

209820-cl-ba
JAN 05 2010

NORTH CAROLINA

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION

HARNETT COUNTY

09 CVS

9CV502902

EMILY N. MCBRYDE, ADMINISTRATRIX)
OF THE ESTATE OF THE LATE)
DEANGELO BARNES)

Plaintiff,

vs.

COMPLAINT

HARNETT HEALTH SYSTEM, INC. D/B/A)
BETSY JOHNSON REGIONAL HOSPITAL,)
CAROLINA COAST EMERGENCY)
PHYSICIANS, LLC., APOLLOMD PHYSICIAN)
SERVICES NC, LLC, DR. DANIEL C.)
MINIOR, SHARON TURNER, TRACY ALLEN,)
AND SHEILA P. RAY,)

Defendants.

FILED
RECEIVED JAN 05 2010
CLERK OF SUPERIOR COURT
HARNETT COUNTY, N.C.

NOW COMES the plaintiff complaining of the defendants and as a cause of action and alleges and says:

PARTIES AND JURISDICTION

1. That the plaintiff is the duly appointed administratrix of the estate of her son, the late DeAngelo Barnes having been duly appointed by the Clerk of Superior Court of Harnett County on November 13, 2009 in file number 09 E 607 and has qualified and is now acting as administratrix. This cause of action is instituted, pursuant to Chapter 28A of the General Statutes of North Carolina and is brought pursuant to the wrongful death statues of North Carolina
2. That the defendant Harnett Health System, Inc. d/b/a Betsy Johnson Regional Hospital (hereinafter referred to as "hospital") operates a hospital in Dunn, Harnett County, North Carolina, known as Betsy Johnson Regional Hospital which is located at 800 Tilghman Drive in Dunn, North Carolina.

3. That the defendant Carolina Coast Emergency Physicians, LLC is a limited liability corporation organized and existing under the laws of the state of North Carolina.
4. That the defendant ApolloMD Physician Services NC, LLC is a Georgia limited liability corporation organized and existing under the laws of the state of Georgia and is authorized to do business in North Carolina.
5. That the defendants Carolina Coast Emergency Physicians, LLC and ApolloMD Physician Services NC, LLC at all times mentioned herein served as independent contractors providing medical doctors to the defendant hospital to work in the defendant hospital's emergency room in Dunn, North Carolina which hospital is known as Betsy Johnson Hospital. The defendant Dr. Daniel C. Minior was one of the doctors provided by these defendants to the defendant hospital and was assigned by these defendants to work in the emergency room at Betsy Johnson Hospital at all times mentioned herein.
6. That the defendant Dr. Daniel C. Minior is a licensed medical doctor who at all times mentioned herein was practicing medicine at Betsy Johnson Regional Hospital in Dunn, North Carolina. It is alleged upon information and belief that Dr. Daniel C. Minior is a citizen and resident of North Carolina.
7. That at all times mentioned herein a physician-patient relationship existed between the late DeAngelo Barnes and the defendant Dr. Daniel C. Minior. The defendant Minior was serving as the medical doctor and physician for the late DeAngelo Barnes. Consequently, the defendant Minior at all times mentioned herein had a duty to exercise reasonable care and diligence, to exercise his best judgment for DeAngelo Barnes and had a duty to exercise the appropriate standard of care and practice among members of the same health care profession with similar training and experience practicing in the same or similar

communities in 2008 with respect to the care and treatment of the DeAngelo Barnes and to exercise reasonable care and diligence in the application of his medical knowledge and skill for the late DeAngelo Barnes.

FACTUAL ALLEGATIONS

8. The allegations contained in paragraphs 1 through 7 are incorporated herein by reference.
9. That the plaintiff is the mother and sole heir of the late DeAngelo Barnes.
10. That the late DeAngelo Barnes was born on August 7, 2001 and, at the time of his death was six years of age.
11. That on December 31, 2007, a Monday, the plaintiff's sister, Angela McBryde was keeping and caring for the late DeAngelo Barnes while the plaintiff, his mother, was attending New Year's Eve services at her church.
12. That Angela McBryde began noticing that DeAngelo Barnes became nauseous and started vomiting. In addition, she noticed that he was having diarrhea and he complained of a stiff neck, shortness of breath and abdominal pain.
13. That as a result of the symptoms set out above, Angela McBryde took the late DeAngelo Barnes (herein after referred to as DeAngelo) to Betsy Johnson Regional Hospital located at 800 Tilghman Drive, Dunn, North Carolina.
14. That Angela McBryde and DeAngelo arrived at Betsy Johnson Regional Hospital around 11:00 p.m. and asked to be seen in the hospital's emergency room.
15. That while waiting to be seen in the emergency room at Betsy Johnson Regional Hospital, DeAngelo continued to be nauseous. In addition, he was very thirsty and his mouth was white and dry.
16. That DeAngelo was first admitted in the emergency room at 12:21 a.m. on January 1, 2008.

