The Indiana Jury Verdict Reporter

The Most Current and Complete Summary of Indiana Jury Verdicts

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Unbiased and Independently Researched Jury Verdict Results

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Civil Jury Verdicts

Timely coverage of civil jury verdicts in Indiana including court, division, presiding judge, parties, cause number, attorneys and results.

Hospital Negligence - A 9 year-old girl undergoing a thyroid uptake study was mistakenly given approximately 100 times the correct dose of a radioactive tracer liquid; although the girl suffered no immediate effects from the overdose, she sought compensation from the hospital for her increased risk of developing thyroid cancer over the course of her lifetime

Ford v. Deaconess Hospital, 82C01-0503-CT-261
Plaintiff: Jerry A. Garau and Deborah K. Pennington, *Garau Germano Hanley & Pennington, P.C.*, Indianapolis
Defense: William W. Drummy and Holly A. Reedy, *Wilkinson Goeller Modesitt Wilkinson & Drummy, LLP.*, Terre Haute; and Douglass Jessen, *Statham Allega & Jessen, LLP.*, Evansville
Verdict: $2,000,000 for plaintiff
County: **Vanderburgh**, Circuit Court: J. Kiely, 2-27-13

In March of 2003, 9 year-old Nicole Ford was having difficulty swallowing. Nicole's mother, Charlotte Ford, consulted on the matter with Dr. Mary Tadros, an endocrinologist. Dr. Tadros suspected a thyroid problem, so she ordered a thyroid uptake study to be performed at Deaconess Hospital in Evansville.

A thyroid uptake study involves the administration of a radioactive tracer called Iodine-131 with a follow-up 24 hours later to determine how much of the tracer had been absorbed by the thyroid. Charlotte took Nicole to Deaconess to begin the study on 3-28-03.

At Deaconess, Nicole came under the care of radiology technologist Denise Bean. It was Bean who would carry out the study with the assistance of fellow radiology technologist Jana Ashley. The record indicates that Ashley was still in training at the time.

Although Nicole was originally slated to take the Iodine-131 in capsule form, her difficulty with swallowing made that impossible. Bean therefore made the decision to substitute a liquid form of the radioactive tracer.

In order to carry out this plan, Bean telephoned the radiopharmacy and placed an order for a quantity of liquid Iodine-131. Inexplicably, however, she mistakenly ordered a quantity of the material that was approximately 100 times the correct dose.

The radiopharmacy soon delivered the order, and technologist Ashley helped Nicole drink the liquid through a straw. Ashley did so without bothering to double check the dosage. Thus, Nicole drank roughly 100 times the intended amount of radioactive liquid.

Nicole displayed no immediate reaction to the overdose. Her follow-up study the next day revealed that her thyroid was completely normal (her swallowing problem also eventually resolved itself without treatment). It was not until the study was later reviewed by another

radiologist that the dosage error was discovered. The error was subsequently confirmed several days later.

Deaconess followed protocol and notified the U.S. Nuclear Regulatory Commission of the error and also launched its own internal investigation. It is the Commission's practice to rank violations of regulations relating to the handling of radioactive materials on a scale with four levels of severity. On this scale, severity level I represents the most significant violations while severity level IV represents the least significant.

The Commission investigated the matter and cited Deaconess with a severity level III violation. The commission also determined that due to the overdose, Nicole had a significantly increased risk of developing thyroid cancer during her lifetime.

On Nicole's behalf, Charlotte presented the case to a medical review panel and blamed the mixup on Deaconess Hospital. The panel members were Dr. Mariam Kirkman, Endocrinology, Indianapolis; Dr. Alex Aisen, Radiology, Indianapolis; and Dr. Mark Tann, Nuclear Medicine, Indianapolis.

It was the unanimous opinion of the review panel that Deaconess Hospital had indeed breached the applicable standard of care and that it was a factor in Nicole's damages. Nicole filed suit against Deaconess as well as against the radiopharmacy that filled the order for the Iodine-131 and against an entity identified as Evansville Radiology, P.C.

As the litigation progressed, both the radiopharmacy and Evansville Radiology settled the claims against them and were dismissed from the case. The litigation continued against Deaconess on a theory of increased risk.

