IN THE SUPERIOR COURT OF FLOYD COUNTY
STATE OF GEORGIA

CHARLES GREGORY SWINFORD, Plaintiff, v. REDMOND PARK HOSPITAL, LLC d/b/a ADVENTHEALTH REDMOND, ROME RADIOLOGY GROUP, PA, MICHAEL P. HOLCOMBE, MD, CATHERINE E. LANKFORD, REBECCA B. JONES, ABC CORPORATIONS 1-3, and JOHN DOES 1-3 Defendants.	)	Civil Action File No. _____ 23CV01928

COMPLAINT

COMES NOW, the Plaintiff Charles Gregory Swinford ("Plaintiff" or "Swinford") and files this Complaint against the Defendants Redmond Park Hospital LLC d/b/a AdventHealth Redmond ("AdventHealth Hospital"), Rome Radiology Group, PA ("Rome Radiology Group"), Michael P. Holcombe, MD ("Dr. Holcombe" or "Holcombe"), Catherine E. Lankford ("Lankford"), Rebecca B. Jones ("Jones"), and ABC Corporation 1-3, and John Does 1-3 (collectively, "Defendants"). Plaintiff shows the Court as follows:

NATURE OF CLAIM

1.

This is an action for the personal injuries, pain and suffering, medical expenses, and all other damages suffered by Plaintiff and proximately caused by Defendants. On December 22, 2021, the Defendants tortiously performed a lumbar MRI procedure on Mr. Swinford while he was under general anesthesia, exposing him to dangerous levels of radiofrequency energy, by placing him too close to the wall of the MRI machine without proper protection. As a result, Mr. Swinford

suffered a burn injury to his left forearm, which killed the surrounding skin, muscle, and tissue, and created a large, deep hole that extended to the ulna bone. Mr. Swinford underwent months of wound care, a skin graft and ulna resection surgery, months of antibiotic therapy, and now has a fractured ulna bone. This is an action to recover for the Defendants' tortious acts and omissions that caused Mr. Swinford to suffer these injuries.

JURISDICTION AND VENUE

2.

The Superior Court has jurisdiction over this civil action. Ga. Const. 1983, Art. VI, Sec. IV, Para. I; O.C.G.A. § 15-6-8.

3.

Venue is proper in Floyd County, as the cause of action arose in said county and Defendant AdventHealth Hospital has an office and transacts business in said county. Ga. Const. 1983, Art. VI, Sec. II, Para. VI; O.C.G.A. § 14-2-510; O.C.G.A. § 14-3-510.

4.

Venue is also proper in Floyd County, as the cause of action arose in said county and Defendant Rome Radiology Group has an office and transacts business in said county. Ga. Const. 1983, Art. VI, Sec. II, Para. VI; O.C.G.A. § 14-2-510; O.C.G.A. § 14-3-510.

5.

Venue is also proper in Floyd County, as Defendants Holcombe, Lankford, and Jones each reside in said county. Ga. Const. 1983, Art. VI, Sec. II, Para. VI.

PARTIES

6.

The Plaintiff, Mr. Swinford, is a resident of Chattooga County, Georgia.

7.

Defendant AdventHealth Hospital is a Georgia Limited Liability Corporation, maintaining its principal place of business in Floyd County and having its registered agent for service of process as Isaac Sendros, 501 Redmond Road NW, Rome, GA 30165, where it may be served with process. Defendant AdventHealth Hospital is subject to the jurisdiction of this Court.

8.

Defendant Rome Radiology Group is a Georgia Professional Association, maintaining its principal place of business in Floyd County and having its registered agent for service of process as Chris Sluder, 901 N. Broad Street, Suite 120 Rome, GA 30161, where it may be served with process. Defendant Rome Radiology Group is subject to the jurisdiction of this Court.

9.

Defendant Dr. Holcombe resides in Floyd County at 200 East 4th Avenue, Rome, GA 30161, where he may be served with process. Defendant Holcombe is, thus, subject to the jurisdiction of this Court.

10.

Defendant Lankford resides in Floyd County at 3 Stonegable Drive NW, Rome GA 30165, where she may be served with process. Defendant Lankford is, thus, subject to the jurisdiction of this Court.

11.

Defendant Jones resides in Floyd County at 22 Ford Road SE, Rome GA 30161, where she may be served with process. Defendant Jones is, thus, subject to the jurisdiction of this Court.

12.

Defendant ABC Corporations 1-3 are corporations/entities whose true names are unknown

to Plaintiff. Upon information and belief, Defendants ABC Corporations 1-3 may have also committed negligent acts and/or omissions which resulted in injury to Plaintiff.

13.

Defendant John Does 1-3 are individuals whose true names are unknown to Plaintiff. Upon information and belief, Defendants John Does 1-3 may have also committed negligent acts and/or omissions which resulted in injury to Plaintiff.

14.

At all times pertinent hereto, Defendant Holcombe was an actual or apparent agent, partner, employee, and/or a servant of Rome Radiology Group and was working within course and the scope of that capacity. Thus, Rome Radiology Group is vicariously liable for any negligent acts and/or omissions of Defendant Holcombe in this matter.