17. That at all times while DeAngelo was in the emergency room of the defendant hospital the defendant Dr. Daniel C. Minior was the only medical doctor assigned by the corporate defendants to examine and treat DeAngelo.
18. That throughout all times mentioned herein, until his release from the emergency room Dr. Daniel C. Minior was the attending physician for DeAngelo and the relationship of doctor patient existed between DeAngelo and the defendant Dr. Daniel C. Minior.
19. That at 12:27 a.m. on January 1, 2008 DeAngelo had a fever of 101.3 and his body temperature was 101.3 Fahrenheit.
20. That at 12:27 a.m. on January 1, 2008 DeAngelo pulse rate was 142 beats per minute.
21. That at 12:27 a.m. on January 1, 2008 DeAngelo respiratory rate was 24 breaths per minute.
22. That at 12:27 a.m. on January 1, 2008 DeAngelo was lethargic, short of breath and had no energy.
23. That at 12:27 a.m. on January 1, 2008 DeAngelo's neck was hurting.
24. That at 12:27 a.m. on January 1, 2008 DeAngelo was so lethargic he could not sit up on his own.
25. That at 1:35 a.m. on January 1, 2008 DeAngelo had a reddened area on his chest and 4 to 5 small red patches on his abdomen and a rash on his stomach and chest and while he was in the emergency room this rash spread to most of his body.
26. That at 12:57 a.m. on January 1, 2008 DeAngelo was sleepy and drowsy.
27. That at 12:57 a.m. on January 1, 2008 DeAngelo spoke with teeth clenched.
28. That at approximately 1:00 a.m. on January 1, 2008 the plaintiff, DeAngelo's mother, came to the emergency room to be with her son she noticed that the heart

monitor indicated that DeAngelo's heart rate was from 168 beats per minutes to 170 beats per minute.

29. That while he was in the emergency room DeAngelo had a heart rate of between 168 to 170 beats per minute.
30. That the plaintiff pointed out to the nurse that the heart monitor showed that DeAngelo's heart was beating at a rate of between 168 to 170 beats per minute.
31. That upon being informed of DeAngelo's heart rate, a nurse told her that it was "ok".
32. That the heart monitor attached to DeAngelo was beeping and the plaintiff mentioned that fact to the defendant Dr. Daniel C. Minior.
33. That the defendant Dr. Daniel C. Minior looked at the heart monitor attached to DeAngelo.
34. That the defendant Dr. Daniel C. Minior told the plaintiff that if an adult's heart was beating as fast as DeAngelo's he would be concerned, but that since DeAngelo was a six year old child, the rate of DeAngelo's heartbeat was not a cause for concern.
35. That Dr. Daniel C. Minior told the plaintiff that the DeAngelo's heartbeat was not a cause for concern.
36. That on three separate occasions the plaintiff went to get the defendant, Dr. Daniel C. Minior to tell him about the beeping of the heart monitor.
37. That on the third such occasion the defendant, Dr. Daniel C. Minior shut the heart monitor off entirely.
38. That DeAngelo continued to complain about his neck hurting.
39. That upon admission to the hospital emergency room DeAngelo was dehydrated.
40. That DeAngelo's urine output was never measured in the emergency room.

41. That DeAngelo's urine output was never recorded in the emergency room records.
42. That DeAngelo's oxygen saturation levels were never checked in the emergency room.
43. That DeAngelo's oxygen saturation levels were never recorded in the emergency room records.
44. That DeAngelo's blood pressure was never taken in the emergency room.
45. That DeAngelo's blood pressure was never recorded in the emergency room records.
46. That DeAngelo's blood pressure was never taken in the hospital.
47. That DeAngelo's blood pressure was never recorded in any the hospital records.
48. That no one in the hospital measured DeAngelo's urine output.
49. That there is no record of DeAngelo's urine output in the hospital records.
50. That DeAngelo's rash was evident no later than one hour after his admission into the emergency room.
51. That DeAngelo's rash was a sign to Dr. Minior and the nurses who saw him that something serious was going on in DeAngelo's body.
52. That Dr. Minior did not document the time that he saw DeAngelo.
53. That Dr. Minior did not treat the DeAngelo for sepsis P.A.
54. That the nursing staff of the defendant hospital did not administer any treatment or medication to DeAngelo for sepsis.
55. That Dr. Minior did not administer any IV fluids to DeAngelo.
56. That Dr. Minior did not make sure that the IV fluids were administered to DeAngelo.
57. That Dr. Minior did not cause IV fluids to be administered to DeAngelo.

