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ARKANSAS STATE CLAIMS COMMISSION

APR 01 2011

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Please Read Instructions on Reverse Side of Yellow copy

Please print in Ink or type

BEFORE THE STATE CLAIMS COMMISSION
Of the State of Arkansas

☐ Mr.
☐ Mrs.
☐ Ms.
☐ Miss Olivian Miller, Administratrix of Estate of Rodney Miller, Claimant

vs.

State of Arkansas, Respondent
University of AR Medical Sciences

Do Not Write in These Spaces
Claim No. 11-0617-CC
Date Filed April 1 (Month) (Day) 2011 (Year)
Amount of Claim $ 3,500,000.00
Fund UAMS

Olivian Miller, Administratrix of Estate of Rodney Miller **COMPLAINT** Wrongful Death, Negligence, Pain & Suffering, etc.

(Name), the above named Claimant, of 542 Archer St., Hampton, AR (Street or R.F.D. & No.) (City)
AR (State) 71744 (Zip Code) 870-798-2325 (Daytime Phone No.) County of Calhoun represented by Chris Averitt & Tony Wilcox (Legal Counsel, if any, for Claim)
of 113 E. Jackson St., Jonesboro, AR 72401 870-972-6900 870-972-6903 (Street and No.) (City) (State) (Zip Code) (Phone No.) (Fax No.)

State agency involved: University of Arkansas for Medical Sciences Amount sought: $3.5 million
Month, day, year and place of accident or act complained of: April 5, 2009 - University of Arkansas for Medical Sciences
Explanation:
SEE ATTACHED

As parts of this complaint, the claimant makes the statements, and answers the following questions, as indicated: (1) Has claim been presented to any state department or officer thereof? No (Yes or No); when? (Month) (Day) (Year); to whom? (Department); and that the following action was taken thereon:

and that $ was paid thereon; (2) Has any third person or corporation an interest in this claim? No; if so, state name and address (Name) (Street or R.F.D. & No.) (City) (State) (Zip Code) and that the nature thereof is as follows:; and was acquired on, in the following manner:

THE UNDERSIGNED states on oath that he or she is familiar with the matters and things set forth in the above complaint, and that he or she verily believes that they are true.

Chris A. Averitt (Print Claimant/Representative Name)

Chris A. Averitt (Signature of Claimant/Representative)

SWORN TO and subscribed before me at Jonesboro, AR (City) (State)

(SEAL) CONSTANCE ROGERS Craighead County Commission #8000107128 Notary Public - Arkansas My Commission Expires March 17, 2017

on this 31st (Date) day of March (Month), 2011 (Year)

Constance Rogers (Notary Public)

My Commission Expires: 3-17-17 (Month) (Day) (Year)

BFI-R7/99

EXPLANATION

This is a negligence claim against the State of Arkansas, University of Arkansas For Medical Sciences and its nurses and other employees for injuries, conscious pain and suffering, loss of life and wrongful death pursuant to Ark. Code Ann. § 16-62-101 and Ark. Code Ann. § 16-62-102[1]. The Claimant, Olivian Miller, is a resident and citizen of Hampton, Arkansas. Olivian Miller was appointed Administratrix of the Estate of Rodney Miller, deceased, by the Calhoun County Circuit Court, Probate Division, on the 3rd day of August, 2009, and she is, therefore, the proper person to bring this claim against the State for conscious pain and suffering and for wrongful death on behalf of the Estate of Rodney Miller. **See Exhibit 1.** At the time of Rodney Miller' death, Olivian Miller was his spouse. The applicable UAMS Medical Records are being provided herewith as **Exhibit 2**.

On March 30, 2009, Rodney Miller was admitted to UAMS Medical Center following an ATV accident. He was initially assessed as having a head injury and a fractured jaw. After arrival, Mr. Miller's mental status worsened, and he required intubation. Subsequent CT scans revealed that Mr. Miller did not have a subdural hematoma, and there was no need for neuro-surgical intervention. On April 2, 2009, Mr. Miller underwent surgery for fixation of his fractured jaw. After the surgery, Mr. Miller was transferred to ICU in stable condition. A full recovery was expected.

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[1] Claimant has filed a lawsuit in the Circuit Court of Pulaski County, Arkansas against one of the specific physicians charged with the care of Mr. Miller as well as against various John Doe Defendants who may have also been physicians charged with the care of Mr. Miller and whose negligence may also have led to his injury and death. The related lawsuit is also against John Doe Insurance companies who may have provided coverage to these physicians.

Beginning on March 30, Mr. Miller was ordered to be in restraints for his own protection because he remained disoriented and could not comprehend what was happening. This order was continued every day between March 30 until April 6, 2009. The April 5, 2009 Order was entered at 7:30 a.m. and was set to expire 24 hours later (on April 6 at 7:30 a.m.). In the April 5, 2009 Restraint Assessment, Mr. Miller was noted to be confused and unable to follow instructions for his personal safety. He was also found to be harmful to himself. The April 5, 2009 Restraint Order indicates as follows: "apply restraint(s) to patient due to disorientation/patient safety, use 2-point, soft restraints for duration of twenty-four (24) hours. May apply Posey Vest as alternative to soft restraints." A posey vest is used to restrain a patient to a bed or chair in order to prevent the patient from injuring himself by falling or otherwise.

Later that same day, Mr. Miller was transferred from ICU to another floor at UAMS. He arrived in an aspen collar and was wearing a hospital wrist band that stated that he was a fall risk. Shortly after he arrived as the new floor, despite the existence of the restraint order, the designation of Mr. Miller as a fall risk, and the determination that he was oriented to self only, UAMS nurses and other non-physician employees negligently left Mr. Miller both unrestrained and unattended.

Paige Bramlett was a staff RN on the H6 floor at UAMS Medical Center delivering care to Rodney Miller on April 5, 2009. According to Ms. Bramlett's Focus Notes, she received Mr. Miller as a transfer from ICU and he was wearing an aspen collar. Ms. Bramlett noted that Mr. Miller was oriented to self only. A nurse possessing, and applying with reasonable care, the degree of skill and learning ordinarily possessed and used by members of the profession in good standing would have ensured compliance with the restraint order until it expired or was discontinued, and would have identified that Mr. Miller needed to be in restraints in order to prevent him from falling or injuring

himself. A nurse possessing, and applying with reasonable care, the degree of skill and learning ordinarily possessed and used by members of the profession in good standing would have instructed the other nursing staff and employees that Mr. Miller could not be left unrestrained and unattended for any period of time due to the risk that he would fall and injure himself.

Ms. Bramlett has executed an Affidavit indicating that she did not have malpractice insurance coverage at that time. This Affidavit is being provided herewith as **Exhibit 3**. The State of Arkansas (UAMS) is vicariously liable before this Claims Commission for the negligent acts of Ms. Bramlett and any other nurse or employee of UAMS who did not carry liability insurance coverage. Counsel for the Claimant are unable to specifically identify the other non-physician employees who may have been responsible for the care of Mr. Miller at the time of his fall and/or who may also have committed acts of negligence which led to his fall, injuries and death. Thus, these other non-physician UAMS employees are considered John Does and Jane Does at this time. One such John or Jane Doe is any ICU nurse (or other nurse) who may have advised Nurse Bramlett that Mr. Miller did not need to be kept in restraints or who may have failed to instruct Nurse Bramlett that Mr. Miller should be kept in restraints. It is anticipated that these other employees will be identified during the course of discovery. UAMS is liable herein for the acts of negligence of these John Does and Jane Does.

This negligence described above caused Mr. Miller to fall and strike his head. After the fall, Mr. Miller became unresponsive and a CT scan revealed a new subdural hematoma with significant midline shift. Mr. Miller was taken to the OR for a crainectomy and later suffered cerebral swelling, with herniation through his craniotomy site.

Thereafter, Mr. Miller's condition continued to deteriorate. He stopped breathing and died on April 11, 2009. The cause of death was the injury sustained as a result of his traumatic fall during his hospitalization at UAMS. The fall, and the resulting injuries and death, were the direct result of the negligence of UAMS nurses and other uninsured employees. At the time of his death, Mr. Miller was gainfully employed. He left a loving family including a wife, son, three daughters, a father, three sisters, and three brothers.

Olivian Miller, individually, and as personal representative of the Estate of Rodney Miller, deceased, prays that she have and recover damages from and against the State of Arkansas, University of Arkansas For Medical Sciences, as compensation to the heirs and the beneficiaries at law of Rodney Miller, for funeral expenses, for loss value of life, for conscious pain and suffering of the deceased prior to his death, for medical expenses attributable to the fatal injury, for the present value of the lost of earnings capacity in the future for the deceased, for the loss of future services to be rendered by Rodney Miller, and for mental anguish sustained by the surviving beneficiaries of the Estate of Rodney Miller as well as all other damages allowed by law.

ARKANSAS STATE CLAIMS COMMISSION
NON VEHICLE PROPERTY DAMAGE/PERSONAL INJURY INCIDENT REPORT FORM

SECTION I
CLAIMANT Olivian Miller, Administratrix of Estate of Rodney Miller **ADDRESS** 542 ArcherStreet
Hampton **CITY & STATE** Arkansas **ZIP CODE** 71744
DATE OF INCIDENT: April 5, 2009 **TIME** Approximately 5:00 p.m.

Give a brief description of incident, showing how incident happened, exact loss and extent of damage to property and/or injury to person: Rodney Miller was hospitalized at UAMS following an ATV accident. The treating physician ordered that Mr. Miller be restrained because he was confused, unable to follow instructions for his personal safety, and harmful to himself. Despite this order, Mr. Miller was left unrestrained and unattended and suffered a fall which led to fatal injuries. He died 4-11-09.

(If personal injury claim only, move on to Section IV)

SECTION II
Has this property been repaired? Yes ( ) No ( ) If repairs have been made, give the following information: Amount: $_____ Have you paid for the repairs? Yes ( ) No ( )

NOTE: Attach a copy of repair bill.

If repairs have not been made, list three estimates below and attach copies of each of them.

	NAME	ADDRESS	AMOUNT
1.			$
2.			$
3.			$

SECTION III
Was property covered by insurance? Yes ( ) No ( )
If yes, what is the deductible? $_____

NAME OF INSURANCE CARRIER ADDRESS

SECTION IV
Is injured covered by medical insurance? Yes ( ) No (X)
If yes, what is the deductible? $_____

NAME OF INSURANCE CARRIER ADDRESS

ARKANSAS STATE CLAIMS COMMISSION
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SECTION V
If incident was investigated by the police or by some other agency, give name and title of officer/person making the investigation: Unknown

SECTION VI
The undersigned states on oath that he/she is familiar with the matters and things set forth in the above statement, and that he/she verily believes that they are true.

Signature of Claimant

Sworn to and subscribed before me at Jonesboro, AR (City & State)

(Notary Seal)

on this 31st day (day) of March (month) 2011 (year).

My Commission Expires 3-17-17.

Constance Rogers
Signature of Notary Public

CONSTANCE ROGERS
Craighead County
Commission #8001071123
Notary Public - Arkansas
My Commission Expires March 17, 2017

Exhibit 1

IN THE CIRCUIT COURT OF CALHOUN COUNTY, ARKANSAS
PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF
RODNEY MILLER, DECEASED

ORDER APPOINTING ADMINISTRATRIX

On this 22nd day of July, 2009, comes on for hearing the petition of Rodney Miller, for appointment of an administrator of the estate of Rodney Miller, deceased, and upon consideration of such petition, and the facts and evidence in support thereof, the Court finds:

1. That no demand for notice of proceedings for the appointment of a personal representative of the estate has been filed herein, the petition is not opposed by any known person, and the same may be heard and decided forthwith.
2. That Rodney Miller, who resided at 542 Archer St., Hampton, Arkansas 71744, died intestate on April 11, 2009.
3. That this Court has jurisdiction and venue properly lies in this County.
4. That Olivian Miller is a proper person and fully qualified by law to serve as administratrix of the estate.
5. That the amount of property which may reasonably be expected to pass through the hands of the administratrix is the proceeds from any wrongful death action.
6. That all distributees of the estate are competent and have filed written waivers of bond and there are no known unsecured claims.

It is, therefore, CONSIDERED, ORDERED, and ADJUDGED that administration of the estate, be, and hereby is, opened and Olivian Miller be, appointed administratrix of the decedent, to serve without bond, and that Letters of Administration shall be issued to said personal representative upon filing of the Acceptance of Appointment.

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CIRCUIT JUDGE
ON Exchange

IN THE CIRCUIT COURT OF CALHOUN COUNTY, ARKANSAS
PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF
RODNEY MILLER, DECEASED

NO. PR-2009-6

ACCEPTANCE OF APPOINTMENT AS PERSONAL REPRESENTATIVE

The undersigned, Olivian Miller, having been appointed administratrix of the estate of Rodney Miller, deceased, hereby accepts the appointment.

DATE this 30 day of July, 2009.

Olivian Miller
Olivian Miller

FILED
CALHOUN COUNTY, AR
AUG 17 2009
ALMA DAVIS, CLERK
BY: Peg Thompson

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IN THE CIRCUIT COURT OF CALHOUN COUNTY, ARKANSAS
PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF
RODNEY MILLER, DECEASED **NO. PR-2009-6**

LETTERS OF ADMINISTRATION

BE IT KNOWN:

That Olivian Miller, whose address is 542 Archer Street, Hampton, Arkansas 71744, having been duly appointed administratrix of the estate of Rodney Miller, deceased, who died intestate on April 11, 2009, and having qualified as such administratrix, is hereby authorized to act as such administratrix, for and on behalf of the estate and to take possession of the property thereof as authorized by law.

ISSUED this 17 day of August, 2009.

Alma Davis
Clerk

By: Faye Thompson
Deputy Clerk

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IN THE CIRCUIT COURT OF CALHOUN COUNTY, ARKANSAS
PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF
RODNEY MILLER, DECEASED

NO. PR-2009-6

LETTERS OF ADMINISTRATION

BE IT KNOWN:

That Olivian Miller, whose address is 542 Archer Street, Hampton, Arkansas 71744, having been duly appointed administratrix of the estate of Rodney Miller, deceased, who died intestate on April 11, 2009, and having qualified as such administratrix, is hereby authorized to act as such administratrix, for and on behalf of the estate and to take possession of the property thereof as authorized by law.

ISSUED this 17 day of August, 2009.

Alma Davis
Clerk

By: Dana Thompson
Deputy Clerk

FILED
CALHOUN COUNTY, AR
AUG 21 2009
ALMA DAVIS, CLERK
BY: D Thompson

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Exhibit 3

Scholtens & Averitt, PLC

113 E. Jackson Avenue • Jonesboro, AR 72401

April 1, 2011

*Jay Scholtens
Attorney at Law
Jay@scholtensaveritt.com

Chris Averitt
Attorney at Law
Chris@scholtensaveritt.com

Arkansas State Claims Commission
101 East Capitol Avenue
Suite 410
Little Rock, Arkansas 72201

Re: Olivian Miller, as Administratrix of the Estate of Rodney Miller, Deceased, v. University of Arkansas For Medical Sciences.

Herewith, please find an original and one copy of the claim forms associated with the above-referenced claim as well as an original and one copy of a narrative explanation with attachments. I am also enclosing three sets of the above on electronic media (saved as PDF documents on three CD's).

As you will see, this claim is against UAMS for the alleged negligence of its nurses and other non-physician employees which we allege led to the injury and death of Rodney Miller.

Please be advised that we have also file a related lawsuit in the Circuit Court of Pulaski County, Arkansas against one of the specific physicians charged with the care of Mr. Miller as well as against various John Doe Defendants who may have also been physicians charged with the care of Mr. Miller and whose negligence may also have led to his injury and death. The related lawsuit is also against John Doe Insurance companies who may have provided coverage to these physicians.

Please also be advised that my co-counsel on this claim will be Tony Wilcox and Scott Lancaster of Wilcox, Parker, Hurst, Lancaster & Lacy, PLC. Thank you for your assistance. Please do not hesitate to contact me should you have any questions.

Sincerely,

Chris A. Averitt

Enclosures

cc: Tony Wilcox
Scott Lancaster

113 E. Jackson Avenue
Jonesboro, AR 72401

870-972-6900 – Telephone
877-972-6900 – Toll Free
870-972-6903 – Fax
www.scholtensaveritt.com

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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

OLIVIAN MILLER, ADMINISTRATRIX
OF THE ESTATE OF RODNEY MILLER CLAIMANT

VS. NO. 11-0617-CC

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES RESPONDENT

AMENDED ANSWER

Comes now the respondent, University of Arkansas for Medical Sciences (UAMS), by and through its undersigned counsel, and for its Amended Answer to the Complaint of claimant, Olivian Miller, states as follows:

1. Respondent admits: that Olivian Miller was appointed Administratrix of the Estate of Rodney Miller by the Calhoun County Circuit Court on July 22, 2009; that on March 30, 2009, Rodney Miller was admitted to UAMS Medical Center following an ATV accident; that he was initially treated for a subarachnoid hemorrhage and right mandibular fracture; that RN Paige Bramlett delivered care to Rodney Miller; that Paige Bramlett did not have in effect at the time any medical malpractice insurance that would provide coverage to her for the allegations against her; and that Rodney Miller died on April 11, 2009. Respondent denies each and every other allegation contained in the four-page Explanation portion of claimant's Complaint.

2. Respondent denies each and every allegation contained in claimant's Complaint that has not been specifically admitted herein.

3. In footnote 1 of her Explanation, claimant notified the Commission that she had filed a lawsuit in the Pulaski County Circuit Court against a UAMS physician and various "John Does" who might also have been physicians charged with the care of Rodney Miller, and who thus might have malpractice insurance coverage. The related lawsuit was also filed against insurance companies who might have provided coverage to the named and John Doe physicians. Since Ark.

Code Ann. Section 19-10-302(a) provides that the Commission shall not hear a claim until the claimant has exhausted all remedies against insurers, this claim was held in abeyance pending the outcome of the Pulaski County Circuit Court proceeding. That case has now been resolved by claimant dismissing the case pursuant to a stipulation with UAMS.

WHEREFORE, having fully answered claimant's Complaint, respondent prays that said Complaint be denied and dismissed, and for all other relief to which it may be entitled.

Respectfully submitted,

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES, Respondent

By: _____

JEFFREY A. BELL, ABA #77009
Sr. Associate General Counsel
University of Arkansas
2404 North University Avenue
Little Rock, AR 72207-3608
(501) 686-2520

EDWIN L. LOWTHER, JR.
Wright, Lindsey & Jennings, LLP
200 West Capitol Avenue, Suite 2300
Little Rock, AR 72201

CERTIFICATE OF SERVICE

I, Jeffrey A. Bell, do hereby certify that a copy of the foregoing pleading has been served on claimant herein by mailing a copy of same, by U.S. Mail, postage prepaid, this 26th day of November, 2012 addressed to the following:

Chris A. Averitt
Scholtens & Averitt, PLC
113 East Jackson Avenue
Jonesboro, AR 72401

Tony Wilcox
Wilcox & Lacy, PLC
600 South Main Street
Jonesboro, AR 72401

_____
Jeffrey A. Bell

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

OLIVIAN MILLER, ADMINISTRATRIX
OF THE ESTATE OF RODNEY MILLER — CLAIMANT

VS. — No. 11-0617-CC

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES — RESPONDENT

CLAIMANT'S SUMMARY OF FACTS, LEGAL ISSUES, EVIDENCE AND TESTIMONY

1. INTRODUCTION

In 2009, Rodney Miller, a hard working man living in South Arkansas with his wife and children, was involved in a 4-wheeler accident and hospitalized at UAMS. After arrival, Mr. Miller's mental status worsened, and he required intubation and ventilator assistance with breathing. He awoke from his coma and was extubated late in the afternoon on April 4, 2009. A full recovery was expected. He remained in the ICU for approximately 24 more hours. Due to his head trauma and medication, he was confused and combative, and believed that he had been kidnapped by his medical care providers. He was identified as a fall risk and restrained to prevent him from attempting to get out of bed without assistance. The restraint order was entered for twenty-four hours beginning at 7:00 a.m. Around noon on April 5, his restraints were removed by a nurse who concluded that he could remain unrestrained so long as he was kept under constant observation. The restraint order was not discontinued. At 5:00 p.m., he was transferred out of ICU to a general floor. Despite the facts that the restraint order remained in place and Mr. Miller was being transferred to a floor with a much lower level of observation, he was transferred with no restraints. He was received by a drug addicted nurse who had been stealing medication from the hospital. After spending five minutes, at most, with Mr. Miller, the receiving nurse inexplicably abandoned him

alone and unrestrained in his room. Within three minutes, Mr. Miller attempted to get out of bed and fell. He was seriously injured and died six days later as a result. It is undisputed that the Restraint Order remained in place and was not discontinued at the time that Nurse Bramlett left Mr. Miller out of restraints.

This is a negligence claim brought by the Estate of Rodney Miller against the University of Arkansas For Medical Sciences and its nurses for injuries, conscious pain and suffering, loss of life and wrongful death. Olivian Miller, Mr. Miller's wife, was appointed Administratrix of the Estate of Rodney Miller, deceased, by the Calhoun County Circuit Court, Probate Division, on the 3rd day of August, 2009, and she is the proper person to bring this claim against the State for conscious pain and suffering and for wrongful death on behalf of the Estate. Exhibit 82.

