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SUPERIOR COURT OF CALIFORNIA, COUNTY OF FRESNO

UNLIMITED CIVIL JURISDICTION

Alan MARCUM, Plaintiff, vs. St. Agnes Medical Center, Dr. Chinnapa Nareddy, Herbert Lee Thomas, Sharon Wimberley, Wayne Thomas, Leisure Care LLC, Does 1-10, Defendants.	Case No. 15CECG01327 FIRST AMENDED COMPLAINT FOR DAMAGES *JURY TRIAL DEMANDED*

GENERAL FACTUAL ALLEGATIONS RELEVANT TO ALL DEFENDANTS

1. Plaintiff Alan Marcum brings his complaint for damages as against defendants St. Agnes Medical Center, Dr. Chinnapa Nareddy, M.D., Herbert Lee Thomas ("Lee"), Sharon Wimberley, Wayne Thomas, and Leisure Care LLC. Plaintiff has complied with all statutory prerequisites regarding a professional negligence action as he caused to be served a pre-claim notice on the medical professional entities on April 9, 2015.

2. Plaintiff is a resident of Sacramento County. The defendants except Wayne Thomas are residents of Fresno County. Wayne resides in Alameda County. All acts alleged herein occurred within Fresno County within the jurisdiction of the Fresno County Superior Court. Therefore, Fresno County is the appropriate venue for this action and the Fresno County Superior Court has jurisdiction over all defendants in this action in light of their substantial contact with the jurisdiction and that all acts alleged herein occurred within the boundary of the county.

3. Following the death of her first husband, Dorothy Marcum married her second husband Herbert Lee Thomas. Following a divorce from his first wife, Herbert Lee Thomas married his second wife Dorothy Marcum. Dorothy's first marriage produced two children: Alan Marcum and Dan Marcum. Lee's first marriage produced three children: Wayne Thomas, Sharon Wimberley (Sharon Thomas) and Suzanne Thomas (Deceased). Lee and Dorothy had no children together. On October 25, 1990, Lee and Dorothy created the Herbert L Thomas and Dorothy A Thomas trust. The beneficiaries of that trust were the children of both Lee and Dorothy. The trust was restated June 21, 2007. At that time, Wayne Thomas and Dan Marcum were added as co-successor trustees, with Alan Marcum named as Dan's available replacement, and Wayne Thomas and Dan Marcum as "co-disability panelists," again with Alan Marcum as Dan Marcum's available replacement. Dan Marcum and Wayne Thomas are also co-personal representatives in Dorothy Thomas' pour-over will (executed as part of the trust). Dorothy Thomas died on April 30, 2013. Immediately after her death, Lee amended the trust. In his amendment, he made sweeping changes, including the removal of Dan and Alan from *all* positions of responsibility as successor trustees, and removing Dan and Alan from the disability panel. Dan Marcum's removal required court approval, as per the terms of the trust, and service of process on him. That did not occur. Notably, the original trust permitted removal of a trustee only for cause and required court approval. Furthermore, Lee also altered the trust to remove the requirement that capacity determinations be made based on the opinion of an attending physician.

4. Lee and Dorothy Thomas resided in a single family residence at 532 W. Rialto, Fresno CA 93705 until they moved to Fairwinds-Woodward, a residential care facility pursuant to 22 CCR §87101(5), owned and operated by Leisure Care LLC. It is regulated by the California Department of Social Services as facility number 107201156. Lee was physically abusive toward Dorothy. Instances of abuse are documented throughout Dorothy's medical records. They include Lee offering conflicting versions of events to medical personnel regarding the circumstances surrounding Dorothy's injuries. Elsewhere in the records medical personnel, including nurses, specifically indicate that abuse of

Dorothy is occurring in the home she shared with Lee. Indeed referral to local authorities was even noted and recommended. For his part, Plaintiff also had personally witnessed physical indicia of abuse to his mother. Indeed, Dan and Alan confronted Lee in 2012 at the Rialto residence regarding physical abuse of their mother. In that meeting, they demanding notification of *all* future ambulance incidents, hospitalizations, and emergency room visits. In response, Lee capitulated, stating: " You have a right to know."

