UNITED STATE BANKRUPTCY COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

IN RE:
TEHUM CARE SERVICES, INC.
Debtor.

Case No. 23-90086 (CML)
Chapter 11

MOTION TO EXTEND TIME TO FILE PROOF OF CLAIM

TO THE HONORABLE UNITED STATES BANKRUPTCY JUDGE:

COMES NOW, Tiffany R. Smith ("Movant"), asking for an extension of time to file her Proof of Claim. In support of this Motion, Movant states:

JURISDICTION AND VENUE

1. This Court has jurisdiction under 28 U.S.C. §§ 157 and 1334. This matter is a core proceeding under 28 U.S.C. § 157(b)(2).

2. Venue is proper under 28 U.S.C. §§ 1408 and 1409.

BACKGROUND

3. The Debtor filed for Chapter 11 bankruptcy protection on February 13, 2023.

4. The Court established August 23, 2023, as the deadline (the "Bar Date") for filing a proof of claim.

5. Movant's claim against the Debtor is a medical malpractice personal injury claim.

In 2016, while incarcerated in an Indiana prison, Movant suffered from undiagnosed acute appendicitis. This resulted in a perforated appendix, generalized peritonitis, emergency surgery, and extensive wound care.

On February 25, 2021, a Medical Review Panel unanimously found that Corizon, LLC (the Debtor's predecessor) and its healthcare providers did not meet the applicable standard of care and the negligence was a factor in the resulting damages. (See Medical Review Panel Opinion, Exhibit 1)

Movant filed her lawsuit in Parke Circuit Court in June 2021. The case moved forward :

- First jury trial setting was in August 2022.
- Defendants asked for continuance in June of 2022.
- Trial reset to May of 2023.
- Debtor filed Chapter 11 on February 13, 2023.
- Parke Circuit Court has stayed all proceedings.

6. Movant's counsel did not file the Proof of Claim by the August 23, 2023 Bar Date due to these circumstances:

   a. From March 2023 to May 2024, a paralegal was responsible for receiving documents and tracking deadlines filed or sent to our firm.

   b. The paralegal did not document the receipt of the Proof of Claim requirement; the paralegal did not calendar the Proof of Claim deadline.

   c. The paralegal has since left the firm.

   d. An associate attorney now handles deadline tracking.

7. Movant's counsel moved for *pro hac vice* appearance approved on March 3, 2023. **[Documents 44 and 50]**.

8. Since filing the *pro hac vice* appearance in February 2023, Movant's counsel maintained communications with Debtor's counsel. For example, there were discussions regarding a relief from stay, the applicability of insurance policies, and potential settlement structures to be announced in 2023 2024.

9. Most recently, in October of 2024, Movant's Counsel discussed the proposed settlement plan, the PI/WD Claims Trust, and the insurance implications of the plan.

10. After reviewing the settlement plan, Movant intended to vote for and take part in the PI/WD Claims Trust Procedure.

11. After not receiving voting materials, Movant's Counsel contacted Debtor's counsel o determine if Movant's claim was properly filed.

12. Movant's Counsel discovered the claim's absence from the register on January 29, 2025 during an email exchange with Debtor's Counsel.

13. This motion is being filed within 2 days of learning of this mistake.

LEGAL BASIS FOR EXTENSION

14. Federal Rule of Bankruptcy Procedure 9006(b)(1) permits deadline extensions after the expiration of the specified time period where the failure to act was the result of *excusable neglect*.

15. Under Pioneer Investment Services Co. v. Brunswick Associates Ltd. Partnership, 507 U.S. 380 (1993), courts consider four factors:

    a. Danger of prejudice to the debtor

    b. Length of delay and impact on proceedings

    c. Reason for delay

    d. Good faith of the movant

16. Movant shows excusable neglect because:

    a. *No prejudice to Debtor exists*. Movant effectively gave notice of its proof of claim in the Movant's counsel's Motion and Order for Pro Hac Vice. A copy of the complaint filed against the Debtor was attached as Exhibit A. [Document 246]. Allowing this claim won't increase the proposed $25,000,000 PI/WD settlement trust amount and the proposed settlement plan expects late filed claims.

    b. *Delay is unimportant and has no impact*. Despite being a sixteen-month delay, this delay does not impact the proceedings as all creditors and claims are eligible for the settlement plan have yet to be voted upon and processed.

    c. *It was a mistake*. The Movant's mistake resulted from an administrative error by former staff that has since been discussed through improved procedures

    d. *Good faith*. Both Movant and her counsel have acted in good faith throughout these proceedings, as shown by:

        - Filing a pro hac vice appearance promptly after the bankruptcy filing.
        - Pursuing resolution through proper channels, including proposed stipulations for relief from stay.
        - Engaging in ongoing discussions about the treatment of national insurance policies.
        - Carefully investigating the implications of the PI/WD Trust structure for Movant's claim.
        - Maintaining regular communication with Debtor's counsel about case developments.
        - Promptly seeking relief after discovering the missed deadline.

17. Finally, the Movant's claim has merit as shown by the finding of the Medical Review Panel that medical malpractice occurred.

18. A proposed proof of claim is attached as Exhibit A. Exbibits supporting the Proof of Claim are attached as Exhibit B.

RELIEF REQUESTED

WHEREFORE, Movant respectfully requests the Court:

1. Extend the time for filing Movant's proof of claim;
2. Accept the proof of claim attached as Exhibit A; and
3. Grant any additional relief deemed just and proper.

Respectfully submitted,

s/ Robert W. Johnson
Robert W. Johnson, Ind. Atty. No. 17391-49
Johnson Jensen LLP
1101 N. Delaware St.
Indianapolis, IN 46202
317.269.7799 Telephone
317.269.7784 Fax
rjohnson@johnsonjensen.com

Attorney for Movant

CERTIFICATE OF SERVICE

I certify that on January 31, 2025, the foregoing document was served upon these all parties of record through the CM/ECF system.

s/ Robert W. Johnson
Robert W. Johnson, Ind. Atty. No. 17391-49

Fill in this information to identify the case:

Debtor Tehum Care Services, Inc.

United States Bankruptcy Court for the: Southern District of Texas (State)

Case number 23-90086

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**

Johnson Jensen LLP
Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor

2. **Has this claim been acquired from someone else?**

☑ No
☐ Yes. From whom?

3. **Where should notices and payments to the creditor be sent?**

Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	**Where should payments to the creditor be sent?** (if different)
Johnson Jensen LLP Robert W. Johnson 1101 N. Delaware St. Indianapolis, IN 46202	
Contact phone 317-269-7799	Contact phone
Contact email rjohnson@johnsonjensen.com	Contact email

Uniform claim identifier for electronic payments in chapter 13 (if you use one):

4. **Does this claim amend one already filed?**

☑ No
☐ Yes. Claim number on court claims registry (if known) Filed on MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**

☑ No
☐ Yes. Who made the earlier filing?

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**

☑ No

☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ___ ___ ___ ___

7. **How much is the claim?** $ 1,250,000. **Does this amount include interest or other charges?**

☑ No

☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**

Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.

Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).

Limit disclosing information that is entitled to privacy, such as health care information.

Personal injury claim of Tiffany R. Smith against Corizon.

9. **Is all or part of the claim secured?**

☑ No

☐ Yes. The claim is secured by a lien on property.

Nature or property:

☐ Real estate: If the claim is secured by the debtor's principle residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.

☐ Motor vehicle

☐ Other. Describe: _____

Basis for perfection: _____

Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: $_____

Amount of the claim that is secured: $_____

Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amount should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: $_____

Annual Interest Rate (when case was filed)_____%

☐ Fixed

☐ Variable

10. **Is this claim based on a lease?**

☑ No

☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**

☑ No

☐ Yes. Identify the property: _____

23900862305040712190082 63

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

	Amount entitled to priority
☑ No	
☐ Yes. *Check all that apply:*	
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$_____
☐ Up to $3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$_____
☐ Wages, salaries, or commissions (up to $15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$_____
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$_____
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$_____
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$_____

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☐ I am the creditor.

☑ I am the creditor's attorney or authorized agent.

☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 01/29/2025
MM / DD / YYYY

/s/Robert W. Johnson
Signature

Print the name of the person who is completing and signing this claim:

Name: Robert W. Johnson
First name Middle name Last name

Title: Attorney for Tiffany R. Smith

Company: Johnson Jensen LLP
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address

Contact phone (317)269-7799 Email rjohnson@johnsonjensen.com

23900862305040712190082 63

Verita (KCC) ePOC Electronic Claim Filing Summary

For phone assistance: Domestic (866) 967-0491 | International 001-424-236-7244

Debtor:
23-90086 - Tehum Care Services, Inc.
District:
Southern District of Texas, Houston Division

Creditor:
Johnson Jensen LLP
Robert W. Johnson
1101 N. Delaware St.

Indianapolis, IN, 46202

Phone:
317-269-7799
Phone 2:
317-331-5851
Fax:
317-269-7816
Email:
rjohnson@johnsonjensen.com

Has Supporting Documentation:
Yes, supporting documentation successfully uploaded
Related Document Statement:

Has Related Claim:
No
Related Claim Filed By:

Filing Party:
Authorized agent

Other Names Used with Debtor:

Amends Claim:
No
Acquired Claim:
No

Basis of Claim:
Personal injury claim of Tiffany R. Smith against Corizon.

Last 4 Digits:
No

Uniform Claim Identifier:

Total Amount of Claim:
1,250,000

Includes Interest or Charges:
No

Has Priority Claim:
No

Priority Under:

Has Secured Claim:
No
Based on Lease:
No
Subject to Right of Setoff:
No

Nature of Secured Amount:
Value of Property:
Annual Interest Rate:
Arrearage Amount:
Basis for Perfection:
Amount Unsecured:

Submitted By:
Robert W. Johnson on 29-Jan-2025 2:31:33 p.m. Eastern Time
Title:
Attorney for Tiffany R. Smith
Company:
Johnson Jensen LLP

VN: 3E2EFB187CBD5B2B3AC07783EC7037A4

61D01-2106-CT-000220
Filed: 6/22/2021 2:41 PM
Clerk
Parke Circuit Court
Parke County, Indiana

STATE OF INDIANA	)	IN THE PARKE CIRCUIT COURT
	) SS:	
COUNTY OF PARKE	)	CAUSE NO.

TIFFANY SMITH,

Plaintiff,

v.

CORIZON, LLC,
KRISTA L. SEXTON-COX, D.O,
RICHARD HINCHMAN, M.D.,
PAMELA F. JOHNSON, F.N.P.,
LOU LAMB, R.N., and
DEBORAH L. JONES, L.P.N.,

Defendants.

COMPLAINT FOR DAMAGES AND REQUEST FOR JURY TRIAL

Plaintiff, Tiffany Smith, by counsel, for this Complaint for Damages, states as follows:

1. Plaintiff filed her Proposed Complaint with the Department of Insurance on March 3, 2018.

2. The Medical Review Panel was formed and convened and rendered their opinion on February 25, 2021 before the Indiana Department of Insurance.

3. Plaintiff also filed a Complaint with the United States District Court, Southern District of Indiana on March 1, 2018 alleging federal claims and state law claims against the Defendants.

4. On June 15, 2021, the US District Court dismissed the Plaintiff's Federal Claims and relinquished its supplemental jurisdiction over Plaintiff's state law claims to be pursued in state court.

5. At all times relevant, Plaintiff, Tiffany Smith, was an inmate at Rockville Correctional Facility in Parke County, Indiana.

6. At all times relevant, Defendant Corizon, LLC was in the business of providing medical services to inmates at the Rockville Correctional Facility in Parke County, Indiana.

7. All acts and omissions of Corizon, LLC alleged were performed or omitted by employees of Corizon, LLC while acting within the scope of their employment.

8. At all times relevant, Defendant Krista L. Sexton-Cox, DO was a qualified health care provider under the terms of Indiana Code § 34-18-2-14. Krista L. Sexton-Cox, D.O. was providing medical services to inmates at the Rockville Correctional Facility in Parke County, Indiana and an employee of Corizon, LLC.

9. At all times relevant, Defendant Richard Hinchman, MD was a qualified health care provider under the terms of Indiana Code § 34-18-2-14. Richard Hinchman, M.D. was providing medical services to inmates at the Rockville Correctional Facility in Parke County, Indiana and an employee of Corizon, LLC.

