STATE OF MAINE
PENOBSCOT, SS.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO.:

KATHRYN E. MARQUIS AS PERSONAL REPRESENTATIVE OF THE ESTATE OF JESSIE L. SNYDER,

Plaintiff

v.

NORTHERN LIGHT EASTERN MAINE MEDICAL CENTER, NORTHERN LIGHT HEALTH, RUTH E. TALLEY, M.D, AND PENOBSCOT RESPIRATORY, P.A.,

Defendants

COMPLAINT

Kathryn E. Marquis as Personal Representative of the Estate of Jessie L. Snyder complains against Northern Light Eastern Maine Medical Center, Northern Light Health, Ruth E. Talley, M.D., and Penobscot Respiratory, P.A., as follows:

PARTIES

1. Kathryn E. Marquis was Jessie L. Snyder's mother. Kathryn is the duly appointed Personal Representative of the Estate of Jessie L. Snyder. Kathryn is a resident of Old Town, County of Penobscot, State of Maine.

2. Jessie was born on May 13, 1986, and died at age thirty-two on April 12, 2019.

3. Defendant Northern Light Eastern Maine Medical Center ("EMMC") is a Maine Hospital Corporation that operates a general hospital in Bangor, County of Penobscot, State of Maine.

4. Ruth E. Talley, M.D., is a physician licensed to practice medicine in the State of Maine. At all times relevant to this Complaint, she was a partner and employee of Penobscot Respiratory, P.A., and also an agent of EMMC.

5. At all times relevant to this Complaint, Penobscot Respiratory, P.A., was a Maine corporation that operated a medical group in Bangor, County of Penobscot, State of Maine.

6. At all times relevant to this Complaint, Penobscot Respiratory, P.A., contracted with EMMC to provide health care providers to EMMC.

7. Northern Light Health ("NLH") is a Maine corporation that operates ten hospitals and numerous practice groups in the State of Maine, including EMMC.

FACTS

8. On April 8, 2019, Christopher H. Byrne, M.D., a vascular surgeon, took Jessie to surgery for a right common femoral-to-below-knee popliteal artery bypass.

9. The surgery was more complicated than expected and lasted over seven hours.

10. During the surgery, there was an event of "significant bleeding." The overall reported surgical "blood loss" was estimated to be 1400 ml, but neither surgery nor anesthesia was confident about the accuracy of that number.

11. A cell saver was used to reclaim lost blood, but the operative team also was unable to calculate how much of the returned blood was usable.

12. There was no estimation of (a) the amount of fluid Jessie lost during surgery to third spacing or (b) the amount of insensible fluid loss that occurred while the wound was open.

13. During surgery the decision was made not to place a central line or arterial line. Thus, the surgical team had no way to assess Jessie's fluid status except by using her vital signs.

14. Following the "significant" bleeding event, Jessie became increasingly hypotensive and required aggressive vasopressor management.

15. Lab tests during surgery showed that her hemoglobin (8.6) and hematocrit (27.3) not only were low but also were lower than they had been pre-surgery.

16. After the operation, in the Post Anesthesia Care Unit ("PACU"), Jessie's care was managed by (a) Sara E. Barwise, M.D., an anesthesiologist employed by EMMC; and later by (b) Ruth E. Talley, M.D., a partner and employee of Penobscot Respiratory, P.A., who also was an agent of EMMC.

17. Lab tests collected at 21:51, shortly after surgery ended, showed Jessie's hemoglobin and hematocrit had further dropped to 6.8 and 21.8, which met both national and EMMC's own criteria for a transfusion.

18. Over the next two hours in the PACU, Jessie received almost no fluid supplementation, despite continued very low blood pressures and the need for aggressive pressor support.

19. For approximately 30 minutes in the PACU, Jessie's blood pressure was so low that providers were not able to detect it. Jessie's pressor support was increased again, but she still was not provided a fluid bolus.

20. At 23:16, Dr. Barwise ordered a blood transfusion for Jessie, because of her low hemoglobin and hematocrit (collected more than an hour earlier) and worsening clinical condition.

21. At 23:50, Jessie was discharged from the PACU to the ICU without receiving a blood transfusion or any significant fluid resuscitation.

