STATE OF WISCONSIN CIRCUIT COURT DANE COUNTY

COPY

STATE OF WISCONSIN,

Plaintiff,

v. Case No. 2006 CF 2512

JULIE THAO
(D.O.B.: 12/14/1964)
227 N Park Street,
Belleville, WI 53508,

Defendant.

CRIMINAL COMPLAINT

I, GREGORY SCHULER, BEING DULY SWORN, UPON INFORMATION AND BELIEF, STATE THAT THE ABOVE-NAMED DEFENDANT:

COUNT 1: NEGLECT OF A PATIENT CAUSING GREAT BODILY HARM

On or about July 5, 2006, at 707 South Mills Street, City of Madison and County of Dane, the above-named defendant did engage in omissions that, because of the failure to provide adequate medical care, created a significant danger to the physical health of Jasmine Gant, a patient of an inpatient health care facility, under circumstances that caused great bodily harm to Jasmine Gant. Contrary to Wis. Stat. § 940.295(3)(a)(3) and (3)(b)(3).

Upon conviction of this charge, a Class H Felony, the maximum penalty for this crime is a fine not to exceed $25,000 or imprisonment not to exceed 6 years, or both.

FACTUAL BASIS

Introduction:

I, Gregory Schuler, am an investigator with the Wisconsin Department of Justice, Medicaid Fraud Control Unit ("MFCU"). Prior to that I was employed with the City of Milwaukee Police Department for 26 years: 12 years in the Squad Patrol units of Third Precinct, Second Precinct, and Metropolitan Division, 14 years in the Criminal Investigation Bureau (1st year General Duty Detective, last 13 years Homicide Unit Detective), 13 years in the Hostage Negotiation Unit (Negotiator 7 years and Negotiation Unit instructor/negotiator 6 years), and 9 years as an Adjunct Instructor at the Milwaukee Police Academy (New Recruits, In-service, and New Detective Training).

The MFCU is charged with investigating and prosecuting criminal offenses affecting the medical assistance program, including laws affecting the health, safety, and welfare of recipients of medical assistance.

In my capacity as an MFCU investigator, I reviewed the investigative materials collected by the Wisconsin Department of Health and Family Services Bureau of Quality Assurance ("BQA") and the Dane County Coroner's Report. I believe the contents of these reports are accurate because I know that these reports have been mandated, prepared and kept in accordance with State law and in the normal course of business. I further base this complaint upon the statement of civilian witnesses Suzette Esterholm, Carla Griffin, Joseph Fok, and Regina Young. I further base this complaint upon the report of fellow investigator John Knappmiller.

Summary of Investigation:

I was charged with the responsibility of investigating the death of a child, Jasmine Gant on July 5, 2006, at Saint Mary's Medical Center ("SMHMC") where the above-named defendant

was employed as a registered nurse. My investigation has revealed that the actions, omissions and unapproved shortcuts of the defendant constituted a gross breach of medical protocol, resulting in the death of this child. The child died from the rapid infusion of lethal chemicals into her bloodstream. My investigation has furthermore uncovered the following:

- The child's attending physician and the defendant's nurse supervisor report that the defendant failed to obtain authorization to remove the lethal chemicals that caused the child's death, from a locked storage system.
- The defendant disregarded hospital protocol by failing to scan the bar code on the medication, a process of which the defendant had been fully trained and was cognizant of. Had the lethal chemicals been scanned, medical professionals would have been forewarned of its lethality and the death would have been prevented.
- The defendant disregarded a bright, clearly written warning on the bag containing the lethal chemicals prior to injecting them directly into the child's bloodstream.
- The defendant injected the lethal chemicals into the bloodstream in a rapid fashion, failing to follow the approved rate for any medications that may have been prescribed for the child, in an apparent effort to save time. The rapid introduction of these chemicals dramatically hastened the death of the child, effectively thwarting any ability to save her life.
- The defendant disregarded hospital protocol and failed to follow professional nursing procedures by not considering the *"five rights"* of patients prior to the administration of the lethal chemicals. The practice at St. Mary's requires the consideration of five factors at least three times prior to the administration of any medication; the most important procedure established to prevent putting a patient's life in jeopardy through medication errors.

Particularized Findings of Fact:

I reviewed the report of BQA Investigator Suzette Esterholm which includes a written statement (signed on July 10, 2006) by the above-named defendant and investigative notes regarding a July 12, 2006, interview of the above-named defendant by Ms. Esterholm. Ms. Esterholm is a Registered Nurse ("RN") and is a nursing consultant for BQA. According to her reports, the defendant stated the following: that on July 5, 2006, Jasmine Gant (age 16) came into the SMHMC at 10:00 or 11:00 AM because Gant was pregnant and ready to begin the process of giving birth. The above-named defendant stated that she failed to put the patient ID

