RETURN DATE: JULY 22, 2025

CHAUNCEY SHERMAN SMITH, ADMINISTRATOR OF THE ESTATE OF GAY SHERMAN WEINTZ	:	SUPERIOR COURT
V.	:	JUDICIAL DISTRICT OF MIDDLESEX AT MIDDLETOWN
MIDDLESEX HEALTH SYSTEM, INC.; MIDDLESEX HOSPITAL; and MIDDLESEX HEALTH SERVICES, INC.	:	JUNE 5, 2025

COMPLAINT

FIRST COUNT: **Chauncey Sherman Smith, Administrator of the Estate of Gay Sherman Weintz v. Middlesex Health System, Inc., Middlesex Hospital, and Middlesex Health Services, Inc.**

1. On November 11, 2024, the plaintiff, Chauncey Sherman Smith, was appointed Administrator of the Estate of Gay Sherman Weintz by the Saybrook Probate Court (PD33) and is duly authorized to act in that capacity.

2. At all times mentioned herein, the defendant, Middlesex Health System, Inc., was a Connecticut corporation, with a business address of 28 Crescent Street, Middletown, Connecticut, and was authorized to transact business in the State of Connecticut.

3. At all times mentioned herein, the defendant, Middlesex Hospital, with a business address of 28 Crescent Street, Middletown, Connecticut, was and continues to be a wholly owned subsidiary of the defendant, Middlesex Health System, Inc.

4. At all times mentioned herein, the defendant, Middlesex Health Services, Inc., was and continues to be a Connecticut corporation, with a business address of 28 Crescent Street, Middletown, Connecticut, and was authorized to transact business in the State of Connecticut.

5. At all times mentioned herein, the defendant, Middlesex Health Services, Inc., was and continues to be a wholly owned subsidiary of the defendant, Middlesex Health System, Inc.

6. At all times mentioned herein, the defendants, Middlesex Health System, Inc., Middlesex Hospital, and/or Middlesex Health Services, Inc., (hereinafter collectively "Middlesex Health defendants") operated and provided hospital and health care services, including emergency department medical services, at the facility known as "Shoreline Medical Center," located at 250 Flat Rock Place, Westbrook, Connecticut.

7. At all times mentioned herein, the Middlesex Health defendants operated and provided hospital and health care services, including emergency department medical services, at the facility known as "Middlesex Hospital," located at 28 Crescent Street, Middletown, Connecticut.

8. At all times mentioned herein, the Middlesex Health defendants provided medical care and treatment to the plaintiff's decedent, Gay Sherman Weintz, through their agents, apparent agents, servants, and/or employees, including emergency medicine physicians at the Shoreline Medical Center and Middlesex Hospital.

9. At all times mentioned herein, attending physicians in the Shoreline Medical Center and Middlesex Hospital emergency departments acting as agents, apparent agents, servants, and/or employees of one or more of the Middlesex Health defendants, were acting within the course and scope of their agency, apparent agency, service, and/or employment with the Middlesex Health defendants.

10. At all times mentioned herein, the Middlesex Health defendants' agents, apparent agents, servants, and/or employees, including the attending physicians in the Shoreline Medical Center and Middlesex Hospital emergency departments, were required to provide that level of care, skill, and treatment which, in light of all the relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare providers.

11. At all times mentioned herein, Katharine F. Campbell, M.D., was an emergency medicine physician licensed to practice in the State of Connecticut.

12. At all times mentioned herein, Katharine F. Campbell, M.D., was an agent, apparent agent, servant, and/or employee of one or more of the Middlesex Health defendants.

13. At all times mentioned herein, Katharine F. Campbell, M.D., was acting within the course and scope of her agency, apparent agency, service, and/or employment with one or more of the Middlesex Health defendants.

14. At all times mentioned herein, Katharine F. Campbell, M.D., was required to provide that level of care, skill, and treatment which, in light of all the relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare providers.

15. At all times mentioned herein, Matthew J. Neulander, M.D., was an emergency medicine physician licensed to practice in the State of Connecticut.

16. At all times mentioned herein, Matthew J. Neulander, M.D., was an agent, apparent agent, servant, and/or employee of one or more of the Middlesex Health defendants.

17. At all times mentioned herein, Matthew J. Neulander, M.D., was acting within the course and scope of his agency, apparent agency, service, and/or employment with one or more of the Middlesex Health defendants.

18. At all times mentioned herein, Matthew J. Neulander, M.D., was required to provide that level of care, skill, and treatment which, in light of all the relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare providers.

19. At all times mentioned herein, Sarah A. Rajchel, M.D., was an emergency medicine physician licensed to practice in the State of Connecticut.

20. At all times mentioned herein, Sarah A. Rajchel, M.D., was an agent, apparent agent, servant, and/or employee of one or more of the Middlesex Health defendants.

21. At all times mentioned herein, Sarah A. Rajchel, M.D., was acting within the course and scope of her agency, apparent agency, service, and/or employment with one or more of the Middlesex Health defendants.

22. At all times mentioned herein, Sarah A. Rajchel, M.D., was required to provide that level of care, skill, and treatment which, in light of all the relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare providers.

23. Beginning in late March 2024, the plaintiff's decedent, Gay Sherman Weintz, began to experience a worsening of underlying depression and anxiety, with increasing episodes of unusual agitation, bizarre behavior, and reported auditory hallucinations.

24. After several visits to the Shoreline Medical Center and Middlesex Hospital emergency departments between March 25, 2024, and March 29, 2024, the plaintiff's decedent was admitted to an inpatient psychiatric program not affiliated with Middlesex Health from March 29, 2024, to April 9, 2024.

25. On or about April 15, 2024, the plaintiff's decedent was taken by ambulance to the Middlesex Hospital emergency department with complaints of a panic attack. During this visit, she was diagnosed with a urinary tract infection, and prescribed oral antibiotic medication.

26. On or about April 16, 2024, the plaintiff's decedent was discharged from Middlesex Hospital to a different psychiatric program (also not affiliated with Middlesex Health), where she was admitted inpatient until April 19, 2024.

27. On the evening of April 20, 2024, the plaintiff's decedent, Gay Sherman Weintz, was brought from her home by ambulance to the emergency department of the Shoreline Medical Center for altered mental status, bizarre behavior, and an episode of urinary incontinence.

28. Initial vital signs taken at the Shoreline Medical Center emergency department at approximately 6:37 p.m. indicated that the plaintiff's decedent's heart rate and blood pressure were elevated.

29. Katharine F. Campbell, M.D., evaluated the plaintiff's decedent, who reported to Dr. Campbell that she did not take her medications that day.

30. At approximately 6:40 p.m., Katharine F. Campbell, M.D., ordered the plaintiff's decedent to be placed under constant observation by a hospital sitter.

31. At approximately 7:17 p.m., the plaintiff's decedent, Gay Sherman Weintz, received an intramuscular injection of a sedating medication to treat agitation.