5. Primary care physician Dr. Garry Steven Sevel even noted in his August 6, 2012, report that Lee was incapable of continuing as Dorothy's primary health caregiver. Specifically, he wrote: "Pt's husband is very confused as to meds pt should be taking, and in my opinion is not giving her needed meds or in my opinion able to be primary care giver." A second letter of similar substance from Dorothy's new primary care physician Dr. Kirandeep Kaur Batth, M.D., was written on 12/4/2012. However, Lee concealed this report from plaintiff. Moreover, Dorothy's medical records from 2012 reveal a woman who was consistently malnourished and dehydrated, with bed sores and other injuries consistent with domestic abuse including a broken rib and black eyes. Lee consistently delayed Dorothy's medical treatment for days or weeks at a time. He deliberately withheld Dorothy's son Dan's contact information from Leisure Care LLC to prevent the facility from contacting him about her care. He resisted and refused efforts to provide in-home caregivers for Dorothy. He failed to take adequate action to ensure that Dorothy's walker could fit through the bathroom door of the home. He rendered himself incommunicado from health caregivers during times when Dorothy was in their care and communication needed to occur with her personal representative/contact. He withheld information from Dan and Alan Marcum, including when she was admitted to the St. Agnes Emergency Room on 4/14/2013 and again on 4/29/2013. He failed to provide nutrition and feeding for Dorothy, often forcing her to go nine to twelve hours at a time without food. He failed to pick up her necessary prescription medication or would cancel them altogether. He repeatedly and consistently allowed her to develop debilitating bedsores. Lee isolated Dorothy from her sons, relatives, and friends she had prior to the marriage. Lee controlled every aspect of Dorothy's life. When Dan and Alan called Dorothy, Lee listened in on all phone calls. When Dan

1 and Alan visited Dorothy, Lee listened to all conversations. Lee and Dorothy rarely
2 visited Dan and Alan. The hospital records revealed this abuse.
3 6. At one juncture in 2012, plaintiff and Dan and Alan hired an in-home caregiver to
4 assist with his mother's care. A-Plus was the in-home care service business. Alan and
5 Dan employed A-Plus in 2012 to provide care to Lee and Dorothy Thomas in their
6 home. However, Lee refused to allow the caregiver to perform its duties, instead relegating
7 them to light housework. At another point in time, Dorothy was enrolled in Horizon Health
8 Care center. Her condition improved. A 1/4/2013 email from Ginger McMurchie stated that
9 Lee had declined training for the family on caring for Dorothy. This was prior to the move to
10 Fairwinds. Next, Wayne was complicit with the Horizon assessment and ratified it without
11 notifying co-trustee Dan Marcum on 1/27/2013. Wayne signed a service contract with a
12 level of care which was insufficient for the level of care Dorothy required. Wayne Thomas
13 purchased virtually the most inexpensive care Fairwinds provided. At the time Dorothy's
net worth exceeded two million dollars.
14 7. Dr. A.P.S. Sidhu M .D., completed Form LIC 602A, a separate interdisciplinary
15 discharge summary that Lee signed on January 30, 2013, the day Dorothy was
16 transferred from Horizon to Fairwinds. Dorothy moved into Fairwinds on January 30,
17 2013, at 11:30am. Yet Lee did not sign off on her intake form until much later that same
18 day, therefore the form could not possibly have been utilized/considered in the
19 admission appraisal process by the caregiver.
20 8. Further records demonstrate that Lee was "tired" of his responsibility as caregiver to
21 Dorothy. Thus, it was unsurprising that Dorothy was taken to the Emergency Room at St.
22 Agnes Medical Center on April 14, 2013, after having suffered a fall on 4/13/2013 while
23 getting out of bed. Unfortunately, the fall caused her to break her back. Lee did not
24 accompany her to the hospital, nor could he be reached by telephone at any time during
25 Dorothy's stay there. Indeed even after she had received medical treatment and was ready
26 for discharge, Lee refused the calls of hospital staff and allowed Dorothy to languish at the
27 hospital.
28 9. On several occasions Dorothy has signed advance healthcare directives (AHCD) and

physician's order for life sustaining treatment (POLST). On each and every occasion, she stated her desire that everything be done to save her in the event medical intervention became necessary. Lee failed to notify Dan of this AHCD and also failed to provide the AHCD to St. Agnes. The Fairwinds AHCD named two specific health care agents, Lee Thomas and Dan Marcum, and it included detailed contact information for both.

10. On April 29, 2013, Dorothy was admitted to the Emergency Room at St. Agnes Medical Center. Upon arrival she is in possession of her POLST and the records so indicate that a Dr. Vallapu confirmed having received and reviewed same. Again, Lee did not accompany her to the hospital. Nor did he respond to numerous calls from hospital staff and was never mentioned as being reasonably available by phone or at St. Agnes. For his part, plaintiff was never informed that Dorothy had been hospitalized or had visited the Emergency Room in 2013.