15.

At all times pertinent hereto, Defendants Lankford and Jones were actual or apparent agents, employees, and/or a servants of AdventHealth Hospital and were working within the course and scope of that capacity. Thus, AdventHealth Hospital is vicariously liable for any negligent acts and/or omissions of Defendants Lankford and Jones in this matter.

16.

At all times pertinent hereto, all other staff at AdventHealth Hospital were actual or apparent agents, employees, and/or a servants of AdventHealth Hospital and were working within the course and the scope of that capacity. Thus, AdventHealth Hospital is vicariously liable for any negligent acts and/or omissions of any such person in this matter.

FACTS

17.

Plaintiff attaches hereto as **Exhibit 1,** and incorporates herein by reference, an affidavit of Emanuel Kanal M.D., a duly qualified radiologist, setting forth the applicable standard of care, at least one negligent act or omission of each of the Defendants which breached the applicable standard of care, and the factual basis for that claim.

18.

Plaintiff attaches hereto as **Exhibit 2,** and incorporates herein by reference, an affidavit of Kristan Harrington, M.B.A., R.T. (R)(MR)(MRSO)(MRSC™), a duly qualified radiological technologist, setting forth the applicable standard of care, at least one negligent act or omission of Defendants Lankford and Jones which breached the applicable standard of care, and the factual basis for that claim.

A. MRI is a medical procedure.

19.

Magnetic Resonance Imaging ("MRI") is a medical procedure.

20.

A radiologist is the medical doctor licensed and responsible for supervising the MRI procedure.

21.

The radiologist is responsible for overseeing the safe execution of the MRI procedure, the accurate interpretation of its images, and the timely communication of the results.

22.

In performing the MRI procedure, the radiologist is assisted by one or more radiological

technologists. The radiological technologists who assist the radiologist are called Magnetic Resonance ("MR") technologists ("MR technologists").

23.

In performing the MRI procedure, the MR technologists work under the supervision of the radiologist.

B. MRI Technology and Radiofrequency Energy.

24.

In an MRI procedure, an MRI machine magnetizes a patient's tissues to produce images containing diagnostic information. Each set of images is commonly referred to as a "sequence." An MRI procedure consists of multiple imaging sequences.

25.

An MRI machine radiates energy at radiofrequencies, which is commonly referred to as "RF energy".

26.

RF energy can severely burn a patient when the MRI procedure is performed improperly.

27.

An MRI machine only generates RF energy while actively imaging the patient during a sequence. During a sequence, an MRI machine pulses RF energy on and off.

28.

The patient's tissues absorb the RF energy and, then, recover at various rates. The MRI machine generates images of the tissues as they recover, providing diagnostic information.

29.

The amount of RF energy a patient absorbs depends on the strength, duration, and frequency

of the RF energy pulses.

C. The Body Coil.

30.

There are different types of MRI machines. The type of MRI machine at issue in this case is shaped like a tube lying on its side, with an opening on either end of the tube. The hollow tube is referred to as the "bore" of the MRI scanner.

31.

The MRI machine at issue has a flat table, where a patient lays, that slides in and out of the bore.

32.

The bore has a plastic faceplate that forms an inner wall.

33.

To radiate RF energy, the MRI machine uses coils, also called antennas.

34.

The coil used in this case to radiate RF energy is called the "body coil".

35.

The body coil is embedded immediately behind the plastic faceplate of the inner bore wall of the MRI machine.

36.

The body coil is a few millimeters away from the plastic faceplate.

37.

The body coil is the closest coil to the faceplate and the patient.

D. The Instructions for Use Manual.

38.

MRI machines are equipped with an Instructions for Use Manual ("IFU"), provided by the manufacturer.

39.

The IFU warns the radiologist, the MR technologist, and the imaging facility that a patient may suffer a severe burn if his tissues are too close to the inner bore wall and, correspondingly, too close to the body coil during active imaging.

40.

The IFU mandates the minimum distance that must exist between the patient's tissues and the inner bore wall to prevent a burn. For example, depending on the machine, the IFU may require ¼ inch, 5 mm, or 1 cm of space between the patient's tissues and the inner bore wall during active imaging.

41.

The IFU mandates this distance because the radiation of RF energy from the body coil is significantly higher in this prohibited area than just a few centimeters further away from the inner bore wall. As used in this Complaint, the prohibited area may be referred to as the "danger zone". [**Ex. 1**, Kanal Affidavit.]

42.

When the patient's tissues penetrate the danger zone during active imaging, there is a much greater risk that the patient will receive too much RF energy from the body coil and, correspondingly, a burn. This type of burn is referred to as a "proximity burn" because it results from a patient's proximity to the body coil.

43.

To mitigate the risk of a proximity burn, the MRI scanner comes equipped with specialized pads. The IFU instructs the radiologist, MR technologist, and the imaging facility to place the pads between a patient's tissues and the inner bore wall of the MRI scanner. The padding is designed to provide the minimum required distance between the patient's tissues and the inner bore wall.

44.

The IFU identifies the padding approved for use with the MRI scanner.

45.