2. STANDARD OF CARE FOR A HEAD TRAUMA PATIENT WITH RESPECT TO RESTRAINT, FALL RISK ASSESSMENT AND FALL RISK PREVENTION

UAMS advertises itself nationwide as a technologically advanced, state of the art hospital. Exhibit 83. In fact, UAMS advertises that it is the only "level one" trauma center in Arkansas. Restraint use, fall risk assessment and fall risk prevention protocols, however, go to the very basic provision of medical care in hospitals of any size. In fact, injuries sustained as a result of falls of patients in hospitals have been determined within the scientific community to be "never events" which are so preventable, they should not occur in the absence of lack of reasonable care. Exhibit 70, 79.

It is undisputed that UAMS and its nurses have the duty to provide for the safety of the patient, including protecting the patient from self harm. See Exhibit 102, CFR 482. Federal law requires that each hospital have a governing body that is legally responsible for the conduct of the

hospital as an institution. CFR 482.12. The governing body must ensure that the services performed by the hospital are provided in a safe and effective manner. CFR 482.12. The hospital also must honor each patient's right to receive health care in a safe setting. CFR 482.13.

These requirements apply across the board to all hospitals and nurses. Given that UAMS is a level one trauma center, the obligation to protect patients from self harm is especially important. This is particularly true with respect to head trauma patients who, because of their injury, suffer from an altered mental thought process and cognitive reasoning deficits that cause them to be unable to make the appropriate choices and decisions concerning their own safety. Rodney Miller is the perfect example of a head trauma patient who was at risk for self harm. It is undisputed that Rodney Miller's initial injury resulted in his inability to think clearly and make sound, personal, safety-related decisions.

In order to satisfy their duty to provide appropriate patient care, hospitals such as UAMS, must have in place and use effective protocols for the use of restraints, for fall risk assessments, and for fall risk prevention. Restraints involve the use of soft wrist and/or soft ankle types of physical restraints to prevent patients with an altered mental thought process or who are otherwise at risk of harm to themselves, from attempting to get out of bed, removing IV lines, etc. UAMS had written protocols describing the conditions which would result in the use of restraints. See Exhibit 25. Rodney Miller met the criteria for the institution of these restraint protocols. The protocols were initiated on March 30, 2009 and became part of Rodney Miller's plan of care at UAMS. At no time had the protocols been modified or discontinued prior to his fall.

Although restraints are typically ordered by physicians, restraints can be discontinued by nurses. A nurse doing so, however, must perform a sufficient evaluation of the totality of the

patient's condition and environmental surroundings so as to ensure the patient's safety should the restraints be removed. If, at any time after removal of the restraints, a change in the patient's condition or environment (i.e. transfer to a floor without the necessary level of observation) occurs, a request should be made by the nurse to the doctor to initiate a new restraint order. Restraint orders can be initiated by a nurse any time with a simple phone call to a doctor. UAMS policy allows an RN to apply restraints, without any physician order, as an emergency measure if a patient presents an immediate, serious danger to his own safety. Exhibit 26. Restraint orders are in place for up to a 24 hour period and continued thereafter by doctor's order as appropriate. Restraints are by far the most effective fall prevention measure available to ensure the safety of patients with an altered mental thought process or who are otherwise at risk of harm to themselves through falls or combative behavior.

UAMS is a Joint Commission accredited hospital. The Joint Commission, no doubt, promotes removal of restraints as soon as there are less restrictive means available which will still provide safety to the patient and eliminate the risk of self harm. The Joint Commission also mandates that hospitals have in place and follow an effective fall risk screening and fall risk protocols to eliminate the occurrence of falls in the hospital setting. See Exhibit 78, Joint Commission Goal #9.

Patients who do not meet the criteria for restraints must still be assessed for fall risk, and, if determined to be a fall risk, must be protected by a properly developed and executed fall prevention plan. Where, as here, restraints are the primary method to prevent falls or self harm, it is particularly important to implement every fall risk prevention method upon removing the restraints from the patient. In fact, the 24 hour time period following the removal of the restraints is the most critical

time period for the patient to be closely monitored for falls.

In most hospital settings, including UAMS, there are three primary patient units: (1) Intensive Care (ICU); (2) Step-Down; and (3) General Floor. In ICU, there is a much higher nurse to patient ratio and the patient is under constant observation. A step-down unit is used to transition patients from ICU to the general floor. Specifically, step-down recognizes that some patients may need a higher level of observation and care than is available on the general floor for a transition period. The general floor has a much lower nurse to patient ratio and provides a much lower level of observation to patients than either the step-down unit or ICU. In this particular case, UAMS' patient to nurse ratio in ICU was 2 to 1, step-down was 3 to 1, and general floor being 4-5 to 1. See Exhibit 97. Although the discharge document completed by Dr. Kate Baxter (Exhibit 13) after Mr. Miller's death states that he was transferred from ICU to the step-down unit (as he should have been), this statement is false. In fact, it is undisputed that, Mr. Miller was transferred, unrestrained, directly from ICU to the general floor. This is true despite the fact that Mr. Miller's ICU nurse, Mikal Childers has testified that Mr. Miller needed constant observation at the time of his transfer.

The first step in fall risk assessment is use of a fall risk screening tool to properly consider and evaluate each risk factor. Relevant factors include the following:

(1) Previous Fall Occurrences;

(2) Mental Status/Orientation. Whether the patient is alert to person, place and time. This is often referred to as alert and oriented times 1 (person) or alert and oriented times 3 (i.e. person, place, time). The ability of the patient to understand instructions is very important. Obviously, if a patient cannot understand instructions, such as "do not get out of bed," a patient is at much greater risk for self harm;

(3) Sensory/Communication deficits;

(4) Elimination Issues;

(5) Medications. Certain medications such as CNS or CVS medications greatly increase the chance for falls;

(6) Mobility issues.

Exhibit 3.

It is undisputed that Rodney Miller had been identified as high fall risk and remained so at the time of his fall.

Once someone has been identified as a fall risk, a fall prevention protocol must be put in place. Fall risk prevention methods include the following:

(1) Restraints; (2) Bed Alarms or Person Alarm; (3) Bed kept in a low position; (4) Placement in direct line of sight with nurse's station; (5) Use of skid resistant socks or shoes; (6) The use of professional sitters or educated sitters if nursing staff is unable to provide the required level of observation; (7) The use of a fall alert wrist band; (8) orientation and reorientation of the patient to physical surroundings; (9) decrease clutter and obstacles in the patient's environment; (10) ensure adequate lighting in the patient's room; (11) store patient's belonging within his reach; (12) place fall precautions signage on his door. Exhibit 86.

The effectiveness of fall prevention screening tools, combined with fall prevention protocols, has led to falls being added to the nationally recognized list of serious reportable events (referred to as "never events," Never events are events that have been determined to be so preventable through the application of evidence-based guidelines that the Department of Health and Human Services Center for Medicare and Medical Services issued standing orders to each state Medicaid Director

pursuant to §5001(c) of the Deficit Reduction Act of 2005 that medical expenses related to falls which occur in a hospital setting were no longer eligible for payment. Exhibit 70. Hospital falls were, based upon the evidence-based guidelines, determined to be so preventable as to be placed in the group of never events which included foreign objects left in the body after surgery, surgery on the wrong patient, surgery on the wrong body part, implementation of the wrong device, patient discharged to wrong person, abduction, sexual assault or rape of a patient on a facility ground, electrical shock, etc. See Exhibit 79, Addendum A.

The rules and regulations of the Federal Government and the requirements of the Joint Commission for accreditation make it clear that falls within a hospital cannot be simply dismissed as "accidents happen." Instead, they have been determined to be a foreseeable risk to patient safety which is prevented through the reasonable application of sound protocols and medical principals. The standard of care applicable to UAMS and its employees at the time of Mr. Miller's death was to have in place and follow an effective restraint policy, fall risk assessment policy and fall prevention policy that would prevent patients, such as Rodney Miller, from suffering serious injury or death resulting from a fall.

It is anticipated that Respondent may attempt to argue that its fall prevention protocols could not have prevented Mr. Miller's fatal fall. However, in the event an accredited hospital cannot adequately protect a patient from the risk associated with falls through the use of fall prevention protocols, the hospital must do so with the use of restraints. Thus, UAMS must admit that either Mr. Miller's condition required him to be in restraints or it was such that his fall could have been prevented through the use of its fall prevention protocols.

The standard of care also requires that the nurses providing services to patients at UAMS not

only comply with their standard of care at UAMS with respect to each protocol, but that they meet the standard of care with respect to the continuity of care to be provided to Rodney Miller. Continuity of care refers to the obligation to ensure patient safety upon transfer from one care giver to another as part of the patient's plan of care. Continuity of care manifests itself in several areas, including accurate charting and record keeping, effective communication, and proper and timely evaluation of any changes in the patient's condition or environment that may necessitate further action on behalf of the healthcare provider to ensure the patient's safety during or following transfer of care. For example, removing restraints from Rodney Miller in the ICU setting because he was under the constant observation of an ICU nurse does not mean that Rodney Miller's safety would be adequately addressed when transferred to a floor without constant personal observation if he was not in restraints. In order to satisfy the standard of care with respect to the continuity of care requirement, proper assessment, evaluation and communication with respect to the patient's condition and changes in his environment must be addressed so as to allow proper evaluation and implementation of the appropriate protocols, including restraint and/or fall risk prevention protocols.

Relevant state law related to the duty of UAMS and its employees with respect to Rodney Miller is set forth in the Arkansas Model Jury Instructions. In addition to the duty imposed by Federal Regulation, the duty of the hospital in general is set forth in AMI 1504 DUTY OF HOSPITAL, SANITARIUM OR NURSING HOME, which provides that a hospital must use ordinary care to determine the mental and physical condition of a patient and furnish a patient the care and attention reasonably required by his mental and physical condition. See Exhibit 101.

The duty of physicians or other medical care providers is set forth in AMI 1501 which provides that in diagnosing the condition of, and in the treating of, a patient, a medical care provider

must possess and apply with reasonable care, a degree of skill or learning ordinarily possessed and used by members of his or her profession in good standing, engaged in the same type of practice or speciality in the locality in which he or she practices or a similar locality. Failure to meet this standard is negligence. See Exhibit 101.

3. THE EXPECTED TESTIMONY OF NURSE DORIS STEVENS

Claimant intends to call Nurse Doris Stevens as an expert witness in this matter. Exhibit 73 and Exhibit 104. Respondent's attorney recently took the deposition of Nurse Stevens and the Commission has ruled that the summary of this expert's expected testimony, as well as the summary of Respondent's expert, can be provided under separate cover. Nurse Stevens is a Registered Nurse who has worked as both a general floor nurse and an ICU nurse for thirty years in Arkansas. She currently works in the Intensive Care Unit at St. Bernards Regional Medical Center in Jonesboro, Arkansas. She is familiar with the standard of care applicable to the nurses at UAMS including Nurse Childers and Nurse Bramlett. Nurse Stevens is expected to testify that the nursing care provided to Rodney Miller by the staff at UAMS fell below the applicable standard of care and that these failures were the cause of Mr. Miller's unwitnessed fall.

More specifically, Nurse Stevens is expected to provide the following opinions at the hearing in this matter:

That UAMS ICU nursing staff did not adequately chart Mr. Miller's treatment and condition;

That Nurse Childers violated written UAMS policy by removing restraints from Mr. Miller despite the existence of a order for restraints and without documenting the basis for their removal in the focus notes;

That Nurse Childers lack of charting and communication caused a breach in the continuity of care between the ICU and the general floor;

That Nurse Childers failed to communicate her conclusion that Mr. Miller needed constant observation at the time of transfer which led Mr. Miller to be transferred to a location in the hospital that would not provide adequate observation of the patient;

That UAMS ICU nursing staff failed to adequately communicate with the nursing staff on the general floor that received Mr. Miller when he was transferred out of ICU;

That, based upon Rodney Miller's condition as described in the medical records, he needed to be in restraints at the time of the accident;

That, regardless of the premature termination of the restraint order, Mr. Miller remained a high fall risk, yet a fall risk assessment was not completed by Nurse Bramlett, and UAMS fall risks safety protocols were not implemented by Nurse Bramlett;

That, given the fact that Mr. Miller was only alert times one and did not know where he was, that he was not unable to understand and follow instructions, that he was susceptible to suffering a fatal injury in the event of a fall, and that he had a history of confusion and combativeness, it was critical that Nurse Bramlett perform an adequate fall risk assessment during her initial assessment of Mr. Miller and to implement all available fall risk protocols;

That Nurse Bramlett's initial assessment of Rodney Miller fell below the applicable standard of care for a nurse providing nursing care to a patient such as Mr. Miller;

That, if Nurse Bramlett was not going to perform an adequate initial assessment of her patient, including completing an adequate fall risk assessment, then she should have placed Rodney Miller in restraints until such time as an adequate assessment could be performed;

That Nurse Bramlett should have initiated fall risk prevention measures such as the utilization of three of the four bed rails that were present on the bed being used by Rodney Miller. Additionally, if UAMS was not adequately staffed to provide adequate supervision of its fall risk patients, UAMS should have provided additional fall risk prevention measures to its nurses such as bed alarms and fall mats. If adequate fall risk prevention measures were not available, then Nurse Bramlett should have used of restraints until such time as Mr. Miller could understand and appreciate her instructions not to get out bed without assistance;

That Nurse Bramlett's report to Dr. Riggs was inaccurate and incomplete, causing a breach in the continuity of care;

That Nurse Childers and Nurse Bramlett failed to provide Olivian Miller with sufficient information and/or education in order to be able to rely on Olivian Miller to serve as some type of substitute medical care provider;

That Nurse Bramlett should not have left Mr. Miller's room prior to completing her initial assessment in order to make a phone call to Dr. Riggs as she to testified to in her deposition;

That it fell below the standard of care for Paige Bramlett to have left Mr. Miller unrestrained and unattended in his condition and that she also could not delegate any of her nursing duties to Mr. Miller's family members;

That Paige Bramlett was unable to adequately perform her duties as a nurse while treating Mr. Miller given her extreme drug addiction and history of drug abuse during the time period of Mr. Miller's hospitalization;

That, as early as 2008, Nurse Bramlett had committed acts which, if reported to the State Nursing Board, would have subjected her to disciplinary action by the Arkansas State Board of Nursing including suspension or revocation of her license;

That Nurse Bramlett's diversion of medication constitutes unprofessional conduct under Arkansas Code § 17-87-309 (Exhibit 68);

That Nurse Bramlett's addiction to the use of habit forming drugs, specifically including narcotics, and her use of suboxone violate Arkansas Code § 17-87-309 (Exhibit 68);

That, as of April 5, 2009, Nurse Bramlett was unfit and incompetent to be a licensed nurse in Arkansas by reason of negligence, habits, and other causes pursuant to Arkansas Code § 17-87-309 (Exhibit 68) ;

That the failure of Nurse Bramlett and other UAMS employees to comply with the applicable standard of nursing care led to Mr. Miller's unwitnessed fall while under UAMS's care.

4. FACTUAL OVERVIEW

On March 30, 2009, Rodney Miller was admitted to UAMS Medical Center following an ATV accident. UAMS advertises nation-wide that it is a technologically advanced hospital and the only adult Level One Trauma Center in Arkansas. See Exhibit 83. He was initially assessed as having a head injury and a fractured jaw. After arrival, Mr. Miller's mental status worsened, and he required intubation and ventilator assistance with breathing. On April 2, 2009, Mr. Miller underwent surgery for fixation of his fractured jaw. After the surgery, Mr. Miller was transferred to ICU in stable condition. A full recovery was expected.

Beginning on March 30, Mr. Miller was ordered to be in restraints for his own protection because he remained disoriented and could not comprehend what was happening. This order was continued every day between March 30 until April 6, 2009.

On April 1, 2009, a CT scan of Mr. Miller's head showed complete resolution of Mr. Miller's intraparenchymal contusion and no evidence of a subdural hematoma. Thus, it was determined that there would be no need for surgical intervention. At that time, the physicians began to focus their efforts on Mr. Miller's mandibular fracture. On April 2, 2009, Mr. Miller underwent surgery for fixation of his mandibular fracture. After the surgery, Mr. Miller was transferred to ICU in stable condition.

Rodney Miller awoke from his coma and was extubated late in the afternoon (at 4:35 p.m.) on April 4, 2009. Following his extubation, Mr. Miller was restrained while in bed and also while seated in a chair for his own safety. On April 5, 2009, the day of the fall, a restraint order was entered at 7:30 a.m. and was set to expire 24 hours later (on April 6 at 7:30 a.m.). In the April 5, 2009 Restraint Assessment, Mr. Miller was noted to be confused and unable to follow instructions for his personal safety. He was also found to be harmful to himself. The April 5, 2009 Restraint Order indicates as follows: "apply restraint(s) to patient due to disorientation/patient safety, use 2-point, soft restraints for duration of twenty-four (24) hours. May apply Posey Vest as alternative to soft restraints." A posey vest is used to restrain a patient to a bed or chair in order to prevent the patient from injuring himself by falling or otherwise.

On the morning of April 5, Nurse Laura Bailey placed Mr. Miller in a posey vest while he was sitting in a chair. At about 12:00 or 12:30 that afternoon, Nurse Mikal Childers decided to remove the restraints from Mr. Miller and to return him to bed. She has testified that she formed the

professional opinion at that time that Mr. Miller required constant observation for his own safety, including at the time of his transfer from ICU.

Later that day, Mr. Miller was transferred from ICU to another floor at UAMS. He arrived in an aspen collar and was wearing a hospital wrist band that stated that he was a fall risk. He had been medicated with dilantin (an anti-epileptic drug used to prevent seizures); and ativan (a drug used to sedate combative patients). The use of these drugs increases fall risk and is to be considered when evaluating whether a patient, such as Mr. Miller, is a fall risk.

Shortly after he arrived, despite the ICU nurse's evaluation that he needed constant observation at the time of transfer; the existence of the restraint order, the designation of Mr. Miller as a fall risk, and the determination that he was oriented to self only, UAMS nurse Paige Bramlett negligently left Mr. Miller both unrestrained and unattended. Within three minutes of being left unobserved and unrestrained for the first time during his hospital stay, Mr. Miller got out of bed, fell, and suffered a fatal, crushing blow to his head.

Paige Bramlett was a staff RN on the H6 floor at UAMS Medical Center. It is now known that Nurse Bramlett was suffering from an extreme addiction to narcotics at this time and was either intoxicated or suffering from withdrawal symptoms. Exhibit 72. Ms. Bramlett conducted her initial assessment of Mr. Miller in less than five minutes and decided that he did not need to be in restraints. She did not conduct a fall risk assessment or initiate sufficient fall risk protocols. Ms. Bramlett noted that Mr. Miller was oriented to self only. He did not know where he was. Nurse Bramlett has testified that, although she told Mr. Miller not to get out of bed, she could not determine if he was able to understand her instructions. In fact, she described him as the typical head injury patient that does not remember what you tell them. Exhibit 58, p.2.

A nurse possessing, and applying with reasonable care, the degree of skill and learning ordinarily possessed and used by members of the profession in good standing would have either restrained Mr. Miller to prevent him from falling, or ensured that UAMS fall risk protocol was implemented and that he was not left unattended before adequate procedures were in place.

The parties herein have stipulated to the following facts:

1. **On March 30, 2009, Rodney Miller was admitted to UAMS. He was treated for a fractured jaw which required surgery on April 2, 2009.**

2. **After surgery, Mr. Miller was transferred to ICU and remained intubated until he was extubated on April 4, 2009.**

3. **On April 5, 2009, Mr. Miller was transferred from ICU to a general floor.**

4. **Shortly after arrival on the general floor, Mr. Miller experienced an unwitnessed fall.**

5. **As a result of the fall, Mr. Miller suffered from a new subdural hematoma with significant midline shift. Mr. Miller underwent a crainectomy and later suffered cerebral swelling, with herniation. Mr. Miller's condition continued to deteriorate, and he died on April 11, 2009.**

6. **Rodney Miller's death was proximately caused by the injuries he sustained in the fall on April 5, 2009.**

7. **Prior to the fall on April 5, 2009, Rodney Miller was expected to make a full recovery.**

UAMS is liable before this Commission for the negligent acts of Ms. Bramlett, Nurse Childers, and the other medical care providers responsible for the continuity of care and safety of Rodney Miller.

5. RODNEY MILLER'S 4-WHEELER ACCIDENT, INITIAL TREATMENT AND TRANSFER TO UAMS

On Sunday, March 30, 2009, Rodney Miller decided to ride his four-wheeler with his friends. Early that evening, Olivian Miller's sister told her that he had been in a wreck. Mrs. Miller was

terrified because her own father had died in a four-wheeling accident. Mrs. Miller drove to the accident scene and called for help. Mr. Miller was transported by ambulance to a hospital in El Dorado. Thereafter, it was decided that he would be airlifted to UAMS due to his head injury.

Given the undisputed facts, the parties have stipulated that Mr. Miller would have made a full recovery from the injuries received in the accident if he had not suffered the fatal fall in the hospital. While it is not expected that Respondent will attempt to reduce Mr. Miller's recovery based upon the facts and circumstances surrounding the four-wheeler accident, any attempt to do so would be improper. The only relevant issue before the Commission is whether the negligence of UAMS's nurses caused him to suffer the fatal fall. Mr. Miller's alleged "fault" for the wreck is completely irrelevant to this claim. In fact, defense counsel has admitted in internal correspondence that the accident "probably has nothing to do with the malpractice claim." Exhibit 63.

