IN THE CIRCUIT COURT FOR DAVIDSON COUNTY, TENNESSEE

JULIE OWEN, Surviving Spouse and Personal Representative of the Estate of the Deceased, JONATHAN OWEN,	)	
Plaintiff,	)	**No. _____**
v.	)	**JURY DEMAND**
SAINT THOMAS WEST HOSPITAL and CHANDRASHEKHAR RAMAIAH, M.D.	)	
Defendants.	)	

VERIFIED COMPLAINT

The Plaintiff respectfully states to the Court and Jury as follows:

PARTIES, VENUE, AND JURISDICTION

1. Jonathan Owen ("Mr. Owen") the Deceased, was an adult citizen and resident of the State of Tennessee at the time of the events described herein.

2. Julie Owen ("Mrs. Owen" or "Plaintiff") is Mr. Owen's surviving spouse and the court-appointed administrator of Mr. Owen's estate.

3. Defendant Saint Thomas West Hospital ("St. Thomas") is a Tennessee nonprofit corporation, registered to do business in Tennessee, with its principal place of business at 4220 Harding Pike, Nashville, Tennessee, 37205. St. Thomas is a hospital, licensed by the Tennessee Department of Health Board of Licensing Health Care facilities.

4. St. Thomas is a "health care provider," "licensee," and/or "management company" as those terms are defined by Tenn. Code Ann. § 29-26-101(a)(2), (3) & (4).

5. St. Thomas may be served through its registered agent, Corporation Service Company, 2908 Poston Ave, Nashville, TN 37203-1312.

6. Defendant Chandrashekhar Ramaiah, M.D. ("Dr. Ramaiah") is a "health care provider," as that term is defined by Tenn. Code Ann. §29-26-101(a)(2)(A), and, upon information and belief, a citizen and resident of Tennessee.

7. This cause of action arose in Davidson County, Tennessee. Venue and a jury demand are proper pursuant to Tenn. Code Ann. § 20-4-101(a). This Court has jurisdiction pursuant to Tenn. Code Ann. § 16-10-101.

LEGAL RELATIONSHIPS

8. At the time of the matters described in this Complaint, Mr. Owen had a physician-patient relationship with Dr. Ramaiah and other physicians who provided care to him at St. Thomas.

9. At the time of the matters described in this Complaint, St. Thomas and its employees and agents had a health care provider-patient relationship with Ms. Turner.

10. At the time of the matters described in this Complaint, Dr. Ramaiah was an actual or apparent agent of St. Thomas.

11. At the time of the matters described in this Complaint, Dr. Ramaiah was selected or recommended by St. Thomas to be involved in providing care and treatment to Mr. Owen.

12. All of the health care providers who provided care and treatment to Mr. Owen at St. Thomas were actual or apparent agents or employees of St. Thomas.

13. All of the health care providers who provided care and treatment to Mr. Owen at St. Thomas were selected or staffed by St. Thomas to be involved in Mr. Owen's care and treatment.

14. At the time of the matters described in this Complaint, Defendants and their employees and agents owed Mr. Owen duties as part of a health care provider-patient relationship.

STATEMENT OF FACTS AND ALLEGATIONS

A. Mr. Owen is admitted to St. Thomas for treatment for COVID-19.

15. In mid-August 2021, Mr. Owen was an otherwise healthy, active 44-year-old man who became infected with COVID-19.

16. On August 20, 2021 Mr. Owen, concerned about his oxygen saturation levels and shortness of breath, called an ambulance to transport him to the hospital for supplemental oxygen and evaluation. When the ambulance arrived at his home, EMS decided that Mr. Owen should be transported to St. Thomas, the closest hospital to his home. Mr. Owen was admitted to St. Thomas.

17. After conducting an initial evaluation, St. Thomas personnel placed him on a non-invasive ventilator, after which he became increasingly stable. During this time, physicians and staff discussed placing Mr. Owen on Extracorporeal Membrane Oxygenation (ECMO) therapy but Mr. Owen remained hopeful that he would get better and wanted to wait and see if he would continue to improve on his own.

