

Lloyd N. Bell (GA #048800)*
Daniel E. Holloway (GA #658026)*
Mauricio A. Gonzalez (CA #230614, GA# 585841)*
BELL LAW FIRM
1201 Peachtree St NE #2000
Atlanta, GA 30361
bell@belllawfirm.com
dan@belllawfirm.com
mauricio@belllawfirm.com
*Pro Hac Vice Admission Pending

Jeffrey J. Steele (#10606)
Justin M. Hosman (#15634)
Alyssa J. Wood (#16613)
STEELE ADAMS HOSMAN
6713 South 1300 East
Cottonwood Heights, Utah
jeff@sahlegal.com
justin@sahlegal.com
alyssa@sahlegal.com

THIRD DISTRICT COURT

SALT LAKE COUNTY, STATE OF UTAH

**BRETT DONER and HEATHER MYERS,
individually and in their capacity as personal
representatives of THE ESTATE OF
GWENDOLYN DONER,**

Plaintiffs,

vs.

**INTERMOUNTAIN HEALTHCARE, INC;
INTERMOUNTAIN MEDICAL CENTER;
INTERMOUNTAIN MEDICAL GROUP;
IHC HEALTH SERVICES, INC;
LIFEFIGHT; LISA JEWKES, RN; RYAN
KIMBALL, PARAMEDIC; DON H. VAN
BOERUM, MD; SARAH MAJERCIK, MD;
CHRISTINA PELO, PA; MURRAY CITY;**

COMPLAINT AND JURY DEMAND

Case No.

Judge:

Discovery Tier 3

**MURRAY CITY FIRE DEPARTMENT;
DANIELLE WINTERS; UNIFIED FIRE
AUTHORITY; UTAH HIGHWAY
PATROL; GOLD CROSS AMBULANCE,
AND DOES 1-10, inclusive,**

Defendants.

Brett Doner and Heather Myers (“Plaintiffs”), by and through their counsel of record, allege and complain against Defendants as follows.

NATURE OF THIS ACTION

1. This action arises out of medical services tortiously provided to 19-year-old Gwendolyn Doner (“Gwen” or “Doner”) in April 2021, resulting in her wrongful death.



2. This action is brought by Gwen’s father, Brett Doner, and her mother, Heather Myers, individually and on behalf of Gwen’s estate.



3. Pursuant to Utah Code Section 78B-3-106, Heather and Brett assert wrongful-death claims, on behalf of all wrongful-death beneficiaries.

4. Brett and Heather also assert claims for damages they suffered directly.

5. 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’ conduct here.

OVERVIEW OF CASE

6. This is a straightforward case.

7. After surviving a head-on vehicular collision with her brain unhealed, Gwen went into respiratory arrest because EMS providers injected her with 500 milligrams of ketamine—over 16 times the maximum indicated dose.

8. Then, for 7-9 minutes, not one of dozens of EMS providers was able or prepared to provide Gwen BVM ventilation—causing Gwen fatal anoxic brain injury. Gwen never regained consciousness and was pronounced dead at IMC about 29 hours later.

9. At IMC, even after Gwen had extensor posturing in all limbs, providers concealed the overdose, the respiratory arrest, and the anoxic brain injury. Then, after internally confirming and documenting anoxic brain injury as the cause of Gwen's death, IMC providers continued to conceal the injury. To this day, despite fiduciary and ethical duties requiring transparency, no Defendant has acknowledged the true cause of Gwen's death—iatrogenic anoxic brain injury.

10. This is also a rare case.

11. While iatrogenic errors are all too common, rarely are they captured on video.

12. Here, Defendants' cameras preserved the events leading to Gwen's death: Winters and Sneddon preparing and handing off a syringe with 500 milligrams of ketamine; Jewkes and Kimball injecting the medication into Gwen's bloodstream; Gwen immediately falling into silence and slipping into respiratory arrest; and then a host of EMS providers fumbling about and slow-walking, unable and unprepared to ventilate Gwen while her brain died from anoxia.

13. Here, the cameras also caught Defendants recognizing and admitting the iatrogenic errors.

Jewkes: Ketamine is in!

Winters: Did you give it all?

Jewkes: [no response]

Ellefsen: Okay, Lisa, did you give her all, all the—?

Jewkes: Yes.

Ellefsen: The whole thing?

Jewkes: I gave it all.

14. Then, 62 seconds later, the cameras captured Winters aghast, as she frantically recognized that the massive dose had, as expected, caused Gwen respiratory arrest.

Winters: I have a problem. I gave her 500 of ketamine. I told her what it was. She gave her the whole damn thing . . . She wasn't supposed to give her that much . . . So, anyway, **she stopped breathing now** . . . So, I need someone to get me some intubation equipment to intubate

15. Here, at the crucial moment Gwen needed and trusted healthcare professionals to do their jobs, the cameras captured and preserved their failure—and her last effective breath.

PARTIES AND JURISDICTION

Plaintiffs

16. **Plaintiff Brett Doner** is a natural person, and the biological father of Gwendolyn Doner. Brett is a resident of the State of Wyoming. Brett asserts claims herein, both individually and on behalf of Gwen's estate.

17. **Plaintiff Heather Myers** is a natural person, and the biological mother of Gwen Doner. Heather is a resident of the State of Wyoming. She asserts claims herein, both individually and on behalf of Gwen's estate.

IHC Defendants

18. **Defendant Intermountain Health Care (“IHC”)** is a Utah-based corporation, doing business in Salt Lake County, Utah.

19. **Defendant Intermountain Medical Center (“IMC” or “Hospital”)** is a Utah-based corporation, doing business in Salt Lake County, Utah. The Hospital’s address is 5121 S. Cottonwood Street, Murray, Utah 84157.

20. IMC is owned, operated, and/or controlled by IHC.

21. IHC is thus vicariously liable for IMC’s wrongful acts and omissions.

22. **Defendant Intermountain Medical Group (“IMG”)** is a Utah-based Corporation, doing business in Salt Lake County, Utah.

23. IMG is owned, operated, and/or controlled by IHC.

24. IHC is thus vicariously liable for IMG’s wrongful acts and omissions.

25. **Defendant IHC Health Services, Inc. (“IHS”)** is a Utah-based corporation, doing business in Salt Lake County, Utah.

26. IHS is owned, operated, and/or controlled by IHC.

27. IHC is thus vicariously liable for IHS’s wrongful acts and omissions.

28. **Defendant LifeFlight (“Life Flight” or “LifeFlight”)** is a Utah-based corporation doing business in Salt Lake County, Utah. Life Flight provides emergency medical services (“EMS”) and transport, doing business as “Intermountain Life Flight.”

29. Life Flight is owned, operated, and/or controlled by IHC, IMC, IMG, and/or IHS.

30. IHC, IMC, IMG, and/or IHS are thus vicariously liable for Life Flight’s wrongful acts and omissions.

31. In this Complaint, the term **“Intermountain Defendants”** refers to IHC, IMC, IMG, IHS, and Life Flight collectively.

32. **Defendant Lisa Jewkes, RN (“Jewkes”)** is a natural person. Jewkes is a registered nurse and an EMS provider with Life Flight, doing business in Salt Lake County, Utah.

33. At all times relevant to this Complaint, Jewkes was acting within the course and scope of her employment with one or more of the Intermountain Defendants.

34. One or more of the Intermountain Defendants are thus vicariously liable for Jewkes’s wrongful acts and omissions.

35. **Defendant Ryan Kimball (“Kimball” or “Ryan”)** is a natural person.¹ Kimball is a paramedic with Life Flight, doing business in Salt Lake County, Utah.

36. At all times relevant to this Complaint, Kimball was acting within the course and scope of his employment with one or more of the Intermountain Defendants.

37. One or more of the Intermountain Defendants are thus vicariously liable for Kimball’s wrongful acts and omissions.

38. **Defendant Don H. Van Boerum, MD (“Van Boerum”)** is a natural person. Van Boerum is a physician with IMC, doing business in Salt Lake County, Utah.

39. At all times relevant to this Complaint, Van Boerum acted within the course and scope of his employment with one or more of the Intermountain Defendants.

¹ Defendant Jewkes committed alleged negligence working side-by-side with a Life Flight provider whom she identified as “Ryan.” On information and belief, that provider was Life Flight paramedic Ryan Kimball. If the “Ryan” that Jewkes identified was actually another person, Plaintiffs will dismiss the claims against Ryan Kimball and will name the actual “Ryan” in place of a John Doe.

40. One of more of the Intermountain Defendants are thus vicariously liable for Van Boerum's wrongful acts and omissions.

41. **Defendant Sarah Majercik, MD ("Majercik")** is a natural person. Majercik is a physician with IMC, doing business in Salt Lake County, Utah.

42. At all times relevant to this Complaint, Majercik acted within the course and scope of her employment with one or more of the Intermountain Defendants.

43. One of more of the Intermountain Defendants are thus vicariously liable for Majercik's wrongful acts and omissions.

44. **Defendant Christina Pelo, PA ("Pelo")** is a natural person. Pelo is a physician assistant with IMC, doing business in Salt Lake County, Utah.

45. At all times relevant to this Complaint, Pelo acted within the course and scope of her employment with one or more of the Intermountain Defendants.

46. One of more of the Intermountain Defendants are thus vicariously liable for Pelo's wrongful acts and omissions.

Murray Defendants

47. **Defendant Murray City ("Murray City" or "MC")** is a city and a political subdivision of the State of Utah.

48. **Defendant Murray City Fire Department ("MCFD")** is, among other things, an EMS provider doing business in Salt Lake County, Utah.

49. MCFD is managed, operated, and/or controlled by Murray City.

50. Murray City is thus vicariously liable for MCFD's wrongful acts and omissions.

51. **Defendant Danielle Winters (“Winters”)** is a natural person. Winters is a paramedic with MCFD, doing business in Salt Lake County, Utah.

52. At all times relevant to this Complaint, Winters was acting within the course and scope of her employment with Murray City and/or MCFD.

53. Murray City and/or MCFD are thus vicariously liable for Winters’ wrongful acts and omissions.

54. **Russell Sneddon (“Sneddon”)** is a natural person. Sneddon is a paramedic with MCFD, doing business in Salt Lake County, Utah. Sneddon will be added as a Defendant upon the completion of the prelitigation panel.

55. At all times relevant to this Complaint, Sneddon was acting within the course and scope of his employment with Murray City and/or MCFD.

56. Murray City and/or MCFD are thus vicariously liable for Sneddon’s wrongful acts and omissions.

57. **Steve Ellefsen (“Ellefsen”)** is a natural person. He is a captain and an emergency medical technician (“EMT”) with MCFD, doing business in Salt Lake County, Utah. Ellefsen will be added as a Defendant upon the completion of the prelitigation panel.

58. At all times relevant to this Complaint, Ellefsen was acting within the course and scope of his employment with Murray City and/or MCFD.

59. Murray City and/or MCFD are thus vicariously liable for Ellefsen’s wrongful acts and omissions.

Gold Cross Defendants

60. **Defendant Gold Cross Services, Inc. (“Gold Cross”)** is a Utah-based Corporation, doing business in Salt Lake County, Utah. Gold Cross provides EMS care and transport.

61. **Joshua Humphrey (“Humphrey”)** is a natural person. Humphrey is an advanced EMT (“AEMT”) with Gold Cross, doing business in Salt Lake County, Utah. Humphrey will be added as a Defendant upon the completion of the prelitigation panel.

62. At all times relevant to this Complaint, Humphrey was acting within the course and scope of his employment with Gold Cross.

63. Gold Cross is thus vicariously liable for Humphrey’s wrongful acts and omissions.

64. **Grace Haynie (“Haynie”)** is a natural person. Haynie is an AEMT with Gold Cross, doing business in Salt Lake County, Utah. Haynie will be added as a Defendant upon the completion of the prelitigation panel.

65. At all times relevant to this Complaint, Haynie was acting within the course and scope of her employment with Gold Cross.

66. Gold Cross is thus vicariously liable for Haynie’s wrongful acts and omissions.

UFA Defendants

67. **Defendant Unified Fire Authority (“UFA”)** is a Utah-based corporation, doing business in Salt Lake County, Utah. UFA provides, among other things, EMS care and transport.

68. **Kurt Stephensen (“Stephensen”)** is a natural person. Stephensen is a paramedic with UFA, doing business in Salt Lake County, Utah. Stephensen will be added as a Defendant upon the completion of the prelitigation panel.

69. At all times relevant to this Complaint, Stephensen was acting within the course and scope of his employment with UFA.

70. UFA is thus vicariously liable for Stephensen's wrongful acts and omissions.

71. **Cory Bates ("Bates")** is a natural person. Bates is an EMT with UFA, doing business in Salt Lake County, Utah. Bates will be added as a Defendant upon the completion of the prelitigation panel.

72.

73. At all times relevant to this Complaint, Bates was acting within the course and scope of his employment with UFA.

74. UFA is thus vicariously liable for Bates's wrongful acts and omissions.

75. **Matthew Anderson ("Anderson")** is a natural person. Anderson is a captain and paramedic with UFA, doing business in Salt Lake County, Utah. Anderson will be added as a Defendant upon the completion of the prelitigation panel.

76. At all times relevant to this Complaint, Anderson was acting within the course and scope of his employment with UFA.

77. UFA is thus vicariously liable for Anderson's wrongful acts and omissions.

UHP Defendants

78. **Defendant Utah Highway Patrol ("UHP")** is a service division of the State of Utah, doing business in Salt Lake County, Utah. UHP provides, among other things, emergency medical care.

79. **Kristopher Cope (“Cope”)** is a natural person. Cope is a corporal or trooper with UHP, doing business in Salt Lake County, Utah. Cope is also a certified EMT. Cope will be added as a Defendant upon the completion of the prelitigation panel.

80. At all times relevant to this Complaint, Cope was acting within the course and scope of his employment with UHP.

81. UHP is thus vicariously liable for Cope’s wrongful acts and omissions.

Doe Defendants

82. The identities and roles of Defendant Does 1-10 are unknown to Plaintiffs at this time, and they are therefore listed as Does.

83. Plaintiffs believe some of Does 1-10 may be other employees or agents of IHC, IMC, IMG, IHS, Life Flight, Murray City, MCFD, Gold Cross, UFA, and/or UHP, who were involved in the care at issue here.

84. Plaintiffs also believe some of Does 1-10 may be other employers or principals of individual Defendants named or to be named in this Complaint.

85. Plaintiffs reserve the right to amend this Complaint to add Doe Defendants as named Defendants, insofar as their identities and roles are later ascertained.

Procedural Requirements

86. Pursuant to Utah Code § 78A-5-102, this Court has jurisdiction over this matter.

87. Pursuant to Utah Code § 78B-3-418, prior to filing this action, Plaintiffs obtained a Certificate of Compliance from the Division of Occupational and Professional Licensing.

88. All statutory conditions precedent to the commencement of this action have been met.

89. Before filing this action, Plaintiffs satisfied all the requirements of the Utah Governmental Immunity Act.

90. Pursuant to Rule 26(c)(3) of the Utah Rules of Civil Procedure, this is a Tier 3 case.

GENERAL MEDICAL PRINCIPLES

The Respiratory System

91. The human body receives oxygen through respiration (breathing), by inhaling air (which contains oxygen) into the lungs.²

92. The respiratory system is the network of organs and tissues that help with breathing.³

93. The respiratory system is made up of the airway, lungs, and blood vessels.⁴

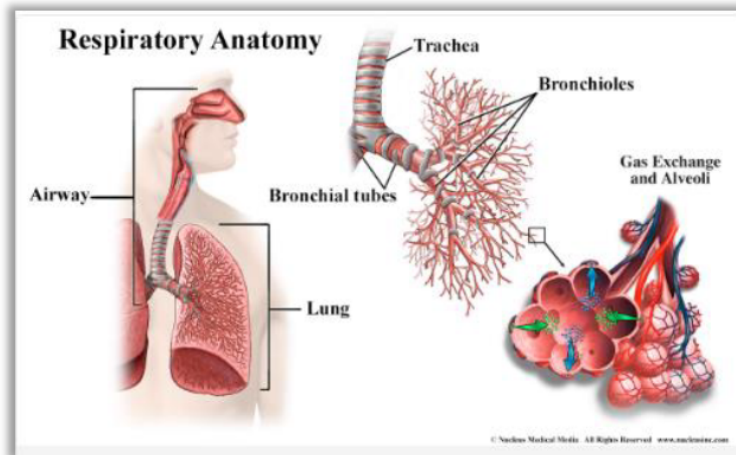
94. The airway consists of the mouth, nose, pharynx (throat), larynx (voice box), trachea (windpipe), bronchial tubes, and bronchioles.⁵

² Richard Taylor & Ewald Weibel, *Design of Mammalian Respiratory System, I, Problem and Strategy, Respiration Physiology*, v 44, 1 (1981).

³ Duncan, Deborah. *Respiratory Care: Assessment and Management*, M & K Update Limited, 2017. ProQuest Ebook Central, <https://ebookcentral-proquest-com.ezproxy.lib.utah.edu/lib/utah/detail.action?docID=5790522>.

⁴ *Id.*

⁵ *Id.*



95. When a person breathes in (inhales), the airway carries oxygen into the lungs through the bronchial tubes, bronchioles, and alveoli.⁶

96. The alveoli are tiny air sacs at the end of the bronchioles.⁷

97. When a person inhales, the alveoli pick up the incoming oxygen. When a person exhales, the alveoli release outgoing waste (carbon dioxide).⁸

98. Alveoli contain tiny blood vessels (called capillaries) which move oxygen into the bloodstream, which then transports the oxygen throughout the body.⁹

⁶ Lars Knudsen & Matthias Ochs, *The micromechanics of Lung Alveoli: Structure and Function of Surfactant and Tissue Components*, Springer Link v 150 (2018), <https://link.springer.com/article/10.1007/s00418-018-1747-9> (last visited August 2022).

⁷ Id.

⁸ Duncan, *Respiratory Care: Assessment and Management*.

⁹ Knudson, *The micromechanics of Lung Alveoli: Structure and Function*.

99. The process of respiration is regulated by the respiratory center of the brain, also known as the medulla oblongata—which controls the speed and depth of breathing by causing the diaphragm to contract.¹⁰

100. The rate and strength at which the diaphragm contracts, and hence the frequency and volume of respiration, depend heavily on the firing patterns in the brain.¹¹

101. The normal respiratory rate is 12-20 breaths (respirations) per minute.¹²

Oxygen Saturation

102. Oxygen saturation (“SpO2”) is a measurement of the amount of oxygen bound to hemoglobin in a person’s bloodstream.¹³

103. A pulse oximeter is a device that clips onto a patient’s finger and measures oxygen saturation.¹⁴

104. Healthcare providers use a pulse-oximeter to monitor a patient’s SpO2.¹⁵

¹⁰ Duncan, *Respiratory Care: Assessment and Management*.

¹¹ Brinkman JE, Toro F, Sharma S. *Physiology, Respiratory Drive*. [Updated 2022 Jun 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK482414/>

¹² Chourpiliadis C, Bhardwaj A. *Physiology, Respiratory Rate*. [Updated 2021 Sep 20]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK537306>

¹³ Hafen BB, Sharma S. *Oxygen Saturation*. [Updated 2022 Nov 23]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK525974/>

¹⁴ Id.

¹⁵ Id.

105. An SpO2 of 97% to 99% is typically normal.¹⁶

The Nervous System

106. The nervous system consists of two subsystems: central and peripheral.¹⁷

107. The central nervous system (“CNS”) consists of the brain and spinal cord.¹⁸

108. The peripheral nervous system (“PNS”) consists of nerves that branch out from the CNS, including the cranial, spinal, and peripheral nerves.¹⁹

109. The PNS relays information between the CNS and the rest of the body.²⁰

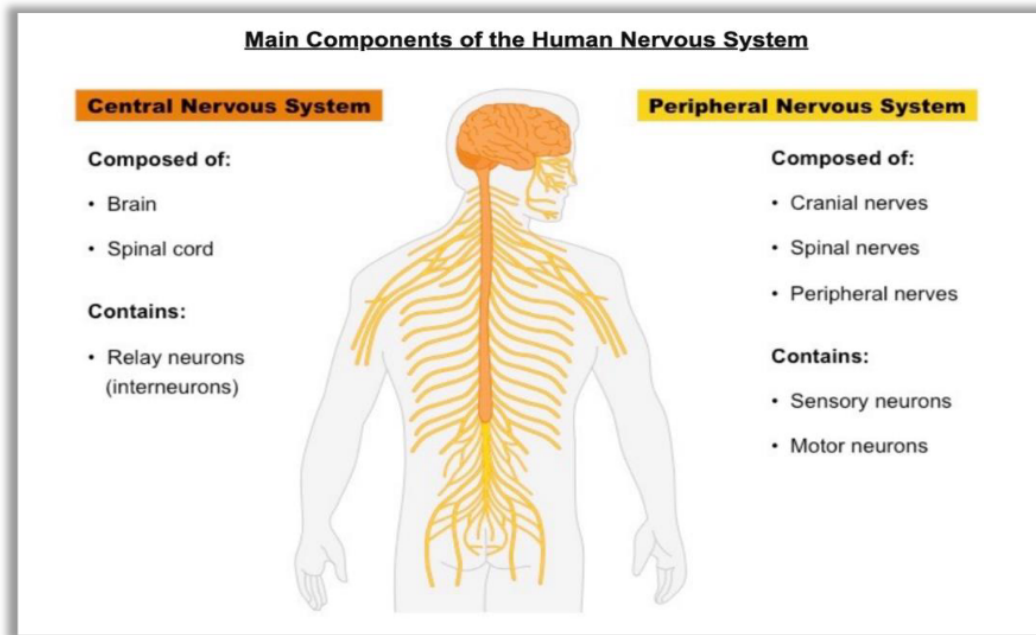
¹⁶ Susan De Meulenaere, Pulse Oximetry: Uses and Limitations, *The Journal for Nurse Practitioners*, Volume 3, Issue 5, 2007, P. 312, 317.

¹⁷ Solomon, Eldra Pearl. *Introduction to Human Anatomy and Physiology*, Elsevier, 2015. ProQuest Ebook Central,

¹⁸ Id.

¹⁹ Id.

²⁰ Id.



110. The PNS consists of two subsystems: somatic and autonomous.²¹

111. The somatic nervous system controls voluntary movements.²²

112. The autonomous nervous system controls automatic or unconscious body functions, such as breathing and heartrate.²³

113. Both the somatic and the autonomous systems have nerves that transmit messages to the CNS, which in turn processes the information and responds.²⁴

²¹ Id.

²² Id.

²³ Id.

²⁴ Id.

114. An interruption or even a slow-down of these transmissions can impair somatic and automatic functions. For example, breathing may slow (depression) or stop (arrest).

Anoxic Brain Injury

115. To work properly, the brain needs a constant supply of oxygen.²⁵

116. Hypoxia refers to low levels of oxygen in the tissues and organs.

117. Anoxia refers to a state of total oxygen deprivation within the tissues and organs.

Anoxia is thus a severe form of hypoxia.

118. When respiratory depression or arrest occurs, oxygen flow is reduced (hypoxia) or stopped completely (anoxia).²⁶

119. In contrast to traumatic brain injuries, which are caused by physical trauma, anoxic brain injuries are caused by oxygen deprivation.²⁷

120. When the brain is deprived of oxygen, brain cells die, damaging the brain.²⁸

121. Once brain cells die, they cannot be revived. The death of brain cells can lead to neurological deficits, permanent disability, and/or death.²⁹

²⁵ Lacerte M, Hays Shapshak A., Mesfin FB. Hypoxic Brain Injury. [Updated 2022 May 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK537310>

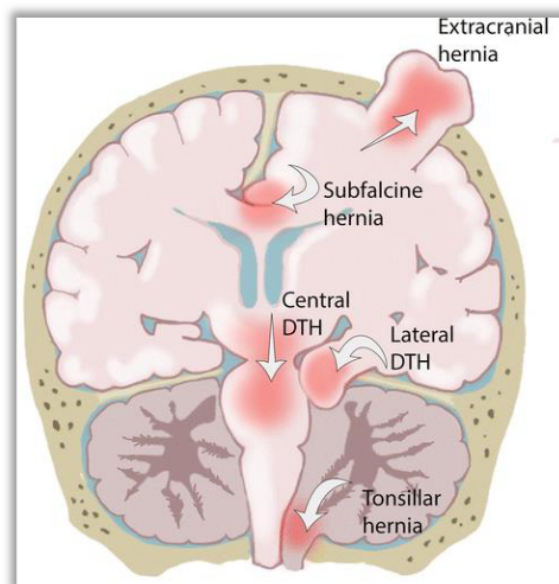
²⁶ Id.

²⁷ Id.

²⁸ Id.

²⁹ Headway, Hypoxic and Anoxic Brain Injury, <https://www.headway.org.uk/about-brain-injury/individuals/types-of-brain-injury/hypoxic-and-anoxic-brain-injury/> (last visited August 2022).

122. When a person's brain is deprived of oxygen for **four to six minutes**, irreversible brain damage or death can occur.³⁰
123. As brain cells die, the brain may start to swell (cerebral edema).³¹
124. Because the brain is encased snugly within the skull, cerebral edema causes intracranial pressure (pressure inside the skull).³²
125. Intracranial pressure can lead to cerebral herniation and brain-death.
126. Cerebral herniation is a shift in cerebral tissue from its normal location into an adjacent place.

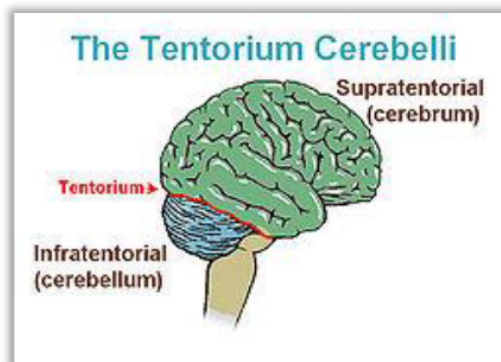


³⁰ Hornbein TF. Hypoxia and the brain. In: *The Lung: Scientific Foundations*, 2nd ed, Crystal RG, West JB, Weibel ER, Barnes PJ (Eds), Lippincott-Raven Publishers, Philadelphia 1997. p.1981.

³¹ McGillicuddy JE. Cerebral protection: pathophysiology and treatment of increased intracranial pressure. 1985 Jan;87(1):85-93. doi: 10.1378/chest.87.1.85. PMID: 3965268.

³² Cook, A.M., Morgan Jones, G., Hawryluk, G.W.J. et al. Guidelines for the Acute Treatment of Cerebral Edema in Neurocritical Care Patients. *Neurocrit Care* 32, 647–666 (2020). <https://doi.org/10.1007/s12028-020-00959-7>

127. A descending transtentorial herniation (“DTH”) occurs when the brain moves down across the tentorium.



Fentanyl: Basic Pharmacodynamics (Effects)

128. Fentanyl is a high-risk medication.

129. Fentanyl is a synthetic opioid with analgesic (pain-inhibiting) and anesthetic (sedating) properties.³³

130. Fentanyl is 50 to 100 times more potent than morphine.³⁴

131. Fentanyl is typically used to treat severe pain.³⁵

132. Like other opiates, fentanyl is a CNS depressant. Fentanyl binds to receptors in the brain and slows brain activity.

133. When brain activity is slowed, brain communication is also slowed.

³³ National Library of Medicine, PubChem Compound Summary, Fentanyl. <https://pubchem.ncbi.nlm.nih.gov/compound/3345> (last visited August 2022).

³⁴ Id.

³⁵ Id.

134. The slowing of communication pathways slows the signals that manage and monitor the respiratory system, slowing breathing and heartrate.

135. Fentanyl is known to cause respiratory depression and respiratory arrest.³⁶

136. If managed improperly, fentanyl can be fatal to a patient.³⁷

137. Mixing fentanyl with other drugs, like ketamine, increases the risk of respiratory depression and arrest.³⁸

138. After administering fentanyl to a patient, healthcare providers must monitor the patient closely, with equipment on hand to manage adverse effects.³⁹

Ketamine: Basic Pharmacodynamics (Effects)

139. Ketamine is a high-risk medication.

140. Ketamine is used for pain-control and sedation.⁴⁰

141. Like fentanyl, ketamine is a CNS depressant. Ketamine decreases brain activity and interrupts communication pathways throughout the body.⁴¹

³⁶ Thomas, A. R., & Schwartz, R. M. (2019). At-risk populations to unintentional and intentional fentanyl and fentanyl+ exposure. *Journal of Transportation Security*, 12(3-4), 73-82. <https://doi.org/10.1007/s12198-019-00202-1>

³⁷ Id.

