

**VIRGINIA: IN THE CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS**

**SHIRLEY FRAZIER BURRELL,**

**Plaintiff,**

**v.**

**No. \_\_\_\_\_  
JURY TRIAL DEMANDED**

**RIVERSIDE HOSPITAL, INC.,  
AND NURSE M. AMES,**

**Defendants.**

**COMPLAINT**

COMES NOW Plaintiff, Shirley Frazier Burrell, and complains against Defendants, Riverside Hospital, Inc. (“Riverside”) and Nurse M. Ames, on the following:

1. This suit was timely filed on February 19, 2008; non-suited on October 18, 2011; and refiled timely.
2. This cause for substantial damages is a medical malpractice action covered by the Virginia Medical Malpractice Act.
3. At all pertinent times, individual Defendant, Nurse M. Ames, and other nurses, aides and/or other staff were employees, representatives and/or other agents of corporate Defendant, Riverside, acting in the course and scope of their relation, with actual or at least apparent or ostensible authority and in the furtherance of it business interests.
4. On and after February 14, 2006, 81-year-old Shirley entrusted herself to Defendants for all necessary and appropriate health treatment and care, and Defendants treated her continuously without interruption for substantially the same condition through February 16, 2006, and after.
5. Shirley underwent right hip arthroplasty on February 14, 2006, and was a “high” fall risk thereafter, requiring fall intervention.
6. Early on February 15, 2006, Riverside assessed Shirley as a “6” on its “FALL RISK ASSESSMENT” – for “Mobility Problem,” “Confusion or Intermittent Confusion,” “Receiving Hypnotics, Narcotics Laxatives or Diuretics,” and “Age greater than 70” – with a score of only 3 requiring Riverside to initiate its “Fall Precaution Protocol” for her. *See*, Exhibit 1, 2/15-16/06 Nurse Care Notes.
7. Beginning the night of February 15, 2006, and continuing into the morning of February 16, 2006, Shirley was documented by Riverside as being of altered mentation and non-

compliant, thereby importing greater (“extreme”) risk to her and concomitantly greater intervention for her by Defendant, Riverside, as follows:

- A. (8:00 p.m.) patient “inappropriate and very anxious”;
  - B. (9:00 p.m.) “pt. remains confused + inappropriate”;
  - C. (9:35 p.m.) “pt. anxious & tearful”;
  - D. (10:45 p.m.) patient given mind-altering medication [Ambien];
  - E. (12:30 a.m.) patient “behavior inappropriate constantly trying to get out of bed;” and
  - F. (2:00 a.m.) “found patient trying to get [out of bed],” despite her “verbalized understanding of instructions to remain in bed” at 12:30 a.m. *Id. See also, Exhibit 2, 2/16/06 Fall Abstraction Data Tool.*
8. Nonetheless, when receiving Shirley as a patient for and during the morning shift on February 16, 2006, Defendants did not bother to look at or completely ignored the foreboding Nurse Care Notes and lack of necessary and appropriate intervention for the immediately preceding shifts, instead of reading and heeding them as they should have done; so were oblivious to the true fall risk status of Shirley.
9. Further, Defendants during the morning shift of February 16, 2006:
- A. Failed to assess Shirley for fall risk as required, and left her “FALL RISK ASSESSMENT” totally blank;
  - B. Medicated her with a strong narcotic, Dilaudid, at 9:20 a.m.; and
  - C. Failed to implement the necessary and appropriate fall risk intervention. *See, Exhibit 3 2/16-17/06 Nurse Care Notes. See also, Exhibit 2, 2/16/06 Fall Abstraction Data Tool.*
10. Consequently, Shirley fell out of bed around 10:30 a.m. on February 16, 2006. *Id.*
11. Defendants, Riverside and Nurse M. Ames, were negligent and breached the applicable standards of care toward Shirley during February 15-16, 2006, as follows:
- A. Failing properly to assess Shirley as an “extreme” or at least “high” fall risk;
  - B. Failing to implement all necessary and appropriate fall risk interventions, including particularly without limitation bed rails, alarm and/or soft restraints;
  - C. Failing to communicate/disseminate an “extreme” and “high” fall risk assessment and the necessity and propriety of fall risk interventions (including particularly

without limitation soft restrains, bed rails and alarm) among all pertinent staff;

