UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
EVANSVILLE DIVISION

AMANDA MOORE and BRADEN WHITFIELD, Individually, and as Parents and Next Friend of AERABELLA WHITFIELD, Deceased, Plaintiff, vs. DEACONESS HOSPITAL, INC. d/b/a DEACONESS GATEWAY HOSPITAL, Defendant.	)	CASE NO. 3:18-cv-134

COMPLAINT FOR DAMAGES

Plaintiffs, Amanda Moore and Braden Whitfield, individually and as the parents and next friends of Aerabella Whitfield, deceased, by counsel, for their Complaint for Damages against Defendant, Deaconess Hospital, Inc. d/b/a Deaconess Gateway Hospital state as follows:

JURISDICTION

1. This action is brought pursuant to the provisions of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), codified at 42 U.S.C. § 1395dd. As such, this Court has jurisdiction over the subject matter of this proceeding pursuant to 28 U.S.C. § 1331.

VENUE

2. Venue is appropriate in this judicial district, pursuant to 28 U.S.C. § 1391(b), for the reasons that Defendant resides in this judicial district and all or a substantial part of the events or omissions giving rise to this claim occurred in this judicial district.

THE PARTIES

3. Aerabella Whitfield ("Aerabella"), now deceased, was at all times material a resident of Owensville, Gibson County, Indiana.

4. Amanda Moore ("Ms. Moore") and Braden Whitfield ("Mr. Whitfield") were the natural parents of Aerabella and were at all times material to these proceedings, residents of Owensville, Gibson County, Indiana.

5. Defendant Deaconess Hospital, Inc. d/b/a Deaconess Gateway Hospital ("Deaconess Gateway") is a corporation organized and existing under the laws of the state of Indiana and having its principal place of business located in Newburgh, Indiana.

ALLEGATIONS

6. Aerabella was born full term on Monday August 1, 2016, at St. Mary's Hospital in Evansville, Indiana. She was the third child born to Ms. Moore.

7. On Thursday, August 4, 2016, approximately four (4) hours after her discharge from St. Mary's Hospital where Ms. Moore had delivered Aerabella, Ms. Moore took Aerabella to the Deaconess Gateway Emergency Department with complaints of tachypnea (fast breathing). She had made these same complaints to doctors at St. Mary's Hospital. Aerabella's continued tachypnea after discharge from St. Mary's Hospital was the primary reason for taking Aerabella to the Deaconess Gateway Emergency Department.

8. Aerabella was seen in the Deaconess Gateway Emergency Department and was admitted to the Pediatric Unit of Deaconess Gateway for further observation in the care of pediatrician Barry S. Phillips, M.D. ("Dr. Phillips"). Ms. Moore advised the Emergency

Department of her concerns about Aerabella's fast breathing, and she repeated her concerns to Dr. Phillips after Aerabella's admission to the Pediatric Unit of Deaconess Gateway. Aerabella was discharged by Dr. Phillips to go home for the weekend on August 5, 2016. She was discharged: (1) without an appropriate medical screening examination; and (2) without being provided adequate treatment to stabilize the emergency condition for which Aerabella was admitted to the Emergency Department and the Pediatric Unit.

9. Physicians on staff at Deaconess Gateway failed to appropriately screen for any form of congenital heart defect, including the congenital heart defects from which Aerabella suffered.

10. Had appropriate screening been done, including screening by way of an echocardiogram, Aerabella's congenital heart defects could have been identified and surgically treated.

11. The documented examination at the Deaconess Gateway Emergency Department, and again after Aerabella's admission to the Pediatric Unit of Deaconess Gateway, failed to reveal the congenital heart defects suffered by Aerabella. The combination of the history provided by Ms. Moore, an adequate cardiovascular exam, and the chest x-ray, should have led to a screening echocardiogram to rule out a congenital heart defect. No echocardiogram or further testing was ordered. Instead, Aerabella's emergency medical condition remained unresolved and Aerabella was discharged from Deaconess Gateway in an unstable condition on August 5, 2016.

