensure patient safety, including a hospital trauma protocol.

359. Administrators also owe patients and their families duties to provide education and training sufficient to ensure that members of the trauma team understand, follow, and comply with the hospital's trauma protocol.

360. Administrators also owe patients and their families duties to regularly organize effective trauma simulations: mock exercises in which team members can improve their clinical skills; the team can enhance its collective ability to deliver organized, coordinated, and timely care; and administrators can identify the providers and workflows required to provide appropriate care in different scenarios.

361. These duties apply with special force at hospitals that are, or hold themselves out to be, major trauma centers, like the Hospital here.

362. These duties apply with special force to major trauma centers, which provide care, or should provide care, through a wide-ranging multi-disciplinary trauma team—like the Hospital here.

363. Here, the trauma team's repeated failures to secure Mr. Storey's airway reveals that Hospital administrators either lacked, or otherwise failed to implement, promulgate, or enforce, a trauma protocol.

364. Here, the repeated failures to secure Mr. Storey's airway even after several physicians were at bedside reveal that Hospital administrators also failed to organize the required team simulations.

365. Had Hospital administrators effectively created, implemented, promulgated, and enforced an effective trauma protocol, Dr. Salazar or others on the trauma team likely would have established an airway on Mr. Storey, promptly after he arrived at the ED—before he could suffer hypoxic cardiac arrest.

366. Had Hospital administrators provided the trauma team the required education and training, Dr. Salazar or another provider likely would have established an airway on Mr. Storey, promptly after he arrived at the ED—before he could suffer hypoxic cardiac arrest.

367. Had Hospital administrators organized effective simulations, the trauma team likely would have secured Mr. Storey's airway, before he could suffer hypoxic cardiac arrest, and even shortly afterward.

368. Had Hospital administrators met the duties outlined above, the trauma team likely would have provided Mr. Storey the ventilation and oxygenation he needed, well before he could experience respiratory arrest, much less death.

369. Each administrative failure thus permitted and likely even enabled the uncoordinated, disorganized, and ineffective care Mr. Storey received.

370. Each administrative failure thus permitted and likely even enabled the failure to secure or even establish an airway.

371. Each administrative failure was thus a cause of Mr. Storey's pain, suffering, injury, and death.

Third Example of Negligent Administration

372. Plaintiff here incorporates by reference all paragraphs of this complaint.

373. As explained above, the standard of care requires healthcare providers to enter clear, complete, accurate, and timely medical records.

374. Documentation informs and drives clinical decision-making downstream.

375. Providers downstream rely upon the clarity, completeness, and accuracy of the medical records they receive.

376. Medical records thus enable clinicians downstream to understand the patient's history, treatment plan, and hospital course, so that those clinicians can provide the patient proper continuity or escalation of care.

377. In short, appropriate documentation is essential to optimizing outcomes, preventing adverse long-term consequences, and safeguarding patient safety.

378. Administrators owe patients and their families duties to create, implement, promulgate, and enforce policies that are necessary to reasonably ensure

patient safety, including policies and guidelines regarding proper documentation.

379. Administrators also owe patients and their families duties to provide education and training sufficient to ensure that clinicians understand, follow, and comply with the hospital's policies and guidelines.

380. Here, as explained above, the Hospital medical records concerning Waymon Storey are unusually unclear, incomplete, and incongruent.

381. The deficient records, moreover, are not limited to one or two providers.

382. Instead, the entire trauma team either entered deficient records or failed altogether to enter records.

383. The deficiencies in these Hospital records are also far from immaterial.

384. They are of a degree rarely seen in hospital records, particularly records from a major trauma center concerning a patient who died there.

385. These pervasive failures to enter records as required reveals that Hospital administrators either lacked, or otherwise failed to implement, promulgate, or enforce, any effective policy or guidelines on proper documentation.

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386. Pursuant to OCGA Title 51, Chapter 4, Plaintiff is entitled to recover from the Corporate Defendants for the harm their negligent administration caused Mr. Storey.

OCGA § 13-6-11 Claims

387. Plaintiff here incorporates by reference all paragraphs of this complaint.

388. Insofar as Plaintiff shows that Defendants have acted in bad faith, have been stubbornly litigious, and have caused Plaintiff unnecessary trouble and

expense, Plaintiff is entitled her expenses of litigation pursuant to OCGA § 13-16-11, including reasonable attorneys' fees.

Prayer for Relief

389. As a direct and proximate result of the Defendants' conduct, Plaintiff is 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 Waymon Storey and Plaintiff suffered, including physical, emotional, and economic injuries.

390. WHEREFORE, Plaintiff demands 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.

November 3, 2023

Respectfully submitted,

/s/ *Lloyd N. Bell*

Lloyd N. Bell
Georgia Bar No. 048800
Daniel E. Holloway
Georgia Bar No. 658026
Mauricio A. Gonzalez
Georgia Bar No. 585841

BELL LAW FIRM
1201 Peachtree St. N.E., Suite 2000
Atlanta, GA 30361
(404) 249-6767 (tel)
bell@BellLawFirm.com
dan@BellLawFirm.com
mauricio@BellLawFirm.com

Attorneys for Plaintiff

Exhibit 1

Affidavit of Keith Borg, MD, PhD, FACEP, Regarding Waymon Storey

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

Introduction

1. This affidavit addresses medical negligence that occurred on December 23, 2021, when 53-year-old Waymon Storey received care at Wellstar Atlanta Medical Center ("AMC" or "Hospital").

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

   a. Plaintiff's 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 Plaintiff's counsel.

   c. Plaintiff's 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 specific matters that Plaintiff's counsel asked me to address. I have not attempted to identify all standard-of-care violations, to state every causation opinion I have, or to anticipate or address issues the Defense may raise or that otherwise might 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 use the term "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.

6. I hold all the opinions expressed below to a reasonable degree of medical certainty—that is, more likely than not.

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 Plaintiff's 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 Plaintiff's 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.

Qualifications

11. I am more than 18 years of age, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

12. I do not recite all my qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA § 24-7-702. My curriculum vitae, which is attached as Exhibit A, provides further detail about my qualifications. I incorporate and rely on that additional information here.

13. The events at issue here occurred in December 2021.

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

    a. In 2021, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession. Specifically, I was licensed by the states of South Carolina and Wyoming to practice as a physician. That's where I was practicing in 2021.

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

    I had this knowledge and experience from being regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to December 23, 2021, with sufficient frequency to establish an appropriate level of knowledge of the matters my opinions address. Specifically, I am an emergency medicine physician, and for many years I have had great familiarity with each of the tasks on which I offer standard-of-care opinions below.

Evidence Considered

15. I have reviewed the following records pertaining to Waymon Storey: the Wellstar Atlanta Medical Center medical records, the Clayton County Emergency Prehospital Care Report, the Clayton County Death Investigation Report, the Georgia Bureau of Investigation autopsy report, and the Georgia Motor Vehicle Crash Report.

16. I invite the Defense to send me any evidentiary materials or commentary that the Defense believes may help exculpate any Defendant.

Principal Opinions

17. My principal opinions are summarized below. In deposition or trial testimony, I may elaborate upon these principal opinions, thereby also offering related, subsidiary, or incidental opinions. In addition, I may later develop and disclose additional principal opinions for this case.

Failure to Recognize Significance of Trauma

18. *Requirements*: Under the circumstances ascertainable from the records identified above, the standard of care requires an ED physician to recognize the severity of the patient's chest trauma and its implications for the patient's ability to maintain ventilation. Specifically, the standard of care requires an ED physician to recognize that the patient's chest trauma has already impaired the patient's ability to ventilate and may soon result in respiratory failure.