58. That the nursing staff of the defendant hospital did not administer IV fluids to DeAngelo.
59. That IV fluids were never administered to DeAngelo while he was in the emergency room.
60. The IV fluids were never administered to DeAngelo while he was in the hospital.
61. That Dr. Minior never took DeAngelo's blood pressure.
62. That Dr. Minior never ordered DeAngelo's blood pressure be taken.
63. That Dr. Minior never took steps to be sure that the DeAngelo's blood pressure was taken.
64. That Dr. Minior never recorded DeAngelo's blood pressure.
65. That Dr. Minior never recorded DeAngelo's blood pressure in the emergency room records.
66. That no one on the defendant's hospital's nursing staff took DeAngelo's blood pressure.
67. That no one on the defendant hospital's nursing staff ever recorded DeAngelo's blood pressure.
68. That Dr. Minior, prior to DeAngelo's death, never recognized that DeAngelo had sepsis.
69. That DeAngelo had an unusually low white blood count while he was in the emergency room on January 1, 2008.
70. That the defendant Dr. Minior did not provide the IV hydration to DeAngelo.
71. That the defendant Dr. Minior did not order IV hydration for DeAngelo.
72. That the defendant Dr. Minior did not make certain that IV hydration was provided for DeAngelo.
73. That no member of the defendant's nursing staff provided IV hydration for DeAngelo while he was in the emergency room.

74. That no member of the defendant's nursing staff provided IV hydration to DeAngelo while he was in the hospital.
75. That Dr. Minior did not make sure that antibiotics were given to DeAngelo.
76. That Dr. Minior waited more than two hours after DeAngelo was admitted to the hospital emergency room before he ordered antibiotics.
77. That the nursing staff of the defendant hospital failed to follow Dr. Minior's order to give antibiotics to DeAngelo until approximately 2 hours after that order was given.
78. That Dr. Minior did not recognize that the IV needle placed into DeAngelo's body had infiltrated.
79. That the nursing staff of the defendant hospital did not recognize that the IV needle placed into DeAngelo's body had infiltrated.
80. That at 1:35 a.m. Nurse Allen notified Dr. Minior concerning the red area of DeAngelo's neck.
81. That no antibiotics were given to DeAngelo while he was in the emergency room
82. That one of the defendant's nursing staff did note a rash on DeAngelo approximate one hour after his admission into the emergency room.
83. Dr. Minior did not recognize the rash on DeAngelo's neck even though the nurse advised him of it.
84. That as early as 2:20 a.m. – 2:30 a.m. DeAngelo's abnormal blood count appears in the record.
85. At 12:58 a.m., a nurse on the defendant's nursing staff noted that an attempt to start the IV fluids to DeAngelo was unsuccessful.
86. That the defendant's nursing staff failed to make Dr. Minior aware of their failure to administer IV fluids which failure was noted at 12:58 a.m.

87. That DeAngelo had sepsis when he was in the emergency room on January 1, 2008. Sepsis is a common infection seen daily in hospitals.
88. That no attempt was made by Dr. Minior to treat DeAngelo's sepsis.
89. That no attempt was made by the defendant's nursing staff to treat DeAngelo's sepsis.
90. That the defendant's nursing staff failed to call in a doctor to treat DeAngelo's sepsis.
91. That the defendant's nursing staff failed to make Dr. Minior aware of the fact that DeAngelo was not getting antibiotics in the emergency room.
92. That at approximately 4:43 a.m. DeAngelo began acting wild and began screaming and telling people to "shut up, your crazy, leave me alone". DeAngelo thought he was talking to his brothers and sisters who were not even in his room. This conduct was not in character with DeAngelo's disposition and indicated that DeAngelo was out of his head and was delirious.
93. That defendant Dr. Daniel C. Minior told the plaintiff that the rash and red bumps were a reaction to medicine that had be given to DeAngelo and that they would "keep an eye on him".
94. That later these red bumps turned into splotches and started spreading to DeAngelo's face and all over his body.
95. That at approximately 4:48 a.m. DeAngelo was admitted to the floor at Betsy Johnson Regional Hospital and transferred from the emergency room to the pediatric ward of the hospital and was taken upstairs and placed in a room.
96. That before DeAngelo left the emergency room the plaintiff asked the nurses about the splotches and they told her to calm down and that they would let the nurses on the pediatric floor know about the splotches.