The radiologist and MR technologist must know the distance required between the patient's tissues and the inner bore wall for the MRI scanner at issue.

46.

The radiologist and MR technologist must know the padding required to be used for large patients in the MRI scanner at issue.

E. Proximity Burns.

47.

The MRI machine radiates RF energy into the patient which, in turn, generates electricity and heat in the patient's tissues.

48.

When the RF energy is too strong, it can generate enough heat to severely burn the patient. The RF energy is too strong and, therefore, can be unsafe in the danger zone.

49.

An MRI proximity burn can be a third-degree burn, where the skin and tissues are destroyed.

50.

An MRI proximity burn can be a fourth-degree burn, where the limb is amputated.

51.

Proximity burns have a distinct location, appearance, and presentation.

52.

Proximity burns are commonly located at the part of a patient's body that was closest to the inner bore wall of the MRI scanner during active imaging.

53.

In a lumbar MRI, a proximity burn is commonly located on the forearm, near the elbow, because this tissue is closest to the inner bore wall.

54.

Proximity burns are commonly round or oval shaped.

55.

In a lumbar MRI, a proximity burn is commonly a round, oval burn located on the forearm, near the elbow.

56.

A proximity burn has a unique presentation.

57.

A proximity burn starts deep in the patient's fat cells because fat cells generate more heat than skin cells in response to radiation of RF energy.

58.

When exposed to the RF energy in the danger zone, the fat may become so hot that it burns.

59.

A human being has no heat or pain sensors in fat cells. As a result, a patient will often not realize the burn is occurring when the fat burns.

60.

After the fat is destroyed, the heat radiates from the fat to the surrounding tissues, burning them.

61.

The heat from fat can burn all the tissues up to and including the skin over the heated fat.

62.

The heat from the fat can burn all the surrounding blood vessels, killing the skin and tissues.

63.

Until the burn reaches the pain sensors in the skin, the patient cannot detect the burn.

64.

An MRI proximity burn starts deep in the fat and works up to the skin. This is different than a stove-top burn where the burn starts at the skin and works down to the fat. Because the burn begins in the fat, an MRI proximity burn often appears minor at first before it reaches the surface skin layer.

65.

In the hours that follow the exposure to the RF energy, an MRI proximity burn often develops blisters.

66.

Next, the skin at the burn appears soft to the touch, as if it is giving way. During this stage, the tissues underneath the skin, which burned first, are dying.

67.

Over the next few days, the skin becomes dark and black.

68.

The skin and tissues slough off, leaving a hole in the patient's body.

69.

The hole from the proximity burn can extend all the way to the bone.

70.

An MRI proximity burn can even damage the bone.

71.

Without the protection of the skin, the patient's tissues and bone are subject to infection.

72.

Proximity burns are caused by a patient's tissues being too close to the inner bore wall of the MRI machine during active imaging.

73.

To avoid a proximity burn, the radiologist and MR technologist simply need to protect the patient from the high levels of RF energy near the inner bore of the machine.

74.

Proximity burns are avoidable when the radiologist properly oversees the MRI procedure.

75.

Proximity burns are avoidable when the MR technologist properly executes the MRI procedure.

F. The MR Screening.

76.

Not all patients can safely undergo an MRI procedure without accommodation.

77.

Prior to permitting the patient into the MRI suite, the MR technologist interviews the patient to screen for factors that increase the risk of an MRI related injury. This screening is commonly referred to as the "MR Screening" or "MR Safety Screening".

78.

It is the duty of the radiologist to define in advance for the MR technologist the risk factors that must be identified and brought to the attention of the radiologist.

79.

It is the duty of the radiologist to define in advance for the MR technologist that a patient's large size and plan to be anesthetized are two risk factors that must be identified in the MR Screening and brought to the attention of the radiologist.

80.

In the MR Screening, the MR technologist screens for risk factors, including a patient's large size and plan to be anesthetized.

81.

A large patient poses a greater risk of his tissues encroaching into the danger zone and, as a result, being burned.

82.

A large patient includes a patient that is morbidly obese or otherwise has a body big enough to encroach into the danger zone.

83.

A large patient includes, but is not limited to, a patient that is 6 feet 4 inches tall and weighs 354 pounds.

84.

It is the duty of the MR technologist during the MR Screening to identify that a patient is large and bring this risk factor to the attention of the supervising radiologist.

85.

An anesthetized patient also presents an increased risk of adverse events, including burns, during an MRI procedure.

86.

An anesthetized patient is unable to advise that he is experiencing discomfort or pain during an MRI procedure.

87.

It is the duty of the MR technologist during the MR Screening to identify a large patient that plans to be anesthetized and bring this risk factor to the attention of the supervising radiologist.

88.

When a patient is both large and plans to be anesthetized, the MR technologist must recognize there is an even greater risk to the patient of a proximity burn and raise these risk factors with the supervising radiologist.

89.

The MR technologist should not proceed with an MRI procedure on a large, anesthetized patient until the technologist receives instruction from the supervising radiologist on the necessary steps to mitigate the increased risk to the patient of a proximity burn.

90.

