

IN THE CLAIMS COMMISSION OF THE STATE OF TENNESSEE
WESTERN DIVISION

FILED

SHARON KIMBRELL ASHLEY,
Individually and as next of kin to
JIMMY KIMBRELL, deceased,

JUN 25 2009
Tennessee Claims Commission
CLERK'S OFFICE

Claimant,

v.

CLAIM NO. 20-050-493

STATE OF TENNESSEE,

Defendant.

COMPUTER
DOCKETED _____
C/S-COMM _____
DCA _____
AG _____
ALJ _____
FEE PAID _____
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JUDGMENT

Sharon Kimbrell Ashley, daughter of the decedent, Jimmy Kimbrell, brought this wrongful death action against the State of Tennessee pursuant to Tenn. Code Ann. § 9-8-307(a)(1)(D) (Supp. 2005), relating to medical malpractice and Tenn. Code Ann. § 9-8-307(a)(1)(E) (Supp. 2005), relating to negligent care, custody and control of persons. A trial was held at Northwest Correctional Complex, hereinafter referred to as NWCX, on March 10, 11 and 12, 2009, before the Honorable Nancy C. Miller-Herron, Claims Commissioner for the State of Tennessee, Western Division. Ms. Danese K. Banks, Esq., and Mr. Marc A. Walwyn, Esq., represented

See

the Claimant. Mr. Arthur Crownover, II, Esq., represented the State of Tennessee.

I.

INTRODUCTION

On or about January 17, 2004, decedent Jimmy Kimbrell was sixty-eight years old and had multiple medical problems, including congestive heart failure, chronic obstructive pulmonary disease, peripheral artery disease, coronary artery disease, hypertension and diabetes. Kimbrell previously had heart bypass surgery and stenting. He also had ulceration of his feet, particularly his left foot. He was seen frequently by health care professionals at the NWCX infirmary¹, including 5:50 p.m. the day before his death.

At 12:45 a.m. on January 17, 2004, Kimbrell was in his cell at NWCX. His cellmate, Timothy Qualls, banged on the door of their cell and summoned Correctional Officer Merrick for him because Claimant was in pain and felt weak and like he was going to pass out. Officer Merrick contacted Betty Smith, who was the Licensed Practical Nurse, hereinafter referred to as LPN, who was on call that

¹ Kimbrell was serving an eight year sentence for possession of cocaine and possession of marijuana with the intent to sell. (Tr., Vol. I, p. 183, lines 15-19)

shift. Smith apparently told the officer to tell Kimbrell to put a cold rag on his head and try to get some sleep.

Qualls summoned Merrick again at 4:00 a.m. Merrick again contacted Smith, who had officers bring Claimant to the clinic. In the clinic, Kimbrell stopped breathing. Officers Ams and Galbraith performed CPR while Smith evaluated Kimbrell. Smith called an ambulance at around 4:15 a.m., which arrived at the clinic at around 4:30 a.m. Kimbrell died en route to the hospital.

II.

QUESTIONS PRESENTED

The issues presented in this case are as follows: (1) whether Defendant breached the standard of acceptable professional practice when Mr. Kimbrell sought medical help at 12:45 a.m. on January 17, 2004; (2) whether Defendant breached the standard of acceptable professional practice when Kimbrell sought medical care at approximately 4:00 a.m. on January 17, 2004; (3) whether Claimant proved, by a preponderance of the evidence, that Jimmy Kimbrell's death was proximately caused by Defendant's negligence, if any; and (4) the amount of damages, if any, suffered by Claimant as a proximate cause of Defendant's negligence, if any.

III.

SUMMARY OF FACT TESTIMONY

Tony Parker, NWCX's warden, testified in this cause. He testified that he became warden at NWCX sometime in 2003 and was warden in January, 2004. (Tr., Vol. I, p. 95, line 18- p. 96, line 6) Parker testified that part of his job is to see that both state and institutional policies regarding inmate health care are followed. (Tr., Vol. I, p. 99, lines 6-16)

Parker testified that in January, 2004, NWCX contracted with Northwest Community Services Agency for the provision of certain medical services to the facility, including physicians. (Tr., Vol. I, p. 102, lines 5-17) He stated that he considered these employees independent contractors, not state employees. (Tr., Vol. I, p. 103, lines 9-17)²

Parker testified that correctional officers receive CPR and first aid training, but only RNs, LPNs and medical staff are allowed to make medical decisions. (Tr., Vol. I, p. 114, lines 8-24) Parker testified that staffing at NWCX was adequate in January, 2004. (Tr., Vol. I, p. 115, lines 6-8)

² During Parker's testimony, Attorney General Crownover stipulated that the nurses were state employees. (Tr., Vol. I, p. 103, line 23-p. 104, line 3)

Warden Parker stated that he was not aware of any complaints Mr. Kimbrell had before he died regarding his medical treatment at NWCX. (Tr., Vol. I, p. 125, line 24-p. 126, line 3)

Warden Parker testified that in January, 2004, inmates at NWCX had access to telephones throughout the housing units and in other parts of the prison. The inmates "would simply go up, pick up the phone and call whoever they wanted to call." (Tr., Vol. I, p. 140, lines 18-20) With the exception of attorney calls, these conversations were recorded. (Tr., Vol. I, p. 140, line 21- p. 141, line 2) The parties involved in the calls are made aware by a recording at the beginning of the calls that a recording is being made. (Tr., Vol. I, p. 142, lines 11-21) These calls are sometimes reviewed during internal affairs investigations (Tr., Vol. I, p. 142, line 22- p. 143, line 3), as they were in the investigation of Kimbrell's death. (Tr., Vol. I, p. 144, lines 9-11)

Parker testified that correctional officers receive CPR and first aid training when they are hired, as well as annual retraining. (Tr., Vol. III³, p. 11, lines 19-24)

Parker testified that prison records indicate that someone called for an ambulance at 4:16 a.m. on January 17, 2004. The ambulance

³ The transcript of the proceedings for March 12, 2009, will be referred to as Vol. III.

arrived at 4:30 a.m. and was through the sally port and enroute to the prison clinic by 4:32 a.m. The ambulance left the sally port on the way back to the hospital at 4:50 a.m. (Tr., Vol. III, p. 12, line 15- p. 13, line 6)

Parker testified he did not know the specific findings of the CQI Committee's review of Mr. Kimbrell's death. (Tr., Vol. III, p. 43, line 13- p. 44, line 4)

Tommy Mills testified that he was deputy warden at NWCX in January, 2004. (Tr., Vol. I, p. 196, lines 17-18) Part of his responsibilities included overseeing inmate health care, although the actual supervision of inmate health care was done by health administrator Samantha Phillips, an employee of Northwest Community Services Agency. (Tr., Vol. I, p. 196, line 22- p. 197, line 20) Mills testified that at that time, NWCX housed approximate 2,300 inmates. (Tr., Vol. I, p. 198, line 4) He said the medical staff included a doctor and around thirty-five nurses, including RNs and LPNs. (Tr., Vol. I, p. 198, line 18- p. 199, line 15) There were some nursing vacancies at the time of Kimbrell's death, which were filled, in part, with the use of overtime. (Tr., Vol. I, p. 199, line 22- p. 200, line 16)

Mills testified that during third shift, there was "one LPN at the annex site" (Tr., Vol. I, p. 201, line 11) and at least one RN and a couple of LPNs at the main compound. (Tr., Vol. I, p. 201, lines 14-22) In January, 2004, Dr. Smith would have been available by phone on the third shift. (Tr., Vol. I, p. 202, line 17- p. 203, line 1)

Mills testified that correctional officers were allowed to call in a code if an inmate is in medical distress. (Tr., Vol. I, p. 205, line 12)

Mr. Bernard Bennett, a counselor at NWCX, testified by deposition on June 21, 2007. (Ex. 23) Bennett was a Unit Manager Guild 1 where Jimmy Kimbrell was housed in January, 2004. (Ex. 23, p. 12, lines 15-19)

