

IN THE CLAIMS COMMISSION FOR THE STATE OF TENNESSEE  
WESTERN DIVISION

**FILED**

**ROBERT BROWN,**  
by and through Next Friend,  
**ANGELA ANDERSON,**

MAR 29 2010

Tennessee Claims Commission  
CLERK'S OFFICE

**Claimant**

v.

**Claim Number 20-070-739**  
**REGULAR DOCKET**

**STATE OF TENNESSEE,**

**Defendant**

COMPUTER \_\_\_\_\_  
BOOKED \_\_\_\_\_  
C/S-COMM \_\_\_\_\_  
DOA \_\_\_\_\_  
AG \_\_\_\_\_  
ALA \_\_\_\_\_  
FEE PAID \_\_\_\_\_  
NOTICE SENT \_\_\_\_\_  
FILED \_\_\_\_\_

**JUDGMENT**

**THIS MATTER CAME TO BE HEARD** on November 18, 2009, before Nancy C. Miller-Herron, Commissioner of Claims for the Western Grand Division of the State of Tennessee. Bill W. Pemberton, Esq., represented the Claimant and Mary M. Bers, Esq., represented the State of Tennessee. This claim arises from Claimant's stay at Western Mental Health Institute, hereinafter referred to as Western, from December 19, 2005 to January 26, 2006. This matter comes before the Commission pursuant to Tennessee Code Ann. § 9-8-307 (a)(1)(D), which concerns medical

malpractice by state employees and § 9-8-307 (a)(1)(E), which involves negligent care, custody and control of persons.

Based upon the evidence presented at trial, the testimony of the parties, the statements of counsel, and the record as a whole, the Commission **ORDERS** that a judgment for Defendant be entered.

I.

**QUESTIONS PRESENTED**

The issues presented in this case are as follows: (1) whether Defendant breached the standard of acceptable professional practice or was negligent in its care, custody and control of Robert Brown by failing to place him on fall observations, either when he was admitted to Western on December 19, 2005, or prior to his fall on December 25, 2005; (2) whether Claimant proved, by a preponderance of the evidence, that Robert Brown's fall was proximately caused by Defendant's negligence, if any; (3) whether Defendant breached the standard of acceptable professional practice by failing to send Robert Brown back to the hospital for brain imaging prior to January 26, 2006; (4) whether Claimant proved, by a preponderance of the evidence, that Robert Brown's brain damage was proximately caused by Defendant's alleged breach of the standard of care; (5) the amount

of damages, if any, suffered by Claimant as a proximate cause of Defendant's negligence, if any.

## II.

### **FACT TESTIMONY REGARDING CLAIMANT'S FALL**

Jamie Cox, R.N., testified live at the trial of this cause. She completed the fall risk assessment form the night Claimant was admitted to Western. (Tr., p. 265, line 24- p. 266, line 2) She acknowledged that she did not mark "yes" by any of the criteria on the left-hand side. (Tr., p. 266, lines 3-7) She said Brown was difficult to assess because he was "uncooperative and confused." (Tr., p. 266, line 16)

Cox stated that she had just started at Western in December, 2005, and that Brown's fall risk assessment "may have been my first one." (Tr., p. 267, lines 19-20) She acknowledged she should have gone back and corrected the fall risk assessment. (Tr., p. 270, lines 17-25)

Mary Beth Pearson, R.N., testified by deposition on October 19, 2009. (Tr. Ex. 6) Pearson stated that she was a nurse at Western in December, 2005, and cared for Robert Brown. (Tr. Ex. 6, p. 3, lines 10-15)

Pearson testified that Brown's admitting diagnosis was "vascular dementia with delusions." (Tr. Ex. 6, p. 4, lines 14-15) As part of their job at Western, nurses do admitting assessments on the patients, which involves a twelve page assessment. (Tr. Ex. 6, p. 5, lines 2-13)

Pearson testified that part of the nursing assessment involves whether or not to place the patient on fall protocols. (Tr. Ex. 6, p. 6, line 23- p. 7, line 1) She stated the purpose of the fall protocols policy "is to put preventative measures forth to try to prevent falls, but falls are not completely preventable." (Tr. Ex. 6, p. 7, lines 21-23)

Pearson acknowledged that part 3 of the nursing admission assessment is a "Nursing Fall Risk Assessment" consisting of ten criteria with a yes or no box to be marked on each. (Tr. Ex. 6, p. 8, lines 13-21) Pearson stated that nurse Jamie Cox did the nursing admission assessment on Claimant. (Tr. Ex. 6, p. 9, line 2) Pearson acknowledged that, under the policy, if one of the ten criteria is marked "yes," the patient should be placed on fall risk protocol. (Tr. Ex. 6, p. 9, lines 7-11) She further acknowledged that on part 3 of Claimant's form, the entire column has a line through the "no" column, which would indicate none of the criteria were present in Claimant's case. (Tr. Ex. 6, p. 9, lines 12-18)

Pearson conceded that on another page of the screening form, Nurse Cox indicated Claimant had poor balance. (Tr. Ex. 6, p. 9, lines 19-23) She said the only time you would not place such a patient on fall protocols would be if the patient lost balance only one time. (Tr. Ex. 6, p. 11, line 25- p. 12, line 24)

Pearson testified that, even if the nursing assessment is incorrect, doctors see patients the day after they are admitted and can make their own assessment of whether he or she should be on fall risk protocols. (Tr. Ex. 6, p. 14, lines 5-11)

Pearson acknowledged that Mr. Brown was not placed on fall risk protocols prior to his fall on December 25, 2005. (Tr. Ex. 6, p. 15, lines 22-25)

Pearson testified that every patient on the acute unit is checked every fifteen minutes. (Tr. Ex. 6, p. 38, lines 1-7) Every fifteen minutes there is a formal notation. (Tr. Ex. 6, p. 38, lines 8-12) If a patient is placed on fall observations, the patient is not allowed to walk long distances alone. (Tr. Ex. 6, p. 39, lines 3-8) However, even on fall observations, patients continue to have free access to the unit, including hallways. (Tr. Ex. 6, p. 39, lines 9-13)

Pearson testified that when she saw Mr. Brown walking down the hallway, “[h]e was walking fine. He ambulated well.” (Tr. Ex. 6, p. 39, line 18)

Pearson testified that a progress note made by Nurse Angie Nixon on December 24, 2005, indicates that Mr. Brown requires “close supervision by staff, wanders aimlessly about unit.” (Tr. Ex. 6, p. 19, line 25- p. 20, line 9)

