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MUSCOGEE COUNTY, GEORGIA
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Danielle F. Forté, Clerk
Muscogee County, Georgia

IN THE SUPERIOR COURT OF MUSCOGEE COUNTY
STATE OF GEORGIA

TAMMY CARNLEY and MICHAEL CARNLEY, Plaintiffs, v. ST. FRANCIS HEALTH, LLC, ST. FRANCIS AFFILIATED SERVICES, LLC, ST. FRANCIS PHYSICIAN PRACTICES, LLC, ST. FRANCIS EMORY HEALTHCARE HOSPITAL PHYSICIANS, LLC, EMORY HEALTHCARE, INC., JAMES E. RAGAN, II, M.D., DENNIS M. BURTON, M.D., DIRECT RADIOLOGY, LLC, VESTA TELEMEDICINE SOLUTIONS, LLC, and JOHN/JANE DOES 1–10, Defendants.	CIVIL ACTION FILE NO. _____ **JURY TRIAL DEMANDED**

PLAINTIFFS' COMPLAINT FOR DAMAGES

COME NOW Plaintiffs TAMMY CARNLEY and MICHAEL CARNLEY and file this Complaint against St. Francis Health, LLC, St. Francis Affiliated Services, LLC, St. Francis Physician Practices, LLC, St. Francis Emory Healthcare Hospital Physicians, LLC, Emory Healthcare, Inc., James E. Ragan, II, M.D., Dennis M. Burton, M.D., Direct Radiology, LLC, Vesta Telemedicine Solutions, LLC, and John/Jane Does 1–10 (collectively, "Defendants"), showing the Court as follows:

Nature of This Action

1.

This action arises out of medical care negligently provided to 47-year-old Tammy Carnley ("Tammy") in connection with an acute ischemic stroke Tammy suffered on or about October 7, 2024, at St. Francis–Emory Healthcare Hospital (the "Hospital") in Columbus, Georgia.

2.

Pursuant to O.C.G.A. § 9-11-9.1, the affidavits of qualified experts competent to testify as to the standard of care required of Defendants are attached hereto as Exhibit 1 (Guy A. Rordorf, M.D.), Exhibit 2 (Anthony Mancuso, M.D.), and Exhibit 3 (Leslie Boyd, RN, BSN, CEN). This Complaint incorporates the opinions and allegations found in those affidavits.

3.

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.

Parties, Jurisdiction, and Venue

4.

Plaintiff TAMMY CARNLEY is a citizen and resident of the State of Georgia. Plaintiff submits to the personal jurisdiction and venue of this Court.

5.

Plaintiff MICHAEL CARNLEY is the husband of Tammy Carnley, is a citizen and resident of the State of Georgia, and brings claims for loss of consortium. Plaintiff submits to the personal jurisdiction and venue of this Court.

6.

Defendant St. Francis Health, LLC ("St. Francis Health") is a Delaware limited liability company registered to transact business in the State of Georgia that owns and operates the Hospital, located at 2122 Manchester Expressway, Columbus, Georgia 31904, in Muscogee County. Its principal office is located at 680 South Fourth Street, Louisville, Kentucky 40202, and it maintains its registered office in Forsyth County, Georgia. It may be served with process through its registered agent, The Corporation Company, at 410 Peachtree Parkway, Suite 4245, Cumming, Georgia 30041.

7.

St. Francis Health is subject to the personal jurisdiction of this Court.

8.

St. Francis Health is subject to the subject-matter jurisdiction of this Court in this case.

9.

St. Francis Health is directly subject to venue in this Court on each of the following independent grounds: St. Francis Health has an office and transacts

business in Muscogee County; and the cause of action originated in Muscogee County.

10.

Pursuant to Article VI, Section II, Paragraph VI of the Georgia Constitution and O.C.G.A. § 9-10-31, St. Francis Health is also subject to venue in this Court because it is a joint tortfeasor with at least one co-defendant who is directly subject to venue here.

11.

St. Francis Health may be served as provided by law.

12.

At relevant times, St. Francis Health was the employer or other principal of one or more of the providers whose care is at issue here.

13.

Defendant St. Francis Affiliated Services, LLC ("Affiliated Services") is a Delaware limited liability company registered to transact business in the State of Georgia. Its principal office is located at 680 South Fourth Street, Louisville, Kentucky 40202, and it maintains its registered office in Forsyth County, Georgia. It may be served with process through its registered agent, The Corporation Company, at 410 Peachtree Parkway, Suite 4245, Cumming, Georgia 30041.

14.

Affiliated Services is subject to the personal jurisdiction of this Court.

15.

Affiliated Services is subject to the subject-matter jurisdiction of this Court in this case.

16.

Affiliated Services is directly subject to venue in this Court on each of the following independent grounds: on information and belief, Affiliated Services transacts business in Muscogee County in connection with the ownership, operation, staffing, or management of the Hospital; and the cause of action originated in Muscogee County.

17.

Pursuant to Article VI, Section II, Paragraph VI of the Georgia Constitution and O.C.G.A. § 9-10-31, Affiliated Services is also subject to venue in this Court because it is a joint tortfeasor with at least one co-defendant who is directly subject to venue here.

18.

Affiliated Services may be served as provided by law.

19.

At relevant times, Affiliated Services was the employer or other principal of one or more of the providers whose care is at issue here.

20.

Defendant St. Francis Physician Practices, LLC ("Physician Practices") is a Delaware limited liability company registered to transact business in the State

of Georgia. Its principal office is located at 680 South Fourth Street, Louisville, Kentucky 40202, and it maintains its registered office in Forsyth County, Georgia. It may be served with process through its registered agent, The Corporation Company, at 410 Peachtree Parkway, Suite 4245, Cumming, Georgia 30041.

21.

Physician Practices is subject to the personal jurisdiction of this Court.

22.

Physician Practices is subject to the subject-matter jurisdiction of this Court in this case.

23.

Physician Practices is directly subject to venue in this Court on each of the following independent grounds: on information and belief, Physician Practices transacts business in Muscogee County in connection with the employment, engagement, or supervision of physicians who provide care at the Hospital; and the cause of action originated in Muscogee County.

24.

Pursuant to Article VI, Section II, Paragraph VI of the Georgia Constitution and O.C.G.A. § 9-10-31, Physician Practices is also subject to venue in this Court because it is a joint tortfeasor with at least one co-defendant who is directly subject to venue here.

25.

Physician Practices may be served as provided by law.

26.

At relevant times, Physician Practices was the employer or other principal of one or more of the providers whose care is at issue here.

27.

Defendant St. Francis Emory Healthcare Hospital Physicians, LLC ("Hospital Physicians") is a Delaware limited liability company registered to transact business in the State of Georgia. Its principal office is located at 680 South Fourth Street, Louisville, Kentucky 40202, and it maintains its registered office in Gwinnett County, Georgia. It may be served with process through its registered agent, C T Corporation System, at 289 S. Culver Street, Lawrenceville, Georgia 30046-4805.

28.

Hospital Physicians is subject to the personal jurisdiction of this Court.

29.

Hospital Physicians is subject to the subject-matter jurisdiction of this Court in this case.

30.

Hospital Physicians is directly subject to venue in this Court on each of the following independent grounds: on information and belief, Hospital Physicians transacts business in Muscogee County in connection with the employment, engagement, or supervision of physicians who provide care at the Hospital; and the cause of action originated in Muscogee County.

31.

Pursuant to Article VI, Section II, Paragraph VI of the Georgia Constitution and O.C.G.A. § 9-10-31, Hospital Physicians is also subject to venue in this Court because it is a joint tortfeasor with at least one co-defendant who is directly subject to venue here.

32.

Hospital Physicians may be served as provided by law.

33.

At relevant times, Hospital Physicians was the employer or other principal of one or more of the providers whose care is at issue here.

34.

Defendant Emory Healthcare, Inc. ("Emory Healthcare") is a Georgia nonprofit corporation. Its principal office is located at 201 Dowman Drive N.E., 101 Administration Building, Atlanta, Georgia 30322, and it maintains its registered office in Fulton County, Georgia. It may be served with process through its registered agent, Cogency Global Inc., at 233 Peachtree Street N.E., Suite 2307, Atlanta, Georgia 30303.

35.

At relevant times, Emory Healthcare participated in the ownership, operation, management, branding, and clinical oversight of the Hospital, and did so jointly with one or more of the other Corporate Defendants and their parent or affiliated entities.

36.

Emory Healthcare is subject to the personal jurisdiction of this Court.

37.

Emory Healthcare is subject to the subject-matter jurisdiction of this Court in this case.

38.

Emory Healthcare is directly subject to venue in this Court because the cause of action originated in Muscogee County.

39.

Pursuant to Article VI, Section II, Paragraph VI of the Georgia Constitution and O.C.G.A. § 9-10-31, Emory Healthcare is also subject to venue in this Court because it is a joint tortfeasor with at least one co-defendant who is directly subject to venue here, including Defendant James E. Ragan, II, M.D., who resides in Muscogee County.

40.

Emory Healthcare may be served as provided by law.

41.

At relevant times, Emory Healthcare was the employer or other principal of one or more of the providers whose care is at issue here, including members of the Nursing Staff as defined below.

42.

The Defendants identified in the preceding paragraphs of this section are referred to collectively as the "Corporate Defendants."

Joint Venture and Common Enterprise

43.

At all relevant times, the Hospital was owned, operated, managed, and held out to the public under the combined name "St. Francis–Emory Healthcare," a name that joins the St. Francis and Emory brands.

44.

That combined name was not incidental. It reflected an agreement among Emory Healthcare and one or more of the other Corporate Defendants and their parent or affiliated entities to combine their property, capital, skill, knowledge, personnel, clinical protocols, and reputation in a common enterprise for the provision of hospital services in Columbus, Georgia, for their mutual benefit and profit.

45.

In that common enterprise, the participating entities shared a mutual right of control over the conduct of the enterprise, including over the clinical standards, protocols, staffing, credentialing, and quality oversight applicable to the care provided at the Hospital.

46.

The Corporate Defendants were accordingly joint venturers in the ownership and operation of the Hospital, and each is liable for the negligent acts and omissions of the others, and of the enterprise's employees and agents, committed within the scope of the venture.

47.

In the alternative, and in addition, each Corporate Defendant acted as the agent of each of the other Corporate Defendants with respect to the ownership, operation, staffing, and management of the Hospital, and each is liable for the acts and omissions of the others undertaken within the scope of that agency.

Holding Out and Apparent Agency

48.

The Corporate Defendants held the Hospital out to the public, and to Tammy and Michael Carnley, as a single integrated healthcare provider operating under the name "St. Francis–Emory Healthcare."

49.

That holding out was accomplished through, among other things, exterior and interior signage, the Hospital's website and marketing materials, advertising in the Columbus market, staff identification badges, patient registration and consent documents, patient education materials, discharge paperwork, and billing

statements, all of which bore the combined St. Francis–Emory Healthcare name and marks.

50.

The Corporate Defendants did not disclose to Tammy or to Michael Carnley, at any time before or during Tammy's Emergency Department stay on October 7, 2024, that any physician, nurse, or other provider rendering care to Tammy was anything other than an employee or agent of the Hospital.

51.

Tammy arrived at the Hospital by ambulance, unresponsive and globally aphasic. She was incapable of selecting, evaluating, inquiring about, or contracting with any individual provider. She and her family looked to the Hospital, and not to any individual physician or staffing entity, for her care.

52.

Plaintiffs justifiably relied upon the Corporate Defendants' holding out in accepting the care rendered at the Hospital.

53.

Each physician, nurse, and other provider who rendered care to Tammy at the Hospital on October 7, 2024, including Dr. Ragan, Dr. Burton, and each member of the Nursing Staff, was therefore an actual agent or, in the alternative, an apparent or ostensible agent of the Corporate Defendants, and the Corporate Defendants are liable for their negligent acts and omissions.

Individual Defendants

54.

Defendant James E. Ragan, II, M.D. ("Dr. Ragan") is a physician and a citizen and resident of the State of Georgia who resides in Muscogee County, Georgia. He was the emergency physician responsible for Tammy's care in the Hospital's Emergency Department on October 7, 2024. He may be served with process at his residence in Muscogee County, Georgia, at the address set forth in the summons issued with this Complaint.

55.

Dr. Ragan is subject to the personal jurisdiction of this Court.

56.

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

57.

Dr. Ragan is directly subject to venue in this Court on each of the following independent grounds: Dr. Ragan resides in Muscogee County; and the cause of action originated in Muscogee County.

58.

Dr. Ragan may be served as provided by law.

59.

At relevant times, Dr. Ragan acted as an employee or other agent of one or more of the Corporate Defendants, or of an emergency medicine staffing or

professional entity presently unidentified to Plaintiffs and named here as a John/Jane Doe defendant, and was acting within the course and scope of that employment or other agency in providing care to Tammy.

60.

As Dr. Ragan's employer or other principal at the time of his negligence, the Corporate Defendant or other entity that employed or otherwise engaged him is vicariously liable for his negligence, because he was acting within the scope of his employment or other agency at that time.

61.

If another entity was the employer or other principal of Dr. Ragan at the 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.

62.

Defendant Dennis M. Burton, M.D. ("Dr. Burton") is a physician and a citizen and resident of the State of Florida. He interpreted and reported the non-contrast CT scan of Tammy's head obtained at the Hospital on October 7, 2024. He may be served with process pursuant to O.C.G.A. § 9-10-94 at his residence in Palm City, Florida, at the address set forth in the summons issued with this Complaint.

63.

At all relevant times, Dr. Burton held, and he continues to hold, an active license to practice medicine in the State of Georgia, License No. 63302, issued by the Georgia Composite Medical Board. He applied for, obtained, and has

maintained that Georgia license for the purpose of practicing medicine upon patients located in the State of Georgia, and he thereby purposefully availed himself of the privilege of conducting activities within this State and of the protections of its laws.

64.

On information and belief, at all relevant times Dr. Burton held clinical privileges at the Hospital, or was otherwise credentialed to interpret diagnostic imaging studies for patients at the Hospital, pursuant to a contract or other arrangement between himself, or one or more teleradiology entities by which he was employed or engaged, and one or more of the Corporate Defendants.

65.

When he interpreted Tammy's CT scan on October 7, 2024, Dr. Burton was engaged in the practice of medicine in the State of Georgia. Under O.C.G.A. § 43-34-31, a physician who is physically located outside Georgia but who, through the use of electronic, radiographic, or other means of telecommunication, performs an act that is part of a patient care service located in Georgia and that affects the diagnosis or treatment of the patient is engaged in the practice of medicine in this state. Georgia law likewise provides that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter. O.C.G.A. § 43-34-301.

66.

Dr. Burton, a nonresident of Georgia, is subject to the personal jurisdiction of this Court pursuant to Georgia's Long Arm Statute, O.C.G.A. § 9-10-91, on each of the following independent grounds:

a. Under O.C.G.A. § 9-10-91(1), Dr. Burton transacted business within the State of Georgia. He obtained and maintained a Georgia medical license, accepted credentials or privileges to read for a Georgia hospital, and purposefully directed his professional services to Georgia by undertaking to interpret diagnostic imaging studies for patients located at the Hospital in Muscogee County, Georgia, including Tammy, and by transmitting his interpretations and reports to providers in Georgia for use in the treatment of Georgia patients. Plaintiffs' causes of action arise from and are connected with those acts.

b. Under O.C.G.A. § 9-10-91(3), Dr. Burton committed a tortious injury in Georgia caused by an act or omission outside Georgia, and he regularly does or solicits business in Georgia, engages in a persistent course of conduct in Georgia, and derives substantial revenue from services rendered in Georgia. His maintenance of an active Georgia medical license, his credentialing to read for a Georgia hospital, and his regular interpretation of imaging studies for patients located at Georgia facilities establish that persistent course of conduct and that revenue.

c. Under O.C.G.A. § 9-10-91(2), and by operation of O.C.G.A. §§ 43-34-31 and 43-34-301, Dr. Burton committed a tortious act or omission within the State of Georgia, where Tammy was located when he interpreted and reported her CT scan, and that act or omission caused injury in Georgia.

67.

The exercise of personal jurisdiction over Dr. Burton comports with traditional notions of fair play and substantial justice. He deliberately undertook to render medical care to patients in Georgia, held a Georgia license permitting him to do so, and could reasonably anticipate being haled into a Georgia court to answer for the manner in which he rendered that care.

68.

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

69.

Dr. Burton is directly subject to venue in this Court on each of the following independent grounds: the cause of action originated in Muscogee County; and, pursuant to O.C.G.A. § 9-10-93, venue as to a nonresident subject to jurisdiction under the Long Arm Statute lies in the county where the transaction took place, where the act or omission occurred, or where the injury occurred, which is Muscogee County.

70.

Dr. Burton may be served as provided by law, including pursuant to O.C.G.A. § 9-10-94.

71.

At relevant times, Dr. Burton acted as an employee or other agent of Defendant Direct Radiology, PLLC, Defendant Vesta Telemedicine Solutions, LLC, or both, and of one or more of the Corporate Defendants, and was acting within the course and scope of that employment or other agency in interpreting and reporting Tammy's CT scan.

72.

As Dr. Burton's employer or other principal at the time of his negligence, Direct Radiology, PLLC, Vesta Telemedicine Solutions, LLC, and the Corporate Defendant or other entity that employed or otherwise engaged him are vicariously liable for his negligence, because he was acting within the scope of his employment or other agency at that time.

73.

If another entity was the employer or other principal of Dr. Burton at the 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.

Radiology Defendants

74.

Defendant Direct Radiology, LLC ("Direct Radiology") is, on information and belief, a professional limited liability company organized under the laws of the State of Florida and engaged in the business of furnishing remote diagnostic radiology interpretation services, commonly called teleradiology, to hospitals and other healthcare facilities, including facilities located in the State of Georgia. It may be served with process pursuant to O.C.G.A. § 9-10-94 through its registered agent, Corporation Service Company, at 1201 Hays Street Tallahassee, FL 32301.

75.

On information and belief, at all relevant times Direct Radiology, alone or together with Vesta Telemedicine Solutions, LLC, employed or otherwise engaged Dr. Burton, assigned to him the diagnostic imaging studies he was to interpret, and furnished his interpretations to its client facilities, including the Hospital.

76.

On information and belief, at all relevant times Direct Radiology was party to a contract or other arrangement with one or more of the Corporate Defendants under which Direct Radiology undertook to provide, and did provide, diagnostic radiology interpretation services for patients presenting to the Hospital in Muscogee County, Georgia, including emergent neuroimaging studies obtained in the Hospital's Emergency Department.

77.

Direct Radiology is subject to the personal jurisdiction of this Court.

78.