- D. Failing to check, monitor, observe and/or otherwise attend to Shirley on a timely meaningful basis;
  - E. Failing to provide Shirley with sufficient means to alarm, alert and/or otherwise call for help and assistance while left alone;
  - F. Not maintaining a substantively honest, accurate, and otherwise complete “patient chart” for her; and
  - G. Other acts and/or omissions as may be investigated, discovered and proved at trial.
12. The in-patient fall and resulting injuries sustained by Shirley required her to undergo hip repair surgery emergently, the general trauma and/or anesthesia agents of which apparently aggravated and exacerbated her pre-operative stroke symptomatology (such as hemiparesis, droop, and speech problems), including particularly without limitation not elevating her blood pressure.
  13. Defendants employed a duplicitous system of patient “double books” vis-à-vis Shirley (as it did and does regarding other patients), with the purpose and effect of concealing the true complete facts of their substandard healthcare and the consequences thereof.
  14. The Nurses Notes of Defendants record only a hip injury from Shirley falling out of bed on February 16, 2006, *compare*, Exhibit 3, 2/16-17/06 Nurse Care Notes, *with*, Exhibit 5, 2/17/06 Procedures/Practices Quality Care Control Report; despite Shirley also sustaining a serious head injury in the fall and a disabling head stroke within hours.
  15. As inculcated by Defendant, Riverside, its nursing staff did not record her head injury in the Nurses Notes and instead only noted the head injury in the contemporaneous ostensibly “privileged” fall incident report, which Riverside intended to keep secret from Shirley, *see*, Exhibit 4, 2/16/06 Fall Quality Care Control Report; expecting and attempting to overturn by its then-pending appeal in *Riverside Hosp., Inc. v. Johnson*, 272 Va. 518 (Nov. 3, 2006) this Court’s adverse decision against it on the discoverability of such incident reports.
  16. Defendants noting the patient’s head injury only in the fall incident report claimed to be privileged (versus in the Nurses Notes of the “patient chart” routinely made available to the disabled patient) had the purpose and effect of rendering the fact and particular circumstances of any head injury open to dispute in litigation and otherwise.
  17. For example, with the Nurses Notes verifying only a hip and no head injury, her consulting physician was left uncertain and questioning whether “she may have struck the back of her head when she fell,” such that subsequently Shirley unfairly and inaccurately was ascribed alcohol abuse/withdrawal, age-related organic brain syndrome, etc. as the

ostensible explanation for her fall-induced head injury and its sequelae. *See, e.g.*, Exhibit 6, 2/16/06 Consultation.

18. Because of the fall, head injury and sequelae suffered, Shirley foreseeably was rendered unable herself to recall and attest completely the fact and circumstances of her fall and head injury, heightening the importance of honest, accurate, and otherwise complete record-keeping in her so-called “patient chart” by Defendants.
19. Upon admission as a patient of Defendant, Riverside, Shirley reasonably relied to her detriment on Defendants dealing with her in good faith in general and on them honestly, accurately, and otherwise completely maintaining her “patient chart” in particular; which Defendants systematically, knowingly and intentionally failed to do, proximately causing her damages.
20. Defendant, Riverside, had intended and achieved material secreting and non-disclosure by:
  - A. Minimizing notations of unfavorable facts in what it denominated the so-called “patient chart” where, in truth, such facts should have been recorded;
  - B. Memorializing such unfavorable facts in parallel, usually contemporaneous, patient records or papers commonly referred to as so-called “incident reports,” other *de facto* accident report and, more recently, direct-entry paperless computer databases;
  - C. Reporting such unfavorable facts in the parallel “sentinel event,” “investigative” and/or other reports;
  - D. Subsequently destroying such paper incident reports; and
  - E. Portraying its record-keeping in a false light to Courts.
21. For decades, Defendant, Riverside, through its nursing staff has documented all known in-patient falls in the routine and ordinary course of its business with “incident reports”: regardless their occasionally shifting title, color and form, the “incident reports” really are Risk Management tools with their genesis in the pre-printed forms of its medical malpractice liability carrier to about 2003, infamous The Virginia Insurance Reciprocal (“TVIR”), which self-servingly denominated the “incident reports” as supposed “Quality Care Control Reports” toward trying to shield the same from discovery and admissibility under inappropriate claim of “privilege.” *See, e.g.*, Exhibit 7, (various) Exemplar Incident Reports.
22. Moreover, beginning about July 1, 1996, Defendant, Riverside, systematically began destroying original handwritten “incident reports” within 3 months of their creation, after inputting data therefrom selectively and inaccurately (so as to reflect more favorably on itself for claim and litigation purposes); and employing a computer software system

developed and distributed by TVIR, self-servingly denominated “Quality Management System” (“QMS”), again toward trying to shield the same from discovery and admissibility under inappropriate claim of “privilege.” *See, e.g.*, Exhibit 8, 1/1/97-10/31/97 Exemplar QMS Database Excerpt.