32. After consulting with the on-call crisis clinician, Katharine F. Campbell, M.D., ordered the plaintiff's decedent to be transferred to the Middlesex Hospital emergency department for observation and further crisis intervention evaluation.

33. The plaintiff's decedent arrived at the Middlesex Hospital emergency department at approximately 9:40 p.m., on April 20, 2024.

34. Vital signs were not taken upon the plaintiff's decedent's arrival to Middlesex Hospital.

35. The order for constant observation was continued, and a hospital sitter was assigned to the plaintiff's decedent.

36. Overnight, the plaintiff's decedent exhibited agitated behavior, was administered sedative medication, and was placed in four-point locking wrist restraints from approximately 2:30 a.m. to 4:00 a.m., on April 21, 2024.

37. On April 21, 2024, at approximately 6:19 a.m., the first set of vital signs was taken at Middlesex Hospital, indicating that the plaintiff's decedent was experiencing tachycardia (heart rate greater than 100 beats per minute).

38. At approximately 8:06 a.m., on April 21, 2024, the plaintiff's decedent underwent a crisis evaluation.

39. Notes from the crisis evaluation indicate that the plaintiff's decedent had recently restarted high doses of psychiatric medications without titration or supervision.

40. At approximately 8:22 a.m., on April 21, 2024, Matthew J. Neulander, M.D., ordered intramuscular haloperidol for the plaintiff's decedent, to treat her agitation.

41. Vital signs taken at 8:24 a.m. indicated tachycardia and elevated blood pressure.

42. Due to her behavior, Matthew J. Neulander, M.D., ordered locking wrist restraints for the plaintiff's decedent at approximately 8:45 a.m.

43. The plaintiff's decedent, Gay Sherman Weintz, was placed in locking wrist restraints at approximately 9:05 a.m., on April 21, 2024.

44. Matthew J. Neulander, M.D., thereafter ordered an enclosed net bed for the plaintiff's decedent.

45. At approximately 11:29 a.m., on April 21, 2024, the plaintiff's decedent's vital signs were taken, and revealed tachycardia and elevated blood pressure.

46. The plaintiff's decedent, Gay Sherman Weintz, remained in wrist restraints until approximately 2:18 p.m., when she was placed into the enclosed net bed.

47. Vital signs taken at approximately 6:07 p.m., on April 21, 2024, revealed tachycardia and elevated blood pressure.

48. Due to the appearance of the plaintiff's decedent's urine, at approximately 6:21 p.m., on April 21, 2024, a urine sample was collected for analysis and culture testing.

49. The plaintiff's decedent, Gay Sherman Weintz, was offered an evening meal on April 21, 2024, and nursing notes indicate that she consumed only 3/4 of her helping of mashed potatoes.

50. Repeat vital signs obtained at 6:30 p.m. revealed tachycardia and elevated blood pressure.

51. Rapid results of the urinalysis were abnormal with the presence of ketones and protein, and the sample appeared contaminated.

52. Katharine F. Campbell, M.D., did not order collection of an additional urine sample, and documented her decision to wait to treat a potential urinary tract infection until the results of the culture were available.

53. On April 21, 2024, at approximately 9:25 p.m., Katharine F. Campbell, M.D., reevaluated the plaintiff's decedent, who was observed to be making frantic repetitive motions with her hands.

54. Katharine F. Campbell, M.D., characterized Ms. Sherman Weintz's behavior, including the hand motions, as "psychogenic in origin," and ordered a sedative injection.

55. The plaintiff's decedent, Gay Sherman Weintz, received an injection of sedating medication at approximately 9:37 p.m., on April 21, 2024.

56. At approximately 11:46 p.m., on April 21, 2024, emergency medicine physician Sarah A. Rajchel, M.D., assumed care of the patients in the Middlesex Hospital emergency department, including the plaintiff's decedent.

57. The plaintiff's decedent, Gay Sherman Weintz, remained in the net bed overnight.

58. At approximately 4:55 a.m., on April 22, 2024, a nurse took the plaintiff's decedent's vital signs, which revealed tachycardia and elevated blood pressure.

59. At approximately 6:53 a.m., a different nurse assumed care of the plaintiff's decedent and noted a respiratory rate of 16 breaths per minute, and documented that, "per previous RN, patient continues with hypertension and heart rate 110s to 120s. Provider aware."

60. Although a nurse documented "provider aware," Sarah A. Rajchel, M.D., did not independently document her awareness of the plaintiff's decedent's abnormal vital signs.

61. Sarah A. Rajchel, M.D., did not document that she ever examined or evaluated the plaintiff's decedent during her shift.

62. Some time prior to 8:45 a.m., the hospital sitter who was assigned to the plaintiff's decedent left the room and, in so doing, failed to maintain constant observation of the decedent because the sitter failed to keep the decedent in his or her direct field of vision.

63. At approximately 8:45 a.m., the hospital sitter who was assigned to constantly observe the plaintiff's decedent documented that the plaintiff's decedent was quiet and lying down when the sitter was not present in the decedent's room and was, therefore, not observing the decedent at that time.

64. At approximately 8:59 a.m., a nurse attempted to take the plaintiff's decedent's vital signs and found her pulseless and apneic. The nurse informed the attending physician and began chest compressions.

65. A rapid glucose test was performed, and the plaintiff's decedent was determined to be hypoglycemic.

66. A code was called and resuscitative efforts, including emergency intubation, were performed.

67. Resuscitative efforts were unsuccessful and the plaintiff's decedent, Gay Sherman Weintz, was pronounced deceased at approximately 9:07 a.m., on April 22, 2024.

68. Agents, apparent agents, servants, and/or employees of the Middlesex Health defendants, including the attending physicians in the emergency departments at Shoreline Medical Center and Middlesex Hospital, deviated from the applicable standard of care in their treatment of the plaintiff's decedent, Gay Sherman Weintz, in one or more of the following ways:

a. in that they failed to administer the plaintiff's decedent's home medications, including sertraline; and/or

b. in that they failed to administer adequate nutrition and hydration, including intravenous fluids, to the plaintiff's decedent; and/or

c. in that they failed to identify and/or evaluate the plaintiff's decedent's symptoms of acute delirium and to adequately and appropriately treat the same; and/or

d. in that they included medical conditions on their differential diagnosis (e.g., hepatic encephalopathy), but failed to order laboratory studies to confirm or rule out the same; and/or

e. in that they failed to ensure that a complete set of vital signs (blood pressure, pulse, temperature, and respiratory rate) was obtained and recorded at least every four hours; and/or

f. in that they failed to timely reassess the plaintiff's decedent's abnormal vital signs; and/or

g. in that they failed to appropriately and adequately respond to the plaintiff's decedent's abnormal vital signs (including elevated blood pressure and tachycardia); and/or

h. in that they failed to investigate or take into account the plaintiff's decedent's reported rapid resumption of high doses of antidepressant and anti-anxiety medications when treating the plaintiff's decedent; and/or

i. in that they failed to adequately monitor the plaintiff's decedent while she was restrained; and/or

