COMMONWEALTH OF KENTUCKY
MCCRACKEN CIRCUIT COURT
DIVISION I
CIVIL ACTION NO.: 15-CI-00362

ROXANNE PRIDEMORE, INDIVIDUALLY AND AS THE ADMINISTRATRIX OF THE ESTATE OF LARRY PRIDEMORE, SR. — PLAINTIFF

v. **PLAINTIFF'S TRIAL BRIEF**

MERCY HEALTH PARTNERS-LOURDES, INC.; D/B/A LOURDES HOSPITAL, INC, ET AL. — DEFENDANTS

* * * * *

Comes the Plaintiff, Roxanne Pridemore, by counsel, and submits her Trial Brief pursuant to the Court's Pre-Trial Order, dated December 22, 2021.

A. KIND OF ACTION

This is a wrongful death/medical and hospital negligence action arising from the death of Larry Pridemore, Sr., during his admission to Mercy Health-Partners-Lourdes, Inc., d/b/a Lourdes Hospital, Inc. ("Lourdes Hospital") from May 21, 2014, to May 27, 2014. Mrs. Pridemore filed suit individually and as the Administratrix of the Estate of Larry Pridemore, Sr., against Lourdes Hospital, Dr. Steven J. McCullough, D.O., and two physician practices, Mercy Health Physicians Kentucky LLC, d/b/a Lourdes Physician Services, LLC ("Mercy Health Physicians"), and Jackson Purchase Medical Associates, P.S.C. ("Jackson Purchase"). Dr. McCullough provided services as the agent, actually, ostensibly or otherwise, and/or as an employee of Mercy Health Physicians and/or Jackson Purchase and also admitted during his deposition taken on January 8, 2018, that he was an agent of the Hospital while providing care and treatment to Mr. Pridemore during his May 21-27th admission.

Filed 15-CI-00362 05/19/2022 Kim Channell, McCracken Circuit Clerk

B. STATEMENT OF ISSUES INVOLVED

1. Did the Defendant, Lourdes Hospital, acting by and through its nursing and ancillary staff and its agents, actually, ostensibly, and/or otherwise, fail to exercise the degree of care and skill ordinarily expected of a reasonable and prudent hospital acting under similar circumstances, and if so, was such failure a substantial factor in causing the death of Larry Pridemore, Sr.?

2. Did the Defendant, Dr. McCullough, fail to exercise the degree of care and skill ordinarily expected of a reasonably prudent Internist and Hospitalist acting under similar circumstances, and if so, was such failure a substantial factor in causing the death of Larry Pridemore, Sr.?

3. Was the Defendant, Dr. McCullough, the actual or ostensible agent of one or more of the other Defendants, Lourdes Hospital, Mercy Health Physicians, and/or Jackson Purchase Medical Associates, P.S.C.?

4. What amount of money is needed to fairly and reasonably compensate the Estate of Larry Pridemore, Sr. for the medical and hospital expenses incurred prior to death?

5. What amount of money is needed to fairly and reasonably compensate the Estate of Larry Pridemore, Sr. for the physical and mental pain and suffering he experienced prior to death?

6. What amount of money is needed to fairly and reasonably compensate Roxanne Pridemore for the loss of services, assistance, aid, society, companionship, and conjugal relation of her husband, Larry Pridemore, Sr.? KRS 411.145; Martin v. Ohio Co. Hosp. Corp., 295 S.W.3d 104 (Ky. 2009)?

7. How should fault and causation be apportioned between Defendants Mercy Health-Partners-Lourdes, Inc., d/b/a Lourdes Hospital, Inc., Dr. Steven J. McCullough, D.O., Mercy Health Physicians Kentucky LLC, d/b/a Lourdes Physician Services, LLC, and Jackson Purchase Medical Associates, P.S.C. pursuant to KRS 411.182?

C. SUMMARY OF FACTUAL SITUATION

Larry Pridemore, Sr. ("Larry") stopped breathing and suffered a cardio-respiratory arrest around 11:00 p.m. at Lourdes Hospital on May 22, 2014. He was restrained at the ankles, wrists, and chest, sedated, lying supine in the bed, and unmonitored at the time of his arrest. Although regaining a pulse during the Code, he went without oxygen for enough time to cause irreversible, and severe, brain damage resulting in his death on May 27, 2014.

Larry's admission to Lourdes Hospital began in the early evening of May 21, 2014, when he presented with complaints of shortness of air and multiple syncopal episodes. The prior day, May 20, 2014, Larry presented to Trigg County ER due to falling backwards and hitting his head during one of the syncopal episodes. CT scans of his head and spine and x-rays of his shoulder and scapula were negative. A chest x-ray showed areas of patchy, hazy, ground glass opacities in both lungs with differential considerations being contusion, atelectasis, aspiration, pneumonia, and/or edema. Larry declined admission to Trigg County Hospital, preferring to follow up the next morning with his primary care provider, Holly McCormick, APRN, for a scheduled appointment. His condition upon discharge from Trigg County Hospital was fair and stable.

Larry presented to Holly McCormick, APRN, at Trigg County Primary Care on May 21, 2014, with intermittent breathing difficulty, fatigue, low blood pressure, and very low oxygen saturation levels. Nurse McCormick reviewed the lab work from the night before and noted an elevated white blood cell count, slight anemia, and elevated BUN/Creatinine levels. Based upon

her physical examination, she instructed Larry to go directly to the ER. Larry preferred to go to Lourdes Hospital because that is where his nephrologist was located. Nurse McCormick provided Larry with a portable Oxygen unit for the one-hour trip to Lourdes Hospital. She also called the Lourdes ER triage desk and spoke with the ER charge nurse to give her a full report about Larry's condition to make his transition as smooth as possible when he arrived there.