19. *Violations*: On December 23, 2021, Dr. Richisa Hamilton violated these requirements, by failing to recognize that Mr. Storey had suffered serious chest injuries in a rollover car accident and that the trauma had already impaired his ability to maintain ventilation and could soon result in respiratory failure.

    Because Dr. Hamilton failed to recognize the extent and significance of Mr. Storey's chest trauma, Dr. Hamilton also failed to include chest trauma, hypoventilation, or hypoxia among her differential diagnoses. Dr. Hamilton also failed to obtain a chest x-ray, which would have assisted in identifying the extent of Mr. Storey's chest injuries.

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

    a. Mr. Storey had just survived a rollover car accident, requiring extrication from a 2-foot vehicular intrusion.

    b. Mr. Storey presented to the ED with obvious traumatic injuries, including visible bone depressions over his sternum and ribs.

c. Mr. Storey presented to the ED with severe hypoxemia—with a critically low oxygen-saturation level.

d. Mr. Storey's oxygen reserves were thus likely depleted by the time he arrived.

e. Mr. Storey had other independent and observable risk-factors for hypoventilation and hypoxia, including his weight and body-mass index.

f. Mr. Storey had a lower tolerance for hypoxia, given such risk-factors.

g. On route to the Hospital, Mr. Storey repeatedly asked EMS to be sat up, suggesting he had positional hypoxia.

h. Consistent with his worsening hypoxia and respiratory effort, Mr. Storey presented to the ED in severe pain and distress.

i. Once at the ED, Mr. Storey's hypoxia did not improve "despite non rebreather mask application."

j. Instead, as his "dyspnea progressed," Mr. Storey's mental status "rapidly declined," from a GCS-score of 15 to 3.

k. As his hypoxia worsened, the trauma team gave Mr. Storey an antipsychotic.

With such evidence, an ED physician should readily recognize that the patient's chest trauma has put him at impending risk of losing his ability to breathe.

Nothing is more basic to the job of an ED physician than recognizing that a patient is losing the ability to breathe. In fact, in a healthcare provider's encounter with a trauma patient, the provider must immediately assess the patient's ABCs—airway, breathing, and circulation. By failing to recognize that Mr. Storey was losing his ability to breathe, Dr. Hamilton deviated from the standard of care. In fact, she deviated grossly from that standard of care.

By failing to recognize something as basic as a patient's failing ability to breathe, Dr. Hamilton also failed to exercise even slight diligence as an ED physician. Had she exercised even slight diligence, Dr. Hamilton would have readily recognized that Mr. Storey's chest trauma had already put him at impending risk of losing his ability to maintain ventilation.

20. *Causation*: Had Dr. Hamilton met the standard of care, the trauma team likely would have provided Mr. Storey the ventilation and oxygenation he needed, well before his hypoxia could result in respiratory arrest, much less death.

Had Dr. Hamilton recognized the extent of Mr. Storey's trauma and its clinical implications, she herself (or others on the trauma team) would have performed an earlier intubation, promptly after his arrival—in a more-controlled setting, with a high probability of obtaining a definitive airway.

With a definitive airway in place, the trauma team then would have easily provided Mr. Storey the ventilation that was required to reverse his hypoxia. As a result, Mr. Storey likely would have returned to normoxia within minutes of his arrival— before he could experience respiratory arrest, much less death.

Dr. Hamilton's failure to recognize the clinical significance of Mr. Storey's presentation was thus a cause of his respiratory arrest, cardiac arrest, and death. Dr. Hamilton's failure was also a cause of the pain and suffering Mr. Storey likely endured as he gradually died from oxygen-deprivation—in the hands of a trauma team, at a major trauma center.

Failure to Intubate

21. *Requirements*: Under the circumstances ascertainable from the records identified above, because the patient's ability to maintain ventilation is impaired before he arrives at the hospital, the standard of care requires an ED physician to perform an intubation on the patient promptly upon the patient's arrival.

In light of the patient's clinical presentation, the standard of care requires an ED physician to seize upon the potentially-narrow window of time to perform the intubation. In this setting, early recognition and intervention increase the chance of success, while decreasing the risk that a crash intubation will be needed.

For these reasons, upon receiving a trauma alert while the patient is on route, the standard of care also requires an ED physician to prepare the trauma team to perform an early intubation promptly upon the patient's arrival.

22. *Violation*: On December 23, 2021, Dr. Hamilton violated these requirements, by failing to intubate Mr. Storey promptly after he arrived at the Hospital Emergency Department. Instead, because Dr. Hamilton failed to intubate him promptly upon arrival, Mr. Storey decompensated further, forcing Dr. Hamilton to attempt an emergent intubation in the uncontrolled setting of cardiac arrest.

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

a. Mr. Storey had just survived a rollover car accident, requiring extrication from a 2-foot vehicular intrusion.

b. Mr. Storey presented to the ED with obvious traumatic injuries, including visible bone depressions over his sternum and ribs.

c. Mr. Storey's prehospital oxygen-saturation level was critically low.

d. Mr. Storey's oxygen reserves were thus likely depleted by the time he arrived.

e. Mr. Storey had other independent and observable risk-factors for hypoventilation and hypoxia, including his weight and body-mass index.

f. Mr. Storey had a lower tolerance for hypoxia, given such risk-factors.

g. Mr. Storey was in severe distress on route to the Hospital.

h. Nevertheless, Mr. Storey had a GCS score of 15 at the time of arrival.

i. Generally, a competent ED physician can rapidly perform an intubation, even on a difficult patient.

Nothing is more basic to the job of an ED physician than securing a patient's airway. Because Dr. Hamilton failed to intubate him promptly upon his arrival at the ED, Mr. Storey's ability to maintain ventilation diminished and failed, resulting in respiratory arrest. By failing to intubate him promptly upon his arrival, Dr. Hamilton thus deviated from the standard of care. In fact, she deviated grossly from the standard of care.

By failing to intubate him promptly after his arrival, Dr. Hamilton also failed to exercise even slight diligence as an ED physician. Had Dr. Hamilton exercised even slight diligence, she would have prepared to intubate Mr. Storey when he was on route to the Hospital, and she would have then started intubation upon his arrival.

23. *Causation*: The fact that his heart still had pulseless electrical activity (PEA) when it arrested strongly suggests that Mr. Storey had hypoxic cardiac arrest.

Had Dr. Hamilton intubated Mr. Storey promptly upon his arrival, the trauma team would have quickly provided him the ventilation required to reverse his hypoxia. As a result, Mr. Storey likely would have returned to normoxia within minutes of his arrival—before he could experience respiratory failure, much less hypoxic cardiac arrest and death.

Dr. Hamilton's failure to intubate Mr. Storey promptly upon his arrival was thus a cause of his respiratory arrest, cardiac arrest, and death. Dr. Hamilton's failure was also a cause of the pain and suffering Mr. Storey likely endured as he gradually died from oxygen-deprivation—in a major trauma center, in the hands of a host of healthcare providers.

Failure to Establish Airway with Supraglottic Device

24. *Requirement*: Under the circumstances ascertainable from the records identified above, when intubation proves unsuccessful or difficult, the standard of care alternatively requires an ED physician to utilize a supraglottic device to establish an airway on the patient.

This requirement is critical when the patient has coded after an extended period of hypoxia, and when every minute that passes may therefore make a difference between life and death.