Bennett testified that when Kimbrell was placed in the cell with inmate Timothy Qualls, Bennett talked with Qualls "and told him if [Kimbrell] had any problems he needed to let the officer know for sure." (Ex. 23, p. 15, lines 7-9) Bennett noted that Kimbrell had a breathing machine when he came to Guild 1 (Ex. 23, p. 15, lines 12-13), so he instructed Qualls to let the officer know if there were problems with Kimbrell's health. (Ex. 23, p. 15, lines 21-24)

Bennett also stated that he spoke with all of the correctional officers about Jimmy Kimbrell. (Ex. 23, p. 17, line 5) He asked them

to keep an eye on Kimbrell and, if he had problems, "to get in touch with medical immediately." (Ex. 23, p. 18, lines 9-10) When asked whether he had been told that Kimbrell had heart problems, Bennett replied: "Nobody ever told me anything medically about that gentleman at all." (Ex. 23, p. 17, lines 22-23)

Andrew Lee Haynes, Associate Warden of Operations, testified by deposition on December 11, 2007. (Ex. 24) He stated that he met Jimmy Kimbrell only once, a day or two before he died (Ex. 24, p. 6, lines 9-10) after Unit Manager Bennett told Haynes one of the inmate's "feet were swollen and he couldn't walk." (Ex. 24, p. 6, lines 17-18) Haynes said he talked with Kimbrell, then asked the clinic to see him and had Kimbrell taken over to the clinic in his wheelchair. (Ex. 24, p. 6, lines 22-23) He said what he did for Kimbrell was no different than what he had done "many other times." (Ex. 24, p. 6, lines 14-16)

Amanda Collins, who testified live in this cause, was a physician's assistant at the prison in January, 2004. (Tr., Vol. I, p. 245, lines 12-22) When ask how her responsibilities differ from a LPN, Collins stated: "I do physicals and make diagnoses and prescribe medications." (Tr., Vol. I, p. 247, lines 5-6) Collins testified

that she provided medical care to Mr. Kimbrell between November, 2003, and his death in January, 2004. (Tr., Vol. I, p. 247, lines 10-14)

Collins testified that she saw Jimmy Kimbrell on January 15, 2004, at Associate Warden Haynes' request. (Tr., Vol. I, p. 251, line 22- p. 252, line 4) She said her notes indicate Mr. Kimbrell presented "in wheelchair with complaints of infection to left foot." (Tr., Vol. I, p. 253, lines 17-19)

Collins testified that the shingles diagnosis was Dr. Smith's, but that she agreed with it. (Tr., Vol. III, p. 145, lines 16-24) She stated that Kimbrell had pain and swelling in both feet, but that shingles was on his left foot only. (Tr., Vol. III, p. 147, lines 1-12)

Collins testified that, with regard to Kimbrell's peripheral vascular disease, he was given aspirin and counseled to quit smoking. (Tr., Vol. III, p. 149, lines 10-11)

Debbie Massey Covington testified by deposition. (Ex. 28) She has worked as a LPN for the TDOC for fourteen years. (Ex. 28, p. 10, lines 16-17) She saw Jimmy Kimbrell in the clinic on January 16, 2004. (Ex. 28, p. 62, lines 9-13)

Covington testified that if she had gotten the call about Mr. Kimbrell, "I myself would probably told him to come to the clinic." (Ex. 28, p. 70, lines 17-19)

Pearl Alexander, a LPN at NWCX, also testified by deposition. She stated that if an officer reported new complaints by an inmate that he was feeling weak and as if he were going to pass out were reported to her, "I think I would see him." (Ex. 47, p. 45, line 24) The purpose of seeing the inmate would be "[t]o see if he had deteriorated." (Ex. 47, p. 46, line 8) She said she would check the inmate's "vitals, skin tone, his general well being." (Ex. 47, p. 46, lines 10-11)

She said she might advise a patient to put a cold cloth on his head and try to rest for the complaints Mr. Kimbrell reported, but that she would check back with the officer in ten minutes to see how the patient was doing. (Ex. 47, p. 49, line 21- p. 50, line 10)

IV.

FACT TESTIMONY REGARDING THE EVENTS OF JANUARY 15-17, 2004

Claimant proffered audio tape recordings of conversations between Jimmy Kimbrell and his now deceased sister, Mary Jo Taylor. Claimant Sharon Kimbrell Ashley identified the callers on an

audio recording of three telephone conversations, as her father, Jimmy Kimbrell, and his sister, Mary Jo Taylor.⁴ (Tr., Vol. I, p. 175, line 18- p. 177, line 4) She identified the callers on a fourth call as herself and an inmate, Charles Bryant. (Tr., Vol. I, p. 177, lines 13-17)

During the first January 15, 2004 conversation between decedent and Taylor, Kimbrell entreats his sister to contact the warden regarding his foot pain:

It is an emergency. And they need to get me to the damn emergency room in—Union City, is what they need to. Okay. It's—I can't go through another night like this. (Tr., Vol. I, p. 316, line 24-p. 317, line 4)

Kimbrell told his sister “can't live another night like this. I am a dead man here in the morning.” (Tr., Vol. 1, p. 317, lines 21-23)

An hour later, Kimbrell talked to his sister again. Kimbrell told her: “A man with congestive heart failure. Yeah. Hell, yeah. I can't stay up two days and nights at a time.” (Tr., Vol. 1, p. 322, lines 12-15)

Timothy Qualls, an inmate at River Bend, testified by telephone. Qualls was Jimmy Kimbrell's cellmate in January, 2004. (Tr., Vol. II,

⁴ Mary Jo Taylor died a week before the trial in this cause.

p. 7, lines 16-24) Qualls stated that Kimbrell was mostly confined to his wheelchair and that his activities were quite limited. (Tr., Vol. II, p. 9, lines 3-5) Qualls said he helped Kimbrell daily. (Tr., Vol. II, p. 9, line 20)

Qualls testified that he was in the cell with Kimbrell the night of January 16, 2004, and the morning of the 17th. Qualls stated that around 12:00 or 12:30 a.m., Kimbrell complained that "his heart was hurting" (Tr., Vol. II, p. 10, lines 11-12) and indicated that Kimbrell "thought he was having a heart attack." (Tr., Vol. II, p. 10, lines 14-15)

Qualls said the first time Kimbrell told him about those symptoms, "I got him some help and he took some of his medication and he got a little better." (Tr., Vol. II, p. 10, lines 22-24)

Qualls indicated that when the officer came to the cell right after midnight, he told the officer Mr. Kimbrell "was having chest pains or problems with his heart and he needed some help." (Tr., Vol. II, p. 31, lines 10-11)

Qualls reported Kimbrell had another spell around 1:30 or 2:00 a.m. Qualls said he "beat on the doors to get him some help." (Tr., Vol. II, p. 11, lines 14-15) He said it took awhile, but the correctional

officer finally came. (Tr., Vol. II, p. 11, lines 18-19) He said two officers came and rolled Kimbrell out of the unit. That was the last time he saw his cellmate. (Tr., Vol. II, p. 12, lines 8-18)

On cross-examination, Qualls acknowledged that he gave a statement to investigators on January 19, 2004, a few days after Mr. Kimbrell's death. (Tr., Vol. II, p. 15, lines 1-11) Qualls further acknowledged that in the January 19th interview, he said a nurse came to the cell at the time of Kimbrell's first spell. However, at the trial of this cause he indicated there were no lights on in the unit and he could not be sure if a nurse or an officer came during the first spell. (Tr., Vol. II, p. 20, lines 11-23) Qualls explained, "They didn't even open our cell door the first time." (Tr., Vol. II, p. 20, lines 23-24)

Qualls testified that he was not sure of the time of Mr. Kimbrell's second spell. (Tr., Vol. II, p. 22, lines 19-22)

Officer David Merrick testified live at the hearing of this cause. Merrick was a correctional officer at Northwest in January, 2004. (Tr., Vol. II, p. 37, lines 2-4) As part of his training, he was instructed in CPR and first aid. (Tr., Vol. II, p. 38, line 10) Specifically, he was trained to do "chest compressions with breaths." (Tr., Vol. II, p. 38, lines 19-20) Merrick indicated his training also included instruction on

the symptoms of a heart attack. The main symptoms he could enumerate were chest pain and shortness of breath. (Tr., Vol. II, p. 39, lines 10-21)