Plaintiff, Roxanne Pridemore ("Roxanne"), drove her husband Larry to Lourdes Hospital immediately and reached the ER at approximately 5:14 p.m. on May 21, 2014.[1] The ER labs confirmed increased creatinine levels and anemia, but normal troponin levels (0.01 ng/ml). His EKG was also normal.[2] A chest x-ray showed patchy right middle lobe and right upper lobe pneumonia and probable atelectasis (collapse) in the left lung base.[3] Larry was diagnosed in the ER with syncope, pneumonia, moderate acute renal failure, and anemia and admitted to the 7th floor, Progressive Care Unit (PCU), under the care of the attending Hospitalist, Dr. McCullough.

Larry arrived in Room 709 in the PCU at approximately 9:29 p.m. on May 21, 2014, with declining saturation levels. Between the hours of 10:00 p.m. and 11:00 p.m., Dr. McCullough visited Larry's bedside to perform a history and physical (H&P) exam and assess low oxygen saturation levels.[4] Dr. McCullough noted in his H&P that Larry was a 64-year-old man who presented with the primary complaint of increasing shortness of breath and was hypoxic with pneumonia. He was weak, fatigued, and suffered from some cough and wheeze. "He [was] acutely ill in appearance [with] mild-to-moderate respiratory distress at rest [and] hypoxic on 2 L" on

[1] See ER Clinical Report-Physicians/Mid-Levels by Dr. Hawkins, pp. 5-11 of the certified Lourdes Hospital chart, attached hereto as Exhibit 1.
[2] Larry had a history of coronary artery disease and cardiac stent (x4) placement. The normal troponin levels (0-0.04ng/ml) and EKG results were reassuring for concerns about Larry's cardiac condition.
[3] See Radiology Report attached hereto as Exhibit 2.
[4] See Dr. McCullough's History and Physical, pp. 487-488 of the certified Lourdes Hospital chart, attached hereto as Exhibit 3.

supplemental oxygen. Dr. McCullough's diagnosed Larry with "hypoxemic respiratory failure" and planned to "treat him in the pneumonia pathway and follow his course expectantly."

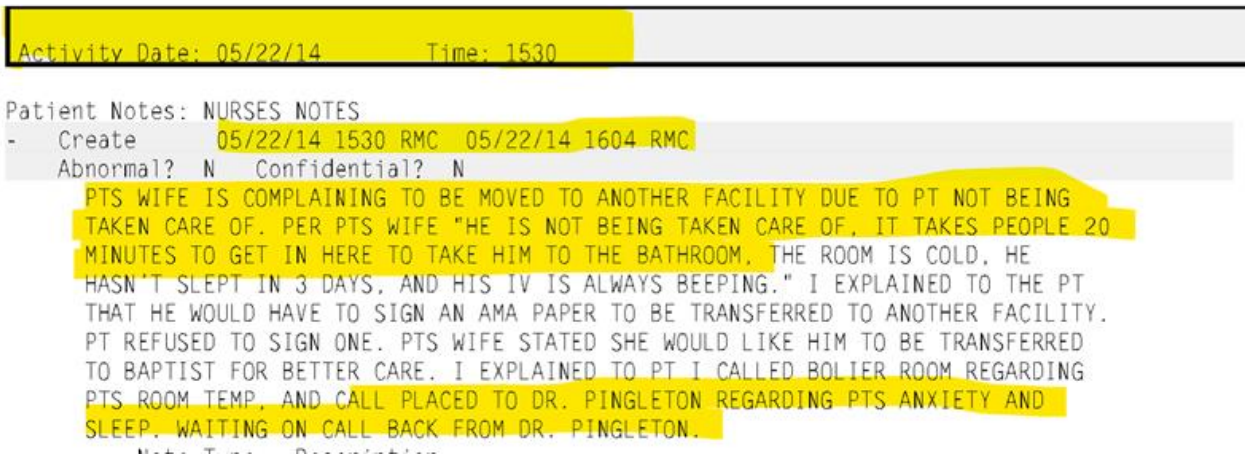
This was Dr. McCullough's one, and only, time visiting Larry to do a face-to-face assessment. He would not return to Room 709 until twenty-four (24) hours later when the Code Blue was called.

At 11:00 p.m. on May 21, 2014, the nurse assigned to Larry's room, 709, Billi Ingram, RN noted that Larry was slightly confused with a dusky complexion but in no apparent distress and resting comfortably. Nurse Ingram further documented that Roxanne told her that her husband had "been falling a lot lately and behaving and speaking strangely, 'like he's not getting enough oxygen to his brain.'"[5] Roxanne would share this concern with Hospital staff, that Larry was not behaving normally, repeatedly over the next twenty-four (24) hours. Roxanne and Larry had been married and together for forty (40) years, so it is accurate to say her concerns were serious and required the attention of Larry's treatment team. Larry's oxygen saturation levels remained low, 91% on 2L supplemental oxygen, at 11:23 p.m.[6] and 12:11 a.m., May 22, 2014, and 90% on 2L at 4:20 a.m. on May 22, 2014.[7]

On May 22, 2014, from 6:50 a.m. to 7:25 a.m., the day shift nurse assigned to Larry's room, 709, Rita Campanur, RN, noted that Larry was "resting in bed…[with]…no complaints of pain [or] signs of distress." Roxanne was at his bedside. Larry's oxygen saturation levels continued to be low at 90% on 2L when taken at 7:25 a.m.[8] Nurse Campanur noted later, at 11:29 a.m., that his oxygen saturation levels were 92% on 2L.[9] Similar notes regarding Larry's status were