11. Regardless, even after being admitted to St. Agnes Medical Center, Dorothy again was presented with forms regarding her wishes in the event life-saving medical care and treatment became necessary. She consistently indicated that everything should be done to save her life, including full resuscitation.

12. Inexplicably, defendant Sharon Wimberley, a healthcare professional herself with twenty years of experience in the industry, approached Dr. Nareddy and informed him that Dorothy should not receive any lifesaving treatment whatsoever. Sharon had never had any authorization to act on Dorothy's behalf or even Lee's behalf. Instead she appears to have simply materialized as the angel of death at Dorothy's side. Sharon knew that Dorothy wanted her AHCD mandating full resuscitation to be followed, yet she disregarded Dorothy's wishes.

13. For his part, Dr. Nareddy did nothing to confirm whether Sharon had any such authorization to change Dorothy's AHCD or POLST. Instead, he simply alters the records/chart and physician's orders requiring full resuscitation to indicate that Dorothy should not be resuscitated or receive any therapies in the event she needed such medical intervention to stay alive and never mentioned that Dorothy had lost capacity. Thus at 4:47:50 all 7-9 medical procedures were halted along with medications "allowing a natural

death" as stated in Dr. Nareddy's notes. All therapies were specifically removed, and no further efforts were made to help her stay alive. A subsequent expert witness review of the records concluded that it was reasonably probable that Dorothy would have continued living had she been taken to intensive care. Thus, in a very real sense Sharon, Lee, Wayne, and Dr. Nareddy killed her.

14. Sharon had departed the hospital and Dorothy died alone of acute respiratory failure at 5:45 p.m. on April 30, 2013, with no family at her bedside. Also, Lee is inexplicably never mentioned as being in the hospital or being in contact with any of the staff in 2013.

15. Less than an hour after Dorothy expired, Wayne resurfaced at 6:40 authorizing release of Dorothy's health information and ordered no autopsy to be performed on Dorothy's corpse. Wayne lacked the authority to make such a decision on her behalf. Indeed, on information and belief it is alleged that Wayne also engaged in a pattern of making financial decisions which were not in Dorothy's best interest and which were not ratified by co-trustee Dan Marcum. These decisions were intended not to benefit Dorothy, but rather to save as much of his potential inheritance for himself and for his sister Sharon. They include consistently denying or cancelling necessary healthcare for Dorothy because he deemed it too expensive for her.

16. Finally, two days after her death, Dr. Nareddy made retroactive alterations to Dorothy's medical records to indicate that the patient's wish was for DNAR (Do Not Attempt Resuscitation) and DNR/DNI (Do Not Resuscitate/Do Not Intubate). All of these actions either violated St. Agnes Medical Center proper best practices and procedures regarding the verification of authority to alter health care directives or the medical center simply failed to have such necessary and appropriate best practices and procedural safeguards in place. On information and belief, St. Agnes Medical Center failed to follow its protocols by allowing Dr. Nareddy to disregard the physician's order for life sustaining treatment thereby ignoring the POLST and AHCD. The nursing staff who are hospital employees found Dorothy not breathing and were unable to even check patient's status because of Dr. Nareddy's instructions (DNAR). The nurses are mandated reporters who failed to report the crime. According to a subsequent expert analysis, had Dorothy simply

been intubated she would have lived. Plaintiff is informed and believes that Dr. Nareddy is an employee of St. Agnes Medical Center and thus is an agent under the legal doctrine of *respondeat superior*.

17. Plaintiff is also informed and believes and based thereon alleges that the hospital must have had some written policy or procedure or protocol in place to ensure that complete strangers were not making changes to patient's wishes as regards the scope of their lifesaving medical treatment. However neither the hospital nor any of its agents took any appropriate action to follow their own procedures in this case. The result was the death of Dorothy Thomas.

18. Lee was the primary caregiver of Dorothy and had authority to make medical decisions on her behalf. However he secreted himself and otherwise rendered himself in absentia during those crucial times that she needed his advocacy. The co-successors trustees and co-personal representatives of the family trust after Lee were Wayne Thomas and Dan Marcum, plaintiff's brother. However Wayne ignored his co-trustee status and engaged in a pattern of decision-making on Dorothy's behalf without first consulting with co-trustee Dan. For a further example, it is alleged on information and belief that Wayne wrote unauthorized checks to third parties from Dorothy's funds without first consulting either Lee or co-trustee Dan.