Upon receiving notice from the MR technologist of the risk factors identified in the MR Screening, it is the duty of the radiologist to assess the risks and benefits of proceeding with the MRI procedure for that patient.

91.

After performing the risk/benefit analysis, the radiologist is required to direct the MR technologist to proceed in one of three ways: (1) proceed with the MRI procedure; (2) cancel the MRI procedure with, or without, further instructions; or (3) proceed with the MRI procedure with specific instruction to mitigate risk. When a patient is large and anesthetized, the radiologist must either cancel the MRI procedure or provide specific steps to mitigate the risks of proximity burn to the patient.

92.

If the risk of proximity burn is too great for a large, anesthetized patient, then the radiologist must cancel the study.

G. Proper MRI Procedure by an MR Technologist.

93.

An MRI procedure should not be executed in the MRI suite by an MR technologist working alone. An MRI procedure should be conducted by either (a) two MR technologists working together; or (b) an MR technologist assisted by another person trained in MRI.

94.

When two MR technologists are present in the MR suite for a procedure, the responsibilities are shared equally between both MR technologists.

95.

Once the patient is in the MRI suite, the MR technologist must obtain informed consent from the patient for the MRI procedure and, if applicable, the use of any contrast injection. To obtain informed consent, the patient must be informed of all known risks for the MRI procedure.

96.

Before any active imaging occurs, the MR technologist must ensure that the patient is centered on the table of the MRI scanner.

97.

When a patient is large, the MR technologist must assess whether the patient can safely fit in the bore of the MR scanner without penetrating the danger zone. When a patient cannot fit in the bore of the MR scanner without penetrating the danger zone, the MR technologist must notify the radiologist and request instructions to mitigate the increased risk to the patient for a proximity burn.

98.

Once a patient is properly centered on the table and the MR technologist has confirmed the patient can safely fit in the bore of the scanner, the MR technologist should then place earplugs in the patient's ears to protect from sound pressure; advance the patient into the bore by sliding the table; and place padding on the areas at risk of proximity burn.

99.

On a large, anesthetized patient, proper padding is essential to prevent a proximity burn. The MR technologist must use the padding approved for use by the specific machine's IFU. The MR technologist must place padding on any area of the patient's body that may encroach the danger zone. For a lumbar MRI procedure, the MR technologist must place padding, among other

areas, at the forearm of the patient, near the elbow. The forearm, near the elbow, is a well-known area of potential proximity burn in a lumbar MRI procedure.

100.

If the padding is worn or otherwise insufficient to keep the patient's tissues out of the danger zone, the MR technologist must stop the scan and advise the radiologist of the issue.

101.

After the patient is advanced into the bore, the MR technologist must reach into the bore of the scanner and ensure that the padding is properly positioned.

102.

After the patient is advanced into the bore, the MR technologist must perform a visual inspection to confirm the patient is out of the danger zone.

103.

After these inspections, if the MR technologist cannot be certain that the pads are properly placed and the patient is outside of the danger zone, then the MR technologist must stop the scan and raise this risk factor to the radiologist.

104.

Once the MR technologist has confirmed that the patient is out of the danger zone and/or has received instructions from the radiologist on steps to mitigate risk from scanning with tissue located in the danger zone, the MR technologist may begin imaging sequence in the MRI procedure.

105.

Before each MRI sequence, the MRI machine may move the table and, correspondingly, the patient to obtain different diagnostic information. Accordingly, after each MRI sequence when

the table moves, the MR technologist should re-check the patient to ensure the padding is properly positioned and the patient is out of the danger zone.

106.

During acting imaging in the MRI procedure, every MRI sequence can be performed in three modes: Normal Operating Mode, First Level Controlled Operating Mode, or Second Level Controlled Operating Mode. Each mode determines the maximum level of RF energy that can be used for the MRI sequence. Normal Operating Mode provides the strongest restrictions on the amount of RF energy. Correspondingly, an MR technologist should only operate an MRI scanner in Normal Operating Mode, unless specifically instructed by the supervising radiologist. When a patient is large and/or anesthetized the MR technologist should only operate in Normal Operating Mode.

107.

During the MRI procedure, after every imaging sequence, the MRI machine provides a read-out of the RF energy absorbed. This measurement is known as the Specific Absorption Rate ("SAR"). With a large and anesthetized patient, the radiologist must prescribe the amount of SAR permitted on the patient. The MR technologist, correspondingly, must monitor and limit the SAR in accordance with the radiologist's instructions.

108.

In performing an MRI procedure, the MR technologist must follow all mitigation measures prescribed by the supervising radiologist.

H. Proper Supervision of an MRI Procedure by a Radiologist.

109.

It is the duty of the radiologist to define, in advance, for the MR technologist what risk

factors must be identified and brought to the attention of the radiologist related to an MRI procedure.

110.

The radiologist must instruct the MR technologist that a patient who is large and/or anesthetized presents an increased risk of proximity burn and, thus, these risk factors must be brought to the attention of the radiologist for special instruction.

111.