[5] See Nursing Note by Billi Ingram, RN, pp. 187-189 of the certified Lourdes Hospital chart, attached hereto as Exhibit 4.
[6] Id. at 189.
[7] See Nursing Notes, pp. 202-203; 213-214 of the certified Lourdes Hospital chart, attached hereto as Exhibit 5.
[8] Id. at p. 203.
[9] Id. at p. 213.

documented at 12:53 p.m. on May 22nd. However, at 3:30 p.m., Larry's anxiety began to increase. Nurse Campanur noted as follows:



Activity Date: 05/22/14 Time: 1530

Patient Notes: NURSES NOTES
- Create 05/22/14 1530 RMC 05/22/14 1604 RMC
Abnormal? N Confidential? N

PTS WIFE IS COMPLAINING TO BE MOVED TO ANOTHER FACILITY DUE TO PT NOT BEING TAKEN CARE OF. PER PTS WIFE "HE IS NOT BEING TAKEN CARE OF, IT TAKES PEOPLE 20 MINUTES TO GET IN HERE TO TAKE HIM TO THE BATHROOM. THE ROOM IS COLD, HE HASN'T SLEPT IN 3 DAYS, AND HIS IV IS ALWAYS BEEPING." I EXPLAINED TO THE PT THAT HE WOULD HAVE TO SIGN AN AMA PAPER TO BE TRANSFERRED TO ANOTHER FACILITY. PT REFUSED TO SIGN ONE. PTS WIFE STATED SHE WOULD LIKE HIM TO BE TRANSFERRED TO BAPTIST FOR BETTER CARE. I EXPLAINED TO PT I CALLED BOLIER ROOM REGARDING PTS ROOM TEMP, AND CALL PLACED TO DR. PINGLETON REGARDING PTS ANXIETY AND SLEEP. WAITING ON CALL BACK FROM DR. PINGLETON.

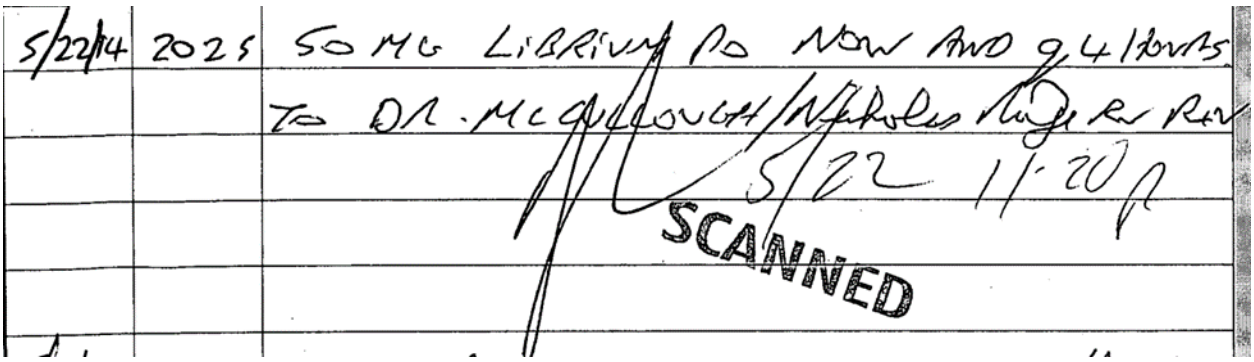
Between 3:45 p.m. and 4:01 p.m., Nurse Campanur called another Hospitalist, Dr. Pingleton, regarding Larry's anxiety and noted she is "waiting on call back from [the doctor]."[10] At approximately 4:55 p.m., hematologist, Dr. William Skinner, M.D., visited the bedside for a consultation and found that Larry was weak, fatigued, hypoxic on supplemental oxygen, and "somewhat agitated."[11] His oxygen saturation levels remained borderline, 93% on 2L, at 5:37 p.m.[12]

At 7:00 p.m. on May 22nd, Larry's agitation, restlessness, and confusion persisted. The nurse assigned to Larry's room, 709, Nicholas Ridge, RN, noted that Larry "appears restless and confused" with the family (Roxanne and her two daughters and grandchildren) at the bedside.[13] At 8:25 p.m. Larry became even more agitated and confused.[14] He pulled the IV out of his arm and was out of his bed swinging his walking cane and heart monitor. Security was called and came to

[10] Id. at p. 214.
[11] See Dr. Skinner's Consultation Report, pp. 80-81 of the certified Lourdes Hospital chart, attached hereto as Exhibit 6.
[12] See Exhibit 5, p. 214.
[13] Id.
[14] Id.

the room to assist in calming Larry down. Nurse Ridge documented that he called Dr. McCullough at this time to advise him that Larry had marked changes in his agitation and confusion. This was the first time Dr. McCullough was made aware of changes in Larry's mental status. **Dr. McCullough did not visit Room 709 to assess Larry himself, nor did Nurse Ridge request Dr. McCullough to come to the bedside**. Instead, Dr. McCullough ordered 50 mg of the sedative drug, Librium, be given by mouth, which Larry refused.[15]

5/22/14 @ 2025. CALLED DR. MCCULLOUGH. 50 MG. LIBRIUM ORDERED. PATIENT AGITATED AND CONFUSED. SECURITY CALLED. PATIENT SWINGING WALKING CANE AND HEART MONITOR. PATIENT REFUSED LIBRIUM. PATIENT PULLED IV OUT OF ARM.