j. in that they allowed the plaintiff's decedent to remain in restraints when her behaviors, as documented in hospital flow sheets, did not merit the continued use of restraints (e.g., quiet, sleeping); and/or

k. in that they failed to order a second urine sample when the first was determined to be contaminated; and/or

l. in that they failed to adequately and appropriately address the results of the plaintiff's decedent's abnormal urine test results, in light of a recent urinary tract infection and prior episode of urinary incontinence; and/or

m. in that they failed to adequately monitor the plaintiff's decedent's cardiac function in light of her continued tachycardia, elevated blood pressure, and the administration of medications known to affect cardiac rhythm; and/or

n. in that they failed to ensure that the plaintiff's decedent was seen and/or evaluated by a hospital physician during the overnight shift from April 21, 2024, to April 22, 2024; and/or

o. in that they characterized the plaintiff's decedent's behaviors and symptoms as "psychogenic" without thoroughly investigating and ruling out physical/organic problems or illnesses that could manifest with similar behaviors/symptoms; and/or

p. in that they failed to order blood tests for the plaintiff's decedent during her time at the Shoreline Medical Center and/or Middlesex Hospital to investigate physical causes of her behaviors/symptoms; and/or

q. in that they failed to ensure that hospital sitter(s) maintained visual access to the plaintiff's decedent at all times, in accordance with their orders for "constant observation"; and/or

r. in that they failed to ensure that hospital sitter(s) were present in the room with the plaintiff's decedent at all times; and/or

s. in that they failed to adequately and/or accurately document the plaintiff's decedent's medical record; and/or

t. in that they failed to ensure that the plaintiff's decedent was monitored every fifteen minutes while she was restrained, in violation of Middlesex Hospital policy; and/or

u. in that they failed to ensure that a complete set of vital signs was obtained every four hours, in violation of Middlesex Hospital policy; and/or

v. in that they failed to include sufficient information in the clinical records to justify their diagnoses and/or to warrant the treatment administered to the plaintiff's decedent, in violation of Conn. Agencies Regs. § 19-13-D3(d)(3); and/or

w. in that they allowed the plaintiff's decedent to remain in restraints when she no longer displayed the behaviors that warranted the use of such restraints, in violation of Conn. Agencies Regs. § 19-13-D3(i)(6); and/or

x. in that they failed to ensure that the plaintiff's decedent's abnormal vital signs were timely reassessed, in violation of Conn. Agencies Regs. § 19-13-D3(i)(6); and/or

y. in that they failed to protect and promote the plaintiff's decedent's rights, in violation of 42 C.F.R. § 482.13; and/or

z. in that they failed to discontinue the use of restraints at the earliest possible time, in violation of 42 C.F.R. § 482.13 (e)(9); and/or

aa. in that they failed to meet the emergency needs of the plaintiff's decedent, in accordance with acceptable standard of practice, in violation of 42 C.F.R. § 482.55; and/or

bb. in that they failed to ensure that Middlesex Hospital maintained adequate medical and nursing personnel qualified in emergency care to meet the needs of the hospital's emergency department, in violation of 42 C.F.R. § 482.55 (b)(2).

69. As a result of one or more of the above deviations from the applicable standard of care, and the medical negligence of the agents, apparent agents, servants, and/or employees of the Middlesex Health defendants, including the attending physicians in the emergency departments of the Shoreline Medical Center and Middlesex Hospital, the plaintiff's decedent, Gay Sherman Weintz, suffered a fatal cardiac arrhythmia in the setting of acute delirium, which resulted in her untimely death.

70. As a further result thereof, the plaintiff's decedent, Gay Sherman Weintz, suffered extreme physical pain, emotional distress, and mental anguish prior to her death.

71. As a further result thereof, the plaintiff's decedent, Gay Sherman Weintz, has been permanently deprived of the opportunity to pursue and enjoy life's activities.

72. As a further result thereof, the plaintiff, Chauncey Sherman Smith, has been forced to incur financial obligations for hospital, and medical care and treatment, funeral, and burial expenses on behalf of the plaintiff's decedent, Gay Sherman Weintz.

73. The plaintiff brings this Count pursuant to Connecticut General Statutes § 52-555.

SECOND COUNT: Chauncey Sherman Smith, Administrator of the Estate of Gay Sherman Weintz v. Middlesex Health System, Inc., Middlesex Hospital, and Middlesex Health Services, Inc.

1. On November 11, 2024, the plaintiff, Chauncey Sherman Smith, was appointed Administrator of the Estate of Gay Sherman Weintz by the Saybrook Probate Court (PD33) and is duly authorized to act in that capacity.

2. At all times mentioned herein, the defendant, Middlesex Health System, Inc., was a Connecticut corporation, with a business address of 28 Crescent Street, Middletown, Connecticut, and was authorized to transact business in the State of Connecticut.

3. At all times mentioned herein, the defendant, Middlesex Hospital, with a business address of 28 Crescent Street, Middletown, Connecticut, was and continues to be a wholly owned subsidiary of the defendant, Middlesex Health System, Inc.

4. At all times mentioned herein, the defendant, Middlesex Health Services, Inc., was and continues to be a Connecticut corporation, with a business address of 28 Crescent Street, Middletown, Connecticut, and was authorized to transact business in the State of Connecticut.

5. At all times mentioned herein, the defendant, Middlesex Health Services, Inc., was and continues to be a wholly owned subsidiary of the defendant, Middlesex Health System, Inc.

6. At all times mentioned herein, the defendants, Middlesex Health System, Inc., Middlesex Hospital, and/or Middlesex Health Services, Inc., (hereinafter collectively "Middlesex Health defendants") operated and provided hospital and health care services, including emergency department medical services, at the facility known as "Shoreline Medical Center," located at 250 Flat Rock Place, Westbrook, Connecticut.

7. At all times mentioned herein, the Middlesex Health defendants operated and provided hospital and health care services, including emergency department medical services, at the facility known as "Middlesex Hospital," located at 28 Crescent Street, Middletown, Connecticut.

8. At all times mentioned herein, the Middlesex Health defendants provided medical care and treatment to the plaintiff's decedent, Gay Sherman Weintz, through their agents, apparent agents, servants, and/or employees, including nurses in the emergency departments at the Shoreline Medical Center and Middlesex Hospital.

9. At all times mentioned herein, nurses in the Shoreline Medical Center and Middlesex Hospital emergency departments, acting as agents, apparent agents, servants, and/or employees of one or more of the Middlesex Health defendants, were acting within

the course and scope of their agency, apparent agency, service, and/or employment with the Middlesex Health defendants.

10. At all times mentioned herein, the Middlesex Health defendants' agents, apparent agents, servants, and/or employees, including the nurses in the Shoreline Medical Center and Middlesex Hospital emergency departments, were required to provide that level of care, skill, and treatment which, in light of all the relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare providers.

