

APR 05, 2021 01:19 PM

Robin C. Bishop
Robin C. Bishop, Clerk of State Court
Cobb County, Georgia

IN THE STATE COURT OF COBB COUNTY
STATE OF GEORGIA

DARELL IGNELZI and KATHRIN
IGNELZI, on behalf of their
daughter, ANORAH IGNELZI,

Plaintiffs

— versus —

SHEEL TODD, MD,
MAK ANESTHESIA, LLC,
MAK ANESTHESIA HOLDINGS,
LLC
MAK ANESTHESIA WELLSTAR,
LLC,

and

JOHN/JANE DOES 1-10,

Defendants.

CIVIL ACTION

FILE NO. _____

HON. _____

PLAINTIFFS' COMPLAINT FOR DAMAGES

Nature of This Action

1. This medical-malpractice action arises out of medical services negligently provided to 10-year-old Anorah Ignelzi at Marietta Eye Clinic (“MEC”), on September 30, 2019.
2. This action is brought by Anorah’s parents, Darell and Kathrin Ignelzi, on Anorah’s behalf.
3. Pursuant to OCGA § 9-11-9.1, the affidavit of Anesthesiologist Erick A. Harris, MD, is attached hereto as Exhibit 1. This Complaint incorporates the opinions and factual allegations set forth in Dr. Harris’s affidavit.
4. As used here, the phrase “standard of care” means: the degree of care and skill ordinarily employed by the medical profession generally under similar conditions and like circumstances as pertained to Defendants’ actions here.
5. This Complaint sets forth relevant medical principles and facts, most of which are uncontroversial.
6. With few exceptions, the medical facts are supported by citations to the medical record and by screenshots of the cited excerpts. Plaintiffs have taken the time and effort to provide such support, in order to make it as easy as possible for Defendants to answer the allegations, so that the parties—and the Court—may ascertain the disputed facts, on which this controversy may turn.
7. Negligence here is plain: During a routine outpatient procedure to remove a tiny benign lesion from the eyelid of a little girl, the anesthesiologist failed to reduce and clear the oxygen-rich air in the surgical field, so that a fire broke out over the girl’s face when the surgeon turned on an electric cautery. As a result, the little girl, Anorah Ignelzi, suffered serious burns, underwent skin-graft surgery, still receives therapy for PTSD, and expects to have additional surgeries.

Parties, Jurisdiction, and Venue¹

8. **Plaintiffs Darell Ignelzi and Kathrin Ignelzi** are citizens of Georgia.
9. **Defendant Sheel Todd, M.D.**, is a citizen of Georgia. Dr. Todd may be served with process at her residence: 3999 Matty Drive NE, Marietta, GA 30066-1113 (Cobb County).
10. Dr. Todd is subject to the personal jurisdiction of this Court.
11. Dr. Todd is subject to the subject-matter jurisdiction of this Court in this case.
12. Dr. Todd has been properly served with this Complaint.
13. Dr. Todd has no defense to this lawsuit based on undue delay in bringing suit, whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

¹ OCGA §§ 14-2-510 and 14-3-510 provide identical venue provisions for regular business corporations and for nonprofit corporations:

“Each domestic corporation and each foreign corporation authorized to transact business in this state shall be deemed to reside and to be subject to venue as follows: (1) In civil proceedings generally, in the county of this state where the corporation maintains its registered office.... (3) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated, if the corporation has an office and transacts business in that county; (4) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated.”

These same venue provisions apply to Professional Corporations, because PCs are organized under the general “Business Corporation” provisions of the Georgia Code. *See* OCGA § 14-7-3. These venue provisions also apply to Limited Liability Companies, *see* OCGA § 14-11-1108, and to foreign limited liability partnerships, *see* OCGA § 14-8-46.

OCGA 9-10-31 provides that, “joint tort-feasors, obligors, or promisors, or joint contractors or copartners, residing in different counties, may be subject to an action as such in the same action in any county in which one or more of the defendants reside.”

14. Dr. Todd is subject to venue in this Court because she is a resident of Cobb County.

15. Pursuant to OCGA 9-10-31, Dr. Todd is also subject to venue in this Court because one of her co-defendants is subject to venue here.

16. At all times relevant to this Complaint, Dr. Todd acted as an employee or agent of one or more of her co-defendants, MAK Anesthesia, LLC; MAK Anesthesia Holdings, LLC; and MAK Anesthesia Wellstar, LLC.

17. **Defendant MAK Anesthesia, LLC (“MAK Anesthesia”)** is a Georgia company with a principal office at 1300 Ridenour Blvd NW, Suite 300, Kennesaw, GA, 30152 (Cobb County). Registered Agent Name: Pamela Weigandt, MD. Physical address: 1300 Ridenour Blvd NW, Suite 300, Kennesaw, GA, 30152 (Cobb County).

18. MAK Anesthesia is subject to the personal jurisdiction of this Court.

19. MAK Anesthesia is subject to the subject-matter jurisdiction of this Court in this case.

20. MAK Anesthesia has been properly served with this Complaint.

21. MAK Anesthesia has no defense to this lawsuit based on undue delay in bringing suit, whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

22. MAK Anesthesia is subject to venue in this Court because MAK Anesthesia maintains its registered office in Cobb County, and also because MAK Anesthesia transacts business in Cobb County.

23. Pursuant to OCGA 9-10-31, MAK Anesthesia is also subject to venue in this Court because one of its co-defendants is subject to venue here.

24. At all times relevant to this Complaint, MAK Anesthesia was the employer or other principal of Defendant Sheel Todd, MD.

25. If another entity was the employer or principal of Dr. Todd during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

26. **Defendant MAK Anesthesia Holdings, LLC (“MAK Anesthesia Holdings”)** is a Georgia company with a principal office at 1300 Ridenour Blvd NW, Suite 300, Kennesaw, GA, 30152 (Cobb County). Registered Agent Name: Pamela Weigandt, MD. Physical address: 1621 N. Roberts Road, Suite 110, Kennesaw, GA, 30144 (Cobb County).
27. MAK Anesthesia Holdings is subject to the personal jurisdiction of this Court.
28. MAK Anesthesia Holdings is subject to the subject-matter jurisdiction of this Court in this case.
29. MAK Anesthesia Holdings has been properly served with this Complaint.
30. MAK Anesthesia Holdings has no defense to this lawsuit based on undue delay in bringing suit, whether based on the statute of limitations, the statute of repose, laches, or any similar theory.
31. MAK Anesthesia Holdings is subject to venue in this Court because MAK Anesthesia Holdings maintains its registered office in Cobb County, and also because MAK Anesthesia Holdings transacts business in Cobb County.
32. Pursuant to OCGA 9-10-31, MAK Anesthesia Holdings is also subject to venue in this Court because one of its co-defendants is subject to venue here.
33. At all times relevant to this Complaint, MAK Anesthesia Holdings was the employer or other principal of Defendant Sheel Todd, MD.
34. If another entity was the employer or principal of Dr. Todd during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.
35. **Defendant MAK Anesthesia Wellstar, LLC (“MAK Anesthesia Wellstar”)** is a Georgia company with a principal office at 1300 Ridenour Blvd NW, Suite 300, Kennesaw, GA, 30152 (Cobb County). Registered Agent Name: Pamela Weigandt, MD. Physical address: 1300 Ridenour Blvd NW, Suite 300, Kennesaw, GA, 30152 (Cobb County).
36. MAK Anesthesia Wellstar is subject to the personal jurisdiction of this Court.

37. MAK Anesthesia Wellstar is subject to the subject-matter jurisdiction of this Court in this case.
38. MAK Anesthesia Wellstar has been properly served with this Complaint.
39. MAK Anesthesia Wellstar has no defense to this lawsuit based on undue delay in bringing suit, whether based on the statute of limitations, the statute of repose, laches, or any similar theory.
40. MAK Anesthesia Wellstar is subject to venue in this Court because MAK Anesthesia Wellstar maintains its registered office in Cobb County, and also because MAK Anesthesia Wellstar transacts business in Cobb County.
41. Pursuant to OCGA 9-10-31, MAK Anesthesia Wellstar is also subject to venue in this Court because one of its co-defendants is subject to venue here.
42. At all times relevant to this Complaint, MAK Anesthesia Wellstar was the employer or other principal of Defendant Sheel Todd, M.D.
43. If another entity was the employer or principal of Dr. Todd during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.
44. **Defendants John/Jane Does 1-10** are those yet-unidentified natural persons and/or entities who may be liable, in whole or part, for the damages alleged herein. Once served with process, John/Jane Does 1-10 are subject to the jurisdiction and venue of this Court.
45. This Court has subject-matter jurisdiction over this case.
46. Venue in this Court is proper as to all Defendants.

General Medical Principles

Papilloma Lesions

47. Squamous papillomas are generally benign (noncancerous) growths on the skin and other tissues of the body.
48. Squamous papillomas often begin in the squamous cells (thin, flat cells) found in the tissue that forms the surface of the skin (the epidermis).
49. When found on the skin, squamous papillomas are more commonly referred to as warts or verrucas.
50. The Human Papilloma Virus (HPV) causes most papillomas.
51. Papillomas do not spread around the body and are not aggressive.
52. Squamous papillomas often occur on the eyelids, especially in children.



53. The standard treatment for most eyelid papillomas is surgical excision.
54. The excision is a routine outpatient procedure typically done only with local anesthesia and lasting only a few minutes.

Operating-Room Fires

55. Fire in the operating room (OR) is a relatively rare event.

56. When a fire in the OR occurs, the medical outcomes are often catastrophic for the injured patient, with severe legal and economic consequences for the surgical team and the facility.
57. Most OR fires are preventable with communication, appropriate education, and management of risks.
58. These preventive measures have little cost and are nearly 100 percent effective.
59. Most claims for harms caused by OR fires arise in an outpatient setting (76 percent), involve the upper body (85 percent), and are cases managed with monitored anesthetic care (81 percent).
60. Patient injuries from an OR fire are often severe—for example, painful and disfiguring burns to face and neck or severe airway injury with tracheostomy and permanent lung damage.
61. Typically, the patient must return to the OR many times to treat acute burn injuries and revise scar tissue, causing recurring anxiety, post-traumatic stress, and economic burden.

*Cause of OR Fires: The Fire
Triad*

62. OR fires are usually caused by the convergence of three elements in a closed environment: an oxidizer, fuel, and an ignition source.
63. These three elements have been called “the Fire Triad” and “the Fire Triangle.”



64. *First*, the most common oxidizers in an operating room are oxygen and nitrous oxide, which are used in anesthetizing the patient.
65. Most surgical fires occur in oxygen-enriched environments, when the concentration of oxygen exceeds 30 percent. (For perspective: the normal concentration of oxygen in “room air” is 21 percent.)
66. When supplemental oxygen is delivered to a patient in an operating room, an oxygen-enriched environment can be created.
67. In an oxygen-enriched environment, materials that may not normally burn in room air can ignite and burn.
68. An open oxygen delivery system, such as nasal cannula or facemask, presents a greater risk of fire than a closed delivery system, such as a laryngeal mask or endotracheal tube.
69. Open delivery of oxygen from a direct source, through a device such as a facemask or nasal cannula, is the major factor contributing to most OR fires.
70. This is not surprising: At oxygen concentrations near 50 percent or higher, any spark or generated heat can ignite a fuel source.
71. Even at oxygen concentrations above 30 percent, the burning process is accelerated.
72. As oxygen concentration rises from 21 to 50 percent, the time required for surgical drapes to ignite decreases and burn-rate increases.
73. The fraction-of-inspired-oxygen (FiO₂) level reflects the oxygen-concentration in the air being delivered to the patient.
74. An FiO₂ level of 1.0 means that the concentration of oxygen is 100%—pure oxygen. Likewise, an FiO₂ level of 0.3 means that the air is 30% oxygen.
75. *Second*, common fuels in ORs include surgical drapes, towels, gauzes, sponges, alcohol-based prep solutions, masks, and endotracheal tubes.
76. Surgical drapes, towels, sponges, and gauzes are made from cotton, paper, or plastics—all excellent fuels.

77. When oxygen-concentration exceeds 50 percent, oxygen becomes trapped within the fine fibers and naps of cotton towels or drapes. This oxygen can vigorously promote combustion—a phenomenon known as “fiber flame propagation.”

78. *Third*, common ignition sources include electrosurgery units (“ESUs”), surgical lasers, fiberoptic lights (such as headlamps and lighted instruments), and defibrillators.

79. Even a static spark may become an ignition source.

80. An ESU is the most commonly used ignition source in the operating room.

81. A monopolar ESU, often called by the brand-name “Bovie,” produces a high-temperature electrical arc.

82. Cautery or cauterization is a medical technique of burning a wound to limit bleeding, damage, or infection.

83. A Bovie is often used by physicians in the operating room to cauterize wounds.



84. A Bovie’s monopolar tip can ignite a fire, as can a loose or worn connector or cable on the device.

85. If the three elements of the Fire Triad converge in a closed environment, any spark may result in flames.

86. For that reason, strategies to prevent OR fires are based on separating the three elements of the Triad.

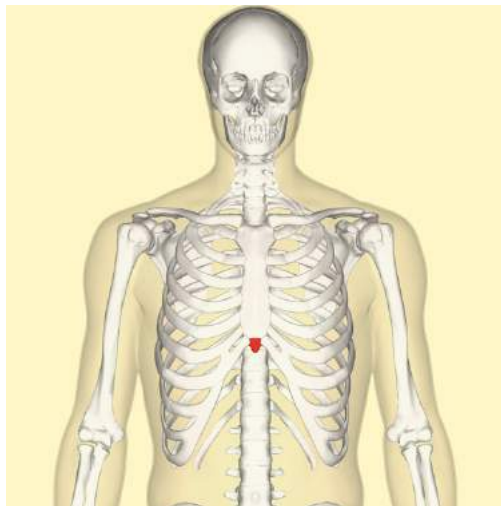
Prevention of OR Fires, Generally

87. The key elements to fire prevention in the operating room are:

- Risk assessment
- Communication among members of the surgical team
- Preventive measures based on level of risk

88. These elements generally reflect the Silverstein Fire Risk Assessment Tool and other formal fire-prevention tools, including those published by the Anesthesia Patient Safety Foundation and the American Society of Anesthesiologists.

89. Such tools assess the risk of a procedure as high if it (a) is above the level of the xiphoid, (b) uses an open oxygen source (*e.g.*, delivery of oxygen via facemask or nasal cannula), and (c) involves the presence of an ESU or other ignition source. This image shows the xiphoid in red.



90. The most important fire-prevention measure is communication among surgical-team members regarding potential fire risk and plans to manage risks.

91. A failure in communication is a factor in most OR fires.

92. Beyond the share responsibility to communicate, responsibilities for controlling the elements of the Fire Triad are allocated according roles.

93. Thus, because nurses are typically responsible for drapes, towels, and sponges (fuels), nurses are also responsible for related preventive measures such as keeping drapes and towels away from ignition sources.

94. Likewise, anesthesiologists are responsible for managing oxygen-concentration levels.

Prevention of OR Fires: Oxygen Concentration

95. The anesthesiologist's monitoring and control of oxygen-concentration plays a crucial role in preventing OR fires.

96. The most effective fire-prevention measure is to eliminate open delivery of oxygen whenever possible.

97. For procedures above the xiphoid, open delivery of oxygen should be avoided whenever possible.

98. If treatment of the patient requires open delivery of oxygen, the most effective fire-prevention measure is to limit oxygen concentration to 30 percent or less, while avoiding nitrous oxide.

99. Before an ESU is turned on in the OR, an anesthesiologist administering oxygen through an open delivery system must ensure that the FiO₂ level is 30% or less.

100. In addition, when the anesthesiologist lowers the FiO₂ level to 30% from a higher setting, the anesthesiologist must preclude the use of an ESU for at least 3-5 minutes, to allow the oxygen-rich air to dissipate.

Prevention of OR Fires: Communication to Prevent Risk-Convergence

101. Because OR fires occur when the three elements of the Fire Triad come together, members of the surgical team must communicate about these elements to mitigate their convergence.

102. Specifically, each provider on the team must alert the others of the risk posed by the elements he or she controls.

103. For example, a nurse must warn of drapes that may turn into fuel, and the anesthesiologist of concentrated oxygen that may serve as an oxidizer.

104. In addition, each member of the surgical team must ask about and ascertain the risk posed by the other elements.

105. Thus, an anesthesiologist must inquire about the possibility that a potential ignition-source like a Bovie might be used, especially if the anesthesiologist plans to introduce concentrated oxygen into the surgical field.

106. Risk assessment and prevention of fire in the OR thus require effective communication, coordination, and teamwork.

Treatment of Anorah Ignelzi

Prologue: Anorah Is Born with Benign Lesion

107. Anorah Ignelzi was born with a tiny “mole like bump” on her lower left eyelid. MEC 2.

108. The lesion was purely a cosmetic issue—it did not “hurt, itch, or cause any discomfort.” MEC 2.

Chief Complaint: Possible Style OS

HPI: This is a 10 year old female who comes in for a chief complaint of Possible Style OS . Patient states for a number of years she has noticed a mole like bump under her os. She states that this it has been fluctuating in size for the past couple of years. It does not hurt, itch or cause any discomfort. Her father states she was not born with this and is unsure of where or what caused this to happen. Patient has no further complaints with her vision or eyes at this time.

MEC 2.

109. As Anorah turned 10, she naturally started to become more self-conscious about her appearance, including the lesion.



110. The following photograph shows Anorah on September 20, 2019—ten days before the events at issue in this lawsuit. MEC 8.

9-20-19



MEC 8.

111. The lesion is barely discernible in the photograph. MEC 8.

*September 10: MEC Diagnoses
Lesion as
Benign Papilloma*

112. On September 10, 2019, Anorah and her father, Darell Ignelzi, visited the Marietta Eye Clinic (MEC) for a medical evaluation of the lesion. MEC 2.

113. Other than the lesion, Anorah had “no further complaints with her vision or eyes” at that time. MEC 2.

Chief Complaint: Possible Style OS

HPI: This is a 10 year old female who comes in for a chief complaint of Possible Style OS . Patient states for a number of years she has noticed a mole like bump under her os. She states that this it has been fluctuating in size for the past couple of years. It does not hurt, itch or cause any discomfort. Her father states she was not born with this and is unsure of where or what caused this to happen. Patient has no further complaints with her vision or eyes at this time.

MEC 2.

114. Optometrist Michael-Vu Do examined Anorah. MEC 2-3.

115. Dr. Do diagnosed the lesion as benign Squamous Papilloma – a “benign neoplasm of the eyelid.” MEC 3.

Diagnostic Procedure: External Photos - OS
Indication: Papilloma

Findings OS: benign neoplasm of eyelid
Diagnoses OS: benign neoplasm of eyelid
Reliability: good
Assessment: baseline for future comparison

MEC 3.

116. Dr. Do explained to Anorah and her father that “Squamous papillomas are common conditions with variable clinical appearance.” MEC 3.

117. Dr. Do further explained that papillomas “may be observed or surgically removed.” MEC 3.

Impression/Plan:

1. **Papilloma - Verrucous papilloma below left lower lid (D31.00)**
Existing condition with new problem, treatment or diagnostic

Plan: Counseling - Papilloma.

I counseled the patient regarding the following:

Eye care: Squamous papillomas are common conditions with variable clinical appearance. They may be observed or surgically removed.

Plan: F/U for Next Visit.

The patient should be scheduled for the following on referral to Dr Long.

MEC 3.

118. Dr. Do also recommended a follow-up visit with Ophthalmologist Byron A. Long.

MEC 3.