According to plaintiffs, Nicole's increased risk of developing thyroid cancer due to the overdose will make it necessary for her to annual thyroid ultrasounds and frequent tests of her thyroid hormone levels for the rest of her life. The cost of this future medical monitoring was estimated at $36,621, while the cost of the future

After the verdict was returned, defendant made a motion for *remittitur* and Lardydell made a motion for *additur*. The court denied both motions. Post-trial, defendant filed a motion for a new trial, *remittitur*, or to alter or amend the judgment. At the time the IJVR reviewed the record, the motion was still pending.

Medical Negligence - A woman with symptoms of shortness of breath and chest pains was prescribed an injection of atropine by her cardiologist; the woman developed an intracranial bleed resulting in permanent injuries that she blamed on the injection

Henry v. Apuri, 02D01-1103-CT-150
Plaintiff: John O. Feighner, *Haller & Colvin, P.C.*, Fort Wayne
Defense: Mark W. Baeverstad, *Rothberg Logan & Warsco, LLP.*, Fort Wayne
Verdict: Defense verdict on liability
County: **Allen**, Superior
Court: J. Boyer, 8-13-12

On 7-14-06, 39 year-old Doris Henry gave birth to her new baby by c-section at Dupont Hospital in Fort Wayne. A week later, on 7-21-06, Henry was experiencing shortness of breath and chest pains. She consulted on the matter with her obstetrician's staff who referred her to the ER at Dupont.

Henry was first seen by the ER staff at Dupont in the early afternoon of 7-21-06. Later that day she was seen by Dr. Bhaktavatsala Apuri, a cardiologist. Dr. Apuri diagnosed Henry with myocardial necrosis and a pulmonary embolism, and he prescribed atropine.

In the early evening the hospital staff at Dupont gave Henry an atropine injection in accordance with Dr. Apuri's instructions. Immediately upon receiving the injection, Henry's heart rate markedly accelerated to 112 and her blood pressure shot up to 215 systolic.

The medical staff responded to this development by giving Henry intravenous nitroglycerin, which produced some improvement in her blood pressure. Henry was also transferred to Parkview Hospital with complaints of right-sided weakness of her arm and leg with tingling in the right side of her body.

Subsequent tests revealed that Henry had suffered an intracranial bleed due to the atropine. In essence, she had suffered a stroke. Henry's treatment included a left parietal craniotomy, evacuation of the hemorrhage, and a pericranial graft.

Despite this treatment, Henry has been left with a permanent loss of spatial sensation on her right side, limitation of function and strength on her right side, and difficulty with cognition. Her medical expenses totaled $172,403.

Henry presented the her case to a medical review panel and was critical of Dr. Apuri's decision to prescribe atropine. The panel members were Dr. Bruce Graham, Cardiology, Muncie; Dr. Ronald Nelson, Cardiology, South Bend; and Dr. John Wulff, Neurology, Muncie.

The panel's unanimous opinion was that Dr. Apuri's treatment of Henry had not breached the cardiologist standard of care. Henry filed suit against Dr. Apuri and repeated her arguments that she should not have been given the atropine.

Henry's identified experts included Dr. Basil Genetos, Cardiology, Fort Wayne. It was the opinion of Dr. Genetos that the use of atropine had not been appropriate in Henry's case and that it had either caused or increased her neurological damage.

Dr. Apuri defended the case and denied having breached the standard of care. His identified experts included Dr. Jeffrey Frank, Neurology, Chicago, IL; Dr. J. Stanley Hillis, Cardiology, Indianapolis; Dr. Joel Kahn, Cardiology, Detroit, MI; and Dr. Ruth Ramsey, Radiology, Chicago, IL.

Dr. Hillis offered the opinion that giving atropine was reasonable in Henry's case based upon her presentation. Dr. Hillis also thought that Henry most likely had developed her intracranial bleed before she had even been given the atropine.

The case was tried for six days in Fort Wayne. The jury deliberated for slightly over two hours before returning a defense verdict for Dr. Apuri. If the court entered a judgment, it was not part of the record at the time the IJVR reviewed it.

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