25. *Violations*: On December 23, 2021, Dr. Hamilton violated this requirement, by attempting to intubate Mr. Storey "5 or more" times—even after intubation proved unsuccessful or difficult.

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

a. A supraglottic device is a common, simple, and effective airway adjunct to establish a patient's airway in seconds.

b. The anatomy of an obese patient can make intubation more challenging than normal.

c. A supraglottic device is an alternative precisely for challenging intubations.

d. By the time of the first unsuccessful intubation, Mr. Storey was already in respiratory arrest or imminently in respiratory arrest.

e. It was therefore essential to establish an airway as soon as possible, before the arrest could become irreversible.

Nothing is more basic to the job of an ED physician than establishing a patient's airway. Here, because Dr. Hamilton failed to utilize a supraglottic device, she failed to establish an airway during the time available to save Mr. Storey's life. Dr. Hamilton thus deviated from the standard of care. In fact, she deviated grossly from the standard of care.

By failing to utilize a supraglottic device, Dr. Hamilton also failed to exercise even slight diligence as an ED physician. Had she exercised even slight diligence, Dr. Hamilton would have promptly used a supraglottic device—right after intubation first failed or proved difficult. Instead, Dr. Hamilton attempted "5 or more" intubations over an extended period of time.

26. *Causation*: Had Dr. Hamilton promptly utilized a supraglottic device, the trauma team likely would have ventilated and oxygenated Mr. Storey, reversing his hypoxia. In turn, because Mr. Storey was in hypoxic arrest, the trauma team likely would have resuscitated Mr. Storey, preventing his death. Dr. Hamilton's failure to utilize a supraglottic device was thus a cause of Mr. Storey's death.

Failure to Place Surgical Airway

27. *Requirement*: Under the circumstances ascertainable from the records identified above, when an ED physician is otherwise unable to establish an airway, the standard of care alternatively requires the ED physician to emergently place a surgical airway on the patient by performing a cricothyrotomy.

This requirement is critical when (a) the patient has received a sedative and paralytic, (b) the patient has arrested after an extended period of hypoxia, and (c) every minute may therefore represent the difference between life and death.

28. *Violation*: On December 23, 2021, Dr. Hamilton violated this requirement, by failing to place a surgical airway on Mr. Storey, promptly after intubation failed.

Nothing is more basic to the job of an ED physician than securing a patient's airway. Here, because Dr. Hamilton failed to place a surgical airway, the trauma team failed to secure Mr. Storey's airway during the time available to save his life. By failing to place a surgical airway, Dr. Hamilton thus deviated from the standard of care. In fact, she deviated grossly from the standard of care.

By failing to obtain a surgical airway, Dr. Hamilton also failed to exercise even slight diligence as an ED physician. Had she exercised even slight diligence, she would have emergently placed a surgical airway on Mr. Storey—immediately after intubation failed. Instead, Dr. Hamilton attempted intubation "5 or more" times.

29. *Causation*: Had Dr. Hamilton promptly placed a surgical airway, the trauma team likely would have provided Mr. Storey the ventilation and oxygenation he needed, reversing the hypoxia that led to his cardiac arrest in the first place. In turn, the trauma team likely would have resuscitated Mr. Storey, preventing his death. Dr. Hamilton's failure to place a surgical airway was thus a cause of Mr. Storey's death.

Keith Borg, MD, PhD, FACEP

SWORN TO AND SUBSCRIBED before me

OCTOBER 20, 2023

NOTARY PUBLIC

My Commission Expires: 04/22/2024

SAMANTHA MEIER NOTARY PUBLIC COM. EXP. 04-22-2024 SOUTH CAROLINA

Exhibit A

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 ROHIT SHARMA, MD, REGARDING WAYMON STOREY

PERSONALLY APPEARS before the undersigned authority duly authorized to administer oaths Rohit Sharma, MD, who after first being duly sworn states as follows.

Introduction

1. This affidavit addresses medical negligence that occurred on December 23, 2021, when 53-year-old Waymon Storey received care at Wellstar Atlanta Medical Center ("AMC" or "Hospital").

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

   a. Plaintiff's 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 and other records myself.

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

   c. Plaintiff's 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 specific matters that Plaintiff's counsel asked me to address. I have not attempted to identify all standard-of-care violations, to state every causation opinion I have, or to anticipate or address issues the Defense may raise or that otherwise might 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 use the term "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.

6. I hold all the opinions expressed below to a reasonable degree of medical certainty—that is, more likely than not.

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 Plaintiff's 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 Plaintiff's 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.

Qualifications

11. I am more than 18 years of age, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

12. I do not recite all my qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA § 24-7-702. My curriculum vitae, which is attached as Exhibit A, provides further detail about my qualifications. I incorporate and rely on that additional information here.

13. The events at issue here occurred in December 2021.

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

    a. In 2021, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the

profession. Specifically, I was licensed by the State of California to practice as a physician. That's where I was practicing in 2021.

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

I had this knowledge and experience from being regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to December 23, 2021, with sufficient frequency to establish an appropriate level of knowledge of the matters my opinions address. Specifically, I am a trauma surgeon, and for many years I have had great familiarity with each of the tasks on which I offer standard-of-care opinions below.

Evidence Considered

15. I have reviewed the following records pertaining to Waymon Storey: Wellstar Atlanta Medical Center medical records, Clayton County Emergency Prehospital Care Report, Clayton County Death Investigation Report, Georgia Bureau of Investigation autopsy report, and Georgia Motor Vehicle Crash Report.

16. I invite the Defense to send me any evidentiary materials or commentary that the Defense believes may help exculpate any Defendant.

Principal Opinions

17. My principal opinions are summarized below. In deposition or trial testimony, I may elaborate upon these principal opinions, thereby offering related, subsidiary, or incidental opinions. In addition, I may later develop and disclose additional principal opinions for this case.

Failure to Secure Airway

18. *Requirements*: Under the circumstances ascertainable from the records identified above, when the ED physician is unable to establish an airway promptly, the standard of care requires the on-call trauma surgeon and any

other trauma surgeon at bedside to secure the patient's airway emergently, either by intubating the patient or by placing a surgical airway with a cricothyrotomy.

19. *Violations*: On December 23, 2021, insofar as they were on-call or at bedside, Dr. Phillip Ramsey, possibly Dr. Vernon Henderson,[1] and possibly other trauma surgeons violated these requirements, by failing to secure Mr. Storey's airway emergently, immediately after Dr. Richisa Hamilton, the ED physician, was unable to establish an airway.

    Nothing is more basic to the job of a trauma surgeon than securing a patient's airway. Here, the trauma surgeons failed to secure Mr. Storey's airway during the window of time available to save his life. By failing to secure Mr. Storey's airway under those circumstances, these trauma surgeons deviated from the standard of care. In fact, they deviated grossly from the standard of care.

    By failing to secure Mr. Storey's airway, these surgeons also failed to exercise slight diligence as trauma surgeons. Had they exercised slight diligence, these surgeons would have emergently secured Mr. Storey's airway—as soon as it became clear that Dr. Hamilton was unable to establish an airway. Instead, Dr. Hamilton attempted intubation "5 or more" times, even as and after the window to save Mr. Storey's life closed.

20. *Causation*: Had even one of these surgeons secured Mr. Storey's airway, Mr. Storey would have received the ventilation and oxygenation he needed, likely reversing the hypoxia that led to his cardiac arrest in the first place. In turn, the trauma team likely would have resuscitated Mr. Storey, preventing his death. Each failure to secure Mr. Storey's airway thus contributed to his death.