Direct Radiology, a nonresident of Georgia, is subject to the personal jurisdiction of this Court pursuant to Georgia's Long Arm Statute, O.C.G.A. § 9-10-91, on each of the following independent grounds:

a. Under O.C.G.A. § 9-10-91(1), Direct Radiology transacted business within the State of Georgia. It solicited and entered into a contract or other arrangement with a Georgia hospital to furnish diagnostic interpretation services to patients located in Georgia, it employed or engaged physicians licensed in Georgia for the purpose of rendering those services to Georgia patients, it caused its physicians to be credentialed to read for a Georgia facility, and it transmitted its physicians' interpretations into Georgia for use in the treatment of Georgia patients. Plaintiffs' causes of action arise from and are connected with those acts.

b. Under O.C.G.A. § 9-10-91(3), Direct Radiology committed a tortious injury in Georgia caused by an act or omission outside Georgia, and it regularly does and solicits business in Georgia, engages in a persistent course of conduct in Georgia, and derives substantial revenue from services rendered in Georgia, including through its ongoing provision

of teleradiology services to Georgia hospitals and other Georgia facilities.

c. Under O.C.G.A. § 9-10-91(2), and by operation of O.C.G.A. §§ 43-34-31 and 43-34-301, Direct Radiology, through its employee or agent Dr. Burton, committed a tortious act or omission within the State of Georgia, where Tammy was located when her CT scan was interpreted and reported, and that act or omission caused injury in Georgia.

79.

The exercise of personal jurisdiction over Direct Radiology comports with traditional notions of fair play and substantial justice. It built a business on furnishing medical interpretations to patients in states including Georgia, contracted to serve a Georgia hospital, and could reasonably anticipate being haled into a Georgia court to answer for the manner in which those interpretations were rendered.

80.

Direct Radiology is subject to the subject-matter jurisdiction of this Court in this case.

81.

Direct Radiology is directly subject to venue in this Court on each of the following independent grounds: the cause of action originated in Muscogee County; and, pursuant to O.C.G.A. § 9-10-93, venue as to a nonresident subject to jurisdiction under the Long Arm Statute lies in the county where the transaction

took place, where the act or omission occurred, or where the injury occurred, which is Muscogee County.

82.

Pursuant to Article VI, Section II, Paragraph VI of the Georgia Constitution and O.C.G.A. § 9-10-31, Direct Radiology is also subject to venue in this Court because it is a joint tortfeasor with at least one co-defendant who is directly subject to venue here.

83.

Direct Radiology may be served as provided by law, including pursuant to O.C.G.A. § 9-10-94.

84.

As Dr. Burton's employer or principal, Direct Radiology is vicariously liable for his negligent acts and omissions in interpreting and reporting Tammy's CT scan, which were committed within the course and scope of that employment or agency.

85.

If a parent, subsidiary, affiliate, successor, or predecessor of Direct Radiology was the entity that employed or engaged Dr. Burton or that contracted with the Corporate Defendants, 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.

86.

Defendant Vesta Telemedicine Solutions, LLC ("Vesta") is a foreign limited liability company registered with the Georgia Secretary of State to transact business in the State of Georgia as a foreign limited liability company. Its principal office is located at 1071 S. Sun Drive, Suite 2001, Lake Mary, Florida 32746, and it maintains its registered office in Fulton County, Georgia. It may be served with process through its registered agent, Registered Agent Solutions, Inc., at 233 Peachtree Street N.E., Suite 2307, Atlanta, Georgia 30303.

87.

On information and belief, Vesta is engaged in the business of furnishing remote diagnostic radiology interpretation services, commonly called teleradiology, to hospitals and other healthcare facilities, including facilities located in the State of Georgia.

88.

On information and belief, at all relevant times Vesta, alone or together with Direct Radiology, employed or otherwise engaged Dr. Burton, assigned to him the diagnostic imaging studies he was to interpret, and furnished his interpretations to its client facilities, including the Hospital.

89.

On information and belief, at all relevant times Vesta was party to a contract or other arrangement with one or more of the Corporate Defendants, with Direct Radiology, or with both, under which Vesta undertook to provide, and did provide,

diagnostic radiology interpretation services for patients presenting to the Hospital in Muscogee County, Georgia, including emergent neuroimaging studies obtained in the Hospital's Emergency Department.

90.

Vesta is subject to the personal jurisdiction of this Court. At all relevant times, including on October 7, 2024, Vesta was registered to transact business in the State of Georgia and maintained a registered office and registered agent in this State, and it is therefore subject to general personal jurisdiction in Georgia.

91.

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

92.

Pursuant to Article VI, Section II, Paragraph VI of the Georgia Constitution and O.C.G.A. § 9-10-31, Vesta is subject to venue in this Court because it is a joint tortfeasor with at least one co-defendant who is directly subject to venue here, including Defendant James E. Ragan, II, M.D., who resides in Muscogee County.

93.

Vesta may be served as provided by law.

94.

As Dr. Burton's employer or principal, Vesta is vicariously liable for his negligent acts and omissions in interpreting and reporting Tammy's CT scan, which were committed within the course and scope of that employment or agency.

95.

If a parent, subsidiary, affiliate, successor, or predecessor of Vesta was the entity that employed or engaged Dr. Burton or that contracted with the Corporate Defendants or with Direct Radiology, 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.

96.

The contracts, employment agreements, staffing arrangements, teleradiology agreements, and credentialing records that establish which entity employed or contracted with each physician are within Defendants' exclusive possession and were not available to Plaintiffs before filing. Plaintiffs will identify the correct employing or contracting entities through discovery and will amend as appropriate.

The Nursing Staff and Unidentified Defendants

97.

As used in this Complaint, the term "Nursing Staff" means the registered nurses and other nursing personnel who, on October 7, 2024, received, triaged, assessed, monitored, or otherwise participated in the care of Tammy Carnley in the Emergency Department of St. Francis–Emory Healthcare Hospital, including but not limited to Presley Adams, R.N., Kelly Cook, R.N., and the presently unidentified triage nurse and primary nurses assigned to Tammy Carnley's care.

98.

At all relevant times, each member of the Nursing Staff was an employee or an actual or apparent agent of one or more of the Corporate Defendants, acting within the course and scope of that employment or agency.

99.

The Corporate Defendants are vicariously liable for the negligence of the Nursing Staff. The claims of nursing negligence asserted in this Complaint are asserted against the Corporate Defendants and, to the extent they are later identified, against John/Jane Does 1–10.

100.

The identities of the individual members of the Nursing Staff are presently known to Defendants and not to Plaintiffs, and will be ascertained through discovery. Plaintiffs will seek leave to substitute those individuals for John/Jane Does 1–10 as appropriate.

101.

John/Jane Does 1–10 are yet-unidentified natural and legal persons who may be wholly or partly liable for the negligence and damages alleged here, including without limitation the presently unidentified members of the Nursing Staff as defined above, and the professional entities, emergency medicine staffing groups, and teleradiology entities other than Direct Radiology and Vesta that employed or contracted with Dr. Ragan or Dr. Burton. Once served with process, John/Jane Does 1–10 are subject to the jurisdiction and venue of this Court.

102.

Each John/Jane Doe defendant is hereby on notice that this action arises out of the care rendered to Tammy Carnley at the Hospital on October 7, 2024, and that, but for a mistake concerning the identity of the proper party, this action would have been brought against that person or entity by name.

Factual Background

103.

At all relevant times, Tammy Carnley was a 47-year-old woman residing in Midland, Georgia, with her husband, Michael Carnley. Before October 7, 2024, Tammy was fully independent, employed by the Muscogee County School District, with a baseline modified Rankin Scale (mRS) of 0, that is, no neurological symptoms or functional impairment.

104.

On or about October 6, 2024, at approximately 11:15 p.m., Tammy was last known to be at her neurological baseline.

105.

In the early morning hours of October 7, 2024, Tammy was found by her husband unresponsive on the floor of their home, with right-sided weakness and asymmetric motor findings, the hallmark signs of an acute stroke.

106.

Emergency Medical Services was called and Harris County EMS responded. EMS paramedics documented a Glasgow Coma Scale of 8, asymmetric motor findings (more movement on the left than the right), and identified "CNS-Stroke" as a secondary impression.

107.

Despite Tammy's obvious stroke presentation, EMS did not activate a pre-arrival stroke alert to the receiving hospital.

108.

Tammy was transported to the Hospital in Columbus, Georgia, arriving at the Emergency Department at approximately 6:36 a.m. on October 7, 2024. Transfer of care to the Emergency Department occurred at approximately 6:39 a.m.

109.

Upon arrival, Tammy presented with right-sided hemiplegia, right facial droop, global aphasia, and a gaze preference, a classic and unmistakable presentation of a large-vessel acute ischemic stroke.

110.

The Nursing Staff received Tammy from the responding paramedics at approximately 6:39 a.m. and obtained and documented her first set of vital signs at approximately 6:43 a.m.: temperature 36.9°C, heart rate 88, respiratory rate 21, blood pressure 142/83, oxygen saturation 93 percent, and point-of-care glucose 112. The normal glucose value excluded hypoglycemia, the most common stroke mimic.

111.

No member of the Nursing Staff activated a stroke alert, a code stroke, or a stroke team response at any time during Tammy's stay at the Hospital. The Hospital's Emergency Department record contains no documentation of any such activation.

112.

No member of the Nursing Staff performed or documented a validated stroke screening assessment, a nursing neurological assessment, a nursing determination of Tammy's last known well time, or a nursing National Institutes of Health Stroke Scale assessment. The only stroke scale assessments in the Hospital's record were performed by physicians.

113.

Dr. James E. Ragan, II, was the emergency physician responsible for Tammy's care in the Hospital's Emergency Department.

114.

Dr. Ragan first evaluated Tammy at approximately 6:44 a.m. His own physical exam documented findings classic for acute stroke, including that Tammy was unresponsive, with motor strength decreased on the right, sensation decreased on the right, and aphasic speech. Dr. Ragan documented a National Institutes of Health Stroke Scale (NIHSS) score of 22 out of 42, indicating a severe stroke, and a baseline mRS of 0.

115.

Despite Tammy's severe stroke presentation, high NIHSS score, and his own examination findings, Dr. Ragan did not promptly recognize and manage Tammy's presentation as an acute stroke, did not emergently consult neurology, did not emergently order CT angiography (CTA), and did not emergently initiate transfer to a comprehensive stroke center.

116.

The Nursing Staff monitored Tammy at approximately thirty-minute intervals throughout the morning of October 7, 2024, documenting vital signs at approximately 6:43, 7:00, 7:30, 8:00, 8:30, 9:10, 9:30, 10:00, 10:30, 11:00, 11:30, and 12:00. Members of the Nursing Staff were accordingly assessing Tammy at her bedside continuously for more than five hours.

117.

During that entire interval, no member of the Nursing Staff documented any communication to Dr. Ragan or to any other physician expressing concern about Tammy's neurological presentation, about the absence of vascular imaging or neurological consultation, or about the passage of time. No member of the Nursing Staff notified a charge nurse, an emergency department nurse manager, a house supervisor, a stroke program coordinator, or an emergency department medical director.

118.

A non-contrast CT scan of Tammy's head was obtained at approximately 7:50 a.m. and read at 8:14 a.m. by Dr. Dennis M. Burton, a radiologist, as showing "Normal CT of the head."

119.

In fact, the 8:14 a.m. CT demonstrated early ischemic changes of a large left middle cerebral artery (MCA) territory infarct. On November 21, 2024, Dr. Phillip McDonald issued an addendum re-read of the identical CT images, identifying a large ill-marginated hypodensity in the cortical-subcortical aspects of the left fronto-parietotemporal lobes with blurring of gray-white matter differentiation and effacement of overlying sulcal spaces, consistent with a left MCA territory large acute infarct.

120.

A normal or reportedly normal non-contrast head CT does not exclude an acute ischemic stroke. The duties of the Nursing Staff to recognize Tammy's stroke presentation, to activate a stroke alert, and to escalate her care did not abate upon Dr. Burton's report of a normal head CT.

121.

Dr. Burton's misread of the 8:14 a.m. CT delayed the recognition and treatment of Tammy's stroke and contributed to the catastrophic delay in transferring Tammy for mechanical thrombectomy.

122.

Neurology was not consulted until approximately 12:26 p.m., approximately five hours and forty-two minutes after Dr. Ragan first evaluated Tammy. Dr. Ragan's own documentation at 12:26 p.m. states: "Patient re-evaluated and now with the flaccidity of the right side. Stroke is now apparent as likely etiology."

123.

CT angiography of the head and neck was not ordered until approximately 12:26 p.m. and not performed until approximately 1:08 to 1:11 p.m., over six hours after Tammy's arrival in the Emergency Department. The CTA confirmed a complete left M1 occlusion, that is, a large vessel occlusion.

124.

At approximately 12:25 p.m., Dr. Mohammed Hussein, a neurologist, evaluated Tammy at bedside, documented an NIHSS of 23, an mRS of 0, and an Alberta Stroke Program Early CT Score (ASPECTS) of 6 to 7 out of 10. Dr. Hussein recommended transfer to a comprehensive stroke center for mechanical thrombectomy.

125.

An ASPECTS of 6 to 7 indicated that a significant portion of Tammy's brain tissue was still salvageable at that time, and that emergent mechanical thrombectomy could have preserved brain function and averted the catastrophic outcome that followed.

126.

At approximately 1:30 p.m., Dr. Smith of Piedmont Columbus Regional Midtown Hospital accepted Tammy for emergency-department-to-emergency-department transfer. At approximately 1:43 p.m., Dr. Stephen Colvin communicated the preliminary critical CTA findings, a large acute left MCA stroke with a thrombosed left M1 segment, to Kelly Cook, R.N. At approximately 1:45 p.m., Presley Adams, R.N., called report to the receiving nurse at Piedmont.

127.

Notwithstanding the acceptance of the transfer at approximately 1:30 p.m. and the calling of report at approximately 1:45 p.m., Tammy did not depart the Hospital until approximately 2:15 p.m. Defendants have offered no explanation for the approximately forty-five minute interval between acceptance of the transfer and Tammy's departure, during which her brain tissue continued to infarct.

128.

Tammy was not transferred from the Hospital to Piedmont Columbus Regional Midtown Hospital (a comprehensive stroke center) until approximately 2:15 p.m. on October 7, 2024, arriving at Piedmont at approximately 2:22 p.m., nearly eight hours after her arrival at the Hospital. During those hours, Tammy's brain tissue was dying.

129.

Upon arrival at Piedmont, repeat imaging revealed that Tammy's ASPECTS had declined catastrophically from 6 to 7 down to 1 out of 10, indicating near-complete infarction of the left MCA territory.

130.

Because of the delay, Tammy was no longer a candidate for mechanical thrombectomy. The treating Piedmont neurologist documented: "No thrombectomy done due to already developed near complete infarct."

131.

Tammy's NIHSS at Piedmont had risen to 33 out of 42, reflecting devastating neurological decline.

132.

Tammy subsequently developed malignant cerebral edema requiring emergency decompressive left hemicraniectomy on October 8, 2024, to save her life. She underwent tracheostomy on October 17, 2024, and placement of a percutaneous gastrostomy (PEG) tube on October 18, 2024.

133.

Tammy was hospitalized at Piedmont from October 7 through October 25, 2024, and was discharged to inpatient rehabilitation with dense right hemiplegia, global aphasia, tracheostomy and PEG-tube dependence, and maximum-assist needs for all transfers and activities of daily living.

134.

As a direct result of the delayed diagnosis and treatment, Tammy has suffered, and continues to suffer, severe and permanent neurological deficits, including but not limited to dense right hemiplegia, global aphasia, inability to communicate, inability to perform activities of daily living, and the need for a lifetime of around-the-clock care.

Notice of Claims

135.

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

136.

Plaintiffs here incorporate by reference the expert affidavits attached hereto.

137.

Plaintiffs hereby provide sufficient notice of their claims against the Defendants.

138.

For each claim of professional negligence alleged in this action, the alleged acts and omissions also constituted ordinary or simple negligence.

139.

Pursuant to O.C.G.A. § 9-11-9.1, the affidavits of qualified experts competent to testify as to the standard of care required of the Defendants are attached hereto as Exhibits 1, 2, and 3.

140.

This Complaint incorporates the opinions and allegations found in those affidavits.

Professional Negligence: Dr. Ragan and the Corporate Defendants

141.

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

142.

At relevant times, Dr. James E. Ragan, II, was a physician engaged in the practice of medicine in the State of Georgia.

143.

On October 7, 2024, Dr. Ragan entered into a physician-patient relationship with Tammy Carnley.

144.

Dr. Ragan thus had a duty to provide care to Tammy within the applicable standard of care.

145.

Dr. Ragan failed to comply with the applicable standard of care in the care he provided Tammy.

146.

On October 7, 2024, Dr. Ragan violated the standard of care by, among other things: failing to recognize and treat Tammy's presentation as an acute stroke despite his own examination findings and a documented NIHSS of 22; failing to emergently order CT angiography concurrently with or immediately after the initial CT head; failing to emergently consult neurology for nearly six hours after his initial evaluation; failing to emergently arrange transfer to a comprehensive stroke center capable of performing mechanical thrombectomy; and failing to recognize the urgency of Tammy's condition and act accordingly.

147.

Each of the foregoing acts and omissions of Dr. Ragan also constituted ordinary or simple negligence.

148.

To the extent that O.C.G.A. § 51-1-29.5 is held to apply to any of the care at issue in this Count, which Plaintiffs deny, the acts and omissions of Dr. Ragan described above also constituted gross negligence, in that they reflect a failure to exercise even slight care.

149.

The negligence of Dr. Ragan proximately caused and contributed to the delay in the recognition, imaging, diagnosis, consultation, and transfer of Tammy Carnley, and thereby to the loss of her opportunity to undergo mechanical thrombectomy while a significant portion of her brain tissue remained salvageable.

150.

At relevant times, Dr. Ragan was an employee or an actual or apparent agent of one or more of the Corporate Defendants, and was acting within the course and scope of his employment or other agency.

151.

The Corporate Defendants are therefore liable for Dr. Ragan's failures to comply with the applicable standard of care.

Professional Negligence: Dr. Burton, Direct Radiology, Vesta, and the Corporate Defendants

152.

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

153.

At relevant times, Dr. Dennis M. Burton was a physician licensed in and engaged in the practice of radiology in the State of Georgia.

154.

On October 7, 2024, Dr. Burton entered into a physician-patient relationship with Tammy Carnley when he undertook to read and interpret her CT scan.

155.

Dr. Burton thus had a duty to provide care to Tammy within the applicable standard of care.

156.

Dr. Burton failed to comply with the applicable standard of care in the care he provided Tammy.

157.

On October 7, 2024, Dr. Burton violated the standard of care by misreading Tammy's 8:14 a.m. CT scan as showing no acute intracranial abnormality, when in fact the CT demonstrated early ischemic changes of a large left middle cerebral artery territory infarct that should have been identified and reported.

158.

Each of the foregoing acts and omissions of Dr. Burton also constituted ordinary or simple negligence.