*September 20: Dr. Long
Confirms Diagnosis and Orders Excision
Surgery*

119. On September 20, 2019, Dr. Long examined Anorah. MEC 5-8.

120. Dr. Long confirmed the diagnosis of a benign verrucous papilloma, noting that it was worsening. MEC 6.

Impression/Plan:

1. **Eyelid Papilloma OS - Because of patients age this will need to be done at the ASC (D23.122)**
Status: Worsening

Plan: Counseling - Eyelid lesion.

I counseled the patient regarding the following:

Skin Care: Tumors of the eyelid can be benign or malignant. Concerning signs would be increased blood vessels or loss of eyelashes in the area of the lesion, or rapid growth.

Expectations: Benign lesions of the eyelid can be monitored, however the only way to confirm the diagnosis of the lesion is with a biopsy. Surgical excision in most cases is curative.

Contact Office if: If you notice increased growth, pain, or swelling of the eyelid.

Plan: Order for Surgery.

The following is the order for surgery: lesion removal - OS. - LLL.

Procedure codes: 67840

Diagnosis codes: D23.122

Provider: Byron Long, MD

Priority: normal

MEC 6.

121. Dr. Long explained to Anorah that “Benign lesions of the eyelid can be monitored,” but that the “only way to confirm the diagnosis of a lesion is with a biopsy.” MEC 6.

122. Dr. Long further explained that surgical excision of a papilloma “in most cases is curative.” MEC 6.

123. After meeting with Anorah and her mother, Kathrin Ignelzi, Dr. Long entered an order for surgery to remove the lesion. MEC 6.

124. During the same visit with Dr. Long, Mrs. Ignelzi signed the consent forms for the “excision of lid lesion.” MEC 13-14, MEC 15-16.



REQUEST AND INFORMED CONSENT TO EXCISION OF LID LESION

MEC 13.

125. As the forms made clear, the surgery as a “routine” procedure, with a good likelihood of success in removing the lesion. MEC 15, MEC 13.

MARIETTA EYE SURGERY
Consent to Routine Procedures and Treatments

MEC 15.

- 5) The likelihood of success of the above procedure is:
 Good, Fair, Poor

MEC 13.

*September 30: The Routine
Procedure Goes Sideways*

126. On September 30, 2019, Anorah underwent this routine procedure to remove the “eyelid lesion of lower left eyelid.” MEC 19.

PREOPERATIVE DIAGNOSIS: Enlarging eyelid lesion of left lower eyelid.

POSTOPERATIVE DIAGNOSIS: Enlarging eyelid lesion of left lower eyelid.

PROCEDURE PERFORMED: Excision of eyelid lesion of left lower eyelid.

SURGEON: Byron A. Long, MD

ANESTHESIA: General with additional local.

MEC 19.

127. Dr. Long was the surgeon, and Dr. Todd the anesthesiologist.

128. Because of Anorah's age and because of the location of the lesion near her eye, the procedure took place in "the main OR," an ambulatory surgery center, as opposed to a doctor's office. MEC 6.

DESCRIPTION OF PROCEDURE: The patient had an enlarging lesion of her lower eyelid which was thought to be papillomatous or viral in nature. The decision was made to do this in the operating room because of her age and the proximity to the eye. The patient was seen in the preoperative holding area where the procedure was discussed with her, and her mother was present. The patient was then brought to the main OR where she was placed under anesthesia by the anesthesia team. A local anesthetic consisting of 2% lidocaine with epinephrine mixed with Marcaine with epinephrine was injected underneath the obvious eyelid lesion and in the surrounding areas. She was then prepped with betadine scrub and draped in the usual aseptic fashion. The surgeon was wearing loupes during the procedure.

MEC 19.

Impression/Plan:

1. **Eyelid Papilloma OS** - Because of patients age this will need to be done at the ASC (D23.122)
Status: Worsening

MEC 6.

129. Prior to the procedure, Anorah "was seen in the preoperative holding area where the procedure was discussed with her," with her mother present. MEC 19.

DESCRIPTION OF PROCEDURE: The patient had an enlarging lesion of her lower eyelid which was thought to be papillomatous or viral in nature. The decision was made to do this in the operating room because of her age and the proximity to the eye. The patient was seen in the preoperative holding area where the procedure was discussed with her, and her mother was present. The patient was then brought to the main OR where she was placed under anesthesia by the anesthesia team. A local anesthetic consisting of 2% lidocaine with epinephrine mixed with Marcaine with epinephrine was injected underneath the obvious eyelid lesion and in the surrounding areas. She was then prepped with betadine scrub and draped in the usual aseptic fashion. The surgeon was wearing loupes during the procedure.

MEC 19.

130. This is Anorah minutes before the procedure.



131. At 07:08, Dr. Todd and RN Meredith Rountree brought Anorah back to the OR. Anorah was watching an iPad and talking with the staff. MEC 32.

132. At 07:08, Dr. Todd started to administer gas and propofol intravenously, and Anorah “was asleep.” MEC 32, MEC 19, MEC 23-24.

Patient came back to the OR at 0708 with Dr. Todd and Meredith Rountree, R.N. Patient was watching IPAD and talking with staff. Gas and propofol were administered by Dr. Todd and patient was asleep. Vitals were stable. Glynnis Jones administered a block with 2% lidocaine w Epi + 0.5% Marcaine to the left lower lid lesion that was to be removed. Patient was prepped with betadine swab. Dr. Long came in the room at 0716. A time out was done at 0717. The procedure began at 0718. I went to my desk to begin charting. I turned around and saw a towel on fire on the left side of the bed. I grabbed it and stepped on it.

MEC 32.

DESCRIPTION OF PROCEDURE: The patient had an enlarging lesion of her lower eyelid which was thought to be papillomatous or viral in nature. The decision was made to do this in the operating room because of her age and the proximity to the eye. The patient was seen in the preoperative holding area where the procedure was discussed with her, and her mother was present. The patient was then brought to the main OR where she was placed under anesthesia by the anesthesia team. A local anesthetic consisting of 2% lidocaine with epinephrine mixed with Marcaine with epinephrine was injected underneath the obvious eyelid lesion and in the surrounding areas. She was then prepped with betadine scrub and draped in the usual aseptic fashion. The surgeon was wearing loupes during the procedure.

MEC 19.

Times
Anes Start. 0708
PACJ Anes End 0830

MEC 23.

133. Glynnis Jones injected local anesthetic to the lesion and surrounding areas—2% lidocaine, epinephrine, and 0.5% Marcaine. MEC 32, MEC 19.

134. Anorah was then “prepped with betadine scrub and draped in the usual aseptic fashion.” MEC 19, MEC 32.

Patient came back to the OR at 0708 with Dr. Todd and Meredith Rountree, R.N. Patient was watching IPAD and talking with staff. Gas and propofol were administered by Dr. Todd and patient was asleep. Vitals were stable. Glynnis Jones administered a block with 2% lidocaine w Epi + 0.5% Marcaine to the left lower lid lesion that was to be removed. Patient was prepped with betadine swab. Dr. Long came in the room at 0716. A time out was done at 0717. The procedure began at 0718. I went to my desk to begin charting. I turned around and saw a towel on fire on the left side of the bed. I grabbed it and stepped on it.

MEC 32.

DESCRIPTION OF PROCEDURE: The patient had an enlarging lesion of her lower eyelid which was thought to be papillomatous or viral in nature. The decision was made to do this in the operating room because of her age and the proximity to the eye. The patient was seen in the preoperative holding area where the procedure was discussed with her, and her mother was present. The patient was then brought to the main OR where she was placed under anesthesia by the anesthesia team. A local anesthetic consisting of 2% lidocaine with epinephrine mixed with Marcaine with epinephrine was injected underneath the obvious eyelid lesion and in the surrounding areas. She was then prepped with betadine scrub and draped in the usual aseptic fashion. The surgeon was wearing loupes during the procedure.

MEC 19

135. The drapes were placed over the mask. MEC 24.

Smooth IV induction \bar{c} propofol, easy mask ventilation. Maintained \bar{c} sevoflurane + 30% FiO₂. Drapes over mask. Surgeon began procedure + excised lesion, surgeon attempted to use cautery \bar{c} resulting fire + burning of mask. Mask removed + area of face doused with saline + water. No airway compromise noted. After a few minutes, pt. \bar{c} laryngospasm broken \bar{c} propofol + positive pressure without difficulty. Pt. emerged with no further incident. IV removed while patient was combative while emerging. Pt. was conversive, protecting airway with no difficulty breathing + SpO₂ \approx 100% prior to transporting to PACU. Report given to PACU RN.

MEC 24.

136. At 07:16, Dr. Long entered the operating room. MEC 32.

Patient came back to the OR at 0708 with Dr. Todd and Meredith Rountree, R.N. Patient was watching IPAD and talking with staff. Gas and propofol were administered by Dr. Todd and patient was asleep. Vitals were stable. Glynnis Jones administered a block with 2% lidocaine w Epi + 0.5% Marcaine to the left lower lid lesion that was to be removed. Patient was prepped with betadine swab. Dr. Long came in the room at 0716. A time out was done at 0717. The procedure began at 0718. I went to my desk to begin charting. I turned around and saw a towel on fire on the left side of the bed. I grabbed it and stepped on it.

MEC 32.

137. At 07:17, the surgical team took a one-minute timeout. MEC 31, MEC 32.

ROOM:	1
OR IN:	0708
TIME OUT:	0717
INCISION:	0718
CLOSURE:	
OR OUT:	0829
<input checked="" type="checkbox"/>	ALLERGIES VERIFIED
<input checked="" type="checkbox"/>	H&P W/IN 30 DAYS
<input type="checkbox"/>	LATEX FREE CASE

MEC 31.

138. During the timeout, the team confirmed that all members had “introduced themselves by name and role;” that the surgeon, anesthesiologist, and nurse had verbally identified the patient, site of surgery, and procedure; and that they had reviewed “anticipated critical events.” MEC 30.

← Before skin incision →

TIME OUT

<input checked="" type="checkbox"/> Confirm all team members have introduced themselves by name and role
<input type="checkbox"/> Surgeon, anesthesia professional, and nurse verbally confirm: <ul style="list-style-type: none"> • Patient • Site • Procedure
Anticipated critical events:
<input checked="" type="checkbox"/> Surgeon reviews: <ul style="list-style-type: none"> • What are the critical or unexpected steps? • What is the operative duration? • Is there anticipated blood loss?
<input type="checkbox"/> Anesthesia team reviews: <ul style="list-style-type: none"> • Are there any patient-specific concerns?
<input type="checkbox"/> Nursing team reviews: <ul style="list-style-type: none"> • Has sterility (including indicator results) been confirmed? • Are there equipment issues or any concerns?

MEC 30.

139. The team also reviewed whether there was “anticipated blood loss.” MEC 30.

140. At 07:18, the procedure started. MEC 32, MEC 31.

Patient came back to the OR at 0708 with Dr. Todd and Meredith Rountree, R.N. Patient was watching IPAD and talking with staff. Gas and propofol were administered by Dr. Todd and patient was asleep. Vitals were stable. Glynnis Jones administered a block with 2% lidocaine w Epi + 0.5% Marcaine to the left lower lid lesion that was to be removed. Patient was prepped with betadine swab. Dr. Long came in the room at 0716. A time out was done at 0717. The procedure began at 0718. I went to my desk to begin charting. I turned around and saw a towel on fire on the left side of the bed. I grabbed it and stepped on it.

MEC 32.

141. At that time, Dr. Long elevated the lesion and used medical scissors to “excise the lesion in its entirety.” MEC 19.

142. Dr. Long then “handed off” the lesion to the surgical assistant. MEC 19.

The lesion was elevated, and Westcott scissors were used to excise the lesion in its entirety. This was handed off to the assistant. There was noted to be some brisk bleeding, and I used a handheld cautery to cauterize this. At the moment the handheld cautery was used to cauterize the area, a flash was seen for just approximately a second. It was noted that there was a quick flash burn that had extended down around the patient's nose and nasolabial area. Immediately, sterile water were poured all around the area to make sure that the flame was no longer present, and we held ice compresses on the area that had been burned. On first examination, it did seem to extend down into the nasolabial areas on both sides and then out towards the patient's ear on the right side. On further examination, the eyelashes on both sides seemed to be singed, but on examination of the eyes there did not seem to be any damage to the corneas. I did place fluorescein on both eyes, and there was no uptake. Her eyebrows also seemed to be somewhat singed. The anesthesiologist monitored her airway until things stabilized. She was allowed to wake up at the conclusion of the case, and I checked her vision by opening both eyes, and she was able to at least count fingers at approximately a foot away. Ice bandages were placed on the burn areas. Once she was found to be stable she was transferred out to the postoperative holding area. I did call the patient's dad and explained the situation to him, and we brought him immediately back to our pediatric holding area where we went in with the anesthesiologist and discussed in detail what had occurred.

MEC 19.

143. That’s when a routine procedure became eventful—and tragic. *See, e.g.,* MEC 32, MEC 18-20, MEC 23-24.

*September 30: Dr. Todd Fails
to Lower FiO₂ Level, Triggering Fire Over
Anorah’s Face*

144. Seeing “some brisk bleeding,” Dr. Long asked for a handheld cautery and swabs. MEC 19, MEC 32.

145. After receiving the cautery and swabs, Dr. Long had an exchange with Dr. Todd. MEC 32.

146. Dr. Todd stated: “You have a handheld cautery.” MEC 32.

147. Dr. Long responded, “yes.” MEC 32.

148. Dr. Long then “used a handheld cautery to cauterize” the wound. MEC 19.

149. “Then fire broke out.” MEC 32.

The lesion was elevated, and Westcott scissors were used to excise the lesion in its entirety. This was handed off to the assistant. There was noted to be some brisk bleeding, and I used a handheld cautery to cauterize this. At the moment the handheld cautery was used to cauterize the area, a flash was seen for just approximately a second. It was noted that there was a quick flash burn that had extended down around the patient's nose and nasolabial area. Immediately, sterile water were poured all around the area to make sure that the flame was no longer present, and we held ice compresses on the area that had been burned. On first examination, it did seem to extend down into the nasolabial areas on both sides and then out towards the patient's ear on the right side. On further examination, the eyelashes on both sides seemed to be singed, but on examination of the eyes there did not seem to be any damage to the corneas. I did place fluorescein on both eyes, and there was no uptake. Her eyebrows also seemed to be somewhat singed. The anesthesiologist monitored her airway until things stabilized. She was allowed to wake up at the conclusion of the case, and I checked her vision by opening both eyes, and she was able to at least count fingers at approximately a foot away. Ice bandages were placed on the burn areas. Once she was found to be stable she was transferred out to the postoperative holding area. I did call the patient's dad and explained the situation to him, and we brought him immediately back to our pediatric holding area where we went in with the anesthesiologist and discussed in detail what had occurred.

MEC 19.

Mimi Samatar was the surgical scrub tech in the room. Per Mimi: Dr. Long used a bishop and blunt Westcott and then dabbed with a 4x4. Then Dr. Long asked for handheld cautery. Then he asked for qtips. He took the qtips. At that point Dr. Todd stated "You have a handheld cautery." He said yes. Then fire broke out. The towel was removed and Mimi removed the hat because it was on fire. Mimi immediately got sterile water and poured it all over the affected area.

MEC 32.

150. There "was an O2 leak around the mask that they did not detect and a bovie was used which caught fire to the O2." WCH 00032.

HPI: THIS IS 10 y.o., female, who sustained a burn injury today, 9/30/2019 to the face and right ear when the pt was at Marietta eye clinic having a papilloma removed from her eye. The oxygen mask was on the face and parents were told there was an O2 leak around the mask that they did not detect and a bovie was used which caught fire to the O2. She was referred to the JMS burn center here at Wellstar for further evaluation and treatment. She was referred by our anesthesia services who was taking care of the pt at marietta eye clinic.

WCH 00032.

151. "A spark from the cautery ignited a fire that extended to the nasolabial" area of Anorah's face. MEC 18.

Anesthesia: MAC General Local Other: _____

Comments: A spark from the cautery ignited a drape
that extended to the nasobio. falls and
ser diluted not

MEC 18.

September 30: The Team
Scrambles

152. The surgical team scrambled to put out the fire and triage Anorah's burns.

153. The facemask was "burning." It was "removed" and Anorah's face was "doused with saline & water." MEC 24.

Smooth IV induction \bar{c} propofol, easy mask ventilation. Maintained \bar{c} sevoflurane & 30% FiO₂. Drapes over mask. Surgeon began procedure + excised lesion, surgeon attempted to use cautery \bar{c} resulting fire + burning of mask. Mask removed + area of face doused with saline + water. No airway compromise noted. After a few minutes, pt. \bar{c} laryngospasm broken \bar{c} propofol + positive pressure without difficulty. Pt. emerged with no further ^{airway} incident. IV removed while patient was combative while emerging. ~~the~~ Pt. was conversive, protecting airway with no difficulty breathing + SpO₂ 100% prior to transporting to PACU. Report given to PACU RN.

MEC 24.

154. RN Rountree "saw a towel on fire on the left side of the bed." She "grabbed it and stepped on it." MEC 32.

Patient came back to the OR at 0708 with Dr. Todd and Meredith Rountree, R.N. Patient was watching IPAD and talking with staff. Gas and propofol were administered by Dr. Todd and patient was asleep. Vitals were stable. Glynnis Jones administered a block with 2% lidocaine w Epi + 0.5% Marcaine to the left lower lid lesion that was to be removed. Patient was prepped with betadine swab. Dr. Long came in the room at 0716. A time out was done at 0717. The procedure began at 0718. I went to my desk to begin charting. I turned around and saw a towel on fire on the left side of the bed. I grabbed it and stepped on it.

MEC 32.

155. Anorah's hat was removed because it too was on fire. MEC 32.

Mimi Samatar was the surgical scrub tech in the room. Per Mimi: Dr. Long used a bishop and blunt Westcott and then dabbed with a 4x4. Then Dr. Long asked for handheld cautery. Then he asked for qtips. He took the qtips. At that point Dr. Todd stated "You have a handheld cautery." He said yes. Then fire broke out. The towel was removed and Mimi removed the hat because it was on fire. Mimi immediately got sterile water and poured it all over the affected area.

MEC 32.

156. Mimi Samatar, the surgical scrub, "immediately got sterile water and poured it all over the affected area" in order "to make sure that the flame was no longer present." MEC 32, MEC 19.

Mimi Samatar was the surgical scrub tech in the room. Per Mimi: Dr. Long used a bishop and blunt Westcott and then dabbed with a 4x4. Then Dr. Long asked for handheld cautery. Then he asked for qtips. He took the qtips. At that point Dr. Todd stated "You have a handheld cautery." He said yes. Then fire broke out. The towel was removed and Mimi removed the hat because it was on fire. Mimi immediately got sterile water and poured it all over the affected area.

MEC 32.

The lesion was elevated, and Westcott scissors were used to excise the lesion in its entirety. This was handed off to the assistant. There was noted to be some brisk bleeding, and I used a handheld cautery to cauterize this. At the moment the handheld cautery was used to cauterize the area, a flash was seen for just approximately a second. It was noted that there was a quick flash burn that had extended down around the patient's nose and nasolabial area. Immediately, sterile water were poured all around the area to make sure that the flame was no longer present, and we held ice compresses on the area that had been burned. On first examination, it did seem to extend down into the nasolabial areas on both sides and then out towards the patient's ear on the right side. On further examination, the eyelashes on both sides seemed to be singed, but on examination of the eyes there did not seem to be any damage to the corneas. I did place fluorescein on both eyes, and there was no uptake. Her eyebrows also seemed to be somewhat singed. The anesthesiologist monitored her airway until things stabilized. She was allowed to wake up at the conclusion of the case, and I checked her vision by opening both eyes, and she was able to at least count fingers at approximately a foot away. Ice bandages were placed on the burn areas. Once she was found to be stable she was transferred out to the postoperative holding area. I did call the patient's dad and explained the situation to him, and we brought him immediately back to our pediatric holding area where we went in with the anesthesiologist and discussed in detail what had occurred.