6. RODNEY MILLER'S INJURIES AND INITIAL TREATMENT AT UAMS.

On March 30, 2009, Rodney Miller was admitted to UAMS Medical Center Hospital from an outside hospital. He was initially assessed as having a head injury and a fractured jaw. Upon his arrival, Mr. Miller was noted as being "very combative." It was also noted that "even while restrained - would not be still!" It was further noted that Mr. Miller "does not follow commands." Mr. Miller was identified as a fall risk and placed in a fall risk bracelet for his own protection.

On March 30, 2009, UAMS initiated its "Protocol for the management of the adult patient experiencing an alteration in thought process." Exhibit 25. This Protocol became a part of Mr. Miller's plan of care and it was never discontinued during his stay.[1] This UAMS policy required that

[1] Modification of the Protocol requires a detailed focus note entry. Discontinuation of the Protocol requires a signature of the responsible medical care provider.

"the patient will remain safe and protected from injury." This UAMS policy also required that UAMS staff would apply soft restraints as necessary and implement orientation measures. Specifically, with respect to restraints, the policy required planning for continuity of care. See Exhibit 25, "*." This policy also requires the use of a "bed alarm when available." It is undisputed that bed alarms were not only available at UAMS at the time of the accident, but were in use on other general floors. The nursing assistant that received Mr. Miller on the general floor has admitted that Mr. Miller's bed did not have a bed alarm although some of the beds at UAMS at that time were so equipped. Cingolani Dep., p.23.

Also, on March 30, 2009, UAMS initiated its "Protocol for the management of the patient requiring restraint." Exhibit 25. This protocol also became part of Mr. Miller's plan of care. On its face, this protocol was never discontinued. It was noted that Mr. Miller would be assessed every two hours. Restraints were to be applied if Mr. Miller was confused/disoriented and at a risk for self-harm OR if he was "at risk for self-injury/falls." This protocol states very specifically that any modification to the protocol had to be documented in a focus note[2].

Additionally, on March 30, 2009, UAMS initiated its "Protocol For The Management Of The Patient At Risk For Falls." Exhibit 86. This protocol became part of Mr. Miller plan of care and was never discontinued. It states that Mr. Miller would remain as independent as possible but also that he would "be protected from self-harm from falling."

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[2] "Focus notes" refer to the descriptive narratives that form a critical portion of the medical chart. In certain situations, such as here, focus notes are required rather than a "check the box" or "fill in the blank" entry so as to ensure complete and thorough medical evaluation. It is also critical to complete focus notes to specifically identify by time and condition changes to the patient's condition that may affect the continuation or deviation from the plan of care. Focus notes are essential to continuity of care.

During his first few days at UAMS, Mr. Miller was noted to be confused, disoriented, and agitated. Due to his confused state and disorientation, Mr. Miller made various attempts to ambulate, to remove his oxygen tube, to remove his IV, and to remove other medical devices, and he took other actions which posed a danger to his personal safety, health and well-being. According to the hospital records, Mr. Miller's mental status continued to worsen after his arrival, and he soon required intubation.

Beginning on March 30, Mr. Miller was ordered to be in restraints for his own protection because he remained disoriented and could not comprehend what was happening. This order was continued every day between March 30 until April 6, 2009. Exhibit 15 is the Restraint Assessment entered on April 5, 2009 (the date of the fall). It states on its face that it would expire on April 6, 2009 at 7:30 a.m. Based upon the testimony in this case, it is undisputed that the Restraint Order remained in place and was not discontinued at the time that Nurse Bramlett left Mr. Miller out of restraints and left his room shortly before his unwitnessed fall at 5:10 p.m. on April 5, 2009.

7. RODNEY MILLER'S CARE IN UAMS ICU PRIOR TO TRANSFER

On Friday, April 3, 2009, Mr. Miller was received by ICU nurse Laura Bailey at approximately 7:00 p.m. Exhibit 2. Nurse Bailey worked a twelve hour weekend night shift (7:00 p.m. until 7:00 a.m - Friday through Sunday). At the time Mr. Miller was received by Nurse Bailey he was intubated and sedated. Nurse Bailey completed a fall risk assessment and rated Mr. Miller an 11. Exhibit 5. Under UAMS's procedures, if a patient's total risk is greater than 7, that patient is considered to be a fall risk. In her fall risk assessment, Nurse Bailey noted that he had suffered a previous fall, that he was disoriented with impaired judgment, that he suffered from a sensory or communication deficit, that he was on CNS medications and that he was unable to ambulate.

Exhibit 5.

The next morning, Nurse Bailey turned Mr. Miller over to the day shift nurse, Mikal Childers. Exhibit 6. Nurse Childers worked a twelve hour weekend day shift (7:00 a.m until 7:00 p.m - Saturday-Monday). Mr. Miller was sedated on propofol, unable to follow commands, and could not open his eyes. Propofol (also known as Diprivan) is a hypnotic agent used to induce and maintain sedation for mechanically ventilated adults. Nurse Childers noted that he was attempting to remove his lines. Mr. Miller remained intubated and in four-point restraints.

At 8:55 a.m., on Saturday, April 4, Mr. Miller was taken off of propofal. Exhibit 6. Shortly thereafter, Mr. Miller became very agitated and was administered Ativan with no results. Additional Ativan was ordered. Ativan (also known as lorazepam) is a high-potency benzodiazepine drug, often used as a sedative. Ativan is often used to sedate aggressive, hospitalized patients. At that time, he was placed in four-point restraints and additional Ativan was administered.

8. MR. MILLER'S NEED FOR RESTRAINTS AND FALL PRECAUTIONS DURING THE TWENTY FOUR HOURS PRECEDING HIS FATAL FALL

Mr. Miller's condition during the twenty-four hours prior to his fatal fall demonstrates his on going need for restraints and fall risk protocols. At 4:35 p.m. on April 4, Mr. Miller was extubated. Exhibit 6. This was approximately 24 hours before he suffered his fatal fall. During this time, he slowly began to respond to his name and attempted to speak. During her day shift on April 4, Nurse Childers performed a fall risk assessment and rated Mr. Miller an 11. Exhibit 6.

Shortly after the extubation, a little before 7:00 p.m., nurse Childers turned Mr. Miller back over to nurse Bailey. It was noted that he needed continued re-focusing and re-orientation. At 7:25, Nurse Bailey noted that Mr. Miller was kicking his legs over the side rail and attempting to get up.

At that time, Nurse Bailey implemented ankle restraints which are an even more aggressive restraint system than that which was in place at that time. Nurse Bailey also attempted unsuccessfully to reorient Mr. Miller.

Mr. Miller's mental condition continued to deteriorate. At 10:50 pm., Nurse Bailey noted that Mr. Miller did not know what had happened or why he was in the hospital. He refused to believe that he had been in an accident or to acknowledge his condition. He later began to ask to go to the restroom to urinate, and Nurse Bailey had to continue to attempt to explain his condition and that he had a foley catheter placed internally in his penis. At 3:00 a.m., Nurse Bailey noted that Mr. Miller was expressing the desire to go home. She also noted that he was argumentative with staff regarding his location.

At 5:35 a.m. on April 5, nurse Bailey noted that staff members had helped Mr. Miller out of bed and onto a chair and that he had been placed in a posey vest restraint. Exhibit 6. His mental condition had not improved. During her entire shift, from 6:40 pm. on April 4 until 6:30 a.m. on April 5, Nurse Bailey noted that Mr. Miller remained confused.

At 7:00 a.m. on April 5, Nurse Bailey turned Mr. Miller back over to Nurse Childers. Exhibit 10. He was still in the posey vest sitting in a chair at that time. In her deposition, Nurse Bailey has testified that she would have informed Nurse Childers what had prompted the posey vest in her report. She testified that the Posey vest had been put in place to prevent him from hurting himself. She testified that he was a very athletic, tall, big guy and that she had been concerned that he would get up and try to walk. Based on her nursing assessment, she had determined that doing so would have been very dangerous to him. Bailey Dep., p.78.

Thus, Nurse Bailey put him in the Posey vest that morning because she felt it was in his best

interest and for his safety. When she transferred care to Mikal Childers, he was still in the Posey vest in the chair. She has testified that she would not have restrained him if she did not feel like he was a fall risk. She was likewise concerned that he was not able to understand and follow her instructions. Bailey Dep., p.79.

Consistently from the time of the removal of the ventilator and tube, Mr. Miller demonstrated confusion, disorientation, the lack of ability to understand instructions, combativeness, and the desire and intent to elope. According to the nursing records, this condition was demonstrated consistently from Mr. Miller's extubation until the time of transfer.

According to Nurse Bailey, she turned Mr. Miller over to Nurse Childers at 7:00 a.m. on the morning on the 5th. At that point, he was awake and restrained in a chair, arguing with staff and needed constant observation. However, his prognosis was good and a full recovery was expected. When she returned to work the following evening, Mr. Miller had been transferred unrestrained to a general floor, fallen, and been transferred back to ICU. At that point, he was obtunded with non-reactive pupils. Bailey Dep., p.94. After sitting with Dr. Pait when he explained the situation to Mrs. Miller, Nurse Bailey knew that at some point in the near future it would result in his death. Bailey Dep., p.95.

9. NURSE CHILDERS' REMOVAL OF THE RESTRAINTS

Upon receiving Mr. Miller, Nurse Childers noted that he was confused, oriented to self only, and that his speech was difficult to understand. Nurse Childers failed to make any nurses notes between 7:00 am. and 12:30 p.m. on April 5. However, in her Restraint Assessment, she indicated he was confused, unable to follow instructions for personal safety, and that he was harmful to himself. Exhibit 11. According to UAMS policy, the ability to follow instructions is one of the

primary restraint discontinuation criteria. Exhibit 26. In the Restraint flow sheet, Nurse Childers indicated that Mr. Miller had remained confused from 7:00 a.m. until 11:00 a.m.

At 12:30 p.m., Nurse Childers noted that Mr. Miller had been placed back in bed. According to her testimony, at that time, Nurse Childers decided to remove the restraints from Mr. Miller. However, she has testified that she also had decided to keep Mr. Miller in restraints while he was out of bed. Childers Dep., p.34. Despite the mandatory requirements of the multiple Protocols that were in place for Mr. Miller, Nurse Childers did not document in her focus note any change of Mr. Miller's condition that led her to decide to take off the restraints. While Nurse Childers did "check a box" noting that the reason for the restraints had resolved, this was done after the fall on the general floor, offered no narrative explanation as required by UAMS policy, and is inconsistent with the sworn testimony in this case related to Mr. Miller's condition.

Nurse Childers has also testified that she believed that Mr. Miller needed to be under constant observation to prevent self harm, up to and including the time of transfer. Childers Dep., p.106. Ms. Childers' testimony is consistent with the fact that, at the time of transfer, all three protocols and a 24 hour order for restraints remained in place. It is anticipated that the Respondent will argue that once restraints had been removed from Mr. Miller, they could not be reapplied. This is simply not true. Even if the restraints had been removed earlier (properly or improperly) recognition of his altered mental state and risk for self harm at the time of transfer would have required that a new restraint order be requested prior to transfer to the general floor where the observation level was inadequate given Mr. Miller's condition.

It is undisputed that Rodney Miller required constant observation, was not oriented to place or time, was unsteady on his feet, could not understand instructions, was taking medications that

would increase the risk of falls, had only arisen from his coma and been removed from a ventilator in the past twenty-four hours, was combative, and refused to acknowledge his situation or limitations. According to the testimony, he believed he had been kidnapped and had the attention span and understanding of a two year old. Based upon the evidence relating to his condition at the time, regardless of why the restraints were removed in the first instance, restraints should have been in place at the time of transfer from ICU to the general floor.

It is anticipated that the Respondent will attempt to argue that Dr. Muhammad Jaffar may have "agreed" with Nurse Childer's decision to take Mr. Miller out of restraints. Nurse Childers has testified that, several hours before she decided to remove the restraints, Dr. Jaffar had told her that Mr. Miller looked good and that he could be transferred from ICU. Dr. Jaffar did not tell her that he was going to discontinue the restraint order and he did not do so. Nurse Childers does not remember a specific conversation with Dr. Jaffar regarding the restraint order. Childers Dep., p.35. She has also testified that she cannot identify any nurse, physician, resident or other medical personnel that was involved or made a decision to remove the restraints from Mr. Miller. Childers Dep., p.41, 92. In other words, the decision to remove the restraints was made by Nurse Childers and not by any other medical professional.

While in ICU, Olivian Miller was allowed to see Mr. Miller in his ICU room. For almost his entire stay at the hospital, she had slept in an ICU waiting room and remained at the hospital. On the morning of April 5, Ms. Miller was allowed to see Mr. Miller. She has testified that he was sitting in a chair wearing a Posey vest and that this was the first time she had seen him sitting up since the accident. Mrs. Miller has testified that, when she walked through the door, he turned and looked at her, and he had a dazed and confused look on his face and asked her what she was doing

there. Miller Dep., p. 49. When she explained that he had been in a wreck and that she had been at the hospital with him, he told her that he had not been in a wreck. At that point, the nurse told her that she had been arguing with him all night about where he was and why he was in the hospital. Mr. Miller stated that he had not been in a wreck and that they had kidnapped him and were holding him hostage. He stated that he wanted to go home, and he told Mrs. Miller to go get the car. He stated that he had a house to pay for. Not only did he deny the wreck, but he also denied owning a four wheeler. Mrs. Miller also remembers that, merely hours before the fall, he mistook a sponge for pineapples and that he could not remember who the president was despite the fact that he had previously been very excited when President Obama was elected. Miller Dep., p. 49-51.

Rodney Miller's sister, Carol Bell, also saw him on that day around noon. At that time, she attempted to feed him. Ms. Bell has testified that Mr. Miller refused to believe that he had been in a wreck and that he would get very upset when she tried to explain to him why he was at the hospital. Bell Dep., p.12-14.

Nurse Childers has also testified that Mr. Miller was exhibiting confusion. She remembers Mr. Miller constantly stating that he needed to get out of bed to urinate. She also remembers having to constantly explain to Mr. Miller that he had a catheter inserted into his penis. She also remembers Mr. Miller kicking his legs over the side of the bed and her telling him that he could not get up. Childers Dep., p.23.

Nurse Childers has also testified that she told Mrs. Miller a general idea of what to expect regarding Mr. Miller's mental capabilities and abilities and disabilities after being aroused from the coma and extubated. She testified that she normally tells family members not expect the patients to be themselves when they first come out of a coma. She lets them know to expect them to be

confused and perhaps angry and impulsive. Nurse Childers also testified that the patients will sometimes suffer from hearing loss, vision loss and/or sensory loss. Childers Dep., p.24.

According to Nurse Childers, she informed Mrs. Miller, prior to the transfer, that head injury patients are impulsive, and that he was like a 2 year old and his condition could change very quickly. She also believes that she informed Mrs. Miller that when Mr. Miller woke up, she believed that he would try to stand up and that this could be dangerous to his health and safety. Childrers Dep., p.19.

Nurse Childers has testified that, given Mr. Miller's mental and physical condition, she considered a potential fall to be a very serious risk to Mr. Miller that could cost him his life. Most importantly, she has also testified that Mr. Miller's condition necessitated that he be constantly observed to prevent injury to himself **at the time of the transfer**. Childers Dep., pp.102, 106. Despite Nurse Childers' recognition of Mr. Miller's limitations and the associated risks, these limitations and risks were not documented by Nurse Childers in Mr. Miller's chart. Likewise, these limitations were either not given by Nurse Childers in her report to the general floor, or were ignored by Nurse Skipper/Bramlett. This constitutes a breach of the standard of care with respect to the continuity of care requirements which must accompany transfer of patients between floors.

10. RODNEY MILLER'S TRANSFER FROM ICU TO THE GENERAL FLOOR.

At some point during this time, the decision was made to transfer Mr. Miller out of ICU. The records indicate that the initial decision was to transfer Mr. Miller to a step down unit. Based upon his condition, Mr. Miller was the perfect candidate for the step down unit as he had only been recently extubated and remained in need of constant observation. In fact, the UAMS discharge summary for Mr. Miller states that he was transferred to a step down unit. Exhibit 13. However, Mr. Miller was not transferred to a step down unit. Rather, he was transferred to H6 which is a

general, surgical sub-specialty floor at UAMS.

According to the records, at 4:00 p.m., Nurse Childers reported to Nurse Felicia Skipper who was a nurse working on H6 at the time. Exhibit 10. Neither Nurse Childers nor Nurse Skipper have an actual recollection of that conversation. Skipper Dep., p. 8; . Childers Dep., p.17. Nurse Childers denies ever speaking to Paige Bramlett about Mr. Miller. Childers Dep., p.82.

Although she does not remember her verbal instructions to Nurse Skipper, Nurse Childers has testified that, based on her observations, Mr. Miller's condition necessitated that he be constantly observed to prevent injury to himself at the time he was transferred out of ICU. Childers Dep., p.106. Nurse Skipper has testified that she does not recall receiving a report from Nurse Childers or having any conversation with Paige Bramlett in regards to receiving or passing on a report from Nurse Childers. More specifically, she does not remember telling Paige Bramlett that the ICU nurse reported that Mr. Miller's condition required constant observation. Skipper Dep., p. 11. Nurse Childers has also indicated that Miller was wearing a blue armband at the time of the transfer to indicate that he was a fall risk. Childers Dep., p.37.

Mrs. Miller has testified that she was told by a nurse earlier on the day of the fall that they were thinking about transferring Rodney out of ICU. Miller Dep., p. 55. Mrs. Miller has testified that she anticipated that they would tell her before Mr. Miller was transferred so that she could go with him. However, this did not happen. Rather, someone came to the ICU waiting room that afternoon to get her after Mr. Miller had been transferred. At that point, she thought she was just going back to the room to see him. However, she was then taken to the general floor where Mr. Miller had already been transferred. Miller Dep., pp. 56-57. UAMS documentation demonstrates that UAMS ICU maintains separate elevators for patient transport that are not to be used by the

family. Exhibit 100.

The UAMS records include an ICU Transfer Assessment that purportedly was completed by Nurse Childers on April 5. Exhibit 21 (UAMS 378). This document indicates a transfer time of 5:15. Nurse Childers has testified that this would be the time that she filled out the Transfer assessment. Childers Dep., p.28. All other UAMS documents indicate that Mr. Miller was received by the general floor at 5:00 p.m. and that the fall took place at 5:10. The Transfer/Discharge Assessment was not completed by Nurse Childers until five minutes after the fall. Interestingly, the **only** reference by nurse Childers to Mr. Miller being "oriented" was charted **after** he had already been transferred to the general floor and fallen.

11. RODNEY MILLER'S ARRIVAL AT THE GENERAL FLOOR.

According to UAMS records, Mr. Miller was received by the general floor at 5:00 p.m. on April 5, 2009 by Paige Bramlett. Exhibit 22. As indicated in detail below, Nurse Bramlett was suffering from an extreme addiction to narcotics at the time and was either under the influence at the time or suffering from withdrawal symptoms. Exhibit 72. She has testified that, upon receipt, Mr. Miller knew his name but did not know the date or where he was. Bramlett Dep., p.11. She noted that he was "oriented to self only." Exhibit 22.

According to Nurse Bramlett, Mr. Miller arrived in a wheelchair. She documented that he was wearing a high risk band which she has testified "could have been" a fall risk band. Bramlett Dep., p.20. There is no need to speculate. Mr. Miller's chart contained a high fall risk designation and directed that Mr. Miller required extra attention for fall precautions and seizure precautions. Exhibit 85. Nurse Childers has also indicated that Miller was wearing a blue armband at the time of the transfer to indicate that he was a fall risk. Childers Dep., p.37.

In her Focus Notes, Nurse Bramlett documented that the call light had been placed within Mr. Miller's reach, that his wife was at the bedside and that Mr. Miller and his wife were "instructed to call for assist before oob (out of bed)." In her risk management statement, Nurse Bramlett indicated that she completed her assessment and gave Mr. Miller the call light. She stated that she told Mr. Miller and his wife that he should not get out of bed without calling her. Nurse Bramlett did not record any other instructions allegedly given to Mr. Miller or his wife at that time. In her deposition, nurse Bramlett has also testified that she instructed Mr. Miller not to get up without assistance but that she was not sure that he was able to understand her instructions. Bramlett Dep., p.11. According to UAMS policy, the ability to follow instructions is one of the primary restraint discontinuation criteria. Exhibit 26.

Nurse Bramlett has testified that she remembers talking with the transferring nurse (Nurse Childers) and being told that Mr. Miller was not in restraints before the transfer. Bramlett Dep., p.40. This is inconsistent with the testimony of both Nurse Childers and Nurse Skipper. In fact Nurse Childers has testified under oath that she never spoke to Nurse Bramlett regarding Mr. Miller. The documents and proof demonstrate that, despite her testimony to the contrary, Nurse Bramlett never spoke with the transferring nurse. Rather, at best, she received an indirect report from Felicia Skipper.

Shortly after these events, Nurse Bramlett gave a statement to the risk manager for UAMS. Exhibit 58. In this statement, Nurse Bramlett indicated that she helped him into bed when he arrived in the wheelchair and that his balance was unsteady. Additionally, Nurse Bramlett has completed a "Manage Event Report" on this incident. Exhibit 67. In this report, Nurse Bramlett stated that she had been told that Mr. Miller had been out of restraints since "early am." This statement is untrue

as Mr. Miller's restraints had not been removed until noon. Thus, he had been out of restraints for a significantly shorter period of time than Nurse Bramlett reported.