Merrick testified that the CPR and first aid training have been gone over every year since he was hired. (Tr., Vol. II, p. 40, lines 4-13) Merrick also testified that he had not been trained to “medically assess” an inmate. (Tr., Vol. II, 40, lines 14-17)

Officer Merrick testified that when an inmate indicates he is sick, the protocol he follows is to call the nurse. (Tr., Vol. II, p. 41, lines 8-16)

In case of a medical emergency, he would call a code four on the radio after which the medical staff would come to assess the situation. (Tr., Vol. II, p. 42, lines 2-13) He does not call 911 directly. (Tr., Vol. II, p. 43, lines 14-17) Merrick said he would call a code four for “major chest pain or unconscious or severe bleeding.” (Tr., Vol. II, p. 43, lines 10-11) He said he had not been trained to differentiate between major and non-major chest pain. (Tr., Vol. II, p. 43, lines 21-24)

Merrick testified he was working Guild 1 on the third shift, 10 p.m. to 6 a.m. on January 16-17, 2004. (Tr., Vol. II, p. 44, lines 7-14)

He said the only time he leaves the unit on his shift is for his lunch break, usually around 12:45 a.m. (Tr., Vol. II, p. 47, lines 12-23) When he leaves the unit for lunch, another officer is present. (Tr., Vol. II, p. 47, line 24- p. 48, line 5)

Looking at the log book for January 17, 2004, Merrick stated that he wrote that "Mr. Kimbrell was complaining about pain and feeling like he was going to pass out." (Tr., Vol. II, p. 53, lines 4-6) Merrick testified that Kimbrell did not specify what part of his body was hurting. (Tr., Vol. II, p. 53, lines 7-17) Merrick did not recall asking where Kimbrell was hurting. (Tr., Vol. II, p. 53, lines 18-23) Merrick wasn't sure whether he talked with Kimbrell through the door or cracked the door open. (Tr., Vol. II, p. 54, lines 7-10)

Merrick testified that Qualls did not tell him that Mr. Kimbrell's heart was hurting at 12:45 a.m. (Tr., Vol. II, p. 68, lines 14-20) In fact, he could not recall even talking to Qualls at 12:45. (Tr., Vol. II, p. 69, lines 10-14) Merrick insisted that if Qualls had told him that Kimbrell was having chest pains, "I would have told the nurse and they would have sent him down to the clinic." (Tr., Vol. II, p. 69, lines 2-4)

Merrick stated that he called Nurse Smith about Kimbrell's complaints. (Tr., Vol. II, p. 54, lines 14-17) Merrick testified he told Smith that Kimbrell "was feeling sick and felt like he was going to pass out." (Tr., Vol. II, p. 55, lines 6-7) He couldn't recall whether he mentioned Kimbrell was in pain. (Tr., Vol. II, p. 55, lines 10-12)

Merrick said Smith "told me to tell him to put a cool rag on his head and try to go to sleep." (Tr., Vol. II, p. 57, lines 4-5) Merrick had no further contact with Kimbrell until 4 a.m. when someone, he thinks Mr. Qualls, knocked on the door of the cell. (Tr., Vol. II, p. 59, lines 9-24)

Merrick stated he "didn't really notice any difference" in Kimbrell's condition at 12:45 a.m. and 4:00 a.m. (Tr., Vol. II, p. 60, lines 12-18) Merrick testified Qualls said that Mr. Kimbrell "needs to see somebody." (Tr., Vol. II, p. 60, lines 7-8) Merrick testified that Qualls did not tell him that Kimbrell's "heart was hurting and he was afraid he was going to die." (Tr., Vol. II, p. 69, line 20- p. 70, line 1)

At 4:00 a.m., Merrick again called Nurse Smith, who told Merrick to send Kimbrell to the clinic, which he did. (Tr., Vol. II, p. 61, lines 1-4) He could not recall whether there was a tone of urgency in Smith's response. (Tr., Vol. II, p. 64, lines 8-10)

Merrick said he contacted Unit 3 about the matter, but did not call a code four. (Tr., Vol. II, p. 61, lines 9-17) Merrick said it did not look like a medical emergency to him. (Tr., Vol. II, p. 62, lines 8-10) However, Merrick acknowledged that he testified during his deposition that Kimbrell looked like he required medical care. (Tr., Vol. II, p. 62, lines 20-24)

Officer Carl Dexter, who also testified at the trial of this cause, was working third shift on January 16-17, 2004. He and another officer responded to Merrick's call to Unit 3 and helped wheel Kimbrell to the clinic. (Tr., Vol. II, p. 78, line 14- p. 79, line 5) He acknowledged that he had sometimes fallen asleep during third shift. (Tr., Vol. II, p. 77, lines 20-22)

Dexter testified he could not see Kimbrell until the door to the cell was opened. (Tr., Vol. II, p. 80, lines 17-23) He saw Kimbrell laying on the bottom bunk "just kind of moaning." (Tr., Vol. II, p. 81, lines 14-15) Dexter estimated it took approximately two minutes to get Kimbrell to the clinic. (Tr., Vol. II, p. 81, lines 20-21)

Dexter acknowledged that he testified in his deposition that it was about twenty to thirty minutes later before he was called to be a chase car driver for the ambulance. (Tr., Vol. II, p. 83, lines 1-11)

Dexter stated that prison records indicate weapons were signed out for the chase vehicle at 4:30 a.m. (Tr., Vol. II, p. 87, lines 19-21; Ex. 33) Dexter stated that there was no delay of the ambulance at the sally port. (Tr., Vol. II, p. 89, lines 2-4)

Correctional Officer Suzette Ams testified by deposition on June 21, 2007. (Ex. 49) Ams was working third shift on the night of January 16-17, 2004. She got a call on the radio that an inmate had to be taken to the clinic. (Ex. 49, p. 22, lines 18-24) She was in the clinic when Kimbrell was brought in in a wheelchair. (Ex. 49, p. 25, lines 13-14) Ams said Kimbrell was on the gurney when he quit breathing. (Ex. 49, p. 26, lines 8-9) Ams helped do chest compressions on Kimbrell (Ex. 49, p. 27, lines 1-4), but let Officer Galbraith take over because he was lighter and could get on the gurney to do the compressions. (Ex. 49, p. 27, lines 21-22)

Correctional Officer Lester Galbraith testified by deposition. (Ex. 34) He was working as a yard officer at NWCX in January, 2004. (Ex. 34, p. 15, lines 19-23)

Galbraith, who took Kimbrell to the clinic in his wheelchair, stated that Jimmy Kimbrell is "the only person I've ever done CPR on and died in front of me." (Ex. 34, p. 19, lines 11-15) He stated he

could tell Kimbrell needed medical care because “he was gasping for breath and couldn’t hardly speak.” (Ex. 34, p. 20, lines 23-24)

Galbraith stated that once they got to the infirmary, the nurse was evaluating Kimbrell so Galbraith left. (Ex. 34, p. 27, lines 20-22) When he came back by the clinic a little later, he saw Officer Ams “trying to start CPR on him.” (Ex. 34, p. 28, lines 14-15) Galbraith said, “they looked like they were nervous and agitated,” (Ex. 34, p. 28, lines 17-18), so he took over doing chest compressions from Ams. (Ex. 34, p. 28, lines 18-21)

Bettye Joyce Smith, L.P.N., testified by deposition on June 10, 2008. Smith testified she stopped practicing nursing when she was diagnosed with epiglottic carcinoma in January, 2005. (Ex. 35, p. 12, line 19- p. 13, line 5)

Smith testified she started working at the prison in Tiptonville as an employee of the Northwest Community Services Agency in 1998.⁵ (Ex. 35, p. 13, lines 13-14)

Smith testified that Dr. James Smith was the physician at NWCX in January, 2004. (Ex. 35, p. 18, lines 18-23) She testified

⁵ Under 8-42-101(3), Tenn. Code Ann. (Supp. 2002), employees of community services agencies shall be considered “state employees” for the purposes of 9-8-307.

