Patient Name: Bailey Reid Gwyn
DOB: 02 / 19 / 2002

Date of Incident: February 6, 2022
Primary Provider: William C. Truman
Facility: NRH (ED)

MALPRACTICE INCIDENT TIMELINE

Pre-Admission Context

Arrival by Law Enforcement | *Approx. 06:00*

- Patient arrived via police transport, not family as falsely recorded.
- Police told mother he was being taken to the hospital to get "help".
- Left in police car; exact arrival time unclear.
- Patient called Nana after arrival and attempted to call aunt but needed help due to vision loss and seizure activity.

Initial Medical Encounter

06:38 | Blood pressure measured: **147/94**

06:50 | Labs drawn

- *Glucose 110 (High)*
- *WBC 12.9 (High)*

07:15 (note created at 08:30) | Urine sample requested

- Patient experienced **exaggerated movement due to seizure disorder** (myoclonus, vertigo).
- EMT Charles Graves reportedly became frustrated but assisted patient to bed.
- Chart notes patient was "acting" if unable to walk — *disparaging language*.

08:20 | Belongings "inventoried" — no belongings actually listed.

Medical Distress and Neglect

09:20 | Nausea episode

- Requested help/bag; help delayed.
- **Vomited and choked on floor**; patient scraped mouth out manually and panicked. No urgent response documented.

12:20 | Ice pack provided by Tamara Coe, CNA

- Requested restroom; nurse said *if patient didn't get up alone, help would not return*.
- Due to Seizure activity, Crohn's and physical distress, patient could not get up independently.
- Eventually had to **bang on window**; EMT Charles made patient wait again.
- Patient **stumbled to restroom across hallway**, passed **bloody, painful stool.**

12:43–12:46 | EKG performed

- EKG **timestamp: 12:46:47**
- *Result: Right Axis Deviation*, conflicting with prior EKG showing "undetermined rhythm."
- **Chest pain present throughout**, though chart says patient "now only" complains of chest pain.

12:45 (note created at 12:52)

- **Zofran and Haldol ordered**, but only Zofran administered.
- Haldol falsely recorded as given.

Food, Accommodations, and Misreporting

Dietary issue | Multiple mentions

- Fruit/veggie tray given despite clear Crohn's history and **carrot/celery intolerance since birth**.
- Refused meal tray due to disease, not noncompliance.

Misreported observations

- **Skin:** Charted as normal; patient was visibly sweaty.
- **Speech:** Reported normal; patient had difficulty speaking.
- **Respiratory pattern:** Reported normal; this was inaccurate.
- **Mood:** Reported "cooperative/calm," though patient was physically unable to stay still.
- **Environment:** Held in **dirty Involuntary Commitment Room**.

Psychiatric Hold and Misdocumentation

Psych narrative & commitment reversal

- ROS (Review of Systems) inaccurately reports "no fever, no chest pain, no GI symptoms."
- Patient **did** experience fever, chills, eye/ear pain, throat pain, dyspnea, chest pain, abdominal cramping, vomiting, blood in stool, diarrhea, palpitations, joint pain/swelling, sweating, and bruising.
- Narrative falsely claims patient was **suicidal and destructive**.
- **Patient denies suicidality or threats**, despite this being listed as IVC justification.

Seizure Activity Misrepresented

- **Documented no seizure activity**, but patient experienced seizures **in bed, on floor, in IVC room, and in police car**.
- Charted "myoclonic jerking with horizontal nystagmus" but dismissed via security footage not medically reviewed. Security logs seem to be a copy and paste of normal vitals.

14:19 | Telepsych evaluation conducted — patient could "barely speak or hold head up."
14:45 | Mother's phone number entered in records
16:22 | Physical exam recorded — no MD had conducted a physical exam.
16:27

- Discharge papers given.
- **Signature on discharge forged.**
  - *Not patient's handwriting.*
  - *"B", "R", and "G" inconsistent; "R" written with left hand; patient is right-handed.*

- Involuntary Commitment form **reversed and faxed to Clerk of Court.**
- Patient **stumbled out to mother's van, nearly collapsed.**

Key Staff Involved

- **Primary MD:** William C. Truman
- **ED MDM Entry:** Dr. Peter S. Vrooman
- **EMT:** Charles B. Graves (documented assessments despite lack of medical license)
- **Nurse:** Ashley S. McKnight, RN
- **CNA Staff:** Jerry L. Brinegar, Josephine R. Frost, Tamara A. Coe
- **Pharm Tech:** Teresa G. Rigney

Throughout Admission (Approx. 06:00–16:30)

- **Patient repeatedly requested access to their service dog** (required for medical and psychiatric stabilization).
- Requests were **ignored or denied** with no documented discussion, evaluation, or justification.
- **No reasonable accommodation** was provided.
- **Violation of the Americans with Disabilities Act (ADA)** and Section 504 of the Rehabilitation Act — hospitals must accommodate service animals unless the animal poses a direct threat (which was never assessed, documented, or communicated).
- **Direct harm resulted** from this denial, including exacerbated seizures, panic, vomiting, and physical destabilization.