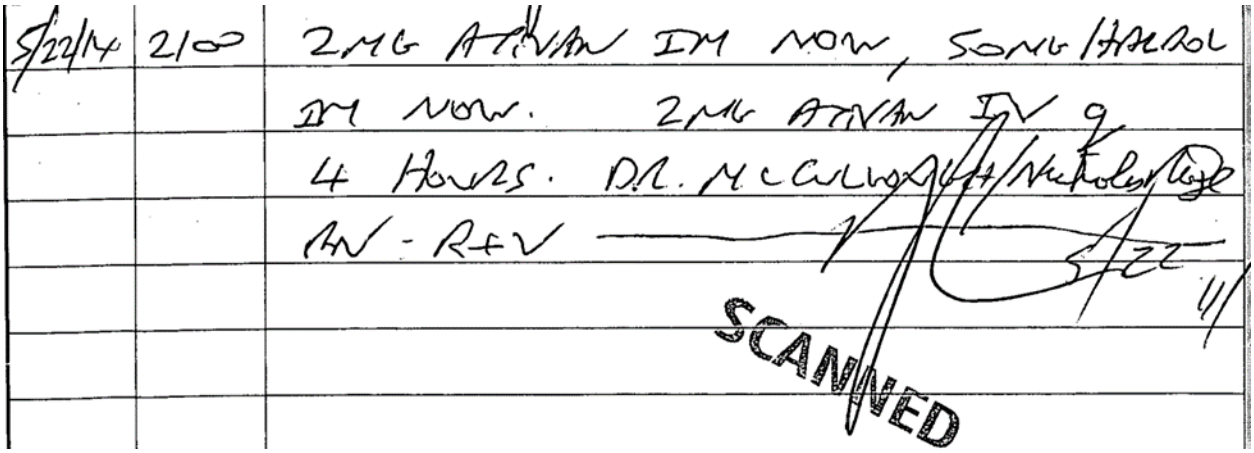


At 9:00 p.m. on May 22, 2014, Nurse Ridge noted that Larry remained combative – yelling at Roxanne, swinging his heart monitor, refusing to wear his supplemental oxygen, and lunging at staff. Nurse Ridge called Dr. McCullough again to advise him of the situation. **Again, Dr. McCullough did not visit Room 709 to assess Larry himself, nor did Nurse Ridge request him to come to the bedside**. Instead, he ordered injections of 2 mg Ativan and 50 mg! Haldol (subsequently corrected to 5 mg) and further ordered that 2 mg Ativan be given every four hours.[16] Ativan and Haldol are sedative medications with the known adverse reaction of causing respiratory

[15] See Nursing Notes, p. 231, and Physician Orders, pp. 41-43 of the certified Lourdes Hospital chart, attached hereto as Exhibit 7.
[16] Id.

suppression.

5/22/14 @ 2100. PT STILL COMBATIVE, WIFE STATING PT YELLING AT HER, PT SWINGING HEART MONITOR, REFUSES TO WEAR. PT REFUSING TO WEAR OXYGEN, 02 91% RA. PT LUNGED AT STAFF.
PATIENT IN RESTRAINTS. DR. MCCULLOUGH CALLED. GIVE 2 MG ATIVAN IM AND 5 MG HALDOL IM.



In addition to ordering chemical restraints, Dr. McCullough ordered that Larry be physically restrained to the bed in the supine position by five-point (ankles, wrists, and chest vest) restraints. He ordered the restraints be applied, beginning at 9:00 p.m. May 22, 2014, and terminating at 9:00 p.m. on May 23, 2014.[17] Despite the Order form referencing "non-violent/non-self-destructive behavior," it is undisputed (by medical record and fact/expert testimony) that both the chemical and physical restraints were ordered to address Larry's violent, aggressive, combative, and self-destructive behavior. Larry's vital signs also showed marked changes around this time, including a pulse increase from 90 bpm (taken at 5:37 p.m.) to 170 bpm![18] The Hospital nursing staff chose not to advise Dr. McCullough of these changes and did not ask him to come to the bedside to perform a face-to-face assessment of Larry in Room 709.

[17] Id.
[18] See Exhibit 5.

At 9:25 p.m., Nurse Ridge noted that Roxanne was "crying and upset as [Larry was] out of restraints and threw water at her."[19] A Code Gray[20] was called to re-restrain Larry as several Hospital security and other staff rushed into the room to pin Larry down to the bed and reapply the five-point restraints. **Neither Nurse Ridge nor any Hospital staff notified Dr. McCullough of this incident, much less contacted him to request he come to the bedside to do a face-to-face assessment of Larry**.

5/22/14 @ 2125. PHARMACY CALLED FOR CLARIFICATION OF HALDOL DOSAGE. WIFE CRYING AND UPSET AS PATIENT OUT OF RESTRAINTS AND THREW WATER AT HER. WIFE MAY HAVE UNTIED RESTRAINTS. CODE GRAY CALLED, PT RE-RESTRAINED.

The Ativan and Haldol injections were given as ordered between 9:37 p.m. and 9:47 p.m.

At 10:05 p.m. on May 22nd, Nurse Ridge contacted Dr. McCullough to advise that Larry was refusing to wear his heart monitor and had thrown the telemetry box out into the hallway and struck a PCA on the leg as she was passing by Room 709. **Again, Dr. McCullough did not visit Larry to do a face-to-face assessment, nor did Nurse Ridge request that Dr. McCullough come to the bedside**. Instead, Dr. McCullough ordered another injection of 2 mg of Ativan and permitted the Hospital nursing staff to remove the heart monitor due to Larry's agitation.[21]

5/22/14 @ 2205. CALLED DR. MCCULLOUGH. GIVE 2 MG ATIVAN IM NOW. DISCONTINUE TELEMETRY AS PATIENT REFUSES TO WEAR IT. (PATIENT THREW TELEMETRY BOX OUT INTO THE HALL AND HIT PCA ON LEG AS SHE WAS PASSING BY.)