³⁸ Merck Manual, Professional Version, Overview of Respiratory Arrest, <https://www.merckmanuals.com/professional/critical-care-medicine/respiratory-arrest/overview-of-respiratory-arrest> (last visited August 2022).

³⁹ Sheridan Memorial Hospital, Street Fentanyl vs Emergency Department Fentanyl, (April 18, 2022), <https://www.sheridanhospital.org/fentanyl-street-vs-emergency-department/> (last visited August 2022).

⁴⁰ National Center for Biotechnology Information (2022). PubChem Compound Summary for CID 3821, Ketamine. Retrieved August 2, 2022 from <https://pubchem.ncbi.nlm.nih.gov/compound/3821>.

⁴¹ https://www.uptodate.com/contents/ketamine-drug-information?source=auto_suggest&selectedTitle=1~2---1~2--ketamine%20interact&search=ketamine (last accessed August, 2022).

142. As a CNS depressant, ketamine decreases activity in the brain and spinal cord, thus slowing down the brain and communication pathways.

143. Ketamine is known to interact with other CNS-depressant medications like fentanyl, potentially resulting in profound sedation, coma, and death.⁴²

Ketamine: Routes of Administration

144. Ketamine has different routes of administration, including intravenous (“IV”), intraosseous (“IO”), and intramuscular (“IM”) administration.⁴³

145. When administered by IV, ketamine is injected into a vein through a catheter or needle.⁴⁴

146. IV administration permits rapid absorption into the bloodstream, allowing the medication to disseminate throughout the body rapidly.⁴⁵

147. When administered by IO, ketamine is delivered through the cortex of a bone into the medullary space, using a hollow needle.⁴⁶

148. IO administration has roughly the same absorption rate as IV administration.⁴⁷

⁴² Medical News Today, What Are the Uses of Ketamine? <https://www.medicalnewstoday.com/articles/302663> (last visited August 2022).

⁴³ Rosenbaum, Ketamine.

⁴⁴ <https://www.drugs.com/article/injection-types-sites.html>

⁴⁵ Id.

⁴⁶ Dornhofer P, Kellar JZ. Intraosseous Vascular Access. [Updated 2022 Jun 11]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK554373/>

⁴⁷ Id.

149. When administered by IM, ketamine is injected deep into muscle tissue.⁴⁸

150. Ketamine is then absorbed into the bloodstream more slowly compared to IV administration.⁴⁹

Ketamine: Dosing

National Model Guidelines

151. The National Association of State EMS Officials (“NASEMSO”) issues National Model EMS Clinical Guidelines (the “National Guidelines”), which include recommendations for the safe use of ketamine by EMS.⁵⁰

152. In April 2021, the 2017 National Guidelines, as revised in 2019, were in effect.

153. Under that version, if ketamine was administered for pain, the indicated dose was **0.25 milligrams per kilogram** of body weight.

6. If the patient is experiencing severe to excruciating pain, administer analgesics
 - a. Ketorolac (one-time dose only):
 - i. Adult: 15 mg IV in adults who are not pregnant
 - ii. Pediatric: (2-16 yo) 0.5mg/kg (maximum dose 15 mg)
 - b. Morphine sulfate: 0.1 mg/kg IV or IO (maximum initial dose 10 mg)
 - c. Fentanyl: 1 mcg/kg IV or IO (maximum initial dose 100 mcg)
 - d. Hydromorphone: 0.015mg/kg IM, IV, or IO (maximum initial dose 2 mg; maximum cumulative dose of 4 mg)
 - e. Ketamine: 0.25mg/kg IM, IV, IO (maximum initial dose 25mg; maximum cumulative dose 100mg)

⁴⁸ Id.

⁴⁹ Id.

⁵⁰ <https://health.wyo.gov/wp-content/uploads/2019/04/National-Model-EMS-Clinical-Guidelines-2017-PDF-Version-2.2.pdf>

154. Because Gwen Doner weighed less than 60 kilograms, the indicated dose for her was **less than 15 milligrams of ketamine** ($0.25 \times 60 = 15$).

155. Under the National Guidelines, moreover, if the indication was pain, the **absolute maximum dose was 25 milligrams**, regardless of weight.

156. That was the maximum dose, whether administered by IV, IO, or IM.

Utah Guidelines

157. The Bureau of Emergency Medical Services and Preparedness of the Utah Department of Health issues EMS Protocol Guidelines (“Utah Guidelines”), which include standards for the safe use of ketamine in the State.

158. In April 2021, the January 2020 Utah Guidelines were in effect.

159. Under that version, if ketamine was administered to an adult for pain, the indicated dose was a **maximum of 30 milligrams**.

160. The 30 milligrams were to be “infused over 15 minutes OR until analgesia [was] attained.”

PARAMEDIC

- Ketamine 30mg** diluted in 100mL of normal saline **IV/IO** infused over 15 minutes OR until analgesia is attained.

- **Pain** or Procedural-related Anxiety:
 - **IV/IO – 0.1-0.3 mg/kg (max 30mg)** diluted in 100mL of normal saline IV/IO drip over 15 minutes

161. In addition, if the indication was pain, the Utah Guidelines authorized administration by IV or IO, but not by IM.

Salt Lake County Protocols

162. Salt Lake County has issued EMS Protocols (the “Salt Lake Protocols”), which include requirements for the safe use of ketamine in the County.

163. In April 2021, the March 15, 2021, Salt Lake Protocols (last reviewed in March 2022) were in effect.

164. Under that version, if ketamine was administered to an adult for pain, the **maximum cumulative dose was 40 milligrams**, unless the desired effect was attained with less.

165. The Salt Lake Protocols authorized administration by IV bolus or IV infusion.

166. *First*, if administered by bolus, the indicated dosing was 10-20 milligram boluses every 5 minutes—“to the desired effect or max dose of 40 mg.”

167. Thus, **the maximum initial bolus was 20 milligrams**.

168. *Second*, if administered by infusion, the indicated dose was 40 milligrams “infused over 15 minutes OR until analgesia [was] attained.”

PARAMEDIC

- ☐ **Ketamine** (Agency Specific Option)
 - Consider the size of the patient for dosing
 - **IV/IO – 10-20mg** every 5 minutes to the desired effect or max dose of 40mg
 - 40mg diluted in 100mL of normal saline IV/IO infused over 15 minutes OR until analgesia is attained.
 - **Intranasal – 50mg x 1 dose**

169. In addition, if the indication was pain, the Salt Lake Protocols authorized administration by IV or IO, but not by IM.

MCFD Guidelines

170. In 2017, MCFD issued its own Standard Operating Guidelines (the “MCFD Guidelines”).⁵¹

171. Referring to the Utah Guidelines and the Salt Lake Protocols, the MCFD Guidelines stated that their purpose was to provide “a guideline for the use of Ketamine along side our State and District 2B Protocols.”

172. The MCFD Guidelines are thus an “addendum” to the Utah Guidelines and Salt Lake Protocols.

MURRAY CITY FIRE DEPARTMENT STANDARD OPERATING GUIDELINES	
CHAPTER NAME:	<i>EMS Operations and Equipment</i>
CHAPTER/SECTION:	<i>Chapter 3 Section 40</i>
SUBJECT:	<i>Ketamine Addendum to State and 2B protocols</i>
PURPOSE:	Provides a guideline for the use of Ketamine along side our State and District 2B Protocols

⁵¹ Murray City Fire Department Standard Operating Guidelines, EMS Operations and Equipment, Ch 3, Sec. 40, Ketamine Addendum to State and 2B protocols (2017).

173. Under the MCFD Guidelines, if ketamine was administered for pain management, the indicated dose was **0.25 milligrams per kilogram** of body weight—just like the National Guidelines.

174. Because Gwen weighed less than 60 kilograms, the indicated dose for her was **less than 15 milligrams** of ketamine ($0.25 \times 60 = 15$).

- 2) Addendum to the Pain and Anxiety Management Protocol
 - a) Ketamine is added and may be used in addition to fentanyl or morphine as a supplemental/secondary medication for major trauma. Pain management dose: **0.25mg/kg** with a typical adult dose range of 25-50mg slow push over 1-2 minutes.

175. The National Guidelines, Utah Guidelines, Salt Lake Protocols, and MCFD Guidelines reflect the presumptive standard of care.

176. Insofar as new versions of these standards have been issued since April 2021, they are substantially the same or do not materially differ from versions that applied in April 2021.

Ketamine Complications: Laryngospasm

177. A laryngospasm is an uncontrolled or involuntary muscle contraction (spasm) of the vocal cords.⁵²

⁵² Brinkman, Physiology, Respiratory Drive.

178. A laryngospasm causes the vocal cords and glottis to close and block the airway, making it difficult to speak and breathe.⁵³

179. Like other parts of the respiratory anatomy, the larynx, vocal cords, and glottis are controlled by the nervous system.

180. As the Utah Guidelines recognize, laryngospasm is a possible adverse effect of ketamine—even when the patient receives a proper, indicated dose.

181. For that reason, for **“every administration”** of ketamine, EMS providers must **“prepare to provide respiratory support including bag-valve-mask ventilation and suction.”**

Adverse Effects:

Laryngospasm: this very rare adverse reaction presents with stridor and respiratory distress.

- After every administration of ketamine:
 - Prepare to provide respiratory support including bag-valve-mask ventilation and suction which are generally sufficient in rare cases of laryngospasm.
 - Institute cardiac monitoring, pulse oximetry and continuous waveform capnography
 - Establish IV or IO access, check blood glucose
 - Establish and maintain physical restraint.

182. In fact, respiratory support with a BVM and suction “are generally sufficient in rare cases of laryngospasm.”

⁵³ Id.

Airway Management

183. Airway management is the process of ensuring adequate ventilation and oxygenation by establishing or maintaining a patent airway, which allows air to flow freely in and out of the lungs.

184. The goal of airway management is to prevent or relieve airway obstruction, facilitate the exchange of gases, and maintain adequate ventilation and oxygenation to support life.

185. Airway management techniques may include use of devices such as airway adjuncts and advanced airway devices.

186. Airway management is a critical skill for providers who encounter patients with compromised airways due to trauma, illness, or other medical conditions.

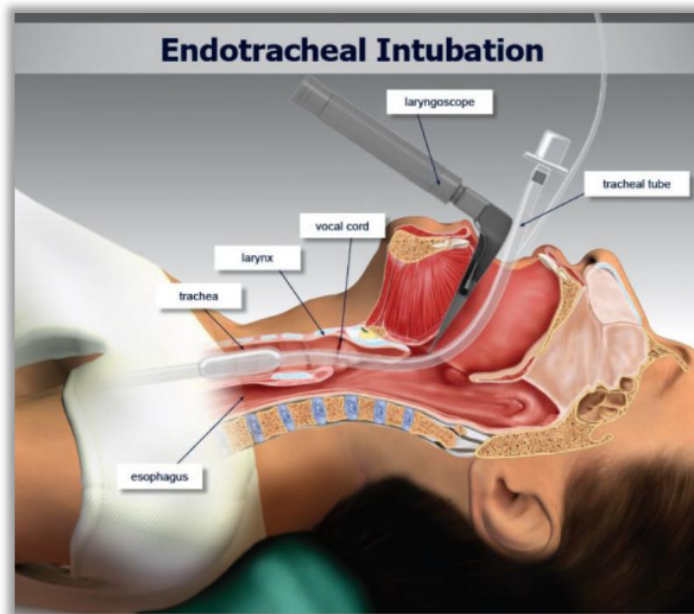
187. Airway management is a priority in emergency situations.⁵⁴

Intubation

188. Intubation is a procedure in which a tube is inserted into a patient's trachea (windpipe) to secure an open airway and facilitate breathing.⁵⁵

⁵⁴ Goto T, Goto Y, Hagiwara Y, Okamoto H, Watase H, Hasegawa K. Advancing emergency airway management practice and research. *Acute Med Surg*. 2019 May 21;6(4):336-351. doi: 10.1002/ams2.428. PMID: 31592072; PMCID: PMC6773646.

⁵⁵ Dörjes V. Airway management in emergency situations. *Best Pract Res Clin Anaesthesiol*. 2005 Dec;19(4):699-715. doi: 10.1016/j.bpa.2005.07.003. PMID: 16408542.



189. The tube is called an endotracheal tube (“ET tube” or “ETT”).
190. An ETT is inserted through the mouth or nose and passed down the throat into the trachea.
191. Intubation is the way to secure a patient’s airway definitively.
192. Healthcare providers rely on intubation to assist a patient who is having difficulty breathing on his or her own.
193. The procedure is often called “endotracheal intubation” or just “intubation.”
194. Intubation is considered the advanced form of airway management.

Intubation: Risks and Complications

195. Failed first intubation attempts are associated with a higher risk of adverse events, higher failure rates at the subsequent attempts, and lower probability of return of spontaneous circulation.⁵⁶

196. Failed intubation attempts endanger the patient by prolonging hypoxia, causing additional trauma to upper airways, and increasing the likelihood of respiratory depression and arrest.⁵⁷

197. In emergency airway management, it is crucial to (a) first generate an airway management plan, which involves determining the safest and most effective way to ventilate the patient, and (b) identify difficult airway situations.⁵⁸

198. Emergency personnel must have knowledge, training, and availability of alternative procedures for effectively and timely securing and managing the airway.⁵⁹

Alternatives to Intubation: Airway Adjuncts

199. Alternative devices to secure the airway include an oropharyngeal airway (“OPA”), nasopharyngeal airway (“NPA”), and laryngeal mask airway (“LMA”).

⁵⁶ Goto, Advancing emergency airway management practice and research p. 336-351.

⁵⁷ Dörge V. Airway management in emergency situations. Best Pract Res Clin Anaesthesiol. 2005 Dec;19(4):699-715. doi: 10.1016/j.bpa.2005.07.003. PMID: 16408542.

⁵⁸ Goto, Advancing emergency airway management practice and research, p. 336-351.

⁵⁹ Dörge V. Airway management in emergency situations. p. 699-715.

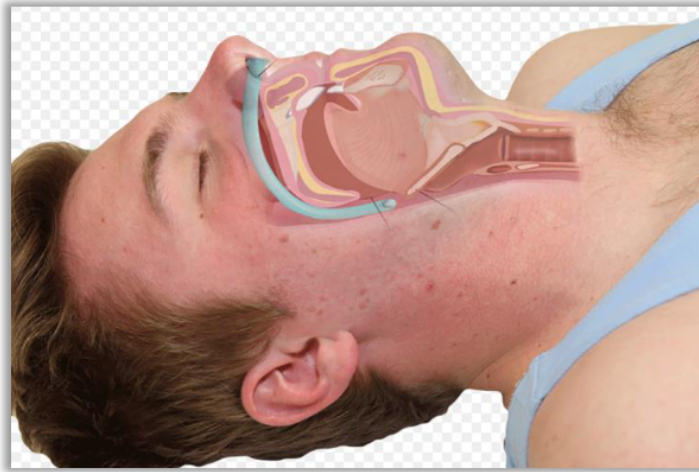
200. An OPA is firm curved plastic tube which can be inserted into the mouth and over the tongue into the pharynx to prevent the tongue from blocking the airway.⁶⁰



201. An NPA is a hollow plastic or soft rubber tube that can be placed into the nose through to the posterior pharynx.⁶¹

⁶⁰ Castro D, Freeman LA. Oropharyngeal Airway. [Updated 2022 Sep 12]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK470198/>

⁶¹ Atanelov Z, Aina T, Amin B, et al. Nasopharyngeal Airway. [Updated 2022 Sep 26]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK513220/>



202. An LMA is a device inserted into the mouth and into the pharynx where it forms an airtight seal on top of the glottis, securing the airway.⁶²

Ventilation

203. Ventilation is the process of moving air in and out of the lungs to facilitate the exchange of gases between the body and the environment.

204. Proper ventilation is essential for maintaining adequate oxygenation and carbon-dioxide elimination in the body.

⁶² <https://www.uptodate.com/contents/supraglottic-devices-including-laryngeal-mask-airways-for-airway-management-for-anesthesia-in-adults>

205. During ventilation, oxygen is taken in from the air and transported to the body's tissues, while carbon dioxide, a waste product of metabolism, is removed from the body and expelled into the environment.⁶³

206. There are two types of ventilation: spontaneous and mechanical.

207. Spontaneous ventilation occurs when a person breathes on their own, using the muscles of the chest and diaphragm to expand and contract the lungs.

208. Mechanical ventilation is a medical intervention in which a machine or BVM is used to assist or replace spontaneous breathing.

209. During mechanical ventilation, the machine or BVM delivers air to the lungs through an ETT or other device, using positive pressure to inflate the lungs and facilitate gas exchange.

210. Mechanical ventilation is typically used when a patient is unable to breathe adequately on his or her own due to a variety of medical conditions, such as respiratory arrest, respiratory failure, or neurological impairment.

BVM Ventilation

211. BVM ventilation stands for "Bag-Valve-Mask" ventilation.

212. BVM ventilation is a technique used to provide manual ventilation to a patient who is breathing inadequately or not at all.

⁶³ Mora Carpio AL, Mora JI. Ventilator Management. [Updated 2022 Mar 27]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK448186/>



213. The BVM system consists of a bag that is squeezed by the healthcare provider to deliver air or oxygen to the patient, a valve that controls the direction of airflow, and a mask that covers the patient's nose and mouth, forming a seal to ensure the air goes into the lungs.

214. BVM ventilation is commonly used in emergency situations such as respiratory arrest, respiratory failure, or cardiac arrest.

215. BVM ventilation is often the initial intervention before more advanced airway management techniques are attempted.

216. BVM can provide sufficient ventilation to maintain oxygenation until advanced airway management, such as intubation, can be performed.

Oxygenation

217. Oxygen stored in the body is quickly depleted when oxygen supply and ventilation are interrupted.⁶⁴

218. Oxygenation is the process of providing greater oxygen supply to the lungs.⁶⁵

219. Assisted oxygenation is a medical intervention that involves the administration of supplemental oxygen to a patient who is unable to maintain adequate oxygen levels without assistance.

220. An oxygen tank is a portable device that stores compressed oxygen and is used to provide supplemental oxygen to patients who require assisted oxygenation.

221. The oxygen is delivered through a tube that is attached to a nasal cannula, face mask, or other device that is placed over the patient's nose and/or mouth.

222. The flow-rate and concentration of oxygen can be adjusted according to the patient's needs.

Preoxygenation

223. Preoxygenation is a medical technique used to increase the oxygen concentration in a patient's lungs and body before the patient undergoes a medical procedure that may cause hypoxia (low oxygen levels).

⁶⁴ <https://www.uptodate.com/contents/preoxygenation-and-apneic-oxygenation-for-airway-management-for-anesthesia#H1292475968>

⁶⁵ Id.

224. Preoxygenation is typically performed prior to procedures such as general anesthesia or intubation, because such procedures can temporarily interrupt the patient's breathing and decrease the patient's oxygen levels.

225. Preoxygenation is an essential step in the process of intubation.

226. During intubation, spontaneous breathing or assisted ventilation is temporarily interrupted, which can result in a decrease in oxygen levels and potentially lead to hypoxia.

227. To prevent hypoxia during intubation, preoxygenation is performed to increase the patient's oxygen levels and reserve.⁶⁶

228. BVM ventilation can be used as a form of preoxygenation before intubation.

229. This is known as pre-oxygenation with BVM ventilation.

Glasgow Coma Scale

230. The Glasgow Coma Scale ("GCS") is an objective and reliable way of recording and tracking a patient's level of consciousness.⁶⁷

231. The GCS tests three categories of function: eye-opening response, verbal response, and motor response.⁶⁸

⁶⁶ <https://www.uptodate.com/contents/preoxygenation-and-apneic-oxygenation-for-airway-management-for-anesthesia#H1292475968>

⁶⁷ Jain S, Iverson LM. Glasgow Coma Scale. In: StatPearls. StatPearls Publishing, Treasure Island (FL); 2021. PMID: 30020670.

⁶⁸ Id.

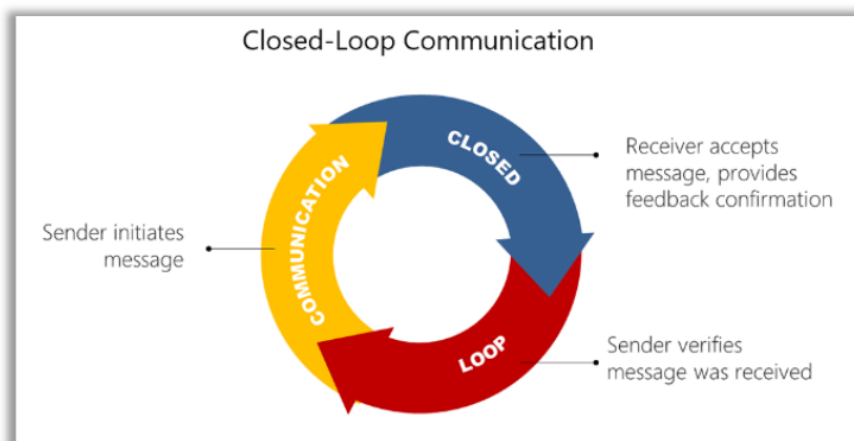
Glasgow Coma Scale		
Response	Scale	Score
Eye Opening Response	Eyes open spontaneously	4 Points
	Eyes open to verbal command, speech, or shout	3 Points
	Eyes open to pain (not applied to face)	2 Points
	No eye opening	1 Point
Verbal Response	Oriented	5 Points
	Confused conversation, but able to answer questions	4 Points
	Inappropriate responses, words discernible	3 Points
	Incomprehensible sounds or speech	2 Points
	No verbal response	1 Point
Motor Response	Obeys commands for movement	6 Points
	Purposeful movement to painful stimulus	5 Points
	Withdraws from pain	4 Points
	Abnormal (spastic) flexion, decorticate posture	3 Points
	Extensor (rigid) response, decerebrate posture	2 Points
	No motor response	1 Point
Minor Brain Injury = 13-15 points; Moderate Brain Injury = 9-12 points; Severe Brain Injury = 3-8 points		

232. A GSC score ranges from 3 (totally unresponsive) to 15 (normal).
233. A score of 13 indicates that the patient has suffered a minor brain injury.
234. A score of 9-12 indicates that the patient has suffered moderate brain injury.
235. A score of 3-8 means the patient is comatose and has suffered severe brain injury.⁶⁹

⁶⁹ Id.

Closed-Loop Communication

236. Closed-loop communication (“CLC”) is a communication model used in emergent medical situations.⁷⁰



237. CLC is used to ensure proper team understanding of communicated messages, to prevent miscommunications, and to avoid medical errors.⁷¹

238. CLC consists of these three steps:

- a. the transmitter communicates a message to the intended receiver, utilizing the receiver’s name when possible,
- b. the receiver accepts the message with acknowledgment of receipt via verbal confirmation, seeking clarification if required, and

⁷⁰ Irim Salik & John V. Ashurst. Closed loop communication training in medical simulation. National Library of Medicine; National Center for Biotechnology Information. January 2022. <https://pubmed.ncbi.nlm.nih.gov/31751089/>

⁷¹ Id.

- c. the original transmitter verifies that the message has been received and correctly interpreted, thereby closing the loop.

239. The three steps have been identified as call out, check back, and closed loop.⁷²

Medication Errors: Never Events

240. The Five Rights of Medication Administration are guidelines providers adhere to when administering medication, to ensure the highest level of safety.

241. In administering medication, these guidelines require providers to confirm the patient, medication, indication, dose, time, and route of administration.⁷³

242. “Never events” are the “kind of mistake that should never happen” in the medical field.⁷⁴

243. Never events are “adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.”⁷⁵

244. The National Quality Forum has compiled a list of never events, including: “Patient death or serious injury associated with a medication error (*e.g.*, errors involving the wrong drug,

⁷² Id.

⁷³ Hughes RG, Blegen MA. Medication Administration Safety. Patient Safety and Quality: An Evidence Based Handbook for Nurses, (Apr. 2008) <https://www.ncbi.nlm.nih.gov/books/NBK2656/> (last visited August 2022).

⁷⁴ Laura Landro, “Surgeons Make Thousands of Snafus,” The Wall Street Journal, p. A2 (December 20, 2012), <https://www.wsj.com/articles/SB10001424127887324461604578189643993571734> (last visited December 6, 2021).

⁷⁵ The Leapfrog Group, “Half of US hospitals reporting to Leapfrog say they won't bill for a ‘never event’” (September 26, 2007), https://web.archive.org/web/20110709195830/http://www.leapfroggroup.org/media/file/Release_-_Adoption_of_Leapfrog_Never_Events_Policy_2007.pdf (last visited archived copy on December 6, 2021).

wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).”⁷⁶

245. Consistent with those principles, Utah Administrative Code § R429-1 requires healthcare providers to report all safety events, including the administration of a medication overdose leading to the death of a patient.

GENERAL ETHICS PRINCIPLES

246. “Physicians have an obligation to deal honestly with patients at all times,” because “open communication is fundamental to the trust that underlies the patient-physician relationship.” ABA Code of Medical Ethics 8.6.

247. “Patients have the right to know their past and present medical status, including conditions that may have resulted from medical error.” *Id.*

248. For those reasons, “individual physicians who have been involved in a (possible) medical error should . . . **disclose the occurrence of the error,**” and “**explain the nature of the (potential) harm.**” *Id.*

249. What’s more, physicians should “acknowledge the error and express professional and compassionate concern toward patients who have been harmed,” and should “explain efforts that are being taken to **prevent similar occurrences** in the future.” *Id.*

⁷⁶ National Quality Forum, *Serious Reportable Events In Healthcare—2011 Update: A Consensus Report*, p. iii (2011).

250. Physicians owe patients these duties “even when new information regarding the medical error will not alter the patient’s medical treatment or therapeutic options.” *Id.*

251. More broadly, physicians must “strive to ensure patient safety” and “play a central role in identifying, reducing, and preventing medical errors.” *Id.*

GENERAL SAFETY PRINCIPLES

Medical Error

252. In 2000, the Institute of Medicine estimated that 44,000 to 98,000 Americans died each year from medical error. After that, the healthcare industry, policymakers, and academia started to focus on patient safety.

253. Nevertheless, in 2016, Johns Hopkins concluded that over 250,000 Americans die each year from medical error. The Johns Hopkins study found that medical error ranks as the third leading cause of death in the United States.

System Failures

254. It is now generally accepted that medical errors result largely from system failures.

255. That is, medical errors are not caused solely by “bad apple” clinicians directly involved in patient care.

256. Instead, medical errors are often the result of systemic failures. As one authority⁷⁷

explains:

Quality, as an important policy consideration, gained significant public focus in the United States with two publications by the Institute of Medicine (IOM): *To Err Is Human* (Kohn, Corrigan, & Donaldson, 2000) and *Crossing the Quality Chasm* (Institute of Medicine, 2001). *To Err Is Human* first brought public attention to the issue of medical errors, concluding that between 44,000 and 98,000 people die every year from these errors. It also diagnosed the quality problem as not one of poorly performing people, but of people struggling to perform within a system that is riddled with opportunities for mistakes to happen. The second IOM report, *Crossing the Quality Chasm*, outlined a number of goals for improving the quality and performance of the U.S. healthcare system, as well as some of the methods for achieving those goals.

257. Systemic sources of medical error are well recognized. They include:

- a. The failure to implement or enforce protocols for urgent or emergent care.
- b. The failure to train, supervise, or support healthcare providers.
- c. Poor communication and teamwork.
- d. Flaws in procedures meant to prevent breakdowns in communication.
- e. Unavailability of equipment, instruments, supplies, or medications.
- f. Gaps in the systems or protocols for preventing medication errors.
- g. Defects in procedures for the handoff of patient care.
- h. Understaffing, particularly overnight, weekends, and holidays.
- i. Problems with morale—from overwork, understaffing, unfair employment practices, and poor management.

⁷⁷ Buchbinder, Sharon B. and Shanks, Nancy H., *Introduction to Health Care Management*, Second Edition, Jones & Bartlett Learning, LLC, 2012, at Chapter 7.

- j. Absence of procedures to escalate safety issues in real-time, without fear of retaliation.
- k. A culture that punishes providers who speak out on patient-safety issues.
- l. A culture that discourages the recognition and remediation of errors.
- m. A culture that condones incompetence, sloppiness, laziness, or apathy.
- n. Flaws in procedures for hiring or credentialing providers.

258. The Joint Commission defines a culture of safety as the collection of “beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and patient safety.”

259. A culture of safety includes the perceived freedom of people to speak up when something does not fit with the goals of safety and quality.