Pearson indicated Mr. Brown was put on fall risk protocols after his fall on December 25, 2005. (Tr. Ex. 6, p. 20, lines 13-22) Brown also was sent to the emergency room following his fall. (Tr. Ex. 6, p. 21, lines 3-5)

Pearson testified that Brown had neuro checks every hour for a day and a half after he returned from the hospital following his fall. (Tr. Ex. 6, p. 43, lines 6-16) Pearson said these checks are done anytime patients strike or bump their heads to look for signs of neurological problems. Mr. Brown’s neuro checks were “all within normal limits.” (Tr. Ex. 6, p. 43, line 18- p. 44, line 4)

Marilyn Russell, a nurse at Western, also testified live at the hearing. Russell testified that a doctor’s order is required to put a patient on fall observations, based on either the nurse’s assessment or the doctor’s. (Tr., p. 77, lines 14-17)

Russell stated that between December 23<sup>rd</sup> and Mr. Brown's fall on December 25, 2005, she noted twice in Brown's chart that he was confused and once that he was disoriented. She acknowledged that being confused or disoriented are factors to be used in a fall risk assessment. She did not make a change to Brown's assessment. (Tr., p. 83, lines 1-13) She also noted that he was aggressive, threatening and unable to be redirected. (Tr., p. 83, lines 14-17) She acknowledged that behavior could be termed "resistive." (Tr., p. 83, lines 20-23)

Russell acknowledged that although Nurse Cox, who did the initial fall assessment, noted that Brown had poor balance, was uncooperative and confused, she marked "no" in the boxes for these factors in her initial fall risk assessment. (Tr., p. 85, lines 5-20)

Russell further acknowledged that if even one of the boxes on the initial fall risk assessment is checked yes, the patient is supposed to be put on fall observation. (Tr., p. 87, lines 1-3)

When asked about what it meant for a patient to be on fall observations at Western in 2005, Russell testified as follows:

It was really just to let the staff know that this patient had been identified as a patient who was at risk to fall, and that's all it meant. We wouldn't do anything different for that patient. (Tr., p. 102, lines 14-17)

Russell also testified that patients on fall observations were allowed to go anywhere on the unit, including the hallway. (Tr., p. 102, lines 18-24) She stated "they're allowed to walk freely on the unit." (Tr., p. 112, lines 2) Russell further stated that fall observations does not require a technician to be right with the patient. (Tr., p. 103, lines 15-18) The technicians are only required to lay eyes on the patient every fifteen minutes. (Tr., p. 103, lines 18-20)

Russell testified that even if Brown had been on fall observations, she would not have done anything different in his care the morning he fell. (Tr., p. 112, lines 6-10)

Russell testified that she was on duty when Mr. Brown fell. She assessed him immediately, then called the doctor, whereupon Mr. Brown was sent to Bolívar General Hospital. (Tr., p. 85, line 21- p. 86, line 6) She agreed that a patient on Coumadin has a higher risk of internal bleeding. (Tr., p. 86, lines 19-22) She underlined the word "Coumadin" two or three times to be sure the doctor on duty saw it, because of the risk of bleeding. (Tr., p. 114, lines 6-13) She also noted that he appeared to be lethargic right after his fall. (Tr., p. 114, lines 19-23)

Russell testified that she came in around 6:30 a.m. the morning of Brown's fall and would have seen him already by the time he fell. (Tr., p. 110, lines 3-11) She stated that if she had seen him having problems with his gait, she would have noticed it and noted it in his chart. (Tr., p. 110, lines 13-21)

Russell testified that Brown fell in the hallway outside of the medication room and that the hallways "are always kept clear." (Tr., p. 111, lines 7-17)

Russell acknowledged that Brown's post-fall fall risk assessment indicated "unsteady or shuffling gait, impaired cognition, and incontinence." (Tr., p. 91, lines 4-7) She further acknowledged that she did not see a notation of incontinence prior to his fall. (Tr., p. 95, lines 9-11)

Russell testified that when Brown returned from the Bolivar Hospital, she performed neuro checks on him. (Tr., p. 116, lines 6-9) During these checks, she measured his level of consciousness. (Tr., p. 116, lines 17-18) She characterized his neurological status at that time as "high." (Tr., p. 116, line 23)

Kevin Turner, M.D., testified live at the hearing of this cause. Dr. Turner, a psychiatrist, has been at Western for twelve years. (Tr., p. 133, lines 1-6)

Dr. Turner testified that he did not rely only on the nurses fall risk assessments in evaluating the possibility of fall risk in patients at Western. He characterized fall risk assessment as an “ongoing evaluation.” (Tr., p. 137, line 14- p. 138, line 3) He acknowledged he would consider the factors listed on the fall risk assessment form. (Tr., p. 138, lines 3-7) Turner further testified that Brown was seen by several physicians and also seen in the medical clinic and that each time his fall risk would have been assessed. (Tr., p. 144, lines 17-22) Turner went on: “And based upon what I saw at the time I did the evaluation, I didn’t see a need to put him on a fall risk.” (Tr., p. 146, lines 12-14)

### III.

#### **FACT TESTIMONY REGARDING CLAIMANT’S SUBDURAL HEMATOMA**

Western nurse Mary Beth Pearson testified that the first indication in the progress notes that Mr. Brown is “incontinent of bowel and bladder” is on December 29, 2005. (Tr. Ex. 6, p. 21, line 13- p. 22, line 1) The note also indicates that he “needed maximum assistance for ADLs.” (Tr. Ex. 6, p. 22, lines 2-6)

Pearson testified that the progress notes indicate he received Ativan on December 30 and 31, but not on January 1 or 2. (Tr. Ex. 6,

p. 22, line 16-p. 23, line 10) He was given the Ativan for “cursing, threatening, being very loud and aggressive.” (Tr. Ex. 6, p. 23, lines 16-17)

Brown was given one or two shots of Ativan every day through January 20, 2006, for aggressive or threatening behavior. (Tr. Ex. 6, p. 24, line 5- p. 28, line 11)

Pearson testified that the progress notes for January 21, 2006, describe Mr. Brown as “quiet and calm.” (Tr. Ex. 6, p. 28, lines 12-15) Though one note on the 21<sup>st</sup> says Brown is aggressive at times, he is not given Ativan on the 21<sup>st</sup> or the 22<sup>nd</sup>. (Tr. Ex. 6, p. 28, line 16- p. 29, line 1)