97. That even after he was transferred to the pediatric ward of the defendant Hospital, DeAngelo never got any fluid or medicine.
98. That nurses made three or four attempts to start an IV, but they could not get it started and consequently DeAngelo never received any fluid or medication from the IV needle.
99. That DeAngelo began to become more confused and get more feisty and tried to bite one of the nurses.
100. That DeAngelo continued to have diarrhea even when he was in bed and this fact was made known to the nursing staff by the plaintiff's husband.
101. At some point, the plaintiff overheard one of the nurses speaking to someone on the phone and the nurse said "Get up here, I don't know what's going on with this Barnes kid".
102. The plaintiff then followed the nurse back to her son's room and when they got there the child was laying still and staring straight up at the ceiling.
103. At this point, the plaintiff became hysterical and they took her out of the room.
104. Immediately thereafter, someone called a code blue and the hospital began resuscitation efforts.
105. That these resuscitation efforts were unsuccessful and DeAngelo died from sepsis at approximately 5:58 a.m. on January 1, 2008.
106. That prior to his death, the late DeAngelo Barnes suffered hours of pain, agony, distress and suffering.
107. After DeAngelo died, Dr. Daniel C. Minior told the plaintiff's mother that he thought the child had fluid in his lungs.
108. Thereafter, Dr. Daniel C. Minior told the plaintiff that he thought that DeAngelo had meningitis and requested that all of the family should stay and be treated for that condition.

109. DeAngelo never had meningitis.

CLAIM AGAINST DEFENDANT DR. DANIEL C. MINIOR

110. The allegations contained in paragraphs 1 through 109 are incorporated herein by reference.

111. That the defendant Dr. Daniel C. Minior was negligent in his care and treatment of the late DeAngelo Barnes in that he breached his duty to the late DeAngelo Barnes and he violated the standard of care recognized and exercised by physicians with training and experience similar to that of Dr. Daniel C. Minior practicing in Dunn, North Carolina and in similar communities in January 2008 in that he:

- a. Failed to exercise reasonable care and diligence in monitoring of the late DeAngelo Barnes and in taking steps to help assure that he was administered the proper medications.
- b. Failed to record DeAngelo Barnes' blood pressure.
- c. Failed to diagnose and recognize that DeAngelo Barnes had sepsis.
- d. Failed to properly treat DeAngelo Barnes' sepsis.
- e. Failed to note the significance of DeAngelo Barnes' unusually low white blood count which existed while DeAngelo Barnes was in the emergency room.
- g. Failed to administer IV hydration to DeAngelo Barnes.
- h. Failed to order that IV hydration be given to DeAngelo Barnes.
- i. Failed to make certain that IV hydration was provided to DeAngelo Barnes.
- j. Failed to order that antibiotics be given to DeAngelo Barnes for more than two hours after DeAngelo Barnes' admission.
- k. Failed to determine that the nurses and hospital staff of the defendant hospital gave antibiotics to DeAngelo Barnes.
- l. Failed to recognize that the IV needle placed into DeAngelo Barnes' body by the

defendant hospital's nursing staff had infiltrated.

- m. Failed to take any action in response to the notification at 1:35 a.m. by Nurse Tracy Allen concerning the red area of DeAngelo Barnes' neck.
- n. Failed to note and respond to the fact that at 12:58 a.m. the nursing notes indicated that the nursing staff of the defendant hospital attempted to start IV fluids for DeAngelo Barnes but that this attempt was unsuccessful.
- o. Failed to take any action whatsoever in response to the fact that the nursing staff failed to start IV fluids for DeAngelo Barnes and that their attempt at 12:58 a.m. to start IV fluids was unsuccessful.
- p. Failed to call in a doctor to examine DeAngelo Barnes and properly examine, diagnose and treat DeAngelo Barnes' sepsis.
- q. Failed to respond properly to the information given by DeAngelo Barnes' mother that DeAngelo Barnes' heart monitor showed an accelerated heartbeat.
- r. Failed to act appropriately in response to the rash and red bumps on DeAngelo Barnes' body.
- s. Failed to act appropriately in response to the splotches that appeared on DeAngelo's face and body.
- t. Failed to properly examine and treat the late DeAngelo Jaheim Barnes.
- u. Failed to note and determine that the late DeAngelo Jaheim Barnes had the signs and symptoms of sepsis including, but not limited to a fever of 101.3, a pulse rate of no less than 142 beats per minute and rising up to 170 beats per minute, a respiratory rate of 24, a white blood count of 2900, tachycardia and leukopenia, metabolic acidosis, lactic acidosis and a blotchy rash.
- v. Failed to do anything to treat the sepsis condition even though all the signs and symptoms exhibited by the late DeAngelo Jaheim Barnes showed that he had sepsis and that he should be immediately treated for that condition.