Administrators

260. Leaders, managers, and administrators of healthcare organizations⁷⁸ (including hospitals) are responsible for acting affirmatively to (a) protect patient safety and (b) prevent systemic failures enabling individual error.

261. Administrators are responsible for the operational infrastructure in which licensed professionals provide treatment to patients.

262. Managing and administering a healthcare organization are distinct from treating patients.

⁷⁸ For the sake of brevity, we refer to these persons collectively as “administrators.” Also, as used herein, “administrators” include medical directors.

263. To illustrate: While licensed professionals may substantively develop a treatment policy relying on professional judgment, administrators are responsible for implementing the policy effectively.

264. Their responsibilities thus include: promulgating the policy, ensuring that providers are trained on and understand the policy, monitoring compliance with the policy, enforcing the policy, and taking corrective action when the policy is not followed or proves ineffective.

265. Because management and administration are distinct, administrators often are not licensed professionals—a fact readily apparent from even a cursory review of bios and postings for those roles.

266. In some cases, licensed professionals perform managerial or administrative functions within a healthcare organization, especially when officially serving in management or administrative roles.

267. When discharging managerial or administrative duties, administrators do not act as licensed healthcare providers, and do not engage in the practice of medicine, even if they also happen to be licensed healthcare professionals.

268. Whether or not performed by licensed professionals, functions that are clearly managerial or administrative include:

- a. Staffing and scheduling.
- b. Organizing the creation and implementation of systems that identify and prevent medical error, including technologies and protocols.
- c. Organizing the training of healthcare providers and others on patient-safety and quality-assurance policies and procedures.

- d. Providing proper supervision and support to individual providers, especially nurses, mid-levels, and residents.
- e. Monitoring standards through assessments, evaluations, and audits.
- f. Taking administrative action against non-compliance with procedures.
- g. Ensuring the competence and qualification of providers at credentialing.
- h. Organizing the creation and implementation of systems that ensure operational support to patient care.
- i. Maintaining provider morale through institutional transparency, accountability, and responsiveness.

269. These functions do not involve, much less require, medical training or judgment.

They involve and require managerial or administrative skill.

PREHOSPITAL TREATMENT OF GWEN DONER

270. This section chronicles the prehospital care that Gwen received, after a wrong-way driver crashed head-on into her car on one of the I-15 to I-215 interchanges, in Murray, Utah.

Video and Documentary Evidence Documents the Acts and Omissions That Led to Gwen's Iatrogenic Death

271. The chronology provides a detailed account of the prehospital care Gwen received, including the acts and omissions that led to her death.

272. The chronology cites to video that captures those acts and omissions.

273. Most notably, the video captures the negligence at the heart of this case as it occurred in real-time:

- a. EMS providers injecting Gwen with a deadly dose of ketamine;

- b. EMS providers recognizing that Gwen went into respiratory arrest as a result of the ketamine overdose; and
 - c. EMS providers lacking the capability to provide Gwen even basic life support—for a time sufficient to cause her anoxic brain injury.
274. Insofar as the negligence is captured on video, it is beyond dispute.
275. The video footage was recorded on these four cameras:
- a. The helmet camera, with sound, of MCFD Captain Steve Ellefsen.
 - b. The body cameras of two UHP Troopers—likely Corporal Cope, Trooper Daniel Hogan, and/or Trooper Calee Van Cott.
 - c. The dash camera of an unidentified law-enforcement vehicle.
276. The following chronology also cites to prehospital records.

*After Giving a Friend a Ride Home, Gwen Has Head-On Collision with
Wrong-Way Driver at Highway Speeds*

277. On the night of April 19, 2021, Gwen and her boyfriend, Tyler Shoemaker, were traveling on Interstate 15 in Salt Lake City, Utah. UHP 2.

278. They were returning from giving a friend a ride home.

279. Gwen was driving her 2006 Ford Taurus, Tyler rode next her, and their dog Blue sat behind them. UHP 2, UHP 8.

280. As they approached the Interstate 215 interchange in the City of Murray, Gwen and Tyler did not know that Justin Wayne Robertson, high on methamphetamine, had also entered the interchange.

281. But Robertson was coming from the opposite direction, going the wrong way, and leading the UHP and others on a high-speed chase. UHP 5.

282. At 20:44, despite Gwen’s effort to avoid a crash, Robertson collided into her Taurus “head-on at highway speeds.” IMC 23.

283. Gwen’s vehicle came to a stop across two lanes of highway. UHP 2, UHP 5.

284. Gwen, Tyler, and Blue sustained injuries, none life-threatening. UHP 8.

285. Tyler and Blue were able to exit the car, but Gwen was pinned inside. UHP 8.

At 21:07:00, Gold Cross AEMTs Humphrey and Haynie Are “at Patient”

286. On April 19, 2021, Defendants Joshua Humphrey and Grace Haynie were AEMTs on Medic Unit A581 of Gold Cross Ambulance. GCS 2.

287. Humphrey was the Lead, and Haynie was the Driver. GCS 2.

288. That night, on their way to Park City, Humphrey and Haynie were “stopped” by UHP officers near the collision involving Gwen’s Taurus. GCS 2.

289. At 21:04:57, Humphrey and Haynie were dispatched to the scene. GCS 2.

290. At 21:05:02, they were on scene, and 21:07:00, they were “at patient.” GCS 2.

291. Humphrey and Haynie remained on scene for about an hour. *See* GCS 2.

At 21:07:00, Life Flight Nurse Jewkes and Life Flight Paramedic Kimball Are “at Patient”—with Gold Cross

292. On April 19, 2021, Lisa Jewkes was a Life Flight nurse, and Ryan Kimball was a Life Flight paramedic.⁷⁹ Video A.

⁷⁹ Despite requests, LifeFlight and IHC have not provided any records concerning the care LifeFlight provided Gwen, including the names of providers on scene.

293. That night, when the Gold Cross ambulance was flagged down by UHP, Humphrey and Haynie happened to be transporting “flight” to Park City—meaning the Life Flight team of Jewkes and Kimball. GCS 2.

294. Jewkes and Kimball were thus at patient together with and at the same time as Humphrey and Haynie.

295. The Gold Cross and Life Flight teams found Gwen on the driver’s seat, pinned by an intrusion of the dash that was at least 12-inches deep. GCS 2.

*Shortly After Gold Cross and Life Flight Are at Patient, UHP Corporal
Cope Is at Patient, Providing “Medical Help”*

296. On April 19, 2021, UHP Corporal Kristopher Cope was riding with UHP Trooper Daniel Hogan, as his assigned Field Training Officer. UHP 8.

297. At 20:54, they responded to a call about the collision involving Gwen. UHP 8.

298. Cope and Hogan arrived shortly after Gold Cross and Life Flight. *See* UHP 8.

299. When they arrived, “a Gold Cross ambulance and two Life Flight personnel were on scene but were still requesting medical help.” UHP 8.

300. When Cope “informed the Life Flight team of [his] medical certifications,” they “quickly put [him] to work.” UHP 8.

301. Cope “assisted Life Flight with placement and securement of a 20 Gauge Intravenous (IV) needle that was inserted into Doner’s left arm.” UHP.

302. Cope then “kept Doner’s arm straight as she was trying to pull away.” UHP 8.

303. Cope remained in that position as “pain medications and sedation was given to Doner.” UHP 8. According to Cope, he “didn’t let go of Doner’s arm for the nearly forty-five (45) minutes it took to free her from the wreckage.” UHP 8.

At 21:07:20, MCFD Paramedics Winters and Sneddon Are Also “at Patient”

304. On April 19, 2021, Danielle Winters and Russell Sneddon were paramedics on Medic Ambulance 83 (“MA 83”) of the MCFD. MCFD 1.

305. At 20:59:13, over 7 minutes after the initial call came into PSAP,⁸⁰ Winters and Sneddon were dispatched to the scene. MCFD 1.

306. At 21:07:20, over 16 minutes after the initial call, Winters and Sneddon were “at scene” and “at patient.” MCFD 1.

307. Winters and Sneddon were thus at Gwen’s side less than a minute after the Gold Cross and Life Flight teams. MCFD 01, GCS 2.

At 21:12, UFA Paramedic Stephensen, EMT Bates, and Captain and Paramedic Anderson Are Also “at Patient”

308. On April 19, 2021, Paramedic Kurt Stephensen and EMT Cory Bates were on Medic Ambulance 110 (“MA110”) of Unified Fire Authority (“UFA”). UFA 2.

⁸⁰ PSAP is the acronym for “public-safety answering point.”

309. Stephensen's role was Patient Care Transport and Primary Patient Caregiver-Transport. UFA 2, IMC 32. Bates's role was Driver and/or Airway Response and Driver/Pilot/Engineer-Response. UFA 2, IMC 32.

310. That night, Stephensen and Bates were dispatched to the scene. UFA 2.

311. UFA Captain Matthew Anderson, a paramedic, was also dispatched to the scene, as member of the MA 110 crew. UFA 2, IMC 32.

312. Anderson's role was "Other Patient Caregiver-At Scene." UFA, IMC 32.

313. At 21:12, about 22 minutes after the initial call into PSAP, Stephensen and Bates were "at patient." UFA 2, IMC 32, Video A.

314. Stephensen, Bates, and Anderson were thus at Gwen's side about 5 minutes after Gold Cross, Life Flight, UHP, and MCFD. UFA 2, MCFD 1, GCS 2.

315. As the UFA team noted: "We responded with Murray units who arrived before us," so that "MA83 was doing patient care inside the vehicle." UFA 4, IMC 33.

316. All five agencies were thus at patient during acts and omission alleged below.

317. Upon arriving, the UFA team was "directed by BC 11 to assist with the critical patient," who "was trapped inside vehicle and needed to be extricated." UFA 4.

Gwen Is Conscious, Responsive, and Breathing, with No Head Abnormalities

318. Gold Cross and Life Flight "established initial patient care." MCFD 8.

319. Humphrey and Haynie then performed an initial assessment. GCS 1.

320. Gwen had fractures on both legs and her right arm. GCS 1.

321. Gwen was pale. GCS 1.

322. Gwen had **“no abnormalities”** on her head, face neck or airway. GCS 1.

		Initial Assessment	
Category	Comments	Abnormalities	
Mental Status		Mental Status	+ Confused, Event Oriented
			- Combative, Person Oriented, Place Oriented, Time Oriented
Skin		Skin	+ Pale
HEENT		Head/Face	No Abnormalities
		Eyes	- Left: Blind, Left: Constricted, Left: Dilated, Left: Non-Reactive, Right: Blind, Right: Constricted, Right: Dilated, Right: Non-Reactive
		Neck/Airway	No Abnormalities

GCS 1.

323. Humphrey and Haynie documented Gwen’s mental status was “confused”—not oriented to person, place, and time. GCS 1.

324. But, because she stated her name, Gwen was in fact oriented to person. GCS 1.

325. In addition, Gwen was “event oriented.” GCS 1.

326. That is, Gwen understood that she had just survived a car accident. She also understood she was trapped in her car, injured and in pain.

327. Gwen “stated her neck hurt,” “stated her name when asked,” and “yelled that she wanted out.” GCS 2.

328. In fact, Gwen was able to have a conversation, denying she had “any allergies to medications” and reporting she was on antidepressants. IMC 37.

329. Thus, minutes after the collision and the arrival of EMS, before she received any medication, **Gwen was conscious, responsive, and breathing.**

330. Within minutes of arrival, the Gold Cross team placed a C-collar on Gwen's neck.⁸¹
GCS 2, MCFD 1 and 7.

331. Meanwhile, Jewkes and Kimball "started a 20g in her AC and started a bag of fluids." GCS 2.

332. In other words, Jewkes and Kimball placed an IV-line in Gwen's elbow-pit, and then started infusing saline through the line. *See* GCS 2.

*MCFD Assumes Care, with Winters and Sneddon as Primary and
Secondary Caregivers*

333. When Winters and Sneddon arrived, "Gold Cross Ambulance personnel and Intermountain Life Flight personnel" were already on scene and "had established initial patient care." MCFD 8.

334. The "extrication patient medical group" thus consisted of "MA 83, MA-110, Gold Cross Ambulance, and Intermountain Life Flight." MCFD 8.

335. "Gold Cross Ambulance was on scene holding C-spine," having already applied the C-collar. MCFD 7.

336. "Life Flight was able to access her left arm from the outside of the car and established a 20 G IV with 1000 bag of fluids with pressure bag." MCFD 7.

337. Winters and Sneddon then "assumed patient care." MCFD 7.

⁸¹ Haynie then "maintained Cspine stabilization" from the back seat, until the time Gwen was extricated from the vehicle. GCS 2, Video A.

While Extrication was being done both Intermountain Life flight, Gold Cross and Murray worked in different locations of the car for access to the patient. Life Flight was able to access her left arm from the outside of the car and established a 20 G IV with 1000 bag of fluids with pressure bag. Life Flight remained on scene and MA83 assumed patient care.

IMC 7.

338. Winters was the “Primary Patient Caregiver,” and Sneddon the “Secondary Patient Caregiver.” MCFD 6.

339. At least three additional responders completed the MCFD team: Captain Steve Ellefsen, who was also an EMT; Engineer Zac Hansen, who was also a paramedic; and Firefighter Jason Hawkes, who was also a paramedic. MCFD 6.

340. Ellefsen was the MCFD “Supervisor” on scene. MCFD 7.

At 21:12:20, Despite the Most Excruciating Pain, Gwen Remains Conscious, Responsive, and “Breathing Normally”

341. At 21:12:20, Winters and Sneddon completed their own assessment of Gwen. MCFD 2-4.

342. Gwen was obviously conscious and responsive. *See* MCFD 1-8.

343. Gwen’s chief complaint was “acute pain due to trauma.” MCFD 4.

344. Indeed, among other traumatic injuries, Gwen had open and closed fractures of her legs, and a closed fracture on her right arm. MCFD 2-3.

345. Accordingly, Gwen was “inconsolable” and “screaming” with pain “all over” that she described as a 10—the most excruciating pain possible. MCFD 7.

346. Though in “pain,” Gwen’s head, neck, and spine were “**normal.**” MCFD 2-3.

Mental Status	Normal Baseline for Patient Combative Confused
Head	Normal Pain
Eye Bilateral: Left: Right:	Reactive Reactive Reactive
Neck	Normal Pain

MCFD 2.

347. Though Gwen was now “combative” and “confused,” her mental status was at **“normal baseline for patient.”** MCFD 2.

348. Gwen was **“responsive.”** MCFD 7.

Upon arrival Gold Cross Ambulance was on scene holding C-spine. C-collar applied prior to arrival. Pt was responsive, strong radial pulse, breathing normally. Pt was inconsolable with and screaming with 10/10 pain. Pt c/o her head hurting, neck pain and pain all over. Vitals were taken.

IMC 7.

349. At this time, shortly before she was injected with 500 milligrams of ketamine, Gwen was also **“breathing normally.”** MCFD 7.

MCFD and Life Flight Agree to Give Gwen Fentanyl and Ketamine for Pain Control

350. Within minutes of their arrival, Winters and Sneddon “pulled up medications” and “confirmed with Life Flight for medication administration.” MCFD 7.

MA83 pulled up medications, confirmed with Life flight for medication administration and both agreed to give both Fentanyl and Ketamine for pain control. MA83 drew up medication handed it to Life flight and confirmed the amount that was being handed over was 100 mcg Fentanyl, Life flight administered 100 mcg IV. MA83 drew up 500 MG of Ketamine and handed to Life flight confirming that the amount that was being handed over was 500 MG Ketamine. Life flight administered 500 MG of Ketamine IV.

MCFD 7.

351. Both teams “agreed” to give Gwen “both Fentanyl and Ketamine for pain control.”

MCFD 7.

At 21:12:46, Jewkes Gives Gwen 100 Micrograms of Fentanyl

352. “MA83 drew up medication” and “handed it to Life flight and confirmed the amount that was being handed over was 100 mcg Fentanyl.” MCFD 7.

353. Life Flight then “administered 100 mcg IV.” MCFD 7.

MA83 pulled up medications, confirmed with Life flight for medication administration and both agreed to give both Fentanyl and Ketamine for pain control. MA83 drew up medication handed it to Life flight and confirmed the amount that was being handed over was 100 mcg Fentanyl, Life flight administered 100 mcg IV. MA83 drew up 500 MG of Ketamine and handed to Life flight confirming that the amount that was being handed over was 500 MG Ketamine. Life flight administered 500 MG of Ketamine IV.

MCFD 7.

354. At 21:12:46, as Gwen wailed, a voice declared, “100 of Fentanyl,” signifying that she had administered the medication. Video A.

355. The voice appears to belong to Jewkes, who would shortly also inject the ketamine.

356. Gwen “improved” with the fentanyl. MCFD 5.

Time	Crew	Medication	Medications Route	Dosage	Response	PTA
21:09:20	Winters, Danielle	Normal Saline	Intravenous (IV)	1000 Liters - Bolus	Improved	No
21:12:20	Winters, Danielle	Fentanyl	Intravenous (IV)	100 Micrograms	Improved	No
21:15:20	Winters, Danielle	Ketamine	Intravenous (IV)	500 Milligrams	Worse	No

MCFD 5.

At 21:13:37, the Ketamine Shot Passes from Sneddon, to Winters, to Jewkes, without Closed-Loop Communication

357. Shortly after fentanyl was given to Gwen, “MA83 drew up 500 MG Ketamine and handed to Life flight confirming that the amount that was being handed over was 500 MG Ketamine.” MCFD 7, MCFD 5, Video A.

MA83 pulled up medications, confirmed with Life flight for medication administration and both agreed to give both Fentanyl and Ketamine for pain control. MA83 drew up medication handed it to Life flight and confirmed the amount that was being handed over was 100 mcg Fentanyl, Life flight administered 100 mcg IV. MA83 drew up 500 MG of Ketamine and handed to Life flight confirming that the amount that was being handed over was 500 MG Ketamine. Life flight administered 500 MG of Ketamine IV.

MCFD 7.

358. Life Flight then “**administered 500 MG of Ketamine IV.**” MCFD 7, Video A.

359. As captured on the video provided by MCFD and UHP, the following occurred in the minutes before, during, and after the Ketamine overdose.

360. At 21:13:26, Sneddon stepped toward the front passenger door of the vehicle, holding out a syringe, plunger-down and tip-up, in his right hand. Video A.

361. At 21:13:27, Winters popped her head through the sunroof. Video A.

362. At 21:13:28, Winters gestured over her torso, explaining something to Ellefsen. Video A.

363. At 21:13:31, Sneddon continued holding the syringe, waiting for Winters to take it. Video A.

364. At 21:13:36, as Winters emerged from the vehicle, a female voice called out: “500 of Ketamine, now!” Video A.

365. The voice seems to belong to Jewkes, who was apparently waiting for the ketamine syringe Sneddon was holding.

366. At 21:13:37, after receiving the ketamine from Sneddon, Winters turned back to the vehicle, syringe in hand. Video A.

367. The hand-off between Sneddon and Winters thus occurred without closed-loop communication (“CLC”).

368. At 21:13:39, Winters passed the ketamine syringe to Jewkes across the roof of the vehicle. Video A.

369. During this handoff, Winters seemed to confirm: “500 of Ketamine.” Video A.



Figure 1: Winters confirming "500 of Ketamine."

370. At 21:13:40, as Gwen shrieked, Jewkes took the syringe in hand. Video A.

371. The handoff between Winters and Jewkes thus occurred with incomplete CLC.

*At 21:13:42, as Jewkes Injects Gwen with 500 Milligrams of Ketamine,
Gwen Loses Consciousness—on Camera*

372. At 21:13:42, Jewkes started to inject the 500 mg of ketamine into Gwen’s bloodstream through the IV line on her left arm. Video A.

373. Over subsequent seconds, as Jewkes pushed the ketamine into Gwen’s arm through the IV line, Gwen continued wailing and shrieking loudly. Video A.

374. At that moment, Gwen was obviously conscious and breathing normally on her own—for the last time in her life.

375. At 21:13:46, after the fingers on Gwen’s left hand extended for a brief moment, the hand suddenly went limp. Video C.

376. At 21:13:52, Gwen suddenly fell silent—evidence that she had lost consciousness. Video A.

377. According to the understatement in MCFD’s records, Gwen was “worse” after the ketamine injection. MCFD 5.

Time	Crew	Medication	Medications		Response	PTA
			Route	Dosage		
21:09:20	Winters, Danielle	Normal Saline	Intravenous (IV)	1000 Liters - Bolus	Improved	No
21:12:20	Winters, Danielle	Fentanyl	Intravenous (IV)	100 Micrograms	Improved	No
21:15:20	Winters, Danielle	Ketamine	Intravenous (IV)	500 Milligrams	Worse	No

MCFD 5.

At 21:14:10, as Winters Asks in Disbelief, Jewkes Flatly Confirms “I Gave It All”

378. At 21:14:07, with Winters peering across the roof of the vehicle, Jewkes completed the ketamine injection. Video A.

379. At 21:14:10, as Jewkes capped the syringe, Winters asked: “How much are you giving her?” or “How much did you give her?” Video A.

380. Jewkes simultaneously declared, unresponsively: “**Ketamine is in!**” And she placed the empty syringe on the roof of the car. Video A.

381. At 21:14:12, in disbelief, Winters asked something like: “**Did you give it all?**” Jewkes provided no discernible answer.



Figure 2: Winters asking Jewkes “Did you give it all?”

382. At 21:14:15, while Jewkes turned to talk with Kimball, Winters darted an exasperated gaze up at Ellefsen—and his helmet camera. Video A.

383. At 21:14:22, understanding that Winters needed an answer to her question, Ellefsen diplomatically asked Jewkes: “What’s your guys’ names?” Video A.

384. At 21:14:24, Jewkes responded flatly: “I’m Lisa, this is Ryan.” Video A.

385. At 21:14:25, a fleeting wail is heard. Video A.

386. At 21:14:25, Ellefsen responded: **“Okay. Lisa, did you give her all, all the?”** Video A.

387. Jewkes interrupted Ellefsen with a flat one-word answer: **“Yes.”** Video A.

388. Ellefsen then calmly replied, “Okay.” Video A.

389. At 21:14:29, Ellefsen turned to Winters and relayed the answer: **“Yes.”**

390. With a look and tone of disbelief, Winters then asked something like, **“The whole thing?”** Ellefsen confirmed, **“Yes, yup.”** Video A.

391. At 21:14:31, Lisa Jewkes muttered, as though defiantly to herself: **“I gave it all.”** Video A.

392. At 21:14:33, as Winters sunk back into the vehicle through the sunroof, Ellefsen announced sanguinely: “All right . . .” Video A.

393. At 21:14:34, a feeble wail faded into night—the last time Gwendolyn Doner was heard. Video A.

394. **About 52 seconds had passed since the ketamine overdose.**

*At 9:15:33, After Gwen Has “Stopped Breathing,” Winters Requests
“Intubation Equipment”*

395. At 21:15:29, Winters again emerged through the vehicle’s sunroof, looking around bewildered and concerned. Video A.

396. At 21:15:33, Winters frantically explained to Ellefsen:

“I have a problem. I gave her 500 of Ketamine. I told her what it was. **She gave her the whole damn thing . . . She wasn’t supposed to give her that much . . . So, anyway, she stopped breathing now . . .** So, I need someone to get me some intubation equipment to intubate her.” Video A.

397. At 21:15:47, Ellefsen leaned closer and asked, “What do you need?” Video A.

398. As Winters responded, “I need intubation . . . ,” Ellefsen answered his own question: “You need intubation.” Winters confirmed, “Yes.” Video A.



Figure 3: Winters explaining to Ellefsen that Jewkes "wasn't supposed to give her that much."

399. At 21:15:49, as responders rolled a gurney toward the vehicle, Winters sank back inside through the sunroof. Video A.

400. Although Gwen had stopped breathing and therefore needed ventilation right away, Winters requested only intubation equipment. *See* Video A.

401. Winters did not request BLS equipment, including an OPA or NPA to secure Gwen's airway, or a BVM to provide her ventilation. *See* Video A.

402. About **2 minutes and 6 seconds** had passed since the ketamine injection.

403. No one had brought any equipment to secure Gwen's airway or provide her assisted ventilation.

MCFD's Records Confirm the Ketamine Overdose Caused Gwen to Lose Consciousness and Stop Breathing

404. MCFD's records confirm what the video shows: that Gwen was conscious and breathing until Jewkes injected her with 500 milligrams of ketamine.

405. Shortly before that, **Gwen's GCS score was 13.** MCFD 5.

406. Shortly before that, **Gwen's respiratory effort was "normal."** MCFD 5.

407. In fact, likely because of the trauma of the collision, Gwen's respiratory rate was elevated, at 24 breaths per minute. MCFD 5.

408. MCFD's records also confirm that Gwen suddenly lost consciousness and stopped breathing immediately after the ketamine injection.

409. Although Gwen had momentarily "improved" with the fentanyl, Gwen was "worse" after receiving the ketamine. MCFD 5.

Activities						
Time	Crew	Medication	Medications		Response	PTA
			Route	Dosage		
21:09:20	Winters, Danielle	Normal Saline	Intravenous (IV)	1000 Liters - Bolus	Improved	No
21:12:20	Winters, Danielle	Fentanyl	Intravenous (IV)	100 Micrograms	Improved	No
21:15:20	Winters, Danielle	Ketamine	Intravenous (IV)	500 Milligrams	Worse	No

MCFD 5.

410. **Gwen’s GCS score suddenly plummeted from 13 to the lowest possible score:**

3. MCFD 5.

411. The ketamine overdose caused Gwen to lose consciousness.

Time	BP	Limb	Pulse	Vitals			SpO2	CO2	GCS	Pain	Stroke Scale	RTS	Pt. Position
				Rhythm	Resp	Effort							
21:08:20 /										10			
21:12:20 130 / 90			144	Regular	24	Normal			13			12	Sitting
21:17:20 /			112	Regular	0	Apneic/Absent	60		3				Sitting
21:25:20 104 / 23			112	Regular	12	Assisted Ventilations (BVM, CPAP, etc)			3			8	
21:40:20 90 / 59			104	Regular	12	Assisted Ventilations (BVM, CPAP, etc)	91		3			8	

MCFD 5

412. The ketamine dose also caused Gwen to go into respiratory arrest. Immediately following the ketamine injection:

- a. Gwen “began to have agonal respirations.” MCFD 7.
- b. Gwen’s respiratory effort then dropped from “normal” to “apneic/absent.” MCFD 5.
- c. **Gwen “went apneic.”** MCFD 7.
- d. As a **result**, Gwen’s respiratory rate plummeted **from 24 to 0.** MCFD 5.

413. As Winters revealed on camera: Gwen “**stopped breathing.**” Video A.

414. The ketamine dose also caused Gwen profound hypoxia.

415. Gwen's **SpO2 level plummeted to 60**—meaning that her blood was not carrying enough oxygen to her brain and other organs. MCFD 5.

With Many Responders Standing Around, Ellefsen Takes 40 Seconds to Ask a Firefighter to Bring Intubation Equipment

416. At 21:15:55, after scanning the scene for about 10 seconds, Ellefsen spotted MCFD Firefighter Brian Jordan (“Jordan”) walking off into the distance. Video A.

417. At 21:15:56, Ellefsen called, “Brian, Brian!” When Jordan kept walking away, Ellefsen shouted, “Brian, Brian, come here!” Video A.

418. At 21:16:01, as Ellefsen beckoned with his hand, Jordan calmly started walking back toward the vehicle. Video A.

419. At 21:16:07, instead of urgently directing Jordan to bring intubation equipment, Ellefsen asked whether Jordan was working for someone else. Video A. Pointing into the distance, Jordan explained he was working on something “down there.” Video A.

420. At 21:16:11, Ellefsen asked Jordan, “Okay, can it wait? We got a priority.” Jordan responded, “Yup, yup.” Video A.



Figure 4: Ellefson informing Jordan that “Danielle needs Intubation equipment.”

421. At 21:16:13, still without a hint of urgency, Ellefson explained: “Okay, cause **she’s not breathing any more. Gave her too much Ketamine. Danielle needs intubation equipment.**”

Video A.

422. At 21:16:19, Jordan responded, “Okay, got it,” and sauntered away. Video A.

423. About **40 seconds** had passed since Winters first requested intubation equipment because Gwen had “stopped breathing.”

