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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF ALAMEDA

RG14721095

WADE AND JENNIFER WESTHOFF,

Plaintiffs,

vs.

CHILDREN'S HOSPITAL AND RESEARCH CENTER OF OAKLAND; ZIAD SABA, M.D.; JAMES GREGG HELTON, M.D.; ERIC ZEE, M.D.; NATALIE Z. CVIJANOVICH, M.D., and DOES 1 THROUGH 100, inclusive,

Defendants.

COMPLAINT FOR:

1. **Professional Negligence and Wrongful Death;**
2. **Negligent Infliction of Emotional Distress;**
3. **Intentional Infliction of Emotional Distress;**
4. **Fraudulent Intentional Misrepresentation; and**
5. **Request for Injunctive Relief**

DEMAND FOR TRIAL BY JURY

COMES NOW, plaintiffs WADE AND JENNIFER WESTHOFF and allege the following:

FACTUAL ALLEGATIONS

1. WADE AND JENNIFER WESTHOFF ("WESTHOFFS") are residents of the State of California and at all times mentioned herein, were husband and wife.

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2. Defendant CHILDREN'S HOSPITAL AND RESEARCH CENTER OF OAKLAND (CHO) is a business entity operating in Oakland, California, and holds itself out on its website as delivering exceptional medical care to children with the best and most experienced specialists. CHO also claims that at all times it acts with "integrity and with the highest ethical standards."

3. ZIAD SABA, M.D. ("SABA"), is a physician duly licenced in the State of California and specializes in interventional cardiology.

4. JAMES GREGG HELTON, M.D. ("HELTON"), is a physician duly licensed in the State of California and holds himself out as a specialist in pediatric cardiology.

5. ERIC ZEE, M.D. ("ZEE"), is a duly licensed physician in the State of California and holds himself out to be a specialist in pulmonology.

6. Defendant NATALIE Z. CVIJANOVICH, M.D. ("CVIJANOVICH"), is a physician duly licensed in the State of California and holds herself out to be a specialist in pediatric medicine.

7. At all times mentioned herein, defendant Does 1 through 100, inclusive, were physicians, surgeons, nurses, healing arts practitioners, case workers and administrative personnel duly licensed in the State of California and were holding themselves out to the public in general, and to plaintiffs and plaintiffs' family, as qualified in those areas of medicine, nursing and the healing arts when they performed services on behalf of plaintiffs' daughter MORGAN SHAYNA WESTHOFF.

8. The true names and capacities, whether individual, corporate, associate or otherwise of defendants Does 1 through 100, inclusive, are not known to plaintiffs, who therefore sue these defendants by such fictitious names and will amend this complaint to show their true names and capacities when ascertained. Plaintiffs are informed and believe, and thereon alleges, that each of the fictitiously named defendants were negligent, reckless, careless or otherwise legally responsible in some manner for the occurrences alleged in this complaint, and that

plaintiffs' damages as alleged in this complaint were legally caused by such acts or omissions.

9. On April 9, 2011, JENNIFER WESTHOFF gave birth to identical twin girls after 31 weeks and 5 days of gestation. Hunter and MORGAN WESTHOFF were born with Patent Ductus Arteriosus (PDA), a condition in which the ductus arteriosus does not close after birth. The ductus arteriosus is a blood vessel that allows blood to bypass the baby's lungs before birth since the mother is providing the oxygenated blood for the child in utero. Soon after birth the lungs fill with air, and the ductus arteriosus is no longer needed. It usually closes within a couple of days after birth. PDA is a common condition in premature children and is more common in girls than in boys. PDA is an easily treatable problem and the overwhelming majority of children born with PDA go on to lead normal, healthy lives.

