# Attorney Case Review Report

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Dear Mr. Smith,

This attorney case review concerns Joshua Jacobs, a six-month-old infant who was repeatedly exposed to ticks, developed symptoms concerning for Rocky Mountain Spotted Fever (RMSF), deteriorated during hospitalization, and died following transfer for higher-level care. The purpose of this report is to identify potential defendants, summarize the relevant clinical timeline, outline apparent deviations from the standard of care, and identify discovery needed to further evaluate liability, causation, damages, and defenses.

## I. EXECUTIVE SUMMARY OF POTENTIAL LIABILITY

A. Potential physician defendants include Dr. David Young, primary pediatrician, and Dr. Andrew Robe, infectious disease specialist. Potential theories include failure to initiate guideline-supported empiric RMSF treatment, failure to adequately document daily physician assessments, failure to respond to clinical deterioration, and failure to order or follow appropriate laboratory and diagnostic studies.

B. Potential nursing defendants include Holly Palmer, RN; Jessica Niece, RN; Nick Smith, RN; and other nursing staff involved in Joshua's care. Potential theories include failure to complete ordered diagnostic studies, failure to notify providers of abnormal findings and deterioration, failure to activate escalation pathways or rapid response, delayed medication administration, delayed initiation of DIC-related orders, and deficient shift assessment documentation.

C. Potential institutional defendants include Charitable Sisters of Mercy Hospital, the Chief Nursing Officer, and the physician practice or physician associate group affiliated with Dr. Young. Potential theories include respondeat superior, ostensible agency, negligent supervision, inadequate enforcement of documentation and escalation policies, and failure to ensure completion of physician orders and timely reporting of abnormal results.

## II. PATIENT BACKGROUND AND CASE OVERVIEW

A. Joshua Jacobs was a six-month-old male infant with no significant known medical history before the events forming the basis of this matter.

**MEDICAL MANAGEMENT AND CLINICAL TIMELINE:** Joshua Jacobs was admitted to Charitable Sisters of Mercy Hospital on May 20, 2020, after evaluation by Dr. Young for a one-week history of diarrhea, two days of fever, and a new rash. His mother reported repeated tick exposure and removal from Joshua's ears on May 17, 18, and 19, and specifically raised concern for RMSF because another family member had recently contracted the disease. Although Dr. Young admitted Joshua for fever and ordered testing to rule out RMSF, he documented that he believed Joshua's illness was viral rather than RMSF.

Over the next several days, Joshua's condition deteriorated despite interventions, with marked decline noted on the evening of May 25, including difficulty breathing, abdominal distention, and mottled skin. He was transferred to the CSMH PICU early on May 26, where he was assessed as having disseminated intravascular coagulation and was then transferred by flight to Children's Mission Hospital after receiving fresh frozen plasma and albumin. Upon arrival, he had neurological deficits, tachycardia, respiratory distress, uncontrolled bleeding, and rash; he was intubated, suffered multiple cardiac arrests, and was pronounced dead at 1:40 a.m. after prolonged resuscitation efforts failed to restore spontaneous circulation.

A. **PHYSICIAN MANAGEMENT ISSUES: DAVID YOUNG, MD, AND ANDREW ROBE, MD**

1. The principal physician management concern is the apparent failure to initiate timely empiric treatment for suspected RMSF despite known tick exposure, fever, rash, gastrointestinal symptoms, family concern for RMSF, and testing ordered to rule out RMSF.
    a. Diagnosis of RMSF should be suspected in patients who are from and endemic area, present in the spring or summer months with fever and at least one of the following: headache, rash, constitutional symptoms, or laboratory abnormalities or thrombocytopenia and elevated liver functions test; and have a known tick bite or exposure to environment where ticks are present. Antimicrobial therapy should promptly be prescribed to all patients suspected to have RMSF on the basis of the preceding symptoms and possible tick exposure. [4]
    b. Empiric Therapy: Intravenously administered doxycycline for the treatment of RMSF in adults and children is recommended. [10]
    c. The availability of tetracycline (doxycycline) antibiotic in the 1940's resulted in a marked reduction in the case-fatality rate of patients with RMSF in the United States. [6]
    d. The use of short courses of doxycycline in children of all ages is also supported by the American Academy of Pediatrics. [14]

e. Delaying treatment beyond the first five days of symptoms, of RMSF, significantly increases the risk of organ failure, sepsis, and death. (Sepsis.org, 2015) [19]

2. Dr. Robe ordered chloramphenicol instead of the empiric treatment recognized by clinical guidelines.
    a. The use of chloramphenicol (the only alternative agent) compared to tetracyclines (aka doxycycline) has been associated with a higher risk of death. [15]
    b. Chloramphenicol is less effective than doxycycline [16]

3. Additional physician management concerns include incomplete or delayed progress-note documentation, possible gaps between billed services and documented assessments, delayed response to clinical deterioration, and failure to consistently order, trend, and respond to laboratory and diagnostic findings relevant to RMSF and evolving coagulopathy.
    a. Dr. Young did not document progress notes for the three-day period from May 21 through May 24, 2020, although daily visits were billed. This should be reviewed for possible documentation and billing concerns.
    b. A delayed entry by Dr. Young for May 24, 2020, entered on May 25, 2020, the day of Joshua's marked deterioration, may warrant further inquiry regarding missing, delayed, or altered records.
    c. Dr. Robe did not document a progress note on May 24, 2020.