The progress notes for January 22 indicate that Brown slept through the night and that he had to be fed his meals. (Tr. Ex. 6, p. 29, lines 8-23) Pearson noted that the progress notes also indicated he had to be helped with his meals on January 14, 2006. (Tr. Ex. 6, p. 30, lines 8-14)

Pearson testified that on January 23, 2006, Brown is much calmer and has to be fed. (Tr. Ex. 6, p. 31, lines 12-21)

Pearson testified that the notes for January 24, 2006, indicated that Brown was unable to take his medications by mouth and that he was “very lethargic.” (Tr. Ex. 6, p. 32, lines 1-7) A note at 10 p.m.

the same day describes Brown as follows: "Patient is asleep and very lethargic." (Tr. Ex. 6, p. 32, lines 8-12)

Pearson was asked whether Mr. Brown's signs of lethargy had a quick onset. She said "Yes, ma'am." (Tr. Ex. 6, p. 46, lines 12-15)

Pearson went on:

He went from being very aggressive and very active on the unit to then he appeared to, you know, clear up, be responding well, communicating better; and then the next day is when he, you know, began appearing sleepier and more sluggish and more lethargic.  
(Tr. Ex. 6, p. 46, lines 16-21)

Pearson testified that Mr. Brown was placed on Thorazine on December 28, 2005. (Tr. Ex. 6, p. 49, lines 8-15) On January 6, 2006, Brown's Thorazine was increased, then decreased by Dr. Turner on January 24, 2006. (Tr. Ex. 6, p. 50, lines 1-12) Pearson testified that Thorazine's affects can be cumulative (Tr. Ex. 6, p. 49, lines 4-7) and can make patients "more sluggish, . . . slower to respond." (Tr. Ex. 6, p. 50, lines 16-17)

Pearson stated that on January 25 and 26, 2006, all of Brown's medications, with the exception of Dilantin, were suspended by Dr. Turner. (Tr. Ex. 6, p. 32, lines 19-23) A note written on January 26, 2006, a day after his medications were suspended indicates Brown remained sedated and that his lethargy increased. (Tr. Ex. 6, p. 33,

line 16- p. 34, line 7) He was transported to the emergency room on January 26 at 10:10 a.m. (Tr. Ex. 6, p. 34, lines 15-16)

Pearson stated that she was part of the treatment team on January 26, 2006, when Dr. Turner assessed Mr. Brown. (Tr. Ex. 6, p. 45, lines 11-18) Pearson said Turner "ordered for him to go out to the ER for an evaluation and CT scan." (Tr. Ex. 6, p. 45, line 24- p. 46, line 1)

Nurse Marilyn Russell also testified about Mr. Brown's condition between January 20, 2006 and January 26, 2006. Russell said she thinks that Brown had to have one or two Ativan shots every day until January 20<sup>th</sup>. (Tr., p. 97, line 18- p. 98, line 10) She also acknowledged changes in his behavior after January 20, including that he was calmer, sleepy during the day and had to be fed his meals. (Tr., p. 98, lines 11-23)

However, Russell stated that on the 22<sup>nd</sup>, his behavior was "getting better." (Tr., p. 120, line 11) She went on, "He's answering questions that morning appropriately. Although he still may be oriented only to his name, but he's answering questions." (Tr., p. 120, lines 15-17)

Russell testified that Western's records indicate that when Dr. Turner saw Brown on the morning of January 23, 2006, Brown was "sleepy but easily aroused." (Tr., p. 121, lines 15-17)

Russell agreed that Mr. Brown's condition was very different on January 24, 2006, when the notes describe him as "very lethargic." (Tr., p. 123, lines 14-22) She said he could still be aroused "[b]y tactile stimulation." (Tr., p. 124, lines 1-3)

Russell stated that on January 25, 2006, Mr. Brown's medications were held, with the exception of the anti-seizure drug Dilantin. (Tr., p. 124, lines 5-11)

Russell stated that a treatment team meeting attended by Dr. Turner was held on January 26, 2006 at 10:10 a.m. Dr. Turner sent Brown for an emergency evaluation and CAT scan. (Tr., p. 124, line 15- p. 125, line 1)

Dr. Kevin Turner testified the head injury was not his primary concern in late January "because he had done so well, and this was three to four weeks later." (Tr., p. 154, lines 4-5) He went on to say the head injury had not been "ruled out." (Tr., p. 154, lines 6-7)

Dr. Turner noted that he sent Mr. Brown back to Bolivar General on December 28, 2005, so he could have a CAT scan "to rule out any intracranial problem." (Tr., p. 184, lines 9-10) Turner

noted that the physician who read the scan compared it to a CT scan done on Mr. Brown the previous May and did not see any change. (Tr., p. 186, lines 1-9)

When asked how long you would monitor a patient like Mr. Brown after a fall, Dr. Turner testified that “we’d continue to monitor him the entire time he was under our care. . .” (Tr., p. 150, lines 10-12)

Dr. Turner testified that taking Coumadin might increase the risk of bleeding, but noted that Brown’s Coumadin level was “subtherapeutic” when he was admitted. (Tr., p. 150, lines 21-25)

When asked whether a decrease in responsiveness in a head injury patient has to be taken seriously, Turner replied:

Certainly, any neurological change we would monitor and assess and watch to see if it progresses which might be indicative of a deteriorating condition. (Tr., p. 151, lines 6-8)

Turner conceded that on January 23<sup>rd</sup>,

we started noticing that he was showing unusual signs of drowsiness, impaired cognition in that sense. That would indicate that, you know, something probably was going on. (Tr., p. 151, lines 20-23)

Turner testified that beginning on the 23<sup>rd</sup>, they were attempting

to determine what was going on with Mr. Brown. Turner said he knew Brown had been receiving “a rather heavy dose of tranquilizers because of his agitation.” (Tr., p. 152, lines 16-18) Turner noted that drugs like Klonopin and Thorazine can build up in a patient’s system over time. (Tr., p. 153, lines 12-17) Turner went on to note that a patient can be doing well on a medication one day “but in a week, they’re oversedated because of the buildup.” (Tr., p. 153, lines 20-21)

Turner testified that Brown left Western for the consult on the 26<sup>th</sup>, he “wouldn’t say that he was in a coma.” (Tr., p. 156, lines 1-2) Noting that subdurals are progressive, Turner said he wouldn’t have any reason to disagree with Dr. Spivak’s assessment that when Brown arrived at Jackson Madison County General Hospital, he was in a “deep coma.” (Tr., p. 156, line 22- p. 157, line 14)