10. The WESTHOFFS were referred to pediatric cardiologist, HELTON. HELTON did not suggest medication to assist in the closing of the PDA but instead advised the WESTHOFFS that the girls' condition would be monitored, and when they were old enough, they would have a catheterization procedure to close the PDAs. Medication such as indomethacin is the first line of treatment for PDA. HELTON also failed to discuss with the WESTHOFFS the procedure which has proven over decades to be tried and true for the closure of a PDA where a cardiac vascular surgeon would go in though a small incision in the chest and simply ligate the PDA with a suture, or close it with a small clamp.

11. The WESTHOFFS were then referred by HELTON to cardiologist SABA. On November 6, 2012, SABA took Hunter Westhoff into a catheterization lab at CHO and inserted an Amplatzer Duct Occluder (ADO) device into Hunter's PDA. The procedure was successful and Hunter is a healthy and happy little girl today.

12. On January 11, 2013, MORGAN was seen by pulmonologist ZEE for a pre-procedure checkup. Unknown to the WESTHOFFS at that time, an echocardiogram was required to confirm that MORGAN did not have high

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pulmonary blood pressure which, according to the manufacturer of the ADO, would make her a poor candidate for closure of a PDA with the device. The manufacturer's product information contains the following in bold type: "**Do not proceed if patient shows evidence of high pulmonary pressure.**" An echocardiogram was also necessary in order to determine the appropriate size of the ADO device for MORGAN's PDA in the event she was an appropriate candidate for the procedure.

13. On January 15, 2013, defendant SABA took MORGAN WESTHOFF into the catheterization lab at CHO to place an ADO into her PDA via the femoral artery in her left thigh. Early during the procedure, SABA learned that MORGAN had dangerously high pulmonary aterial blood pressure or pulmonary hypertension. At that time, he appropriately stopped the procedure and consulted with defendant HELTON who was present about proceeding in light of the high pulmonary blood pressure which posed a significant risk of the procedure not being successful with potentially fatal consequences. HELTON spoke with the WESTHOFFS who were waiting at CHO and advised them of the complication and that the plan was to consult with ZEE, and then ZEE, SABA and HELTON would determine how to proceed. At no time were the WESTHOFFS advised of the high risk to almost certainty of a failure if SABA were to proceed with the ADO placement. Nor were the WESTHOFFS consulted about the wisdom of stopping the procedure and calling a cardiac pediatric surgeon to ligate the PDA at that time or to cancel the procedure and have MORGAN undergo a surgical ligation procedure at another time. Unfortunately, ZEE, SABA and HELTON decided that SABA would proceed with the attempted ADO placement despite the pulmonary hypertension.

14. After the catheterization procedure, SABA advised the WESTHOFFS that he was "uncomfortable" with the ADO placement but that it was "good enough."

15. While in the Post Anesthesia Care Unit (PACU), MORGAN, who had a partially paralyzed vocal cord which was injured during a prior intubation

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procedure, was given water to drink as authorized by the CHO PACU nurses. MORGAN began coughing, and a CHO nurse took MORGAN, turned her over on her stomach and began striking her back rather forcefully several times.

16. An x-ray was then taken in the recovery room of MORGAN's chest which revealed that the ADO device had moved or embolized into MORGAN's aorta. SABA advised the WESTHOFFS that he was going to take MORGAN back into the catheterization lab and would "retrieve the ADO device" and replace it with a more suitable device, a vascular plug, which he said he should have utilized in the first place in light of MORGAN's pulmonary hypertension. SABA drew a picture of the vascular plug and MORGAN's anatomy on paper that was at MORGAN's bedside.

17. SABA then took MORGAN back to the catheterization lab without consulting with a cardiac pediatric surgeon or assuring that one was available to intervene on short notice. SABA and HELTON failed to advise the WESTHOFFS that the procedure SABA was about to undertake was fraught with risk and was unlikely to be successful since the ADO device had been deployed and was now larger than it was when inserted, and was not designed with any features that would make it graspable in an extraction attempt.

18. At approximately 5:00 p.m. on January 15, 2013, SABA began his procedure to retrieve the ADO through a series of makeshift wire snares he inserted through an incision in MORGAN's left leg femoral artery. At 7:00 p.m., HELTON advised the WESTHOFFS that the procedure had proven to be extremely difficult, and they had not yet succeeded in retrieving the ADO.