Larry was now strapped to the bed in the supine position without any equipment attached to monitor his cardiac or respiratory condition. **Dr. McCullough further did not order, nor did the Hospital nursing staff request, a sitter or nurse be assigned to Room 709 to continuously**

[19] See Exhibit 7.
[20] Although requested in Interrogatory No. 16 of Plaintiff's First Set of Interrogatories and Second Set of Requests for Production of Documents, the Hospital has not yet produced the Code Gray policy and procedure; however, it is Plaintiff's understanding that Code Gray is called for combative, aggressive, and/or violent patients.
[21] Id.

monitor Larry or that Larry be transferred to a more intensive care unit to receive 1:1 monitoring and assessment.

The second dose of Ativan was given at 10:24 p.m.

At 10:30 p.m., Nurse Ridge noted that Larry was attempting to rest. He further noted that Roxanne had previously been asked to leave the room to allow Larry to calm down but at some point, between 10:30 and 11:00 p.m., she was permitted back into the room to rest in an empty bed next to Larry.[22]

5/22/14 @ 2230. PT ATTEMPTING TO REST, ASKED WIFE TO GO TO WAITING ROOM TO GIVE PT CHANCE TO CALM DOWN. WIFE BACK AT BEDSIDE AT 2250 ASKING TO SLEEP IN BED 1. PERMISSION GIVEN TO SLEEP IN BED 1, PT LEFT LEG MOVING OFF OF SIDE OF BED, COLOR WNL AND BREATHING REGULARLY. WIFE IN BED 1.

While Larry had clearly calmed down and was resting, neither Dr. McCullough nor the Hospital nursing staff removed the physical restraints or recommenced cardiac and respiratory monitoring. Larry remained strapped to his bed in five-point restraints on his back with the monitoring equipment disconnected. Larry was also left alone without continuous observation or monitoring by trained Hospital staff during this time. **Dr. McCullough had still not visited Larry to do a face-to-face assessment of his condition**.

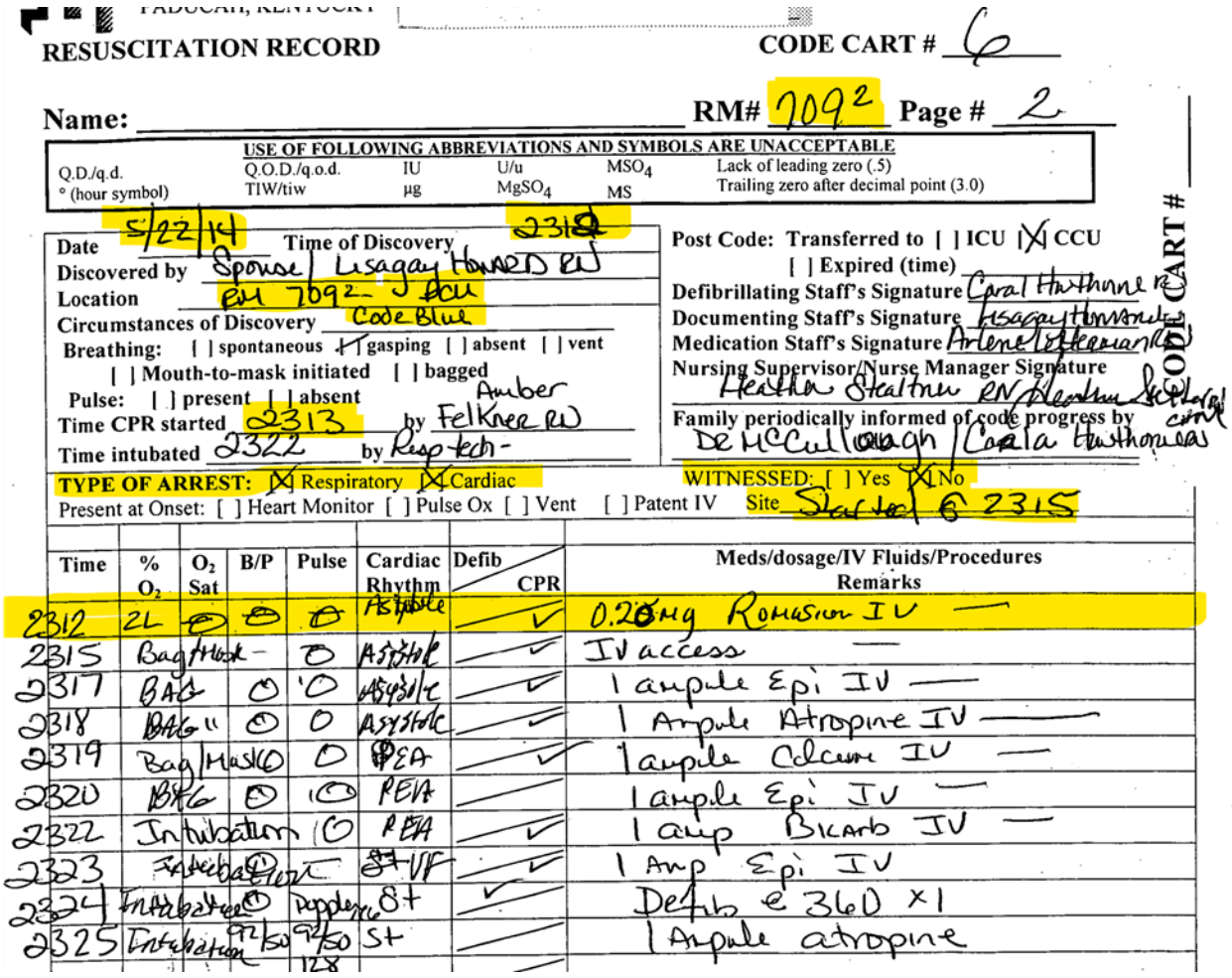
According to Nurse Ridge's documentation, at 11:10 p.m. on May 22nd, Roxanne found Larry to be apneic. The Code Blue was called.[23]