18. Throughout his hospitalization, Mr. Owen's wife, daughters, and other family members were not allowed to visit him due to COVID-19 protocols that restricted visitor access to patients.

19. On August 25, Mr. Owen became increasingly hypoxic, and physicians and staff at St. Thomas, including Dr. Ramaiah, determined that ECMO should be initiated.

20. At approximately 4 p.m. that day, Dr. Ramaiah called Mr. Owen's wife, Julie Owen, to discuss the procedure. Dr. Ramaiah explained to Mrs. Owen that he would access Mr. Owen via the femoral artery and neck vein and informed her that Mr. Owen would be out of work for several weeks as a result of the procedure. He did not mention gaining central access directly

to Mr. Owen's heart or otherwise explain that the procedure came with a risk of serious injury and/or death.

21. Based on Dr. Ramaiah's explanation, Mr. Owen, and Mrs. Owen, remotely, consented to the procedure, optimistic that it would help Mr. Owen improve.

B. Dr. Ramaiah punctures Mr. Owen's heart while knowingly, recklessly, and intentionally lacking the resources to timely resuscitate him.

22. At approximately 6 p.m. on August 25, Mr. Owen was brought into surgery for placement of the ECMO by Dr. Ramaiah.

23. During the procedure, Dr. Ramaiah punctured Mr. Owen's heart multiple times causing Mr. Owen to go into cardiac arrest.

24. There was no bypass machine in the operating room—a clear and reckless violation of the standard of care for ECMO cannulation, compounding Dr. Ramaiah's prior violation of failing to disclose the risks of surgery or even potential for direct cardiac access.

25. Mr. Owen suffered without oxygen to his brain for more than 20 minutes as Dr. Ramaiah and the surgical staff at St. Thomas scrambled to remedy their mistake without a bypass machine present.

26. Ultimately, Dr. Ramaiah performed a sternotomy to manage cardiac tamponade, wherein Mr. Owen's chest was opened, bypass was—belatedly—started, and Mr. Owen's heart was resuscitated.

27. Dr. Ramaiah then placed him on veno-venous (VV) ECMO and Mr. Owen's chest was left open with a wound VAC.

28. After the procedure, Dr. Ramaiah called Mrs. Owen at around 8 p.m. and stated words to the effect that there were "a lot of problems and complications," with the procedure, that Mr. Owen had "coded for 20 to 25 minutes," and that Dr. Ramaiah had to "open up his chest," but

did not explain why or how that happened and did not mention that he had punctured Mr. Owen's heart during the procedure.

29. Dr. Ramaiah also told Mrs. Owen, "I think you need to come" to the hospital.

30. Shocked and confused, Mrs. Owen rushed to St. Thomas to see her husband. After waiting 30 minutes upon her arrival, Mrs. Owen was dressed in head-to-toe PPE and a St. Thomas nurse brought her back to her husband. An anesthesiologist told Mrs. Owen, "We are breaking lots of protocols to get you back here," and told Mrs. Owen that she should "tell Jonathan what she needs to say," because, "hearing is the last to go."

31. When Mrs. Owen finally saw her husband, he was covered in blood, unconscious, and intubated. After spending a few moments with her husband, amidst several doctors and nurses rushing around, Mrs. Owen left the hospital devastated, unsure if she would ever see her husband alive again.

C. Mr. Owen fights for his life as Dr. Ramaiah and St. Thomas staff misinform Mrs. Owen of their gross negligence and Mr. Owen's condition.

32. On August 26, Dr. Ramaiah operated on Mr. Owen to wash out and change his wound VAC dressing.

33. On August 27, Dr. Ramaiah operated to close Mr. Owen's chest.

34. On August 27, and over the next few days, Mr. Owen began having seizures. St. Thomas staff and physicians grew increasingly concerned that Mr. Owen had suffered brain damage as a result of being deprived of oxygen to his brain for many minutes during the ECMO procedure performed by Dr. Ramaiah.

35. Meanwhile, Mr. Owen's COVID-19-related symptoms, including his lung function and oxygen saturation, steadily improved.