MEC 19.

157. After a few minutes, Anorah had a laryngospasm, which was "broken" when Dr. Todd administered another dose of propofol, and positive air pressure. MEC 24.

Smooth IV induction \bar{c} propofol, easy mask ventilation. Maintained \bar{c} sevoflurane 30% FiO₂. Drapes over mask. Surgeon began procedure + excised lesion, surgeon attempted to use cautery \bar{c} resulting fire + burning of mask. Mask removed + area of face doused with saline + water. No airway compromise noted. After a few minutes, pt. \bar{c} laryngospasm broken \bar{c} propofol + positive pressure without difficulty. Pt. emerged with no further ^{airway} incident. IV removed while patient was combative while emerging. Pt. was conversive, protecting airway with no difficulty breathing + SpO₂ 100% prior to transporting to PACU. Report given to PACU RN.

MEC 24.

158. Marie Hernandez came in and began wiping burned areas of Anorah's head and neck with BSS (a sterile cleaning solution) and gauze. MEC 32.

159. Dr. Todd, Marie, and Nurse Rountree "began checking all of the head, neck and face" for burns. MEC 32.

160. Nurse Rountree "ran out and got florisene stripes and BSS to make sure there were no burns to the corneas." MEC 32, MEC 31.

Marie Hernandez came into the room. Maire began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the comeas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 32.

161. The team “proceeded to clean the patient and continued placing cold slush on gauze with pressure” to the burned areas. MEC 32.

Marie Hernandez came into the room. Maire began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the corneas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 32.

*September 30: Anorah Awakes
to Pain on Her Burned Face*

162. Anorah awoke to discover her face had been burned.

163. She was “combative while emerging.” MEC 24.

Smooth IV induction \bar{c} propofol, easy mask ventilation. Maintained \bar{c} sevoflurane 30% FiO₂. Drapes over mask. Surgeon began procedure + excised lesion, surgeon attempted to use cautery \bar{c} resulting fire + burning of mask. Mask removed + area of face doused with saline + water. No airway compromise noted. After a few minutes, pt. \bar{c} laryngospasm broken \bar{c} propofol + positive pressure without difficulty. Pt. emerged with no further ^{airway} incident. IV removed while patient was combative while emerging. ~~the~~ Pt. was conversive, protecting airway with no difficulty breathing + SpO₂ 100% prior to transporting to PACU. Report given to PACU RN.

MEC 24.

164. Anorah was "crying" and "stating her eyes were burning and her face and right ear were burning." MEC 32.

165. At 07:50, "Lidocaine jelly was placed on affected area on right side of face and bridge of nose." MEC 32, MEC 31.

166. At 07:55, Dr. Long returned to the room with Akten ointment and instructed others to apply it to both of Anorah's eyes. MEC 32, MEC 31.

167. Meanwhile, Marie "continued placing cool gauze and pressure to the affected areas." MEC 32, MEC 33.

Marie Hernandez came into the room. Maire began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the corneas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 32.

NURSES NOTES 0750 2% lidocaine jelly to burn areas around nose Dr. Long cool wet compresses to face Akten ointment to each eye. 0802 Dr. Todd gave 2cc oxycodone elixir 0815 floriscene strips to each eye Dr. Long reported Evans M. J. 0820 Drs Todd & Long talked with presentation INITIALS/SIGNATURE <i>HE H Evans et al</i>	ALDRETE ALGORITHM	
	ACTIVITY	2-ABLE TO MOVE EXTREMITY 1-ABLE TO MOVE EXTREMITY 0-NOT ABLE TO CONTROL EXTREMITY
	RESP	2-ABLE TO BREATHE DEEPLY AND FREELY 1-OPPORTUNISTIC BREATHING 0-APNEIC
	CIRC	1-87% OR MORE ANESTHETIC 1-80-86% PRE ANESTHETIC 0-80% OR MORE ANESTHETIC (over)
LOC	2-SELF AWARE 1-UNABLE TO CALLING 0-NOT RESPONDING	
COLOR	2-PINK 1-PALE, DUSKY, IN-ADVICE OTHER 0-ANESTHETIC	

MEC 33.

168. At 08:02, Dr. Todd gave Anorah intravenous pain medication and an oral elixir of oxycodone. MEC 32, MEC 33.

169. As she “began calming down,” Anorah “began asking questions about why her eyes and ear were burning.” MEC 32.

Marie Hernandez came into the room. Marie began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got floriscene strips and BSS to make sure there were no burns to the corneas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 32.

<p>NURSES NOTES <u>0750 2% lidocaine jelly to burn areas around nose</u> <u>Dr. Lee cool wet compresses to face</u> <u>After treatment to each eye. 0802 Dr Todd gave 2kcc</u> <u>oxycontin bid 0815 morphine 4mg to each by Dr. Long</u> <u>reported Evans M. J. 0820 Drs Todd & Long talked over</u> <u>with physician</u> INITIALS/SIGNATURE <u>JE / Evans</u> </p>	<p>ALDRETE ALGORITHM</p> <p>ACTIVITY 2-ABLE TO MOVE 1 EXTREMITIES 1-ABLE TO MOVE 2 EXTREMITIES 0-NOT ABLE TO CONTROL ANY EXTREMITIES</p> <p>RESP 2-ABLE TO BREATHE DEEPLY AND FREELY 1-DYSPNEIC/LIMITED BREATHING 0-APNEIC</p> <p>CIRC 2-80% PRE ANESTHETIC 1-30-50% PRE ANESTHETIC 0-10% PRE ANESTHETIC</p> <p>LOC 2-FULLY AWARE 1-AROUSABLE BY CALLING 0-NOT RESPONDING</p> <p>COLOR 2-PINK 1-PALE, DUSKY, JAUNDICE, OTHER 0-CYANOTIC</p>
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MEC 33.

170. At 8:57, Anorah's pain was an 8, on a scale of 1-10. MEC 34.

0835 Small sips of apple juice
0848 Gauze & sterile water changed frequently for comfort
0857 Pain scale - 8, medicated for pain & Tylenol po.

MEC 34.

September 30: Anorah Is
 Referred to Joseph Still Burn Center at Cobb
 Hospital

171. At 08:20, Dr. Todd and Dr. Long spoke with Anorah's parents. MEC 33, MEC 24, MEC 43.

<p>NURSES NOTES <u>0750 2% lidocaine jelly to burn areas around nose</u> <u>Dr. Lee cool wet compresses to face</u> <u>After treatment to each eye. 0802 Dr Todd gave 2kcc</u> <u>oxycontin bid 0815 morphine 4mg to each by Dr. Long</u> <u>reported Evans M. J. 0820 Drs Todd & Long talked over</u> <u>with physician</u> INITIALS/SIGNATURE <u>JE / Evans</u> </p>	<p>ALDRETE ALGORITHM</p> <p>ACTIVITY 2-ABLE TO MOVE 1 EXTREMITIES 1-ABLE TO MOVE 2 EXTREMITIES 0-NOT ABLE TO CONTROL ANY EXTREMITIES</p> <p>RESP 2-ABLE TO BREATHE DEEPLY AND FREELY 1-DYSPNEIC/LIMITED BREATHING 0-APNEIC</p> <p>CIRC 2-80% PRE ANESTHETIC 1-30-50% PRE ANESTHETIC 0-10% PRE ANESTHETIC</p> <p>LOC 2-FULLY AWARE 1-AROUSABLE BY CALLING 0-NOT RESPONDING</p> <p>COLOR 2-PINK 1-PALE, DUSKY, JAUNDICE, OTHER 0-CYANOTIC</p>
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MEC 33.

I spoke with parents with Dr. Long & informed them of the events in the OR. Parents were upset & requested that Dr. Long & I leave the room.

MEC 24.

172. Dr. Todd and Dr. Long apologized to Anorah's parents about "what happened with her." MEC 43.

8:20-
went at and explained to wife and husband what had happened and recommended for her to see her pediatrician today. We did then
we are sorry what happened with her
Digital photographs were taken. Uncle's vision was at least CF A C"
VJg

MEC 43.

173. Dr. Todd and Dr. Long also told Anorah's parents that her burns were not bad, that they were first-degree burns, and that there was no need to take Anorah to the emergency room.

174. Distraught, Mr. Ignelzi asked Dr. Todd and Dr. Long to leave, and asked to speak with MEC's director. MEC 24.

I spoke with parents with Dr. Long & informed them of the events in the OR. Parents were upset & requested that Dr. Long & I leave the room.

MEC 24.

175. At 09:15, Dr. Pamela Weigandt met with Anorah's parents.² MEC 34.

176. Dr. Weigandt informed them that MEC was referring Anorah to the Joseph Still Burn Center at Cobb Hospital, where burn-specialist Claus Brandigi was expecting them. MEC 34, MEC 20.

0857 Main scale - 8 Medications given pain & Tyland po.
0858 Dr. Todd in to see pt. Plan to send to Cobb Burn
0915 Center, Dr. Weigandt in to see pt. Referral
to Burn Center By Pass ER. Info given
to Family sp
0920. Instructions given to Family. Crackers + drink
given to pt. pt. tolerated. Compresses continued
throughout at frequent intervals. Areas around
face + eyes remain pink. Rt. ear pinkish-red
0930 Discharged per ambulatory + Dad. J Evans

MEC 34.

The decision was made to send the patient to a burn specialist at Cobb Hospital; Dr. Klaus Bradigi M.D. Dr. Weigandt called him to alert him of the situation. He said to send her right away and he would exam and treat her.


Byron A. Long, MD

MEC 20.

177. Dr. Weigandt also promised Anorah's parents that MEC would pay all costs associated with Anorah's burns.

178. At 09:30, MEC discharged Anorah. MEC 34.

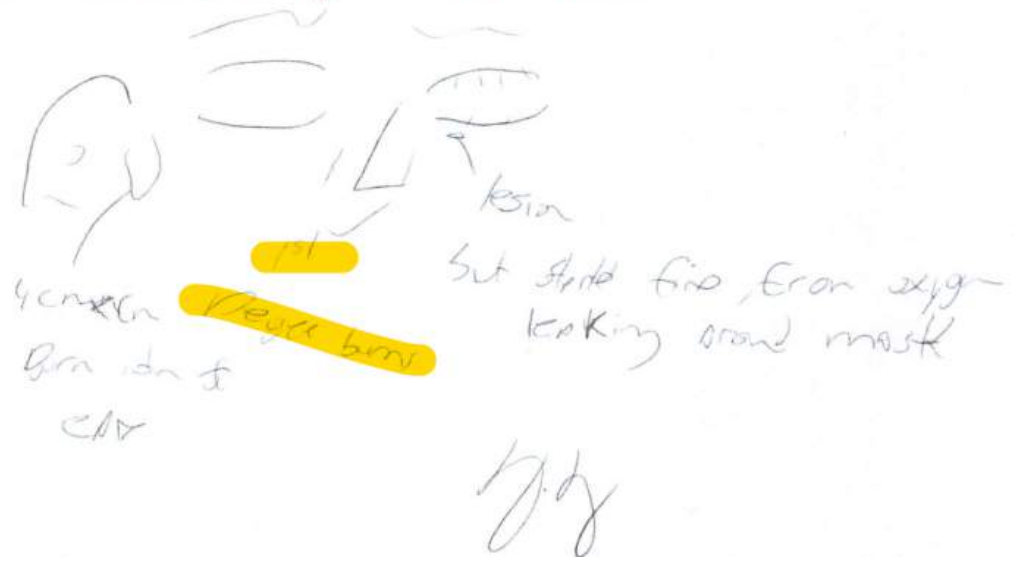
179. As they departed with Anorah, MEC gave Anorah's parents gauze and an opened bottle of saline solution "to keep the gauze wet."

September 30: Anorah's Burns

180. Dr. Long and Dr. Todd downplayed Anorah's burns as only first-degree burns. MEC 43.

² As noted above, Dr. Weigandt is the registered agent for each of the three corporate defendants here.

9.30.19 - excision of lesion LLL



MEC 43.

181. But, as the Still Burn Center soon confirmed, they were second-degree burns.
WCH 00002.



182. The fire, moreover, covered significant surface areas on Anorah's head, face, and neck. The flames:

- travelled “down into the nasolabial areas on both sides and then out towards the patient’s ear on the right side.” MEC 19.
- burned “the right temporal side of [Anorah’s] face as well as the right ear.” MEC 32.
- burned the area “over the bridge of the nose bilateral where the mask had been placed.” MEC 32.
- singed Anorah’s eyelashes, eyebrows, and hair. MEC 19, MEC 32.



The lesion was elevated, and Westcott scissors were used to excise the lesion in its entirety. This was handed off to the assistant. There was noted to be some brisk bleeding, and I used a handheld cautery to cauterize this. At the moment the handheld cautery was used to cauterize the area, a flash was seen for just approximately a second. It was noted that there was a quick flash burn that had extended down around the patient's nose and nasolabial area. Immediately, sterile water were poured all around the area to make sure that the flame was no longer present, and we held ice compresses on the area that had been burned. On first examination, it did seem to extend down into the nasolabial areas on both sides and then out towards the patient's ear on the right side. On further examination, the eyelashes on both sides seemed to be singed, but on examination of the eyes there did not seem to be any damage to the corneas. I did place fluorescein on both eyes, and there was no uptake. Her eyebrows also seemed to be somewhat singed. The anesthesiologist monitored her airway until things stabilized. She was allowed to wake up at the conclusion of the case, and I checked her vision by opening both eyes, and she was able to at least count fingers at approximately a foot away. Ice bandages were placed on the burn areas. Once she was found to be stable she was transferred out to the postoperative holding area. I did call the patient's dad and explained the situation to him, and we brought him immediately back to our pediatric holding area where we went in with the anesthesiologist and discussed in detail what had occurred.

MEC 19.

Marie Hernandez came into the room. Maire began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the corneas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 32.

September 30: Dr. Todd Changes FiO2 Entries on Anesthesia Record

183. Dr. Todd's anesthesia record for Anorah's surgery at MEC contains handwritten entries for FiO2 levels in 15-minute blocks. MEC 23.

184. The entry for the block leading up to the surgery (07:00-07:15) reflects an FiO2 level of 1.0, or 100% oxygen-concentration. MEC 23.

185. The entry for the next block (07:15-07:30), when the excision and the fire occurred, reflects an oxygen level of 0.3, or 30% oxygen-concentration, precisely the maximum limit. MEC 23.

186. If they are to be believed, these two entries mean that Dr. Todd dropped the FiO2 level from 100% to 30% within minutes of the fire's eruption. MEC 23.

187. But the 07:15-07:30 entry has been overwritten, blotting out the original entry. MEC 23. The same is true for other entries in the anesthesia record. MEC 23.

Procedure: Lower lid excision of lesion

Time	7:00	7:30	8:00	8:30	9:00	Totals	Assessments
O2	0						<input checked="" type="checkbox"/> Genet <input type="checkbox"/> MAC
MR							<input type="checkbox"/> Mod <input checked="" type="checkbox"/> Field <input type="checkbox"/> Addi
SEVO	2.1						<input type="checkbox"/> Age
Versed/Fentanyl	mg/ug		1.5			- 25	
Lidocaine	mg					200	
Propofol	mg	100	100				
Zofran/Decadron	mg/mg						
<u>Ketorolac</u>			15				
Fluids	LA / NS					500mL	
EBL/JOP							
Antibiotic Therapy	Ancef 1g / 2g		Cleason 600mg / 900mg		Other		
Position	EKG	GR	ST	ST	ST	ST	Times
SpO2	100	100%	100%	100%	100%		Anes Start: 0708
FiO2	1.0	0.3	1.0	0.21	0.21		PACJ Anes End: 0830
CO2	30	35	40	+	+		
Temp	Normal						

MEC 23.

188. The original entries, moreover, have not been crossed out with a line so that they remain readable next to the new entries. MEC 23.

189. Instead, the original entries have been made unreadable by reshaping them into new numbers. MEC 23.

190. In addition, the person making these changes did not scribble her or his initials or otherwise annotate the record, to call out and verify the changes. MEC 23.

*September 30: Cobb Diagnoses
2nd-Degree Burns on Head, Face, and Neck*

191. At 10:21, Anorah was admitted to WellStar Cobb Hospital with second-degree burns on “multiple sites of head, face, and neck.” WCH 00002.

Admission Information					
Arrival Date/Time:		Admit Date/Time:	09/30/2019 1021	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Cobb Out Burn Wound and H
Admit Provider:		Attending Provider:	Claus Brandt, MD	Referring Provider:	Javald Sayeed, MD

WCH 00002.

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
T81.89XA [Principal]	Other complications of procedures, not elsewhere classified, initial encounter	Yes	No		Yes
T20.26XA	Burn of second degree of forehead and cheek, initial encounter	Yes	No		No
T20.24XA	Burn of second degree of nose (septum), initial encounter	Yes	No		No
T20.211A	Burn of second degree of right ear (any part, except ear drum), initial encounter	Yes	No		No
T26.02XA	Burn of left eyelid and periorcular area, initial encounter	Yes	No		No
T26.01XA	Burn of right eyelid and periorcular area, initial encounter	Yes	No		No
T31.0	Burns involving less than 10% of body surface	Yes	No		No
T20.29XD	Burn of second degree of multiple sites of head, face, and neck, subsequent encounter	Exempt from POA reporting			

WCH 00002.

192. At 11:21, Dr. Brandigi and Nurse Practitioner Kimberly Smith examined Anorah. WCH 00029.

H&P by Kimberly N Smith, NP at 9/30/2019 11:21 AM

Author: Kimberly N Smith, NP	Service: Burn	Author Type: —
Filed: 9/30/2019 11:33 AM	Date of Service: 9/30/2019 11:21 AM	Status: Signed
Editor: Kimberly N Smith, NP (Nurse Practitioner)		Cosigner: Claus Brandigi, MD at 10/2/2019 12:29 PM

THIS IS 10 y.o., female, who sustained a burn injury today, 9/30/2019 to the face and right ear when the pt was at Marietta eye clinic having eye surgery. The oxygen mask was on the face and a bovie was used near the mask. She was referred to the JMS burn center here at Wellstar for further evaluation and treatment. She was referred by our anesthesia services who was taking care of the pt at marietta eye clinic.

WCH 00029.

193. Dr. Brandigi informed Anorah’s parents that her burns were much worse than MEC had indicated to him.

194. Anorah had “epidermal loss to the face and right ear.” WCH 00029-30.

H&P by Kimberly N Smith, NP at 9/30/2019 11:21 AM (continued)

HEENT: mild swelling to the left eye
 CHEST: Equal rise and fall of chest
 CV: Cap refill is brisk
 ABD: Soft, BS + all quadrants
 EXT: Full AROM all extremities, all extremities are neurovascularly intact
SKIN: epidermal loss to the face and right ear

WCH 00030.

195. Dr. Brangidi decided to admit Anorah to Cobb with second-degree burns, in order to “monitor for worsening of the wound given burn injury is less than 24 hours in age.” WCH 00032.

196. In addition, with Anorah's parents' consent, Dr. Brangidi decided to perform graft surgery to the head the following day. WCH 00032.

ASSESSMENT:
1.5 %TBSA 2ND DEGREE BURN

PLAN:
Options for care were discussed at length with the patient and family. The decision was made to admit the pt and monitor for worsening of the wound given burn injury is less than 24 hours in age
Will plan for the OR tomorrow for skin sub to the head

Risks and benefits were discussed and consent was obtained

WCH 00032.