When a patient is large and/or anesthetized, the standard of care requires the radiologist to specify the steps to be undertaken to mitigate the elevated risks of proceeding with the MRI procedure. The potential mitigating steps include, but are not limited to, to the following:

A. The radiologist may instruct the MR technologist to cancel the MRI procedure and reschedule the procedure to be performed on a different MRI scanner or a non-MR modality. A large patient, for example, may be more safely scanned in an open bore or larger bore MRI scanner where the risk of penetrating the danger zone is mitigated.
B. The radiologist may instruct the MR technologist to restrict the scanner to Normal Operating Mode. This reduces the maximum RF energy and, as a result, the risk of burn.
C. The radiologist may instruct the MR technologist to monitor and limit the SAR to a prescribed value. Limiting the SAR limits the RF energy the patient is exposed to and, as a result, the risk of burn.
D. The radiologist may instruct the MR technologist to decrease the duration of active scanning in each MRI sequence. By decreasing the duration of each of the sequences, the radiologist limits the RF energy and, thus, the risk of burn.
E. The radiologist may instruct the MR technologist take pauses, or “cool down” periods,

between each MR imaging sequence. By waiting even a short time, like 30 to 60 seconds, during each MR imaging sequence, the tissue will have an opportunity to cool down somewhat before the next imaging sequence.

112.

It is the duty of the radiologist to instruct the MR technologists on the exact steps that must be taken to prevent a proximity burn to a patient.

I. Proximity Burns are Preventable.

113.

When the radiologist oversees the MRI procedure in accordance with the standard of care, a proximity burn does not occur.

114.

When the radiologist oversees the MRI procedure in accordance with the standard of care, a proximity burn down to the ulna bone does not occur.

115.

When the MR technologist executes the MRI procedure in accordance with the standard of care, a proximity burn does not occur.

116.

When the MR technologist executes the MRI procedure in accordance with the standard of care, a proximity burn down to the ulna bone does not occur.

117.

An MR-related proximity burn can only occur if the MR technologist(s) executing and/or radiologist overseeing the safe execution of that MRI procedure did not exercise the requisite standard of care.

J. Role of the Hospital.

118.

In accordance with established industry standards, an MRI facility, such as a hospital, should have at least three individuals in place to oversee the safe execution of MRI procedures: an MR Medical Director, an MR Safety Officer, and an MR Safety Expert.

119.

In accordance with established industry standards, the hospital must ensure that all necessary personnel, including MR technologists, are trained yearly on MRI safety, including the prevention of proximity burns.

120.

In accordance with established industry standards, the hospital must ensure that all necessary personnel, including radiologists with privileges at their hospital, are trained yearly on MRI safety, including the prevention of proximity burns.

K. The Defendants' Treatment of Mr. Swinford.

121.

On December 11, 2021, Mr. Swinford was admitted to AdventHealth Hospital with a complaint of low back pain.

122.

On December 11, 2021, a representative of AdventHealth Hospital filled out an MRI Eligibility Screening Sheet for a lumbar MRI scheduled on December 11, 2021. On this screening sheet, Mr. Swinford is listed as 360 lbs and 6 feet 4 inches tall. Defendant Lankford, an MR technologist, signed this sheet.

123.

On December 11, 2021, Mr. Swinford underwent a lumbar MRI procedure. Dr. Samuel Key was the radiologist, and Defendant Lankford was an MR technologist for the procedure. The procedure was completed uneventfully.

124.

Mr. Swinford continued to complain of back pain while in the hospital. On December 21, 2021, a second lumbar MRI was ordered to detect possible infection. The second lumbar MRI was scheduled for December 22, 2021 (the "Lumbar MRI Procedure").

125.

The Lumbar MRI Procedure was not an emergency.

126.

Dr. Holcombe was the radiologist supervising the Lumbar MRI Procedure.

127.

Defendants Lankford and Jones were the two MR technologists executing the Lumbar MRI Procedure.

128.

Dr. Holcombe was responsible for supervising Defendants Lankford and Jones for the Lumbar MRI Procedure.

129.

The Lumbar MRI Procedure was ordered to be performed under general anesthesia.

130.

On December 21, 2021, a representative of AdventHealth Hospital filled out an MRI Eligibility Screening Sheet for the Lumbar MRI Procedure. On the screening sheet, Mr. Swinford

was listed as 354 lbs and 6 feet 4 inches tall. Defendant Lankford signed this sheet.

131.

In violation of the standard of care, Defendant Holcombe failed to instruct Defendants Lankford and Jones, in advance, that a large and anesthetized patient were two risks that must be flagged and raised with the supervising radiologist.

132.

There is no record that Defendant Holcombe even recognized that Mr. Swinford's large size and plan to be anesthetized increased the risk of proximity burn.

133.

In violation of the standard of care, Defendants Lankford and Jones failed to identify and raise with Dr. Holcombe the risks that Mr. Swinford was large and planned to be anesthetized.

134.

There is no record that Defendants Lankford or Jones even recognized that Mr. Swinford's large size and plan to be anesthetized increased the risk of proximity burn.

135.

On December 22, 2021, prior to the procedure, Mr. Swinford purportedly indicated his consent to proceeding with the Lumbar MRI Procedure according to a consent form.

136.

The consent form purported to list the risks associated with the Lumbar MRI Procedure. The consent form did not include burns as a risk.