Smith was available by phone when he was not on site. (Ex. 35, p. 19, lines 16-24)

Smith testified that Mr. Kimbrell died on third shift and that she worked a double shift that day. (Ex. 35, p. 20, lines 8-15) Smith testified that if an inmate wants to see a health care provider on third shift, he “would have to talk to the unit officer and the unit officer would call the clinic.” (Ex. 35, p. 26, lines 15-17) Then if they needed to come into the clinic, “an officer could bring them over.” (Ex. 35, p. 26, lines 22-24)

Smith testified that whether an inmate on third shift would be allowed to come to the clinic “would be more or less left to the nurse.” (Ex. 35, p. 27, lines 11-12) However, the nurse would go to the inmate if an officer called a medical emergency. (Ex. 35, p. 27, lines 12-18) If the officer did not call a “Code 4,” the nurse would make an assessment about whether the inmate needed to come to the clinic based on the type of problem and what the officer told her about it. (Ex. 35, p. 30, lines 12-13) Smith continued: “A lot of it depends on the officer’s tone of voice when he’s calling me.” (Ex. 35, p. 31, lines 23-24)

Smith explained that it would have been “against policy” for her to talk to an inmate over the phone to assess his condition. (Ex. 35, p. 32, lines 1-3) Smith went on to state that the officer would not have been qualified to take an inmate’s vital signs. (Ex. 35, p. 32, line 22- p. 33, line 9) Smith testified that there was no protocol or certain questions a nurse would ask to assess an inmate’s medical condition when a unit officer called. (Ex. 35, p. 46, lines 12-19)

Smith further testified that she was the only health care provider physically on-site at Site 2 on third shift the night Mr. Kimbrell died. (Ex. 35, p. 39, lines 18-24)

Smith testified that decedent was seen in the clinic on January 16, 2004, during 2nd shift by a nurse named Sara Quintera. (Ex. 35, p. 47, lines 12-20) Smith said she didn’t know why he came to the clinic that day, but he was “in there real often complaining about foot pain.” (Ex. 35, p. 48, lines 5-6) Smith said she was not certain, but that she believed Kimbrell had shingles on his foot. (Ex. 35, p. 49, lines 9-11) Smith stated that shingles would not be an emergency. (Ex. 35, p. 49, lines 18-19)

Smith testified that Kimbrell had several medical conditions, including chronic obstructive pulmonary disease, severe emphysema,

and congestive heart failure. She knew he previously had by-pass surgery. (Ex. 35, p. 50, lines 3-12)

Smith testified that she got a call from an officer about Mr. Kimbrell at 12:45 a.m. on January 17, 2004. The officer told her that Kimbrell "was feeling weak he said and he felt like he might pass out." (Ex. 35, p. 54, lines 20-22) She said she couldn't recall anything else the officer said but that she could "hear inmate Kimbrell in the background talking to him." (Ex. 35, p. 54, line 24- p. 55, line 2) She couldn't understand what Kimbrell was saying to the officer. (Ex. 35, p. 55, lines 5-7) She then acknowledged she heard a voice and assumed it was inmate Kimbrell. (Ex. 35, p. 55, lines 20-24)

Smith testified she instructed the officer as follows:

I told the officer to have inmate Kimbrell lie down, put a cold cloth on his head and try to go to sleep. But I also told the officer that if he needed me to call me and he told me okay. (Ex. 35, p. 56, lines 9-14)

Smith testified after receiving this call from the officer, she documented the call and "glanced through the chart, I imagine." (Ex. 35, p. 68, lines 2-3) Smith conceded she did not have any independent recollection of looking at the chart. (Ex. 35, p. 68, lines 5-10)

Smith testified she was next contacted about Mr. Kimbrell around 4:00 a.m. (Ex. 35, p. 68, lines 17-20) Smith testified the officer called and said Kimbrell “needed attention.” (Ex. 35, p. 69, lines 1-3) Smith indicated she could tell he did by the tone of the officer’s voice. (Ex. 35, p. 69, lines 3-4) Smith said the officer indicated he could get Kimbrell to the clinic in a wheelchair. (Ex. 35, p. 69, lines 4-6)

Smith testified she didn’t know why she thought Kimbrell was feeling weak when the officer called at 12:45 a.m. (Ex. 35, p. 70, p. 17-18) Smith indicated that in earlier visits to the clinic, Kimbrell indicated the pain in his foot made him feel weak. (Ex. 35, p. 71, lines 7-8) Smith conceded: “I don’t know why he was weak and I don’t know why he felt like he was going to pass out.” (Ex. 35, p. 71, lines 21-23) She further testified that feeling weak and like he was going to pass out were not, in her opinion, separate complaints. (Ex. 35, p. 81, lines 11-12)

Smith testified that if Kimbrell had come to her during the second shift complaining he was weak and felt like he might pass out, she’s sure she would have taken his blood pressure and pulse. (Ex. 35, p. 76, lines 2-9) Smith said there would have been no physician

or P.A. on site during second shift. (Ex. 35, p. 78, lines 19-21) If Kimbrell had been in the clinic complaining about chest pain, she would have done an EKG. (Ex. 35, p. 82, lines 18-19) She also would have questioned him about the location and duration of the pain and done a cardiac assessment. (Ex. 35, p. 83, lines 9-15) She also would have done a "GI assessment" to see if acid reflux or indigestion might be causing the pain. (Ex. 35, p. 83, lines 16-19)

Smith stated that if Mr. Kimbrell had come to the clinic with dangerously low blood pressure, she would have called the physician immediately. (Ex. 35, p. 85, lines 20-24)

Smith testified that when Kimbrell arrived in the clinic in a wheelchair, he was in respiratory distress, but was still breathing. (Ex. 35, p. 104, lines 11-14) Smith said that "all of the sudden his chest turned red." (Ex. 35, p. 105, line 10) Smith stated that within a very short period of time, Kimbrell became cyanotic, turning blue. (Ex. 35, p. 105, lines 22-23; p. 108, lines 9-12)

Smith reported that Kimbrell's pulse "went away." (Ex. 35, p. 108, lines 20-21) So Smith checked the carotid pulse in Kimbrell's neck. When there was no pulse, Smith and Officer Ams started CPR. (Ex. 35, p. 109, lines 3-10) Ams was doing respirations with the

Ambu bag and Smith was doing chest compressions. (Ex. 35, p. 110, lines 22-24) At one point, Smith reported, they were able to get the pulse back momentarily. (Ex. 35, p. 112, lines 7-18)

Smith reported that while Officers Galbraith and Ams did CPR, she called for the ambulance and "attempted to do some notes." (Ex. 35, p. 113, lines 19-21) She insisted she continued to oversee the CPR. (Ex. 35, p. 114, lines 7-8) Smith stated that once Galbraith got there, she also used the automatic emergency defibrillator. (Ex. 35, p. 117, lines 6-7)

Health administrator Samantha Phillips testified live at the hearing of this cause. She stated she is responsible for "general oversight and management of the health services unit." (Tr., Vol. II, p. 151, lines 2-4) Phillips emphasized that the director of nursing is "in charge directly of nursing staff," (Tr., Vol. II, p. 151, lines 11-12) and reports to a physician "who is our clinical lead." (Tr., Vol. II, p. 151, lines 13-14) Phillips noted that there is a chain of command: LPNs report to RN shift supervisors and the director of nursing who reports to Phillips. (Tr., Vol. II, p. 152, lines 18-23)

Phillips stated she was part of a central office CQI committee which conducted a mortality review of Mr. Kimbrell's case. (Tr., Vol.