197. At 12:16, Pediatric Nurse Practitioner Lisa Samples examined Anorah. WCH 00033.

Consults by Lisa A Samples, NP at 9/30/2019 12:16 PM

Author: Lisa A Samples, NP
Filed: 9/30/2019 12:36 PM
Editor: Lisa A Samples, NP (Nurse Practitioner)

Service: Pediatrics
Date of Service: 9/30/2019 12:16 PM

Author Type: Nurse Practitioner
Status: Signed
Cosigner: Kelly S Garrison, MD at 10/2/2019 9:51 AM

Consult Orders
1. Consult to Pediatrics [845474745] ordered by Claus Brandig, MD at 09/30/19 11:21

WCH 00033.

198. Anorah had burns "to left lower eyelid with edema to the upper lid, right cheek just adjacent to nares, right face along hair line and right ear." WCH 00035.

PHYSICAL EXAMINATION:

Temp: 98.5 F HR: 94 RR: 20 SpO2: 98%

General: Awake and alert, appropriately interactive for age

HEENT: Moist mucus membranes

Lymphatic: No lymphadenopathy, neck supple

CV: RRR, no murmurs, rubs, or gallops

Respiratory: Normal respiratory effort, lungs CTAB

Abdomen: Normal bowel sounds, soft, nontender, nondistended

Skin: Burns to left lower eyelid with edema to the upper lid, right cheek just adjacent to nares, right face along hair line and right ear

Musculoskeletal: Normal ROM, no swelling or edema

Neurological: normal for age. No gross deficits

WCH 00035.

199. After this examination, the plan was still to “watch burn for any worsening and go to OR in the am.” WCH 00036.

Assessment/Plan:

Patient Active Problem List

Diagnosis

- Burns involving less than 10% of body surface

Anorah Ignelzi is a 10 y.o. old patient presenting following a burn to face/head. Plan to watch burn for any worsening and go to OR in the am.

- May remain without IV. Encourage PO.
- Pain control PRN with ibuprofen PRN
- Burn management per burn team

Thank you for the opportunity to assist on this patient's case.

WCH 00036.

*October 1: Anorah Has
Epiburn Grafting Surgery at Cobb*

200. On October 1, 2019, starting at about 08:50, Anorah underwent grafting surgery with Epiburn grafts. WCH 00039, WCH 00047-48.

Progress Note by Margaret A Summers, PA at 10/1/2019 6:54 AM

Author: Margaret A Summers, PA
Filed: 10/1/2019 6:54 AM
Editor: Margaret A Summers, PA (Physician Assistant)

Service: Burn
Date of Service: 10/1/2019 6:54 AM

Author Type: Physician Assistant
Status: Signed
Cosigner: Claus Brandigl, MD at 10/2/2019 12:29 PM

To OR today for surgical preparation and application of skin substitute to head

Electronically Signed by Claus Brandigl, MD on 10/2/2019 12:29 PM

WCH 00039.

Procedure in Detail:

The patient was brought to the operating room and placed on the table in supine position. After adequate general anesthesia was administered, the wounds were prepped with betasept and patient was draped in the usual manner.

Wound bed was prepared surgically using forceps, metzenbaum scissors, and a norsen. Pseudo-eschar and thin dermal eschar were shaved using a norsen to the superficial dermis level of excision.

After all devitalized tissue was removed, it was determined that Epiburn grafts would be best for this patient. Wounds were irrigated and covered with Epiburn grafts. Grafts were dressed using conformant, saline soaked kerlix and stretch net .

WCH 00047-48.

201. This was Anorah shortly before this surgery.



202. During the procedure, Dr. Brangidi found seven significant second-degree and deep second-degree burns on Anorah's head, face, and neck, covering surface areas as large as 8 x 5 centimeters. WCH 00048.

Findings:

**Location and measurements of second/deep second degree injury
(all measurements are in centimeters)**

R Neck 4 x 4
R Cheek 8 x 5 + 4 x 4
R Ear 7 x 5
Right upper eyelid 2 x 2
Nose 5 x 5
Left upper eyelid 5 x 3
L Cheek 5 x 5

WCH 00048.

203. On October 2, 2019, at 13:30, Anorah was discharged from Cobb. WCH 00027.

204. After the surgery Anorah had to wear head-bandages for about two weeks.



*Subsequent Weeks: Follow-up
at Cobb*

205. Anorah returned to Cobb for a follow-up appointment on October 4, 2019. WCH 00199-202.



WCH 00201, WCH 00202.

206. She then returned to Cobb for another follow-up appointment on October 9, 2019. WCH 00228-32.

207. Anorah returned for a third follow-up on October 17, 2019. CH 00260-64.

208. She returned once again for a follow-up on November 21, 2019. WCH 00286.

209. This is Anorah about four months after her graft surgery.



*October 2019 to Present:
Anorah Receives Ongoing Therapy for PTSD*

210. Since October 3, 2019, Anorah has received psychological counseling from the same therapist, Melanie Kissell. THC 0002-03.

211. In the days after the fire, “Anorah presented with symptoms consistent to PTSD including depression, elevated fear, trouble concentrating, and excessive worry.” THC 0002.

Anorah Ignelzi is an 11-year-old Caucasian female seeking mental health treatment after experiencing a facial burn injury during a surgical eye procedure. Anorah presented with symptoms consistent to PTSD including depression, elevated fear, trouble concentrating, and excessive worry. Anorah was referred by her parents for counseling services. Anorah had not received prior mental health treatment. Anorah participates and engages in trauma informed, child centered play therapy sessions. During sessions, Anorah presents as playful and open. She demonstrates an ability to self-regulate and a willingness to process her experience in a safe, therapeutic environment.

THC 0002.

212. During therapy sessions, Anorah reported feeling “more angry and sad than she did before the operation.” THC 0002.

213. She also demonstrated “confusion and frustration about [people’s] reactions to her facial burns.” THC 0002.

Anorah has many protective and resiliency factors that support her recovery and contribute to a good prognosis. During session, Anorah has reported she now feels more angry and sad than she did before the operation. Anorah also demonstrates confusion and frustration about other’s reactions to her facial burns and has stated “I don’t like it when people try and make me happy.”

THC 0002.

214. At home, Anorah began “isolating herself and going to her room for extended periods of time” and experiencing “anger outbursts daily.” THC 0002.

215. Anorah also demonstrated “symptoms typical to sustaining traumatic stress including a lack of interest in school, increased appetite, engaging in hypervigilant behaviors and exaggerated negative beliefs about the world being a dangerous place.” THC 0002.

216. Anorah’s family was also “impacted by Anorah's burn injury as evidenced by, increased arguing between members, tearfulness, avoidance, anxiety related to Anorah’s future, and an increased financial burden on household resources.” THC 0002.

Mr. and Mrs. Ignelzi reported that Anorah has recently begun isolating herself and going to her room for extended periods of time and that she experiences anger outbursts daily. Mr. & Mrs. Ignelzi reported these behaviors were not identified as problems prior to her burn injury. Additionally, Anorah demonstrates symptoms typical to sustaining traumatic stress including a lack of interest in school, increased appetite, engaging in hypervigilant behaviors and exaggerated negative beliefs about the world being a dangerous place. The family unit as a whole has been impacted by Anorah’s burn injury as evidenced by, increased arguing between members, tearfulness, avoidance, anxiety related to Anorah’s future, and an increased financial burden on household resources. Treatment goals identified by Mr. and Mrs. Ignelzi include:

THC 0002.

217. In sessions, Anorah engaged in “expressive art and play activities displaying themes of safety, regression, fear, and loss of power and control.” THC 0003.

218. She often represented herself in drawings wearing masks, indicating that that represented “her mixed feelings of anger, sadness, and happiness.” THC 0003.

During sessions client engages in expressive art and play activities displaying themes of safety, regression, fear, and a loss of power and control. Anorah often represents herself in drawings wearing masks and has indicated this represents her mixed feelings of anger, sadness, and happiness. It is recommended for Anorah to continue in family and individual counseling services until symptomology reduces by 80% or treatment goals are met at a rate of 80%. Symptomology reduction and treatment goal achievement is determined by mixed methods including parent and child self-reported measures, clinical observation, and PTSD assessment instruments.

THC 0003.

219. On December 3, 2019, Anorah's therapist "recommended for Anorah to continue in family and individual counseling services until symptomology reduces to 80% or treatment goals are met at a rate of 80%." THC 0003.

220. Therapy goals included "developing a healthy understanding about her experience," "learning healthy coping strategies to use in moments of distress," and "processing her thoughts and feelings about her experience." THC 0002.

*s. Treatment goals identified by Mr. and Mrs. Ignelzi include:
Anorah developing a healthy understanding about her experience.
Anorah learning healthy coping strategies to use in moments of distress.
Anorah processing her thoughts and feelings about her experience.
The family unit recovering from this experience in healthy and adaptive ways.*

THC 0002.

221. Over the year and half that have followed, Anorah has remained in therapy with the same professional, working diligently to move past the trauma of the fire by meeting those goals and others. She remains in therapy today.

Epilogue: Future Surgeries

222. Since her graft surgery, Anorah has remained under the care of Dr. Brandigi at the Still Burn Center, with periodic appointments to check on her progress.

223. As she grows older, the focus is on ensuring that her skin heals properly.

224. As of the time of the filing of this Complaint, tentative plans are in place for one or more laser surgeries to address skin discoloration due to the burns.

225. In addition, Anorah's doctors are considering whether she may need other forms of surgery to address scars surfacing and resurfacing as she grows older.

Injury from Professional Negligence

Count 1: Failure to Limit O₂ Concentration Against All Defendants

226. Plaintiffs incorporate by reference all paragraphs of this Complaint as though fully set forth herein.

227. Fires in operating rooms occur when the three elements of the Fire Triad come together: an oxidizer like oxygen, fuel, and an ignition source.

228. As the anesthesiologist on the surgical team, Dr. Todd was responsible for monitoring and controlling the concentration of oxygen during the surgery.

229. Dr. Todd violated the standard of care by failing to limit the concentration of oxygen in the surgical field around Anorah's head.

230. *First*, assuming that oxygen supplementation was indicated at that time, Dr. Todd failed to keep FiO₂ levels within the maximum 30% limit required by the standard of care, precisely during the 15-minute window when the excision took place and the fire erupted.

231. Dr. Todd then changed the original handwritten entry for the FiO₂ level actually delivered, by overwriting and reshaping the entry to read 0.3, or 30%, precisely the uppermost limit allowed by the standard of care.

232. Dr. Todd, moreover, overwrote the original entry without scribbling her initials or otherwise annotating the record to call out and verify the change—conduct that itself violates the standard of care.

233. Dr. Todd's attempt to cover up the actual FiO₂ level evidences her breach.

234. *Second*, even assuming that Dr. Todd did lower the FiO₂ level from its prior setting of 100% to 30%, Dr. Todd failed to prevent the use of the Bovie for at least 3-5 minutes, to allow the oxygen to dissipate from the surgical field.

235. Dr. Todd's failure to meet the standard of care was all the more egregious because this procedure, though routine, was a high-risk for fire.

236. As a result of Dr. Todd's failure to meet the standard of care, the air in the surgical field around Anorah's face was rich in oxygen—an oxidizer.

237. When that oxidizer came into contact with an ignition source (the Bovie) and fuel (towel, cap, even Anorah's hair), fire erupted and spread over Anorah's face.

238. Had Dr. Todd made sure that the FiO₂ remained within the 30% limit around the surgical field, the heat generated by the Bovie would not have sparked the flames that burned Anorah's head, face, and neck.

239. But-for Dr. Todd's failure, therefore, the fire would not have occurred.

240. Dr. Todd's failure to meet the standard of care thus caused Anorah pain and suffering, physical injury, and enduring psychological trauma.

241. As Dr. Todd's employer or other principal at the time of the surgery, MAC Anesthesia, MAC Anesthesia Holdings, and/or MAC Anesthesia Wellstar is or are vicariously liable for her negligence, because she was acting within the scope of her employment or agency with one or more of those entities at that time.

*Count 2: Failure to
Communicate
Against All Defendants*

242. Plaintiffs incorporate by reference all paragraphs of this Complaint as though fully set forth herein.

243. Fires occur in operating rooms when three elements converge: an oxidizer like oxygen, an ignition source like a Bovie, and fuel.

244. The standard of care requires the surgical team to communicate about these elements to mitigate their convergence in the operating room. This requirement applies with special force where the procedure is high-risk for fire.

245. Specifically, the standard of care requires providers to alert the surgical team of the risk posed by the elements they control.

246. Thus, the standard of care requires the nurse to warn of drapes that may turn into fuel, and the anesthesiologist to warn of concentrated oxygen that may serve as an oxidizer.
247. In addition, the standard of care requires each member of the surgical team to ask about and ascertain the risk posed by the other elements.
248. Thus, an anesthesiologist must inquire about the possibility that a potential ignition-source like a Bovie might be used, especially if the anesthesiologist plans to introduce concentrated oxygen into surgical field.
249. Here, Dr. Todd failed to meet these requirements.
250. *First*, Dr. Todd failed to warn the surgical team that she planned to introduce and had introduced oxygen-rich air into the surgical field.
251. There is no record that Dr. Todd voiced the warning during any pre-operative communications or even during the timeout just before the procedure started.
252. When the surgeon asked for the Bovie aloud, Dr. Todd again failed to sound the warning, during the time it took to bring, set up, and activate the instrument.
253. Instead, Dr. Todd merely observed flatly: “You have a handheld cautery.”
254. Even after the surgeon said “yes,” Dr. Todd again failed to sound a warning.
255. Had Dr. Todd issued the warning, even at that eleventh hour, the Bovie would have remained off, and no fire would have erupted.
256. *Second*, Dr. Todd failed to inquire whether a Bovie might be used.
257. When the team discussed “anticipated critical events” including “anticipated blood loss,” Dr. Todd failed to inquire about the potential use of a Bovie, even though she herself planned to introduce oxygen-rich air into the room.
258. Only after the surgeon asked *for* the Bovie did Dr. Todd reflect, vacantly: “You have a handheld cautery.”
259. Had Dr. Todd inquired about the possible use of a Bovie, she could have taken deliberate action to delay or prevent its use.

260. In addition, the surgeon and others would have realized that she was planning to introduce or had introduced concentrated oxygen, so that the whole team would have worked together to avoid the convergence of oxygen and Bovie.

261. Dr. Todd's failure to warn and inquire thus permitted the convergence of concentrated oxygen with the Bovie, leading to the fire.

262. But-for these failures by Dr. Todd, therefore, the fire would not have occurred.

263. Dr. Todd's failure to meet the standard of care thus caused Anorah pain and suffering, physical injury, and enduring psychological trauma.

264. Dr. Todd's failures to meet the standard of care were all the more egregious because this procedure, though routine, was a high-risk for fire.

265. As Dr. Todd's employer or other principal at the time of the surgery, MAC Anesthesia, MAC Anesthesia Holdings, and/or MAC Anesthesia Wellstar is or are vicariously liable for her negligence, because she was acting within the scope of her employment or agency with one or more of those entities at that time.

OCGA § 13-6-11 Claims

Against All Defendants

266. Plaintiffs incorporate by reference all paragraphs of this Complaint as though fully set forth herein.

267. Plaintiffs show that Defendants have acted in bad faith, have been stubbornly litigious, and have caused Plaintiffs unnecessary trouble and expense.

268. Plaintiffs are thus entitled to their expenses of litigation pursuant to OCGA § 13-16-11, including reasonable attorneys' fees.

269. Pursuant to OCGA Title 51, Chapter 4, Plaintiffs are entitled to recover from all Defendants for all damages caused by the Defendants' professional negligence.

270. As a direct and proximate result of the Defendants' conduct, Plaintiffs, on behalf of Anorah Ignelzi, are entitled to recover from Defendants reasonable compensatory damages in an amount exceeding \$10,000.00 to be determined by a fair and impartial jury, for all damages Anorah suffered, including physical, emotional, and economic injuries.

271. WHEREFORE, Plaintiffs demand a trial by jury and judgment against the Defendants as follows:

- a. Compensatory damages in an amount exceeding \$10,000.00 to be determined by a fair and impartial jury;
- b. All costs of this action;
- c. Expenses of litigation pursuant to OCGA § 13-6-11, including reasonable attorneys' fees;
- d. Punitive damages; and
- e. Such other and further relief as the Court deems just and proper.

Respectfully submitted,

/s/ Lloyd N. Bell

Lloyd N. Bell

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Attorneys for Plaintiffs



Eric A. Harris MD, MBA

Associate Professor of Clinical Anesthesiology

Board Certified in Adult and Pediatric Anesthesiology

AFFIDAVIT OF ERIC HARRIS, M.D., REGARDING ANORAH IGNELZI

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Eric A. Harris, M.D., who after first being duly sworn, states as follows.

Introduction

1. This affidavit addresses medical negligence that occurred during a surgical procedure performed on Anorah Ignelzi at Marietta Eye Clinic in Marietta, Georgia, on September 30, 2019.
2. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.
3. This affidavit addresses matters that Plaintiffs' counsel have asked me to address. I have not attempted to identify all standard-of-care violations. I have not attempted to state every causation opinion I have. I have not attempted to anticipate or address issues the Defense might raise or that otherwise might arise as the case unfolds.
4. I use the term "standard of care" to refer to that degree of care and skill ordinarily exercised by members of the medical profession generally under the same or similar circumstances and like surrounding conditions as pertained to the medical providers I discuss here.
5. Plaintiffs' counsel drafted this affidavit after consulting with me, and I reviewed the draft and edited it to make sure it correctly states my views.
6. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation, but I have not attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional details.

Exhibit 1



Eric A. Harris MD, MBA

Associate Professor of Clinical Anesthesiology

Board Certified in Adult and Pediatric Anesthesiology

7. I hold all the opinions expressed below to a reasonable degree of medical certainty — that is, more likely than not. If additional information becomes available later, my views may change.

8. I understand that Plaintiffs' counsel will provide this affidavit to the Defendants, and that their insurance company will hire lawyers and medical experts to review this case and to review this affidavit. If anyone on the Defense believes that I have not been given, or have overlooked or misconstrued, any relevant information, I invite the Defense to communicate with me by letter, copied to Plaintiffs' counsel. The Defense need not wait to take my deposition to communicate with me. I will consider any information the Defense wishes to bring to my attention, and, if appropriate, I will provide a supplemental affidavit.

Evidence Considered

9. I have reviewed medical records from Marietta Eye Clinic pertaining to treatment provided to Anorah Ignelzi in September 2019. I have also reviewed medical records from Wellstar Cobb Hospital, where Anorah has received treatment for the burns suffered at Marietta Eye Clinic.

Principal Opinions

10. My principal opinions are summarized here. In deposition or trial testimony, I may elaborate upon these principal opinions, and in doing so, I may offer related, subsidiary, or incidental opinions.

- i. **Task & Requirement:** Limiting concentration of oxygen in surgical field.

Standard of care requirements: When supplementing oxygen through a facemask, the standard of care requires an anesthesiologist to limit FiO₂ levels to 30% or less before a Bovie or another potential ignition-source can be turned on, in order to mitigate the risk of fire.

In addition, when the anesthesiologist lowers the FiO₂ level to 30% or less from a higher setting, the standard of care requires the anesthesiologist to



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prevent the use of an ignition-source for at least 3-5 minutes, to allow the combustible oxygen-rich air to dissipate from the surgical field.

These requirements apply with particular force when the surgical field is on the patient's head, near the facemask.

Violations: Dr. Todd likely violated the standard of care by failing to lower the FiO₂ level from 100% to 30% or less prior to the activation of the Bovie. As overwritten, the anesthesia record shows that Dr. Todd dropped the FiO₂ level from 1.0 (100%) to .03 (30%) at around the time of the fire. But the 0.3 figure has been written over the original entry, so that the original number is unreadable. That change, moreover, has been made without initials or other annotation to call out and verify the change—conduct that itself violates the standard of care. Based on these facts, Dr. Todd likely failed to drop the FiO₂ level from 100% to 30% in the first place, in violation of the standard of care.