5/22/14 @ 2310. PATIENT'S WIFE STATES THAT PATIENT IS NOT BREATHING. CODE BLUE CALLED. PATIENT TRANSFERRED TO CCU.

According to Dr. McCullough's summary note, he responded to the Code to find Larry unresponsive, pulseless, and apneic. The Code lasted for seventeen (17) minutes before

[22] Id.
[23] Id.

resuscitation.[24] The Resuscitation Record indicates that Dr. McCullough and the Hospital staff believed Larry suffered a respiratory arrest due to the sedative medications given to him three (3) hours prior as the drug Romazicon was administered at the outset of the Code, which is an antagonist or reversal for the sedative medications Ativan and Haldol.[25]



RESUSCITATION RECORD — CODE CART # 6

Name: _____ RM# 7092 Page # 2

USE OF FOLLOWING ABBREVIATIONS AND SYMBOLS ARE UNACCEPTABLE

Q.D./q.d.	Q.O.D./q.o.d.	IU	U/u	MSO_4	Lack of leading zero (.5)
° (hour symbol)	TIW/tiw	µg	$MgSO_4$	MS	Trailing zero after decimal point (3.0)

Date 5/22/14 Time of Discovery 2312
Discovered by Spouse/Lisagay Howard RN
Location RM 7092 - J ICU
Circumstances of Discovery Code Blue
Breathing: [ ] spontaneous [X] gasping [ ] absent [ ] vent
[ ] Mouth-to-mask initiated [ ] bagged
Pulse: [ ] present [ ] absent
Time CPR started 2313 by Amber Felkner RN
Time intubated 2322 by Resp tech -

Post Code: Transferred to [ ] ICU [X] CCU
[ ] Expired (time) _____
Defibrillating Staff's Signature Carol Hathorne RN
Documenting Staff's Signature Lisagay Howard RN
Medication Staff's Signature Arlene Lefkowitz RN
Nursing Supervisor/Nurse Manager Signature Heather Stoltner RN
Family periodically informed of code progress by DR McCullough / Carla Hathorne RN

TYPE OF ARREST: [X] Respiratory [X] Cardiac WITNESSED: [ ] Yes [X] No
Present at Onset: [ ] Heart Monitor [ ] Pulse Ox [ ] Vent [ ] Patent IV Site Started @ 2315

Time	% O_2	O_2 Sat	B/P	Pulse	Cardiac Rhythm	Defib / CPR	Meds/dosage/IV Fluids/Procedures Remarks
2312	2L	0	0	0	Asystole	✓	0.2 mg Romazicon IV
2315	Bag/Mask	-	0	Asystole	✓	IV access
2317	BAG	0	0	Asystole	✓	1 ampule Epi IV
2318	BAG	0	0	Asystole	✓	1 Ampule Atropine IV
2319	Bag/Mask	0	0	PEA	✓	1 ampule Calcium IV
2320	BAG	0	0	PEA		1 ampule Epi IV
2322	Intubation	0	0	PEA	✓	1 amp Bicarb IV
2323	Intubated			ST/VF	✓	1 Amp Epi IV
2324	Intubated	0	Doppler	ST	✓	Defib @ 360 x1
2325	Intubation	92%	92/50 128	ST		1 Ampule atropine

As noted above, although regaining a pulse after the seventeen (17) minute code, Larry went without oxygen for enough time to cause irreversible, and severe, brain damage resulting in his death on May 27, 2014. In two subsequent physician notes, the Consultation Note by pulmonologist, Dr. Keith Kelly, M.D. and the Discharge Summary by Dr. Rebecca Spencer, M.D.,

[24] See Dr. McCullough's Summary Note, pp. 498-499 of the certified Lourdes Hospital chart, attached hereto as Exhibit 8.
[25] See Resuscitation Record, pp. 524-526, of the certified Lourdes Hospital chart, attached hereto as Exhibit 9.

it was documented that Larry died from acute hypoxemic respiratory failure and cardiorespiratory arrest secondary to his compromised respiratory disease (pneumonia) resulting in anoxic brain injury leading to legal brain death or anoxic encephalopathy.[26] Dr. Spencer also noted that Larry underwent a 2-D echo which "showed a normal ejection fraction of 71%," which confirmed cardiac disease was an unlikely contributing factor to Larry's cardiorespiratory arrest. Indeed, neither Dr. Kelly nor Dr. Spencer indicated in their records that Larry suffered an heart attack or some other catastrophic heart failure or pulmonary event unrelated to the respiratory disease, suppression, and arrest most likely contributing to cause cardiac arrest and ultimately anoxic brain injury.

