

1 DR. SIMMER: Thank you. Are there any
2 questions?

3 Thank you very much.

4 The Commission welcomes our third
5 participant, Alison...I'm sorry.

6 MS. BROWN HEIMSATH: It's a hard one.
7 Heimsath.

8 DR. SIMMER: Thank you.

9 MS. BROWN HEIMSATH: Thank you for allowing
10 me to be here. My name is Alison Brown Heimsath. I'm
11 a registered nurse, although I'm not here in that
12 capacity today.

13 My mother, who is sitting next to me, Lynette
14 Brown, testified on November 15th in Lansing in
15 regards to my dad's death, which occurred June 9th,
16 1999, in a Royal Oak hospital. I just kind of wanted
17 to give you a summary of what it was that led to his
18 death.

19 He, on May 15th, went to the emergency room
20 and complained of shortness of breath and difficulty
21 breathing. He also complained of decreased colostomy
22 output and abdominal pain. He had a past medical
23 history of, let's see, emphysema, as well as colon
24 cancer and lung cancer, although he wasn't in
25 remission as far as his cancers went. He was status

1 post chemo and radiation. And he had only one working
2 lung, as he had had radiation therapy to the chest
3 area. He was oxygen-dependent at home, at evenings
4 only, but he was still employed full-time in two
5 courts, District Courts, as a magistrate.

6 Basically, he went to the emergency room and
7 was treated there. He had labs and chest x-ray,
8 abdominal x-ray, and then was admitted as an inpatient
9 to a general medical floor with a diagnosis of
10 abdominal pain, possible pneumonia, and treated for a
11 fecal impaction.

12 Was it about 24 hours later? He had an
13 incident on the general medical floor on the 17th at
14 1:40 in the morning --

15 MS. BROWN: On the Monday morning, a.m.

16 MS. BROWN HEIMSATH: Right -- where he
17 vomited times one, and was given IV Compazine and
18 morphine as well for his abdominal pain. So at that

19 point, the four siderails were up on the bed as well.
20 MS. BROWN: And they were all the time he was
21 in the hospital room.
22 MS. BROWN HEIMSATH: Right, right. And then
23 a few minutes after four he was found by a nurse's
24 aide, and she stated that she found him after he had
25 tried to get out of bed, that he had been vomiting,

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1 that he had aspirated and was not breathing when she
2 discovered him.
3 MS. BROWN: His heart never --
4 MS. BROWN HEIMSATH: Right. She actually
5 made a point of saying that he had a pulse but that he
6 was in respiratory arrest.
7 So at that point a code was called. Narciam
8 [phonetic] was given to try to reverse the effects
9 that he had from the narcotics. He was intubated.
10 During the intubation period, and I'm not
11 criticizing the physician for this, but during the
12 intubation period his dentures that he had in his
13 mouth were broken and they were assumed to have been
14 aspirated, as well -- his broken dentures were assumed
15 to have been aspirated as well as that he had
16 aspirated on the vomit, since he had been vomiting.
17 As far as the aspirated teeth, that was
18 interesting because I discovered it later by looking
19 at the chart. They never mentioned that to us nor did
20 they do a bronchoscopy on him. A bronchoscopy was
21 done one week later, at our own insistence, but not
22 done -- my impression was that they were trying to --
23 MS. BROWN: Cover up.
24 MS. BROWN HEIMSATH: -- make sure that we
25 didn't know, you know, some of the details on it. But

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1 basically at that point he obviously was transferred
2 to the ICU unit, and that was in the early hours of
3 that morning.
4 And then by 6:30 on that morning he was fully
5 alert and conscious, was following commands and was of
6 normal mental status. Obviously, he continued to be
7 intubated and was on a respirator. However, 18 hours
8 later he, because of his agitation, was put on an IV
9 of Ativan, Ativan drip, and then also Norcuron, which
10 is a paralytic drip. Agitation -- and then, you know,

11 after that his mental status obviously was changed.

12 But then basically over the next three weeks
13 his condition deteriorated. Each -- they were doing
14 chest x-rays on him every few hours, and each one
15 looked a little worse until basically his only lung
16 that he had that was in use, his right lung, was no
17 longer, you know, functioning or working as well.

18 And then also during that three-week period
19 that he was in ICU he developed ARDS, which is Adult
20 Respiratory Distress Syndrome; DIC, which is a
21 blood-clotting type of disorder; and a cerebral
22 hemorrhage from the GIC that he had developed, and
23 then he passed away on June 9th, 1999.

24 So I thought for me when I think it over, I
25 think it's unfortunate. He did have some health

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1 problems but certainly he went into the hospital in
2 the emergency room in good shape. He was still
3 employed full-time. He drove himself to the emergency
4 room and --

5 MS. BROWN: I was visiting --

6 MS. BROWN HEIMSATH: -- basically, then, he
7 left the emergency -- you know, left the hospital
8 three weeks later in a body bag type of thing.

9 And I felt really that the main cause of it
10 was a couple of things that happened but basically
11 that he was heavily medicated on both a narcotic and a
12 sedative. That he -- this was his second vomiting
13 episode. He was a patient that was at high risk for
14 aspiration because of the fact that he only had one
15 functioning lung.