36. On August 31, Mrs. Owen was contacted by Dr. Christina MacMurdo, a palliative care physician for St. Thomas. Dr. MacMurdo asked Mrs. Owen to explain her understanding of "what has happened here." Mrs. Owen repeated what Dr. Ramaiah had told her—that Mr. Owen's heart stopped during the procedure, that he coded for 20 minutes, and that he needed to be resuscitated, but that she did not know why.

37. The next day, Dr. Ramaiah, seemingly at the request of Dr. MacMurdo, called Mrs. Owen and in a very cold, sterile fashion, revealed to Mrs. Owen for the first time that he had punctured Mr. Owen's heart during surgery and "that's when he coded."

38. In Mr. Owen's medical record, Dr. Ramaiah made a note about this phone call writing, "Apparently [Mrs. Owen] had questions about what happened at the time of ECMO cannulation, she has asked for more information. I explained to her that there was a complication during the procedure with the perforation of the RV that led to tamponade and cardiac arrest requiring resuscitation. I did discuss this with her on the day of the procedure as well."

39. Dr. Ramaiah's note is false. While Dr. Ramaiah informed Mrs. Owen that there had been problems and complications with the surgery, he had never disclosed to her that he had punctured Mr. Owen's heart—much less that he had done so twice.

D. <u>Mr. Owen's case becomes known to numerous St. Thomas employees.</u>

40. It became apparent to Mrs. Owen that Mr. Owen's condition was widely known by St. Thomas nurses and staff.

41. Each time Mrs. Owen or her family were at the hospital, nurses—many of whom were not even involved in Mr. Owen's care—would approach to give a hug and express concern and condolences for Mr. Owen.

42. In one instance, Mrs. Owen's brother struck up a conversation with a male traveling nurse who asked which patient he was here to see. When Mrs. Owen's brother said he was at the hospital for Mr. Owen, the nurse's face dropped and the nurse said, "We are all very pissed off about what happened."

43. At the time, Mrs. Owen did not understand why so many knew and were upset about what had happened to Mr. Owen, but over the next few weeks, it became clear.

D. Mr. Owen is taken off ECMO, but physicians remain concerned about his neurological condition due to prolonged oxygen deprivation.

44. On September 2—after being on ECMO for only eight days—Mr. Owen's oxygen saturations had significantly improved and stabilized, and St. Thomas physicians determined that his lung function was stable such that he should be decannulated from ECMO.

45. ECMO was stopped, and Mr. Owen's lung function remained stable.

46. However, physicians remained concerned about potential neurological damage, and, as a result, Mr. Owen was taken for an MRI on the evening of September 2.

E. St. Thomas misinforms Mrs. Owen about the results of Mr. Owen's MRI before reversing course and determining that Mr. Owen was permanently incapacitated.

47. On the morning of September 3, Mrs. Owen received a call from a St. Thomas employee with the results of the MRI.

48. The employee told Mrs. Owen that Mr. Owen had not suffered any brain damage.

49. Overwhelmed with relief, Mrs. Owen dropped to her knees and cried. Mrs. Owen's mother also heard the call, and both were overcome with emotion.

50. Mrs. Owen immediately began contacting friends, family, and supporters to share the good news—including posting it on Mr. Owen's CaringBridge website—receiving a flood of supportive responses from Mr. Owen's friends and family around the world.

51. A few hours later, Mrs. Owen received another call from a St. Thomas employee. She told Mrs. Owen that they had "misread the results" of the MRI. The employee told Mrs. Owen that she needed to come to the hospital, but that she should not bring Mr. and Mrs. Owen's two daughters with her.

52. Mrs. Owen and Mr. Owen's mother, Donna, arrived at St. Thomas to a meeting of five doctors, some of whom were visibly crying when they arrived. However, Dr. Ramaiah, who was apparently on vacation, was not there.

53. The physicians begin to explain to Mr. Owen's family that Mr. Owen had indeed suffered an anoxic brain injury as a result of being without oxygen for upwards of 20 minutes during the ECMO procedure by Dr. Ramaiah. They went on to explain that Mr. Owen would likely never recover, and that the best-case scenario would be that Mr. Owen would be able to open his eyes but would remain quadriplegic and never be able to communicate, eat, talk, or move any limbs.