---

[1] The Hospital's medical records identify a "Dr. Henderson" as a physician who was bedside during the time leading up to Mr. Storey's death. I understand that Plaintiff's counsel have investigated the identity of that physician, and have come to the conclusion that he was likely Surgeon Vernon Henderson.

Sharma 10/31/23

Rohit Sharma, MD

SWORN TO AND SUBSCRIBED before me

_____, 2023

PLEASE SEE ATTACHED FOR NOTARIAL FORM

_____

NOTARY PUBLIC

My Commission Expires:

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Santa Barbara)

On October 31st 2023 before me, Corinne Yingling, Notary Public
(insert name and title of the officer)

personally appeared Rohit Sharma,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature Corinne Yingling (Seal)

MGC1 CORINNE YINGLING COMM. # 2434705 NOTARY PUBLIC - CALIFORNIA SANTA BARBARA COUNTY COMM. EXPIRES JAN. 16, 2027 MGC1

Exhibit A

ROHIT SHARMA, M.D. FACS

P.O. BOX 90911, 1221 STATE ST., SUITE 12, SANTA BARBARA, CA 93101-2699
(805) 500-3173 • ROHIT@ROHITSHARMAMD.COM

EDUCATION

August 2006 – May 2010
University of California, Davis School of Medicine
Doctor of Medicine

August 2001 – June 2006
California State University, Northridge
Bachelor of Arts, Biomedical Physics and Biology

POSTGRADUATE TRAINING

July 2015 – June 2016
Harbor-UCLA Medical Center, Torrance, CA
Fellowship - Surgical Critical Care

June 2014 – June 2015
Santa Barbara Cottage Hospital, Santa Barbara, CA
Chief Resident - Surgery

June 2011 – June 2014
Santa Barbara Cottage Hospital, Santa Barbara, CA
Residency - Surgery

June 2010 – June 2011
Santa Barbara Cottage Hospital, Santa Barbara, CA
Internship - Surgery

EMPLOYMENT HISTORY

July 2019 – Present
Telemedicine Intensivist
Lompoc Valley Medical Center, Lompoc, CA

September 2016 – Present
General Surgeon
Santa Barbara County Public Health Dept, Santa Barbara, CA

August 2016 – Present
Associate Trauma Director

Santa Barbara Cottage Hospital, Santa Barbara, CA

August 2016 – Present
Surgical Intensivist
Central Coast Critical Care Associates, Santa Barbara, CA

August 2016 - Present
Acute Care Surgeon
Santa Barbara, CA

BOARD CERTIFICATIONS

American Board of Surgery - General Surgery, 3/9/2016
American Board of Surgery - Surgical Critical Care, 9/12/2016
American Board of Anesthesia - Neurocritical Care Subspecialty, 10/15/2022

LICENSURE

California Medical License – A120300
California Fluoroscopy License - RHC00202751

PUBLICATIONS

Outlaw M., Khurshudyan A., Topping G., Kaminski S., Sharma R., Johnson A. "Increased ketamine-related delirium rates as part of an opiate-sparing protocol in trauma patients." *Accepted to Am Surg, 2023.*

Ganske W, Sharma R, Kaminski S, Johnson A. "Shark-Related Injuries in the United States: A National Trauma Data Bank Analysis." *Am Surg*. 2021 Jun 14:31348211024171. doi: 10.1177/00031348211024171. PMID: 34126790.

St Hilaire, C., Johnson, A., Loseth, C., Alipour, H., Faunce, N., Kaminski, S. and R Sharma. "Facial Fractures After Geriatric Ground-Level Falls Are a Marker of Functional Decline and Warrant Trauma Center Admission." *Am Surg*. 2020 Oct;86(10):1302-1306. doi: 10.1177/0003134820964228. Epub 2020 Oct 19. PMID: 33074742.

Hilaire CS, Johnson A, Loseth C, Alipour H, Faunce N, and R Sharma. "Facial fractures and associated injuries in high- versus low-energy trauma: all are not created equal." *Maxillofac Plast Reconstr Surg* 42, 22 (2020). doi:10.1186/s40902-020-00264-5. PMID: 32601595.

Achamallah N, Fried J, Love R, Matusov Y, and R Sharma. "Pupillary Light Reflex Is Not Abolished by Epinephrine and Atropine Given During Advanced Cardiac Life Support in Patients Who Achieve Return of Spontaneous Circulation." *J Intensive Care Med.* 2020 Feb 18:885066620906802. doi: 10.1177/0885066620906802. PMID: 32066312.

Loseth C, Johnson A, and R Sharma. “Splenic Injury After Colonoscopy.” *CRSLS*. Epub Jan 16, 2020. http://crsls.sls.org/splenic-injury-after-colonoscopy/

M Paisley, A Johnson, S Price, B Chow, L Limon, R Sharma, S Kaminski. “Reversal of Warfarin Anticoagulation in Geriatric Traumatic Brain Injury.” *Trauma Surg Acute Care Open.* 2019;4:e000352. doi:10.1136/tsaco-2019-000352. PMID: 316897435.

Langdon S, Johnson A, and R Sharma. “Debris Flow Syndrome: Injuries and Outcomes After the Montecito Debris Flow.” *Am Surg.* 2019 Oct 1;85(10):1094-1098. PMID: 31657301.

Sharma R, Li J, Johnson A, DeBoard Z, Grotts J, Zikakis I, and S Kaminski. “Race and the Acute Management of Severe Blunt Traumatic Brain Injury.” *Trauma Surg Acute Care Open.* 2019;4:e000358. doi:10.1136/tsaco-2019-000358. PMID: 31565678.

Reddy S, Sharma R, Grotts J, Ferrigno L, and S Kaminski. “Prophylactic Fresh Frozen Plasma Infusion is Ineffective in Reversing Warfarin Anticoagulation and Preventing Delayed Intracranial Hemorrhage After Falls.” *Neurohospitalist*. 2015 Oct; 5(4): 191-196. doi:10.1177/1941874414564981. PMID: 26425246.

Sharma R, Reddy S, Thoman D, Grotts J, and L Ferrigno. “Laparoscopic versus Open Bowel Resection in Emergency Small Bowel Obstruction: Analysis of the National Surgical Quality Improvement Program Database.” *J Laparoendosc Adv Surg Tech A*. 2015. Aug 14; 25(8):625-30. doi: 10.1089/lap.2014.0446. PMID: 26171658.

Reddy S, Sharma R, Grotts J, Ferrigno L, and S Kaminski. “Incidence of Intracranial Hemorrhage and Outcome After Falls in the Geriatric Trauma Patients Taking Pre-Injury Anticoagulants.” *Am Surg*. 2014 Oct; 80(10): 975-8. PMID:25264642

ONGOING TOPICS OF RESEARCH

Colonoscopy screening and detection of colon cancer

Novel anticoagulant reversal strategies

Ketamine induced delirium in trauma patients

Increases in suicide attempts associated with stay-at-home orders due to COVID-19

NTDB analysis of trends in advanced directives limiting care in comorbid elderly trauma patients

“Can we be FASTeR? A multicenter trial utilizing right-sided role to improve sensitivity of the FAST examination.” Multicenter trial. Site coordinator and Investigator.

PROJECTS AND INITIATIVES

REBOA: spearheaded implementation of a Resuscitative Endovascular Balloon Occlusion of the Aorta program for trauma patients in cardiac arrest due to hemorrhage in the ER/OR/ICU.