Turner noted that the most common reason that psychiatric patients have a change in consciousness is oversedation from medication. (Tr., p. 163, lines 11-15) Turner stated that when Brown didn’t improve after they stopped the medications he sent him to the emergency room “to recheck the CAT scan.” (Tr., p. 163, lines 17-19) He characterized the chances of a bleed occurring weeks after a fall as “extremely rare.” (Tr., p. 164, line 4)

Turner testified that Mr. Brown was on a host of medications when he was admitted to Western, including Aricept for dementia and the anticonvulsant Depakote to treat agitation. (Tr., p. 171, lines 1-6)

Dr. Turner testified that Western's records indicate that at 12:30 a.m. on January 25, 2006, Brown was asleep, but "he opens his eyes to verbal stimulation." (Tr., p. 196, lines 9-11) Turner testified his first thought about Brown's increased sedation was that "the tranquilizers were accumulating and exhibiting a sedative effect." (Tr., p. 197, lines 1-3) So he decided to eliminate them. (Tr., p. 197, lines 7-8) Because Mr. Brown had not been showing deterioration before, Turner did not think a bleed resulting from the fall was causing the sedation. (Tr., p. 197, lines 11-14)

Turner did order a repeat CAT scan on January 26 because, if the sedation was caused by the medication, he would have expected to see at least some improvement by then. (Tr., p. 198, lines 11-14)

#### **IV.**

#### **EXPERT MEDICAL TESTIMONY**

Donna Bledsoe testified by deposition on behalf of Claimant on September 25, 2009. (Tr. Ex. 4) Ms. Bledsoe worked for twenty years at the Veterans' Medical Center in Augusta, Georgia and for two years with the Carl Vinson Veterans Affairs Medical Center, both

of which were inpatient psychiatric hospitals. (Tr. Ex. 4, p. 12, lines 15-20) Bledsoe currently is a professor of nursing at Dalton State College. (Tr. Ex. 4, p. 14, lines 3-6) She stated that her specialization “was in adult psychiatric mental health nursing.” (Tr. Ex. 4, p. 25, lines 17-18)

When asked what breaches of the nursing standard of care would characterize this case, Bledsoe responded that “[t]he most central point for me is the assessment, the assessment for fall risk.” (Tr. Ex. 4, p. 17, lines 14-15) She noted that Mr. Brown wasn’t assessed for fall risk and that he was on several medications that can cause a sudden drop in blood pressure. (Tr. Ex. 4, p. 30, lines 13-16) Bledsoe noted his history indicated “right-sided weakness.” (Tr. Ex. 4, p. 31, lines 5-6)

Bledsoe characterized the main thing was Mr. Brown’s agitation and confusion, which impairs a patients’ judgment, causing them to have an increased risk of falling. (Tr. Ex. 4, p. 31, line 9- 19)

Bledsoe reviewed Western’s fall risk assessment policy and the fall record policy. (Tr. Ex. 4, p. 34, lines 12-20)

With regard to the fall risk assessment, Bledsoe noted that:

The nurse completing the form simply drew a line through no from start to the finish and then signed the form in spite of the fact that

she testified later that she really didn't know why she did that because Mr. Brown was unable to communicate during that assessment. (Tr. Ex. 4, p. 37, lines 11-16)

Bledsoe noted that other staff said Brown was "too confused, too cognitively impaired, too agitated, to answer any questions." (Tr. Ex. 4, p. 37, lines 19-20) Bledsoe stated that the other information the nurse had about Mr. Brown's history and what brought him to Western should also have prompted her to mark "yes" by confused on the fall assessment form. (Tr. Ex. 4, p. 38, lines 1-5) Bledsoe also testified the nurse should have marked "yes" beside incontinent because the history indicates Brown wore adult briefs. (Tr. Ex. 4, p. 38, lines 9-11)

Bledsoe acknowledged that a patient should be reassessed for fall risk after significant changes in his or her condition, including changes in medication that would involve fall risk. (Tr. Ex. 4, page 41, lines 3-7) Bledsoe further acknowledged that a patient can fall even if he is on fall risk and it would not necessarily indicate negligence "[i]f he had been assessed properly and if everything had been done to prevent it . . ." (Tr. Ex. 4, p. 43, lines 4-5)

Bledsoe testified that the lack of an appropriate fall risk assessment and the lack of reassessment in light of medications may

have contributed to or caused Mr. Brown's fall. (Tr. Ex. 4, p. 43, line 25- p. 44, line 8)

Bledsoe testified that the drug Ativan, which Claimant was taking at Western, can cause difficulty with balance and increase confusion in some patients. (Tr. Ex. 4, p. 44, line 23-p. 45, line 4) She testified that although Brown fell more than 24 hours after his last dose of Ativan, it could have played a role in his fall since Ativan "can begin to accumulate in the system." (Tr. Ex. 4, p. 45, lines 21-25) She further noted that he was on other medications, including Dilantin, Depakote, Aricept and Namenda that could have increased his fall risk. (Tr. Ex. 4, p. 46, line 24- p. 47, line 1) She noted that Brown was taking Dilantin for seizures. (Tr. Ex. 4, p. 47, lines 5-8)

When asked whether there were indications prior to December 25, 2005, that Brown's balance was an issue, Bledsoe noted that the functional needs assessment done on the day he was admitted indicated he had poor balance. (Tr. Ex. 4, p. 45, line 5- 14)

Bledsoe acknowledged that Mr. Brown was on assault risk precautions at the time of his fall. (Tr. Ex. 4, p. 52, lines 13-14)

Bledsoe testified that under Western's policies, because of Mr. Brown's periodontal disease, a pain reassessment should have been done every shift. However, he was not reassessed until much later.