II, p. 159, lines 3-24) Phillips could not recall specific findings in the report, but she did not recall any “findings of concern.” (Tr., Vol. II, p. 160, lines 7-8) Phillips stated there also was an internal affairs investigation of the incident, but she did not recall seeing it. (Tr., Vol. II, p. 161, lines 4-16)

Phillips testified that Joseph Vernon conducted the internal affairs investigation. At the time his mother, Jane Vernon, was director of nursing. (Tr., Vol. II, p. 163, lines 5-15)

Phillips testified that she couldn't recall that LPN Smith “documented anything that would have triggered the chest pain protocol.” (Tr., Vol. III, p. 165, lines 14-16) She conceded that if Timothy Qualls did tell Officer Merrick that Kimbrell was having chest pain, “that should have been reported to the nurse, or he should have called the code.” (Tr., Vol. III, p. 169, lines 15-17)

V.

EXCLUSION OF TESTIMONY OF LOUIS JOHNSON, M.D. PURSUANT TO THE “LOCALITY RULE”

During the trial of this cause, Defendant proffered the testimony of Nashville physician, Louis Johnson, M.D. The Commission excluded the testimony of Dr. Johnson because Defendant failed to establish that Dr. Johnson had knowledge of the standard of

professional practice in Tiptonville, Tennessee.⁶ Even though Dr. Johnson's earlier deposition testimony did not establish that he was qualified to testify regarding the standard of care in Tiptonville, the parties were allowed to conduct *voir dire* of Dr. Johnson to give Defendant the opportunity to establish his expertise with regard to the standard of care. In addition, Defendant was allowed to make an offer of proof regarding what Dr. Johnson would have testified to regarding breach of the standard of care and the parties were allowed to file post-trial briefs on the locality rule question.

After reviewing the post-trial briefs, the Commission declines to change its earlier ruling excluding Dr. Johnson's testimony. Under Tennessee law, experts must do more than simply assert they are familiar with the standard of care in a similar community. Instead, they must "present facts demonstrating how they have knowledge of the applicable standard of professional care in a similar community." *Carpenter v. Klepper*, 205 S.W.3d 474, 478 (Tenn. Ct. App. 2006), citing *Robinson v. LeCorps*, 83 S.W.3d 718, 724 (Tenn. 2002).

⁶ Defendant's lawyer initially argued that a state-wide standard of care should be considered. Although the Commissioner notes that the Tennessee Supreme Court has stated that the legislatively mandated locality rule should be relegated to the "ash heap" of history, *Street v. Calvert*, 541 S.W.2d 576, 583 (Tenn. 1976), it is still the law in Tennessee.

Dr. Johnson testified that he had never practiced in Tiptonville, Tennessee or in a community of similar size. (Tr., Vol. III p. 56, lines 14-19) He stated that he had seen referral patients from smaller communities outside of Nashville and had reviewed their records. However, Dr. Johnson never testified about why he knew their standards of care were the same. He had never been to Tiptonville prior to the trial and, in fact, at the trial of this cause, Dr. Johnson could not even remember Tiptonville's size. (Tr., Vol. III p. 57, line 24–p. 58, line 1)⁷ He was aware that Baptist Hospital in Union City was the nearest hospital. However, he did not seem to be familiar with the level of care, the number of beds, the size of the staff or available technology and medical specialties at either the Union City hospital or the Dyersburg Hospital. (Vol. III, p. 15 lines 10-13)

Defendant simply did not carry its burden of proof that the smaller communities near Nashville from which Dr. Johnson received referrals are similar to Tiptonville, Tennessee. And although Dr. Johnson seemed to be a highly qualified and caring physician, his testimony failed to demonstrate that his opinion on the applicable standard of care was based on his knowledge of the standard of care

⁷ Dr. Johnson, who was forthright throughout his testimony, admitted that he did not research Tiptonville other than to determine the size of its population, and he could not remember that at trial. (Tr., Vol. III, p. 57, lines 16-20)

in Tiptonville or in a community similar to it. Without such a demonstration, Dr. Johnson's testimony simply is not admissible under Tennessee law.

VI.

SUMMARY OF TESTIMONY OF MEDICAL EXPERTS ON BREACH OF THE STANDARD OF CARE

James Herman Smith, M.D., testified by deposition on June 10, 2008. (Ex. 36) Dr. Smith worked at NWCX from April, 2003 until June, 2007. (Ex. 36, p. 8, lines 8-10) At the time he worked at NWCX, he had a contract to work for Medical Correction Services, hereinafter referred to as MCS. (Ex. 36, p. 43, lines 15-17) In order to be employed by MCS, Smith testified he had to request employment with the Tennessee Department of Health. (Ex. 36, p. 43, lines 23-24) Smith emphasized that though he was working at a state prison, the contract he signed was with MCS. (Ex. 36, p. 44, lines 20-24)

Dr. Smith was on call in the wee hours of January 17, 2004, but was not present at the facility. (Ex. 36, p. 13, lines 14-16) He did not get a call that night until after Mr. Kimbrell was in cardiac arrest. (Ex. 36, p. 15, line 23- p. 16, line 4)

Dr. Smith testified that he saw Kimbrell often and that Kimbrell complained of extremity pain in his legs. (Ex. 36, p. 35, lines 12-14) Smith went on, "during the time you have shingles, you have pain." (Ex. 36, p. 35, lines 16-17) Smith stated that, in his opinion, shingles was causing the pain in Kimbrell's foot. (Ex. 36, p. 36, lines 1-2) Smith also stated that Kimbrell had cellulitis in both legs. (Ex. 36, p. 36, lines 5-6)

Dr. Smith stated that, hypothetically, if he had received Kimbrell's complaint during first shift, "I think we would have had him come to the clinic." (Ex. 36, p. 56, lines 11-16) He said when they see people in the clinic "we always get their vital signs, try to weigh them." (Ex. 36, p. 57, lines 8-9) That would include "blood pressure, pulse and temperature." (Ex. 36, p. 57, lines 14-15)

When asked whether the medical care rendered to Mr. Kimbrell when he was at NWCX deviated from the standard of care in Lake County, Tennessee, Dr. Smith responded, "I don't believe it did." (Ex. 36, p. 70, lines 2-7)

When asked whether any of the nurses or other practitioners deviated from the standard of care in Kimbrell's treatment, Dr. Smith

responded, "I don't know that they did, but I don't have a complete medical record." (Ex. 36, p. 70, lines 8-16)

Dr. Smith also opined that the policies, procedures and protocols for the care and treatment of inmates at NWCX

probably exceeded the local standard of care. The requirements for the Tennessee Department of Correction are fairly high compared to the community standard. (Ex. 36, p. 76, lines 3-7)

Board-certified emergency physician, Richard Martin Sobel, M.D., testified live at trial as Claimant's expert witness. He stated he provided physician services for three Florida prisons during the 1980's. (Tr., Vol. II, p. 185, lines 17-19) He further noted that "throughout the course of emergency medicine practice, you—you commonly see inmates." (Tr., Vol. II, p. 185, lines 21-23) Dr. Sobel said there was even a prison ward in the hospital where he did his internship. (Tr., Vol. II, p. 186, lines 1-3) Dr. Sobel testified that while he was state regional medical director in Alabama, he entered a contract with Elmore County Jail. (Tr., Vol. II, p. 186, lines 18-20) In addition, while he served as an attending at Grady Memorial in Atlanta, he saw patients in the detention ward. (Tr., Vol. II, p. 187, lines 3-5)

Dr. Sobel testified that he has lectured on cardiac arrest and served as affiliate faculty for the American Heart Association in three states. (Tr., Vol. II, p. 188, lines 9-20) He stated he also has been involved in “research, lecturing and editing on cardiovascular problems for medical journals.” (Tr., Vol. II, p. 188, lines 20-21)

Dr. Sobel currently works “at a number of emergency departments.” (Tr., Vol. II, p. 190, lines 5-6) He is medical director and emergency physician at a facility in rural Georgia “in a community not terribly unlike Tiptonville.” (Tr., Vol. II, p. 190, lines 9-11) He also works in a level two facility in a busy urban emergency room in the Atlanta area. (Tr., Vol. II, p. 190, lines 13-15) Finally, he also works in a “community hospital practice” one and a half hours south of Atlanta. (Tr., Vol. II, p. 190, lines 15-18) Sobel also spends time as a medical records reviewer and expert witness. (Tr., Vol. II, p. 190, lines 20-24)