bracelet on the patient, which is required upon admission to the birthing unit. The above-named defendant stated that Gant had a strep infection and that the Doctor ordered that Penicillin be administered to prevent infection of the baby. The above-named defendant stated that she decided to get a bag containing Epidural (Bupivacaine) to show the patient what it looked like. The defendant acknowledged that she "had no business getting it out" of the locked storage. The defendant stated that she brought the Epidural into the room and placed it on a counter. The defendant stated that another nurse entered the birthing suite, delivered the Penicillin bag and hollered: "your penicillin is here on the counter!" placing it on the counter. Contrary to what others present in the room reported, the defendant insisted that Gant began "crying" and was in a "panic" causing the defendant to inadvertently scoop up the bag containing Epidural (Bupivacaine) and fail to look at the medication. She further admits that she was not going to scan the medication in the Bridge System, so that she would be certain of what she was giving the patient, until after she started infusing the patient with the drug. However, the defendant stated that she administered the Epidural (Bupivacaine) to Gant intravenously through an (IV) and then proceeded to work on rewinding a videotape. Within five minutes, Gant's mother started screaming "Oh my God!" Gant had a stiff back, was experiencing seizure, was gasping for air and was clenching her jaw. Gant was declared dead at 18:30 (6:30PM). The defendant stated to Esterholm that "I allow priority for compassion to override the need for detail."

Investigator John Knappmiller and I interviewed Carla Griffin who is employed as the Director of Birthing Suites at Saint Mary's Hospital Medical Center. Ms. Griffin is a Certified Registered Nurse and was the direct supervisor of the above-named defendant on July 5, 2006. Ms. Griffin stated that the location of the July 5, 2006, incident is St. Mary's Hospital Medical Center ("SMHMC"), 707 South Mills Street, Madison, Wisconsin 53715. Ms. Griffin stated that

a central principle that all nurses are taught and are required to follow is "the five rights of medication administration: 1) Right Patient, 2) Right Route, 3) Right Dose, 4) Right Time and 5) Right Medication." Griffin stated these "*five rights*" are taught to all nurses and are the accepted standard of care in the nursing profession and it is supposed to ensure that a patient is properly medicated. Griffin state that a failure to abide by the "*five rights*" constitutes inadequate medical care. Griffin stated that SMHMC has a series of safety measures in place to safeguard medication and to avoid medication administration errors beyond the "*five rights.*" Among the security measures, she stated that SMHMC has a locked medication storage system known as "Pyxis." The Pyxis system must be unlocked electronically and with fingerprint scan recognition technology in order to obtain medications. The Pyxis system maintains a record of who accessed the system, the time that they accessed the system and what medications they took from the system. Further, Griffin stated that SMHMC has a computer system that all nurses are required to use when giving a patient a medication. The computer system is known as the "Bridge System" which is used to scan the medication before it is given. In doing so, the computer identifies the medication and whether the medication has been ordered for the patient. Ms. Griffin made it clear that the Bridge system is a precautionary safety measure that is to be used ***before*** a nurse gives a medication to a patient. She stated that the defendant admitted to her that, contrary to protocol, she had not used the Bridge system for this patient and was not planning on using it until ***after*** she administered the drugs to the patient. Griffin stated that by doing this the defendant defeats the safety aspect of the Bridge System. Another safety measure is that the medications are clearly labeled, so that the nurse can simply look at the medication to identify it before giving it to a patient. Additionally, Griffin stated that a Doctor must order a medication before it is administered to a patient. She stated that that there was no Doctor's order for the

Epidural (Bupivacaine). She states that Epidural (Bupivacaine) is a potent anesthetic that is only supposed to be administered in the epidural space of the spinal column. It is not to be administered directly to a patient intravenously (IV).

I reviewed the Pyxis system records from SMHMC and they show that the defendant retrieved the three (3) Epidural related drugs that are necessary when an anesthesiologist is about to administer an Epidural to a patient. These were removed from the Pyxis system by the defendant on July 5, 2006, at 11:38 AM and 11:39 AM.

I went to the Dane County Coroner's office and viewed the Epidural (Bupivacaine) Bag used in this incident. The bag is labeled with an oversized, hot-pink label on the front side with bold black writing that states: **CAUTION EPIDURAL**. The bag has a second label on the backside that is hot-pink in color with bold black writing that states: **FOR EPIDURAL ADMINISTRATION ONLY**. The bag has a white label with a bar-code for use with the Bridge System. I also viewed the Penicillin bag that was seized from the scene of the incident. The Penicillin Bag does not have a pink cautionary label. The Penicillin bag has two small orange labels, indicating that the contents of the bag and the patient's name.

By ignoring the "five rights," the defendant failed to provide adequate medical care to Gant. Further, the defendant violated the required SMHMC policy that all nurses must use the "Bridge System" to avoid deadly errors such as this. In so doing, the defendant, again, failed to provide adequate medical care to Gant.

I spoke with Joseph Fok, Gant's Attending Physician. Fok stated that he never ordered the Epidural for this patient and never requested that anyone bring an Epidural into this patient's birthing suite. Further, Fok stated that Gant experienced cardiac arrest, convulsions, central nervous system complications, and death as a result of poisoning by intravenous anesthetic

(Epidural/Bupivacaine). Therefore, the defendant's omissions (failing to obtain a Doctor's order before introducing medication into the patient's room, not looking at the medication, failing to abide by the *five rights* and not scanning the medication as required) were failures to provide adequate medical care that created a significant danger to the physical health of Jasmine Gant and caused great bodily harm to Jasmine Gant.

PEGGY A. LAUTENSCHLAGER
Attorney General

GREGORY SCHULER
Criminal Investigator
Medicaid Fraud Control Unit
Wisconsin Department of Justice

Subscribed and sworn to before me,
and approved for filing, this 2nd day
of November, 2006.

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