Thromboelastography (TEG): Lead multidisciplinary group facilitating the implementation of TEG for the use in Trauma, and Cardiac surgery.

Emergency Dept. Blood Storage (EDB): Lead multidisciplinary group for the implementation of a system to allow rapid access to emergency blood for the massively hemorrhaging patient.

Andexanet Alfa: Developed protocols for the use of the novel direct thrombin inhibitor reversal agent, Andexanet Alfa.

Clinical Documentation Improvement Champion: Surgical representative for hospital-wide CDI program.

Trauma Simulation: obtained state-of-the-art TraumaFx mannequin and designed trauma simulation program for use by Emergency Dept and Trauma Surgery physicians to practice trauma related skills and mock resuscitations.

INVITED SPEAKERSHIP, PRESENTATIONS, AND POSTERS

Podium Presentation. “Increased ketamine-related delirium rates as part of an opiate-sparing protocol in trauma patients.” Southern California Chapter of the American College of Surgeons Annual Meeting, January 22, 2023.

Master of Ceremonies. 19th Annual Trauma/Critical Care Symposium. Santa Barbara, CA. July 2022.

Invited Speaker. “Morality in the Trauma Bay.” 19th Annual Trauma/Critical Care Symposium. Santa Barbara, CA. July 2022.

Invited Speaker. “Basic Trauma and Burn Support. Surgery in Critical Care. Vascular Access.” Fundamentals of Critical Care Support Course. Santa Barbara Cottage Hospital. June 2022.

Invited Speaker. “Basic Trauma and Burn Support. Vascular Access.” Fundamentals of Critical Care Support Course. Santa Barbara Cottage Hospital. June 2021.

Invited Speaker. “The Universe is Trying to Kill you...Shock to a Biophysicist.” Surgical Grand Rounds, Santa Barbara Cottage Hospital. Santa Barbara, CA. July 22, 2020.

Invited Speaker. “Basic Trauma and Burn Support. Vascular Access.” Fundamentals of Critical Care Support Course. Santa Barbara Cottage Hospital. June 2020.

Invited Speaker. “Resuscitation of Massive Hemorrhage.” Medical Grand Rounds. Santa Barbara Cottage Hospital. Santa Barbara, CA. October 10, 2019.

Podium Presentation: “Debris Flow Syndrome: Injuries and Outcomes After the Montecito Debris Flow.” 13th Annual Riverside University Health System Trauma Conference, Oct 15, 2019.

Moderator. 18th Annual Trauma/Critical Care Conference. Santa Barbara, CA. July 12, 2019.

Invited Speaker. “Basic Trauma and Burn Support. Vascular Access.” Fundamentals of Critical Care Support Course. Santa Barbara Cottage Hospital. June 2019.

Invited Speaker. “Trauma Update.” Critical Care Round Up. Santa Barbara Cottage Hospital. April 5, 2019

Podium Presentation: “Debris Flow Syndrome: Injuries and Outcomes After the Montecito Debris Flow.” The Southern California Chapter of the American College of Surgeons Annual Meeting, January 26, 2019.

Invited Speaker. “Advanced Ventilator Strategies.” Saving the Brain - 11th Annual Neuroscience Symposium of the Central Coast.
Santa Barbara, CA. November 2, 2018.

Invited Speaker. “Blood loss and mass casualty.” AACN RN/MD Luncheon.
Santa Barbara, CA. October 19, 2018.

Invited Speaker. “Necrotizing Fasciitis” 17th Annual Trauma/Critical Care Conference. Santa Barbara, CA. July 13, 2018.

Moderator. 17th Annual Trauma/Critical Care Conference. Santa Barbara, CA. July 13, 2018.

Invited Speaker. “Basic Trauma and Burn Support. Vascular Access.” Fundamentals of Critical Care Support Course. Santa Barbara Cottage Hospital. June 2018.

Invited Speaker. “Resuscitation of Massive Hemorrhage.” 16th Annual Trauma/Critical Care Conference. Santa Barbara, CA. July 7, 2017.

Keynote Moderator. “Mary Roach.” 16th Annual Trauma/Critical Care Conference. Santa Barbara, CA. July 7, 2017.

Invited Speaker. “Basic Trauma and Burn Support. Vascular Access.” Fundamentals of Critical Care Support Course. Santa Barbara Cottage Hospital. June 2017.

Invited Speaker. “Airway Pressure Release Ventilation.” Critical Care Nursing Meeting. Santa Barbara Cottage Hospital. November 18, 2016

Podium Presentation. “The Impact of Race on the Management of Severe Traumatic Brain Injury: an NTDB analysis.” American College of Surgeons Committee on Trauma, Region IX, 2014 Regional Resident Trauma Paper Competition. Dec 2014.

Poster Presentation. “The Impact of Race on the Management of Severe Traumatic Brain Injury: an NTDB analysis.” 73rd Annual Meeting of The American Association for the Surgery of Trauma. September 2014.

Podium Presentation. “Incidence of Intracranial Hemorrhage and Outcome After Falls in the Geriatric Trauma Patients Taking Pre-Injury Anticoagulants.” Santa Barbara Cottage Hospital Resident Research Symposium, June 13, 2014.

Poster Presentation. “Laparoscopic Versus Open Bowel Resection in Emergent Small Bowel Obstruction: Analysis of the National Surgical Quality Improvement Program Database.” 85th Annual Meeting of the Pacific Coast Surgical Association, February 15, 2014.

Podium Presentation. “Incidence of Intracranial Hemorrhage and Outcome After Falls in the Geriatric Trauma Patients Taking Pre-Injury Anticoagulants.” Southern California Chapter of the American College of Surgeons Annual Meeting, January 17, 2014.

Poster Presentation. “A prophylactic warfarin reversal policy utilizing frozen plasma is ineffective in preventing delayed intracranial hemorrhage after trauma.” 72th Annual Meeting of The American Association for the Surgery of Trauma, September 18, 2013.

HOSPITAL COMMITTEES

2021-Present
Dept. of Surgery - *Vice Chair*

2016-Present
Trauma Performance Improvement Committee - *Member*
Trauma Operations Committee - *Member*
Trauma Symposium Planning Committee - *Member*

Blood Utilization Committee - *Chair*
Massive Transfusion Protocol Audit Committee - *Chair*
Pharmacy and Therapeutics Committee - *Member*
Research Advisory Committee - *Chair*
Critical Care Committee - *Member*
Medical Advisory Panel - *Member*
Clinical Documentation Improvement Committee - *Member*
Institutional Review Board - *Member*

2012 - 2015
Graduate Medical Education Committee - *Member*
Santa Barbara Cottage Hospital

2011 - 2012
Internal Medicine Residency Review Committee - *Member*
Santa Barbara Cottage Hospital

PROFESSIONAL MEMBERSHIPS

American College of Surgeons
American Association for Physician Leadership

AWARDS AND HONORS

Physician of the Year, 2022. Santa Barbara Cottage Hospital

Faculty Teaching Award 2016, General Surgery, Santa Barbara Cottage Hospital

Resident Teacher of the Year, 2014. Santa Barbara Cottage Hospital

“El Residente” ICU-Resident of the Year, 2014. Santa Barbara Cottage Hospital

Blue Ribbon Award Winner for Scientific & Clinical Investigation. “Laparoscopic Versus Open Bowel Resection in Emergent Small Bowel Obstruction: Analysis of the NSQIP Database.” Santa Barbara Cottage Hospital Resident Research Symposium, June 13, 2014.