According to Nurse Bramlett's testimony, she completed her "typical assessment." Mr. Miller knew his name but he did not know the date and he did not know where he was. She showed him the call light and told him not to get up. However, she could not assure herself that he understood this instruction. Bramlett Dep., p.11. Nurse Bramlett also acknowledged to the UAMS risk manager after the incident that she is used to working with head injury patients and knows that they do not remember what you tell them, so she is very aware that they need to be closely monitored. Exhibit 58. In her risk management statement, Nurse Bramlett also admitted that Mr. Miller was unbalanced and slow to answer her questions. She also stated that he repeatedly told her: "I've got a brick house to pay for." Thus, Mr. Miller exhibited signs that he did not comprehend his condition or where he was and that he intended to get out of bed in an attempt to leave his room if given the chance.

Nurse Bramlett has testified that she understood that Mr. Miller was still subject to a restraint order when she received him at 5:00 p.m on April 5, 2009. She even remembers recognizing the fact that a restraint order was in place and questioning Mr. Miller's arrival on the general floor unrestrained. Bramlett Dep., p.16. She also has testified that she understood that, in ICU, unlike her general floor, patients are constantly observed. Bramlett Dep., p.17.

Nurse Bramlett has freely admitted that she did not complete a fall risk screening with respect to Mr. Miller, but had she done so, she would have confirmed that he remained a fall risk at that time. Bramlett Dep., pp. 57-59, 68. Inexplicably, she has testified that she did not complete the assessment because she "did not have time." Bramlett Dep., p.21. There was no reason to abandon

Mr. Miller prior to completing her assessment and even Respondent's expert witness has confirmed her confusion with respect Ms. Bramlett's decision[3]. However, she concedes that Mr. Miller was a fall risk. She has testified that the fall prevention protocol is very detailed. Bramlett Dep., pp.24-25. These fall prevention measures were not utilized for Mr. Miller.

Betty Casali was the manager of the floor at the time. Casali Dep., p. 6. She informed the UAMS Risk Manager that Mr. Miller had been confused and argumentative upon arrival and that a fall risk evaluation had not yet been done. Exhibit 31. She testified that she would have thought Mr. Miller would have had a fall sign outside of his door because almost everybody has some sort of a fall sign. Casali Dep., p.29. However, no sign was placed on Mr. Miller's door. Betty Casali also testified that fall prevention should have also included ensuring that the door remained open and that Mr. Miller was close to the nurses' station and receiving frequent observation. Casali Dep., p.47. Although Mr. Miller was placed close to the nurses station, Nurse Bramlett testified that this was merely coincidence. She also admitted that his door was shut at the time she heard the fall.

Additionally, in her statement to the risk manager, Nurse Bramlett stated that the "side rails were up x 2." Exhibit 58. According to Nursing Director, Candace Connors, the beds are equipped with four bed rails. Nurse Bramlett used the two closest to Mr. Miller's head only. Conners Dep., p.7. She did not use the two additional rails closer to his feet. Conners Dep., p. 8. Obviously, these

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[3] Respondent maintains that, despite Nurse Bramlett's addiction and dependency during this time period, there is no "proof" that Nurse Bramlett was intoxicated at the specific time of Mr. Miller's fall. As Dr. Skolly will testify, Nurse Bramlett's "withdrawals," given her level of dependency, would have had just as a severe impact, if not more of an impact on her decision making ability. Exhibit 72. Given this dependency, and the fact that this event occurred near the end of Nurse Bramlett's 12 hour shift, combined with the lack of any logical explanation for Mr. Bramlett's abandonment of her assessment, it is reasonable to conclude that Ms. Bramlett abandoned the assessment to tend to her addiction/withdrawals before the shift's end.

are the rails that most likely are to keep a patient in Mr. Miller's condition from getting out of bed.

This event qualified as a "sentinel event" for reporting purposes. In the Manage Event Report completed by Paige Bramlett on the same day of the incident, Ms. Bramlett was required to identify protocols and interventions that were in place, or being used to prevent falls with this patient. The only protocols and interventions identified by Paige Bramlett were "bed in low position, fall alert (i.e. note in chart) in place; and patient wearing blue band." See Exhibit 67, p. Tutton 529. Fall alerts and blue bands are used to identify the patient as a fall risk. No one in this case disputes that Rodney Miller was recognized as a high fall risk and in need of protection via either restraints or application of the fall risk protocol. The only fall risk prevention protocol/intervention identified by Nurse Bramlett in her official report was "bed in low position." Clearly, interventions such as (1) Restraints; Bed Alarms Placement in direct line of sight with nurse's station; use of skid resistant socks or shoes; use of professional sitters or educated sitters if nursing staff is unable to provide the required level of observation; orientation and reorientation of the patient to physical surroundings; decrease clutter and obstacles in the patient's environment; ensure adequate lighting in the patient's room; store patient's belonging within his reach; place fall precautions signage on his door were simply ignored. Exhibit 86.

The 24 hour flow sheet for Rodney Miller on April 5, 2009 is provided as Exhibit 30. It is clear from reviewing this document that most of it has not been filled out and that most of what has been filled out was done by Nursing Assistant, Sarah Meyers, as opposed to Nurse Bramlett.

Moreover, despite not having time to complete a fall risk assessment, Nurse Bramlett decided not to restrain Mr. Miller. She has testified that she, as a nurse, can release a patient from the restraint without an order. Bramlett Dep., p.71. She has testified very specifically that she is the

person with respect to Mr. Miller that made all those determinations upon his arrival to the floor and that if she was wrong in that determination, it falls on her and no one else. Bramlett Dep., p.72. In essence, Nurse Bramlett has testified that she spent approximately five minutes with Mr. Miller. Based upon her incomplete initial assessment, the fact that Mr. Miller had not been in restraints when he arrived, and the fact that she had been told he had not been in restraints for some period of time prior to transfer, she made the decision that he did not need to be in restraints. It is beyond dispute that the events that led to Rodney Miller's death were entirely foreseeable given his condition. It is also clear that multiple violations of protocol, errors in judgment, and breaches of the standard of care occurred and combined to cause an entirely preventable death.

12. THE CONVERSATION BETWEEN OLIVIAN MILLER AND NURSE BRAMLETT

There is a factual dispute as to Ms. Miller's presence and involvement during the five minute assessment performed by Paige Bramlett. It is claimant's position, that based upon violation of the Restraint Protocol, the failure to properly assess Rodney Miller as a fall risk, the failure of Nurse Bramlett to institute either restraints or fall prevention protocols, and Respondent's admissions that it was not relying upon Ms. Miller as an educated "sitter," that issues related to Ms. Miller's presence, or lack thereof, in Mr. Miller's room are simply irrelevant and a red herring asserted by Respondent. With this said, Respondent's position is also contrary to the facts and is totally reliant upon witness testimony which lacks veracity from a witness with no credibility.

According to Mrs. Miller, she was escorted to Mr. Miller's new room on the sixth floor around 5:00 p.m. When she arrived, there was already a nurse in the room with Mr. Miller. Mr. Miller had already been placed in the bed. Miller Dep., p. 57. The Nurse then informed Mrs. Miller that she could stay in the room with Mr. Miller now that he had been transferred out of ICU.

Previously, Mrs. Miller had spent every night in the ICU waiting room. Mrs. Miller responded that she would need to go back to the ICU waiting room to get her clothing and other belongings. Miller Dep., p. 58-59.

Mrs. Miller has testified that she does not know what Nurse Bramlett had previously said to Mr. Miller when she arrived. Mrs. Miller walked out of the room, and Nurse Bramlett followed her out. Miller Dep., p. 60. Mrs. Miller walked to the elevator and went back to the fourth floor. As the elevator doors were opening, she received a page to return to the sixth floor. She immediately returned and learned of Mr. Miller's fall. Miller Dep., p. 61.

On the other hand, according to Nurse Bramlett, Mrs. Miller was present when she did her assessment. Bramlett Dep., p. 9. Nurse Bramlett now claims to have showed Mrs. Miller how to use the call light and to have told Mrs. Miller that if she left the unit to let her know. Bramlett Dep., p.10. Nurse Bramlett claims that Mr. Miller was asleep when she left him in the room. Subsequently, when she heard him fall, she claims to have seen Mrs. Miller standing in the hall on her cell phone. Bramlett Dep., p.45.

Nurse Bramlett never documented the alleged instruction to Mrs. Miller not to leave the room without letting her know. She did not document this alleged statement in her focus notes and she did not make this statement to the UAMS risk manager in her initial report after the accident. Exhibits 22 and 58.

Additionally, Nurse Bramlett has completed a "Manage Event Report" on this incident. Exhibit 67. In this report, Nurse Bramlett stated that the contributing factors to this incident were "altered mental status/cognitive impairment, dizziness/vertigo." She admits in the report that no fall risk assessment had been performed but states that fall protocols were in place prior to the fall. The

protocols mentioned are: bed in low position, fall alerts in place, patient wearing blue band." The only "fall alert" in place was the high fall risk notification in the patient's chart, which was simply ignored by nurse Bramlett. More importantly, nowhere in this report, her statement to the UAMS Risk Manager, or in any of her charting, did Nurse Bramlett indicate that a family member's failure to follow instructions had been an alleged contributing factor. This allegation by Nurse Bramlett was made, for the very first time, during her deposition after she had conferred with Respondent's attorneys.

Mr. Miller's sister, Carol Bell has testified that she spoke to Olivian Miller on the phone almost immediately after the fall. Bell Dep., p.19. Ms. Bell testified that Mrs. Miller was very upset and she could hear people calling Mr. Miller's name in the background. Bell Dep., p.20. Mrs. Miller told Ms. Bell that she had gone to get her clothes at the time that Mr. Miller had fallen. Bell Dep., p.21, 35. During the excitement surrounding the attempted resuscitation of her husband following his fall, Mrs. Miller told Mrs. Bell that she and the nurse left at the same time since the nurse had told her she could sleep in the room, and she left to go get her clothes from ICU. Bell Dep., p.36.

It is claimant's position that this Commission should find Mrs. Miller's testimony to be more credible than Nurse Bramlett's on this issue. Mrs. Miller loved her husband dearly. She had slept in an ICU waiting room night after night praying for her husband to recover. She never would have knowingly left her husband unattended contrary to a nurse instruction. She has no reason to lie. Mrs. Miller is prepared to testify extensively on this issue at the hearing.

Because Mr. Miller had been transferred unaccompanied by Ms. Miller and was, in fact, already in bed with his feet covered upon her arrival, Mrs. Miller was unaware that Mr. Miller's leg

restraints had been removed. Miller Dep., p. 68. Nurse Bramlett does not even contend that she advised Mrs. Miller that Mr. Miller was no longer restrained. Likewise, the nursing assistant did not know whether or not Mr. Miller had leg restraints on at the time. Cingolani Dep., p.27. UAMS admits that Mrs. Miller was not educated as a "sitter." While her education as a sitter would have covered several categories, it most certainly would have identified that Mr. Miller was no longer restrained and that there was nothing to physically prevent him from attempting to get out of bed.

Additionally, Nurse Bramlett has testified that she did not base her determination to request a discontinuation of the restraints on whether or not a family member would be in the room to observe Mr. Miller. Bramlett Dep., p.78. Likewise, the charge nurse that day, Felicia Skipper, has testified that she does not believe it was Mrs. Miller's fault that he fell. Skipper Dep., p. 56.

Regardless of what was said during the above conversation, Mr. Miller was left unattended through no fault of Olivian Miller.

13. NURSE BRAMLETT DID NOT FOLLOW UAMS PROTOCOL IN ALLEGEDLY ASKING OLIVIAN MILLER TO ACT AS A SITTER

As indicated above, Claimant denies that Nurse Bramlett instructed her to stay with Mr. Miller or to inform her if she left his room. To the contrary, Olivian Miller informed Nurse Bramlett that she was going back to ICU to retrieve her things and Nurse Bramlett followed her out of the room.

However, even if Nurse Bramlett had made this statement, she would be in violation of UAMS policy. UAMS has a Policy regarding family members acting as patient observers. Exhibits 33, and 66. In such an event, family members are required to be educated by the nurse and provided with a Family Education Sheet. Exhibits 33, 66. As noted by defense counsel in Exhibit 64, reliance

on a family member to act as an observer required that the family member receive and complete a Family Education Fact Sheet. The completion of the Family Education Fact Sheet, likewise, is required to be documented in the focus note. There is no such documentation in the focus notes in this case because Paige Bramlett simply did not make an attempt to do so. Likewise, since ICU does not use family members as observers, no education qualifying Ms. Miller as a sitter occurred during Mr. Miller's ICU stay. Exhibit 64. In fact, as indicated previously, there is nothing documented at all about Olivian Miller being allegedly asked to watch Mr. Miller and/or to inform Nurse Bramlett if she left the room. Additionally, as noted by UAMS Risk Manager in Exhibit 64, Olivian Miller "was not on the floor long enough for Paige to determine hours wife could stay, etc."

This is obviously why Nurse Bramlett had no choice but to admit that she did not base her decisions on whether or not a family member would be in the room to observe Mr. Miller and why the charge nurse that day, Felicia Skipper, testified that she does not believe it was Mrs. Miller's fault that he fell. Bramlett Dep., p.78; Skipper Dep., p. 56.

14. THE STATE COURT ACTION AGAINST DR. DAVID RIGGS AND DR. RIGGS' CRITICISMS OF PAIGE BRAMLETT

Initially, simultaneous actions were required against Dr. David Riggs in Circuit Court (as he maintained insurance coverage) and UAMS. The case against Dr. Riggs was later dismissed pursuant to a Stipulation that the issues presented in this case relate solely to the treatment Mr. Miller received from the nursing staff at UAMS. Exhibit 77. In conducting discovery in the Dr. Riggs matter, both of the key nurses (Childers and Bramlett) testified that the decision to remove the restraints was entirely their decision independent of any physician. Dr. Riggs also testified that his decision to not immediately require the restraints to be placed back on Rodney Miller, or to require

constant/uninterrupted observation was based upon a combination of false information provided by Nurse Bramlett and the failure of Nurse Bramlett to provide other pertinent information. This was a major breach in the continuity of care standard.

Nurse Bramlett testified that she left Mr. Miller's room and went across the hall to the nurses station. At that time, Nurse Bramlett called Dr. David Riggs and told him that she had decided that Mr. Miller did not need to be in restraints, and she asked Dr. Riggs to formally discontinue the restraint order. Bramlett Dep., p.66-67. Dr. Riggs made a note of the phone call two days later in a progress note. Exhibit 12. Oddly enough, everyone agrees that if Nurse Bramlett truly believed Mr. Miller did not need restraints, this phone call was unnecessary and, certainly, was not urgent. Even the Defendant's own expert is confused as to why Nurse Bramlett felt the need to abandon Mr. Miller after such a short time to call Dr. Riggs.

Dr. Riggs was a resident at UAMS working under an attending physician and was present and making rounds. Riggs Dep., p. 9. Prior to receiving the call from Nurse Bramlett, he had not observed Mr. Miller personally in any form or fashion, nor had he reviewed his chart Riggs Dep., p.12.

According to Dr. Riggs, Nurse Bramlett falsely told him that Mr. Miller was alert times three. Riggs Dep., p.19. Nurse Bramlett denies making this statement to Dr. Riggs and has admitted that Mr. Miller was only alert times one. Bramlett Dep., p.73. Thus, much like Olivian Miller, Dr. Riggs has challenged the accuracy of Nurse Bramlett's testimony.

Also according to Dr. Riggs, Nurse Bramlett failed to tell him that she could not assure herself that he could understand her instruction not to get out bed. Dr. Riggs has testified that this concerns him because Mr. Miller had a head injury, had been identified as a fall risk and because

there had been a restraint protocol in place. Thus, according to Dr. Riggs, it was crucial for Nurse Bramlett to make sure that Mr. Miller could understand the instructions for him not to get out of bed without assistance if he was going to be left out of restraints. Riggs Dep., p.21.

Dr. Riggs has also testified that Nurse Bramlett did not disclose what medications Mr. Miller was on, or that he had a history of at least one fall within the last six months. She did not disclose that Mr. Miller had been in a posey vest earlier in the day or that he had a history in his chart of being agitated, attempting to remove his restraints, and expressing a desire to leave the hospital. She also did not disclose that he was only oriented times one and that she had not performed a fall risk assessment. Dr. Riggs has testified that if Nurse Bramlett had disclosed these issues, Dr. Riggs would not have agreed to issue a discontinuation of the restraint order until he had a chance to personally observe the patient. He also would not have allowed Nurse Bramlett to leave Mr. Miller's room until he got there. Riggs Dep., p.22-26. Nevertheless, based upon Nurse Bramlett's false and incomplete representations, Dr. Riggs agreed by phone to formally discontinue the restraint order and indicated that he would be there shortly to examine the patient.

It is also important to note that Mrs. Miller has testified that, although not instructed to do so, she did inform Nurse Bramlett that she was leaving to retrieve her personal items from ICU and that Nurse Bramlett saw her leave the room. This is consistent with the sworn testimony of both Nurse Skipper and Nurse Bramlett who testified that one sitting at the nurses station would be able to see anyone coming from or going into Mr. Miller's room and that, at no time, did either of them observe Ms. Miller leave the room after Paige Bramlett exited.

15. THE FATAL FALL

Nurse Bramlett has testified that she received Mr. Miller at 5:00 p.m. and that it took her five

minutes, if that, to do her assessment. She then left the room to make the call to Dr. Riggs. She estimates that she was out of the room for three minutes at the time that he fell. Bramlett Dep., p.43. She charted the fall at 5:10 p.m. Exhibit 22. She remembers being on the phone with someone at the time that she heard the fall but she does not believe that she was on the phone with Dr. Riggs. Bramlett Dep., p.43.

Nurse Bramlett has testified that Mr. Miller was not placed close to the nurses station on purpose but that it was just coincidence. Bramlett Dep., p.69. Nurse Bramlett has testified that she heard Mr. Miller fall because he fell up against the door. Bramlett Dep., p.45. She was at the nurses station at the time that she heard him fall. Bramlett Dep., p.46. She has admitted that anyone at the nurses station would have been in a position to see someone like Mrs. Miller enter or leave Mr. Miller's room. Bramlett Dep., p.49. She claims that she never saw anyone, including Mrs. Miller, leave the room. Bramlett Dep., p.105. The door was shut at the time that she heard him fall Bramlett Dep., p.68. Upon hearing the fall, she returned to Mr. Miller's room. She testified that when she pushed open the door, he was laying against it. Bramlett Dep., p.81.

Another witness that heard the fall was charge nurse Felicia Skipper. Nurse Skipper has testified that her first recollection of Mr. Miller was when she heard a loud thud. She was between 12 to 15 feet from his door at the time. The door was shut. She and Nurse Bramlett were both at the nurses station charting. Nobody else was at the nurses station. Skipper Dep., p. 12, 16.

When the two nurses heard the thud, they ran to the door and had to push the door open. Skipper Dep., p. 22. Mr. Miller had slid down against the door. He was facing the window sitting up. He was awake. She does not recall him talking. The two nurses got him back to bed and called for help. Skipper Dep., p.23. Within 2 minutes of finding Mr. Miller on the floor, he was losing

consciousness. Skipper Dep., p.29.

16. NURSE PAIGE BRAMLETT'S DRUG ADDICTION AND COMPETENCY ISSUES

UAMS' defense in this matter depends solely upon its argument that Nurse Bramlett exercised sound nursing judgment in deciding to leave Mr. Miller out of restraints, to abandon a fall risk assessment before completion, and to ignore fall risk prevention measures, and that she is being truthful when she claims that she instructed Mrs. Miller to let her know if she left Mr. Miller's room. During the course of this litigation, it has been discovered that Nurse Bramlett was severely addicted to narcotics at the time of her encounter with Mr. Miller and that she was obtaining the narcotics by stealing syringes from the hospital and by stealing other drugs from her husband and his mother.

Paige Bramlett's drug addiction and abuse during the relevant time period is now well known and established by the evidence. Claimant is providing herewith a written report from Dr. Susan M. Skolly-Danziger on this issue. Dr. Skolly's report is an exhaustive examination of Paige Bramlett's history of drug abuse, addiction and dependency. Exhibit 72. Thus, the analysis contained herein is only a summary of the evidence of Paige Bramlett's drug addiction and abuse history.

At the time she was hired, Paige Bramlett signed a UAMS Employee Drug-Free Awareness Statement where she acknowledged and agreed that **any employee who abuses drugs on the job poses an imminent danger to patients**. Exhibit 37. Obviously, drug abuse impairs nursing judgment. She was encouraged that if she ever recognized her own diseased state of addiction to seek the assistance from the UAMS Employee Assistance Program. As described below, Nurse Bramlett became addicted to narcotics in 2008 but did not admit her addiction to UAMS until she was caught stealing patients' medication in 2010.

UAMS claims that it did not learn of Nurse Bramlett's drug addiction and diversion until

2010 when Nurse Bramlett's supervisor, Betty Casali, received a call from the night shift nurse (Dana Philips) who was concerned that Nurse Bramlett had checked out an unusually large amount of Dilaudid[4] syringes one weekend in November of 2010. She also reported that she had exhibited unusual behavior (repeating sentences several times). Casali Dep., pp. 8, 9. This led to an investigation at UAMS where it was confirmed that Nurse Bramlett had been stealing an enormous amount of Morphine and Dialudid syringes from the hospital.