10. At all times relevant, Defendant Pamela F. Johnson, FNP was a qualified health care provider under the terms of Indiana Code § 34-18-2-14. Pamela F. Johnson, F.N.P. was providing medical services to inmates at the Rockville Correctional Facility in Parke County, Indiana and an employee of Corizon, LLC.

11. At all times relevant, Lou Lamb, RN was a licensed health care provider in the State of Indiana. Lou Lamb, R.N. was providing medical services to inmates at the Rockville Correctional Facility in Parke County, Indiana and an employee of Corizon, LLC.

12. At all times relevant, Deborah L. Jones, LPN was a licensed health care provider in the State of Indiana. Deborah L. Jones, L.P.N. was providing medical services to inmates at the Rockville Correctional Facility in Parke County, Indiana and an employee of Corizon, LLC.

13. On August 10, 2016 at approximately 10:57 pm, Plaintiff Tiffany Smith reported to the Rockville Correctional Facility Infirmary (hereinafter "Infirmary") with complaints of "stomach pain lower all the way to back." Plaintiff Tiffany Smith reported she was experiencing constant stabbing, shooting pain around her right side into the back right side of her abdomen. Additionally, her abdomen was swollen. She also reported decreased appetite, nausea, and vomiting. Lou Lamb, RN saw Plaintiff Tiffany Smith. Nurse Lamb noted that Plaintiff Tiffany Smith's abdomen was very tender to touch and visible swelling below and to the right side of her umbilical area.

14. Plaintiff Tiffany Smith was sent back to her housing unit on August 10, 2016.

15. On August 11, 2016, Plaintiff Tiffany Smith returned to the Infirmary. Plaintiff Tiffany Smith was seen by Defendant Pamela F. Johnson, FNP. Plaintiff Tiffany Smith reported right lower quadrant pain that "won't quit." Plaintiff Tiffany Smith had slight abdominal swelling and abdominal guarding with palpitation. Defendant Pamela F. Johnson, FNP noted Plaintiff Tiffany Smith's pain was in her left lower belly.

16. Defendant Pamela F. Johnson, FNP ordered a CBC with differential and chemical profile 29. Plaintiff Tiffany Smith's lab results returned that day for WBCs up to 12.4 and Hgb 11.4.

17. Defendant Pamela F. Johnson, FNP reported the results to Defendant Richard Hinchman, MD and Defendant Krista L. Sexton-Cox, DO.

18. Defendant Richard Hinchman, MD ordered a urinalysis and if negative, to see if the next CBC showed an increase in WBCs.

19. Defendant Krista L. Sexton-Cox, DO ordered Plaintiff Tiffany Smith be admitted to the infirmary and ordered another CBC.

20. Plaintiff Tiffany Smith was admitted to the Infirmary overnight.

21. On August 12, 2016 at approximately 2:31 pm, Plaintiff was seen by Defendant Pamela F. Johnson, FNP. Plaintiff Tiffany Smith had been sleeping all day and taking Tylenol and Ibuprofen for pain. Plaintiff Tiffany Smith was experiencing right lower quadrant pain with abdominal swelling.

22. On August 12, 2016, Defendant Pamela F. Johnson, FNP consulted with Defendant Krista L. Sexton-Cox, DO. Defendant Krista L. Sexton-Cox, DO ordered to not allow pain medication, repeat her CBC on Monday (August 18, 2016), monitor vital signs, administer IV fluids, and keep Plaintiff Tiffany Smith in the Infirmary.

23. On August 12, 2016 at approximately 4:48 pm, Defendant Krista L. Sexton-Cox, DO documented Plaintiff Tiffany Smith had abdominal pain, decreased appetite, change in bowel habits, nausea, bowel sounds x4, hypoactive on the right upper and lower quadrants with tenderness on the right lower quadrant.

24. On August 12, 2016 at approximately 8:14 pm, Plaintiff Tiffany Smith's temperature was 102.0 degrees and she rated her pain as ten out of ten. Corizon employee Deborah L. Jones, LPN examined Plaintiff Tiffany Smith and noted diffuse tenderness with localized tenderness and guarding in the right lower quadrant. Additionally, Plaintiff Tiffany

Smith was experiencing decreased appetite chills, fever, fatigue, and malaise. Plaintiff Tiffany Smith described her pain as stabbing. Corizon employee Vada Yates, ASN reported Plaintiff Tiffany Smith's condition to the physician who ordered Tylenol.

25. Plaintiff Tiffany Smith reported her symptoms to Defendants Lou Lamb and Defendant Deborah Jones on August 11 and August 12, 2016.

26. On August 12, 2016 at approximately 8:50 pm, Defendant Krista L. Sexton-Cox, DO ordered Plaintiff Tiffany Smith to be sent to the emergency room.

27. Plaintiff Tiffany Smith was transported to Terre Haute Regional Hospital.

28. Plaintiff Tiffany Smith underwent an abdominal CT which confirmed a perforated appendicitis and appendicolith.

29. Plaintiff Tiffany Smith was diagnosed with acute appendicitis with generalized peritonitis, anemia, and hypokalemia.

30. On August 13, 2016, Plaintiff Tiffany Smith underwent a laparoscopic appendectomy. The surgeon, Dr. Timothy Darnauer, noted that Plaintiff Tiffany Smith's abdomen was gangrenous and friable with surrounding inflammatory tissue and pus.

31. Plaintiff Tiffany Smith remained in the care of Terre Haute Regional Hospital until August 17, 2016.

32. Defendants, each of them, failed to diagnose Plaintiff Tiffany Smith's appendicitis and treat her in a timely manner.

33. As a proximate result of the Defendants' negligence, Plaintiff Tiffany Smith has been injured and damaged as follows:

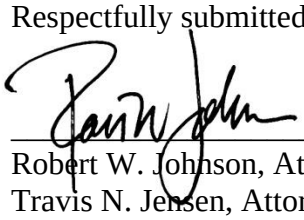
a. She sustained an extremely painful abscesses and infections;
b. The abscesses in her abdomen and required surgical repair;
c. Significant scarring from surgical wounds; and
d. Pain, suffering and mental anguish.

WHEREFORE, Plaintiff Tiffany Smith prays for damages against the Defendants in an amount which will fully and fairly compensate her for her damages sustained, for costs of this action, for prejudgment interest, and for all other just and proper relief in the premises.

DEMAND FOR JURY TRIAL

Plaintiff requests a trial by jury.

Respectfully submitted,



Robert W. Johnson, Attorney No. 17391-49
Travis N. Jensen, Attorney No. 22409-49
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BEFORE THE INDIANA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE DIVISION

TIFFANY SMITH, Plaintiff, vs. CORIZON, INC., CORIZON HEALTH, INC., KRISTA L. SEXTON-COX, D.O., RICHARD HINCHMAN, M.D., AND PAMELA F. JOHNSON, FNP Defendants.	)	Claim No. 1019036

SUBMISSION OF PLAINTIFF TIFFANY SMITH
TO THE MEDICAL REVIEW PANEL

MEDICAL REVIEW PANEL:

Rex A. Allman, M.D.
Pulaski Memorial Medical and Surgical Group
540 Hospital Drive
Winamac, IN 46996-1173

Kent W. Erb, M.D.
Sheridan Family Medicine
611 E. 10th Street
Sheridan, IN 46069-9106

Linda K. Han, M.D.
PPG – Oncology
11104 Parkview Circle Dr., Suite 010
Fort Wayne, IN 46845-1672

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Indianapolis, IN 46204
Attorneys for Plaintiff

Carol A. Dillon
Ashlie K. Keaton
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Indianapolis, Indiana 46250-4365
Attorneys for Defendant

BEFORE THE INDIANA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE DIVISION

TIFFANY SMITH, Plaintiff, vs. CORIZON, INC., CORIZON HEALTH, INC., KRISTA L. SEXTON-COX, D.O., RICHARD HINCHMAN, M.D., AND PAMELA F. JOHNSON, FNP Defendants.	)	Claim No. 1019036

SUBMISSION OF PLAINTIFF TIFFANY SMITH
TO THE MEDICAL REVIEW PANEL

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BEFORE THE INDIANA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE DIVISION

TIFFANY SMITH, Plaintiff, vs. CORIZON, INC., CORIZON HEALTH, INC., KRISTA L. SEXTON-COX, D.O., RICHARD HINCHMAN, M.D., AND PAMELA F. JOHNSON, FNP Defendants.	)	Claim No. 1019036

SUBMISSION OF PLAINTIFF TIFFANY SMITH
TO THE MEDICAL REVIEW PANEL

LIST OF EXHIBITS

Proposed Complaint for Damages

Indiana Department of Corrections, Corizon, Inc. medical records (Corizon records)

Terre Haute Regional Hospital medical records (THRH records)

Union Hospital medical records

BEFORE THE INDIANA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE DIVISION

TIFFANY SMITH, Plaintiff, vs. CORIZON, INC., CORIZON HEALTH, INC., KRISTA L. SEXTON-COX, D.O., RICHARD HINCHMAN, M.D., AND PAMELA F. JOHNSON, FNP Defendants.	)	Claim No. 1019036

SUBMISSION OF PLAINTIFF TIFFANY SMITH
TO THE MEDICAL REVIEW PANEL

I. INTRODUCTION

Plaintiff, Tiffany Smith ("the Patient"), filed her Proposed Complaint for Damages with Indiana Department of Insurance on March 3, 2018. The Proposed Complaint alleges that:

- The medical staff of Corizon, Inc. and Corizon Health, Inc. ("Corizon")
- Krista L. Sexton-Cox, D.O. ("Dr. Cox"),
- Richard Hinchman, M.D. ("Dr. Hinchman"), and
- Pamela F. Johnson, FNP ("NP Johnson")

each were negligent in their care as they **failed to diagnose the Patient's appendicitis and treat her promptly while she was a patient in their care**. The Defendants – each – Corizon, Dr. Cox, Dr. Hinchman and NP Johnson knew that the Patient was reporting a sudden onset of abdominal pain on her lower right side, vomiting, nausea, and loss of appetite. The Defendants also knew that the Patient's abdomen was swollen, her WBC was elevated, and she was in pain. Yet, despite this knowledge, the Defendants did not include appendicitis in their differential diagnosis. Instead, they waited until she had a 102-degree fever before sending her to an emergency room.

Because of the Defendants' negligence, the Patient's appendectomy was performed **after** her appendix had ruptured, the Patient experienced infection and abscesses which required surgical

repair; several weeks of wound vac treatment; significant scarring from surgical wounds; and pain, suffering and mental anguish. (TAB 1: Proposed Complaint for Damages.)