424. About **2 minutes and 40 seconds** had passed since the ketamine injection.

425. No one had brought any equipment to secure Gwen’s airway or provide her assisted ventilation.

*At 21:16:24, Still Waiting for Intubation Equipment, Winters Pleads
Ellefsen for "Something to Make Her Breathe"*

426. At 21:16:21, just as Jordan left the scene, Winters emerged from the vehicle, again looking around at a loss. Video A.

427. At 21:16:23, evidently noticing her distress, Ellefsen called out, "Hey, Danielle!" Video A.

428. At 21:16:24, Winters stepped forward and pled frantically: **"I need something to make her breathe."** Video A.



Figure 5: Winters pleading, "I need something to make her breathe."

429. At 21:16:27, Ellefsen responded, "Okay, I got Brian Jordan on it." Winters responded, "Okay, thank you." Video A.

430. At 21:16:31, Winters quickly turned to respond to a firefighter behind her. She then reentered the vehicle. Video A.

431. About **2 minutes and 48 seconds** had passed since the ketamine injection.

432. Over **1 minute and 50 seconds** had passed since Gwen stopped breathing.

433. No one had brought any equipment to secure Gwen's airway or provide her assisted ventilation.

*Though Gwen Is Still Not Breathing, No One Provides Gwen Ventilation
for an Additional 6 Minutes*

434. During the subsequent six additional minutes:

- a. No one brought a BVM or any other tool to manage Gwen's airway.
- b. Winters and **Sneddon** therefore failed to provide Gwen ventilation during that additional time, even though she was still not breathing.
- c. Gwen thus remained without adequate oxygenation of her blood, and therefore her brain, during that entire time.

435. It appears, moreover, that neither Winters nor anyone else even attempted to secure Gwen's airway during that time—through intubation or otherwise.

436. In fact, it appears that Winters did not even receive the intubation equipment she had requested, during those additional six minutes.

437. At 21:18:38, Firefighters Hansen and Hawkes tore off the driver's door from Gwen's car. UHP Troopers then haul it away. Videos B and D.

438. At 21:19:19, Gwen was now more clearly visible. She was slumped over and pinned against the dashboard. Video D.

439. Gwen's head and torso remained wrapped in a white sheet, motionless. A firefighter was holding her left arm outside the vehicle.

440. At 21:19:36, Firefighter Hansen lifted up the white sheet covering Gwen and took a peak underneath. Video D.

Starting at 21:19:32, After Talking with Jewkes, a UHP Trooper Spends 3 Minutes Searching Three Ambulances

441. At 21:19:27, a UHP Trooper had a conversation with Jewkes.⁸² Videos B and D.

442. At 21:19:32, this Trooper walked away, past the front of the car.



Figure 6: UHP Trooper searching ambulance compartments/and cabinets.

⁸² This Trooper was likely Corporal Kristopher Cope, Trooper Daniel Hogan, or Trooper Calee Van Cott.

443. Over the subsequent 3 minutes, this Trooper searched the cabinets and compartments of a MCFD ambulance, a UFA ambulance, and third ambulance, searching for something he did not find. Video B.

444. As he walked deliberately from one rig to the next, this Trooper passed countless other first responders, from various agencies, who were milling about idly. Video B.

445. At 21:22:35, having given up the search and returned to the vehicle, this Trooper engaged in a short conversation with Jewkes and Kimball. Video B.

At 21:22:29, After Finally Receiving a BVM, Winters Finally Appears to Provide Gwen Assisted Ventilation

446. At 21:22:14, Winters reemerged from the sunroof. Video A.

447. At 21:22:17, Winters reached out with both hands and received a BVM reservoir, from a hand wearing a white glove. Video A.

448. At 21:22:19, a thin tube stretched into the sunroof—likely the tube for delivering oxygen to the BVM from a tank outside the vehicle. Video A.

449. At 21:22:22, after placing the BVM inside the vehicle, Winters reemerged and received a facemask from a hand with a white glove. Video A.

450. At 21:22:29, Winters was inside the vehicle, presumably trying to ventilate Gwen through the facemask. Video A.

451. Although Gwen was overdosed with ketamine at about 21:13:42 and stopped breathing by 21:15:33, this is the first time she received ventilatory assistance.

452. Until Gwen was later extricated from the vehicle, Winters remained in the front passenger's seat, attending to Gwen.

453. About **9 minutes** had passed since the ketamine injection.
454. About **7 minutes had passed since Gwen had stopped breathing.**

*At 21:23:03, Sneddon and Winters Finally Appear to Provide Gwen
Oxygenation Support*

455. At 21:22:38, the BVM tube was indeed connected to an oxygen tank sitting on the hood of the vehicle. Video A.

456. At 21:22:42, Jordan was standing behind Sneddon, studying a tube-like object. Video A.

457. Because Jordan wore white gloves, it was likely he who had just handed the BVM to Winters. Video A.

458. At 21:22:55, Sneddon looked down at Winters through the sunroof, affirming something by holding up his thumb. Video A.

459. At 21:22:58, Sneddon grabbed the oxygen tank with his left hand, apparently reading the gauge and adjusting the flow-rate. Video A.

460. At 21:23:03, Sneddon turned back to Winters and shouted, “Hey, you’re up to two-five, two-five!” Video A.

461. At 21:23:05, Sneddon visually confirmed the numbers by holding up two fingers followed by five. Video A.

462. About **9 and 23 seconds** had passed since the ketamine injection.

463. About **7 minutes and 25 seconds** had passed since Gwen had stopped breathing.

*At 21:26:19, Winters and Sneddon Interrupt Ventilation for 67 Seconds,
to Attempt Intubation*

464. At about 21:25, Winters performed a GCS assessment. MCFD 6.
465. As seen on video, Gwen remained completely unresponsive. Video A.
466. Gwen had “no eye movement when assessed,” “no motor response,” and “no verbal/vocal response.” MCFD 6.
467. Gwen’s GCS thus remained at 3—the lowest possible score. MCFD 6.
468. At 21:26:08, Sneddon and Winters had a brief conversation, apparently deciding to try intubation. Video A.
469. At 21:26:09, Sneddon reached back with his left arm, to take the endotracheal tube from Jordan. Video A.
470. At 21:26:10, Winters continued holding the BVM mask to Gwen’s face. Video.
471. At 21:26:19, as Winters removes the BVM mask from Gwen’s face, Sneddon positioned the laryngoscope for an attempt at intubation. Video A.
472. At 21:27:24, about **1 minute and 7 seconds** later, Sneddon and Winters aborted the intubation. Video A.
473. At 21:27:26, as Sneddon withdrew the laryngoscope and endotracheal tube, Winters placed the BMV mask back on Gwen’s face. Video A.
474. At least **67 seconds** had passed since Gwen was last ventilated with the BVM—prior to this intubation attempt.
475. During those **67 seconds**, Gwen had gone without adequate oxygenation of her blood, and therefore her brain.

476. About 13 minutes and 44 seconds had passed since the ketamine injection.
477. At least 11 minutes and 46 seconds had passed since Gwen stopped breathing.

At 21:28:27, About 13 Minutes After Gwen Stopped Breathing, Gwen Is Said to Be “Kind of Breathing on Her Own”

478. At 21:27:38, a male voice asked, “How’s her O2 doing?” And a male voice said something like, “I don’t see a number here.” Video A.

479. At 21:27:44, Ellefsen’s camera went black for a split second. Video A.

480. At 21:28:01, Gwen’s left thigh was visible for the first time. Humphrey was using the black strap to tie a tourniquet there. Video A.

481. At 21:28:06, Winters squeezed the BVM bag. Video A.

482. At 21:28:27, a male voice remarked something like: “. . . kind of breathing on her own. . . .” Video A. The voice appears to belong to Sneddon. Video A.

483. Ellefsen responded something like: “Good, good . . . don’t let it slip.” Video A.

484. About **14 minutes and 45** seconds had passed since the ketamine injection.

485. **At least 12 minutes and 47 seconds had passed since Gwen stopped breathing.**

At 21:29:21, Winters and Sneddon Again Interrupt Ventilation for an Attempted Intubation—This Time for Over 107 Seconds

486. At 21:29:10, Sneddon removed the BVM mask from Gwen’s face, stopping the ventilation. Video A.

487. At 21:29:21, Sneddon lowered the endotracheal tube toward Gwen’s mouth, to re-attempt intubation. Video A.

488. No one pre-oxygenated Gwen or monitored her oxygen saturation. *See* Video A.

489. At 21:30:22, Ellefsen asked: “Okay, so do we have a game plan of when we’re going to move her?” Video A.

490. At 21:30:24, Winters looked at Ellefsen, with an anguished gaze, apparently concerned about the failure to secure Gwen’s airway.⁸³ Video A.

491. At 21:30:45, Sneddon withdrew the tube and laryngoscope, aborting the attempt. Video A.

492. At 21:30:57, after finding the BVM mask and attaching it to the reservoir, Winters squeezed the BVM, restarting ventilation. Video A.

493. At least **1 minute and 47 seconds** had passed since Gwen was last ventilated with the BVM—prior to this intubation attempt.

494. During those **107 seconds**, Gwen went without adequate oxygenation of her blood, and therefore her brain.

495. About 17 minutes and 17 seconds had passed since the ketamine injection.

*At 21:30:54, at Sneddon’s Direction, Jordan Searches Through
Equipment Bags for About 90 Seconds*

496. At 21:30:48, Sneddon examined the ETT he had been using. Video A.

497. At 21:30:52, Sneddon handed the tube to Jordan, explaining something. Video A.

⁸³ As was true at other times Winters and/or Sneddon were attending to Gwen, Jordan stood passively nearby, often holding equipment.

498. Ellefsen asked Sneddon: “What you got Russ?” As he remained engaged with Jordan, Sneddon did not respond. Video A.

499. At 21:31:05, Jordan went off to search for equipment, by rummaging through bags sitting on the highway. Videos A, B, and D.



Figure 7: Ryan searching bags sitting on the highway.

500. Jordan held an ETT, as though it guided his search. Videos B and D.

501. At 21:32:37, Jordan stopped searching and walked back to the vehicle, carrying equipment bags. Video B.

502. About **17 minutes and 33 seconds** had passed since the ketamine injection.

At 21:31:17, Though Winters and Sneddon Interrupt Ventilation for 94 Seconds, Gwen’s SpO2 Bounces Back up to 91

503. At 21:31:13, Winters squeezed the BVM bag. Video A.

504. At 21:31:17, preparing for the extrication, a firefighter now held a blue stretcher upright on the back seat behind Gwen. Video A.

505. At 21:31:17, Winters had withdrawn the BVM and was now palpating behind Gwen's ears, under her jaw. Video A.

506. At 21:32:35, as Ellefsen leaned forward, his camera provided a closer view of Gwen. She remained motionless, with her mouth agape. Video A.



Figure 8: Gwen after failed attempts at ventilation.

507. At 21:32:42, as Sneddon reached around Winters to hand her the BVM, he suggested, "Danielle, do you want to get a couple of breaths in real quick?" Video A.

508. At 21:32:44, Winters responded something like, "She's actually at 91."

509. At 21:32:48, Sneddon echoed something like "91? That's fantastic." Video A.

510. At 21:32:50, Winters placed the mask on Gwen's face again. Video A.

511. At 21:32:51, Winters squeezed the BVM bag. Video A.

512. At 21:32:53, Sneddon seemed to say “. . . breathing on her own,” to which Winters seemed to respond, “Yes.” Video A.

513. About **1 minute and 34 seconds** had passed since Gwen was last ventilated.

At 21:33:16, as Gwen Is Extricated and Moved to an Ambulance, Winters and Sneddon Stop Ventilation Altogether

514. At 21:33:16, Winters squeezed the BVM bag with her left hand. Video A.

515. Winters did not again squeeze the BVM bag, for the additional minutes she remained on camera. Video A.

516. At 21:33:43, as Winters was now searching with both hands, she was no longer even holding the BVM mask to Gwen’s face. Video A.

517. The BVM was not seen on camera again.

518. At 21:33:46, Winters clipped a pulse-oximeter on Gwen’s finger. Video A.

519. Over the subsequent three minutes, Gwen was extricated from the vehicle and transported on a gurney onto a UFA 110 ambulance. Video A.

520. By then, over 23 minutes had passed since the ketamine injection.

At 21:40:22, on Route to IMC, Gwen’s GCS Score Remains 3

521. At 21:37:33, the UFA rig left the accident scene, transporting Gwen to Intermountain Medical Center (“IMC” or “Hospital”). IMC 32, UFA 2.

522. As Primary Patient Caregiver-Transport, Stephensen was in the back of the rig with Winters, attending to Gwen. Bates was driving. *See* IMC 32.

523. According to UFA's Prehospital Care Report, there was a transport delay, because of a "Vehicle Crash Involving this Unit." IMC 29.

524. At 21:40:22, Stephensen and Winters completed and noted a GCS assessment of Gwen. IMC 31, MCFD 6.

525. Gwen had "no eye movement when assessed," "no motor response," and "no verbal/vocal response." IMC 31.

526. Gwen's GCS score thus remained a 3. IMC 31, UFA 3, UFA 5, MCFD 5.

527. Gwen continued to be completely unresponsive.

528. At 21:42:51, Stephensen called Medical Control, to let them know that a Trauma 1 patient was incoming. UFA 4, IMC 33, IMC 31.

529. At about that time, IMC prepared blood for a transfusion to Gwen. IMC 91.

530. At 21:43, the UFA ambulance transporting Gwen arrived at the Hospital. UFA 5, IMC 21, IMC 8.

*In Transferring Care to IMC, UFA Reports Only That Life Flight Had
"Given Her Ketamine"*

531. The UFA team then "delivered" Gwen to Trauma Bay 1, provided a "report" to the trauma team, and transferred care to the trauma team. UFA 5, IMC 33.

532. The UFA team also provided IMC a written Prehospital Care Report, which was signed by Stephensen, Bates, and Anderson. IMC 29-35.

533. Anonymizing the source of the information with the passive voice, the Prehospital Care Report explained that "it was reported that Life Flight which was still on scene had given her Ketamine." IMC 33, UFA 4.

534. UFA's Prehospital Care Report failed to make any other mention of ketamine, including the fact that Life Flight had injected Gwen with 500 milligrams.

535. UFA's Prehospital Care Report also omitted the information most crucial to providers downstream: that Gwen had stopped breathing and that EMS providers then failed to provide her prompt ventilation and oxygenation.

HOSPITAL TREATMENT OF GWEN DONER

Gwen Is Admitted to IMC for Trauma and Unconsciousness

536. At 21:43, Surgeon David Morris admitted Gwen to IMC as a Trauma 1 ("T1") patient. IMC 47-48, IMC 9.

537. The T1 designation means that the patient has the most serious types of injuries and therefore requires faster response time and a larger team.

538. Dr. Morris became the attending physician. IMC 9.

539. At 22:12, Surgeon Richard A. Rasmussen triaged Gwen. IMC 36.

540. Gwen's chief complaints were trauma 1 and a GCS score of 3. IMC 36.

541. At 22:47, ER Physician Theodore A. ("TJ") Hartridge, a resident, intubated Gwen under "emergent conditions," without complication. IMC 54-55.

542. Dr. Morris and Emergency Medicine Physician David Pomeranz supervised the intubation. IMC 55, IMC 25.

543. At 22:00, the trauma team ordered various x-rays and CTs, including a CT of Gwen's brain/head. IMC 25-27, IMC 11-14.

544. The X-rays and CTs were then taken over the subsequent 1-2 hours. *See* IMC 25-27, IMC 11-14.

545. X-rays confirmed that Gwen had suffered serious fractures on her right arm and both of her legs. IMC 11-14.

Brain CT Reveals Only a Small Contusion (Bruise) in Gwen's Left Frontal Lobe

546. At 22:00, Dr. Hartridge ordered the CT of Gwen's brain/head. IMC 14, IMC 75. The reason for the CT was "trauma." IMC 75.

547. At 22:32, Gwen underwent the CT. IMC 75.

548. At 22:39, Radiologist David S. Francom reported on the CT. IMC 75-76.

Dictated by: FRANCOM, MD, DAVID S.				
Dictated DT/TM: 04/19/2021 10:39 pm				
Signed by: FRANCOM, MD, DAVID S.				
Signed (Electronic Signature): 04/19/2021 10:39 pm				
Transcribed by: DSF				
<hr/>				
Accession	Exam Date/Time	Exam	Ordering Physician	Patient Age at Exam
15400-CT-21-0105565	4/19/2021 22:32 MDT	CT Brain/Head Trauma	HARTRIDGE,TJ	19 years
Reason for Exam				
(CT Brain/Head Trauma) Trauma / Injury				

IMC 75.

549. The quality of the images was "adequate for interpretation and recommendations." IMC 75.

550. Gwen's brain was "normal" and was "without acute abnormality." IMC 75.

FINDINGS:

* Technical adequacy: No or minimal limitations: Quality of the images is adequate for interpretation and recommendations.

* Brain: Normal for age without acute abnormality.
Hemorrhage: Equivocal.
Midline shift: Negative.

* Ventricles, Basal Cisterns and Extra-axial Space: Appropriate size of ventricles for cortical volume. No abnormal extra-axial collections and/or masses identified.
Basal Cisterns: Patent.

* Calvarium, Sella and Skull Base: Normal for age.

* Vascular: Normal for age.

* Visible Sinuses: Normal for age.

* Mastoids: Normal for age.

* Orbits And Soft Tissues: Normal for age.

IMC 75.

551. Gwen had only a “small focal area of increased density . . . in the left frontal lobe white matter.” IMC 76, IMC 27, IMC 14.

552. Dr. Francom correctly interpreted this sign as a “small hemorrhagic contusion.” IMC 76, IMC 27, IMC 14.

Report

IMPRESSION:

1. Small focal area of increased density is seen in the left frontal lobe white matter which may represent a small hemorrhagic contusion. Short-term 6 hour follow-up recommended.

IMC 76.

553. Dr. Francom recommended a “short-term 6 hour follow-up.” IMC 76.

554. During the CTs, Gwen “became more active and required propofol for sedation.”
IMC 47.

555. Then, when providers placed a subclavian line for “better IV access,” Gwen responded to “painful stimuli with grimacing, and withdrawing.” IMC 47.

556. The brain/head CT was consistent with the clinical course of patient who had recently suffered anoxic brain injury.

*Dr. Pomeranz Identifies Ketamine Overdose as Only Suspected Cause of
Gwen’s Altered Mental Status*

557. At 23:50, Dr. Hartridge placed the central line on Gwen’s right subclavian vein. IMC 54. Dr. Morris supervised the procedure. IMC 54.

558. At that time, Gwen was being sedated with propofol and fentanyl. IMC 54.

559. At 22:53, ER Physician David Pomeranz evaluated Gwen. IMC 24.

560. Dr. Pomeranz diagnosed Gwen’s fractures to her legs, arm, and rib. IMC 24.

561. Dr. Pomeranz’s only diagnoses related to Gwen’s brain were “altered mental status” and “focal hemorrhagic contusion of left frontal lobe.” IMC 24.

562. In his History of Present Illness (“HPI”), Dr. Pomeranz noted the prehospital history IMC had just received from EMS providers. *See* IMC 24.

563. Dr. Pomeranz noted that Gwen “was actually given 500 mg ketamine IV by flight service as per EMS, along with 100 mcg fentanyl.” IMC 24.

564. Connecting Gwen’s mental status with the ketamine dose, Dr. Pomeranz then noted that Gwen “was GCS 13 originally, now GCS 3 as per EMS.” IMC 24.

ED NOTE:

HISTORY OF PRESENT ILLNESS:

30-year-old female brought in by EMS for front end highway speed MVC. Patient was actually given 500 mg ketamine IV by flight service as per EMS, along with 100 mcg fentanyl. Patient was GCS 13 originally, now GCS 3 as per EMS. Breathing spontaneously though, has bilateral open lower extremity fractures, right upper extremity fracture.

EMS states on the scene there was severe front-end damage, passenger space intrusion, that other vehicle was going the wrong way on a freeway and struck head-on.

IMC 24.

565. Dr. Pomeranz performed his own physical exam of Gwen. *See* IMC 25.
566. Gwen remained “**comatose, GCS 3.**” IMC 25.
567. Yet Gwen’s head was “**normocephalic and atraumatic.**” IMC 25.

Secondary Survey:

GENERAL: The patient is well-developed, well-nourished, **comatose, GCS 3**

HEENT: Head is **normocephalic and atraumatic.** mouth is clear. Mucous membranes are moist. TMs are clear bilaterally. Nontender to palpation orbits, maxillary, nasal bones, mandible. Dentition intact. No stridor.

NECK: In c-collar, no step-offs or deformities no pulsatile masses, no lacerations, skin intact. No ecchymoses.

IMC 25.

568. As a result, Dr. Pomeranz’s differential diagnosis again traced Gwen’s altered mental status to the ketamine injection, stating: “GCS 3 here, but did receive 500 mg ketamine IV accidentally by paramedics.” IMC 24.

569. Dr. Pomeranz then went further, affirmatively excluding collision trauma as the cause of Gwen’s altered mental status: “**No evidence of head neck facial or chest trauma.**” IMC 24-25.

MEDICAL DECISION MAKING/DIFFERENTIAL DX:

30-year-old female with high-speed MVC, GCS 3 here, but did receive 500 mg ketamine IV accidentally by paramedics. No evidence of head neck

facial or chest trauma. Fast negative. Patient seen in conjunction with trauma service, narrow pulse pressures, will transfuse 1 to 2 units PRBCs.

IMC 24-25.

570. Dr. Pomeranz also did not note a causal connection between the small bruise on Gwen's brain and her altered mental status. IMC 24-25.

571. Dr. Pomeranz's differential diagnosis thus identified the ketamine dose as the only and likely reason for Gwen's altered mental status—the only fact that explained why Gwen was “comatose, GCS 3.”

572. Given this differential, Dr. Pomeranz decided “to intubate patient to protect airway **with excessively high ketamine overdose** and multiple extremity fractures with polytrauma needing transfusion.” IMC 25.

Decision to intubate patient to protect airway with excessively high ketamine overdose and multiple extremity fractures with polytrauma needing transfusion. Intubation successful. Extremity open fractures irrigated by trauma service and splinted. Neurovascular intact after. Will get CT, x-rays, management as per trauma service with orthopedic consultation.

IMV 25.

573. Dr. Pomeranz also decided to “get CT, x-rays, management as per trauma service with orthopedic consultation.” IMC 25.

574. Dr. Pomeranz thus understood and noted that EMS had injected Gwen with 500 milligrams of ketamine on scene.

575. Dr. Pomeranz also recognized and noted that the ketamine dose likely explained Gwen's altered mental status at the Hospital.

576. The following morning, when they arrived at IMC, no one disclosed those facts to Brett or Heather. In fact, no one mentioned ketamine or overdose to them.

Dr. Morris and Dr. Hartridge Provide Initial Trauma Care, Including Intubation

577. After the ER evaluation, Gwen came under the care of Dr. Morris and Dr. Hartridge. IMC 37-48.

578. Even now, Gwen was "spontaneously breathing with OPA in place." IMC 45.

579. "There was a faint distal pulse palpated." IMC 45.

580. Gwen "was transferred over to the trauma bed." IMC 45.

581. Gwen's blood pressure was low—"notable at 90/70." IMC 45.

582. Gwen was then intubated. IMC 45.

583. Dr. Morris and Dr. Hartridge identified "significant trauma to the right upper extremity and bilateral lower extremities with open fractures throughout." IMC 45.

584. Dr. Morris and Dr. Hartridge dressed and splinted Gwen's open fractures. IMC 45.

585. Dr. Morris and Dr. Hartridge gave Gwen a transfusion of 1 unit of blood "due to mild hypotension and notable sources of significant blood loss." IMC 45.

586. Gwen "had excellent response to transfusion." IMC 47.

587. After the transfusion, Gwen's blood pressure was "all wnl"—that is, all within normal limits. IMC 47.

588. Dr. Morris and Dr. Hartridge did not identify any trauma to Gwen's neck or head.

See IMC 37-48.

589. Gwen was then "taken to OR following trauma bay course for wash out and orthopedic repair." IMC 46.

590. Dr. Morris "was present during the trauma evaluation" and was therefore "aware of this assessment and plan." IMC 47.

591. Dr. Morris "directly supervised the assessment and resuscitation." IMC 47.

592. Dr. Morris "spent approximately 60 minutes in reviewing the patient's data, examining the patient, discussing the clinical situation with staff members in formulating the plan of care, and providing direct bedside care." IMC 48.

Dr. Morris and Dr. Hartridge Recognize That Ketamine Dose Caused Gwen's Altered Mental Status

593. Gwen "was GCS of 3-4 upon presentation to the trauma bay." IMC 45.

594. Prior to the intubation, Gwen's GCS score was 3. IMC 47.

595. Dr. Morris and Dr. Hartridge determined that Gwen's GCS score was "**likely secondary to dose of ketamine given in the field.**" IMC 45.

TRAUMA BAY COURSE: The patient was evaluated per ATLS guidelines.

Patient was spontaneously breathing with OPA in place on primary survey, breath sounds are diminished in the right chest, there was symmetrical chest rise. There was a faint distal pulse palpated. Patient was transferred over to the trauma bed. EMS report was obtained, initial blood pressure was obtained notable at 90/70. Additional IV access was obtained in the left upper extremity. Patient was GCS of 3-4 upon presentation to the trauma bay, most likely secondary to dose of ketamine given in the field. Patient was intubated, please see attached intubation procedure note. Secondary survey was notable for significant trauma to the right upper extremity and bilateral lower extremities with open fractures throughout. Open fractures were dressed and splinted. OG tube was placed. Foley catheter was placed. Chest x-ray was unremarkable for any acute cardiopulmonary process requiring immediate intervention. Patient was given 1 unit of

IMC 45.

596. As Dr. Morris explained: “Neuro status is decreased suspected **due to ketamine dose.**” IMC 47.

CTA of RLE showed at least single vessel runoff to right foot, which was dopplerable. Pulse palpable in R foot. Ortho consulted. Plan for OR tonight for washout. Abx and tetanus given in trauma bay. Plan for STICU admission post op. **Neuro status is decreased suspected due to ketamine dose.** CT scan brain looked like there might be some edema but no major obvious issues. We will see how she progresses after the OR. Rib fracture may be motion artifact. No other obvious torso injuries. Given high energy mechanism, CTA neck considered but contrast load already high given extremity CTA. Could consider in AM. Apparent mild metabolic and respiratory acidosis so will continue resuscitation.

IMC 47.

597. As Dr. Morris further explained: “Initial GCS reported at 13. Given IM dose of ketamine IV in error (reported 500 mg), **resulting in unresponsiveness.**” IMC 47.

Young woman involved in a MVC. Prolonged extrication. **Initial GCS reported at 13. Given IM dose of ketamine IV in error (reported 500 mg), resulting in unresponsiveness.** OPA placed and BVM used. Patient arrived to TB as a T1 with BVM assisted ventilation.

IMC 47.

598. Dr. Morris and Dr. Hartridge thus recognized that the ketamine dose was the cause of Gwen’s sudden and continuing unresponsiveness.

599. Yet when they arrived at IMC, no one disclosed those facts to Brett or Heather. In fact, no one even mentioned ketamine or overdose to them.

Dr. Morris and Dr. Hartridge Learn that Gwen “Went Apneic” After Receiving 500 MGs of Ketamine by IV

600. At 00:37, now April 20, 2021, Dr. Morris and Dr. Hartridge entered an HPI for Gwen. IMC 37.

601. Dr. Morris and Dr. Hartridge documented the prehospital history the Hospital had received from “EMS reports.” IMC 37.

TRAUMA ACTIVATION LEVEL: 1

HISTORY OF PRESENT ILLNESS: ZZZIM, NORSE-AA is a 30-year-old female that presents as a trauma 1 after motor vehicle accident as a restrained driver. Per EMS report it was noted that a car was going the wrong direction on the highway and ended up colliding with the patient's vehicle head-on at highway speeds. He was noted that the patient required prolonged extrication of greater than 45 minutes due to the entire front of the vehicle collapsing into the driver side. The patient had significant trauma initially noted on scene with open fractures to the right lower extremity left lower extremity in the femur, into the right upper extremity. Was initially noted to be a GCS of roughly 13 and had sustained a positive loss of consciousness. IV access was obtained of the left arm, and per EMS reports 500 mg of IV ketamine was accidentally administered. Is noted that the initial intent for that much ketamine was for an IM dosage. The patient went apneic following that, the patient was given an OPA and BVM. Attempts at intubation were made in the field however were unsuccessful in passing tube due to laryngeal spasm and that her cords obstructed every attempt. After successful location from the vehicle the patient was emergently transported. While the patient was GCS of 13, they were able to determine that the patient's medical history was significant for depression, and that the patient takes an antidepressant. The patient at that time denied any allergies to medications. As reported from the other individual in the accident, there is a history of substance abuse, and the patient has been in recovery for quite some time.