On November 19, 2010, Nurse Bramlett was confronted with her drug use and theft and admitted to having a serious drug addiction problem. Casali Dep., pp. 11-16. Nurse Bramlett then completed a handwritten statement about her drug use. Exhibit 44. This statement is filled with false representations by Nurse Bramlett as to the extent of her addiction. In her statement, she falsely stated that she had only begun taking narcotics 5 or 6 months earlier. She did admit that her addiction had rapidly progressed to the point that she was taking injections of both morphine and dialudid.

On that same day, Candace Connors of UAMS filed a complaint against Nurse Bramlett with the Arkansas State Board of Nursing. Exhibit 38 and Exhibit 84. Included in the Complaint was Nurse Bramlett's statement. Ms. Bramlett's use of narcotics had also been corroborated through an investigation of her narcotic overrides, Pyxis utilization and wasting of controlled substances. The Complaint also established that Nurse Bramlett had acknowledged her drug addiction when confronted.

Nurse Bramlett then entered into substance abuse treatment at The Bridgeway rehabilitation center. Exhibit 43. She was diagnosed with Opiate Dependency and Substance Induced Depressive

[4] Dilaudid is a very powerful narcotic and is five times more powerful than Morphine.

Disorder. She was admitted and placed on opiate detoxification orders and enrolled in a program of individual and group psychotherapy and introduced to a 12-step program of recovery.

During this time period, on December 3, 2010, Nurse Bramlett authored a revised statement to the Arkansas State Nursing Board as part of an official Nursing Board inquiry. Exhibit 45. She stated that she began working the weekend option shift at UAMS in February of 2008. At that point, she became very depressed and isolated. In early 2009, she began taking un-prescribed hydrocodone that she would obtain from her friends and family. She became almost immediately addicted and began suffering the side effects of drug abuse such as inability to concentrate, weight loss and other withdrawal symptoms. Nurse Bramlett lied to the Arkansas State Nursing Board about her drug use and diversion during its investigation. She did not admit that her addiction dated back to 2008 or earlier and she did not admit that her diversion dated back to 2009.

During her time at Bridgeway, Nurse Bramlett stated that "she used whatever she can get." She admitted to using IV Dilaudid, IV Morphine, Demerol, oxycodone and hydrocodone. She stated she had been using on a daily basis. She admitted that she had used pain medication prior to admission for 2 years (i.e. since 2008). She reported repeated and unsuccessful attempts to quit. She stated that she supported her addiction by stealing drugs from family members and her workplace. She also admitted to "using intravenous methamphetamine for just under a year." Exhibit 46. There is no medical use for IV Methamphetamine. This is simply "street meth." During detoxification, she suffered diarrhea, vomiting, cramps and headache.

In a Consent Agreement with the State Board, Nurse Bramlett ultimately admitted to addiction to opioids since 2009. Nurse Bramlett was discharged from inpatient detoxification with prescriptions for an antidepressant and a medication that blocks euphoria from opioids and prevents

relapse. Nurse Bramlett was fined $1,700 as a civil penalty. The Arkansas State Board of Nursing agreed to allow Nurse Bramlett to practice nursing, on probation, subject to several conditions. Exhibit 49. She was to complete a drug addiction program, be subjected to drug testing, and remain drug free. Medical records indicate that Nurse Bramlett began using narcotics almost immediately after her discharge from Bridgeway, and, in fact, has now been terminated by UAMS for repeated drug diversion.[5]

During the course of this claim, UAMS initially argued that Nurse Bramlett's drug abuse and addiction was after the incident giving rise to this claim. However, Claimant has uncovered a wealth of evidence to demonstrate that Nurse Bramlett was addicted to, and abusing, opioids in April of 2009.

During this claim, the claimant has obtained Nurse Bramlett's medication history from Walgreens pharmacy. Exhibit 47. This demonstrates narcotic use back to March of 2007 and opioid use back to April of 2007. In fact, shortly before Mr. Miller's fatal accident, Nurse Bramlett had been prescribed hydrocodone, Tussionex suspension, clonazepam, Alprazolam, and Meritab. This does not include the drugs that she was stealing from UAMS and her family at the time.

In early 2009, Nurse Bramlett's husband, Doug Bramlett, discovered that she had taken 75 pills of his Hydrocodones (10mg Vicodin) in a very short period of time. Doug Bramlett Dep., p.10-11. He then required her to seek the assistance of a psychiatrist in March of 2009. Exhibit 55. On April 21, 2009, Nurse Bramlett admitted to her psychiatrist that she had been abusing opiates for the past six months, or in other words, well before Rodney Miller's fall.

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[5] It is unclear at this point whether UAMS has reported Nurse Bramlett's most recent drug diversion to the State Nursing Board.

Thereafter, on June 1, 2009, Nurse Bramlett sought treatment for her addiction from Dr. Regina Foley. Exhibit 50. Remarkably, even though UAMS did not report Nurse Bramlett to the Nursing Board until November of 2010, Doug Bramlett testified that it was another UAMS nurse who had recommended Dr. Foley to his wife in 2009 for drug addiction treatment. Doug Bramlett Dep., p.14. Nurse Bramlett reported to Dr. Foley that her drugs of choice were intravenous Morphine, and Dilaudid; oxycodone and vicodin. Paige Bramlett confided in Dr. Foley that her addiction had been going on for one year (June 2008) and that she had started recreationally but had worked her way up to "12-13/day." In addition to the pills, Bramlett admitted to IV drug use on her first visit with Dr. Foley. Exhibit 50, Foley 38. She admitted going thorough withdrawal symptoms and that she had been unable to quit on her own. Not surprisingly, Nurse Bramlett specifically admitted that her drug/withdrawal symptoms included difficulty concentrating. Exhibit 50, Foley 38.

Dr. Foley started her on suboxone to prevent opioid/narcotic withdrawal and in an attempt to discontinue the practice of abusing opioids. She was also prescribed Ativan. During this time, Nurse Bramlett continued to secretly obtain Alprazolam and hydrocodone from other physicians.

Dr. Foley has given a deposition in this case. In her deposition, Dr. Foley has testified that Nurse Bramlett lied to her upon intake and told her that she was a stay at home mom. She did not tell her that she was a working nurse. However, later in the treatment, Dr. Foley discovered that she was working as a nurse. Foley Dep., p.7. At that time, Dr. Foley told her she could not be a working nurse with her addiction/dependency. Foley Dep., p.30. She also told her she should not work as a nurse while taking Suboxone. Foley Dep., p.38. She also told her that she needed to contact the nursing board. Dr. Foley has also testified that if she had known about Nurse Bramlett's other

narcotic use, she would have requested that she report herself to the nursing board or Dr. Foley would have reported her. Foley Dep., p.42. She would have set limits on how much time she had to do so, and if not, Dr. Foley would have done it for her. Foley Dep., p.42. This is consistent with a letter written to Nurse Bramlett from the State Nursing Board instructing her that if she had been prescribed Suboxone, then she needed to surrender her license. Exhibit 49, Bramlett Nursing Board File 022.

Dr. Foley explained that suboxone is a opioid antagonist/agonist, and that it is a combination medication that treats withdrawal symptoms and patients can successfully come off controlled substances using Suboxone as a replacement therapy. It is prescribed for opiate dependance. Dr. Foley determined the first time she saw her on June 1, 2009 that she was opiate dependent. Dr. Foley testified that, based on her chart and the information Bramlett provided, the drug abuse began in June of 2008. Foley Dep., p.12.

Dr. Foley testified that she was not aware that Nurse Bramlett was having other prescriptions filled at the time that she was prescribing suboxone. She testified that she would not have prescribed her Suboxone if she had known that. Foley Dep., p.14. She acknowledged that suboxone can be abused and that it has the potential to impair judgment. Foley Dep., p.15.

Dr. Foley told Nurse Bramlett that she needed to admit she was an addict. She also told her that she needed a therapist and to do a 12-step program. However, Nurse Bramlett never did these things. Dr. Foley also testified that, on one occasion during her course of treatment, Nurse Bramlett tested positive for marijuana. Foley Dep., p.20.

Thus, although Nurse Bramlett's drug abuse and addiction were not discovered in 2010, it is now well documented that she was extremely addicted to narcotics at the time of her encounter

with Mr. Miller. Remarkably, the Wallgreen records reflect that she continued to call in prescriptions of hydrocodone for herself after her treatment with Bridgeway. Exhibit 47. Moreover, Doug Bramlett has testified that she has recently been fired by UAMS for diverting more drugs. Doug Bramlett Dep., p.28.

Due to the above-described pattern of drug addiction and abuse, Claimant has hired an expert toxicologist to provide her opinions in this matter. Exhibit 72. As the commission will see, Dr. Skolly has established that impairment from a controlled substance can occur either from the intoxicating side effects of the substance itself or from the negative effects on the body when a tolerant individual skips either medication or takes less drug than what is needed to maintain homeostasis. Common side effects in opioid withdrawal are body aches, diarrhea, irritability, headache, cramps, vomiting, chills, nausea, tremors, loss of appetite, night sweats and fatigue.

Dr. Skolly has also established that these symptoms, particularly in a nurse, would affect the ability to concentrate and perform one's duties and responsibilities in a meaningful and diligent manner. Bramlett herself identified the inability to concentrate as a side effect of her drug use. Exhibit 50, Foley 38. Thus, it is Dr. Skolly's opinion that, at the time of her encounter with Mr. Rodney Miller on April 5, 2009, Paige Bramlett was addicted and dependent upon opioids and was impaired by either the use of a combination of benzodiazepines or due to experiencing withdrawal symptoms from not being able to maintain a stabilizing dose of opioid medications.

Nurse Bramlett's drug addiction and diversion violates the Arkansas Nurses Act. This Act prohibits Nurses from providing medical care while actively taking or dependent upon narcotics. Nurse Bramlett's diversion of medication constitutes unprofessional conduct under Arkansas Code § 17-87-309. Nurse Bramlett's addiction to the use of habit forming drugs, specifically including

narcotics, and her use of suboxone also violates Arkansas Code § 17-87-309. Moreover, Nurse Bramlett was unfit and incompetent to be a licensed nurse in Arkansas by reason of negligence, habits, and other causes pursuant to Arkansas Code § 17-87-309.

Paige Bramlett's drug addiction has also revealed that, during the time of her addiction, she was more than capable of lying to her employer, her family and her physicians and was capable of stealing from her employer and her family. The commission should take these facts into consideration when it evaluates Nurse Bramlett's attempts to blame Mrs. Miller for the death of Mr. Miller that resulted from injuries received while under Nurse Bramlett's care.

17. THE FALSE TESTIMONY OF NURSE BRAMLETT'S ASSISTANT

Paige Bramlett's testimony is inconsistent with Nurse Childers, Dr. Riggs, Felicia Skipper and Olivian Miller, each of whom have specifically testified that portions of the sworn testimony of Paige Bramlett are false. Paige Bramlett has also stolen from her employer, falsified medical records to conceal her theft, submitted false statements to both her employer and the State Nursing Board during the formal investigation and stolen from and lied to her family. Ms. Bramlett simply is not a credible witness. UAMS has attempted to bolster the testimony of Nurse Bramlett through the testimony of her former assistant. This testimony has also proven to be false and to lack credibility.

The 24 Hour Patient Flow Sheet for 4/5/09 demonstrates that Paige Bramlett's nursing assistant was named Sarah Meyers. Exhibit 30. Sara Meyers is now named Sara Cingolani and she has given a deposition in this matter.

In the summer of 2012, Nurse Meyers spoke with the UAMS Risk Manager. Exhibit 29. At first, she did not remember anything about this patient. However, after speaking with the risk manager, she claimed to rememberehim. In her initial response to UAMS' inquiry, she stated that

she was in another patient's room when the Mr. Miller fell and that she did not go and help. Exhibit 29. This statement directly conflicts with the deposition testimony offered last month.

In her deposition, she testified that she was at the nurses station and that she heard Mr. Miller fall and that she assisted after the fall. During her deposition, Nurse Cingolani testified that she had met with the UAMS attorneys the previous day and that they had told her about Nurse Bramlett's addiction problem at the time of the fall. Nurse Cingolani also stated that she already knew about Nurse Bramlett's addiction problem prior to them telling her. Cingolani Dep., p.12. She also acknowledged that she has remained being facebook friends with Paige Bramlett following her move to North Carolina. Cingolani Dep., p.13.

Although Nurse Bramlett is her friend, she testified that if she knew a nurse was giving herself IV morphine and IV Dilaudid or taking ten to thirteen Vicodin or opiates a day, she would not want Bramlett to provide her care. Cingolani Dep., p.44. She also agreed with the Drug-Free Awareness statement where it says, "As a health care institution employees who abuse drugs on the job are an imminent danger to patients, visitors, and others we serve." Cingolani Dep., p.45.

In her deposition, Ms. Cingolani claimed that she was present when Mr. Miller was transported from ICU and that she witnessed Paige Bramlett and Felicia Skipper put him in the bed. Cingolani Dep., p.16. This is inconsistent with Paige Bramlett's testimony that she was the only person who assisted Mr. Miller from the wheelchair to the bed upon arrival. Bramlett Dep., p.59.

Ms. Cingolani has also attempted to testify that she heard Mr. Miller acknowledge that he knew where he was (which would have made him alert to place). Cingolani Dep., p.20. This is inconsistent with Nurse Bramlett's testimony and focus note entry that he was only alert to self and was not alert to place or time.

Ms. Cingolani also attempted to testify that she now remembers Nurse Bramlett telling Mr. Miller's wife that if she wants to leave the room, to either come to the desk or call before she left to let someone know. Cingolani Dep., p. 25. When asked by Respondent's attorney how she had such a vivid recollection of this conversation, she tied her memory very specifically to remembering being at the nurses desk, hearing Mr. Miller fall, and running to help him. Cingolani Dep., p.35. She testified that being at the nurse's station and hearing the thud made this whole event stick out in her mind including conversations with Ms. Miller. She testified that she, Felicia and Paige were all at the nurse's station. Cingolani Dep., p.41. She testified that the thud she heard from the nurse's station is what stood out in her mind about that day and was the cornerstone for the rest of her recall.

In a scene that cannot be adequately described without a videotape of the deposition, Ms. Cingolani was presented with the notes from her conversation with the UAMS Risk Manager the previous summer (Exhibit 29). At that time, Ms. Cingolani reluctantly admitted that she had in fact previously reported an entirely different story to the risk manager. Specifically, she had previously reported that she had been in another patient's room at the time of the fall and that she did not go to help. Cingolani Dep., p.41. It was Nurse Cingolani who tied her memory of the alleged conversation between Mrs. Miller and Nurse Bramlett to these other events. Thus, her entire alleged memory of this conversation is tied to her false claims of having been present at the nurses desk, having heard Mr. Miller fall, and running to help. The commission should disregard this testimony as someone who really has no memory of these events and who is merely trying to help her friend. Additionally, Felicia Skipper has testified that she and Paige Bramlett were the only two at the nurses desk at the time that they heard the fall. Neither Nurse Bramlett or Nurse Skipper remember Ms. Cingolani being present during that time.

18. RODNEY MILLER'S DEATH.

After the fall, Mr. Miller was returned to ICU. The doctors explained to Mrs. Miller that they would have to do surgery due to a blood clot. Mrs. Miller told the doctors to do whatever they had to do to help her husband. Miller Dep., p. 70. After the surgery, the doctor explained that he had left two parts of the skull off because there was a lot of swelling. Mrs. Miller testified that she knew he was not getting better and that his head was just swelling more and more. At some point, they drilled a hole in the top of his head to relieve the pressure. Miller Dep., p. 72. For six agonizing days, the Miller family had to watch their loved one deteriorate. As a direct result of the fall, Mr. Miller had gone from a patient with a prognosis for a full recovery to a man fighting desperately for his life.

The doctors explained to Mrs. Miller that all they could do was put in a feeding tube and send him to a nursing home. Mrs. Miller was concerned that she would be required to make the decision to take him off of the machines that were keeping him alive. Miller Dep., p. 73. She did not have to make that call because his body shut down on its own. Miller Dep., p. 74.

The parties have stipulated to the following facts:

> **As a result of the fall, Mr. Miller suffered from a new subdural hematoma with significant midline shift. Mr. Miller underwent a crainectomy and later suffered cerebral swelling, with herniation. Mr. Miller's condition continued to deteriorate, and he died on April 11, 2009.**
>
> **Rodney Miller's death was proximately caused by the injuries he sustained in the fall on April 5, 2009.**

Prior to the fall on April 5, 2009, Rodney Miller was expected to make a full recovery. The Stipulation is submitted herewith as Exhibit 76. Mr. Miller died on April 11, 2009, two days after his fortieth birthday. Mr. Miller's Death Certificate is submitted as Exhibit 75.

19. CLAIMANT'S DAMAGES.

Should the Commission find in favor of the Claimant, the damages to be rewarded are set forth in Arkansas Model Jury Instruction 2216 entitled "Measure of Damages-Wrongful Death-Cause of Action." The damages to be awarded are:

(A) Pecuniary injuries' consisting of the present value of benefits, including money, goods or services that Mr. Miller would have contributed to his wife, children and statutory beneficiaries had he lived;

(B) Mental anguish suffered and reasonably probable to be suffered in the future by Mr. Miller's wife, children and statutory beneficiaries;

(C) The loss of consortium, including society, services, companionship and marriage relationship of Mrs. Miller;

(D) Reasonable value of funeral expenses;

(E) Conscious pain and suffering of Mr. Miller prior to his death;

(F) Medical expenses attributable to fatal injury;

(G) The value of any salary lost by Mr. Miller prior to his death;

(H) The scars and disfigurement as a result of injuries received by the decedent prior to his death; and

(I) Mr. Miller's loss of life.

A proposed Verdict form is attached hereto as Attachment 1.

According to Arkansas law, damages awarded for items A through D go directly to the specific beneficiaries and elements awarded under sections E through I are awarded to Mr. Miller's probate estate to be divided and disbursed as appropriately directed by the Probate Court. See

Exhibit 101, AMI 2216.

In its internal reporting, UAMS has evaluated this claim as a severity scale of "A" which means UAMS has evaluated the claim to be worth in excess of $1 million. Exhibit 56. Olivian Miller, individually, and as personal representative of the Estate of Rodney Miller, deceased, is seeking $3.5 million in damages from the State of Arkansas, University of Arkansas For Medical Sciences, as compensation to the heirs and the beneficiaries at law of Rodney Miller, for funeral expenses, for loss value of life, conscious pain and suffering of the deceased prior to his death, for medical expenses attributable to the fatal injury, for the present value of the lost of earnings capacity in the future for the deceased, for the loss of future services to be rendered by Rodney Miller, and for mental anguish sustained by the surviving beneficiaries of the Estate of Rodney Miller as well as all other damages allowed by law.

Rodney was an outgoing, loveable person. He never met a stranger. He was very affectionate. He was competitive when it came to sports, fishing and deer hunting. He was an outdoorsman. Miller Dep., p. 13. He loved fishing with his son. Miller Dep., p. 14. He married Olivian Miller in 2003. They had their ups and downs but they had a great relationship for the most part. Miller Dep., p.15. It is anticipated that the Respondent may argue that Mr. Miller's life did not hold value because he had underwent rehabilitation for drug use in the past. However, such personal attacks have no relevance to the fatal fall that Mr. Miller suffered while under the care of UAMS and also are not relevant to the loss suffered by Mr. Miller and his family.

Rodney worked at Calion Lumbar Company. Miller Dep., p. 16. He was a hoist operator. He stacked the pallets. He normally worked a 40-hour work week. Miller Dep., p.17. He made $13.05 an hour. He also received bonuses twice a year around June and Christmas bonuses that was

in excess of $1,000. Miller Dep., p.18. Mrs. Miller also worked and shared in the family expenses. Miller Dep., p. 19.

He was a big Laker's fan. In fact, while he was in a coma, his son asked Olivian to tell him that Kobe Bryant had gotten hurt and that the Laker's probably would not make the playoffs. He thought that would wake his father up. Miller Dep., p. 45, 46.

At the time of his death, Mr. Miller had a very large and a very loving family. Relevant photographs are submitted herewith as Exhibit 88. He was married to Olivian Miller. They had two children that were born of their marriage (Keenan - 15 and Maya - 12). Mikaela Garrett (16) is Mrs. Miller's daughter from a previous relationship. She was not even a year old when Olivian and Rodney began dating. She called him father and he acted as a father figure to her. Miller Dep., p. 6.[6] Rodney miller also had two other adult daughters from other relationships named Aviva Thomas and Shacoria Smith. Mr. Miller is also survived by his father, Ray Miller, his three sisters (Carol Bell; Carolyn Williams; Marcia Miller); and his three brothers (Stanley Miller, Fred Miller, Don Avery).

Mrs. Miller testified to some of her suffering during her deposition. She testified that she has spoken a lot with her pastor and engaged in a lot of prayer. She has had to move to Milwaukee to find work and is struggling as a single parent with three children. Miller Dep., p. 79.

Mrs. Miller testified it is very difficult to raise her son without a father. She testified that she cannot teach him to be a man. For example, last Easter, she had to help him learn to tie a tie with the help of the Internet. It is also difficult on her daughters who miss him everyday. Miller Dep.,

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[6] Mikaela is a person with respect to whom Mr. Miller stood in loco parentis, and, as such, is a proper wrongful death beneficiary pursuant to Ark. Code Ann. Section 16-62-102(d)(3). See Exhibit 87.

p. 80-81. Mrs. Miller said it is also difficult because Mr. Miller is not around to help counsel and discipline the children. Miller Dep., p. 82.