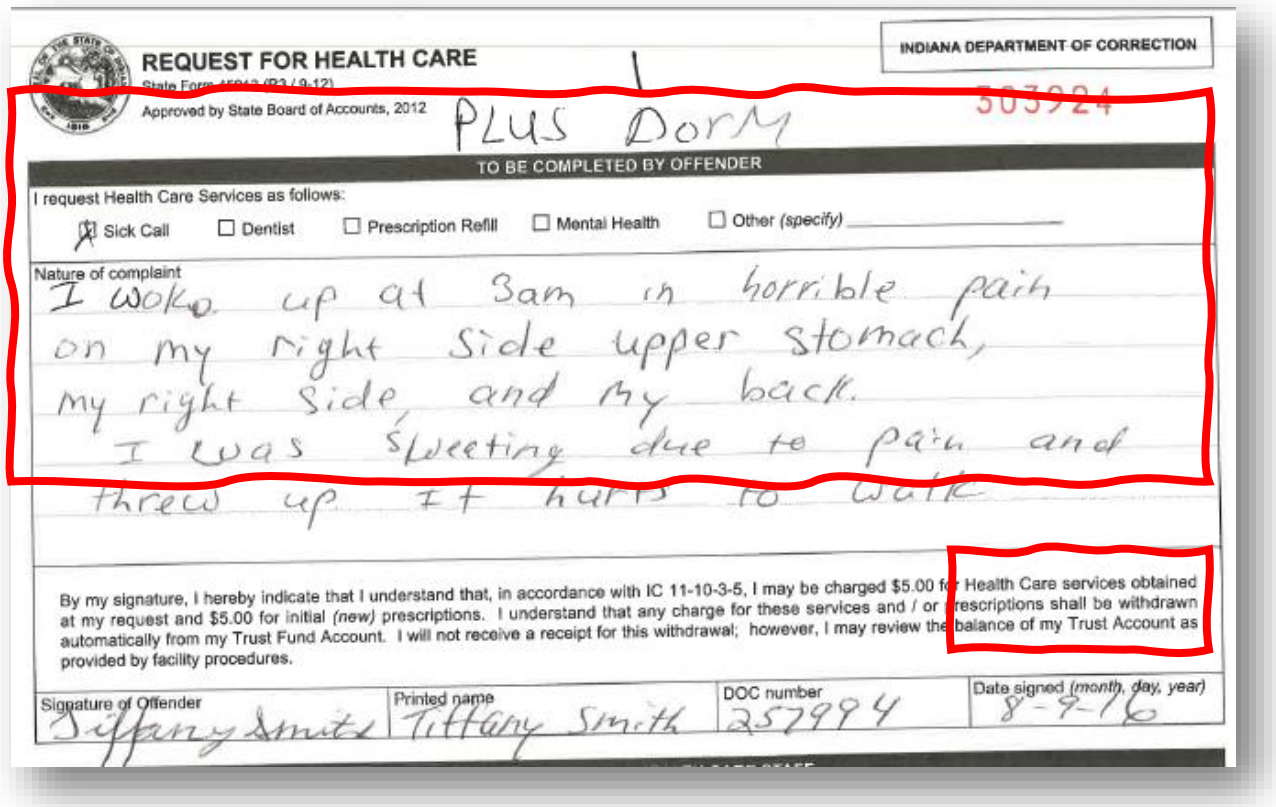
II. CHRONOLOGIC STATEMENT OF FACTS

August 9, 2016 at 3:00 AM

Rockville Correctional Facility

On August 9, 2016 at 03:00 hours, the Patient, age 35, experienced **a sudden onset of pain in the right lower quadrant of her abdomen** while sleeping in her housing unit. During the daytime hours on August 9, the Patient made a written request to visit to the Infirmary at the Rockville Correctional Facility.

(TAB 2, Corizon Records, p. 871.) The Patient was not seen in the Infirmary on August 9.



REQUEST FOR HEALTH CARE

State Form 45613 (R3 / 9-12)

Approved by State Board of Accounts, 2012

INDIANA DEPARTMENT OF CORRECTION

PLUS Dorm

503924

TO BE COMPLETED BY OFFENDER

I request Health Care Services as follows:

☒ Sick Call ☐ Dentist ☐ Prescription Refill ☐ Mental Health ☐ Other (specify) _____

Nature of complaint

I woke up at 3am in horrible pain on my right side upper stomach, my right side, and my back. I was sweeting due to pain and threw up. It hurts to walk

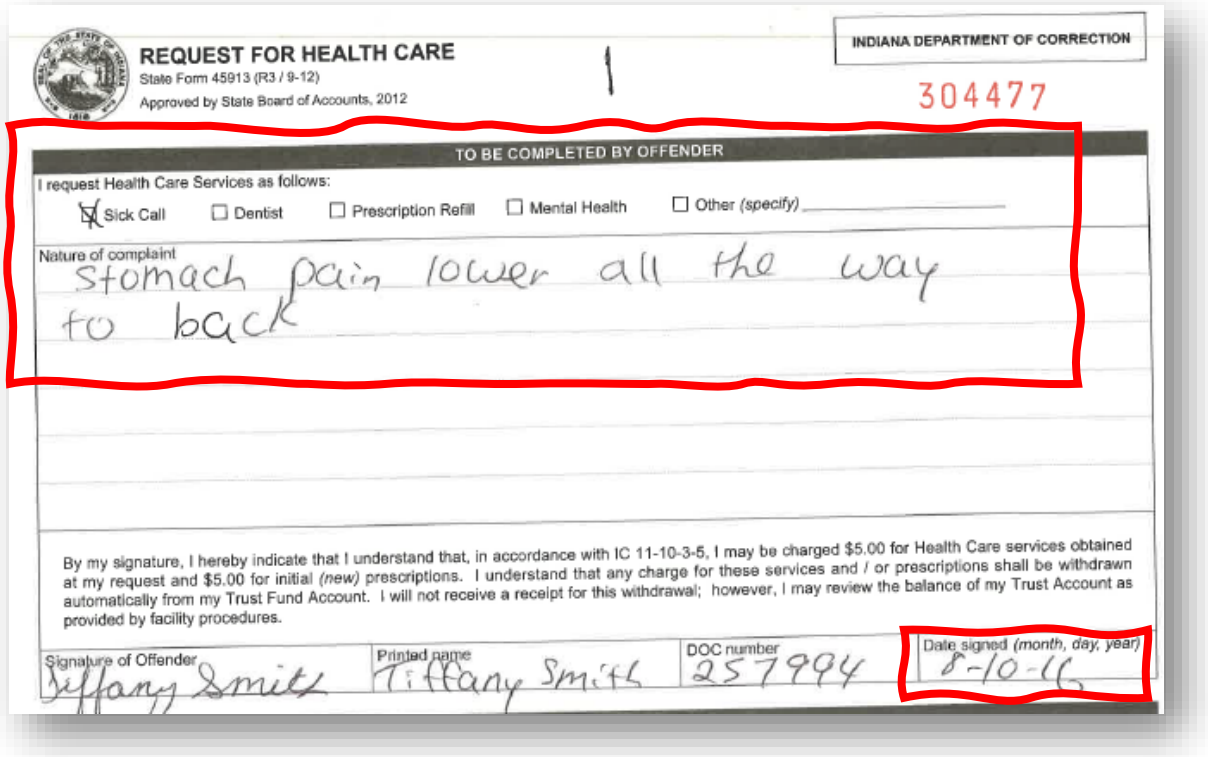
By my signature, I hereby indicate that I understand that, in accordance with IC 11-10-3-5, I may be charged $5.00 for Health Care services obtained at my request and $5.00 for initial (new) prescriptions. I understand that any charge for these services and / or prescriptions shall be withdrawn automatically from my Trust Fund Account. I will not receive a receipt for this withdrawal; however, I may review the balance of my Trust Account as provided by facility procedures.

Signature of Offender	Printed name	DOC number	Date signed (month, day, year)
Tiffany Smith	Tiffany Smith	257994	8-9-16

August 10, 2016

Rockville Correctional Facility

On August 10, 2016, the Patient made a **second** written request to be seen in the Infirmary because of the stomach pain. In this request, she described her symptoms again:



REQUEST FOR HEALTH CARE
State Form 45913 (R3 / 9-12)
Approved by State Board of Accounts, 2012

INDIANA DEPARTMENT OF CORRECTION
304477

TO BE COMPLETED BY OFFENDER

I request Health Care Services as follows:
☒ Sick Call ☐ Dentist ☐ Prescription Refill ☐ Mental Health ☐ Other (specify) _____

Nature of complaint
Stomach pain lower all the way to back

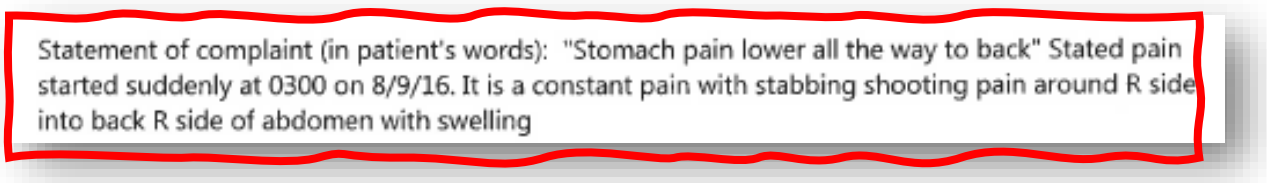
By my signature, I hereby indicate that I understand that, in accordance with IC 11-10-3-5, I may be charged $5.00 for Health Care services obtained at my request and $5.00 for initial (new) prescriptions. I understand that any charge for these services and / or prescriptions shall be withdrawn automatically from my Trust Fund Account. I will not receive a receipt for this withdrawal; however, I may review the balance of my Trust Account as provided by facility procedures.

Signature of Offender	Printed name	DOC number	Date signed (month, day, year)
Tiffany Smith	Tiffany Smith	257994	8-10-16

(TAB 3, Corizon Records, p. 872.)

Rockville Correctional Facility Infirmary

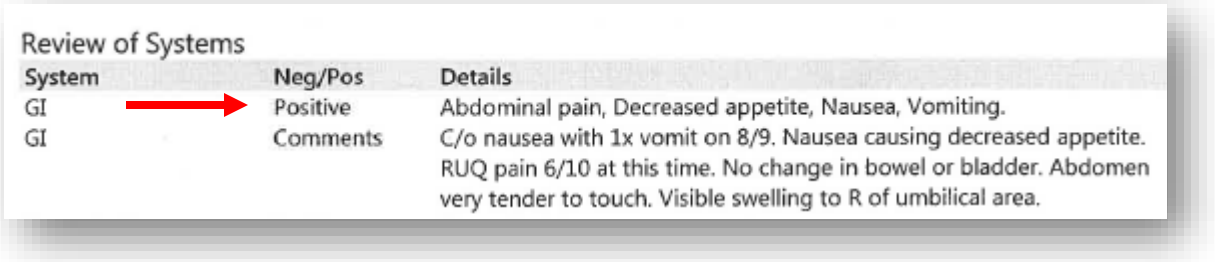
Late in the evening of August 10, 2016 at 22:57 hours, the Patient was seen in the Infirmary for a nurse visit with Lou Lamb, RN. The Patient told the nurse the pain **started suddenly** at 03:00 AM on August 9, 2016. **The pain was constant and stabbing/shooting around the right side into the back-right side of the abdomen** with swelling.



Statement of complaint (in patient's words): "Stomach pain lower all the way to back" Stated pain started suddenly at 0300 on 8/9/16. It is a constant pain with stabbing shooting pain around R side into back R side of abdomen with swelling

(TAB 4, Corizon Records, p. 33.)

The Patient's vital signs were: B/P: 128/80, P: 82, and T: 98.3. She complained of "stomach pain lower all the way to back." **She awoke from sleep with a sudden onset of pain** (10/10) at 3:00 a.m. on August 9, 2016. She described the pain as constant with **stabbing/shooting pain around right side** into the back-right side of abdomen **with swelling**.



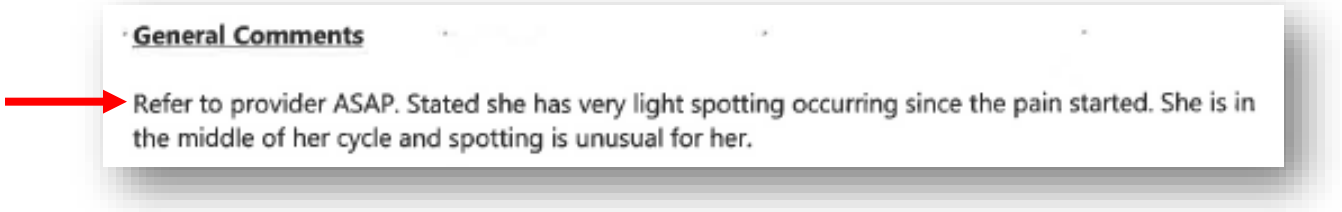
Review of Systems

System	Neg/Pos	Details
GI	Positive	Abdominal pain, Decreased appetite, Nausea, Vomiting.
GI	Comments	C/o nausea with 1x vomit on 8/9. Nausea causing decreased appetite. RUQ pain 6/10 at this time. No change in bowel or bladder. Abdomen very tender to touch. Visible swelling to R of umbilical area.

(TAB 4, Corizon Records, p. 35.)

Ninety minutes after taking the Ibuprofen, her Pain was 6/10. Vital signs were recorded as: BP 128/80, pulse 82, respirations 18, and temperature 98.3. Besides abdominal pain, the Patient also reported **decreased appetite, nausea and vomiting**. She stated she had no changes in her bowel or bladder. Her abdomen was **very tender** to touch and there was visible swelling to the right of the umbilicus. Finally, the Patient reported that she was in the middle of her menstrual cycle and had light spotting since the pain occurred, which was unusual for her.