19. At 8:00 p.m., HELTON advised the WESTHOFFS that they were still not having any progress in snaring the ADO device from MORGAN's aorta.

20. At 9:15 p.m., WADE WESTHOFF was in the hallway when he confronted a Code Blue team urgently rushing to the catheterization lab and overhead them state that a 21-month-old female with an embolized PDA had coded. WADE

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WESTHOFF witnessed the Code Blue team rush into the catheterization lab and saw multiple people in surgical scrubs covered in blood working on a patient, which he knew to be his daughter MORGAN WESTHOFF.

21. At 9:45 p.m., HELTON advised the WESTHOFFS that MORGAN had suffered a cardiac arrest for two to three minutes, but he believed they "got her back up" quickly.

22. At 10:15 p.m., the WESTHOFFS met with HELTON and a CHO case worker. They also met for the first time with a pediatric cardiac surgeon who advised that he had been at Stanford Medical Center all day and had just arrived. The surgeon advised that in light of everything MORGAN had been through that day, it was no longer advisable for him to try surgical intervention to remove the ADO.

23. On January 16, the WESTHOFFS were advised that MORGAN was not doing well. At 5:00 p.m., the WESTHOFFS had MORGAN baptized. At 6:00 p.m., they were advised that brain function studies were consistent with brain death.

24. On January 17, 2013, the WESTHOFFS were advised that MORGAN's condition was not improving and that follow up brain function studies were consistent with brain death. Defendant CVIJANOVICH advised the WESTHOFFS that CHO would officially pronounce MORGAN dead just after midnight on Friday, January 18.

25. At about 11p.m. on January 17th, CVIJANOVICH, on behalf of CHO, met with the WESTHOFFS and insisted that they agree to donate MORGAN's organs. Still reeling from the course of events of the last three days, with no sleep, and not having any representative of CHO explain to them what happened and why their daughter was brain dead, the WESTHOFFS declined CHO's multiple aggressive requests for organ donation.

26. Just after 12 a.m. on January 18, 2013, CVIJANOVICH pronounced MORGAN dead. A few minutes later, CVIJANOVICH contacted the Alameda

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County Coroner about the death. She advised the WESTHOFFS that based on the information she provided, the Coroner decided to take her case and investigate her death and would perform an autopsy. CVIJANOVICH then advised the WESTHOFFS that this would alter their final moments of MORGAN's life.

27. CVIJANOVICH told the WESTHOFFS how CHO would disconnect MORGAN from life support and put her in the reflection room of the hospital which is like a small apartment room with a bed. CVIJANOVICH advised the WESTHOFFS that, due to the fact that the Alameda County Coroner was going to perform an autopsy, that the hospital could not remove any of the lines or tubes from MORGAN and that the WESTHOFFS could not hold or touch MORGAN as she stopped breathing, but they could lie in the bed with her. MORGAN was then brought into the reflection room by a nurse who was assisting with her breathing. After MORGAN was laid in the bed with her parents, the nurse ceased assisting MORGAN's breathing, and she expired. The WESTHOFFS were then told they could leave the hospital at that time or lie in the bed with their dead daughter until the coroner's office arrived to take the body. The WESTHOFFS elected to lie with their daughter's body, which they did for several hours until approximately 4:00 a.m.

28. At 4:00 a.m., two CHO nurses entered the reflection room and advised the WESTHOFFS that the coroner's personnel were there to take the body and that they needed to take MORGAN and prepare her for the Coroner. One nurse wrapped MORGAN in blankets and took her away.

29. Several hours later, CVIJANOVICH contacted the WESTHOFFS to advise them that "the coroner had released MORGAN's body and that she was back at CHO." CVIJANOVICH told the WESTHOFFS that since CHO was a teaching hospital, they wanted to do their own post-mortem of MORGAN's chest area only to understand what happened to MORGAN. Believing the County Coroner conducted a complete autopsy, the WESTHOFFS agreed and signed the appropriate form that was faxed to them by CVIJANOVICH and faxed it back.