159.

To the extent that O.C.G.A. § 51-1-29.5 is held to apply to any of the care at issue in this Count, which Plaintiffs deny, the acts and omissions of Dr. Burton described above also constituted gross negligence, in that they reflect a failure to exercise even slight care.

160.

Dr. Burton's misread delayed the recognition and treatment of Tammy's stroke and proximately caused and contributed to the catastrophic delay in transferring Tammy for mechanical thrombectomy, and thereby to the loss of her opportunity to undergo that procedure while a significant portion of her brain tissue remained salvageable.

161.

At relevant times, Dr. Burton was an employee or an actual or apparent agent of Direct Radiology, Vesta, or both, and of one or more of the Corporate Defendants, and was acting within the course and scope of his employment or other agency.

162.

Direct Radiology is therefore liable for Dr. Burton's failures to comply with the applicable standard of care.

163.

Vesta is therefore liable for Dr. Burton's failures to comply with the applicable standard of care.

164.

The Corporate Defendants are therefore liable for Dr. Burton's failures to comply with the applicable standard of care.

Negligence: Direct Radiology, LLC

165.

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

166.

Direct Radiology undertook to furnish diagnostic radiology interpretation services to the Hospital, including the emergent interpretation of neuroimaging studies obtained on patients presenting to the Hospital's Emergency Department.

167.

Having undertaken that service, Direct Radiology owed Tammy Carnley a duty of ordinary care in the conduct of its business, independent of the professional duty owed her by Dr. Burton.

168.

Direct Radiology breached that duty. Its acts and omissions include, among other things: failing to adopt and enforce adequate systems for identifying, prioritizing, and expediting emergent stroke imaging studies; failing to adopt and enforce adequate protocols for the communication of critical or time-sensitive imaging findings to the ordering facility; failing to ensure that the radiologists to whom it assigned emergent neuroimaging studies possessed the training, experience, and competence to identify early ischemic changes on a non-contrast head CT; failing to adopt and enforce adequate quality assurance, peer review, over-

read, and error-detection processes; and failing to adequately supervise the radiologists it employed or engaged.

169.

Each of the foregoing acts and omissions constituted ordinary or simple negligence.

170.

The administrators, managers, and other personnel responsible for the foregoing acts and omissions were employees, servants, or actual or apparent agents of Direct Radiology, acting within the course and scope of that employment or agency, and Direct Radiology is vicariously liable for their negligence.

171.

The negligence of Direct Radiology created an unnecessary and unreasonable potential for error in the interpretation of Tammy's emergent neuroimaging, facilitated rather than prevented that error, and proximately caused and contributed to the delay in the recognition, diagnosis, and treatment of her stroke, and thereby to the loss of her opportunity to undergo mechanical thrombectomy while a significant portion of her brain tissue remained salvageable.

Negligence: Vesta Telemedicine Solutions, LLC

172.

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

173.

Vesta undertook to furnish diagnostic radiology interpretation services to the Hospital, directly or through Direct Radiology, including the emergent interpretation of neuroimaging studies obtained on patients presenting to the Hospital's Emergency Department.

174.

Having undertaken that service, Vesta owed Tammy Carnley a duty of ordinary care in the conduct of its business, independent of the professional duty owed her by Dr. Burton.

175.

Vesta breached that duty. Its acts and omissions include, among other things: failing to adopt and enforce adequate systems for identifying, prioritizing, and expediting emergent stroke imaging studies; failing to adopt and enforce adequate protocols for the communication of critical or time-sensitive imaging findings to the ordering facility; failing to ensure that the radiologists to whom it assigned emergent neuroimaging studies possessed the training, experience, and competence to identify early ischemic changes on a non-contrast head CT; failing to adopt and enforce adequate quality assurance, peer review, over-read, and error-detection processes; and failing to adequately supervise the radiologists it employed or engaged.

176.

Each of the foregoing acts and omissions constituted ordinary or simple negligence.

177.

The administrators, managers, and other personnel responsible for the foregoing acts and omissions were employees, servants, or actual or apparent agents of Vesta, acting within the course and scope of that employment or agency, and Vesta is vicariously liable for their negligence.

178.

The negligence of Vesta created an unnecessary and unreasonable potential for error in the interpretation of Tammy's emergent neuroimaging, facilitated rather than prevented that error, and proximately caused and contributed to the delay in the recognition, diagnosis, and treatment of her stroke, and thereby to the loss of her opportunity to undergo mechanical thrombectomy while a significant portion of her brain tissue remained salvageable.

Professional Negligence: Nursing Staff and the Corporate Defendants

179.

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

180.

At relevant times, the members of the Nursing Staff were registered nurses and other nursing personnel engaged in the practice of nursing in the State of Georgia.

181.

On October 7, 2024, the Nursing Staff undertook to provide nursing care to Tammy Carnley and thereby assumed a duty to provide that care within the applicable standard of care.

182.

As used in this Count, the phrase "standard of care" means the degree of care and skill ordinarily employed by the nursing profession generally under similar conditions and like surrounding circumstances.

183.

The nursing standard of care imposes duties that are independent of physician orders and of physician judgment. The recognition of a patient's stroke presentation, the performance and documentation of stroke screening and serial neurological assessment, the activation of a hospital stroke alert, structured communication with the treating physician, escalation of unaddressed patient care concerns through the nursing chain of command, and patient advocacy are nursing functions that a registered nurse must perform on the nurse's own professional judgment.

184.

The Nursing Staff failed to comply with the applicable standard of care in the nursing care they provided Tammy.

185.

On October 7, 2024, the Nursing Staff violated the standard of care by, among other things:

a. failing to recognize Tammy's presentation, a patient found unresponsive at home, with unilateral motor and sensory deficits, aphasia, gaze preference, and a depressed level of consciousness, as an acute stroke until proven otherwise;

b. failing to perform and document a validated stroke screening assessment and to obtain and document Tammy's last known well time;

c. failing to activate the Hospital's stroke alert or code stroke response, independently and without waiting for a physician order;

d. failing to assign Tammy the highest acuity designation and to treat her as a time-critical emergency, with the assessment, documentation, and reassessment intervals that designation requires;

e. failing to perform and document serial neurological assessments of a patient with a profound and unexplained neurological deficit;

f. failing to recognize that hours were elapsing without vascular imaging, without neurological consultation, and without transfer, for a patient whose presentation was that of a large vessel occlusion;

g. failing to communicate to Dr. Ragan and to any other treating physician, clearly, directly, and in a structured manner, Tammy's stroke presentation and the passage of time without a stroke workup;

h. failing to escalate Tammy's care through the nursing chain of command, to the charge nurse, the emergency department nurse manager or house supervisor, and the stroke program coordinator or emergency department medical director, when her condition continued to go unaddressed, and failing to act as the patient advocate for a woman who was aphasic, unresponsive, and wholly unable to advocate for herself; and

i. failing, after the transfer had been accepted at approximately 1:30 p.m. and report had been called at approximately 1:45 p.m., to effect that time-critical emergency transfer without avoidable delay.

186.

Each of the foregoing acts and omissions of the Nursing Staff also constituted ordinary or simple negligence.

187.

To the extent that O.C.G.A. § 51-1-29.5 is held to apply to any of the nursing care at issue in this Count, which Plaintiffs deny, the acts and omissions of the

Nursing Staff described above also constituted gross negligence, in that they reflect a failure to exercise even slight care.

188.

The negligence of the Nursing Staff proximately caused and contributed to the delay in the recognition, imaging, diagnosis, consultation, and transfer of Tammy Carnley, and thereby to the loss of her opportunity to undergo mechanical thrombectomy while a significant portion of her brain tissue remained salvageable.

189.

At relevant times, each member of the Nursing Staff was an employee or an actual or apparent agent of one or more of the Corporate Defendants, and was acting within the course and scope of that employment or agency.

190.

The Corporate Defendants are therefore liable for the Nursing Staff's failures to comply with the applicable standard of care.

Administrative Negligence: Corporate Defendants

191.

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

192.

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

193.

The Corporate Defendants owed Tammy Carnley and her family ordinary duties of care.

194.

The Corporate Defendants breached those duties.

195.

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

196.

The Corporate Defendants breached those duties through the acts and omissions of administrators not licensed for the professions listed in O.C.G.A. § 9-11-9.1(g).

197.

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

198.

Administrators of the Corporate Defendants failed, for example, to adopt adequate stroke protocols designed to ensure that patients presenting with signs of

acute stroke receive timely evaluation, treatment, and transfer to an appropriate facility.

199.

Administrators of the Corporate Defendants also failed, for example, to provide adequate training to staff on whatever stroke protocols existed, and to audit compliance with those protocols.

200.

Administrators of the Corporate Defendants also failed to develop and implement appropriate administrative systems for stroke alert activation, emergent neurological consultation, and timely inter-facility transfer for stroke patients requiring advanced intervention.

201.

Administrators of the Corporate Defendants also failed to adopt, implement, train upon, and audit compliance with an adequate nursing chain of command policy, so that nursing personnel who identified an unaddressed time-critical patient condition would have a clear and enforced pathway to escalate that concern.

202.

Administrators of the Corporate Defendants also failed to adopt and enforce adequate systems for the credentialing, supervision, and quality review of the physicians, including teleradiologists, to whom the interpretation of emergent neuroimaging studies was entrusted.

203.

Negligent administration by the Corporate Defendants created unnecessary and unreasonable potential for error by providers involved in Tammy's care.

204.

Negligently administered systems and organizational practices facilitated, rather than prevented, individual error.

205.

By violating duties of ordinary care, the Corporate Defendants harmed Tammy.

206.

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.

207.

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

Loss of Consortium: Michael Carnley

208.

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

209.

At all relevant times, Michael Carnley was, and continues to be, the lawful husband of Tammy Carnley.

210.

As a direct and proximate result of the negligence of the Defendants alleged in this Complaint, Michael Carnley has been deprived of, and will continue to be deprived of, the services, society, companionship, affection, comfort, consortium, and support of his wife, Tammy Carnley.

211.

Michael Carnley is entitled to recover from Defendants damages for his loss of consortium in an amount to be determined by a fair and impartial jury.

Causation and Damages

212.

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

213.

Had Defendants complied with the applicable standard of care, Tammy would have been promptly identified as a candidate for mechanical thrombectomy, timely transferred to a comprehensive stroke center, and would have undergone thrombectomy while a significant portion of her brain tissue remained salvageable,

as reflected by the ASPECTS of 6 to 7 documented at the Hospital, compared to the ASPECTS of 1 documented after the delay in transfer.

214.

As the direct and proximate result of the wrongdoing alleged in this Complaint, Tammy Carnley has suffered, and will continue to suffer for the remainder of her life, pain, suffering, and permanent injury, including dense right-sided paralysis, global aphasia, inability to communicate, inability to care for herself, and other devastating neurological deficits.

215.

As the direct and proximate result of the wrongdoing alleged in this Complaint, Tammy Carnley experienced distress, anguish, humiliation, discomfort, pain, suffering, and other harms during her hospitalization in October 2024 and continues to experience these harms.

216.

As the direct and proximate result of the wrongdoing alleged in this Complaint, Tammy Carnley has incurred substantial past medical expenses, and will incur substantial future medical expenses, including the costs of acute hospital care, decompressive hemicraniectomy, tracheostomy, PEG-tube placement, rehabilitation, and ongoing medical treatment.

217.

As the direct and proximate result of the wrongdoing alleged in this Complaint, Tammy Carnley will require lifetime attendant care and life-care services, the reasonable value of which Plaintiffs are entitled to recover.

218.

As the direct and proximate result of the wrongdoing alleged in this Complaint, Tammy Carnley has suffered, and will continue to suffer, lost wages and lost earning capacity, having been gainfully employed by the Muscogee County School District prior to October 7, 2024, and having been rendered unable to work as a result of her catastrophic neurological injuries.

219.

As the direct and proximate result of the wrongdoing alleged in this Complaint, Tammy Carnley has suffered a permanent loss of her capacity to labor and earn money.

220.

As the direct and proximate result of the wrongdoing alleged in this Complaint, Plaintiff Michael Carnley has suffered loss of consortium and other compensable damages as set forth above.

Prayer for Relief

221.

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

222.

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

a. compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury, including damages for past and future pain and suffering, past and future medical expenses, past and future lost wages and lost earning capacity, loss of capacity to labor and earn money, future life-care and attendant-care costs, and loss of consortium;

b. all costs of this action; and

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

This 28th day of September 2026. Respectfully submitted,

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EXHIBIT 1

AFFIDAVIT OF GUY A. RORDORF, M.D., REGARDING TAMMY CARNLEY

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Guy A. Rordorf, M.D., who after first being duly sworn, states as follows.

Introduction

1.

This affidavit addresses medical negligence that occurred during Tammy Carnley's presentation to St. Francis–Emory Healthcare Hospital ("St. Francis") in Columbus, Georgia, on October 7, 2024.

2.

I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.

3.

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

4.

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 medical providers I discuss here.

Qualifications

5.

I am a physician licensed to practice medicine and am board certified in Neurology and in the subspecialty of Vascular Neurology. My professional qualifications include, among other things, the following:

a. I received my Doctor of Medicine degree from the University of Geneva, Switzerland, and completed residency training in Neurology at the Massachusetts General Hospital.

b. I am certified by the American Board of Psychiatry and Neurology in Neurology and, in the subspecialty of Vascular Neurology, and I hold subspecialty certification in Neurocritical Care from the United Council for Neurologic Subspecialties.

c. I am an Associate Professor of Neurology at Harvard Medical School.

d. I am an attending neurologist at the Massachusetts General Hospital and at Newton-Wellesley Hospital. I have previously served as Director of the Neuroscience Intensive Care Unit at the Massachusetts General Hospital and as Neurology Director of the Neurovascular Service at Newton-Wellesley Hospital.

e. For more than twenty-five years, continuing through the present and within the last five years, I have been engaged in the active clinical practice of vascular neurology and neurocritical care. That practice regularly includes the evaluation and treatment of patients with acute ischemic stroke, including patients who present through the emergency department. It encompasses the recognition of acute stroke, the interpretation of head CT, CT angiography, and CT perfusion imaging in the acute setting, decisions regarding intravenous thrombolysis and mechanical thrombectomy, and the timely transfer of patients with large vessel occlusion to centers capable of performing thrombectomy.

f. I regularly teach residents and fellows, including emergency-department and medicine residents, on the recognition and acute management of stroke, and I have lectured on emergency-room management of acute stroke.

g. I have authored or co-authored numerous peer-reviewed publications concerning acute ischemic stroke, neuroimaging in acute stroke (including CT perfusion, diffusion- and perfusion-weighted imaging, and CT angiography), and endovascular therapies. I am a member of the Stroke Council of the American Heart Association, the American Society of Neuroimaging, the Neurocritical Care Society, and the American Academy of Neurology.

6.

By virtue of my active practice and teaching, within the last five years, in the diagnosis and treatment of acute ischemic stroke—the very condition at issue in this case—I am familiar with the standard of care that applied to the physicians who evaluated, imaged, and managed Tammy Carnley on October 7, 2024, including the standard governing the timely recognition and treatment of acute stroke in the emergency-department setting and the interpretation of neuroimaging obtained in that setting.

7.

In forming the opinions stated below, I have reviewed the medical records pertaining to Tammy Carnley's care, including the Harris County EMS prehospital care report of October 7, 2024; the St. Francis Hospital emergency-department records of October 7, 2024, together with the associated imaging and radiology reports; and the Piedmont Columbus Regional Midtown Hospital records of the October 7 through October 25, 2024 admission. My curriculum vitae is attached to this affidavit.

Standard of Care

8.

Acute ischemic stroke is a time-critical emergency. Brain tissue deprived of blood flow is progressively and irreversibly lost with the passage of time. When a patient presents with signs of acute stroke—such as sudden unilateral weakness, aphasia, and altered level of consciousness—the standard of care requires the treating physicians to recognize the likelihood of stroke promptly, to activate the

institution's stroke protocol, to obtain the appropriate neuroimaging on an emergent basis, to obtain neurologic consultation without delay, and, where a large vessel occlusion is present, to arrange timely transfer to a facility capable of performing mechanical thrombectomy.

9.

For a patient with a large vessel occlusion of the middle cerebral artery, mechanical thrombectomy can restore blood flow to threatened but not-yet-infarcted brain tissue (the ischemic penumbra). The benefit of thrombectomy depends on treating while salvageable tissue remains; as time passes, the penumbra is lost to completed infarction. In appropriately selected patients, timely thrombectomy substantially improves the likelihood of a good functional outcome, and a substantial proportion of such patients recover with little or no lasting neurological deficit. Radiographic surrogates such as the ASPECTS score are used to estimate the extent of established infarction; a declining ASPECTS score reflects ongoing, progressive tissue loss.

Principal Opinions

10.

Standard of care. Tammy Carnley presented to St. Francis on October 7, 2024 with findings classic for an acute stroke. The standard of care required the physicians evaluating and imaging her to recognize the acute stroke, to activate the stroke protocol, to obtain CT angiography emergently, to obtain neurologic

consultation without delay, and to arrange prompt transfer for thrombectomy given the large vessel occlusion.

11.

Violation — James E. Ragan, M.D. Dr. Ragan, the emergency physician, first evaluated Mrs. Carnley at approximately 6:44 a.m. His own examination documented findings classic for acute stroke—unresponsiveness, right-sided motor and sensory deficits, and aphasic speech—and he assigned an NIH Stroke Scale score of 22, indicating a severe stroke. Despite these findings, no stroke alert or stroke protocol was activated, CT angiography was not ordered, and neurology was not consulted until approximately 12:26 p.m.—nearly six hours after his initial evaluation. In my opinion, to a reasonable degree of medical certainty, Dr. Ragan's failure to timely recognize the acute stroke and to timely activate the stroke protocol, obtain CT angiography, obtain neurologic consultation, and initiate transfer was a deviation from the standard of care.

12.

Violation — Dennis M. Burton, M.D. Dr. Burton, the radiologist, interpreted the non-contrast head CT read at approximately 8:14 a.m. as "Normal CT of the head." That study in fact demonstrated early ischemic changes of a left middle cerebral artery territory infarct—findings that were identified on the identical images in a later addendum by Dr. Phillip McDonald and that are consistent with the left M1 occlusion subsequently confirmed on CT angiography. In my opinion, to a reasonable degree of medical certainty, Dr. Burton's failure to identify and report

these findings was a deviation from the standard of care, and, in my opinion, a gross deviation. An accurate reading at 8:14 a.m. should have prompted immediate CT angiography, neurologic consultation, and transfer.

13.