16 So I think the fact that he was heavily
17 medicated, that the siderails were all up on the bed,
18 and I would guess that he was probably trying to get
19 out of bed to go into the bathroom, you know, and that
20 that was how this happened. So I think it had to do
21 with the medications.

22 MS. BROWN: They were -- when I was there the
23 Monday afternoon, they were very short of help in the
24 hospital, nursing help. He was the last room down
25 from the nurse's station. I'm assuming they were even

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1 shorter, from the hospital records, during the wee
2 small hours when this happened to him. He was never

3 checked in the period between the first vomiting --

4 MS. BROWN HEIMSATH: And the second.

5 MS. BROWN: -- and the one many hours later.

6 And no doctor saw him at any time after the first
7 vomiting.

8 I believe that the -- it would appear to me,
9 from having spent much time with the hospital records,
10 that the computer was down in the emergency room and
11 that much of the information that they obtained in the
12 emergency room did not travel with him to the hospital
13 room.

14 So they were unaware in the hospital room he
15 was functioning on just one lung. They did not know
16 who his internist was. They did not know the seven
17 oncologists that were taking care of him. In other
18 words, the communication was totally lacking between
19 his care in the emergency room and the information
20 that traveled -- that did not travel with him to the
21 hospital.

22 MS. BROWN HEIMSATH: I think there were a lot
23 of things that went wrong from beginning to end, but
24 for me I feel like the worst thing that happened was
25 the fact that he was so heavily -- was in a strange

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1 environment, had all the siderails up, was very
2 heavily medicated on both a narcotic and Ativan as
3 well, and then basically was a high-risk patient due
4 to the fact that he had a compromised respiratory and,
5 basically aspirated.

6 MS. BROWN: And he was alone.

7 MS. BROWN HEIMSATH: And it wouldn't have
8 happened to him at home because he wouldn't have had
9 siderails up nor would he be on those medications.

10 MS. BROWN: And I would have called 911.

11 MS. BROWN HEIMSATH: Right. So I think the
12 whole thing was just very unfortunate.

13 MS. BROWN: And then there was a big cover-up
14 while he was still living. And, you know, I think --
15 I don't know if there's any legal difference between a
16 cover-up when someone has died, but I felt there was a
17 great one between someone who was still living for
18 weeks, and particularly when I could not get them to
19 do the bronchoscope for the teeth that they believe
20 were aspirated from his dentures, for a week, because
21 they never told me about any of that.

22 MS. BROWN HEIMSATH: I just asked one day to
23 read the chart and --
24 MS. BROWN: She read it.
25 MS. BROWN HEIMSATH: -- saw it on the chart

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1 that that had happened to him in the code. And I
2 don't criticize the physician for breaking his
3 dentures because in an emergency situation you're
4 trying to --
5 MS. BROWN: No, no, but I should have been
6 told immediately.
7 MS. BROWN HEIMSATH: So I don't know what can
8 be learned from it but I think it was a combination of
9 siderails being up, high risk --
10 MS. BROWN: Yes. And when I testified at the
11 first hearing, the paper that -- I had not expected to
12 testify, and I certainly did not write what I filed as
13 part of the record, which is "Note from Lynette
14 Brown," and it's 10 typewritten pages, single spaced,
15 margins crowded, and it was done for the lawyers to
16 work their way through the folders of the records
17 after I had arranged the records, you know, in
18 chronological order, et cetera. So that was the note
19 that you got as part of your record.
20 MS. BROWN HEIMSATH: I guess basically that's
21 it.
22 DR. SIMMER: Okay. Thank you very much. I
23 think that is very illustrative.
24 MS. BROWN HEIMSATH: Thank you.
25 DR. SIMMER: And are there any questions

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1 among members of the Commission?
2 MS. McDONALD: Only that the records did not
3 travel with him, that's what you're saying? The
4 records weren't coming --
5 MS. BROWN HEIMSATH: That was part of it,
6 that the records didn't go from the ER up to the
7 floor.
8 MS. BROWN: The three-page emergency room
9 report was typed and transcribed three days later.
10 And, you know, but none of that -- what traveled with
11 him, for instance, on the chart, where it says
12 attending physician, it says none. And all of this
13 information was in the computer and, you know

14 Dr. Simpson had been his doctor for decades, and there
15 were just a number of things like that.

16 Now, for instance, on the information that
17 traveled with him, this wasn't important for him, but
18 the information that traveled with him said he had no
19 allergies. Actually, he had an allergy to the iodine
20 dye for CAT scan, which had been discovered about ten
21 years earlier at the hospital and which was
22 permanently on his record, you know how it appears.
23 And so the only explanation is that the computer was
24 down when he was in the ER.

25 MS. BROWN HEIMSATH: Basically, they weren't

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1 fully aware that he was he was a respiratory risk
2 patient and that he could aspirate and --

3 MS. BROWN: So this shows how important
4 communication is and that this information travels
5 with the patient.

6 MS. BROWN HEIMSATH: Thank you.