IN THE SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Civil Division

[redacted] personal representative
of the Estate of STEPHANIE STEPHENS
[redacted]

Plaintiffs

v. : Case No.:

GEOFFREY MOUNT-VARNER, M.D.
Personally and in his capacity as Acting Medical
Director for the Fire and Emergency Medical
Services Department
12710 Woodbridge Court
Bowie, Maryland 20721

and

DISTRICT OF COLUMBIA
SERVE: The Honorable Adrian M. Fenty
Mayor of the District of Columbia
c/o Erica Easter, Tabatha Braxton
or Arlethia Thompson
Office of the Secretary
John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Room 419
Washington, D.C. 20004

Also Serve:
Peter J. Nickles
Attorney General for the District of
Columbia
c/o Darlene Fields, Gale Rivers or
Tonia Robinson
Office of the Attorney General for the
District of Columbia
441 4th Street, N.W.
Room 600 – South
Washington, D.C. 20001

Defendants

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COMPLAINT

JURISDICTION

1. Jurisdiction is invoked over Defendants pursuant to D.C. Code §§11-921, 13-422, and 13-423.

PARTIES

2. Plaintiff [redacted] is the mother of Stephanie Stephens and is the personal representative of the Estate of Stephanie Stephens.

3. Decedent Stephanie Stephens was born on April 2, 2007.

4. Geoffrey Mount-Varner, M.D., was the acting Medical Director of the District of Columbia Fire and Emergency Medical Services Department (hereinafter "FEMS") from no later than December of 2009 or January of 2010 through February 11, 2010, and is vicariously liable for the wrongful acts of the paramedic and emergency medical technicians who provided care and treatment to Stephanie Stephens under Dr. Mount-Varner's medical license during that time period.

5. Dr. Mount-Varner is a resident of Maryland.

6. District of Columbia was Dr. Mount-Varner's employer from no later than December of 2009 or January of 2010 through February 11, 2010, and is vicariously liable for Dr. Mount-Varner's wrongful acts and the wrongful acts of the paramedic and emergency medical technicians who provided care and treatment to Stephanie Stephens.

FACTS

7. Plaintiff incorporates by reference each and every allegation as set forth in Paragraphs 1 through 6 and further alleges that on March 17, 2010, Plaintiff sent to Dr. Geoffrey Mount-Varner a Notice of Intention to File Suit pursuant to the "Medical Malpractice Proceedings Act of 2006," D.C. Code §16-2802.

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8. The Notice of Intent was hand delivered to Dr. Mount-Varner at his work address of 1923 Vermont Avenue, N.W., Washington, D.C. 20001. Notice of Intent to file suit was also faxed with confirmation receipt, on 3/17/2010 and send by regular mail and certified mail to this work address on 3/17/2010, with certified mail receipt confirmation received back on 3/24/2010. On 3/18/2010, Tyra of the Office of the Medical Director, 1923 Vermont Avenue N.W., Washington D.C. called this law office confirming receipt on 3/17/2010 of the Notice of Intention to file suit.

9. The Notice of Intention to File Suit was also mailed to the District of Columbia Office of Risk Management, Attn: Claims, 441 4th Street, N.W., Suite 800 South, Washington, D.C. 20001.

10. The ninetieth day to file suit against Dr. Mount-Varner and the District of Columbia under D.C. Code §16-2802 is June 15, 2010.

11. A Notice pursuant to D.C. Code §12-309 was sent to the District of Columbia on March 05, 2010.

12. On February 10, 2010, at approximately 4:40 a.m. Stephanie Stephens was having difficulty breathing.

13. Stephanie Stephens, a two year old infant, was at her home located at 880 Southern Avenue, S.E., #403, Washington, D.C. 20032.

14. Stephanie Stephens' mother [redacted] called 911 for help at approximately 4:40 a.m. and told 911 that the infant Stephanie Stephens was having difficulty breathing. [redacted] dressed Stephanie Stephens in winter clothing in anticipation of transport to the hospital in the cold winter weather prevailing at this time, and [redacted] and her companion Freddie Colter had also put on winter clothing in preparation for riding to the hospital with Stephanie Stephens.

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15. The District of Columbia sent emergency medical technicians, including a paramedic, to the home. According to computer dispatch records the computer tracking of dispatch showed that unit Medic Team 33 was dispatched to the Stephen's home at 4:48 a.m. and it arrived at the home at 4:58 a.m. Medic Team 33 was then back in service and left the Stephens home at 5:08 a.m., only ten minutes after arrival, leaving without transporting Stephanie Stephens to the hospital.