11. Beginning in late March 2024, the plaintiff's decedent, Gay Sherman Weintz, began to experience a worsening of underlying depression and anxiety, with increasing episodes of unusual agitation, bizarre behavior, and reported auditory hallucinations.

12. After several visits to the Shoreline Medical Center and Middlesex Hospital emergency departments between March 25, 2024, and March 29, 2024, the plaintiff's decedent was admitted to an inpatient psychiatric program at a facility not affiliated with Middlesex Health from March 29, 2024, to April 9, 2024.

13. On or about April 15, 2024, the plaintiff's decedent was taken by ambulance to the Middlesex Hospital emergency department with complaints of a panic attack. During this visit, she was diagnosed with a urinary tract infection, and prescribed oral antibiotic medication.

14. On or about April 16, 2024, the plaintiff's decedent was discharged from Middlesex Hospital to a different psychiatric hospital (also not affiliated with Middlesex Health), where she was admitted inpatient until April 19, 2024.

15. On the evening of April 20, 2024, the plaintiff's decedent, Gay Sherman Weintz, was brought from her home by ambulance to the emergency department of the Shoreline Medical Center for altered mental status, bizarre behavior, and an episode of urinary incontinence.

16. Initial vital signs taken at the Shoreline Medical Center emergency department at approximately 6:37 p.m. indicated that the plaintiff's decedent had an elevated heart rate and elevated blood pressure.

17. The plaintiff's decedent reported that she did not take her medications that day.

18. At approximately 6:40 p.m., an attending physician at the Shoreline Medical Center ordered constant observation by a hospital sitter for the plaintiff's decedent.

19. Due to agitation, the plaintiff's decedent was administered an injection of sedating medication.

20. The plaintiff's decedent was thereafter transferred to the Middlesex Hospital emergency department for observation and further crisis intervention evaluation.

21. The plaintiff's decedent, Gay Sherman Weintz, arrived at the Middlesex Hospital emergency department at approximately 9:40 p.m., on April 20, 2024.

22. Vital signs were not taken upon the plaintiff's decedent's arrival to Middlesex Hospital.

23. From approximately 2:30 a.m. to 4:00 a.m., on April 21, 2024, the plaintiff's decedent was placed in locking wrist restraints.

24. The plaintiff's decedent's vital signs were not taken during the time that the decedent was restrained.

25. On April 21, 2024, at approximately 6:19 a.m., the first set of vital signs was taken at Middlesex Hospital, indicating that the plaintiff's decedent was experiencing tachycardia (heart rate greater than 100 beats per minute).

26. Vital signs taken at 8:24 a.m. revealed tachycardia and elevated blood pressure.

27. Due to her behavior, the plaintiff's decedent, Gay Sherman Weintz, was placed in four-point locking wrist restraints at approximately 9:05 a.m., on April 21, 2024.

28. At approximately 11:29 a.m., on April 21, 2024, the plaintiff's decedent's vital signs were taken, and revealed tachycardia and elevated blood pressure.

29. The plaintiff's decedent, Gay Sherman Weintz, remained in wrist restraints until approximately 2:18 p.m., when she was placed into an enclosed net bed.

30. Vital signs taken at approximately 6:07 p.m., on April 21, 2024, revealed tachycardia and elevated blood pressure.

31. Due to the appearance of the plaintiff's decedent's urine, at approximately 6:21 p.m., on April 21, 2024, a sample was collected for analysis and culture testing.

32. The plaintiff's decedent, Gay Sherman Weintz, was offered an evening meal on April 21, 2024, and nursing notes indicate that she consumed only 3/4 of her helping of mashed potatoes.

33. Repeat vital signs obtained at 6:30 p.m. revealed tachycardia and elevated blood pressure.

34. Rapid results of the urinalysis were abnormal with the presence of ketones and protein, and the sample appeared contaminated.

35. A repeat urine sample was not collected.

36. Vital signs taken at approximately 4:55 a.m., on April 22, 2024, revealed tachycardia and elevated blood pressure.

37. At approximately 6:53 a.m., a nurse documented the plaintiff's decedent's respiratory rate, but did not take any other vital signs at that time.

38. Some time prior to 8:45 a.m., the hospital sitter who was assigned to the plaintiff's decedent left the room and, in so doing, failed to maintain constant observation of the decedent because the sitter failed to keep the decedent in his or her direct field of vision.

39. At approximately 8:45 a.m., the hospital sitter who was assigned to constantly observe the plaintiff's decedent documented that the plaintiff's decedent was quiet and lying down when the sitter was not present in the decedent's room and was, therefore, not observing the decedent at that time.

40. At approximately 8:59 a.m., a nurse attempted to take the plaintiff's decedent's vital signs and found her pulseless and apneic. She informed the attending physician and began chest compressions.

41. A rapid glucose test was performed, and the plaintiff's decedent was determined to be hypoglycemic.

42. A code was called and resuscitative efforts, including emergency intubation, were performed.

43. Resuscitative efforts were unsuccessful and the plaintiff's decedent, Gay Sherman Weintz, was pronounced deceased at approximately 9:07 a.m., on April 22, 2024.

44. Agents, apparent agents, servants, and/or employees of the Middlesex Health defendants, including the emergency department nurses at Shoreline Medical Center and Middlesex Hospital, deviated from the applicable standard of care in their treatment of the plaintiff's decedent, Gay Sherman Weintz, in one or more of the following ways:

a. in that they failed to administer the plaintiff's decedent's home medications, including sertraline; and/or

b. in that they failed to administer adequate nutrition and hydration, including intravenous fluids, to the plaintiff's decedent; and/or

c. in that they failed to obtain and record a complete set of vital signs (blood pressure, pulse, temperature, and respiratory rate) at least every four hours; and/or

d. in that they failed to timely reassess the plaintiff's decedent's abnormal vital signs; and/or

e. in that they failed to timely inform the attending physicians of the abnormal vital signs; and/or

f. in that they failed to appropriately and adequately respond to the plaintiff's decedent's abnormal vital signs (including elevated blood pressure and tachycardia); and/or

g. in that they failed to adequately monitor the plaintiff's decedent while she was restrained; and/or

h. in that they failed to obtain a second urine sample when the first was determined to be contaminated; and/or

i. in that they failed to adequately and appropriately address the results of the plaintiff's decedent's abnormal urine test results, in light of a recent urinary tract infection and prior episode of urinary incontinence; and/or

j. in that they failed to adequately monitor the plaintiff's decedent's cardiac function in light of her continued tachycardia, elevated blood pressure, and the administration of medications known to affect cardiac rhythm; and/or

k. in that they failed to inform nursing staff in their chain of command (e.g., charge nurse or supervisor) of the failure of the attending emergency department physicians to adequately and appropriately address the plaintiff's decedent's repeated abnormal vital signs; and/or

l. in that they failed to ensure that the plaintiff's decedent was seen and/or evaluated by a hospital physician during the overnight shift from April 21, 2024, to April 22, 2024; and/or