Exhibit 3

AFFIDAVIT OF CHRISSY WHITE, RN, REGARDING WAYMON STOREY

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

Introduction

1. This affidavit addresses nursing negligence that occurred on December 23, 2021, when 53-year-old Waymon Storey received care at Wellstar Atlanta Medical Center ("AMC" or "Hospital").

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

   a. Plaintiff's 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 Plaintiff's counsel.

   c. Plaintiff's 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 specific matters that Plaintiff's counsel asked me to address. I have not attempted to identify all standard-of-care violations, to state every causation opinion I have, or to anticipate or address issues the Defense may raise or that otherwise might 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 use the term "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.

6. I hold all the opinions expressed below to a reasonable degree of medical certainty—that is, more likely than not.

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 Plaintiff's 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 Plaintiff's 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.

Qualifications

11. I am more than 18 years of age, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

12. I do not recite all my qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA § 24-7-702. My curriculum vitae, which is attached as Exhibit A, provides further detail about my qualifications. I incorporate and rely on that additional information here.

13. The events at issue here occurred in December 2021.

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

    a. In 2021, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the

profession. Specifically, I was licensed by the State of Wyoming to practice as a registered nurse. That's where I was practicing in 2021.

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

I had this knowledge and experience from being regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to December 23, 2021, with sufficient frequency to establish an appropriate level of knowledge of the matters my opinions address. Specifically, I am an emergency department registered nurse, and for many years I have had great familiarity with each of the tasks on which I offer standard-of-care opinions below.

Evidence Considered

15. I have reviewed the following records pertaining to Waymon Storey: Wellstar Atlanta Medical Center medical records, Clayton County Emergency Prehospital Care Report, Clayton County Death Investigation Report, Georgia Bureau of Investigation autopsy report, and Georgia Motor Vehicle Crash Report.

16. I invite the Defense to send me any evidentiary materials or commentary that the Defense believes may help exculpate any Defendant.

Principal Opinions

17. My principal opinions are summarized below. In deposition or trial testimony, I may elaborate upon these principal opinions, thereby also offering related, subsidiary, or incidental opinions. In addition, I may later develop and disclose additional principal opinions for this case.

Failure to Monitor

18. *Requirements*: Under the circumstances ascertainable from the records identified above, the standard of care requires a hospital nurse attending to

the patient to monitor, report, and document the patient's vital signs—at least every 5 minutes for the first 30 minutes after the patient arrives.[1]

The required vital signs include the patient's temperature, heart rate, respiratory rate, blood pressure, and oxygen saturation (SpO2 level).

The purpose of closely monitoring the patient is early detection of any clinical deterioration, to provide appropriate treatment or intervention without delay.

19. *Violations*: On December 23, 2021, according to Hospital records, Nurse Morning Strickland, Nurse Jessica Kainer, and possibly other nurses at the Hospital's Emergency Department ("ED") each violated these requirements, by failing to monitor Mr. Storey's vitals as required, from the time of his arrival until he coded. Hospital nurses thus repeatedly violated the standard of care.

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

a. Mr. Storey had just survived a rollover car accident, requiring extrication from a 2-foot vehicular intrusion.

b. Mr. Storey presented to the ED with severe hypoxemia—with a critically low oxygen-saturation level.

c. Mr. Storey had other independent and observable risk-factors for hypoventilation and hypoxia, including his weight and body-mass index.

d. Mr. Storey was in severe pain and distress upon his arrival at the ED.

e. Mr. Storey had obvious traumatic injuries, including bone depressions in his sternum and ribs.

Because monitoring a patient's vitals enables early detection of clinical deterioration, nothing is more basic to the job of a nurse than monitoring a patient's vitals. By failing to monitor Mr. Storey's vitals as required, Nurse Strickland, Nurse Kainer, and possibly other Hospital nurses deviated from the standard of care. In fact, they deviated grossly from the standard of care.

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[1] If the hospital has a policy for monitoring patients, the standard of care also requires the nurses to follow that policy insofar as it meets the standard of care.

By failing to monitor Mr. Storey's vitals as required, these nurses also failed to exercise even slight diligence. Had they exercised even slight diligence, they would have monitored Mr. Storey's vitals as required.

20. *Causation*: Had Nurse Strickland, Nurse Kainer, or another Hospital nurse monitored, reported, and documented Mr. Storey's vitals as required, his vitals (especially his oxygen saturation and respiratory rate) likely would have alerted the trauma team that Mr. Storey's hypoxia was rapidly worsening.

So alerted, the trauma team then likely would have recognized that Mr. Storey's already-impaired ability to maintain ventilation was diminishing quickly. As a result, the trauma team likely would have intubated Mr. Storey without delay—before his hypoxia resulted in respiratory arrest, much less death.

Each failure to monitor Mr. Storey's vitals thus contributed to his respiratory arrest, cardiac arrest, and death. Each such failure was also a cause of the pain and suffering he likely experienced as he gradually died from oxygen-deprivation—in a major trauma center, in the hands of healthcare providers.

Chrissy White
Chrissy White, RN

SWORN TO AND SUBSCRIBED before me

October 30, 2023

Chalis Bremkamp
NOTARY PUBLIC

My Commission Expires: Aug 29, 2029

CHALIS BREMKAMP
NOTARY PUBLIC
STATE OF WYOMING
COMMISSION ID: 146452
MY COMMISSION EXPIRES: 08/29/2029

Exhibit A

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

Exhibit 4

Affidavit of Jonathan Schwartz, MD, MBA,

Regarding Waymon Storey

PERSONALLY APPEARS before the undersigned authority duly authorized to administer oaths JONATHAN SCHWARTZ, MD, MBA, who after first being duly sworn, states as follows.

Introduction

1. This affidavit addresses medical negligence that occurred on December 23, 2021, when 53-year-old Waymon Storey received care at Wellstar Atlanta Medical Center ("AMC" or "Hospital").

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

    a. Plaintiff's 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 Plaintiff's counsel.

    c. Plaintiff's 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 specific matters that Plaintiff's counsel asked me to address. I have not attempted to identify all standard-of-care violations, to state every causation opinion I may have, or to anticipate or address issues the Defense may raise or that otherwise might 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 use the term "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.

6. I hold all the opinions expressed below to a reasonable degree of medical certainty—that is, more likely than not.

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 Plaintiff's 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 Plaintiff's 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.

Qualifications

11. I am more than 18 years of age, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

12. I do not recite all my qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA § 24-7-702. My curriculum vitae, which is attached as Exhibit A, provides further detail about my qualifications. I incorporate and rely on that additional information here.

13. The events at issue here occurred in December 2021.

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

    a. In 2021, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession. Specifically, I was licensed by the State of Michigan to practice as a physician. That's where I was practicing in 2021.

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

    I had this knowledge and experience from being regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to December 23, 2021, with sufficient frequency to establish an appropriate level of knowledge of the matters my opinions address. Specifically, I am an internal medicine physician, and for many years I have had great familiarity with caring for patients in a hospital setting, documenting the care provided to such patients, and administratively ensuring proper documentation by physicians and nurses.

Evidence Considered

15. I have reviewed the following records pertaining to Waymon Storey: Wellstar Atlanta Medical Center medical records, Clayton County Fire and Emergency Services Prehospital Care Report, Clayton County Death Investigation Report, Georgia Bureau of Investigation autopsy report, and Georgia Motor Vehicle Crash Report.

16. I invite the Defense to send me any evidentiary materials or commentary that the Defense believes may help exculpate any Defendant.