Dr. Sobel stated he has testified in several cases in Tennessee. He said he was familiar not only with the local standard of care in Tiptonville in January, 2004 (Tr., Vol. II, p. 193, lines 6-9; p. 194, lines 4-10), but also with “acceptable medical and nursing practice for correctional institutions.” (Tr., Vol. II, p. 193, lines 16-19)

Claimant tendered Dr. Sobel as an expert and the State did not object. (Tr., Vol. II, p. 195, lines 5-11) Dr. Sobel testified that he reviewed Kimbrell's medical records from Baptist Memorial Hospital for both December 9, 2003 and January 17, 2004, his autopsy report, death certificate, prison medical records, internal affairs report on Kimbrell's death and the ambulance records for January 17, 2004. (Tr., Vol. II, p. 195, line 20-p. 196, line 23) He also reviewed the transcripts of the phone calls Kimbrell made to his family, the interview with Timothy Qualls and some of the pleadings in this case. (Tr., Vol. II, p. 197, lines 1-9)

Dr. Sobel noted that, dating back to 2000, Kimbrell had a history of coronary artery bypass surgery, COPD and cardiomyopathy with arrhythmia. (Tr., Vol. II, p. 200, line 23-p. 201, line 5) Dr. Sobel stated that hospital records from February, 2003, indicate that Kimbrell was being treated for peripheral vascular disease (Tr., Vol. II, p. 203, lines 14-18), or "hardening of the arteries of his lower extremities that impaired circulation in his feet." (Tr., Vol. II, p. 203, lines 20-23) During that hospitalization, Kimbrell had a stent put in to keep the vessel open. (Tr., Vol. II, p. 204, lines 3-4)

Sobel testified that after such stenting, a patient is put on Plavix to prevent occluding of the stent. (Tr., Vol. II, p. 204, lines 12-20) Mr. Kimbrell was put on Plavix at that time, February, 2003. (Tr., Vol. II, p. 204, line 20-p. 205, line 1) Sobel stated that if Plavix is not maintained, there is a high risk of the stents clotting off which "would cause his legs to be exquisitely painful" (Tr., Vol. II, p. 205, lines 21-22) and impair his ability to walk. (Tr., Vol. II, p. 206, lines 4-5) Sobel testified that prison medical records indicated that the provider was seeking an authorization of medical necessity from the prison physician regarding the Plavix, which apparently never occurred. (Tr., Vol. II, p. 207, lines 7-12)

Sobel also testified that Kimbrell's blood pressure of 90/60 would be "far below your target" blood pressure. (Tr., Vol. II, p. 209, lines 5) He said blood pressure that low would exacerbate his congestive heart failure and make it difficult to overcome his emphysema. (Tr., Vol. II, p. 209, lines 12-20) Sobel noted that Kimbrell was weak and dizzy when he saw the physician's assistant on January 15, 2004, both symptoms of low blood pressure. (Tr., Vol. II, p. 210, line 24-p. 211, line 7)

Dr. Sobel testified that by the time Kimbrell was incarcerated at NWCX in the fall of 2003, he was "severely decompensated." (Tr., Vol. II, p. 213, lines 12-15) Kimbrell had severe edema and "was too short of breath to get out of his wheelchair." (Tr., Vol. II, p. 213, lines 22-23)

Sobel testified that Kimbrell's severe foot pain was due to peripheral artery disease, (Tr., Vol. II, p. 214, lines 22-24) although the health care providers at the prison "were presuming he had shingles." (Tr., Vol. II, p. 215, lines 6-7) Dr. Sobel testified that Kimbrell "didn't have shingles at all," (Tr., Vol. II, p. 238, line 14) and noted that "[y]ou cannot get shingles in both your legs, it's impossible." (Tr., Vol. II, p. 238, lines 16-18)

Sobel testified that the records from NWCX show "persistent medical neglect by this facility and management by LPNs rather than physicians or even a P.A." (Tr., Vol. II, p. 232, lines 5-7) Sobel stated:

He goes to jail and he decompensates and becomes progressively worse and worse and no one is doing anything about it. (Tr., Vol. II, p. 239, lines 6-9)

Dr. Sobel testified that the medical records indicate Kimbrell was seen by P.A. Amanda Collins on January 15, 2007. Sobel

described Kimbrell's condition as "decompensated and getting worse." (Tr., Vol. II, p. 256, lines 10-11) Sobel testified that Kimbrell should have been sent to the emergency room that day, and that based on the autopsy, he believes Kimbrell's condition could have been turned around if he had been sent to the emergency room. (Tr., Vol. II, p. 258, line 19- p. 259, line 4)

Dr. Sobel stated that he agreed with the pathologist that Kimbrell died of myocardial insufficiency, not a large heart attack. (Tr., Vol. II, p. 263, lines 11-22) Dr. Sobel further stated that Kimbrell's life was still salvageable at 12:45 a.m. on January 17, 2004. (Tr., Vol. II, p. 265, lines 21-23) Sobel even opined that Kimbrell could have been saved at 4 a.m. if he had received immediate emergency care. (Tr., Vol. II, p. 266, lines 3-17) Sobel stated:

A correctional officer has got to know when to call 911 on a patient that's breathing like a guppy and is not even verbal and not even able to get out of bed. (Tr., Vol. II, p. 267, lines 21-24)

Sobel characterized it as inconceivable that the nurse

took him into the clinic sometime around 4 o'clock and she spent another 15 minutes doing her nursing assessment before she even called the ambulance. (Tr., Vol. II, p. 268, lines 19-23)

Dr. Sobel opined that Smith's advice that Kimbrell put a cold cloth to his head had no medicinal value to his complaint that he was weak and felt like he was going to pass out. (Tr., Vol. II, p. 276, line 24-p. 277, line 19) Dr. Sobel insisted that Smith's presumption that Kimbrell's pain was what was making him feel like he was going to pass out was a "differential diagnosis, albeit ridiculous," (Tr., Vol. II, p. 278, lines 12-15) which exceeded her scope of practice as a nurse. (Tr., Vol. II, p. 278, lines 2-7) Sobel insisted that during the 12:45 a.m. time frame, Smith should have done a nursing assessment, including taking vital signs, and reported to a physician. (Tr., Vol. II, p. 279, line 24-p. 281, line 3)

Dr. Sobel further opined that while she was on the phone with Officer Merrick at 4:00 a.m., "she should have made a determination if 911 needed to be called." (Tr., Vol. II, p. 281, lines 12-14) Sobel stated,

Clearly at that point, he—he needs to be intubated. He has to have a tube put down his throat. And has to have, I believe, [blood] pressure support. (Tr., Vol. II, p. 266, lines 21-23)

Sobel noted that there would have been plenty of information available for LPN Smith to make that assessment since

This man was gasping for air per Mr. Galbraith. His mental status was altered. He was lethargic. He was moaning, per Mr. Dexter. He needed assistance to get in a wheelchair. He clearly had a medical emergency. (Tr., Vol. II, p. 281, lines 17-24)

Dr. Sobel opined that if Kimbrell had been intubated in a timely way, it is "likely he would have survived." (Tr., Vol. II, p. 285, line 23) When asked whether, to a reasonable degree of medical certainty, the medical care rendered to Kimbrell met the standard of care, Dr. Sobel replied, "not even close." (Tr., Vol. II, p. 290, line 19-p. 291, line 1) At one point, Sobel characterized the treatment of Mr. Kimbrell as "torture." (Tr., Vol. II, p. 298, lines 9-11)

Dr. Sobel also noted that Dr. Smith's testimony indicated that "he would not have let Mr. Kimbrell sit in his cell with complaints of feeling like he was going to pass out." (Tr., Vol. II, p. 293, lines 14-17) Sobel also noted that "nobody can really recall what happened in the quality improvement committee." (Tr., Vol. II, p. 294, lines 2-4)

When asked whether he found there was medical malpractice committed by a state employee, Dr. Sobel responded, "Absolutely, I do." (Tr., Vol. II, p. 300, line 17)

VII.