(Tr. Ex. 4, p. 57, lines 10-19) Bledsoe could not say how much this pain increased Brown's agitation. (Tr. Ex. 4, p. 57, lines 20-24) Bledsoe noted that Brown's niece told the social worker that Brown's initial agitation had a lot to do with his mouth pain. (Tr. Ex. 4, p. 61, lines 14-16)

Bledsoe stated that the breach of the standard of care was "not assessing the patient carefully and appropriately" (Tr. Ex. 4, p. 62, lines 16-17) "[a]nd then not monitoring." (Tr. Ex. 4, p. 62, line 19)

Gary Salzman, M.D. testified as an expert on behalf of Claimant at the hearing of this cause. Dr. Salzman, who is licensed in Missouri, has practiced medicine since 1985. (Tr., p. 207, lines 13-15)

Dr. Salzman specializes in internal medicine, critical care medicine and pulmonary medicine. (Tr., p. 207, lines 16-17) Salzman is board certified in all three areas. (Tr., p. 208, lines 15-18) He is a professor of medicine at the University of Missouri and chief of the respiratory and critical care division at the University. (Tr., p. 208, lines 2-5)

Dr. Salzman opined that the failure to place Mr. Brown on fall observations when he was admitted to Western was a breach of the standard of care. (Tr., p. 210, lines 2-4) He based this opinion

primarily on the fall risk assessment done when Brown was admitted.  
(Tr., p. 224, line 22- p. 225, line 6)

He also opined that in light of Mr. Brown's increasing lethargy and need for assistance in ADLs beginning January 20, a repeat CAT scan or MRI should have been ordered to check for a subdural hematoma. (Tr., p. 211, lines 6-9) Salzman insisted Turner should have reevaluated Brown "before there was irreversible neurological damage." (Tr., p. 211, lines 11-13) He notes that Brown "has, really, a marked downhill course from the 20<sup>th</sup> through the 26<sup>th</sup>." (Tr., p. 212, lines 5-7)

Salzman testified that the change in Mr. Brown on January 22, 2006, that he was sitting in his room and smiling, that he slept through the night and needed no PRN injection, could have two interpretations. One was that he was getting better, and the other was that he was getting more sedated because of an expanding subdural hematoma. (Tr., p. 244, lines 12-16) Then at 8 p.m. on the 24<sup>th</sup>, Western's records indicate Brown was "very lethargic." Since evaluation of a possible subdural hematoma is life-threatening and can't wait, he should have been sent for imaging. (Tr., p. 251, lines 1-15) When asked whether, to a reasonable degree of medical certainty, earlier intervention could have made a difference, Saltzman

stated: "I think even up to the 25<sup>th</sup>, there was an opportunity to diagnose and treat this subdural without permanent neurological damage." (Tr., p. 212, lines 18-20)

Saltzman opined that the early head injury, coupled with the fact he was on the blood thinner Coumadin, should have prompted more monitoring and more evaluation by Brown's physicians. (Tr., p. 213, lines 12-14)

Saltzman stated it was appropriate for Dr. Turner to reduce Brown's medication, which could have caused sleepiness and lethargy. But, he opined, since the possibility of a subdural hematoma is life threatening, it should have taken priority and been done in addition to reducing the medicine. (Tr., p. 213, line 24- p. 214, line 6) Saltzman insisted you can't wait two days and then if he doesn't get better, send him for a CAT scan. (Tr., p. 251, lines 15-17) If you do, it can result in "irreversible brain damage." (Tr., p. 252, lines 1-2) In regard to the late December CAT scan, Saltzman noted that a CAT scan, though it was the appropriate test to do, "can miss an early subdural hematoma." (Tr., p. 255, lines 3-4)

Board certified neurologist Gary Duncan, M.D., testified as an expert on behalf of Defendant. Dr. Duncan practices at General Hospital and Meharry and is interim chair of neurology at Meharry

Medical College. (Tr., p. 275, lines 14-21) Dr. Duncan opined that doctors at Western did not breach the standard of care. (Tr., p. 277, lines 4-5)

Dr. Duncan observed that Western's staff sent Mr. Brown back to the local hospital three days after the fall because the hospital did not do a CAT scan on his first visit. He opined that "[t]he standard would say that's all you need to do. You need a CT scan in the emergency room." (Tr., p. 279, lines 19-21) He went on to say that you would expect that an enlarging subdural hematoma "would be visible by the third day." (Tr., p. 279, lines 23-24)

When asked how the subdural got there, Duncan replied:

Well, two ways. One, that there was a very tiny subdural that was not picked up [on the December 28<sup>th</sup> CT scan] and that enlarged; and, two, that he had another injury and created another subdural.  
(Tr., p. 280, lines 10-15)

When asked whether Brown's being on Coumadin and in an agitated state would have changed the standard of care for sending him out for another CT scan, Dr. Duncan replied: "I think that it did not—it was not against the standard of care. I think that was the standard of care." (Tr., p. 281, lines 1-3)

When asked about the January 22, 2006 notation, Duncan noted that it says Brown, "Wakes up, has a smiling face." (Tr., p. 283, line 4) Duncan stated that with a subdural hematoma, you would expect "an asymmetry, perhaps, of one side versus the other, a crooked smile or an inability to use one arm versus the other." (Tr., p 283, lines 8-10) Duncan went on to say that "[s]leepiness is not a sign of a subdural hematoma. It's not indicative of it." (Tr., p. 283, lines 12-13) Duncan further stated that although a patient with a subdural can be lethargic, "it's not the symptom that turns the light bulb on to say this is a subdural." (Tr., p. 283, lines 19-20)

When asked about the notations on January 24, 2006, Duncan responded: "But when you say he's very lethargic, then you—that—you know, antenna are raised then that something is going on." (Tr., p. 286, lines 7-9)

Duncan was asked to read from Western's healthcare clinic notes at 10 a.m. on January 24, 2006. These notes describe Brown as "alert." (Tr., p. 287, lines 18-19) It was ten hours later he was described as "[v]ery lethargic." (Tr., p. 288, lines 9-10)

Duncan also reads from a notation made just after midnight on January 25, 2006, which says: "Patient asleep but opens eyes to verbal stimuli. Pupils equal and reactive." (Tr., p. 288, lines 19-20)

Dr. Duncan stated that at that time there is no indication of a neurological issue from that entry. (Tr., p. 289, lines 3-6)

Dr. Duncan was asked about the 10:40 a.m. entry on January 25, 2006, which says, "Remains very sedated. Eating well. Meds are being held with the exception of Dilantin." Duncan stated that since Brown had been at Western a month, it was logical to assume "medications may have finally taken effect and maybe he's too sedated, too medicated. So they stopped the medications." (Tr., p. 289, lines 18-20)

When asked whether it would have changed the standard of care that he was on Coumadin, Duncan acknowledged that patients taking Coumadin have a greater risk of subdural hematoma with a head injury. (Tr., p. 290, lines 4-9) But he went on to say that doctors at Western had been told on December 28, 2005, that he did not have a subdural hematoma. Duncan described the other signs of a hematoma that he would have expected, including asymmetry in his face, weakness on one side when he walked, visual loss, a new speech abnormality. (Tr., p. 290, line 22- p. 291, line 7) Duncan emphasized that "[l]ethargy can be due to many, many things." (Tr., p. 291, line 4) He stated that what you would be looking for, would be

a “neurological problem that is specific to brain or spinal cord function.” (Tr., p. 291, lines 9-10)