54. Mr. Owen's family was devastated by this news.

55. Despite the grim outlook, Mrs. Owen knew that Mr. Owen was a fighter and remained hopeful for a miracle, so she asked St. Thomas staff to wean Mr. Owen off sedation in the hopes that he would wake up.

56. As Mr. Owen was weaned off sedation, his eyes opened and he begins to move his limbs, but St. Thomas physicians told Mrs. Owen that these movements were involuntary. Mr. Owen's brain function was not improving.

57. Nevertheless, Mr. Owen's COVID-related symptoms continued to improve, and he was weaned off the ventilator. Mr. Owen made a full recovery from COVID-19, but he would never recover from Dr. Ramaiah's and St. Thomas's reckless, ruthless care.

F. Mrs. Owen makes the heart-wrenching decision to remove Mr. Owen from life support.

58. Over the next several days, without improvement to Mr. Owen's brain function, it became clear to Mrs. Owen and her family that Mr. Owen, permanently lacking significant brain activity, would never return to any quality of life—much less the active, successful life he led before the botched ECMO procedure.

59. Mrs. Owen looked to her family, support network, and faith for guidance, and on September 20, 2021, she made the toughest decision of her life—to remove her husband and her daughters' father from life support.

G. Dr. Ramaiah callously admits to gross negligence.

60. On the same day, Mrs. Owen asked to have a meeting with Dr. Ramaiah in hopes that she would receive closure.

61. Mrs. Owen, her mother, and a St. Thomas nurse were present for the meeting wherein Dr. Ramaiah clinically and cold-heartedly described certain portions of the ECMO procedure—omitting any mention of his egregious recklessness in performing an undisclosed central cannulation in which he perforated Mr. Owen's heart, twice, without a bypass machine available.

62. Dr. Ramaiah spoke uninterrupted for nearly 30 minutes. When Mrs. Owen attempted to ask questions, Dr. Ramaiah repeatedly cut her off.

63. Finally, Mrs. Owen insisted Dr. Ramaiah answer an important question that had been weighing on her: "Did you have a bypass machine in the room?"

64. Astonishingly, Dr. Ramaiah responded in words to the effect of: "No, we did not. Those machines are expensive, and they are hard to clean. I didn't want it in the room if I didn't have to have it."

65. Mrs. Owen was in a state of shock at Dr. Ramaiah's admission that this life-saving machine was not in the operating room as matter of convenience.

H. Mr. Owen dies, not from COVID-19, but from Defendants' gross negligence.

66. Mr. Owen died on September 22, 2021.

67. An autopsy was performed, and the cause of his death was determined to be Anoxic Encephalopathy associated with ECMO Procedure due to Perforation of the Right Ventricle.

68. At the time of his death, Mr. Owen had made a full or near-full recovery from COVID-19.

69. Mr. Owen did not die from COVID-19. Mr. Owen did not die from a respiratory condition. Mr. Owen died as a result of the August 25, 2021 ECMO cannulation and resulting lack of oxygen to his brain.

70. Because of Dr. Ramaiah's multiple perforations of Mr. Owen's right ventricle, his and St. Thomas' failure to ensure that a bypass machine was present and available for use during the ECMO cannulation, and his and St. Thomas' failure to ensure that the intraoperative complication could be immediately addressed, Mr. Owen's brain was deprived of oxygen for approximately 20 minutes, rendering him unable to continue living without mechanical assistance.

71. Neither Dr. Ramaiah nor St. Thomas disclosed to Mrs. Owen the true nature of the errors that led to Mr. Owen's incapacity and eventual death.

72. Mr. Owen experienced immense pain and suffering in the days before his death. He was deprived of the opportunity to continue living his life, earning income for his family, and enjoying the loving company of his family.