IMC 37.

602. In those reports, unidentified EMS providers reported the following:

- a. Gwen was “initially noted to be a GCS of roughly 13 and had **sustained a positive loss of consciousness,**”
- b. **“500 mg of IV ketamine was accidentally administered,”**
- c. “the initial intent for that much ketamine was for an IM dosage,” and
- d. Gwen **“went apneic following that,** the patient given an OPA and BVM,”
- e. “attempts at intubation were made in the field,” and
- f. those attempts “were unsuccessful in passing tube due to laryngeal spasm and that her cords obstructed every attempt.”

IMC 37.

603. Dr. Morris and Dr. Hartridge thus recognized that Gwen not only “sustained a positive loss of consciousness” but also “went apneic” because of the ketamine dose.

604. Yet when they arrived at IMC, no one disclosed those facts to Brett or Heather. In fact, no one mentioned ketamine, overdose, or apnea to them.

605. Recognizing that the apnea caused Gwen's altered mental status, Dr. Morris and Dr. Hartridge ordered hourly neurological checks, and decided to "consider repeat CT upon admission to STICU" post-surgery. IMC 46.

*With "No Obvious Head or Neck Trauma," Dr. Larcom Recommends
Immediate Leg Surgery without Consent*

606. At 01:00, Orthopedic Surgeon Peter G. Larcom completed a consultation with the trauma team. IMC 55-56.

607. The reason for the consultation was: "Open left proximal femoral shaft fracture, open right tibial shaft fracture, open right bimalleolar ankle fracture, closed right humeral shaft fracture." IMC 55.

608. Dr. Larcom prepared his own HPI for Gwen. IMC 55.

609. There, he erroneously stated that Gwen was "around 30 years of age." IMC 55.

610. Referring to prehospital care by EMS, Dr. Larcom also erroneously noted that "patient was intubated at that time for airway protection." IMC 55.

611. Dr. Larcom also performed a physical assessment of Gwen. IMC 56.

612. Gwen "**had no obvious head or neck trauma.**" IMC 56.

PHYSICAL EXAMINATION:
HEENT AND NECK: The patient had no obvious head or neck trauma.
CARDIAC: Regular rate and rhythm.

IMC 56.

613. Dr. Larcom concluded that Gwen was "a good candidate for I and D of all open wounds and stabilization of each of the above-noted fractures with open reduction and internal fixation plan for the ankle." IMC 56.

614. At that time, because Brett and Heather had not yet been notified of the vehicular collision, “there was no one noted with whom to discuss the various risks, benefits, and alternatives.” IMC 56.

615. As a result, “no family members, friends or significant others were available to obtain informed consent.” IMC 56.

616. Nevertheless, because “surgery was felt to be highly indicated,” IMC “made preparations to proceed.” IMC 56.

617. The surgery Dr. Larcom recommended was “to proceed given the extreme nature of the patient’s injuries.” IMC 56.

618. Gwen thus “went to the OR for most of the night.” IMC 14.

*Under General Anesthesia, Gwen Undergoes Overnight Surgery That
“Definitively Fixed” Her Legs*

619. Gwen went to the operating room “overnight” for “washout and fixation” of the fractures on her legs. IMC 9.

620. Gwen received general anesthesia via an endotracheal tube. IMC 48.

621. Dr. Larcom then performed surgery to fix the fractures on Gwen’s legs. IMC 9, IMC 48-52.

622. By the end of the surgery, Dr. Larcom considered the case “complete.” IMC 51.

623. As Dr. Majercik noted, Gwen’s legs were “definitively fixed.” IMC 14.

624. Gwen was then admitted to the shock-trauma intensive care unit (STICU). IMC 9.

625. The treatment plan was then for Dr. Larcom to operate on Gwen’s arm a day later. IMC 13, IMC 56.

*After Gwen Is “Extensor Posturing” on All Four Limbs, Dr. Majercik
Decides to Order Repeat CT of Gwen’s Brain*

626. In the STICU post-operatively, Gwen came under the care of Trauma Surgeon Sarah Majercik and Physician’s Assistant Christina Pelo. *See* IMC 13-14.

627. At 06:00, Gwen was taken off propofol and fentanyl, which she had been receiving for sedation and pain. IMC 11, IMC 17.

628. Off sedation, Gwen’s GCS score rose slightly, to a 4. IMC 11.

629. At about 07:53, Gwen was “posturing off sedation this morning post-operatively.” IMC 14.

630. Gwen was “extensor posturing x4 extremities with noxious stimuli.” IMC 10.

NEUROLOGIC: GCSE1V1TM2 - extensor posturing x4 extremities with noxious stimuli. No additional active movement observed.

IMC 10.

631. That is: “When attempting to wean her sedation this morning, she was noted to be extensor posturing in all four extremities.” IMC 14.

632. At 08:28, Dr. Majercik sent Gwen “down for a repeat brain CT now.” IMC 14.

633. At that time, Dr. Majercik also decided to obtain a “CTA of the neck as [Gwen] did not have one on her original workup.” IMC 14.

634. When Brett and Heather arrived later that morning, neither Dr. Majercik, nor PA Pelo, nor anyone else, informed Brett or Heather of the extensor posturing.

Dr. Majercik and PA Pelo Recognize Gwen's Mental Status Is "Possibly Related to Large IV Ketamine Dosage"

635. At 07:53, Dr. Majercik and PA Pelo performed a physical exam. IMC 9-14.

636. Gwen's head remained "**normocephalic and atraumatic.**" IMC 9.

GENERAL: Intubated
HEENT: Normocephalic, atraumatic. PERRL. ET tube in place.
NECK: Supple. Trachea midline. Cervical spine without stepoffs or deformities. Cervical collar in place.

IMC 9.

637. Besides posturing, Gwen had "no additional active movement." IMC 10.

638. With the posturing in mind, Dr. Majercik and PA Pelo summarized the events that led to Gwen's altered mental status: "Reported GCS 13 at scene, given 500mg IV ketamine by EMS, GCS 3-4 upon arrival to trauma bay." IMC 11.

639. Dr. Majercik and PA Pelo then went further, affirmatively excluding the small contusion as a cause of Gwen's altered mental status, declaring: "**AMS not explained by initial CT head/brain.**" IMC 11.

NEURO:
GCS: E1V1M2
Recent Imaging: CT head/brain with small L frontal IPH
Sedation/Pain: IV Prop and Fent off since 6AM

Focal hemorrhagic contusion of left frontal lobe
Altered Mental Status

- Reported GCS 13 at scene, given 500mg IV ketamine by EMS, GCS 3-4 upon arrival to trauma bay
- CT head on admission with small punctate lesion
- Currently GCS 4T, off sedation
- AMS not explained by initial CT head/brain
- Possibly related to large IV Ketamine dosage, but will obtain stat CT head/brain and CTA head/brain now
- Continue off sedation, q1 hour neuro checks

IMC 11.

640. Instead, Dr. Majercik and PA Pelo expressly identified the ketamine dose as the possible cause, stating that Gwen’s altered mental status was **“Possibly related to large IV Ketamine dosage.”** IMC 11.

Dr. Majercik Suspects Gwen May Have Experienced “Prolonged Hypoxia at the Scene”

641. Dr. Majercik then even considered what indeed happened—that Gwen may have suffered prolonged hypoxia resulting in anoxic brain injury.

642. But, because there was **“no reported prolonged hypoxia at the scene,”** Dr. Majercik ruled out “anoxic injury” as “unlikely.” IMC 14.

ATTENDING TRAUMA SURGEON ATTESTATION: patient seen. Agree with documented note, exam and plan. Admitted last night after being hit by a car going the wrong way on the freeway at high speeds. She has multiple extremity injuries and a small hemorrhagic contusion of her brain. No intra-abdominal injuries. She went to the OR for most of the night and got her lower extremities definitively fixed. When attempting to wean her sedation this morning, she was noted to be extensor posturing in all four extremities, giving her a 6-7T. Will have her go down for a repeat brain CT now. Will also obtain a CTA of the neck as she did not have one on her original workup. She could have had fat emboli given the severity of her extremity fractures. There is no reported prolonged hypoxia at the scene, but her extrication did take about 45 minutes by report. At any rate, she has been normoxic since arrival to the hospital, so anoxic injury seems unlikely. Otherwise she has been hemodynamically stable. She is oxygenating and ventilating fine on current, minimal settings. She will likely need an MFT today if her mental status does not improve and she doesn't move toward extubation. She is on insulin protocol for hyperglycemia. She is COVID positive, got perioperative antibiotics. Will hold on VTE prophylaxis for now until her brain injury is deemed stable for 48-72 hours.

Sarah Majercik, MD

IMC 14.

643. In that context, Dr. Majercik went out of her way to document that Gwen had been “normoxic since arrival to the hospital.” IMC 14.

644. Thus, in case Gwen did have an anoxic brain injury, Dr. Majercik wanted a record that the hypoxic event did not happen at the Hospital, but rather “at the scene” as a result of the “IV Ketamine dosage.” See IMC 14.

645. Dr. Majercik then sought a definitive diagnosis, by ordering “stat CT head/brain and CTA head/brain now.” IMC 11.

646. Dr. Majercik and PA Pelo also ordered that Gwen be kept “off sedation,” and receive hourly neurological assessments. IMC 11.

*At 09:07, the Second CT Reveals Early Signs of Diffuse Swelling
Consistent with Anoxic Brain Injury*

647. At about 09:07, Gwen underwent another “CT Brain/Head” without contrast, as well as a “CT Angio Brain and Neck.” IMC 65-67.

648. The reason for this second CT was “Trauma/Injury.” IMC 67.

649. At 09:15, Radiologist John M. Jacobs reported on this CT. IMC 67.

650. This second CT confirmed the findings of the first. *See* IMC 67, IMC 74-75.

651. Gwen still had the same small contusion: “a petechial hemorrhage in the subcortical white matter of the left frontal lobe.” IMC 67.

652. In fact, “the area of the hemorrhage” had “not changed in size or density compared to prior study.” IMC 67.

653. This CT thus revealed a “stable left frontal petechial hemorrhage.” IMC 67.

FINDINGS: There is again noted to be a petechial hemorrhage in the subcortical white matter of the left frontal lobe. The area of hemorrhage has not changed in size or density compared to prior study. There is no significant surrounding edema.

The gray-white interface is unremarkable. There is no evidence of mass effect or edema. The ventricles and CSF spaces are appropriate for age. There is no evidence of herniation.

IMPRESSION: Stable left frontal petechial hemorrhage.

This report was electronically signed by John M. Jacobs, MD on 4/20/2021 9:15 AM.

***** Final *****

IMC 67.

654. In his report on the CT, Dr. Jacobs made the following additional findings :

- a. the “gray-white interface [was] unremarkable,”
- b. the “ventricles and CSF spaces [were] appropriate for age,”
- c. there was at that time “no evidence of mass effect or edema,” and
- d. there was at that time “no evidence of herniation.”

IMC 67.

655. In fact, this CT showed early signs of diffuse cerebral edema (swelling), which was suspicious for a significant anoxic brain injury.

656. In fact, the CT showed subtle but definite evidence of diffuse anoxic brain injury, in the form of brain edema, loss of contrast differentiation of deep gray matter structures (globus pallidus nuclei and thalami), and obliteration of subarachnoid spaces at the skull base (basilar cisterns) and ventricles.

657. The CT correlated with Gwen’s clinical deterioration, including her posturing.

658. The CT was also consistent with the clinical course of patient who had recently suffered anoxic brain injury.

At 09:07, the CTA Shows Normal Patency of Arteries, Consistent with Course of Anoxic Brain Injury

659. At 09:14, Radiologist Aaron L. Bress reported on the CTA. IMC 65-67.

660. The reason for the CTA was “Trauma/injury to vessel.” IMC 65.

661. In his report on the CTA, Dr. Bress made the following findings:

- a. the arteries studied in Gwen’s head and neck were “normal,”
- b. the anterior and posterior intracranial circulation in Gwen’s brain were both “normal,” and
- c. there was “no hemodynamically significant stenosis or other vascular abnormality.”

IMC 66.

662. The CTA showed normal patency of extracranial (carotid and vertebral) and intracranial arteries.

663. The CTA correlated with Gwen’s clinical deterioration.

664. The CTA was also consistent with the clinical course of patient who had recently suffered anoxic brain injury.

At About 02:30, Upon Learning of the Vehicular Collision, Brett and Heather Embark on Six-Hour Drive to IMC

665. Upon information and belief, it took UHP several hours to identify and locate Heather as Gwen’s next-of-kin.

666. At 02:28, while asleep at home in Casper, Wyoming, Heather received a call from UHP informing her of the collision.

667. Heather and her husband, John Myers, immediately mobilized to drive down to IMC with their two other children.

668. Heather and John also immediately called Brett at his home, but Brett was asleep and did not hear his telephone ring.

669. Heather and her family drove a few minutes to Brett's home, to wake him.

670. At about 03:30, Heather and her family set off for Salt Lake City, with Brett close behind.

*Despite Gwen's Posturing, Dr. Majercik Assures Brett and Heather That
Gwen's Brain Is "Absolutely Okay"*

671. At about 09:30, Brett and Heather arrived at the Hospital.

672. Dr. Majercik and PA Pelo then "updated" Brett and Heather "on patient condition and plan of care at bedside." IMC 14.

673. Dr. Majercik and PA Pelo assured Brett and Heather that Gwen had a "long road of physical therapy ahead," but was otherwise going to be totally fine.

674. Dr. Majercik assured Brett and Heather that the small bruise seen on the CTs was "no big deal." Dr. Majercik explained that she sent home patients with such contusions "all the time."

675. Despite her private concerns over possible "prolonged hypoxia" and "anoxic brain injury," and despite even the extensor posturing she had just witnessed, Dr. Majercik added that Gwen's brain was "absolutely okay."

676. Dr. Majercik assured Brett and Heather that Gwen would “wake up soon.”

677. Relying on this update, Brett and Heather called family and friends to share the good news that that Gwen was going to be fine.

678. Relying on this update, Brett and Heather hovered for hours over Gwen, repeatedly asking: “Can you hear us, Gwenny? Can you wake up now?”

679. By that time of the update, as their notes reveal, Dr. Majercik and PA Pelo had already recognized these material facts about Gwen’s physical condition:

- a. EMS providers had injected Gwen with 500 milligrams of ketamine,
- b. Gwen had altered mental status (was unconscious) even after being taken off sedation hours earlier,
- c. Gwen now had extensor posturing in all four limbs,
- d. if followed by a prolonged period of hypoxia, the ketamine dose was the suspected cause of Gwen’s mental status and extensor posturing,
- e. if there was a prolonged period of hypoxia, Gwen likely suffered anoxic brain injury, leading to her current mental status and extensor posturing,
- f. anoxic brain injury was “unlikely” the cause, but only because EMS providers had not reported any “prolonged hypoxia at the scene.”

See IMC 9-14.

680. During their update, neither Dr. Majercik, nor PA Pelo, nor anyone else, disclosed any one of these facts to Brett and Heather. In fact, no one even mentioned ketamine, overdose, hypoxia, anoxia, or posturing to them.

*After Abrupt Clinical Changes Concerning for Brain Herniation, Dr.
Majercik and PA Pelo Order Repeat CTs*

681. During the afternoon, while still under the care of Dr. Majercik and PA Pelo, Gwen decompensated abruptly.

682. *First*, Gwen became “very hemodynamically unstable.” IMC 24, IMC 17-18.

683. At 14:45, a nurse notified PA Pelo that that Gwen had “abruptly” become tachycardic and hypertensive. IMC 17. That is, Gwen’s heartrate had abruptly spiked to the “low 170s,” and her systolic blood pressure had increased to “the high 150s/110s.” IMC 17.

Trauma Event Note

Patient is a 19 year old female s/p MVC with multiple orthopedic injuries, small intraparenchymal contusion and rib fracture.

Notified by RN at 1445 that patient has abruptly become tachycardic and hypertension. All shift patient has been normotensive, with mild tachycardia in low 100s. I immediately presented to patient's bedside, patient HR in low 170s, SBP in high 150s/110s. Initially thought that patient may be starting to wake as her sedation has been off since 7am without any additional pain medication. Patient given 100mcg of IV fentanyl and 20mg IV propofol. SBP improved to 130s, but patient remained tachycardic into 170s. It appeared to be sinus tachycardia on the monitor but unclear due to fast rate, patient given 5mg IV Metoprolol. Rate improved to 120s, stat EKG obtained demonstrating sinus tachycardia. Stat ABG obtained with pCO2 of 17, bicarb of 9.6 and lactate increased from 3 to 8.3, hgb stable from previous CBC. Patient given 1L fluid bolus for elevated lactate and possible under resuscitation from AM OR.

IMC 17.

684. Subsequently, despite various efforts to stabilize them, Gwen’s heartrate and blood pressure swung dramatically. *See* IMC 17-18.

685. *Second*, Gwen had “increased UOP”—increased urinary output. IMC 18.

After approximately 10 minutes, patient became hypotensive with MAPs in low 50s, HR climbing from 120s back into 140s. Patient given additional 1L bolus x2, 1amp bicarb and 2g IV calcium. Hypotension improved. Full set of labs sent off (CBC, CMP, lactate, lipase, troponin, TEG). Patient noted to have increased UOP, added on urine electrolytes and urine osms. Patient then had another episode of hypertension and tachycardia similar to previous, decision was made to place patient back on control mode of ventilator and sedation in hopes of stabilizing hemodynamics. Patient started on 30mg IV propofol gtt and 50mcg IV Fentanyl gtt. Again after approximately 5-10 minutes, patient became profoundly hypotensive with MAPs in low 40s, remained tachycardic into 120-130s. Given 1L bolus with limited response in BP, started on Levophed gtt, given small dose of Phenylephrine as a temporizing measure and 2U PRBC ordered. While waiting for PRBCs to arrive, patient remained hypotensive, Levo increased to 0.5 and started on Vasopressin gtt. During this time, Dr. Lanspa was asked to come to bedside and perform bedside TTE, no obvious heart strain, no cardiac dysfunction, patient appeared volume replete, positive bilateral lung sliding.

IMC 18.

686. *Third*, after Dr. Majercik and PA Pelo finally decided to repeat a “complete physical examination,” Gwen’s pupils were “dilated” and “non-reactive,” and she was now “without gag reflex.” *See* IMC 18.

687. Given those abrupt clinical changes, Dr. Majercik and PA Pelo decided to send Gwen “for STAT repeat CTs,” in order to “re-evaluate for possible additional injuries contributing to patient condition.” IMC 18.

688. Because herniation was now a concern, Dr. Majercik and PA Pelo gave Gwen a “23% bolus” of hypertonic saline, “due to poor neuro examination.”⁸⁴ IMC 18.

At this point, complete physical examination repeated, all compartments remained soft, no bloody strikethrough noted on surgical dressings, and abdomen soft. However pupils noted to be non reactive without gag reflex. NPi obtained with pupillometer and bilateral pupils dilated and non reactive (pupils had previously been reactive bilaterally on all neuro exams throughout the day, last at approximately 1400). Once receiving PRBCs and both pressors, patient’s hemodynamics improved, decreasing pressor support. Given neurologic examination, hemodynamics and steadily increasing lactate, decision was made to send patient for STAT repeat CTs - CT head/brain, CTA head/neck, CTA pulmonary (to rule out PE), and CT abdomen/pelvis with IV contrast to re-evaluate for possible additional injuries contributing to patient condition. Patient given x1 23% bolus prior to CT due to poor neuro examination. Parents at bedside throughout this STICU course, updated on plan of care and at this point planned for EEG upon return from CT to rule out possible seizure.

Dr. Majercik had been present at bedside throughout this course and plan of care. Patient clinical case discussed with night attending Dr. VanBoerum prior to shift change by Dr. Majercik.

IMC 18.

689. Prior to shift change, Dr. Majercik discussed Gwen’s “clinical case” with “night attending Dr. Van Boerum.” IMC 18.

690. According to PA Pelo’s note, Brett and Heather were “at bedside through this STICU course,” and were “updated on plan of care.” IMC 18.

691. In fact, neither PA Pelo, nor Dr. Majercik, nor anyone else, informed Brett or Heather of these acute clinical changes, let alone of the concerns they raised.

⁸⁴ Hypertonic saline has been shown to improve outcomes in cases of elevated intracranial pressure.

*At 17:41, a Third CT Shows Diffuse Cerebral Swelling and Herniation—
Portents of Brain-Death*

692. At about 17:41, Gwen underwent a “CT Brain/Head w/o Contrast.” IMC 57.
693. The indication for this third CT was “altered level of consciousness.” IMC 57.
694. By 18:13, Dr. Logan A. McLean read and reported on the CT.
695. In his written report, Dr. McLean made the following findings:
- a. “Diffuse **cerebral edema.**”
 - b. “New effacement basilar cisterns with new descending transtentorial herniation.”
 - c. “New loss of gray-white differentiation involving the medial right occipital lobe, which is in the right posterior cerebral artery distribution.”
 - d. “New mild loss of gray-white differentiation in the left temporal lobe, which may represent edema and/or ischemia.”

IMC 57-58.

IMPRESSION:

1. Diffuse cerebral edema.
2. New effacement basilar cisterns with new descending transtentorial herniation.
3. New loss of gray-white differentiation involving the medial

right occipital lobe, which is in the right posterior cerebral artery distribution.

4. New mild loss of gray-white differentiation in the left temporal lobe, which may represent edema and/or ischemia.
5. Unchanged acute left deep frontal interparenchymal hemorrhage measuring 0.6 cm.

IMC 57-58.

696. Moreover, the small hemorrhagic contusion identified in the prior CTs measured “0.6 cm” and was “**unchanged.**” IMC 58.

697. At 18:02, Dr. McLean called Dr. Van Boerum and PA Pelo, to report his critical findings: “Descending cerebral herniation” and “cerebral edema.” IMC 58, IMC 18.

Critical Finding called and reported to:
Provider: Christina Pelo PA-C and Dr. Van Boereum
Time: 4/20/2021 6:02 PM
Critical finding type: Descending cerebral herniation, cerebral edema

IMC 58.

698. In fact, the CT revealed severe diffuse brain edema and early herniation.

699. These were ominous findings heralding brain death.

700. The CT correlated with Gwen’s clinical deterioration, including her extensor posturing and her hemodynamic instability.

701. The CT was also consistent with the clinical course of a patient who had recently suffered profound prolonged hypoxia resulting in anoxic brain injury.

At 17:46, Second CTA Reveals Cessation of Blood Supply to Gwen’s Brain—Another Portent of Brain-Death

702. At about 17:46, Gwen underwent a “CT Angio Brain and Neck.” IMC 58.

703. The indication for this second CTA was “altered level of consciousness.” IMC 58.

704. By 18:27, Dr. McLean read and reported on the CTA.

705. In his written report, Dr. McLean made the following findings:

- a. “No visualized intracranial arterial flow.”
- b. “New right internal carotid artery dissection near the bifurcation.”
- c. “New irregularity of the left internal carotid artery, which may represent dissection or vasospasm.”

- d. “No visualized flow with the right vertebral at the skull base of intracranially (V2-V4). This finding may represent dissection or vasospasm.”
- e. “No visualized **flow** in the left vertebral artery at the mid cervical segment, skull base and intracranially (V2-V4). This finding may represent dissection or vasospasm.”

IMC 60.

706. At 18:13, before finishing his written report, Dr. McLean called Dr. Van Boerum and PA Pelo to report his critical findings up to that point: “right carotid dissection” and “absence of intracranial flow.” IMC 60, IMC 18.

707. In fact, the CTA revealed that there was no antegrade flow to Gwen’s brain.

708. In fact, the CTA revealed no contrast opacification of intracranial arteries and of most cervico-cephalic (neck) arteries (except for partial filling of the left carotid artery), consistent with cessation of blood supply to the brain.

709. These findings indicated brain-death.

710. The CTA correlated with Gwen’s clinical deterioration, and was consistent with the clinical course of a patient who had recently suffered anoxic brain injury.

*Dr. Van Boerum and PA Pelo Inform Brett and Heather That Gwen Is
Brain-Dead*

711. Dr. McLean called Dr. Van Boerum and PA Pelo while Gwen was still in the CT suite. IMC 18, IMC 58, IMC 60.

712. Once Gwen returned to Trauma, PA Pelo called the Emergency Department Social Worker to bedside. IMC 18.

713. Dr. Van Boerum and PA Pelo then “discussed devastating findings with patient’s parents at bedside.” IMC 18.

While patient in CT, received call from radiologist reporting profound CT angio findings of possible dissection, herniation and lack of cerebral blood flow. Dr. VanBoerum present for call from radiologist. Once patient returned from CT, other imaging reviewed, ED SW called to bedside and myself and Dr. VanBoerum discussed devastating findings with patient's parents at bedside. Patient's family appropriately emotional, discussed timing of formal brain death examination later this evening and gave family appropriate time to grieve. Charge RN and Donor services aware of patient condition. I then passed off care to fellow APP Hayley Mollard.

Christina Pelo, PA-C

IMC 18.

714. Gwen’s family was “appropriately emotional.” IMC 18.

715. Dr. Van Boerum and PA Pelo discussed with Brett and Heather “the timing of formal brain death examination later [that] evening.” IMC 18

716. Dr. Van Boerum and PA Pelo gave Brett and Heather “appropriate time to grieve.” IMC 18.

717. PA Pelo informed the Charge Nurse and Organ Services of Gwen’s condition. IMC 18. PA Pelo “then passed off care to fellow APP Hayley Mollard.” IMC 18.

*After Performing Formal Brain-Death Exam, Dr. Van Boerum
Pronounces Gwen Officially Dead*

718. Leading up to 02:42, now April 21, 2021, Dr. Van Boerum performed the formal brain-death examination. IMC 17.

719. Gwen’s family “was present at the bedside for the exam.” IMC 17.

720. At its conclusion, Gwen’s family was “informed of her passing and the declaration of brain death.” IMC 17.

721. Dr. Van Boerum officially pronounced Gwen dead at 02:42. IMC 17.

Document Type:	Progress Note Generic
Service Date/Time:	4/21/2021 02:46 MDT
Result Status:	Auth (Verified)
Document Subject:	Brain Death Note
Sign Information:	VANBOERUM,MD,DON (4/21/2021 02:57 MDT)

Date of Service

04/21/2021

Time of death 2:42 AM

Brain death examination was performed which included absence of pupillary reflex, absence of corneal reflex, absence of cough or gag, absent peripheral reflexes to noxious stimuli, no response to cold caloric administration. Patient's temperature is 36.8. She has been off of any sedating or sensory altering medications for around 12 hours and only was on them for a brief while. CT angiogram of the head and neck was done earlier which showed no evidence of blood flow to the brain. I then performed an apnea test where blood gas was drawn at 10 minutes. PCO2 was 75.4 on that gas. We actually went an additional 3 minutes without any respiratory effort but did not obtain an additional blood gas, due to malfunction of the art line at that point.

Patient's family was present at the bedside for the exam. They were informed of her passing and the declaration of brain death which had previously been explained to them. Donor services had spoken with the family a few hours ago and had informed them of the fact that her name was on the donor registry. Family had stated at that time that they did wish to pursue organ donation. Therefore we are turning over patient care to donor services.

Don H. Van Boerum, MD FACS

IMC 17.

Gwen's "Cause of Death" Is "Cerebral Anoxic Injury"

722. At 02:53, minutes after formally declaring Gwen dead, Dr. Van Boerum entered a Death and Discharge Summary. IMC 23.

723. This Summary identified Dr. Morris, Dr. Larcom, and Orthopedic Surgeon Allen R. Groebs as consulting physicians. IMC 23.

724. Dr. Van Boerum identified the following as the cause of Gwen's death: "**Cerebral anoxic injury of unclear etiology.**" IMC 23.

Discharge Summary

Document Type:	Discharge Summary
Service Date/Time:	4/21/2021 02:53 MDT
Result Status:	Auth (Verified)
Document Subject:	Trauma Death and Discharge Summary
Sign Information:	VANBOERUM,MD,DON (4/26/2021 22:18 MDT)

DATE OF ADMISSION: 04/19/21 21:43:30
DATE OF DEATH: 04/21/2021 02:42

CAUSE OF DEATH:
Cerebral anoxic injury of unclear etiology

IMC 23.

725. Thus, as the physician declaring the cause of Gwen’s death, Dr. Van Boerum recognized and documented that Gwen had died from an anoxic brain injury.