Mr. Miller's sister, Carol Bell, has also given a deposition in this matter. She testified that their family was very tight. Ms. Bell testified that because she is ten years older than him, he saw her as a big sister/mama. Bell Dep., p.28. She testified that Mr. Miller was a nice person who was always smiling and hugging. He was full of life, and he loved fishing and hunting and basketball. Bell Dep., p.34.

Claimant anticipates that Rodney Miller's family will be present at the hearing to testify if the Commission would like to hear from each of them as time allows. Additionally, Exhibits 89-95 contain sworn affidavits of Mr. Miller's family that provide some of the details of the loss and suffering they have experienced due to Mr. Miller's death.

Additionally, Claimant has engaged economist Dr. Ralph Scott to provide expert testimony related to the economic damage suffered as a result of the death of Rodney Miller and, where required by law, to reduce those numbers to present value. Dr. Scott's Report is submitted herewith as Exhibit 80. Dr. Scott will be available to testify at the hearing. Respondent's attorneys have chosen not to take Dr. Scott's deposition.

Dr. Scott first established Mr. Miller's average income, using an inflation adjustment, over the periods of 2004 and 2008 as documented by tax returns. Dr. Scott determined that Mr. Miller's average base line income for this time period equates to $31,191.65 per year. Dr. Scott completed his report April 30, 2012. This resulted in a past lost income of $92,830.70. Based upon statistical studies, Dr. Scott ran two retirement scenarios for Rodney Miller. Scenario (1) would assume retirement age of approximately sixty years. Scenario (2) assumes retirement at approximately sixty-

eight years of age. Using these two retirement scenarios, scenario 1 resulted in a loss of future income amounting to $424,221.19, with scenario 2 resulting in a loss of $556,310.00. Past lost wages are added, the total loss of income, reduced to present value where appropriate, is $517,051.90 assuming retirement at age sixty or $649,140.80 assuming retirement at age sixty-eight. See Exhibit 80, table one.

Dr. Scott also calculated the loss of household services. Dr. Scott's opinion is based on sound economic principals using accepted methods and data. To approach these calculations, Dr. Scott has used fifteen hours per week as the time spent by Rodney Miller providing services to his family such as household upkeep, maintenance, yard activity, etc. During Mr. Miller's life expectancy and the average expense of replacement services, Dr. Scott has projected these losses to amount to $26,233.96 for past and $182,700.96 future household services, totaling $208,934.92.

Arkansas law requires that in the case of a wrongful death, the fact finder **shall** award damages for the loss value of life. Obviously, placing a value on a human life is a very difficult endeavor. Thus, the Courts have recognized and accepted economic principals to use as guidelines in establishing the value of someone's life in the event of a wrongful death. In internal correspondence, Respondent's attorney has conceded that good trial judges have allowed this type of evidence to be considered by Arkansas juries in rendering loss of life damage awards. See Exhibit 59. As explained in Dr. Scott's report, economists often used the "human capital" concept as a guideline to be used in quantifying the value of human life. This concept is construed by economists as yielding a **"minimum"** measure of a value of a life because it focuses exclusively on lifetime earnings and ignores many aspects of the "enjoyment of life" analysis. Dr. Scott will testify at the hearing that the loss of Mr. Miller's life would be worth at least $517,051.90 to $649,140.80 based

solely upon the human capital methodology. Again, losses associated with the loss of enjoyment of life should be construed in addition to this amount in order to arrive in a more accurate evaluation of the loss of life suffered by Mr. Miller. For comparative purposes, Dr. Scott has calculated projections using a $50,000.00 per year and a $100,000.00 per year award for the loss of enjoyment of life. Dr. Scott's calculations are summarized on table 5 "summary of economic loss", (assuming a $50,000.00 per year loss of enjoyment of life) and table 6, (assuming $100,000.00 loss of enjoyment of life) for a total range of $2.4 million to $4.2 million.

It should be noted that Dr. Scott's numbers do not account for mental anguish, pain and suffering suffered by Rodney Miller prior to his death or mental anguish suffered by his family members, the loss of consortium suffered by Mrs. Miller or the loss of instruction, training and supervision given to his children. Likewise, Dr. Scott's opinion does not take into account the funeral expenses or and medical expenses.

20. EXPERT ISSUES

Both parties anticipate calling a nursing expert to testify at the hearing. The parties have deposed these two experts and have agreed, with previous permission from the Commission, to submit information on these two experts under separate cover when their transcripts have been received.

However, it is timely to mention at this point that UAMS has also produced evidence in response to a Freedom of Information Act request, that it previously hired and consulted two other nursing experts. These nursing experts, for the most part, agree with Claimant and are highly critical of the care received by Rodney Miller while a patient at UAMS. In fact, defense counsel candidly admitted in internal correspondence that he would try a third expert and that if he "struck out" there

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as well, it was time for UAMS to cut their losses. Exhibit 65. Not surprisingly, UAMS will not be offering testimony from these two consulting experts at the hearing.

The first nursing consultant hired by UAMS to evaluate the case was Mary Watson. Exhibit 60. Nurse Watson's curriculum vitae is provided as Exhibit 98. She is an Advanced Practice Nurse. Her current position is Falls Nurse/Patient Safety Practitioner for Central Arkansas Veterans Health Care System in Little Rock and North Little Rock.

Nurse Watson indicated that she believes that Mr. Miller should have been transferred to a step down unit and not to a general floor. Also that Nurse Bramlett did a poor assessment and relied too much on the indirect report from ICU. She also believes that Nurse Bramlett was relying too much on Mr. Miller's wife. She should have spent more time with her patient and made sure the precautions were in place. Nurse Watson also believed that all four side rails should have been up to prevent falls. She also should have placed floor mats by the bed and should have had a bed alarm in place.

The second nursing expert paid by UAMS to review the case was Janice Hutchinson. Exhibit 61. Nurse Hutchinson's experience included working as a nurse at St. Vincent in Little Rock. Exhibit 99. Nurse Hutchinson indicated that the restraints should not have been discontinued. Nurse Hutchinson indicated that a nurse cannot do an adequate assessment in five minutes. She concluded that Nurse Bramlett has an "indefensible position" and that she did not have adequate time to do an assessment of Mr. Miller or his wife. She testified that an assessment should take thirty minutes.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I, Chris A. Averitt, do hereby certify that a copy of the foregoing pleading has been served on Respondent herein by providing an electronic copy via hand deliver this 19th day of August 2013 to Respondent's Counsel:

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_____
Chris A. Averitt

ATTACHMENT 1 - RODNEY MILLER PROPOSED VERDICT FORM

LOSSES SUFFERED BY EACH STATUTORY BENEFICIARY

Olivian Miller $_____

Keenan Miller $_____

Maya Miller $_____

Mikaela Garrett $_____

Aviva Thomas $_____

Shacoria Smith $_____

Ray Miller $_____

Carol Bell $_____

Carolyn Williams $_____

Marcia Miller $_____

Stanley Miller $_____

Fred Miller $_____

Don Avery $_____

REASONABLE VALUE OF FUNERAL EXPENSES $_____

CONSCIOUS PAIN AND SUFFERING PRIOR TO DEATH $_____

MEDICAL EXPENSES ATTRIBUTABLE TO THE FATAL INJURY $_____

VALUE OF SALARY LOST BY RODNEY MILLER PRIOR TO DEATH $_____

SCARS AND DISFIGUREMENT AS RESULT OF INJURIES $_____

VALUE OF RODNEY MILLER'S LOSS OF LIFE $_____

TOTAL: $_____

DEPOSITION SUMMARY INDEX

1. Laura Bailey
2. Carol Bell
3. Doug Bramlett
4. Paige Bramlett
5. Betty Casali
6. Mikal Childress
7. Sara Cingolani
8. Candace Connors
9. Christina Davis
10 Dr. Regina Foley
11. Dr. Muhammad Jaffer
12. Olivian Miller
13. Dr. David Riggs
14. Felicia Skipper

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

OLIVIAN MILLER, ADMINISTRATRIX
OF THE ESTATE OF RODNEY MILLER — CLAIMANT

VS. — No. 11-0617-CC

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES — RESPONDENT

CLAIMANT'S SUPPLEMENTAL PRE-HEARING BRIEF REGARDING EXPERT TESTIMONY FROM NURSE DORIS STEVENS AND MICHELLE MCFAIL

Claimant intends to call Nurse Doris Stevens as an expert witness at the hearing. Respondent intends to call nurse Michelle McFail as an expert witness at the hearing. The Commission previously ruled that the parties could supplement their pre-hearing submissions to include the depositions and summaries for these two nursing experts. The Claimant hereby submits the following supplemental brief relating to the expected testimony of these two witnesses, along with their depositions and summaries.

1. **Nurse Michelle McFail**

UAMS intends to call Michelle McFail as its only expert on the standard of care issues in this matter. Nurse McFail is an RN certified only in Obstetrics. She is currently in an administrative position at Baptist Health. All of her nursing experience has either been as a nurse in the labor and delivery/nursery portions of the hospital or in her current administrative position. McFail Dep., p. 25. She has never been a nurse assigned to the general population of a hospital or to the ICU. She also has never treated patients suffering from head trauma. She was not practicing in Arkansas at the time of Mr. Miller's fall and has only been in Arkansas since 2010. Since 2010, she only spent 2-3 months in a floor nurse position before moving into an administrative position. She admitted she had done no research to determine what policies or procedures were in place in other hospitals

in Arkansas. McFail Dep., p. 95.

Nurse McFail has testified that the area that she will be offering opinion testimony in this claim only relates to restraints. Nurse McFail testified that she reviews restraint decisions at Baptist. However, she does not evaluate patients, perform fall risk assessments, or perform restraints assessments herself. Nevertheless, she intends to offer her opinion that Nurse Childress did not violate the standard of care by removing the restraints from Rodney Miller in the ICU and that Nurse Bramlett did not violate the standard of care in deciding to leave Mr. Miller out of restraints when he arrived at the general floor.

Despite these opinions, Nurse McFail has acknowledged that Nurse Childress had concluded that Mr. Miller was a significant fall risk and needed to be constantly observed at the time of transfer. She also admits that Mr. Miller had been telling people that he had been kidnaped and that he wanted to go home. She also admits that the most important instruction that Paige Bramlett gave to Rodney Miller was not to get up and that Paige Bramlett was not sure if he was able to understand this instruction. McFail Dep., p. 104.

Nurse McFail admitted in her deposition that she had not been provided by defense counsel several pieces of relevant evidence. UAMS had concealed from her the two previous adverse opinions from other Little Rock Nurses. McFail Dep., p. 101. UAMS also did not provide her with key witness statements given immediately after the fall that conflicted with the foundation of her opinions. McFail Dep., pp. 106-108. For example, in forming her opinion that Mr. Miller did not need to be in restraints, Nurse McFail assumed/concluded that Mr. Miller was able to understand and follow commands at the time that he was left alone by Paige Bramlett. McFail Dep., p.103. Remarkably, Nurse McFail was not provided Paige Bramlett's April 21, 2009 statement to the

UAMS Risk Manager. In her statement, Nurse Bramlett admitted that Miller's balance was very unsteady, that he was unbalanced, and that he responded to her instruction to not get out of bed by telling her repeatedly "I've got to get out of the hospital." Nurse Bramlett also admitted in her statement that she knows that head injury patients do not remember what you tell them and that she was very aware that they need to be closely monitored.

Nurse McFail has testified that the opinions she will offer at the hearing will be limited to the issue of restraints. She will not offer opinions as to what Mikal Childress should have done as an ICU nurse when she made the determination that Mr. Miller needed constant observation to alert someone else to that observation. She will not offer opinions that relate to the speciality of an ICU nurse. She will not offer any opinions with respect to any difference in an assessment that should be conducted with respect to a patient who has suffered head trauma. She will not offer opinions with respect to continuity of care. She will not offer opinions as to what is proper fall risk protocol or prevention. She will not offer opinions with respect to Paige Bramlett's drug use, addiction, or dependency. She will not offer opinions as to whether it was or was not within the standard of care for Paige Bramlett to allegedly leave Olivian Miller responsible for observing Rodney Miller before completing the education process. She will not offer opinions as to whether bed alarms were feasible and available during this time period.

Nurse McFail will not offer opinions relating to the applicable standard for ensuring that there is a continuity of care for patients being transferred from ICU to a general floor. However, she did acknowledge that there were numerous protocols that had been put in place as part of Mr. Miller's plan of care that had never been discontinued, including the Protocol For The Management Of The Adult Patient Experiencing Alteration In Thought Processes and The Protocol For The

Management Of The Patient Requiring Restraint. She also acknowledged that these protocols require that any modifications, including a decision relating to restraints, must be documented in the nurse's focus notes and admitted that Nurse Childress did not document the restraints being removed in her focus notes. She also admitted that Nurse Childress' conclusion that Mr. Miller needed constant observation at the time of the transfer was not documented anywhere in the records. McFail Dep., p. 34-39.

Nurse McFail will not offer opinions relating to fall assessments or prevention protocols. In fact, she testified specifically: " I am not testifying on falls." McFail Dep., p. 87. However, she did admit that Paige Bramlett did not complete a full assessment of Rodney Miller and did not complete the fall risk assessment. She acknowledges that Nurse Bramlett left Mr. Miller alone before completing a fall risk assessment. McFail Dep., p. 32-33. She also admits that Paige Bramlett did not need to leave the room to call a doctor regarding her decision to leave Mr. Miller out of restraints. She also acknowledges that initial assessments often take as long a thirty minutes.

Nurse McFail also admits that the Center for Medicare and Medicaid Services (CMS) has mandated that hospitals reduce the number of hospital falls and that injuries suffered from falls in hospital settings are considered "never events" that should not happen and that hospitals must absorb all costs incurred when a patient is injured from a fall in a hospital. She understands that falls are considered never events because they have been determined to be reasonably preventable through application of evidence-based guidelines. She also agrees that fall risk prevention protocols and sound nursing judgment, when use in conjunction with each other, reduce the number of falls. She also admits that the Joint Commission requires hospitals to have fall prevention protocols that are effective at reducing the number of falls. McFail Dep., p. 83-87.

Nurse McFail will not offer any opinions relating to whether it was or was not within the standard of care for Paige Bramlett to allegedly leave Olivian Miller responsible for observing Rodney Miller before completing the education process. However, she is aware that UAMS had a policy with respect to educating family members who were going to serve as observers or sitters for patients and is also aware that Paige Bramlett did not complete all the steps of the process of the education of Olivian Miller before leaving the room that day. McFail Dep., p. 53. She is also aware that it was determined that Ms. Miller was not on the floor long enough to be educated. She also acknowledged that Ms. Miller has testified that she made Ms. Bramlett aware that she was leaving the room to retrieve her things and that the two walked out of the room at the same time.

Thus, Nurse McFail will not offer opinion testimony on many of the issues involved in this case but will limit her opinions to the issue of restraints.

2. Nurse Doris Stevens

The Claimant intends to call Nurse Doris Stevens as an expert witness in this matter. Nurse Stevens is a Registered Nurse who has worked as both a general floor nurse and an ICU nurse for thirty years in the State of Arkansas. She currently works in the Intensive Care Unit at St. Bernards Regional Medical Center in Jonesboro, Arkansas. She is familiar with the standard of care applicable to the nurses at UAMS including Nurse Childers and Nurse Bramlett. Nurse Stevens will testify, considering the totality of all of the circumstances and issues, that the nursing care provided to Rodney Miller by the staff at UAMS fell below the applicable standard of care and that these failures were the cause of Mr. Miller's unwitnessed fall.

Although defense counsel did not ask Nurse Stevens to specifically state all of her opinions during her deposition, he did ask her to verify that her opinions had been fairly summarized in

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Plaintiff's Supplemental Responses to UAMS' Expert Witness Interrogatories. As such, Nurse Stevens confirmed that she will provide the following opinions at the hearing in this matter:

That UAMS ICU nursing staff did not adequately chart Mr. Miller's treatment and condition;

That Nurse Childress violated written UAMS policy by removing restraints from Mr. Miller despite the existence of a order for restraints and without documenting the basis for their removal in the focus notes;

That Nurse Childress lack of charting and communication caused a breach in the continuity of care between the ICU and the general floor;

That Nurse Childress failed to communicate her conclusion that Mr. Miller needed constant observation at the time of transfer which led Mr. Miller to be transferred to a location in the hospital that would not provide adequate observation of the patient;

That UAMS ICU nursing staff failed to adequately communicate with the nursing staff on the general floor that received Mr. Miller when he was transferred out of ICU;

That, based upon Rodney Miller's condition as described in the medical records, he needed to be in restraints at the time of the accident;

That, regardless of the premature termination of the restraint order, Mr. Miller remained a high fall risk, yet a fall risk assessment was not completed by Nurse Bramlett, and UAMS fall risks safety protocols were not implemented by Nurse Bramlett;

That, given the fact that Mr. Miller was only alert times one and did not know where he was, that he was not unable to understand and follow instructions, that he was susceptible to suffering a fatal injury in the event of a fall, and that he had a history of confusion and combativeness, it was critical that Nurse Bramlett perform an adequate fall risk assessment during her initial assessment of Mr. Miller and to implement all available fall risk protocols;

That Nurse Bramlett's initial assessment of Rodney Miller fell below the applicable standard of care for a nurse providing nursing care to a patient such as Mr. Miller;

That, if Nurse Bramlett was not going to perform an adequate initial assessment of her patient, including completing an adequate fall risk assessment, then she should have placed Rodney Miller in restraints until such time as an adequate assessment could be performed;

That Nurse Bramlett should have initiated fall risk prevention measures such as the utilization of three of the four bed rails that were present on the bed being used by Rodney Miller. Additionally, if UAMS was not adequately staffed to provide adequate supervision

of its fall risk patients, UAMS should have provided additional fall risk prevention measures to its nurses such as bed alarms and fall mats. If adequate fall risk prevention measures were not available, then Nurse Bramlett should have used of restraints until such time as Mr. Miller could understand and appreciate her instructions not to get out bed without assistance;

That Nurse Bramlett's report to Dr. Riggs was inaccurate and incomplete, causing a breach in the continuity of care;

That Nurse Childress and Nurse Bramlett failed to provide Olivian Miller with sufficient information and/or education in order to be able to rely on Olivian Miller to serve a some type of substitute medical care provider;

That Nurse Bramlett should not have left Mr. Miller's room prior to completing her initial assessment in order to make a phone call to Dr. Riggs as she to testified to in her deposition;

That it fell below the standard of care for Paige Bramlett to have left Mr. Miller unrestrained and unattended in his condition and that she also could not delegate any of her nursing duties to Mr. Miller's family members;

That Paige Bramlett was unable to adequately perform her duties as a nurse while treating Mr. Miller given her extreme drug addiction and history of drug abuse during the time period of Mr. Miller's hospitalization;

That, as early as 2008, Nurse Bramlett had committed acts which, if reported to the State Nursing Board, would have subjected her to disciplinary action by the Arkansas State Board of Nursing including suspension or revocation of her license;

That Nurse Bramlett's diversion of medication constitutes unprofessional conduct;

That Nurse Bramlett's addiction to the use of habit forming drugs, specifically including narcotics, and her use of suboxone violate Arkansas law and the standard of care;

That, as of April 5, 2009, Nurse Bramlett was unfit and incompetent to be a licensed nurse in Arkansas by reason of negligence, habits, and other causes;

That the failure of Nurse Bramlett and other UAMS employees to comply with the applicable standard of nursing care led to Mr. Miller's unwitnessed fall while under UAMS's care.

Thus, unlike Nurse McFail, Nurse Stevens is prepared to offer her expert opinions on all of the issues involved in this case such as inadequate charting, the need for restraints, different levels

of care between ICU, a step down unit, and a floor unit; Nurse Bramlett's inadequate assessment; failure to adequately educate Mrs. Miller; and the impact of Nurse Bramlett's drug addiction and abuse. In a nurse malpractice matter, in determining the degree of skill and learning the law requires of the nurses, and in deciding whether the nurses applied the degree of skill and learning required, only the expert testimony from the qualified nursing experts may be considered. Likewise, in deciding whether the negligence of the nurses was a proximate cause of the injuries, only the expert testimony from the qualified nursing experts may be considered. AMI 1501. In this case, only Nurse Stevens will offer expert testimony as to the standard of care relating to the critical issues of continuity of care and falls (and the other issues identified above). Thus, her testimony relating to the standard of care and proximate cause in all of these issues (other than restraints) will be un-refuted at the hearing

Respondent's argument is both circular and self-defeating. Respondent argues that it was proper to leave Mr. Miller out of restraints but also argues that UAMS' fall prevention protocols would not have been effective to prevent Mr. Miller's fall. Nurse McFail seeks to support the decision to allow Mr. Miller to remain unrestrained despite the fact that she has no opinion relating to falls or fall prevention. As demonstrated below, this argument is circular because restraints cannot be removed from a patient unless and until it has been determined that the fall risk protocol will be effective to protect the patient from self harm. Thus, one cannot evaluate the restraint issue without evaluating the fall risk prevention issue. This argument is also self-defeating because, by arguing that the fall prevention protocol would not have been effective, UAMS is supporting the conclusion that Mr. Miller should have remained in restraints.