137.

The consent form stated, in part, as follows:

> Dr. Holcombe (Dr. Name or Dr. Signature) discussed the information above with me including: the potential benefits, risks, and side effects of the procedure, the

> problems that might occur during recuperation, the likelihood of achieving goals, the reasonable alternatives and relevant risks, benefits and side effects of the alternatives, including the risks of not receiving care. My physician also discussed any limitations on the confidentiality of information learned from the Operating Room about the patient.
>
> I voluntarily consent to allow Dr. Holcombe (Dr. Name or Dr. Signature) or any physician designated or selected by him/her and all medical personnel under the direct supervision and control of such physician and other personnel who may be otherwise involved in performing such procedure(s), to perform the procedure(s) described or otherwise referred to in this consent.

138.

Defendant Lankford witnessed and signed the consent form.

139.

Neither Defendant Lankford, Defendant Jones, nor Defendant Holcombe informed Mr. Swinford of the serious risk of a proximity burn to him considering his large size and plan to be anesthetized.

140.

On December 22, 2021, the Lumbar MRI Procedure was performed.

141.

Mr. Swinford was placed under general anesthesia for the Lumbar MRI Procedure.

142.

The Lumbar MRI Procedure was performed using a GE 3T Tesla scanner. At the time of the Lumbar MRI Procedure, a GE 3T Tesla scanner was one of the most powerful MRI scanners available, and it was capable of producing enough RF energy to cause a severe proximity burn.

143.

Mr. Swinford was placed on the MRI table and moved into the inner bore of the MRI scanner.

144.

In violation of the standard of care, Defendants Lankford and Jones positioned Mr. Swinford in the danger zone of the MRI scanner.

145.

In violation of the standard of care, Defendants Lankford and Jones failed to properly pad Mr. Swinford, particularly at his left elbow and forearm.

146.

In violation of the standard of care, Defendants Lankford and Jones scanned Mr. Swinford while the tissues of his left forearm were in the danger zone of the MRI scanner, without proper protection.

147.

In violation of the standard of care, Dr. Holcombe did not cancel the Lumbar MRI Procedure and/or provide proper instructions to mitigate the risk of proximity burn to Mr. Swinford. Defendant Holcombe did not properly instruct Defendants Lankford and Jones to limit the RF energy by, for example, placing the machine in Normal Operating Mode, limiting the duration of the sequences, introducing cool down periods, or using a different imaging machine.

148.

In violation of the standard of care, Defendants Lankford and Jones did not properly limit the RF energy from the machine by, for example, placing the machine in Normal Operating Mode, limiting the duration of the sequences, introducing cool down periods, or using a different imaging machine.

149.

In violation of the standard of care, the Defendants permitted Mr. Swinford to be scanned

in the danger zone, exposing him to dangerous levels of RF energy, without proper protection.

L. The Results of the Defendants' Failures.

150.

Immediately after the scan, the post-anesthesia evaluation was performed. The record indicated Mr. Swinford presented with a slight tear in his left elbow.

151.

At approximately 11:08 am, Mr. Swinford complained of severe pain and swelling in his left forearm.

152.

Mr. Swinford developed a wound on his left forearm. The wound grew at the hospital. The wound became black and blistered. His skin sloughed off. The wound deepened.

153.

The wound was located on Mr. Swinford's left, upper forearm, a common location for a proximity burn in a lumbar MRI.

154.

This is a picture of the wound on December 25, 2021.

155.

Even though the wound's presentation indicated Mr. Swinford suffered a proximity burn, members of the staff at AdventHealth Hospital appeared not to recognize it as a burn from an MRI procedure. For example, multiple records describe the wound as a "MRI burn?", and one record refers to it as a "pressure ulcer".

156.

The skin sloughed off all the way to the bone.

157.

This is a picture of the wound on April 8, 2022, with the ulna bone visible.

158.

Mr. Swinford underwent months of wound care due to the proximity burn.

159.

On October 5, 2022, Mr. Swinford underwent a debridement of the wound with a partial resection of the ulna. The surgeon noted necrosis. The surgeon noted damage to the ulna.

160.

Due to the burn, Mr. Swinford obtained an infection in his ulna bone. Mr. Swinford underwent months of intravenous antibiotics.

161.

On January 19, 2023, the wound closed for the first time. However, Mr. Swinford's bone was permanently injured. The bone was necrotic, lacked vascularity, and was more susceptible to fracture due to the burn.

162.

On April 27, 2023, following a minor fall, Mr. Swinford was diagnosed with a fracture of the ulna shaft at the site of the proximity burn.

163.

The ulna bone has failed to heal properly, due to the proximity burn.

164.

The ulna bone remains fractured today, due to the proximity burn.

165.

The ulna bone may be permanently fractured, due to the proximity burn.

166.

As a result of the Defendants' negligence, Mr. Swinford was severely injured. Mr. Swinford has suffered injuries, disabilities, enormous pain and suffering, and medical expenses. These injuries will continue into the future.

167.