73. Mrs. Owen and her daughters suffered tremendously from the loss of their beloved husband and father, a caring and kind man who was revered by his family. Each family member

experienced trauma, pain, and loss, as they have tried to cope with Mr. Owen's preventable death. They have lost his companionship, support, love, and the rock of their family, whose income the family relied upon to survive.

COMPLIANCE WITH STATUTORY NOTICE AND GOOD FAITH REQUIREMENTS

74. Plaintiff, through counsel, complied with the provisions of Tenn. Code Ann. § 29-26-121 requiring individuals asserting a potential health care liability claim to give written notice of such potential claim to each health care provider that will be a named Defendant at least 60 days prior to filing a complaint ("Pre-Suit Notice" or "Notice").

75. On June 6, 2022, Notice was given to the Defendants in accordance with Tenn. Code Ann. § 29-26-121.

76. The Affidavit of John Spragens and supporting documentation demonstrating compliance with regard to Notice are attached to this Complaint as **Exhibit 1**.

77. The Complaint was filed more than 60 days after June 6, 2022.

78. The Complaint was filed more than 60 days after Plaintiffs sent Pre-Suit Notice.

79. Defendants had the opportunity to review the facts of this matter between the time of their receipt of Pre-Suit Notice and the filing of this Complaint.

80. Neither Defendants nor any agent acting on a Defendant's behalf, ever communicated to counsel for Plaintiff any inability or problem with obtaining or reviewing the pertinent medical records, which counsel for the Plaintiff provided directly or provided access to via an appropriate, HIPAA-compliant release for the Defendants to use to obtain records.

81. In accordance with Tenn. Code Ann. §29-26-122, Plaintiff's counsel has consulted with one or more experts who provided a signed written statement confirming that upon information and belief they are competent under Tenn. Code Ann. §29-26-115 to express opinions

in this case and believe, based on the information available from medical records concerning the care and treatment of Mr. Owen, that there is a good faith basis to maintain this action consistent with the requirements of Tenn. Code Ann. § 29-26-115 ("good faith requirement"), and to the extent necessary (which Plaintiff disputes), § 14-5-101(b)(2). The Certificate of Good Faith demonstrating compliance with the above requirements is attached to this Complaint as **Exhibit 2**.

82. In July 2022, Mrs. Owen, through counsel, contacted St. Thomas and Dr. Ramaiah in an effort to learn more about the circumstances leading to her husband's death and open negotiations to avoid litigation, but both St. Thomas and Dr. Ramaiah ignored her letter.

CAUSATION AND DAMAGES

83. Plaintiff incorporates the allegations set forth above as if fully described herein.

84. As a direct and proximate result of the negligence, gross negligence, and recklessness of the Defendants and their agents and employees, Mr. Owen, Mrs. Owen, and their two daughters suffered injuries they would not have otherwise incurred—including Mr. Owen's pain and suffering and death, Mrs. Owen's loss of her beloved husband, and her daughters' loss of their father.

85. Mr. Owen would not have died had Dr. Ramaiah and St. Thomas not breached their duties to Mr. Owen, as more fully described above.

86. This lawsuit seeks all wrongful death damages available in Tennessee, including economic damages and non-economic damages. These requested damages include, but are not limited to, medical and funeral expenses, lost earnings, lost earning capacity, physical pain and suffering, emotional pain and suffering, loss of enjoyment of life, and the pecuniary value of life, including loss of spousal and parental consortium.

87. This lawsuit seeks punitive damages for the acts described herein involving a conscious disregard for the known risk of harm posed to Mr. Owen, which constitutes reckless conduct.

88. Defendants are not protected by any statutory cap on punitive damages because Tennessee's statutory cap on punitive damages is unconstitutional, including as held by the United States Court of Appeals for the Sixth Circuit in 2018 and Tennessee courts, including the Williamson County Circuit Court in 2019.

89. Alternatively, Tenn. Code Ann. §29-39-104 is unconstitutional because it violates the right to a trial by jury enshrined in both the United States Constitution and the Tennessee Constitution.

90. Defendants are not protected by any COVID-19 related immunities or limitations on liability because their acts and omissions constituted gross negligence or reckless conduct, and because the medical care involved did not involve "covered countermeasures" within the meaning of applicable federal law.

