This is NOT a Game:
Real Claims, Real Lives, Real Risk

Jillian Book, JD
Tammy Gamrat, BS, RN, CPHRM

2025

Illinois Health and Hospital Association

Objective

Describe and apply damage and risk mitigation strategies learned during the management of liability claims.

Claim #1 – Facts

Sunday afternoon, 3:20 p.m.

- 31-year-old female presented to the ER with complaints of nausea, vomiting, decreased urination and bowel movements, abdominal pain, and shortness of breath
  - Surgery on Friday – laparoscopic excision of endometriosis, left oophorectomy and diagnostic hysteroscopy
  - Saturday afternoon – call to fellow with abdominal pain
  - Sunday morning, 8:40 a.m. – call to fellow with continued abdominal pain. Instructed to go to the ED
- Triage vital signs

Temperature 97.5°	Pulse 130	SpO_2 94%
BP 101/75	Respirations 22	

Claim #1 – Facts

- Seen by ED physician at 3:32 p.m.
- Physical Examination – pale and clammy, mild abdominal distention and diffuse tenderness to palpation
  - CBC - low WBC (2.54)
- 3:45 p.m. – CT scans ordered and completed shortly thereafter
- 4:05 p.m. vital signs

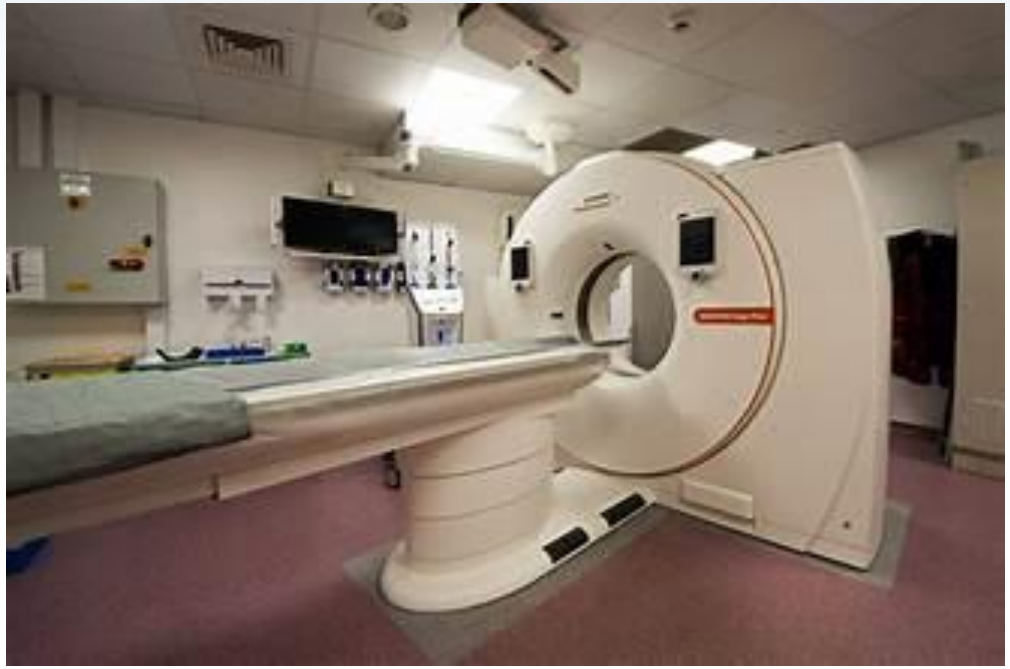
BP 110/74	Pulse 117
Respirations 22	SpO_2 94%

- 5:27 p.m. – ordered IV antibiotics (Zosyn)
- 5:49 p.m. vital signs

BP 91/59	Pulse 124
Respirations 20	SpO_2 91%

Claim #1 – Facts

- 5:58 p.m. – CT scans resulted
  - CT chest – negative
  - CT abdomen – “may represent early formation of abscess”
- ED physician called the fellow, plan to transfer
- Differential diagnosis included pelvic abscess and sepsis



Claim #1 – Facts

- Vitals signs prior to transfer:

Temperature 98.2°	Pulse 136	SpO_2 98%
BP 106/60	Respirations 18	

- ED physician documented that the patient was "*stabilized such that, within reasonable medical probability, no material deterioration of the individual's emergency medical condition is likely to occur from or during transfer*"

Claim #1 – Facts

- Patient arrived at the Chicagoland hospital at 10 p.m.
  - Fellow did not see the patient, only the resident
  - Fellow and resident discussed the CT and disagreed – they did not suspect an abscess
- Following morning (Monday)
  - Lactic acid – 17.1 (critical)
  - ABG – pH of 6.98
  - Rapid response called at 10:32 a.m.
  - Code called at 10:39 a.m.
- Exploratory laparotomy (Tuesday)
- Patient died nine days later (the following Thursday)