23. This duplicitous system of patient “double books” also was done with the complicity, under the auspices and using the official logo of Virginia Hospital & Healthcare Association (“VHHA”), the activist trade association dominated by Defendant, Riverside, and the other big healthcare systems in Virginia, Bon Secours, Sentara, INOVA, and Carillion; which spawned TVIR.
24. Defendant, Riverside, TVIR and VHHA systematically taught insured members how to keep the duplicitous “double books” with QCCRs. Through TVIR, VHHA and Defendant, Riverside, coached insured hospital nurses explicitly about how not to write up patient charts and about now instead to complete ostensible “privileged” routine incident reports.
25. The tutorial about such documented strategy and tactics is summarized graphically by pictures of a healthcare provider not only avoiding a lawyer, but turning the tables and pursuing the lawyer with a hypodermic needle! *See, e.g.*, Exhibit 9, 1/27/95 Risk Management Aspects of Documentation.
26. Since the demise of VHHA’s TVIR, Defendant, Riverside, has continued inculcating its nurses in keeping duplicitous “double books”.
27. Immediately after its QCCR/QMS patient records scam was exposed publicly by *Riverside Hosp., Inc v. Johnson*, 272 Va. 518 (2006), Defendant, Riverside, continued it under modified names, “Quality Referrals” and “Midas,” format; and direct paperless modifiable computer database entry.
28. For decades, through its experience, “incident reports,” database and otherwise, Defendant, Riverside, has had actual knowledge of its significant chronic problem with in-patient falls, which historically occur more than every other day and which often cause injury, including gravely serious ones.
29. Also the high prevalence and serious consequences of in-patient hospital falls, the predictive value of risk factors in assessment, and the efficacy and importance of fall risk precautions has been well known to Defendant, Riverside, though not the unsuspecting public, for literally decades, including by the “reliable authority” of various health care literature.
30. Indeed, for years, Defendant, Riverside, has taught fall risk assessment and intervention as basic curriculum at both of its accredited nursing schools.
31. Likewise, for years, Defendant, Riverside, “oriented” and “partnered” all of its (new) nursing staff about fall risk assessment and intervention.

32. Further, Defendant, Riverside, previously has been sued in this Court for substandard fall risk assessment and intervention resulting in grave personal injury. *See, e.g., Johnson v. Riverside Hosp., Inc.*, No. CL00-29638-DP; and *Seibert v. Riverside Hosp., Inc.*, No. 40366-DP.
33. Despite the foregoing actual and constructive knowledge, Defendant, Riverside, has been lax, made light, and even denied its substantial ongoing in-patient fall problem.
34. The foregoing negligence and breaches of Defendants proximately caused Shirley past, present and future bodily injuries (including fracture, stroke and radical effects on her health and lifestyle), physical pain, mental anguish, disfigurement, deformity, associated humiliation, embarrassment, inconvenience, medical, assisted-living and other expenses.
35. Defendants justly are indebted to Plaintiff for such general and special compensatory damages in the principal amount of \$10,000,000.00.
36. Particularly in light of the aforesaid actual and constructive knowledge of Defendants, their abandonment of soft restraints, rails, alarms, other interventions, precautions and assistance/oversight toward Plaintiff represents a wide deviation from the prevailing standard of care, recklessness and a conscious disregard of the health, safety and well-being of Shirley.
37. Accordingly, Defendants should be punished and made an example by imposition of punitive or exemplary damages in the additional amount of \$350,000.00.
38. Plaintiff demands trial by jury.

WHEREFORE Plaintiff prays the Court for judgment over and against Defendants, Riverside Hospital, Inc. and Nurse M. Ames, jointly and severally, in the principal amount of \$10,350,000.00, plus interest at the judgment rate from malpractice on February 15, 2006, until paid in full, and all costs.

Respectfully submitted,

SHIRLEY FRAZIER BURRELL

By: \_\_\_\_\_  
Of counsel

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**EXHIBITS**

1. 2/15-16/06 Nurse Care Notes.
2. 2/16/06 Falls Abstraction Data Tool.
3. 2/16-17/06 Nurse Care Notes.
4. 2/16/06 Fall Quality Care Control Report.
5. 2/17/06 Procedures/Practices Quality Care Control Report.
6. 2/16/06 Consultation.
7. (various) Exemplar Incident Reports.
8. (1/1/97-10/31-97) Exemplar QMS Database Excerpt.
9. 1/27/95 Risk Management Aspects of Documentation.