Dr. Duncan was asked about Dr. Saltzman’s opinion that if a CAT scan had been done on January 25, 2006, instead of January 26, 2006, the brain damage would not have been as extensive. Duncan opined that “[t]here is no way to know that.” (Tr., p. 292, line 13) He went on to note that between January 25 and 26 there was nothing that happened indicating “his brain was damaged except for the lethargy.” (Tr., p. 292, line 23- p. 293, line 1)

When asked whether oversedation or acute subdural hematoma was more severe, Duncan acknowledged “the hematoma would be much more severe.” (Tr., p. 300, line 20)

When asked whether Dr. Turner’s decision to reduce Brown’s medications as a first response to his lethargy, Duncan responded: “I think it was reasonable. I think it’s what I would do.” (Tr., p. 307, lines 17-18)

Patricia Cunningham, R.N., testified live as an expert witness for the Defendant. Cunningham, a nurse practitioner, has a doctorate in psychiatric mental health nursing. (Tr., p. 312, lines 9-15) She is an associate professor of nursing at the University of Tennessee,

teaching both undergraduates and doctoral students. (Tr., 312, line 18- p. 313, line 6)

Nurse Cunningham opined that there was no breach of the standard of care with regard to Mr. Brown's fall. (Tr., p. 316, lines 17-21) She noted that just because the initial fall risk assessment was not done correctly, it doesn't mean he was put at risk. (Tr., p. 323, lines 8-11) She noted that the factors listed on the fall risk assessment would have been factors considered by the staff in subsequent assessments of Mr. Brown. (Tr., p. 322, lines 4-10)

Cunningham characterized Brown, who was on assault protocol, as "a very watched man." (Tr., p. 322, line 25- p. 323, line 2)

Cunningham opined that there was no connection between the medications Brown was given, including Ativan, and his fall on December 25<sup>th</sup>. (Tr., p. 323, line 21- p. 324, line 25) She further stated that she saw no connection between his blood pressure and the fall. (Tr., 325, lines 10-19) Similarly, she stated she saw no connection between his confusion and agitation and the fall or between his dental pain and the fall. (Tr., p. 325, line 24- p. 326, line 19) Finally, Cunningham opined that there was no connection

between Western's alleged failure to evaluate Brown's physical and mental condition and the fall. (Tr., p. 326, lines 20-25)

Cunningham specifically opined that she saw no connection between the failure to put him on fall observations and the fall. (Tr., p. 327, lines 11-14)

Cunningham stated that in reviewing the record of Brown's stay at Western, she did not see any significant change in either his incontinence of bowel and bladder or the assistance needed with ADL's. (Tr., p. 331, line 20- p. 332, line 12) She also conceded on cross-examination that no incontinence is recorded in Brown's chart at Western until after his fall. (Tr., p. 344, lines 12-20)

## V.

### **FACT TESTIMONY REGARDING DAMAGES**

Samuel Bada, M.D., testified by deposition on November 11, 2009. (Tr. Ex. 5) Dr. Bada stated that he is Mr. Brown's primary care physician. (Tr. Ex. 5, p. 3, lines 16-17) He has provided Mr. Brown with medical care related to his injury at Western. (Tr. Ex. 5, p. 4, lines 15-17) Dr. Bada followed up with him on the surgeries he had related to the fall. (Tr. Ex. 5, p. 5, lines 10-12) Dr. Bada stated that a neurosurgeon did an evacuation after the brain bleed. (Tr. Ex. 5, p. 4, lines 16-19)

Dr. Bada testified that after Brown's surgery, he prescribed "both home health and physical therapy and assistance with activities of daily living." (Tr. Ex. 5, p. 5, lines 24-25)

Dr. Bada stated that he is not able to communicate with Mr. Brown and Mr. Brown is not able to ambulate on his own. (Tr. Ex. 5, p. 8, lines 5-13) Bada said he believed Brown was ambulatory when he first treated him in 2005. (Tr. Ex. 5, p. 8, lines 14-15) Dr. Bada stated that home health would most likely be required for the remainder of Brown's life. (Tr. Ex. 5, p. 10, lines 14-20)

When Dr. Bada sees Mr. Brown in his office, the ambulance service brings him there. (Tr. Ex. 5, p. 11, lines 8-11) He sees Brown about every two or three months and consults with home health in between. (Tr. Ex. 5, p. 11, line 15- p. 12, line 5)

LPN Charles Middleton testified by deposition on November 11, 2009. (Tr. Ex. 7) He takes care of patients in their home and currently helps take care of Robert Brown. (Tr. Ex. 7, p. 3, lines 16-24) He has been with Mr. Brown for fourteen months. (Tr. Ex. 7, p. 5, line 6)

Middleton testified that he helps feed Brown through a PEG tube because he is "not capable of swallowing food at this moment." (Tr. Ex. 7, p. 4, lines 12-15) Middleton helped at first with Brown's

Foley catheter and gives Brown laxatives and stimulation to help him have bowel movements. (Tr. Ex. 7, p. 5, lines 12-25)

Middleton stated that it has taken fourteen months for Mr. Brown to speak to him. Brown will now say a few words to him. (Tr. Ex. 7, p. 25, lines 4-6) Middleton testified that Rick Anderson is usually the only person with whom Brown will talk. (Tr. Ex. 7, p. 6, lines 5-15) Middleton stated that when he asks Brown how he is feeling, he'll shake his head no but is unable to tell Middleton what is wrong. (Tr. Ex. 7, p. 7, lines 15-20)

Middleton testified he works five hours a day twelve days in a row, then he takes off two days. Mr. and Mrs. Anderson take care of Brown the rest of the time. (Tr. Ex. 7, p. 8, lines 15-18) Middleton stated that he used to work eight hours a day, but the family had to cut him down to five hours a day. (Tr. Ex. 7, p. 8, lines 19-22)

Middleton testified that he also helps take care of Brown's skin, "[m]aking sure his skin is intact." (Tr. Ex. 7, p. 9, lines 22-25) He stated that although Brown has a special bed, "he still has to be turned every two hours . . ." to avoid bedsores. (Tr. Ex. 7, p. 10, lines 1-10)

Middleton testified that Brown can't walk or even sit in a wheelchair. (Tr. Ex. 7, p. 10, lines 11-21) Brown is incontinent of

bowel and has bladder accidents as well. (Tr. Ex. 7, p. 11, line 22-p. 12, line 9)

Middleton testified that CNAs come in and give Brown a bath. (Tr. Ex. 7, p. 26, lines 9-10)