Lawsuit/Allegations

- Lawsuit filed by husband – wrongful death and survival
- ED physician and hospital named as defendants
- Additional defendants included the Chicagoland hospital, the surgeon, fellow, resident, and medical group
- Filed in Cook County
- Allegations against other defendants:
  - Causing thermal injury to bowel
  - Failure to recognize the injury before closing
  - Failure to properly inspect for injury
  - Failure to expedite surgical and ID consult upon admission
  - Failure to initiate proper sepsis protocols upon admission

Lawsuit/Allegations

Allegations against hospital and ED physician:

- Failed to order a surgical consult
- Failed to order an ID consult
- Failed to immediately begin IV antibiotics
- Transferred an unstable patient
- Failed to maintain appropriate transfer policy
- Failed to maintain an appropriate “Sepsis Alert” policy

Causation and Damages

- 31-year-old wrongful death
- Survived by husband
- No claim for cost of medical care
- Conscious pain and suffering of the patient
- Grief, sorrow and mental suffering of the husband
- Loss of society of the husband

- Consideration – partial settlement

Case Strengths and Weaknesses

Strengths:

- Correct tests and treatment ordered – blood work, CT scan, IV fluids, and IV antibiotics
- ED physician correctly diagnosed sepsis and possible pelvic abscess
- Patient was stable at time of transfer
- Length of time at Chicagoland hospital before Code
- Set-off and “empty chair”

Case Strengths and Weaknesses

Weaknesses:

- Patient met SIRS criteria
- No surgical consultation
- Missed the window to save the patient
- Transferred the patient