When someone such as Mr. Miller is placed in restraints for their own protection, the restraints are to be removed only when less restrictive methods are available and effective to ensure the patient's safety. In this case, the "less restrictive" method available was the UAMS fall prevention protocol. Until and unless the patient meets the criteria to ensure that the fall prevention protocol is an effective, less restrictive method to ensure his safety, the restraints should not be removed.

In determining the effectiveness of the fall prevention protocol, the totality of the patient's condition and circumstances must be considered. The question is not whether a single procedure, with certainty, would have prevented the fall (i.e. three raised bed rails v. two raised bed rails) but whether the fall risk protocol, when implemented, would be an effective measure to prevent harm to the patient once the restraints have been removed.

Respondent contends that because no one element of the fall prevention protocol can be identified as an absolute, certain, fail proof method of fall prevention, then there can be no criticism of the failure to implement the fall prevention protocol. Nurse Stevens' opinions are consistent with UAMS' own policies and procedures which require both that the patient demonstrates the ability to follow instructions and that alternative methods or least restrictive methods be successful. See UAMS Policy "Restraints and Seclusions" discontinuation criteria Section D(3) and (5), Respondents' Exhibit 27. Respondent's contention is actually consistent with Nurse Stevens' opinion and testimony that, if the fall prevention protocol cannot be relied upon as effective, Mr. Miller's restraints should not have been removed. Respondent's contention also ignores Nurse Stevens' opinions that you cannot take a single factor in insolation but, instead, must consider the totality of the patient's condition and physical environment.

It is Nurse Stevens' professional opinion that Respondent failed to adequately assess Mr. Miller as a fall risk and failed to implement a fall prevention protocol that would be effective to protect Mr. Miller from harm. Nurse Stevens will be the only expert testimony on these issues. Nurse Stevens has also opined that given the lack of an effective fall prevention protocol in Mr. Miller's plan of care, it was a breach of the standard of care to remove restraints. While Respondent attempts to offer the opinion of Nurse McFail in opposition, Nurse McFail candidly admits that she is not offering any opinions as to the adequacy, or lack thereof, of the fall risk assessment, or fall prevention protocol. Thus, Nurse McFail's opinion is offered in a vacuum and ignores UAMS' own restraint discontinuation criteria which requires the patient demonstrate ability to follow instructions and that alternative methods are successful.

Respectfully Submitted,

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By: _____
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CERTIFICATE OF SERVICE

I, Chris A. Averitt, do hereby certify that a copy of the foregoing pleading has been served on Respondent herein by providing an electronic copy via regular mail this 4th day of September, 2013 to Respondent's Counsel:

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Chris A. Averitt

BEFORE THE ARKANSAS CLAIMS COMMISSION

OLIVIAN MILLER, ADMINISTRATRIX
OF THE ESTATE OF RODNEY MILLER — CLAIMANT

VS. NO. 11-0617-CC

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES — RESPONDENT

PRE-HEARING BRIEF
OF UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

This is a medical malpractice case. On the afternoon of April 5, 2009, Rodney Miller got up out of his hospital bed on one of the general floors at University Hospital ("UAMS"), fell, and hit his head on the room's door. He subsequently died from the head trauma. The sole liability issues are whether one or more UAMS nurses breached the standard of care in their examination and treatment of Mr. Miller, and if so, whether this breach was the proximate cause of Mr. Miller's death.

The facts are relatively straight forward. On March 30, 2009, an intoxicated Mr. Miller lost control of his ATV and drove into a ditch near his Hampton home. The impact rendered him unconscious. He was initially treated at an El Dorado hospital, but because of the severity of his injuries, he was airlifted to UAMS where he was admitted to the ICU and treated for these injuries, which included a closed head injury.

Because he was intubated and placed on a ventilator, Mr. Miller was ordered by a physician to be placed in restraints early into his hospital stay. The order was renewed every 24 hours and after extubation of the tube, it remained in place

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through the morning of April 5, 2009, due to some confusion and agitation on Mr. Miller's part.

On April 5, ICU Nurse Mikal Childress was assigned to Mr. Miller for the 7a-7p shift. When she initially saw him that morning, Mr. Miller was out of his bed, sitting in a chair, and restrained by a Posey vest. Later that morning he was examined by Dr. Erin Large, a UAMS resident, and Dr. Muhammad Jaffar, an intensive care intensivist who was Mr. Miller's attending physician. These doctors determined that he was awake, alert and able to follow their commands, and noted in the physician's progress notes that "no restraints needed." (UAMS 063)

Dr. Jaffar shared this opinion with both Mr. and Mrs. Miller. He specifically told Mr. Miller in front of his wife that he was at high risk for falls and he needed to make sure that when he went to the floor, that he needed to hit the call button or call somebody every time before he came out of the bed because he might fall. (Jaffar Dep at pp. 15-16). At the time he spoke with the Millers, Mr. Miller was awake, he was able to follow commands, and he did not appear at risk of harming himself or others. (Id. at pp 51-52) Dr. Jaffar added that the education process was intended not just for Mr. Miller, but also his wife, and that he stressed this fact to both of them. (Id. at pp. 68-69). Nurse Childress provided similar instructions. (Childress Dep at pp. 97-99)

Physical restraints are a last resort option at UAMS per both the Joint Commission's regulations and hospital policy. Only if a patient is deemed a threat to himself or others are two or four point restraints used. Once this behavior that

required the restraints is assessed to no longer exist, restraints **MUST** be removed at the earliest reasonable opportunity. A nurse is permitted to make this determination and is not required to wait on a physician's order before removing restraints. In accordance with that policy, Nurse Childress removed the restraints at noon, documenting that the "reason for restraints has resolved" and that Mr. Miller "demonstrates ability to follow directions." (UAMS 375).[1] Once the restraints are removed, a new physician's order must be entered before restraints can be reapplied.

Also that day, the UAMS Trauma Team physicians concluded that Mr. Miller could be transferred from the ICU to a floor unit, and arrangements were made for the move. In discovery claimant's counsel has questioned why Mr. Miller was not transferred to a "step-down unit," which because of the patient to nurse ratio, provides a higher level of monitoring of a patient than a floor unit although not necessarily a higher level of nursing skills. The transfer decision is totally irrelevant to any issue in this case. It is undisputed that the decision to transfer Mr. Miller to Unit H-6 was made by a physician. By stipulation dated September 17, 2012, the parties expressly agreed that "after a diligent inquiry by both parties, neither party has discovered evidence from which a reasonable inference could be drawn that any . . . physicians at UAMS were negligent in their care and treatment of Rodney Miller or that any fault on their part was a proximate cause of Mr.

[1] Although Nurse Childress documented the removal of restraints in the chart, she did not write a narrative note for her decision in the ICU Focus Notes in accordance with UAMS policy. Claimant's counsel has spent an inordinate amount of time in discovery addressing the absence of the focus note, but this non-entry has no relevancy to Mr. Miller's fall and is simply not an issue.

Miller's death." Any attempt to re-open this issue at the hearing should be immediately quashed.

The restraints were removed at noon. Although claimant contends that Nurse Childress breached the standard of care by removing Mr. Miller's restraints without a doctor's order, the clear evidence is that she did so only after making an independent assessment that the issues requiring restraints had resolved. Her assessment was consistent with that of two doctors and made in accordance with Joint Commission regulations, hospital policy and sound nursing practice.

Before the transfer, Nurse Childress gave verbal "report" on Mr. Miller's condition to Felicia Skipper, the charge nurse on H-6. Nurse Skipper in turn shared the report with Paige Bramlett, the RN assigned to Mr. Miller. Upon his arrival on H-6, Nurse Bramlett, assisted by PCT Sarah Myers Cingolani, began her initial assessment of him. Mr. Miller cooperated fully with the nurse and her aide as they took his vital signs and Nurse Bramlett started her head-to-toe assessment. He followed her commands, showed no signs of agitation and made no attempt to leave his bed during the examination. She rated his state of consciousness as Alert and Oriented X 1.

After completing this part of her assessment, Nurse Bramlett told both Mr. and Mrs. Miller, who was in the room during the assessment, that Mr. Miller needed to remain in bed, and that he should be constantly monitored. She told Mrs. Miller that if she needed to leave the room for any reason, that she should let a nurse know. Mr. Miller's room was directly across from the nurse's station. PCT

Myers was present during this conversation, and corroborates Nurse Bramlett's account.

Part of an initial assessment is to review the patient's chart. After starting but not completing her physical assessment of Mr, Miller, Nurse Bramlett stepped out of the patient's room, reviewed Mr. Miller's chart, and noted that while he was no longer restrained, the restraint order had not been marked as discontinued. As it is the customary nursing practice to let a doctor know he has a new patient on the floor, she then called Dr. David Riggs, the floor physician assigned to Mr. Miller. Shortly after she ended that conversation, Nurse Bramlett and others heard a loud thud from Mr. Miller's room. They quickly responded to the noise, and after having some difficulty entering the room, found Mr. Miller lying up against the door. Initially he did not appear seriously injured, but his condition quickly deteriorated, and a Rapid Response Team was called. Mr. Miller was taken to the OR for a craniotomy, but did not recover.

The first liability issue is whether Nurse Childress acted beneath the standard of care by removing Mr. Miller's restraints in the ICU. As previously noted, her assessment that he no longer required them was consistent with the views of two physicians who had examined Mr. Miller two hours before the restraints were taken off at noon. Having made that assessment, Nurse Childress was required by Joint Commission regulations and UAMS policy to remove the restraints, a decision she was free to make without physician input or order. Additionally, Mr. Miller was not taken to the floor until 5 p.m. For the five hours

between the time that the restraints were removed and the transfer, there is no evidence that the untethered Mr. Miller made any attempt to get up out of his bed or that he posed any risk to himself.

The second liability issue is whether Nurse Bramlett acted beneath the standard of care in leaving the room to review the medical chart and call Dr. Riggs before completing her initial assessment of Mr. Miller. The resolution of this issue hinges in part on the credibility of Dr. Jaffar, Nurse Childress, Nurse Bramlett, PCT Myers and Mrs. Miller. Floor nurses are assigned multiple patients, and no patient is assigned a hospital employee to monitor him on a one-on-one, around-the-clock basis. Hospitals rely on educated family members to help provide this monitoring. Nurse Bramlett said she impressed upon Mrs. Miller the need to remain in the room with her husband, or notify a nurse if she wished to step out. This account is consistent with PCT Myers' recollection. It is also consistent with the information that both Dr. Jaffar and Nurse Childress said they shared with Mrs. Miller and her husband earlier that day.

Mrs. Miller, on the other hand, will testify that she does not recall ever meeting Dr. Jaffar, or receiving instructions from him in the ICU. Although she does recall a nurse assessing her husband on the floor unit, she has no recollection of being told to remain with her husband when a nurse wasn't in the room. Finally, she claims that she walked out of the room with Nurse Bramlett, and that Nurse Bramlett had to know that her husband was being left unattended. Nurse

Bramlett's testimony is that when she left the room to review the chart, Mrs. Miller was still in it.

During the course of discovery, the focus of claimant's counsel has shifted from these relatively straight-forward issues to an indictment of Nurse Bramlett. Nurse Bramlett was considered to be an excellent nurse by both her superiors and peers, and had won honors for her patient care. Unbeknownst to UAMS, however, Nurse Bramlett had a problem with opiates which began before Mr. Miller's accident. Claimant's counsel is attempting to twist this fact into an implication that Nurse Bramlett was either stoned or experiencing withdrawal symptoms during the five to 10 minutes she spent with Mr. Miller before he fell, and thus was not competent to assess Mr. Miller that day. However, there is not one whit of evidence that Nurse Bramlett was under the influence of drugs at 5 p.m. on April 5, 2009. To the contrary, the evidence is that she appeared normal throughout her shift that started 10 hours earlier at 7 a.m., and that she attended to Mr. Miller as she did her other patients.

UAMS further anticipates that claimant's counsel will strive hard to impeach the testimony of Nurse Bramlett, essentially claiming that the Commission should not believe a word she says. This attack is based on the undisputed fact that as might be expected of an addict hiding her addiction, Nurse Bramlett lied about the onset, severity and extent of her problem between June 2009, when she first saw a specialist in the area of dependency, and November 2010 when her problems first came to light at UAMS.

If Nurse Bramlett were the sole witness on what was said to Mrs. Miller, then collateral evidence attacking her credibility might have greater weight. However, at least three other UAMS witnesses – none of whom is alleged to have any impairment issues – corroborate that Mrs. Miller was told to remain with her husband. Nevertheless, UAMS anticipates that claimant will call up to five witnesses[2] whose testimony addresses almost exclusively Nurse Bramlett's dependency problems. Unless claimant can offer credible proof that Nurse Bramlett was impaired at the time she examined Mr. Miller, the Commission should not allow counsel to belabor this point.

The truth of the matter is that Nurse Bramlett acted within the nursing standard of care in her assessment of Mr. Miller. Mr. Miller arrived from ICU in a wheelchair, not tethered by four-point restraints to it or strapped down in a Posey vest. After Mr. Miller cooperated with the nurses in being moved from the wheelchair to his bed, Nurse Bramlett completed an initial assessment in which she determined that Mr. Miller, as was the case earlier that day, was able to follow commands, was not agitated or combative, and showed no signs of attempting to escape his bed. His behavior simply did not support the use of restraints. Further, under the circumstances that existed at that time, Nurse Bramlett's decision to complete a more formalized fall assessment after reviewing the chart and speaking with the doctor simply did not fall outside the standard of care.

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[2] Theses witnesses are Candace Conners, Betty Casali, Doug Bramlett, Dr. Regina Foley and Dr. Susan M. Skolley-Danzinger. If Dr. Skolly-Danzinger, a recently disclosed plaintiff's expert who has not been deposed, appears and testifies at the hearing, UAMS will call Dr. Henry Simmons, director of the Arkansas Poison Center and board certified in multiple areas including medical toxicology, as a rebuttal expert witness.

Mr. Miller's fall was tragic. However, it was not caused by negligence on the part of UAMS. It was simply an unfortunate accident. The fact is that Nurse Childress acted within the standard of care in deciding to remove restraints. The fact is that Nurse Bramlett acted with the standard of care in educating Mrs. Miller on the necessity of not leaving Mr. Miller unattended. There simply is no other issue of relevance. Because these UAMS nurses complied with the standard of care, at the close of this hearing the Commission should find in the hospital's favor.

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CERTIFICATE OF SERVICE

On August 19, 2013, a copy of the foregoing was mailed to the following:

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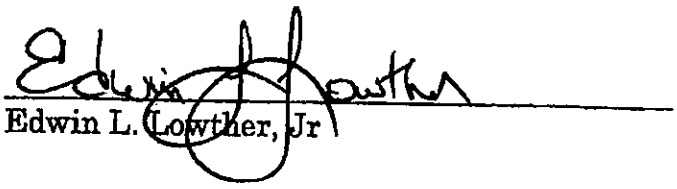

Edwin L. Lowther, Jr

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September 10, 2013

Mr. Chris A. Averitt
Attorney at Law
Scholtens & Averitt
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Jonesboro, AR 72401

RE: **Estate of Rodney Miller**

Dear Mr. Averitt:

Attached please find my updated report in the above-cited matter. I have revised my original computations to reflect the trial date of September 12, 2013. I have also utilized a revised work life expectancy based on the cited update to the work life expectancy data utilized in my original report. My methodology is identical to that explained in my original report.

If you have any questions or if I can be of further assistance in this matter, please do not hesitate to contact me.

Yours very truly,

Ralph D. Scott, Jr.

RALPH D. SCOTT, JR., Ph.D.

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September 10, 2013

Mr. Chris A. Averitt
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RE: **Estate of Rodney Miller**

Dear Mr. Averitt:

At your request, I have calculated the value of the loss of life of Rodney Miller ("Miller") in connection with the wrongful death lawsuit resulting from his death on April 11, 2009. Additionally, I have calculated the value of the household services that Miller would have provided for his family had he remained alive. My computations are discussed in detail below and are summarized in the attached tables.

LOSS OF LIFE

Running through the history of economic thought there has been a general consensus that the monetary value of life can, *at a minimum*, be determined by the present value of projected lifetime earnings. Present value represents the amount of money that would be needed at a point in time so that with appropriate financial investments a flow of lifetime earnings could be duplicated. The present value of projected lifetime earnings is commonly called "human capital" in economic literature. Conceptually, human capital is identically equal to the concept of "earning capacity" that appears in tort litigation. The present value of projected lifetime earnings can be simultaneously interpreted as a measure of the loss of life suffered by the decedent

because it represents the loss of human capital or earning capacity that would have provided the basis for lifetime personal expenditures and also a societal loss because of the elimination of the decedent's productive efforts from which society would have derived benefit. It should be stressed that the valuation of human capital is identical to computations of lost earning capacity which arise in personal injury litigation and can be calculated with equal precision. As stated above this approach should be construed as yielding a ***minimum*** measure of the value of life because it focuses exclusively on lifetime earnings and ignores many aspects of the "enjoyment of life". Given these comments a starting point for my analysis of loss of life would entail a consideration of the present value of the income flows that would have been generated by Miller had he remained alive. This component of loss of life as well as "loss of enjoyment of life" is discussed below.

Present Value of Potential Lifetime Earnings

The evaluation of the present value of Miller's potential lifetime earnings, which represents his human capital, entails a consideration of the income flows that he could have generated had he remained alive. In assigning a value to these income flows a distinction should be made between past and projected future magnitudes. Past potential earnings are not discounted; however future potential earnings should be discounted and converted into present value terms. Past earnings are calculated in accordance with equation (1), below:

(1) Past Earnings = (Base Income)(Time Interval Between Date of Death and Current Date)

In the present instance base income is assumed to range from $29,493.55 to $31,563.52 per year. The lower end of this range is based on Miller's average inflation adjusted earnings over the period 2004 through 2008 as documented by tax returns for those years. Base income is adjusted upward in accordance with historical inflation rates in subsequent years to yield a figure of $31,563.52 by the present time. This range is indicative of Miller's earning capacity at the time of his death. The time interval amounts to 4.422 years. Performing the computation indicated by equation (1), based on the assumptions above, yields a past value of income amounting to **$135,836.10.**

The present value of future income, which represents Miller's human capital or earning capacity, is calculated by projecting his base income over his remaining work life expectancy and discounting in accordance with equation (2), below:

$$\text{(2) Present Value of Future Income} = \sum_{t=1}^{T} \text{Base income}/(1+r)^t$$

where T = work life expectancy, which is alternatively assumed to be 16.71 additional years ("Scenario 1") or 22.54 additional years ("Scenario 2"). Scenario (1) is

based on Miller's statistical work life expectancy based on Gary R. Skoog, James E. Ciecka, and Kurt V. Krueger: "The Markov Process Model of Labor Force Activity: Extended Tables of Central Tendency, Shape, Percentile Points, and Bootstrap Standard Errors", *Journal of Forensic Economics*, 22 (2), 2011.

Base Income = $31,563.52 per year as discussed above.

r = discount factor used to convert future magnitudes into present value terms. For computational purposes I have assumed r to be equal to 2.5% to reflect the real rate of return (interest minus inflation) on inflation indexed government bonds. These bonds would be a financial instrument almost perfectly suited to protecting against the effects of future inflation.

Performing the calculation indicated by equation (2), based on the assumptions above, yields a present value of projected future income amounting to **$426.789.61** or **$538,834.37** for Scenarios (1) or (2), respectively. Adding the values of past and projected future income yields figures of **$562,625.71** or **$674,670.47**, respectively. My computations are presented on a year by year basis in the attached Table (1).

Loss of Enjoyment of Life

As discussed above, the present value of lifetime earnings would represent a minimum valuation of the loss of life because it focuses exclusively on productivity and ignores other aspects of the value of life. Many other joys and pleasures which are independent of earning capacity and are generally considered to be "priceless" have been lost as a result of Miller's death. Consequently my figures should not be interpreted as capturing the total value of loss of life but rather those aspects of loss of life that are readily quantifiable. In the attached Table (3) I have noted that an additional figure for loss of enjoyment of life is to be determined by the jury. I have provided information on Miller's statistical life expectancy, 33.8 additional years at the time of his death (based on the Center for Disease Control publication: *United States Life Tables, 2006*), to assist the jury in this determination. I have also provided computations, summarized in the attached Table (4), in which future loss of life figures can be reduced to present value. The methodology encompassed in my computations could be utilized for any annual value determined by the jury.

In summary, Miller's loss of life would be worth at least **$562,625.71** or **$674,670.47** or (the present value of his expected lifetime earnings or human capital). Losses associated with the lost enjoyment of life should be considered in addition to this amount in order to arrive at a more accurate valuation of the loss of life suffered by Miller.

LOSS OF HOUSEHOLD SERVICES

Because of his death Miller is no longer able to provide for his family the services he previously performed. I have assumed that an average of 15 hours per week was involved in these activities based on the expected testimony of his surviving spouse. In evaluating these services I have used an hourly rate of $11.01 per hour. This hourly rate is based on an average of the current minimum wage, $7.25 per hour, and the $14.01 hourly value of household services reported by Bryant, Zick and Kim in their study: *Household Work: What Its Worth and Why?* (Cornell Cooperative Extension, 1992). The assumptions outlined above indicate an annual value for household services amounting to $8,587.80. Calculating past and projected future losses in accordance with the methodology explained above yields loss amounts of **$37,974.55** and **$177,165.84,** respectively. Future losses are projected over the next 29.37 additional years based on Miller's remaining life expectancy. Adding past and projected future losses yields a total loss of household services amounting to **$215,140.38**. My computations are presented on a year by year basis in the attached Table (2).