- w. Failed to do a workup on the acidosis condition that existed in the late DeAngelo Barnes.
 - x. Failed to properly diagnose sepsis in the late DeAngelo Jaheim Barnes.
 - y. Failed to properly treat sepsis with proper medication.
 - z. Gave medication that was totally ineffective and did not address the patient's septic condition.
 - aa. Failed to administer IV fluids to the patient even though the nurses had inserted IV needles into the patient's hand in preparation for the administration of IV fluids.
 - bb. Did not treat the patient's bacterimia.
 - cc. Did not treat the infection coursing through the plaintiff's body.
112. That as a result of the negligence of the defendant, Dr. Daniel C. Minior the plaintiff's intestate suffered pain, discomfort and distress and died at 5:58 a.m. on January 1, 2008.
113. That had the defendant, Dr. Daniel C. Minior not violated the appropriate standard of care he could have saved DeAngelo Jaheim Barnes by the timely administration of the appropriate drugs to fight and cure the sepsis in DeAngelo Barnes' body.
114. At all times mentioned herein, the defendant, Dr. Daniel C. Minior was an agent and employee of the defendant hospital acting within the course and scope of his employment with the defendant hospital. Therefore, the negligence and the negligent acts and omissions of the defendant, Dr. Daniel C. Minior are attributed to the defendant hospital and the defendant hospital is liable to the plaintiff for the negligence of the defendant Dr. Daniel C. Minior as alleged herein.
115. In the alternative, the plaintiff alleges that the defendant Dr. Daniel C. Minior was

at all times mentioned herein an apparent agent of the defendant Hospital in that the defendant Hospital by its' words, conduct and internet web site postings represented and led the public in general and the plaintiff to reasonably believe that the emergency room staff including Dr. Daniel C. Minior were all agents and employees of the defendant Hospital and that the emergency room was part of the hospital and that the doctors practicing in the hospital's emergency room are employers of the defendant Hospital. Neither the defendant hospital or any other person or entity ever gave notice to the plaintiff that Dr. Minior was not an employee of the defendant Hospital. The defendant Hospital at all times mentioned herein held itself out to the public as operating its emergency room and providing emergency services.

116. That the defendant Hospital at all times mentioned herein held itself out to the public and to the plaintiff as providing emergency medical services. The plaintiff looked to the defendant Hospital rather than to the individual doctors in the emergency room to perform emergency medicine services and to provide appropriate medical care. The plaintiff, on behalf of her son and intestate accepted emergency medicine services in the reasonable belief that those services were being rendered by the hospital or its employees.
117. That at all times mentioned herein, the defendant Dr. Daniel C. Minior was an agent and employee of the defendant Carolina Coast Emergency Physicians and was acting within the course and scope of his employment for the defendant Carolina Coast Emergency Physicians.
118. That at all times mentioned herein, the defendant Dr. Daniel C. Minior was an agent and employee of the defendant AppoloMD Physician Services NC and was acting within the course and scope of his employment for the defendant AppoloMD Physician Services NC.

119. That the negligence of the defendant Dr. Daniel C. Minior is set out herein, is imputed to the defendant Hospital and ApolloMD physician services NC., LLC and Carolina Coast Emergency Physicians NC.

CLAIM FOR RELIEF AGAINST DEFENDANT HARNETT HEALTH SYSTEM, INC.

120. The allegations contained in paragraphs 1 through 119 are incorporated herein by reference.

121. That at all times mentioned herein it was the duty of the defendant hospital to exercise that degree of care in accordance with the standards of practice among members of the healthcare profession with similar training and experience situated in the same or similar community at the time of the acts alleged herein. Defendant Hospital, acting through its agents and employers owed the plaintiffs intestate a duty to exercise reasonable care and diligence, to exercise their best medical judgment and to comply with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities in 2008.

122. That nevertheless, the defendant hospital breached and disregarded its duty, failed to exercise such care and skill in that defendant hospital failed to properly administer nursing services to the plaintiff and failed to properly administer proper nursing care to the plaintiff's intestate and in particular the defendant hospital violated the standard of care applicable to the defendant hospital in that it:

- a. Failed to provide competent professional personnel capable of properly examining patients with sepsis and in properly diagnosing sepsis and in recognizing the need to call in appropriate medical doctors to examine and treat patients with sepsis.