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30. The WESTHOFFS had a funeral and burial ceremony for MORGAN on January 25, 2013. The WESTHOFFS then requested a meeting with the staff of CHO which occurred on January 29, 2013, to begin to try and understand what happened to their daughter, MORGAN. During this interview, the WESTHOFFS inquired about the findings of CHO with their own post-mortem and of the Alameda County Coroner's Office during the autopsy and inquired as to who had the ADO device. At that time, the WESTHOFFS were advised by the CHO staff and doctors that the Alameda County Coroner's Office never conducted an autopsy on MORGAN and, in fact, had never even taken her body. They also advised the WESTHOFFS that they did not have the ADO device. The WESTHOFFS suddenly realized that they had buried their daughter without her having had a complete *and independent* autopsy and that the ADO device was buried with her. The WESTHOFFS also failed to get any explanation as to what happened to their daughter or how her death could have been avoided.

31. WADE WESTHOFF then called the Alameda County Coroner's Office and spoke with Karen about whether or not the Coroner's Office performed an autopsy on his daughter MORGAN. Karen reviewed the records and advised Mr. WESTHOFF that a doctor at CHO had represented to the Coroner's Office that MORGAN had died from known complications of a heart catheterization procedure to try and correct a birth defect. Karen advised Mr. WESTHOFF that under those circumstances, the Coroner's Office typically does not conduct an autopsy and no autopsy was performed on his daughter MORGAN and that the Coroner's office had never taken MORGAN from CHO.

32. On January 18, 2013, the day that MORGAN was pronounced dead by CHO and their doctors, CHO sent the WESTHOFFS a patient survey inquiring as to "how they could improve MORGAN's care" and asking for a charitable contribution to the hospital. Thereafter on September 12, 2013, the WESTHOFFS tried explaining to the CHO administration and the Chief of Pediatrics, David Durand,

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M.D., that they needed to do a better job of explaining to families what happened when medical mistakes occur and made several proposals as to how they could do a better job of educating its staff about dealing with grieving parents and patients. The WESTHOFFS also requested that the hospital stop sending them fundraising solicitations and surveys. The hospital initially agreed with the WESTHOFFS, but in January of 2014, it declined all of the WESTHOFFS' suggestions to improve communications and transparency but agreed to stop sending solicitations for fundraising. The solicitations continued, even after the WESTHOFFS put the hospital on formal statutory notice on January 13, 2014, that they intended to bring this action.

33. On January 13, 2014, plaintiffs served all defendants named in this lawsuit with notices pursuant to California Code of Civil Procedure § 364 that this action would be filed.

FIRST CAUSE OF ACTION

FOR PROFESSIONAL NEGLIGENCE AND WRONGFUL DEATH

(Against CHO, ZEE, HELTON, SABA and DOES 1 through 50)

34. Plaintiffs incorporate herein by reference paragraphs 1 through 31 and 33 above as though fully set forth herein.

35. ZEE, HELTON, SABA and CHO's employees and agents conducted themselves below the appropriate standard of care in their care and treatment of MORGAN which was a substantial factor in bringing about the cascade of errors leading to her death.

36. CHO, through its employees, agents, administration and governing body fell below the applicable standard of care by: (1) not having appropriate protocols and guidelines in place which required a patient to have an echocardiogram performed before closure of a PDA was attempted with an ADO in order to assure that the patient was a candidate for such a procedure and did

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not have high pulmonary blood pressure; (2) failing to have policies, practices and procedures in place to have a cardiac vascular surgeon available to consult with interventional cardiologists when a patient was found to have pulmonary hypertension or to be available on short notice to take a child to the operating room to convert a catheterization procedure into a ligation procedure; (3) allowing the attempted retrieval of an ADO device that had been improperly deployed or embolized after deployment, putting the patient at risk of severe injury or death; (4) failing to see to it that PACU nurses did not allow a child with difficulty swallowing due to partially paralyzed vocal cords to have liquids during recovery, increasing the likelihood the child would aspirate, putting the ADO placement at risk; and (5) having a policy whereby nurses in the PACU would take a child like MORGAN and strike her back, increasing the likelihood of ADO embolization or dislodgment.