Plaintiff is entitled to recover from the Defendants damages to compensate him for medical expenses, past and future; pain and suffering, past and future; his physical injuries, past and future;

and his physical disabilities, past and future. Plaintiff is further entitled to recover from Defendants all other damages Plaintiff suffered as a proximate cause of Defendants' negligent acts and omissions.

168.

Plaintiff's injuries and damages were proximately caused by the negligence of Defendants.

M. Severity of Burn:

169.

Dr. Kanal, a radiologist and an expert in MRI safety, has opined that this is one of the worst proximity burns that he has seen in his 40-year career.

170.

Mrs. Harrington, an MR technologist and an expert in MRI safety, has opined that this is one of the worst proximity burn that she has seen in her 25-year career.

171.

The burn to Mr. Swinford was the result of a breach of the standard of care by the Defendants.

N. Actions of AdventHealth Hospital

172.

Upon information and belief, Defendant AdventHealth Hospital provided no annual safety training on MRI for Defendants Holcombe, Lankford, and/or Jones.

173.

Upon information and belief, Defendant AdventHealth Hospital failed to have any of the necessary safety officers in place to monitor the safe execution of MRI procedures.

174.

Upon information and belief, Defendants AdventHealth Hospital, Holcombe, Lankford, and/or Jones took no action whatsoever to protect Mr. Swinford from the increased risk of proximity burn.

COUNT ONE – PROFESSIONAL MALPRACTICE OF DEFENDANTS HOLCOMBE AND ROME RADIOLOGY GROUP

175.

Plaintiff incorporates by reference the allegations in paragraphs 1-174 as if restated herein verbatim.

176.

At all material times hereto, Defendants Holcombe and Rome Radiology Group were charged with the duty of using due and proper care in treating, caring for, and attending to Plaintiff.

177.

At all material times hereto, Defendant Holcombe was an agent or employee of Rome Radiology Group, and Defendant Holcombe was acting within the course and scope of his employment or agency with Defendant Rome Radiology. Accordingly, Defendant Rome Radiology Group is vicariously liable for the acts and omissions of Defendant Holcombe and the resulting damages sought by Plaintiff based on the doctrine of *respondeat superior*.

178.

Defendants Holcombe and Rome Radiology Group, personally and/or through their employees or agents, committed negligence in their treatment of Plaintiff. That is, they violated the applicable standard(s) of care for professionals such as themselves in like and similar circumstances. Defendants violated the standard of care in at least one of the following ways:

a. Failing to define for the MR technologists the risk factors that must be identified and brought to the attention of the radiologist prior to proceeding with the MR procedure;

b. Failing to perform the necessary risk/benefit assessment of proceeding with the Lumbar MRI Procedure on Mr. Swinford, a morbidly obese, anesthetized patient;

c. Failing to specify the steps to be undertaken to mitigate the elevated risks of a proximity burn from proceeding with the Lumbar MRI Procedure on Mr. Swinford, a morbidly obese, anesthetized patient; and/or

d. Failing to obtain the necessary and appropriate informed consent from the Plaintiff prior to performing the Lumbar MRI Procedure

179.

The negligence of Defendant Holcombe and the Defendant Rome Radiology Group, by its employment and/or agency relationship with Defendant Holcombe, directly and proximately caused injury to Plaintiff.

180.

Mr. Swinford's injuries were proximately caused by the acts and omissions of Defendant Holcombe and Defendant Rome Radiology Group. Had Defendant Holcombe and Defendant Rome Radiology Group exercised the appropriate standard of care, Mr. Swinford would not have suffered this proximity burn and the resulting pain and disability.

181.

Plaintiff is entitled to recover from Defendants Holcombe and Rome Radiology the full value of his past, present, and future medical expenses, physical, mental, and emotional pain and suffering, and all other damages proximately caused by the Defendants acts and omissions.

182.

As required by Georgia law, Plaintiff attaches hereto as **Exhibit 1**, and incorporates herein by reference, the affidavit of Emanuel Kanal M.D., a duly qualified radiologist, setting forth at least one negligent act or omission of Defendants Holcombe and Rome Radiology and the factual basis for that claim.

COUNT TWO – PROFESSIONAL MALPRACTICE OF DEFENDANTS LANKFORD, JONES AND ADVENTHEALTH HOSPITAL

183.

Plaintiff incorporates by reference the allegations in paragraphs 1-182 as if restated herein verbatim.

184.

At all material times hereto, Defendants Lankford, Jones, and AdventHealth Hospital were charged with the duty of using due and proper care in treating, caring for, and attending to Plaintiff.

185.

At all material times hereto, Defendants Lankford and Jones were agents or employees of AdventHealth Hospital, and Defendants Lankford and Jones were acting within the course and scope of their respective employment or agency with Defendant AdventHealth Hospital. Accordingly, Defendant AdventHealth Hospital is vicariously liable for the acts and omissions of Defendants Lankford and Jones and the resulting damages sought by Plaintiff based on the doctrine of *respondeat superior*.

186.