FIRST CAUSE OF ACTION
WRONGFUL DEATH STATUTE/TENNESSEE HEALTH CARE LIABILITY ACT
(Tenn. Code Ann. §§ 20-5-113, 29-26-101 *et seq.*)

91. Plaintiff incorporates the allegations set forth above as if fully described herein.

92. The relationship of health care provider-patient existed between Mr. Owen, on the one hand, and each Defendant, including each Defendant's actual or apparent agents.

93. Defendants and their agents and employees owed Mr. Owen a duty to provide medically appropriate care and treatment in August and September 2021.

94. Defendants failed to comply with the applicable recognized standard of acceptable professional practice ("standard of care") when they provided treatment to Mr. Owen in August and September 2021.

95. The ways in which Defendants and their agents and employees failed to comply with the applicable standard of care include, but are not limited to:

a. Perforating Mr. Owen's ventricle once during ECMO cannulation;

b. Perforating Mr. Owen's ventricle a second time during ECMO cannulation;

c. Failing to disclose to Mr. Owen and/or Mrs. Owen material details regarding the ECMO procedure and its (allegedly) foreseeable risks and benefits, including but not limited to the possibility of central heart access and the risks therefrom, including the risks of perforation, bleeding, infection, and injury to vessels, including the risk of brain dysfunction or death;

d. Failing to ensure that trained staff was present and prepared to deal with any complications arising from ECMO cannulation;

e. Failing to ensure that a bypass machine was present and available for use during the procedure;

f. Deliberately deciding not to have a bypass machine present and available during the procedure;

g. Failing to communicate with Mr. Owen's wife about a possible intraprocedural complication;

h. Failing to communicate with Mr. Owen's wife about the actual intraprocedural complications that occurred;

i. Willfully misrepresenting factual events to Mrs. Owen;

j. After the MRI, informing Mrs. Owen that her husband's brain activity was normal and/or his prognosis was good, when in fact the opposite was true;

k. Failing to inform Mrs. Owen about the events that transpired and lead to her husband's death; and

l. Other acts of negligence, gross negligence, recklessness, and willful manipulation.

96. All of the above acts of negligence also constitute grossly negligent and/or reckless conduct, and in some cases willful misconduct.

97. Plaintiff lacks sufficient information to detail every act of negligent, grossly negligent, reckless, and/or willful misconduct and may include further and additional acts based on information revealed in discovery.

98. As a result of Defendants' breaches of the standard of care, Mr. Owen was injured and died, and his estate and survivors suffered damages as described herein.

SECOND CAUSE OF ACTION
LOSS OF CONSORTIUM

99. Plaintiffs incorporate the allegations set forth above as if fully described herein.

100. Mrs. Owen and her two daughters relied upon their husband and father for company, cooperation, affection, assistance, aid, services, and companionship.

101. As a result of the above-described conduct by Defendants resulting in Mr. Owen's death, Mrs. Owen and her daughters lost the enjoyment of their husband and father's company, cooperation, affection, assistance, aid, services, and companionship.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for the following relief:

102. That proper process issue and be served upon the Defendants, and the Defendants be required to appear and answer this Complaint within the time required by law;

103. That the Plaintiff be awarded fair and reasonable damages, including compensatory and punitive damages, in an amount to be determined by the jury not to exceed $30 million in compensatory damages and $60 million in punitive damages;

104. That the Plaintiff be awarded the costs of trying this action;

105. That this action be heard by a jury;

106. That costs of this action be taxed to the Defendants;

107. That prejudgment interest be awarded to the Plaintiff for economic damages;

108. That the Plaintiff be awarded all and any such other and further relief as the Court deems proper; and

109. That the Plaintiff's right to amend this Complaint to conform to the evidence be reserved.

Respectfully submitted,

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VERIFICATION

I, Julie Owen, declare under penalty of perjury under the laws of Tennessee, that the factual allegations in the foregoing Verified Complaint are true to the best of my knowledge, information, and belief.

Dated: December 23, 2022

JULIE OWEN