4. Laboratory and diagnostic follow-through should be a focus of discovery. Records suggest thrombocytopenia, falling hematocrit and hemoglobin, abnormal coagulation concerns, and clinical decline were not adequately escalated or addressed. Hospital policies regarding admission testing, repeat labs, critical-result notification, physician notification, and documentation should be obtained.
    a. Laboratory findings of RMSF thrombocytopenia (low level of platelets), hyponatremia (low sodium), elevations in serum aminotransferases (ALT and AST liver function), bilirubin (liver function to measure old red blood cells broken down), azotemia (kidney function high levels of nitrogen-containing compounds ie: urea and creatinine in the blood), prolongation of PT and PTT (prolonged clotting factors). [3]
    b. Definitive diagnosis: Acute and convalescent serology should be sent on patients clinically suspected of having RMSF. Clinically available PCR testing of blood samples and RMSF. [12]
    c. Testing of skin biopsies is a potential method of disease confirmation, although these results are often delayed. [12]
    d. Complete Blood Count (CBC) & Chemistries: For stable infants on a general medical floor, these are typically assessed once daily (e.g., morning labs) if trending is needed. In an intensive care setting, they may be

ordered every 6 to 12 hours depending on how rapidly the patient's condition changes. [13]

5. The clinical timeline also raises concerns regarding the response to abnormal laboratory values and worsening clinical condition. Joshua's marked deterioration was documented on the evening of May 25, 2020, but the first clearly documented physician response appears to occur after transfer to the PICU in the early morning of May 26, 2020. Policies regarding escalation of care, rapid response, chain of command, and provider notification should be reviewed carefully.
    a. As the illness (RMSF) progresses, the thrombocytopenia becomes more prevalent and may be sever. The low platelet count may be accompanied by a reduced fibrinogen concentration and elevated fibrin split products or Disseminated intravascular coagulation (DIC) is rare. [2]
    b. According to the Joint Commission (2019), critical access hospitals are to develop and implement written procedure to report critical results of tests and diagnostic procedures in a timely manner to a responsible licensed caregiver so that a patient can be promptly treated. As, critical results of tests and diagnostic procedures (ie. Laboratory values), that fall significantly outside the normal range and may indicate a life-threatening situation.

6. Failure to respond timely to clinical deterioration or change in condition. Nursing documentation reflects Joshua's initial marked deterioration at approximately 7:20 p.m. on May 25, 2020, with further worsening at approximately 9:45 p.m. Dr. Young's first documented response appears to have occurred at approximately 2:10 a.m. on May 26, 2020, upon Joshua's arrival to the PICU. Policies regarding provider notification, escalation of care, and rapid response activation should be reviewed.

B. **NURSING MANAGEMENT ISSUES**
    1. **Holly Palmer, RN:** Records should be evaluated for failure to complete ordered diagnostic studies, including the punch biopsy ordered by Dr. Robe on May 22, 2020, and failure to notify providers regarding abnormal laboratory findings on May 24, 2020.
    2. **Jessica Niece, RN:** Records should be evaluated for failure to timely notify providers, charge nurse, and/or rapid response personnel when Joshua showed signs of deterioration at approximately 7:20 p.m. and again at approximately 9:45 p.m. on May 25, 2020.
        a. Medication-administration issues should be reviewed, including whether ampicillin was administered as ordered and whether chloramphenicol was delayed. The timing and appropriateness of chloramphenicol, as compared with guideline-supported doxycycline therapy for suspected RMSF, should be reviewed with appropriate experts.

3. **Nick Smith, RN:** Records should be evaluated for delayed administration of ordered medication and delayed initiation of DIC-related orders, including fresh frozen plasma and albumin, before flight transfer to Children's Mission Hospital.

C. **GENERAL NURSING AND DOCUMENTATION ISSUES**

a. The nursing record should be reviewed for missing or incomplete shift assessments, progress notes, medication administration records, physician notification documentation, chain-of-command documentation, and rapid response or escalation documentation.

D. **INSTITUTIONAL AND NURSING LEADERSHIP ISSUES: DEBORAH RICHCREEK, MSN, RN, CNO**

a. The Chief Nursing Officer and hospital leadership should be evaluated for responsibility over nursing standards, regulatory compliance, escalation policies, evidence-based protocols, staff education, supervision, and enforcement of policies governing physician orders, provider notification, critical-result reporting, and rapid response activation.

## IV. REQUESTS FOR PRODUCTION AND INTERROGATORIES

A. Request all hospital policies and procedures in effect during the relevant period addressing provider notification, rapid response activation, escalation/chain of command, medication administration, physician order completion, laboratory and diagnostic-result reporting, documentation requirements, pediatric admission protocols, infectious disease consultation, and staffing.

B. Request complete medical records from the pediatric office, Charitable Sisters of Mercy Hospital, and Children's Mission Hospital, including progress notes, orders, medication administration records, laboratory reports, diagnostic reports, transfer records, code records, nursing notes, flowsheets, and audit trails.

C. Request staffing records for the relevant units and shifts, including assignments, charge nurse coverage, ratios, acuity, supervisor coverage, rapid response availability, and PICU transfer staffing.

D. Request credentials, continuing education records, competency records, policy acknowledgments, disciplinary history if applicable, and role descriptions for all providers and nurses who provided direct or indirect care to Joshua.

## V. PLAINTIFF WEAKNESSES AND ANTICIPATED DEFENSES

A. The defense may argue contributory negligence or comparative fault related to Joshua's repeated tick exposure, the timing of tick removal, and household pet flea/tick prevention. These arguments should be anticipated and addressed through testimony regarding parental reports, timing of symptom onset, and the medical providers' independent duty to evaluate and treat suspected RMSF once the risk was reported.

B. The defense may also argue that RMSF can be difficult to definitively diagnose early in the disease course. Plaintiff's response should focus on whether the standard of care

required empiric treatment based on clinical suspicion and tick exposure, rather than waiting for definitive confirmatory testing.

Please let me know if you would like additional analysis, a chronology table, deposition questions, or a focused expert-review memorandum for this case.

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