19. Dan Marcum refuses to commence or maintain an elder abuse action at this time because of the cost of an attorney. Dan agrees with Alan that Herbert Lee Thomas, Sharon Wimberley, Wayne Thomas, Leisure Care LLC, Dr. Chinnapa Nareddy, and St. Agnes Medical Center all committed elder abuse to Dorothy. Alan does not accuse Dan of elder abuse. Dan has authorized Alan to commence and maintain this action on behalf of their mother.

ALLEGATIONS SPECIFIC TO FAIRWINDS/LEISURE CARE LLC

20. 22 *CCR* 87455(c)(2) states that residents who require 24 hour skilled nursing cannot be admitted into residential care facilities like Fairwinds. Notably, Fairwinds is a non-medical facility (and therefore not subject to MICRA). Yet, Dorothy required such care *and was still admitted there*.

21. Dorothy was in fact "bedridden" under Title 2287606 and *Health & Safety Code* §1569.72(e)&(f) of California law. Specifically regulation 87582(d)(2) provides that a resident is "bedridden" who cannot independently transfer to and from bed and is unable to leave the building unassisted for emergency purposes. According to the Physician's Report for Residential Care Facilities for the Elderly, Dorothy was non-ambulatory and not independently able to transfer from her bed. Under the law, Dorothy was in fact bedridden. Thus, despite the report not specifically indicating she was bedridden, a clear profit motive was at play for both the Thomas family to enroll Lee and Dorothy in less expensive care and for Fairwinds to receive another patient despite not being equipped or able to handle her. Fairwinds/Leisure Care LLC violated California regulations in accepting Dorothy. Pursuant to California law under 22 CCR 87637, a resident cannot be cared for if the care exceeds the limits of the provider's license, department of health relocation order 87637(2).

22. Fairwinds/Leisure Care LLC is required to perform reappraisals in writing pursuant to 87463 whenever there is a change in the medical condition and said reassessment/reappraisal must be delivered to the State of California licensing agency within seven calendar days pursuant to regulation 80061 and 87561. Here, Dorothy experienced a material change in her circumstances when she broke her back on April 13, 2013. Yet no reassessment or reporting was done. She was dead fifteen days later.

23. Under California 22 CCR 87455, a resident must be removed from the facility if she requires twenty-four skilled nursing care or intermediate care as specified in the regulations. According to a registered nurse, on January 1, 2013, the facility was incapable of providing care to Dorothy due to her care needs. Still, after admission Fairwinds/Leisure Care LLC did nothing to move Dorothy to a facility that court provide a higher level of care.

24. Under California regulation 87202, a special fire clearance must be issued to the facility when someone like Dorothy resides there. But Fairwinds/Leisure Care LLC had no such clearance. Fairwinds/Leisure Care LLC also did not maintain a copy of the admission agreement with the client and the client's authorized representative in the file for Dorothy as required by 22 CCR 80068. No such agreement was maintained and/or it was willfully concealed from Alan Marcum when he requested the file after presenting HIPPA papers to

Fairwinds.

25. Dorothy moved into Fairwinds on January 30, 2013 at 11:30am. Lee did not sign off on her intake form until the same day; therefore the form was not used in the admission appraisal process by Fairwinds.

26. California law (22 CCR 87303) requires a comfortable temperature must be maintained for residents at all times. Yet on the afternoon of April 29, 2013, the day Dorothy had to go to the hospital, the air conditioning was not functioning and the room was ninety five degrees, causing increased edema for Dorothy and an inability to elevate her legs.

27. By February 14, 2013, it was clear to the physical therapists of Dorothy that she needed more assistance and care. Both Wayne and Lee chose a level of care well below what Dorothy required.

28. On or about February 4, 2013, a medical note indicates that Lee is not giving Dorothy her required medication. Fairwinds did nothing to ensure that she received her medication.

29. On January 31, 2013, a registered nurse found Dorothy suffering in Fairwinds because she was not receiving the level of care she required. This is documented in the nurse's medical note that Fairwinds is incapable of offering the required level of care. Dorothy was calling for help ten or more times a day and not receiving adequate assistance.

30. As demonstrated by a series of electronic mail correspondences between Alan Marcum and the director of health and wellness, Dorothy's falls were concealed from Alan by Fairwinds/Leisure Care LLC despite her having confirmed that he is authorized to receive medical information. This director cannot dispute or claim that she was unaware of the falls because she received the prescription for medication for Dorothy arising directly from the falls.