Middleton testified that Brown likes to see him and Rick Anderson “cutting up and laughing” (Tr. Ex. 7, p. 26, lines 19-20) and he “enjoys music.” (Tr. Ex. 7, p. 26, line 22)

Robert Brown’s niece and Next Friend, Angela Anderson, testified live at the trial of this cause. Mr. Brown now lives with Ms. Anderson at her residence in Jackson, Tennessee. (Tr., p. 26, lines 11-12) Ms. Anderson testified that when she was growing up in her paternal grandparents’ home, Mr. Brown also lived there. She stated that “he was more like a daddy to me than an uncle.” (Tr., p. 26, lines 22-23)

Anderson testified that Mr. Brown had lived with her since his stroke in April, 2005. (Tr., p. 27, lines 12-19)

Anderson testified that the day her uncle was airlifted to Jackson General for brain surgery, Dr. Spivak told her he only had about a 5% chance of survival. (Tr., p. 38, lines 21-25) Anderson stated her uncle had two surgeries for his brain bleed. (Tr., p. 40, lines 2-8)

After her uncle was discharged from Jackson General, he went first to a transitional facility; Ms. Anderson stayed with him around the clock. (Tr., p. 40, lines 11-14) At the transitional facility, her uncle was put on PEG feeding. (Tr., p. 40, lines 19-20) She finally took him home on May 26, 2006. (Tr., p. 40, line 23- p. 41, line 3)

Anderson testified about her uncle's current condition. He cannot walk or feed himself and still is on PEG feeding. He can't have anything by mouth. His caregivers comb his hair and shave him and put him in a special chair. (Tr., p. 41, lines 11-24) A nurse is with him thirty hours a week and a CNA comes to give him a bath. (Tr., p. 42, lines 2-3) He gets back and forth to the doctor in an ambulance. (Tr., p. 42, lines 15-17)

Anderson testified that before going to Western, he could "walk around the block." (Tr., p. 42, line 13) He didn't have to have a nurse or a catheter or a PEG feeding tube. He could even go out to eat with the family. (Tr., p. 42, lines 7-14)

Anderson stated her uncle receives social security income in the amount of six hundred ninety-four (\$694.00) dollars a month. (Tr., p. 42, lines 18-23) He had been on social security for about two years before his stroke. (Tr., p. 60, lines 17-19)

When asked to describe her uncle's ability to hold a conversation, Ms. Anderson insisted, that "[h]e wouldn't be able to hold a conversation." (Tr., p. 47, line 18) She said he was able to do so before his admission to Western. (Tr., p. 47, lines 19-20)

On cross-examination, Ms. Anderson stated that Brown came back to Maplewood Health Care for nursing care after his stroke and that he was admitted to Jackson Madison-County General Hospital after a seizure in May, 2005. (Tr., p. 51, line 18- p. 52, line 1) She said she was never told he was wearing diapers at that time. (Tr., p. 52, lines 7-9) Anderson further testified that he had another seizure at Maplewood in June, 2005 and fell out of the wheelchair he was sitting in. (Tr., p. 52, line 14- p. 53, line 3) He went back to Jackson General. (Tr., p. 53, lines 4-6) After Jackson General, he was sent first to Ripley Behavior Center, then to Charter Lakeside. (Tr., p. 53, lines 13-24) He went from there to Baptist Hospital, then to Regional Hospital in Jackson. (Tr., p. 54, lines 9-24)

Angela Anderson's husband, Ricky Anderson, testified at the trial of this cause. Mr. Anderson testified that he helps with Mr. Brown's care, including turning him every hour to hour and a half to avoid bedsores. (Tr., p. 66, lines 2-8) Mr. Anderson also helps his wife feed Mr. Brown. (Tr., p. 66, lines 10-11)

Ricky Anderson testified that Brown could communicate fine before his fall. He said Brown's ability to communicate was "a little limited" after his stroke, but still he could communicate. (Tr., p. 66, lines 22-23) Mr. Anderson stated that Mr. Brown talks "sparingly" and then only to he and his wife. He can answer questions. (Tr., p. 67, lines 1-3) He cannot "hold a conversation." (Tr., p. 67, line 5)

## **VI.**

### **APPLICABLE LAW**

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 claimant'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).

Like all negligence cases, a cause of action based on Tenn. Code Ann. § 9-8-307(a)(1)(E) (Supp. 2005) for negligent care, custody and control of persons, requires a Claimant to prove the following:

- (1) a duty of care owed by the defendant to the plaintiff;
- (2) conduct by the defendant falling below the standard of care;
- (3) an injury or loss;
- (4) causation in fact; and
- (5) proximate or legal cause. *Coln v. City of Savannah*, 966 S.W. 2d 34, 37 (Tenn. 1998).

It is well-settled that the State of Tennessee owes a duty of care to those in its mental health institutions. See, e.g. *Conley v. State*, 141 S.W.3d 591 (Tenn. 2004) So the Commission will address whether there was a breach of the standard of care or a breach of duty and whether the alleged breach was the proximate cause of the claimant's injuries.

## VII.

### 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.

**A. Claimant failed to prove that the failure to put Mr. Brown on fall observations was the proximate cause of his fall on December 25, 2005.**

There seems to be no dispute with regard to the way Nurse Cox filled out the initial fall risk assessment when Claimant was admitted to Western. The fall observation protocol in place at Western in December, 2005, provided that the fall risk assessment form would be filled out on admission. The form enumerates 10 criteria to be assessed with a yes or no answer. The policy states: "If yes is checked on any of the criteria, the patient shall be placed on fall status, and the physician shall be notified for further orders or instructions." (Ex. 12, p. 1) Instead of filling out the form properly, Cox drew a straight line through the no column, even though several witnesses and Cox herself acknowledged that some of the questions

should have been answered yes and the physician notified. (Ex. 2, p. 284; Tr., p. 87, lines 1-3; Tr. Ex. 6, p. 8, lines 12-18; Tr., p. 270, lines 17-25) The Commission **FINDS** that Nurse Cox did, indeed, breach the standard of care in completing the fall risk assessment when Mr. Brown was admitted.