Causation. The failures described above caused a critical delay in Mrs. Carnley's treatment. At approximately 12:25 p.m. at St. Francis, her ASPECTS score was recorded as 6–7, confirming that salvageable brain tissue remained at that time; by approximately 3:23 p.m. at Piedmont, her ASPECTS score had fallen to 1, reflecting near-complete infarction. She did not arrive at Piedmont until approximately 2:22 p.m., and thrombectomy was not performed because the infarct had by then progressed to near-complete. Had the acute stroke been recognized at approximately 8:14 a.m. and CT angiography, neurologic consultation, and transfer been initiated promptly thereafter, Mrs. Carnley would, to a reasonable degree of medical certainty, have reached the thrombectomy-capable center several hours earlier, while she remained a candidate for thrombectomy. In my opinion, to a reasonable degree of medical certainty, she more likely than not would have undergone mechanical thrombectomy and would have had a substantially better neurological outcome, with a reasonable probability of little or no lasting deficit. The delay deprived her of that opportunity.

14.

Damages. Mrs. Carnley, who was 47 years old and fully independent at baseline (modified Rankin Scale 0), sustained a completed left middle cerebral

artery territory infarct with cerebral edema requiring emergency decompressive hemicraniectomy, and she required tracheostomy and gastrostomy tube placement. She was left with dense right hemiplegia and global aphasia, dependent for all activities of daily living. In my opinion, to a reasonable degree of medical certainty, these injuries were proximately caused by the delay in recognition and treatment described above.

Gross Negligence

15.

I understand that Georgia law, at OCGA § 51-1-29.5, may apply a heightened standard to certain medical care provided in a hospital emergency department, under which liability requires proof by clear and convincing evidence of gross negligence, meaning the absence of even slight care or diligence. Whether that standard applies to the care at issue here is a legal question that I do not decide.

16.

To the extent that standard applies, it is my opinion, to a reasonable degree of medical certainty, that the conduct described above satisfies it. In particular, the interpretation of a head CT bearing early ischemic changes of a large acute infarct as a "Normal CT of the head," and the failure over the course of nearly six hours to recognize and act upon a severe stroke that was documented on examination with an NIH Stroke Scale score of 22, each reflect the absence of even slight care under the circumstances.

20.

My curriculum vitae, setting forth my education, training, licensure, appointments, and publications, is also attached to this affidavit.

Guy A. Rordorf, M.D.

SWORN TO AND SUBSCRIBED before me
this 23th day of July, 2026.

NOTARY PUBLIC

My Commission Expires: 11-16-2029

REBECCA L. CROSS NOTARY PUBLIC COMMONWEALTH OF MASSACHUSETTS MY COMMISSION EXPIRES 11-16-29

Curriculum Vitae

Date Prepared: February 11, 2022

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Place of Birth: Mendrisio - Switzerland

Education

1981	B.S., LICEO CANTONALE MENDRISIO, SWITZERLAND
1988	M.D., UNIVERSITY OF GENEVA, MEDICAL SCHOOL, SWITZERLAND

Postdoctoral Training

10/88-09/89	Resident in Neurology, Neurology, University Hospital
10/89-12/89	Resident in Medicine, Medicine, University Hospital
01/90-06/91	Jacob Javits Research Fellow in Medicine, Medicine, Massachusetts General Hospital
07/91-06/92	Resident in Neurology, Neurology, Massachusetts General Hospital
07/92-06/93	Intern in Medicine, Medicine, Massachusetts General Hospital
07/93-06/95	Resident in Neurology, Neurology, Massachusetts General Hospital
07/95-06/96	Clinical Assistant in Neurology, Neurology, Massachusetts General Hospital

Faculty Academic Appointments

1990-1991	Research Fellow in Medicine, Harvard Medical School
1991-1992	Clinical Fellow in Neurology, Harvard Medical School
1992-1993	Clinical Fellow in Medicine, Medicine-Harvard Medical School
1996-1998	Instructor in Neurology, Harvard Medical School
1998- 2012	Assistant Professor of Neurology, Harvard Medical School

6/1/2012-present	Associate Professor of Neurology, Harvard Medical School

Appointments at Hospitals/Affiliated Institutions

07/1995 - 06/1996	Clinical Assistant in Neurology, Massachusetts General Hospital, Boston,MA
06/1996 – 01/2012	Assistant in Neurology, Massachusetts General Hospital, Boston,MA
2007-current	Neurologist – Newton Wellesley Hospital, Newton MA
02/2012-current	Neurologist – Massachusetts General Hospital, Boston, MA

Other Professional Positions

01/08	Neurohospitalist, Newton Wellesley Hospital, Newton, MA

Major Administrative Leadership Positions

Local

1996-1998	Assistant Director Neuroscience Intensive Care Unit, Massachusetts General Hospital
1996-2002	Director Neurocritical Care - Stroke Fellowship Program, Massachusetts General Hospital.
1998-2005	Associate Director Neuroscience Intensive Care Unit, Massachusetts General Hospital
2005-2007	Director Neuroscience Intensive Care Unit, Massachusetts General Hospital
2007-	Director Neurovascular Service, Newton Wellesley Hospital, Newton, MA
2007-	Chair Q/A Committee Vascular Center, Massachusetts General Hospital
2007-	Neurology Director Vascular Center, Waltham MA, Massachusetts General Hospital
2018-	Department of Medicine Newton Wellesley Hospital Quality Improvement/Peer Review Committee

National

2005-2008	Neurocritical Care Society, Board of Directors

Committee Service

Local

1996-2007	Critical Care Committee, Massachusetts General Hospital

2004-2008 Drug Formulary Approval Committee, Massachusetts General Hospital
2007- Q/A Committee Vascular Center, Massachusetts General Hospital
2007- Executive Committee Vascular Center, Massachusetts General Hospital
2008- Stroke Task Force, Newton Wellesley Hospital, Newton, MA

National

2005-2008 Long Range Committee, Neurocritical Care Society

Professional Societies

1998- Stroke Council of the American Heart Association , Member
1998- American Society of Neuroimaging, Member
2004- Neurocritical Care Society, Member
2005- American Academy of Neurology

Editorial Activities

2001- Ad Hoc Reviewer, Stroke
2001- Ad Hoc Reviewer, New England Journal of Medicine
2004- Ad Hoc Reviewer, Journal of Neurocritical Care
2005- Ad Hoc Reviewer, Expert Review of Cardiovascular Therapy
2005- Ad Hoc Reviewer, Cerebrovascular Disease
2013- Ad Hoc Reviewer, Circulation

Honors and Prizes

2005 Partners in Excellence Award, Partners Health Care
2006 Partners in Excellence Award, Partners Health Care
2007 Fondazione per lo studio delle malattie neurodegenerative, Swiss Fundation
2010 Partners in Excellence Award, Partners Health Care
2011 The Locke Award for Excellence in Inpatient Education In Medicine
2012 Nominated for the McGovern Award for Clinical Excellence
2014 Nominated for the McGovern Award for Clinical Excellence
2016 Nominated for the McGovern Award for Clinical Excellence
2019 Nominated for the McGovern Award for Clinical Excellence

Report of Funded and Unfunded Projects

Funding Information

Past

1995-1996 Site Investigator, Company, Safety/Efficay study of 15 mg/kg/day Tirilizad Mesylate in North American Women with Subarachnoid Hemorrhage
1995-1996 Site Investigator, Company, A phase I/II safety study of FIBLAST trofermin (basic fibroblastic growth factor) in the treatment of patients with acute thromboembolic cerebrovascular occlusion.
1996-1997 Site Investigator, Company, A double blind, placebo controlled parallel group, 3 day

	treatment and 3 month follow up multicenter study to evaluate the safety and efficacy of intravenous fofphenytoin (CEREBYX) in patients with acute ischemic stroke
1999-2002	Co-P.I., American Heart Association, AHA 9950065N, Pelvic vein thrombosis as a source of paradoxical emboli in cryptogenic stroke
2001-2002	Site Investigator, Company, Cooling for acute ischemic brain damage (COOL AID): a randomized pilot clinical trial of endovascular cooling for acute ischemic stroke
2002-2003	Site Investigator, Company, A prospective, non randomized evaluation of the concentric retreiver system for the treatment of neurovascular thrombotic occlusions
2003-2005	Co-P.I., N.I.H., 1 RO1 NS42607-01A2, Use of Induced Hypertension for the Treatment of Acute Ischemic Stroke
2004-2005	Site Investigator, Company, Phase II randomized pharmaokinetic, dose finding, and dose frequency determination using rt-PA in Intraventricular Hemorrhage

Current

2009-	Site Investigator. Mechanical Retrieval and Recanalization of Stroke clots Using embolectomy (MR-Rescue), NIH-NINDS/P50 NS44378
	This trial investigate new methods to recanalize an acutely occluded cerebral blood vessel
2010-	Site Investigator. Efficacy and safety study of desmoteplase to treat acute ischemic stroke (DIAS-4), H. Lundback A/S
	This trial investigates the possibility of extending the window of time during which stroke victims presenting with an acute ischemic stroke can be treated. This trial extend the time from last known well from 4:30 hours to 8 hours
2011-	Site Investigator. A phase IIa safety study of intravenous thrombolysis with alteplase in MRI-selected patients (MR WITNESS), NIH-NINDS/2 P50 NS051343-06
	This trial investigate the potential of successfully treat patient that wake up with acute ischemic stroke symptoms after last seen well before going to sleep.
2013-	IRIS trial PI for Massachusetts General Hospital.
	This trial is a randomized multicenter placebo controlled trial to assess the efficacy of pioglitazone in preventing recurrent strokes
2015-	Randomized double-blind Evaluation in secondary stroke prevention comparing the Efficacy and safety of the oral Thrombin inhibitor dabigatran etexilate versus aspirin in patients with embolic stroke of undetermined source (RESPECT ESUS)
	PI at the Newton Wellesley Hospital
2015-	POINT trial: Platelet-Oriented Inhibition in New TIA and minor ischemic stroke
	PI at the Newton Wellesley Hospital

Event Adjudication Committee:

2009- 2013	Evaluation of the Safety and Effectiveness of the DuraHeart Left Ventricular Assist System in Patients Awaiting Transplantation

Data Monitoring Committee

2015- *a*MAZE TRIAL: LEFT ATRIAL APPENDAGE LIGATION WITH THE LARIAT® SUTURE DELIVERY SYSTEM AS ADJUNCTIVE THERAPY TO PULMONARY VEIN ISOLATION FOR PERSISTENT OR LONGSTANDING PERSISTENT ATRIAL FIBRILLATION

Report of Local Teaching and Training

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs)

2000- Yearly teaching conference for neurology ICU fellows: Subarachnoid Hemorrhage, ICU management. Massachusetts General Hospital, Boston MA

2002-2007 Associate Director and Director Neuroscience ICU, Massachusetts General Hospital
Responsibility: Continuous teaching of clinical neurology, stroke care and neuro and general critical care to medical students rotating through neurology, neurology residents and Neurocritical Care fellows.

2004- Yearly teaching conference for SICU fellows and residents on Neurology management of critically ill patients

2007- Yearly teaching conference for medicine residents: Stroke pathophysiology and management. Newton Wellesley Hospital, Newton MA

Clinical Supervisory and Training Responsibilities

1999- 8 Fellows for 840 hrs/year, supervising stroke and intensive care training, Harvard University - Massachusetts General Hospital

2001- 18 Neurology Residents for 840 hrs/year, supervising stroke and critical care training, Harvard University - Massachusetts General Hospital

2008- 16 Medicine Residents for 560hrs/year, supervising general neurology training, Harvard University – Newton Wellesley Hospital, Newton, MA

Formally Supervised Trainees

Training Duration	*Name*	*Current Position*
1997-1999	Mustapha Ezzeddine	MD *Assistant Professor – UMDNJ
		Published three manuscripts

1997-1999	Colin McDonald MD*	Director Acute Stroke Service - South Shore Hospital , MA Published two manuscripts and 2 chapters in Up To Date
1998-1999	Alan Segal MD*	Assistant Professor - Director Stroke Service - Cornell University Published four manuscripts
1999-2000	Jon Rosand MD*	Professor in Neurology - Massachusetts General Hospital, HMS Obtained a K award grant
1999-2000	Jamary Oliveira - Filho MD*	Director Neurology Intensive Care Unit - Salvator De Bahia – Brasil Published one manuscript
1999-2001	Igor Ougorets MD*	Assistant Professor - Director Neurointensive Care Unit -Cornell University
1999-2001	David Greer MD*	Professor in Neurology – Yale University Developed and started study on indicator of prognosis in coma, published this year
2000-2001	Kim-En Lee MD*	Associate Consultant in Neurology - Director Stroke Service - Singapore National Neuroscience Inst. Wrote thesis required by Hospital in Singapore
2001-2003	Neeraj Badjatia MD*	Assistant Professor - Columbia Universtiy Medical Center NY Published 3 manuscripts
2002-2003	Eric Smith MD*	Instructor in Neurology - Massachusetts General Hospital, HMS

		Published 2 mansucripts
2002-2003	Cenk Ayata MD PhD*	Associate Professor of Neurology - Massachusetts General Hospital, HMS Published one manuscript, double blinded randomized trial on efficacy of statin in subarachnoid hemorrhage
2002-2003	Raul Nogueira MD*	Associate Professor of Neurology and Radiology, Emory University Published 2 manuscripts
2003-2004	Leigh Hochberg MD PhD	ICU Staff Massachusetts General Hospital Obtained K award grant
2003-2005	Joshua Levine	Assistant Professor - University of Pennsylvania Applied for K award grant
2003-2005	Kiwon Lee	Assistant Professor - Jefferson Medical Center Philadelphia Published one manuscript
2004-2005	Than Nguyen	Associate Professor of Neurology - Boston Univeristy Published one manuscript
2005-2007	Sherry Chou	Instructor in Neurolgy - Brigham and Women's Hospital, HMS Published one manuscript
2005-2007	Julius Gene Latorre	Associate Professor - Syracuse University Medical Center Published one manuscript

*formal supervision and mentoring as the Fellowship Director

Formal Teaching of Peers (e.g., CME and other continuing education courses)

1995- Stroke and Subarachnoid Hemorrhage for Clinician

CME, Course title: Hemorrhagic and Ischemic Stroke Updates

1996- Multiple presentations at the Massachuestts General Hospital weekly Stroke Conference, CME accredited

1996- Multiple presentations at the Massachusetts General Hospital weekly Neurocritical Care Conference, CME accredited

1999- Update on New Techniques and Review of Established Principles of Management of Cerebrovascular Emergencies
CME, Course title: Hemorrhagic and Ischemic Stroke Updates

2003- Neurovascular update: Present Practices and Future Directions
CME, Course title: Hemorrhagic and Ischemic Stroke Updates

2005- Carotid and Vertebral Dissection: Why does it happen? When should we look for it? How do we diagnose and treat it? Massachusetts General Hospital

2006- Ischemic and Hemorrhagic Update: Acute treatment for patients not eligible for intra-arterial therapy
CME, Course title: Hemorrhagic and Ischemic Stroke Updates

2008- Ischemic and Hemorrhagic Update: Office management of the stroke prone patients: who should be screened, what tests should be used

CME, Course title: Hemorrhagic and Ischemic Stroke Updates

2012- Ischemic and Hemorrhagic update: Targeting specific causes of stroke
CME, Course title: Hemorrhagic and Ischemic Stroke Updates
Moderator

Local Invited Presentations

1996- Update on New Techniques and Review of Established Principle of Management of Cerebrovascular Emergencies

Newton Wellesley Hospital

1998- Stroke Update and Comprehensive Review
Newton Wellesley Hospital

1998 Emergency Room Management of Acute Stroke
Medical Grand Rounds – Massachusetts General Hospital

2002- Current Management of Stroke and Intracranial Hemorrhage from Emergency Room through Hospitalization
Newton Wellesley Hospital

2005- Ischemic and Hemorrhagice Update: Nonthrombolytic acute therapy

2012- Current concepts and controversies in vascular and endovascular surgery: Timing of CEA after TIA or stroke
Massachusetts General Hospital

2012- Safety and Efficacy of CEA and CAS
Massachusetts General Hospital

2014- Dissecting the Etiologies of Stroke in the Young. Massachusetts General Hospital, Neurology Grand Rounds

2016 Newton Wellesley Hospital Gd Rounds: Advances in Stroke

Report of Regional, National and International Invited Teaching and Presentations

Regional, National and International Invited Presentations and Courses

Regional
No presentations below were sponsored by outside entities

1997- Acute Stroke Treatment, Newton-Wellesley Hospital Medical Grand Rounds

10/2012 Stroke: Hemorrhagic and Ischemic Updates, Newton- Wellesley Hospital, Medical Grand Rounds

1/2014 Dissection and collage disorders. Boston Medical Center. Neurology Grand Round

National
No presentations below were sponsored by outside entities

1998- Emergent Evaluation of the Acute Stroke Patient , Florida Hospital - Orlando*[Invited*

Lecture]

1998- Management of the Patient with Subarachnoid Hemorrhage, Florida Hospital - Orlando*[Invited Lecture]*

2001- Acute Stroke Management: Intensive Care of Stroke, American Academy of Neurology*[Invited Lecture]*

2002- Critical Care of Stroke: Intensive Care of Stroke, American Academy of Neurology*[Invited Lecture]*

2008- Psychiatric Complications in the ICU: diagnosis and managment, Neurocritical Care Meeting*[Invited Lecture]*

2009- Induced Hypertension and Hypervolemia in the Treatment of Acute Ischemic Stroke, Stroke Meeting, San Diego*[Invited Lecture]*

2017 Subarachnoid hemorrhage: pathophysiology and management: Integris Baptist Hospital, Oklahoma City, OK

International

No presentations below were sponsored by outside entities

1998- Diagnosis and Classification of Strokes in the Emergency Room, European Society of Emergency Medicine, San Marino Italy*[Invited Lecture]*

2005- Blood Pressure Management after Acute Ischemic Stroke, Swiss Neurological Society, Bienne, Switzerland*[Invited Lecture]*

2006- Ischemic and hemorrhagic stroke: a diagnostic and therapeutic update, Ospedale Locarno - Switzerland*[Invited Lecture]*

2007- Acute Care Neurology, Ospedale Beata Vergine, Mendrisio Switzerland *[Invited Lecture]*

2012- Management of Acute Stroke, Bermuda *[Invited Lecture]*

Report of Clinical Activities and Innovations

Current Licensure and Certification

1998 FMGEMS part II

1991 FMGEMS part I

1993 FLEX part I and II

1995 Massachusetts Medical License - #80689

1996 American Society of Neuroimaging - Neurosonology Certificate

1996 American Board of Psychiatry and Neurology - #42912

2006 American Board of Neurology and Psychiatry Recertification

2007 New Hampshire Medical License - # 13757

2008 Maine Medical License - # 017751

2008 American Board of Neurology and Psychiatry: Vascular Neurology Board - #605

2008 United Council for Neurological Subspecialites - Neurocritical Care Certification - #NCC00391-08

2016 American Board of Psychiatry and Neurology Recertification #42912

2016 American Board of Psychiatry and Neurology: Vascular Neurology Board Recertification #605

Practice Activities

1996- Inpatient Neurology, NeuroCritical Care and Stroke Massachusetts General Hospital
Clinical Activity Description: Acute stroke patients seen in the emergency room and throughout the hospital. Critically ill patients with stroke, subarachnoid hemorrhage, intracranial hemorrhage, head trauma, status epilepticus, neuromuscular diseases seen, managed and treated in the Neuroscience Intensive Care Unit. Patients with common and rare neurological diseases seen as inpatient in the general neurology clinic.
Time spent: 20 weeks a year