- b. Negligently permitted either incompetent or inadequately trained or supervised personnel to work at the defendant Hospital which resulted in the failure to properly examine and treat the plaintiff's intestate.
- c. Allowing its emergency room personnel and nursing personnel to examine and treat the plaintiff's intestate when as evidence by the inadequate care and treatment of the plaintiff's intestate they failed to exhibit the knowledge and skill and experience of practitioners with similar training and experience practicing in the Dunn, North Carolina community or other similar communities in 2008.
- d. Failed to insure through its policies and procedures that the plaintiff's intestate receive the requisite degree and standard of hospital care and treatment regularly experienced at similar hospitals.
- e. Breached an implied representation of its duty to the plaintiff's intestate that the defendant hospital and its nursing staff was competent and would provide proper care and treatment for him and monitor and oversee and supervise the
- f. Failed to provide qualified trained, experienced and capable nursing staff and emergency room physicians to properly administer and monitor the examination and treatment of patients with sepsis.
- g. The defendant hospital was negligent in that the care and treatment given by the defendant hospital through its agents and employees both named herein and unnamed, was not in accordance with the standards of practice exercised among registered nurses and other nurses, emergency room doctors and hospital staffs with similar training and experience as those of the individuals who were assigned to care for the plaintiff who practice in communities similar communities to Harnett County. This failure to provide with the standard of care as detailed herein constitutes negligence.

- h. Failed to exercise reasonable care and diligence in the application of its knowledge and the knowledge of its personnel to the care and treatment given to the plaintiff's intestate and it did not use its best judgment in the treatment and care of the plaintiff's intestate during that period of time in which the plaintiff's intestate was under the care and treatment of the defendant hospital ; and it did not exercise that degree of care which was in accordance with the standard of practice among hospitals and hospital staff similarly trained and experienced situated in similar communities at the time of the treatment of the plaintiff's intestate.
- i. That the negligence of the individual defendants named herein and others unnamed who were assigned by the defendant hospital to render care to the plaintiff is imputed to the defendant hospital.
- j. Failed to exercise due and reasonable care for its patient.
- k. Failed to exercise due and reasonable care in the selection and/or retention of its employees who were involved in the care and treatment of the plaintiff as set out above who were not sufficiently trained and skilled to examine and treat patients with sepsis or were incompetent or were inexperienced.
- l. That the agents and employees of the defendant hospital which were assigned and rendered care and treatment to the plaintiff's intestate, which employees and agents are named herein, as well as others unnamed each failed to exercise reasonable care and diligence in the treatment and care of the plaintiff's intestate and that the defendant hospital is responsible under the doctrine of Respondeat Superior.
- m. That the emergency room doctors and nurses, agents and employees of the defendant Hospital failed to call in medical doctors, and experts immediately

upon discovery of the signs and symptoms exhibited by plaintiff's intestate with respect sepsis.

- n. Failed to make reasonable effort to monitor and oversee the treatment prescribed by and administered by the emergency room physicians and nurses practicing at the defendant hospital.
- o. The defendant hospital, acting through its agents and employees failed to administer antibiotics and other appropriate medications to the plaintiff's intestate when all of the signs and symptoms exhibited by the plaintiff's intestate would indicate, in the exercise of the appropriate standard of care, that he had sepsis and that he needed antibiotics and other appropriate medications.
- p. That the nurses, emergency doctors, agents and employees of the defendant hospital did not diagnose the plaintiff's intestate's sepsis and did not administer antibiotics and other appropriate medications to him and did not otherwise properly work up the patient in response to the signs and symptoms of sepsis.
- q. That the nurses, emergency doctors, agents and employees of the defendant hospital failed to diagnosis or treat sepsis suffered and experienced by the plaintiff's intestate prior to his death and did not treat his sepsis or refer him to a doctor to deal with that sepsis when they knew or should have known that the plaintiff's intestate had sepsis and that he would die if he did not get the appropriate medications.
- r. That the nurses, emergency doctors, agents and employees of the defendant hospital failed to note the patient's clear signs and symptoms that he had sepsis and that he would die if he did not get appropriate medications and if the sepsis was not treated properly.
- s. That the nurses, emergency doctors, agents and employees of the defendant hospital did not recognize the seriousness of DeAngelo's

infection and did not treat him appropriately or refer her to doctors who would treat her appropriately.

- t. That the defendant hospital failed to make reasonable effort to monitor and oversee the patient's septic condition.
- u. The defendant hospital failed to exercise reasonable care and diligence and its examination and treatment of the plaintiff's intestate January 1, 2008.
- v. That the agents and employees of the defendant hospital, including the emergency room doctors and nursing personnel failed to exhibit the knowledge and skill which was possessed by other emergency room doctors and nursing personnel with similar training and experience practicing in the Dunn, Harnett County communities or similar communities at all times mentioned.
- w. That the agents and employees of the defendant hospital, including the emergency room doctors and nursing personnel failed to exercise care and diligence in the application of their knowledge as licensed medical doctors and nursing personnel to the care and treatment of the plaintiff's intestate and did not use their best judgment in the treatment and care of the plaintiff's intestate during the period and time that the plaintiff's intestate was a patient at the defendant hospital's emergency room on January 1, 2008.
- x. That the emergency room doctor named herein and the nursing personnel who were involved in the examination or treatment of the plaintiff's intestate were acting within the course and scope of their employment for the defendant hospital and were agents and employees of the defendant hospital in the administration of emergency room services and nursing services to the plaintiff's intestate.
- y. That the negligence of the individual emergency room doctor, Dr. Daniel C. Minor as set out above and the nursing personnel is imputed to the defendant hospital.

