Supreme Court of Pennsylvania

Court of Common Pleas
Civil Cover Sheet

York County

For Prothonotary Use Only:	TIME STAMP
Docket No:	

The information collected on this form is used solely for court administration purposes. This form does not supplement or replace the filing and service of pleadings or other papers as required by law or rules of court.

SECTION A

Commencement of Action:
☒ Complaint ☐ Writ of Summons ☐ Petition
☐ Transfer from Another Jurisdiction ☐ Declaration of Taking

Lead Plaintiff's Name:	Lead Defendant's Name:
Terry R. Murray, Sr.	Wellspan Health
Are money damages requested? ☒ **Yes** ☐ **No**	Dollar Amount Requested: (check one) ☐ within arbitration limits ☒ outside arbitration limits
Is this a *Class Action Suit*? ☐ **Yes** ☒ **No**	**Is this an *MDJ Appeal*?** ☐ **Yes** ☒ **No**

Name of Plaintiff/Appellant's Attorney: Matthew A. Casey, Esq., Roberta A. Golden, Esq, Blake A. Kaplan,Esq.

☐ **Check here if you have no attorney (are a Self-Represented [Pro Se] Litigant)**

SECTION B

Nature of the Case: Place an "X" to the left of the **ONE** case category that most accurately describes your ***PRIMARY CASE.*** If you are making more than one type of claim, check the one that you consider most important.

TORT *(do not include Mass Tort)*
- ☐ Intentional
- ☐ Malicious Prosecution
- ☐ Motor Vehicle
- ☐ Nuisance
- ☐ Premises Liability
- ☐ Product Liability *(does not include mass tort)*
- ☐ Slander/Libel/ Defamation
- ☐ Other: _____

MASS TORT
- ☐ Asbestos
- ☐ Tobacco
- ☐ Toxic Tort - DES
- ☐ Toxic Tort - Implant
- ☐ Toxic Waste
- ☐ Other: _____

PROFESSIONAL LIABLITY
- ☐ Dental
- ☐ Legal
- ☒ Medical
- ☐ Other Professional: _____

CONTRACT *(do not include Judgments)*
- ☐ Buyer Plaintiff
- ☐ Debt Collection: Credit Card
- ☐ Debt Collection: Other _____
- ☐ Employment Dispute: Discrimination
- ☐ Employment Dispute: Other _____
- ☐ Other: _____

REAL PROPERTY
- ☐ Ejectment
- ☐ Eminent Domain/Condemnation
- ☐ Ground Rent
- ☐ Landlord/Tenant Dispute
- ☐ Mortgage Foreclosure: Residential
- ☐ Mortgage Foreclosure: Commercial
- ☐ Partition
- ☐ Quiet Title
- ☐ Other: _____

CIVIL APPEALS
Administrative Agencies
- ☐ Board of Assessment
- ☐ Board of Elections
- ☐ Dept. of Transportation
- ☐ Statutory Appeal: Other _____
- ☐ Zoning Board
- ☐ Other: _____

MISCELLANEOUS
- ☐ Common Law/Statutory Arbitration
- ☐ Declaratory Judgment
- ☐ Mandamus
- ☐ Non-Domestic Relations Restraining Order
- ☐ Quo Warranto
- ☐ Replevin
- ☐ Other: _____

Updated 1/1/2011

ROSS FELLER CASEY, LLP
By: MATTHEW A. CASEY, ESQUIRE (#84443)
ROBERTA A. GOLDEN, ESQUIRE (#52901)
BLAKE A. KAPLAN, ESQUIRE (#324938)
One Liberty Place
1650 Market Street, 34th Floor
Philadelphia, PA 19103
(215) 574-2000 *Attorneys for Plaintiff*

TERRY R. MURRAY SR., Individually and as Administrator of the Estate of **TERRY LYNN ODOMS**, **deceased** 245 East College Avenue York, PA 17403	:	**COURT OF COMMON PLEAS** **YORK COUNTY**
Plaintiff	:	DOCKET NO.
v.	:	
WELLSPAN HEALTH 1001 S. George Street York, PA 17403	:	CIVIL ACTION – MEDICAL PROFESSIONAL LIABILITY ACTION
and	:	
Defendants (cont.)	:	**JURY TRIAL DEMANDED**

NOTICE TO PLEAD

NOTICE

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW. THIS OFFICE CAN PROVIDE YOU WITH INFORMATION ABOUT HIRING A LAWYER.

IF YOU CANNOT AFFORD TO HIRE A LAWYER, THIS OFFICE MAY BE ABLE TO PROVIDE YOU WITH INFORMATION ABOUT AGENCIES THAT MAY OFFER LEGAL SERVICES TO ELIGIBLE PERSONS AT A REDUCED FEE OR NO FEE.

Lawyer Referral Service
York County Bar Association
137 E. Market Street
York, PA 17401
(717) 854-8755

ADVISO

Le han demandado a used en la corte. Si usted quiere defenderse de estas demandas expuestas en las paginas siguientes, usted tiene veinte (20) dias de plazo al partir de la fecha de la demanda y la notificacion. Hace falta asentar una comparencia escrita o en persona o con un abogado y entregar a la corte en forma escrita sus defensas o sus objeciones a las demandas en contra de su persona. Sea avisado que si usted no se defiende, la corte tomara medidas y puede continuar la demanda en contra suya sin previo aviso o notificacion. Ademas, la corte pueda decidir a favor del demandante y requiere que usted cumpla con todas las provisiones de esta demanda. Usted puede perder dinero o sus propiedades u otros derechos importantes para usted.

LLEVE ESTA DEMANDA A UN ABOGADO INMEDIATAMENTE, SI NO TIENE ABOGADO O SI NO TIENE EL DINERO SUFICIENTE DE PAGAR TAL SERVICIO, VAYA EN PERSONA O LLAME POR TELEFONO A LA OFICINA CUYA DIRECCION SE ENCUENTRA ESCRITA ABAJO PARA AVERIGUAR DONDE SE PUEDE CONSEGUIR ASISTENCIA LEGAL.

ESTA OFICINA LO PUEDE PROPORCIONAR CON INFORMACION ACERCA DE EMPLEAR A UN ABOGADO. SI USTED NO PUEDE PROPORCIONAR PARA EMPLEAR UN ABOGADO, ESTA OFICINA PUEDE SER CAPAZ DE PROPORCIONARLO CON INFORMACION ACERCA DE LAS AGENCIAS QUE PUEDEN OFRECER LOS SERVICOS LEGALES A PERSONAS ELEGIBLES EN UN HONORARIO REDUCIDO NINGUN HONORARIO.

Lawyer Referral Service
York County Bar Association
137 E. Market Street
York, PA 17401
(717) 854-8755

WELLSPAN YORK HOSPITAL, a/k/a YORK HOSPITAL d/b/a WellSpan York Hospital
1001 S. George Street
York, PA 17403
Defendants

CIVIL ACTION COMPLAINT
(Professional Liability-Medical Malpractice)

Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of his father Terry Lynn Odoms, deceased, by and through his undersigned attorneys, Ross Feller Casey, LLP, brings this medical malpractice action against the above-named Defendants arising from his father's death and demands compensatory and punitive damages in a sum in excess of the local arbitration limits, exclusive of interest, costs, and damages for pre-judgment delay, upon the claims and causes of action set forth below.

INTRODUCTION, PARTIES, AND JURISDICTIONAL FACTS

1. Terry Lynn Odoms died on August 16, 2019, in the WellSpan York Hospital. Despite presenting via ambulance with abnormal vital signs, Mr. Odoms had been left abandoned in the emergency department waiting room for hours.

2. In addition to the failures of the personnel assigned to the ED that day, Terry Lynn Odoms' preventable death was due to the outrageous and reckless actions of Defendants WellSpan Health and Wellspan York Hospital in knowingly running a woefully and dangerously understaffed ED in which patient care policies went ignored and unenforced, with wholly foreseeable, devastating consequences.

3. The Plaintiff brings direct corporate claims against the Defendants demanding compensatory damages for these Defendants' negligence in their non-delegable responsibilities to

Mr. Odoms and punitive damages for these Defendants' direct willful, wanton, and reckless conduct as will be more fully set forth herein.

4. The Plaintiff also brings vicarious liability claims against the Defendants demanding compensatory damages arising from the negligence of Defendants' agents and punitive damages arising from Defendants' knowingly allowing their agents to act in outrageous and reckless disregard of Mr. Odoms' health and well-being.

5. WellSpan Health and WellSpan York Hospital had known for a year, if not more, that the ED was dangerously understaffed, yet, in reckless disregard of the consequences, failed to take appropriate, necessary, steps to remedy this critical situation.