Even assuming that Dr. Todd did lower the FiO₂ level to 30%, she violated the standard of care by failing to preclude the use of the Bovie for least 3-5 minutes, to allow the oxygen-rich air to dissipate.

The requirements Dr. Todd violated applied with particular force here, because Dr. Todd herself controlled and had introduced the oxygen-rich air, and because she knew or should have known that the Bovie could be used.

Causation: As a result of Dr. Todd's failure to meet the standard of care, the air in the surgical field around Anorah's head was rich in oxygen—an environment conducive to fire. Had Dr. Todd made sure that the FiO₂ was within the 30% limit in and near the surgical field, the heat generated by the Bovie would not have sparked the flames that burned Anorah's face. But-for Dr. Todd's failures, therefore, the fire that caused physical injury and psychological trauma to Anorah would not have occurred.

Damages: Dr. Todd's failure to meet the standard of care thus caused Anorah pain and suffering, physical injury, and enduring psychological trauma.

- ii. **Task & Requirement:** Communicating to avoid risk.



Eric A. Harris MD, MBA

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Board Certified in Adult and Pediatric Anesthesiology

Standard of care requirements: Fires occur in the operating room when three elements converge: an oxidizer, an ignition source, and fuel. The standard of care requires the surgical team to communicate clearly and promptly about these elements to mitigate their convergence.

First, the standard of care requires providers to alert the surgical team of the risk posed by the elements they control. Thus, the standard of care requires the nurse to warn of drapes that may turn into fuel, and the anesthesiologist to warn of concentrated oxygen that may turn into an oxidizer.

Second, the standard of care requires members of the surgical team to ask about and ascertain the risks posed by the other elements. Thus, an anesthesiologist must inquire about the possibility that a potential ignition-source like a Bovie might be used, especially if the anesthesiologist plans to introduce concentrated oxygen into the surgical field.

Violations: Dr. Todd failed to meet these requirements.

First, Dr. Todd failed to warn the surgical team that she planned to introduce and had introduced oxygen-rich air into the surgical field. There is no record that Dr. Todd voiced the warning during any pre-operative communications or even during the timeout just before the procedure started. When the surgeon asked for the Bovie aloud, Dr. Todd again failed to sound the warning, during the time it took to bring, set up, and activate the instrument. Instead, Dr. Todd merely observed: "You have a handheld cautery." Even after the surgeon said "yes," Dr. Todd again failed to convey any warning.

Second, Dr. Todd failed to inquire whether a Bovie might be used. When the team discussed "anticipated critical events" including "anticipated blood loss," Dr. Todd failed to inquire about the potential use of a Bovie, even though she herself planned to introduce oxygen-rich air into the room. Even after the surgeon asked for the Bovie, Dr. Todd merely observed, blankly: "You have a handheld cautery."

Causation: Dr. Todd's failure to communicate led to a preventable fire.

Had Dr. Todd issued the warning, even at that eleventh hour, the Bovie would have remained off, and no fire would have erupted.



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Had Dr. Todd inquired about the possible use of the Bovie, she could have taken deliberate action to delay or prevent its use. In addition, the surgeon and others would have realized that she was planning to introduce or had introduced concentrated oxygen, so that the whole team would have worked together to avoid the convergence of oxygen and Bovie.

Dr. Todd's failure to warn and inquire thus permitted the convergence of concentrated oxygen with the Bovie, leading to the fire. But-for these failures by Dr. Todd, therefore, the fire would not have occurred.

Damages: These failures to meet the standard of care thus caused Anorah pain and suffering, physical injury, and enduring psychological trauma.

Qualifications

11. I am more than 18 years old, suffer from no legal disabilities, and give this affidavit based on my own personal knowledge and belief.
12. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA 24-7-702.
13. My Curriculum Vita, which is attached as Exhibit A, provides further detail about my qualifications. I incorporate and rely on that information here.
14. The events at issue here occurred in September 2019.
15. I am qualified to provide expert testimony pursuant to OCGA 24-7-702.
 - a. In September 2019, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession.

Specifically, I was licensed by the State of Florida to practice as a physician. That is where I was practicing in September 2019.



Eric A. Harris MD, MBA

Associate Professor of Clinical Anesthesiology

Board Certified in Adult and Pediatric Anesthesiology

- b. In September 2019, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the tasks identified above on which I offer standard-of-care opinions.

I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to June 2019, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

Specifically, I am a physician specializing in sedation and anesthesiology in the operating room, as well as in alternate sites, and for many years I have had great familiarity with each of the tasks on which I offer standard-of-care opinions here.

Attached Documents

16. The documents identified below are attached to this affidavit largely for the benefit of the insurance adjusters responsible for evaluating this case on behalf of the Defendants, and for the lawyers provided by the insurance company.
17. Attached to this affidavit is a document that recites medical principles that apply here. The Defendants themselves will not need that recitation of basic medical information. Plaintiff's counsel created the medical-principles document for the benefit of the Defense. I have reviewed the document, and the principles stated there are correctly stated and apply here.
18. Also attached to this affidavit is a chronology of facts pertaining to this case. In forming my substantive view of the case, I have relied on the medical records themselves, not the chronology. The chronology, however, provides a useful reference for relevant facts contained in the records in less-organized fashion. Plaintiff's counsel created the chronology. I have not edited it.



Eric A. Harris MD, MBA

Associate Professor of Clinical Anesthesiology

Board Certified in Adult and Pediatric Anesthesiology

Supporting Literature

19. The general points discussed above are elementary, are likely well known to the Defendants, and should not require a literature search. Insofar as any Defendant consulted or should have consulted reliable authorities on these points in treating Anorah Ignelzi, the literature cited in the attached medical-principles document represents such authorities, which here may also prove helpful to adjustors and lawyers in their evaluation of this case.

Eric A. Harris MD, MBA

Eric A. Harris, M.D., M.B.A.

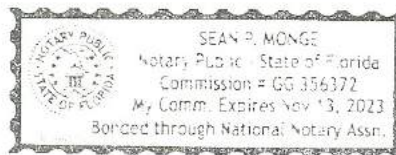
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SWORN TO AND SUBSCRIBED before me

this 1 day of April, 2021.

Seam Monge

NOTARY PUBLIC



My Commission Expires:

April 1, 2021

I. Personal

Eric A. Harris, MD, MBA
Home phone: (954) 385-8501
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Email: eharris2@med.miami.edu
Home Address: 2450 Provence Circle Weston FL 33327-1300 USA
Current academic rank: Associate Professor of Clinical Anesthesiology
Current track: Clinical educator
Primary appointment: Department of Anesthesiology, Perioperative Medicine, and Pain Management
Citizenship: USA

II. Higher Education

Graduate School: University of Miami School of Business
Coral Gables, FL
January 1997 – December 1998
Degree: Executive MBA in Health Administration

Residency: Anesthesiology
Jackson Memorial Hospital
Miami, FL
July 1994 - June 1997

Internship: Internal Medicine
Mt. Sinai Medical Center
Miami Beach, FL
July 1993 - June 1994

Medical School: University of Miami School of Medicine
Miami, FL
August 1989 - May 1993
Degree: M.D.

College: Amherst College
Amherst, MA
August 1985 – May 1989
Degree: B.A. in English and biology, *cum laude*

Certifications:

2020	American Heart Association ACLS re-certification
2019	Pediatric Advanced Life Support re-certification
2020	Florida medical license renewal, DEA re-certification
2016	Passed ABA Pediatric Anesthesiology Certification
June 1998	Diplomate, American Board of Anesthesiology
June 1994	National Board of Medical Examiners Part III
September 1993	National Board of Medical Examiners Part II
June 1991	National Board of Medical Examiners Part I

III. Experience

Academic:

July 1997 - present	Attending Anesthesiologist Jackson Memorial Hospital, Miami, FL Associate Professor of Clinical Anesthesiology University of Miami School of Medicine
August 1998 - present	Director of Anesthesiology for Radiology Services <i>Responsibilities:</i> Supervision of resident physicians and certified nurse anesthetists, as well as solo provision of anesthesia.

Non-academic:

March 2006 – present	Faculty member, “The Difficult Airway Course: Anesthesiology”. Responsibilities include attending annual conferences (three to five per year) and teaching airway management techniques via lectures and small group interactive sessions.
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Hospital appointments:

July 1997 – present:	Jackson Memorial Hospital, Bascom Palmer Eye Institute, University of Miami Hospital (formerly Cedars Medical Center)
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IV. Publications

Peer reviewed: (note: * indicates PubMed indexed)

Harris EA (2017) Anesthetic Management for Thoraco-Omphalopagus Conjoined Twins in the Interventional Radiology Suite. *J Anesth Adv Res* 1 (1).

Harris EA, Gaynor B (2014) Trigemino-cardiac Reflex after Direct Infusion of Chemotherapy into the Ophthalmic Artery for Retinoblastoma. *J Clin Exp Ophthalmol* 5:365. doi: 10.4172/2155-9570.1000365

*Sinclair D, Lubarsky D, Vigoda M, Birnbach D, Harris EA *et. al*, A Matrix Model for Valuing Anesthesia Service with the Resource Based Relative Value System. *J Multidiscip Healthcare* 2014 (7), 449-58.

Harris, EA. Imaging of thoraco-omphalopagus conjoined twins in the interventional radiology suite. *Int J Clin Med Imaging* 2014, 1 (3).

*Harris EA. Letter to the Editor regarding ‘Autonomic cardio-respiratory reflex reactions and superselective ophthalmic arterial chemotherapy for retinoblastoma’ by Phillips, McGuirk, Chahal, et al. *Pediatr Anesth* Feb 2014; 24 (2): 229-30.

*Harris EA, Arheart KL, Fischler KE. Does the site of anterior tracheal puncture affect the success rate of retrograde intubation? A prospective, manikin-based study. *Anesth Research and Practice* Vol 2013, Article ID 354317, 6 pages, doi: 10.1133/2013/354317.

*Harris EA, Fischler KE. Does the site of anterior tracheal puncture affect the success rate of retrograde intubation? *Br. J. Anaesth.* June 2013; 110 (6): 1064-1065

Harris EA. Use of the Valsalva Maneuver in Addition to Controlled Hypotension During Endovascular AVM Embolization: A Novel Approach to Reducing Distal Particle Embolization? *British Journal of Medicine and Medical Research* 2012; 2(3): 444-53.

*Harris EA. Sedation and anesthesia options for pediatric patients in the radiation oncology suite. *Intl. Jnl. of Pediatrics*, Vol. 2010, Article ID 870921, 9 pages, 2010. doi:10.1155/2010/870921.

*Harris EA, Lubarsky DA, Candiotti KA. Monitored anesthesia care (MAC) sedation: clinical utility of fospropofol. *Therapeutics and Clinical Risk Mgmt* 2009; 5: 949-959.

*Harris EA, Lubarsky DA, Candiotti KA. Fospropofol disodium injection: a review of its use as a sedative-hypnotic agent for monitored anesthesia care (MAC) sedation in adult patients undergoing diagnostic or therapeutic procedures. *Clinical Medicine: Therapeutics* 2009; 1: 1-9.

*Harris EA, Penning DH: Letter to the Editor regarding "Endotracheal tube malposition within the pediatric population: a common event despite clinical evidence of correct placement." Canadian Jnl. of Anesthesia 2008 May; 56(5): 386.

*Harris EA, Arheart KL, Penning DH: Endotracheal tube malposition within the pediatric population: a common event despite clinical evidence of correct placement. Canadian Jnl. of Anesthesia 2008 Oct; 55(10): 685-90.

*Lubarsky DA, Candiotti K, Harris E: Understanding modes of moderate sedation during gastrointestinal procedures: a current review of the literature. J Clin Anesth 2007 Aug; 19(5): 397-404.

*Harris EA: Tension Pneumothorax in a Parturient Undergoing Cesarean Section. Anesthesia & Analgesia 2000 May; 90: 1173-74.

Books / book chapters:

Harris EA, Candiotti K. "Anesthesia in the Radiation Oncology Suite" in Anesthesia Outside the Operating Room, 2nd Edition. RD Urman, WL Gross, BK Philip, eds. Oxford University Press, NY, 2018.

Harris EA. "Practice Procedure" in Non-Operating Room Anesthesia. MS Weiss, LA Fleisher, eds., Elsevier Saunders, PA, 2014.

Harris EA. "Airway Management of the Patient with an Unstable Cervical Spine" in Fundamentals of Neuroanesthesia – A Physiologic Approach to Clinical Practice, K. Ruskin, S. Rosenbaum, I. Rampil eds., Oxford University Press, NY, 2014.

Ranasinghe JS, Wahl KM, Harris EA, Lubarsky DA (eds). Anesthesiology Board Review: Pearls of Wisdom, 3e. McGraw Hill Medical, NY 2012.

Harris EA. "Anesthetic Considerations for Radiotherapy" in A Clinical Manual on Out-of-OR Anesthesia Practice, R. Urman, W Gross, B. Phillips eds., Oxford Press, NY 2011

Harris EA, Santos M. "Case 46: Neuro" in Core Clinical Competencies in Anesthesiology: A Case-Based Approach, CJ Gallagher MC Lewis, DA Schwengel eds. Cambridge University Press, NY, 2010.

Lubarsky DA, Harris EA. "Anesthetic Complications" in Complications in Dermatologic Surgery, K. Nouri, ed. Mosby Elsevier, 2008.

Other:

Harris EA. Pre-Anesthetic Assessment of the Patient for Endovascular Coiling. Anesthesiology News 2005 May; 31(5): 39-42.

National presentations:

- October 2019 “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Fiberoptic Skills Review”, “Code Airway Review”, “The Uses of Aintree Catheters” The Difficult Airway Course: Anesthesiology, Chicago, IL.
- April 2019 “Scenarios for the Can’t Intubate/Can Ventilate Patient”, “Easy Techniques for the Difficult Airway”, “Fiberoptic Skills Review”; “Code Airway Review” The Difficult Airway Course: Anesthesiology, Boston, MA.
- November 2018 “Scenarios for the Can’t Intubate/Can Ventilate Patient”, “Easy Techniques for the Difficult Airway”, “Fiberoptic Skills Review”; “Code Airway Review” The Difficult Airway Course: Anesthesiology, San Francisco, CA.
- October 2018 “Scenarios for the Can’t Intubate/Can Ventilate Patient”, “Easy Techniques for the Difficult Airway”, “Fiberoptic Skills Review”; “Code Airway Review” The Difficult Airway Course: Anesthesiology, Baltimore, MD.
- April 2017 “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Fiberoptic Skills Review”; “Code Airway Review” The Difficult Airway Course: Anesthesiology, Boston, MA.
- November 2016 “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Fiberoptic Skills Review”; “Code Airway Review” The Difficult Airway Course: Anesthesiology, Las Vegas, NV.
- October 2015 Moderator, Medically Challenging Case Presentations, American Society of Anesthesiologists Annual Meeting
- October 2015 “Fiberoptic Skills Review”; The Difficult Airway Course: Anesthesiology, Washington, DC
- March 2014 “Retrograde Intubation”, “King LT-D Tube®”, “Surgical Airway Management”, “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Fiberoptic Skills Review”; The Difficult Airway Course: Anesthesiology, Orlando, FL.

- November 2013 “Retrograde Intubation”, “King LT-D Tube®”, “Surgical Airway Management”, “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Fiberoptic Skills Review”; The Difficult Airway Course: Anesthesiology, Las Vegas, NV.
- June 2013 “Retrograde Intubation”, “King LT-D Tube®”, “Surgical Airway Management”, “Easy Techniques for the Difficult Airway”, “Code Airway Review I”; The Difficult Airway Course: Anesthesiology, New Orleans LA.
- April 2012 “Retrograde Intubation”, “King LT-D Tube®”, “Surgical Airway Management”, “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Code Airway Review I”; The Difficult Airway Course: Anesthesiology, Las Vegas NV.
- October 2011 “On the Road Again: Anesthesia for the Outpatient out of the OR” ASA Annual Meeting, Chicago IL
- September 2011 “Retrograde Intubation”, “King LT-D Tube®”, “Surgical Airway Management”, “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Fiberoptic Skills Review”; The Difficult Airway Course: Anesthesiology, Boston MA.
- May 2011 “Retrograde Intubation”, “King LT-D Tube®”, “Surgical Airway Management”, “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Code Airway Review I”; The Difficult Airway Course: Anesthesiology, Boston MA.
- December 2010 “Santeria vs. General Anesthesia: Does the Former Preclude the Latter?” 64th Annual Post-Graduate Assembly in Anesthesiology, New York City
- November 2010 “Retrograde Intubation”, “King LT-D Tube®”, “Surgical Airway Management”, “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Code Airway Review I”; The Difficult Airway Course: Anesthesiology, Las Vegas NV.
- September 2010 “Retrograde Intubation”, “King LT-D Tube®”, “Pediatric Airway Management”, “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Code Airway Review I”; The Difficult Airway Course: Anesthesiology, St. Louis MN.
- October 2009 “Retrograde Intubation”, “King LT-D Tube® and Combitube®”, “Surgical Airway Management”, “Double Lumen Tube Workshop”, “Easy Techniques for the Difficult Airway”, “Code Airway Review I”; The Difficult Airway Course: Anesthesiology, Las Vegas NV.