1996- Outpatient Neurology
Clinical Activity Description: Patients with common and rare neurological disorders seen in a clinic setting. I evaluate and treat outpatients two half sessions a week
Time spent: 2 half days a week

2007- Outpatient Neurology
Clinical Activity Description: Neurology Director Vascular Center , Waltham MA, half a day a week during which I see patients with common and rare neurological disorders
Time spent: 1 half day a week

2008- Inpatient Neurology, Newton Wellesley Hospital, Newton, MA
Clinical Activity Description: consult, evaluate, care and treat patients with common a rare neurological disorders admitted in a general medical and surgical unit
Time spent: 20 weeks a year

Clinical Innovations

1997- Pioneered the use of induced hypertension for the treatment of acute ischemic stroke

1999- Pioneered the use of diffusion/perfusion MRI to detect symptomatic vasospasm after subarachnoid hemorrhage

2008- Conduct the trial to look at the effect of statin use on the prevention of vasospasm

2008- Chair of Vascular Center Q/A Committee. Developed, implemented and supervised a first in the country program of independent NIH Stroke Scale trained practitioners to assess any patient undergoing carotid procedure pre, post and 30 days post procedure for neurological complications

2008- Created and started first in the North East and second in the country multispecialty Fibromuscular Dysplasia clinic

2008- Defined, developed and worked as Neuro-hospitalist in an acute care medical center at Newton Wellesley Hospital, first in the Northeast and at the time one of the first neuro-hospitalists in the country

Report of Scholarship

Original Articles

Research Investigations

1. **Rordorf G**, Uemura Y, Bonventre J. Characterization of Phospholipase A2 (PLA2) Activity in Gerbil Brain: Enhanced Activities of Cytosolic, Mitochondrial and Microsomal Forms after Ischemia and Reperfusion. The Journal of Neuroscience. 1991;11(6):1829-1836.
2. **Rordorf G**, Koroshetz W.J, Bonventre J.V.. Heat Shock Protects Cultured Neurons from Glutamate Toxicity. Neuron. 1991;7:1043-1051.
3. Kim D.K., **Rordorf G**, Nemenoff R.A., Koroshetz W.J, Bonventre J.V. Glutamate Stably Enhances the Activity of Two Cytosolic Forms of Phospholipase A2 in Brain Cortical Cultures. Biochemistry Journal. 1995;310:83-90.
4. Polidori C, Frei B, **Rordorf G**, Ogilvy C, Koroshetz W, Beal m.F. Increased Levels of Plasma Cholesterol Ester Hydroperoxides in Patients with Subarachnoid Hemorrhage. Free Radical Biology and Medicin. 1997;23(5):762-767.
5. **Rordorf G**, Ogilvy C.S, Gress D.R, Crowell R.M, Choi I.S. Patients in Poor Neurological Condition after Subarachnoid Hemorrhage: Early Management and Long Term Outcome. Acta Neurchirurgica. 1997;139(12):1143-1151.
6. **Rordorf G**, Cramer S.C, Efird J.T, Schwamm L.H, Buonanno F, Koroshetz W.J. Pharmacological Elevation of Blood Pressure in Acute Stroke: Clinical Effects and Safety. Stroke. 1997;28(11):2133-2138.
7. Cramer S, **Rordorf G**, Kaufman J, Buonanno F, Koroshetz W, Schwamm L. Clinically Occult Pelvic-Vein Thrombosis in Cryptogenic Stroke. The Lancet. 1998;351:1927-1928.
8. Polidori M.C, Frei B, Cherubini A, Nelles G, **Rordorf G**, Keaney J, Schwamm L, Mecocci P, Koroshetz W.J, Beal M.F. Increased Plasma Levels fo Lipid Hydroperoxides in Patients with Ischemic Stroke. Free Radical Biology and Medicine. 1998;25:561-567.
9. **Rordorf G**, Koroshetz W, Copen W, Cramer S, Schaefer P, Budzik R, Schwamm L, Buonanno F, Gonzalez G. Regional Ischemia and Ischemic Injury in Patients with Acute MCA Stroke as Defined by Early Diffusion Weighted and Perfusion Weighted MRI. Stroke. 1998;29(5):939-944.
10. Schwamm L.H, Koroshetz W.J, Sorensen A.G, Wang B, Copen W.A, Budzik R, **Rordorf G**, Buonanno F, Schaefer P.W, Gonzalez R.G. Time Course of Lesion Development in Patients with Acute Stroke: serial Diffusion and Hemodynamic Weighted Magnetic Resonance Imaging. Stroke. 1998;29:2268-2276.
11. Zaroff J.G, **Rordorf G**, Newell J.B, Ogilvy C.S, Levinson J.R. Cardiac Outcome in Patients with Subarachnoid Hemorrhage and Electrocardiographic Abnormalities. Neurosurgery. 1999;44:34-40.
12. **Rordorf G**, Koroshetz W.J, Copen W.A, Gonzalez R.G, Yamada K, Schaefer P, Schwamm L.H, Ogilvy C.S, Sorensen A.G. Diffusion Weighted and Perfusion Weighted Imaging in Vasospasm after Subarachnoid Hemorrhage. Stroke. 1999;30(3):599-605.
13. Ay H, Oliveira-Filho J, Buonanno F, Ezzeddine M, Schaefer P.W, **Rordorf G**, Schwamm l.H, Gonzalez R.G, Koroshetz W.J. Diffusion-Weighted Imaging Identifies a Subset of Lacunar Infarction Associated With Embolic Source. Stroke. 1999;30:2644-2650.
14. Gonzalez R.G, Schaefer P, Buonanno F, Schwamm L.H, Budzik R, **Rordorf G**, Wang B, Sorensen A.G, Koroshetz W.. Diffusion-weighted MR Imaging: Diagnositc Accuracy in Patients Imaged

within 6 Hours of stroke Symptom Onset. Radiology. 1999;210(1):155-162.

15. Sorensen A.G, Copen W.A, Ostergaard L, Buonanno F, Gonzalez R.G, **Rordorf G**, Rosen B.R, Schwamm L.H, Weisskoff R. M., Koroshetz W.J. Hyperacute Stroke: Simultaneous Measurement of Relative Cerebral Blood Volume, Relative Cerebral Blood Flow, and Tissue Mean Transit Time in Patients Presenting with Hyperacute Stroke. Radiology. 1999;210(2):519-527.
16. Ay H, Buonanno F, **Rordorf G**, Schaefer P.W, Schwamm L.H, Wu O, Gonzalez R.G, Yamada K, Sorensen A.G, Koroshetz W.J. Normal Diffusion-Weighted MRI during Stroke-Like Deficits. Neurology. 1999;52:1784-1792.
17. Ezzeddine* M, Rosand J, Primavera J.M, Hedley-White E.T, **Rordorf G**. Clinical Characteristics of Pathologically Proven Cholesterol Emboli to the Brain. Neurology. 2000;54:1681-1684.
18. Carter B, Buckley D, Ferraro R, **Rordorf G**, Ogilvy C.S. Factors Associated with Reintegration to Normal Living after Subarachnoid Hemorrhage. Neurosurgery. 2000;46(6):1326-1333.
19. **Rordorf G**, Koroshetz W, Efird J, Cramer S. Predictors of Mortality in Stroke Patients Admitted to an Intensive care Unit. Critical Care Medicine. 2000;28(6):1301-1305.
20. Zaroff J.G, **Rordorf G**, Titus J.S, Newell J.B, Nowak N.J Torchiana D.F, Aretz H.T, Picard M.H. Regional Myocardial Perfusion After Experimental Subarachnoid Hemorrhage. Stroke. 2000;31:1136-1143.
21. Zaroff J.G, **Rordorf G**, Ogilvy C.S, Picard M . Regional Patterns of Left Ventricular Systolic Dysfunction After Subarachnoid Hemorrhage: Evidence for Neurally-Mediated Cardiac Injury . Journal of the American Society of Echocardiography. 2000;13:774-779.
22. **Rordorf G**, Koroshetz W, Ezzeddine M, Segal A, Buonanno F. A Pilot Study of Drug-Induced Hypertension for Treatment of Acute Stroke. Neurology. 2001;56:1210-1213.
23. Lev M, Farkas J, Rodriguez V, Schwamm L, Hunter G, Putman C, **Rordorf G**, Buonanno F, Budzik R Jr, Koroshetz W, Gonzalez RG. CT Angiography in the Rapid Triage of Patients with Hyperacute Stroke to Intraarterial Thrombolysis: Accuracy in the Detection of Large Vessel Thrombus. Journal of Computed Assisted Tomography. 2001;25:520-528.
24. Oliveira-Filho J, Ezzeddine M, Segal A, Buonanno F, Chang Y, Ogilvy C.S, **Rordorf G**, Schwamm L.H, Koroshetz W, McDonald C. Fever in Subarachnoid Hemorrhage. Relationship to Vasospasm and Outcome. Neurology. 2001;56:1299-1304.
25. Wu O, Koroshetz W, Ostergaard L, Buonanno F, Copen W, Gonzalez R.G, **Rordorf G**, Rosen B, Schwamm L, Weisskoff R, Sorensen A.G. Predicting Tissue Outcome in Acute Human Cerebral Ischemia Using Combined Diffusion and Perfusion Weighted MR Imaging. Stroke. 2001;32(4):933-937.
26. **Rordorf G**, Bellon R, Budzik Jr R, Farkas J, Reinking G, Pergolizzi R, Ezzeddine M, Norbash A, Gonzalez R.G, Putman C. Silent Thromboembolic Events Associatied with the Treatment of Unruptured Cerebral Aneurysms with Guglielmi Detachable coils: Prospective Study Using Diffusion-Weighted Imaging. American Journal of Neuroradiology. 2001;22:5-10.
27. Segal* A, Abernethy W, Palacios I, BeLue R, **Rordorf G.** Stroke as a Complication of Cardiac Catheterization: Risk Factors and Clinical Features. Neurology. 2001;56:975-977.
28. Ay H, Oliveira-Filho J, Buonanno F, Schaefer P, Furie K, Chang Y, **Rordorf G**, Schwamm L, Gonzalez RG, Korosehtz W. “Foootprints” of transient ischemic attacks: a diffusion-weighted MRI study. Cerebrovascular Diseases. 2002;14:177-186.
29. Singhal AB, Caviness VS, Begleiter AF, Mark EJ, **Rordorf G**, Koroshetz W. Cerebral Vasoconstriction and Stroke after the Use of Serotonergic Drugs. Neurology. 2002;58:130-133.

30. Ezzeddine MA, Lev MH, McDonald CT, **Rordorf G**, Oliveira-Filho J, Aksoy FG, Farkas J, Segal AZ, Schwamm LH, Gonzalez RG, Koroshetz W. CT Angiography with whole Brain Perfused Blood Volume Imaging: Added Clinical Value in the Assessment of Acute Stroke. Stroke. 2002;33(4):959-966.
31. Yu D, Schaefer P, **Rordorf G**, Gonzalez R. Magnetic Resonance Angiography in Acute Stroke. Seminars in Roentgenology. 2002;37(3):212-218.
32. Hunter GJ. Silvennoinen HM. Hamberg LM. Koroshetz WJ. Buonanno FS. Schwamm LH. **Rordorf G**. Gonzalez RG. Whole-brain CT perfusion measurement of perfused cerebral blood volume in acute ischemic stroke: probability curve for regional infarction. Radiology. 2003;227(3):725-730.
33. Hoh BL, Topcuoglu MA, Singhal AB, Pryor JC, Rabinov JD, **Rordorf G**, Carter BS, Ogilvy CS. Effect of clipping, craniotomy, or intravascular coiling on cerebral vasospasm and patient outcome after aneurysmal subarachnoid hemorrhage. Neurosurgery. 2004;55(4):779-789.
34. Cramer SC, **Rordorf G**, Maki JH, Kramer LA, Grotta JC; Burgin WS, Hinchey JA, Benesch C, Furie KL, Lutsep HL, Kelly E, Longstreth WT, Jr . Increased pelvic vein thrombi in cryptogenic stroke: results of the Paradoxical Emboli from Large Veins in Ischemic Stroke (PELVIS) study . Stroke. 2004;35:46-50.
35. Badjatia N*, Topcuoglu M.A, Pryor J.C, Rabinov J.D, Ogilvy C.S, Carter, B.S, **Rordorf G**. Preliminary Experience with Intra-Arterial Nicardipine as a Treatement for Cerebral Vasospasm. American Journal of Neuroradiology. 2004;25:819-826.
36. DeGeorgia MA, Krieger DW, Abou-Chebel A, Devlin TG, Jauss M, Davis SM, Koroshetz WJ, **Rordorf G**, Warch S. Cooling for Acute Ischemic Brani Damage (COOL AID): a feasibility trial of endovascular cooling. Neurology. 2004;63(2):312-317.
37. Schwamm LH, Rosenthal ES, Swap CJ, Rosand J, **Rordorf G**, Buonanno F, Vangel MG, Koroshetz WJ, Lev MH. Hypoattenuation on CT angiographic sources images predicts risk of intracerebral hemorrhage and outcome after intra-arterial reperfusion therapy. American Journal of Neuroradiology. 2005;7(August):1798-1803.
38. Badjatia N, Topcuoglu M, Buonanno F, Smith E, Nogueira R, **Rordorf G**, Carter B, Ogilvy C.S, Singhal A. Relationship between hyperglycemia and symptomatic vasospasm after subarachnoid hemorrhage. Critical Care Medicine. 2005;33(7):1603-1609.
39. Sims* J, **Rordorf G**, Smith E, Koroshetz W, Lev M, Buonanno F, Schwamm L. Arterial Occlusion Revealed by CT Angiography Predicts NIH Stroke Score and Acute Outcomes after i.v. tPA Treatment. Am J Neuroradiol. 2005;26:246-251.
40. Lee K*, Badjatia N, Neimat J, **Rordorf G**. Hemicraniectomy for Massive Basal Ganglia Hemorrhage. Applied Neurology. 2006;(2):35-38.
41. Nguyen* T.N, **Rordorf G**, Schwamm L.H, Smith E.E. MRI contrast extravasation with enlarging hyperacute thrombolysis-related hemorrhage. Neurology. 2006;66:30-34.
42. Badjatia N*, Bodock M, Guanci M, **Rordorf G**. Rapid infusion of cold saline (4 degrees C) as adjunctive treatment of fever in patients with brain injury. Neurology. 2006;66(11):1739-41.
43. Murugappan A, Coplin W.M., Al-Sadat A.N., McAllen K.J., Schwamm L.H., Wechsler L.R., Kidwell C.S., Saver J.L., Starkman S, Gobin Y.P. , Duckwiler G, Krueger M, **Rordorf G**, Broderick J.P., Tietjen G.E., and Levine S.R. . Thrombolytic therapy of acute ischemic stroke during pregnancy . Neurology. 2006;66(5):768-770.
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Neurocritical Care https://doi.org/10.1007/s12028-021-01343-9

Preoperative Antithrombotic Treatment in Acutely Symptomatic Carotid Artery Stenosis
Juan Carlos Martinez-Gutierrez, Alexis Roy, Salvatore D'Amato, Jillian Berkman, Daniel Montes, Cheryl Kimball, Guy Rordorf, Lori Chibnik, Javier Romero, Scott Silverman
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3. Schwarzschild M, **Rordorf G**, Bekken K, Buonanno F, Schmahmann J.D.. Normal-Pressure Hydrocephalus with Misleading Features of Irreversible Dementias: A Case Report. Journal of Geriatric Psychiatry and Neurology. 1997;10:51-54.
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8. Nguyen-Huynh M, Lev M, **Rordorf G**. Spontaneous Recanalization of Internal Carotid Artery Occlusion. Stroke. 2003;34:1032-1034.
9. Lee K, Badjatia N, Neimat J, **Rordorf G**. Hemicraniectomy for massive basal ganglia bleed. pplied

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*trainees

Reviews/Chapters/Editorials

1. **Rordorf G** and Koroshetz W.J.. Excitatory Neurotransmission: its Role in Ischemic Brain Injury. In: Neurological Disorders Novel Experimental and Therapeutic Strategies; L. Vecsei, A. Freese, K. Swartz and M.F. Beal, editors. Ellis Horwood;1992. p. 3-38.
2. Furie K.L., Ogilvy C.S., Smrcka M, Suwanwela N, Can U, Ay H, Cramer S.C., Greenberg S.M., **Rordorf G**, Finkelstein S.P., Foster G.P., Koroshetz W.J., Suwanwela N, Kistler J.P. . Cerebrovascular Disease. In: Atlas of Clinical Neurology Roger N. Rosenberg editor in chief . Butterworth-Heineman;1997.
3. Ogilvy C.S. and **Rordorf G**. Mechanisms and Treatment of Coma After Subarachnoid Hemorrhage. In: Subarachnoid Hemorrhage: Pathophysiology and Management Joshua B. Bederson editor . The American Association of Neurological Surgerons;1997. p. 157-173.
4. Singer R, Ogilvy C, **Rordorf G**. Congenital Vascular Malformations of the Neuraxis. In: UpToDate, Bruce Rose editor in chief. UpToDate;2004.
5. **G. Rordorf**, McDonald C. Hypertensive Hemorrhage. In: UpToDate, Bruce Rose editor. UpToDate;2004.
6. Singer R, Ogilvy C, **Rordorf G**. Subarachnoid Hemorrhage. In: UpToDate, Bruce Rose editor in chief. UpToDate;2004.