6. WellSpan Health and WellSpan York Hospital had known for a year, if not more, that patient care policies to ensure the wellbeing of patients waiting to be seen in the ED were being ignored and disregarded, increasing the risk that a patient would receive deficient care and suffer grave injuries and/or death, as in fact occurred to Mr. Odoms.

7. Defendants knew, or should have known, that their patient care policies were being ignored due to the inability of staff to meet the demands and burdens placed on them because of Defendants' failures to ensure appropriate staffing or limit or divert services when staffing necessary to patient well-being could not be provided.

8. Rather than rectify this inexcusably dangerous situation, Defendants allowed it to continue, placing profit ahead of patient safety and wellbeing.

9. Terry Lynn Odoms was brought to the ED by ambulance, arriving just before 10:00 on August 16, 2019. The EMTs documented difficulty obtaining pulse oximetry readings. They had placed Mr. Odoms on supplemental oxygen.

10. On arrival, Mr. Odoms was seen by a nursing assistant while still on the ambulance stretcher. No vital signs are documented in the chart at this time.

11. The EMTs then removed Mr. Odom's oxygen, transferred him from the ambulance stretcher to a hospital wheelchair, and wheeled him through a doorway to the "pivot nurse" area.

12. The pivot nurse is a critical part of patient flow, intake, and care decisions. The pivot nurse performs a "brief" triage and selects the patient emergency severity index ("ESI") acuity level, which prioritizes a patient's need to be seen, prior to the patient's assessment and initial evaluation by a triage nurse. The pivot nurse retains responsibilities for patients in the waiting room that are vital to ensuring proper patient care and patient safety for those patients awaiting ED bed assignment and provider care.

13. The pivot nurse, on information and belief Anissa Page, RN, took report from the EMT while sitting at her desk. She did not leave her desk to walk over to where Mr. Odoms' wheelchair had been placed. She did not speak to him.

14. The pivot nurse, on information and belief Nurse Page, documented the EMT's report of difficulty in getting a pulse oximetry reading, which is highly concerning for Mr Odom's having an abnormally, and dangerously, low oxygen saturation. On information and belief, Mr. Odom's oxygen saturation level is not documented at any time while he was in the ED until he was found unresponsive in the waiting room hours later.

15. The pivot nurse, on information and belief Nurse Page, initially assigned Mr. Odoms an ESI 3 acuity level at 10:15.

16. At 10:20, she changed Mr. Odom's triage category to ESI level 2, a more acute level that designates a very ill patient at high risk of deterioration and in need of immediate care.

17. Notwithstanding his acute status and the documented difficulty in obtaining blood oxygen levels, Mr. Odoms was not provided supplemental oxygen while in the ED. No orders were entered or protocols initiated to ensure that he had oxygen support while sitting in the ED waiting to be seen.

18. On information and belief, there was no triage nurse on shift when Mr. Odoms presented to the ED due to staffing shortages. Instead, the pivot nurse had been pressed into double duty, required by WellSpan Health and WellSpan York Hospital to fulfill the role of both pivot nurse and triage nurse.

19. Incomplete vital signs were documented by a staff member believed to be a nursing assistant at around 10:25 and demonstrated a patient in acute distress, with an abnormally elevated heart rate of 120 and respiratory rate of 28. Terry Lynn Odoms was struggling to breathe, unable to get enough oxygen.

20. Rather than take Mr. Odoms immediately to a treatment area as his condition demanded, at 10:25, the nursing assistant wheeled Mr. Odoms into the WellSpan ED waiting room.

21. On information and belief, at no time was Mr. Odoms seen and evaluated by a nurse before being wheeled into the waiting room.

22. Terry Lynn Odoms suffered a cardio-respiratory event in that wheelchair in the waiting room of the WellSpan York Hospital Emergency Department, abandoned by WellSpan and its staff without care for over two hours. The event is captured in horrific detail on surveillance video.

23. Mr. Odoms was not evaluated even one time between 10:25 when the nursing assistant wheeled him into the waiting room and 12:25 when he was found unresponsive in this wheelchair.

24. Mr. Odoms was not seen by anyone that morning, notwithstanding hospital policies that expressly required ongoing assessment of patients in the waiting room who have not yet been taken to a treatment area and rounding on patients at the top of each hour to avoid this very type of catastrophe.

25. Video of the waiting room reveals the truly shocking and appalling abandonment of this patient. WellSpan personnel walked by Mr. Odoms a dozen times. On seven occasions, personnel came out of a triage room directly in front of Mr. Odoms. And yet, even as he stretched out his arm, clearly in distress and seeking help, seeking to garner the strength to rise up from his chair, no one approached him. No one helped him as he struggled to breathe and became unconscious in the waiting room.

26. The record further reflects that because he was incapacitated and unable to respond when his name was called out verbally, the WellSpan staff documented Mr. Odoms as "LWBS," left without being seen, and removed him from the patient tracking board about 20 minutes before he was discovered unresponsive.

27. No one responsible for Mr. Odoms' care took the time to walk into the waiting room. Had anyone done so, that staff member would have seen that Mr. Odoms was exactly where he had been left in a wheelchair at 10:25.

28. The events resulting in Terry Lynn Odoms' premature death led to an investigation by the Pennsylvania Department of Health. The Department's findings reveal appalling care in violation of Pennsylvania law.

29. WellSpan and WellSpan Health admitted that the dangerously deficient staffing levels that day and the unavailability of inpatient hospital beds, caused patients to be held in the ED while awaiting medical care and admission.

30. In reckless indifference to patients, including Terry Lynn Odoms, WellSpan and WellSpan Health knowingly permitted their ED to operate while woefully understaffed.

31. In an outrageous fashion and reckless indifference to the rights of Terry Lynn Odoms, WellSpan and WellSpan Health recklessly failed to remedy the staffing deficiencies and ensure staff accountability to follow the most basic standards of patient rounding and interaction to ensure patient well-being while waiting to be seen by a provider.

32. Plaintiff, Terry R. Murray Sr. is an adult citizen and resident of the Commonwealth of Pennsylvania residing therein at 245 East College Avenue, York, PA 17403. Plaintiff, Terry R. Murray Sr. is a surviving son of Terry Lynn Odoms, Deceased.

33. Mr. Murray is the Administrator of the Estate of Terry Lynn Odoms, Deceased, having been appointed by the Registrar of Wills of York County of the Commonwealth of Pennsylvania on October 1, 2019. *See* Short Certificate Letters of Administration, attached as **Exhibit A**.

34. Terry Lynn Odoms was born on October 14, 1946. He died on August 16, 2019, at 72 years of age.

35. Plaintiff brings this action on behalf of his father's Estate and on behalf of himself and the other beneficiaries of Terry Lynn Odoms under and by virtue of the Wrongful Death Act, 42 Pa. C.S.A. §8301, the Survival Act, Pa. C.S.A. §8302, and the applicable Rules of Civil Procedure and decisional law interpreting those Acts.

36. Notice of the institution of this action, as required by Pa. R. Civ. P. 2205, was given to the following individuals, who are the heirs-at-law of Terry Lynn Odoms:

(1) Terry R. Murray Sr. (adult son)

(2) Randy Williams (adult son)

37. Defendant WellSpan Health is a partnership, corporation, or other legal entity organized and existing under the laws of the Commonwealth of Pennsylvania, with a professional place of business located at 1001 S. George Street in York, Pennsylvania. At all relevant times, WellSpan Health owned, maintained, operated and/or managed a network of hospitals, clinics and medical practices, including WellSpan York Hospital, and employed physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians, and other agents, servants and employees who purportedly possessed skill and training for the purposes of providing medical care and services to the general public, and Terry Lynn Odoms in particular. The claims asserted against this Defendant are both direct under *Thompson v. Nason*, 591 A.2d 703 (Pa. 1991), and its progeny of case law, including *Scampone v. Highland Park Care Ctr., LLC,* 57 A.3d 582 (Pa. 2012) (*Scampone* 2) and *Scampone v. Grane Healthcare Co.*, 169 A.3d 600 (Pa. Super. 2017) (*Scampone* 3) for the professional negligence of its actual, apparent, and/or ostensible agents, servants, and employees who participated, or failed to participate, in the care of Terry Lynn Odoms on August 16, 2019. Pursuant to Pa.R.Civ.P. 1042.3, a Certificate of Merit as to this Defendant will be filed separately with the Court.