As for Plaintiff's claims of medical negligence and causation, she has disclosed three (3) expert witnesses –two nurses, Mary Jane Smith, MSN, MA, RN, BC, and Stephanie Iseri, RN, BSN, CMSRN, LNC, and one physician, Dr. David Goldsten who is Board-Certified in Internal and Pulmonary Medicine. [27] All are expected first and foremost to testify that the Defendants violated Lourdes Hospital's Restraint Use policy, effective June 4, 2013.[28] See Williams v. St. Claire Medical Center, 657 S.W.2d 590, 594-595 (Ky. App. 1983) (a hospital owes a duty to its patients to enforce its published rules and regulations pertaining to patient care, the breach of which may result in independent liability of the hospital).

[26] See Dr. Kelly's Consultation Note and Dr. Spencer's Discharge Summary, pp. 19-20; 73-75 of the certified Lourdes Hospital chart, attached collectively hereto as Exhibit 10.
[27] See Plaintiff's Expert Disclosures attached hereto as Exhibit 11.
[28] See Lourdes Hospital Restraint and Seclusion Use policy, BSG Pridemore RFP 000266-000282, attached hereto as Exhibit 12.

RESTRAINT AND SECLUSION USE

INDEX

Based on the medical records and the testimony in this case, including the testimony of Dr. McCullough, the Lourdes Hospital nursing and ancillary staff, and expert witnesses on behalf of the Defendants, chemical and physical restraints were ordered and administered to Larry to manage his violent, aggressive, and self-destructive behavior. Between the hours of approximately 8:25 p.m. and 10:35 p.m. on May 22, 2014, physician orders were given for Librium, Ativan, and Haldol. Under the Hospital Policy, such orders for chemical restraints required a face-to-face physician's assessment within an hour of the intervention.

Chemical Restraint – A drug or a medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. A medication ordered to address violent or aggressive patient behavior is considered a restraint for violent or self destructive behavior and requires a face-to-face physician's assessment within one hour of the intervention.

Dr. McCullough testified that he never considered coming to the bedside prior to or after ordering chemical restraints, and indeed he only assessed Larry one time, between 10:00 p.m. and 11:00 p.m. on May 21st *and did not return to the bedside until the Code Blue was called twenty-four (24) hours later*. The Hospital nursing and ancillary staff, including the assigned nurse, Nicholas Ridge, RN, and the charge nurse, Carla Hawthorne, RN, also did not ask Dr. McCullough

to come to Larry's room to complete the required face-to-face assessment nor did they advocate for such an assessment by Dr. McCullough before administering the chemical restraints.

Additionally, the Defendants applied five-point restraints (ankles, wrists, and a chest vest) to restrain Larry twice between 9:00 p.m. and 9:30 p.m. on May 22, 2014, without an in-person physician evaluation within one (1) hour of the initiation of the restraints as required under the Hospital Policy. They also failed to limit (either by Order or by nursing advocacy) the initial and continuing use of the physical restraints to four (4) hours as required under the Hospital Policy.

Initiation of Restraint or Seclusion Process

- Only a physician may order the use of restraint and/or seclusion. A Registered Nurse may initiate the use of restraint during an emergency and notify the physician to obtain a verbal order as soon as possible (within minutes) after initiation of the restraint or seclusion.
- The physician must conduct an **in-person evaluation within one (1) hour** of the initiation of the restraints or seclusion.

- Physician orders for the initial and continuing use of restraints or seclusion are time-limited to the following:
  - Four hours for patients ages 18 and older
  - Two hours for children and adolescents ages 9 to 17
  - One hour for children under age 9

Further, the Defendants failed to comply with the Restraint Documentation Requirements of the Policy. On page 42 of the Lourdes Hospital chart, attending Nurse Ridge completes and co-signs (with Dr. McCullough) the Restraint Order for "Non-Violent / Non Self-Destructive Behavior Medical/Surgical Healing" which is not the proper form for the use of physical restraints for a patient like Larry who was exhibiting violent, aggressive, and self-destructive behavior prior to the orders for chemical and physical restraints. Nor was the documentation sufficient to meet the requirements under the Policy, which required among other things reporting that Mr. Pridemore's medical condition, symptoms, and physical disabilities were taken into consideration when determining how to restrain him safely and properly.

Last, the Hospital Policy required the Defendants to continually observe with 1:1 staff and make assessments every fifteen (15) minutes after the application of physical restraints for violent or self-destructive behavior and to remove the restraints at the earliest possible time, based on the assessment and re-evaluation of the patient's condition.

- **Restraint for Violent or Self-Destructive Behavior** - Patients will be continually observed with 1:1 staff and assessed every 15 minutes after the application of restraint.

As noted above, the Defendants failed to properly monitor Larry after he was given sedative medications (chemical restraints) and placed in five-point restraints. The Defendants failed to recommence telemetry devices to monitor Larry's condition and failed to place a sitter in his room or transfer him to the Critical Care Unit ("CCU") where he could get 1:1 or 1:2 nursing care. The Defendants left Larry in his room unattended, with no medical devices in place to monitor his condition, all while he was restrained with restraints on his wrists, ankles, and chest. Further, by 10:30 p.m. on May 22, 2014, Nurse Ridge noted that Larry was attempting to rest. Dr. McCullough also stated in his post-Code Progress Record that Mr. Pridemore had "calmed down with sedation" prior to being found unresponsive.[29] The Defendants violated the Hospital's Policy and the standard of care by failing to remove Larry's physical restraints and to reapply monitoring equipment, such as telemetry and the pulse oximeter, at the earliest possible time.

[29] See Exhibits 7 and 8.

- Time-limited orders do not mean that restraint or seclusion must be applied for the entire length of time for which the order is written. The removal or restraint as soon as the patient meets

BSG Pridemore RFP 000279

the behavior criteria for discontinuation is encouraged, regardless of the expiration time of the order.

