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CONFIDENTIAL ATTORNEY WORK PRODUCT

Mr. John P. Foley, Esq.
2000 Fairy Tale Lane
Anytown, USA

RE: Estate of John Radford v Mickey Medical Center

Dear Mr. Foley:

Pursuant to your request, I have screened the hospital medical records of Mr. John Radford for the period 05/29/00 – 05/30/00. I have included my comments and recommendations for your consideration.

John Radford was a 50-year-old man who presented to the Emergency Room (ER) of Mickey Memorial Medical Center with a five day history of nausea, vomiting and progressive weakness. He had been unable to eat during the five day period. Due to missed diagnosis and inappropriate treatment, Mr. Radford died from a small bowel obstruction in less than twelve hours from when he was first seen.

Mr. Radford had a history of alcoholism and had been treated for seizures due to alcohol withdrawal in January of 2000. The alcoholism was focused on during his initial and ongoing evaluation and treatment even after drug screening and alcohol blood levels came back negative and Mr. Radford had stated that his last drink was a week ago.

Mr. Radford was first seen in the Emergency Room at 5:53 on 5/29/00 with the complaints listed above and a rapid pulse (142), low blood pressure (BP) (50/42) –

this BP was dangerously low and warranted treatment, and high respiratory rate (22). These vital signs are indicative of Mr. Radford's dehydrated condition and support his report of nausea, vomiting, and not eating for the past five days.

The ER admitting nurse's note documents that Mr. Radford had general, non-radiating, cramping, intermittent abdominal pain and that the abdomen was tender in all quadrants, soft and distended. These symptoms are described as the clinical manifestations of small bowel obstruction according to Brunner and Suddarth's textbook of Medical-Surgical Nursing, (pg 1055): "The initial symptom is usually crampy pain that is wavelike and colicky."

There is no mention in the medical record of Mr. Radford's history of bowel movements except to state that he did not have diarrhea and there is no description of the emesis (vomit) he had been experiencing. These would be important observations if the doctors or nurses were investigating the possibility of a diagnosis of small bowel obstruction (SBO).

The ER physician ordered an abdominal x-ray (KUB), which was appropriate given Mr. Radford's symptoms, however, no action was taken when the KUB results showed a possible SBO. The comment on the report said the exam had been limited by difficulty in positioning Mr. Radford and a follow-up exam was recommended.

The abdominal pain nursing assessment and the KUB results were not followed-up on. The ER doctor states in his discharge summary that Mr. Radford did not have abdominal pain. His abdominal symptoms were ignored and instead, Mr. Radford was treated with intravenous (IV) fluids to address his dehydration and medications (Ativan and Librium) which are typical of treating anxiety and aggressive behavior in patients who are experiencing alcohol withdrawal. Standard blood work was obtained as well as urine drug screening and alcohol blood levels. The drug screening and alcohol blood levels came back negative and the other blood work showed chemistry and enzyme levels indicative of kidney compromise and decreased liver function (not unusual given his dehydrated state and history of alcohol abuse).

Mr. Radford's ER stay lasted 2 ½ hours before he was transferred to the inpatient unit. By the time of transfer, his pulse rate and BP had improved (110; 110/60) which indicates he was responding to the IV fluids. His intake and output records indicate that Mr. Radford had a 1000 ml fluid deficit when he presented to the ER. This confirms how severely dehydrated he was because he took in 1100 mls of IV

fluid and produced only 100 mls of urine. Diagnosis at the time of transfer was renal insufficiency and hypotension.

Once in the inpatient unit, the doctors continue to NOT address the possible cause of the nausea and vomiting. They appear to continue to focus on his alcohol abuse even though the tests were negative. There is no mention in the record of the KUB results although there is an order for abdominal flat plate x-ray to be done in the morning.

At the time of admission to the inpatient unit, all the chart documentation indicates Mr. Radford was alert and oriented and appeared to be improving. The nursing admission assessment indicates Mr. Radford's abdomen is soft, normal and not tender which is hard to believe given the SBO which had to be progressing at this point and the previous nursing assessment of abdominal pain.

By midnight on 6/30/00, Mr. Radford began to act anxious and disoriented. He was treated with Librium and Ativan and Nurse Home documented "will continue to monitor." There should have been documentation of the response to the medications, but there is none in the chart. Mr. Radford was only checked on hourly throughout the night although his BP began to drop after several hours on the unit and his agitated state worsened.

Nurse Home continued to administer Ativan and "monitor" Mr. Radford even when he began hallucinating, talking to imaginary people, and attempting to get out of bed. The nurse should have contacted the physician and informed him of Mr. Radford's deteriorating state. No intervention was done until 0451 when the telemetry (heart monitor) showed Mr. Radford's heart rate had decreased to 60 and then to 58 and Nurse Home found Mr. Radford to be unresponsive on his bed with red-tinged brown emesis around him. When resuscitation was attempted, he spewed fecal-smelling, dark brown liquid from his mouth and nose (a sign of bowel obstruction). The code was called at 0500 and there is a note in the chart about the code, but no code record.

Brunner's et al described what is seen when a small bowel obstruction becomes complete: "If the obstruction is complete, the peristaltic waves initially become extremely vigorous and eventually assume a reverse direction, with the intestinal contents propelled toward the mouth instead of toward the rectum. If the obstruction is in the ileum, fecal vomiting takes place ... If the obstruction continues uncorrected, hypovolemic shock occurs from dehydration and loss of plasma volume." (pg 1056).

There is documentation that an autopsy was to be done by the Medical Examiner and that the county morgue was contacted, however the chart indicates that no autopsy was performed.

In this case, both the ER and inpatient doctors and nurses failed to appropriately evaluate and treat Mr. Radford for his presenting condition of nausea, vomiting and abdominal pain which resulted in his death from a small bowel obstruction. Both physicians failed to promptly follow-up on the KUB report and Nurse Home failed to communicate Mr. Radford's worsening condition.

There may have been prejudice on the part of the health care staff given Mr. Radford's alcohol abuse. He could have had a history of being evaluated in that ER. Past medical records are needed to investigate this possibility.

I can assist you in further developing this case by locating a Gastroenterologist expert witness and creating a detailed chronological timeline. In addition, I suggest a request for production of the autopsy report, to determine if an autopsy was actually performed, the code record and the discharge summaries from previous ER events. It would be highly unusual not to have had an autopsy performed in this case.

Thank you for the opportunity to consult on this case. I will follow up within two days to answer any further questions about the case and determine how you would like to proceed.

Very truly yours,

Candy Cane, RN, MS, CLNC
Paule Toon & Associates, LLC