m. in that they failed to ensure that the hospital sitter(s) maintained visual access to the plaintiff's decedent at all times in accordance with the orders for "constant observation"; and/or

n. in that they failed to ensure that the hospital sitter(s) were present in the room with the plaintiff's decedent at all times; and/or

o. in that they were unfamiliar with the hospital sitter's role and expectations concerning constant observation; and/or

p. in that they failed to adequately and accurately document the plaintiff's decedent's medical record; and/or

q. in that they failed to ensure that the plaintiff's decedent was monitored every fifteen minutes while she was restrained, in violation of Middlesex Hospital policy; and/or

r. in that they failed to obtain and record a complete set of vital signs every four hours, in violation of Middlesex Hospital policy; and/or

s. in that they failed to include sufficient information in the clinical records to justify their diagnoses and/or to warrant the treatment administered to the plaintiff's decedent, in

violation of Conn. Agencies Regs. § 19-13-D3(d)(3); and/or

t. in that they allowed the plaintiff's decedent to remain in restraints when she no longer displayed the behaviors that warranted the use of such restraints, in violation of Conn. Agencies Regs. § 19-13-D3(i)(6); and/or

u. in that they failed to ensure that the plaintiff's decedent's abnormal vital signs were timely reassessed, in violation of Conn. Agencies Regs. § 19-13-D3(i)(6); and/or

v. in that they failed to protect and promote the plaintiff's decedent's rights, in violation of 42 C.F.R. § 482.13; and/or

w. in that they failed to ensure that the use of restraints was discontinued at the earliest possible time, in violation of 42 C.F.R. § 482.13 (e)(9); and/or

x. in that they failed to meet the emergency needs of the plaintiff's decedent, in accordance with acceptable standard of practice, in violation of 42 C.F.R. § 482.55; and/or

y. in that they failed to ensure that Middlesex Hospital maintained adequate medical and nursing personnel qualified in emergency care to meet the needs of the hospital's emergency department, in violation of 42 C.F.R. § 482.55 (b)(2).

45. As a result of one or more of the above deviations from the applicable standard of care, and the medical negligence of the agents, apparent agents, servants, and/or employees of the Middlesex Health defendants, including the nurses in the emergency departments at Shoreline Medical Center and Middlesex Hospital, the

plaintiff's decedent, Gay Sherman Weintz, suffered a fatal cardiac arrhythmia in the setting of acute delirium, which resulted in her untimely death.

46. As a further result thereof, the plaintiff's decedent, Gay Sherman Weintz, suffered extreme physical pain, emotional distress, and mental anguish prior to her death.

47. As a further result thereof, the plaintiff's decedent, Gay Sherman Weintz, has been permanently deprived of the opportunity to pursue and enjoy life's activities.

48. As a further result thereof, the plaintiff, Chauncey Sherman Smith, has been forced to incur financial obligations for hospital, and medical care and treatment, funeral, and burial expenses on behalf of the plaintiff's decedent, Gay Sherman Weintz.

49. The plaintiff brings this Count pursuant to Connecticut General Statutes § 52-555.

WHEREFORE, the plaintiff claims money damages. The amount in demand, exclusive of interest and costs, is in excess of FIFTEEN THOUSAND DOLLARS ($15,000.00).

I hereby certify that I have knowledge of the financial responsibilities of the plaintiff and deem them sufficient to pay the costs.

Hereof fail not, but of this writ, with your doings thereon, make due service and return according to law.

Dated at West Hartford, Connecticut, this 5th day of June, 2025

BY _____
Ryan K. Sullivan
Commissioner of the Superior Court

We hereby enter our appearance
for the plaintiff in this action.

Ris Cassi & Davis, P.C.
RISCASSI AND DAVIS, P.C.
Juris No. 50361

[redacted]

Ryan Sullivan, Esq.
RisCassi & Davis, P.C.
91 South Main Street
West Hartford, CT 06107

April 24, 2025

Re: Estate of Gay Sherman Weintz v. Middlesex Health

Dear Mr. Sullivan:

Thank you for asking me to review this case. I am a registered nurse licensed in Rhode Island with more than twenty years of experience in emergency and trauma nursing, including field hospital experience while deployed with the United States Armed Forces. I hold a bachelor's degree and a master's degree in the science of nursing, and a certification in emergency nursing. I currently work in the emergency department of a teaching hospital designated by the American Nurses Association's Magnet Recognition Program. I have experience with hospital sitter services for patients who require observation. Accordingly, I am familiar with the standard of care as it existed in 2024 for nurses working in hospital emergency departments.

My opinions in this case are based on my review of the following documents:

1. Autopsy report, April 23, 2024;
2. Middlesex Hospital records April 15-16 and April 20-22, 2024;
3. Middlesex Health corrective action plan (dated August 26, 2024) prepared in response to Connecticut Department of Public Health ("DPH") investigation number 39862, conducted July 12, 2024.

According to the records, in late March 2024, Gay Sherman Weintz, then 55 years old (date of birth July 17, 1968), began to experience a worsening of underlying depression and anxiety, with increasing episodes of unusual agitation, bizarre behavior, and reported auditory hallucinations. She presented to Middlesex Hospital emergency department on March 27, 2024, and was discharged to an inpatient psychiatric program, where she was admitted from March 29 to April 9, 2024.

On April 15, 2024, Ms. Weintz was brought by ambulance to Middlesex Hospital in Middletown, Connecticut, for a panic attack. Ms. Weintz underwent blood and urine testing and an EKG. Ms. Weintz was diagnosed with a urinary tract infection ("UTI") and was treated with oral antibiotics. After undergoing a psychiatric crisis consultation, Ms. Weintz was discharged to a different inpatient mental health facility on April 16, 2024, where she was admitted until April 19, 2024.

On the evening of April 20, 2024, Ms. Weintz again began to exhibit bizarre behavior and experienced an episode of urinary incontinence at home. She was brought by ambulance to Middlesex Shoreline Medical Center (a Middlesex Health facility) in Westbrook, Connecticut. The first set of vital signs taken at 6:37 p.m. indicates that Ms. Weintz had an elevated heart rate and elevated blood pressure. While in the emergency department, Ms. Weintz appeared agitated and was given intramuscular sedating medication. After demonstrating concerning behaviors (*e.g.*, attempting to jump out of bed), an emergency department physician ordered a crisis consultation and constant observation by a hospital sitter for Ms. Weintz. Vital signs taken at 9:30 p.m. indicated a heart rate of 93 and blood pressure of 144/91. At the recommendation of the crisis clinician, Ms. Weintz was transferred by ambulance to Middlesex Hospital for observation and crisis intervention evaluation.

Ms. Weintz arrived at the Middlesex Hospital emergency department at approximately 10:30 p.m. on April 20, 2024. Ms. Weintz's vital signs were not checked on her arrival. At approximately 2:30 a.m. on April 21, 2024, an attending emergency department physician was called to Ms. Weintz's bedside due to concerns about her agitated behaviors. He ordered sedating medications and 4-point locking wrist restraints. At approximately 2:50 a.m., the physician noted that Ms. Weintz's heart rate was elevated (110 beats per minute) and "irregular." Restraints were removed at approximately 4:00 a.m.