31. Fairwinds utilized witnesses for Dorothy's AHCD that worked for and at Fairwinds. This is in violation of California law. *Probate Code* §4674.

32. Fairwinds should have enacted the processes/procedures for removing Dorothy from the facility pursuant to 22 *CCR* 87224. However no action was taken.

33. Fairwinds was required to provide the AHCD to the responding emergency personnel. 22 *CCR* 85075.3. Fairwinds never did this.

34. The advanced healthcare directive signed on 2/21/2013 at Fairwinds was concealed and never taken to St. Agnes and is the only directive listing Lee and Dan as the only medical agents. Dorothy signed a statement, "I want this person to help make my medical decisions."

35. Fairwinds' facility number is 107201156. The license did not allow any bedridden people on the second floor where Dorothy resided. The license allows only three bedridden people on the first floor and they must be recovering from surgery or near a status above bedridden. From 3/29/2011 to 08/12/2015 Fairwinds received 15 citations from the Department of Social Services.

ALLEGATIONS SPECIFIC TO ST. AGNES MEDICAL CENTER

36. On or about January 21, 2013, Dorothy filled out a Physician's Order for Life Saving Treatment (POLST). It provided for all life-saving treatment. And she arrived at the emergency room on April 29, 2013, with it and provided it to the admitting physician at St. Agnes, one Hemanth K. Vallapu, the authorized agent/representative of St. Agnes, per the hospital's own stamp. This evidence demonstrates the hospital was on full notice of her AHCD at all times upon her admission.

37. *Probate Code* §4780 - 4786 requires St. Agnes and its physicians to honor this POLST and to make all healthcare decisions in accord with this document.

38. The hospital made her sign another advance AHCD. Again, she indicates that they are to do everything possible to save her. Under California law codified at *Probate Code* §4731, the physicians at the hospital must have obtained a copy of this new document and ensured that it was made part of the patient's medical records. St. Agnes date-stamps indicate the document was prepared and received by the hospital, and the document on its face also indicates it is not in conflict with the POLST. Hospitals are required to follow AHCD orders. *Cardoza v. USC Univ. Hospital*, (2008) B.195092.

39. The back of the POLST states modifying "based on known desires of patient." *Probate Code* §4657 provides that Dorothy was/is presumed to have capacity. Indeed there is nothing in the records to indicate that Dorothy lacked capacity to execute these documents until after she is deceased, at which time Dr. Nareddy enters a cryptic / incomplete /

unintelligible note which may have been his effort to falsify records on the issue of capacity. However, per *Probate Code* §4732, any indication / representation regarding capacity or lack thereof must be immediately entered into the patient's records and communicated to the patient. This was simply not done such that no legitimate factual dispute can be raised as to the issue of capacity. Nor were any of the measures required by *Probate Code* §4736 taken by the physicians at St. Agnes. These facts should foreclose in advance any bogus contention that Dorothy lacked capacity.

40. By 4:47 p.m. on April 30, 2013, Dr. Nareddy knew that his withholding of seven to nine medical treatments to Dorothy, would result in her death, as he writes in his note: "allow a natural death." As Dorothy expires, and according to Nareddy's narrative, he discussed "in detail" with Sharon Wemberly at Dorothy's bedside the likely result of failing to administer medical treatment (likely death) and that he "would be" signing the death certificate. This demonstrates the requisite intent and awareness of likelihood of harm as well as the egregious nature of their failure to administer treatment and the clear result being that Dorothy would die without treatment. Before a hospital or physician can make a decision about the patient and her care, California law requires a consult with the patient. *Probate Code* §4730. The hospital and physician are furthermore required to comply with her AHCD and individual care instructions as much as possible. *Probate Code* §4733. In the medical records, at 4:47:50, Dr. Nareddy's Physician's Orders changes from " Full Resuscitation" to " DNAR Limited Measures." The "A" indicates not to even attempt resuscitation. Thus, medical procedures were halted with orders for "allowing a natural death." No further efforts were made to help her stay alive. Indeed, *a subsequent expert witness review of the records concluded that it was reasonably probable that Dorothy would have continued living had she been taken to intensive care*. Thus, in a very real sense Sharon, Lee, Wayne, and Dr. Nareddy killed her.