- March 2009 “Retrograde Intubation”, “King LT-D Tube[®] and Combitube[®]”, “Surgical Airway Management”, “Code Airway Review I and II”; The Difficult Airway Course: Anesthesiology, Miami FL.
- December 2008 “Management of the Severely Anemic Parturient who is a Jehovah’s Witness: Is Barbiturate Coma an Option?” 62nd Annual Post-Graduate Assembly in Anesthesiology, New York City
- November 2008 “Retrograde Intubation”, “King LT-D Tube[®] and Combitube[®]”, “Pediatric Airway Management”, “Code Airway Review I and II”; The Difficult Airway Course: Anesthesiology, Las Vegas NV
- March 2008 “Retrograde Intubation”, “King LT-D Tube[®] and Combitube[®]”, “Surgical Airway Management”, “Code Airway Review I and II”; The Difficult Airway Course: Anesthesiology, Miami FL.
- October 2007 “The Anesthetic Management of Endovascular AVM Treatment” ASA Annual Meeting, San Francisco
- September 2007 “Retrograde Intubation”, “King LT-D Tube[®] and Combitube[®]”, “Surgical Airway Management”, “Code Airway Review I and II”; The Difficult Airway Course: Anesthesiology, Las Vegas NV
- April 2007 “Retrograde Intubation”, “King LT-D Tube[®] and Combitube[®]”, “Surgical Airway Management”, “Code Airway Review I and II”; The Difficult Airway Course: Anesthesiology, Boston MA
- November 2006 “Retrograde Intubation”, “King LT-D Tube[®] and Combitube[®]”, “Pediatric Airway Management”, “Code Airway Review I and II”; The Difficult Airway Course: Anesthesiology, Las Vegas NV
- March 2006 “Retrograde Intubation”, “King LT-D Tube[®] and Combitube[®]”, “Surgical Airway Management”, “Code Airway Review I and II”; The Difficult Airway Course: Anesthesiology, Miami FL.
- December 2005 “Clinically Significant Pneumocephalus Following an Attempted Labor Epidural: A Case Report.” 59th Annual Post-Graduate Assembly in Anesthesiology, New York City
- December 2003 “Anesthesia for Pediatric CT Scans: Can We Do Better?” 57th Annual Post-Graduate Assembly in Anesthesiology, New York City

- December 2002 “Anesthesia in the MRI Suite,” 56th Annual Post-Graduate Assembly in Anesthesiology, New York City
- December 2000 “Endotracheal Tube Malposition Within the Pediatric Population,” 54th Annual Post-Graduate Assembly in Anesthesiology, New York City
- March 1998 “Anesthetic Concerns in the Parturient with Pregnancy Induced Hypertension,” 9th Annual Miami Review Course in Anesthesiology

Regional Presentations:

- June 2012 Invited guest speaker, Florida Association of Nurse Anesthetists 2012 annual meeting – “Management of the Difficult and Failed Airway”
- June 2011 Invited guest speaker, Florida Society of Anesthesiologists 2011 annual meeting – “New Frontiers – Anesthesiology in the MRI Suite”
- March 2010 6th Annual Perioperative Medicine Summit, Miami Beach FL. “New Developments in Anesthesiology for the Non-Anesthesiologist.”
- June 2010 Invited guest speaker, Florida Society of Anesthesiologists 2010 annual meeting – “New Advances in Airway Management”

Local Presentations:

- August 2018 “Post-Operative Management of the Patient at High Risk of Ventilatory Failure” - Grand Rounds, University of Miami / Miller School of Medicine Department of Anesthesiology, Perioperative Medicine, and Pain Management
- September 2016 “In the Age of Video Laryngoscopy and Sugammadex, Is There Still a Need for Awake Flexible Bronchoscopic Intubation?” - Grand Rounds, University of Miami / Miller School of Medicine Department of Anesthesiology, Perioperative Medicine, and Pain Management
- May 2014 “Management of a Sheared Epidural Catheter in the Parturient” – Morbidity and Mortality Conference, University of Miami / Miller School of Medicine Department of Anesthesiology, Perioperative Medicine, and Pain Management
- January 2012 “The Surgical Approach to the Failed Airway”; Grand Rounds, University of Miami / Miller School of Medicine Department of Anesthesiology, Perioperative Medicine, and Pain Management

- November 2011 “Principles and Pharmacology of IV Sedation”; Dept. of Radiology fellows’ conference, University of Miami / Miller School of Medicine
- January 2011 “Sedation Update – 2011”; Grand Rounds, University of Miami / Miller School of Medicine Department of Gastroenterology
- March 2008 “Anesthesiology in the MRI Suite”; Grand Rounds, University of Miami / Miller School of Medicine Department of Anesthesiology, Perioperative Medicine, and Pain Management
- September 2005 “Management of the Difficult Airway”; Grand Rounds, University of Miami / Miller School of Medicine Department of Anesthesiology, Perioperative Medicine, and Pain Management
- August 2001 “Anesthesiology in the Radiology Suite”; Grand Rounds, University of Miami / Miller School of Medicine Department of Anesthesiology, Perioperative Medicine, and Pain Management
- April 2000 “New Faces in Airway Management”; Grand Rounds, University of Miami / Miller School of Medicine Department of Anesthesiology, Perioperative Medicine, and Pain Management

V. Professional

Editorial responsibilities:

June 2010 – March 2019 Editorial board member, Journal of Anesthesia & Clinical

Research

October 2011 – March 2019 Reviewer, The Indian Journal of Anaesthesia

Honors and Awards:

1998 Valedictorian, Executive MBA Program in Health Administration
 1997 Executive MBA Alumni Scholarship, University of Miami School

1997 of Business
Robert D. Dripps, M.D. Memorial Award (presented to the
outstanding graduating resident in anesthesiology.)
1992 Induction into Alpha Omega Alpha Medical Honor Society

VI. Service

2007 – 2018 Faculty Senate Library and Information Resources Committee
2007 – 2018 Medical Library Committee, Miller/UM School of Medicine

Medical Principles

General Medical Principles

Papilloma Lesions

1. Squamous papillomas are generally benign (noncancerous) growths on the skin and other tissues of the body.
2. Squamous papillomas often begin in the squamous cells (thin, flat cells) found in the tissue that forms the surface of the skin (the epidermis).
3. When they are found on the skin, squamous papillomas are more commonly referred to as warts or verrucas.
4. The Human Papilloma Virus (HPV) causes most papillomas.
5. Papillomas do not spread around the body and are not aggressive.
6. Squamous papillomas often occur on the eyelids, especially in children.



7. The standard treatment for most eyelid papillomas is surgical excision.
8. The excision is a routine outpatient procedure typically done only with local anesthesia and lasting only a few minutes.

Operating-Room Fires Generally

9. Fire in the operating room (OR) is a relatively rare event.

10. When a fire in the OR occurs, the medical outcomes are often catastrophic for the injured patient, with severe legal and economic consequences for the surgical team and the facility.
11. Most OR fires are preventable with communication, appropriate education, and management of risks.
12. Since these preventive measures have little cost and are nearly 100 percent effective, they are prioritized in patient safety initiatives.
13. Most claims for harms caused by OR fires arise in an outpatient setting (76 percent), involve the upper body (85 percent), and are cases managed with monitored anesthetic care (81 percent).
14. Patient injuries from an OR fire are often severe—for example, painful and disfiguring burns to face and neck or severe airway injury with tracheostomy and permanent lung damage.
15. Typically, the patient must return to the OR many times to treat acute burn injuries and revise scar tissue, causing recurring anxiety, post-traumatic stress, and economic burden.

Cause of OR Fires – the Fire Triad

16. Operating-room fires are usually caused by the convergence of three elements in a closed environment: an oxidizer, fuel, and an ignition source.
17. These three elements have been called “the Fire Triad” and “the Fire Triangle.”



18. *First*, the most common oxidizers in an operating room are oxygen and nitrous oxide, used in anesthetizing the patient.
19. Most surgical fires occur in oxygen-enriched environments, when the concentration of oxygen exceeds 30 percent. (For perspective: the normal concentration of oxygen in “room air” is 21 percent.)
20. When supplemental oxygen is delivered to a patient in an operating room, an oxygen-enriched environment can be created.
21. In an oxygen-enriched environment, materials that may not normally burn in room air can ignite and burn.
22. An open oxygen delivery system, such as nasal cannula or facemask, presents a greater risk of fire than a closed delivery system, such as a laryngeal mask or endotracheal tube.
23. Open delivery of oxygen from a direct source, through a device such as a facemask or nasal cannula, is the major factor contributing to most OR fires.
24. This is not surprising: At oxygen concentrations near 50 percent or higher, any spark or generated heat can ignite a fuel source.
25. Even at oxygen concentrations above 30 percent, the burning process is accelerated.
26. As oxygen concentration rises from 21 to 50 percent, the time required for surgical drapes to ignite decreases and burn-rate increases.
27. The fraction-of-inspired-oxygen (FiO₂) level reflects the oxygen-concentration in the air being delivered to the patient.
28. An FiO₂ level of 1.0 means that the concentration of oxygen is 100%—pure oxygen. Likewise, an FiO₂ level of 0.3 means that the air is 30% oxygen.
29. *Second*, common fuels in operating rooms include surgical drapes, towels, gauzes, sponges, alcohol-based prep solutions, endotracheal tubes, and laryngeal masks.

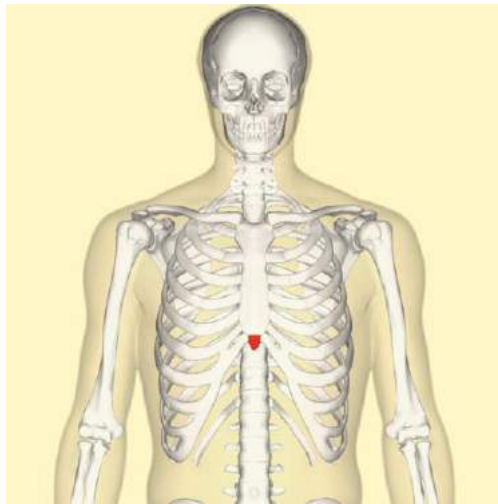
30. Surgical drapes, towels, sponges, and gauzes are made from cotton, paper, or plastics—all excellent fuels.
31. When oxygen concentration exceeds 50 percent, oxygen becomes trapped within the fine fibers and naps of cotton towels or drapes. This oxygen can vigorously promote combustion—a phenomenon known as “fiber flame propagation.”
32. *Third*, common ignition sources include electrosurgery units (“ESUs”), surgical lasers, fiberoptic lights such as headlamps and lighted instruments, and defibrillators. Even a static spark may become a source of ignition.
33. An ESU is the most commonly used ignition source in the operating room.
34. A monopolar ESU, often called by the brand-name “Bovie,” produces a high-temperature electrical arc.
35. Cautery or cauterization is a medical technique of burning a wound to mitigate bleeding, damage, or infection.
36. A Bovie is often used by physicians in the operating room to cauterize wounds.



37. A Bovie’s monopolar tip can ignite a fire, as can a loose or worn connector or cable on the device.
38. If the three elements of the Fire Triad are combined in a closed environment, any spark may result in an eruption of flames.
39. Strategies to prevent OR fires are based on separating the three elements of the triad.

Prevention of OR Fires – Generally

40. The key elements to fire prevention in the operating room are:
 - Risk assessment
 - Communication among members of the surgical team
 - Preventive measures based on level of risk
41. These elements generally reflect Silverstein Fire Risk Assessment Tool and other formal fire-prevention tools, including those published by the Anesthesia Patient Safety Foundation and the American Society of Anesthesiologists.
42. Such tools assess the risk of a procedure as “high” if the procedure (a) is above the level of the xiphoid, (b) uses an open oxygen source (*e.g.*, delivery of oxygen via facemask or nasal cannula), and (c) involves the presence of an ESU or other ignition source. This image shows the xiphoid in red.



43. The most important fire-prevention measure is communication among surgical team members regarding potential fire risk and plans to manage risks.
44. A failure in communication is a factor in most OR fires.
45. Beyond the share responsibility to communicate, responsibilities for controlling the elements of the Fire Triad are allocated according roles.

46. Because nurses are typically responsible for drapes, towels, and sponges (fuels), nurses are also responsible for related preventive measures such as keeping drapes and towels far from ignition sources.
47. Likewise, anesthesiologists are responsible for managing oxygen-concentration levels.

Prevention of OR Fires – Oxygen Concentration

48. The anesthesiologist's monitoring and control of oxygen-concentration plays a crucial role in preventing OR fires.
49. The most effective fire-preventive measure is to eliminate open delivery of oxygen whenever possible.
50. For procedures above the xiphoid, open delivery of oxygen should be avoided whenever possible.
51. If treatment of the patient requires oxygen supplementation, the most effective fire-prevention measure is to limit oxygen concentration to 30 percent or less, while avoiding nitrous oxide.
52. Before an ESU is turned on in the OR, an anesthesiologist administering oxygen through an open delivery system must ensure that the oxygen-concentration level is 30% or less.
53. In addition, when the anesthesiologist lowers oxygen-concentration to 30% from a higher setting, the anesthesiologist must preclude the use of an ESU for at least 3-5 minutes, to allow the oxygen-rich air to dissipate.

Prevention of OR Fires – Team Communication

54. Because OR fires occur when the three elements of the Fire Triad come together, members of the surgical team must communicate about these elements to mitigate their convergence.
55. Specifically, each provider on the team must alert the team of the risk posed by the elements he or she controls.

56. A nurse, for example, must warn of drapes that may turn into fuel, and the anesthesiologist of concentrated oxygen that may turn into an oxidizer.
57. In addition, each member of the surgical team must ask about and ascertain the risk posed by the other elements.
58. Thus, an anesthesiologist must inquire about the possibility that a potential ignition-source like a Bovie might be used, especially if the anesthesiologist plans to introduce concentrated oxygen into surgical field.
59. Risk assessment and prevention for fire in the OR thus require effective communication, coordination, and teamwork.

Supporting Literature

60. *Fire Safety in the Operating Room*, Wahr, Joyce, UpToDate, Wolters Kluwer, March 19, 2021.
61. *Operating Room Fires*, Jones, Teresa S. et al., *Anesthesiology*, Vol. 130, 492-501, March 2019.
62. *Recommendations to Reduce Surgical First and Patient Related Injury: FDA Safety Communication*, U.S. Food & Drug Administration, May 29, 2018.
63. *Scoring Fire Risk for Surgical Patients*, *OR Manager*, Vol. 22, No. 1, 2006.
64. *Surgical Fires: How They Start and How to Prevent Them*, Silverstein, Kenneth L. and Joseph, Stephanie, Editorial Collaboration Between Medscape and U.S. Food & Drug Administration, Medscape, October 12, 2011.
65. *Scoring Fire Risk for Surgical Patients*, *OR Manager*, Vol. 22, No. 1, 2006.

Medical Chronology

Treatment of Anorah Ignelzi

Prologue: Anorah Is Born with Benign Lesion

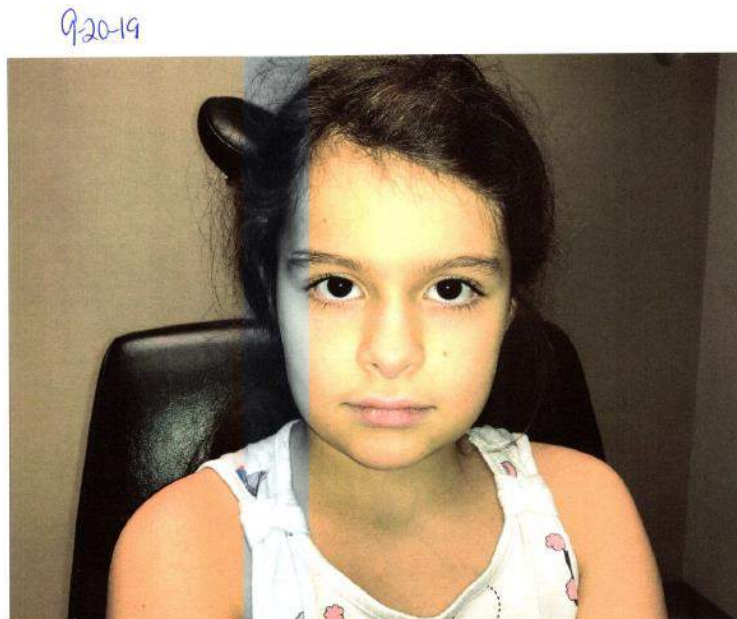
1. Anorah Ignelzi was born with a tiny mole-like bump on her lower left eyelid. MEC 0002.
2. The lesion was purely a cosmetic issue—it did not “hurt, itch, or cause any discomfort.” MEC 0002.

Chief Complaint: Possible Style OS

HPI: This is a 10 year old female who comes in for a chief complaint of Possible Style OS . Patient states for a number of years she has noticed a mole like bump under her os. She states that this it has been fluctuating in size for the past couple of years. It does not hurt, itch or cause any discomfort. Her father states she was not born with this and is unsure of where or what caused this to happen. Patient has no further complaints with her vision or eyes at this time.

MEC 0002.

3. This is Anorah on September 20, 2019—ten days before the events at issue in this lawsuit. MEC 0008.



MEC 0008.

4. The lesion is barely discernible in the photograph. MEC 0008.

*September 10: MEC Optometrist Diagnosis Lesion
as Benign Papilloma*

5. On September 10, 2019, Anorah and her father, Darell Ignelzi, visited the Marietta Eye Clinic (MEC) for a medical evaluation of the lesion. MEC 0002.
6. Other than the lesion, Anorah had “no further complaints with her vision or eyes” at that time. MEC 0002.

Chief Complaint: Possible Style OS

HPI: This is a 10 year old female who comes in for a chief complaint of Possible Style OS . Patient states for a number of years she has noticed a mole like bump under her os. She states that this it has been fluctuating in size for the past couple of years. It does not hurt, itch or cause any discomfort. Her father states she was not born with this and is unsure of where or what caused this to happen. Patient has no further complaints with her vision or eyes at this time.

MEC 0002.

7. Optometrist Michael-Vu Do examined Anorah. MEC 0002-03.
8. Dr. Do diagnosed the lesion as benign Squamous Papilloma – a “benign neoplasm of the eyelid.” MEC 0003.

Diagnostic Procedure: External Photos - OS
Indication: Papilloma

Findings OS: benign neoplasm of eyelid
Diagnoses OS: benign neoplasm of eyelid
Reliability: good
Assessment: baseline for future comparison

MEC 0003.

9. Dr. Do explained to Anorah and her father that “Squamous papillomas are common conditions with variable clinical appearance.” MEC 0003.

10. Dr. Do further explained that papillomas “may be observed or surgically removed.” MEC 0003.

Impression/Plan:

1. **Papilloma - Verrucous papilloma below left lower lid (D31.00)**
Existing condition with new problem, treatment or diagnostic
- Plan: Counseling - Papilloma.**
I counseled the patient regarding the following:
Eye care: Squamous papillomas are common conditions with variable clinical appearance. They may be observed or surgically removed.
- Plan: F/U for Next Visit.**
The patient should be scheduled for the following on referral to Dr Long.

MEC 0003.

11. Dr. Do also recommended a follow-up visit with Ophthalmologist Byron A. Long. MEC0003.

September 20: Dr. Long Confirms Diagnosis and Orders Excision Surgery

12. On September 20, 2019, Dr. Long examined Michaela. MEC 0005-08.
13. Dr. Long confirmed the diagnosis of a benign verrucous papilloma, noting that it was worsening. MEC 0006.

Impression/Plan:

1. **Eyelid Papilloma OS - Because of patients age this will need to be done at the ASC (D23.122)**
Status: Worsening
- Plan: Counseling - Eyelid lesion.**
I counseled the patient regarding the following:
Skin Care: Tumors of the eyelid can be benign or malignant. Concerning signs would be increased blood vessels or loss of eyelashes in the area of the lesion, or rapid growth.
Expectations: Benign lesions of the eyelid can be monitored, however the only way to confirm the diagnosis of the lesion is with a biopsy. Surgical excision in most cases is curative.
Contact Office if: If you notice increased growth, pain, or swelling of the eyelid.
- Plan: Order for Surgery.**
The following is the order for surgery: lesion removal - OS. - LLL.
Procedure codes: 67840
Diagnosis codes: D23.122
- Provider: Byron Long, MD
Priority: normal

MEC0006.

14. Dr. Long explained to Anorah that “Benign lesions of the eyelid can be monitored,” but that the “only way to confirm the diagnosis of a lesion is with a biopsy.” ME C0006.
15. Dr. Long further explained that surgical excision of a papilloma “is curative” in “most cases.” MEC 0006.
16. After meeting with Anorah and her mother, Kathrin Ignelzi, Dr. Long entered an order for surgery to remove the lesion. MEC 0006.
17. During the same visit with Dr. Long, Mrs. Ignelzi signed the consent forms for the “excision of lid lesion.” MEC0013-14, MEC0015-16.

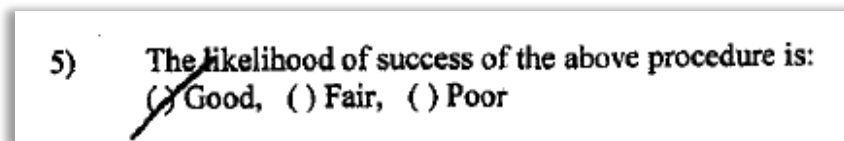


MEC 0013.

18. The forms identified the surgery as a “routine” procedure, with a good likelihood of success in removing the lesion. MEC0015, MEC0013.



MEC 0015.



MEC 0013.

September 30: The Lesion Is Removed

19. On September 30, 2019, Anorah underwent this routine procedure to remove the “eyelid lesion of lower left eyelid.” MEC 0019.

PREOPERATIVE DIAGNOSIS: Enlarging eyelid lesion of left lower eyelid.

POSTOPERATIVE DIAGNOSIS: Enlarging eyelid lesion of left lower eyelid.

PROCEDURE PERFORMED: Excision of eyelid lesion of left lower eyelid.

SURGEON: Byron A. Long, MD

ANESTHESIA: General with additional local.

MEC 0019.