SUMMARY OF ADDITIONAL TESTIMONY ON DAMAGES

Decedent's son, Jimmy Allan Kimbrell testified on behalf of Claimant. He stated he visited his father at the hospital in 2003, when his father was in the hospital in Dyersburg, not long before he was transferred to NWCX. Jimmy Allan Kimbrell was not allowed in the hospital room with his father, but he went to the door of his room to make sure he was okay. (Tr., Vol. I, p. 74, lines 11-15)

Jimmy Allan Kimbrell stated that he had not been able to visit his father while he was at NWCX or West Tennessee State Penitentiary because he worked sixteen hours a day. (Tr., Vol. I, p. 84, lines 15-16; p. 89, lines 3-8) On cross examination, he conceded he lived in Dyersburg, only about thirty-five miles from where his father was incarcerated beginning in November, 2003, (Tr., Vol. I, p. 89, lines 9-13) and that he was on his father's visitor's list. (Tr., p. 88, lines 21-24)

Jimmy Allan Kimbrell apparently was not in contact with his father by phone or letter after he was incarcerated in August, 2003, although he saw decedent frequently before the incarceration, "at least every third day for sure." (Tr., p. 93, lines 6-7)

Jimmy Allan Kimbrell testified he has the skills to build subdivisions because of the things his father taught him. Decedent taught him how to read blue prints, wire and plumb a house. He stated he worked with his father in the 1970's installing fire and sprinkler systems. (Tr., Vol. I, p. 75, lines 13-20) Jimmy Allan Kimbrell testified his father also taught him to fish and helped him rebuild a car that became the road test car for the Indianapolis 500. (Tr., Vol. I, p. 75, line 24-p. 76, line 18)

Jimmy Allan Kimbrell testified about the various jobs decedent held during his life. Decedent was a fireman (Tr., Vol. I, p. 77, lines 23-24), an instructor for the fire department teaching fire inspectors (Tr., Vol. I, p. 81, lines 5-7; p. 83, lines 3-4), and an owner of an alarm system company in Dyersburg. (Tr., Vol. I, p. 83, lines 23-24)

Jimmy Allan Kimbrell testified that his father was a teacher, his teacher, and that not a week goes by that he doesn't come across a problem his father couldn't help him solve. (Tr., Vol. I, p. 86, lines 15-23)

Jimmy Allan Kimbrell testified that his father did not support him financially prior to his incarceration. (Tr., Vol. I, p. 89, lines 19-23) Jimmy Allan Kimbrell further testified that he thought the Social

Security Administration had determined that his father was disabled and that his dad used that money for living expenses. (Tr., Vol. I, p. 91, line 23-p. 92, line 8)

Claimant Sharon Kimbrell Ashley, decedent's daughter, also testified. In addition to the jobs enumerated by her brother Jimmy Allan Kimbrell, Ashley stated that her father also did sheet metal work and worked as an electrician. (Tr., Vol. I, p. 148, lines 21-23) Ashley further testified her father got his first summer job at age fifteen in an ice cream parlor. (Tr., Vol. I, p. 149, lines 9-10) After her father finished high school, he worked consistently. (Tr., Vol. I, p. 150, lines 13-14) Ashley testified that her father worked for Frazier Williams and International Harvester. (Tr., Vol. I, p. 151, lines 3-5) He did all of the duct and electrical work for a 117 house subdivision in Frazier. (Tr., Vol. I, p. 151, lines 7-10)

Ashley testified her father had his heart attack in 1988, followed by a triple by-pass. (Tr., Vol. I, p. 151, lines 13-19) After that, he received social security disability and did "side work." (Tr., Vol. I, p. 151, lines 20-21) Prior to his incarceration, he was "walking—he was helping a friend rewire a house, he—and he had been doing some plumbing work." (Tr., Vol. I, p. 156, lines 10-13)

On cross-examination, Ashley testified that prior to his incarceration, decedent was receiving Social Security disability payments of \$517.00 a month and supplemental security income of fifty-seven dollars (\$57.00) a month. (Tr., Vol. I, p. 191, lines 1-4) She stated he spent the \$572 a month on living expenses. (Tr., Vol. I, p. 191, lines 15-18)

Ashley testified her father finished 9th grade, but later completed his GED, then took courses at Dyersburg State and the University of Tennessee at Martin. (Tr., Vol. I, p. 152, line 22- p. 153, line 2)

Ashley testified her father suffered from heart problems and COPD prior to his incarceration. She insisted the problem with his feet didn't develop until after his incarceration. (Tr., Vol. I, p. 153, lines 3-8, 14-20) She said when he began having foot problems, he was treated for shingles and gout, but it did not help. (Tr., Vol. I, p. 154, lines 1-6) Ashley said her father's medications included Albuterol and Plavix before he was incarcerated. (Tr., Vol. I, p. 154, lines 13-17)

Ashley testified she did not visit her father at NWCX for two reasons. One was that the necessary paperwork had not been processed. (Tr., Vol. I, p. 160, lines 14-16) Several other family

members had visited him there. (Tr., Vol. I, p. 164, lines 16-22) The last time she saw her father was at his sentencing in July or August of 2003. (Tr., Vol. I, p. 165, lines, 18-19) However, she talked with him by phone once or twice a week. (Tr., Vol. I, p. 166, lines 1-4)

Ashley indicated that another reason she didn't go was because his "feet were so swelled and it hurt him to put on his shoes." (Tr., Vol. 1, p. 163, lines 3-5) She stated decedent was not allowed in the prison common area without his shoes. (Vol. 1, p. 163, lines 5-8)

Ashley testified that her father was her security and that the loss of her father greatly affected her everyday life. (Tr., Vol. I, p. 179, lines 14-21)

Ashley testified that her father's funeral cost \$4,776.08. (Tr., Vol. I, p. 179, lines 1-2; Ex. 15)

Mitchell Keith Kimbrell, decedent's youngest son, also testified in this cause. He last saw his father at NWCX around Christmastime, 2003 when he was able to get time off work. (Tr., Vol. I, p. 213, lines 13-23) During that visit, Mitchell Kimbrell observed that his father's ankles "were real swollen and purple and had blisters on them." (Tr., Vol. I, p. 214, lines 12-14) Decedent was wheeled in in a wheel chair

for that final visit. (Tr., Vol. I, p. 214, line 24- p. 215, line 1) That was the only time he visited his father in prison. (Tr., Vol. I, p. 222, lines 18-23)

Mitchell Kimbrell testified he spoke with his father by phone about a week before his death. (Tr., Vol. I, p. 216, lines 14-16) Mitchell Kimbrell said he was going to visit his father again before he had to return to work, but his father told him not to come because "he didn't feel like seeing anybody." (Tr., Vol. 1, p. 216, lines 22-24)

Mitchell Kimbrell testified that decedent "wasn't just my dad, he was my best friend." (Tr., Vol. I, p. 217, lines 6-7) When asked how his father's death had affected him, Mitchell Kimbrell stated: "I ain't hardly slept in five years." (Tr., Vol. I, p. 217, lines 5-6) He added that he had a number of health problems related to his spinal cord cancer which would prevent him from staying for the entire trial. (Tr., Vol. I, p. 217, lines 18-23)

Mitchell Kimbrell testified that, prior to going to prison, his father did some work to supplement his Social Security disability benefits. As far as Mitchell Kimbrell knows, all of his earnings went to cover his living expenses. (Tr., Vol. I, p. 226, lines 14-22)

The life expectancy table proffered by Claimant indicated that decedent had a life expectancy of 12.9 years. (Ex. 17)

Dr. Sobel testified that a diagnosis of end-stage COPD just means "advanced COPD." (Tr., Vol. II, p. 316, line 19) He said it doesn't mean a patient is "going to die today or tomorrow or even necessarily five years from now." (Tr., Vol. II, p. 316, lines 20-22)

VIII.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commissioner has thoroughly reviewed the record in this case, including the testimony of the witnesses who appeared at the hearing of this cause, the arguments of counsel and, indeed, the entire record as a whole. After carefully weighing the credibility of each of the witnesses, the Commissioner makes the following findings of fact and conclusions of law.