Vital signs taken at approximately 6:19 a.m. on April 21, 2024, indicated that Ms. Weintz's heart rate and blood pressure were elevated. When her vital signs were checked again at approximately 8:24 a.m., both heart rate and blood pressure had increased. After undergoing additional crisis evaluations, it was determined that Ms. Weintz would remain in the emergency department of Middlesex Hospital until a hospital psychiatrist was available to reevaluate Ms. Weintz.

Ms. Weintz was placed in locking restraints at approximately 9:05 a.m. Later that morning, an attending physician ordered an enclosed net bed (nonviolent restraint enclosed on all four sides) for Ms. Weintz as an alternative form of restraint. Ms. Weintz's vital signs were checked at approximately 11:29 a.m. and indicated elevated heart rate and blood pressure of 160/99. Ms. Weintz remained in locked restraints until approximately 2:18 p.m., when she was placed in the net bed. Vital signs taken at approximately 6:07 p.m. indicated a heart rate of 115 beats per minute and a blood pressure of 174/103. Due to the appearance of Ms. Weintz's urine, a sample was collected for culture and urinalysis at approximately 6:21 p.m.

Nursing notes indicate that Ms. Weintz ate only some of her dinner (3/4 of the serving of mashed potatoes). Repeat vital signs taken at 6:30 p.m. indicated a heart rate of 114 and very elevated blood pressure of 184/117. Rapid results of the urinalysis were abnormal, indicating the presence of ketones and protein. The sample was also noted to be "grossly contaminated."

Vital signs were not taken again until 4:55 a.m. on April 22, 2024. At that time, Ms. Weintz's heart rate was 120 beats per minute; her blood pressure was 174/106. Nursing notes from approximately 6:53 a.m. indicate that Ms. Weintz was resting; vital signs were not taken. At approximately 8:59 a.m., a nurse noted that she entered Ms. Weintz's room to take vital signs and found Ms. Weintz "pulseless, apneic." The nurse began CPR and informed the attending

physician. A code was called, and resuscitative measures were attempted. A rapid glucose was taken at approximately 9:05 a.m., and the patient was found to be in a state of severe hypoglycemia with a critically low blood glucose level of 33 mg/dL. Resuscitation was not successful, and Ms. Weintz was pronounced deceased at 9:07 a.m.

Results of the urine culture came back in the afternoon on April 22, 2024, and indicated the presence of "multiple bacterial morphotypes." On autopsy, Ms. Weintz's cause of death was noted to be "cardiac arrhythmia in the setting of acute delirium of uncertain type."

In my professional opinion, there is evidence of negligence on the part of the nursing staff at Middlesex Hospital who were caring for Ms. Weintz from April 20-22, 2024. First, Ms. Weintz presented to the hospital with abnormal vital signs. Nurses failed to timely perform repeat assessments, to include observations and vital signs. In light of the medications that Ms. Weintz was administered, her heart rate and respiration rate needed to be checked at regular intervals. On every occasion that Ms. Weintz's vital signs were checked, she was tachycardic and hypertensive. Nurses failed to ensure that these concerning abnormal vital signs were consistently communicated to the attending physicians.

When results were communicated to attending physicians on a few occasions, the physicians failed to take further actions to investigate and treat the underlying causes of the abnormal vital signs. The standard of care requires hospital nurses to escalate concerns about patient care through their chain of command. When attending physicians failed to promptly take action to address Ms. Weintz's condition (e.g., by ordering medications, intravenous hydration, cardiac monitoring, admission to a medical floor, etc.), it was the responsibility of Middlesex Hospital nurses to report these failures through their chain of command, to ensure that Ms. Weintz received appropriate medical care.

Additionally, nursing staff failed to ensure that Ms. Weintz received adequate nutrition and hydration. They documented concerns about the appearance of Ms. Weintz's urine and noted that she ate very little of her evening meal on April 21, 2024. However, they took no further action to address these basic needs. When Ms. Weintz's urine sample was determined to be "grossly contaminated," nurses should have tried again to obtain a clean urine sample for more accurate testing, but failed to do so.

The records indicate that Ms. Weintz was restrained continuously for nearly twelve hours. First, she was put in locking wrist restraints from approximately 9:05 a.m. to 2:18 p.m. on April 21, 2024. Then, she was restrained in an enclosed net bed from approximately 2:18 p.m. on April 21, 2024, until the time of her death at approximately 9:00 a.m. on April 22, 2024. The standard of care requires that the least restrictive form of patient restraint be used and discontinued at the earliest possible time that a patient no longer displays the concerning behavior. Observation sheets included in the medical records indicate many instances, while Ms. Weintz was restrained, that she was "lying down" or "quiet." It was a deviation from the standard of care for Middlesex Hospital nurses to allow Ms. Weintz to be continuously restrained when she was not displaying behaviors to justify the need for such restraints. They failed to timely reassess and document Ms. Weintz's behaviors that would merit the continued use of the restraints (including the net bed).

Nurses also failed to adequately supervise the hospital sitters who were assigned to constantly observe Ms. Weintz. Constant observation means that the patient should be in the direct field of vision of the sitter at all times. Documents from the Connecticut Department of Public Health investigation dated October 8, 2024, indicate that the sitter responsible for observing Ms. Weintz on the morning of April 22, 2024, had left the room on several occasions and was, at times, on her cell phone. Hospital nurses were negligent in their supervisory responsibilities by failing to ensure that sitters assigned to observe Ms. Weintz were performing constant observation as required. One of the hospital nurses acknowledged knowing that the patient was under constant observation but admitted to being unfamiliar with the sitter's role and expectations, highlighting a breakdown in staff training, oversight, and compliance with hospital policy for high-risk patient monitoring.

My opinions, which are to a reasonable degree of medical certainty, are based on my experience, training, education, and my review of the available records. I reserve the right to supplement or amend my opinions if I am provided with additional information that changes them. Thank you for the opportunity to review this case.

Sincerely,

[redacted]

[redacted]

Julianne Lombardo Klaassen, Esq.
Ryan Sullivan, Esq.
RisCassi & Davis, P.C.
91 South Main Street
West Hartford, CT 06107

April 25, 2025

Ms. Klaassen and Mr. Sullivan:

Thank you for asking me to review the case of Gay Weintz (date of birth 7/17/68). Below, I list my education and qualifications, records reviewed, the timeline that I have independently extracted from the medical record, and what I believe to be breaches in the standard of care.

Educational background and qualifications:

I am board-certified in both Emergency Medicine and Addiction Medicine with more than 15 years of experience as an attending. I see patients, conduct clinical research, and serve as the Director for an Emergency Psychiatry unit within an emergency department at an academic medical center. I have a Ph.D. in cognitive neuroscience. My research in behavioral emergencies and substance use disorders has been cited more than 4550 times (h-index 33), and I have written more than 90 peer-reviewed articles, 30 book chapters, and 4 edited books. My work in behavioral emergencies has been supported by numerous federal and private grants, and has been recognized as innovative by the American College of Emergency Physicians and the American Foundation for Suicide Prevention.