37. CHO, through its employees, agents, administrators and risk managers, negligently failed to intervene in the recklessness being committed by the doctors that were granted privileges at the hospital, participated in covering up the medical errors that occurred involving MORGAN's care and treatment in order to confuse or obfuscate the truth and confuse the WESTHOFFS for their own personal gain to the detriment of MORGAN and her parents.

38. ZEE saw MORGAN on January 11, 2013, specifically for the purpose of evaluating her health and condition to proceed with closure of her PDA on Tuesday, January 15, with a catheterization procedure to deploy and ADO device. ZEE knew, or in the exercise of reasonable care should have known, that it was critically important to determine if MORGAN had pulmonary hypertension which would have made the attempted ADO placement contra-indicated. ZEE negligently advised the WESTHOFFS and SABA that MORGAN was healthy and a candidate to proceed with the catheterization procedure. Had ZEE properly screened MORGAN during that pre-procedure physical examination, he would have discovered that MORGAN had pulmonary hypertension and should have so

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advised the significance of that to the WESTHOFFS and MORGAN's other doctors.

39. On January 15, 2013, ZEE was contacted by HELTON and advised that Dr. SABA had learned for the first time during the catheterization procedure that MORGAN had high pulmonary blood pressure. According to HELTON, ZEE participated in the fateful decision that SABA should continue attempting to deploy the ADO device into MORGAN's PDA, despite the known risks of proceeding in that manner and high likelihood that MORGAN would suffer serious or fatal consequences of that decision.

40. Defendant HELTON fell below the applicable standard of care by not explaining to the WESTHOFFS the alternatives of closure of a PDA through a catheterization procedure to plug the PDA versus medication or ligation; recommended the catheterization procedure without confirming that MORGAN did not have pulmonary hypertension; failed to supervise the pre-procedure care of MORGAN to determine that *somebody* obtain an echocardiogram to confirm that MORGAN's pulmonary blood pressure was normal; participated in the reckless decision to proceed with placement of the ADO even after learning that MORGAN had very high pulmonary blood pressure; failing to consult with a cardiac surgeon after learning that MORGAN had dangerously high pulmonary blood pressure; failing to intervene in SABA's reckless conduct of proceeding with ADO placement; failing to intervene as SABA spent hours trying to extricate the ADO device while it became obvious that extraction was not going to be successful as MORGAN bled and Dr. SABA broke snare after snare with his futile attempts to retrieve the device until MORGAN finally went into cardiac arrest and suffered irreversible brain damage.

41. Defendant SABA fell below the applicable standard of care in not explaining to the WESTHOFFS the alternatives to the catheterization procedure he wanted to do instead of referring the WESTHOFFS to a qualified cardiac or vascular surgeon to ligate the PDA; recklessly and negligently proceeded with the

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catheterization procedure without first confirming that MORGAN had normal pulmonary blood pressure; proceeding with the catheterization procedure even after learning that MORGAN had high pulmonary blood pressure at the beginning of the catheterization procedure versus stopping the procedure and having a cardiac surgeon ligate the PDA at that time or rescheduling MORGAN for the appropriate procedure on another day; negligently deciding that he could retrieve a deployed ADO device knowing that it was not designed with any features intended to re-grasp the device once deployed; failing to consult with a cardiac surgeon before attempting the retrieval; failing to consult with a cardiac surgeon early on when the initial retrieval attempts were proving unsuccessful and guide wires or snares were breaking during his futile attempts to retrieve the device; failing to take charge of monitoring MORGAN during the retrieval of the device to make sure that she did not sustain an adverse event such as cardiac arrest and irreversible brain damage.