- z. Failed to properly staff and man the emergency room of the hospital on January 1, 2008 and was severely understaffed and was without the proper number of doctors, nurses and staff to properly administering care for the emergency room patients at the hospital.
123. That the defendant hospital regularly accepts, treats and examines and administers nursing care to patients who are covered by Federal Medicare laws and whose bills are paid by Medicare. The defendant hospital regularly accepts Medicare patients and Medicare benefits from the Federal Government. That as a condition to accepting money from Medicare, the defendant hospital agreed with the United States Government and the various agencies of the Federal Government that it would be liable and responsible for the negligence of any of the doctors, hospitals, independent contractors or other agencies or entities practicing in that hospital and that it would be liable to the victims of negligence committed by any such doctors, employees, independent contractors or agencies or entities practicing in that hospital. That the plaintiff's intestate was and the plaintiff's estate is a third-party beneficiary of that contract and is therefore entitled to recover of the defendant hospital for the negligence of any and all doctors, nurses, independent contractors, or other entities of any sort or nature which rendered services to the plaintiff's intestate and through their negligence and violation of the appropriate standard of care caused harm to the plaintiff's intestate and caused his death.

CAUSE OF ACTION AGAINST APOLLOMD PHYSICIAN SERVICES NC, LLC
AND CAROLINA COAST EMERGENCY PHYSICIANS, LLC

124. The allegations contained in paragraphs 1 through 123 are incorporated herein by reference.
125. That at all times mentioned herein, the defendant Dr. Daniel C. Minior was acting as an employee and agent of the defendants ApolloMD Physician Services NC,

LLC and Carolina Coast Emergency Physicians, LLC and was acting within the course and scope of his employment with these defendants. Consequently, the negligent acts and omissions of Dr. Daniel C. Minior are imputed to the defendants, ApolloMD Physician Services NC, LLC and Carolina Coast Emergency Physicians, LLC. That the defendants, ApolloMD Physician Services NC, LLC and Carolina Coast Emergency Physicians, LLC are indebted to the plaintiff for the death of the late DeAngelo Barnes and for the pain, suffering, discomfort and emotional distress suffered by the late DeAngelo Barnes prior to his death.

CLAIM AGAINST SHARON TURNER, TRACY ALLEN AND SHEILA RAY

126. The allegations contained in paragraphs 1 through 125 are incorporated herein by reference.
127. That the defendants Sharon Turner, Tracy Allen, and Sheila P. Ray are registered nurses duly licensed to practice nursing in the State of North Carolina and at all times held themselves out to the general public as registered nurses and as individuals who have expertise in the field of nursing. These nurses were all healthcare providers and registered nurses licensed in the State of North Carolina and were practicing nursing as agents, servants and employees of the defendant hospital acting within the course and scope of their employment by the defendant hospital and were engaged in the practice of nursing. These nurses were all assigned to care for and administer treatment for DeAngelo Barnes.
128. That the negligence of the individual defendants alleged herein is imputed to the defendant hospital.
129. That the negligence of the nurses named as defendants herein as well as the negligence the defendant hospital's agents as well as its implied agents and employees which is unnamed are imputed to the defendant hospital.

130. That the negligence of the nurses named as defendants herein, Sharon Turner, Tracy Allen, and Sheila P. Ray as well as the negligence the defendant hospital's agents as well as its implied agents and employees which are unnamed are imputed to the defendant hospital.
131. That the individual nurses named herein Sharon Turner, Tracy Allen, and Sheila P. Ray were all negligent in the care and treatment of the late DeAngelo Barnes in that they:
 - a. Failed to exhibit the knowledge and skill which was possessed by other nurses with similar training and experience practicing in the Dunn, Harnett County communities or similar communities at all times mentioned.
 - b. Failed to exercise reasonable care and diligence in the application of their knowledge as licensed registered nurses to the care and treatment of the late DeAngelo Barnes and they did not use their best judgment in the treatment and care of the late DeAngelo Barnes in the administration of nursing services during the period of time in which he was under their care.
 - c. Did not exercise for the late plaintiff DeAngelo Barnes that degree of care, skill and training which was in accordance with the standards of practice among registered nurses and nursing staffs similarly situated, experienced and trained in Dunn, Harnett County or similar communities and did not comply with this standard of practice among members of the same health care profession with similar training and experience practicing in the same or similar communities in 2008.
 - d. Failed to take DeAngelo Barnes' blood pressure.
 - e. Failed to record DeAngelo Barnes' blood pressure.
 - f. Failed to bring to Dr. Minior's attention that the late DeAngelo Barnes had a heart rate of 168 beats per minute to 170 beats per minute or otherwise inform him that