Principal Opinions

17. My principal opinions are summarized below. In deposition or trial testimony, I may elaborate upon these principal opinions, thereby also offering related, subsidiary, or incidental opinions. In addition, I may later develop and disclose additional principal opinions for this case.

Failure to Document

18. *Requirements*: Under the circumstances present in this case, the standard of care requires physicians, nurses, and other providers involved in the patient's care to enter clear, complete, and accurate records concerning the care provided to the patient. Under these circumstances, the standard of care also requires these physicians and nurses to enter such records promptly.

    These requirements serve a clinical purpose beyond merely memorializing information. Especially here, the required documentation informs and drives clinical decision-making, in a setting where fast and accurate communications are essential for patient care and safety. These requirements, for example, help ensure that providers work in a coordinated and effective fashion.

In short, these requirements help optimize outcomes, prevent adverse long-term consequences, and safeguard patient safety.

19. *Violations*: In December 2023, physicians, nurses, and other providers who cared for Mr. Storey at the Hospital violated these requirements, by entering records that are unclear, incomplete, and incongruent. It appears, moreover, that such providers also violated these requirements by failing to enter records promptly.

For example, the records concerning oxygen delivery omit or confuse important facts, such as the time and the rate at which oxygen was administered. Likewise, the records of the attempted intubations document at most two of the "5 or more" intubation attempts, without noting information regarding the other attempts.

The providers who violated these requirements include Dr. Richisa Hamilton, Dr. Philip Ramsay, Dr. Naqeeb Faroqui, Nurse Morning Strickland, Nurse Jessica Kainer, and may also include physicians identified in the records as "Dr. Henderson" and "Dr. Anderson," Dr. or Nurse Joshua Willis, Nurse Wendy Tribble, RCP Jacob Byrd, and others.

The deficiencies in these Hospital records are far from moderate or immaterial. They are of a degree rarely seen in hospital records, particularly records from a major trauma center concerning a patient who died there. These violations were thus a gross departure from the standard of care.

In fact, in my years of experience as a physician and administrator, I have rarely seen records that are so unclear, incomplete, and incongruent—particularly concerning the care provided to a patient at the hour of his untimely death.

Jonathan Schwartz, MD, MBA

SWORN TO AND SUBSCRIBED before me

November 1st, 2023

Annette Marie DeLeon

NOTARY PUBLIC

My Commission Expires: August 21 2027

ANNETTE MARIE DELEON
Notary Public - State of Michigan
County of Saginaw
My Commission Expires Aug 21, 2027
Acting in the County of Saginaw

Exhibit A

Jonathan M. Schwartz, MD MBA

Board Certification

Diplomat, American Board of Internal Medicine
Certificate Number 215221

Initial Certification	08/19/2003 – 12/31/2013
Recertification	09/25/2013 – 12/31/2023

Professional Experience

Grosse Pointe Physician Services, PLLC Grosse Pointe Farms, MI Owner, Hospitalist	01/2016 – present
Wayne Health Wayne State University Physician Practice Group Detroit, Michigan	07/2019 — 12/2020
Memorial Hospital of Sweetwater County Rock Spring, Wyoming Hospitalist	10/2018 – 4/2021
University of Michigan Hospital and Medical Center Ann Arbor, Michigan Hospitalist	4/2015 – 12/2015
University of Michigan School of Medicine Ann Arbor, Michigan Assistant Professor of Medicine	4/2015 – 12/2015
The Grosse Pointe Medical Group, PLLC Grosse Pointe Park, Michigan Owner, Private Practice, Internal Medicine	1/2013 – 3/2015
Henry Ford Medical Group Detroit, Michigan	7/2002 – 12/2012
Medical Director, Managed Care	7/2007 – 12/2012
Senior Staff Physician, Internal Medicine	7/2004 – 12/2012
Associate Staff, Internal Medicine	7/2002 – 6/2004
Director, Physician Leadership Development Program	7/2005 – 12/2012
Medical Director, Referring Physician Office	7/2007 – 6/2010
Director, Referring Physician Programs & Services	7/2004 – 6/2007
Associate Medical Director, Managed Care	7/2003 – 6/2007
Assistant to the Chief Executive Officer	7/2003 – 6/2004

Education

Health Services Administration Fellowship (non-clinical) 7/2002 – 6/2003
Henry Ford Health System
One Ford Place
Detroit, Michigan 48202

Internal Medicine Residency 7/2000 – 6/2002
Henry Ford Hospital
2799 W. Grand Blvd
Detroit, Michigan 48202

Internal Medicine Internship 7/1999 – 6/2000
Henry Ford Hospital
Detroit, Michigan

Doctor of Medicine 7/1995 – 6/1999
Case Western Reserve University School of Medicine
2109 Adelbert Rd
Cleveland, Ohio 44106

Master of Business Administration 7/1993 – 6/1995
Case Western Reserve University Weatherhead School of Management
10900 Euclid Avenue
Cleveland, Ohio 44106

Premedical Coursework, Non Degree 7/1992 – 6/1993
Case Western Reserve University

Bachelor of Science in Business Administration (Summa Cum Laude) 1/1988 – 3/1991
The Ohio State University
College of Business Administration (Honors Program)
2100 Neil Avenue
Columbus, Ohio 43210
Major Field of Study: Accounting & Management Information Systems

Hospital Privileges

Covenant Healthcare (Locum, CompHealth) 1447 N Harrison Street Saginaw, Michigan 48602	5/2021 - present
Detroit Receiving Hospital 4201 St. Antoine Street Detroit, Michigan 48201	07/01/2019 – 12/2020
Memorial Hospital of Sweetwater County 1200 College Drive Rock Springs, Wyoming 82901	12/07/2018 – 04/2021
Aultman Hospital (Locum, Hayes Locums) 2609 6th Street SW Canton, Ohio 44710	11/2018 – 01/2019
SageWest Riverton (Locum, Locum Life) 2100 W. Sunset Drive Riverton, Wyoming 82501	7/13/2017 – 11/14/2019
TriHealth Good Samaritan Hospital (Locum, Hayes Locums) 375 Dixmyth Ave Cincinnati, Ohio 45220	6/21/2017 – 09/2018
TriHealth Bethesda North Hospital (Locum, Hayes Locums) 10500 Montgomery Road Cincinnati, Ohio 45242	10/19/2016 – 09/2018
Billings Clinic Hospital (Locum, Hayes Locums) 2800 10th Ave N Billings, Montana 59101	7/15/2016 – 8/31/2018
Altru Hospital (Locum, CompHealth) 1200 S. Columbia Rd Grand Forks, North Dakota 58201	1//1/2016 – 9/01/2016
University of Michigan Medical Center 1500 E. Medical Center Drive Ann Arbor, Michigan 48109	4/1/2015 – 12/31/2015
Gallup Indian Medical Center (Locum, CompHealth) 516 E. Nizhoni Blvd Gallup, New Mexico 87301	10/1//2014 – 3/31/2015
Great River Medical Center (Locum, CompHealth) 1221 S. Gear Ave West Burlington, Iowa 52655	12/1/2014 – 3/31/2015

Beaumont Grosse Pointe Hospital (Bon Secours-Cottage) 468 Cadieux Rd Grosse Pointe, Michigan 48230	2/25/2014 – 1/1/2015 7/21/2005 – 4/25/2013
St. John Hospital and Medical Center 22101 Moross Rd. Detroit, Michigan 48236	4/1/2014 – 12/31/2014
Henry Ford Hospital 2799 W. Grand Blvd. Detroit, Michigan 48202	7/1/2002 – 12/31/2012
Henry Ford Cottage Hospital 159 Kercheval Ave. Grosse Pointe Farms, Michigan 48236	7/1/2002 – 9/27/2010