41. *Probate Code* §4733 requires hospitals to comply with an individual's health care instructions. *Probate Code* §4736 provides that where a hospital declines to comply with health care instructions, it must inform the patient and immediately make efforts to transfer the patient to another institution that is willing to comply, *and* provide continuing care to the

patient until the patient's transfer is complete. If it appears the transfer cannot be accomplished in all cases appropriate pain relief and other palliative care shall be continued. Probate Code §4742 contains penalties for intentionally concealing not following the health care directive. Here, Dr. Nareddy dictated on 4/30/2013 at 16:46:27: "I discussed with the patient's daughter as mentioned, Sharon (355-7070), and she mentions very clearly that patient never wanted any intubation or chest compression so has been made DNR." The time of this dictation demonstrates that Sharon communicated with the physician *prior to* Dorothy's expiration, thereby demonstrating gross negligence/intentional conduct that would certainly result in substantial harm.

42. *Probate Code* §4653 provides that nothing in this division shall be constructed to condone, authorize, or approve mercy killing, assisted suicide, or euthanasia. This division is not intended to permit any affirmative or deliberate act or omission to end life other than withholding or withdrawing health care pursuant to an advance health care directive, by a surrogate, or as otherwise provided, so as to permit the natural process of dying. See also *Probate Code* §§4654, 4657, and 4658.

ALLEGATIONS SPECIFIC TO WAYNE THOMAS

43. Wayne Thomas signed and negotiated a service contract with Fairwinds on January 27, 2013, as the authorized representative for Dorothy. In the document, he negotiates a level of care and/or service plan which was insufficient for the level of care Dorothy required. He went with the most inexpensive plan possible.

44. Wayne Thomas concealed and/or deliberately withheld emergency contact information from Fairwinds and omitted Dan and Alan's information.

45. Wayne Thomas, on April 30, 2013, at 6:40 p.m., before even notifying Dan and Alan of her demise, decided to dispose of the corpse without an autopsy, effectively destroying evidence of his and his sister's misdeeds.

ALLEGATIONS SPECIFIC TO LEE THOMAS

46. Lee Thomas was not reasonably available as Dorothy's caretaker as that term is given meaning in the California Probate Code at §4635. Both times Dorothy was placed into an ambulance on April 14, 2013, and April 29, 2013, and for transport to the hospital, Lee did

not provide her with any of her personal effects for the trip. He was not reasonably available for her care. On April 14, 2013, Dorothy wanted to leave hospital and go home. But neither she nor the hospital staff were able to reach the husband telephonically. He was not reasonably available.

47. *Probate Code* §4743 provides that anyone who willfully takes those actions which are counter to a lawful AHCD with regard to medical treatment and care which then results in the hastening of death is liable for homicide. The AHCD at Fairwinds was willfully concealed from St. Agnes by Sharon, Lee, and Wayne, and the physician Dr. Nareddy. A healthcare provider or institution who fails to follow the directive or willfully conceals is liable for actual damages and attorneys' fees. Probate Code §4742.

48. HIPPA papers including the authorizations to release medical records were concealed from Alan and Dan Marcum by Lee, Wayne and Sharon so they had no ability to obtain any health information. They did this deliberately to ensure that Alan or Dan did not have access to information about Dorothy's health care information. Indeed after Dorothy's death, a copy of her trust was provided to Alan and Dan Marcum, but the HIPPA medical record release authorizations were deliberately removed from the document. California *Probate Code* §4653 provides that a surrogate cannot withhold information so as to permit the natural process of dying. The law says you cannot make a deliberate act/omission. It must say so in other than in the AHCD. The AHCD must state her wishes to die. To this end, Probate Code §§250-259, the so-called "slayer laws" are at issue here with respect to disinheriting Lee and his progeny.

49. *Probate Code* §4714 provides that a surrogate shall make healthcare decisions in accordance with the patient's individual health care instructions. Also, *Probate Code* §4743 provides that any person who willfully conceals an AHCD with the intent of withholding or withdrawing of health care necessary to keep the patient alive and hastened death is subject to prosecution for unlawful homicide.

50. On 9/4/2013 Lee amended the trust removing Dan and Alan as successor trustees removing Dan and Alan from the disability panel. And he also changed the determination of incapacity of a trustmaker, removing the opinion of the attending physician. Dan and Wayne

are listed in the will of Dorothy Thomas as being co-personal representatives.

First Cause of Action: Negligence Resulting in Wrongful Death as Against Sharon Wimberley

51. Plaintiff incorporates factual averments one through nineteen herein by reference.

52. The elements of a cause of action for wrongful death are a tort, such as negligence, and resulting death. *Boeken v. Philip Morris USA, Inc.*, 48 Cal.4th 788, 806 (2010). The elements of negligence are the existence of a legal duty of care, breach of that duty, and proximate cause resulting in injury. *McIntyre v. Colonies-Pacific*, LLC 228 Cal.App.4th 664, 671 (2014).