In addition to the above opinions, Dr. Goldstein will testify that Dr. McCullough violated the standard of care by (1) failing to discontinue use of restraints once Larry calmed down; (2) failing to monitor oxygen levels and to order supplemental oxygen; (3) failing to initiate 1:1 observation or to transfer Larry to the ICU or CCU; and (4) administering sedatives on a patient with unstable vital signs and respiratory issues, including his obstructive sleep apnea which is listed on the black box warning for Ativan, without monitoring and/or direct observation.

Dr. Goldstein will also criticize the Lourdes Hospital nursing and ancillary staff by testifying that they failed (1) to closely observe and monitor Larry; (2) to advocate for Larry by challenging Dr. McCullough's orders; (3) to recommence use of telemetry equipment and pulse oximeters; and (4) to provide Larry with a "sitter". The Hospital also violated the standard of care by relying on family members who had no medical training to observe and monitor a patient's health.

On the issue of causation, Dr. Goldstein will testify that Larry's respiratory arrest was the result of the administration of Ativan and Haldol and not because of his underlying health

condition. The sedatives, which played no role in treating the underlying health conditions, coupled with the diagnosis of pneumonia, and associated compromised respiratory function, caused Larry to stop breathing leading to cardiorespiratory arrest. He will testify that Larry went without oxygen for a significant period of time; long enough to cause irreversible, and severe, brain damage which ultimately resulted in his death.

In addition to her criticisms regarding violations of the Hospital Restraint Use policy, Mary Jane Smith will testify that the Hospital failed to (1) insist Dr. McCullough come to the bedside to do an assessment prior to or shortly after the order for chemical and physical restraints; (2) monitor Larry after the restraints were applied and sedative medications were administered; (3) recommence telemetry devices when Larry calmed down; (4) place a sitter in the room or transfer him to the ICU/CCU; and (5) report unstable vital signs to Dr. McCullough contemporaneous with his decision to order chemical and physical restraints.

Mary Jane Smith will further testify that the Hospital failed to adequately staff the PCU by requiring the nursing staff to care for up to eight (8) patients at one time. Concerning the types and means of physical restraint used, Nurse Smith will testify that the Hospital violated the standard of care by using a vest restraint when it was not only unnecessary, but dangerous given Larry's respiratory disease and compromised function coupled with the administration of sedative medication. The Hospital also should have placed mitts on Larry's hands which would have prevented him from pulling off the heart monitor and pulse oximeter as well as applied the pulse oximeter to alternative parts of the body out of reach from Larry's grasp (such as on his toe or forehead) so he could be continuously monitored with equipment.

Stephanie Iseri will testify that the Hospital violated the standard of care by failing to:

(1) evaluate, monitor, and directly observe Larry despite his known respiratory issues, agitated state, and unstable vital signs; (2) notify Dr. McCullough of changes to vitals and agitation; (3) provide 1:1 nursing and/or provide a "sitter"; (4) insist on Dr. McCullough coming to bedside; (5) place Larry in a room closer to the nursing station or in ICU; (6) remove the four point and vest restraints after he calmed down; and (7) continue heart monitoring and pulse oximeter after he calmed down.

Plaintiff Roxanne Pridemore was married to Larry Pridemore, Sr, for forty (40) years. They had a close and loving marriage. Pursuant to KRS 411.145 and Martin v. Ohio Co. Hosp. Corp., 295 S.W. 3d 104 (Ky. 2009), Mrs. Pridemore is entitled to seek damages for post-death loss of spousal consortium, including compensation for the loss of services, assistance, aid, society, companionship, and conjugal relationship of her husband.

D. ITEMIZATION OF DAMAGES

1. Hospital and Medical Expenses: $73,896.89.

2. Larry Pridemore, Sr.'s Physical and Mental Pain and Suffering and Loss of Enjoyment of Life Prior to Death: $5,000,000.00.

3. Roxanne Pridemore's Loss of Services, Assistance, Aid, Society, Companionship, and Conjugal Relationship of Her Husband, Larry Pridemore, Sr.: $5,000,000.00.

E. EXHIBITS AND CHARTS WHICH MAY BE USED AT TRIAL

Plaintiff's list of exhibits and charts which may be used and/or introduced as evidence at trial will be filed separately.

F. LIST OF NAMES OF WITNESSES WHO MAY TESTIFY AT TRIAL

Plaintiff's list of witnesses who may testify at trial will be filed separately.

G. PROPOSED STIPULATIONS

1. Authenticity of medical and hospital record and hospital business records, such as policies, procedures, protocols, etc.

2. Amount of hospital and medical expenses incurred: $73,896.89.

3. Plaintiff will be prepared to stipulate (or object) to admissibility of Defendants' exhibits prior to trial (if they are disclosed and/or furnished to Plaintiff's counsel).

4. Plaintiff will submit a separate list of proposed factual stipulations to Defendants.

H. STATEMENT OF PRINCIPLES OF LAW

Applicable legal authorities have been cited in the Plaintiff's Motions *in Limine*, Proposed Jury Instructions, and Section B of this Trial Brief.

I. PROPOSED JURY INSTRUCTIONS

Plaintiff's Proposed Jury Instructions will be filed separately.

Respectfully submitted,

/s/Jeff W. Adamson

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CERTIFICATE OF SERVICE

It is hereby certified that the foregoing was filed with the above Court electronically via the Kentucky Courtnet 2.0 eFiling system on the 19th day of May 2022.

This is to further certify a true and correct copy of the foregoing was served by electronic mail on this the 19th day of May 2022, to the following:

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/s/ Jeff W. Adamson
_____
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