Nurse Lamb contacted a "provider" but did not identify this person. But despite the subjective and objective findings, Nurse Lamb sent the Patient back to her housing unit and instructed her to contact Sick Call if her symptoms did not subside or became worse. Nurse Lamb did note, however, to **refer to provider ASAP**.



General Comments

Refer to provider ASAP. Stated she has very light spotting occurring since the pain started. She is in the middle of her cycle and spotting is unusual for her.

(TAB 4, Corizon records, pp. 33-36.)

August 11, 2016

Rockville Correctional Facility Infirmary

On August 11, 2016 at 07:46 hours, the Patient returned to the Infirmary, about 53 hours since the onset of her symptoms. She saw a provider, Defendant NP Johnson. The Patient reported that she had a **right lower quadrant pain that "won't quit"** and that she had been taking Ibuprofen constantly. The Patient rated her pain as 7/10. She also reported that she had regular periods and spotted before this cycle.

History of Present Illness:
1. Abdominal Pain RLQ
Pt states woke up Tues this week at 3 am with RLQ pain that wont quit. She has been taking IBU constantly since and no fever noted.
No constipation
LMP 8/10/16
She usually has regular periods and started spotting prior to this period
Pain Level 7/10

(TAB 4, Corizon Records, p. 37.)

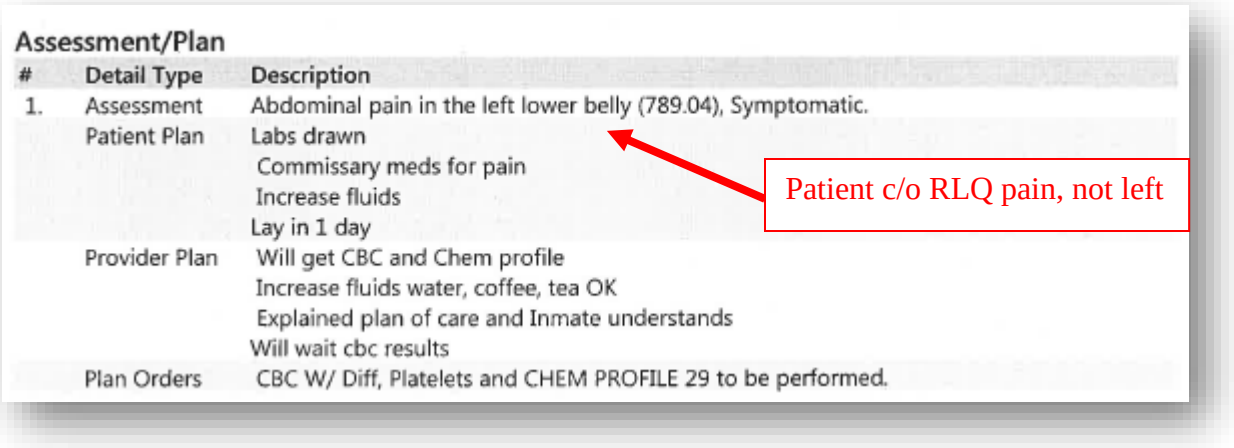
On examination, **slight swelling was noted in the abdomen**. Vital signs were: T: 97.8, B/P: 124/76, P: 98. She had **abdominal guarding with palpation**. Obturator and psoas signs were normal.

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress - due to pain.
Constitutional	Normal	Well nourished. Well developed.
Respiratory	Normal	Inspection - Normal. Auscultation - Normal. Palpation - Normal. Chest wall tenderness - Absent. Cough - Absent. Effort - Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Heart sounds - Normal S1, Normal S2. Extra sounds - None. Murmurs - None. Extremities - Normal.
Abdomen	*	Anterior palpation - Guarding. Abdominal tenderness - RLQ.
Abdomen	Comments	just started period slight rebound She pointed to spot on abdomen for pain RLQ
Abdomen	Normal	Auscultation - Normal. Percussion - Normal. Anterior palpation - No rebound. Obturator sign - Normal. Psoas sign - Normal.

(TAB 4, Corizon records, p. 38.)

Despite the subjective and objective findings, the NP Johnson's plan was to (1) draw a CBC with differential and Chemical profile 29, (2) commissary for medications, (3) increase fluids and (4) have the Patient lay in for one (1) day 24-hour work related restriction due to pain. She was confined to her cell except for meals, medications, and bathroom.



Assessment/Plan

#	Detail Type	Description
1.	Assessment	Abdominal pain in the left lower belly (789.04), Symptomatic.
	Patient Plan	Labs drawn
		Commissary meds for pain
		Increase fluids
		Lay in 1 day
	Provider Plan	Will get CBC and Chem profile
		Increase fluids water, coffee, tea OK
		Explained plan of care and Inmate understands
		Will wait cbc results
	Plan Orders	CBC W/ Diff, Platelets and CHEM PROFILE 29 to be performed.

Patient c/o RLQ pain, not left

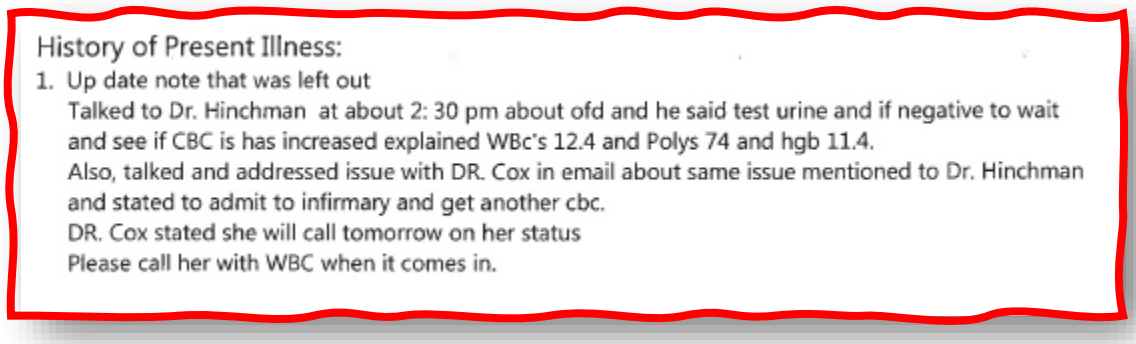
(TAB 4, Corizon records, p. 39.)

The Patient's labs returned that day revealed an **elevated WBC 12.29** [3.66-11.99], polys 84.2 [36.0-78.0] with a decreased hemoglobin 11.3 [11.5-15.6] and hematocrit within normal limits.

NP Johnson spoke with Defendant Dr. Hinchman at about 14:30 hours who recommended testing the Patient's urine and if negative, to see if the next CBC shows an increase in WBCs.

NP Johnson also spoke with Defendant Dr. Kristie Cox. The Patient was admitted to the Infirmary and the plan was to obtain another CBC the next morning.

Defendant Dr. Cox would call tomorrow on her status.



History of Present Illness:

1. Up date note that was left out
   Talked to Dr. Hinchman at about 2: 30 pm about ofd and he said test urine and if negative to wait and see if CBC is has increased explained WBc's 12.4 and Polys 74 and hgb 11.4.
   Also, talked and addressed issue with DR. Cox in email about same issue mentioned to Dr. Hinchman and stated to admit to infirmary and get another cbc.
   DR. Cox stated she will call tomorrow on her status
   Please call her with WBC when it comes in.

(TAB 4, Corizon records, p. 42.)

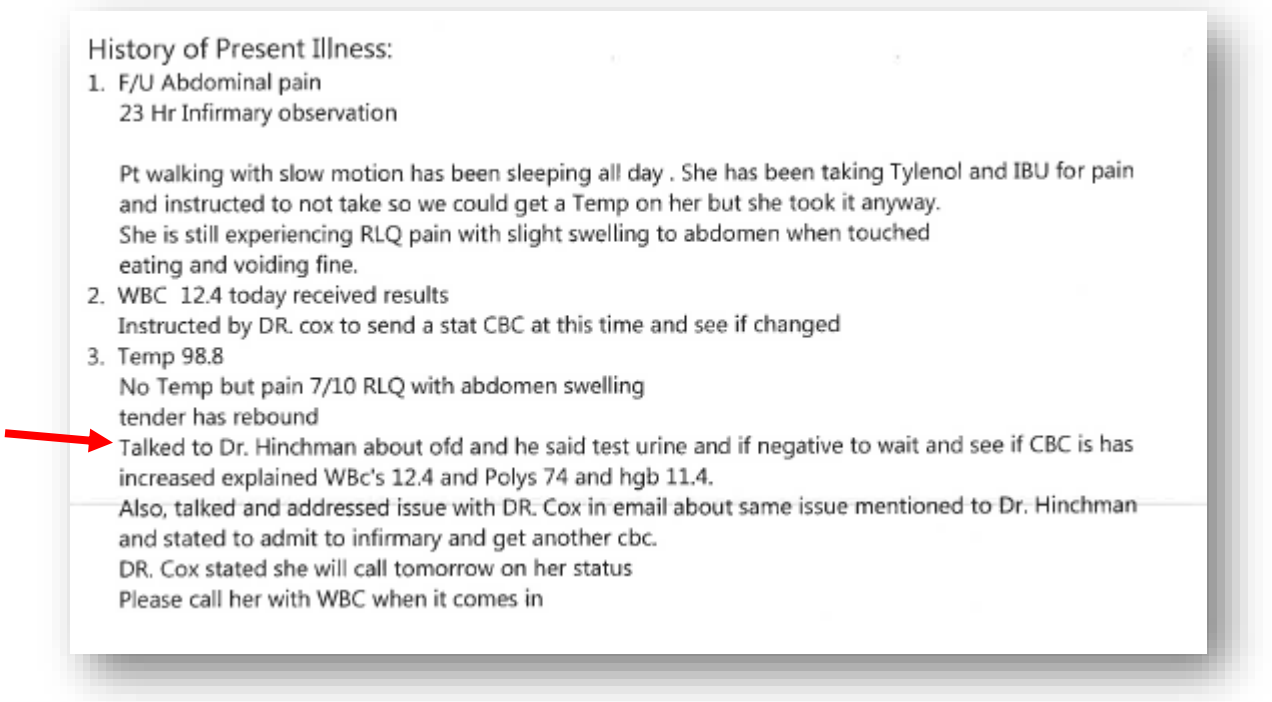
As of August 11, 2016, the medical documentation shows Defendant NP Johnson, Defendant Dr. Hinchman, and Defendant Dr. Cox communicated with each other and each aware of the Patient's condition, reported symptoms, and objective findings.

August 12, 2016

Rockville Correctional Facility Infirmary

On August 12, 2016 at 14:31 hours, Defendant NP Johnson saw the Patient in the Infirmary for a **third** time **in the 3½ days** since the onset of the Patient's symptoms. (Corizon records, pp. 44-46.)

Defendant NP Johnson documented that the Patient had been sleeping all day and taking Tylenol and Ibuprofen for pain, even though she had been told not to take pain medication so Infirmary staff could take her temperature. She continued to have right lower quadrant pain with slight swelling, pain 7/10, and rebound tenderness noted. Her WBC of 12.4 was noted. Defendant NP Johnson notes discussions with both Defendant Dr. Hinchman and Defendant Dr. Cox. Defendant Dr. Hinchman told Defendant NP Johnson to test the urine, and if negative, see if CBC is increased. Defendant NP Johnson noted that she was **"instructed by Dr. Cox to send a stat CBC at this time and see if changed."** (TAB 4, Corizon records, pp. 44-46.)