However, such a finding does not necessarily lead to the conclusion that either her breach of the standard of care or the failure of other providers at Western to place Mr. Brown on fall observation was the proximate cause of Robert Brown's fall. Dr. Turner testified that the fall risk assessment was not a one time thing, but an "ongoing evaluation." (Tr., p. 137, line, 14- p. 138, line 3) Turner further testified that between his admission on December 19 and his fall on December 25, Brown was seen by several physicians and in the medical clinic, and that each time his fall risk would have been assessed. (Tr., p. 144, lines 17-22) Turner went on: "And based upon what I saw at the time I did the evaluation, I didn't see a need to put him on a fall risk." (Tr., p. 146, lines 12-14)

Secondly, Marilyn Russell, a nurse at Western who was on duty when Claimant fell, testified that patients on fall observations were allowed to go anywhere on the unit, including the hallway. (Tr., p. 102, lines 18-24) Moreover, Russell emphasized that fall

observations does not require a technician to be right beside the patient. (Tr., p. 103, lines 15-18) The technicians are only required to lay eyes on the patient every fifteen minutes. (Tr., p. 103, lines 18-20) The technicians were required to do that with Claimant anyway since he was on assault observation.

Russell testified that even if Brown had been on fall observations, she would not have done anything different in his care the morning he fell. (Tr., p. 112, lines 6-10)

Although no staff member at Western actually saw him fall, a patient reported to the staff that he lost his balance and fell. It is undisputed that the fall occurred in the hallway outside of the medication room and that the hallways "are always kept clear." (Tr., p. 111, line 17)

Thus, even if Claimant had been on fall observations, he would have been allowed to walk on Christmas morning in the very hallway where he fell. There was no evidence that there were any obstructions in the hallway which contributed to Claimant's fall. In fact, the testimony was that the hallway was kept clear. Moreover, it seems quite possible that as part of the on-going evaluation done by physicians at Western, Claimant might not have stayed on fall

observations even if the fall risk assessment had been filled out correctly when he was admitted.

The Commission therefore **FINDS** that Claimant failed to prove by a preponderance of the evidence that either Nurse Cox's botched fall risk assessment or the subsequent decision(s) not to place Mr. Brown on fall observations was a proximate cause of Robert Brown's fall.

**B. Claimant did not prove by a preponderance of the evidence that the failure of Western's physicians to send Claimant for a second brain imaging before January 26, 2006, was a breach of the standard of care.**

The Commission heard both the Claimant's expert, who specializes in internal medicine, critical care medicine and pulmonary medicine, and Defendant's expert, a board certified neurologist, testify live. The Commission gave a little more weight to the testimony of Defendant's expert, neurologist Gary Duncan, M.D.

Dr. Duncan testified that the Western staff acted within the standard of care. He noted that three days after Mr. Brown's fall on December 25, 2005, Dr. Turner sent Brown back to the emergency room because the ER doctors did not do a CT scan on the day he fell. Dr. Duncan said the standard of care is to do a CT scan in the emergency room. (Tr., p. 279, lines 18-20) Dr. Duncan also testified

that you would expect an enlarging subdural hematoma to be “visible by the third day,” although it was not in this case. (Tr., p. 279, lines 22-24)

Dr. Duncan testified that expected symptoms of a subdural hematoma would include “an asymmetry, perhaps, of one side versus the other, a crooked smile or an inability to use one arm versus the other.” (Tr., p. 283, lines 7-10) He went on to say that lethargy is “not the symptom that turns the light bulb on to say this is a subdural.” (Tr., p.283, lines 19-20)

Dr. Duncan testified that at 8 p.m. on the 24<sup>th</sup>, when Brown was “very lethargic,” it would raise the staff’s antenna that something was going on. (Tr., p. 286, lines 7-9) He notes that earlier that same day, during a clinic visit, he was described as “alert.” (Tr., 287, lines 18-20) He stated that this was in keeping with Brown’s variable mental status throughout his stay at Western. (Tr., p. 288, lines 1-8)

Duncan further notes that even though Brown was described as “very lethargic” late in the evening on the 24<sup>th</sup>, the note from 12:30 a.m. on the 25<sup>th</sup> says, “Patient asleep but opens eyes to verbal stimuli. Pupils equal and reactive.” (Tr., p. 288, lines 16-20) This entry in the progress notes again gives no indication of a neurological issue. (Tr., p. 289, lines 4-6)

Dr. Duncan testified that given that the doctors at Western had been told Brown did not have a subdural hematoma and given the kind of medications he was taking, the most logical thing for Western's staff to do was "to stop his medications safely and see if the patient wakes up." (Tr., p. 289, lines 15-17)

Duncan conceded that being on Coumadin increased the chances that Brown would have had a hematoma, but it did not change the standard of care for what the doctors were required to do a month after his fall. He noted that having a "more definite neurological symptom as opposed to lethargy" might have required different action by the staff. He said you might be looking for "weakness or visual loss" or new speech abnormalities. (Tr., p. 291, lines 1-7)

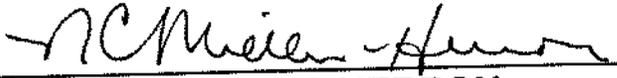
Duncan also opined that there is "no way to know" whether a CT scan on January 25, 2006, would have left Brown with less extensive injuries. (Tr., p. 292, line 8-p. 293, line 3)

When asked whether it was a reasonable medical decision to first reduce Mr. Brown's medications in response to the changes in Brown and his lethargy, Duncan stated, "I think it was reasonable. I think it's what I would do." (Tr., p. 307, lines 17-18)

There is no question that Robert Brown's fall at Western on December 25, 2005, resulted in devastating and permanent injuries that have greatly affected his life, and that of his family. However, given the results of the CT scan on December 28, 2005, indicating Brown did not have a subdural hematoma, the absence of more definite neurological symptoms (besides lethargy) during the January 22-25, 2006 time frame, the types of lethargy-inducing drugs Brown was taking, and the passage of almost a month between the fall and the manifestation of Brown's brain injury, the Commission **FINDS** that Claimants did not prove by a preponderance of the evidence that Western doctors breached the standard of care by failing to send Mr. Brown for a second brain scan before January 26, 2006.

In light of the foregoing findings, this cause must be **DISMISSED.**

**IT IS SO ORDERED.**

  
**NANCY C. MILLER-HERRON,**  
**COMMISSIONER**

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was mailed by first class U.S. mail, postage prepaid, to:

Mr. Bill W. Pemerton, Esq.  
Maddox & Anderson, PLLC  
One Central Plaza, 6<sup>th</sup> Floor  
835 Georgia Ave.  
Chattanooga, TN 37402

Ms. Mary M. Bers, Esq.  
Senior Counsel  
Office of the Attorney General  
P.O. Box 20207  
Nashville, TN 37202-0207

on this the 29<sup>th</sup> day of March, 2010.

  
**MARSHA RICHESON, CLERK**  
**TENNESSEE CLAIMS COMMISSION**