- DeAngelo Barnes' heart rate was higher than normal.
- g. Failed to relate to Dr. Minior the fact that DeAngelo Barnes was dehydrated and failed to bring that fact to his attention.
 - h. Failed to measure DeAngelo Barnes' urine output.
 - i. Failed to record DeAngelo Barnes' urine output.
 - j. Failed to take DeAngelo Barnes' oxygen saturation levels.
 - k. Failed to record DeAngelo Barnes' oxygen saturation levels.
 - l. Failed to take DeAngelo Barnes' blood pressure.
 - m. Failed to record DeAngelo Barnes' blood pressure.
 - n. Failed to notify Dr. Minior that DeAngelo Barnes was not receiving IV medications or fluids.
 - o. Failed to notify the nurses on the pediatric floor of DeAngelo Barnes' condition and of the splotches on his skin and failed to notify the nurses on the pediatric floor about DeAngelo Barnes' history and course of the events that occurred in the emergency room.
 - p. Failed to give to DeAngelo Barnes medication which Dr. Minior ordered.
 - q. Failed to administer antibiotics to DeAngelo Barnes even after being ordered to do so by Dr. Minior.

RULE 9(j) CERTIFICATION

- 132. The allegations contained in paragraphs 1 through 131 are incorporated herein by reference.
- 133. The plaintiff specifically asserts that the provisions of N.C. Gen. Stat., Rule 9(j) are unconstitutional under the constitution of North Carolina to wit: Article 1, Section 18, 9 and 25. However, and without prejudice to or waiver of the above-asserted constitutional claims the plaintiff specifically asserts that pursuant to Rule 9(j) of the North Carolina Rules of Civil Procedure, the undersigned attorney

for the plaintiff certifies that the professional nursing, hospital and medical care rendered by the defendants to the plaintiff's intestate has been reviewed by a person who is reasonable expected to qualify as an expert witness under Rule 702 of the Rules of Evidence and who is willing to testify that the professional care rendered by the defendants to the plaintiff's intestate did not comply with the applicable standard of care and that such failure to comply with the appropriate standard of care was a cause of the death of the plaintiff's intestate.

CAUSATION AND DAMAGES

134. The allegations contained in paragraphs 1 through 133 are incorporated herein by reference.
135. That the plaintiff incorporates herein by reference the previous paragraphs of this complaint.
136. That as a direct and proximate result of the above-described negligence of the defendants and their employees, agents, or apparent agents, the late DeAngelo Barnes died on January 1, 2008.
137. That as a direct and proximate result of the above-described negligence and the death of the late DeAngelo Barnes, his mother, the plaintiff herein has been deprived of his services, care, society, companionship, comfort, and guidance.
138. That this action brought pursuant to the Wrongful Death Act of North Carolina and other applicable North Carolina Laws in effect on the date of death of the late DeAngelo Barnes. This action is for all damages recoverable under the Wrongful Death Act, the terms and provisions of which are incorporated herein by reference as though fully set out herein and which include the following:
 - a. Compensation for pain and suffering of deceased;
 - b. Reasonable funeral expenses;
 - c. Autopsy expenses;

d. The present monetary value of the decedent to the persons entitled to receive damages recovered, including, but not limited to, compensation for the loss of services, care and assistance, society, companionship, comfort, and guidance of the decedent to the persons entitled to the damages recovered.

139. That the negligence of the defendants are alleged above and the breach of their duty to the plaintiff's intestate as alleged herein was and is the cause of the death of the late DeAngelo Barnes and of the pain, discomfort, distress and agony suffered by the late DeAngelo Barnes prior to his death.

WHEREFORE, the plaintiff prays to the court as follows:

1. That the plaintiff have and recover from the defendants, jointly and severally, a sum in excess of \$10,000 sufficient to compensate for the pain, suffering and agony of the late DeAngelo Barnes for his death and to compensate for the wrongful death of the late DeAngelo Barnes.
2. That the plaintiff have and recover of the defendants, jointly and severely punitive damages in an amount to be set by the jury.
3. That the cost of this action be taxed through the defendants, jointly and severely.
4. That the plaintiffs have a trial by jury by all issues allowed by law.

This is the 29 day of December, 2009.

BRENT ADAMS & ASSOCIATES


BRENTON D. ADAMS, State Bar No. 11

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