Records reviewed:

1. ED presentation to Middlesex Hospital in Middletown (04/15/24 18:24)
2. ED Arrival at 4/20/2024 1819 Unit: Middlesex Health Emergency Department - Westbrook
3. Medical autopsy (4/23/24) by Dr. Christopher C. Borck, MD
4. Toxicology report (5/11/24) by NMS Labs (Horsham, Pennsylvania)
5. Draft opinions by [redacted] MSN, RN, CEN

Summary of key timeline events in this case:

- (4/20/24 18:19) ED Arrival at 4/20/2024 1819 Unit: Middlesex Health Emergency Department - Westbrook
  - Ms. Weintz presents for "Altered Mental Status and Manic Behavior," arriving by ambulance
- (04/20/24 18:37) Initial vitals: T 98.6F, HR 112, RR 20, BP 161/95, SpO2 97%
- (4/20/24 18:37) ED note by Dr Katharine F Campbell MD
  - Physical exam: notable for awake/ alert, moving all extremities and "psychomotor retardation. Unable to assess mood, thought content, or judgement."
  - "DDx: Psychiatric episode, medical illness such as drug ingestion/toxidrome, hepatic encephalopathy,"
  - "Testing Ordered and Independently Reviewed by Me: Laboratory studies and Urinalysis"

Of note, urine would not be obtained for another 24 hours (i.e., resulting at 18:48 the following day). When abnormal UA results returned at this time, these results were consistent with a contaminated sample. However, no repeat urine sample was collected. Additionally, no laboratory studies that would assess hepatic encephalopathy or electrolyte disturbance from drug ingestion were obtained during the remainder of the stay.

- (4/20/24 19:00) vitals show tachycardia
  - T not obtained, HR 114, RR 19, BP 160/83, SpO2 97%
- (4/20/24 19:03) midazolam 5mg IV
  - This is canceled in favor of lorazepam 1mg tablet but reordered at 19:13 by PA Joseph Castro
  - Administered 19:17 IM
- (4/20/24 21:00) Partial vital signs are normal
  - T not obtained, HR 89, RR 12, BP 137/88, SpO2 96%
- (4/20/24 21:29) Report given to EMS
  - Transferred to Middletown CIU
- (4/20/24 21:30) Partial vital signs indicate mildly elevated blood pressure
  - T not obtained, HR 93, RR 10, BP 144/91, SpO2 96%
- (4/20/24 21:40) Arrival at Middletown ED

Of note, repeat vital signs would not be obtained for another 8 hours and 39 minutes (i.e., at 06:19 the following day).

- (4/21/24 02:35) restraints ordered
  - Monitoring every 2 hours
- (4/21/24 02:45) haloperidol administered IM
  - Lorazepam not administered despite being noted as given in Dr. Eisenberg's note.
- (4/21/24 03:00) addendum to note by Dr Edward Eisenberg
  - "Patient resting comfortably"
- (4/21/24 03:37) Restraint order discontinued
  - Restraints actually removed at 04:00
- (4/21/24 06:13) A CIWA-Ar (The Clinical Institute Withdrawal Assessment Alcohol Scale Revised or CIWA-AR) was obtained, and indicated a level of 6
  - (<8 indicates minimal to no alcohol withdrawal)
  - However, RNs note that Ms. Weintz has "Orientation and Clouding of Sensorium: Cannot do serial additions or is uncertain about date."
- (4/21/24 06:15) ED Quick Updates Quick Updates Carmela Indomenico, RN
  - "Quick Updates - Free Text: pt. restless in bed and attempting to jump oob. pt redirected and reposiioned [sic] in bed. pt with unsteady gait"
- (4/21/24 06:19) Vital signs indicate tachycardia
  - T 98.6F, HR 104, RR 12, BP 149/80, SpO2 98%

Of note, Ms. Weintz would remain tachycardic (i.e., a heart rate >100) until her death approximately 27 hours later.

- (4/21/24 08:06) seen by crisis counselor Janice Keeman LCSW
  - Impression: "The periods of lucidity call into question whether there is a feigning aspect, but there is also concern for an organic component because of significant the change in functioning has been including with restarting medications at a high dose without any titration or supervision. Regardless, she is currently presenting as gravely disabled."
- (4/21/24 08:24) vital signs indicate tachycardia, elevated blood pressure
  - T 97.5F, HR 114, RR 18, BP 165/88, SpO2 97%
- (4/21/24 08:25) haloperidol injection 5mg given
- (4/21/24 11:29) vital signs indicate tachycardia, elevated blood pressure
  - T 97.8F, HR 100, RR 18, BP 160/99, SpO2 96%
- (4/21/24 14:18) restraints discontinued
- (4/21/24 16:15) Restraints ordered (net bed)
- (4/21/24 18:07) vital signs indicate tachycardia and elevated blood pressure
  - T 98.2F. HR 115, RR 16, BP 174/103, SpO2 95%
- (4/21/24 18:30) vital signs indicate tachycardia, elevated blood pressure
  - T 97.9F, HR 114, RR 15, BP 184/117, SpO2 97%

Of note, no vitals would be recorded for another 10 hours and 25 minutes (i.e., until 04:55 the next day).

- (4/21/24 18:34) Intake/Output Intake (mL) Gina Branciforte, RN
  - P.O. (mL): 120 mL
  - Urine
  - Urine Color: Amber
  - Urine Appearance: Clear
  - Also ate ¾ mashed potatoes at 18:35

Of note, this is the only intake recorded for Ms. Weintz during her 39-hour stay.

- (4/21/24 18:35) first labs: UPT negative
- (4/21/24 18:48) first labs: abnormal UA results
  - Ketones 40 mg/dl
  - Specific gravity >=1.030
  - Blood small
  - Leukocyte Esterase large
- (4/21/24 18:49) first labs: urine drug screen results abnormal
  - Negative for barbiturates, cocaine, fentanyl, opiates, PCP
  - Positive for cannabinoids and benzodiazepines
- (4/21/24 19:02) Manual Urine Microscopic resulted
  - (Specimen does not represent a clean catch. Consider repeating if clinically indicated.)
- (4/21/24 21:37) midazolam 2.5mg IM administered
- (4/22/24 04:55) vital signs indicate tachycardia, elevated blood pressure
  - T 99.1F, HR 120, RR 16, BP 174/106, SpO2 97%
- (4/22/24 06:53) vital signs indicate elevated blood pressure, tachycardia
  - T not obtained, HR 110s-120s, RR 16, BP noted as "HTN", SpO2 not obtained
- (04/22/24 08:59) ED note by Nichole Bigdeliazari RN
  - This RN attempted to update VS. Pt noted to be pulseless, apneic. Provider Cinti MD notified at bedside. Compressions started immediately by this RN.
- (04/22/24 09:05)
  - FSG = 33 mg/dl
    - D50 administered
- (04/22/24 09:07) time of death
- (4/22/24 12:59) urine culture: "Multiple bacterial morphotypes present, 50,000-100,000 cfu/mL. Suggest appropriate recollection if clinically indicated."