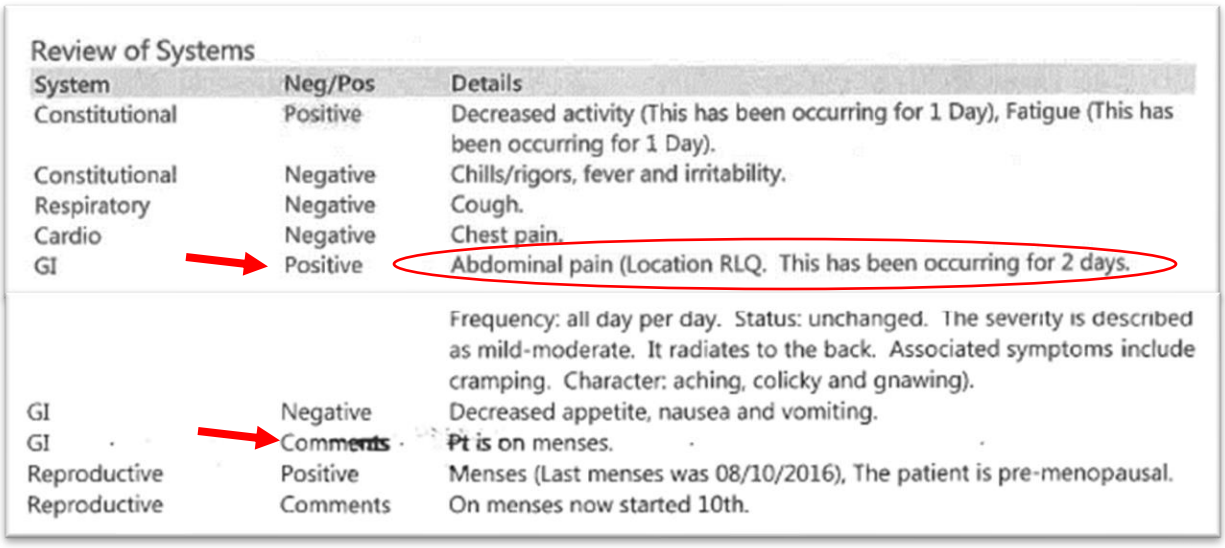
History of Present Illness:

1. F/U Abdominal pain
   23 Hr Infirmary observation

   Pt walking with slow motion has been sleeping all day . She has been taking Tylenol and IBU for pain and instructed to not take so we could get a Temp on her but she took it anyway.
   She is still experiencing RLQ pain with slight swelling to abdomen when touched
   eating and voiding fine.
2. WBC 12.4 today received results
   Instructed by DR. cox to send a stat CBC at this time and see if changed
3. Temp 98.8
   No Temp but pain 7/10 RLQ with abdomen swelling
   tender has rebound
   Talked to Dr. Hinchman about ofd and he said test urine and if negative to wait and see if CBC is has increased explained WBc's 12.4 and Polys 74 and hgb 11.4.
   Also, talked and addressed issue with DR. Cox in email about same issue mentioned to Dr. Hinchman and stated to admit to infirmary and get another cbc.
   DR. Cox stated she will call tomorrow on her status
   Please call her with WBC when it comes in

(TAB 4, Corizon records, p. 44.)

Her temperature was 98.8, other vital signs were within normal limits. The Patient had decreased activity and fatigue for one day, right lower quadrant abdominal pain constant for two days with mild-moderate severity. Pain radiated to the back with cramping. Pain was described as "aching, colicky and gnawing." LMP: Current; 8/10/2016. (TAB 4, Corizon records, pp. 44-46.)

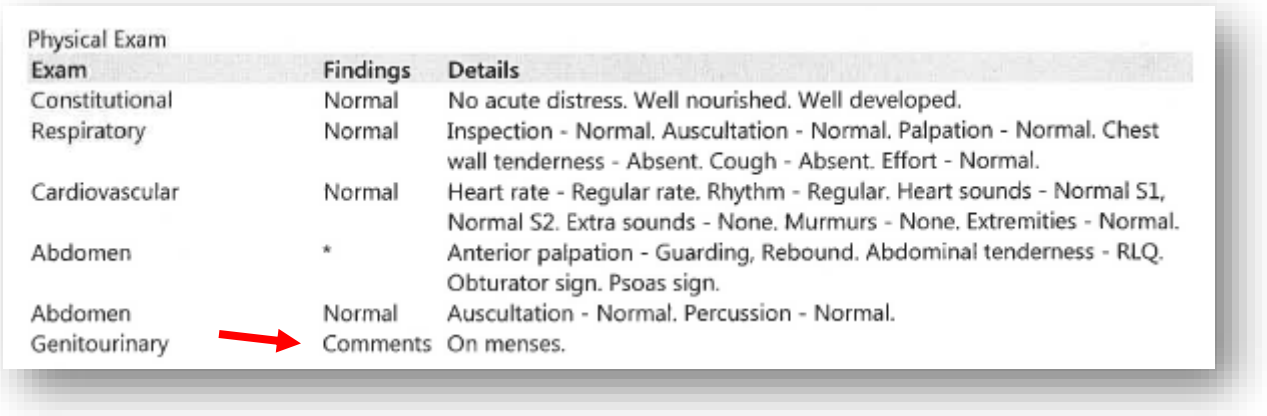


Review of Systems

System	Neg/Pos	Details
Constitutional	Positive	Decreased activity (This has been occurring for 1 Day), Fatigue (This has been occurring for 1 Day).
Constitutional	Negative	Chills/rigors, fever and irritability.
Respiratory	Negative	Cough.
Cardio	Negative	Chest pain.
GI	Positive	Abdominal pain (Location RLQ. This has been occurring for 2 days. Frequency: all day per day. Status: unchanged. The severity is described as mild-moderate. It radiates to the back. Associated symptoms include cramping. Character: aching, colicky and gnawing).
GI	Negative	Decreased appetite, nausea and vomiting.
GI	Comments	Pt is on menses.
Reproductive	Positive	Menses (Last menses was 08/10/2016), The patient is pre-menopausal.
Reproductive	Comments	On menses now started 10th.

(TAB 4, Corizon records, pp. 44-45.)

On exam, right lower quadrant abdominal tenderness with guarding and rebound noted. Defendant NP Johnson documented **obturator sign and psoas signs**.



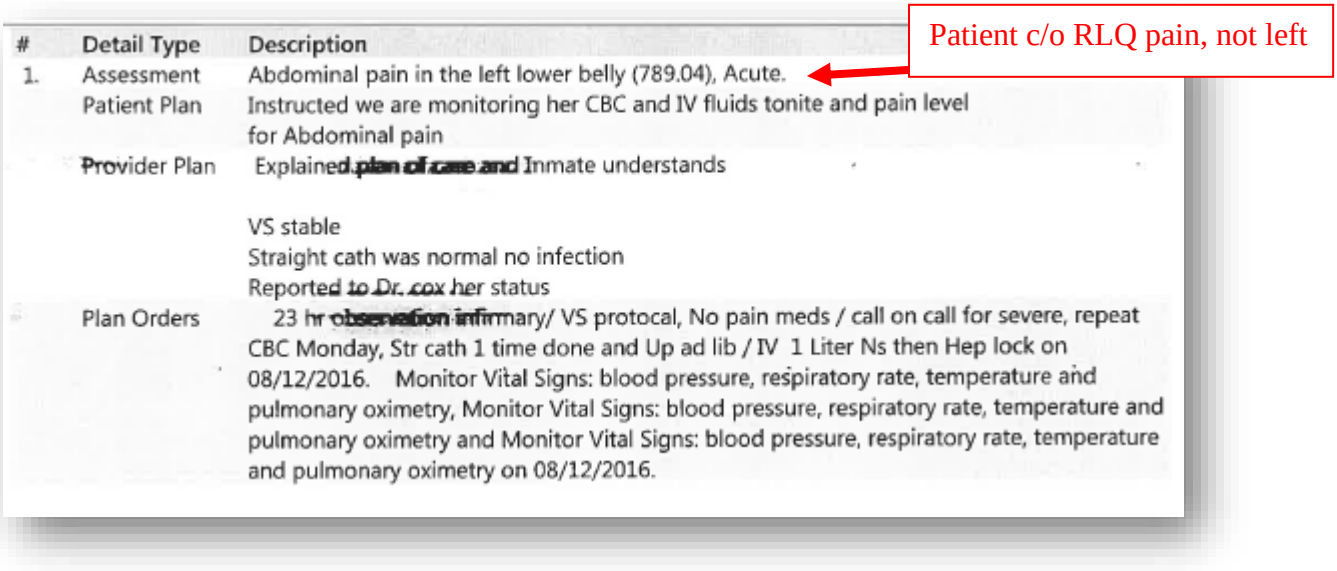
Physical Exam

Exam	Findings	Details
Constitutional	Normal	No acute distress. Well nourished. Well developed.
Respiratory	Normal	Inspection - Normal. Auscultation - Normal. Palpation - Normal. Chest wall tenderness - Absent. Cough - Absent. Effort - Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Heart sounds - Normal S1, Normal S2. Extra sounds - None. Murmurs - None. Extremities - Normal.
Abdomen	*	Anterior palpation - Guarding, Rebound. Abdominal tenderness - RLQ. Obturator sign. Psoas sign.
Abdomen	Normal	Auscultation - Normal. Percussion - Normal.
Genitourinary	Comments	On menses.

(TAB 4, Corizon records, p. 45.)

Defendant NP Johnson's plan was to continue observation in the Infirmary with monitoring vital signs, no pain medications, repeat CBC on Monday (August 15.) Defendant NP Johnson -- after consultation with both Defendant Dr. Hinchman and Defendant Dr. Cox -- the plan was to

not allow pain medication, **repeat her CBC on Monday (August 15)**, monitor vital signs, administer IV fluids and keep her in the Infirmary for 23-hour observation. (TAB 4, Corizon records, p. 45.)



#	Detail Type	Description
1.	Assessment	Abdominal pain in the left lower belly (789.04), Acute.
	Patient Plan	Instructed we are monitoring her CBC and IV fluids tonite and pain level for Abdominal pain
	Provider Plan	Explained plan of care and Inmate understands VS stable Straight cath was normal no infection Reported to Dr. cox her status
	Plan Orders	23 hr observation infirmary/ VS protocal, No pain meds / call on call for severe, repeat CBC Monday, Str cath 1 time done and Up ad lib / IV 1 Liter Ns then Hep lock on 08/12/2016. Monitor Vital Signs: blood pressure, respiratory rate, temperature and pulmonary oximetry, Monitor Vital Signs: blood pressure, respiratory rate, temperature and pulmonary oximetry and Monitor Vital Signs: blood pressure, respiratory rate, temperature and pulmonary oximetry on 08/12/2016.

(TAB 4, Corizon records, p. 46.)

Again, the medical documentation shows Defendant NP Johnson, Defendant Dr. Hinchman, and Defendant Dr. Cox communicated with each other and each aware of the Patient's condition.

At 15:28, the Patient was catheterized by Defendant NP Johnson and resting in the Infirmary. (TAB 4, Corizon records, p. 47.)

At 16:48, Defendant Dr. Cox documented the Patient had a complaint of for abdominal pain, change in bowel habits, decreased appetite, and nausea; she denied urinary symptoms. Right lower quadrant tenderness with hypoactive bowel sounds was detected on exam. Her temperature was 98.3, other vital signs were within normal limits. (TAB 4, Corizon records, pp. 49-50.)

At 20:14, three and a half hours later, the Patient's **temperature was up to 102.0.** Pulse was 97 and B/P was 130/88. On exam, she had diffuse tenderness with localized tenderness and **guarding to the right lower quadrant**. **She rated her pain 10/10. The Patient now had chills, fever, fatigue and malaise and decreased appetite.** Nurse Yates called the physician [name not documented] at 20:37, who ordered Tylenol 325 mg., 3 tablets orally every six hours. Tylenol was given as ordered at 20:45. Repeat vital signs at 21:12 p.m. noted: Temperature 99.4, BP 106/76 (lying), pulse 107, and respirations 21. Awaiting stat CBC results. (TAB 4, Corizon records, pp. 52-54.)

At 20:14, Defendant Dr. Cox noted the Patient's pain was elevated and now has a fever. (TAB 4, Corizon records, pp. 55-56.)

At 20:50 p.m., Defendant Dr. Cox called with orders to send the Patient to the emergency department. (TAB 4, Corizon records, p. 58.)

Ambulance to Terre Haute Regional Hospital

The Patient was transported by ambulance to Terre Haute Regional Hospital Emergency Department where she was evaluated by the ER physician. A CT of the abdomen and pelvis, with contrast, was performed which demonstrated perforated appendicitis and appendicolith, as well a small pericardial effusion. No definite abscess was seen on the CT. Her diagnoses included: **rupture of appendix**, anemia, elevated sedimentation rate, hypokalemia, and leukocytosis. Her medical history was significant for Gravida 3 with caesarean section x2, LEEP [Loop Electrosurgical Excision Procedure], and [cervical] cancer. **Diagnoses included acute appendicitis with generalized peritonitis, anemia, and hypokalemia.** (TAB 4, Corizon records, pp. 59-60 and TAB 5, Terre Haute Regional Hospital records, pp 4-12.)