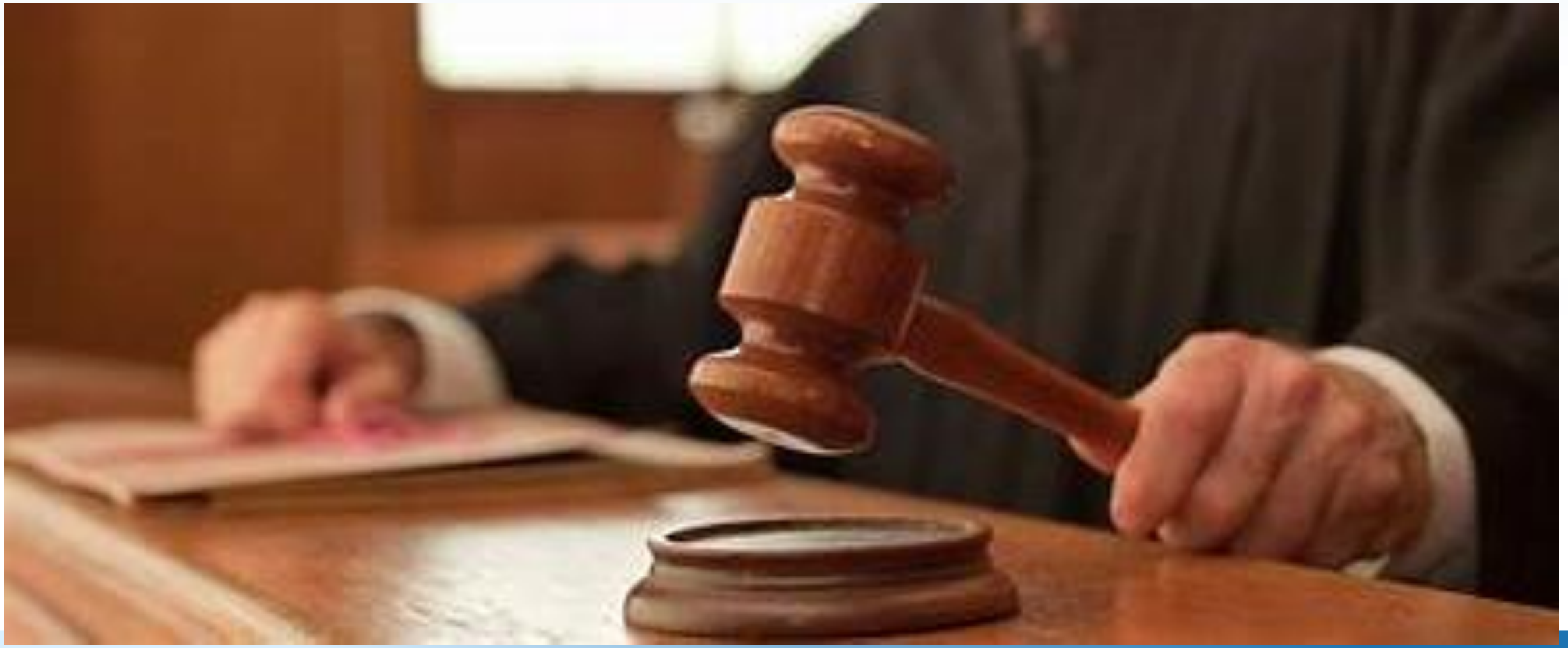
Demand

$4 million demand made to the remaining defendants

Discussion Points and Considerations

- What deviations from the standard of care if any did you identify?
- Any aggravating factors?
- Thoughts about demand?
- Should an attempt be made to settle this case?
  - If so, what is the case settlement value?
  - If so, what amount is too much where it should instead be tried?
- Rationale for settling case vs. taking case to trial?

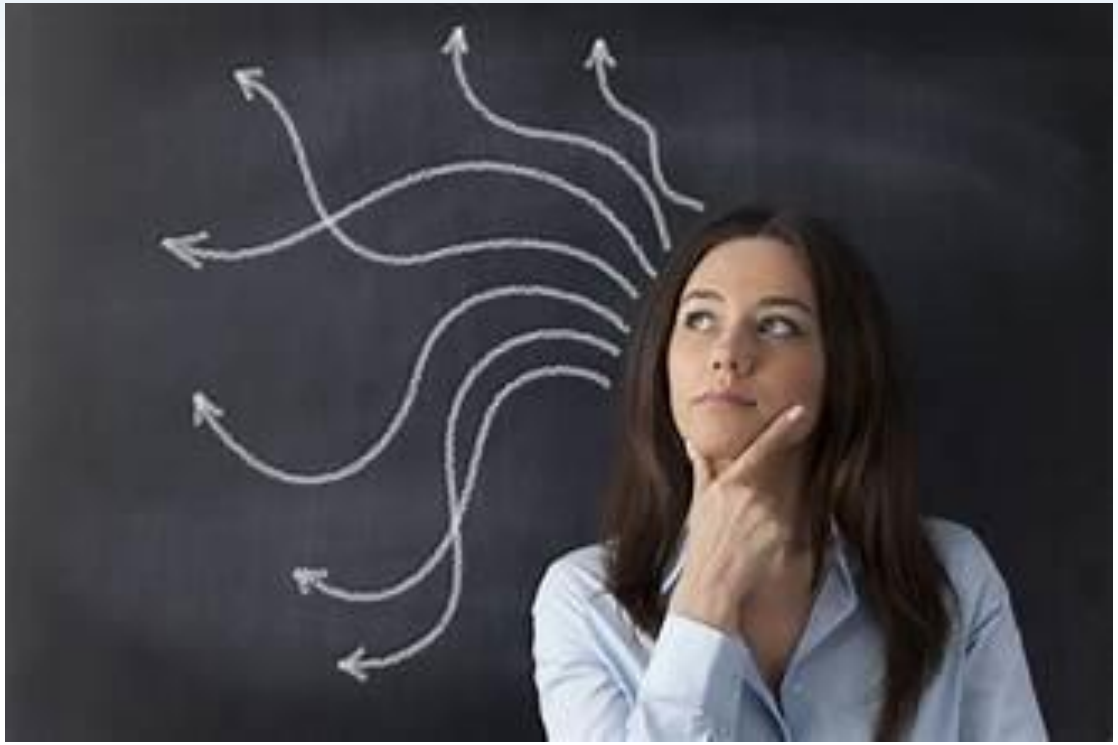
Case Outcome



Risk Management Considerations

The Big Three:

- EMTALA Policies & Procedures
- Sepsis Policies & Procedures
- Efforts to Reduce Apparent Agency Exposure



EMTALA Policies & Procedures
Impacts of IL Regulations

- Self-reporting requirement
- IDPH investigations may include a clinical review by a physician
- Minimum fines of $50K
- Aggravating factors may increase fine
  - Violation causes serious or permanent physical, mental, or emotional harm
  - Violation proximately caused death
  - Prior violations of the Act
  - Failure to self-report to IDPH
  - Hospital requested proof of insurance, prior authorization, or monetary payment before MSE/stabilizing treatment

Be Proactive!

Consider performing an EMTALA gap analysis/FMEA

- Ensure P&Ps are consistent with EMTALA and IL regs
- Education Education Education!!!!
  - All staff who may encounter an individual presenting to the ED – registration, security, greeters
- Establish a process for self-reporting & initiating own investigation
- Be prepared for investigations – RCA, P&Ps, education (agenda and attendance), signage, central logs….