726. As shown above, Gwen was admitted and remained in an altered mental status throughout her IMC admission. Gwen arrived and remained unconscious, unresponsive, and comatose.

727. As shown above, physicians along the way recognized that the ketamine dose was the suspected cause of Gwen’s altered mental status.

728. Nevertheless, Dr. Van Boerum now noted that Gwen’s cause of death—anoxic brain injury—was “of an unclear etiology.” IMC 23.

*To Sustain Her Organs for Donation, Gwen Remains on Life Support at
IMC for Days—with Her Parents at Bedside*

729. Because Donor Services had previously informed Gwen’s family that Gwen was on the donor registry, the family “had stated at that time that they did wish to pursue organ donation.” IMC 17.

730. Accordingly, after formally pronouncing Gwen dead, Dr. Van Boerum transferred patient care to Donor Services. IMC 17.

731. From April 21 to 24, 2021, while Donor Services made arrangements, Gwen remained on life-support in the same bed, to sustain her organs.

732. During those days, Brett and Heather remained bedside, day and night.

*PA Mollard Equivocally Documents That Gwen's Death Was "Possibly
Due to Cerebral Edema from an Anoxic Brain Injury"*

733. In Dr. Van Boerum's Trauma Death and Discharge Summary, PA. Mollard entered a "Brief Summary of Hospital Course." IMC 23-24.

734. There, PA Mollard acknowledged that Gwen was a "previously healthy 19-year-old female restrained driver in a motor vehicle crash as described in the HPI." IMC 24.

735. PA Mollard also echoed the conclusions previously reached by Dr. Morris and Dr. Hartridge: Gwen's GCS score "was felt secondary to the accidental 500 mg of ketamine given in the field." IMC 24.

736. In reference to the "absence of cerebral blood flow" Dr. McLean found in the second CTA, PA Mollard noted: "This was thought possibly **due to cerebral edema from an anoxic brain injury** versus ischemia from a carotid artery injury not seen on prior CT angiogram." IMC 24.

BRIEF SUMMARY OF HOSPITAL COURSE: This was a previously healthy 19-year-old female restrained driver in a motor vehicle crash as described in the HPI. She arrived to GCS of 3 but this was felt secondary to the accidental 500 mg of ketamine given in the field. Initial CT imaging of her brain only showed a small punctate hemorrhage which remained stable on repeat imaging. She went to the operating room for multiple orthopedic injuries including an open femur fracture. Her mental status did not improve postop and then during the day yesterday she became very hemodynamically unstable and then her pupils became fixed. Please see critical care progress note and trauma event note by Christina Pelo on 4/20/21 for further details. Repeat imaging including CT angio brain and neck was done and showed absence of cerebral blood flow. **This was thought possibly due to cerebral edema from an anoxic injury** versus ischemia from a carotid artery injury not seen on prior CT angiogram. Donor connect was contacted. She was registered as a organ donor and family wish to donate her organs. All brainstem reflexes were absent. An apnea test was done which confirmed brain death with an initial PCO2 of 48 and a final PCO2 of 75 after 12 minutes of no spontaneous respiratory effort. Time of death was called at 0242 by Dr. Van Boerum who performed patient examination and the apnea test. Donor connect will now assume primary care. **Autopsy will be needed to ascertain precise cause of death.**

Hayley D Mollard, PA-C
Trauma and Critical Care Physician Assistant
Intermountain Medical Center

Electronically Signed on 04/26/21 10:18 PM

IMC 24.

737. PA Mollard signed this Summary at 22:18 on April 26, 2021—at least two days after Gwen’s organs had been harvested for donation, and two days after Brett and Heather had returned to Wyoming.

738. Nevertheless, though Dr. Van Boerum had declared “Cerebral anoxic injury” the cause of Gwen’s death, PA Mollard now walked back on the declaration, stating: “Autopsy will be needed to ascertain precise cause of death.” IMC 24.

739. By that time, of course, an autopsy was an impossibility.

***Brett and Heather Leave IMC without a Clue That Iatrogenic Errors
Killed Gwen***

740. From April 21 to 24, 2021, Brett and Heather had countless conversations with Dr. Van Boerum, Dr. Majercik, PA Pelo, nurses, and other providers.

741. During some of those conversations, Brett and Heather even expressly asked for information and insight into the cause and nature of Gwen’s death.

742. On the morning of April 21, for example, Heather asked Dr. Majercik to “please explain how this could have happened?”

743. Dr. Majercik explained that she “had never seen this happen” in all her years of practice.

744. By that time, IMC providers already knew that EMS providers had injected Gwen with 500 milligrams of ketamine on scene.

745. By that time, IMC providers also knew that Gwen had died from “cerebral anoxic injury” at the Hospital.

746. With those indisputable facts as bookends, IMC providers also knew or had to reasonably infer that the following chain of events causally connected the ketamine dose the anoxic brain injury:

- a. Life Flight injected Gwen with 500 milligrams of ketamine—over 16 times the maximum indicated dose;
- b. the ketamine overdose led to respiratory arrest and other complications;
- c. Life Flight and other EMS providers then failed to treat the respiratory arrest, with prompt ventilation and oxygenation;
- d. Gwen thus went a prolonged period of time without breathing;
- e. Gwen thus experienced prolonged hypoxia, and anoxia;
- f. Gwen’s brain stopped functioning because it suffered anoxic injury secondary to overdose and respiratory arrest;
- g. Gwen died from the anoxic brain injury; and
- h. **Gwen’s** death was iatrogenic—caused by medical error.

747. This sequence of events is the only one that reasonably connects the ketamine injection to Gwen's death.

748. Nevertheless, although he internally documented "cerebral anoxic injury" as the cause of Gwen's death, Dr. Van Boerum outwardly did not disclose any of these facts to Brett or Heather.

749. Nor did anyone else.

750. On April 24, 2021, after Gwen's organs had been harvested to save other lives, Brett and Heather left IMC with mixed feelings: while they felt the existential anguish of looking ahead to life without Gwen, they found comfort in the belief that healthcare providers had done all they could to save her.

751. Brett and Heather returned to their lives in Wyoming believing Gwen had died from a tragic accident—not from hidden iatrogenic errors.

PROFESSIONAL NEGLIGENCE

752. For each count of professional negligence alleged below, the alleged acts and omissions also constituted ordinary or simple negligence.

753. For each count of professional negligence alleged below, the alleged acts and omissions also rose to the level of gross negligence.

754. The following requirements of the standard of care (in Counts 1-13) generally apply to healthcare providers who participate in caring for a patient during and following the administration of a high-risk medication to the patient.

Count 1: Failure to Follow Medication-Use Process

755. Plaintiffs here incorporate by reference all allegations in this Complaint.

756. When a provider decides to administer the medication to a patient, the standard of care requires the provider to identify and verify each element of the medication-use process: dose, concentration, route of administration, rate of administration, contraindications, and indication.

757. These requirements apply with special force when a provider administers a medication that has multiple indications, indicated doses, and delivery routes, such as ketamine.

758. These requirements also apply with special force in a prehospital setting, where providers have limited resources, assistance, and control.

759. On April 19, 2021, MCFD Paramedic Winters, MCFD Paramedic Sneddon, Life Flight Nurse Jewkes, and Life Flight Provider Ryan Kimball each violated these requirements, by failing to identify and verify elements of the medication use-process, including the dose indicated for Gwendolyn Doner.

760. Soon after they arrived on scene, Winters and Sneddon “pulled up medications” and “confirmed with life flight for medication administration.” MCFD 7. Both teams then “agreed” to administer “both fentanyl and ketamine for pain control.” MCFD 7.

761. While Winters, Sneddon, Jewkes, and Kimball thus identified and verified the indication (pain control), they failed to identify and verify other elements of the medication-use process, including the dose, route of administration, and rate of administration.

762. Each failure bypassed a key safeguard against medication error, clearing the way for the administration of a dangerous dose of ketamine—over 16 times the maximum indicated dose.

763. The resulting overdose then caused Gwen to go into respiratory arrest, which in turn caused her to suffer anoxic brain injury leading to her death.

764. Had Jewkes, Kimball, Winters, or Sneddon identified and verified the indicated dose, the 500 milligrams of ketamine would not have been drawn up into the syringe in the first place, let alone administered to Gwen.

765. Each violation was thus a cause of Gwen's injury and death.

Count 2: Failure to Draw Up Indicated Dose

766. Plaintiffs here incorporate by reference all allegations in this Complaint.

767. When a provider draws up the medication into a syringe, the standard of care requires the provider to draw up precisely the indicated dose. The standard of care prohibits the provider from drawing up more than the indicated dose, as this could lead to an unintended overdose.

768. If a provider orders, directs, requests, and/or agrees to the amount of medication to be drawn up, the provider must order, direct, request, and/or agree to precisely the indicated dose. The standard of care prohibits the provider from ordering, directing, requesting, and/or agreeing to more than the indicated dose, let alone a dangerously high dose.

769. These requirements apply with special force when the provider will be handing the medication off to another provider for administration to the patient.

770. These requirements also apply with special force when a provider administers a medication that has multiple indications, indicated doses, and delivery routes, such as ketamine.

771. These requirements also apply with special force in a prehospital setting, where providers have limited resources, assistance, and control.

772. On April 19, 2021, Sneddon violated these requirements, by drawing up 500 milligrams of ketamine—over 16 times the maximum indicated dose.

773. On April 19, 2021, as evidenced by video, Jewkes, Kimball, Winters, and Sneddon violated these requirements, by ordering, directing, requesting, and/or agreeing to drawing 500 milligrams of ketamine—over 16 times the maximum indicated dose.

774. These violations were all the more egregious because (a) the medication was to be administered in the chaotic prehospital setting of a vehicle collision, (b) 500 milligrams was over 16 times the maximum dose, (c) the medication was handed off twice before it was injected by a provider from another agency, and (d) ketamine has multiple indications, indicated doses, and delivery routes.

775. Each violation bypassed a key safeguard against medication error, enabling the administration of a dangerous dose of ketamine—at least 470 milligrams more than the maximum indicated dose. The resulting overdose then caused Gwen to go into respiratory arrest, which in turn caused her to suffer anoxic brain injury leading to death.

776. Had Sneddon drawn up the indicated dose, the 500 milligrams of ketamine would not have been administered to Gwen.

777. Had even one among Jewkes, Kimball, and Winters ordered, directed, requested, and/or agreed to the indicated dose, the 500 milligrams of ketamine would not have been drawn up in the first place, let alone injected.

778. Each violation was thus a cause of Gwen's injury and death.

Count 3: Failure to Label Syringe

779. Plaintiffs here incorporate by reference all allegations in this Complaint.

780. When a provider prepares the medication away from the patient, or when there is a break in the medication-delivery process, the standard of care requires the provider to label the syringe with the medication's name, dose, dosage units, and concentration.⁸⁵

781. A break in the medication-delivery process occurs when a provider prepares multiple medications for sequential administration or when the medication will be handed off to another provider.

782. These requirements apply with special force when a provider administers a medication that has multiple indications, indicated doses, and delivery routes, such as ketamine.

783. These requirements also apply with special force when the syringe contains more than the dose indicated for the patient.

784. These requirements also apply with special force in a prehospital setting, where providers have limited resources, assistance, and control.

785. On April 19, 2021, Sneddon violated these requirements, by failing to label the syringe used to administer ketamine to Gwen, even though Sneddon prepared the medication away from Gwen and intended to and did hand off the syringe to other providers.

⁸⁵ These requirements apply when the medication is to be administered using a syringe. In lieu of the concentration, a provider can provide the dose and volume to be administered—information from which the concentration can be calculated.

786. These violations were all the more egregious because (a) 500 milligrams was over 16 times the indicated dose, (b) the medication was handed off twice before it was injected by a provider from another agency, (c) the medication was administered in the chaotic setting of a vehicle collision, and (d) ketamine has multiple indications, indicated doses, and delivery routes.

787. Sneddon's violation bypassed a key safeguard against medication error, clearing the way for the administration of a dangerous dose of ketamine. The resulting overdose then caused Gwen to go into respiratory arrest, which in turn caused her to suffer anoxic brain injury leading to death.

788. Had Sneddon labeled the syringe, Sneddon, Winters, Jewkes, and/or Kimball likely would have reflected upon the amount of ketamine in the syringe and the dangerous error it invited. As a result, one or more of them likely would have blocked the hand-off or injection of the medication.

789. Sneddon's violation was thus a cause of Gwen's injury and death.

Count 4: Failure to Stop Hand-Off

790. Plaintiffs here incorporate by reference all allegations in this Complaint.

791. If the medication syringe contains a dose higher than indicated for the patient, the standard of care requires a provider not to participate in the hand-off of the syringe. Instead, the standard of care requires a provider to stop the hand-off.

792. This requirement applies with special force when a provider administers a high-risk medication that has multiple indications, indicated doses, and delivery routes, such as ketamine.

793. This requirement also applies with special force in a prehospital setting, where providers have limited resources, assistance, and control.

794. On April 19, 2021, Sneddon, Winters, Jewkes, and Kimball each violated this requirement, by failing to halt the hand-off of a dose of ketamine that was 16 times higher than indicated for Gwen. In fact, Sneddon, Winters, and Jewkes actively participated in the hand-off—from Sneddon, to Winters, to Jewkes, who then injected the medication, while Kimball watched.

795. These violations were also all the more egregious because Sneddon, Winters, Jewkes, and Kimball each knew that the syringe contained 500 milligrams of ketamine—creating the risk of a massive overdose. Sneddon prepared the syringe, Winters and Jewkes called out “500 of Ketamine” during their hand-off, and Kimball witnessed the hand-offs.

796. These violations were all the more egregious because (a) the medication was to be administered in the chaotic prehospital setting of a vehicle collision, and (b) ketamine has multiple indications, indicated doses, and delivery routes.

797. Each violation enabled the administration of a dangerous dose of ketamine. The resulting overdose then caused Gwen to go into respiratory arrest, which in turn caused her to suffer anoxic brain injury leading to death.

798. Had even one of these providers halted the hand-off process, the 500 milligrams of ketamine would not have even reached Jewkes for administration to Gwen.

799. Each violation was thus a cause of Gwen’s injury and death.

Count 5: Failure to Use Closed-Loop Communications

800. Plaintiffs here incorporate by reference all allegations in this Complaint.

801. During hand-off of the medication, the standard of care requires providers to use closed-loop communication—to convey, receive, and confirm accurate information about the medication.

802. The required information includes the medication’s name, dose, dosage units, concentration, route of administration, rate of administration, and indication.

803. These requirements apply with special force when a provider administers a medication that has multiple indications, indicated doses, and delivery routes, such as ketamine.

804. These requirements also apply with special force in a prehospital setting, where providers have limited resources, assistance, and control.

805. On April 19, 2021, Sneddon, Winters, and Jewkes violated these requirements, by failing to use closed-loop communications during the hand-off of the ketamine administered to Gwen.

806. During the hand-off from Sneddon to Winters, neither uttered any of the required information, including the indicated dose.

807. During the hand-off from Winters to Jewkes, neither uttered any of the required information, including the indicated dose. Instead, unless 500 milligrams was the dose they intended, Winters and Jewkes called out the contents of the syringe—“500 of ketamine.” Because providers normally draw up precisely the indicated dose (so that the contents of the syringe are the same as the indicated dose), the communication between Winters and Jewkes invited confusion and error, instead of protecting against them.

808. Each violation bypassed a key safeguard against medication error, clearing the way for the administration of a dangerous dose of ketamine—at least 16 times and 470 milligrams over

the maximum indicated dose. The resulting overdose then caused Gwen to go into respiratory arrest, which in turn caused her to suffer anoxic brain injury leading to death.

809. Had Sneddon and Winters during their hand-off, or Winters and Jewkes during theirs, used closed-loop communication, they likely would have reflected upon the amount of ketamine in the syringe. As a result, at least one of them would have stopped the hand-off or the injection of the medication, or clarified that no more than the indicated dose was to be injected.

810. Each violation was thus a cause of Gwen's injury and death.

Count 6: Failure to Know or Identify Indicated Dose

811. Plaintiffs here incorporate by reference all allegations in this Complaint.

812. Before a provider gives the medication to a patient, the standard of care requires the provider to know, or accurately identify, the medication's name, indicated dose, dosage units, concentration, route of administration, rate of administration, and indication.

813. These requirements apply with special force when a provider injects a medication that has multiple indications, indicated doses, and delivery routes, such as ketamine.

814. These requirements also apply with special force in a prehospital setting, where providers have limited resources, assistance, and control. In contrast to a hospital, moreover, a prehospital setting lacks automated warnings and other safeguards against dosing error.

815. On April 19, 2021, Jewkes and Kimball violated these requirements, by administering ketamine to Gwen without knowing or identifying the dose that was indicated for her. Instead, Jewkes and Kimball administered many times the indicated dose. Then, because they

did not know or identify the indicated dose, Jewkes and Kimball failed to react to the overdose with even a hint of concern, even after Winters and Ellefsen questioned them.

816. Jewkes and Kimball thus displayed zero knowledge or understanding of the indicated dose—and zero insight into how far they had exceeded it.

817. Each violation enabled the administration of a dangerous dose of ketamine. The resulting overdose then caused Gwen to go into respiratory arrest, which in turn caused her to suffer anoxic brain injury leading to death.

818. Had Jewkes and/or Kimball known or identified the indicated dose, Jewkes likely would not have injected Gwen with 500 milligrams of ketamine. In fact, had even one of them known or identified the indicated dose, they likely would have requested MCFD to draw up the precise indicated dose in the first place, instead of an amount that invited iatrogenic error.

819. Each violation was thus a cause of Gwen's injury and death.

Count 7: Failure to Know General Effects of Overdose

820. Plaintiffs here incorporate by reference all allegations in this Complaint.

821. Before a provider administers the medication to a patient, the standard of care requires the provider to understand and be mindful of the general physiological effects of the medication, including any potential impact on the patient's ability to breathe.

822. On April 19, 2021, Jewkes, Kimball, Winters, and Sneddon each violated these requirements, by lacking the understanding and/or awareness that a bolus of 500 milligrams of ketamine would likely and imminently cause Gwen respiratory arrest, requiring immediate assisted ventilation and oxygenation.

823. When Winters asked Jewkes if she had given Gwen “all” the ketamine, Jewkes responded with the non-sequitur “ketamine is in!” When Ellefsen re-asked the question, Jewkes flatly responded “yes,” without showing any concern over the iatrogenic injury she had just caused. Throughout this time, Kimball stood in silence, also demonstrating zero concern. As their behavior revealed, Jewkes and Kimball lacked the required understanding and awareness.

824. Winters and Sneddon displayed at best partial understanding of the imminent effects of the medication. While Winters assessed Gwen’s respiratory status, neither she nor Sneddon did anything to obtain, much less deploy, a basic airway adjunct or a BVM.

825. Had Winters and Sneddon fully understood that respiratory arrest was imminent, they would have mobilized immediately to secure Gwen’s airway with a basic airway adjunct, and to provide Gwen ventilation and oxygenation with a BVM.

826. Because Jewkes, Kimball, Winters, and Sneddon did not know or were not mindful of the imminent effects of the ketamine injection, they failed to provide Gwen prompt ventilation and oxygenation.

827. As a result, Gwen went into unabated respiratory arrest, which in turn caused her to suffer anoxic brain injury leading to death.

828. Had even one among Jewkes, Kimball, Winters, and Sneddon fully understood the general physiological effects of the medication, they would have promptly provided Gwen ventilation and oxygenation. In turn, properly oxygenated blood would have perfused Gwen’s brain and other organs, preventing anoxic brain injury and death.

829. Each violation was thus a cause of Gwen’s injury and death.

Count 8: Inability to Recognize and Respond to Complications

830. Plaintiffs here incorporate by reference all allegations in this Complaint.

831. Before a provider administers the medication to a patient, the standard of care requires the provider to have the competence to recognize and respond to potential complications.

832. Such complications include overdose, laryngospasm, respiratory depression, respiratory arrest, and other adverse reactions to the medication.

833. These requirements apply with special force in a prehospital setting, where providers have limited resources, assistance, and control.

834. On April 19, 2021, Jewkes, Kimball, Winters, and Sneddon failed to recognize and respond to the imminent complications of the ketamine injection, including respiratory arrest. In fact, Jewkes and Kimball failed to recognize even the overdose.

835. Had Jewkes, Kimball, Winters, and/or Sneddon recognized the imminent complications, they would have mobilized immediately to respond to them, by securing Gwen's airway with a basic airway adjunct, and providing Gwen ventilation and oxygenation with a BVM. Insofar as they failed to do so, Jewkes, Kimball, Winters, and Sneddon demonstrated that they lacked the required competence.

836. Because they lacked the competence to recognize and respond to complications, they failed to provide Gwen prompt ventilation and oxygenation.

837. As a result, one complication—respiratory arrest—went unabated, causing Gwen to suffer anoxic brain injury leading to death.

838. Had even one among Jewkes, Kimball, Winters, and Sneddon possessed the competence to recognize and respond appropriately to the imminent complications, they likely

would have provided Gwen prompt ventilation and oxygenation. In turn, with adequate ventilation and oxygenation, properly oxygenated blood would have perfused Gwen's brain and other organs, preventing anoxic brain injury and death.

839. Each violation was thus a cause of Gwen's injury and death.

Count 9: Inability to Ventilate and Oxygenate Patient

840. Plaintiffs here incorporate by reference all allegations in this Complaint.

841. If the high-risk medication is ketamine or fentanyl, the standard of care requires the provider to possess the competence and capability to provide the patient assisted ventilation and oxygenation, if necessary.

842. These requirements apply with special force in a prehospital setting, where providers have limited resources, assistance, and control.

843. On April 19, 2021, Winters, Sneddon, Jewkes, and Kimball each violated these requirements, by administering ketamine and fentanyl to Gwen without having the required competence and capability.

844. Had they possessed the required competence and capability, they would have mobilized immediately to secure Gwen's airway with a basic airway adjunct and to provide Gwen ventilation and oxygenation—all in an organized and coordinated way. They did not. Had they possessed the required competence and capability, they also would have had BLS and ALS airway-management equipment on hand. They did not.

845. Insofar as they failed to secure Gwen's airway and to provide her ventilation and oxygenation, Jewkes, Kimball, Winters, and Sneddon proved that they lacked the competence and capability to administer ketamine and/or fentanyl in the first place.

846. Because Jewkes, Kimball, Winters and Sneddon lacked the required competence and capability, they failed promptly to provide Gwen ventilation and oxygenation. As a result, Gwen's respiratory depression and arrest went unabated, causing Gwen to suffer anoxic brain injury leading to death.

847. Had even one among Jewkes, Kimball, Winters, and Sneddon possessed the required competence and capability, they likely would have immediately provided Gwen ventilation and oxygenation. In turn, properly oxygenated blood would have perfused Gwen's organs, preventing anoxic brain injury and death.

848. Each violation was thus a cause of Gwen's injury and death.

Count 10: Failure to Have Equipment On-Hand

849. Plaintiffs here incorporate by reference all allegations in this Complaint.

850. Before a provider administers ketamine and/or fentanyl to a patient, the standard of care requires the provider to have on-hand equipment sufficient to provide the patient ventilation, oxygenation, oxygen-saturation (SpO₂) monitoring, and end-tidal CO₂ monitoring.

851. These requirements apply with special force in a prehospital setting, where providers have limited resources, assistance, and control.

852. On April 19, 2021, Winters, Sneddon, Jewkes, and Kimball each violated these requirements, by administering ketamine and fentanyl to Gwen without having required equipment on-hand, or even readily available. This failure proved fatal when Gwen stopped breathing.

853. As video and other records reveal, Winters, Sneddon, Jewkes, and Kimball failed to have on-hand any ALS equipment sufficient to intubate Gwen, including an ETT or supraglottic device. Winters, Sneddon, Jewkes, and Kimball also failed to have on-hand even BLS equipment sufficient to ventilate and oxygenate Gwen, including a BVM and a basic airway adjunct.

854. Because the equipment was not on-hand or even readily available, MCFD Firefighter Brian Jordan and a UHP Trooper had to rummage through bags and ambulances to find part of the equipment piecemeal—all while Gwen suffered hypoxic and then anoxic brain injury. Not only did Winters, Sneddon, Jewkes, and Kimball fail to have the equipment nearby, they did not even know whether or where they had the equipment.

855. Because Winters, Sneddon, Jewkes, and Kimball did not have required equipment on-hand or even readily available, they failed to provide Gwen prompt ventilation and oxygenation. As a result, Gwen's respiratory arrest went unabated, causing Gwen to suffer anoxic brain injury leading to death.

856. Had even one among Winters, Sneddon, Jewkes, and Kimball had the required equipment on-hand or even readily available, they likely would have provided Gwen immediate ventilation and oxygenation. In turn, properly oxygenated blood would have perfused Gwen's brain, preventing anoxic brain injury and death.

857. Each violation was thus a cause of Gwen's injury and death.

Count 11: Iatrogenic Overdose Leading to Death

858. Plaintiffs here incorporate by reference all allegations in this Complaint.

859. When a provider administers the medication to a patient, the standard of care requires the provider to administer the dose indicated for the patient. The standard of care prohibits the provider from administering more than the indicated dose, especially an unsafe dose.

860. On April 19, 2021, Jewkes, Kimball, Winters, and Sneddon “agreed” to give Gwen “both fentanyl and ketamine for pain control.” MCFD 7.

861. On April 19, 2021, Jewkes violated this requirement, by injecting Gwen with a bolus of 500 milligrams of ketamine.

862. On April 19, 2021, Jewkes, Kimball, Winters, and Sneddon violated this requirement, by administering a bolus of 500 milligrams of ketamine to Gwen.

863. These violations ran widely afoul of the National Guidelines, the Utah Guidelines, the Salt Lake Protocols, and the MCFD Guidelines.

864. These violations were all the more shocking because they caused a “never event” of public concern—the death of a young woman from medication error.

865. These violations were all the more egregious because 500 milligrams was over 16 times the maximum indicated dose, and exceeded the maximum indicated dose by at least 470 milligrams.

866. Because Jewkes injected Gwen with 500 milligrams of ketamine instead of the indicated dose, Gwen experienced a massive overdose.

867. Because Jewkes, Kimball, Winters, and Sneddon administered Gwen 500 milligrams of ketamine instead of the indicated dose, Gwen experienced a massive overdose.

868. As a result of each violation, Gwen went into respiratory arrest, which in turn caused her anoxic brain injury leading to death.

869. Had Jewkes injected Gwen with the indicated dose instead of 500 milligrams, Gwen would not have suffered respiratory arrest, anoxic brain injury, or death.

870. Had Jewkes, Kimball, Winters, and Sneddon administered the indicated dose instead of 500 milligrams, Gwen would not have suffered respiratory arrest, anoxic brain injury, or death.

871. Each violation was thus a cause of Gwen's injury and death.

Count 12: Failure to Monitor SpO2 and CO2

872. Plaintiffs here incorporate by reference all allegations in this Complaint.

873. When a provider takes part in administering ketamine and/or fentanyl to a patient, the standard of care requires the provider to monitor:

- a. the patient's oxygen-saturation (with a pulse-oximeter), and
- b. the patient's end-tidal CO2 levels (with waveform capnography).

874. On April 19, 2021, Winters, Sneddon, Jewkes, and Kimball violated these requirements, by failing to continuously monitor Gwen's oxygen-saturation, and by failing altogether to monitor Gwen's end-tidal CO2 levels.

875. On April 19, 2021, Humphrey and Haynie each also violated these requirements, by failing to continuously monitor Gwen's oxygen-saturation, and by failing altogether to monitor Gwen's end-tidal CO2 levels.

876. Because they failed to meet these requirements, Winters, Sneddon, Jewkes, Kimball, Humphrey, and Haynie also failed to provide Gwen prompt ventilation and oxygenation

with a BVM. As a result, Gwen's respiratory arrest went unabated, causing her anoxic brain injury leading to death.

877. Had even one of these providers properly monitored Gwen's SpO2 during and after the ketamine administration, they likely would have realized that Gwen's blood was carrying insufficient oxygen to Gwen's organs, and that she therefore needed immediate ventilation and oxygenation.

878. Had even one of these providers properly monitored Gwen's end-tidal CO2 during and after the ketamine administration, they likely would have realized that Gwen's respiratory drive was depressed and that she therefore needed immediate ventilation and oxygenation.

879. As a result, these providers likely would have provided Gwen prompt ventilation and oxygenation. In turn, with prompt ventilation and oxygenation, properly oxygenated blood would have perfused Gwen's brain, preventing anoxic brain injury and death.