20. Dr. Long was the surgeon, and Dr. Todd the anesthesiologist.
21. Because of Anorah’s age and because of the location of the lesion near her eye, the procedure took place in “the main OR,” an ambulatory surgery center, as opposed to a doctor’s office. MEC 0006.

DESCRIPTION OF PROCEDURE: The patient had an enlarging lesion of her lower eyelid which was thought to be papillomatous or viral in nature. The decision was made to do this in the operating room because of her age and the proximity to the eye. The patient was seen in the preoperative holding area where the procedure was discussed with her, and her mother was present. The patient was then brought to the main OR where she was placed under anesthesia by the anesthesia team. A local anesthetic consisting of 2% lidocaine with epinephrine mixed with Marcaine with epinephrine was injected underneath the obvious eyelid lesion and in the surrounding areas. She was then prepped with betadine scrub and draped in the usual aseptic fashion. The surgeon was wearing loupes during the procedure.

MEC 0019.

Impression/Plan:

- 1. Eyelid Papilloma OS - Because of patients age this will need to be done at the ASC (D23.122)**
Status: Worsening

MEC 0006.

22. Prior to the procedure, Anorah “was seen in the preoperative holding area where the procedure was discussed with her,” with her mother present. MEC 0019.

DESCRIPTION OF PROCEDURE: The patient had an enlarging lesion of her lower eyelid which was thought to be papillomatous or viral in nature. The decision was made to do this in the operating room because of her age and the proximity to the eye. The patient was seen in the preoperative holding area where the procedure was discussed with her, and her mother was present. The patient was then brought to the main OR where she was placed under anesthesia by the anesthesia team. A local anesthetic consisting of 2% lidocaine with epinephrine mixed with Marcaine with epinephrine was injected underneath the obvious eyelid lesion and in the surrounding areas. She was then prepped with betadine scrub and draped in the usual aseptic fashion. The surgeon was wearing loupes during the procedure.

MEC 0019.

23. This is Anorah moments before the routine procedure.



24. At 07:08, Dr. Todd and RN Meredith Rountree brought Anorah back to the OR. Anorah was watching an IPAD and talking with the staff. MEC 0033.

25. At that time, Dr. Todd administered gas and propofol intravenously, and Anorah “was asleep.” MEC 0033, MEC 0019, MEC 0024.

Patient came back to the OR at 0708 with Dr. Todd and Meredith Rountree, R.N. Patient was watching IPAD and talking with staff. Gas and propofol were administered by Dr. Todd and patient was asleep. Vitals were stable. Glynnis Jones administered a block with 2% lidocaine w Epi + 0.5% Marcaine to the left lower lid lesion that was to be removed. Patient was prepped with betadine swab. Dr. Long came in the room at 0716. A time out was done at 0717. The procedure began at 0718. I went to my desk to begin charting. I turned around and saw a towel on fire on the left side of the bed. I grabbed it and stepped on it.

MEC 0033.

DESCRIPTION OF PROCEDURE: The patient had an enlarging lesion of her lower eyelid which was thought to be papillomatous or viral in nature. The decision was made to do this in the operating room because of her age and the proximity to the eye. The patient was seen in the preoperative holding area where the procedure was discussed with her, and her mother was present. The patient was then brought to the main OR where she was placed under anesthesia by the anesthesia team. A local anesthetic consisting of 2% lidocaine with epinephrine mixed with Marcaine with epinephrine was injected underneath the obvious eyelid lesion and in the surrounding areas. She was then prepped with betadine scrub and draped in the usual aseptic fashion. The surgeon was wearing loupes during the procedure.

MEC 0019.

26. Glynnis Jones injected local anesthetic to the lesion and surrounding areas—2% lidocaine, epinephrine, and 0.5% Marcaine. MEC 0033, MEC 0019.

Patient came back to the OR at 0708 with Dr. Todd and Meredith Rountree, R.N. Patient was watching IPAD and talking with staff. Gas and propofol were administered by Dr. Todd and patient was asleep. Vitals were stable. Glynnis Jones administered a block with 2% lidocaine w Epi + 0.5% Marcaine to the left lower lid lesion that was to be removed. Patient was prepped with betadine swab. Dr. Long came in the room at 0716. A time out was done at 0717. The procedure began at 0718. I went to my desk to begin charting. I turned around and saw a towel on fire on the left side of the bed. I grabbed it and stepped on it.

MEC 0033.

DESCRIPTION OF PROCEDURE: The patient had an enlarging lesion of her lower eyelid which was thought to be papillomatous or viral in nature. The decision was made to do this in the operating room because of her age and the proximity to the eye. The patient was seen in the preoperative holding area where the procedure was discussed with her, and her mother was present. The patient was then brought to the main OR where she was placed under anesthesia by the anesthesia team. A local anesthetic consisting of 2% lidocaine with epinephrine mixed with Marcaine with epinephrine was injected underneath the obvious eyelid lesion and in the surrounding areas. She was then prepped with betadine scrub and draped in the usual aseptic fashion. The surgeon was wearing loupes during the procedure.

MEC 0019

27. Anorah was then “prepped with betadine scrub and draped in the usual aseptic fashion.” MEC 0019, MEC 0033.
28. At 07:16, Dr. Long entered the operating room. MEC 0032, MEC 0033.
29. At 07:17, the surgical team observed a one-minute timeout to make sure everyone was on the same page. MEC 0031.

ROOM:	1
OR IN:	0708
TIME OUT:	0717
INCISION:	0718
CLOSURE:	
OR OUT:	0829
<input checked="" type="checkbox"/> ALLERGIES VERIFIED	
<input checked="" type="checkbox"/> H&P W/IN 30 DAYS	
<input type="checkbox"/> LATEX FREE CASE	

MEC 0032.

30. During the timeout, the team confirmed that “all team members have introduced themselves by name and role;” that the surgeon, anesthesia professional, and nurse had verbally identified the patient, site of the surgery, and procedure; and that they reviewed “anticipated critical events.” MEC 0031.

← Before skin incision →

TIME OUT

<input checked="" type="checkbox"/> Confirm all team members have introduced themselves by name and role
<input type="checkbox"/> Surgeon, anesthesia professional, and nurse verbally confirm: <ul style="list-style-type: none"> • Patient • Site • Procedure
Anticipated critical events: <input checked="" type="checkbox"/> Surgeon reviews: <ul style="list-style-type: none"> • What are the critical or unexpected steps? • What is the operative duration? • Is there anticipated blood loss? <input type="checkbox"/> Anesthesia team reviews: <ul style="list-style-type: none"> • Are there any patient-specific concerns? <input type="checkbox"/> Nursing team reviews: <ul style="list-style-type: none"> • Has sterility (including indicator results) been confirmed? • Are there equipment issues or any concerns?

MEC 31.

31. The team also reviewed whether there was any “anticipated blood loss.” MEC 31.
32. At 07:18, the procedure started. MEC 0032, MEC 0033.
33. At that time, Dr. Long elevated the lesion and used medical scissors to “excise the lesion in its entirety.” MEC 0019.
34. Dr. Long then “handed off” the lesion to the surgical assistant. MEC 0019.

The lesion was elevated, and Westcott scissors were used to excise the lesion in its entirety. This was handed off to the assistant. There was noted to be some brisk bleeding, and I used a handheld cautery to cauterize this. At the moment the handheld cautery was used to cauterize the area, a flash was seen for just approximately a second. It was noted that there was a quick flash burn that had extended down around the patient's nose and nasolabial area. Immediately, sterile water were poured all around the area to make sure that the flame was no longer present, and we held ice compresses on the area that had been burned. On first examination, it did seem to extend down into the nasolabial areas on both sides and then out towards the patient's ear on the right side. On further examination, the eyelashes on both sides seemed to be singed, but on examination of the eyes there did not seem to be any damage to the corneas. I did place fluorescein on both eyes, and there was no uptake. Her eyebrows also seemed to be somewhat singed. The anesthesiologist monitored her airway until things stabilized. She was allowed to wake up at the conclusion of the case, and I checked her vision by opening both eyes, and she was able to at least count fingers at approximately a foot away. Ice bandages were placed on the burn areas. Once she was found to be stable she was transferred out to the postoperative holding area. I did call the patient's dad and explained the situation to him, and we brought him immediately back to our pediatric holding area where we went in with the anesthesiologist and discussed in detail what had occurred.

MEC 0019.

35. That's when a routine procedure became eventful—and tragic. MEC 0033, MEC 0018-21, MEC 0025.

September 30: Dr. Todd Fails to Lower Oxygen Level, Fueling Fire Over Anorah's Face

36. Seeing “some brisk bleeding,” Dr. Long asked for a handheld cautery and swabs. MEC 0033.

The lesion was elevated, and Westcott scissors were used to excise the lesion in its entirety. This was handed off to the assistant. There was noted to be some brisk bleeding, and I used a handheld cautery to cauterize this. At the moment the handheld cautery was used to cauterize the area, a flash was seen for just approximately a second. It was noted that there was a quick flash burn that had extended down around the patient's nose and nasolabial area. Immediately, sterile water were poured all around the area to make sure that the flame was no longer present, and we held ice compresses on the area that had been burned. On first examination, it did seem to extend down into the nasolabial areas on both sides and then out towards the patient's ear on the right side. On further examination, the eyelashes on both sides seemed to be singed, but on examination of the eyes there did not seem to be any damage to the corneas. I did place fluorescein on both eyes, and there was no uptake. Her eyebrows also seemed to be somewhat singed. The anesthesiologist monitored her airway until things stabilized. She was allowed to wake up at the conclusion of the case, and I checked her vision by opening both eyes, and she was able to at least count fingers at approximately a foot away. Ice bandages were placed on the burn areas. Once she was found to be stable she was transferred out to the postoperative holding area. I did call the patient's dad and explained the situation to him, and we brought him immediately back to our pediatric holding area where we went in with the anesthesiologist and discussed in detail what had occurred.

MEC 0019.

Mimi Samatar was the surgical scrub tech in the room. Per Mimi: Dr. Long used a bishop and blunt Westcott and then dabbed with a 4x4. Then Dr. Long asked for handheld cautery. Then he asked for qtips. He took the qtips. At that point Dr. Todd stated "You have a handheld cautery." He said yes. Then fire broke out. The towel was removed and Mimi removed the hat because it was on fire. Mimi immediately got sterile water and poured it all over the affected area.

MEC 0033.

37. After being handed the cautery and swabs, Dr. Long had an exchange with Dr. Todd. MEC 0033.
38. Dr. Todd stated: "You have a handheld cautery." MEC 0033.
39. Dr. Long responded, "yes." MEC 0033.
40. Dr. Long then "used a handheld cautery to cauterize" the wound. MEC 0019.
41. "Then fire broke out." MEC 0033.
42. There "was an O2 leak around the mask that they did not detect and a bovie was used which caught fire to the O2." WCH 00033.

HPI: THIS IS 10 y.o., female, who sustained a burn injury today, 9/30/2019 to the face and right ear when the pt was at Marietta eye clinic having a papilloma removed from her eye. The oxygen mask was on the face and parents were told there was an O2 leak around the mask that they did not detect and a bovie was used which caught fire to the O2. She was referred to the JMS burn center here at Wellstar for further evaluation and treatment. She was referred by our anesthesia services who was taking care of the pt at marietta eye clinic.

WCH 00033.

43. "A spark from the cautery ignited a fire that extended to the nasolabial" area of Anorah's face. MEC 0018.

Anesthesia: MAC [] General [] Local [] Other: _____

Comments: _____

MEC 0018.

September 30: Team Scrambles to Triage Burns

- 44. Between that time and 8:30, the surgical team scrambled to put out the fire and triage Anorah's burns.
- 45. The facemask on Michaela's face was "burning." MEC 0025. The facemask was "removed" and Anorah's face was "doused with saline & water." MEC 0025.

Smooth IV induction \bar{c} propofol, easy mask ventilation. Maintained \bar{c} sevoflurane + 30% FiO₂. Drapes over mask. Surgeon began procedure + excised lesion. Surgeon attempted to use cautery \bar{c} resulting fire + burning of mask. Mask removed + area of face doused with saline + water. No airway compromise noted. After a few minutes, pt. \bar{c} laryngospasm broken \bar{c} propofol + positive pressure without difficulty. Pt. emerged with no further ^{airway} incident. IV removed while patient was combative while emerging. ~~The~~ Pt. was conversive, protecting airway with no difficulty breathing + SpO₂ 100% prior to transporting to PACU. Report given to PACU RN.

MEC 0025.

- 46. RN Rountree "saw a towel on fire on the left side of the bed." She "grabbed it and stepped on it." MEC 0033.

Patient came back to the OR at 0708 with Dr. Todd and Meredith Rountree, R.N. Patient was watching IPAD and talking with staff. Gas and propofol were administered by Dr. Todd and patient was asleep. Vitals were stable. Glynnis Jones administered a block with 2% lidocaine w Epi + 0.5% Marcaine to the left lower lid lesion that was to be removed. Patient was prepped with betadine swab. Dr. Long came in the room at 0716. A time out was done at 0717. The procedure began at 0718. I went to my desk to begin charting. I turned around and saw a towel on fire on the left side of the bed. I grabbed it and stepped on it.

MEC 0033.

47. Anorah's hat was quickly removed because it too was on fire. MEC 0033.

Mimi Samatar was the surgical scrub tech in the room. Per Mimi: Dr. Long used a bishop and blunt Westcott and then dabbed with a 4x4. Then Dr. Long asked for handheld cautery. Then he asked for qtips. He took the qtips. At that point Dr. Todd stated "You have a handheld cautery." He said yes. Then fire broke out. The towel was removed and Mimi removed the hat because it was on fire. Mimi immediately got sterile water and poured it all over the affected area.

MEC 0033.

48. Mimi Samatar, the surgical scrub, "immediately got sterile water and poured it all over the affected area." MEC 0033, MEC 0019.

Mimi Samatar was the surgical scrub tech in the room. Per Mimi: Dr. Long used a bishop and blunt Westcott and then dabbed with a 4x4. Then Dr. Long asked for handheld cautery. Then he asked for qtips. He took the qtips. At that point Dr. Todd stated "You have a handheld cautery." He said yes. Then fire broke out. The towel was removed and Mimi removed the hat because it was on fire. Mimi immediately got sterile water and poured it all over the affected area.

MEC 0033.

The lesion was elevated, and Westcott scissors were used to excise the lesion in its entirety. This was handed off to the assistant. There was noted to be some brisk bleeding, and I used a handheld cautery to cauterize this. At the moment the handheld cautery was used to cauterize the area, a flash was seen for just approximately a second. It was noted that there was a quick flash burn that had extended down around the patient's nose and nasolabial area. Immediately, sterile water were poured all around the area to make sure that the flame was no longer present, and we held ice compresses on the area that had been burned. On first examination, it did seem to extend down into the nasolabial areas on both sides and then out towards the patient's ear on the right side. On further examination, the eyelashes on both sides seemed to be singed, but on examination of the eyes there did not seem to be any damage to the corneas. I did place fluorescein on both eyes, and there was no uptake. Her eyebrows also seemed to be somewhat singed. The anesthesiologist monitored her airway until things stabilized. She was allowed to wake up at the conclusion of the case, and I checked her vision by opening both eyes, and she was able to at least count fingers at approximately a foot away. Ice bandages were placed on the burn areas. Once she was found to be stable she was transferred out to the postoperative holding area. I did call the patient's dad and explained the situation to him, and we brought him immediately back to our pediatric holding area where we went in with the anesthesiologist and discussed in detail what had occurred.

MEC 0019.

49. Marie Hernandez came into the room and began wiping burned areas of Anorah's face with BSS (a sterile cleaning solution) and gauze. MEC 0033, MEC 0032.
50. Dr. Todd, Marie, and Nurse Rountree "began checking all of the head, neck and face" for burns. MEC 0033.

Marie Hernandez came into the room. Marie began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the corneas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 0033.

51. Nurse Rountree “ran out and got florisene stripes and BSS to make sure there were no burns to the corneas.” MEC 0033, MEC 0032.
52. The team then “proceeded to clean the patient and continued placing cold slush on gauze with pressure” to Anorah’s face. MEC 0033.

Marie Hernandez came into the room. Maire began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the comeas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 0033.

53. In the midst of all this activity, at about 07:30, Dr. Todd gave Anorah another dose of propofol intravenously to keep her asleep. MEC_____.

*September 30: Anorah Wakes to Pain on Her
Burned Face*

54. Anorah awoke to discover her face had been burned. MEC 0033.
55. She was “crying” and “stating her eyes were burning and her face and right ear were burning.” MEC 0033.

Marie Hernandez came into the room. Maire began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the comeas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 0033.

56. At 07:50, "Lidocaine jelly was placed on affected area on right side of face and bridge of nose." MEC 0034, MEC 0033.
57. At 07:55, Dr. Todd removed the IV catheter, thus discontinuing the general anesthesia. MEC 0034.

IV SITE		
IV CATHETER REMOVED @	0755	BY Dr. Todd
SITE APPEARANCE	CLEAN	DRY INTACT

MEC 0034.

58. At 07:55, Dr. Long returned to the room with Akten ointment and instructed others to apply it to both of Anorah's eyes. MEC 0034, MEC 0033.

<p>NURSES NOTES: 0750 2% lidocaine jelly to burn areas around nose @ ear cool wet compresses to face @ Dr. Long here Akten Ointment to each eye. 0802 Dr. Todd gave 2% ac eye ointment @ 0815 floriscene strips to each by Dr. Long reported to Evans @ 0820 Dr. Todd + Long talked over Initials/SIGNATURE: <u>HE / H Evans</u></p>	<p>ALDRETE ALGORITHM</p> <p>ACTIV: 2-ABLE TO MOVE 4 EXTREMITIES 1-ABLE TO MOVE 2 EXTREMITIES 0-SOFTABLE TO CONTROL ANY EXTREMITIES</p> <p>RESP: 2-ABLE TO BREATHE DEEP, F AND REGULAR 1-OPRNEIC/LIMITED BREATHING 0-APNEIC</p> <p>CIRC: 3-8/9 10% PRE ANESTHETIC C 1-20-50% PRE ANESTHETIC C 0-10% PRE ANESTHETIC C</p> <p>LOC: 2-SELF AWARE 1-ABSOULTELY UNCALMING 0-NO RESPONSE</p> <p>COLOR: 2-PINK 1-PALE, DISCY, INJURIE OTHER 0-PHOSPH</p>
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MEC 0034.

Marie Hernandez came into the room. Marie began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got floriscene strips and BSS to make sure there were no burns to the corneas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 0033.

- 59. Meanwhile, Marie “continued placing cool gauze and pressure on the affected areas.” MEC 0033.
- 60. At 08:02, Dr. Todd gave Anorah intravenous pain medication and an oral elixir of oxycodone. MEC 0033, MEC 0034.

Marie Hernandez came into the room. Maire began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the corneas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 0033.

61. As she “began calming down,” Anorah “began asking questions about why her eyes and ear were burning.” MEC 0033.
62. As late as 8:57, Anorah reported that her pain was an 8 on a scale of 1-10. MEC 0035.

0835 Small sips of apple juice
0848 Gauze & sterile water changed frequently for comfort.
0857 Pain scale - 8 Medicated for pain & Tyland po.

MEC 0035.