38. Defendant WellSpan York Hospital is a corporation or other legal entity organized and existing under and by virtue of the laws of the Commonwealth of Pennsylvania, which at all relevant times owned, maintained, operated and/or controlled a hospital located at 1001 S. George Street in York, Pennsylvania. At all relevant times, WellSpan York Hospital employed physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians and other agents, servants and employees who purportedly possessed skill and training for the purposes of providing medical care and services to the general public, and Terry Lynn Odoms in particular. The claims asserted against this Defendant are both direct under

Thompson v. Nason, 591 A.2d 703 (Pa. 1991), and its progeny of case law, including *Scampone v. Highland Park Care Ctr., LLC,* 57 A.3d 582 (Pa. 2012) (*Scampone* 2) and *Scampone v. Grane Healthcare Co.*, 169 A.3d 600 (Pa. Super. 2017) (*Scampone* 3) for the professional negligence of its actual, apparent, and/or ostensible agents, servants, and employees who participated, or failed to participate, in the care of Terry Lynn Odoms on August 16, 2019. Pursuant to Pa.R.Civ.P. 1042.3, a Certificate of Merit as to this Defendant will be filed separately with the Court.

39. WellSpan Health and WellSpan York Hospital may be referred to collectively as the "WellSpan Defendants" or "Defendants."

40. At all relevant times, Defendants and their agents, servants, and employees were engaged in the practice of medicine, pursuing their respective specialties and/or health care duties, and were obligated to use the professional skill, knowledge and care that they possessed, and to pursue their professions in accordance with reasonably safe and accepted standards of medicine and professional care in general, and in their specialties in particular, as well as institutional standards of medical care, in their care and treatment of Terry Lynn Odoms.

41. At all relevant times, Defendants engaged as their actual, apparent or ostensible agents, servants and/or employees various physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians who at all times were acting within the course and scope of their agency and/or employment with Defendants and under their exclusive control. The Defendants are liable for the negligent acts or omissions of their authorized servants, employees, and actual or ostensible agents under theories of respondeat superior, master-servant, agency, and right of control.

42. At all relevant times, a physician or provider-patient relationship existed between Terry Lynn Odoms and Defendants.

43. At all relevant times, Defendants undertook and/or assumed a duty to Terry Lynn Odoms to provide him with timely and appropriate medical care, management and treatment in connection with his condition and to avoid the risk of harm and death.

44. The carelessness, recklessness, and negligence of Defendants and each of them, jointly and severally, as described herein, increased the risk of harm to Terry Lynn Odoms and was a substantial factor in causing his premature death.

45. The catastrophic injuries and premature death of Terry Lynn Odoms and the damages and injuries to Mr. Odoms and his beneficiaries at law were caused solely and exclusively by the negligent acts and omissions of Defendants, their agents, servants and employees as described more specifically herein, jointly and severally, and were not caused by any act or failure to act on the part of Terry Lynn Odoms.

46. All Defendants herein are vicariously liable to Plaintiff for the negligent acts and omissions of those persons and/or entities whose conduct was under their supervision, control or right of control, and which conduct directly and proximately caused plaintiff's decedent's injuries and losses.

47. At all relevant times, Defendants had actual or constructive knowledge of the medical care and treatment, or lack thereof, provided to Terry Lynn Odoms.

48. At all relevant times, plaintiff and plaintiff's decedent relied on the knowledge, care, skill, treatment and advice of the Defendants in connection with their medical care and treatment of plaintiff's decedent, Terry Lynn Odoms.

49. The amount in controversy exceeds the prevailing, local arbitration limits.

50. Venue in this action is proper in York County as medical care giving rise to the action occurred in York County. *See* Pa. R. Civ. P. 1006.

OPERATIVE FACTS

51. This case arises from the catastrophic injuries and premature death suffered by Terry Lynn Odoms due to Defendants' failure to treat him and their abandonment of him on his arrival to the hospital.

52. On August 16, 2019, at 9:59 Terry Lynn Odoms arrived, via ambulance, to the WellSpan Hospital Emergency Department ("ED").

53. After a WellSpan staff member came over to the ambulance stretcher, and may have taken initial vital signs, though none are recorded in the record at this time, the EMTs moved Mr. Odoms from the stretcher to a wheelchair. Mr. Odom's oxygen, which had been placed by the EMTs, was discontinued.

54. At 9:59, the WellSpan ED staff created an Emergency Encounter for Terry Lynn Odoms.

55. Terry Lynn Odoms' complaint at the time of his arrival was nausea.

56. Mr. Odoms was wheeled by the EMT through a doorway or hallway to the location of the pivot nurse, but his wheelchair was placed in front of an adjoining desk area. The EMT then proceeded to the pivot nurse's desk and apparently gave a report to the pivot nurse.

57. The pivot nurse, on information and belief Anissa Page, RN, did not speak with or examine Terry Lynn Odoms. In fact, the pivot nurse never even got out of her chair to walk over to Mr. Odoms' location.

58. An ED Triage Note by Nurse Page timed at 10:13 indicates that the patient arrived via EMS for nausea/vomiting.

59. An addendum to the ED Triage Note reported dizziness since "last night," a history of vertigo, low temperature, and difficulty getting a pulse oximetry reading.

60. At 10:15, the ED assigned Terry Lynn Odoms a Patient Acuity/ESI Level of 3 and documented Triage as completed.

61. At 10:20, WellSpan changed Terry Lynn Odoms' Patient Acuity Level to ESI 2, **which means WellSpan personnel knew and understood that there was a high risk that Terry Lynn Odoms would deteriorate absent prompt medical intervention.**

62. At 10:25, Terry Lynn Odoms had a heart rate of 120 (tachycardic) and a respiratory rate of 28 (tachypneic) recorded by a nursing assistant, each of which is abnormally elevated, and each of which was flagged in the medical record as being abnormally elevated.

63. Despite this highly concerning presentation, and WellSpan's knowledge that Terry Lynn Odoms was at a high risk of deteriorating without timely medical intervention, at 10:25, the nursing assistant wheeled Terry Lynn Odoms' wheelchair into the adjoining waiting room, leaving him there unattended.

64. To this point, Mr. Odoms had not been seen by a nurse. His oxygen saturation levels, noted to be low by the EMTs, had not been recorded, and his supplemental oxygen, which had been removed on arrival, was not replaced.

65. WellSpan personnel **abandoned Terry Lynn Odoms, leaving him completely unattended for the next two hours**. No nurse, doctor, or staff member came to assess Terry Lynn Odoms. As anticipated by his high Patient Acuity score, Terry Lynn Odoms deteriorated, unnoticed and without any intervention or recognition by anyone in the WellSpan ED.

66. At 11:06 a.m, shocking security footage shows Terry Lynn Odoms in distress, stretching out and raising his hand, obviously trying to gain someone's, anyone's, attention to alert someone that he needed help.

67. No one responded to Terry Lynn Odoms.

68. Video shows that over the course of the two hours between Terry Lynn Odoms' being wheeled into the waiting room and his being discovered unresponsive, WellSpan ED staff walked past Mr. Odoms on **12 different occasions.**

69. WellSpan staff came within 1-2 feet of Mr. Odoms multiple times, sometimes standing right in front of him and looking in his direction, and yet failed to make any effort to evaluate him though he was slumped over and motionless.

70. Security footage reveals WellSpan staff coming out of the Triage Room directly in front of Terry Lynn Odoms **seven times.**

71. Though Mr. Odoms remained exactly where he had been wheeled by WellSpan ED staff, at 12:05, WellSpan ED staff removed Mr. Odoms' name from the tracking board and documented him as "LWBS," having "left without being seen" because no response was heard when they called his name three times.

72. In reckless disregard of the consequences, no one walked out to the waiting room to see if Mr. Odoms was still there.

73. He was right where they had put him, but incapacitated and unable to respond.

74. At 12:23 p.m., a WellSpan ED staff member, on information and belief a nursing assistant, noticed that Terry Lynn Odoms, who had already categorized as "left without being seen," was unresponsive in his wheelchair in the waiting room.

75. A code was initiated at 12:25 p.m.

76. Doctors pronounced Terry Lynn Odoms dead at 1:31 p.m., one hour and eight minutes after they found him unresponsive in the WellSpan ED waiting room, where he had desperately been awaiting medical attention.

77. While Terry Lynn Odoms, an ESI level 2 patient requiring immediate medical care, remained unseen and untreated in the WellSpan waiting room, two ESI 4 (lesser acuity) patients who arrived after him were triaged, examined by providers, and discharged.

78. The Pennsylvania Department of Health ("DOH") undertook an unannounced special monitoring visit to WellSpan on August 22, 23, and 30, 2019, because of the errant events that had caused Terry Lynn Odoms' death.