42. The defendants, and each of them, participated in a coverup of each other's negligent conduct and knowingly allowed MORGAN to be buried without a full and complete autopsy having been conducted and to be buried with the ADO device, thereby depriving the WESTHOFFS of the evidence that would help them determine what happened to their daughter and prosecute this action. As such, plaintiffs are entitled to appropriate remedies in the interest of justice, as the trial judge will see fit.

43. As a direct result of the negligence of the defendants, and each of them, plaintiffs lost their daughter MORGAN and have lost the care, comfort, moral support, solace and companionship that she would have provided for the rest of their lives.

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SECOND CAUSE OF ACTION

FOR NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

(Against CHO, CVIJANOVICH, and DOES 40 through 100)

44. Plaintiffs incorporate herein by reference paragraphs 1 through 43 above as though fully set forth herein.

45. Defendants CHO and CVIJANOVICH assumed a special relationship with plaintiffs as their child was laying lifeless in CHO's intensive care unit and plaintiffs were being advised that their child was "brain dead" and that they must make end-of-life decisions for their precious child, MORGAN.

46. Plaintiffs, who initially were told that the catheterization procedures to be performed on both of their daughters was a relatively simple procedure which representations were confirmed after Hunter's successful procedure on November 6, 2012, witnessed three days of hectic and calamitous medical care being provided to their daughter, MORGAN, including WADE WESTHOFF's contemporaneous witnessing of the Code Blue and seeing massive amounts of blood which came from his daughter, MORGAN. The WESTHOFFS had been told by SABA that he was "uncomfortable" with the ADO placement, but that it was "good enough." The WESTHOFFS also learned from the cardiac surgeon on the evening of January 15 that he had been performing surgical procedures all day at Stanford Medical Center and was not readily available to assist with the care of their daughter on January 15, as SABA had repeatedly represented to the WESTHOFFS. Furthermore, the WESTHOFFS' multiple requests for an explanation as to what had happened to their daughter were never answered. Therefore, when CVIJANOVICH, on behalf of CHO, told the WESTHOFFS that the Alameda County Coroner's Office was going to conduct a full and complete autopsy, the WESTHOFFS were relieved that an independent government agency would be conducting an autopsy and hopefully give them the answers they could not obtain from the CHO administration, risk management or doctors.

47. Defendant CHO and CVIJANOVICH knew that plaintiffs wanted to know why their daughter was brain dead, what had happened to her and once they were advised that the Coroner's Office would be conducting an autopsy, that the WESTHOFFS were relying upon that independent autopsy to be conducted.

48. When the WESTHOFFS were advised by CHO and CVIJANOVICH that their daughter had to be taken off of life support, the initially believed they would have had the opportunity to say goodbye to the child by holding her as life support was taken away, as she expired. CVIJANOVICH and CHO took away that opportunity by telling the WESTHOFFS that MORGAN was "evidence" which they could not touch as she expired. The WESTHOFFS were caused extreme emotional distress and agony by not being able to cradle their daughter as the CHO personnel removed her from life support and she expired.

49. After MORGAN expired on January 18, the WESTHOFFS were told that it would be several hours until the Coroner would pick up MORGAN's body and offered the opportunity to remain laying in bed with MORGAN until that time. The WESTHOFFS believed the representations of the defendants and elected to lay with their dead child for several hours so as not to abandon her before she was taken by the Coroner. At approximately 4:00 a.m., the CHO nurses advised plaintiffs that the Coroner representatives had arrived to take their child. The conduct of the defendants in telling the WESTHOFFS that the Coroner's Office would eventually take MORGAN resulted in hours of cruel and unjust agony as they lay with their daughter's body waiting for the Coroner to arrive.