August 13, 2016

Terre Haute Regional Hospital Admission (08/13/2016 – 08/17/2016)

Early in the morning on August 13, 2016, the Patient was evaluated by general surgeon Timothy Darnauer, DO. The Patient related a history of abdominal pain with fevers and chills, and vomiting (once) since August 9, 2016. On exam, Dr. Darnauer observed right lower quadrant tenderness with rebound, no guarding or distension were noted. Her temperature was 99.5, and other vital signs were within normal limits. Dr. Darnauer concluded her physical exam, and the CT results, suggested **acute perforated appendicitis**, and he recommended a **laparoscopic appendectomy**. Intravenous Unasyn, an antibiotic was ordered and initiated. (TAB 5, THRH records, pp. 28-32.)

Appendectomy

The Patient was taken to surgery for a laparoscopic appendectomy performed by Dr. Darnauer. His Operative Note documented that the Patient had been:

> "…**complaining of abdominal pain present since Tuesday August 9, 2016. The patient had one episode of nausea and vomiting at home. However, was not brought in for medical attention until late evening on August 12, 2016 into the morning August 13, 2016…The patient's physical examination was consistent with acute appendicitis.**"

His Operative Note described multiple adhesions covering the appendix, terminal ileum, and cecum. Dissection of the adhesions was necessary to view the appendix which he described as "grossly inflamed," "grossly perforated," and "gangrenous throughout." Pus was draining from the appendix. Serosanguinous fluid in the pelvis and right upper quadrant were suctioned out using suction irrigation. He noted that "once all the remaining fluid had been removed," the site was closed. **Based on his Operative Note, Dr. Darnauer did not irrigate the abdomen, place drains or convert to an open procedure despite decreased visualization and the presence of pus.** An addendum noted the appendix to be friable with inflammatory tissue and pus, no formed abscess was identified. (TAB 5, THRH records, p. 55-57.)

On the evening of August 13, 2016, Dr. Darnauer evaluated the Patient. He noted her laparoscopic incisions to be clean and dry, with tenderness around the incisions. Her abdomen was soft [no evaluation of abdominal distension noted]. Temperatures of 96.1-100.7 were recorded. (TAB 5, THRH records, pp. 49-52, 57.)

August 14, 2016

Terre Haute Regional Hospital

The following day, on August 14, 2016, the Patient was seen by a physician assistant (PA) who noted the incision sites clean and dry. On postoperative day #1, the Patient had a low-grade fever of 100.5, however, her WBC was normal, 6.1. She continued to receive intravenous Unasyn every six hours. The PA auscultated crackles to the right lung field and diminished breath sounds in the left lower lung. A chest x-ray was performed which identified left basilar atelectasis. (TAB 5, THRH records, pp. 44-48.)

August 15, 2016

Terre Haute Regional Hospital

On August 15, 2016, the PA saw the Patient and noted intermittent low-grade fevers despite IV antibiotics. The PA documented the Patient would continue oral antibiotics for five days after her return to the correctional facility, as she was at risk for abscess formation. The Patient's abdomen was soft, distended, but passing flatus and slowly improving. Her incision sites were clean and dry with tenderness at the sites. (TAB 5, THRH records, pp. 40-43.)

August 16, 2016

Terre Haute Regional Hospital

On August 16, 2016, the Patient was examined by an MD and the PA again. Her temperature was 96.9, other vital signs were within normal limits. Antibiotics were discontinued. Although she was passing flatus and had a bowel movement, her abdomen remained distended. Incision sites were clean and dry with tenderness noted around incisions. The PA noted possible discharge that day if abdominal distension improved. The MD documented her concern for risk of abscess formation, given the Patient's abdomen was still distended, and therefore, kept her another day. The MD spoke with Defendant Dr. Cox at the Rockville Corrections Facility regarding the Patient's discharge and was advised she would be cared for in the Infirmary. (TAB 5, THRH records, pp. 36-39.)

August 17, 2016

Terre Haute Regional Hospital - discharge

On August 17, 2016, the Patient was examined by an MD and PA. Vital signs were within normal limits, no fevers recorded. Despite her lingering abdominal distension, the Patient was discharged to the correctional facility and would follow up [with the surgical service] in two weeks. (TAB 5, THRH records, pp. 33-35.)

Rockville Correctional Facility - return

Upon her return to the correctional facility Infirmary on August 17, 2016, her vital signs were normal. Her surgical incisions were well approximated, and no sign of infection was noted. Motrin and Tylenol #3 were ordered for pain. (TAB 6, Corizon records, p. 67-73.)

August 18, 2016

Rockville Correctional Facility Infirmary

On August 18, 2016 a provider note [unsigned] documented a fever of 102.1 that morning. Her fever improved with Tylenol and Motrin. The Patient had mild abdominal tenderness in all quadrants. The provider planned a catheter urinalysis; start treatment with Augmentin, an antibiotic; and repeat a CBC in the morning. A Nursing Note by Jill McMullen, LPN, documented Defendant Dr. Cox knew of the increase in temperature; blood work was drawn and sent; and Ibuprofen was given. A fever of 102.1 with BP 110/60, pulse 100, and respirations 18 were documented. The CBC revealed an elevated WBC 13.6 [3.4-10.8]. (TAB 6, Corizon records, pp. 74-88.)

August 19, 2016

Rockville Correctional Facility Infirmary

On August 19, 2016, the Patient was evaluated by Defendant NP Johnson at 07:00 for constipation and continued right lower quadrant abdominal pain without swelling. No guarding or rebound tenderness noted on exam. Her pain was improved with pain medication. Augmentin was to be given. Colace was ordered, and she was to remain in the Infirmary. Later that day, at 16:30, she complained of increasing left lower quadrant pain and was given Motrin for her pain. Assessment of her abdominal incision revealed no signs of infection. Tachycardia was noted, her pulse was 109, and later documented as 116; other vital signs were within normal limits. Pain was 10/10 in the late afternoon. She was taking Augmentin, an antibiotic. She declined dinner. (TAB 6, Corizon records, pp. 89-98.)

Approximately three hours later, at 20:40 note, on August 19, 2016, the Patient was seen at 20:11 in the Infirmary by Vada Yates, ASN [RN]. The Patient complained of increased abdominal pain. Her BP was initially 104/60, and later 90/42, lying, and her pulse was 106-118. She described her pain as 10/10 and worse pain than when her appendix ruptured. On exam, Nurse Yates noted diffuse abdominal pain to the lower quadrants, and increased tenderness. She reported chills, fatigue, malaise, and decreased appetite**. Defendant NP Johnson was contacted at 20:29 and EMS was called at 20:35**. She was transported to Union Clinton Hospital for further evaluation. (TAB 6, Corizon records, pp. 99-102.)

Union Hospital-Clinton Emergency Department (08/19/2016)

On August 19, 2016 at 21:37, only 2 days after her discharge from Terre Haute Regional Hospital, the Patient was taken to the Union Hospital-Clinton Emergency Room with abdominal pain now on the left side. She rated her pain as a 9/10. She was afebrile. Vital signs were: B/P: 106/69, **P: 118, R: 22**. The Patient was evaluated, and it was noted her **abdomen was diffusely tender, bowel tones were hypoactive and her abdomen was distended** with recent history of appendectomy. A CT of the abdomen and pelvis, with contrast, was performed. The CT revealed bilateral atelectasis, right greater than left. A small to moderate-sized dependent right pleural effusion and a small dependent left pleural effusion were also identified. A small to moderate-sized pericardial effusion was noted. Small bowel loops were diffusely mildly thick-walled with prominent free fluid; moderate ascites was noted. A rim-enhancing gas and fluid collection in the right lower quadrant was identified and measured **7.1 x 7.3 x 12.1 cm. in size and suspicious for abscess**. Material adjacent to and within the fluid collection was suspected to be related to surgical material that could be related to her recent appendectomy. Multiple areas of rim-enhancing fluid and gas collections in the lower abdomen and pelvis were identified and represented sequela of ruptured appendicitis and indications of peritonitis. An abdominal x-ray found no evidence of obstruction or ileus. An initial WBC of 4.2 [4.5-10.8] was noted with repeat WBC 3.8. An initial

hemoglobin of 10.3 [12.0-16.0] was noted at 20:21, however a decreased hemoglobin of 9.7 was noted only a few hours later (at 02:56). After consultation with Dr. Darnauer, the Patient was transferred to Terre Haute Regional Hospital. (TAB 6, Corizon records, pp. 112-116, 894-898 and TAB 7, Union Hospital records, pp. 6-8.)

August 20, 2016

Return to Terre Haute Regional Hospital (08/20/2016 – 09/07/2016)

The Patient was transferred to Terre Haute Regional Hospital Emergency Department. Tachycardia with a pulse of 130 was noted; other vital signs: Temperature 97.8, BP 110/78, and respirations 18. On exam, her abdomen was distended with hypoactive bowel sounds. No guarding or rebound tenderness was observed. The ER doctor consulted with Dr. Darnauer and she was admitted to his service with a **diagnosis of postoperative intra-abdominal abscess with sepsis**. (TAB 8, THRH records, pp. 288-295.)

Her abdomen was distended, and she had hypoactive bowel tones. She had **guarding and rebound pain**. Her **pulse was 130** and her other vital signs were within normal limits. The ER doctor ordered **Fentanyl for pain and IV fluids**. The ER doctor consulted with Dr. Darnauer who admitted the Patient. (TAB 9, THRH records, 1524-1531 and TAB 8, THRH records, pp. 296-300.)

August 20-23, 2016

Abscess Drained

In the early morning of August 20, 2016, Dr. Darnauer examined the Patient noting a distended tender abdomen. (TAB 10, THRH records, 306-313, and TAB 11 at 325-329.) Lovenox had been given for venous thromboembolism prophylaxis, and two units of fresh frozen plasma were transfused to counter the anticoagulation effects of Lovenox. (TAB 12, THRH records, pp. 822, 824-826.) To drain the abscess, Interventional Radiology was consulted and an **emergent percutaneous ultrasound-guided drainage of the intra-abdominal abscess with drain placement was performed**. (TAB 13, THRH records pp. 472-473.) Cultures of the abscess aspirate were positive for E. Coli, Streptococcus Constellatus, and Bacteroides Ovatus. (TAB 14, THRH records, p. 819.) A post-procedure chest x-ray identified interstitial edema and bilateral pleural effusions. (TAB 15, THRH records, p. 487.)

On August 21, 2016, the Patient was seen by Rosa Turcios, MD. An elevated temperature of 100.0 with pulse 119 was noted. Dr. Turcios documented a maximum temperature of 101.2. An elevated WBC 12.3 [4.8-10.8] was noted. Antibiotic therapy included Zosyn, Vancomycin, and Diflucan. Her abdomen was distended with the IR drain in the right lower quadrant draining

purulent fluid. She was described as cachectic/emaciated due to poor oral intake. Nutritional support was needed, and a feeding tube would be considered if no improvement. If her tachycardia persisted, transfusion of packed red blood cells might be necessary. (TAB 16, THRH records, pp. 364-369, TAB 17, THRH records, pp. 336-337, and TAB 18, THRH records, p. 447.)

On August 22, 2016, the Patient was evaluated again by Dr. Turcios. A temperature of 99.7 and pulse of 109 were noted; other vital signs were within normal limits. Her pain had improved, and she denied nausea and vomiting. On exam, her abdomen was distended with purulent and greenish drainage noted from IR drain. Lab tests revealed an elevated WBC 14.6, and decreased hemoglobin 8.8 and hematocrit 26.6. Blood cultures x2 were negative. (TAB 19, THRH records, pp. 358-363.)

On August 23, 2016, Dr. Turcios observed continued abdominal distension and **IR drain with purulent and greenish drainage**. Lab tests revealed a slightly improved WBC 14.5, and decreased hemoglobin 8.5 with hematocrit 25.4. She was afebrile with a pulse of 106, BP 117/67. Dr. Turcios suggested the percutaneous drain could be the source of infection. (TAB 20, THRH records, pp. 353-357.)