In the case at bar, the gravamen of Claimant's cause of action is medical malpractice. Under Tenn. Code Ann. § 29-26-119(a) (Supp. 2005), the claimant in a medical malpractice action has the burden of proving the following three elements:

- (1) The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices

or in a similar community at the time the alleged injury or wrongful action occurred;

(2) That the defendant acted with less than or failed to act with ordinary and reasonable care in accordance with such standard; and

(3) As a proximate result of the defendant's negligent act or omission, the plaintiff suffered injuries which would not otherwise have occurred.

It is well established that except where the alleged deviation is within the common knowledge of a lay person, expert testimony is required to establish the standard of care itself, that there was a deviation from it and that this deviation was the proximate cause of decedent's injuries. See *Payne v. Caldwell*, 796 S.W.2d 142, 143 (Tenn. 1990); *Kilpatrick v. Bryant*, 868 S.W.2d 594, 597-598 (Tenn. 1998).

In the case at bar, only two witnesses testified on the standard of care,⁸ including decedent's treating physician at the prison, Dr. Smith, who was not proffered as an expert witness.

The most Smith would say when asked whether the medical staff violated the standard of care was "I don't believe it did." (Ex. 36, p. 70, lines 2-7) When asked whether any of the nurses or other

⁸ As has already been discussed, the Commission excluded the testimony of Louis Johnson, M.D. under the locality rule. Defendant was allowed to make an offer of proof.

practitioners deviated from the standard of care in Kimbrell's treatment, Dr. Smith responded, "I don't know that they did, but I don't have a complete medical record." (Ex. 36, p. 70, lines 8-16)

Claimant proffered the testimony of Richard Martin Sobel, M.D., who testified that he was familiar with the standard of care in Tiptonville, Tennessee. Dr. Sobel testified that he concurred with the autopsy report which indicated that Mr. Kimbrell died not of a massive heart attack, but from myocardial insufficiency. (Tr., Vol. II, p. 263, lines 11-22) Dr. Sobel stated that nurse Betty Smith exceeded her scope of practice when, at 12:45 a.m. on January 17, 2004, she made a differential diagnosis over the phone that it was Mr. Kimbrell's foot pain which was making him feel like he was about to pass out. (Tr., Vol. II, p. 278, lines 2- 15) Sobel opined that Smith should have seen Mr. Kimbrell at that time so that she could take his vital signs, do a nursing assessment and call the physician on call, if necessary. (Tr., Vol. II, p. 279, line 24- p. 281, line 3) Instead, she told Officer Merrick to have Kimbrell put a cold rag on his head and try to sleep.

Dr. Sobel further opined that if Betty Smith had done such an assessment and sent Kimbrell to the hospital during that time frame,

his condition could have been turned around and his life saved. (Tr., Vol. II, p. 258, line 19- p. 259, line 4)

As Dr. Sobel noted, even Dr. Smith himself testified that if he had received a report of Kimbrell's complaints during his shift, he would have had him brought to the clinic. (Ex. 36, p. 56, lines 11-16) Two LPNs, Covington and Alexander, also testified that if they had received the early morning call, they would probably have seen Mr. Kimbrell. (Ex. 28, p. 70, lines 17-19; Ex. 47, p. 45, line 24)

Dr. Sobel also testified about the 4 a.m. time frame. He insisted that LPN Betty Smith should have asked enough questions during the call with Officer Merrick to discern whether she should call 911 immediately. LPN Smith herself testified that the tone of Merrick's voice was much more urgent during the second call. (Ex. 35, p. 69, lines 3-4) Instead, Betty Smith waited for Kimbrell to arrive at the clinic, then spent an additional ten minutes doing an assessment in the prison clinic.

Dr. Sobel opined that this delay prevented Mr. Kimbrell from being intubated in time to save his life. (Tr., Vol. II, p. 266, lines 12-23; p. 284, lines 19-23; p. 285, lines 21-23) Dr. Sobel opined that if

Kimbrell had been intubated in a timely way, it is “likely he would have survived.” (Tr., Vol. II, p. 285, line 23)

When asked whether, to a reasonable degree of medical certainty Kimbrell’s medical care met the local standard of care, Dr. Sobel opined, “[n]ot even close.” (Tr., Vol. II, p. 291, line 1) Sobel characterized the medical care given Kimbrell during the January 15-17, 2004 time frame as “egregiously deficient.” (Tr., Vol. II, p. 291, line 13)

The Commission would also note that it was extremely curious that none of the State’s witnesses could seem to remember anything about the findings of the prison’s own quality improvement committee regarding the circumstances of Mr. Kimbrell’s death.

The Commission **FINDS** that Claimant proved by a preponderance of the evidence that Defendant violated § 9-8-307(a)(1)(D), relating to medical malpractice.

Specifically, the Commission **FINDS** that LPN Betty Smith breached the standard of care at 12:45 a.m. by failing to do a nursing assessment and either consult a physician or call for an ambulance and by failing to summon emergency care immediately following the 4 a.m. call.

The Commission further **FINDS** that the foregoing breaches in the standard of care were the proximate cause of decedent's death.

With regard to damages, the record is replete with references to Mr. Kimbrell's pain and suffering from January 15-17, 2004, particularly in the wee hours of January 17, 2004. Officer Merrick called LPN Betty Smith at 12:45 a.m., in part because Mr. Kimbrell was in pain. (Tr., Vol. II, p. 53, lines 4-6) When Officer Dexter arrived at Kimbrell's cell to help transport him to the clinic, he saw Kimbrell laying on the bottom bunk "just kind of moaning." (Tr., Vol. II, p. 81, lines 14-15)

The Commission **FINDS** that decedent, Jimmy Kimbrell, suffered significant physical pain as a result of LPN Betty Smith's breaches of the standard of care.

With regard to loss of consortium, the concept consists not only of tangible services provided by the decedent, "but also intangible benefits each family member receives from the continued existence of other family members," *Jordan v. Baptist Three Rivers Hospital*, 984 S.W.2d 593, 602 (Tenn. 1999), including "attention, guidance, care, protection, training, companionship, cooperation, affection, [and] love...." *Id.* Under Tennessee law, adult children clearly can be

entitled to loss of consortium damages for the death of a parent. *Knowles v. State*, 49 S.W.3d 330, 340 (Tenn. Ct. App. 2001); *Jordan*, 984 S.W.2d at 601.

The Commission would note that only one of his three children, Mitchell Kimbrell, visited Mr. Kimbrell while he was in prison. However, both Mitchell Kimbrell and Sharon Ashley testified that their father was not up to having visitors. (Tr., Vol. 1, p. 163, lines 5-8; p. 216, lines 22-24)

In addition, Sharon Ashley and Mitchell Kimbrell kept in touch with their father by telephone and all three of Kimbrell's children testified of their close bond with their father. Mitchell Kimbrell testified he spoke with his father by phone about a week before his death. (Tr., Vol. I, p. 216, lines 14-16)

Sharon Ashley testified that she talked with her father by phone once or twice a week. (Tr., Vol. I, p. 166, lines 2-4) She testified that her father was her security and that the loss of her father greatly affected her everyday life. (Tr., Vol. I, p. 179, lines 14-21)

The Commission **FINDS** that Claimant is entitled to some loss of consortium damages arising from the death of Jimmy Kimbrell.

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED that Claimant have judgment against the Defendant for all damages including, but not limited to, pain and suffering of the decedent, funeral and burial expenses, and loss of consortium, in the amount of one hundred fifty thousand dollars (\$150,000.00).

IT IS FURTHER ORDERED that costs of this cause are taxed pursuant to § 9-8-307(d).


NANCY C. MILLER-HERRON
COMMISSIONER

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing has this date been forwarded by first class postage to:

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on this the 25th day of June, 2009.



MARSHA RICHESON, CLERK
Tennessee Claims Commission