79. The Pennsylvania DOH found multiple egregious failures of the WellSpan Defendants' compliance with the licensure requirements of the Department's Rules and Regulations for Hospitals, including: (1) dangerously inadequate staffing that required the pivot nurse whose responsibility was to assess and manage patient responsibilities for people who have not yet been taken to a treatment area, to perform double duty triaging arriving patients, taking her away from the critical pivot role; (2) failures to enforce and ensure compliance with express hospital policies for rounding and ongoing assessment of waiting room patients who had not yet been seen by a provider at clearly defined intervals based on acuity and time to ensure patient safety and timely treatment; (3) failures to document vital signs and perform an appropriate initial assessment with the consequence that standing protocols that would have ensured provider interaction or interventions were not initiated for Terry Lynn Odoms; (4) failures to require a nurse or staff to walk through the lobby or waiting area to see if the patient is or is not present before removing a patient from the ED tracking board; and, (5) failure to provide an EMTALA mandated medical screening for a patient who arrived by ambulance.

80. WellSpan Health made conscious decisions regarding the staffing of the hospital and knowingly short-staffed the WellSpan ED.

81. It was aware of the staffing deficiencies for a year at least, yet had failed to take necessary steps to rectify this dangerous situation.

82. This intentional and reckless corporate financial decision jeopardized the health and safety of all patients, and Terry Lynn Odoms in particular.

83. Between 7:00 a.m. and 11:00 a.m., during the time of Terry Lynn Odoms' arrival to the WellSpan ED, the pivot nurse was performing both pivot and triage duties, as WellSpan York Hospital did not have another nurse available due to the WellSpan Defendants' reckless decisions to understaff the hospital.

84. As a consequence of the understaffing and the extra burden on the pivot nurse, Mr. Odoms went unseen and unevaluated by any nurse. For all intents and purposes neither the pivot nor triage role was fulfilled as required by standard of care.

85. WellSpan Health and WellSpan York Hospital knew on August 16, 2019, that they did not have nursing coverage for both pivot and triage duties, yet they consciously disregarded that risk, intentionally understaffed the ED, and allowed it to operate in this dangerous fashion.

86. The failure of WellSpan Health and WellSpan York Hospital to have both a pivot nurse and a triage nurse, *at all times*, on information and belief was in direct violation of express hospital policies.

87. The failure of WellSpan Health and WellSpan York Hospital to have both a pivot nurse and triage nurse, *at all times*, demonstrates a shocking, reckless and wanton disregard for the safety and well-being of all patients, and Terry Lynn Odoms in particular.

88. During Terry Lynn Odoms' time at WellSpan, the ED was at capacity, with patients on "medical hold," meaning there were patients in the ED still waiting for an admission bed.

89. Despite being at capacity, with numerous patients on "medical hold," thus exacerbating the need to keep patients in the waiting room, the WellSpan Defendants knowingly and recklessly caused and allowed the ED to be short-staffed, creating an unreasonable risk of harm to Terry Lynn Odoms.

90. The Medical Care Availability and Reduction of Error Act (MCARE Act) defines a Serious Event as an event, occurrence, or situation involving the clinical care of a patient in a medical facility (hospital) that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health services to the patient.

91. The Pennsylvania DOH, in its investigation, found that the WellSpan Defendants failed to report this Serious Event within 24 hours as required by Pennsylvania law.

92. Rather than abide by Pennsylvania law, the WellSpan Defendants instead delayed making a Serious Event report until after they had conducted an internal Root Cause Analysis.

93. 28 Pa. Code § 117.1 (b) states that "where there is an emergency service, it shall provide prompt examination or treatment, or both, to all persons who come or are brought into the hospital in need of treatment, irrespective of ability to pay. The treatment shall be of the highest type consistent with the facilities available and with the standards established in the medical community of which the hospital is a part."

94. The Pennsylvania DOH found that WellSpan failed to meet this regulation and failed to provide a medical screening examination to a patient who presented via ambulance to the hospital ED.

95. WellSpan's own policies regarding Responsibilities of Hospital, Hospital Personnel, and Physicians include:

a. Medical Screening Exam (MSE)

(1) When an individual comes to the hospital concerned that they may have an emergency medical condition and requests medical care, the hospital must provide for an appropriate MSE within the capability of the ED, including ancillary services routinely available to the ED to determine whether an Emergency Medical Condition exists;

(2) The MSE is to be provided by Qualified Medical Personnel that have been designated as qualified medical personnel;

(3) Individuals coming to the Emergency Department must be provided an MSE beyond initial triage.

96. In egregious and knowing violation of the standard of care, including these Defendants' own express policy pronouncements, and in reckless disregard of the consequences to the patient's well-being, the WellSpan Defendants failed to follow EMTALA requirements for medical screening.

97. 28 Pa. Code § 103.22(b)(16) states that "The patient has the right to expect good management techniques to be implemented within the hospital considering effective use of the time of the patient and to avoid the personal discomfort of the patient."

98. The Pennsylvania DOH found that WellSpan failed to meet 28 Pa. Code § 103.22(b)(16) as it failed to implement good management techniques by failing to ensure that patients in the ED were monitored and received necessary treatment in a timely manner.

99. 28 Pa. Code § 103.22(b)(6) states that "The patient has the right to expect emergency procedures to be implemented without unnecessary delay."

100. The Pennsylvania DOH found that WellSpan failed to meet 28 Pa. Code § 103.22(b)(6) by failing to implement emergency procedures without unnecessary delay.

101. In egregious disregard of patient wellbeing and safety, the WellSpan Defendants failed to enforce and ensure compliance with their express policies aimed at ensuring appropriate and timely patient management and care.

102. The WellSpan ED Rounding Policy and Standard Work Instructions require that hospital personnel:

- At the top of each hour, identify patients in the Waiting Room for bed assignment greater than one hour;
- Call patient's name. Walk to patient's location, introduce yourself, verify ID band;
- Document patient's initials, chief complaint, ESI and current wait time on Rounding Log;
- Ask the patient how they are feeling, ask if there is an increase/improvement in pain, and evaluate patient's appearance;

All of these findings are to be documented on a Rounding Log.

103. In deviation and gross departure from the standard of care, and with knowing and reckless disregard of Terry Lynn Odoms' health and well-being, WellSpan failed to perform any of the above steps for Mr. Odoms at the top of the 11 a.m. and 12 p.m. hours.

104. WellSpan's Nursing Policy requires that patients with a Level 2 acuity score, such as Mr. Odoms, have their vital signs taken every hour.

105. In reckless disregard of the consequences, this was not done for Mr. Odoms.

106. The Pennsylvania DOH investigation found no evidence that anyone rounded while Mr. Odoms was in the waiting room; the video surveillance tape makes clear that no one did.

107. On August 22, 2019, six days after Mr. Odoms had died, but before the DOH had secured the ED video surveillance and conducted its investigation, Keith Noll, President of WellSpan York Hospital, sent the Odoms family a letter, a copy of which is attached as **Exhibit B**.

108. The letter, on its face, seeks to assure Terry Lynn Odoms' family that WellSpan quickly and properly attended to Mr. Odoms in the ED.

109. The surveillance video makes plain that Mr. Noll's letter intentionally and badly misled the family regarding the events surrounding Mr. Odoms' death.

110. The letter conceals the damning and shocking reality of WellSpan's wholesale abandonment of Terry Lynn Odoms.

111. By way of just one example, the letter states that the ED team responded as soon as they recognized Terry Lynn Odoms was no longer responsive. WellSpan York Hospital President, Keith Noll, however, fails to mention that Mr. Odoms was left unattended for hours in direct violation of law and hospital policy.

112. The carelessness and negligence of Defendants, jointly and severally, as described herein, increased the risk of harm to Terry Lynn Odoms and did, in fact, cause his catastrophic injuries and premature death.