August 24-25, 2016

Multiple intra-abdominal abscesses

On August 24, 2016, a repeat abdominal CT was performed due to no significant improvement of the Patient's abdominal distension. The CT identified **multiple intra-abdominal abscesses**, and a small collection in the central posterior abdomen not reachable by drainage catheter. Her **pericardial effusion had increased in size**, and a moderate right and small left pleural effusion were noted. (TAB 21, THRH records, pp. 479-482.)

On exam, the IR drain had greenish output. Her pulse was 115, and other vital signs within normal limits. An elevated WBC 17.1 was noted. Body fluid cultures were positive for E. Coli. (TAB 22, THRH records, pp. 372-375.)

Extensive Exploratory Laparotomy Procedure

Despite antibiotics and the IR drain, the Patient failed to improve. Her WBC continued to increase. On August 24-25, 2016, the Patient underwent an **extensive exploratory laparotomy with evacuation of six intra-abdominal abscesses, extensive lysis of adhesions (which took over two hours to dissect), repair of serosal tear of the right colon, repair of colotomy of the transverse colon, partial omentectomy, abdominal washout with 3500 ml. of normal saline, and placement of two Jackson-Pratt drains**, a nasogastric tube, and a Foley catheter.

Complications included a colotomy which was repaired intra-operatively. Following surgery, she was transported to the ICU. (TAB 23, THRH records, pp. 756-758 and TAB 24, THRH records, pp. 763-775.)

A postoperative chest x-ray was performed and identified cardiomegaly with moderate congestive heart failure and small bilateral pleural effusions. (TAB 25, THRH records, p. 486.)

Although both JP drains were freely draining serosanguinous fluid, her abdomen remained distended. Cultures obtained during surgery were positive for E. Coli and Streptococcus Gordonii. Her WBC was 17.1. Edema was noted to her lower extremities. (TAB 26, THRH records, pp. 344-352.)

On postoperative day one, August 26, 2016, Dr. Turcios noted abdominal distension with surgical dressing intact and JP drains with serosanguinous drainage. An elevated WBC 20.4, and decreased hemoglobin 6.2 with hematocrit 18.5 were noted. (TAB 27, THRH records, pp. 338-343.)

Due to her low hemoglobin and hematocrit, two units of blood were transfused on August 27, 2016. (TAB 28, THRH records, pp. 823-824.)

August 30, 2016

Multiple intra-abdominal abscesses remain

On August 30, 2016, the Patient complained of increased abdominal pain and a CT of the abdomen and pelvis, with contrast, was performed. (TAB 29, THRH records, pp. 422-426.) The CT identified multiple intra-abdominal fluid collections, most of which had decreased in size; however, an anterior lower pelvic fluid collection had increased in size, and a new small right lower quadrant collection was noted. Her bilateral pleural effusions were unchanged, and her pericardial effusion was stable. (TAB 30, THRH records, pp. 476-477.) PA Lee documented no abdominal distension, or guarding, with the wound clean. (TAB 29, THRH records, pp. 422-426.)

September 1, 2016

Thoracentesis Procedure

On September 1, 2016, the Patient underwent thoracentesis due to a **right-side large pleural effusion.** Approximately 1200 mls. of yellow fluid was drained. (TAB 31, THRH records, pp. 474-475.) Chest x-ray showed possible trace residual pleural fluid on the left and small to moderate effusion on the right. There may also have been some minimal infiltrate or atelectasis at the medial right base. (TAB 32, THRH records, p. 485.)

September 7, 2016

Terre Haute Regional Hospital - discharge

During her hospitalization, she improved slowly. On September 5, 2016, an elevated WBC 18.9 was noted. She was tolerating her diet. With minimal output, her drains were removed two days later. On September 7, 2016, she was discharged to Rockville Corrections Facility Infirmary with instructions for follow up care at the Wound Center in one week. (TAB 33, THRH records, pp. 330-335.)

Return to Rockville Correctional with a Wound Vacuum

Following her exploratory laparotomy and subsequent release from Terre Haute Regional Hospital on September 7, 2016, the Patient was returned to the infirmary at Rockville Corrections Facility for ongoing nursing observation and care. (TAB 34, Corizon records, p. 120, 122.) The wound vac was not compatible with the facility's system and another wound vac was ordered. The Patient's wound vac was removed, and a sterile dressing applied. Her wound measured 21 cm x 14 cm and approximately 3-4 cm deep. A small amount of bloody drainage was noted but no signs of infection were observed. (TAB 34, Corizon records, pp. 123-125.)

On September 8, 2016, NP Graber noted the abdominal wound cultures were positive for E. Coli and Streptococcus, and treatment with antibiotics had been completed. The wound was open and required weekly wound care at the Wound Care Center. Minimal drainage and centrally located abdominal tenderness were noted. The Patient was afebrile. (TAB 34, Corizon records, pp. 126-129, 130-132, 135-154.)

Lab tests collected on September 8, 2016 revealed an elevated WBC 15.2 [3.4-10.8] and decreased hemoglobin 8.0 [11.1-15.9] and hematocrit 26.1 [34.0-46.6]. (TAB 34, Corizon records, pp. 146-147.)

While caring for the Patient in the Infirmary on September 9, 2016, Cynthia Smyth, RN, described the surgical wound as **"large open wound from chest cavity to groin."** At this time, a wound vac was applied. (TAB 34, Corizon records, pp. 168-172.)

September 12, 2016

Outpatient Wound Care at Terre Haute Regional Hospital (09/12/2016 – 12/05/2016)

On September 12, 2016, the Patient was **readmitted again** to Terre Haute Regional Hospital for follow up. A culture of her wound grew E. coli, so Levaquin was started again for 2 weeks. Dr. Victoria Potoczak took the Patient to **surgery for an excision debridement for a non-healing surgical wound. The debridement involved an area 21.2 x 5.1 x 2.6 cm.** The surgeon

added Prisma and black foam to the wound vac and the plan was to see the Patient in one week. (TAB 35 and 36, THRH records, p. 1456-1457 and 1462-1500.)

September 19, 2016-November 28, 2016

Outpatient Wound Care at Terre Haute Regional Hospital

On September 19, 2016, post-surgical follow up monitoring and treatment of her surgical wound by the Terre Haute Regional Hospital Wound Center was approved. (TAB 37, THRH records, p, 1461.)

Over these weeks, the Patient was evaluated and treated at the Wound Center on an outpatient basis, then returned to the infirmary. Her incision measured 19.2 x 4.3 x 0.3 cm. There was a large amount of serosanguinous exudate noted. The wound was debrided and measured the same after as before the procedure. The Patient asked to see the surgeon as she was experiencing nausea and vomiting. (TAB 38, Corizon records, p. 333.)

The Patient was discharged from the Infirmary to the general population on October 19, 2016. Dr. Cox ordered her "medical idle" [status] for eight weeks due to an open wound. Upon discharge from Infirmary, she denied nausea, vomiting, diarrhea, fever, and chills. No abdominal distension was reported. (TAB 39, Corizon records, pp. 704-712.)

The Patient was seen by Dr. Cox on October 24, 2016 in follow up for wound care. Her wound was healing well and measured 1.9 x 13.9 cm. in size. She continued to have wound assessment and dressing change 2-3 times a week in the Infirmary. (TAB 40, Corizon records, pp. 713-716.)

On November 7, 2016, the Patient was seen by Dr. Cox in follow up for wound care. Dr. Cox noted improvement of the wound, with granulation tissue observed, no erythema, minimal drainage, and the wound measured much smaller in size. No fever was recorded. (TAB 41, Corizon records, pp. 727-731.)

On November 9, 2016, the Patient was evaluated by NP Johnson for complaint of six-day history of acute onset diarrhea. Physical exam noted an old scar which was ½ inch wide and healing, and no abdominal tenderness, guarding, or rebound were noted. She was admitted to the Infirmary for 23-hour observation and a stool specimen for C-difficile was sent. A course of Metronidazole, an antibacterial, was prescribed. (TAB 42, Corizon records, pp. 732-741.)

Her stay in the Infirmary was extended beyond 23-hour observation and she was attended to by NP Johnson and Dr. Cox. The Patient's stay in the Infirmary was uneventful, and Dr. Cox discharged her on November 14, 2016. Her abdominal pain and cramping, and diarrhea resolved following treatment with Imodium. She had no diarrhea since Wednesday [the 9th], and lab tests

indicated a negative c-difficile. No abdominal tenderness was noted on exam. Dr. Cox observed the abdominal incision to be healing well with no drainage or erythema. The Patient was afebrile. She was to complete her course of antibiotics (Metronidazole) and was discharged from the Infirmary to the general population and instructed to follow up as needed. (TAB 43, Corizon records, pp. 790-791.)

On November 21, 2016, the Patient was seen in the Infirmary by Dr. Cox in follow up for diarrhea which had since resolved and follow up for her wound. The Patient voiced no complaints or problems. She was afebrile. Upon exam, Dr. Cox observed the incision was healing well with no erythema and only minimal drainage. No abdominal tenderness was noted on palpation. A bandaid was applied to the wound and her visit concluded. (TAB 44, Corizon records, pp. 797-800.)

An abdominal wound dressing change in the Infirmary on November 25, 2016 by Nurse Yates revealed a well healing wound. Although the wound was noted to be healing, a 2 cm. area was open and draining. (TAB 44, Corizon records, p. 801.)

On November 28, 2016, the Patient was seen in the Infirmary by Ashely Kennett, LPN. Nurse Kennett observed the Patient's wound was healing well, and no signs of infection were observed. She noted the scab had pulled apart in the middle, but no drainage was observed. The wound was covered. No fever was recorded. (TAB 43, Corizon records, pp. 790-791.)

December 5, 2016

"Discontinue Medical Idle"

On December 5, 2016, the Patient was seen by Dr. Cox in the Infirmary for anemia and follow up for open wound. The Patient was doing well and had no complaints or problems. On exam, her wound was well healed, completely scabbed over, and no erythema, drainage, or signs of infection were observed. No abdominal tenderness was noted on palpation. She was afebrile. Her vital signs were: **weight 95 pounds**.

The Patient's weight on August 10, 2016 (at her 2nd visit to the infirmary) was 130 pounds. (TAB 4, Corizon records, p. 38.) The Patient lost 35 pounds in 4 months.

Dr. Cox concluded that the Patient's anemia had resolved, and her wound care could be discontinued. A "Discontinue Medical Idle" status due to treatment completed was ordered. (TAB 45, Corizon records, pp. 805-808.)

The Patient's Abdominal scarring – June 2018





III. DISCUSSION OF EVIDENCE

Corizon staff breached the standard of care by failing to properly assess and diagnose acute appendicitis. Acute appendicitis is the most common abdominal surgical emergency in the world. Symptoms of appendicitis are well known and include abdominal pain (classically migrating from the periumbilical area to the right lower quadrant, loss of appetite, nausea, and vomiting). Symptoms of appendicitis are usually accompanied by an elevated white blood cell count; however, a normal WBC does not exclude the diagnosis of appendicitis. An elevated sedimentation rate and C-reactive protein may be elevated. Delay in treatment may cause perforation, peritonitis, and greatly increased morbidity and mortality. If the appendix ruptures, there usually is a period of pain diminishment.

Instead, the Defendants documented the Patient's menstrual period as a possible reason for her symptoms on August 11, 12, and 13.

August 10

The Patient however– exhibited classic symptoms of appendicitis (a sudden onset of RLQ pain) when she ***first*** presented to the Infirmary at the Rockville Corrections Facility, yet the Defendants failed to recognize and diagnose appendicitis.

Before seeing any medical provider, the Patient made an August 9 written request for medical assistance describing her symptoms as:

> **I woke up at 3 am in horrible pain on my right side upper stomach, my right side, and my back. I was sweeting (sic) due to pain and threw (sic) up. It hurts to walk.**

On August 10, the Patient made another written request for medical assistance that same day[1] because of her symptoms. This request described her symptoms as:

> **stomach pain lower all the way to back**

On the evening of August 10, Corizon Nurse Lou Lamb saw the Patient and advised the Patient to return to her unit and follow up in Sick Call if her symptoms did not subside or worsened. However, she did note that the Patient was to see a provider ASAP.