EMTALA & IL Regulations

EMTALA

https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act

Hospital Licensing Requirements 250.710 b-g

https://ilga.gov/commission/jcar/admincode/077/077002500G07100R.html

Hospital Emergency Service Act

https://www.ilga.gov/Legislation/ILCS/Articles?ActID=1233&ChapterID=21

IHA Memo

https://team-iha.org/advocacy-policy/regulatory-policy-issues/hospital-operations/hospital-licensing-rules-related-to-emergency-treatment-adopted/

Sepsis

- Consider performing a sepsis gap analysis
- Ensure screening tools and treatment protocols are consistent with published evidence-based practice for all populations
- Education
- Quality review/feedback

Apparent Agency

- **Educate and Inform Patients**
  - Consent language
  - Signage – posted in key places
  - Website
  - Name badges, etc. don't hold independent contractors out as hospital employees

- **Establish relationships on paper and in practice**
  - Contracts
  - Billing
  - Marketing

Claim #2 – Facts

- 36-year-old male presented to the ER with nausea, vomiting and dizziness after paintballing
  - Question of direct hit by paintball
- No loss of consciousness, no neck stiffness. Exam was unremarkable
- Head CT was negative
- Vital sign ranges
  - BP 125-160/74-121
  - HR 73-88
  - Respirations 16-20
  - Temperature 98.1 – 98.4˚

Claim #2 – Facts

- Given fluid boluses and anti-nausea medications
- Admitted for observation with concussion diagnosis
  - Persistent dizziness
  - Slight drop in hemoglobin (13.7)
  - No focal weakness on exam
- Discharged two days later with vertigo diagnosis
  - Still with mild dizziness with lateral gaze
  - MRI script given for outpatient study
  - Follow-up with primary care physician

Claim #2 - Facts

- One year later, contact from an independent health care advocate
- Per the advocate's report:
  - Patient complained of right-sided facial numbness
  - Denied being hit by a paint ball
  - Denied receiving script for MRI
  - MRI which showed arterial dissection
  - Out-of-state medical record excerpt provided
    - Diagnosis of acute ischemic stroke
    - Presented with vertigo, right facial numbness and gait instability
    - Reported popping sensation with neck pain after a game of paintball

Discussion Points and Considerations

- What deviations from the standard of care if any did you identify?
- What demand would you expect from the advocate?
- Should an attempt be made to settle this claim?
  - If so, what is the settlement value?
- Do you believe that there are any aggravating factors in this claim?

Pre-Suit Claim Outcome

Risk Management Implications

- Review such complaints from a diagnostic safety perspective – are there resources or processes that could be improved/changed?
- Are discharge instructions clearly communicated?
- Grievance & Complaint Processes – how would your process stand up to a call from an advocate?

Claim #3 – Facts

- 90-year-old male fell while reaching for a door handle, fell out of wheelchair and hit his head
- The following day, he voiced complaints of neck pain, and an x-ray showed a potential fracture
- CT also completed which showed bilateral fracture of C1
- Patient was transferred for neurosurgical assessment due to concern of vertebral artery injury
- No surgery and patient was discharged with an Aspen collar

Claim #3 - Facts

- Resulted in a lawsuit
- Discovery request for incident reports and investigation materials
  - Incident report
  - Post-fall documentation
- Facility was part of a patient safety organization (PSO)
  - Successfully able to argue PSQIA protections for the incident report
  - Post-fall documentation was not submitted to PSO
    - Court found the documents were not privileged
    - Deadline for production – 21 days

Claim #3 - Facts

- Decision was made to take a friendly-contempt
- Court entered the contempt and a fine of $100/day retroactive to the date of the order
- As of the date of the order, it had already been 79 days
- Plaintiff demand of $700,000

Discussion Points and Consideration

- What route would you take?
  - Produce the forms?
  - Appeal?
  - Attempt to negotiate?
    - The fine is payable to Plaintiff

- Consider cost of appeal *v*. accruing fine *v*. settlement
- What impact will this have on future cases?

Outcome

PSQIA Protections

Deliberations & Analysis Pathway

- Internal processes to collect patient safety information, analyze it, and improve processes
- Protected as Patient Safety Work Product (PSWP) within the organization's Patient Safety Evaluation System (PSES)
- Protected even if not reported to PSO

Risk Management Recommendations

- Include debriefs, huddles, etc. in PSES policy or plan
- Open Debrief with an announcement/reminder: The debrief is occurring under the hospital's PSES and considered PSWP and considered confidential and privileged
- Debriefing "forms" should contain PSWP language

Questions