Defendants Lankford, Jones, and AdventHealth Hospital, personally and/or through their employees or agents, committed negligence in their treatment of Plaintiff. That is, they violated

the applicable standard(s) of care for professionals such as themselves in like and similar circumstances. Defendants Lankford, Jones, and AdventHealth Hospital violated the standard of care in at least one of the following ways:

a. Failing to properly inform Dr. Holcombe that Mr. Swinford's MRI Screening revealed risk factors of his large size and plan to be anesthetized;

b. Failing to ensure that Mr. Swinford's tissues were not in the danger zone during active imaging;

c. Failing to use appropriate padding for Mr. Swinford, including but not limited to, on his left forearm;

d. Failing to confirm through inspection, prior to the MRI procedure, that Mr. Swinford's padding was appropriately positioned and he was adequately distanced from the bore wall;

e. Failing to confirm through inspection, after any sequence in which the table moved, that Mr. Swinford's padding was appropriately positioned and he was adequately distanced from the bore wall;

f. Proceeding with the MRI procedure despite the fact that Mr. Swinford's tissues, including but not limited to his left forearm, were in the danger zone;

g. Failing to properly inform Dr. Holcombe that Mr. Swinford's tissues, including but not limited to his left forearm, were in the danger zone; and/or

h. Failing to follow specific instruction, if any, from the supervising radiologist on the steps to mitigate the risk of proximity burn.

187.

The negligence of Defendants Lankford, Jones, and AdventHealth Hospital, by its

employment and/or agency relationship with Defendants Lankford, Jones, and any other staff member within the scope of his or her employment and/or agency, directly and proximately caused injury to Plaintiff.

188.

Mr. Swinford's injuries were proximately caused by the acts and omissions of Defendants Lankford, Jones, and AdventHealth Hospital. Had Defendant Defendants Lankford, Jones, and AdventHealth Hospital exercised the appropriate standard of care, Mr. Swinford would not have suffered this proximity burn and the resulting pain and disability.

189.

Plaintiff is entitled to recover from Defendants Lankford, Jones, and AdventHealth Hospital the full value of his past, present, and future medical expenses, physical, mental, and emotional pain and suffering, and all other damages proximately caused by the Defendants' acts and omissions.

190.

As required by Georgia law, Plaintiff attaches hereto as **Exhibit 2** and incorporates herein by reference, the affidavit of Kristan Harrington, a duly qualified MR technologist, setting forth at least one negligent act or omission of Defendants Lankford, Jones, and AdventHealth Hospital and the factual basis for that claim.

COUNT THREE – NEGLIGENCE OF
ADVENTISTHEALTH HOSPITAL

191.

Plaintiff incorporates by reference the allegations in paragraphs 1-190 as if restated herein verbatim.

192.

Defendant AdventHealth Hospital, the imaging facility, had a duty to ensure that its MR technologists, including Defendants Jones and Lankford, were properly trained on MRI safety, including prevention of proximity burns.

193.

Defendant AdventHealth Hospital, the imaging facility, had a duty to ensure that radiologists with privileges at its hospital, including Defendant Holcombe, were properly trained on MRI safety, including prevention of proximity burns.

194.

Defendant AdventHealth Hospital, the imaging facility, had a duty to have multiple persons in place to oversee the safe execution of the MRI procedure, including an MR Medical Director, MR Safety Officer, and MR Safety Expert.

195.

Defendant AdventHealth Hospital negligently failed to properly train Defendants Jones and Lankford.

196.

Defendant AdventHealth Hospital negligently failed to ensure Defendant Holcombe had proper training on MRI safety.

197.

Defendant AdventHealth Hospital negligently failed to have proper safety personnel in place to oversee the safe execution of the Lumbar MRI Procedure.

198.

Mr. Swinford's injuries were proximately caused by the acts and omissions of Defendant

AdventHealth Hospital, as hereinbefore alleged. Had Defendant AdventHealth Hospital exercised the appropriate standard of care, Mr. Swinford would not have suffered this proximity burn and the resulting pain and disability.

199.

Plaintiff is entitled to recover from Defendant AdventHealth Hospital the full value of his past, present, and future medical expenses, physical, mental, and emotional pain and suffering, and all other damages proximately caused by the Defendants acts and omissions.

COUNT FOUR – PUNITIVE DAMAGES
AGAINST ALL DEFENDANTS

200.

Plaintiff incorporates by reference the allegations in paragraphs 1-199 as if restated herein verbatim.

201.

The acts and omissions of the Defendants and/or their employees and agents as hereinbefore alleged showed intent, willful misconduct, malice, fraud, wantonness, oppression and/or that entire want of care which raised the presumption of conscious indifference to the consequences entitling the Plaintiff to an award of punitive damages in an amount sufficient to deter the Defendants from the same or similar actions in the future, in accordance with O.C.G.A. §51-12-5.1.

JURY TRIAL DEMANDED

202.

Plaintiff demands a trial by a jury of twelve (12) persons on all matters that can be so tried.

WHEREFORE Plaintiff demands judgment in his favor on all issues raised by the Complaint against Defendants in excess of $10,000.00 for the damages identified above, and demands he recover punitive damages, and such other and further relief as the Court deems just and proper.

This 14th day of NOVEMBER, 2023.

WEATHERBY LAW FIRM, PC

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[Signed by ADW w/ exp. perm.]