Abstracts

1. Nogueira R, Lev M, Roccatagliata L, Gonzalez R, Ogilvy C, Hirsch J, **Rordorf G**, Rabinov J, Pryor J. Effects of Intra-arterial Nicardipine on the Cerebral Blood Flow of Patients with Subarachnoid Hemorrhage Induced Vasospasm as Measured by Cine CT Perfusion. Neurocritical Care Meeting. 2006.
2. Chou S; Latorre, JG; Ogilvy, C; **Rordorf, G**. Clinical Outome After Early Anticonvulsant Discontinuation in Aneurysmal Subarachnoid Hemorrhage Patients. Neurocritical Care Society Meeting. 2006.
3. Chou, S; Latorre JG; Nogueira R; Ogilvy C; **Rordorf G**. Safety and Feasibility of Continuous Intravenous Nicardipine Infusion Following Intra-arterial Nicardipine Treatment for Vasospasm Post Aneurysmal Subarachnoid Hemorrhage. Neurocritical Care Society Meeting. 2006.
4. Chou S; Ayata C; Smith E; Nogueira R; Carter B; Ogilvy CS; **Rordorf G**. Safety and Feasibility of Simvastatin in Delayed Vasospasm Prevention following Aneurysmal Subarachnoid Hemorrhage-A Randomized, Double-blind, Placebo-Controlled Study. Society of Critical Care Medicine 36th Congress. 2007.
5. Muehlschlegel S, **Rordorf G**, Bodock M, Sims J. Dantrolene i.v. in the Treatment of Cerebral Vasospasm After Subarachonid Hemorrhage - A Prospective Phase I Study. Neurocritical Care

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6. Kwolek C, Rordorf G, Patel V, Rosenfield K, Hirsch J, Jaff . Prospective Independent neurologic evaluation of patients undergoing carotid revascularization. Can we match the CREST results. Society of Vascular Surgery, 2014

7. Nelson S, Edlow B, Wu O, Rosenthal ES, Westover MB, Rordorf G. Investigating Perfusion Deficits in Patients with Subarachnoid Hemorrhage. Neurocritical Care Society Meeting. Scottsdale, AZ, 2015. Poster number TBD

8. Shyam Rao**,** Zoe Wolcott, David Chung, Faheem Sherriff, Ayaz Khawaja, Aman Patel, W. Taylor Kimberly and Guy Rordorf. An early EVD clamp trial approach for subarachnoid hemorrhage is associated with a lower ventriculoperitoneal shunt rate, shorter length of stay, and fever EVD complications. Neurocritical Care Society Meeting 2017,
Shyam Rao was awarded the Young Investigator Award

EXHIBIT 2

AFFIDAVIT OF ANTHONY MANCUSO, M.D., REGARDING TAMMY CARNLEY

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Anthony Mancuso, M.D., who after first being duly sworn, states as follows.

Introduction

1. This affidavit addresses medical negligence that occurred during Tammy Carnley's presentation to St. Francis–Emory Healthcare Hospital ("St. Francis") in Columbus, Georgia, on October 7, 2024.

2. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.

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

4. 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 medical providers I discuss here.

5. Plaintiffs' counsel drafted this affidavit after consulting with me, and I reviewed the draft and edited it to make sure it correctly states my views.

6. 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 details.

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

Evidence Considered

8. I have reviewed medical records pertaining to Tammy Carnley's October 7, 2024 presentation to St. Francis, including the emergency department records and the diagnostic imaging studies and radiology reports generated during that encounter. I have also reviewed the Harris County EMS prehospital care report and the records of Piedmont Columbus Regional Midtown Hospital, the comprehensive stroke center to which Mrs. Carnley was ultimately transferred.

Principal Opinions

9. My principal opinion is summarized here. In deposition or trial testimony, I may elaborate upon this principal opinion, and in doing so, I may offer related, subsidiary, or incidental opinions.

   i. **Task & Requirement:** Interpreting and reporting on radiology.

Standard of care requirement: The standard of care requires a radiologist who interprets a non-contrast CT scan of the head obtained for a patient with acute neurological symptoms to identify and accurately report abnormalities visible on that study, including the early ischemic signs of an acute stroke.

Violations: Dr. Dennis M. Burton violated this requirement when he interpreted and reported Tammy Carnley's non-contrast CT scan of the head — performed at approximately 7:50 a.m. and electronically signed by Dr. Burton at 8:14 a.m. on October 7, 2024 — as showing a "Normal CT of the head," with "no evidence of intracranial hemorrhage, infarction, or mass lesion," when in fact that study demonstrated the early ischemic changes an acute infarct in the left middle cerebral artery (MCA) territory.

Specifically, Dr. Burton failed to identify and report the ill-defined hypodensity in the cortical-subcortical aspects of the left temporal lobe, with loss of the gray-white matter differentiation and effacement of the overlying sulcal spaces, that was present on the 8:14 a.m. study and that is characteristic of a left MCA territory acute infarct. Those same findings were later identified, on a re-read of the identical images, in an addendum to the radiology report.

Dr. Burton also failed to identify a focal hyperdensity at the junction of the M1 and M2 segments of the left middle cerebral artery essentially

diagnostic of a thrombus/embolus at that location accounting for the acute infarct that was present; a specific finding that was a potentially treatable cause of the acute cerebral infarct.

Causation: As a result of this violation, Tammy Carnley's acute ischemic stroke was not diagnosed or treated during her early hours at St. Francis. An accurate interpretation reported at 8:14 a.m. should have prompted immediate stroke workup — including emergent CT angiography to identify the large vessel occlusion and emergent neurologic consultation — hours earlier than each in fact occurred. CT angiography, when finally performed, confirmed a complete occlusion of the left M1 segment, that is, a large vessel occlusion amenable to mechanical thrombectomy. When neurology evaluated Mrs. Carnley at approximately 12:25 p.m., she had an Alberta Stroke Program Early CT Score (ASPECTS) of 6 to 7, indicating that a significant volume of brain tissue remained salvageable at that time. But for Dr. Burton's failure to identify and report the infarct, Mrs. Carnley's stroke would have been recognized, and the process of transfer for mechanical thrombectomy would have begun, substantially sooner, while more of her brain tissue remained salvageable.

Damages: This violation thus deprived Tammy Carnley of the opportunity for substantially earlier diagnosis and treatment of her stroke, and proximately contributed to her preventable, permanent,

and catastrophic brain injury, including dense right-sided hemiplegia and global aphasia.

Gross Negligence

10. I understand that, to the extent the care at issue is deemed to have been bona fide emergency medical care provided in a hospital emergency department, Georgia law (OCGA § 51-1-29.5) requires that liability be established by clear and convincing evidence that the provider's actions showed gross negligence. I understand "gross negligence" to mean the absence of even slight diligence, and "slight diligence" to mean that degree of care which every person of common sense, however inattentive, exercises under the same or similar circumstances. To the extent that standard applies, it is also my opinion, held to a reasonable degree of medical certainty, that Dr. Burton's interpretation of the 8:14 a.m. CT scan as a "Normal CT of the head" — given the size and conspicuity of the left MCA territory infarct and clear evidence of an occlusive thrombus/embolus present on that study and Mrs. Carnley's obvious acute neurological presentation — reflected the absence of even slight care and constituted gross negligence.

Qualifications

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

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

13. My Curriculum Vitae, which is attached as **Exhibit A**, provides further detail about my qualifications. I incorporate and rely on that information here.

14. The events at issue here occurred in October 2024.

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

    a. In October 2024, 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 Florida to practice as a physician. That is where I was practicing in October 2024.

    b. In October 2024, I had actual professional knowledge and experience in the area of practice or specialty to which my opinion relates — specifically, the task identified above on which I offer standard-of-care opinions.

    I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing area of specialty of my profession for at least three of the five years prior to October 2024, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinion addresses.

    Specifically, I am a physician specializing in diagnostic radiology and neuroradiology, including the interpretation of computed tomography

imaging of the head and brain, and for many years I have had great familiarity with the task on which I offer standard-of-care opinions here.

Anthony Mancuso, M.D.

SWORN TO AND SUBSCRIBED before me
this 20th day of June, 2026.

NOTARY PUBLIC
My Commission Expires: 4/24/2028

ALEXANDER LUCA
Notary Public
State of Florida
Comm# HH519909
Expires 4/24/2028

CURRICULUM VITAE

PERSONAL DATA

NAME:	Anthony A. Mancuso, M.D.
DATE OF BIRTH:	
PLACE OF BIRTH:	Brooklyn, New York
CITIZENSHIP:	U.S. Citizen

EDUCATION

1965-1967	Miami Dade Junior College Miami, Florida A.A.
1967-1969	Florida State University Tallahassee, Florida B.S.
1969-1973	University of Miami School of Medicine Miami, Florida M.D.
1973-1974	Internship, Mercy Hospital San Diego, California
1974-1977	Residency, UCLA, CHS, Diagnostic Radiology Los Angeles, California

PROFESSIONAL EXPERIENCE

Appointments:

1977-1978	Adjunct Instructor, UCLA, Fellowship in Head and Neck Radiology and Computerized Tomography/Ultrasound, Los Angeles, California
1978-1979	Adjunct Assistant Professor, Department of Radiology, UCLA/ Co-Chief, CT and Ultrasound Section (1979-1980), Los Angeles, California
1979-1981	Assistant Professor in Residence - Department of Radiology, UCLA/Chief, CT Section (1980-1981), Los Angeles, California Fellowship in Neuroradiology (February 1 - July 31, 1981)
1981-1983	Associate Professor of Radiology (Neuroradiology Section), Department of Radiology, University of Utah School of Medicine,

1983-1984	Associate Professor of Radiology, University of Florida College of Medicine and Chief of Radiology, Veterans Administration Medical Center, Gainesville, Florida
1984-1989	Clinical Director of MRI, Shands Hospital, University of Florida College of Medicine, Gainesville, Florida
1986-present	Professor of Radiology, University of Florida College of Medicine, Gainesville, Florida
1990-1992	Clinical Director, Radiology Research, University of Florida College of Medicine, Gainesville, Florida
1998-2001	Associate Chairman for Research, Department of Radiology, University of Florida College of Medicine, Gainesville, Florida
5/2000-3/2001	Interim Chairman of Department of Radiology, University of Florida College of Medicine, Gainesville, Florida
4/2001-present	Chairman of Department of Radiology, University of Florida College of Medicine, Gainesville, Florida

Visiting Professorships:

- University of California at San Francisco, Department of Radiology, San Francisco, California, March 5, 1979
- Loyola University Medical School, Department of Radiology, Chicago, Illinois, March 27-28, 1979
- University of Washington, Department of Radiology, Seattle, Washington, May 5-7, 1983
- University of Miami, Department of Radiology, Miami, Florida, March 21-23, 1984
- University of Kentucky, Department of Radiology, Lexington, Kentucky, October 1984
- Columbia University College of Physicians and Surgeons, Department of Radiology, New York, New York, April 1986
- University of Texas Health Science Center at Dallas, Department of Radiology, Dallas, Texas, October 21-22, 1986
- Columbia University College of Physicians and Surgeons, Department of Radiology, New York, New York, April 1988
- Harvard University, Massachusetts General Hospital, Department of Radiology, Boston, Massachusetts, April 1988
- University of Pittsburgh, Department of Radiology, Pittsburgh, Pennsylvania, March 13-14, 1991
- University of Virginia, Department of Radiology, Charlottesville, Virginia, January 21-22, 1993
- Wayne State University, Department of Radiology, Detroit, Michigan, February 2-4, 1994
- University of Toronto, Department of Radiology, Toronto, Canada October 1-3, 1995
- University of Texas-M.D. Anderson Hospital, Houston, Texas--Doubleday Lecturer, May 20-21, 1996
- Allegheny University Hospitals, Pittsburgh –May 7th and 8th, 1998
- University of Virginia- Keat's Society Endowed Honorary Lectureship- May 13-15,2011

Committee Service

- Member, Research Advisory Committee - Department of Radiology, UCLA, Los Angeles, California, 1979-1981
- Member, Resident Selection Committee - Department of Radiology, UCLA, Los Angeles, California, 1979-1981
- Member, Medical Care Evaluation Committee, Shands Hospital, Gainesville, Florida, 1984-1985
- Member, Emergency Room Advisory Committee, Shands Hospital, Gainesville, Florida, 1984-1985
- Member, Department of Radiology Finance Committee, Shands Hospital, Gainesville, Florida, 1984-1986
- American College of Radiology (ACR) - Coding Index and Thesaurus Committee, 1985-1990
- Member, Radiological Society of North America (RSNA) Program Committee, Neuroradiology/ Head and Neck Radiology, 1986-1991
- American College of Radiology (ACR) - Malpractice Awareness Task Force/Expert Witness Program, 1986-1990
- Association of University Radiologists (AUR) - Staufer Award Committee (Research Award), 1986-1987
- Medical Care Evaluation Committee, Shands Hospital, 1987-1990
- American College of Radiology (ACR) - Interdisciplinary Committee on Diagnostic Imaging in Cancer Management, 1986-1987
- American Medical Association - Panel on Magnetic Resonance Imaging, 1984-1988
- Brain Institute Task Force, University of Florida College of Medicine, 1990-1992
- American Society of Head and Neck Radiology, Publications Committee, 1990-1991
- Search Committee for Chairman of Radiation Oncology, 1991-1992
- MRI Research Committee, Department of Radiology, University of Florida College of Medicine, 1991-2001
- Finance Committee, Department of Radiology, University of Florida College of Medicine, 1991-1998
- CT Quality Assurance Committee, Department of Radiology, University of Florida College of Medicine, 1992-1994
- University of Florida Research Advisory Committee, University of Florida College of Medicine, 1992-1994
- American Board of Radiology - Committee on Certificate of Added Qualifications for Neuroradiology, 1992-1995

- Masters Thesis Committee - Jason Rosenberg, 1992-1993
- Second World Congress on Laryngeal Cancer - Advisory Committee, 1993-1994
- American Society of Head and Neck Radiology Publications Committee, 1993-1995
- UFCOM Search Committee for Anatomy and Cell Biology Chair, Spring, 1995
- CQI Committees Read and Return; Communications; MRI (Radiology Department), 1996-1998
- UFCOM Neurology Chairman Search Committee, 1999 and 2000-2001
- Ad Hoc Committee UF AGH—UF Shands Consolidation, 1998-1999
- UF COM College Incentive Fund Review Committee-2000-2001
- Medical Executive Committee, Shands at AGH, May 2001-2006
- Medical Executive Committee, Shands at UF, 2001-present
- Florida Group Practice Executive Committee, 2001-present
- Otolaryngology Chairman Search Committee-- Chairman, 2001-2002 and 2003-2004
- UF COM Promotion and Tenure Committee-Associate Chairman-2002 and Chairman 2003
- UF Group Practice Association—3rd Vice President- 2008 to present
- UF Executive Fiscal Advisory Committee—2008 to present
- Pathology Chairman Search Committee-- Chairman, 2010
- Chairman UF Executive Fiscal Advisory Committee—2010 to present
- UF Group Practice Association—President- 2010 to present

Membership in Scholarly Societies:

- Radiological Society of North America
- American Society of Head and Neck Radiology (Secretary, 1982-1985; Executive Committee, 1985-1986; Vice President, 1988; President Elect, 1989-1990; President, 1990-1991; Past President 1991-1992)
- American Society of Neuroradiology, Senior Member
- American Society for Head and Neck Surgery, Honorary Member
- European Society of Head and Neck Radiology, Honorary Member, 2011

Editorial Experience:

- Editorial Board: American Journal of Neuroradiology (1992-2000); Journal of Computed Axial Tomography (1993-2006); Acta Radiologica Portugesa (1993-1995); International Journal of Radiation Oncology, Biology and Physics (1998-2006)

- Referee for following journals: Radiology, Journal of Magnetic Resonance in Medicine, Journal of Computer Assisted Tomography, International Journal of Radiation Oncology, Biological Physics, Investigative Radiology, Head and Neck, Cancer, AJNR

- Review of proposed texts for Williams and Wilkins, Lea and Febiger, C. V. Mosby

Grants:

- National Research Service Award Fellowship for training in Academic Radiology from NIH/PHS, 1976-1980 (Principal Investigator).

- Grant-in-aid from Berlex Corporation to study Gadolinium-DTPA in cerebral lesions, 1985 ($35,000). Renewal 1986 ($35,000). New study in pediatric patients on same contrast, 1987 ($35,000) (Principal Investigator).

- Division of Sponsored Research, University of Florida granted the Department of Radiology $150,000 for support of second whole body imager (Principal Investigator).

- NIH-NCI grant #U01 CA 54026-01, "Comparison of CT and MRI in Staging of Cervical Metastases." $400,000 over 4 years. Funded October 1991 (Principal Investigator).

- RSNA seed grant, "Detection of Unknown Primary Tumors of the Head and Neck Using 2-[F-18] Fluoro-2-Deoxy-D-Glucose."—Principal Investigator: Suresh K. Mukherji, M.D. $20,000. Funded Spring 1993 (Co-Principal Investigator).

- Eli Lilly Olanzepine Research Study—Co-Principal Investigator: Katherine N. Scott, Ph.D. Funded February 1998 (Consultant and over-reading of films).

- K-30 Fellowship Funding, "Evidence Based Radiology"—Principal Investigator: Christopher Sistrom, M.D. $40,000. Funded 1999 (Mentor).

- Magnetic Resonance Imaging (MRI) of the Upper Trachea During Respiration and Valsalva maneuver. Mallinckrodt—Principal Investigator: Ilona M. Schmalfuss, M.D. Funded 1999 (Co-Principal Investigator).

- AHA Women and Minorities Access to Research Grant, "Pilot Study of Cerebral Vascular Reserve as a Risk Factor for Stroke in Pediatric Sickle Cell Disease"—Principal Investigator: Lorna Sohn Williams, M.D. $59,900. Funded 2000 (Co-Principal Investigator).

- "Study of the Dynamic Motion of Oropharynx." Kos Pharmaceuticals—Principal Investigator: Ilona M. Schmalfuss, M.D. $41,888. Funded February 2000 (Co-Principal Investigator).

- "Muscle Composition and Function for Swallowing in Head/Neck Cancer Patients Undergoing Radiotherapy." University of Florida (Opportunity Grant). Phormax—Co-Principal Investigator: Ilona M. Schmalfuss, M.D. $10,000. Funded October 2000 (Co-Principal Investigator).

- "New Faculty Start-Up." HHMI funding —Principal Investigator: Christopher L. Sistrom, M.D. $115,000. Funded March 2001 (Mentor).

- "Free Text Versus Structure Format for Radiology Reports: Measuring Performance and Preference of Selected Medical Personnel in Extracting Case Specific Information." GE funding—Principal Investigator: Christopher L. Sistrom, M.D. $50,000. Funded July 2001 (Mentor).

Gift:

- Secured, as a gift to the Department of Radiology, University of Florida, College of Medicine a 0.15 T whole body imager from Technicare Corporation for dedicated research on coil development and proton imaging, 1985. Included were warranty and installation. Total worth $950,000 - 1,000,000.

Patent:

- Patent received: Angled segment receiver coil for NMR imaging of the head. Filed U. S. Patent Court, 1986. Patent #4,784,146.

- Patent received: Method for improving delivery of pharmaceutical aerosols. Patent #6,567,686.