16. According to best belief and investigation the unit was Paramedic Engine Company 33, Truck Company 8, Ambulance 33, Third Battalion, under the Fire and Emergency Medical Services control (hereafter FEMS).

17. The paramedics who responded and entered the Stephens' apartment were an unidentified male (hereafter EMT 1) and two females, unidentified to date. The taller of the two female EMTS (hereafter EMT2) is believed to be the senior paramedic on Team 33, and the shorter of the two females, hereafter EMT3 is believed to be junior to EMT2. Under FEMS protocols the EMT with the greatest degree of training or certification is supposed to be the team leader and coordinate the effort and make any command decisions for the FEMS team regarding treatment or transport. Plaintiff alleges the taller female EMT2 was in charge and was the team member who ultimately gave a false medical diagnosis and made the decision to deny transport to Stephanie Stephens based on an inadequate examination and incorrect medical diagnosis.

18. The paramedics did not bring in any equipment except a stethoscope, carried by EMT1.

19. The male EMT1 performed a brief examination of Stephanie Stephens with a stethoscope. EMT2 and EMT3 did not come within touching distance of Stephanie Stephens.

20. After the brief examination with the stethoscope, the male EMT1 conferred briefly with the two female paramedics. Since there was only 10 minutes from arrival to

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departure, and since the Stephen's apartment was a third/fourth floor walk up, there could only have been a miniscule amount of time spent on medical evaluation and discussion.

21. EMT2 believed to be senior of the team told [redacted] that Stephanie Stephens was okay, that she just had a little congestion, that they had seen a lot of that. She diagnosed Stephanie Stephens as having a mild cold or croup. She instructed [redacted] to take Stephanie Stephens into the shower and run the hot water continuously to create steam as the air in the apartment was dry. She instructed [redacted] to go the next day to obtain children's Tylenol, and to call them back if Stephanie Stephens got worse.

22. EMT2 and/or the other members of the FEMS team told [redacted] that Stephanie Stephens did not need to go to the hospital for any further diagnosis, treatment or observation. EMT2 and/or the other members of the FEMS team told [redacted] that they were not taking Stephanie Stephens to the hospital.

23. [redacted] relied upon the professional medical diagnosis and advice from the FEMS team and/or the senior paramedic EMT2. [redacted] followed the medical care instructions from the senior paramedic to take Stephanie Stephens into the bathroom and run the shower continuously to provide moist air to relieve her congestion. [redacted] performed this prescribed "therapy" repeatedly over the next 8 hours, at intervals. If this steam therapy provided any relief to Stephanie Stephens it affirmatively worsened her condition by masking the seriousness of the underlying pneumonia, thus delaying any further attempt to seek medical treatment. When the FEMS team leader falsely diagnosed Stephanie Stephen's condition as merely congestion, and prescribed this steam therapy, and refused to transport Stephanie Stephens based on this false diagnosis, these medical actions affirmatively worsened Stephanie Stephen's condition as these affirmative actions inevitably delayed the proper medical treatment long beyond any normal delay caused by a 911 dispatch error or traffic, weather or difficulty in locating the victim address by a FEMS team becoming lost, etc.. If the FEMS team 33 had

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transported Stephanie Stephens to the hospital immediately or even a few hours later the resources available at the emergency room would have likely saved Stephanie Stephen's life.

24. The EMT2 diagnosis of "congestion" was incorrect, as Stephanie Stephens was subsequently diagnosed with severe pneumonia, which caused her death the next day.

25. A special relationship was created by this intervention and affirmative action by this FEMS team 33, based upon the existing circumstances of this case. By making an incorrect medical diagnosis based upon a medically inadequate examination, and refusing to transport the sick child Stephanie Stephens, this FEMS team went beyond the general duty owed to the public by the FEMS of response and transport. The FEMS team made an affirmative decision to deny transport to this sick child based upon that inadequate examination and incorrect medical diagnosis. Since this was a two year old infant with breathing difficulties, her condition was more vulnerable than an adult in the general public to rapid deterioration should the diagnosis be incorrect. Since this was a two year old infant, she lacked the capacity to fully explain her condition to the adult FEMS team, raising the risk of misdiagnosis and potentially more serious consequences of an incorrect diagnosis and resultant refusal to transport. Since this medical diagnosis was undertaken at a time when the District of Columbia was in the beginning of a second snow storm within a few days, with many inches of snow already on the ground, a special relationship was created by this incorrect medical diagnosis since Stephanie Stephens had no immediate alternative means of transport to seek medical attention or a second opinion. Her mother [redacted] had no automobile, nor did any member of her household. The WMATA bus system and MetroAccess were both closed. WMATA trains were supposedly running underground on 2/10/2010, beginning at 5:00 a.m., but the nearest subway station to Stephanie Stephen's apartment on 880 Southern Avenue was the Green Line Station at Southern Avenue which was an above ground station. The sidewalks were still completely buried with

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20 inches of prior snow making it difficult to carry a sick infant for any distance under the circumstances.