Breaches of the standard of care:

Ms. Weintz presented to the Middlesex Health Emergency Department (ED) - Westbrook on 4/20/2024 at 18:19 for "Altered Mental Status and Manic Behavior." She was kept first at the Westbrook ED then transferred to the Middletown ED for a combined total of nearly 39 hours. During this time, she was restrained for more than 24 of those hours. While in restraints, she was not administered intravenous fluid, water, or food other than a small amount of mashed potatoes. Her home medications were not restarted. Such inhumane treatment offends the conscience and does not meet the standard of care.

The breaches in the standard of care are as follows:

1) Failure to identify or evaluate acute delirium: The medical examiner has identified the cause of death as "cardiac arrhythmia in the setting of acute delirium of uncertain type." Delirium is characterized "by an alteration of attention, consciousness, and cognition, with a reduced ability to focus, sustain or shift attention."[1] The hallmark of delirium is its waxing and waning nature.

Factors that are known to precipitate a delirium include both dehydration and medication side effects. Both of these factors were present in Ms. Weintz's case, involving both lack of appropriate fluids and a sudden discontinuation of her home sertraline upon arriving at the ED. An assessment of delirium by the CAM-ICU did not suggest delirium shortly after arrival, suggesting that Ms. Weintz had been taking her medications and

eating/drinking normally before ED arrival. However, by 4/21/24 at 06:13, the ED's own assessment indicated a likely delirium. A CIWA-Ar (The Clinical Institute Withdrawal Assessment Alcohol Scale Revised or CIWA-AR) was obtained, and indicated minimal to no alcohol withdrawal. However, as part of this scale, RNs noted that Ms. Weintz had "Orientation and Clouding of Sensorium: Cannot do serial additions or is uncertain about date." This finding is consistent with a delirium but inconsistent with a psychiatric illness, in which a patient's level of awareness does not fluctuate.

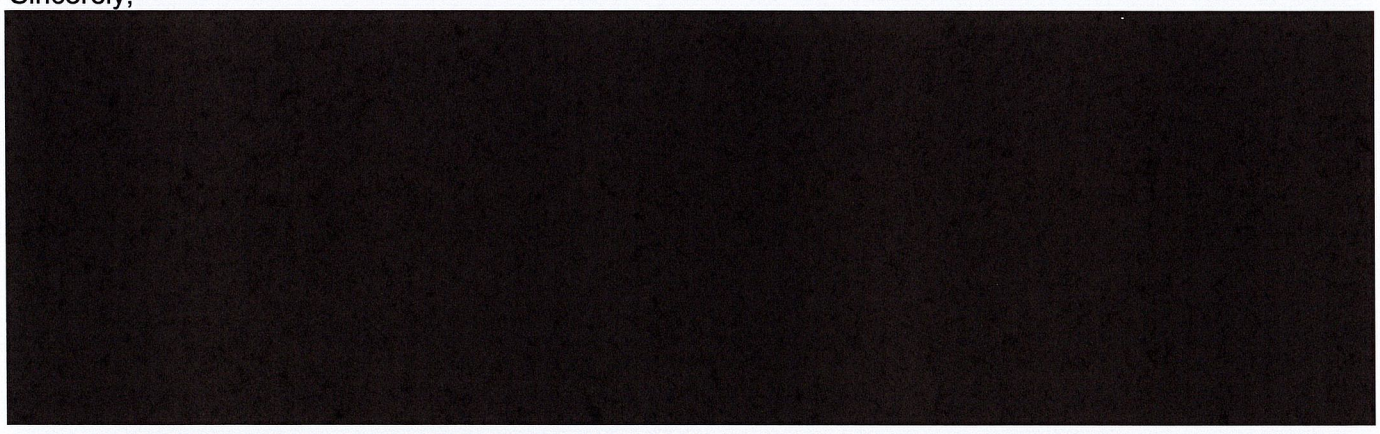
2) Failure to monitor a patient while in restraints: This includes appropriate vital signs, behavioral monitoring, appropriate provision of food/water, and resumption of the patient's home meds. Of note, approximately 50% of Ms. Weintz's home dose of sertraline would be expected on average to be metabolized within 26 hours (i.e., the average half-life of sertraline is approximately 26 hours although individual differences exist).[2] Ms. Weintz experienced multiple symptoms after her home medications were suddenly discontinued after ED arrival, including restlessness (noted 4/21/24 02:59 by Carmela Indomenico, RN); uneven gait (noted 4/21/24 06:15 by Carmela Indomenico, RN); and irritability/mood swings. Sudden discontinuation of her home medications likely explains her worsening of symptoms while in the ED despite administration of antipsychotics, and should have prompted reevaluation.

3) Failure to provide adequate fluids and nutrition resulting in a severely low glucose of 33 mg/dl: This markedly low glucose level likely caused or significantly contributed to Ms. Weintz's death. Hypoglycemia may contribute to death by one of 2 mechanisms: a) impairment of cardiac function, or b) prolongation of the QT interval, especially in the setting of other QT-prolonging agents like haloperidol. Excessive lengthening of the QT interval often causes fatal arrhythmias, consistent with the opinion offered by the medical examiner.

A third potential mechanism is that hypoglycemia typically causes markedly decreased mental status, thus making it difficult for the patient to protect her own airway. However, this third mechanism is thought to be less likely in Ms. Weintz's case, given that she had no evidence of cerebral edema or aspiration on autopsy to suggest this.

I make these opinions with a reasonable degree of medical certainty. These opinions are based on my experience, education, and a review of the available medical records for Ms. Weintz. I reserve the right to supplement or amend my opinions if new or additional information is provided for this case.

Sincerely,

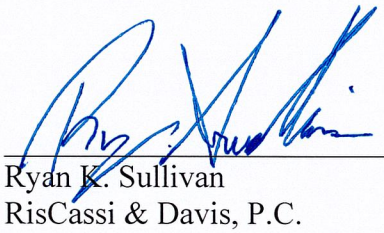


1. https://www.ncbi.nlm.nih.gov/books/NBK470399/
2. https://www.health.harvard.edu/diseases-and-conditions/going-off-antidepressants

CERTIFICATE

Chauncey Sherman Smith, Administrator of the Estate of Gay Sherman Weintz v. Middlesex Health System, Inc., Middlesex Hospital, and Middlesex Health Services, Inc.

I hereby certify that I have made a reasonable inquiry, as permitted by the circumstances, to determine whether there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. This inquiry has given rise to a good faith belief on my part that grounds exist for an action against each named defendant.



Ryan K. Sullivan
RisCassi & Davis, P.C.
Juris No. 50361