12. The documented examination on this initial visit failed to stabilize Aerabella's emergency medical condition, and the testing to determine the cause of her emergency medical

condition was inadequate and not consistent with testing provided for similar emergency infant complaints related to symptoms of neo-natal congenital heart defects. As a result, Aerabella was discharged to home on August 5, 2016, with continuing tachypnea, without being stabilized, and without an appropriate medical screening examination to diagnose the complaints associated with her emergency medical condition.

13. Aerabella's condition remained unresolved over the weekend and on the morning of August 8, 2016. Ms. Moore took Aerabella to Dr. Phillips at his offices at the Deaconess Gateway Clinic at the first available appointment on Monday morning August 8, 2016, with complaints about Aerabella's continuing episodes of rapid breathing. She also reported increased fussiness and poor feeding. Dr. Phillips re-admitted Aerabella urgently to the Deaconess Gateway Pediatric Unit at 12:34 pm for screening labs, including an echocardiogram, as per Dr. Phillips' order. No echocardiogram was ever conducted by Deaconess Gateway, its physicians, or its nursing staff.

14. Documentation for screening tests on Aerabella at Deaconess Gateway on August 8, 2016, showed oxygen desaturation occurring at 1:15 pm. Oxygen was given with no response. Aerabella was also noted to be very fussy with a respiratory rate in the 90s at this time. Because Aerabella was acutely hypoxic, tachypneic and fussy, she presented as a medical emergency but, again, was neither screened nor provided adequate treatment to stabilize the emergency condition for which she was re-admitted.

15. The Deaconess Gateway nursing staff notified Dr. Phillips at 2:10 pm (some 55 minutes after the oxygen screening tests), that Aerabella was hypoxic, or suffering from an inadequate oxygen supply.

16. Dr. Phillips immediately transferred care to the critical care physician for the Deaconess Gateway Pediatric Unit, intensivist Gamal F. Monem, M.D. ("Dr. Monem"). Dr. Monem was a critical care physician who was on call to take care of acutely ill children. However, Dr. Monem was instead in the GI endoscopy suite performing a procedure and, as such, was unavailable to immediately assess Aerabella in spite of Dr. Phillips' transfer of care to him.

17. Despite Dr. Monem's unavailability for an immediate and critical assessment, no other doctor was on call for that purpose and no other doctor was expeditiously called to assist.

18. Under EMTALA, any physicians, including Deaconess Gateway physicians Dr. Phillips and Dr. Monem, who are responsible for the examination or treatment of an individual in a hospital, including a physician on-call for the care of a patient, who negligently violates the requirement to conduct an adequate emergency medical screening test, is in violation of EMTALA and is subject to a civil money penalty of not more than $50,000 for each such violation. (*See* EMTALA, Section 1395dd(d)(1)(C).)

19. The Deaconess Gateway nursing staff provided an assessment to Dr. Monem at 2:30 pm by phone advising him that the screening conducted by the nursing staff indicated that Aerabella was fine. Aerabella went into cardiopulmonary arrest at 2:53 pm, some 23 minutes after the Deaconess Gateway nursing staff's assurances that Aerabella was fine.

20. Despite Aerabella's ongoing emergency medical condition, and her mother's regularly expressed concerns to Deaconess Gateway staff about Aerabella's fast breathing, the staff discounted and disregarded Ms. Moore's complaints as well as Aerabella's need for

immediate emergency medical attention. Nothing was done to address Aerabella's problems until she stopped breathing and coded around 2:53 pm.

21. The Deaconess Gateway Emergency Department physician, Gregory T. Jacobs, M.D. ("Dr. Jacobs") was then notified to present to Aerabella's room to establish an airway (placing an endotracheal tube), since Dr. Monem was unavailable until someone could oversee his patient in the GI endoscopy suite. Dr. Monem showed up at 3:16 pm, approximately 23 minutes into the resuscitation effort.

22. Dr. Jacobs assessed the CPR resuscitation effort to be disorganized. In his assessment, there was no leader running the code. Furthermore, he observed that there was no intravenous access to administer medications. There appeared to be two other physicians present at the time Dr. Jacobs arrived. Dr. Jacobs established an airway approximately 20 minutes after the time of Aerabella's arrest at 2:53 pm.

23. Dr. Monem noted in his review of the medical records after he arrived that Aerabella's admission x-ray displayed a heart size that seemed large to him.