Summary (Updated Key Allegations – Now 9 Total)

1. **Forged medical discharge signature**
2. **Neglect of medical emergencies** (seizures, vomiting, Crohn's flare, choking)
3. **Failure to administer ordered medications**
4. **Inaccurate documentation across medical records**
5. **No physical exam by an MD despite documentation**
6. **Psychiatric misrepresentation leading to improper IVC**
7. **Withholding of food/dietary failure despite Crohn's and allergies**
8. **Inhumane, unsanitary conditions in IVC room**
9. **ADA violation: Denial of access to service animal**

Legal Violations and Statutory Citations

The following laws and regulations appear to have been violated based on the documented facts of this incident:

I. Disability Rights & Civil Rights Violations

1. Americans with Disabilities Act (ADA) – Title II & III

- **42 U.S.C. § 12101 et seq.; 28 C.F.R. § 35.136**
- The hospital failed to provide reasonable accommodations by:
  - Denying access to the patient's **service dog**, despite repeated requests.
  - Failing to accommodate known **Crohn's disease dietary restrictions**.
- ADA Title II requires public entities (e.g., hospitals) to accommodate qualified individuals with disabilities unless the animal or request poses a direct threat — no such determination was made.

2. Section 504 of the Rehabilitation Act of 1973

- **29 U.S.C. § 794**
- Prohibits discrimination on the basis of disability in programs receiving federal funding.
- The hospital denied basic accommodations necessary for seizure disorder, Crohn's disease, and PTSD, violating the patient's right to equal access to care.

3. Civil Rights Act – Title VI

- **42 U.S.C. § 2000d**
- Discriminatory treatment or neglect of care, if related to disability or psychiatric labeling, may violate civil rights protections for patients receiving care in federally funded institutions.

II. Medical Record & Privacy Violations

4. HIPAA – Health Insurance Portability and Accountability Act

- **45 C.F.R. § 164.502 et seq.**
- The medical record includes:
  - A **forged discharge signature**.
  - False statements regarding the patient's symptoms, behavior, and mental status.
  - Omission of critical events (e.g., seizure episodes, vomiting, blood in stool, service dog denial).
- These inaccuracies and falsifications may constitute **HIPAA violations** and threaten the integrity of the patient's medical record.

5. Federal False Records Law

- **18 U.S.C. § 1001**
- Knowingly falsifying records or signatures in matters involving federally regulated institutions is a federal crime.

III. Patient Safety & Emergency Care Violations

6. EMTALA – Emergency Medical Treatment and Labor Act

- **42 U.S.C. § 1395dd**
- Requires all ED patients to receive:
  - A **medical screening examination** by a qualified provider.
  - Stabilization prior to discharge.

- The patient received **no physical exam by an MD**, and critical symptoms (e.g., seizures, vomiting, GI bleeding) were **not properly evaluated or treated**, constituting potential EMTALA violations.

7. Medical Malpractice / Negligence (Common Law Tort)

- State-level standards for professional care were violated by:
  - **Neglecting urgent medical needs** (e.g., choking, seizure episodes, Crohn's flare).
  - Failing to administer ordered medications (e.g., Haldol).
  - **Forging documentation** and improperly discharging the patient while still in distress.

8. Deliberate Indifference to Serious Medical Needs

- **42 U.S.C. § 1983; 8th and 14th Amendments**
- If the hospital was acting under "color of law" (e.g., during involuntary psychiatric commitment), its **failure to respond to life-threatening symptoms** and basic requests may rise to a **constitutional violation**.

IV. Documentation Fraud & Forgery

9. Forgery of Medical Documents

- Likely a **violation of state criminal law**, as well as federal standards of medical ethics and licensing.
- The discharge signature was **forged**, as evidenced by:
  - Discrepancies in letter formation ("B", "R", and "G").
  - Patient is right-handed; signature written with left hand.

10. Failure to Report Patient Harm or Adverse Events

- Most states require **reporting of serious patient incidents** (e.g., choking, seizures, self-care inability, bloody stools).
- No such reports were filed; the hospital failed to recognize or document patient harm, in violation of public health reporting requirements.

This statement reflects my direct lived experience and is submitted as part of a civil rights and disability-based complaint.

Under penalty of perjury, I affirm that the facts stated above are true and correct to the best of my knowledge —