113. As a direct result of the negligence and and reckless omissions of Defendants, individually, jointly and severally, as described herein, Terry Lynn Odoms was needlessly exposed to an increased risk of harm and was caused to suffer:

114. As described herein, the medical care and treatment provided by Defendants, their agents, servants, and employees, to Terry Lynn Odoms was negligent and reckless and deviated from the accepted standards of medical, nursing, and emergency department care, increased the risk of harm to Terry Lynn Odoms, and was a substantial factor in causing him to suffer the following harm, without limitation, all of which was avoidable with prompt, proper, and adequate care:

a. PEA arrest;
b. organ dysfunction and failure;
c. hyperkalemia;
d. acute respiratory distress and failure;
e. multiple interventions producing physical pain and discomfort;
f. conscious physical pain and suffering;
g. mental anguish, anxiety, panic, fright, and fear of impending death;
h. emotional pain and stress until time of death;
i. loss of opportunity for treatment and resolution of his underlying condition;
j. diminution of probability of survival;
k. diminution of life expectancy;
l. loss of enjoyment of life's pleasures until time of death;
m. medical expenses;
n. disfigurement;
o. humiliation;
p. funeral and burial expenses;
q. costs of estate administration;
r. injuries and damages documented in Mr. Odoms' medical records from physicians, and other medical and non-medical professionals who provided care to Mr. Odoms for the sequelae of his unrecognized and untreated medical emergency;
s. such other injuries, damages and losses as described more fully herein and compensable at law under the Survival Act and the decisional law of this Commonwealth interpreting that Act; and,
t. hastened and avoidable death.

115. As a direct result of the negligence of defendants, jointly and severally, and the carelessness and recklessness, as more fully set forth above and in the counts below, Terry Lynn

Odoms' beneficiaries have suffered and will continue to suffer substantial damages and losses, including:

a. profound psychological and emotional loss;
b. loss of the comfort, care, society, support and services of their father; and,
c. such other injuries, damages and losses as described more fully herein and compensable at law under the Wrongful Death Act and the decisional law of this Commonwealth interpreting that Act, including *Rettger v. UPMC Shadyside*, 991 A.2d 915 (Pa. Super. 2010).

116. Plaintiff demands both compensatory and punitive damages of Defendants who ignored Terry Lynn Odoms' complaints and symptoms in a shocking, reckless and wanton disregard for the safety and well-being of Mr. Odoms to the full extent cognizable under Pennsylvania law.

COUNT I – CORPORATE NEGLIGENCE AND RECKLESSNESS

Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, deceased v. WellSpan Health

117. The preceding and subsequent paragraphs of this complaint are incorporated as though fully set forth herein pursuant to Pa.R.C.P. No. 1019(g).

118. In addition to the derivative and vicarious liability of WellSpan for the negligent acts and omissions of its agents, servants and employees, as described more particularly herein, WellSpan Health further owed direct and non-delegable duties to Terry Lynn Odoms under the tenets set forth in *Thompson v. Nason*, 591 A.2d 703 (Pa. 1991), and its progeny of case law, including *Scampone v. Highland Park Care Ctr., LLC,* 57 A.3d 582 (Pa. 2012) (*Scampone* 2) and *Scampone v. Grane Healthcare Co.*, 169 A.3d 600 (Pa. Super. 2017) (*Scampone* 3).

119. Defendant WellSpan Health's duties included; (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) a duty to select and retain only competent physicians; (3) a duty to oversee all persons who practice medicine within its walls as

to patient care; and (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for patients.

120. WellSpan Health knowingly failed to maintain a safe and adequate facility.

121. WellSpan Health knowingly permitted the WellSpan York Hospital ED to be understaffed and recklessly failed to remedy critical staffing issues.

122. WellSpan Health knowingly failed to oversee all persons who cared for patients within its walls as to patient care.

123. WellSpan Health knowingly failed to formulate, adopt, and/or enforce adequate rules and policies to ensure quality care for patients.

124. WellSpan Health had a duty to Terry Lynn Odoms to exercise reasonable care in the appointment and reappointment of physicians, fellows, nurses/CRNPs, technicians, and staff.

125. WellSpan Health had a duty to its patients, and to Terry Lynn Odoms, in particular, to provide reasonable and competent medical care and services and to avoid conduct that would increase the risk of and in fact cause harm to its patients, including Mr. Odoms.

126. It is believed and therefore averred that the physician, physician assistants, nursing and technical staff who participated in the care of Terry Lynn Odoms at WellSpan, as more particularly defined herein, did not possess the requisite training, experience, technical skills and judgment to render proper care and services to patients with his clinical history, presenting signs and symptoms, and abnormalities demonstrated.

127. The corporate negligence of WellSpan Health, acting by and through its actual, apparent and/or ostensible agents, servants and employees, consisted of one or more of the following:

i. Failing to have physicians, interns, residents, fellows, physician assistants, nurse practitioners, technicians, nurses, and staff appropriate in number, training, and/or experience to timely and properly adhere to the accepted standards of care in the evaluation, diagnosis and management of Terry Lynn Odoms;

ii. Failing to properly oversee physicians, interns, residents, fellows, physician assistants, nurse practitioners, technicians, nurses, and staff to ensure timely and proper adherence to the accepted standards of care in the evaluation, diagnosis and management of Terry Lynn Odoms;

iii. Failing to have the facilities and equipment necessary to timely and properly detect, monitor, treat, prevent injury to, and/or respond to patients in the ED;

iv. Failing to properly implement and/or enforce necessary policies, procedures. Guidelines, and/or protocols regarding:

a. A patient who presents with a clinical history and/or physical signs and symptoms such as those demonstrated by Terry Lynn Odoms;

b. Vital signs, chief complaints, patient care protocols or standing orders for patients presenting a clinical history and/or physical signs and symptoms, such as those demonstrated by Terry Lynn Odoms

c. Patient flow and clinical management of patients waiting to be seen in the ED, including initial assessments and rounding on patients in the ED with a clinical history and/or physical signs and symptoms such as those demonstrated by Terry Lynn Odoms;

d. Safe, timely, effective, efficient and equitable care of a patient presenting with a clinical history and/or physical signs and symptoms such as those demonstrated by Terry Lynn Odoms;

e. Detection of a patient's clinical deterioration while waiting to be seen by a provider;

f. ED evaluation procedures;

g. ED rounding procedures;

h. ED monitoring procedures;

i. ED patient flow procedures;

j. Procedures regarding removal of a patient from the ED patient tracking board;

k. Procedures for documenting a patient as "LWBS" and/or "left without being seen";

l. Obtaining vital signs in the ED;

m. Scope of initial patient assessment;

n. ESI designations and response;

o. Symptom management and evaluation;

p. Physician notification regarding patient condition;

q. Cardiac and/or respiratory status monitoring protocols;

r. Staffing protocols;

s. Supervision of physician staff;

t. Supervision of nursing staff;

u. Supervision of graduate medical trainee physicians (fellows, residents, interns);

v. Pivot and triage nurse roles and duties;

w. Pivot and triage nurse staffing;

x. Staffing of the ED with the requisite number of physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians;

y. Staffing schedules within the ED of physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians;

z. Staffing WellSpan with the requisite number of physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians to ensure appropriate patient care;

aa. Staffing schedules of WellSpan physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians to ensure appropriate patient care;

bb. Assessment and reassessment of patient acuity levels;

cc. Scope of nursing practice;

dd. Chain of command and reporting;

ee. Escalation of reporting of patient care issues;

ff. Implementation of hospital protocols, policies, or standing orders regarding ED patient evaluation and management;

gg. Implementation of hospital protocols, policies, or standing orders regarding vital sign and presenting symptom abnormalities;

hh. Proper communication of clinical findings among health care providers;

ii. Proper and timely nursing assessment;

jj. Proper and timely response to nursing staff communication by physician staff;

kk. Medical record documentation.

128. In violation of the accepted standard of care, WellSpan Health did not have adequate policies or procedures implemented at the time, and/or if such policies were in place, WellSpan Health failed to ensure that the medical, resident, fellow, nursing, ancillary nursing, and technician staff were aware of, familiar with, and followed such policies.

129. WellSpan Health knew, or should have known, that it did not have adequate written policies and procedures in place, as described above.

130. WellSpan Health knew, or should have known, that the medical, resident, fellow, nursing and technician staff were not familiar with and/or failed to follow the hospital's written policies and procedures with respect to the matters described above, to the extent that they existed.

131. WellSpan Health knew, or should have known, that medical, resident, fellow, nursing, and technician staff did not possess the adequate training, skill or knowledge in the evaluation and management of ED patients such as Terry Lynn Odoms.

132. WellSpan Health knew, or should have known, that it failed to provide its medical, resident, fellow, nursing, and technician staff with the proper training, skill or knowledge to care for patients like Terry Lynn Odoms.

133. WellSpan Health knew that its failure to have an adequate number of appropriately trained nurses on shift recklessly increased the risk that a patient like Mr. Odoms would die unnecessarily because of gaps and failures of care.

134. As a direct and proximate result of the corporate negligence and recklessness of WellSpan Health, as described herein, Terry Lynn Odoms was deprived of necessary, timely and appropriate evaluation, diagnosis, treatment and management of his condition, allowing it to progress, unrecognized until he was beyond cure.