24. No echocardiogram was ever ordered stat for emergency medical screening purposes and none was ever performed during either of Aerabella's emergency medical admissions or during the resuscitation event. There was no administration of prostaglandin E to stabilize Aerabella during the resuscitation efforts. Efforts to revive Aerabella were stopped at 3:35 pm due to her lack of response.

25. The facts of this case illustrate violations of EMTALA. The cascade of events described led to a "perfect storm" in that various errors within the Deaconess Gateway system, on two separate but related occasions, resulted in the failure of Deaconess Gateway to conduct an

appropriate medical screening examination. As a result, Aerabella was released from her initial admission without being provided adequate treatment to stabilize the emergency condition for which she presented and was ultimately twice admitted. These failures led to and were the cause of the death of Aerabella from otherwise very treatable congenital heart defects.

26. The autopsy reported Aerabella's cause of death as being due to coarctation of the aorta (a congenital condition in which the aorta is narrowed), with a large ventricular septal defect (a large hole in the septum of the heart). This type of congenital heart defect is one that is discovered during screening and surgically corrected in the neonatal period, usually within the first seven days of life with a very low mortality rate. The autopsy report also noted cardiomegaly (an enlarged heart).

27. Deaconess Gateway holds itself out to the public as a tertiary care center, and a regional referral center specializing in emergency medicine and pediatric intensive care services. At all times material, Deaconess Gateway held itself out to the public as having qualified physicians and staff to screen and stabilize patients presenting at Deaconess Gateway, including those suffering with the symptoms exhibited by Aerabella and described to Deaconess Gateway physicians and staff.

28. The limited screening examinations of Aerabella by the medical staff of Deaconess Gateway on August 4-8, 2016, failed to comport with the guidelines for emergency treatment at Deaconess Gateway. Aerabella did not receive an appropriate medical screening examination for purposes of determining whether an emergency medical condition then existed. No consideration was given to any differential diagnosis, and the limited testing conducted failed to identify the cause of her congenital heart defects.

29. Aerabella was treated differently from the way pediatric patients presenting to Deaconess Gateway for emergency evaluation and treatment with the same or similar complaints and conditions were to be treated.

30. At the times she presented to Deaconess Gateway, Aerabella was suffering an emergency medical condition in that she had a coarctation of her aorta and a large VSD, and her complaints and symptoms pointed to a congenital heart defect.

31. Deaconess Gateway and its medical staff knew or should have known from Aerabella's charted medical history and her present complaints that Aerabella was suffering from an emergency medical condition that required further screening and stabilization before her discharge.

32. Deaconess Gateway and its medical staff, however, failed to appropriately stabilize Aerabella's condition after testing failed to verify her condition, and instead released and transferred her from Deaconess Gateway on August 5, 2016, in an unstable condition and prior to determining the cause of her congenital heart defects. After re-admitting her with on-going complaints of tachypnea, the medical staff's continuing disregard for Aerabella's emergent condition and its failure to adequately screen and stabilize Aerabella, led to Aerabella's death.

33. As a result of the foregoing violations of EMTALA by Deaconess Gateway and its medical staff, Aerabella, Ms. Moore and Mr. Whitfield each suffered personal harm by way of the following:

a. Aerabella sustained severe bodily injuries, physical and mental pain and suffering, and an abrupt and untimely death on August 8, 2016, due to undiagnosed congenital heart defects;

b. Ms. Moore and Mr. Whitfield each sustained and continue to undergo severe emotional distress and mental pain and suffering; and

c. Ms. Moore and Mr. Whitfield incurred medical, hospital, and related health care expenses, and funeral and burial expenses, on Aerabella's behalf.

WHEREFORE, Plaintiffs, Amanda Moore and Braden Whitfield, individually and as the parents and next friends of Aerabella Whitfield, deceased, by counsel, demand judgment against Defendant, Deaconess Hospital, Inc. d/b/a Deaconess Gateway Hospital, for all such damages and relief as are just and proper in the premises.

REQUEST FOR TRIAL BY JURY

Plaintiffs, by counsel, respectfully requests that all issues set forth herein triable of right by a jury be so tried.

Respectfully submitted,

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