880. Each violation was thus a cause of Gwen's injury and death.

Count 13: Failure to Bring BLS and ALS Equipment

881. Plaintiffs here incorporate by reference all allegations in this Complaint.

882. If the provider is an EMS provider responding to an EMS call, the standard of care requires the provider to bring basic life-support ("BLS") equipment. If the provider is a paramedic and/or a member of an advanced life-support ("ALS") team, the standard of care requires the provider to bring ALS equipment, in addition to BLS equipment.

883. BLS equipment and ALS equipment each includes equipment sufficient to secure the patient's airway, ventilate the patient, and oxygenate the patient.

884. BLS equipment specifically includes basic airway adjuncts (OPA and NPA), a suction unit, a BVM, and an oxygen tank.

885. ALS equipment includes a laryngoscope, an endotracheal tube (“ETT”), and other tools sufficient to intubate the patient.

886. ALS equipment also typically includes a supraglottic airway device, which can be used to secure a patient’s airway if intubation fails.

887. On April 19, 2021, Winters and Sneddon each violated these requirements, by failing to bring required equipment to the scene of Gwen’s collision, including an OPA, NPA, BVM, and supraglottic device.

888. On April 19, 2021, Jewkes and Kimball each violated these requirements, by failing to bring required equipment to the scene, including an OPA, NPA, BVM, and supraglottic device.

889. On April 19, 2021, Humphrey and Haynie each violated these requirements, by failing to bring BLS equipment to the scene, including an OPA, NPA, BVM, and oxygen tank.

890. On April 19, 2021, Stephensen, Bates, and Anderson each violated these requirements, by failing to bring required equipment to the scene, including an OPA, NPA, BVM, and supraglottic device.

891. On April 19, 2021, insofar as they responded to the scene, other MCFD, Life Flight, Gold Cross, and UFA providers violated these requirements, by failing to bring required equipment to the scene.

892. Because providers failed to bring required equipment, they failed to secure Gwen’s airway on scene, and failed to provide her prompt ventilation and oxygenation. As a result, Gwen’s respiratory arrest went unabated, causing her anoxic brain injury leading to death.

893. Had providers brought the required equipment, Gwen likely would have received prompt ventilation and oxygenation. In turn, with prompt ventilation and oxygenation, properly oxygenated blood would have perfused Gwen's brain, preventing anoxic brain injury and death.

894. Each violation was thus a cause of Gwen's injury and death.

895. The following requirements of the standard of care (Counts 14-20) generally apply to healthcare providers when a patient under their care receives an unsafe dose of ketamine and goes into respiratory depression or arrest.

Count 14: Failure to Respond Emergently to Iatrogenic Overdose

896. Plaintiffs here incorporate by reference all allegations in this Complaint.

897. The standard of care requires a provider to respond emergently to the overdose.

898. On April 19, 2021, Jewkes and Kimball violated this requirement, by failing to respond to the overdose at all, much less emergently.

899. On April 19, 2021, Sneddon and Ellefsen violated this requirement, by failing to respond emergently to the overdose. In fact, their behavior revealed that they did not even understand that the overdose required emergent ventilation and oxygenation. As captured on video, Sneddon and Ellefsen did not take any emergent action toward providing Gwen prompt ventilation or oxygenation. When Winters requested intubation equipment, for example, Ellefsen took 40 seconds just to spot and direct Jordan to fetch the equipment.

900. On April 19, 2021, Humphrey and Haynie violated this requirement, by failing to respond emergently to the overdose. As captured on video, they did not take any discernible action toward providing Gwen prompt ventilation or oxygenation, let alone emergent action.

901. On April 19, 2021, Stephensen, Bates, and Anderson also violated this requirement, by failing to respond emergently to the overdose. As captured on video, they did not take any discernible action toward providing Gwen prompt ventilation or oxygenation, let alone emergent action

902. On April 19, 2021, Cope (a certified EMT) also violated this requirement, by failing to respond emergently to the overdose. As captured on video, Cope did not take any discernible action toward providing Gwen ventilation or oxygenation, let alone emergent action.

903. On April 19, 2021, insofar as they participated in Gwen's care in the minutes immediately following the ketamine administration, other healthcare providers violated this requirement, by failing to respond emergently to the overdose.

904. Each of the providers identified in this Count failed to respond emergently to the overdose, even after Gwen went into respiratory arrest.

905. As captured on video, with the possible exception of Winters, no one took any emergent action toward providing Gwen ventilation and oxygenation. No one, for example, stood up and asked the dozens of first-responders on scene, from at least five agencies, some of whom were milling about, whether *anyone* had a BVM.

906. No one other than Winters manifested any urgency in voice or behavior.

907. Because of the collective lack of urgency, Winters did not start bagging Gwen for about 9 minutes after the ketamine injection and for about 7 minutes after Winters recognized that

Gwen “stopped breathing.” During those invaluable minutes, Gwen suffered irreversible and fatal anoxic brain injury.

908. Had providers understood and acted upon the urgency of the situation, Gwen likely would have received prompt ventilation and oxygenation. In turn, properly oxygenated blood would have perfused Gwen’s brain, preventing anoxic brain injury and death.

909. Each violation was thus a cause of Gwen’s injury and death.

Count 15: Failure to Secure Airway of Overdosed Patient

910. Plaintiffs here incorporate by reference all allegations in this Complaint.

911. To prepare the patient to receive ventilation and oxygenation if needed, the standard of care requires a provider to secure the patient’s airway immediately—using at minimum a basic airway adjunct, like an OPA or NPA.

912. On April 19, 2021, once Jewkes injected Gwen with 500 milligrams of ketamine, Jewkes and Kimball violated this requirement, by failing to secure Gwen’s airway immediately.

913. On April 19, 2021, once Jewkes injected Gwen with 500 milligrams of ketamine, Winters and Sneddon violated this requirement, by failing to secure Gwen’s airway immediately.

914. On April 19, 2021, once Jewkes injected Gwen with 500 milligrams of ketamine, Humphrey and Haynie violated this requirement, by failing to secure Gwen’s airway immediately.

915. On April 19, 2021, once Jewkes injected Gwen with 500 milligrams of ketamine, Stephensen, Bates, and Anderson violated this requirement, by failing to secure Gwen’s airway immediately.

916. On April 19, 2021, once Jewkes injected Gwen with 500 milligrams of ketamine, Cope violated this requirement, by failing to secure Gwen's airway immediately or by failing to advocate for securing Gwen's airway immediately.

917. On April 19, 2021, insofar as they participated in Gwen's care in the minutes immediately following the ketamine injection, other Life Flight, MCFD, Gold Cross, UFA, and UHP providers violated this requirement, by failing to secure Gwen's airway immediately.

918. Because providers failed to secure Gwen's airway promptly, they also failed to provide her prompt ventilation and oxygenation. As a result, Gwen's respiratory depression and arrest went unabated, causing her to suffer anoxic brain injury leading to death.

919. Had providers secured Gwen's airway promptly after the ketamine injection, Gwen likely would have received prompt ventilation and oxygenation. In turn, with ventilation and oxygenation, properly oxygenated blood would have perfused Gwen's brain, preventing anoxic brain injury and death.

920. Each violation was thus a cause of Gwen's injury and death.

***Count 16: Failure to Ventilate and Oxygenate Overdosed Patient in
Respiratory Arrest***

921. Plaintiffs here incorporate by reference all allegations in this Complaint.

922. When the patient shows signs of respiratory depression or arrest, the standard of care requires a provider to provide the patient ventilation and oxygenation immediately with a BVM.

923. On April 19, 2021, after Jewkes injected Gwen with 500 milligrams of ketamine and Gwen then showed signs of respiratory depression and arrest, Winters and Sneddon violated these requirements, by failing to provide Gwen ventilation and oxygenation for about 7 minutes.

924. On April 19, 2021, after Jewkes injected Gwen with 500 milligrams of ketamine and Gwen then showed signs of respiratory depression and arrest, Jewkes and Kimball violated these requirements, by failing to provide Gwen ventilation and oxygenation.

925. On April 19, 2021, after Jewkes injected Gwen with 500 milligrams of ketamine and Gwen then showed signs of respiratory depression and arrest, Humphrey and Haynie violated these requirements, by failing to provide Gwen ventilation and oxygenation.

926. On April 19, 2021, after Jewkes injected Gwen with 500 milligrams of ketamine and Gwen then showed signs of respiratory depression and arrest, Stephensen, Bates, and Andersen violated these requirements, by failing to provide Gwen ventilation and oxygenation.

927. On April 19, 2021, after Jewkes injected Gwen with 500 milligrams of ketamine and Gwen then showed signs of respiratory depression and arrest, Cope violated these requirements, by failing to provide Gwen ventilation and oxygenation, or by failing to advocate on her behalf for prompt ventilation and oxygenation.

928. On April 19, 2021, insofar as they participated in Gwen's care in the minutes immediately following the ketamine injection, other MCFD, Life Flight, Gold Cross, UFA, and UHP providers also violated these requirements, by failing to provide Gwen ventilation and oxygenation, or by failing to advocate on her behalf for prompt ventilation and oxygenation.

929. Because providers failed to provide Gwen ventilation and oxygenation when she first showed signs of respiratory depression, Gwen's respiratory depression and arrest went unabated, causing her to suffer anoxic brain injury leading to death.

930. Had Winters, Sneddon, Jewkes, Kimball, Humphrey, Haynie, Stephensen, Bates, Anderson, Cope, or another person provided Gwen prompt ventilation and oxygenation, properly oxygenated blood would have perfused Gwen's brain, preventing anoxic brain injury and death.

931. Each violation was thus a cause of Gwen's injury and death.

***Count 17: Unreasonable and Unnecessary Interruptions to BVM
Ventilation***

932. Plaintiffs here incorporate by reference all allegations in this Complaint.

933. If a provider ventilates the patient with a BVM ("bags" the patient), the standard of care requires the provider to bag the patient continually—with no more than minimal, reasonable, and necessary interruptions.

934. On April 19, 2021, Winters and Sneddon violated these requirements, by failing to bag Gwen continually, with no more than minimal, reasonable, and necessary interruptions.

935. At 21:26:19 and 21:29:10, for example, Winters and Sneddon stopped bagging Gwen for 67 and 107 seconds, respectively, each time to attempt intubation.

936. At about 21:31:17, for no discernible reason, Winters again stopped bagging Gwen, this time for 94 seconds. In fact, during this interruption, Winters went back to bagging Gwen only because Sneddon handed her the BVM, reminding her: "Danielle, do you want to get a couple of breaths in real quick?"

937. Each interruption violated these requirements because it lasted more than a minimal and reasonable period of time.

938. Each interruption also violated these requirements because it was unnecessary. An OPA, NPA, or supraglottic device would have secured Gwen's airway appropriately at that time.

939. On April 19, 2021, insofar as they participated in Gwen's care during the interruptions, other healthcare providers also violated these requirements, by failing to assist in the ventilation process so as to ensure that any interruptions were minimal, reasonable, and necessary.

940. Insofar as Winters and Sneddon failed to bag Gwen appropriately, they also failed to provide her appropriate ventilatory assistance and oxygenation support, during a time when she was experiencing hypoxia.

941. These violations thus likely worsened Gwen's anoxic brain injury and contributed to her death.

Count 18: Premature Ending of BVM Ventilation

942. Plaintiffs here incorporate by reference all allegations in this Complaint.

943. If a provider ventilates the patient with a BVM, the standard of care requires the provider to keep ventilating the patient until there is a clinically significant improvement in the patient's respiratory effort.

944. On April 19, 2021, Winters and Sneddon violated this requirement, by failing to maintain ventilation despite the absence of a clinically significant improvement in Gwen's respiratory effort. Instead, at 21:33:16, Winters and Sneddon stopped ventilation altogether, putting the BVM away.

945. On April 19, 2021, insofar as they were participating in Gwen's care at the time Winters and Sneddon stopped ventilation, other healthcare providers also violated this requirement, by failing to maintain or advocate for continued ventilation, despite the absence of a clinically significant improvement in Gwen's respiratory effort.

946. Because Winters and Sneddon stopped bagging Gwen before there was a clinically significant improvement in her respiratory effort, Winters and Sneddon failed to ventilate and oxygenate Gwen during a time when she was still experiencing anoxic brain injury.

947. These violations thus likely worsened Gwen's anoxic brain injury and contributed to her death.

Count 19: Failure to Disclose Respiratory Arrest

948. If the patient experiences respiratory arrest without ventilation for a clinically significant amount of time, the standard of care requires a provider to communicate those facts to providers downstream upon transferring the patient's care.

949. If the provider is an EMS provider transferring the patient to a hospital, the standard of care requires the provider to provide an oral report that is substantially complete.

950. These requirements apply with special force to a provider physically handing off the patient.

951. On April 19, 2021, insofar as they failed to inform IMC providers that Gwen was in respiratory arrest without ventilation for a clinically significant length of time, Winters and Sneddon violated these requirements. These violations were all the more egregious insofar as Winters and Sneddon physically handed off Gwen to IMC.

952. On April 19, 2021, insofar as they had a duty to inform IMC providers that Gwen was in respiratory arrest without ventilation for a clinically significant length of time, and insofar as they failed to meet that duty, Jewkes and Kimball violated these requirements. These violations were all the more egregious because Jewkes and Kimball worked at, for, or with IMC.

953. On April 19, 2021, insofar as they had a duty to inform IMC providers that Gwen was in respiratory arrest without ventilation for a clinically significant length of time, and insofar as they failed to meet that duty, UFA and other providers also violated these requirements. These violations were all the more egregious insofar as such providers physically handed off the patient to IMC.

954. Insofar as such violations occurred, IMC providers did not receive a complete and accurate account of Gwen's prehospital care, including potentially deadly complications. Insofar as the incomplete or inaccurate information led IMC providers to provide Gwen substandard care that caused her additional harm, these violations were a cause of such additional harm.

Count 20: Incomplete, Erroneous, Spoliated, or Withheld Reports

955. Plaintiffs here incorporate by reference all allegations in this Complaint.

956. The standard of care requires a provider to document and provide an accurate and complete patient-care report about the administration of the medication, including any significant complications that followed.

957. On and after April 19, 2021, Jewkes and Kimball violated these requirements, by failing to prepare any record documenting the care they provided Gwen. In the alternative, insofar as they did prepare such record, it has been spoliated, or wrongfully withheld from Plaintiffs.

958. On April 19, 2021, Winters, Sneddon, and Ellefsen violated these requirements, by preparing a report that contains material inaccuracies—which disguise, downplay, or omit serious standard-of-care violations. Winters reported, for example, that she successfully bagged Gwen with a BVM just four minutes after the ketamine injection. In fact, as video reveals, Winters started bagging Gwen about **nine minutes** after the ketamine injection.

959. On April 19, 2021, Humphrey and Haynie violated these requirements, by preparing a report that contains material inaccuracies—which disguise, downplay, or omit serious standard-of-care violations. Although they noted that “the flight team with Murray fire administered medications,” for example, Humphrey and Haynie omitted the information most crucial to providers downstream: that Gwen stopped breathing and that providers then failed to provide her any ventilation or oxygenation, for minutes.

960. On April 19, 2021, Stephensen and Anderson violated these requirements, by preparing a report that contains material inaccuracies—which disguise, downplay, or omit serious standard-of-care violations. Although they noted that “it was reported that Life Flight was still on scene and had given her ketamine,” for example, Stephensen and Anderson failed to mention that Life Flight had given Gwen 500 milligrams of the drug.

961. In addition, Stephensen, Bates, and Anderson omitted from the same UFA report the information most crucial to providers downstream: that Gwen stopped breathing and that providers then failed to provide her any ventilation or oxygenation, for minutes.

962. Because of these violations, IMC providers did not receive a complete and accurate account of Gwen’s prehospital care, including potentially deadly complications. Based on that incomplete or inaccurate information, IMC providers provided Gwen “care” that was likely futile

and unnecessary. Insofar as such care gave rise to additional damages, these violations were thus a case of such damages.

963. The following requirements of the standard of care (in Counts 21-22) generally apply to healthcare providers when a patient under their care receives an unsafe dose of ketamine and they decide to intubate the patient. Insofar as an EMT, AEMT, or other provider lacks the authority to administer ketamine or intubate a patient, these requirements do not apply to that provider.

Count 21: Failure to Pre-Oxygenate Patient in Respiratory Arrest

964. Plaintiffs here incorporate by reference all allegations in this Complaint.

965. The standard of care requires the provider to pre-oxygenate the patient appropriately prior to the initial intubation attempt. If the provider makes more than one intubation attempt, the standard of care requires the provider to pre-oxygenate the patient appropriately between attempts.

966. On April 19, 2021, Winters and Sneddon violated these requirements, by failing to pre-oxygenate Gwen properly. No one appears to have checked Gwen's SpO2 levels, to confirm she was pre-oxygenated enough to safely interrupt ventilation and make the intubation attempt.

967. On April 19, 2021, Humphrey and Haynie each violated these requirements, by failing to assist Winters in properly pre-oxygenating Gwen. Neither Humphrey nor Haynie checked Gwen's SpO2 levels, to assist Winters in confirming that Gwen was pre-oxygenated enough to safely interrupt ventilation and make the intubation attempt.

968. On April 19, 2021, insofar as they participated in Gwen's care at the time of the intubation attempts, other healthcare providers also violated these requirements, by failing to confirm that Gwen was pre-oxygenated enough to safely interrupt ventilation and make the attempts.

969. These violations were all the more egregious because the interruptions were not minimal, reasonable, or even necessary.

970. Insofar as providers failed to pre-oxygenate Gwen prior to an intubation attempt, they also deprived Gwen's brain of precious oxygen at a time when she was experiencing hypoxia.

971. These violations thus likely worsened Gwen's anoxic brain injury and contributed to her death.

Count 22: Failure to Revert to Airway Adjunct

972. Plaintiffs here incorporate by reference all allegations in this Complaint.

973. If intubation proves unsuccessful or unreasonably difficult, the standard of care requires a provider to abandon intubation promptly and use an OPA, NPA, or supraglottic device to secure the patient's airway.

974. In fact, if an initial intubation attempt proves unsuccessful, the Salt Lake Protocols require the provider to "revert to a supraglottic airway device or BVM oral/nasal airway." The Salt Lake Protocols also require the provider to "avoid multiple attempts at intubation."

975. On April 19, 2021, Winters and Sneddon violated these requirements, by attempting to intubate Gwen multiple times, even though intubation proved unsuccessful and unreasonably difficult from the start, as Winters herself noted in her report.

976. On April 19, 2021, Winters and Sneddon also violated these requirements, by failing to secure Gwen's airway promptly with an OPA, NPA, or supraglottic device, even after the first intubation attempt failed.

977. On April 19, 2021, Jewkes and Kimball violated these requirements, by witnessing the multiple attempts at intubation without intervening on Gwen's behalf to revert to an airway adjunct.

978. On April 19, 2021, insofar as they participated in Gwen's care at the time of the intubation attempts, other healthcare providers also violated these requirements, by failing to advocate for the use of an OPA, NPA, or supraglottic device to secure Gwen's airway, both before the initial intubation and in lieu of each subsequent intubation.

979. In fact, on scene, no provider secured Gwen's airway at any time.

980. Insofar as they violated these requirements by attempting the failed intubations, providers denied Gwen precious oxygen at a time when she was experiencing hypoxia and then anoxic brain injury. In fact, Winters herself reported she was able to secure Gwen's airway on the way to the hospital, using an OPA and NPA.

981. These violations thus likely worsened Gwen's anoxic brain injury and contributed to her death.

ADDITIONAL TORT CLAIMS

Count 23: Breach of Fiduciary Duty to Inform

982. Plaintiffs here incorporate by reference all allegations in this Complaint.

983. Healthcare providers stand in a fiduciary relationship with their patients. Providers thus owe patients fiduciary duties, including the duty to inform patients of all material information concerning their physical condition. This duty requires healthcare providers to apprise a patient of material physical conditions throughout the course of the patient's care.

984. Healthcare organizations also stand in a fiduciary relationship with their patients. Through their leaders, managers, and administrators, healthcare organizations owe patients the same fiduciary duties.⁸⁶ Whether directly or through providers, administrators must ensure that patients are informed of all material information concerning their physical condition.

985. If a patient is incapacitated, healthcare providers and organizations owe these same fiduciary duties to the patient's next-of-kin—in this case, Brett and Heather.

986. On and after April 19-24, 2021, the following providers and administrators breached their fiduciary duties to Brett and Heather.

- Dr. Don Van Boerum
- Dr. Sarah Majercik
- PA-C Christina Pelo
- Other providers who provided care to Gwen at IMC and who knew or had reason to know about one or more of the facts listed below.
- Administrators at the Intermountain Defendants who knew or had reason to know about one or more of the facts listed below.

⁸⁶ For the sake of brevity, we refer to these persons collectively as “administrators.” Also, as used herein, “administrators” include medical directors.

987. These providers and administrators breached this duty, by failing to inform Brett and Heather of facts concerning Gwen’s physical condition, including that:

- a. Life Flight injected Gwen with over 16 times the maximum indicated dose of ketamine, a high-risk drug, causing a massive overdose;
- b. the ketamine overdose led to respiratory arrest and other complications;
- c. Life Flight and other EMS providers then failed to provide prompt ventilation and oxygenation;
- d. Gwen thus experienced prolonged hypoxia, and anoxia;
- e. Gwen had extensor posturing and hemodynamic instability at IMC;
- f. Gwen’s brain stopped functioning because it suffered anoxic injury secondary to respiratory arrest and overdose;
- g. Gwen died from the anoxic brain injury; and
- h. Gwen’s death was iatrogenic—caused by medical error.

988. Each failure to disclose each fact was all the more egregious for the following reasons.

989. *First*, these providers and administrators failed to disclose this information even after CT imaging provided objective evidence of the iatrogenic anoxic brain injury.

990. *Second*, while withholding material information, these providers expressly misrepresented Gwen’s physical condition.

991. At first, while withholding all information about the ketamine overdose and its complications, these providers told Brett and Heather that Gwen would soon “awake,” because she had not suffered any significant head injury.

992. Then, after CTs showed that the ketamine overdose had resulted in anoxic brain injury, these providers represented to Brett and Heather that Gwen had suffered a fatal *traumatic* brain injury—from the force of the crash.

993. *Third*, because Brett and Heather were suddenly living every parent’s worst nightmare, they placed complete trust in the ability and integrity of these providers and administrators. Far from honoring that trust, they betrayed it.

994. *Fourth*, each breach was obviously intended to placate and misdirect Brett and Heather—so that they would not question what had happened to Gwen, so that the grounds for this lawsuit would not come to light.

995. *Fifth*, even now, not one of these providers or administrators—no one affiliated with the Intermountain Defendants—has informed Brett or Heather of any fact surrounding the iatrogenic death of their daughter. These providers and administrators thus remain in breach of their fiduciary duties.

996. These breaches caused Brett and Heather severe emotional distress and other damages.

997. *First*, on April 20, 2021, providers and administrators failed to inform Brett and Gwen of any fact surrounding the ketamine overdose and its complications. Instead, providers initially represented to Brett and Heather that Gwen would imminently “wake up,” because she had not suffered a head injury. Hours later, after Brett and Heather had taken refuge in that false hope, providers crushed the hope, announcing that Gwen had a fatal brain injury after all.

998. *Second*, in revealing a brain injury, providers and administrators again failed to disclose the ketamine overdose and its complications. In addition, providers failed to inform Brett

and Gwen of any facts surrounding Gwen's brain injury, including the CT imaging showing that she had suffered a fatal anoxic brain injury.

999. Months later, when attorneys uncovered the truth, the revelation made Brett and Heather relive Gwen's death, with all the attendant emotional distress. But this time, the nightmare included the anguish of betrayal—from knowing that providers and administrators had withheld the truth, in a cruel violation of trust.

1000. *Third*, because no one has acknowledged even one of the errors that led to Gwen's death, the breaches continue to cause emotional distress.

1001. In addition, these breaches caused Brett and Heather economic damages, including those associated with treatment of emotional distress.

Count 24: Breach of Ethical Duty to Disclose

1002. Plaintiffs here incorporate by reference all allegations in this Complaint.

1003. "Patients have the right to know their past and present medical status, including conditions that may have resulted from medical error." Accordingly, "individual physicians who have been involved in a (possible) medical error **should . . . disclose the occurrence of the error,**" and "**explain the nature of the (potential) harm.**" ABA Code of Medical Ethics 8.6.

1004. What's more, physicians should "acknowledge the error and express professional and compassionate concern toward patients who have been harmed," and should "**explain efforts that are being taken to prevent similar occurrences in the future.**" *Id.*

1005. Physicians owe patients these duties "even when new information regarding the medical error will not alter the patient's medical treatment or therapeutic options." *Id.*

1006. If a patient is incapacitated, physicians owe these ethical duties to the patient's next-of-kin—in this case, Brett and Heather.

1007. On and after April 19-24, 2021, the physicians identified in Count 23 breached these duties, by failing to disclose to Brett and Heather any of the facts enumerated in Count 23. Those facts speak to the occurrence, nature, and harm of the medical errors that led to Gwen's anoxic brain injury and death.

1008. On and after April 19-24, 2021, the physicians identified in Count 23 also breached these duties, by failing to acknowledge the errors to Brett and Heather, and by failing to explain any effort being taken to prevent their reoccurrence.

1009. Instead, these physicians undertook to misdirect and mislead Brett and Heather, by representing to them that Gwen's death was an accident.

1010. Each failure was all the more egregious for the reasons outlined in Count 23.

1011. Each failure also caused Brett and Heather severe emotional distress and other damages, as outlined in Count 23.

Count 25: Negligent Infliction of Emotional Distress

1012. Plaintiffs here incorporate by reference all allegations in this Complaint.

1013. As explained in Counts 23 and 24, providers and administrators owe patients fiduciary and/or ethical duties to inform and disclose.

1014. Providers and administrators also owe patients and their families the ordinary duty not to cause them emotional distress.

1015. On and after April 19-24, 2021, the providers and administrators identified in Count 23 breached this duty, by inflicting upon Brett and Heather severe emotional distress.

1016. These providers and administrators inflicted severe emotional distress on Brett and Heather, by deceptively concealing the facts enumerated in Count 23.

1017. In addition, after meeting with these administrators, these providers inflicted such distress directly, by misrepresenting the actual cause of Gwen's death.

1018. On April 20, 2021, even after CT imaging confirmed that Gwen had suffered a fatal anoxic brain injury, these providers told Brett and Heather that Gwen had suffered a fatal *traumatic* brain injury—from the force of crash.

1019. Thus, while withholding material facts, these providers expressly misrepresented Gwen's physical condition.

1020. These providers and administrators knew or should have realized that their deceptive disclosures involved an unreasonable risk of causing emotional distress to Brett and Heather.

1021. These providers and administrators knew or should have realized that their deceptive disclosures could cause the sort of emotional distress that might result in illness or bodily harm to Brett and Heather, as Gwen's parents.

1022. Even if unintentionally, these deceptive disclosures caused Brett and Heather to sustain severe emotional distress, characterized by illness or bodily harm.

1023. As a result of these disclosures, Brett and Heather suffered severe or extreme emotional distress, as outlined in Count 23.

1024. In addition, this tortious conduct has caused Brett and Heather pecuniary damages associated with treatment of emotional distress.

Count 26: Intentional Infliction of Emotional Distress

1025. Plaintiffs here incorporate by reference all allegations in this Complaint.

1026. On and after April 19-24, 2021, the providers and administrators identified in Count 23 intentionally inflicted severe emotional distress on Brett and Heather, as outlined above, in Counts 23-25.

1027. In making such selective, deceptive disclosures, these providers engaged in outrageous and intolerable conduct. In context of the tragedy Brett and Heather were living, the disclosures were much worse than merely unreasonable, unkind, or unfair behavior. Instead, the disclosures offended all generally accepted standards of decency and morality.

1028. In making such disclosures, providers also acted with reckless disregard of the probability of causing emotional distress.

1029. This tortious conduct has caused Brett and Heather severe or extreme emotional distress, as explained in Count 25.

1030. In addition, this tortious conduct has caused Brett and Heather pecuniary damages associated with treatment of the emotional distress.

Count 27: Negligent Misrepresentation

1031. Plaintiffs here incorporate by reference all allegations in this Complaint.

1032. Based on the grounds outlined in Counts 23-26, the providers identified in Count 23 are also liable to Plaintiffs for negligent misrepresentation.