135. As a direct and proximate result of the corporate negligence and recklessness of WellSpan Health, as described herein, Terry Lynn Odoms suffered catastrophic, permanent, and fatal injuries and damages as described herein.

WHEREFORE, Plaintiff demands of Defendants, jointly and severally, damages in an amount excess of Fifty Thousand Dollars ($50,000.00), and in excess of the prevailing arbitration limits, exclusive of pre-judgment interest, post-judgment interests and costs, as well as punitive damages.

COUNT II – CORPORATE NEGLIGENCE AND RECKLESSNESS

Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, deceased v. WellSpan York Hospital

136. The preceding and subsequent paragraphs of this complaint are incorporated as though fully set forth herein pursuant to Pa.R.C.P. No. 1019(g).

137. In addition to the derivative and vicarious liability of WellSpan York Hospital for the negligent acts and omissions of its agents, servants and employees, as described more particularly herein, WellSpan York Hospital further owed direct and non-delegable duties to Terry Lynn Odoms under the tenets set forth in *Thompson v. Nason*, 591 A.2d 703 (Pa. 1991), and its progeny of case law, including *Scampone v. Highland Park Care Ctr., LLC,* 57 A.3d 582 (Pa. 2012) (*Scampone* 2) and *Scampone v. Grane Healthcare Co.*, 169 A.3d 600 (Pa. Super. 2017) (*Scampone* 3).

138. Defendant WellSpan York Hospital's duties included; (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) a duty to select and retain only competent physicians; (3) a duty to oversee all persons who practice medicine within its walls as to patient care; and (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for patients.

139. WellSpan York Hospital knowingly failed to maintain a safe and adequate facility.

140. WellSpan York Hospital knowingly permitted the WellSpan York Hospital ED to be understaffed and recklessly failed to remedy critical staffing issues.

141. WellSpan York Hospital knowingly failed to oversee all persons who cared for patients within its walls as to patient care.

142. WellSpan York Hospital knowingly failed to formulate, adopt, and/or enforce adequate rules and policies to ensure quality care for patients.

143. WellSpan York Hospital had a duty to Terry Lynn Odoms to exercise reasonable care in the appointment and reappointment of physicians, fellows, nurses/CRNPs, technicians, and staff.

144. WellSpan York Hospital had a duty to its patients, and to Terry Lynn Odoms, in particular, to provide reasonable and competent medical care and services and to avoid conduct that would increase the risk of and in fact cause harm to its patients, including Mr. Odoms.

145. It is believed and therefore averred that the physician, physician assistants, nursing and technical staff who participated in the care of Terry Lynn Odoms at WellSpan York Hospital as more particularly defined herein, did not possess the requisite training, experience, technical skills and judgment to render proper care and services to patients with his clinical history, presenting signs and symptoms and abnormalities demonstrated.

146. The corporate negligence of WellSpan York Hospital, acting by and through its actual, apparent and/or ostensible agents, servants and employees, consisted of one or more of the following:

i. Failing to have physicians, interns, residents, fellows, physician assistants, nurse practitioners, technicians, nurses, and staff appropriate in number, training, and/or experience to timely and properly adhere to the accepted standards of care in the evaluation, diagnosis and management of Terry Lynn Odoms;

ii. Failing to properly oversee physicians, interns, residents, fellows, physician assistants, nurse practitioners, technicians, nurses, and staff to ensure timely and proper adherence to the accepted standards of care in the evaluation, diagnosis and management of Terry Lynn Odoms;

iii. Failing to have the facilities and equipment necessary to timely and properly detect, monitor, treat, prevent injury to, and/or respond to patients in the ED;

iv. Failing to properly implement and/or enforce necessary policies, procedures. Guidelines, and/or protocols regarding:

a. A patient who presents with a clinical history and/or physical signs and symptoms such as those demonstrated by Terry Lynn Odoms;

b. Vital signs, chief complaints, patient care protocols or standing orders for patients presenting a clinical history and/or physical signs and symptoms, such as those demonstrated by Terry Lynn Odoms

c. Patient flow and clinical management of patients waiting to be seen in the ED, including initial assessments and rounding on patients in the ED with a clinical history and/or physical signs and symptoms such as those demonstrated by Terry Lynn Odoms;

d. Safe, timely, effective, efficient and equitable care of a patient presenting with a clinical history and/or physical signs and symptoms such as those demonstrated by Terry Lynn Odoms;

e. Detection of a patient's clinical deterioration while waiting to be seen by a provider;

f. ED evaluation procedures;

g. ED rounding procedures;

h. ED monitoring procedures;

i. ED patient flow procedures;

j. Procedures regarding removal of a patient from the ED patient tracking board;

k. Procedures for documenting a patient as "LWBS" and/or "left without being seen";

l. Obtaining vital signs in the ED;

m. Scope of initial patient assessment;

n. ESI designations and response;

o. Symptom management and evaluation;

p. Physician notification regarding patient condition;

q. Cardiac and/or respiratory status monitoring protocols;

r. Staffing protocols;

s. Supervision of physician staff;

t. Supervision of nursing staff;

u. Supervision of graduate medical trainee physicians (fellows, residents, interns);

v. Pivot and triage nurse roles and duties;

w. Pivot and triage nurse staffing;

x. Staffing of the ED with the requisite number of physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians;

y. Staffing schedules within the ED of physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians;

z. Staffing WellSpan with the requisite number of physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians to ensure appropriate patient care;

aa. Staffing schedules of WellSpan physicians, interns, residents, fellows, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians to ensure appropriate patient care;

bb. Assessment and reassessment of patient acuity levels;

cc. Scope of nursing practice;

dd. Chain of command and reporting;

ee. Escalation of reporting of patient care issues;

ff. Implementation of hospital protocols, policies, or standing orders regarding ED patient evaluation and management;

gg. Implementation of hospital protocols, policies, or standing orders regarding vital sign and presenting symptom abnormalities;

hh. Proper communication of clinical findings among health care providers;

ii. Proper and timely nursing assessment;

jj. Proper and timely response to nursing staff communication by physician staff;

kk. Medical record documentation.

147. In violation of the accepted standard of care, WellSpan York Hospital did not have adequate policies or procedures implemented at the time, and/or if such policies were in place, WellSpan York Hospital failed to ensure that the medical, resident, fellow, nursing, ancillary nursing, and technician staff were aware of, familiar with, and followed such policies.

148. WellSpan York Hospital knew, or should have known, that it did not have adequate written policies and procedures in place, as described above.

149. WellSpan York Hospital knew, or should have known, that the medical, resident, fellow, nursing and technician staff were not familiar with and/or failed to follow the hospital's written policies and procedures with respect to the matters described above, to the extent that they existed.

150. WellSpan York Hospital knew, or should have known, that medical, resident, fellow, nursing, and technician staff did not possess the adequate training, skill or knowledge in the evaluation and management of ED patients such as Terry Lynn Odoms.

151. WellSpan York Hospital knew, or should have known, that it failed to provide its medical, resident, fellow, nursing, and technician staff with the proper training, skill or knowledge to care for patients like Terry Lynn Odoms.

152. WellSpan York Hospital knew that its failure to have an adequate number of appropriately trained nurses on shift recklessly increased the risk that a patient like Mr. Odoms would die unnecessarily because of gaps and failures of care.

153. As a direct and proximate result of the corporate negligence and recklessness of WellSpan York Hospital, as described herein, Terry Lynn Odoms was deprived of necessary, timely and appropriate evaluation, diagnosis, treatment and management of his condition, allowing it to progress, unrecognized until he was beyond cure.

154. As a direct and proximate result of the corporate negligence and recklessness of WellSpan York Hospital, as described herein, Terry Lynn Odoms suffered catastrophic, permanent, and fatal injuries and damages as described herein.

WHEREFORE, Plaintiff demands of Defendants, jointly and severally, damages in an amount excess of Fifty Thousand Dollars ($50,000.00), and in excess of the prevailing arbitration limits, exclusive of pre-judgment interest, post-judgment interests and costs, as well as punitive damages.

COUNT III – NEGLIGENCE AND RECKLESSNESS

Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, deceased v. WellSpan Health

155. The preceding and subsequent paragraphs of this Complaint are incorporated as though set forth fully herein Pa.R.C.P. No. 1019(g).