No private taxi cab service was available. The only practical option for Stephanie Stephens to get transport to the hospital at 4:48 on February 10, 2010 or to seek a second medical opinion was from the FEMS service. Given that there was no immediate alternative possibility of transportation, that this was an infant who could not fully communicate, that breathing difficulties with an infant are well known under FEMS protocols to be at risk of more rapid deterioration than those of an adult, the decision to make an affirmative incorrect medical diagnosis, based upon an inadequate and grossly insufficient examination, and the refusal to transport based upon this affirmative act of diagnosis goes beyond the duty owed to the general public, and created a special relationship with this infant child. The refusal to transport this seriously ill child based upon a grossly inadequate examination and incorrect diagnosis were voluntary and affirmative actions undertaken within the skill set, expected on-job medical duties, and experience and training of the professional paramedic FEMS Team 33 and team leader EMT2. Therefore the subsequent denial of transport based upon an inadequate medical examination and/or prescribing palliative measures were affirmative medical actions which may have served to mask the serious nature of the illness directly and affirmatively caused a eight to nine hour delay in treatment for which FEMS team leader EMT2 was directly responsible for in the performance of her on-scene medical duties.

26. EMT2 and/or the other members of the FEMS team failed to inform [redacted] [redacted] of the risks or possible consequences associated with not seeking further medical care for infant respiratory distress.

27. No documentation has been produced in response to requests to the FEMS which indicates any discussion of risks and possible consequences of not seeking medical care and treatment took place. No document exists which indicates [redacted] ever refused

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transport. No effort was made by the FEMS team to persuade [redacted] to transport Stephanie Stephens to the hospital. On the contrary, the FEMS team affirmatively asserted that they would not transport Stephanie Stephens.

28. EMT2 delegated to EMT1 OR EMT3 or another emergency medical technician the preparation of a patient care report and this report was never prepared.

29. EMT2 herself did not prepare a patient care report or supervise the execution of the patient care report. According to the FEMS, there was no ambulance run report or any documentation of this incident by Medic Team 33 of any kind.

30. EMT2 and/or the emergency medical technicians did not adequately document the patient history, signs or symptoms, all patient care given, and discussions with [redacted] regarding risks and consequences of not seeking medical for breathing problems for the infant Stephanie Stephens.

31. The patient care provided was inadequately documented, indeed apparently not documented at all.

32. EMT2 and/or the emergency medical technicians did not classify Stephanie Stephens' situation as life-threatening or even potentially life-threatening.

33. EMT2 and/or the emergency medical technicians did not consider calling a supervisor or Medical Control or any on call medical physician for guidance or help persuading [redacted] to take Stephanie Stephens to the hospital. Instead they told her in no uncertain terms that there was no need to go to the hospital, without any attempt to seek further guidance from their supervisors or any higher medical authority outside Medic Team 33 at the scene.

34. Approximately 8 ½ hours after [redacted] called 911, she called 911 again as Stephanie Stephanie's condition had worsened and Stephanie Stephens was then transported to the Children's National Medical Center hospital at approximately 2:30 p.m. on 2/10/2010 where she rapidly worsened further.

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35. Stephanie Stephens died on February 11, 2010 at approximately 12:33 a.m.

36. Stephanie Stephens died from Streptococcus pneumoniae, with septicemia, severe sepsis with septic shock.

37. If Stephanie Stephens had been transported to the hospital by EMT2 and/or the emergency medical technicians of Medic Team 33 when they arrived at her address at approximately 4:58 a.m. on 2/10/2010 she probably would have survived the Streptococcus pneumoniae, with septicemia.

38. Under D.C. Code §5-404.01, the Medical Director for FEMS is responsible for providing medical oversight for all aspects of pre-hospital medical services provided by the District.

39. Under D.C. Code §5-404.01, the Medical Director for FEMS is responsible for written policies, procedures, and protocols for pre-hospital medical care provided by the District.

40. Under D.C. Code §5-404.01, the Medical Director for FEMS is responsible for medical training of personnel providing pre-hospital medical care for the District.

41. Under D.C. Code §5-404.01, paramedics and emergency medical technicians operate under the medical license of the Medical Director for FEMS.

42. Under D.C. Code §5-404.01, the Medical Director is personally liable for death or injury that results from the provision of pre-hospital medical care by the District's emergency medical technicians or paramedics if the death or injury is the result of willful misconduct or gross negligence of the Medical Director.