53. Probate Code 4714 states Sharon Wimberley owed Dorothy Thomas a legal duty to follow her POLST and Advanced Healthcare Directive that mandated full resuscitation, and decisions in accordance with Dorothy's written care instructions. In other words, Sharon's obligations encompassed a duty to follow the AHCD mandating full resuscitation. The POLST mandated CPR, full treatment, trial period of artificial nutrition including feeding tubes. She further owed a duty of due care to refrain from making unauthorized oral changes to that directive or to take any action which could or would reasonably and proximately result in the expiration of Dorothy. However, Sharon Wimberley breached this duty by approaching Dr. Nareddy and informing him that Dorothy should not receive any lifesaving treatment whatsoever. Sharon had never had any authorization to act on Dorothy's behalf. Dr. Nareddy at Sharon's direction fails to provide life-saving treatment, which directly caused in Dorothy's death.

Second Cause of Action: Elder Abuse as Against Herbert Lee Thomas, Wayne Thomas, St. Agnes Medical Center, Dr. Nareddy, Sharon Wimberley and Leisure Care LLC

54. Plaintiff incorporates factual averments one through twenty-two herein by reference.

55. Dorothy Thomas was at all times an elder as that term is defined by California *Welfare and Institutions Code* section 15610 *et seq.*

56. The defendants conduct alleged herein constitute abuse of an elder or a dependent adult" as defined in Welfare and Institutions Code section 15610.07, which is defined as physical abuse, neglect, fiduciary abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a

care custodian of goods or services necessary to avoid physical harm or mental suffering. The Act defines neglect as "the negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise. *Carter v. Prime Healthcare Paradise Valley LLC*, (2011) 198 Cal. App. 4th 396, 902. Neglect includes, but is not limited to, the failure to assist in personal hygiene, or in the provision of food, clothing, or shelter, failure to provide medical care for physical or mental health needs, failure to protect from safety and health hazards, and the failure to prevent malnutrition and dehydration. Id.

57. With respect to defendant Lee, he had a consistent pattern of delaying and denying treatment for Dorothy, as well as other factual averments previously alleged, which if true would give rise to liability under the Elder Abuse Act.

58. With respect to defendant Wimberley, she changed Dorothy's AHCD from full resuscitation to do not resuscitate despite not having the authorization to do so, which lead to Dorothy's death. Dr. Nareddy is complicit in this change which resulted in the withholding of necessary and appropriate medical treatment for Dorothy. St. Agnes Medical Center was further complicit and participated in this tort by and through its failure or inability to require its agents to follow protocol, or to even have the appropriate protocols or safeguards to guard against this course of action which resulted in Dorothy's death.

59. With respect to defendant Leisure Care LLC, it failed to report incidents of abuse. It failed to provide Dorothy's AHCD to caregivers. It allowed Wayne Thomas to select the level of care for Dorothy despite the fact that Wayne was not a personal representative and co-trustee/co-personal representative Dan Marcum was not appropriately consulted. Leisure Care LLC failed to inform the correct personal representatives of Dorothy's various health issues. Leisure Care LLP took in a bed-ridden patient that it was not authorized to accept. On information and belief, managing agents of Leisure Care LLC were aware of these misdeeds. As a consequence, the Marcums were never informed of the improper and lackluster care and treatment of their mother at the hands of the Thomases, and it was that lackluster care and treatment which ultimately resulted in Dorothy's demise. This is contra to 22 *CCR* §87468(8)&(9), which provides that communications from family and

responsible persons should receive a prompt and appropriate response.

60. These defendants were guilty of recklessness, oppression, fraud and malice in the commission of the abuse described above. Recklessness involves "deliberate disregard" of the "high degree of probability that an injury will occur" and "rises to the level of a conscious choice of a course of action...with knowledge of the serious danger to others involved in it. *Carter v. Prime Healthcare*, (2011) 198 Cal. App. 4th 396, 405.

61. Under *Welfare and Institutions Code* section 15657(a), defendants are liable to plaintiff for reasonable attorney fees and costs.

62. Under *Civil Code* section 3294, defendants are liable for punitive damages.

Third Cause of Action: Financial Elder Abuse as Against Herbert Lee Thomas, Wayne Thomas and Sharon Wimberley

63. Plaintiff incorporates factual averments one through thirty-one herein by reference.

64. Dorothy Thomas was at all times an elder as that term is defined by California *Welfare and Institutions Code* section 15610 *et seq*.