156. The negligent and reckless acts and omissions of this Defendant and its Employees/Agents consisted of one or more of the following:

a. failure to adequately, timely, and appropriately perform physical examination, including pulmonary, respiratory, and cardiac examination;

b. failure to adequately, timely, and appropriately perform visual examination;

c. failure to adequately, timely, and appropriately perform a medical screening exam;

d. failure to ensure that a patient is timely seen by a medical provider;

e. failure to adequately, timely, and appropriately conduct, interpret and/or document proper physical examinations of Terry Lynn Odoms;

f. failure to adequately, timely and appropriately suspect and/or identify Terry Lynn Odoms' deteriorating condition;

g. failure to adequately, timely, and appropriately appreciate the significance of Terry Lynn Odoms' abnormal clinical presentation;

h. failure to adequately, timely, and appropriately order and/or ensure consultation with and evaluation by proper medical personnel;

i. failure to adequately, timely, and appropriately form an appropriate and complete differential diagnosis;

j. failure to adequately, timely, and appropriately order or perform necessary and required laboratory studies;

k. failure to adequately, timely and appropriately obtain and document an accurate, proper, sufficient history, including signs, symptoms, diagnostic findings, interventions, and complaints with regard to Terry Lynn Odoms;

l. failure to adequatly, timely, and appropriately implement protocols and standing orders based up the patient's presenting clinical condition and complaints;

m. failure to adequately, timely and appropriately respond to the signs, symptoms, history and/or findings with regard to Terry Lynn Odoms;

n. failure to adequately, timely and appropriately create and/or maintain complete and accurate documentation;

o. failure to adequately, timely and appropriately order and/or perform further medical consultation and testing for Terry Lynn Odoms;

p. failure to adequately, timely, and appropriately order and/or perform and/or appreciate the results of physical assessments and/or diagnostic testing performed for Terry Lynn Odoms;

q. failure to adequately, timely and appropriately communicate with other healthcare providers and/or the patient with regard to his condition;

r. failure to adequately, timely and appropriately initiate cardiac monitoring and/or order or obtain cardiac studies;

s. failure to adequately, timely and appropriately ensure the necessary intervention and/or treatment for Terry Lynn Odoms' condition;

t. failure to adequately, timely, and appropriately order, obtain and/or recommend appropriate studies and tests for Terry Lynn Odoms in light of his signs, symptoms, history and/or findings;

u. failure to properly and appropriately perform the responsibilities of a pivot nurse;

v. failure to properly and appropriately assess and evaluate a patient as the pivot nurse;

w. failure to ensure that appropriate interventions, including oxygen, are implemented for patients waiting to be seen in the ED;

x. failure to adequately, timely, and appropriately monitor patients in the ED waiting room;

y. failure to adequately, timely, and appropriately round on patients in the ED waiting room;

z. failure to properly and appropriately perform the responsibilities of a triage nurse;

aa. failure to perform a complete and timely triage evaluation;

bb. failure to implement chain of command to ensure patient safety;

cc. failure to ensure appropriate staffing of the ED for patient flow and monitoring in the waiting room;

dd. failure to adequately, timely and appropriately oversee and supervise the nursing and ancillary medical staff at WellSpan with respect to monitoring Terry Lynn Odoms' signs, symptoms, and condition;

ee. failure to adequately, timely and appropriately implement an adequate, necessary, thorough and/or prompt assessment and treatment plan;

ff. failure to adequately, timely and appropriately order and/or administer necessary and appropriate medication;

gg. failure to adequately, timely and appropriately order consultations with specialists; and

hh. acting with willful or wanton conduct or reckless indifference to the risk of harm to Terry Lynn Odoms and/or failing to act in conscious disregard of the risk.

157. The foregoing negligence and recklessness increased the risk of harm to and were a substantial contributing factor in the catastrophic injuries and premature death of Terry Lynn Odoms.

158. As a direct and proximate result of the negligence and recklessness as described herein, Terry Lynn Odoms was deprived of necessary, timely and appropriate evaluation, diagnosis, treatment and management of his condition, allowing it to progress, unrecognized until he was beyond cure.

159. As a direct and proximate result of the negligence and recklessness as described herein, Terry Lynn Odoms suffered catastrophic, permanent, and fatal injuries and damages as described herein.

WHEREFORE, Plaintiff demands of Defendants, jointly and severally, damages in an amount excess of Fifty Thousand Dollars ($50,000.00), and in excess of the prevailing arbitration limits, exclusive of pre-judgment interest, post-judgment interests and costs, as well as punitive damages.

COUNT IV – NEGLIGENCE AND RECKLESSNESS

Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, deceased v. WellSpan York Hospital

160. The preceding and subsequent paragraphs of this Complaint are incorporated as though set forth fully herein Pa.R.C.P. No. 1019(g).

161. The negligent and reckless acts and omissions of this Defendant and its Employees/Agents consisted of one or more of the following:

a. failure to adequately, timely, and appropriately perform physical examination, including pulmonary, respiratory, and cardiac examination;

b. failure to adequately, timely, and appropriately perform visual examination;

c. failure to adequately, timely, and appropriately perform a medical screening exam;

d. failure to ensure that a patient is timely seen by a medical provider;

e. failure to adequately, timely, and appropriately conduct, interpret and/or document proper physical examinations of Terry Lynn Odoms;

f. failure to adequately, timely and appropriately suspect and/or identify Terry Lynn Odoms' deteriorating condition;

g. failure to adequately, timely, and appropriately appreciate the significance of Terry Lynn Odoms' abnormal clinical presentation;

h. failure to adequately, timely, and appropriately order and/or ensure consultation with and evaluation by proper medical personnel;

i. failure to adequately, timely, and appropriately form an appropriate and complete differential diagnosis;

j. failure to adequately, timely, and appropriately order or perform necessary and required laboratory studies;

k. failure to adequately, timely and appropriately obtain and document an accurate, proper, sufficient history, including signs, symptoms, diagnostic findings, interventions, and complaints with regard to Terry Lynn Odoms;

l. failure to adequatly, timely, and appropriately implement protocols and standing orders based up the patient's presenting clinical condition and complaints;

m. failure to adequately, timely and appropriately respond to the signs, symptoms, history and/or findings with regard to Terry Lynn Odoms;

n. failure to adequately, timely and appropriately create and/or maintain complete and accurate documentation;

o. failure to adequately, timely and appropriately order and/or perform further medical consultation and testing for Terry Lynn Odoms;

p. failure to adequately, timely, and appropriately order and/or perform and/or appreciate the results of physical assessments and/or diagnostic testing performed for Terry Lynn Odoms;

q. failure to adequately, timely and appropriately communicate with other healthcare providers and/or the patient with regard to his condition;

r. failure to adequately, timely and appropriately initiate cardiac monitoring and/or order or obtain cardiac studies;

s. failure to adequately, timely and appropriately ensure the necessary intervention and/or treatment for Terry Lynn Odoms' condition;

t. failure to adequately, timely, and appropriately order, obtain and/or recommend appropriate studies and tests for Terry Lynn Odoms in light of his signs, symptoms, history and/or findings;

u. failure to properly and appropriately perform the responsibilities of a pivot nurse;

v. failure to properly and appropriately assess and evaluate a patient as the pivot nurse;

w. failure to ensure that appropriate interventions, including oxygen, are implemented for patients waiting to be seen in the ED;

x. failure to adequately, timely, and appropriately monitor patients in the ED waiting room;

y. failure to adequately, timely, and appropriately round on patients in the ED waiting room;

z. failure to properly and appropriately perform the responsibilities of a triage nurse;

aa. failure to perform a complete and timely triage evaluation;

bb. failure to implement chain of command to ensure patient safety;

cc. failure to ensure appropriate staffing of the ED for patient flow and monitoring in the waiting room;

dd. failure to adequately, timely and appropriately oversee and supervise the nursing and ancillary medical staff at WellSpan with respect to monitoring Terry Lynn Odoms' signs, symptoms, and condition;

ee. failure to adequately, timely and appropriately implement an adequate, necessary, thorough and/or prompt assessment and treatment plan;

ff. failure to adequately, timely and appropriately order and/or administer necessary and appropriate medication;

gg. failure to adequately, timely and appropriately order consultations with specialists; and

hh. acting with willful or wanton conduct or reckless indifference to the risk of harm to Terry Lynn Odoms and/or failing to act in conscious disregard of the risk.

162. The foregoing negligence and recklessness increased the risk of harm to and were a substantial contributing factor in the catastrophic injuries and premature death of Terry Lynn Odoms.

163. As a direct and proximate result of the negligence and recklessness as described herein, Terry Lynn Odoms was deprived of necessary, timely and appropriate evaluation, diagnosis, treatment and management of his condition, allowing it to progress, unrecognized until he was beyond cure.