43. Geoffrey Mount-Varner, M.D., was the acting Medical Director of the District FEMS in February 2010.

44. From March 2008 through February 2010, at the request of the District, the Maryland Fire Rescue Institute tested District of Columbia paramedics.

45. The testing included a written test and a videotaped practical skills assessment.

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46. Large numbers of paramedics failed the written test.

47. Large numbers of paramedics failed the practical skills assessment.

48. EMT2, and the emergency medical technicians EMT1 and EMT3 who treated Stephanie Stephens, participated or should have participated in the testing.

49. EMT2, and the emergency medical technicians EMT1 and EMT3 who treated Stephanie Stephens, failed this test or failed to take this test thus failing to demonstrate knowledge of the national standards of care as it applies to paramedics responding to difficult breathing complaints and conditions.

50. The test results were available prior to Stephanie Stephens' death and the District and Dr. Geoffrey Mount-Varner had an opportunity to take actions to protect persons such as Stephanie Stephens by removing from patient care those EMTs such as EMT1, EMT2 and EMT3 who failed to demonstrate the necessary required practical medical skills necessary for providing even adequate emergency medical treatment to the public by taking and passing this test.

51. The senior EMT2 and/or other members of the FEMS team in question had been subject to prior disciplinary actions and/or demotions due to violations of protocols and/or failures to provide adequate service according to the standards and protocols of the FEMS.

52. Despite numerous poor performances, and the inability to demonstrate adequate competence by passing the Maryland Fire Rescue Institute written and video-tape performance tests, Dr. Mount-Varner chose to place EMT2 as senior paramedic on Medic Team 33, and allow EMT1, EMT2, and EMT3 to be in contact with patients and not to retrain EMT1, EMT2, and EMT3 prior to allowing them to participate in the treatment of Stephanie Stephens.

53. Allowing EMT2 EMT1 and EMT3 to have contact with patients, and/or to assume senior leadership of an FEMS team was grossly negligent and represented a total disregard for the safety of those patients.

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COUNT I – Medical Malpractice

54. Plaintiff incorporates by reference each and every allegation as set forth in Paragraphs 1 through 53 and further alleges that during all relevant times the training and supervision of paramedics by Defendant Mount-Varner was grossly negligent.

55. Defendant Geoffrey Mount-Varner's training and supervision of the paramedic and emergency medical technicians Medic Team 33 that provided care and treatment to Stephanie Stephens was grossly negligent and grossly inadequate.

56. Defendant Geoffrey Mount-Varner had actual knowledge that EMT2, the paramedic who treated and cared for Stephanie Stephens, and/or the other members of the FEMS Medic Team 33, EMT1 and EMT3 on the morning of 2/10/2010 were not competent to have contact with patients.

57. Defendant Mount-Varner knew, and/or it was reasonably foreseeable, that EMT2 and/or the other members of the FEMS Medic Team 33 EMT1 and EMT3 would encounter persons with difficulty breathing distress and that EMT2 and/or the other members of the FEMS Medic Team 33 EMT1 and EMT3 posed a high risk to patients with difficulty breathing.

58. That the affirmative actions of EMT2 and/or the other members of the FEMS Medic Team 33 EMT1 and EMT3 as the emergency medical technicians who provided care and treatment to Stephanie Stephens worsened Stephanie Stephen's medical condition. The incorrect medical diagnosis and denial of transport when no other transport or medical attention was easily available was grossly negligent. The prescription of palliative actions addressing cold symptoms may have masked the seriousness of the underlying condition causing a fatal delay in treatment.

59. EMT2 and/or the other members of the FEMS Medic Team 33 EMT1 and EMT3 who provided care and treatment to Stephanie Stephens, grossly departed from the national

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standard of care by, and were grossly negligent in: (1) diagnosing Stephanie Stephens as having only congestion or a mild cold, (2) informing [redacted] that she did not need to take Stephanie Stephens to the hospital, (3) convincing [redacted] all she should do was to take Stephanie Stephens into the bathroom and run the shower and run the hot water continuously to create steam as the air was dry and go the next day to obtain children's Tylenol, (4) failing to inform [redacted] of the risks and possible consequences associated with not seeking medical care for breathing problems, (5) failing to properly or adequately examine Stephanie Stephens by allowing only a cursory exam with a stethoscope only by a junior team member, failing to perform any examination personally, as the senior medical EMT at the scene, bringing no medical or diagnostic equipment to the scene beyond that stethoscope carried by the junior EMT1, (6) failing to properly care and treat Stephanie Stephens' breathing problem by failing to give her oxygen, and transport her to the hospital, (7) failing to adequately document the patient history, signs or symptoms, all patient care given, and discussions with the patient regarding risks and consequences of not seeking medical care for breathing problems, (8) failing to classify Stephanie Stephens' situation as life-threatening, (9) failing to contact a supervisor or Medical Control for guidance on persuading Stephanie Stephens to go to the hospital, (10) refusing transport to an infant in respiratory distress during a weather emergency which would obviously and foreseeably limit any medical second opinion or further medical treatment due to lack of alternative transport or access to emergency medical care, and (11) such other acts or omissions that may be revealed during discovery.