SCHOLASTIC HONORS

Honorary Societies:

- National Beta Honor Society (High School)
- Phi Theta Kappa (Miami Dade Junior College)
- Alpha Omega Alpha (junior year, University of Miami Medical School, Vice President, senior year)

Awards and Honors:

1967-1968	Haydon Burns Scholarship (Miami Dade Junior College)
1969-1973	Complete tuition scholarship to University of Miami School of Medicine
1969	B.S., Magna Cum Laude
1973	M.D. with honors - graduating second in class of 115
1978	Summa Cum Laude award. Radiological Society of North America for exhibit: Correlated CT Anatomy and Pathology of the Larynx. Annual Scientific Assembly and Meeting of the Radiological Society of North America, Chicago, Illinois, November 26 - December 1, 1978
1979	Certificate of Special Merit. American Roentgen Ray Society for exhibit: Correlated CT anatomy and Pathology of the Larynx. Annual American Roentgen Ray Society Meeting, Toronto, Canada, March 1979
1979	Certificate of Special Merit. American Roentgen Ray Society for exhibit: CT of the Nasopharynx - Normal Variations of North and Pathological Correlations. Annual American Roentgen Ray Society Meeting, Toronto, Canada, March 1979
1980	Gold Medal. American Society of Neuroradiology for exhibit: High Resolution CT of the Temporal Bone, Los Angeles. Annual Meeting of the American Society of Neuroradiology, 1980
1991	Certificate of Merit. Morphologic Characteristics Useful in Guiding the Diagnostic Work-up of Infiltrative Diseases of the Head and Neck. Exhibit presented at the Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1991
1992	Certificate of Merit. CT of Normal and Abnormal Facial Nodes. Exhibit presented at the Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1992

1993	Cum Laude Certificate. Radiographic Appearance of the Irradiated Larynx and Hypopharynx by Computed Tomography. Exhibit presented at the Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1993
1994-present	Listed in *Best Doctors in America®: Southeast Region*
1995	Examiner for American Board of Radiology Certificate of Added Qualifications in Neuroradiology Oral Examinations
1996	Leonard C. Doubleday Lecturer and Honorary Membership in The Houston Radiologic Society
1996	Keynote Speaker-International Congress on Head and Neck Cancer Toronto, Canada
1997	Presidential Citation—American Society for Head and Neck Surgery
2005	Gold Medial Recipient—American Society of Head and Neck Radiology, San Francisco, California, September 2005
2100	Lifetime Achievement Award – European society of Head and Neck Radiology, September 2011

LICENSURE AND CERTIFICATION

LICENSURE:	Florida, #ME0042665 California, #G027974
CERTIFICATION:	1978, Diplomate of the American Board of Radiology 1995, American Board of Radiology Certificate of Added Qualifications in Neuroradiology

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11. Dillon W, Mancuso AA. In: Newton, Potts (eds.) Nasopharynx and oropharynx. In: Newton, Potts (eds.) Modern Neuroradiology, Vol. III, 1987.

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    a. Associate Editor and Sole author: Chapter 4;Diagnostic Imaging
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    Chapter 18: Larynx
    Chapter 20: Hypopharynx
    Chapter 21: Cervical Esophagus
    Chapter 22: Nose and Paranasal Sinuses
    Chapter 23: Nasopharynx
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ARTICLES SELECTED FOR ABSTRACTING, PROCEEDINGS:

1. Mancuso AA, Hanafee WN, Winter J, Ward P. A comparison of computed tomography and conventional pluridirectional tomography in the evaluation of paranasal sinus pathology. J Comput Assist Tomogr 1978; 2.

2. Mancuso AA, Hanfee WN, Calcaterra T. CT scanning of the larynx. J Comput Assist Tomogr 1978; 2:522.

3. Bein ME, Mancuso AA, Mink JH, Hansen GC. Computed tomography in the evaluation of mediastinal lipomatosis. J Comput Assist Tomogr 1978; 2.

4. Mancuso AA, Bohman L, Hanafee WN, Maxwell, Ward BH. Nasopharynx - Normal variations of normal and pathological correlations. AJR 1979; 133(2):345.

5. Mancuso AA, Hanafee WN, Ward PH, Calcaterra T. Correlated CT anatomy and pathology of the larynx. AJR 1979; 133(2):345.

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7. Mancuso AA. In: Moss A, Goldberg H (eds.) Ultrasound of the neck. Computed tomography, ultrasound and x-ray: An integrated approach. UCSF, Department of Radiology Postgraduate Education Division, 1980.

8. Rice D, Mancuso AA, Hanafee WN. Computed tomography with simultaneous contrast sialography, epitomes of progress - Otolaryngology. West J Med 1981; 133(4):321-322.

9. Mancuso AA. Cervical lymph node cancer. OR Digest 1981; 13-14.

10. Mancuso AA, Hanafee WN. Elusive head and neck carcinoma beneath intact mucosa. OR Digest 1984; 13-14.

11. Mancuso AA, Harnsberger HR, Mauaki AS, et al. Computed tomography of cervical and retropharyngeal lymph nodes: Normal anatomy, variants of normal and applications in staging head and neck cancer. Parts I and II. Radiology 1983; 148:709-723. Abstract in Year Book of Diagnostic Radiology, Kieffer SA (ed.).

12. Mancuso AA, Virapongse C, Quisling RG. Early clinical experience with Gd-DTPA enhanced MRI in acute cerebral infarction and chronic ischemic changes. In: Excerpta Medica, Contrast Agents in Magnetic Resonance Imaging. Elsevier Science, 1986.

13. Mancuso AA. Impact of CT and MRI on the diagnosis of head and neck cancer. Excerpta Medica, Proceedings of VI European Congress of Radiology. Elsevier Science, 1987.

14. Tart RP, Mancuso AA, et al. Facial lymph nodes: Normal and abnormal CT appearance. Radiology 1993; 188:695-700. Year Book of Neuroradiology 1995; (in press)

15. Mukherji SK, Mancuso AA, et al. Irradiated paragangliomas of the head and neck: CT and MR appearance. AJNR 1994; 15:357-363. Year Book of Neuroradiology 1995 (in press)

PRESENTATIONS AT SCIENTIFIC MEETINGS

1. Mancuso AA, Calcaterra TC, Hanafee WN. The role of CT scanning in the management of cancer of the larynx. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1976.

2. Mancuso AA. CT scanning of the larynx and nasopharynx. The Eleventh Annual Conference on Radiology in Otolaryngology and Ophthalmology. American Otolaryngologic Association, Los Angeles, California, May 21-23, 1977.

3. Mancuso AA. CT screening of the paranasal sinuses. Western Neuroradiologic Society, Palm Springs, California, October 7-9, 1977.

4. Participation in a panel on "Adult Head and Neck Problems" by invitation of Paul Ward, M.D., Chief of the Department of Head and Neck Ophthalmology and Otolaryngology. American Otolaryngologic Association, Los Angeles, California, January 23, 26, 1978.

5. Mancuso AA, Hanafee WN. CT scanning of the larynx. International Symposium on Computed Tomography. Harvard University, Miami, Florida, March 19-24, 1978.

6. Mancuso AA, Hanafee WN. A comparison of CT scanning and pluridirectional tomography in the evaluation of paranasal sinus pathology. International Symposium on Computed Tomography. Harvard University, Miami, Florida, March 19-24, 1978.

7. Mancuso AA, Hanafee WN. A comparison of computed tomography and laryngography in the evaluation of laryngeal pathology. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 30, 1978.

8. Mancuso AA, Rice D, Hanafee WN. CT scanning of the parotid gland during contrast sialography. Computed tomography: International Symposium and Course. Harvard University, Las Vegas, Nevada, April 1979.

9. Mancuso AA, Hanafee WN, Ward P. Comparison of CT scanning and laryngography in laryngeal cancer. Computed tomography: International Symposium and Course. Harvard University, Las Vegas, Nevada, April 1979.

10. Featured speaker by invitation: Computed tomography of the larynx; CT of the paranasal sinuses and nasopharynx. Western Society of Neuroradiology, Carmel, California, October 5-7, 1979.

11. Mancuso AA, Bohman LG, Hanafee WN, Maxell DS. CT of the nasopharynx: Normal and variants of normal. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Atlanta, Georgia, November 1979.

12. Mancuso AA. New techniques in otolaryngologic diagnosis. Pacific Coast Otolaryngologic Society, San Diego, California, May, 1980.

13. Mancuso AA, Maceri D, Rice D, Hanafee WN. CT diagnosis of cervical lymph node cancer. Western Neuroradiologic Society, San Diego, California, October 1980.

14. Stone D, Mancuso AA, Rice D, Hanafee WN. CT parotid sialography. Western Neuroradiologic Society, San Diego, California, October 1980.

15. By invitation: One of five panelists of Oncodiagnosis Symposium. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Dallas, Texas, November 1980.

16. By invitation: Workshop on CT of the larynx, nasopharynx, parapharyngeal space, paranasal sinuses, salivary glands. Los Angeles Radiological Society Mid-Winter Conference, Los Angeles, California, January 1981.

17. Radiological Society of North America Refresher Course: Computed tomography of the head and neck. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1981.

18. Radiological Society of North America Categorical Course : Radiation therapy, head and neck cancer imaging. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1981.

19. Radiological Society of North America Refresher Course: Computed tomography of the upper aerodigestive tract and neck. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1982.

20. Mancuso AA. CT of the larynx tumor and trauma. American Society of Head and Neck Radiology Postgraduate Course, Los Angeles, California, May 1981.

21. Mancuso AA. Ultrasound, CT and NMR in head and neck disease and radiology of the sinuses. International Congress and Postgraduate Course on Radiology in Otolaryngology, Paris, France, June 1982.

22. Mancuso AA. CT of cervical and retropharyngeal lymph nodes: Normal, variations of normal and applications in staging head and neck cancer. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1982.

23. Mancuso AA. The CT evaluation of recurrent and residual cancer of the upper aerodigestive tract and neck. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1982.

24. Mancuso AA. The CT-clinical approach to patients with symptoms related to cranial nerves V, VII, IX-XII and cervical sympathetics. American Society of Head and Neck Radiology Meeting and Postgraduate Course, Boston, Massachusetts, May 1983.

25. Radiological Society of North America Refresher Course: Computed tomography of the pharynx, larynx and neck. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1983.

26. A CT-clinical approach to patients with symptoms related to cranial nerves V, VII, IX-XII and cervical sympathetics. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1983.

27. By invitation of the American College of Surgery, Otolaryngology Interdisciplinary Panel Discussion. 69th Clinical Congress of the American College of Surgeons, Atlanta, Georgia, 1983.

28. Mancuso AA. MRI of the upper pharynx and neck: Variations of normal and possible applications in detecting and staging malignant tumors. Society of Magnetic Resonance in Medicine, New York, August 1974.

29. Radiological Society of North America Refresher Course: MRI and CT of the pharynx. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Washington, D. C., November 1984.

30. Mancuso AA. MRI of the upper pharynx and neck: Variations of normal and possible applications in detecting and staging malignant tumors. Part I - Normal variations. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Washington, D. C., November 1984.

31. Mancuso AA. MRI of the upper pharynx and neck: Variations of normal and possible applications in detecting and staging malignant tumors. Part II - Pathology. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Washington, D. C., November 1984.

32. Radiological Society of North America Refresher Course: MRI and CT of the pharynx. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1985.

33. Mancuso AA. High performance receiver coils for imaging the head and neck and 0.15 T: Clinical experience with thin section studies. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, 1985.

34. Mancuso AA. 1. CT and MRI of facial nerve disorders. 2. Imaging of the thyroid and parathyroids. 3. CT and MRI of the pharynx. Annual Meeting of the American Society of Head and Neck Radiology, Seattle, Washington, May 1986.

35. Invited speaker/panelist: Management of parotid tumors. American College of Surgeons Clinical Congress, New Orleans, Louisiana, November 1986.

36. Invited speaker/panelist: Magnetic resonance imaging seminar. Los Angeles Radiologic Society, Los Angeles, California, November 1986.

37. Radiological Society of North America Refresher Course: MRI and CT of the pharynx. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1986.

38. Invited guest: Radiological Society of North America sponsored lecturer for VI European Congress of Radiology, Lisbon, Portugal, June 1987.
    a. Keynote lecture: Impact of CT and MRI in the diagnosis of head and neck cancer.
    b. Refresher Course: Cervical lymph node metastases - oncologic imaging and diagnosis.

39. Invited guest: European Society for Therapeutic Radiology and Oncology: Practical planning problems in radiotherapy of head and neck cancer, Lisbon, Portugal, May 1987.

40. Radiological Society of North America Refresher Course: MRI and CT of the pharynx. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1987.

41. Radiological Society of North America Refresher Course: Oncodiagnostic Panel. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1987.

42. Scientific Committee and Faculty: XI International Congress of Head and Neck Radiology. European Society of Head and Neck Radiology, Uppsala, Sweden, June 6-11, 1988.

43. Invited speaker: Second International Conference on Head and Neck Cancer. American Society for Head and Neck Surgery Sponsor, Boston, Massachusetts, August 1988.

44. Invited panelist: Cervical metastasis in aerodigestive cancer. American Academy of Otolaryngology and Head and Neck Surgery, Washington, D. C., September 1988.

45. Radiological Society of North America Refresher Course: MRI and CT of the pharynx and floor of the mouth. Scientific Assembly and Annual Meeting of the RSNA, Chicago, Illinois, 1988.

46. Invited lecturer and panelist: The impact of new imaging technique on cancer staging and curability. International Congress of Radiation Oncology. Paris, France, July 1989.

47. Invited lecturer, panelist, moderator: 17th International Congress of Radiology. Paris, France, July 1989.
48. Invited lecturer, panelist: American College of Surgeons Clinical Congress Postgraduate Course: Otorhinolaryngology: Carcinoma of the tongue. Atlanta, Georgia, October 1989.

49. Radiological Society of North America Refresher Course: CT and MRI of the pharynx and floor of the mouth. Also Moderator of Scientific Session, Chicago, Illinois, 1989.

50. Magnetic Resonance Imaging 1990: National Symposium: MRI of lower cranial nerves; MR and CT of the temporal bone; MR and CT of the paranasal sinuses, Las Vegas, Nevada, April 1990.

51. American Society of Head and Neck Radiology: Special Focus Session - Cases and controversies in head and neck cancer, New Orleans, Louisiana, May 1990.

52. Invited lecturer (four lectures): The Royal Australian College of Radiologists Annual Meeting, Perth, Western Australia, October 1990.

53. Radiological Society of North America, Chicago, Illinois, December 1990:
    a. Refresher course; CT and MRI of the pharynx and floor of the mouth
    b. Moderator: Scientific session
    c. Scientific presentation: Barreda R, Mancuso AA, Stringer S. Suppurative retropharyngeal lymphadenitis: A medical or surgical disease?

54. American Society of Head and Neck Radiology, Boston, Massachusetts, April 3-6, 1991:
    a. Paper: CT of submucosal laryngeal masses.
    b. Lectures: Imaging of major salivary glands and normal anatomy of deep spaces of the face and suprahyoid neck.

55. Invited Panelist on New Advances in Head and Neck Imaging. American Society of Neuroradiology, Washington D. C., June 1991.

56. Radiologic Society of North America, Chicago, Illinois, December 1991.
    a. Moderator: Scientific session
    b. Refresher course: Imaging of the larynx and hypopharynx
    c. Scientific presentation: CT of submucosal laryngeal masses

57. American Society of Head and Neck Radiology: Imaging of the thyroid and parathyroids, Chicago, Illinois, April 22-26, 1992.

58. Invited Panelist on Cancer of the Paranasal Sinuses. Third International Conference on Head and Neck Cancer, San Francisco, California, August 1992.

59. Radiologic Society of North America, Chicago, 1992.
    a. Moderator: Scientific session
    b. Refresher Course: Imaging of the larynx and hypopharynx
    c. Scientific presentations: Coauthored three papers presented by Tart RP and Mukherji SK.

60. American Society of Head and Neck Radiology/American Society of Neuroradiology Course and Meeting: Imaging of the oral cavity and oropharynx, Vancouver, May 1993.

61. Radiologic Society of North America, Chicago, 1993
    a. Refresher Course: Imaging of the larynx and hypopharynx
    b. Scientific presentations: Coauthored five papers, presented by Mukherji SK

62. Invited Speaker and Panelist: Second World Congress on Laryngeal Cancer, Sydney, Australia, February 21-24, 1994.
    a. Workshop on imaging advances
    b. Salvage treatment for early glottic failure (Panelist)

c. Favorable supraglottic cancer (Panelist)
d. Pyriform sinus cancer (Panelist)

63. American Society of Neuroradiology, Nashville, TN, May 1994. Core Curriculum Course in Neuroradiology: Suprahyoid neck diseases

64. International Congress of Head and Neck Radiology, Washington, DC, June 15-19, 1994.
a. Imaging of airway and speech disorders (Invited Speaker)
b. Moderator/Panelist: Special focus session on controversies of modern nodal imaging alternatives
c. Paper: The value of pretreatment CT as a predictor of outcome and supraglottic carcinoma treated with RT alone

65. Radiologic Society of North America, Chicago, 1994.
Refresher Course: Imaging of the larynx and pharynx.

66. American Society of Head and Neck Radiology, Pittsburgh, May 1995
Speaker and Moderator of a panel on "Diseases of the Larynx and Pharynx."

67. Radiologic Society of North America, Chicago, December 1995.
Refresher Course: Imaging of the larynx and Pharynx.

68. American Society of Head and Neck Radiology, Los Angeles April 1996. Invited Lecture: Imaging of Lymph Nodes.

69. International Conference on Head and Neck Cancer. Toronto, July 28 to August 1,1996. Invited Keynote Speaker: Imaging Techniques Now and in the 21st Century

70. Radiologic Society of North America, Chicago, December 1996. Update Course in Head and Neck Imaging: Imaging of the Major Salivary Glands.

71. American Society of Head and Neck Radiology, Toronto, May 1996
Unknown Case Panelist; Lecture on Volume Acquisition CT Techniques

72. Radiologic Society of North America, Chicago, December 1997
Update Course in Head and Neck Imaging.

73. American Society of Head and Neck Radiology, Phoenix, April 1997
Imaging of Recurrent Head and Neck Cancer

74. Symposium Neuroadiologicum, Philadelphia, May 1998
Program Committee, Focused Panel Coordinator, Presentation-Post treatment evaluation of Head and Neck Cancer: When is it cancer and when is it not?

75, Combined ASNR/American Society of Head and Neck Radiology Meeting, San Diego, April 1999
Imaging of Head and Neck Cancer

76. Radiologic Society of North America, Chicago, 1998
Update Course in head and Neck Imaging.

77. Radiologic Society of North America, Chicago, 1999
Course in Advanced Topics in Head and Neck Cancer

78. Radiologic Society of North America, Chicago, 2000
Course in Advanced Topics in Head and Neck Cancer

79. Combined ASNR/American Society of Head and Neck Radiology Meeting, Boston, MA, April 2001
    a. CT Findings at the Primary Site of Oropharyngeal Squamous Cell Carcinoma about 6 Weeks Following Definitive Radiotherapy as Predictors of Primary Site Control
    b. Post-RT CT Results as a Predictive Model for Establishing the Necessity of Planned Post-RT Neck Dissection in Patients with Cervical Metastatic Disease from Squamous Cell Carcinoma

80. American Society of Head and Neck Radiology Meeting, Cleveland OH, September 2002,Cervical Metastatic Disease Imaging.