*September 30: Anorah Is Referred to the Joseph
Still Burn Center at Cobb Hospital*

63. At 08:20, Dr. Todd and Dr. Long talked with Anorah’s parents. MEC 0034.

NURSES NOTES 0750 2% lidocaine jelly to burn areas around nose @ low cool wet compresses to face After ointment to each eye. 0802 Dr Todd gave 2cc oxycodone bid 0815 florisene strips to each eye by Dr Long Legally Evans M J 0820 Drs Todd + Long talked over Initials/SIGNATURE <i>HE / Evans</i>	ALDRETE ALGORITHM	
	ACTIVITY	2-ABLE TO MOVE EXTREMITIES 1-ABLE TO MOVE EXTREMITIES 0-NOT ABLE TO CONTROL ANY EXTREMITIES
	RESP	2-ABLE TO BREATHE DEEPLY AND FREELY 1-DYSPNEIC/LIMITED BREATHING 0-APNEIC
	CIRC	2-B/P 20% PRE-ANESTHETIC 1-20-50% PRE-ANESTHETIC 0-50% PRE-ANESTHETIC
	LOC	2-FULLY AWARE 1-AROUSABLE BY CALLING 0-NOT RESPONDING
COLOR	2-PINK 1-PALE, DUSKY, JAUNDICE, OTHER 0-CYANOTIC	

MEC 0034.

64. At about 08:30, Anorah was taken to the post-anesthesia care unit, “with Marie Hernandez continuing to hold cold gauze on the affected areas.” MEC 0033, MEC 0034, MEC 0035, MEC 0032.

Marie Hernandez came into the room. Maire began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the corneas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

65. At 08:30, Dr. Long saw Anorah and her family. MEC 0035. He recommended that Anorah visit a pediatric emergency room. MEC 0035.

0828 Received in PACU. Awake + talking. Parents present. Cold compresses to face.
0830 Dr. Long in to see family + patient. Recommended to be seen in Pediatric ER before discharge.

MEC 0035.

66. Dr. Long also told the family: "we are sorry what happened with her." EMC ____
67. At 08:58, Dr. Todd saw Anorah and her family, informing them of the plan to send her to a burn Dr. Claus Brandigi, a burn specialist at the Joseph M. Still Burn Center at WellStar Cobb Hospital. MEC 0035, MEC 0020.

0857 Pain scale - 8 Medicated for pain + Tylenol po.
0858 Dr. Todd in to see pt. Plan to send to Cobb Burn Center.
0915 Dr. Weigandt in to see pt. Referral to Burn Center by Bypass ER. Info given to family + pt.
0920 Instructions given to family. Crackers + drink given to pt. Tolerated. Compresses continued throughout at frequent intervals. Areas around face + eyes remain pink. Rt. ear pinkish-red.
0930 Discharged per ambulatory + Dad.

MEC 0035.

The decision was made to send the patient to a burn specialist at Cobb Hospital; Dr. Klaus Bradigi M.D. Dr. Weigandt called him to alert him of the situation. He said to send her right away and he would exam and treat her.


Byron A. Long, MD

MEC 0020.

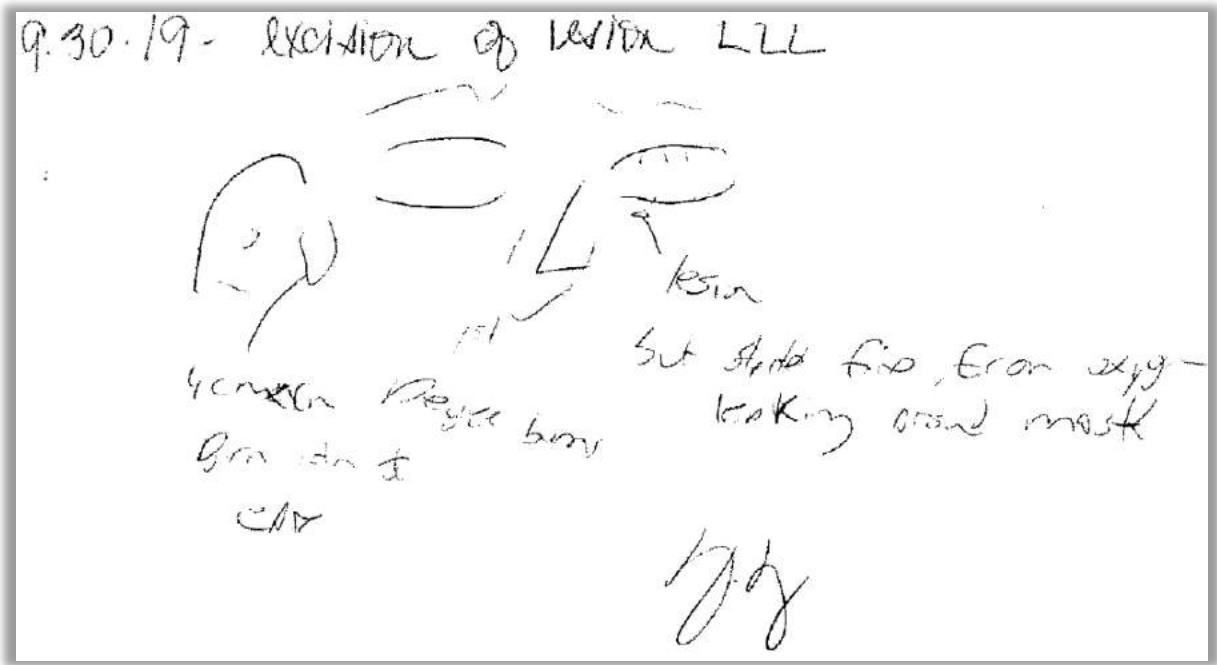
68. At 09:15, Anesthesiologist Pamela Weigandt saw Anorah. MEC 0035.
69. Dr. Weigandt informed the family of the referral to the Still Burn Center, which would allow Anorah to bypass the ER. MEC 0035

70. At 09:30, MEC discharged Anorah. MEC 0035.
71. MEC discharged Anorah with wrappings around her head.



September 30: Anorah's Burns

72. The fire caused what Dr. Long judged to be first-degree burns.



73. The fire:

- travelled “down into the nasolabial areas on both sides and then out towards the patient’s ear on the right side.” MEC 0019.
- burned “the right temporal side of [Anorah’s] face as well as the right ear.” MEC 0033.
- burned the area “over the bridge of the nose bilateral where the mask had been placed.” MEC 0033.
- singed Anorah’s eyelashes, eyebrows, and hair. MEC 0019, MEC 0033.

The lesion was elevated, and Westcott scissors were used to excise the lesion in its entirety. This was handed off to the assistant. There was noted to be some brisk bleeding, and I used a handheld cautery to cauterize this. At the moment the handheld cautery was used to cauterize the area, a flash was seen for just approximately a second. It was noted that there was a quick flash burn that had extended down around the patient's nose and nasolabial area. Immediately, sterile water were poured all around the area to make sure that the flame was no longer present, and we held ice compresses on the area that had been burned. On first examination, it did seem to extend down into the nasolabial areas on both sides and then out towards the patient's ear on the right side. On further examination, the eyelashes on both sides seemed to be singed, but on examination of the eyes there did not seem to be any damage to the corneas. I did place fluorescein on both eyes, and there was no uptake. Her eyebrows also seemed to be somewhat singed. The anesthesiologist monitored her airway until things stabilized. She was allowed to wake up at the conclusion of the case, and I checked her vision by opening both eyes, and she was able to at least count fingers at approximately a foot away. Ice bandages were placed on the burn areas. Once she was found to be stable she was transferred out to the postoperative holding area. I did call the patient's dad and explained the situation to him, and we brought him immediately back to our pediatric holding area where we went in with the anesthesiologist and discussed in detail what had occurred.

MEC 0019.

Marie Hernandez came into the room. Marie began wiping the affected area with BSS and gauze and Marie, Dr. Todd, and I began checking all of the head, neck and face. I ran out and got florisene strips and BSS to make sure there were no burns to the corneas. No stain noted. We proceeded to clean the patient and continued placing cold slush on gauze with pressure to the affected areas. Affected areas noted were the right temporal side of the face as well as the right ear, over the bridge of the nose bilateral where the mask had been placed, singed eyelashes on both eyes, left eyebrow was singed and some of the ends of her hair. Nasal passages and throat were thoroughly checked to ensure no airway compromise by Drs. Taylor and Todd. Patient was crying stating her eyes were burning and her face and right ear were burning. Lidocaine jelly was placed on affected area on right side of face and bridge of the nose. Dr. Long came in the room and Akten ointment was placed in both eyes per Dr. Long. Marie continued placing cool gauze and pressure to the affected areas. Aquaphor was then applied to affected areas. Dr. Todd administered pain med via IV and then oxycodone elixir orally. Patient began calming down and began asking questions about why her eyes and ear were burning. Patient was taken to the PACU at 0830 with Marie Hernandez continuing to hold cold gauze on the affected areas.

MEC 0033.

*September 30: Dr. Todd Changes Oxygen Entries
on Anesthesia Record*

74. Dr. Todd's anesthesia record for Anorah's surgery at MEC contains handwritten entries for FiO2 levels in 15-minute blocks. MEC 0024.
75. The entry for the block leading up to the surgery, 07:00-07:15 reflects an FiO2 level of 1.0, or 100% oxygen-concentration. MEC 0024.

76. The entry for the next block, 07:15-07:30, when the excision and the fire occurred, reflects an oxygen level of 0.3, or 30%, precisely the limit.
77. If they are to be believed, these two entries mean that Dr. Todd dropped the FiO2 level from 100% to 30% within minutes of the fire’s eruption. MEC 0024.
78. But the 07:15-07:30 entry has been overwritten, blotting out the original number. The same is true for other entries in the record. MEC 0024.

Procedure: Lower lid excision of lesion											
Procedure:											
Time										Totals	
O2	100	•	30	x	0500	x	30				
MIR											
SEVO	2.1										
Versed/Fentanyl	mg/ug			1/35						- 25	
Lidocaine	mg									200	
Propofol	mg	100	80	100							
Zofran/Decadron	mg/mg										
Ketorolac				15							
Fuids	LA / NS										500mL
EBL/JOP											
Antibiotic Therapy	Ancef 1g / 2g			Cleburn 600mg / 900mg			Other				
Position	EKG	GR	ST	ST	ST	ST	80				
SpO2		100	100%	100%	100%	100%	100%				
FiO2		1.0	0.3	1.0	0.3	0.21					
CO2		30	35	40	+	+					
Temp		37.5									
Time											
Anes Start	0708										
PACU Anes End	0830										

MEC 0024.

79. The original entries, moreover, have not been crossed out with a line so that they remain readable next to the new entries. MEC 0024.
80. Instead, the original entries have been made unreadable by reshaping them into new numbers. MEC 0024.
81. In addition, the person making these changes did not scribble her or his initials or otherwise annotate the record to call out and verify the changes. MEC 0024.

*September 30: Cobb Diagnoses 2nd-Degree Burns
on Head, Face, and Neck*

82. At 10:21, Anorah was admitted to the Cobb Burn and Wound Center at WellStar Cobb Hospital, with second-degree burns on “multiple sites of head, face, and neck.” WCH 00002.

Admission Information					
Arrival Date/Time:		Admit Date/Time:	09/30/2019 10:21	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Cobb Outpatient Burn Wound and HBOC
Admit Provider:		Attending Provider:	Claus Brandigi, MD	Referring Provider:	Javald Sayeed, MD

WCH 0002.

83. At 11:21, Dr. Claus Brandigi and Nurse Practitioner Kimberly N. Smith examined Anorah. WCH 00029.

H&P by Kimberly N Smith, NP at 9/30/2019 11:21 AM			
Author: Kimberly N Smith, NP	Service: Burn	Author Type: —	
Filed: 9/30/2019 11:33 AM	Date of Service: 9/30/2019 11:21 AM	Status: Signed	
Editor: Kimberly N Smith, NP (Nurse Practitioner)		Cosigner: Claus Brandigi, MD at 10/2/2019 12:29 PM	
<p>THIS IS 10 y.o., female, who sustained a burn injury today, 9/30/2019 to the face and right ear when the pt was at Marietta eye clinic having eye surgery. The oxygen mask was on the face and a bovie was used near the mask. She was referred to the JMS burn center here at Wellstar for further evaluation and treatment. She was referred by our anesthesia services who was taking care of the pt at marietta eye clinic.</p>			

WCH 00029.

84. As a result of her burns, Anorah had “epidermal loss to the face and right ear.” WCH 00029-30.

H&P by Kimberly N Smith, NP at 9/30/2019 11:21 AM (continued)
<p>HEENT: mild swelling to the left eye CHEST: Equal rise and fall of chest CV: Cap refill is brisk ABD: Soft, BS + all quadrants EXT: Full AROM all extremities, all extremities are neurovascularly intact SKIN: epidermal loss to the face and right ear</p>

WCH 00030.

85. Dr. Brangidi decided to admit Anorah to the Hospital with second-degree burns, in order to “monitor for worsening of the wound given burn injury is less than 24 hours in age.” WCH 00032.

ASSESSMENT:

1.5 %TBSA 2ND DEGREE BURN

PLAN:

Options for care were discussed at length with the patient and family. The decision was made to admit the pt and monitor for worsening of the wound given burn injury is less than 24 hours in age
Will plan for the OR tomorrow for skin sub to the head

Risks and benefits were discussed and consent was obtained

WCH 00032.

86. In addition, with Anorah’s parents’ consent, Dr. Brangidi decided to perform graft surgery to the head the following day. WCH 00032.

87. At 12:16, Pediatric Nurse Practitioner Lisa Samples examined Anorah. WCH 00033.

Consults by Lisa A Samples, NP at 9/30/2019 12:16 PM

Author: Lisa A Samples, NP

Filed: 9/30/2019 12:36 PM

Editor: Lisa A Samples, NP (Nurse Practitioner)

Service: Pediatrics

Date of Service: 9/30/2019 12:16 PM

Author Type: Nurse Practitioner

Status: Signed

Cosigner: Kelly S Garrison, MD at 10/2/2019 9:51 AM

Consult Orders

1. Consult to Pediatrics [845474745] ordered by Claus Brandig, MD at 09/30/19 11:21

WCH 00033.

88. Anorah had burns “to left lower eyelid with edema to the upper lid, right cheek just adjacent to nares, right face along hair line and right ear.” WCH 00035.

PHYSICAL EXAMINATION:

Temp: 98.5 F HR: 94 RR: 20 SpO2: 98%

General: Awake and alert, appropriately interactive for age

HEENT: Moist mucus membranes

Lymphatic: No lymphadenopathy, neck supple

CV: RRR, no murmurs, rubs, or gallops

Respiratory: Normal respiratory effort, lungs CTAB

Abdomen: Normal bowel sounds, soft, nontender, nondistended

Skin: Burns to left lower eyelid with edema to the upper lid, right cheek just adjacent to nares, right face along hair line and right ear

Musculoskeletal: Normal ROM, no swelling or edema

Neurological: normal for age. No gross deficits

WCH 00035.

89. After this examination, the plan was still to “watch burn for any worsening and go to OR in the am.” WCH 00036.

Assessment/Plan:

Patient Active Problem List

Diagnosis

- Burns involving less than 10% of body surface

Anorah Ignelzi is a 10 y.o. old patient presenting following a burn to face/head. Plan to watch burn for any worsening and go to OR in the am.

- May remain without IV. Encourage PO.
- Pain control PRN with ibuprofen PRN
- Burn management per burn team

Thank you for the opportunity to assist on this patient's case.

WHC 00036.

October 1: Anorah Has Grafting Surgery

90. On October 1, 2019, starting at about 08:50, Anorah underwent skin-grafting surgery using Epiburn grafts. WCH 00039, WHC 00047-48.

Progress Notes by Margaret A Summers, PA at 10/1/2019 6:54 AM

Author: Margaret A Summers, PA
Filed: 10/1/2019 6:54 AM
Editor: Margaret A Summers, PA (Physician Assistant)

Service: Burn
Date of Service: 10/1/2019 6:54 AM

Author Type: Physician Assistant
Status: Signed
Cosigner: Claus Brandtgi, MD at 10/2/2019 12:29 PM

To OR today for surgical preparation and application of skin substitute to head

Electronically Signed by Claus Brandtgi, MD on 10/2/2019 12:29 PM

WCH 00039.

Procedure in Detail:

The patient was brought to the operating room and placed on the table in supine position. After adequate general anesthesia was administered, the wounds were prepped with betasept and patient was draped in the usual manner.

Wound bed was prepared surgically using forceps, metzenbaum scissors, and a norsen. Pseudo-eschar and thin dermal eschar were shaved using a norsen to the superficial dermis level of excision.

After all devitalized tissue was removed, it was determined that Epiburn grafts would be best for this patient. Wounds were irrigated and covered with Epiburn grafts. Grafts were dressed using conformant, saline soaked kerlix and stretch net .

WCH 00047-48.

91. This is Anorah shortly before this surgery.



92. During the procedure, Dr. Brangidi found seven significant second-degree burns on Anorah's head and neck, covering body-surface areas as large as 8 x 5 centimeters. WCH 00048.

Findings:

**Location and measurements of second/deep second degree injury
(all measurements are in centimeters)**

R Neck 4 x 4
R Cheek 8 x 5 + 4 x 4
R Ear 7 x 5
Right upper eyelid 2 x 2
Nose 5 x 5
Left upper eyelid 5 x 3
L Cheek 5 x 5

WCH 00048.

93. On October 2, 2019, at 13:130, Anorah was discharged from Cobb. WCH 00027.

Subsequent Weeks: Follow-up at Cobb

94. Anorah returned to Cobb for a follow-up appointment on October 4, 2019. WCH 00199-202.



WCH 00201, WCH 00202.

95. She then returned to Cobb for another follow-up appointment on October 9, 2019. WCH 00228-32.
96. Anorah returned for a third follow-up on October 17, 2019. CH 00260-64.
97. She returned once again for a follow-up on November 21, 2019. WCH 00286.
98. This is Anorah about four months after her graft surgery.



Epilogue: Anorah Receives Therapy for PTSD

99. Since October 3, 2019, Anorah has been undergoing psychological therapy with the same therapist.
100. In the days after the fire, “Anorah presented with symptoms consistent to PTSD including depression, elevated fear, trouble concentrating, and excessive worry.” THC 0002.
101. During therapy sessions, Anorah reported feeling “more angry and sad than she did before the operation.” THC 0002.
102. She also demonstrated “confusion and frustration about other’s reactions to her facial burns.” THC 0002.
103. At home, Anorah began “isolating herself and going to her room for extended periods of time” and experiencing “anger outbursts daily.” THC 0002.
104. Anorah also demonstrated “symptoms typical to sustaining traumatic stress including a lack of interest in school, increased appetite, engaging in hypervigilant behaviors and exaggerated negative beliefs about the world being a dangerous place.” THC 0002.

105. Anorah's family was also "impacted by Anorah's burn injury as evidenced by, increased arguing between members, tearfulness, avoidance, anxiety related to Anorah's future, and an increased financial burden on household." THC 0002.
106. In sessions, Anorah engaged in "expressive art and play activities displaying themes of safety, regression, fear, and loss of power and control." THC 0003.
107. Anorah often represented herself in drawings wearing masks, indicating that that represented "her mixed feelings of anger, sadness, and happiness." THC 0003.
108. On December 3, 2019, Anorah's therapist "recommended for Anorah to continue in family and individual counseling services until symptomology reduces to 80% or treatment goals are met at a rate of 80%." THC 0003.
109. Therapy goals included "developing a healthy understanding about her experience," "learning healthy coping strategies to use in moments of distress," and "processing her thoughts and feelings about her experience." THC 0002.
110. Over the year and half that have followed, Anorah has remained continuously in therapy with the same professional, working diligently to move past the trauma of the fire by meeting those goals, and others. She remains in therapy today.

Epilogue: Other Surgeries

111. Since her graft surgery, Anorah has remained under the care of Dr. Brandigi at the Still Burn Center, with periodic appointments to check on her progress.
112. As she grows older, the focus is on ensuring that her skin heals properly.
113. As of the time of the filing of the Complaint in this lawsuit, plans are in place for one or more laser surgeries to address skin discoloration due to the burns.
114. In addition, Anorah's doctors are considering whether she may need other forms of surgery to address scars surfacing and resurfacing as she grows older.