1033. On April 20-24, 2021, these providers represented to Brett and Heather that important facts were true.

1034. *First*, these providers repeatedly represented to Brett and Heather that Gwen was going to “wake up” because she had not suffered a significant head injury.

1035. This representation was not true.

1036. These providers made that representation even while knowing and documenting that EMS providers had injected Gwen with 500 milligrams of ketamine, Gwen had likely gone into respiratory arrest on scene, and Gwen was extensor posturing at IMC.

1037. *Second*, these providers also repeatedly represented to Brett and Heather that Gwen had suffered and died from a *traumatic* brain injury—caused by the impact of the auto collision.

1038. This representation was not true.

1039. These providers made that representation, even after CT imaging confirmed that Gwen had suffered and died from an *anoxic* brain injury, and even after Dr. Van Boerum noted the injury as the cause Gwen’s death.

1040. These providers made these and other representations without using reasonable care to determine whether the representations were true.

1041. As medical professionals, these providers were obviously in a better position than Brett and Heather to know the true facts—namely, that Gwen died from an iatrogenic anoxic brain injury shortly after receiving a massive overdose of ketamine. This was all the more true after these providers learned about and documented the CT findings.

1042. These providers had a financial interest in the transaction—protecting their jobs and shielding themselves and their employer from liability.

1043. Because they held the integrity and ability of medical professionals in the highest regard, Brett and Heather reasonably relied on the representations.

1044. Brett and Heather suffered damages as a result of relying on the representations, including emotional distress, anguish, and pecuniary losses.

Count 28: Concealment (Fraudulent Non-Disclosure)

1045. Plaintiffs here incorporate by reference all allegations in this Complaint.

1046. The providers and administrators identified in Count 23 were in a type of relationship with Brett and Heather that those providers and administrators had a duty to disclose important facts to Brett and Heather.

1047. On and after April 20-24, 2021, these providers and administrators knew about and yet failed to disclose to Brett and Heather the facts enumerated in Count 23.

1048. Each of those facts was obviously important.

1049. Brett and Heather did not know about any of these facts.

1050. Each failure to disclose each fact was a substantial factor in causing Brett and Heather damages, including emotional distress, anguish, and pecuniary losses.

Count 29: Fraud

1051. Plaintiffs here incorporate by reference all allegations in this Complaint.

1052. By the deception pled in Counts 23-28, the providers identified in Count 23 also committed fraud upon Brett and Heather.

1053. On April 20-24, 2021, for example, these providers repeatedly made false statements about an important fact—the cause of Gwen’s death. Although Gwen actually died

from an iatrogenic anoxic brain injury, these providers falsely stated that she had died from a traumatic brain injury despite receiving appropriate care.

1054. These providers made the false statements knowing that they were false, or at minimum recklessly and without regard for their truth. When they made the statements, these providers already knew that Gwen had actually suffered an iatrogenic anoxic brain injury caused by medical errors—and by systemic administrative problems that enabled the errors.

1055. These providers, moreover, made the false statements intending for Brett and Heather to rely on the statements.

1056. Because they held the integrity and ability of medical professionals in the highest regard, Brett and Heather reasonably relied on the statements.

1057. Brett and Heather suffered damages as a result of relying on the statements, including emotional distress, mental anguish, and pecuniary losses.

ADMINISTRATIVE NEGLIGENCE

1058. Plaintiffs here incorporate by reference all allegations in this Complaint.

1059. Leaders, managers, and administrators of EMS organizations⁸⁷ owe patients an ordinary duty to safeguard patient safety.

1060. To ensure patient safety in the administration of medications, the following requirements apply to administrators responsible for EMS.

⁸⁷ For the sake of brevity, we refer to these persons collectively as “administrators.” Also, as used herein, “administrators” include medical directors.

Count 30: Failure to Ensure Availability and Use of Safety References

1061. Plaintiffs here incorporate by reference all allegations in this Complaint.

1062. Administrators must ensure that reference materials sufficient to guide safe medication administration are readily available and routinely used at the point of care.

1063. Such materials include checklists, dosing cards, protocols, and policies.

1064. Such materials must be readily available in printed form, and/or easily accessible in digital form on computers or mobile devices.

1065. This requirement applies with special force to medication that has multiple indications, indicated doses, and delivery routes, such as ketamine.

1066. This requirement also applies with special force in a prehospital setting, where providers have limited resources, assistance, and control.

1067. On April 19, 2021, MCFD administrators violated this requirement, by failing to ensure that required materials were readily available to and used by Winters, Sneddon, and Ellefsen at the point of care of Gwen Doner.

1068. On April 19, 2021, administrators at the Intermountain Defendants violated this requirement, by failing to ensure that required materials were readily available to and used by Jewkes and Kimball at the point of care of Gwen Doner.

1069. On April 19, 2021, UFA administrators violated this requirement, by failing to ensure that required materials were readily available to and used by Stephensen, Bates, and Anderson at the point of care of Gwen Doner.

1070. All these administrators are thus liable for ordinary negligence.

1071. Because these administrators failed to ensure that required reference materials were readily available and routinely used at the point of care, providers on scene drew up and administered 500 milligrams of ketamine—leading to massive overdose and death.

1072. Had administrators ensured that the required reference materials were readily available and routinely used at the point of care, one or more of the providers likely would have consulted the materials, realized that 500 milligrams is a dangerous dose, and prevented the preparation and administration of that amount of ketamine.

1073. Each administrative failure was thus a cause of Gwen's overdose, anoxic brain injury, and death.

Count 31: Failure to Ensure Availability of Life-Support Equipment

1074. Plaintiffs here incorporate by reference all allegations in this Complaint.

1075. Administrators must ensure that providers respond to EMS calls with equipment sufficient to provide timely ventilation and oxygenation. Administrators must also ensure that EMS providers have such equipment at-hand at the patient's side.

1076. On April 19, 2021, MCFD administrators violated these requirements, by failing to ensure that Winters, Sneddon, Ellefsen, and other MCFD providers responded to Gwen's collision with equipment sufficient to provide her timely ventilation and oxygenation.

1077. On April 19, 2021, administrators at the Intermountain Defendants violated this requirement, by failing to ensure that Jewkes, Kimball, and any other Life Flight providers responded to Gwen's collision with equipment sufficient to provide her timely ventilation and oxygenation.

1078. On April 19, 2021, Gold Cross Administrators violated this requirement, by failing to ensure that Humphrey, Haynie, and any other Gold Cross providers responded to Gwen's collision with equipment sufficient to provide her timely ventilation and oxygenation.

1079. On April 19, 2021, UFA administrators violated this requirement, by failing to ensure that Stephensen, Bates, Anderson, and any other UFA providers responded to the scene of Gwen's collision with equipment sufficient to provide her timely ventilation and oxygenation.

1080. Because administrators failed to ensure that their respective providers brought the required equipment and had it at-hand at Gwen's side, providers on scene failed to provide Gwen prompt ventilation and oxygenation.

1081. Had administrators ensured that their providers responded to the call with the required equipment and had it at-hand at the patient's side, providers on scene likely would have provided Gwen prompt ventilation and oxygenation. In turn, with adequate ventilation and oxygenation, properly oxygenated blood would have perfused Gwen's brain, preventing anoxic brain injury and death.

1082. Each administrative failure was thus a cause of Gwen's injury and death.

Count 32: Failure to Ensure Basic Provider Competence

1083. Plaintiffs here incorporate by reference all allegations in this Complaint.

1084. Administrators must ensure that their organization's healthcare providers have the competence to meet the professional standard of care in administering high-risk medications.

1085. Administrators must specifically provide, among other things:

- Initial and ongoing education, training, and testing sufficient to develop and validate provider competence in preparing medication, administering medication, and responding to complications.
- Initial and ongoing education, training, and testing sufficient to develop and validate provider competence in responding to patients who experience respiratory depression and arrest.
- Ongoing enforcement and quality-assurance sufficient to develop and validate provider competence.

1086. These requirements apply with special force to high-risk medications that have multiple indications, indicated doses, and delivery routes, like ketamine.

1087. Administrators must also ensure that providers comply with other professional duties owed to patients, including the ethical duty to disclose medical error.

1088. By April 19, 2021, administrators at IHC, IMC, IMG, IHS, Life Flight, MCFD, Gold Cross, and UFA violated these requirements, by failing to ensure the required competence of their respective providers who participated in Gwen's care at the scene of the accident.

1089. As demonstrated by Jewkes's and Kimball's repeated and wide departures from the standard of care, administrators at the Intermountain Defendants failed to ensure the required competence of Life Flight providers who participated in Gwen's care.

1090. As demonstrated by Winters's, Sneddon's, and Ellefsen's departures from the standard of care, MCFD administrators failed to ensure the required competence of MCFD providers who participated in Gwen's care.

1091. As demonstrated by Humphrey's and Haynie's departures from the standard of care, Gold Cross administrators failed to ensure the required competence of Gold Cross providers who participated in Gwen's care.

1092. As demonstrated by Stephensen's, Bates's, and Anderson's departures from the standard of care, UFA administrators failed to ensure the required competence of UFA providers who participated in Gwen's care.

1093. All these administrators were thus negligent.

1094. Because administrators failed to ensure that their respective providers had the competence required to provide prehospital care, providers committed the standard-of-care violations outlined above. Because providers lacked the required competence, they specifically:

- a. failed even to bring, much less have at-hand, equipment sufficient to secure Gwen's airway and provide her prompt ventilation and oxygenation;
- b. failed to draw up the indicated dose of ketamine;
- c. instead drew up and administered an amount that was over 16 times the maximum indicated dose;
- d. failed to anticipate and prevent the complications that predictably followed, including overdose, laryngospasm, respiratory arrest, hypoxia, and apnea;
- e. failed to apprehend the urgency and danger of the overdose, which required immediate ventilation and oxygenation;
- f. failed promptly to secure Gwen's airway;
- g. failed to provide Gwen prompt ventilation and oxygenation with a BVM;
- h. instead focused on intubation, even though it was pointless without a BVM and even though airway adjuncts were quicker temporizing alternatives;
- i. contrary to protocol, insisted with tunnel-vision on reattempting intubation, even after it predictably proved unsuccessful;
- j. after belatedly finding and deploying a BVM, bungled the ventilation;
- k. created or provided patient-care reports that were incomplete, inaccurate, spoliated, and/or wrongfully withheld; and

1. failed to disclose material information about Gwen's condition to Brett and Heather.

1095. Had administrators made sure that providers had the required competence, some or all these violations would have been avoided. As a result, providers would not have administered the massive overdose to Gwen in the first place. And, even if they had, they would have had the competence and capability to respond promptly and appropriately to Gwen's respiratory arrest, preventing anoxic brain injury and death.

1096. Each administrative violation was thus a cause of Gwen's overdose, anoxic brain injury, and death.

GROSS NEGLIGENCE

1097. Plaintiffs here incorporate by reference all paragraphs of this Complaint.

1098. Defendants acted with gross negligence when caring for Gwen.

1099. Defendants failed to observe even slight care when caring for Gwen.

1100. Defendants acted with carelessness and recklessness to a degree that showed utter indifference to the consequences when caring for Gwen.

1101. Defendants' oral and written instructions given while caring for Gwen were the result of gross negligence and willful misconduct.

1102. Defendants' acts and omissions while providing medical instructions and medical care to Gwen were the result of gross negligence and willful misconduct.

1103. Insofar as Defendants failed to obtain consent from Gwen or her next-of-kin in rendering EMS to Gwen, Defendants failed to act in good faith.

1104. Individual Defendants' acts and omissions while providing care to Gwen were inconsistent with the training Defendants received from their employer or other principal, and were the result of gross negligence and willful misconduct.

1105. Thus, insofar as Defendants argue that Utah Code § 26-8a-601 applies, Defendants are all the same liable because their conduct amounted to gross negligence.

1106. Defendants' gross negligence, moreover, caused Gwen and Plaintiffs economic and non-economic damages, in an amount to be proved at trial.

COMPENSATORY DAMAGES

1107. Plaintiffs here incorporate all other paragraphs of this Complaint.

1108. Plaintiffs are entitled to damages for Gwen's wrongful death.

Early Years

1109. Gwendolyn Mary Doner was born in Dillon, Montana, on September 5, 2001.



1110. Her parents, Brett and Heather, had known each other all their lives, having grown up in the small town of Dillon, Montana.

1111. In 2001, when Brett was 22 and Heather was 20, they got married.

1112. In 2004, Brett and Heather divorced.

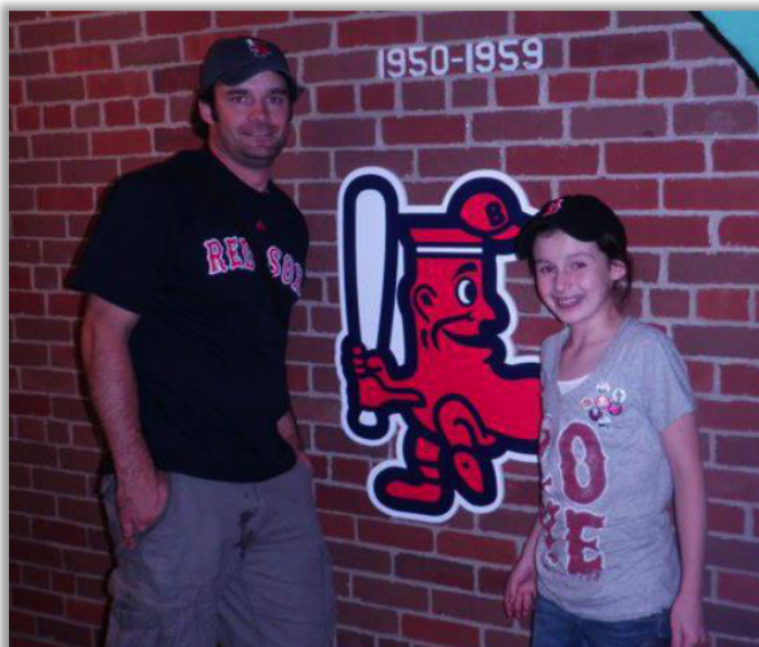
1113. Gwen was the only child Brett and Heather had together.

1114. By the time Gwen started preschool, Heather had moved to Tooele, Utah, to continue her teaching career.

1115. Already exerting the unifying influence she would have all of her life, Gwen motivated Brett to settle in Tooele himself, to be close to her.

1116. In 2014, when Heather and her second husband found a job near extended family in Casper, Wyoming, they moved there with Gwen and their other children.

1117. Within months, Brett also moved to Casper—as always to co-parent Gwen.



1118. Gwen then grew up and went to middle school and high school in Casper.

Gwen's Families

1119. In 2007, Heather married John Myers.

1120. At that time, John had a daughter named Vanessa from a prior relationship. Had she not passed away, Vanessa would be 17 today.

1121. After marrying, Heather and John had two children of their own: Adyson, who is 15, and Braylen, who is 12.



1122. Gwen was thus the oldest of the four children in the Myers home.

1123. In 2018, after dating her for years, Brett married Brook Belsom.

1124. Brook already had a son named Wyatt from a previous relationship. He is now 18.



1125. Gwen was thus the oldest of the two children in the Doner home.

One Extended Family

1126. In her early years, Gwen brought Brett and Heather together.

1127. For her sake, Brett and Heather learned to co-parent together.

1128. For her sake, Brett and Heather always shared physical custody of Gwen, so that she always spent equal time with each parent.

1129. For her sake, Brett and Heather always lived in the same town, with only temporary exceptions.

1130. As she grew into adolescence, thanks to her free spirit and generous personality, Gwen exerted a unifying influence over both families.

1131. Her siblings looked up to her as the oldest child. They all considered Gwen their closest sibling.

1132. Gwen organized visits and sleepovers, so that the two families would be together.

1133. When she went from one household to the other, she brought a sibling or two in tow, to make it a blended gathering.

1134. Because of Gwen, the two families spent most holidays together.

1135. Because of Gwen, the two families became an extended family.

School

1136. At an early age, Gwen was diagnosed with both dyslexia and ADHD.

1137. School was always hard for Gwen.

1138. Heather, a teacher, tutored Gwen after school and on weekends—through countless hours over the years.

1139. Every summer, Heather and Gwen worked together to make sure Gwen was caught up and ready for the coming school-year.

1140. Gwen always had to work a lot harder than most kids to get ahead.

1141. She generally did, keeping up with her age group all the way through high school.

Vanessa's Death

1142. In 2017, when Gwen was only 15, Vanessa unexpectedly passed away.

1143. Vanessa had been born with a congenital heart defect called hypoplastic left-heart syndrome. Her heart had three chambers, instead of four.

1144. Gwen and Vanessa had grown up together since the time Gwen was 4, and Vanessa 9 months old.



1145. Gwen had grown up seeing Vanessa undergo three open-heart surgeries.

1146. Gwen had also grown up seeing Vanessa overcome developmental delays.

1147. All their lives, Gwen watched over and took care of Vanessa.

1148. In early 2017, physicians informed the family that Vanessa's heart and other organs were failing.

1149. Although doctors said that Vanessa still had a few years to live, she actually deteriorated quickly, within months.

1150. Heather and Gwen came down to Salt Lake City, intending to spend a week with Vanessa at her mother's home. That never happened.

1151. Instead, 15 minutes after Heather and Gwen arrived, Vanessa suddenly died—in Gwen's arms.

Aftermath of Vanessa's Death

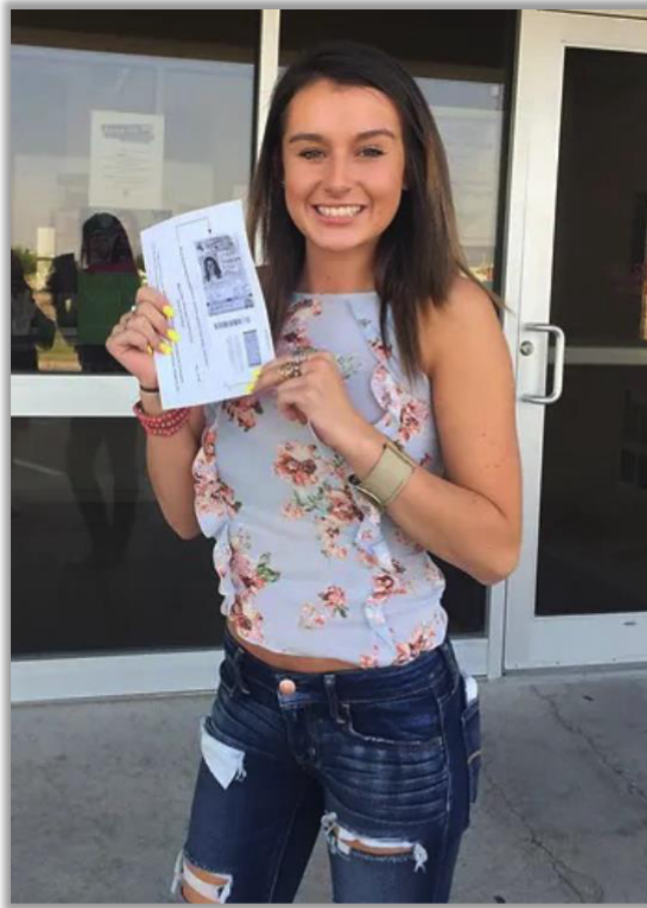
1152. Vanessa's death was devastating to Gwen.

1153. Gwen started having a harder time in school—both socially and academically.

1154. Gwen also started self-medicating by using marijuana.

1155. She was caught in possession of alcohol, was put on probation, and was then arrested for breaking probation by possessing marijuana.

1156. Through it all, Gwen managed to graduate from high school.



1157. By early 2020, even as the pandemic was starting, Gwen set her eyes on turning a new leaf by moving Salt Lake City.

New Beginning

1158. In March 2020, Gwen decided to enroll in Steps Recovery in Salt Lake City—a rehabilitation and counseling program.

1159. Though the move meant leaving beloved family and friends, Gwen said she was ready to start fresh, expand her horizons, and shape her own life.

1160. In the Steps Recovery program, Gwen received treatment for depression, anxiety, and substance-abuse.

1161. Because she had witnessed Vanessa's death, Gwen also received treatment for post-traumatic stress disorder (PTSD).

1162. Through the program, Gwen got to the roots of her adolescent mental-health crisis: the loss of her sister and her own dyslexia.

1163. As the youngest participant, Gwen saw how older participants had lived much of their lives, and she wanted something different.

1164. Gwen graduated from the Steps Recovery program on April 27, 2020.

1165. The healing transformation she had started with the decision to move to Salt Lake City was now complete.

The Best Time of Life

1166. Over the year that followed, while the world was sinking from the pandemic, Gwen seemed to be going in the opposite direction—rising.

1167. With newfound mental health, Gwen was moving forward, building a new life.

1168. Gwen religiously attended weekly counseling sessions, thus developing mutually uplifting and supportive friendships with other participants.

1169. Gwen started a romantic relationship with Tyler Shoemaker, whom she had met in Steps Recovery.

1170. Because Tyler adored their daughter and treated her gently, Brett and Heather were happy with the relationship.

1171. Gwen got a job as an associate at TJ Maxx. She said she loved working with her older coworkers, and always had stories about them.

1172. In thinking of careers, Gwen said she wanted to devote her life to helping people.

1173. Gwen thought about going into teaching, like her mother, but was afraid that college would be too difficult at this point in her life.

1174. Gwen instead enrolled at Healing Mountain Massage School, to train to become a holistic-health practitioner.



1175. As the year progressed, with the pandemic raging, Gwen and Tyler got an apartment in Midvale, Utah, to be closer to Healing Mountain.

1176. Before her death, Gwen was still proudly decorating the apartment.

1177. With winter's end, Brett and Heather had never seen Gwen more enthusiastic about spring.

1178. Brett and Heather privately rejoiced at Gwen's maturity and transformation.

1179. One night, Gwen called elated to share that she had gotten an A on her anatomy test—her first A ever on a test.

1180. Gwen’s confidence in her academic ability was germinating.

1181. She said this was the best time in her life.

Unfillable Void

1182. Even during her toughest years, Gwen spread joy with the breadth of her spirit, and the reach of her personality.

1183. Gwen lit up the room when she walked in.

1184. Gwen had a gift for comic relief. When a moment got tense, she knew how to break the tension with humor. She knew how to break the ice.

1185. People gravitated towards Gwen.



1186. Especially as she got older, Gwen enjoyed hiking, yoga, and meditation—which meant that everyone in the family tried hiking, yoga, and meditation.

1187. If Gwen laughed, everyone laughed.

1188. She had a unique laughter that you had to hear to believe—part hilarious, part contagious, part inspiring.

1189. Brett cannot ever recall her laughter without crying.

1190. Gwen’s personality was also a unique blend of toughness and tenderness.

1191. Gwen would conclude any heated debate with conciliatory words.

1192. One of her common refrains was: “We disagree, but I still love you.”

1193. The outspoken values of her world-view were love, empathy, acceptance.

1194. So people felt loved, understood, and accepted by her.

Legacy

1195. Gwen’s values extended to the meekest of creatures.

1196. Gwen found the good in everyone.

1197. Gwen was a champion for the underdog.



1198. She would make it a point to call people in her life, just to see how they were doing.

1199. After Steps Recovery, although she was in recovery herself, Gwen stayed in touch with other participants, to make sure they were getting along okay.

1200. On the night of her death, Gwen was out on the highways in the first place, only because she was helping a friend.

1201. As a child, Gwen wanted her parents to keep every stray animal she brought home, because “animals need care just like people.”



1202. Later in life, Gwen volunteered at the Humane Society.

1203. That proved painful for her, because she wanted to save every animal.

1204. She would send pictures of herself playing with them, hoping to inspire an adoption.

1205. As a teen, Gwen filled an ever-expanding space within her social circle.

1206. By now, she was not only the “ringleader” to her siblings and cousins, but also to grandparents, uncles, aunts, friends, and neighbors of all ages.

1207. The void left by her death has brought unspeakable harm to the people in that circle, particularly her nuclear families.

1208. Those harms obviously include severe emotional distress, spiritual and mental anguish, physical and mental health issues, and economic damages.

1209. Those harms also include the loss of Gwen’s presence and company—loss of the love, companionship, society, comfort, advice, care, protection, and affection Plaintiffs shared with Gwen, now and in the future.

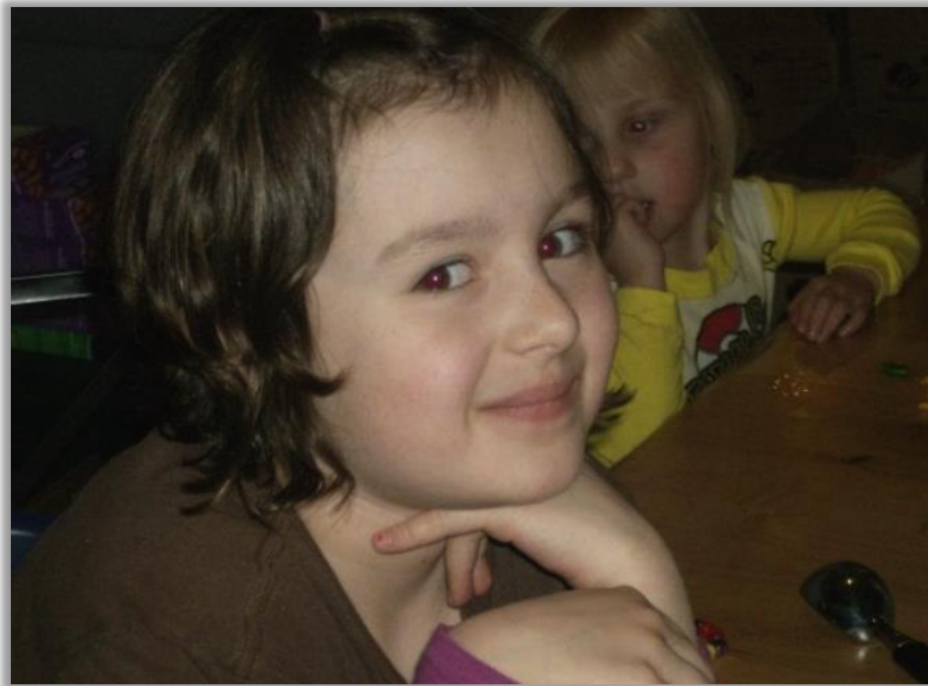
1210. If asked, Brett will tell you that the saddest thing in his life is knowing he will never hear Gwen laugh again.

1211. Still, there was a bigger world Gwen was poised to touch—so broad was her spirit, so big her dreams.

1212. Brett and Heather remember Gwen’s reaction when she first heard about the Peace Corps as a child.

1213. From that moment on, Gwen always said she would join the Corps one day—to “help others and see the world.”

1214. At the time of her death, she continued to harbor that dream.



1215. Reminding themselves of the “privilege and blessing” it was to live with Gwen for 19 years, Brett and Heather look forward to honoring her life.

1216. They hope to prevent other children from dying as she did, other parents from enduring as they do. They hope to help others as Gwen did.

PUNITIVE DAMAGES

1217. Plaintiffs here incorporate by reference all paragraphs of this Complaint.

1218. Defendants’ conduct while caring for Gwen was willful and malicious.

1219. Defendants’ conduct while caring for Gwen was intentionally fraudulent.

1220. Defendants’ conduct while caring for Gwen manifested a knowing and reckless indifference toward, and disregard of, the rights of others, including Gwen and her family.

1221. Defendants knew that their conduct would, in a high degree of probability, result in substantial harm to Gwen and her family.

1222. Defendants' conduct while caring for Gwen was highly unreasonable and was an extreme departure from ordinary care, in a situation where a high degree of danger or harm would be apparent to a reasonable person.

1223. Plaintiffs seek punitive damages against the Defendants.

1224. An award of punitive damages is reasonably likely against Defendants.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendants as follows:

1225. for general damages including without limitations, pain and suffering in an amount to be proved at trial and awarded by a jury;

1226. for economic damages, including medical expenses and funeral expenses, in an amount to be proved at trial and awarded by a jury;

1227. for punitive or exemplary damages in an amount to be proven at trial;

1228. for costs of suit herein and for attorneys' fees;

1229. for prejudgment and post-judgment interest until paid in full; and

1230. for such further relief as the Court deems just and proper.

JURY DEMAND

Pursuant to Utah Rules of Civil Procedure 38, Plaintiffs hereby request trial by jury and tender herewith the associated fee.

DATED this 10th day of April, 2023.

BELL LAW FIRM

Lloyd N. Bell
Mauricio A. Gonzalez
Daniel E. Holloway

STEELE ADAMS HOSMAN

Jeffrey J. Steele
Justin M. Hosman
Alyssa J. Wood