50. After the plaintiffs buried their child, they sought a meeting with CHO representatives and doctors in order to find out what the County Coroner had concluded after their autopsy and to retrieve the ADO device. When plaintiffs were advised by CHO administration and doctors that the Coroner's Office had not only never conducted an autopsy, but never took MORGAN's body, the WESTHOFFS felt betrayed, violated and lost after realizing that they had buried their

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child without an independent autopsy having been conducted and without the ADO device being removed from her body.

51. As a direct result of the defendants conduct, plaintiffs have suffered severe emotional distress which caused them to seek counseling from their Catholic church and from professional mental health workers in order to try and help deal with the emotional damages caused by these defendants ever since January of 2013.

THIRD CAUSE OF ACTION

FOR INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS

(As Against Defendants CHO, CVIJANOVICH and DOES 40 through 100)

52. Plaintiffs incorporate herein by reference paragraphs 1 through 51 above as though fully set forth herein.

53. Defendants CHO and CVIJANOVICH knew that by lying to the plaintiffs about the Alameda County Coroner conducting an autopsy, that they were likely to cause plaintiffs emotional distress if they ever learned that the Coroner never did do an autopsy. The conduct of defendants CHO and CVIJANOVICH in lying to the plaintiffs about the County Coroner conducting an autopsy of their daughter, MORGAN, was unprofessional and reckless, and they knew that they were likely to inflict severe emotional distress on the parents.

54. Plaintiffs suffered severe emotional distress as a result of the defendants' intentional misrepresentations.

FOURTH CAUSE OF ACTION

FOR FRAUDULENT INTENTIONAL MISREPRESENTATION

(As Against Defendants CHO, CVIJANOVICH and DOES 40 through 100)

55. Plaintiffs incorporate herein by reference paragraphs 1 through 54 above as though fully set forth herein.

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56. Defendants CHO and CVIJANOVICH represented to the plaintiffs that the Alameda County Coroner was going to take MORGAN's body and perform a complete autopsy. At the time the defendants made those representations, they knew they were false, and then intended the plaintiffs to rely upon their representations. Plaintiffs reasonably relied upon the representations of CHO and CVIJANOVICH that the Alameda County Coroner's Office was going to conduct an autopsy and, therefore, had a funeral and burial service for their daughter without seeking an independent autopsy.

57. When plaintiffs learned after the burial of their daughter that the Alameda County Coroner's Office never conducted an autopsy and never even took the body of their daughter as represented by defendants CHO and CVIJANOVICH, they suffered severe emotional distress and have been receiving extensive therapy from their Catholic church and professional mental health care workers ever since.

58. The conduct of the defendants CHO and CVIJANOVICH were intended to mislead the plaintiffs into believing an independent autopsy was going to be conducted, to induce the plaintiffs to rely upon the Coroner's autopsy in lieu of obtaining their own independent autopsy, and to impair the plaintiffs' ability to discover the full depth of the medical errors that had been committed upon their daughter while at CHO.

FIFTH CAUSE OF ACTION

REQUEST FOR INJUNCTIVE RELIEF

(Against CHO)

59. Plaintiffs incorporate herein by reference paragraphs 1 through 58 above as though fully set forth herein.

60. On September 20, 2013, WADE WESTHOFF met with CHO administrators, including David Durand, M.D., Chief of Pediatrics at CHO. Mr. WESTHOFF made a

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presentation to the CHO administration based upon the extensive research he had done concerning certain hospitals that have a program of transparency and honesty with their patients when there are medical mistakes. Mr. WESTHOFF pleaded with the hospital administration to make certain changes to their practices and policies to become more transparent, open and honest with patients and their families when mistakes happen. Mr. WESTHOFF also pleaded with the hospital administration to stop sending solicitations for monetary contributions to CHO and patient surveys. He explained to Dr. Durand and the hospital administrators that every time they open the mailbox and receive one of these solicitations from CHO, they relive the horrors that they experienced at CHO in January of 2013. Several weeks later, Dr. Durand told the WESTHOFFS that the hospital would refuse to adopt any of the transparency practices Mr. WESTHOFF was suggesting but promised that CHO would stop sending patient survey questionnaires or solicitations for fundraising.