August 11

On August 11, 2016, Defendant health care providers Johnson, Hinchman, and Cox were each presented with the Patient. Defendant NP Johnson took the history, did the exam, and

[1] The Patient's medical chart shows that prior visits to the Infirmary were "intake" visits. The Patient had no history of sick calls.

consulted with Defendant Dr. Hinchman and Defendant Dr. Cox. Despite the information collected and discussed, however, each failed to recognize the symptoms of acute appendicitis when the Patient presented to the Infirmary.

Defendant NP Johnson's exam demonstrated right lower quadrant abdominal pain with guarding. No fever was reported; however, the Patient had been taking Ibuprofen which would mask a fever. An elevated WBC of 12.4 was documented, yet the elevated lab and complaint of right lower quadrant abdominal pain and malaise were not recognized as symptoms of appendicitis. Instead, Defendant NP Johnson commented on the Patient's menses as a possible explanation for her symptoms. Defendant NP Johnson further documents discussions with both Defendant Dr. Hinchman and Defendant Dr. Cox about the Patient. After discussing the Patient with both medical doctors, Defendants each had no concern about a diagnosis of acute appendicitis, which is an emergency. Instead, comments were made about her menstrual period.

August 12

On August 12, 2016, Defendants NP Johnson, Defendant Dr. Hinchman, and Defendant Dr. Cox **again** failed to recognize the symptoms of acute appendicitis. The Patient was asleep most of the day even though she was not on any pain medication because the Defendants wanted to have an accurate body temperature. Given the reports of pain from August 9, 10, and 11, the Patient's appendix ruptured before the 12th because a period of pain relief typically follows appendiceal rupture. The pain relief period was likely the reason the Patient slept most of the day on the 12th. (TAB 4, Corizon records, pp. 44-46.)

It was not until 20:15 when an ambulance was finally called for the Patient. The emergency appendectomy **took place 4 full days** after the Patient first had symptoms.

The Defendants did not render appropriate medical care to the Patient when she was first seen at the Infirmary. On August 10, 11, and 12, the Defendants failed to appropriate medical action. The lack of any response to the Patient's initial complaints on August 10, 11, and 12 is troubling. The Patient did not have a history of hypochondria or frequent sick call requests. The Patient had been incarcerated less than a year and had not reported to the Infirmary for any sick calls.

The records show that the Defendants had the power and authority to get diagnostic imaging immediately. When the Patient returned to the prison after the emergency appendectomy, the Patient was closely monitored and immediately sent out for a CT scan when Defendant Dr. Cox suspected infection. Why wasn't this level of attention and care used on August 10, 11, and 12?

Since appendicitis is a medical emergency and surgery needs to be performed soon, the diagnosis must be made quickly. The standard to rule in or rule out appendicitis is a CT scan. The

standard of care required Corizon staff to immediately send the Patient for a CT scan on August 10, 2016 or August 11 or earlier in the day on August 12.

What was initially intermittent pain, progressed to constant, severe pain (10/10), and appropriate further medical evaluation and care was delayed three days, resulting in a perforated appendix with peritonitis. Defendant Corizon, Defendant NP Johnson, Defendant Dr. Hinchman, and Defendant Dr. Cox each breached the standard of care.

There is no documentation of the differential diagnosis including appendicitis. There is no differential diagnosis documented.

As a direct and proximate result of the delayed diagnosis of appendicitis, the Patient's appendicitis was allowed to progress to gangrene which lead to a cascade of issues, including sepsis, pleural effusions requiring thoracentesis, pericardial effusion, extensive laparotomy with evacuation of six intra-abdominal abscesses, placement of multiple drains into the abdominal cavity, extensive wound care, including wound debridement causing significant pain and suffering and medical expenses and substantial permanent scarring of her abdomen.

IV. CONCLUSION

WHEREFORE, Plaintiff Tiffany Smith requests that the Medical Review Panel find that the evidence **does** support the conclusion that Defendants Corizon, Defendant NP Johnson, Defendant Dr. Hinchman, and Defendant Dr. Cox failed to meet the applicable standard of care as charged in the complaint and that the conduct complained of **was** a factor of the resultant damages.

So dated: December 19, 2019

Respectfully submitted,

Robert W. Johnson, Attorney No. 17391-49
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katz.korin.cunningham.

RECEIVED
MAR 29 2021
STATE OF INDIANA
DEPT. OF INSURANCE

Sally Franklin Zweig
szweig@kkclegal.com
Direct: 317-464-2626

March 25, 2021

Randall Evans
Manager, Patient's Compensation Section
311 West Washington Street; Suite 300
Indianapolis, IN 46204-2787

VIA CERTIFIED MAIL
E-RECEIPT REQUESTED
9314 8699 0430 0080 7645 68

Re: ***Tiffany Smith v. Corizon, Inc., Corizon Health, Inc., Corizon, LLC, Krista L. Sexton-Cox, DO, Richard Hinchman, M.D., and Pamela F. Johnson, FNP***

Dear Mr. Evans:

Enclosed, please find copies of the following:

1. The Panel's Opinion as to Defendants;
2. The Panel's determination for Defendants as required under I.C. 34-18-9-4; and
3. The signed Oaths of the panel members.

Thank you very much for your cooperation.

Very truly yours,

KATZ.KORIN.CUNNINGHAM.PC

Sally Franklin Zweig

Enclosures
cc: Janet M. Horne/Robert Johnson/Travis Jensen *(via e-mail) (w/enclosures)*
Carol Dillon/Ashlie Keaton *(via e-mail) (w/enclosures)*

FILED
MAR 25 2021
State of Indiana
Department of Insurance

INDIANA DEPARTMENT OF INSURANCE
PATIENT'S COMPENSATION DIVISION

TIFFANY SMITH,

Plaintiff,

v.

CORIZON, INC., CORIZON HEALTH, INC., CORIZON, LLC, KRISTA L. SEXTON-COX, DO, RICHARD HINCHMAN, M.D., and PAMELA F. JOHNSON, FNP,

Defendants.

OPINION OF THE MEDICAL REVIEW PANEL AS TO ALL DEFENDANTS

The Medical Review Panel ("Panel") in this matter convened on February 25, 2021. Having reviewed all of the evidence submitted by the parties to the Panel in this case, the Panel hereby renders its expert opinion.

The Panel is of the unanimous opinion that the evidence supports the conclusion that Defendants failed to meet the applicable standard of care as charged in the Complaint and that such conduct was a factor in the damages claimed.

Sally Franklin Zweig
non-voting chairperson

Rex A. Allman, M.D.

Kent W. Erb, M.D.

George A. Negrete, M.D.

Dated: This 25th day of February 2021

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing **OPINION OF THE MEDICAL REVIEW PANEL AS TO ALL DEFENDANTS** has been served on **March 25, 2021**, by United States Certified, Return Receipt Requested Mail, postage prepaid and properly addressed to the following:

Janet M. Horne
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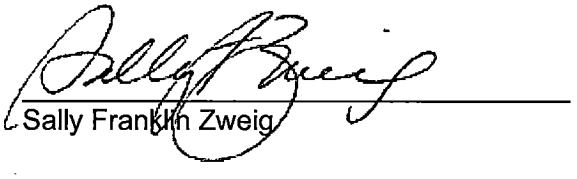

Sally Franklin Zweig

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Defendants.

MEDICAL REVIEW PANEL'S DETERMINATION
REQUIRED UNDER I.C. 34-18-9-4
AS TO ALL DEFENDANTS

The Medical Review Panel ("Panel") having convened on February 25, 2021, is of the unanimous opinion that the names of Defendants should not be forwarded to the appropriate board of professional registration for review of fitness to practice.

Sally Franklin Zweig
non-voting chairperson

Rex A. Allman, M.D.

Kent W. Erb, M.D.

George A. Negrete, M.D.

Dated: This 25th day of February 2021

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing **MEDICAL REVIEW PANEL'S DETERMINATION REQUIRED UNDER I.C. 34-18-9-4 AS TO ALL DEFENDANTS** has been served on **March 25, 2021**, by United States Certified, Return Receipt Requested Mail, postage prepaid and properly addressed to the following:

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Robert Johnson
Travis Jensen
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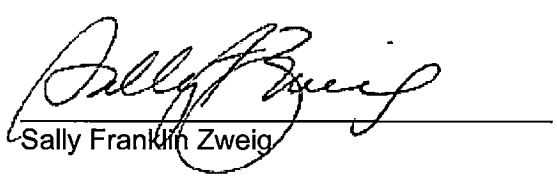

Sally Franklin Zweig

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INDIANA DEPARTMENT OF INSURANCE
PATIENT'S COMPENSATION DIVISION

TIFFANY SMITH,

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CORIZON, INC., CORIZON HEALTH, INC., CORIZON, LLC, KRISTA L. SEXTON-COX, DO, RICHARD HINCHMAN, M.D., and PAMELA F. JOHNSON, FNP,

Defendants.

OATH

I affirm under penalties of perjury that I will well and truly consider the evidence submitted by the parties; that I will render my opinion without bias, based upon the evidence submitted by the parties, and that I have not and will not communicate with any party or representative of a party before rendering my opinion, except as authorized by law.

Rex A. Allman, M.D.
Pulaski Memorial Medical and Surgical Group
540 Hospital Dr
Winamac, IN 46996-1173

Dated this 24 day of August, 2020

FILED
MAR 25 2021
State of Indiana
Department of Insurance

INDIANA DEPARTMENT OF INSURANCE
PATIENT'S COMPENSATION DIVISION

TIFFANY SMITH,

Plaintiff,

v.

CORIZON, INC., CORIZON HEALTH, INC., CORIZON, LLC, KRISTA L. SEXTON-COX, DO, RICHARD HINCHMAN, M.D., and PAMELA F. JOHNSON, FNP,

Defendants.

OATH

I affirm under penalties of perjury that I will well and truly consider the evidence submitted by the parties; that I will render my opinion without bias, based upon the evidence submitted by the parties, and that I have not and will not communicate with any party or representative of a party before rendering my opinion, except as authorized by law.

Kent W. Erb, M.D.
Sheridan Family Medicine
611 E. 10th St.
Sheridan, IN 46069-9106

Dated this 28 day of August, 2020

FILED

MAR 25 2021

State of Indiana
Department of Insurance

INDIANA DEPARTMENT OF INSURANCE
PATIENT'S COMPENSATION DIVISION

TIFFANY SMITH,

Plaintiff,

v.

CORIZON, INC., CORIZON HEALTH, INC., CORIZON, LLC, KRISTA L. SEXTON-COX, DO, RICHARD HINCHMAN, M.D., and PAMELA F. JOHNSON, FNP,

Defendants.

OATH

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George A. Negrete, MD
General Surgery
Hamilton Surgical Associates
355 Westfield Rd., Suite 120
Noblesville, IN 46060

Dated this 24 day of August, 2020

Tiffany Smith
Date of Loss - August 10, 2016
Preliminary Medical Expenses

Dates of Service	Provider	Memo	Amount Billed	Paid by IDOC	Self-Pay	Paid by Corizon	Amount Adjusted	Balance Due	Math
08/13/16 - 08/17/16	Terre Haute Regional Hospital	Inpatient Stay	$ 64,201.46						$ 64,201.46
Total			$ 64,201.46	$ -	$ -	$ -	$ -	$ -	

Total Paid: $ -

Tiffany Smith
Date of Loss - August 13, 2016
Preliminary Medical Expenses

Dates of Service	Provider	Memo	Amount Billed	Paid by IDOC	Self-Pay	Paid by Corizon	Amount Adjusted	Balance Due	Math
08/19/16	Parke County EMS	Ambulance	$ 895.00						$ 895.00
08/19/16	Union Hospital Clinton	Emergency Room	$ 10,474.26			$ 3,770.74	$ 6,703.52		$ -
08/20/16	Trans-Care	Ambulance	$ 1,408.00	$ 433.62			$ 974.38		$ -
08/20/16 - 09/07/16	Terre Haute Regional Hospital	Inpatient Stay	$ 220,722.74				$ 190,461.45		$ 30,261.29
09/12/16 - 09/30/16	Terre Haute Regional Hospital	Inpatient Stay	$ 15,826.56						$ 15,826.56
Total			$ 249,326.56	$ 433.62	$ -	$ 3,770.74	$ 198,139.35	$ -	

Total Paid: $ 4,204.36

From Insurance Itemization
From Insurance EOB
From Medical Bill
From Both
From Med Pay
From Client Provided Bill