My computations of economic loss are summarized in the attached tables. If you have any questions or if I can be of further assistance in this matter please do not hesitate to contact me.

Yours very truly,

Ralph D. Scott, Jr.

RALPH D. SCOTT, JR., Ph.D.

TABLE 1

ESTATE OF RODNEY MILLER
CALCULATION OF HUMAN CAPITAL / EARNING CAPACITY

Year	Base Income	Year Fraction	Lost Earnings	Present Value Factor	Economic Loss	Cumulative Economic Loss
PAST:						
2009	$ 29,493.55	0.7260	$ 21,413.13	1.0000	$ 21,413.13	$ 21,413.13
2010	29,971.14	1.0000	29,971.14	1.0000	29,971.14	51,384.27
2011	30,923.57	1.0000	30,923.57	1.0000	30,923.57	82,307.84
2012	31,563.52	1.0000	31,563.52	1.0000	31,563.52	113,871.35
2013	31,563.52	0.6959	21,964.75	1.0000	21,964.75	135,836.10
Total		4.4219	135,836.10		135,836.10	135,836.10
FUTURE:						
2013/14	31,563.52	1.0000	31,563.52	0.9756	30,793.68	30,793.68
2014/15	31,563.52	1.0000	31,563.52	0.9518	30,042.61	60,836.29
2015/16	31,563.52	1.0000	31,563.52	0.9286	29,309.86	90,146.15
2016/17	31,563.52	1.0000	31,563.52	0.9060	28,594.99	118,741.14
2017/18	31,563.52	1.0000	31,563.52	0.8839	27,897.55	146,638.69
2018/19	31,563.52	1.0000	31,563.52	0.8623	27,217.12	173,855.81
2019/20	31,563.52	1.0000	31,563.52	0.8413	26,553.29	200,409.10
2020/21	31,563.52	1.0000	31,563.52	0.8207	25,905.65	226,314.75
2021/22	31,563.52	1.0000	31,563.52	0.8007	25,273.80	251,588.55
2022/23	31,563.52	1.0000	31,563.52	0.7812	24,657.37	276,245.92
2023/24	31,563.52	1.0000	31,563.52	0.7621	24,055.97	300,301.89
2024/25	31,563.52	1.0000	31,563.52	0.7436	23,469.24	323,771.13
2025/26	31,563.52	1.0000	31,563.52	0.7254	22,896.82	346,667.95
2026/27	31,563.52	1.0000	31,563.52	0.7077	22,338.36	369,006.31
2027/28	31,563.52	1.0000	31,563.52	0.6905	21,793.52	390,799.83
2028/29	31,563.52	1.0000	31,563.52	0.6736	21,261.97	412,061.80
2029/30	31,563.52	0.7100	22,410.10	0.6572	14,727.81	426,789.61
Total (Scenario 1)		16.7100	527,426.38		426,789.61	426,789.61
2029/30	31,563.52	1.0000	31,563.52	0.6572	20,743.39	432,805.19
2030/31	31,563.52	1.0000	31,563.52	0.6412	20,237.45	453,042.64
2031/32	31,563.52	1.0000	31,563.52	0.6255	19,743.85	472,786.50
2032/33	31,563.52	1.0000	31,563.52	0.6103	19,262.30	492,048.79
2033/34	31,563.52	1.0000	31,563.52	0.5954	18,792.49	510,841.28
2034/35	31,563.52	1.0000	31,563.52	0.5809	18,334.13	529,175.41
2035/36	31,563.52	0.5400	17,044.30	0.5667	9,658.96	538,834.37
Total (Scenario 2)		22.5400	$ 711,441.68		$ 538,834.37	$ 538,834.37

TOTAL HUMAN CAPITAL / EARNING CAPACITY (SCENARIO 1) $ 562,625.71

TOTAL HUMAN CAPITAL / EARNING CAPACITY (SCENARIO 2) $ 674,670.47

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TABLE 2

ESTATE OF RODNEY MILLER
CALCULATION OF LOST HOUSEHOLD SERVICES

Year	Base Annual Value	Year Fraction	Annual Loss	Present Value Factor	Economic Loss	Cumulative Economic Loss
PAST:						
2009	$ 8,587.80	0.7260	$ 6,234.98	1.0000	$ 6,234.98	$ 6,234.98
2010	8,587.80	1.0000	8,587.80	1.0000	8,587.80	14,822.78
2011	8,587.80	1.0000	8,587.80	1.0000	8,587.80	23,410.58
2012	8,587.80	1.0000	8,587.80	1.0000	8,587.80	31,998.38
2013	8,587.80	0.6959	5,976.17	1.0000	5,976.17	37,974.55
Total		4.4219	37,974.55		37,974.55	37,974.55
FUTURE:						
2013/14	8,587.80	1.0000	8,587.80	0.9756	8,378.34	8,378.34
2014/15	8,587.80	1.0000	8,587.80	0.9518	8,173.99	16,552.33
2015/16	8,587.80	1.0000	8,587.80	0.9286	7,974.63	24,526.96
2016/17	8,587.80	1.0000	8,587.80	0.9060	7,780.12	32,307.08
2017/18	8,587.80	1.0000	8,587.80	0.8839	7,590.36	39,897.45
2018/19	8,587.80	1.0000	8,587.80	0.8623	7,405.23	47,302.68
2019/20	8,587.80	1.0000	8,587.80	0.8413	7,224.62	54,527.30
2020/21	8,587.80	1.0000	8,587.80	0.8207	7,048.41	61,575.70
2021/22	8,587.80	1.0000	8,587.80	0.8007	6,876.50	68,452.20
2022/23	8,587.80	1.0000	8,587.80	0.7812	6,708.78	75,160.97
2023/24	8,587.80	1.0000	8,587.80	0.7621	6,545.15	81,706.12
2024/25	8,587.80	1.0000	8,587.80	0.7436	6,385.51	88,091.63
2025/26	8,587.80	1.0000	8,587.80	0.7254	6,229.77	94,321.40
2026/27	8,587.80	1.0000	8,587.80	0.7077	6,077.82	100,399.22
2027/28	8,587.80	1.0000	8,587.80	0.6905	5,929.58	106,328.80
2028/29	8,587.80	1.0000	8,587.80	0.6736	5,784.96	112,113.75
2029/30	8,587.80	1.0000	8,587.80	0.6572	5,643.86	117,757.61
2030/31	8,587.80	1.0000	8,587.80	0.6412	5,506.20	123,263.82
2031/32	8,587.80	1.0000	8,587.80	0.6255	5,371.91	128,635.72
2032/33	8,587.80	1.0000	8,587.80	0.6103	5,240.88	133,876.61
2033/34	8,587.80	1.0000	8,587.80	0.5954	5,113.06	138,989.67
2034/35	8,587.80	1.0000	8,587.80	0.5809	4,988.35	143,978.02
2035/36	8,587.80	1.0000	8,587.80	0.5667	4,866.68	148,844.70
2036/37	8,587.80	1.0000	8,587.80	0.5529	4,747.98	153,592.68
2037/38	8,587.80	1.0000	8,587.80	0.5394	4,632.18	158,224.86
2038/39	8,587.80	1.0000	8,587.80	0.5262	4,519.20	162,744.06
2039/40	8,587.80	1.0000	8,587.80	0.5134	4,408.97	167,153.03
2040/41	8,587.80	1.0000	8,587.80	0.5009	4,301.44	171,454.47
2041/42	8,587.80	1.0000	8,587.80	0.4887	4,196.53	175,651.00
2042/43	8,587.80	0.3700	3,177.49	0.4767	1,514.84	177,165.84
Total		29.3700	252,223.69		177,165.84	177,165.84

TOTAL LOST HOUSEHOLD SERVICES $ 215,140.38

TABLE 3

ESTATE OF RODNEY MILLER
SUMMARY OF ECONOMIC LOSS

	Scenario 1	Scenario 2
LOSS OF LIFE		
HUMAN CAPITAL		
Earning Capacity		
Past	$ 135,836.10	$ 135,836.10
Projected Future	426,789.61	538,834.37
Total	562,625.71	674,670.47
Total Human Capital	562,625.71	674,670.47
LOSS OF ENJOYMENT OF LIFE	To Be Determined	
_____ (Annual Value) X 33.8 (Life Expectancy) =	_____	_____
TOTAL LOSS OF LIFE	562,625.71 +	674,670.47 +
LOST HOUSEHOLD SERVICES		
Past	37,974.55	37,974.55
Projected Future	177,165.84	177,165.84
Total	215,140.38	215,140.38
TOTAL ECONOMIC LOSS	$ 777,766.10 +	$ 889,810.86 +

TABLE 4

ESTATE OF RODNEY MILLER
SUMMARY OF ECONOMIC LOSS

	Scenario 1	Scenario 2
LOSS OF LIFE		
HUMAN CAPITAL		
Lost Earning Capacity		
Past	$ 135,836.10	$ 135,836.10
Projected Future	426,789.61	538,834.37
Total	562,625.71	674,670.47
Total Human Capital	562,625.71	674,670.47
LOSS OF ENJOYMENT OF LIFE	To Be Determined	
_____ (Annual Value) X 33.8 (Life Expectancy) X 0.7412 (Present Value Factor) =	_____	_____
TOTAL LOSS OF LIFE	562,625.71 +	674,670.47 +
LOST HOUSEHOLD SERVICES		
Past	37,974.55	37,974.55
Projected Future	177,165.84	177,165.84
Total	215,140.38	215,140.38
TOTAL ECONOMIC LOSS	$ 777,766.10 +	$ 889,810.86 +

ECONOMIC AND FINANCIAL CONSULTING GROUP, INC.

6 RICHLAND HILLS COVE • CONWAY, AR 72034 • (501) 450-1306

September 10, 2013

Mr. Chris A. Averitt
Attorney at Law
Scholtens & Averitt
113 E. Jackson Avenue
Jonesboro, AR 72401

RE: **Estate of Rodney Miller**

Dear Mr. Averitt:

At your request, I have performed additional computations in the above cited matter. Specifically, I have considered potential jury awards for enjoyment of life amounting to $50,000.00 per year or $100,000.00 per year. My computations are summarized in the attached Tables (5) through (8). My methodology is identical to that explained in my report of this date. If you have any questions or if I can be of further assistance in this matter please do not hesitate to contact me.

Yours very truly,

Ralph D. Scott, Jr.

RALPH D. SCOTT, JR., Ph.D.

TABLE 5

ESTATE OF RODNEY MILLER
SUMMARY OF ECONOMIC LOSS

				Scenario 1	Scenario 2
LOSS OF LIFE					
HUMAN CAPITAL					
Earning Capacity					
Past				$ 135,836.10	$ 135,836.10
Projected Future				426,789.61	538,834.37
Total				562,625.71	674,670.47
Total Human Capital				562,625.71	674,670.47
LOSS OF ENJOYMENT OF LIFE				To Be Determined	
$ 50,000.00	X	33.8	=	1,690,000.00	1,690,000.00
Annual Value		Life Expectancy			
TOTAL LOSS OF LIFE				2,252,625.71	2,364,670.47
LOST HOUSEHOLD SERVICES					
Past				37,974.55	37,974.55
Projected Future				177,165.84	177,165.84
Total				215,140.38	215,140.38
TOTAL ECONOMIC LOSS				$ 2,467,766.10	$ 2,579,810.86

TABLE 6

ESTATE OF RODNEY MILLER
SUMMARY OF ECONOMIC LOSS

				Scenario 1	Scenario 2
LOSS OF LIFE					
HUMAN CAPITAL					
Earning Capacity					
Past				$ 135,836.10	$ 135,836.10
Projected Future				426,789.61	538,834.37
Total				562,625.71	674,670.47
Total Human Capital				562,625.71	674,670.47
LOSS OF ENJOYMENT OF LIFE				To Be Determined	
$ 100,000.00 (Annual Value)	X	33.8 (Life Expectancy)	=	3,380,000.00	3,380,000.00
TOTAL LOSS OF LIFE				3,942,625.71	4,054,670.47
LOST HOUSEHOLD SERVICES					
Past				37,974.55	37,974.55
Projected Future				177,165.84	177,165.84
Total				215,140.38	215,140.38
TOTAL ECONOMIC LOSS				$ 4,157,766.10	$ 4,269,810.86

TABLE 7

ESTATE OF RODNEY MILLER
SUMMARY OF ECONOMIC LOSS

	Scenario 1	Scenario 2
LOSS OF LIFE		
HUMAN CAPITAL		
Lost Earning Capacity		
Past	$ 135,836.10	$ 135,836.10
Projected Future	426,789.61	538,834.37
Total	562,625.71	674,670.47
Total Human Capital	562,625.71	674,670.47
LOSS OF ENJOYMENT OF LIFE	To Be Determined	
$ 50,000.00 (Annual Value) X 33.8 (Life Expectancy) X 0.7412 (Present Value Factor) =	1,252,628.00	1,252,628.00
TOTAL LOSS OF LIFE	1,815,253.71	1,927,298.47
LOST HOUSEHOLD SERVICES		
Past	37,974.55	37,974.55
Projected Future	177,165.84	177,165.84
Total	215,140.38	215,140.38
TOTAL ECONOMIC LOSS	$ 2,030,394.10	$ 2,142,438.86

TABLE 8

ESTATE OF RODNEY MILLER
SUMMARY OF ECONOMIC LOSS

	Scenario 1	Scenario 2
LOSS OF LIFE		
HUMAN CAPITAL		
Lost Earning Capacity		
Past	$ 135,836.10	$ 135,836.10
Projected Future	426,789.61	538,834.37
Total	562,625.71	674,670.47
Total Human Capital	562,625.71	674,670.47
LOSS OF ENJOYMENT OF LIFE	To Be Determined	
$ 100,000.00 (Annual Value) X 33.8 (Life Expectancy) X 0.7412 (Present Value Factor) =	2,505,256.00	2,505,256.00
TOTAL LOSS OF LIFE	3,067,881.71	3,179,926.47
LOST HOUSEHOLD SERVICES		
Past	37,974.55	37,974.55
Projected Future	177,165.84	177,165.84
Total	215,140.38	215,140.38
TOTAL ECONOMIC LOSS	$ 3,283,022.10	$ 3,395,066.86

STATE CLAIMS COMMISSION DOCKET
OPINION

Amount of Claim $ $3,500,000.00

Claim No. 11-0617-CC

Olivian Miller, Administratrix of of Estate of Rodney Miller — Claimant

vs.

University of AR for Medical Sciences — Respondent

State of Arkansas

Date Filed April 1, 2011

Attorneys Chris Averitt & Tony Wilcox, Attorneys — Claimant

Jeff Bell & Edwin Lowther, Jr., Attorneys — Respondent

Type of Claim Wrongful Death, Pain & Suffering, Negligence, etc.

FINDING OF FACTS

This claim was filed for wrongful death, pain and suffering and negligence in the amount of $3,500,000.00 against the University of Arkansas for Medical Science. Present at a hearing September 12, 2013, was the Claimant, represented by Chris Averitt and Tony Wilcox, Attorneys, and the Respondent, represented by Jeff Bell and Edwin Lowther, Attorneys.

The Claimant's deceased spouse was a patient at the Respondent's hospital. He had serious trauma to his head and had been in the hospital's ICU until very shortly prior to the circumstances that are the subject of this litigation. While in the ICU the deceased was in restraints until shortly before his transfer to the area where he suffered the injury which led to his death. Also, while in the ICU the deceased was agitated and went in and out of lucidity. The doctors, staff and family were aware that if the deceased suffered any fall that involved his head he would likely not survive.

The deceased doctors determined that he no longer needed the "constant care" offered in the ICU and could be transferred to a lower care level area which offered "continuing care." Within 10-12 minutes after his transfer the Claimant's spouse suffered the fall that caused his death two days after his 40th birthday. This short time frame of patient care is the subject of this claim as all parties knew the deceased should not be left alone.

At the time of the patient's death the Respondent had a policy that if staff were not present a family member could be a stand-in-care-taker, if, as in this instance, they stated they would not leave the patient alone. This policy also required that such non-medical family members receive a "Family Education Fact Sheet", training prior to undertaking their care responsibilities and signed a form acknowledging the training. In this instance the lead nurse testified that she had done her initial assessment, including making notes, of the patient within seven (7) minutes after he was placed in his room and then left the room to begin entering her notes into a database.

The adequacy of this speedy assessment and note-taking is less than creditable. She further testified that the spouse of the deceased was in the room when she left and that she had asked the spouse if she would remain in the room. The Claimant testified that she was never asked that question, received no policy required training or fact sheet, never signed any form and that another nurse was in the room when she stepped out of the room to retrieve some belongings from the ICU waiting room. The Claims Commission majority finds the Claimant's testimony most creditable.

Continued
(See Back of Opinion Form)

CONCLUSION

The Claims Commission hereby awards this claim **in the amount of $1,200,000.00 and will be include the claim in a claims bill to be the submitted to the 89th General Assembly, Arkansas State Legislature 2014 Fiscal Session, for subsequent approval and payment.**

Date of Hearing **September 12, 2013**

Date of Disposition **October 14, 2013**

Chairman

* Commissioner

Commissioner

**Appeal of any final Claims Commission decision is only to the [illegible]

The nurse testified that she saw no need to place the deceased back in restraints and that he appeared lucid in responding to her questions. The Claimant and other family members testified that the deceased, while in the hospital, became agitated quickly and that his mental state could change quickly as well. The Respondent did not refute this latter testimony.

The Claimant's legal counsel presented unrefuted evidence and testimony that the lead nurse involved here was taking various drugs at the time of the incident, including a drug that, if it had been known she was taking, would have caused her to immediately have her nursing license stripped away. By requirement, no nurse in Arkansas can take this drug and maintain their certification. The nurse testified that she was addicted to multiple prescriptions secured from various sources as well as using intravenous drugs such as methamphetamines. She, when her drug use was discovered, was suspended from work, put on probation and had to go through a very extensive drug rehabilitation program. She also testified that she did not believe her drug use had affected her job. The Claims Commission majority finds this last testimony less that persuasive.

In the four (4) to five (5) minutes after being left alone the deceased got out of his bed and made it to the doorway of his room. At this point he fell, hitting his head and died five days later, two days after his 40th birthday.

Hospitals have a duty to provide the best care available and protect their patients from undue risk to themselves and the facility. This is why departing patients are taken in a wheelchair to their awaiting vehicle. In seeking to support its' view of this incident the Respondent finally obtained, on its' third try, an expert witness to testify on its' behalf.

This incident was obviously unfortunate, but in weighing all the evidence and testimony the Claims Commission majority finds negligence on the part of the Respondent and in favor of the Claimant.

The Claimant provided expert testimony as to the deceased earning levels and other benefits provided to his family. The Claims Commission majority finds this evidence reasonable for a just turned 40-year old husband, father, and worker. The award in this claim is $1,200,000.00, to be broken down as follows:

$625,000.00 for deceased loss of earnings for at least 25 years
$250,000.00 for deceased personal injury, pain and suffering
$250,000.00 for spouse and children's mental anguish
$60,000.00 in expenses
$15,000.00 for the sister of the deceased for reimbursement of funeral expenses
$1,200,000.00

The Claims Commission urges the court over-seeing this estate to divide the award as it sees fit, but that $15,000.00 be paid to the deceased sister to reimburse her for the expense of the deceased funeral.

Therefore, having found negligence on the part of the Respondent, the Claims Commission majority awards this claim in the amount of $1,200,000.00.

*Commissioner Bill Lancaster dissents the majority opinion.

The Claims Commission hereby awards this claim **in the amount of $1,200,000.00 and will be include the claim in a claims bill to be the submitted to the 89th General Assembly, Arkansas State Legislature 2014 Fiscal Session, for subsequent approval and payment.**

IT IS SO ORDERED

EDWARD L. WRIGHT (1903-1977)
ROBERT S. LINDSEY (1913-1991)
ALSTON JENNINGS (1917-2004)
GORDON S. RATHER, JR.
JOHN R. TISDALE
JOHN WILLIAM SPIVEY III
LEE J. MULDROW
N.M. NORTON
CHARLES T. COLEMAN
EDWIN L. LOWTHER, JR.
GREGORY T. JONES
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JUDY SIMMONS HENRY
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Reply to Little Rock Office

November 20, 2013

VIA HAND DELIVERY

Mr. Norman L. Hodges, Jr.
Director
Arkansas State Claims Commission
101 East Capitol Ave., Suite 410
Little Rock, AR 72201-3823

RE: Olivian Miller v UAMS (Arkansas Claims Commission)
Claim Commission No. 11-0617-CC

Dear Norman:

Pursuant to Ark. Code Ann. § 19-10-211, respondent University of Arkansas for Medical Sciences appeals to the General Assembly from that portion of the Arkansas Claims Commission order of October 14, 2013, awarding claimant Olivian Miller $250,000 for the deceased's personal injury, pain and suffering and $60,000 in expenses. For grounds, UAMS states that there is insufficient evidence to support the award for deceased's personal injury, pain and suffering, and that expenses are not recoverable in a wrongful death action.

Cordially yours,

WRIGHT, LINDSEY & JENNINGS LLP

Edwin L. Lowther, Jr.

ELL/slr

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