61. Despite the promises of Dr. Durand on behalf of CHO, the mail and solicitations have continued, including a solicitation for a major fundraising event on March 9, 2014, which arrived at the WESTHOFFS' home approximately February 25, 2014, after counsel for the WESTHOFFS provided notice to CHO on January 13, 2014, pursuant to California Code of Civil Procedure § 364 that the WESTHOFFS intended to sue CHO and many of the doctors who cared for MORGAN.

62. Sorry Works began as an advocacy organization in February of 2005 and currently acts as a consultant to the health care industry, including hospitals, to help develop policies and practices of disclosure of medical errors and actually apologized to the patients or their family after medical errors which hurt or kill. After a recent news story focusing on the solicitations CHO continues to send to the WESTHOFFS, Sorry Works commented that what CHO is doing was unacceptable and "with one click of a button" they should be able to stop all mailings to a grieving family.

63. Plaintiffs request this Court to issue an Order enjoining CHO from sending any fundraising solicitations or patient surveys to the WESTHOFF household and that they be permanently deleted from all such mailing lists.

64. The representation to family members that the County Coroner is going to conduct an autopsy when they know that such an autopsy is not going to be performed is never justified and is a breach of the hospital's duty to abide by basic ethical and moral standards. Plaintiffs also request this Court to issue an Order enjoining CHO from making such untrue representations to any of the families who find themselves in a position of having lost a loved one at CHO.

WHEREFORE, plaintiffs pray as follows:

As to the FIRST CAUSE OF ACTION for Professional Negligence and Wrongful Death, plaintiffs seek:

1. General damages in excess of the jurisdictional limit of this Court;
2. Special damages according to proof;
3. All costs of suit incurred herein;
4. Pre-judgment interest as allowed by law; and
5. Such other and further relief as the Court may deem just and proper in light of the defendants' conduct.

As to the SECOND CAUSE OF ACTION for Negligent Infliction of Emotional Distress, plaintiffs seek:

1. General damages in excess of the jurisdictional limit of this Court;
2. All special damages according to proof;
3. Damages plaintiffs will seek by way of a motion to amend their complaint pursuant to California Code of Civil Procedure § 425.13;
4. All costs of suit incurred herein;
5. Pre-judgment interest; and

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6. Such other and further relief as the Court may deem just and proper.

As to the THIRD CAUSE OF ACTION for Intentional Infliction of Emotional Distress, plaintiffs seek:

1. General damages in excess of the jurisdictional limit of this Court;

2. All special damages according to proof;

3. Damages plaintiffs will seek by way of a motion to amend their complaint pursuant to California Code of Civil Procedure § 425.13;

4. All costs of suit incurred herein;

5. Pre-judgment interest; and

6. Such other and further relief as the Court may deem just and proper.

As to the FOURTH CAUSE OF ACTION for Fraudulent Intentional Misrepresentation, plaintiffs seek:

1. General damages in excess of the jurisdictional limit of this Court;

2. All special damages according to proof;

3. Damages plaintiffs will seek by way of a motion to amend their complaint pursuant to California Code of Civil Procedure § 425.13;

4. All costs of suit incurred herein;

5. Pre-judgment interest; and

6. Such other and further relief as the Court may deem just and proper.

As to the FIFTH CAUSE OF ACTION, Request for Injunctive Relief, plaintiffs seek:

1. An injunction prohibiting defendant CHO from sending to plaintiffs any solicitations for fundraising or any patient surveys; and

2. An Order enjoining defendant CHO from misrepresenting to any surviving family of a CHO patient who dies in their hospital that the Alameda

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County Coroner's Office will conduct an autopsy when they know that such an autopsy is not going to be performed.

DATED: April 9, 2014

AGNEWBRUSAVICH
A Professional Corporation

By: _____
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