60. Geoffrey Mount-Varner, M.D. is vicariously liable for the grossly negligent wrongful acts of the paramedic and emergency medical technicians of FEMS Medic Team 33, EMT1, EMT2 and EMT3 who provided care and treatment to Stephanie Stephens.

61. District of Columbia is vicariously liable for the wrongful and grossly negligent acts of Dr. Mount-Varner's and of the paramedic and emergency medical technicians of FEMS

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Medic Team 33, EMT1, EMT2 and EMT3 who provided care and treatment to Stephanie Stephens.

62. As a direct and proximate result of the gross negligence of Defendants, described above, Stephanie Stephen's Streptococcus Pneumoniae and respiratory difficulty when untreated resulted in her death.

WHEREFORE, for the foregoing reasons, Plaintiff respectfully demands judgment against Defendants, jointly and severally, under Count I in the full and just amount of Five Million Dollars ($5,000,000) plus interest and costs.

COUNT II – Wrongful Death

63. Plaintiff incorporates by reference the allegations set forth in Paragraphs 1 through 62 and further alleges that this action arises under Title 16, § 2701 *et seq.* of the District of Columbia Code, and is brought by [redacted] as the personal and legal representative of the Estate of Stephanie Stephens.

64. Stephanie Stephens' death was the direct and proximate result of the grossly negligent acts and/or omissions of Defendants and/or their employees, servants, and/or agents.

65. The above-referenced acts and omissions were the proximate cause of Stephanie Stephens' death.

66. At the time of her death, Stephanie Stephens was the youngest child of [redacted] [redacted].

67. As a result of the grossly negligent acts and/or omissions of the Defendants, the Estate of Stephanie Stephens and the heirs of Stephanie Stephens have incurred medical bills, the expense of burial, loss of income, and loss of the future services, protection, care, and assistance from this child.

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WHEREFORE, Plaintiff [redacted] respectfully demands judgment against Defendants, jointly and severally, under Count II in the full and just amount of Five Million Dollars ($5,000,000), plus interest and costs.

COUNT III – Survival Action

68. Plaintiff incorporates by reference Paragraphs 1 through 67 and further alleges that this action arises under the District of Columbia Survival Statute, Title 12, §101 *et seq.* of the District of Columbia Code, and is brought by [redacted] as the personal representative and legal representative of the Estate of Stephanie Stephens.

69. As a direct and proximate result of the Defendants' grossly negligent acts and omissions, the Estate of Stephanie Stephens has been deprived of all probable future earnings.

70. As a further direct and proximate result of the grossly negligent acts and omissions of the Defendants the Decedent sustained permanent injuries, mental anguish, and pain and suffering prior to her death and sustained a loss of future income and incurred medical bills.

WHEREFORE, Plaintiff [redacted] demands judgment of the Defendants, jointly and severally, under Count III in the full and just amount of Five Million Dollars ($5,000,000), plus interest and costs.

COUNT IV – Punitive Damages

71. Plaintiff incorporates by reference Paragraphs 1 through 70 and further alleges that Defendant Mount-Varner is liable for punitive damages.

72. Defendant Mount-Varner acted with a willful disregard for the rights of Stephanie Stephens. The FEMS Medic Team 33, EMT1, EMT2 and EMT3 who provided care and treatment to Stephanie Stephens acted with a willful disregard for the rights of Stephanie Stephens.

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73. Defendant Mount-Varner's conduct was outrageous, grossly fraudulent, grossly negligent and/or reckless toward the safety of Stephanie Stephens and the community. The acts of FEMS Medic Team 33, EMT1, EMT2 and EMT3 who provided care and treatment to Stephanie Stephens were outrageous, grossly fraudulent, grossly negligent and/or reckless toward the safety of Stephanie Stephens and the community.

WHEREFORE, Plaintiff [redacted] demands judgment of the Defendants, jointly and severally, under Count IV in the full and just amount of Two Million Dollars ($2,000,000), plus interest and costs.

JURY DEMAND

Plaintiffs request a jury of 6 on all issues of this Complaint.

Respectfully submitted,

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