Licensure and Regulatory Information

NPI Number 1104994631

CAQH Number 10892228

State of Michigan Board of Medicine Physician Practitioner
- License Number 4301073836
- Issued 02/25/2002
- Expires 01/31/2024

State of Michigan Board of Pharmacy Controlled Substance Prescriber
- License Number 5315008848
- Issued 02/25/2002
- Expires 01/31/2024

State of Ohio Board of Medicine
- License Number 35.094492
- Issued 10/30/2009
- Expires 01/01/2022

State of Iowa Physician License
- License Number MD.42160
- Issued 10/24/2014
- Expires 11/01/2021

State of Iowa Board of Pharmacy Controlled Substance Provider
- License Number 1246562
- Issued 10/30/2014
- Expires 02/28/2021

State of North Dakota Physician License
- License Number 13941
- Issued 03/18/2016
- Expires 11/12/2021

State of Montana Physician License
- License Number 48176
- Issued 03/23/2016
- Expires 03/31/2022

Montana Medical Legal Panel
- Number 9091 current

State of Wyoming Physician License
- License Number 11106A
- Issued 07/14/2017
- Expires 06/30/2021

State of Wyoming Board of Pharmacy Controlled Substance Provider
License Number CS01475
Issued 06/06/2017
Expires 06/30/2021

State of Washington Physician License
License Number MD60881154
Issued 09/20/2018
Expires 11/12/2021

State of Minnesota
License Number 68420
Issued 11/06/2020
Expires 11/30/2021

State of Wisconsin
License Number 1069-320
Issued 11/13/2020
Expires 10/31/2021

DEA Controlled Substance Prescriber
License Number BS7696315
Issued 1/19/2017
Expires 2/29/2023
Michigan Assignment

License Number FS5881431
Issued 4/01/2016
Expires 02/28/2022
Wyoming Assignment

License Number FS8255829
Issued 4/05/2019
Expires 2/28/2022
Ohio Assignment

Other Certifications
Advanced Cardiac Life Support (ACLS) expires 7/2022
Basic Life Support (BLS) expires 7/2022

Examinations
USMLE

Exam I	(attempted and completed once)	06/10/1997
Exam II	(attempted and completed once)	08/25/1998
Exam III	(attempted and completed once)	09/25/2001

Medical Malpractice Insurance
Certificates of Insurance available on request

Publications

Schwartz, J.M.: Insurance Status and the Transfer of Hospitalized Patients. *Annals of Internal Medicine*, 2014:160(11):810

Yaremchuck, K; Schwartz, J; Neslon, M: Copayment Levels and Their Influence on Patient Behavior in Emergency Room Utilization in an HMO Population. *Journal of Managed Care Medicine*, 2010; Vol. 13, No. 1:27–31.

Frolkis, J P; Zyzanski S J; Schwartz, J M; Suhan, P S: Physician Noncompliance with the 1993 National Cholesterol Education Program (NCEP–ATPII) Guidelines. *Circulation*. 1998; 98:851–855.

Teaching

Oakland University School of Business Administration (Rochester Hills, Michigan) 2011 – 2012
Adjunct Faculty
Hospital Administration (HCM 634) Executive MBA Program
Guest Lecturer 2010
Executive MBA Program

University of Michigan Ross School of Business (Ann Arbor, Michigan) 2007 – 2012
Guest Lecturer
MBA program, Seminar in Healthcare Management

Research

Physician Compliance with NCEP–ATPII Guidelines in a Cardiac ICU 1996 – 1997
Mt. Sinai Medical Center, Cleveland, Ohio

Lectures and Presentations

Oakland University School of Management
Conference on Cost in Healthcare
Expert Panel Member and Lecturer 2008

American Medical Group Association Annual Conference
"Physician Leadership Education" 2008
"Specialty Access: A Novel Approach" 2007

Six Clinics Annual Meeting
"Specialty Access: A Novel Approach" 2006

Board of Trustees, Henry Ford Hospital and Health Network
"Specialty Access" 2006

Board of Trustees, Henry Ford Health System Joint Conference
"Specialty Access" 2005
"Physician Leadership Development" 2005
"In–Sourcing Care of HFMG Capitated Patients" 2004

Advisory Board and Panel Membership

Oakland University Executive MBA Program Advisory Board	2007 – 2012
United Health, South East Michigan Physician Advisory Committee	2007 – 2009
American Medical Group Association Expert Panel on the Economic Costs Associated with Metabolic Syndrome	2007

Committee Experience

United Physicians. Regional Physician Leadership Council, East Region	2014
Henry Ford Health System Henry Ford Medical Group	
Care Management Redesign Team	2011 – 2012
Chair, Patient Alignment Work Group Chair, End Stage Renal Disease Patient Work Group Chair, Radiology Utilization Work Group Chairs Council	2003 – 2012
Finance Committee	2003 – 2012
Contracting Subcommittee	2010 – 2012
Practice Affairs Committee	2009 – 2012
Credentials Committee	2006 – 2008
Specialty Access Task Force	2005 – 2007
Referring Physician Committee	2002 – 2003
Henry Ford Health System	
Growth, Contact Center Subcommittee	2008 – 2012
Service Excellence Committee	2006
Corporate University Steering Committee	2005 – 2012
Safety Net Access and Charity Care	2006 – 2012
Telecommunications Assessment Steering Committee	2006
Patient Transportation Steering Committee	2006 – 2007
Retail Strategies Committee, Access Subcommittee	2006
Health Alliance Plan	
Benefits Administration Committee	2007 – 2012
Network Medical Director Committee	2007 – 2012
Henry Ford Physician Network	
Payment and Contract Advisory Committee	2011 – 2012
HFMG–HAP–HFH Steering Committee	2007 – 2012
HFMG–HAP–HFH Joint Operating Committee	2007 – 2012
HFMG – HAP – HFH Leadership Committee	2003 – 2009

Professional Society Membership

American College of Physicians	2002 – present
American Medical Association	2004 – present
Society of General Internal Medicine	2014 – 2015
Society of Hospital Medicine	2014 – 2015
American College of Healthcare Executives	2002 – 2013
American College of Physician Executives	2007 – 2013
Michigan State Medical Society	2005 – 2014
Liaison Committee with Third Party Payers	2005 – 2012
Committee on Health Care Quality, Efficiency, and Economics	2005 – 2014
Sub Committee on Data Integrity	2005
Sub Committee on Pay for Performance	2005
Wayne County Medical Society	2005 – 2014
Delegate Body Member	2005 – 2009
Legislative Affairs Committee	2006 – 2012
Young Physician Committee	2006 – 2009

Awards and Special Recognition

Henry Ford Health System Board of Trustees: "Focus on People" 2008
An award given for exceptional contributions to financial and operational performance, awarded for team work related to development of a corporate policy and practice for uninsured and underinsured patients.

Henry Ford Health System Board of Trustees: "Focus on People" 2004
An award given for exceptional contributions to financial and operational performance, awarded for work related to improving insourcing of admissions to Henry Ford Hospital.

Academic Scholarships and Honors

Pace Setters Award for Outstanding Achievement in the College of Business,
The Ohio State University

The Ohio State University–University College Summa Award,
The Ohio State University

Beta Alpha Psi National Accounting Honors Fraternity

Golden Key National Honor Society

Community Involvement

Detroit Institute for Children
Board of Directors and Executive Committee of Board 2013 – 2015