81. American Society of Clinical Oncology, New Orleans, LA, June 4-8, 2004
    Invited speaker and panelist: "Emerging Approaches in Head and Neck Cancer Management."

82. American Academy of Orofacial Pain – Invited Speaker: Responsibility of Clinicians and Diagnostic Radiologists in the Effective Use of Imaging In Patients with Facial Pain- Las Vegas April 2006

83. American Society Of Head and Neck Radiology -Gold Medalist Oration- Invited Speaker-Avoiding False Negative CT and MR Interpretations: Proven Methods to Avoid Missing Critical, Subtle Findings on Imaging Studies of the Head and Neck Phoenix, AZ October 2006

SCIENTIFIC EXHIBITS

- Mancuso AA, Hanafee WN, Ward P. Correlated CT anatomy and pathology of the larynx. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, 1978 (summa cum laude).

- Mancuso AA, Hanafee WN, Ward P. Correlated CT anatomy and pathology of the larynx. Annual Meeting of the American Roentgen Ray Society, Toronto, 1979 (special merit award).

- Mancuso AA, Bohman L, Hanafee WN, Ward P. CT of the nasopharynx: Normal variations of normal and pathological correlations. Annual Meeting of the American Roentgen Ray Society, Toronto, 1979 (special merit award).

- Mancuso AA, Bohman L, Hanafee WN, Ward P. CT of the nasopharynx: Normal variations of normal and pathological correlations. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Atlanta, Georgia, 1979.

- Hanafee WN, Mancuso AA, Winter J, Jenkins H, Bergstrom JF. Edge enhancement CT scanning in inflammatory lesions of the middle ear. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Atlanta, Georgia, 1979.

- Ward P, Mancuso AA, Hanafee WN, Berci G. Evaluation of computerized tomography, cinelaryngoscopy and laryngography in determining the extent of laryngeal disease. American Academy of Otorhinolaryngologists. Dallas, Texas, October 8-12, 1979.

- Hanafee WN, Mancuso AA, Bentson JR, Jenskins H, Winter J. Edge enhancement CT scanning of the temporal bone. American Society of Neuroradiology Meeting, Spring, 1980 (summa cum laude).

- Stone D, Mancuso AA, Rice D, Hanafee WN. CT parotid, sialography. Radiological Society of North America, Dallas, November 1980.

- Akins EW, Hill JA, Mancuso AA, et al. Assessment of left ventricular wall thickness in patients with chronic myocardial infarction by MRI. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1986.

- Yancey JM, Kaude JV, Ackerman N, Googe RE, Mancuso AA, Love IL. Gd-DTPA enhancement of experimental kidney and soft tissue carcinoma. Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, 1986.

- Zedvinskis DP, Benson MT, Kerr HH, Cacciarelli AA, Madrazzo B, Mancuso AA. Congenital anomalies: The cervical lymphatic system - Embryologic and pathologic anatomy. Scientific Assembly and Annual Meeting of the Radiological Society of North America, December 1990.

- Dalen K, Benson MT, Kerr HH, Cacciarelli AA, Mancuso AA. Congenital anomalies of the branchial apparatus: Embryologic and pathologic anatomy. Scientific Assembly and Annual Meeting of the Radiological Society of North America, December 1990.

- Sims HM, de Vries EJ, Mancuso AA. Type IV second branchial cleft cysts. Presented at the 95th Annual Meeting of the American Academy of Otolaryngology/Head and Neck Surgery, Kansas City, Missouri, September 22-26, 1991.

- Stiles WA, de Vries EJ, Mancuso AA. Castleman's disease in a retropharyngeal mass. Presented at the 95th Annual Meeting of the American Academy of Otolaryngology/Head and Neck Surgery, Kansas City, Missouri, September 22-26, 1991.

- de Vries EJ, Mancuso AA. Masticator space neurofibroma. Presented at the 95th Annual Meeting of the American Academy of Otolaryngology/Head and Neck Surgery, Kansas City, Missouri, September 22-26, 1991.

- Trimas SJ, de Vries EJ, Mancuso AA, Cassisi NJ. Avascular carotid body tumor. Presented at the 95th
  Annual Meeting of the American Academy of Otolaryngology/Head and Neck Surgery, Kansas City, Missouri, September 22-26, 1991.

- Slattery WH, de Vries EJ, Mancuso AA. Actinomycosis osteomyelitis of the skull base. Presented at the 95th Annual Meeting of the American Academy of Otolaryngology/Head and Neck Surgery, Kansas City, Missouri, September 22-26, 1991.

- Tart RP, Mukherji S, Mancuso AA. Morphologic characteristics useful in guiding the work-up of infiltrative diseases of the head and neck. Presented at the Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1991. (Certificate of merit)

- Tart RP, Mukherji SK, Stringer S, Mancuso AA. CT of normal and abnormal facial lymph nodes. Presented at the Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Ilinois, December 1992. (Certificate of merit)

- Tart RP, Kotzur IM, Mancuso AA, et al. MRI of retropharyngeal lymph nodes: Variations of normal anatomy. Presented at the Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1993.

- Tart RP, Kotzur IM, Mancuso AA, et al. CT of the buccal space: Normal anatomy and review of pathology presenting as buccal space masses. Presented at the Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1993.

- Mukherji SK, Kotzur IM, Mancuso AA, et al. Radiographic appearance of the irradiated larynx and hypopharynx by CT: Expected changes versus recurrent tumor. Presented at the Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, December 1993. (Cum Laude Certificate)

- Mukherji SK, Mancuso AA, et al. Can pretreatment CT predict local control in T2 glottic carcinoma treated with radiation therapy alone? International Congress of Head and Neck Radiology, Washington, DC, June 15-19, 1994. (Winner, Resident's Award)

EXHIBIT 3

AFFIDAVIT OF LESLIE BOYD, RN, BSN, CEN

REGARDING TAMMY CARNLEY

PERSONALLY APPEARS before the undersigned authority duly authorized to administer oaths, LESLIE BOYD RN, BSN, CEN, who after first being duly sworn states as follows.

Introduction

1. This affidavit addresses nursing negligence that occurred on October 7, 2024, when 47-year-old Tammy Carnley received care at St. Francis–Emory Healthcare Hospital ("St. Francis" or "Hospital") in Columbus, Georgia.

2. 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.

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

4. I understand the purpose of this affidavit is to satisfy the requirements of O.C.G.A. § 9-11-9.1 which requires the plaintiff "to file with the complaint an affidavit of an expert competent to testify, which affidavit shall set forth specifically at least one negligent act or omission claimed to exist and the factual basis for each such claim." This affidavit does not purport to express every opinion I hold regarding negligence but rather to satisfy the requirements of Georgia law.

5. I offer standard-of-care opinions regarding nursing conduct only. I offer no opinion regarding the physician care rendered to Tammy Carnley, and no opinion regarding whether or to what extent earlier vascular imaging, earlier neurological consultation, earlier transfer, or mechanical thrombectomy would have altered her neurological outcome. Those are medical questions outside

the scope of nursing practice, and I defer to the physician experts retained in this case.

Qualifications

6. 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.

7. 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.

8. I am qualified to provide expert testimony pursuant to O.C.G.A. § 24-7-702.

   a. On October 7, 2024, and at all times relevant to this affidavit, 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 held an active and unrestricted license issued by the State of Georgia to practice as a registered nurse. I also hold a compact license which allows me to practice in over 30 states.

   b. On October 7, 2024, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to—specifically, the emergency department nursing 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 October 7, 2024, with sufficient frequency to establish an appropriate level of knowledge of the matters my opinions address. I have practiced as a registered nurse for more than thirty years, and my practice has focused on emergency services. I received my Bachelor of Science from Georgia State University in Atlanta, Georgia in 1990.

From 2020 through the present — and thus throughout the period from October 2019 through October 7, 2024 — I have practiced clinically as a Staff Nurse in the Emergency Department at Northside Hospital in Atlanta, Georgia. I also practiced at Emory University Hospital in Smyrna, Georgia as a Staff Nurse and Assistant Nurse Manager from 2015 through 2024. I previously served as Staff Nurse in the Emergency Department at Northside Hospital from 2014 through 2018; as Clinical Manager of the Emergency Department, and as a Staff and Charge Nurse in the Emergency Department, at Emory Adventist Hospital in Smyrna, Georgia from 2007 through 2014; as a Staff and Charge Nurse in the Emergency Department at Wellstar Cobb Hospital in Austell, Georgia from 1994 through 2007; and as a Staff and Charge Nurse in the Emergency Department at R.T. Jones Hospital in Canton, Georgia from 1992 through 1994.

I am certified as a Certified Emergency Nurse by the Emergency Nurses Association, and I hold current American Heart Association Health Care Provider certifications in CPR, Advanced Cardiovascular Life Support, and Pediatric Advanced Life Support. In my emergency department practice during the period from October 2019 through October 7, 2024, I cared for patients presenting with signs and symptoms concerning for acute stroke on a regular and recurring basis. In that practice I regularly assessed patients presenting with altered mental status, aphasia, unilateral weakness, and other signs of acute stroke; performed and documented stroke screening and neurological assessments; determined or assisted in determining last known well times; initiated institutional stroke-response and stroke-alert processes; communicated changes and concerns to treating physicians; and escalated unresolved concerns through the nursing chain of command.

Having served as a Charge Nurse and as an Emergency Department Clinical Manager, I am also familiar with hospital stroke protocols and with the responsibilities those protocols assign to nursing personnel, and with the operation of the nursing chain of command from the standpoint of both the bedside nurse who escalates a concern and the nurse leader who receives it.

c. I am a registered nurse. Kelly Cook, RN, Presley Adams, RN, and the presently unidentified triage and primary nurses whose conduct I address were registered nurses and nursing personnel. I am therefore a member of the same profession as the providers whose conduct I discuss.

Evidence Considered

9. In forming the opinions expressed in this affidavit, I have reviewed the medical records for Tammy Carnley from St. Francis–Emory Healthcare Hospital for the encounter of October 7, 2024; the Harris County EMS Prehospital Care Report for that date; the records of Piedmont Columbus Regional Midtown Hospital for the admission of October 7 through October 25, 2024; and the November 21, 2024 addendum re-read of the October 7, 2024 head CT.

10. I have not been provided with the St. Francis emergency department nursing flowsheets or triage documentation, the Hospital's 2024 stroke-alert, stroke-screening, and nursing chain of command policies, the Hospital's staffing and assignment records for October 7, 2024, the electronic health record audit trail, the interfacility transport records, or any deposition testimony. As more records become available, I will review as requested and reserve the right to modify or add to my opinions based on new or additional evidence.

Failure to Initiate the Hospital's Stroke-Response Process

11. *Requirements*: Under the facts and circumstances ascertainable from the medical records, the standard of care requires hospital emergency department nurses to recognize findings concerning for acute stroke and to act upon them without delay. Specifically, upon recognizing such findings the nurse is required to perform and document a stroke screening assessment; to obtain and document the patient's last known well time; and to initiate the institution's stroke-response process, or immediately obtain activation through the appropriate designated provider, without waiting passively for the patient's condition to be independently addressed.

12. *Violations*: On October 7, 2024, nurses at St. Francis–Emory Healthcare Hospital, including the triage and primary nurses assigned to Tammy Carnley's care, violated the standard of care by failing to perform and document a stroke screening assessment, by failing to obtain and document her last known well time, and by failing to initiate the Hospital's stroke-response process. These nursing violations delayed activation of the Hospital's stroke-response process and deprived the treating team of the prompt nursing screening, documentation, and notification required by the standard of care. This was a departure from the standard of care.

13. The factual basis for this allegation based on the medical records, is the following:

    a. On October 7, 2024, at approximately 06:36 hrs, Tammy Carnley arrived by ambulance at the St. Francis emergency department, and transfer of care from EMS occurred at approximately 06:39 hrs.

    b. The responding paramedics documented a Glasgow Coma Scale of 8, more movement on the left than the right, and a secondary impression of "CNS-Stroke." No pre-arrival stroke alert was called in to the Hospital.

    c. At approximately 06:43 hrs, nursing documented the Patient's first set of vital signs: temperature 36.9°C, heart rate 88, respiratory rate 21, blood pressure 142/83, oxygen saturation 93 percent, and point-of-care glucose 112. The normal glucose value excluded hypoglycemia, the most common stroke mimic.

    d. The emergency physician's note documents that at approximately 06:44 hrs the Patient was unresponsive, with motor strength decreased on the right, sensation decreased on the right, and aphasic speech, and records a National Institutes of Health Stroke Scale score of 22 out of 42 and a baseline modified Rankin Scale score of 0. Those neurological findings appear in the physician's documentation. The record contains no corresponding nursing neurological assessment or nursing stroke screen from that period or any later point in the encounter.

e. The paramedics reported that the Patient had last been known well at approximately 22:30 the previous evening and had been found face down on the floor of her home by her husband that morning. Her husband was not at the bedside on her arrival but was available later that day.

f. The record contains no nursing documentation of a last known well time, and no documentation of any nursing effort to obtain or clarify that time from the responding paramedics or from the Patient's family. Last known well time governs the timing of acute stroke treatment decisions.

g. The 46-page St. Francis emergency department record contains no documentation that any nurse initiated a stroke alert, a code stroke, or any other stroke-response process at any point during the Patient's nearly eight-hour stay.

h. The head CT obtained at approximately 07:50 hrs was read at 08:14 hrs as "Normal CT of the head." A normal or reportedly normal non-contrast head CT does not exclude an acute ischemic stroke and did not relieve the nurses of the obligation to screen for stroke and to initiate the Hospital's stroke-response process.

Failure to Assess Serially and to Escalate

14. *Requirements*: Under the facts and circumstances ascertainable from the medical records, the standard of care requires hospital emergency department nurses to perform and document serial neurological assessments of a patient with a profound and unexplained neurological deficit, to communicate their findings and concerns directly to the treating physician, and, when the patient's condition continues to go unaddressed, to escalate those concerns through the nursing chain of command. Specifically, the nurses are required to act as the advocate for a patient who cannot advocate for herself.

15. *Violations*: On October 7, 2024, nurses at St. Francis–Emory Healthcare Hospital, including Kelly Cook, RN, and Presley Adams, RN, violated the

standard of care by failing to perform and document serial neurological assessments of Tammy Carnley and by failing to escalate the absence of a timely stroke evaluation through the nursing chain of command. These nursing violations deprived the treating physician, and the Hospital personnel above him, of the prompt nursing assessment, notification, and escalation required by the standard of care. This was a departure from the standard of care.

16. The factual basis for this allegation based on the medical records, is the following:

    a. Vital signs were recorded at approximately 06:43, 07:00, 07:30, 08:00, 08:30, 09:10, 09:30, 10:00, 10:30, 11:00, 11:30, and 12:00 hrs. Despite that repeated documentation, the record contains no corresponding serial nursing neurological assessments documenting whether the Patient's profound deficits had improved, persisted, or worsened.

    b. The record contains no documented communication by any nurse to the emergency physician expressing concern about the Patient's neurological presentation, about the absence of vascular imaging or neurological consultation, or about the passage of time.

    c. The record contains no documented notification of a charge nurse, an emergency department nurse manager, a house supervisor, a stroke program coordinator, or an emergency department medical director.

    d. Neurology was not consulted until approximately 12:26 hrs, and CT angiography was not performed until approximately 13:08 hrs — more than six hours after the Patient's arrival.

    e. At approximately 12:25 hrs, the consulting neurologist interpreted the imaging as demonstrating an Alberta Stroke Program Early CT Score (ASPECTS) of 6 to 7 and recommended transfer for consideration of mechanical thrombectomy.

    f. The receiving hospital accepted the Patient for emergency-department-to-emergency-department transfer at approximately 13:30 hrs. At approximately 13:43 hrs, preliminary CT angiography findings of a

large acute left middle cerebral artery stroke with a thrombosed left M1 segment were reported to Kelly Cook, RN. Report was called by Presley Adams, RN, at approximately 13:45 hrs. The Patient departed St. Francis at approximately 14:15 hrs. The record presently reviewed does not explain the interval between acceptance at approximately 13:30 hrs and departure at approximately 14:15 hrs.

g. The Patient arrived at the receiving hospital at approximately 14:22 hrs. Repeat imaging read at approximately 15:23 hrs was interpreted as demonstrating an ASPECTS of 1. No thrombectomy was performed.

17. Again, this affidavit is given for the limited purpose of satisfying the Georgia procedural requirements under the law, and is not an expression of all my opinions regarding this matter.

Leslie R Boyd RN, BSN, CEN

LESLIE BOYD RN, BSN, CEN

SWORN TO AND SUBSCRIBED before me

September 1, 2026

NOTARY PUBLIC

My Commission Expires: September 18, 2029

JORDYN HYMAN
Notary Public, Georgia
Chatham County
My Commission Expires
September 18, 2029

LESLIE R. BOYD, R.N., B.S.N., C.E.N.

4310 Woodhaven Way, Smyrna, GA 30082 • 770-354-8920 • leslierboydrn@gmail.com

PROFESSIONAL SUMMARY

An accomplished, seasoned and pragmatic registered nurse with over 30 years experience. Broad range of healthcare experience with a focus in emergency services. Superior communication and leadership skills.

PROFESSIONAL EXPERIENCE

Emory University Hospital ***Staff Nurse /Assistant Nurse Manager***	**Smyrna, GA**	**2015 –2024**
Northside Hospital ***Staff Nurse, Emergency Department***	**Atlanta, GA**	**2014 – 2018** **2020 - Present**
Emory Adventist Hospital ***Clinical Manager, Emergency Department***	**Smyrna, GA**	**2007 – 2014**
Staff/Charge Nurse, Emergency Department		
Wellstar Cobb Hospital ***Staff/Charge Nurse, Emergency Department***	**Austell, GA**	**1994 – 2007**
R.T. Jones Hospital ***Staff/Charge Nurse, Emergency Department***	**Canton, GA**	**1992 – 1994**
Staff/Charge Nurse, Labor and Delivery Department		
Staff/Charge Nurse, Medical Surgical Unit		

EDUCATION

Georgia State University, Atlanta, GA, 1990, ***Bachelor of Science***

LICENSURE AND CERTIFICATIONS

State of Georgia, Active
American Heart Association Health Care Provider, CPR, Current
American Heart Association Health Care Provider, ACLS, Current
American Health Association Health Care Provider, PALS, Current
Emergency Nurses Association, Certified Emergency Nurse, Current

HONORS

Recipient, Leadership in Nursing, Emory Adventist Hospital, 2014
Recipient, Professionalism Recognized in Dedicated Employees, Wellstar Cobb Hospital, 1996