65. Dorothy Thomas was a beneficiary of the Herbert L. Thomas and Dorothy A. Thomas Family Trust Dated October 25, 1990, which was amended in 2007 to allow for Dan Marcum and Wayne Thomas to be joint personal representatives of Dorothy and Lee Thomas.

66. Upon information and belief, Wayne Thomas profited individually in taking and secreting money from the family trust by making unauthorized distributions of trust funds by writing checks from trust monies without the approval of Dan Marcum. Further, he made decisions about Dorothy's care which were not in her best interest and which were not ratified by co-trustee Dan. Instead those decisions were designed solely to enhance his and Sharon's inheritance to the detriment of Dorothy's care and comfort. Lee is equally liable in this regard for his pattern of denying Dorothy care and comfort and medical treatment for the sole purpose of conserving her money in order to give it to his offspring from a prior union an enhanced inheritance. For her part, Sharon secured the delivery of her inheritance at the expense of Dorothy's comfort and care by taking those actions necessary to end her life and

thus cause trust funds to be delivered forthwith to her.

67. Their conduct alleged herein constituted financial abuse under *Welfare and Institutions Code* section 15657.5 as defined in *Welfare and Institutions Code* section 15610.30.

68. These defendants are guilty of recklessness, oppression, fraud and malice in the commission of the abuse described above.

69. Under *Welfare and Institutions Code* section 15657.5(a), defendants are liable to plaintiff for reasonable attorney fees and costs.

70. Under *Civil Code* section 3294, defendants are liable for punitive damages.

<u>Fourth Cause of Action: Civil Conspiracy As Against Herbert Lee Thomas Wayne Thomas and Sharon Wimberley</u>

71. Plaintiff incorporates factual averments one through thirty-nine herein by reference.

72. The elements of an action for civil conspiracy are the formation and operation of the conspiracy and damage resulting to plaintiff from an act or acts done in furtherance of the common design. *Applied Equipment Corp. v. Litton Saudi Arabia Ltd.*, 7 Cal.4th 503,511 (1994).

73. Lee Thomas, Wayne Thomas, and Sharon Wimberley conspired together to facilitate the death of Dorothy Thomas. As part of the conspiracy, Lee Thomas made himself unavailable to receive phone calls from St. Agnes Hospital after Dorothy had been taken there on 4/14/2013 and April 29, 2013 for shortness of breath. Sharon Wimberley acting in concert with Wayne Thomas and Lee Thomas failed to follow Dorothy's AHCD and POLST and changed Dorothy's instructions to do not resuscitate and withholding of therapies despite the fact that Sharon is not authorized to do so. Then Wayne Thomas tried to conceal Lee's culpability and any evidence of Sharon's misdeed by telephoning the hospital and attempting to dispose of the evidence by ordering that no autopsy be performed on Dorothy's corpse.

74. The above-referenced acts are done in the furtherance of a common design and causes plaintiff damage in the form of the death of his mother, Dorothy Thomas.

75. Lee Thomas, Wayne Thomas, and Sharon Wimberley withheld and concealed the

Fairwinds advanced care health directive from Dan and St. Agnes.

Fifth Cause of Action: Negligence As against all Defendants Leisure Care LLC, St. Agnes Medical Center, and Dr. Nareddy

76. Plaintiff incorporates factual averments one through forty-three herein by reference.

77. The elements of negligence are the existence of a legal duty of care, breach of that duty, and proximate cause resulting in injury. *McIntyre v. Colonies-Pacific, LLC* 228 Cal.App.4th 664, 671 (2014).

78. These defendants, and each of them, owed Dorothy Thomas a duty of care to refrain doing such acts that would cause Dorothy harm. The health care defendants can and should later be added in an amended pleading as to this cause if action if the pre-claim notice period expires without any satisfactory resolution of the claims asserted in the pre-claim notice.

79. These defendants, and each of them, breached their duty of care by committing the above-referenced acts that amounted to a failure to provide appropriate level of care to Dorothy Thomas.

80. As a result of the defendants' breach, Dorothy Thomas suffered physical harm in form of physical injuries and her eventual death.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays judgment against defendant as follows:

1. For general damages according to proof;
2. For special damages and punitive damages according to proof;
3. For prejudgment interest as allowed by law;
4. For attorneys' fees;
5. For costs of suit;
6. For such other and further relief as the court may deem proper.

DATED: January 8, 2016

Shafeeq Sadiq
Attorneys for Plaintiff Alan Marcum