Background Information
Tammy Jarbo-Blankenship vs. Seattle Children's Hospital

This medical malpractice lawsuit has been brought by Tammy Jarbo-Blankenship (plaintiff) and filed against Seattle Children's Hospital (defendant) and its employees following the death of Tammy's son 15 year old son, Michael P. Blankenship.

On March 9, 2009 Michael was admitted to the dental clinic at Seattle Children's Hospital for routine oral surgery (4 teeth extracted) and teeth cleaning. Michael's surgery was by Barbara Sheller, DDS. Assisting Dr. Sheller was dental resident Soultana Chatzpolous, DDS.

On this day, as during many past treatments at Seattle Children's, Michael was sedated during the procedure. Because Michael was autistic he was typically sedated (general anesthesia) while receiving dental work.

The surgery went fine. At the conclusion of surgery, Michael was given an injection of Morphine for pain control.

Upon discharge from the hospital, Michael was prescribed Fentanyl to help manage pain. The medication is also known as a Duragesic pain patch, which is considered a narcotic or opiate. A Fentanyl or Duragesic pain patch is applied to the top of the patient's skin. The patch is considered an opiate and the drug is absorbed through the patient's skin over a period of time lasting up to 48 to 72 hours.

The medical records show that the Fentanyl prescription order form was signed by Dr. Chatzpolous, the dental resident who was assisting Dr. Sheller during Michael's surgery. The records do not reveal whether Dr. Sheller was or was not consulted about the prescription.

A Fentanyl pain patch comes in different dosages, ranging from the lowest dose of 12.5 micrograms per hour (mc/hr) to the highest of 100mc/hr patch. There are also patches available in doses of 25mc/hr, 50mc/hr and 75 mc/hr. Michael was prescribed the highest dosage available – the 100mc/hr patch.

Dr Sheller initially prescribed Michael codeine tablets for post-surgery pain. Tammy reminded Dr. Sheller that Michael could not take any type of oral medication because of his autism. This fact was already well documented in Michael's chart.

Tammy and her fiancé at the time, Shane Buckley, were present at the hospital when Michael was discharged. Tammy and Shane filled the Fentanyl prescription at the pharmacy inside Seattle Children's Hospital. The pharmacist told them that they should apply the Fentanyl patch to Michael's mid-back later that night. He also stated that the patch should remain on Michael's back because it would last for a period of time from 48 to 72 hours.

Later that night, at approximately 9 p.m., Tammy applied the Fentanyl patch to Michael's upper middle back as directed by the pharmacist. Michael then went back to sleep.

The next morning, Tammy found Michael unresponsive. She called paramedics to her home; they attempted to resuscitate Michael. Their efforts failed. Michael was pronounced dead in his bedroom at approximately 9 a.m.

The King County Medical Examiner performed an autopsy and toxicology study. The autopsy revealed no significant health problems or diseases. The toxicology report revealed a high level of Fentanyl in Michael's system. The report also showed that Michael had a small level of Ketamine in his system. Ketamine is a drug used by anesthesiologists to sedate patients during surgery.

The King County Medical Examiner determined that Michael's cause of death was combined Ketamine and Fentanyl intoxication. The manner of death was classified as accidental.

Michael was 15 years old at the time of his death. He lived with his mother, Tammy, and his younger brother, Jeffrey, age 12. Michael and his brother rarely saw their father who is not making a claim in this lawsuit.

Tammy and her attorney, Chris Davis, believe that Seattle Children's violated the standard of care by prescribing medication that never should have been prescribed to a 15 year-old boy. There are serious risks and warnings associated with using Fentanyl, which either the defendants were unaware of and/or

which they failed to communicate to Michael's mother as expected of a reasonably prudent and careful healthcare provider.

Tammy and her attorney also claim that the *Physician's Desk Reference* book, a reference guide commonly used by physicians across the country, states that Duragesic medication like Fentanyl can cause life-threatening respiratory arrest and therefore should not be prescribed in certain situations.

Tammy and her attorney also assert that according to the *Physician Desk Reference*, in Michael's case there were at least five (5) warning signs (also called "contraindications") present that should have alerted the defendants that Fentanyl never should have been prescribed. The plaintiff argues that even if it was proper to prescribe Fentanyl, Michael still never should have been given the highest dose available, particularly when he had no history of taking narcotic medication over a long period of time.

Media Contact:
Mischelle Weedman-Davis
Davis Law Group, P.S.
Mischelle@DavisLawGroupSeattle.com
206-727-4000 x102