22. Although Dr. Barwise expected that the transfusion ordered at 23:16 would be accomplished no later than 30 minutes after she ordered it, she did not check why the transfusion had not started by the time Jessie was transferred to the ICU at 23:50 (34 minutes later).

23. Jessie was admitted to the ICU at approximately midnight on April 9, 2019. She had been out of surgery for roughly 2 ½ hours. Although her providers knew that her heart was fragile, and despite critically low blood pressures and hemoglobin/hematocrit levels, Jessie was not given a fluid bolus or a transfusion in the PACU before arriving in the ICU.

24. Upon admission to the ICU, Jessie reported chest pain, likely related to increased workload of the heart and diminished perfusion from hypotension and anemia. This ominous problem was not reported to Dr. Talley, however, and instead was masked with morphine.

25. Jessie still was not provided an arterial line or central line in her first two hours in the ICU. Although surgery had expressed concern about using an arterial line during the operation *when she was more stable*, no one in the PACU consulted surgery about the risks and benefits of starting an arterial line after surgery when Jessie had become unstable.

26. There were no contraindications to starting a central line, yet Jessie's providers failed to start a central line both in the PACU and in the ICU before Jessie arrested.

27. Between midnight and 02:45 on April 9, 2019, Jessie's vital signs continued to worsen.

28. Despite Jessie's worsening clinical condition, neither Dr. Talley nor Dr. Barwise acted to ensure that Jessie received the blood transfusion that was previously ordered at 23:16.

29. Despite Jessie's worsening clinical condition neither a central line nor an arterial line were placed to better monitor Jessie's hemodynamic status and to aid in determining how much fluid she needed.

30. Despite Jessie's alarming hemoglobin and hematocrit at 21:51, neither Dr. Barwise nor Dr. Talley rechecked those values.

31. Although, after midnight, Dr. Talley did belatedly begin fluid resuscitation, without a central line and arterial line she was "flying blind" in terms of how much fluid to give Jessie.

32. Dr. Talley did nothing between midnight and 02:53 to investigate why Jessie's transfusion had not occurred.

33. At 02:53, Jessie experienced cardiopulmonary arrest.

34. At 03:16, Jessie's hemoglobin was so low that it was undetectable by iSTAT.

35. At 03:17, because of resuscitation, Jessie had a return of spontaneous circulation.

36. At 03:41, Jessie finally received her first blood transfusion. She was safely transfused with blood that had been present in EMMC's blood bank the entire time that Jessie was severely anemic and waiting for a transfusion.

37. Jessie was a universal blood type recipient, so she could receive any blood type.

38. The EMMC blood bank had a sufficient supply of leukoreduced blood that was safe for Jessie during the entire time that Jessie was severely anemic and waited for her transfusion, but neither Dr. Talley nor Dr. Barwise communicated with the blood bank to ensure that Jessie received a transfusion in a timely way.

39. The blood bank in fact reported that either Dr. Talley or Dr. Barwise incorrectly reported that Jessie was stable and could wait several hours for a transfusion.

40. At 04:00, even after the belated transfusion, Jessie's hemoglobin and hematocrit were still dangerously low at 5.8 and 19.9 respectively.

41. As a result of the cardiopulmonary arrest, caused by Defendants' malpractice, Jessie suffered a severe anoxic brain injury.

42. Jessie died on April 12, 2019, as the result of the arrest and anoxic brain injury.

43. EMMC, acting by and through its employees and agents, including but not limited to Dr. Barwise and Dr. Talley, failed to meet the standard of care in the care. EMMC's negligence includes, but is not limited to, the following:

a. Failing to ensure Jessie received a timely blood transfusion;

b. Failing to protect Jessie's ABCs (airway, breathing, and circulation), including but not limited to intubating her earlier;

c. Failing to ensure that Jessie received an arterial line and central line earlier;

d. Failing to consult with surgery about an arterial line after Jessie's status deteriorated;

e. Failing to ensure that Jessie received sufficient fluid resuscitation;

f. Failing to adequately assess Jessie's risk for circulatory shock and non-compensatory respiratory acidosis;

g. Failing to adequately monitor and treat Jessie; and

h. Failing to communicate effectively and reasonably with other providers regarding Jessie's evolving status, including but not limited to failing to communicate to the blood bank that Jessie did not require CMV negative blood and that she could not wait for CMV negative blood from another city.