164. As a direct and proximate result of the negligence and recklessness as described herein, Terry Lynn Odoms suffered catastrophic, permanent, and fatal injuries and damages as described herein.

WHEREFORE, Plaintiff demands of Defendants, jointly and severally, damages in an amount excess of Fifty Thousand Dollars ($50,000.00), and in excess of the prevailing arbitration limits, exclusive of pre-judgment interest, post-judgment interests and costs, as well as punitive damages.

FIRST CAUSE OF ACTION—WRONGFUL DEATH ACT

Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, deceased v. All Defendants

165. Plaintiff incorporates by reference the preceding and subsequent paragraphs of this Civil Action Complaint as though fully set forth herein pursuant to Pa.R.C.P. No. 1019(g).

166. Plaintiff Terry R. Murray Sr., as the duly appointed, qualified, and acting Administrator of the estate of Terry Lynn Odoms, deceased, bring this Wrongful Death Action on behalf of the estate of Terry Lynn Odoms under 42. Pa C.S. §8301, the Pennsylvania Rules of Civil Procedure—including Pa. R.C.P. No. 2202—and decisional case law.

167. Under the Wrongful Death Act, Terry Lynn Odoms, deceased, left surviving him two sons, respectively, Terry R. Murray Sr., and Randy Williams (collectively, "beneficiaries") — who are the beneficiaries entitled to recover under the Wrongful Death Act.

168. As a result of the negligent and reckless acts and omissions of the Defendants, as described more fully, *supra*, Terry Lynn Odoms suffered catastrophic, permanent, and fatal injuries and premature death resulting in the entitlement to damages by the aforementioned beneficiaries under the Wrongful Death Act.

169. Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, claims the full measure of damages recoverable under and by virtue of the Wrongful Death Act and the decisional law interpreting the Act.

170. Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, claims damages for the loss of earnings, maintenance, support, comfort, care, society, guidance, tutelage, and other losses recognized under the Wrongful Death Act, which the beneficiaries would have received from Terry Lynn Odoms had his death not occurred.

171. Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, claims damages for the monetary support that Terry Lynn Odoms would have been expected to provide to the beneficiaries during his lifetime had his death not occurred.

172. Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, claims the loss of pecuniary value of services which Terry Lynn Odoms would have been expected to provide to the beneficiaries during his lifetime had his death not occurred, including the damages for the profound emotional and psychological losses suffered by the Wrongful Death beneficiaries as recognized by the decisional law of this Commonwealth, including *Rettger v. UPMC Shadyside*, 991 A.2d 915 (Pa. Super. 2010).

WHEREFORE, Plaintiff demands of Defendants, jointly and severally, damages in an amount excess of Fifty Thousand Dollars ($50,000.00), and in excess of the prevailing arbitration

limits, exclusive of pre-judgment interest, post-judgment interests and costs, as well as punitive damages.

SECOND CAUSE OF ACTION—SURVIVAL ACT

Plaintiff Terry R. Murray Sr., Individually and as Administrator of the Estate of Terry Lynn Odoms, deceased v. All Defendants

173. Plaintiff incorporates by reference the preceding and subsequent paragraphs of this Civil Action Complaint as though fully set forth herein pursuant to Pa.R.C.P. No. 1019(g)

174. Plaintiff Terry R. Murray Sr., as the duly appointed, qualified, and acting Administrator of the estate of Terry Lynn Odoms, deceased, brings this Survival Action of behalf of the Estate of Terry Lynn Odoms under 42 Pa. C.S. §8302, the Pennsylvania Rules of Civil Procedure, and decisional law interpreting this Act.

175. As a result of the negligent and reckless acts and omissions of the Defendants, as described *supra* and *infra*, Terry Lynn Odoms suffered catastrophic, permanent, fatal injuries and premature death, resulting in the entitlement to damages by the Estate of Terry Lynn Odoms, deceased, under the aforementioned Survival Act.

176. Plaintiff Terry Murray Sr., as Administrator of the Estate of Terry Lynn Murray, brings this action on behalf of the Estate to recover the full measure of damages recoverable under the Survival Act and decisional case law.

177. On behalf of the Estate of Terry Lynn Odoms, Plaintiff claims damages for all economic losses to the Estate.

178. On behalf of the Estate of Terry Lynn Odoms, Plaintiff claims damages for Terry Lynn Odoms' conscious physical discomfort, pain and suffering, loss of enjoyment of life and

life's pleasures, and all other damages and losses recoverable under the Survival Act and the decisional law interpreting the Act.

WHEREFORE, Plaintiff demands of Defendants, jointly and severally, damages in an amount excess of Fifty Thousand Dollars ($50,000.00), and in excess of the prevailing arbitration limits, exclusive of pre-judgment interest, post-judgment interests and costs, as well as punitive damages.

ROSS FELLER CASEY, LLP

By: */s/ Matthew A. Casey*
MATTHEW A. CASEY, ESQUIRE
ROBERTA A. GOLDEN, ESQUIRE
BLAKE A. KAPLAN, ESQUIRE
Attorneys for Plaintiff

Dated: August 5, 2021

CERTIFICATE OF COMPLIANCE

I certify that this filing complies with the provisions of the *Case Records Public Access Policy of the Unified Judicial System of Pennsylvania* as set forth by the Supreme Court of Pennsylvania requiring filing confidential information and documents differently than filing non-confidential information and documents.

ROSS FELLER CASEY, LLP
Attorneys for Plaintiff

By: *S/: Matthew A. Casey*
MATTHEW A. CASEY, ESQUIRE

DATED: August 5, 2021

VERIFICATION

Plaintiff, Terry R. Murray, Sr., hereby verifies that the within Civil Action Complaint is based on first-hand information and on information furnished to her counsel and obtained by counsel in the course of this lawsuit. The language of the document is that of counsel and not of the affiant. To the extent that the contents of the document are based on information furnished to counsel and obtained by counsel during the course of this lawsuit, the affiant has relied upon counsel in taking this verification. All statements are founded upon reasonable belief. This verification is made subject to the penalties of 18 Pa.C.S. §4904 relating to unsworn falsification to authorities.

Date: 8/5/2021

Terry Murray Sr.
Terry R. Murray, Sr.

EXHIBIT A

Commonwealth of Pennsylvania - Short Certificate
County of York

REGISTER OF WILLS
YORK COUNTY, PA

I, **Bradley C. Jacobs,** Register for the Probate of Wills and Granting Letters of Administration in and for YORK County, do hereby certify that on October 01, 2019, LETTERS OF ADMINISTRATION in common form were granted by the Register of said County, on the estate of

TERRY LYNN ODOMS, late of YORK CITY in said county, deceased, to TERRY R. MURRAY SR. and that same has not since been revoked.

IN TESTIMONY WHEREOF, I have here unto set my hand and affixed the seal of said office at YORK, PENNSYLVANIA, on October 01, 2019.

File No: 6719-1681

Date of Death : August 16, 2019

S.S. #: [redacted]

Bradley C Jacobs
Register of Wills

BRADLEY C. JACOBS
Register of Wills & Clerk of Orphans' Court
My Commission Expires First Monday, January, 2020

NOT VALID WITHOUT OFFICIAL SIGNATURE AND SEAL OF OFFICE

EXHIBIT B

1001 South George Street
P.O. Box 15198
York, PA 17405-7198
717.851.2345 Tel
www.wellspan.org

WELLSPAN
York Hospital

August 22, 2019

RE: Mr. Terry Odoms MRN# [redacted]

To the family of Mr. Terry Odoms,

On behalf of York Hospital, I want to offer our sincere condolences on the recent loss of your brother, Terry Odoms.

During such a difficult time, you may not have had the chance to ask questions about the circumstances of your brother's passing. Our York Hospital leadership team would like to meet with you to review the care administered to your brother during his time in the York Hospital Emergency Department on Friday, August 16. After arriving at the Emergency Department by ambulance, your brother was quickly seen by one of our nurses. He became unresponsive as he waited in the Emergency Department. The Emergency Department team responded as soon as they recognized your brother was no longer responsive, taking your brother to a room where CPR was started. Resuscitation attempts were unsuccessful.

We know this is a very difficult time for you. We have Spiritual Care available at York Hospital that can provide free help for family members in a difficult time like this. Please do not hesitate to contact them if you think it would be helpful for you or any member of your family. The telephone number is (717) 851-3467.

We are truly sorry for your loss and recognize that you may have questions regarding the treatment that your brother received at the Hospital. Please contact me when you receive this letter so we can meet to review your brother's care. I can be reached at (717)851-2530.

Sincerely,

Keith Noll
President, WellSpan York Hospital
Sr Vice President, WellSpan Health