44. EMMC is vicariously liable for the negligence of its agents and employees, including Dr. Barwise and Dr. Talley, as stated above.

45. Dr. Talley's negligence includes, but is not limited to, the following:

a. Failing to ensure Jessie received a timely blood transfusion;

b. Failing to protect Jessie's ABCs (airway, breathing, and circulation), including but not limited to intubating her earlier;

c. Failing to ensure that Jessie received an arterial line and central line earlier;

d. Failing to consult with surgery about an arterial line after Jessie's status deteriorated;

e. Failing to ensure that Jessie received sufficient fluid resuscitation;

f. Failing to adequately assess Jessie's risk for circulatory shock and non-compensatory respiratory acidosis;

g. Failing to adequately monitor and treat Jessie; and

h. Failing to communicate effectively and reasonably with other providers regarding Jessie's evolving status, including but not limited to failing to communicate to the blood bank that Jessie did not require CMV negative blood and that she could not wait for CMV negative blood from another city.

46. Penobscot Respiratory, acting by and through its employees and agents, including Dr. Talley, failed to meet the standard of care. Penobscot Respiratory' s negligence includes, but is not limited to the following:

a. Failing to ensure Jessie received a timely blood transfusion;

b. Failing to protect Jessie's ABCs (airway, breathing, and circulation), including but not limited to intubating her earlier;

c. Failing to ensure that Jessie received an arterial line and central line earlier;

d. Failing to consult with surgery about an arterial line after Jessie's status deteriorated;

e. Failing to ensure that Jessie received sufficient fluid resuscitation;

f. Failing to adequately assess Jessie's risk for circulatory shock and non-compensatory respiratory acidosis;

g. Failing to adequately monitor and treat Jessie; and

h. Failing to communicate effectively and reasonably with other providers regarding Jessie's evolving status, including but not limited to communicating with the blood bank that Jessie did not require CMV negative blood and that she could not wait for CMV negative blood from another city.

47. At all times relevant to this Complaint, Dr. Talley was a partner and employee of Penobscot Respiratory, P.A. and an agent of EMMC.

48. Both Penobscot Respiratory and EMMC are vicariously liable for the negligence of Dr. Talley, as stated above.

49. As a direct and proximate result of the negligence of the Defendants' negligence, Jessie experienced personal injuries and damages. Jessie experienced a cardiopulmonary arrest and a resulting anoxic brain injury, which caused her death.

50. If Defendants had not breached the medical standard of care as described above, Jessie would not have suffered cardiopulmonary arrest and resulting anoxic brain injury and death.

COUNT I – SURVIVAL ACTION

51. Plaintiff repeats and realleges the allegations of Paragraphs 1 through 50 as if fully set forth herein.

52. As a direct and proximate result of the negligence of Defendants, as set forth above, Jessie went into cardiopulmonary arrest and a resulting anoxic brain injury, which caused her death.

53. As a direct and proximate result of the negligence of Defendants, as set forth above, Jessie suffered damages during her lifetime.

54. The elements of damage include, but are not limited to:

a. conscious pain and suffering:

b. extraordinary medical expenses: and

c. loss of enjoyment of life.

COUNT II – WRONGFUL DEATH ACTION

55. Plaintiff repeats and realleges the allegations of Paragraphs 1 through 54 as if fully set forth herein.

56. As a direct and proximate result of the negligence of the Defendants, as set forth above, Jessie died.

57. As a direct and proximate result of the negligence of Defendants, as set forth above, Jessie's heirs have suffered damage, including, but not limited to:

a. loss of the comfort, society and companionship of their loved one;

b. medical expenses;

c. funeral expenses; and

d. emotional distress.

WHEREFORE, Plaintiff Kathryn E. Marquis as Personal Representative of the Estate of Jessie L. Snyder demands judgment against Defendants for compensatory damages, interest, costs, and such other and further relief as the Court deems just and equitable.

Dated: February 13, 2023

Travis M. Brennan, Esq.
Maine Bar No. 4525
Charles P. Hehmeyer, Esq.
Maine Bar No. 10096
Berman & Simmons, P.A.
P.O. Box 961
Lewiston, ME 04243-0961
(207) 784-3576
Attorney for Plaintiff
BrennanService@bermansimmons.com